A Critical Review of Health and Education in the "Least Developed Countries" (LDCs)

Atif Jahanger[1]

[1] Zhongnan University of Economics and Law

Received: 10 December 2018 Accepted: 31 December 2018 Published: 15 January 2019

Abstract

Abstract- In the framework of educational globalization and the growing power of international organizations in health and educational governance sector in the least developed countries (LDCs) have faced the latest stage of stress about whether their learning strategies should go behind the global educational models or seek out solutions of their diverse problems by encouraging restricted native literacy practices.

Index terms— child health, child nutrition, education, human capital.

1 Introduction

any kids in less developed countries are suffering from low quality nutrition and health. The United Nations estimates that one-third of pre-school age kids in the less developed country a total of 180 million kids under the age of 5 are experiencing slow-moving development compared to global standards **??**United Nations, 2000). Many investigators have tried to estimate the effect of child health on schooling results; however, there are redoubtable boundaries to acquiring realistic estimates. Data are frequently scarce, but more importantly there are numerous viable assets of bias when attempting to estimate relationships between kid health and training.

Studies in Indonesia and India by Soemantri, **??**ollitt, and Kim (1989), Soewondo Seshadri and Gopaldas (1989), and Pollitt, E., Hathirat, P., Kotchabhakadi, N., Missel, L., Valyasevi, A. (1989). Investigate big and statistically significant forces on cognitive development and school presentation of iron supplementation amongst weak children, but Pollitt et al. (1989) have investigated that there is no such impact in Thailand. Nokes, Bosch, and Bundy (1998) also an assessment of the iron supplementation literature. Bobonis, Miguel , and Sharma (2006) has conduct health program in India in a poor urban area of Delhi and provided deworming and supplementation medicine to 200 preschool kids at the Age of 2 to 6 years.30 percent sample kids were found to have worm diseases according to the international standard,69 percent of kids had restrained to face anemia. After five months of continuous treatment of schools children has weight gains and one-fifty a reduction in absenteeism. Miguel and Kremer (2004) has the same study in Kenyan primary schools and found the Same results. Three recent randomized evaluation studies by economists on the impact of health intercessions on education outputs. These studies have carried out by real-world non-government organizations (NGOs) and their findings may be of beneficial interest to policymakers in the least developed countries. All three paper about school-based health interventions which some economists have investigated may be the most cost-effective looms for delivering nutrition and health services in the least developed countries (Bundy and Guyatt, 1996).

While remarkable socioeconomic progress occurred around the world in the past decades, the majority of the least developed countries (LDCs), which make up the most vulnerable and poor families of the countries, were not able to share the global progress. In the first meeting of the United Nations seminar on Development and trade detained in 1964, hand over from the (OECD) countries promoter for generating a new group in the middle of developing countries to magnetize particular hold up events to help the LDCs countries in reducing poverty, and work out education and health interrelated troubles. Many researcher and policymaker adviser shown that the education started after 1990s when significant international evaluation such as the Trends in International Mathematics and Science Study (TIMSS), the International Adult Literacy Survey (IALS) and the

Programmed for International Student Assessment (PISA), the Programmed for the International Assessment of Adult Competencies (PIAAC), instigates within the OECD backgrounds ongoing to be a international observable fact determining the educational schemes of Least Developed countries during a homogeneous testing management **??** Source: UNDP data 2018, processed by the author Table 1 shows that the average HDI Index LDCs is 0.524, life expectancy birth 64.8 years, expected years schooling 9.8 years, and mean years schooling 4.7 years. It means that LDCs are lagging compared to developing countries and OECD, where the indicator value is higher than LDCs. In a developing country, the average HDI index is 0.681, average life expectancy birth is 70.7 years and average expected years schooling is 12.2 years. While in OECD all indicators value is more than LDCs and Developing Country, HDI Index is 0.895;average life expectancy birth is 80.6 years, an average expected years schooling is 16.2 years, and average mean years schooling 8.4. The average infant mortality rate in LDCs was at 108.55 per 1,000 live births in 1990, and every year decrease, but still high at 46.96 per 1,000 live births in 2017. And the average under-five mortality rate was at 175.30 per 1,000 live births in 1990, and every year decrease, but still high at 66.33 per 1,000 live birth since 2017. We can be seen in the Figure **??**umber 5. Figure **??** shows that the average female mortality rate for an adult was at 192.72 per 1,000 live births in 2017, and every year decrease but still high (In 1960 at 458.39 per 1,000 live births). Mortality Rate Adult Male was at 243.93 per 1,000 live births in 2017, and every year decrease but still high (In 1960 at 413.54 per 1,000 live births).

2 Source: World Bank Data 2018, processed by the author

The average maternal mortality ratio in LDCs was estimated at 436 per 100,000 births in 2015. From figure **??**, we can see that the maternal mortality ratio is decreasing over time, but still higher.

3 Source: World Bank Data 2018, processed by the author

Figure 14 shows that in 2016, 81,45 % of the population (of the corresponding primary official school age) in LDCs are enrolled in primary school. Its means, close to 20% are not enrolled in primary school. At the secondary school level, just 37.38% are enrolled and more than 60% of the population (corresponding secondary official school age) are not enrolled. This is a very high concern. Similarly, in tertiary schools, just 9.76% are enrolled. Figure 15 shows that in 2016, the adult literacy rate in LDCs is 62.95%. it means close 40% of people ages 15 and above cannot both read and write with understanding a short simple statement about their everyday life. Also in figure 15, the youth literacy rate in LDCs is 76.70%. It means 23,3% of people ages 15-24 cannot both read and write with understanding a short simple statement about their everyday lives.

4 Source: World Bank Data 2018, processed by the author

Figure **??**6 shows that in 2016, the pupil-teacher ratio in primary education in LDCs was 37.84 students per teacher, and in secondary education, the ratio stood at 25.23 pupils per teacher in LDCs. A critical review of Health and Education in the "Least Developed Countries" (LDCs)

5 II. Conclusion and Recommendation

Forty-seven countries in the list of LDCs have serious problem in economic, health and education situations, which need to be a common concern. 13.28 % of the population in the word or one billion people live in LDCs, which high dependency ratio (78.05 per 100 people), low GNI per capita (2.722) US. Dollars), low HDI index (0.524), and low life expectancy birth (64.8 years). Also, low expected years of schooling (9.8) , its mean your schooling (4.7 years). Under 5 mortality ratio, infant mortality ratio, maternal mortality ratio, male adult mortality rate, and female adult mortality rate in LDCs is high, respectively 66.33 per 1,000 live births (2017), 46.96 per 1,000 live births (2017), 436 per 100,000 Adult and youth literacy ratio in LDCs shows that in 2016, close 40% of people ages 15 and above cannot both read and write and 23.3% of people ages 15-24 cannot both read and write with understanding a short, simple statement about their everyday life. The pupil-teacher ratio in primary education in LDCs was 37.84 students per teacher, and in secondary education, the ratio stood at 25.23 pupils per teacher. In 2016, 70.97% children of primary school age in LDCs can get completion until the last grade primary education and close to 30% cannot complete and in 2017, 26,44 million children of primary school age in LDCs are not enrolled in primary education or 18,07 % children are out of primary school.

The governments of Last Developed Countries must go away from (Non-Profit Organization) NGO style and free of charge clinic health care service condition and evolution people to market-rate health insurance strategies. Cohn & Rossmiller (1987) have investigated in developed and less developed countries (LDCs) and presents a few guidelines and implications for educational policy in LDCs. The research presents no source for closing that LDCs should decrease their plane of expenses for education or be indifferent about educational services. This research does recommend that notice must gradually more be directed to how capital is used in the educational process. In order to give confidence for policy-makers and development support organizations to spend money in inventive ways to build up social resources, it is essential to construct a proof base for the result of social capital on health in developing countries, principally for multifaceted health matters such as HIV and AIDS (Thomas-Slayter & Fisher, 2011). Future research on social capital and health in the developing world should focus on applying hypothetical conceptualizations of social capital that can be contrasted across backgrounds

in the developing world, acclimatizing and validating tools for measuring social capital, and designing sampling strategies to collect multilevel data on social capital in developing countries.

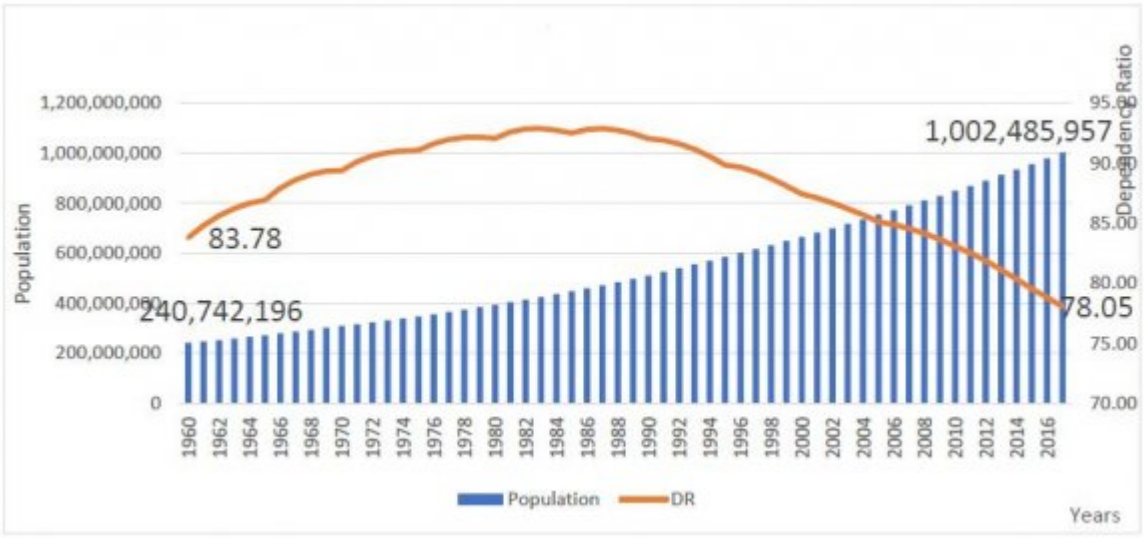
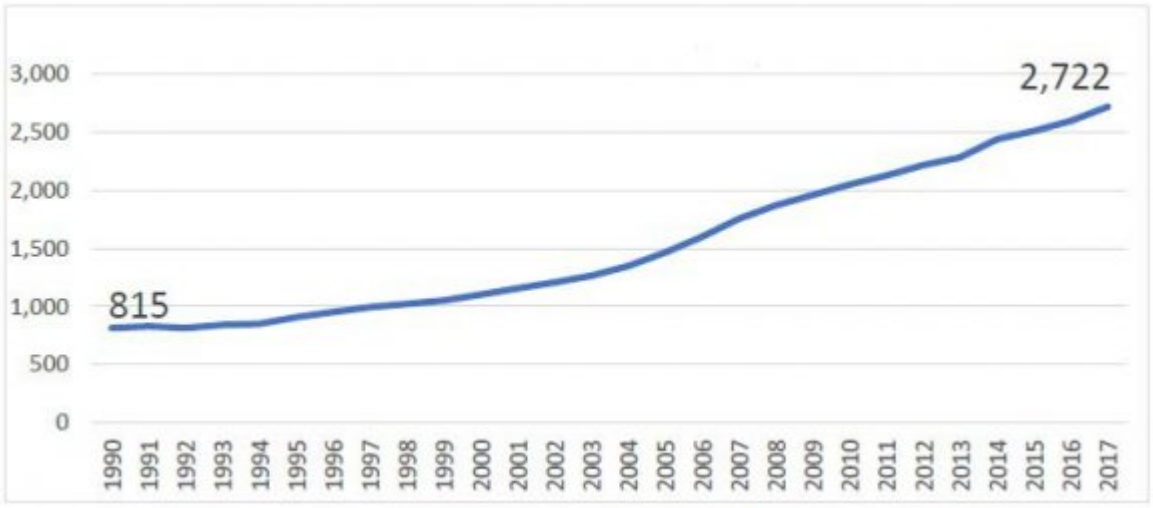


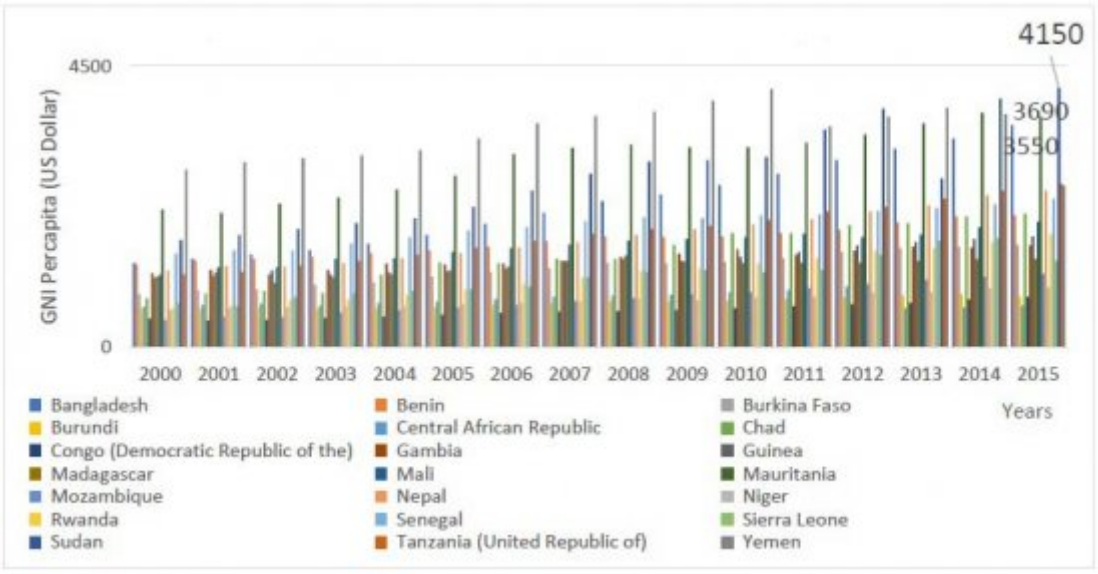
Figure 1: M



122

Figure 2: Figure 1 :Figure 2 :Figure 2

103



4

Figure 3: Figure 4

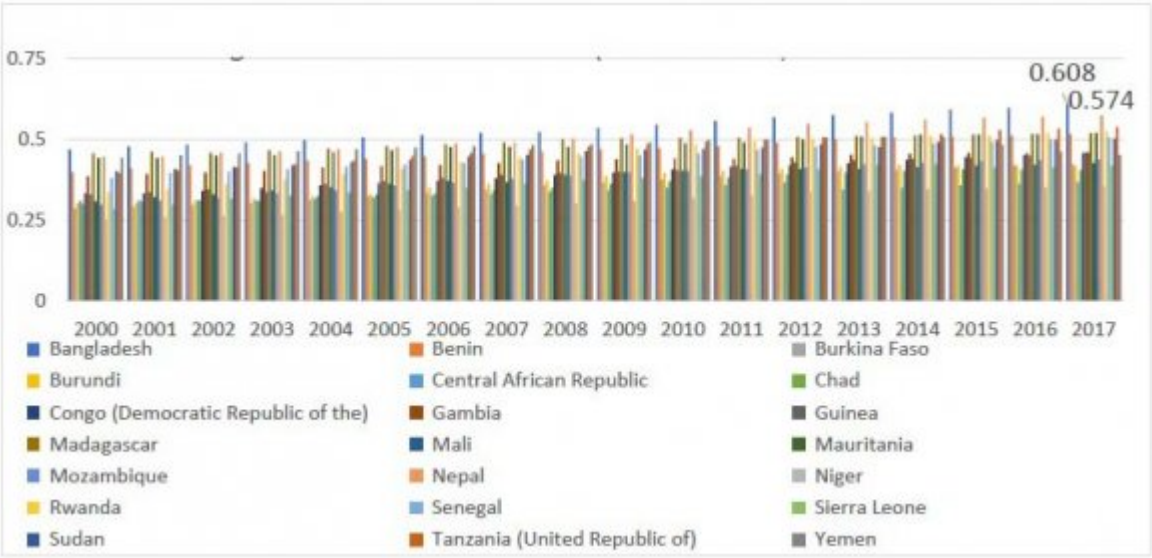
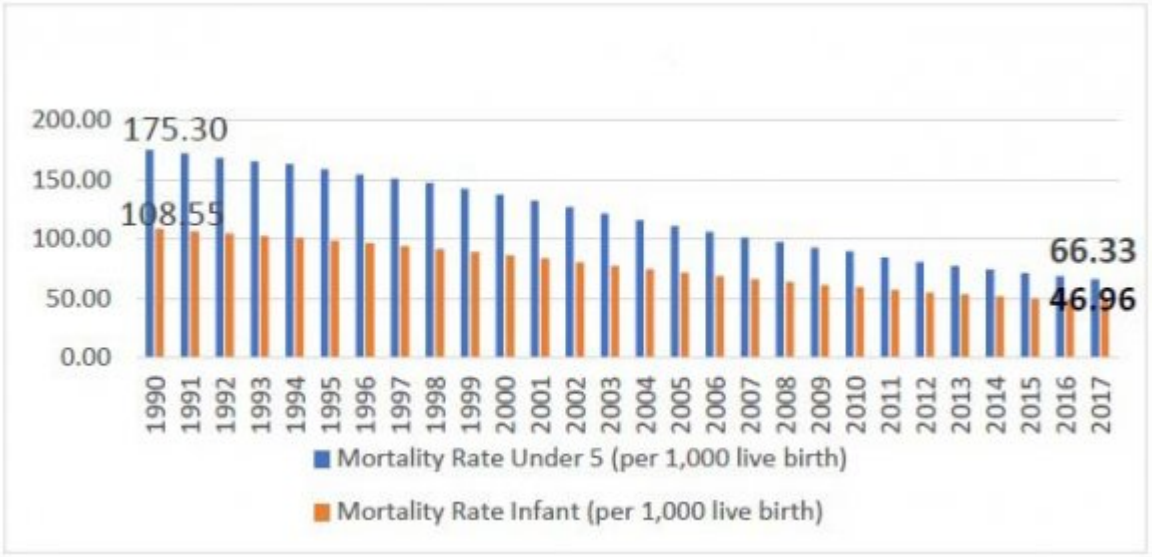


Figure 4: A



45

Figure 5: Figure 4 :Figure 5 :

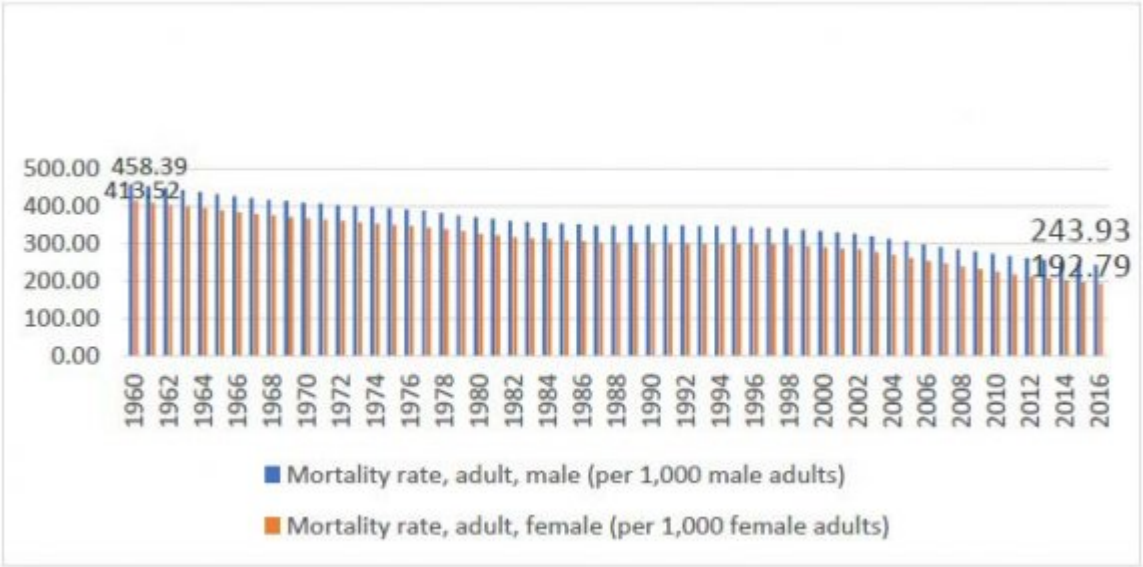


Figure 6: A

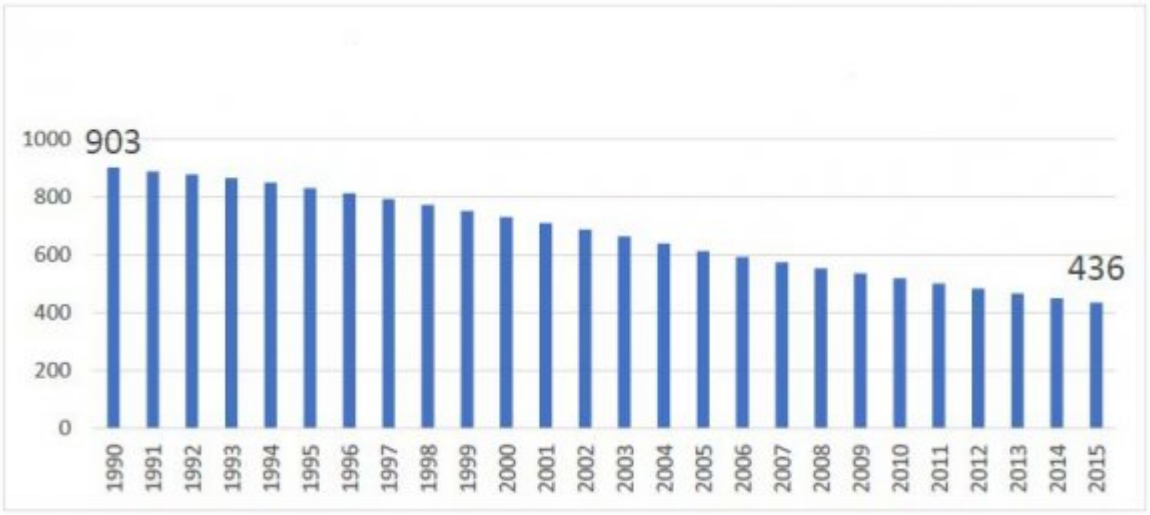


Figure 7: Figure 6 :Figure 7 :Figure 8 :

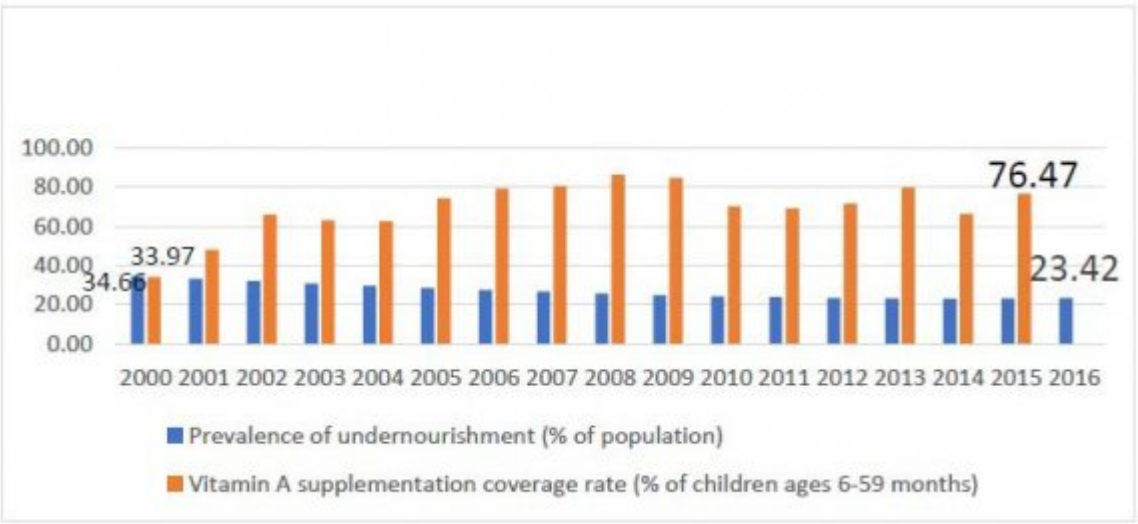


Figure 8: Figure 10 :Figure 9 :

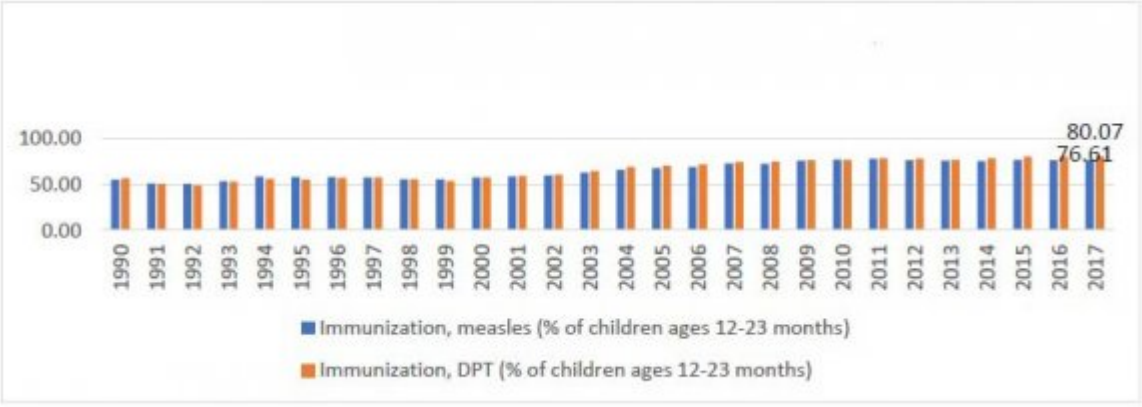


Figure 9: Figure 11 :Figure 12 :

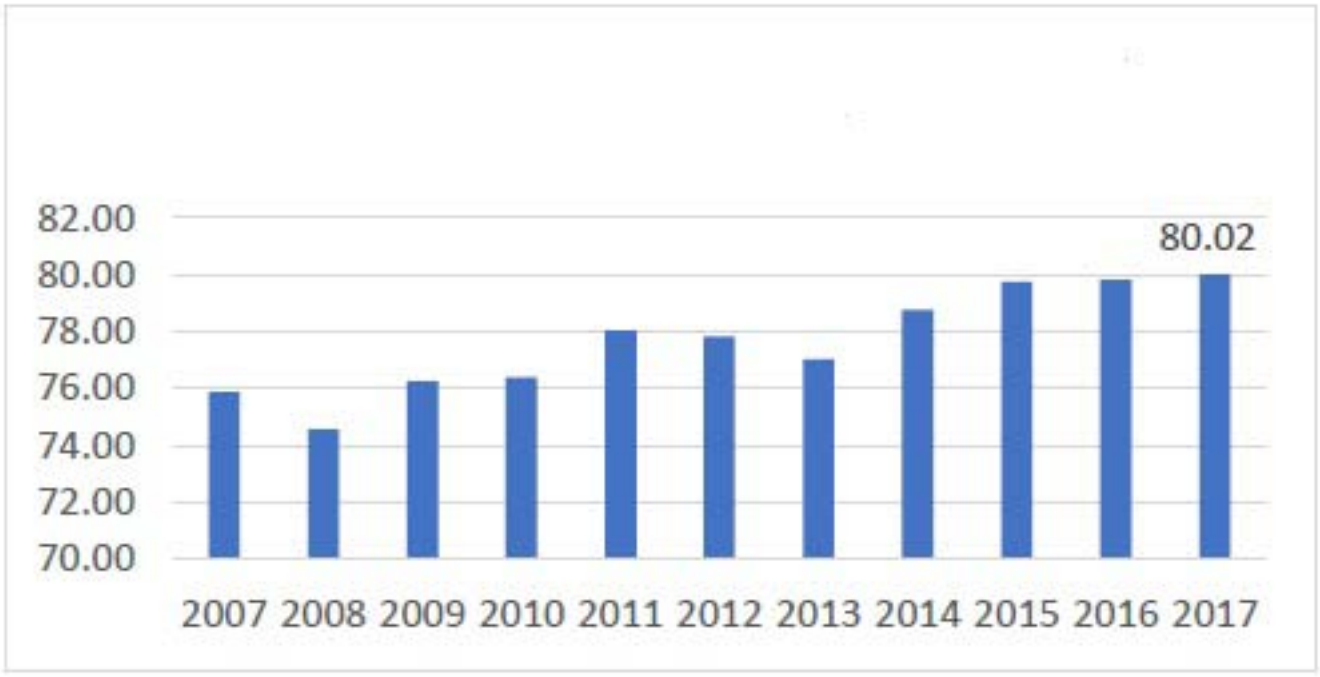
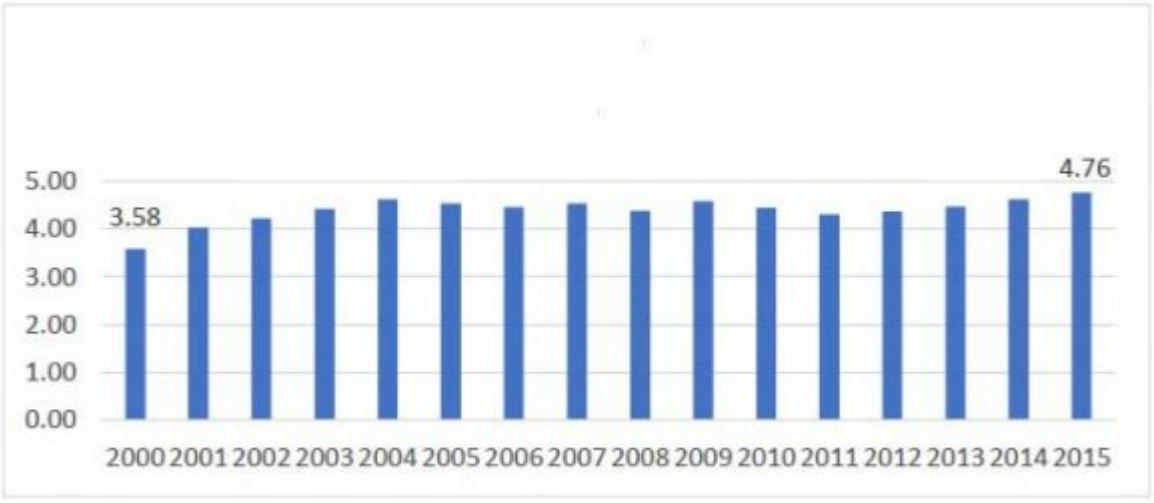


Figure 10: A



1314

Figure 11: Figure 13 :Figure 14 :

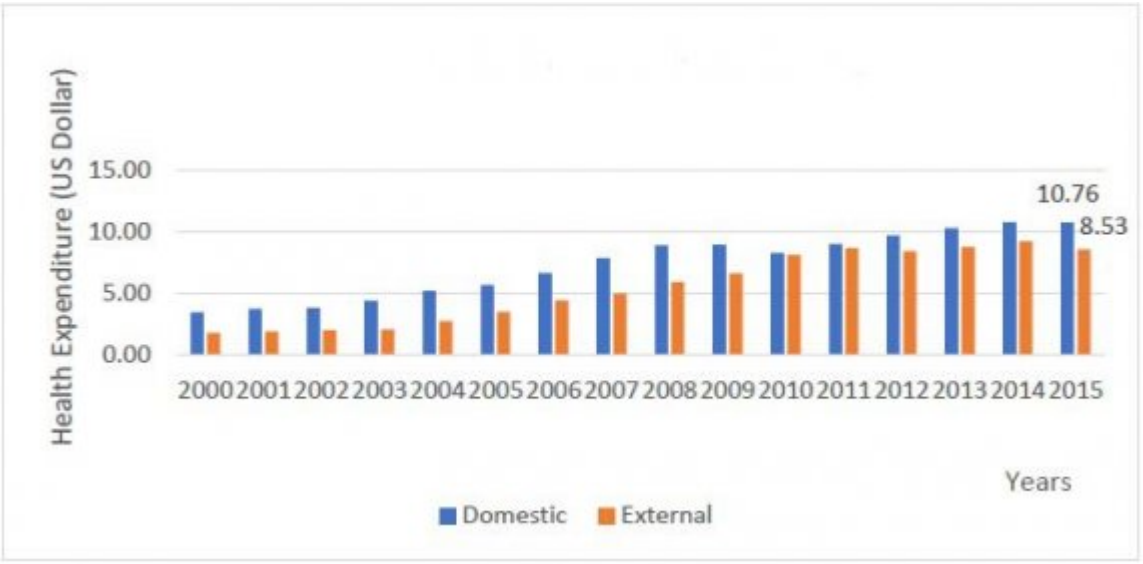
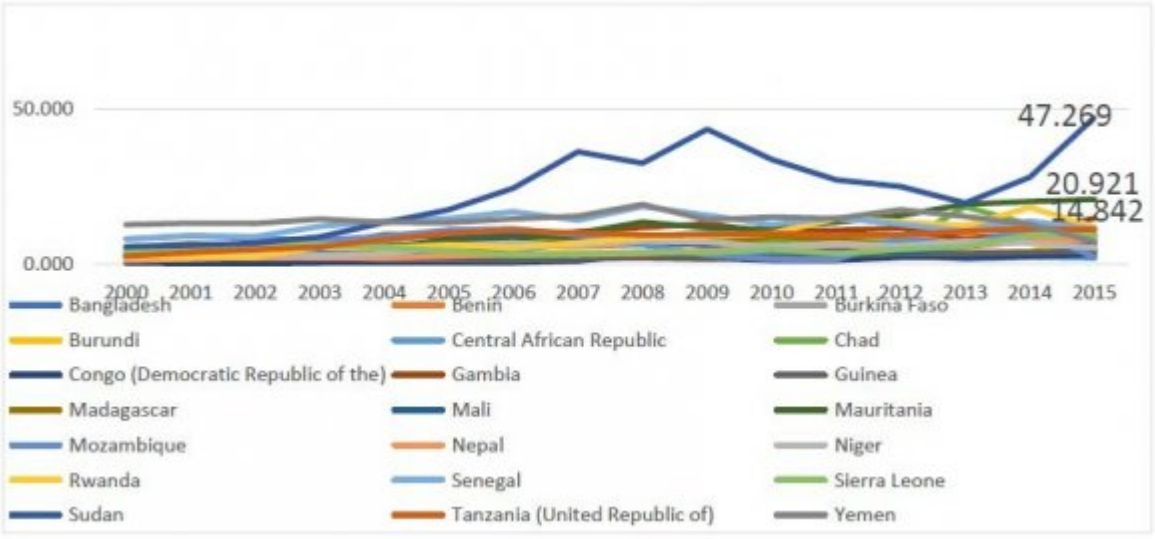


Figure 12: A



15

Figure 13: Figure 15 :

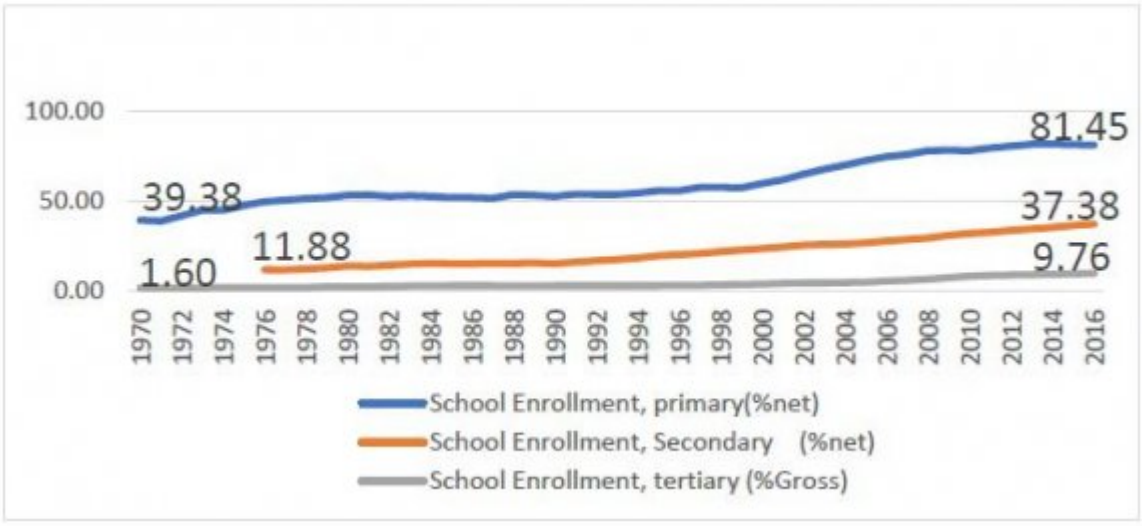
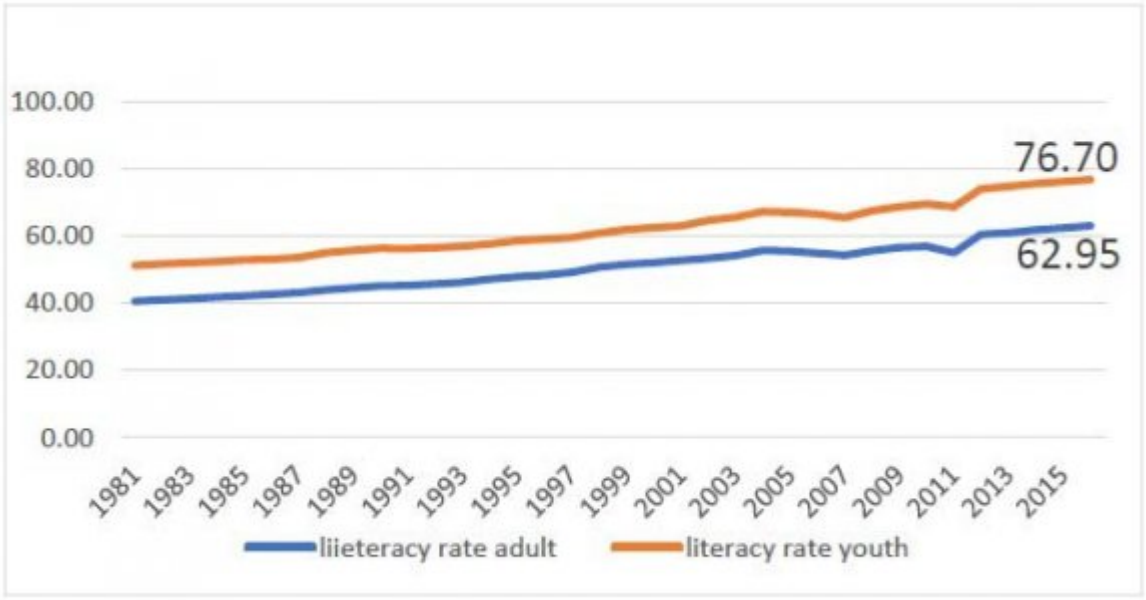


Figure 14: (



1718

Figure 15: Figure 17 :Figure 18 :

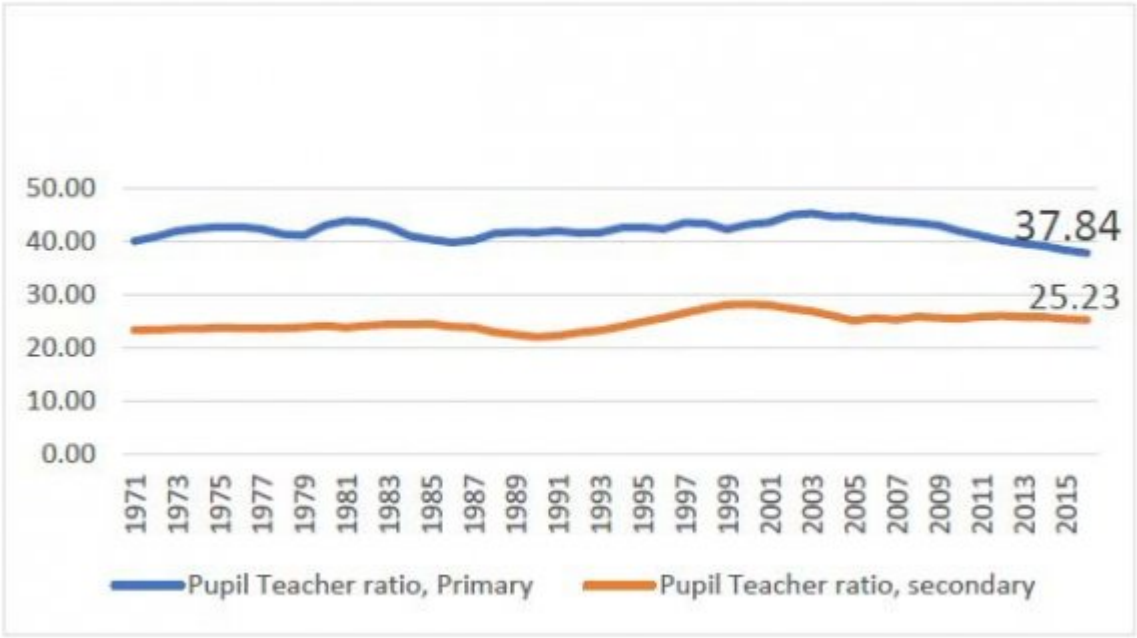


Figure 16:

1

HDI and its components	LDCs (47 countries)	Developing Countries	OECD
Human Development Index(values	0.524	0.681	0.895
Life Expectancy Birth (Years)	64.8	70.7	80.6
Expected Years Schooling(Years)	9.8	12.2	16.2
Mean Years Schooling (Years)	4.7	7.3	8.4

Figure 17: Table 1 :

.1 Acknowledgement

The authors are thankful to Almighty God for this opportunity to research and express their gratitude towards the global scholar community for creating such platforms to share knowledge and to spread awareness.

.2 Conflicts of Interest

[] , 10.1080/03057925.2017.1301399. https://doi.org/10.1080/03057925.2017.1301399

[] , 10.3368/jhr.XLI.4.692. https://doi.org/10.3368/jhr.XLI.4.692

[] , 10.1016/j.socscimed.2006.06.022. https://doi.org/10.1016/j.socscimed.2006.06.022

[] , 10.1093/ajcn/50.3.687. https://doi.org/10.1093/ajcn/50.3.687

[Sirven ()] 'Endogenous social capital and self-rated health: Cross-sectional data from rural areas of Madagascar'. N Sirven . 10.1093/ajcn/50.3.687. https://doi.org/10.1093/ajcn/50.3.667 *Social Science and Medicine* A.G., Pollitt, E., &kim,l. (ed.) 2006. 1989. 63 p. . (Iron defi667-674)

[Szreter and woolcock ()] *Health by association ? Social capital, social theory and the political economy of public health. International References Références Referencias*, S Szreter , M &woolcock . 10.1016/j.socscimed.2006.04.003. 2004.

[Pollitt et al. ()] 'Iron deficiency and education achievement in Thailand'. E Pollitt , P Hathirat , N Kotchabhakadi , L Missel , A &valyasevi . *American Journal of Clinical Nutrition* 1989. 50 (3) p. .

[Bobonis et al. ()] 'Iron deficiency, anemia and school participation'. G Bobonis , E Miguel , C P Sharma . 10.3368/jhr.XLI.4.692. *Journal of Human Resources* 2006. 41 (4) p. .

[Silva and Harpham ()] *Maternal social capital and child nutritional status in four developing countries. Health and Place*, De Silva , M J Harpham , T . 10.1016/j.healthplace.2006.02.005. https://doi.org/10.1016/j.healthplace.2006.02.005 2007. 13 p. .

[Bundy and guyatt ()] 'Schools for health: Focus on health, education, and the schoolage child'. D A P Bundy , J &guyatt . 10.1016/0169-4758(96)30011-2. https://doi.org/10.1016/0169-4758(96)30011-2 *Parasitology Today* 1996. 12 p. .

[Edgeworth and Collins ()] 'Self-care as a response to diarrhoea in rural Bangladesh: Empowered choice or enforced adoption?'. R Edgeworth , A E Collins . *Social Science and Medicine* 2006. 63 p. .

[Addey et al. ()] 'The rise of international large-scale assessments and rationales for participation'. C Addey , S Sellar , G Steiner-Khamsi , B Lingard , A Verger . 10.1080/03057925.2017.1301399. *Compare: A Journal of Comparative and International Education* 2017. 47 p. 434452.

[Miguel et al. ()] 'Worms: Identifying impacts on education and health in the presence of treatment externalities'. E Miguel , M ; C Kremer , C Van Den Bosch , D &bundy . 10.1111/j.1468-0262.2004.00481.x. https://doi.org/10.1111/j.14680262.2004.00481 *children: A report of the international nutritional anemia consultative group USAID*, (Washington, DC) 2004. 1998. 72 p. . (The effects of iron deficiency and anemia on mental and motor performance)