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

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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. This article presents an outline of (Least Developed Country) LDCs Asset in which there are several indicators, including health, school enrollment, and literacy. Economic growth has been elevated in the year leading to the economic crisis but remains weak. It repeatedly does not the advantage of the population at large, comes at high ecological costs, as shown by the rate of resource reduction and environmental damages, and youth unemployment remains very high. This article terminated with an appeal for developing circumstantially related literacy plans and policies throughout an asset point of view; and offers instructions for further research to investigate the Least Developed Countries literacy rate, school enrollment, and health policies.

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

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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. This article presents an outline of (Least Developed Country) LDCs Asset in which there are several indicators, including health, school enrollment, and literacy. Economic growth has been elevated in the year leading to the economic crisis but remains weak. It repeatedly does not the advantage of the population at large, comes at high ecological costs, as shown by the rate of resource reduction and environmental damages, and youth unemployment remains very high. This article terminated with an appeal for developing circumstantially related literacy plans and policies throughout an asset point of view; and offers instructions for further research to investigate the Least Developed Countries literacy rate, school enrollment, and health policies.

Keywords: child health, child nutrition, education, human capital.

I. Introduction

Many 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, Pollitt, 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 (Addey, Sellar, Steiner-Khamsi, Lingard, & Verger, 2017).

(De Silva, McKenzie, Harpham, & Huttly, 2005) Have investigated that a systematic evaluation of mental

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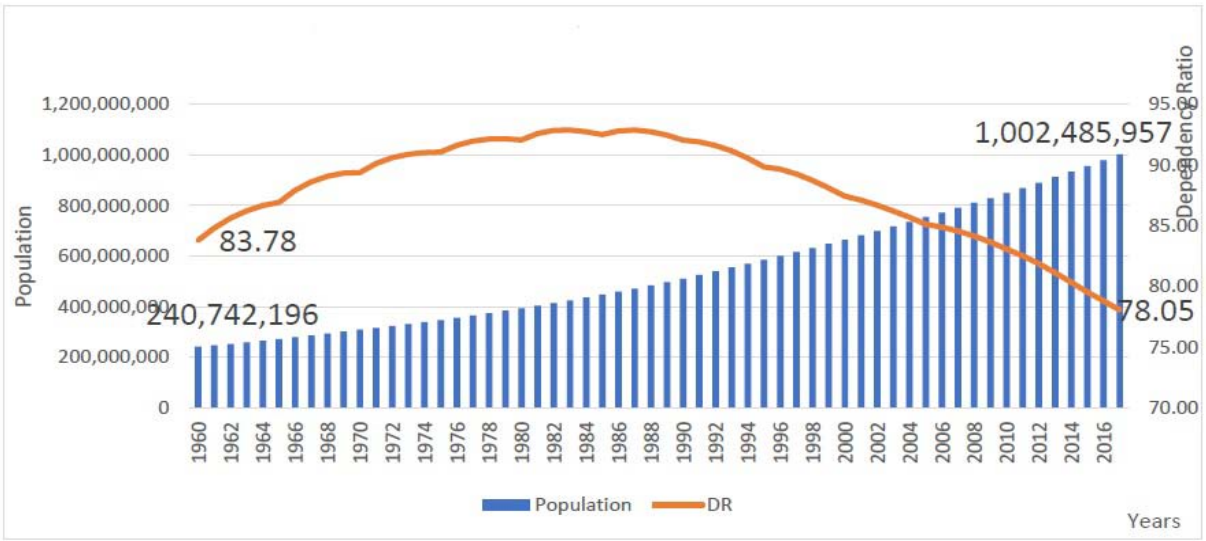
health and social capital have found in 21 research papers and which only two research papers have investigated in developing countries. Sirven (2006) observes social capital as an arbitrating feature in the corridor among the result of income on self-assessment health in the rural republic of Madagascar. (Szreter & Woolcock, 2004) Has contained access to suitable capital and the potential to advantage from that property throughout social relations inside and between organizations & communities. Edge worth and Collins (2006) discover the function of social capital in supplementary households throughout times of independence action of diarrhoeal ailment in the rural area of Bangladesh.

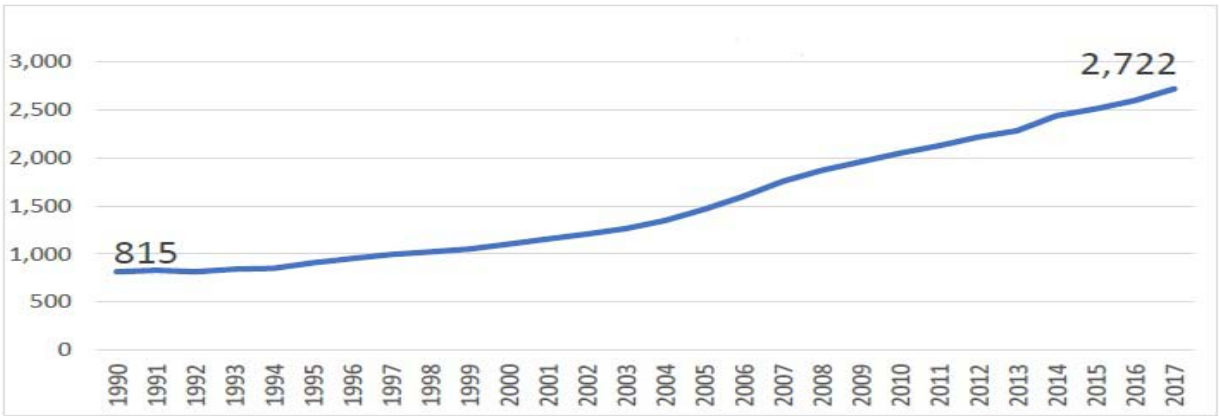
United Nations Economic and Social Council every three years reviewed the list of LDCs to determine LDC's status follow three criteria: (1) Human Assets (2) Per capita income (3) Economic Vulnerability. There are 47 countries in the list of LDCs 2018. Before, several people in this countries have graduated from Least Developed countries status, Botswana in 1994, Cape Verde in 2007, Maldives in 2011, Samoa in January 2014, and Equatoria Guinea in June 2017. In addition to the overview of LDCs, this paper will focus on discussing LDCs Human Asset in which there are several indicators, including health, school enrollment, and literacy.



Source: World Bank Data 2018, processed by the author

Figure 1: Population and Dependency Ratio in LDCs 19060-2017

Figure 1 shows that in 2017, the population of LDCs was one (1) Billion - 13.28% of the world's population total (7,53 billion in 2017). Although the LDCs dependency ratio decreases, it is still very high, from 83.78 in 1960 and 2017, it is still 78.05. The high number of LDCs Dependency Ratios shows that the population is in unproductive age (under 15 years and over 64 years). Its means the burden that must be borne by the productive population to finance residents who are not productive. This high dependency ratio can affect a country's economic development.



Source : World Bank Data 2018, processed by the author

Figure 2: GNI per capita (PPP) in LDCs 1990-2017

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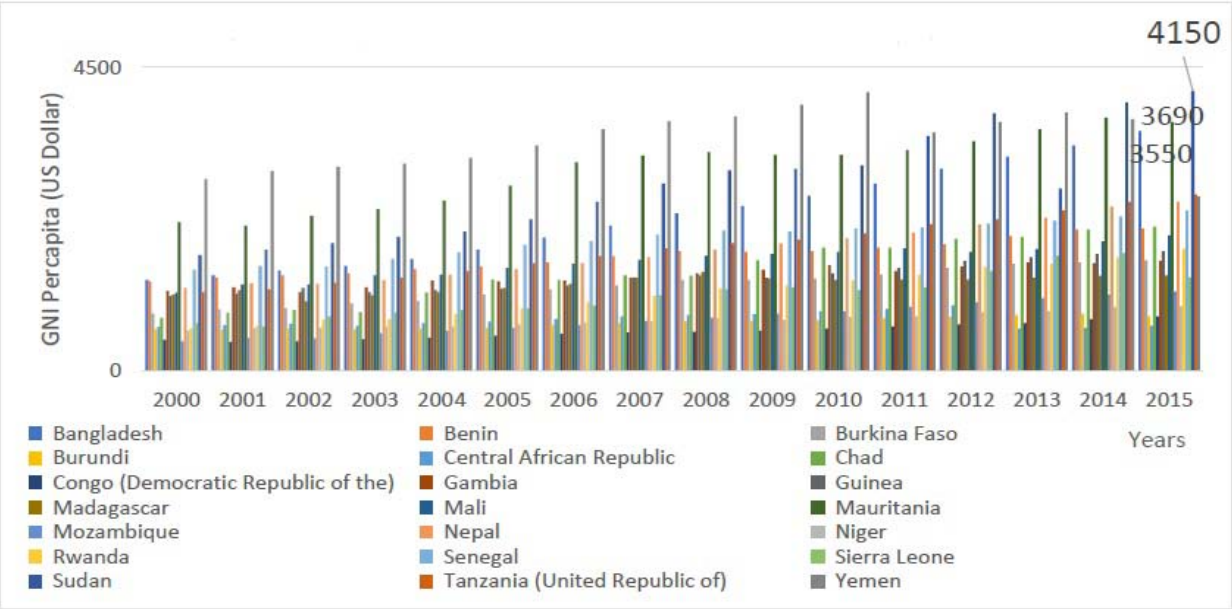
Figure 2 shows that in 2017, the average GDP percentage in LDCs only USD 2,722. The Highest GNI Percentage LDCs in 2015 are Sudan (4,150 US Dolar), Mauritania (3,690 US Dollar) Bangladesh (3,550 US Dollar). Majority LDCs have a GNI percentage below 2,000 USD. This can be seen in figure 3.



Source: World Bank Data 2018, processed by author

Figure 3: GNI per capita in LDCs (21 Countries) 2000-2015

Table 1: HDI and its component 2017 LDCs, Developing Countries, and OECD

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

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.

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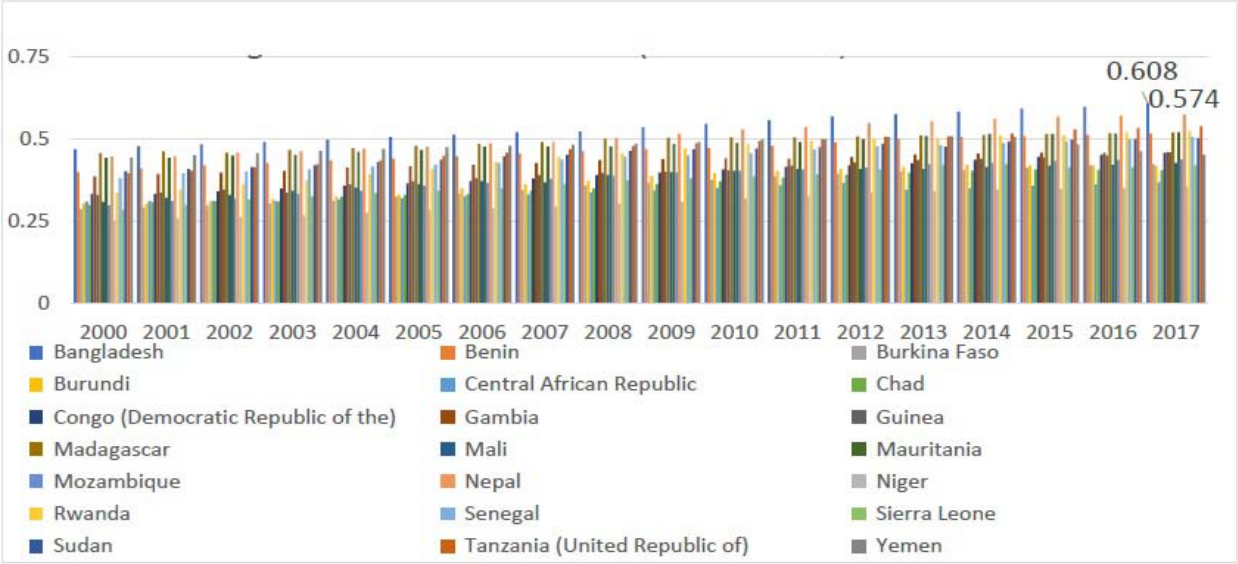
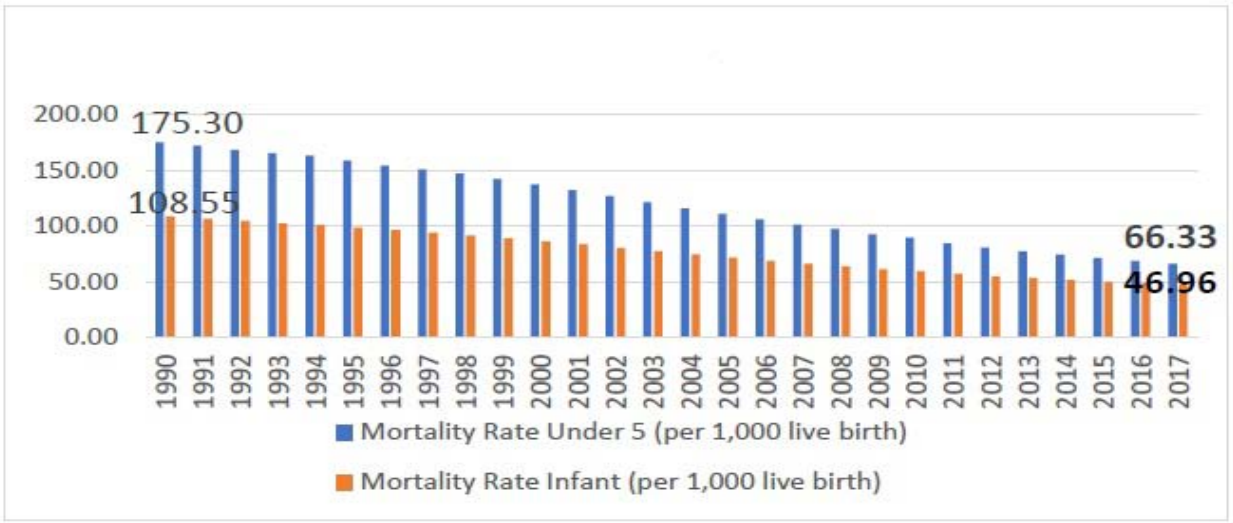


Source: World Bank Data 2018, processed by the author

Figure 4: HDI Index in LDCs (21 Countries) 2000-2017

Figure 4 shows that the highest HDI index in 21 LDCs in 2017 is Bangladesh at 0.608 and Nepal at 0.574. The majority of LDCs countries have HDI index below 0.4. HDI Index of Central African Republic and Niger is the lowest in all LDCs, which values 0.367 and 0.354 are respectively.



Source: World Bank Data 2018, processed by author

Figure 5: Under five year age Mortality Rate and infant mortality Rate (per 1,000 Live Birth) in LDCs 1990-2017

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 number 5.

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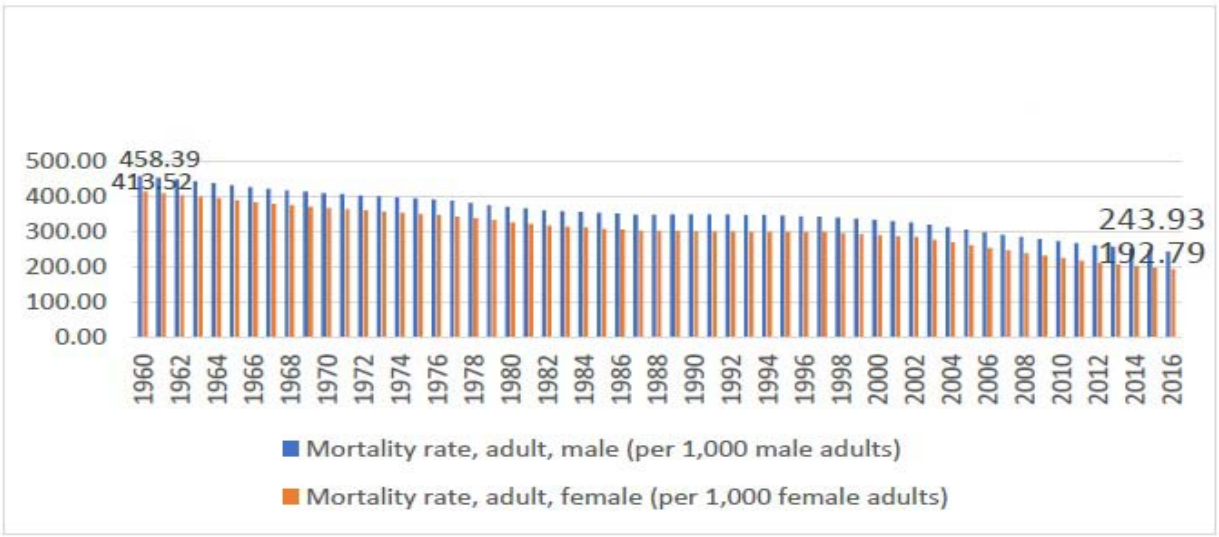
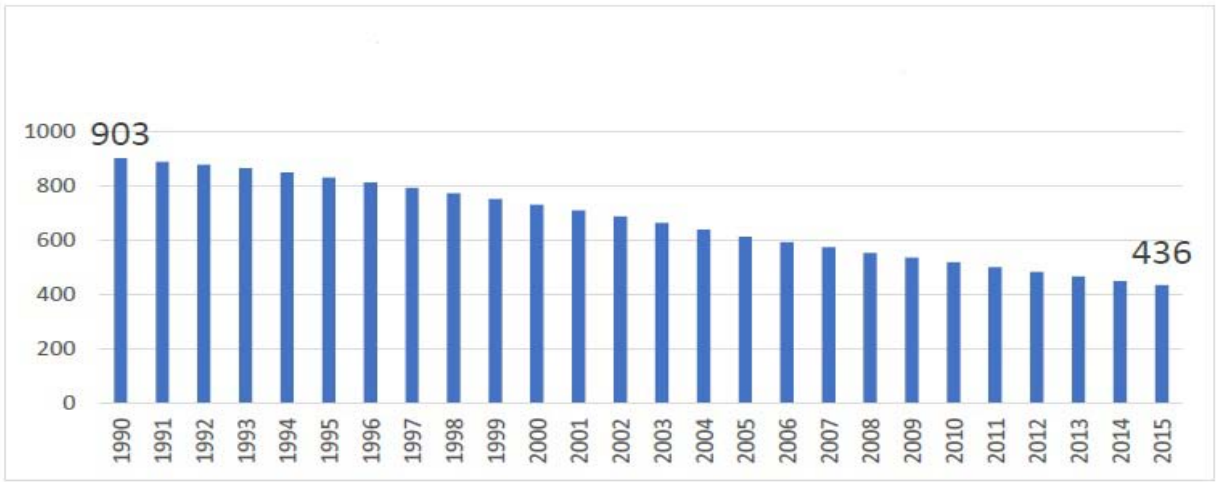


Source: World Bank Data 2018, processed by the author

Figure 6: Mortality Rate, Adult Male and Female (Per 1,000 Live Birth) in LDCs 1990-2017

Figure 6 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).



Source: World Bank Data 2018, processed by the author

Figure 7: Mortality Ratio in LDCs 1990-2015(Modeled Estimate, per 100,000 live birth)

The average maternal mortality ratio in LDCs was estimated at 436 per 100,000 births in 2015. From figure 7, we can see that the maternal mortality ratio is decreasing over time, but still higher.

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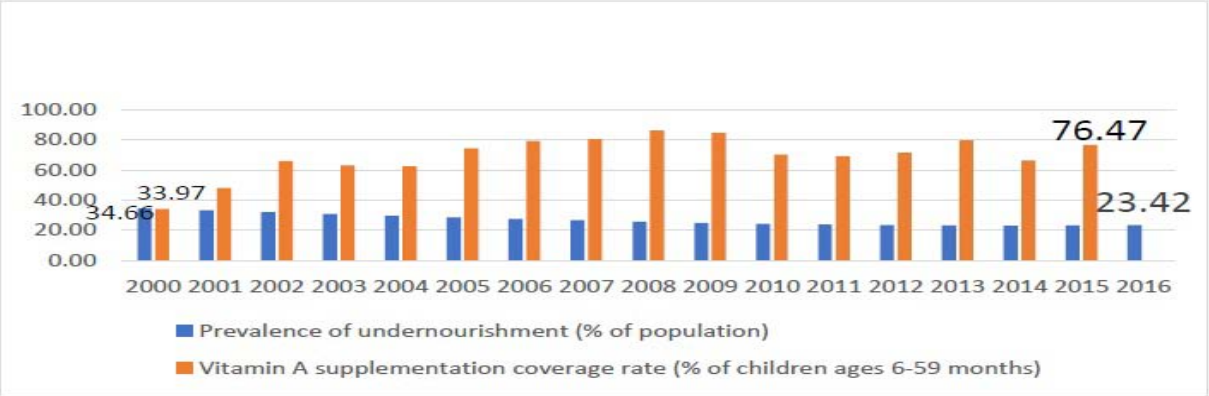
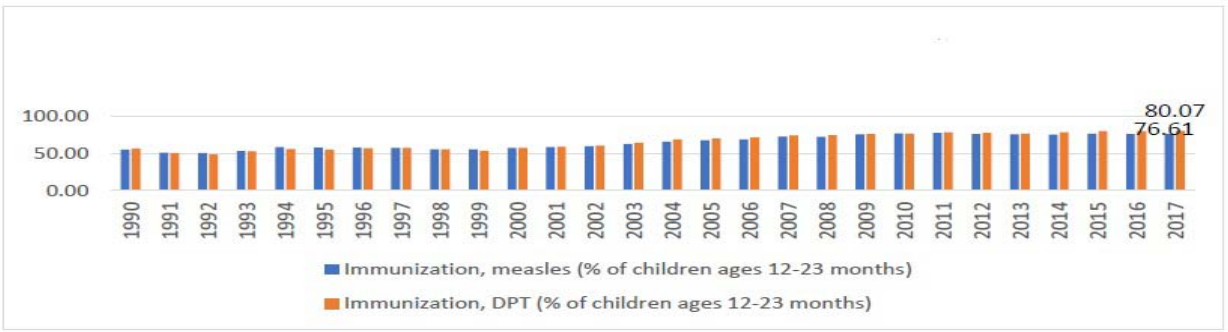


Source: World Bank Data 2018, processed by the author

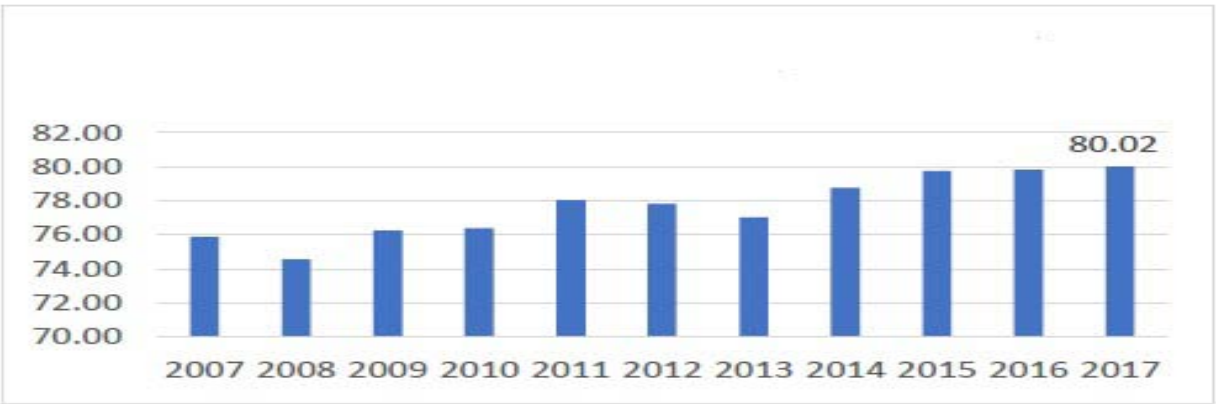
Figure 8: Prevalence of undernourishment and Vitamin a supplementation coverage rate in LDCs 2000-2016

In figure 8, we can see that the average prevalence of undernourishment in LDCs is a very deep concer; there is 23, 42% of population undernourishment. It means, close to a quarter of the population does not have to require nutrition. The Supplementation of Vitamin A in LDCs do not cover all children age 6-59 months, just 76,47% is covered and close to a quarter child do not have to require vitamin A supplementation.



Source: World Bank Data 2018, processed by the author

Figure 9: Measles Immunization and DPT Immunization in LDCs 2000-2016



Source: World Bank Data 2018, processed by the author

Figure 10: HepB3 Immunization in LDCs 2007-2017(% of one-year-old children)

Not all children in LDCs get Measles, DPT, and HepB3 Immunization. In 2017, just 76.61 % of children age 12-23 months got Measles Immunization and 80.07% got DPT Immunization. Also, HepB3Immunization covers 80.02% of one-year-old children. This can be seen in Figures no. 9 &10.

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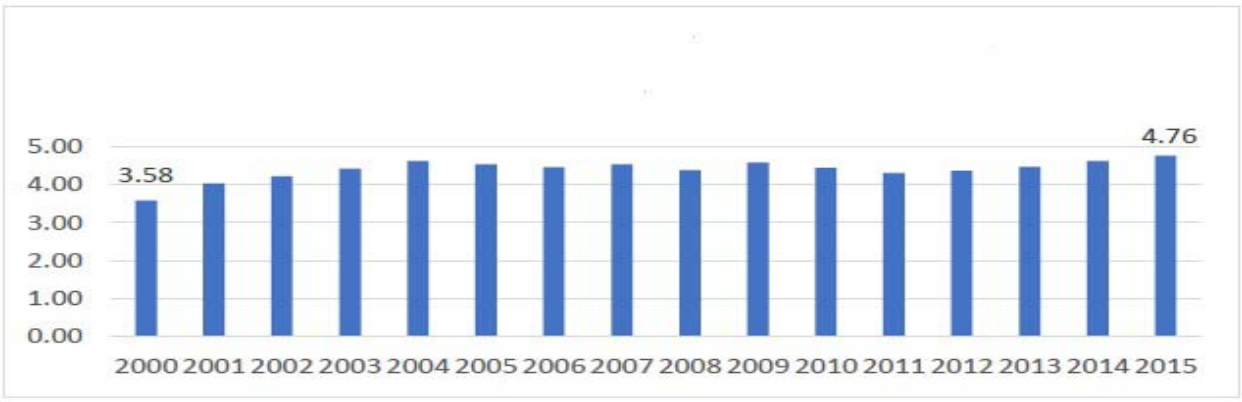
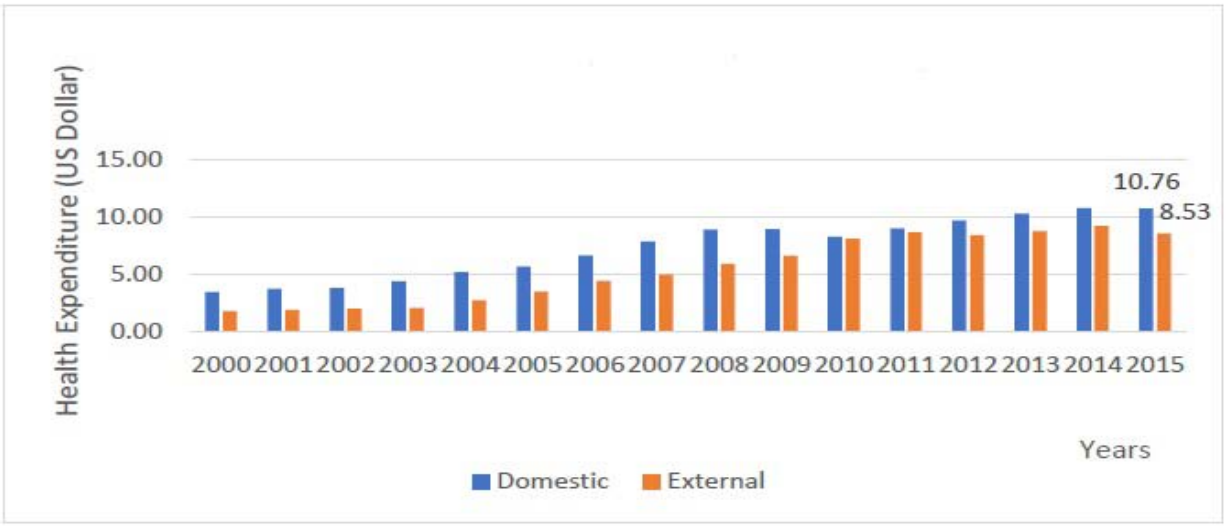


Source: World Bank Data 2018, processed by the author

Figure 11: Current health expenditure (5% of GDP) in LDCs 2000-2015

Figure 11 shows that LDCs spend less than 5% of their GDP on health. In 2015, just 4.76% of GDP allocated for current health expenditure.



Source: World Bank Data 2018, processed by the author

Figure 12: Health expenditure per capita in LDCs (5% of GDP) 2000-2015

In figure 12, the average health expenditure per capita is very low in LDCs from 2000-2015 and depend on an external donor. In 2015, domestic health expenditure per capita is 10.76 US dollar and external health expenditure per capita is 8.53 US dollars.

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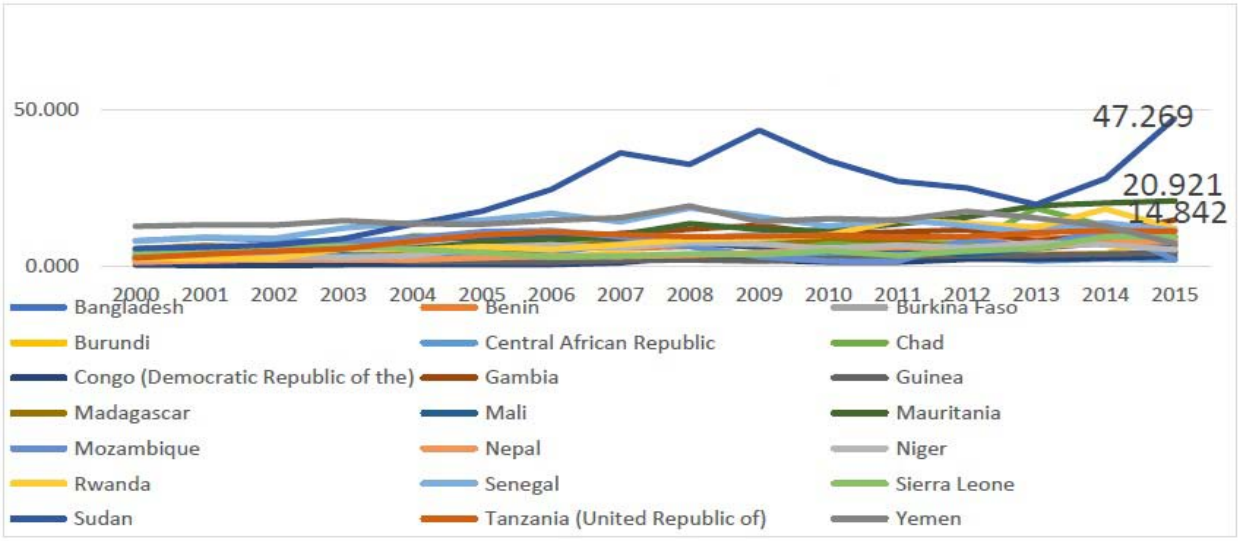
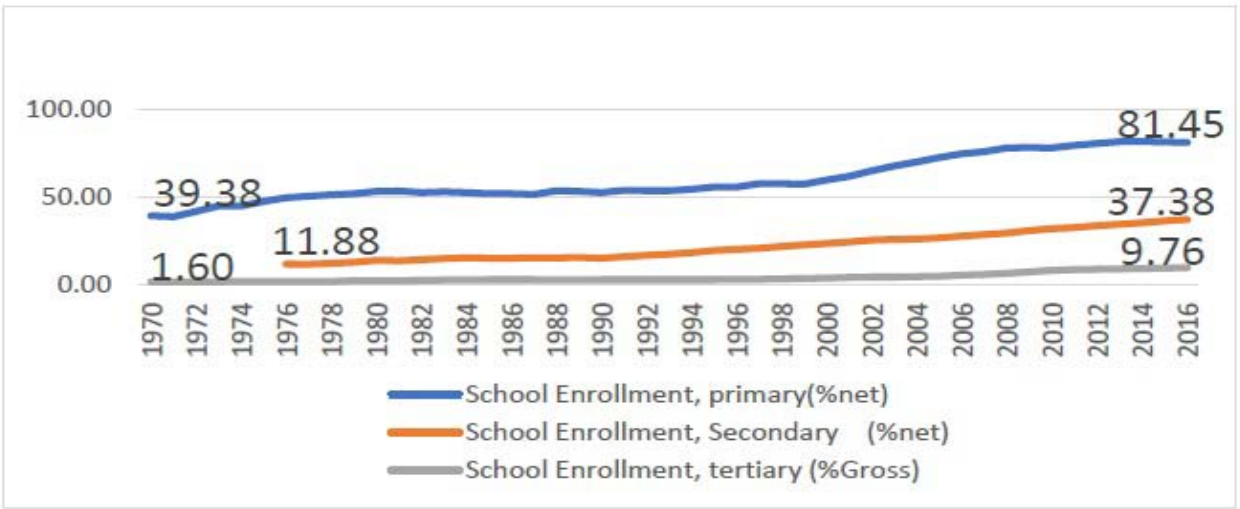


Source: World Bank Data 2018, processed by the author

Figure 13: Domestic General Government Health Expenditure (DGGHE) Per capita in LDCS (21 Countries) 2000-2015

Figure 13 shows that almost all LDCs have Domestic General Government Health Expenditure (DGGHE) per capita are very low. The highest DGGHE in LDCs is Sudan (47.269 US Dollar), Mauritania (20.9 US Dollar) Gambia (14.842 US Dollar).



Source: World Bank Data 2018, processed by the author

Figure 14: School Enrollment in LDCs 1970-2016

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.

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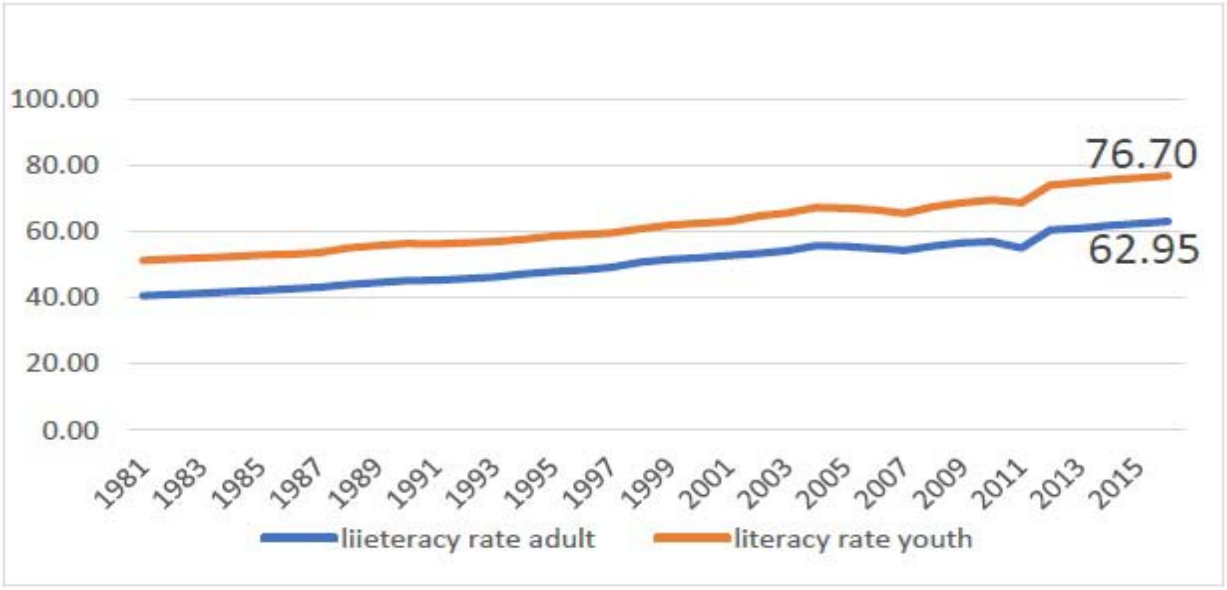
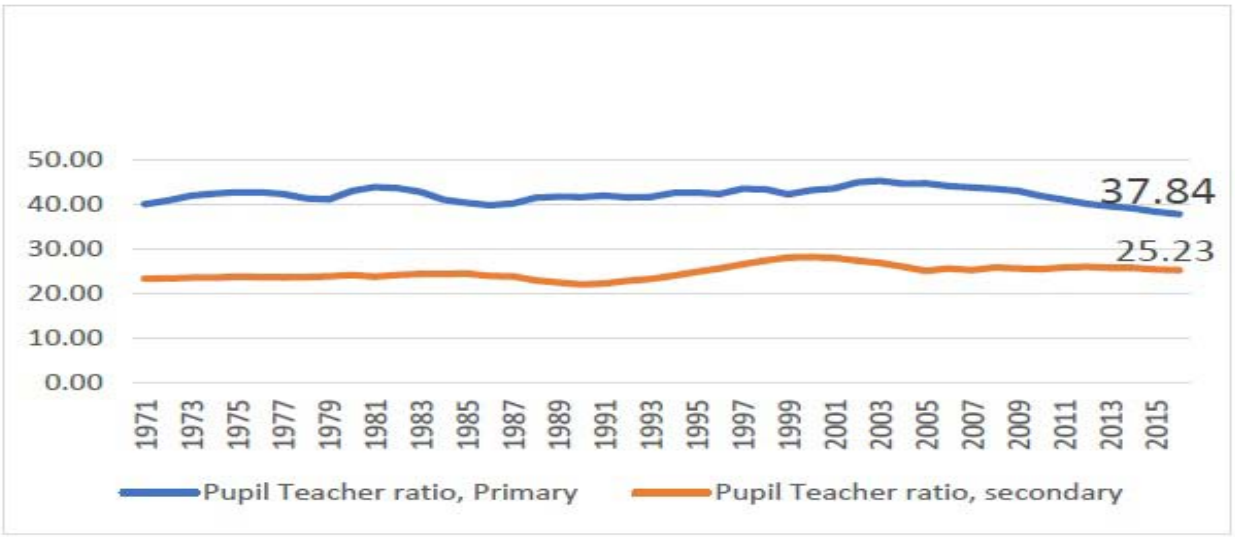


Source: World Bank Data 2018, processed by the author

Figure 15: Literacy Rate in LDCs 1981-2016

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.



Source: World Bank Data 2018, processed by the author

Figure 16: Pupil-Teacher Ratio in LDCs 1971-2016

Figure 16 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.

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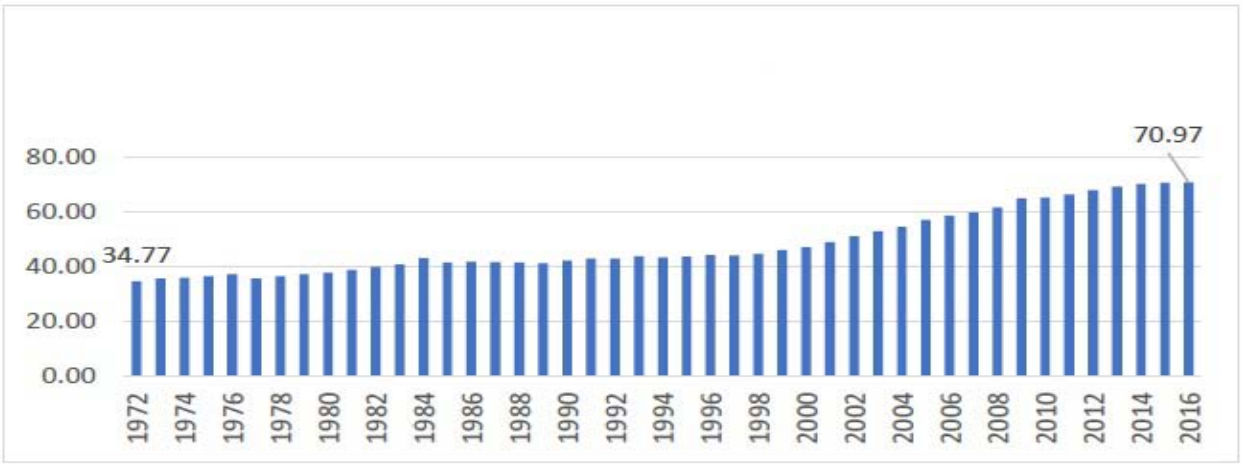
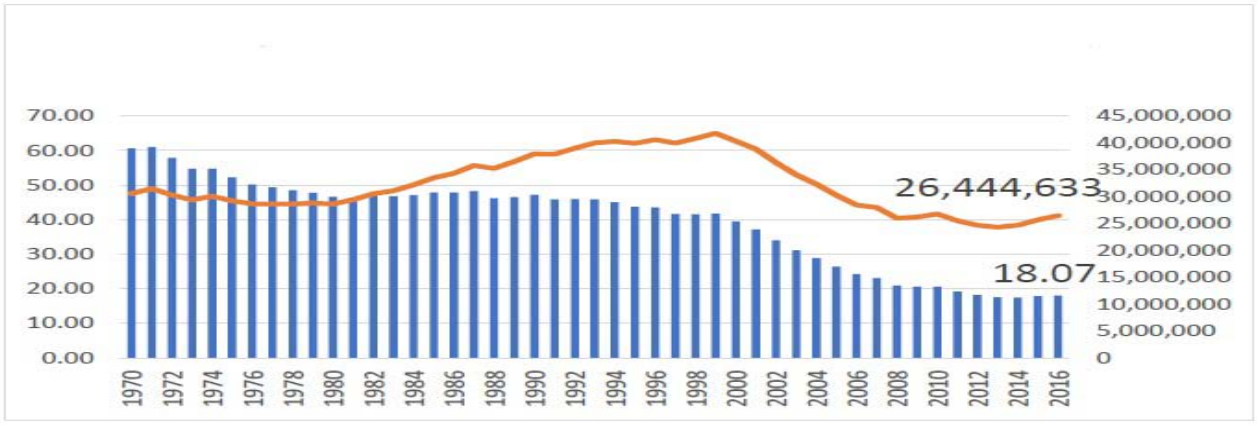


Source: World Bank Data 2018, processed by the author

Figure 17: Primary completion rate in LDCs 1971-2016

Figure 17 shows that in 2016, 70.97% of children of primary school age in LDCs can completion until the last grade primary education and close to 30% cannot complete.



Source: World Bank Data 2018, processed by the author

Figure 18: Children out of Primary School in LDCs 1971-2016

Figure 18 shows that in 2017, 26.44 million children of primary school age in LDCs are not enrolled in primary education or 18,07 % of children are out of primary school.

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 (2015), 243.93 per 1,000 males (2016), 192.79 per 1,000 females (2016). 23.42 % of the population in LDCs is undernourishment (2016), 23.5 % of children age 6-59 months does not have to require vitamin A supplementation (2016).

In 2017, just 76.61 % of children age 12-23 months got Measles Immunization, 80.07% got DPT Immunization, and HepB3 Immunization covers 80,02%. Current Health Expenditure in LDCs very small, Domestic health just 4.76% of their GDP. Population health in the developing world has the potential to benefit from efforts to improve social capital. Expenditure per capita and External Expenditure per capita are also very low, respectively ,10.76 and 8.53 US dollars. The situation of education in LDCs also very concern, in 2016 close to 20% population's primary school age are not enrolled in primary school. At the secondary school level, more than 60% of the

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population (corresponding secondary official school age) are not enrolled. Similarly, in tertiary schools, just 9.76% are enrolled.

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.

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.

Conflicts of Interest

The authors declare no conflict of interest.

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