AFRICAN ANTI-ABORTION COALITION

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1st November, 2007.

President George W. Bush
President of the United States of America,
White House,
Washington DC, USA.

His Excellency,

Facts and Figures on the Economics of Contraception and Abortion : A Reply to G8 Leaders

On 27th July 2007, the African Anti-abortion Coalition (AAAC) wrote to the governments of G8 countries, to protest the "tie of foreign aid to Africa to abortion rights." A number of governments and international agencies reacted to our letter and clarified their positions. Among these responses were letters from the British Prime Minister Gordon Brown, Canadian Prime Minister Rt. Hon. Stephen Harper, World Bank and European Commission.

The World Bank stated that, their aim is "to work with countries to help them better educate their girls and young women, to provide them with equal economic performance to have fewer households living below the poverty line."

The European Commission in response asserts that, "The European Commission is strongly committed to the goal of universal access to sexual and reproductive health and rights..."

The official position of the United Kingdom was articulated by the Department of International Development (DFID), which in sum, stated that, "DFID does not tie aid to provision of abortion services. However, DFID is committed to tackling the human tragedy of unsafe abortion."

The AAAC council appreciates the time, taken by governmental and international agencies, to address their responses on the issues raised. However, due to the importance of this subject matter, AAAC council provides clarification on the major points raised by international agencies. Furthermore, AAAC council would like to expand the options of views available to heads of governments in the United Nations, to allow them make informed decisions on the subject matter.

The aim of foreign aid is to provide poverty alleviation, and promote sustainable development. The responses of the governments and international agencies are in-line with the recommendations of the International Conference on Population and Development (ICPD), 5th -13th September, 1994, Cairo Egypt, and the more recent expansion in the THE PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS OF WOMEN IN AFRICA – Articles #14 (1a, 2c), #26, and MAPUTO PLAN OF ACTION. The ICPD set goals and targets on reproductive health and rights for all by 2015.

The international agencies always proffer two objectives, for their support of programs, to spread the use of modern contraceptives in sub-Saharan Africa: First, as a strategy for HIV/AIDS prevention; second, to lower maternal mortality ratio (MMR). The World Health Organization (WHO), UNICEF, UNFPA, and UNAIDS have provided Reproductive Health Indicator Database (RHI) that could be used for analysis, to answer the major questions of this discussion:

1. *What is the relationship between HIV/AIDS prevalence in the adult (15-49 years) population and modern contraceptive prevalence in Sub-Saharan Africa?*
2. *What is the relationship between maternal mortality, HIV/AIDS prevalence and modern contraceptive prevalence?*

Definitions:

Maternal mortality ratio (MMR) is defined as the number of **maternal** deaths per 100,000 live births. The maternal mortality ratios have been rounded according to the following scheme: < 100: no rounding; 1000: rounded to nearest 100. Estimated number of deaths to women while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidents.
Source: Maternal Mortality in 2000, Estimates Developed by WHO, UNICEF, UNFPA. Geneva, Department of Reproductive Health and Research, World Health Organization, 2004

Contraceptive prevalence is the percentage of women of reproductive age (15-49) who are using (or whose partner is using) a contraceptive modern method (for example condoms) at a particular point in time.

Source: World Contraceptive Use 2005. New York, Department of Economic and Social Affairs, Population Division, United Nations, 2006.
Note:
(i) Statistics provided by the above source, refer to women aged 15-49 who are in a marital or consensual union.
(ii) The latest contraceptive prevalence data refer to the most recent available data as of 1st October 2005.

Proportion of adults (15-49 years) living with HIV/AIDS (%):
Estimated percentage of the adult population aged 15-49 living with HIV/AIDS.

To calculate the adult HIV prevalence rate, the estimated number of adults aged 15-49 living with HIV/AIDS in 2005 was divided by the 2005 adult population aged 15-49.
Source: 2006 Report on the Global HIV/AIDS Epidemic. Geneva, Joint United Nations Programme on HIV/A IDS (UNAIDS), May 2006.

Statistical Analyses:

All data were collected from the WHO website: Reproductive Health Indicators Database Link at: http://www.who.int/reproductive_indicators/alldata.asp

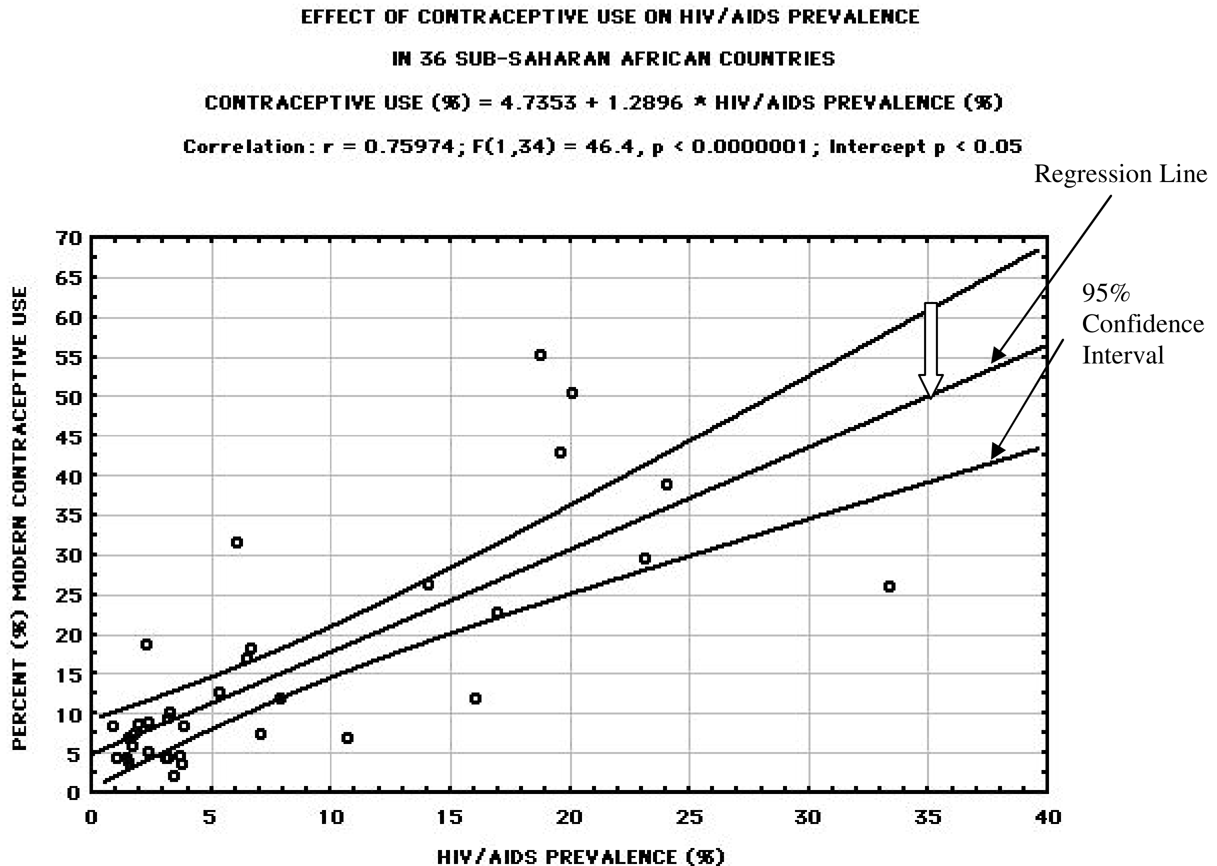
All data were analyzed using the statistical software package (Statistica, StatSoft, OH, USA). Multiple regression analysis (Statistica, StatSoft, OH, USA) was used to examine the relationship between two variables, and the linear relationship plotted as a straight line, with curved lines indicating the 95% confidence intervals. The level of significance was set at $p < 0.05$.

A. ***What is the relationship between HIV/AIDS prevalence and modern contraceptive use in Sub-Saharan Africa?***

Figure 1, shows a direct relationship between modern contraceptive prevalence (for example, use of condoms) and HIV/AIDS prevalence in 36 Sub-Saharan African countries, plotted from table 1.

***Could one say that, the promotion of condom use has actually increased HIV rates in Africa, by encouraging young people to be more promiscuous*?**
These assertions made in the past, are now supported by facts *from the current WHO, UNAIDS, UNFPA, and UNICEF data.*

Figure 1. shows the relationship between modern **contraceptive prevalence (%)** and **Proportion of adults (15-49) living with HIV/AIDS (%)** in 36 Sub-Saharan African countries.



The graph (Figure 1) suggests that, contraceptive use in Sub-Saharan Africa should be kept below 4.7% (intercept), which is that used by groups at most risk (prostitutes and their clients, homosexuals, injection drug users etc), for HIV not to spread in the general adult population. However, ***for a 50% rise in contraceptive use in the population, HIV/AIDS prevalence will increase by 35% (white arrow),*** given by:

Equation 1.

Contraceptive Prevalence (%) = 4.7353 + 1.2896 * HIV/AIDS Prevalence (%).

HIV/AIDS prevalence = **35%**

Coefficient of correlation = 0.76, $F(1,34) = 46.4$, $p < 0.0000001$,

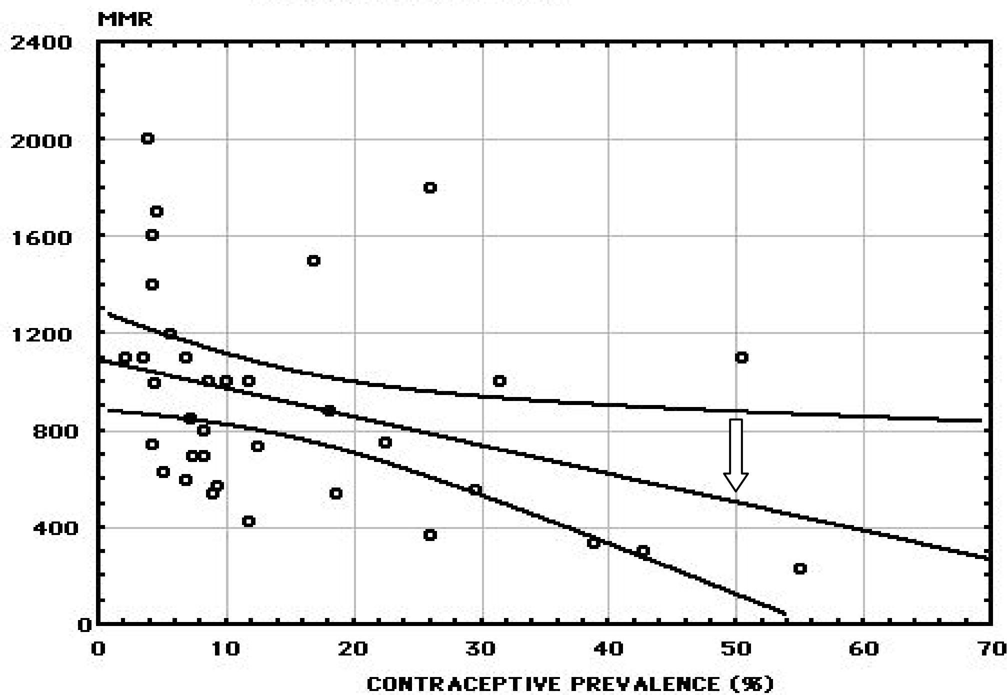
The intercept 4.7353 is significant $p < 0.05$.

B. Could Africa lower Maternal Mortality Ratio by 50% (to MMR=500) using the current condom model?

Figure 2. shows the relationship between **modern contraceptive prevalence (%)** and **maternal mortality ratio (per 100,000)** in 36 Sub-Saharan African countries.

Maternal Mortality Ratio (MMR) declined slightly, because of higher contraceptive use, that is, lesser number of women became pregnant, even though as we showed (from direct correlation of contraceptive use and HIV/AIDS prevalence in Figure 1), they died from HIV/AIDS, and deaths were discounted from MMR. In other words, this is an 'illusive gain' in improved health of the African woman, and a shift in statistical death count from MMR to deaths due to HIV/AIDS.

EFFECT OF CONTRACEPTIVES ON MATERNAL MORTALITY RATIO IN SUB-SAHARAN AFRICA



The graph (Figure 2) suggests that, if there was no use of modern contraceptives in Africa, maternal mortality would be about 1086.5 per 100,000. However, to achieve about 50% drop in MMR to about 500 per 100,000 in Africa, modern contraceptive use prevalence has to rise to 50% in countries, given the relationship:
Equation 2.

MMR = 1086.5 – 11.726 * Contraceptive Prevalence (%)
For MMR of 500 = **50% modern contraceptive prevalence**

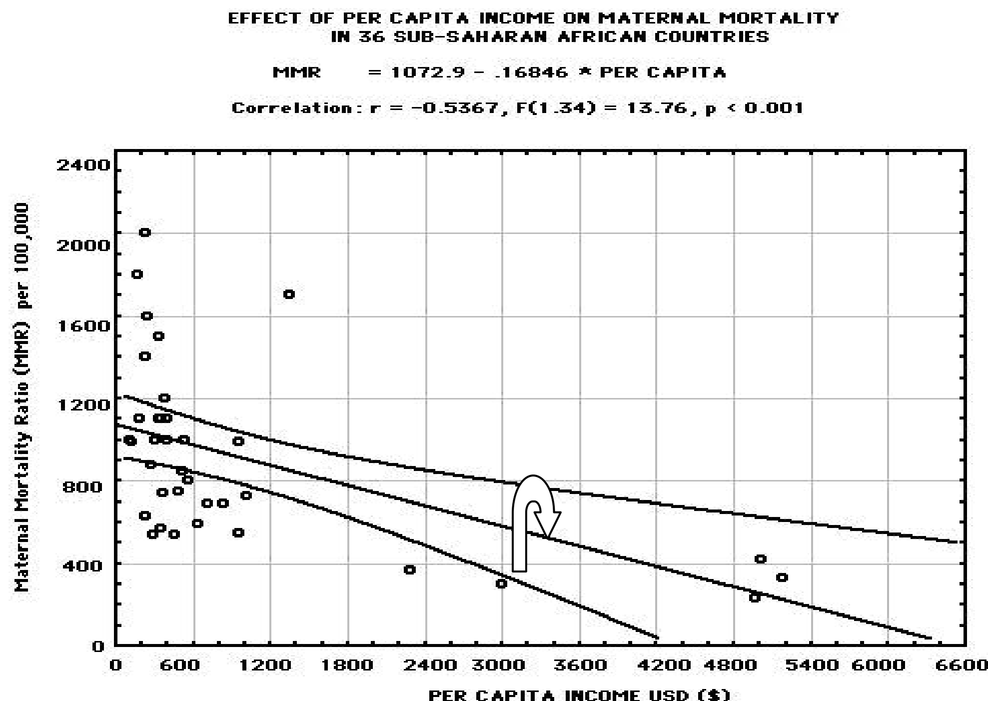
To achieve a MMR reduction of about 50% to 500 per 100,000 using the condom model, African countries would need to increase modern contraceptive prevalence to 50% (Figure 2, white arrow), which will in turn increase HIV/AIDS prevalence by 35% (Figure 1, white arrow).

C. <u>We could decrease maternal mortality ratio by 50% (MMR = 500) by raising the standard of living in Africa.</u>

One way to reduce MMR by 50%, to an average of about 500 per 100,000, is to improve the standard of living of the people in Africa. This would mean a rise in per capita income. Let us forecast what rise in per capita income would be required, to attain a 50% reduction in MMR.
Figure 3 shows the relationship between maternal mortality ratio (MMR) and per capita income.
<u>Equation 3.</u>

MMR = 1072.9 - 0.16846 * PER CAPITA ($ USD).
For MMR of 500 = **$ 3400.8**

A rise in per capita income to USD ($) 3,400 would reduce MMR to about 500 per 100,000 in Africa (Figure 3, curved white arrow).



D. <u>*Caution!! – raised standard of living might increase HIV/AIDS prevalence if Abstinence education is not promoted in Africa.*</u>

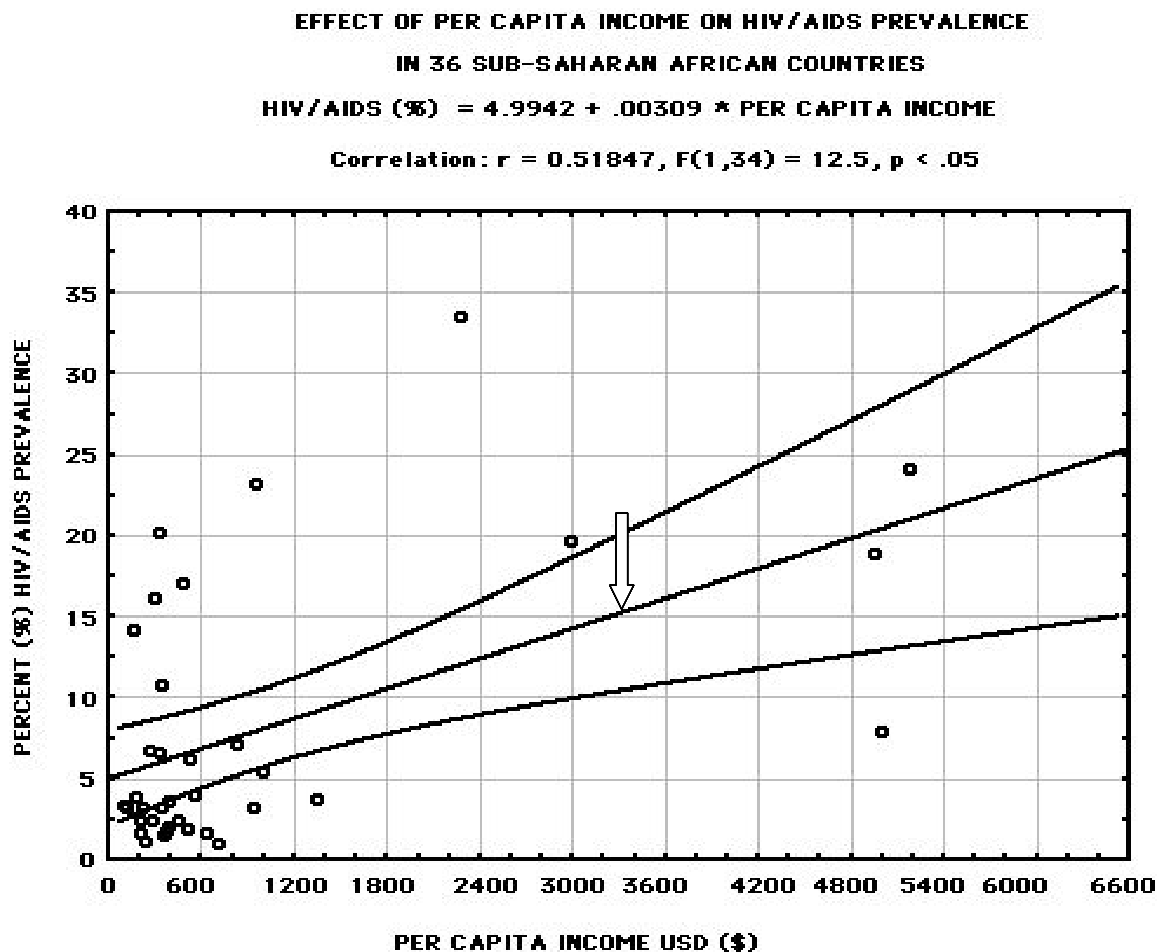
Figure 4 shows the relationship between per capita income and HIV/AIDS prevalence.
<u>Equation 4.</u>

HIV/AIDS (%) = 4.9942 + 0.00309 * PER CAPITA INCOME (USD $).

Correlation: $r = 0.5$; $F(1,34) = 12.5$, $p < 0.05$

For PER CAPITA INCOME of $3400, HIV/AIDS prevalence = 15.5%

If Abstinence education is not promoted in Africa, but the condom model left in place, raising the standard of living to a per capita income of $3400, would give rise to HIV/AIDS prevalence of 15.5% (Figure 4, white arrow).



The link between HIV/AIDS prevalence and per capita income shows that, with improved standard of living, without **Abstinence education**, some people will use their extra income to purchase condoms and hence, there will be a surge in HIV/AIDS prevalence.

Most people would agree that, promoting contraceptive use goes hand-in-hand with the abortion mentality, since most countries with high contraceptive use prevalence, also have high abortion rates. The European experience demonstrated that, ***more abortions, more poverty.***

E. <u>*The Economic Consequence: More Abortions More Poverty in Europe*</u>

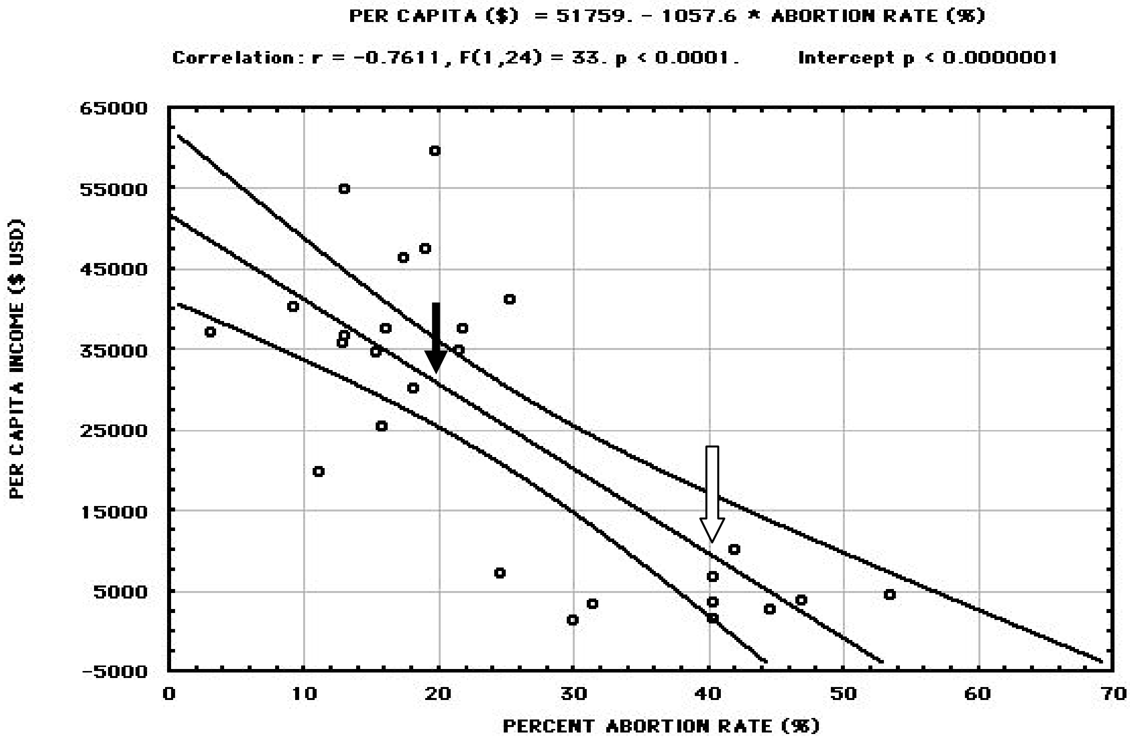
Figure 5 demonstrates the inverse relationship between per capita income and abortion rate in 26 European countries (from table 2). The higher the abortion rate, the lower the per capita income in Europe.

<u>Equation 5.</u>

Per capita income ($) = 51,759 - 1057.6 * Abortion rate (%).

Correlation: $r = -0.76$, $F(1,24) = 33$, $p < 0.0001$, Intercept ($51,759) $p < 0.000001$

More abortions more poverty in Europe



Equation 5 suggests that, if there was no abortion in Europe, there would be a per capita income of $51,758.664 USD. However, for every percent rise in abortion rate, the people of Europe lost an income of $1,057.6 USD. Countries in Eastern Europe, with over 40% abortion rate had less than $10000 USD in per capita income (Figure 5, white arrow). While mainly, Western European countries, with abortion rate below 20%, had per capita income of above $30,000 USD (Figure 5, black arrow). ***It therefore follows that, the cornerstone of wealth creation is to extinct abortions.*** *Why would Western Europe not want to export this antiabortion ideology to Africa?*

RECOMMENDATIONS OF THE AAAC COUNCIL TO WORLD LEADERS

A. Measures for HIV/AIDS Prevention

Simply, the *condom model- for- all approach* should be abolished. The facts may support, a condom use in target population of people living with HIV/AIDS, and groups at risk including prostitutes, IV drug users, homosexuals and others, found to have very high prevalence rates. Even in these groups, effort should be made for conversion using faith-based approach, and the ***Abstinence*** message emphasized, but the use of condoms may be an option, while they make their journey of faith. The cornerstone for HIV/AIDS prevention in the youth should be the **Abstinence**-only education, and **Be-faithful** messages in the adult population. The case study of Uganda showed that, the HIV prevalence fell from a high of 30.2% in 1992 to 4.2% in 2000 [Kirungi et al 2002]. Close analysis of the trend shows that, the HIV/AIDS prevalence began to fall in the late 1980s (when condom use was only about 5%) and 1990s, [Mbulaiteye, et al 2002; STD/AIDS Control Programme, Ministry of Health, 2003], several years before condoms were available in large numbers. However, with availability of condoms in large numbers, the drop in HIV prevalence has stalled, and even increased in 2006 to 6.7%. Okware et al concluded, this means that "much of the credit for turning the tide must go to the 'home grown', community derived solutions to the problem: **A – abstinence** and **B – be faithful** [Green, 2003; Hogle, 2002; Population, Health and Nutrition Information Project, 2002]. We have demonstrated based on continental analyses, using data from WHO, UNICEF, UNFPA, and UNAIDS that, countries using the condom model have increased HIV prevalence.

B. Dismantling Aid Programs Based on Contraception for Reduction of Maternal Mortality from Any Cause

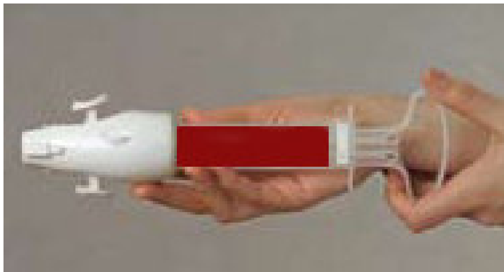
Most international aid agencies proffer reduction of maternal mortality, as the reason for support of contraceptive use. As we have shown, promoting contraceptive use in Africa would only result in more deaths from HIV/AIDS, even though these would be discounted from the maternal mortality ratio, creating an 'illusive gain'. These international aid programs should be dismantled by governments, and replaced with programs that target improved standard of living, without the condom model approach.

C. Dismantling Aid Programs for so-called Safe Abortion option that spreads HIV/AIDS.

Some international agencies say that their aid package supports the so called 'safe abortion' option, in order to reduce maternal mortality from unsafe abortions in Africa.

Indeed, the effect of abortion in most part is long-term, causing infertility, psychological problems, cancers, infections, stroke and cardiovascular diseases. The rising trend of these diseases, among women in Africa, could be related to increased prevalence of abortion and contraceptive use. **Therefore, it is sheer falsehood that abortion could be safe**. Some international agencies (eg. Ipas, Planned Parenthood and others), sometimes refer as 'safe', the immediate effects of abortion procedure, when Ipas manual vacuum aspirator (Ipas MVA - Figure 6) is used. The use of the term 'safe' with Ipas MVA shows that, these international organizations have very poor knowledge of practical health care delivery in developing countries especially in Africa. The Ipas MVA plus *has become the easiest way to spread HIV infection in Africa, in women of child-bearing age, who have undergone MVA abortion procedure*. The ease with which MVAs are used, has made it possible for untrained teenagers and university undergraduates in Africa, to use the MVA device in room-to-room service, to perform MVA abortion procedure on desperate girls in hostels. There is no pre-testing for HIV, so infection is spread from person-to-person, in a procedure with high reuse of gloves, syringes and materials. If the aim of introducing the Ipas MVA was to reduce maternal mortality from so-called unsafe abortions, what in practical terms could be achieved is the quadrupling of the HIV infection rate in Africa. Again we ask, what is the rationale for use of MVAs as a public health measure, even for so-called 'safe abortion'? At present, in most African countries, MVA abortion procedure is now being used as a means of contraception. Press reports in South Africa affirm this, where Ipas and IPPF claim to perform 10,000 abortions a week. ***The work of Ipas and IPPF contravenes the constitution in most African countries. We had earlier called for Ipas and IPPF to be expelled from African countries, where their work constitutes a serious constitutional breach. Similarly, African countries should suspend contribution and cooperation with UNFPA, for sponsoring illegal population control activities of pro-abortion groups.*** The US government has already declared UNFPA, an organization committing 'crimes against humanity', and has suspended contributions. African governments should follow this example, by a leading permanent member of the United Nations Security Council.

Figure 6. Ipas MVA plus used for abortion.



We had alleged earlier that, the aim of using the Ipas MVA plus, is to facilitate collection of fetal tissues for stem cell research and transplantation, as the market for stem cell derived tissues is projected to grow into trillions of US dollars. Europe, America and other industrialized countries have moved to prohibit uncontrolled use of embryonic and fetal derived tissues, through several human ethics protocols. Africa remains unrestricted and unregulated for biotechnology companies, who are financing pro-abortion groups to spread the use of Ipas MVA plus. The aim of the pro-abortion movement in Africa is to create a depot, for sourcing stem cells for *Trans-Atlantic Stem Cell Tissue Trafficking*.

D. Restructuring Foreign Aid to Africa: Supplemental Aid based on Carbon Emission Business Exchange

Most people in Sub-Saharan Africa spend two thirds of time and resources, in the quest for basic food, water, electricity and transportation. The foreign aid and loan programs even at current levels, if transparently used would go a long way to provide basic needs like provision of portable water, electricity and transportation. The restructuring of aid packages must go directly to projects in developing countries in agriculture, water, electricity and transportation. A new principle of direct allocation and project execution could be instituted. African governments, when they accept the aid project, must allow donors the independence of execution, according to agreed standards. Project execution must be under joint parliamentary oversight in donor and recipient countries, and violations prosecuted according to the laws in both countries. Part of foreign aid could be a business exchange, for carbon emissions under the Kyoto protocol. Developed countries of the North, may execute environmentally friendly projects in Africa that cuts carbon emission, for example, building gas turbine projects in Nigeria at no cost, and taking credits for the cut down in carbon emissions from diesel generators. Similarly, provision of solar panels to homes, could reduce use of electric generators. The provision of electrically powered trains, buses and bio-ethanol from non-food by-products of cassava and palm, could further reduce carbon emissions. The totality of these effects is that, per capita income would rise and give health and nutrition benefits, that will reduce maternal mortality.

E. Job Creation and World Bank loan facility for African Women A Valid Strategy for HIV Prevention

In Africa, 58% of people living with AIDS are women, and lack of jobs is the one single factor that makes them most vulnerable. While it is not true that contraception is a way to empower women, it is true that, economic independence is the best approach to enhance women's health. Even in conditions when women are well educated, their dependence on male bosses to provide jobs for them makes them, vulnerable to sexual harassment and puts them at risk for HIV infection [Krishnan et al. 2007]. For example, it is known that, female workers in the organized private sector of the banking industry in Africa could be subjected to sexual harassment by customers, endorsed by their supervisors, to meet their financial targets. The solution to this problem is to provide special loan schemes, for women to own independent businesses in Africa. This may be as small as petty trading, tailoring, to large scale manufacturing. These loan schemes could be provided by World Bank direct assistance to the people. The World Bank should have loan partnerships with local banks in Africa, whereby the World Bank provides the funding and the controlling low interest rate. The applications and finance administration, would work through the local banks, not involving local governments. The local bank can only charge a stipulated fixed percent commission, for each loan provided. The system would be kept transparent by financial auditors, of both the World Bank and federal government. Similar programs for apprenticeship training, with low interest loans to employers, and remuneration to participants, could be done by World Bank, USAID, DFID, NORAD, Ford Foundation etc.

F. Dismantling the Failed Concept of Aid as an Instrument of Population Growth Control

The failed concept that, foreign aid could be used to control population growth in Africa should be dismantled from all donor programs. This has led to a catastrophe for Africa in HIV/AIDS prevalence. As we demonstrated here, the compliance with the demand of donor nations, to accept aid on the basis of wide prevalence of contraceptive use, has only led to spread of HIV/AIDS infection in Africa. These policies could not be justified on any basis. ***This policy of aid for population control implies coercion***, ***however, abstinence-education controls population growth on a voluntary basis***.

G. Averting the Social and Economic Consequence of Abortion Psycho *More abortions, more poverty in Africa*.

We can forecast that, *if Africa was to attain the level of contraceptive use and related abortion levels in Eastern Europe in individual countries, more than 35% of the adult population, will be infected with HIV/AIDS, and the entire Sub-Saharan Africa will be dependent on foreign aid for daily survival at less than 50 cents a day*. All countries must have zero tolerance for conditions that, lead to contraception and abortions. Here, faith-based approach should provide women counseling services, and effort should be made to promote an open society, where discussions are held on issues related to sexual violence. What the secrecy of abortion and contraception does is to reinforce taboos, and perpetuate sexual violence. The position should be clear that, society finds it offensive and must punish offenders, protect and rehabilitate victims of sexual violence. Legalized abortion and widespread contraceptive use only widen the scope of sexual violence to the future generation, hiding and perpetuating the social ills of sexual violence.

All African countries should establish National (Federal) Ethics and Moral Commission for Science, Culture and Religion. The mandate of the NEMC or FEMC should among other things include:

a. ***Protection of life from stem cell level to full human development***.
   Africa is the World largest exporter of embryonic stem cells, with European based In vitro fertilization (IVF) satellite clinics, established in most big cities in Africa, to retrieve embryonic stem cells from poor uneducated African women. The egg donor programs are conducted without ethical informed consent, but on the basis of 'food for eggs', as a result, most donors are not aware of the health hazards, including kidney and liver failure. African governments have no legislation and law enforcement structures in place, to protect women and bring under control the unethical practice of in vitro fertilization as required by the Helsinki Declaration. Most investigators of unethical stem cell research have relocated their laboratory in Africa, using proxies in both governmental and non-governmental institutions, to carry out research, which would otherwise not pass ethical boards in Europe and America. Ethical councils should be constituted as broadly as possible in expertise, to make reviews feasible in good time. A review of the ethical boards in Europe and their functions have been provided at: http://www.ethikat.org/_english/publication/Fuchs_International_Ethics_Councils.pdf

b. ***Protection against vaccine contaminants that may cause infertility***.
   Many in Africa believe that, their fertility could be damaged by vaccines for common diseases like tetanus, polio, malaria etc. They believe that, vaccines for tetanus, polio and malaria, have been mischievously merged with immunogenic components to cause infertility in women of childbearing age in Africa. Most people in rural communities in Nigeria have refused vaccination for polio, for the fear of infertility, threatening the World polio eradication program. Despite all assurances, there is still suspicion of the link between vaccines and infertility. It is therefore, imperative that, there be constituted international and national vaccine safety monitoring agencies, charged with quality assurance beyond that, asserted by industry and international donor agencies. This would reassure the people in Africa, and improve cooperation. Failure to accomplish such confidence building measures may undermine the use of vaccination, in the preventive strategy for diseases, with devastating effects on World health.

c. ***Protection of culture and religion using national ethical code of conduct***.
   The situation in Africa, is a gradual and continuing erosion of African cultural values by strong modern influence, but leaves nothing in its place. All African countries must strive to reach a national consensus, on what would constitute common elements of their cultural diversity, and use these values to derive an ethical and moral code of conduct for their country. The traditional structure and religious influence are still strong in Africa, and could contribute immensely to formulation of ethical and moral codes for each country, which would reflect African traditional values of truth and transparency, respect for elders and women, and proclamation of sexual harassment, contraception and abortion as abominations. It is no secret today that, in both public and private sectors, schools, universities and even churches, sexual harassment is epidemic and translates into an abortion/contraception psycho. At the root of corruption in Africa, are sexual crimes. ***The commission must deinstitutionalize sexual harassment, educate the people, prosecute offenders, and rehabilitate victims***. The State must enforce sexual harassment laws with vigor, transparency and community participation.

We have provided concrete evidence that, abortion and contraception have negative influence on health and economy. We decided to make our views known to all heads of UN member states, and to request their assistance, to review the policies that adversely affect Africa and elsewhere. The new emergent African intelligentsia wants to engage with the international community, in order to offer an African Perspective to science and culture, and enrich World knowledge system. There will be no future, if contraception and abortion thrive in Africa, and hence our protest.

We thank you in anticipation.

Yours truly,

Prince Dr Philip C. Njemanze MD, Chairman, for AAAC Council.

Table 1. RHI database from WHO, UNICEF, UNFPA, UNAIDS for Africa, 2006.

	Country	MMR per 100,000	Modern Contraceptives	HIV/AIDS prevalence	§Per capita Income $
1	Angola	1700	4.5	3.7	1350.00
2	Benin	850	7.2	1.8	510.00
3	Botswana	330	38.8	24.1	5180.00
4	Burkina	1000	8.6	2.0	400.00
5	Burundi	1000	10.0	3.3	100.00
6	Cameroon	730	12.5	5.4	1010.00
7	Central	1100	6.9	10.7	350.00
8	Chad	1100	2.1	3.5	400.00
9	Congo	990	4.4	3.2	950.00
10	Congo, Dem Republic	990	4.4	3.2	120.00
11	Côte d'Ivore	690	7.3	7.1	840.00
12	Eritrea	630	5.1	2.4	220.00
13	Gabon	420	11.8	7.9	5010.00
14	Gambia	540	8.9	2.4	290.00
15	Ghana	540	18.7	2.3	450.00
16	Guinea	740	4.2	1.5	370.00
17	Guinea-Bissau	1100	3.6	3.8	180.00
18	Kenya	1000	31.5	6.1	530.00
19	Lesotho	550	29.5	23.2	960.00
20	Malawi	1800	26.1	14.1	160.00
21	Mali	1200	5.7	1.7	380.00
22	Mozambique	1000	11.8	16.1	310.00
23	Namibia	300	42.7	19.6	2990.00
24	Niger	1600	4.3	1.1	240.00
25	Nigeria	800	8.2	3.9	560.00
26	Rwanda	1400	4.3	3.1	230.00
27	Senegal	690	8.2	0.9	710.00
28	Sierra Leone	2000	3.9	1.6	220.00
29	South Africa	230	55.1	18.8	4960.00
30	Sudan	590	6.9	1.6	640.00
31	Swaziland	370	26.0	33.4	2280.00
32	Tanzania	1500	16.9	6.5	340.00
33	Togo	570	9.3	3.2	350.00
34	Uganda	880	18.2	6.7	280.00
35	Zambia	750	22.6	17.0	490.00
36	Zimbabwe	1100	50.4	20.1	340.00

§World Bank Per capita income 2007.

Table 3. shows the list of European countries with percentage of legally aborted pregnancies and per capita income.

	COUNTRY	**% legally Aborted Pregnancies**	**§Per capita income in USD ($)**
1	Russia	53.500	4460.000
2	Romania	46.900	3830.000
3	Belarus	44.600	2760.000
4	Hungary	42.000	10030.00
5	Ukraine	40.400	1520.000
6	Bulgaria	40.300	3450.000
7	Latvia	40.300	6760.000
8	Serbia	31.400	3280.000
9	Georgia	30.000	1350.000
10	Sweden	25.300	41060.00
11	Lithuania	24.600	7050.000
12	Britain	21.800	37600.00
13	France	21.500	34810.00
14	Norway	19.700	59590.00
15	Denmark	19.000	47390.00
16	Italy	18.100	30010.00
17	Iceland	17.400	46320.00
18	Finland	16.100	37460.00
19	Spain	15.800	25360.00
20	Germany	15.300	34580.00
21	Holland	13.000	36620.00
22	Switzerland	13.000	54930.00
23	Belgium	12.900	35700.00
24	Greece	11.100	19670.00
25	Ireland	9.200	40150.00
26	Austria	3.000	36980.00

Source.: Wm Robert Johnston 21st February, 2007.
§World Bank Per capita income, 2007.

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Sent to.:

1. World Leaders, G8 Leaders, heads of state in Africa, and other UN member states.
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