SAARC Development Goals

Commitments & Achievements

South Asian Network for Social & Agricultural Development

SANSAD

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South Asian Network for Agricultural & Social Development

Contents

Abbreviations

AAY:	Antyodaya Anna Yojana
ADB:	Asian Development Bank
AIDS:	Acquired Immuno Deficiency Syndrome
ANDS:	Afghanistan National Development Strategy
ANM:	Auxiliary Nurse Midwives
APL:	Above Poverty Line
ASEAN:	Association of South-East Asian Nations
BHUs:	Basic Health Units
BISP:	Benazir Income Support Program
BPHS:	Basic Package of Health Services
CCTs:	Conditional Cash Transfers
CDIAC:	Carbon Dioxide Information Analysis Center
CFCs:	Chloro-Floro Carbons
CGHS:	Central Government Health Scheme
CLTS:	Community-Led Total Sanitation
CMR:	Child Mortality Rate
CPHEEO:	Central Public Health and Environment Engineering Organisation
CPI:	Consumer Price Index
CPI:	Consumer Price Index
CPRSPD:	Centre for Poverty Reduction and Social Policy Development
CTBs:	Community Toilet Blocks
DAC:	Development Assistance Committee
DFID:	Department for International Development
DOTS:	"Directly Observed Therapy, Short-course"
EDPT:	Early Diagnosis and Prompt Treatment
EFA:	Education for All
EPI:	Expanded Program of Immunization
EU:	European Union
FAO:	Food and agriculture Organization
FBS:	Federal Bureau of Statistics
FCI:	Food Corporation of India
FPS:	Fair Price Shops
FSP:	Food Support Program
FY:	Financial Year
GDI:	Gender-adjusted Development Index
GDP:	Gross Domestic Product
GEM:	Gender Empowerment Measure
GER:	Gross Enrolment Ratio
GNI:	Gross National Income
GNM:	General Nursing and Midwives
GoI:	Government of India
GPI:	Gender Parity Index
HDI:	Human Development Index
HDR:	Human Development Report
HIPC:	Heavily Indebted Poor Countries
HPI:	Human Poverty Index
ICDS:	Integrated Child Development Services
ICIMOD:	International Centre for Integrated Mountain Development
IFIs:	International Financial Institutions
IMR:	Infant Mortality Rate

ISACPA: Independent South Asian Commission on Poverty Alleviation
ITMN: Insecticide Treated Mosquito Nets
JHU: Johns Hopkins University
JMP: Joint Monitoring Programme for Water Supply and Sanitation
JNNURM: Jawaharlal Nehru National Urban Renewal Mission
LDC: Least Developing Country
MCH: Maternal and Child Health
MDGs: Millennium Development Goals
MDM: Mid Day Meal Scheme
MDRI: Multilateral Debt Relief Initiative
MMR: Maternal Mortality Ratio
MRP: Mixed Recall Period
MSDP: Mumbai Sewage Disposal Project
MSP: Minimum Support Price
MTDF: Medium Term Development Framework
NACP: National AIDS Control Programme
NER: Net Enrolment Ratio
NGO: Non Government Organisation
NHDR: National Human Development Report
NHFS: National Family and Health Survey
NLM: National Literacy Mission
NMR: Neo-natal Mortality rate
NPA: National Plan of Action
NPAG: Nutrition Programme for Adoloscent Girls
NREGA: National Rural Employment Guarantee Act
NREGS: National Rural Employment Guarantee Scheme
NRHM: National Rural Health Mission
NRVA: National Risk and Vulnerability Assessment
NSAPR: National Strategy for Accelerated Poverty Reduction
ODA: Official Development Assistance
ODP: Ozone Depletion Potential
ODS: Ozone-Depleting Substances
OECD: Organisation for Economic Co-operation for Development
PCV: Pneumococcal Conjugate Vaccine
PDS: Public Distribution System
PIHS: Pakistan Integrated Household Survey
PPP: Public-Private Partnership
PPP: Purchasing Power Parity
PRSP: Poverty Reduction Strategy Paper
PSLM: Pakistan Social and Living Standards Measurement Survey
RHCs: Rural Health Centers
RPP: Regional Poverty Profile
SAARC: South Asian Association for Regional Cooperation
SDGs: SAARC Development Goals
SEZs: Special Economic Zones
SGRY: Sampoorna Gramin Rojgar Yojana
SSA: Sarva Shiksha Abhiyan
SSP: Slum Sanitation Program
STR: Student Teacher Ratio
TPDS: Targeted Public Distribution System
TSC: Total Sanitation Campaign
ULBs: Urban Local Bodies
UN: United Nations
UNDP: United Nations Development Programme
UNICEF: United Nations Children's Fund
UPE: Universal Primary Education
URP: Uniform Recall Period
USD: United States Dollar
WB: World Bank
WBNP: Wheat Based Nutrition Programme
WHO: World Health Organization
WPI: Wholesale O\Price Index

Foreword

The Millennium Development Goals (MDGs) are arguably the most ambitious developmental objectives ever embraced by the international community. In September 2000, 189 member countries of the United Nations reaffirmed their commitment in the Millennium Declaration, to a global partnership to reduce extreme poverty and end inequality. The MDGs are internationally agreed time-bound and quantified targets for achieving, in most cases by 2015, the reduction of extreme income poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS and other major diseases, ensuring environmental sustainability and developing a global partnership for development.

Four years after the inception of the MDGs, regional Heads of State from South Asia came together in Islamabad for the 12th South Asian Association for Regional Cooperation (SAARC) Summit to assess its progress. By the end of the summit, the Independent South Asian Commission on Poverty Alleviation (ISACPA) released a report entitled "An Engagement with Hope" wherein the MDGs were consolidated into the four broad categories of livelihood, health, education and environment to form the SAARC Development Goals (SDGs). In addition to this SAARC mandate, two other sources of inspiration have guided the preparation of the SDGs: firstly, the regional imperative for galvanizing a popular imagination which allows zero tolerance for a continuation of poverty, and secondly, the international imperative of achieving the Millennium Development Goals (MDGs) by 2015.

The four major categories of the SDGs encompass 22 goals, eight of which relate to livelihood, four to health, four to education and six to the environment, and are the collective vision of South Asian countries to address the problems of poverty and social development. As in the MDGs, the SDGs were also meant to be localized and relevant national targets and indicators adopted to measure progress on combating poverty in the region. We know now that globally the countries that tailored the Goals to their own contexts and needs are the ones that have been most successful, and the foresight and leadership of South Asian Governments in this regard deserves recognition.

The present report is an attempt to assess the progress of South Asian countries towards achieving the targets as inscribed in the SAARC Development Goals. The report reviews and analyzes the trends of only some select measures, where comparable data is available, which have far reaching implications for achieving

balanced and sustainable human development. In particular, the report provides a rich sketch of progress of SAARC countries on health, education and literacy, child and maternal mortality, attempts towards reduction of poverty, improving access to safe sources of water and sanitation, gender parity and women's empowerment as reflected in the trend values of indicators for the targets envisaged in SDGs. This report takes the MDG targets as the benchmark to assess the progress of various countries and is a consolidated evaluation of progress of SAARC countries in achieving the SDGs targets, making it a useful reference document to frame a policy response to bridge the gaps.

It is very important to recognize the remarkable progress made on many of the indices in almost every country in South Asia in the last decade, despite this being a period of exceptional social and political turbulence. Going by official data, the progress on health milestones in Nepal and Bangladesh, and income poverty in India, have been unprecedented. Driven by high rates of GDP and a buoyant global economy, the overarching goal of reducing poverty by half is well within reach of South Asia as a whole. But in sharp contrast, the stark and growing inequalities and low levels of human development in the South Asian region have revived a lively debate on inclusive growth and the balance between wealth creation and redistribution. More than 400 million people are below the poverty line in South Asia, which houses almost 40% of the world's poor. Women, children and those from socially excluded groups continue to bear the brunt of the growing income inequalities. 300 million people are undernourished in South Asia, and 73 million children in India, Bangladesh and Pakistan alone account for half of the world's underweight children. Maternal mortality in the region is at an all time high. Given that chronic poverty in South Asia is intimately linked to social exclusion and discrimination along the lines of caste, tribe, gender, religion and language, it is easy to identify those who are systematically denied decent livelihoods and social services. At the same time, it is very difficult to penetrate social power structures that have been constructed through thousands of years of privilege, often legitimized by organized religion.

We are approaching the 2015 deadline for achieving the MDGs in a context that is much less conducive both in terms of the financial and climate crisis. The need for citizens' action to pressure their national and local governments to keep their MDG commitments and meet the rights and aspirations of the poor and excluded has never been greater. I commend the team at SANSAD for the wake-up call that this document gives to governments and the very valuable tool it provides for advocates and activists to increase state accountability in relation to the Millennium and SAARC Development Goals.

ENDPOVERTY 2015 millennium campaign

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Preface

The whole world is currently passing through a phase of severe financial crisis which may turn into a deep recession if adequate safeguard and compensatory measures are not initiated across the board. The impacts of financial crisis are increasingly being visible in across the region of the world, including SAARC countries. The ILO estimates that, in December 2008, there were 12.8 per cent more unemployed men and 6.7 per cent more unemployed women in the world than in December 2007. The rise in unemployment rates and the rising level of prices of essential commodities may have the potential to halt the progress made on poverty and nutrition front in SAARC countries. Hence the government of these countries should remain vigilant and take substantial and multidimensional measures to ensure that gains made are not eroded.

SAARC countries adopted targets of bridging the development deficits by 2010, a more progressive benchmark than reflected in MDGs indicators, through close monitoring of SDGs indicators. We are left with one year to reach the SDGs targets, and are half way the deadline of MDGs. Hence, it is the most appropriate time to make an assessment of the gains against the grounds to be covered.

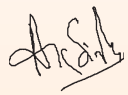
As a part of this study, we solicited country papers from experts in different SAARC countries. However, we received country papers for two countries only, namely Afghanistan and Nepal. We ourselves prepared country Reports for other SAARC countries. After preparing first draft, we circulated country paper to various organizations to get their comments. Finally we incorporated those suggestions in country Reports. Thus, the views expressed in this Report are of different authors, and not necessarily those of SANSAD.

We hope that the systematic cross-country view and the detailed analysis of recent most data sets made in this report will serve as a location point. We visualize that rigorous analysis of achievement of targets of SDGs/ MDGs will help countries to contrast their performances with those of others and make necessary adjustments in their approach to bridge the gap in developmental deficits. We have strong belief that by allowing SAARC countries to compare their progress with those of other parts of the region, a country can then look behind the numbers, identifying the causes of uneven progress, both between and within countries, and

exploring the necessary institutional and policy changes to realize maximum possible benefits for maximum possible number.

I would like to utilize this opportunity for extending my sincere thanks to staff members of SANSAD Secretariat and other contributors without whose assistance this Report would not have been published. I owe a considerable debt to a number of friends and colleagues for making comments and showering encouragements. In particular, I must thank Salil Shetty (Director, UNMC), Minar Pimple (Deputy Director, UNMC), Mandira Moddie (Specialist, UNMC), Fe Loreli Cajegas (Oxfam Novib), Lennard Roubos (ICCO) and Board members of SANSAD for their compassionate encouragement in various stages of report writing. I am greatly appreciative to the work of Dr. Swee Ang (SANSAD intern from Philippines) who initiated the process of Report writing. We must acknowledge our gratitude towards South Asian Facilitation Group Members of Global Call to Action against Poverty (GCAP) who decided to prepare and publish this Report.

It will be inattentive if I miss to mention my utmost gratitude towards funders of SANSAD for financing this study.



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CHAPTER ONE

Introduction

At the United Nations (UN) Millennium Summit held at the UN headquarters in September 2000, all UN Member States reaffirmed their commitment to uphold the organisation's Charter and to tackle inequity at the global level. At the meeting, several key social and developmental challenges facing the global community were identified and actions required to address them were formulated. In the process, the Millennium Development Goals (MDGs) was set up. Building on the United Nations global conferences of the 1990s, the United Nations Millennium Declaration of 2000 marked a strong commitment to the right to development, to peace and security, to gender equality, to the eradication of the many dimensions of poverty and to sustainable human development. Embedded in that Declaration, which was adopted by 147 heads of State and 189 states, were what have become known as the eight Millennium Development Goals, including 18 time bound targets.

To monitor progress towards the goals and targets, the United Nations system, including the World Bank and the International Monetary Fund, as well as the Development Assistance Committee of the Organisation for Economic Co-operation and Development, came together under the Office of the Secretary-General and agreed on 48 quantitative indicators. The indicators built upon an intergovernmental process to identify relevant indicators in response to global conferences. The Secretary-General presented the goals, targets and indicators to the General Assembly in September 2001 in his report entitled "Road map towards the implementation of the United Nations Millennium Declaration".

The goals and targets are interrelated and should be seen as a whole. They represent a partnership between the developed countries and the developing countries "to create an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty".

Each separate issue highlighted in the MDGs are accompanied by clearly defined objectives that help address them. Each objective is further given a pre-set target date in which it should be achieved, with most targets being aimed to be resolved by the year 2015. The MDGs have now become a universal framework for tackling social and developmental agendas. Since the Millennium Declaration of 2000, 189 countries have adopted the MDGs. Indicators and targets for each goal are presented in next page.

Table: Goals, Targets and Monitorable Indicators of MDGs ***Millennium Development Goals (MDGs)***	
Goals and Targets (from the Millennium Declaration)	Indicators for Monitoring Progress
Goal 1: Eradicate extreme poverty and hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day Target	1.1 Proportion of population below $1 (PPP) per day[1] 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
1.B: Achieve full and productive employment and decent work for all, including women and young people Target	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below $1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
1.C: Halve, between 1990 and 2015, the proportion ofpeople who suffer from hunger	1.8 Prevalence of underweight children under-five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary 2.3 Literacy rate of 15-24 year-olds, women and men
Goal 3: Promote gender equality and empower women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education 3.2 Share of women in wage employment in the non-agricultural sector 3.3 Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate 4.2 Infant mortality rate 4.3 Proportion of 1 year-old children immunised against measles
Goal 5: Improve maternal health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal mortality ratio 5.2 Proportion of births attended by skilled health personnel
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.1 Contraceptive prevalence rate 5.2 Adolescent birth rate 5.3 Antenatal care coverage (at least one visit and at least four visits) 5.4 Unmet need for family planning

Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years 6.2 Condom use at last high-risk sex 6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria 6.7 Proportion of children under 5 sleeping under insecticide-treated bednets 6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 6.9 Incidence, prevalence and death rates associated with tuberculosis 6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course
Goal 7: Ensure environmental sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest 7.2 CO2 emissions, total, per capita and per $1 GDP (PPP) 7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.5 Proportion of total water resources used 7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums

Goal 8: Develop a global partnership for development	
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction – both nationally and internationally Target 8.B: Address the special needs of the least developed countries Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction	Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States. Official development assistance (ODA) 8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income 8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied 8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes 8.5 ODA received in small island developing States as a proportion of their gross national incomes
Target 8.C: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly) Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	Market access 8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty 8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product 8.9 Proportion of ODA provided to help build trade capacity Debt sustainability 8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11 Debt relief committed under HIPC and MDRI Initiatives 8.12 Debt service as a percentage of exports of goods and services

Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14 Telephone lines per 100 population 8.15 Cellular subscribers per 100 population 8.16 Internet users per 100 population

Source: Official list of MDG indicators, UNDP(Extracted from http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm)

Four years after the inception of the MDGs, regional heads of Government from South Asia came together in Islamabad for the 12th South Asian Association for Regional Cooperation (SAARC) Summit to assess its progress. By the end of the summit, the Independent South Asian Commission on Poverty Alleviation (ISACPA) released a report entitled "An Engagement with Hope" wherein the MDGs were consolidated into the four broad categories of livelihood, health, education and environment to form the SAARC Development Goals (SDGs). Like the MDGs, the SDGs also represent a framework for overcoming social and development challenges, albeit one that caters specifically to the challenges of South Asian states. However, unlike the MDGs the SDGs have been narrowed down to four major categories and 22 goals. At the 13th SAARC Summit held in Dhaka in 2005, regional governments and heads of state formally adopted the SDGs for the period of five years from 2007 to 2012. Although the SDGs represent a collective response of South Asian countries to address the problem of poverty and social development, formulation of the actual targets and indicators for each of the 22 goals was left to the individual countries to decide.

At the 12th SAARC Summit held in Islamabad, Pakistan (4 -6 January 2004) the Heads of States in their declaration directed the Independent South Asian Commission for Poverty Alleviation (ISACPA) to submit to the Thirteenth SAARC Summit "a comprehensive and realistic blue-print setting out SAARC Development Goals for the next five years in the areas of poverty alleviation, education, health, and environment giving due regard, among others, to suggestions made in the ISACPA Report".

The 13th SAARC Summit held in Bangladesh in January 2006, the SAARC Heads of State and Governments adopted the SAARC Development Goals (SDGs) for the period of 5 years from 2007 to 2012. Taking into consideration both the South Asian context and specificities and the relevant linkages with international goals such as the MDGs, the SDGs include 22 priority goals for the period 2007-2012, eight of which pertain to livelihood, four to health, four to education and six to the environment. Progress towards achieving these specific SDGs will also effectively determine the success the countries will have in combating poverty in the region.

1.	Livelihood	8 Goals
2.	Health	4 Goals
3.	Education	4 Goals
4.	Environment	6 Goals

In addition to this SAARC mandate, two other sources of inspiration have guided preparation of the SDGs: firstly, the regional imperative for galvanizing a popular imagination which allows zero tolerance for a continuation of the inhumanity of poverty, and secondly, the international imperative of achieving the Millennium Development Goals (MDGs) by 2015. In order to prepare the goals for the mandated areas of poverty alleviation (livelihood), education, health, and environment, ISACPA took into consideration three key factors: the specificities of South Asia, linkages with the international goals as set out in the MDGs, and finally, the importance of focusing on process goals as much as on outcome goals.

While the SDGs express the regional will for a comprehensive and strategic response to the problem of poverty and social development, the formulation of specific targets and indicators for these goals to be carried out at the individual country level. The SDGs will develop interface with national-level poverty reduction strategy paper (PRSP) and national development plans.

The first meeting of the SAARC Ministers on Poverty Alleviation held in Colombo, August 6-8, 2006 decided that SAARC Member States initiate national level consultation for formulation of specific targets and indicators of SDGs.

The SAARC Leaders during the 13th Summit endorsed the SAARC Development Goals (SDGs) as recommended by the Independent South Asian Commission on Poverty Alleviation (ISACPA). It was a formidable challenge for the Commission to elaborate the SDGs particularly to identify indicators, benchmark them along with projected targets for the next five years, and to develop a credible monitoring and evaluation framework. The Commission, at its third meeting held at the Secretariat on 25 January 2007, finalized the recommendations and decided to prepare a report titled “Taking SDGs Forward”. We have now monitorable and doable indicators against all the SDGs. The report “Taking SDGs Forward” recommends adoption of 75 indicators for the 22 SDGs. It is expected that adoption of these indicators will help to achieve the SDGs during the next five year period between 2007 and 2012.

SAARC Development Goals and Monitorable Indicators	
Goals	***Indicators***
Livelihood SDGs	
Goal 1 Eradication of Hunger Poverty	i. Malnutrition in children under five years ii. Malnutrition for overall population (in average intake)
Goal 2 Halve proportion of people in Poverty by 2010	i. Percentage of people living on less than 1$ per day (PPP terms) ii. Head Count poverty ratio based on nationally determined poverty line(s)
Goal 3 Ensure adequate nutrition and dietary improvement for the poor	i. Percentage of the poor covered by various food support programmes. ii. Micro-nutrient supplements e.g. % of people having access to Vitamin A, iodized salt etc.
Goal 4 Ensure a robust pro-poor growth process	i. Budgetary/fiscal expenditures for pro-poor growth sectors as % of GDP, and as % of total government expenditures ii. % of poor covered by micro-credit and similar programmes iii. Reduction of Income/Consumption Inequality (Gini coefficient) iv. Rate of growth of employment (disaggregated) v. Assets ownership by poor (quantifiable indicators to be developed) **Additional indicators**: rate of increase of income/ consumption of bottom % of the population compared to top 20 % of the population
Goal 5 Strengthen connectivity of poorer regions and of poor as social groups	i. Transport Connectivity for the Poor in Rural areas (e.g., length of rural roads/availability of boats per 1000 population/average time/distance taken to reach nearest road/major population centre) ii. Communications Connectivity – % of people using telephone/cell phone iii. % of rural population having access to electricity iv. Representation of the excluded groups (dalits/tribals/ indigenous groups) in Local Governance. v. Mass media connectivity – percentage of people using TV and radio
Goal 6 Reduce social and institutional vulnerabilities of the poor, women, and children	i. % of children who are working ii. Share of Women in Employment (wage/self/ organized/ unorganized) iii. Coverage or amount of public expenditure as % of GDP on Social Protection for the Vulnerable Groups iv. Early marriage (average age at marriage; % of girls married before legal age) v. Birth registration (% of children registered) vi. Sex ratio at birth
Goal 7 Ensure access to affordable justice	i. Average Time required in disposal of legal disputes ii. Access to alternate dispute resolution. iii. Access to free legal aid for the poor (marginalized groups)

Goal 8 Ensure effective participation of poor and of women in anti-poverty policies and programmes	i. Percentage of women in local governments/ parliament/ civil service etc. ii. Gender Budgeting – Budgetary expenditures for Women/ Poor as % of total budgetary amount.
Health SDGs	
Goal 9 Maternal health	i. Maternal Mortality Ratio (MMR) ii. Percentage of births covered by the Skilled Birth Attendants (SBA) iii. Life expectancy of women as a ratio of life expectancy of men iv. Age specific fertility rate of 15 to 24 years girls
Goal 10 Child health	i. Immunisation coverage (measles can be a proxy) ii. Under 5 mortality Rate (CMR) iii. IMR iv. Neo-natal Mortality Rate
Goal 11 Affordable health-care	i. Out of pocket expenditure on health as a % of total household expenditure ii. Total government expenditure on health as a % of GDP iii. % of budget allocated to primary health care vis a vis total health budget iv. No. of doctors per 1000 of population
Goal 12 Improved hygiene and Public health Education SDGs	i. % of population with access to safe drinking water ii. % of population having access to sanitation iii. Policies on health education (no. of programs, preventing and health promoting, on communicable diseases e.g. HIVAID, TB and Malaria) iv. Prevalence rate of HIVAIDS, TB and Malaria
Education SDGs	
Goal 13 Access to primary/ communal school for all children, boys and girls	i. %-age of children having access to primary schools by distance (physical or time to be decided by respective countries) ii. Gross Enrolment Rate/Net Enrolment Rate iii. Public expenditure on education in terms of GDP iv. Gender parity at primary and secondary level
Goal 14 Completion of primary education cycle	i. Survival rates (along with drop out)
Goal 15 Universal functional literacy	i. Adult literacy rate
Goal 16 Quality education at primary, secondary and vocational levels	i. %-age of trained teachers ii. Students teacher ratio (STR) iii. %-age of schools with toilets for girls
Environment SDGs	
Goal 17 Acceptable level of forest cover	i. Percentage of forest cover ii. Percentage or extent of community/social forest
Goal 18 Acceptable level of water and soil quality	i. Chemical Fertilizers /pesticides consumption per ha of arable land ii. Percentage of contaminated wells/water sources

Goal 19 Acceptable level of air quality	i. Carbon dioxide emissions (Metric tons per capita) ii. Particulate matter (PM 2.5/10) in the major metropolitan centres iii. Percentage of firewood in total energy mix
Goal 20 Conservation of bio-diversity	i. % and no. of protected areas out of the total land area (with management plan) ii. No. of protected species
Goal 21 Wetland conservation	i. No. and % of protected wetland sites
Goal 22 Ban on dumping of hazardous waste, including radio-active waste	i. Solid waste generation per capita (kg p.a) ii. % of waste treated iii. Regulatory framework for hazardous waste treatment in place.

Source: available www.saarc.org.

Attainment of the SDGs is primarily a responsibility of the individual Member States. MDGs have been contextualised for South Asia through the SDGs, meaning that they are complementary to each other. Attainment of SDGs therefore is directly linked to the progress made towards achieving the MDGs.

Putting in place the benchmarks against indicators as agreed and monitoring mechanism must reflect the distinctiveness and specificity of a country and its regions, and as such are essentially national tasks, although harmonizing indicators have to be done at the regional level. However, so far no country of the South Asian region has been able to complete this task for majority of the indicators. In such a scenario, it is almost impossible to locate the achievement gaps in SAARC Development Goals. Nevertheless, we do have data across majority of the indicators for almost all SAARC countries to assess the trends and progress of SDGs. Thus, this report takes MDG targets as the benchmark to assess the progress of various countries in relation to indicators envisaged in SDGs.

The document intends to assess magnitude of progress in achieving SDG separately for six countries of South Asian region and the South Asia as a whole. The next chapter captures development strides, as reflected in trends magnitude of values of various SDG indicators for the South Asian region as a whole. Chapter 3 highlights the progress made by Afghanistan in achieving human and social development as reflected in trends in SDGs/MDGs mandated development indicators. Progress made and achievement recorded on SAARC Development Goals by Bangladesh is the subject matter of Chapter 4 of this document. Next Chapter highlights the ground realities of India on SDG front. Chapter 6 maps the progress of Nepal on education; livelihood, health and environment sustainability over some recent years through analyzing the values of indicators pertaining to SDGs. Chapter 7 of the document provides the consolidated picture of progress of social and human development in Pakistan with respect to indicators envisaged in SAARC Development Goals. Mapping the progress of Sri Lanka with respect to achievements across social and human development indicators as envisaged in SDGs/MDGs is the subject matter of Chapter 8 of the Report. In the concluding Chapter, We ponder over the way forward and present a consolidated Charter of Demand to accelerate the pace of progress towards achieving SDGs across countries.

CHAPTER TWO

SAARC Development Goals

Mapping the Progress and Prospects of South Asian Region

A Historical Overview of Adoption and Commitments of SDGs

Ever since its inception in 1980, the South Asian Association for Regional Cooperation (SAARC), a Bangladeshi initiative, has been in the process of making a contribution toward regional integration. The association was formally established on December 8, 1995 by seven founding members. Afghanistan joined the association as its eighth member at the 14 Summit held in April last. SAARC has a unique blend of national interests, religions (Hinduism, Islam and Buddhism), and ideologies. Yet the eight-member association has been striving to advance the cause of regional integration and progress in spite of inherent odds. SAARC wish to reach the level of other successful regional organizations. Emulating the examples of ASEAN or EU is a far cry and long way off.

Established in 1985, SAARC comprises Afghanistan, India, Pakistan, Bangladesh, Sri Lanka, Nepal, Maldives and Bhutan which encompasses some 1.5 billion people. The objectives, as stated in its charter include: promoting and improving quality of life of peoples in South Asia; accelerating economic growth, social progress and cultural development; promoting and strengthening collective self-reliance; and building mutual trust, understanding and appreciation of one another's problems.

SAARC countries appreciated the Independent South Asian Commission on Poverty Alleviation (ISACPA) for its elaboration of the SAARC Development Goals (SDGs), which reflect the regional determination to make faster progress towards attaining the Millennium Development Goals (MDGs). They agreed that the national plans for poverty alleviation should appropriately mirror the regional consensus reached in the form of the SDGs and the Plan of Action on Poverty Alleviation. Deciding that resource mobilization for achieving the SDGs would remain a high priority in the Decade of Poverty Alleviation, the Leaders directed translation of the highest regional level political commitment into action for creating opportunities for productive employment and greater access to resources for the poor that are essential for them to enhance their livelihood and realize their potentials. They entrusted the Two-tier Mechanism on Poverty Alleviation to monitor the progress and fine-tune the approaches towards pro-poor growth process. They also endorsed the SAARC Development Goals (SDGs), as recommended by the Commission, and called for follow-up and implementation of the Plan of Action on Poverty Alleviation,

adopted by the 12th SAARC Summit. They entrusted the ISACPA to continue its advisory role.

To make an assessment of the progress made towards achieving the SDGs adopted, SAARC countries decided that Finance Ministers should meet within the first quarter after every Summit and also on the sidelines of the World Bank and ADB annual meetings, to take stock of macro-economic developments and outlook for South Asia, achievement of SAARC Development Goals as co-related to Millennium Development Goals (MDGs) and to assess the investment climate, foreign capital inflows, financial sector reforms and other areas of cooperation.

Deciding that resource mobilization for achieving SAARC development goals would remain the top priority, the leaders directed action for creating opportunities for productive employment and greater access to resources for the poor. Deep poverty yet remains the most intimidating challenge in the region. Various mechanisms have been introduced to provide a far-reaching framework to alleviate poverty.

The SAARC Regional Poverty Profile (RPP), SAARC Development Goals (SDGs), recommendations of Independent South Asian Commission on Poverty Alleviation (ISACPA), observance of the "SAARC Decade of Poverty Alleviation 2006 - 2015" and SAARC Social Charter are some of our efforts towards this goal, while the major obstacle in the process is the funding arrangement to implement the regional poverty projects.

In this respect, they emphasized on undertaking sustained efforts, including developing and implementing regional and sub-regional projects towards the attainment of SAARC Development Goals (SDGs). They noted the decision by the Ministers on Poverty Alleviation to obtain an inter-governmental mid-term review of the attainment of the SDGs to be completed by 2009.

SDGs: Mapping Achievements and Gaps in SAARC Region as a Whole

The SDGs were conceptualized and formulated as a strategic regional response to the urgent imperatives of ridding South Asia of poverty and achieving the international Millennium Development Goals (MDGs) by 2015. Indeed in certain aspects, the SDGs seek to go much further than the MDGs targets and faster. The SDGs are also in a sense a road map for the implementation of the SAARC Social Charter. Endorsed at the Thirteenth SAARC Summit in Bangladesh in 2005, the SDGs mandate covers several important development goals within the four broad areas of livelihood, health, education and environment.

At the very beginning, it is pertinent to note here that, to the best of our knowledge, no country in the South Asian region have charted out a clear roadmap and concrete time-bound targets regarding SDGs, even though, these countries have pledged, on numerous occasions, to prioritize SDGs in their developmental plans. In so far as setting up of specific numerical targets for SDGs, as distinct from mainstreaming of MDGs within developmental plan strategies, is concerned, no progress has yet been made. Furthermore, as may be clear from the issues

discussed earlier, SDGs reflect, as majority of the SAARC perceive it to be, the regional determination to make faster progress towards attaining the Millennium Development Goals (MDGs) and we have country specific reports, at least available in public domain, only. We have the data set on MDGs to monitor the progress of countries across development indicators. Although data availability for SDGs indicators is a concern for us, but to map the progress of SDGs in various South Asian countries, we can make good use of data sets pertaining to indicators of MDGs as the majority of indicators of MDGs are overlapping with those of SDGs. Under such constrained circumstances, our country specific analysis as well as the analysis of progress of South Asian region as a whole is based on exploratory analysis of only those indicators which are included in Millennium Development Goals. This is the major caveat of the analysis of this report. As a result of data limitations and in order to focus on the most basic measures of social and economic deprivation, this report looks closely at the major socio-economic indicators as inscribed in SDGs and MDGs.

Another important point to note here is that we have readily available time series data sets across indicators for major South Asian countries for the years up to 2007 only. The availability and quality of data, although slowly improving, continue to be a major problem that limits our ability to monitor progress and the formulation of effective national policies

Notwithstanding these constraints, we have tried to incorporate all the recent and relevant information to make the report as descriptive as possible.

Global Progress in Poverty Eradication, Health Care, Education and Sustainable Environment

The single most important success to date has been the unprecedented breadth and depth of the commitment to the MDGs – a global collective effort that is unsurpassed in 50 years of development experience. This global collective effort is yielding results.

There has been sound progress in some MDG areas, even in some of the more challenging regions, and a number of targets are expected to be reached by their target dates, mostly 2015:

- The overarching goal of reducing absolute poverty by half is within reach for the world as a whole. Those living in extreme poverty in the developing regions accounted for slightly more than a quarter of the developing world's population in 2005, compared to almost half in 1990.
- In the developing world as a whole, enrolment in primary education reached 88 per cent in 2007, up from 83 per cent in 2000. And most of the progress was in regions lagging the furthest behind. In sub-Saharan Africa and Southern Asia, enrolment increased by 15 percentage points and 11 percentage points, respectively, from 2000 to 2007.

- Deaths of children under five declined steadily worldwide - to around 9 million in 2007, down from 12.6 million in 1990, despite population growth.
- In all but two regions, primary school enrolment is at least 90 per cent;
- The gender parity index in primary education is 95 per cent or higher in six of the 10 regions, including the most populous ones;
- Deaths from measles fell from over 750,000 in 2000 to less than 250,000 in 2006, and about 80 per cent of children in developing countries now receive a measles vaccine;
- The number of deaths from AIDS fell from 2.2 million in 2005 to 2.0 million in 2007, and the number of people newly infected declined from 3.0 million in 2001 to 2.7 million in 2007;
- Malaria prevention is expanding, with widespread increases in insecticide-treated net use among children under five in sub-Saharan Africa: in 16 out of 20 countries, use has at least tripled since around 2000.
- The incidence of tuberculosis is expected to be halted and begin to decline before the target date of 2015;
- Some 1.6 billion people have gained access to safe drinking water since 1990;
- The use of ozone-depleting substances has been almost eliminated and this has contributed to the effort to reduce global warming; at the global level, the world came together to achieve a 97 per cent reduction in the consumption of substances that deplete the Earth's protective ozone layer, setting a new precedent for international cooperation.
- The share of developing countries' export earnings devoted to servicing external debt fell from 12.5 per cent in 2000 to 6.6 per cent in 2006, allowing them to allocate more resources to reducing poverty;
- The private sector has increased the availability of some critical essential drugs and rapidly spread mobile phone technology throughout the developing world.

Source: MDG Report 2008 and 2009; UNDP.

During the period 2000-2006, South Asia was able to achieve high macroeconomic growth with the regional average GDP growth accelerating from 4.2% in 2000 to an estimated 8.2% in 2006, outstripping the average growth rate for developing countries of 6.5%. Bhutan, India and Maldives are expected to reach especially high GDP growth rates in 2006, projected as high as 19% for Maldives, and exceeding 6 % in all countries but one. 2005 per capita income stands at US$ 2300 in the Maldives, and US$1000 in Sri Lanka, roughly doubling their respective 1990 levels (see Table below). Conversely, Nepal continues to have the lowest per capita income in Asia and one of the lowest globally.

A Disjuncture between Impressive Growth Performance and Low Levels of Human Development in South Asian Region

Table: Economic performance trends in South Asia

	GDP (millions $)			*Real GDP growth (%)*			*GDP per capita*				
	1990	*1995*	*2000*	*2005*	*2005*	*2006*	*1990*	*1995*	*2000*	*2005*	*% change 2005/ 2000*
Afghanistan					13.8	8.4					
Bangladesh	29634	36427	45469	58195	6.2	6.7	266	301	350	422	21
Bhutan	277	297	435	595	5.8	10			476	751	58
India	316940	355160	457380	632934	8.5	8.7	316	371	450	596	32
Maldives	262	363	539	667	-3.6	19	1229	1482	1986	2271	14
Nepal	3344		5574	5851	2.3	5	183		241	311	29
Pakistan	39812	60480	73274	109127	7.8	6.6	390	508	526	736	40
Sri Lanka	7936	12925	16543	19652	5.3	6.3	466	755	899	1010	12
South Asia					**8.1**	**8.2**					

Source: World Economic Situation and Prospects 2007; excerpted from www.unicef.org/rosa/ROSA_Social_policy_Economic.pdf

Macro economic growth has contributed to considerable numeric reductions in urban and rural poverty rates throughout the region - with the proportion of the population living below $1 a day decreasing from 41.3% in the 1990s to 31.3% the early 2000s.

Table: Poverty and Inequality in South Asia

	Poverty headcount rate		*Inequality (Gini coefficient)*	
	start period	*end period*	*start period*	*end period*
Bangladesh	33.8 (1989)	30.0 (2003)	28.9 (1989)	31.8 (2000)
Bhutan		31.7 (2003)		41.6 (2003)
India	42.3 (1993)	31.0 (2003)	29.7 (1990)	31.7 (1999)
Maldives		17.3 (2003)		34.8 (2003)
Nepal	34.4 (1996)	24.1 (2004)	37.7 (1996)	47.2 (2004)
Pakistan	47.7 (1991)	17.0 (2002)	33.2 (1991)	30.6 (2002)
Sri Lanka	3.8 (1990)	5.8 (2002)	30.1 (1990)	40.2 (2002)

Source: World Economic Situation and Prospects 2007; excerpted from www.unicef.org/rosa/ROSA_Social_policy_Economic.pdf

However, there is a serious disjuncture across South Asia between the stunning growth rates and trade performance on the one side, and the desolate performance on all indicators of human development, as represented by the SDGs/ MDGs. This is due to a host of factors, ranging from household level behaviors, systematic political and economic exclusion and discrimination, to a wide-spread structural neglect of rural development and agricultural performance. For example, despite the poverty *ratio* reductions, more than 400 million people under the poverty line in South Asia, and it continues to house almost 40% of the world's poor. Most of the poor face multiple forms of disadvantage – they tend to be women or children, and primarily are from socially excluded groups, as will be shown later. South Asian countries are also experiencing growing income inequalities, with the benefits of economic growth being inadequately (re)distributed to the destitute, socially excluded and marginalized. Over the last decade, for several countries (e.g. Sri Lanka, Nepal) the Gini-coefficient has increased by one quarter or one third. The only – positive - outlier in absolute poverty reduction and in income distribution is Pakistan.

Income inequality is accompanied by an only negligible reduction in hunger, measured as the proportion of the population below the minimum level of dietary energy consumption. It decreased from 25% to 22% only, owing to stagnant food production in a situation of increasing population. Even Pakistan – the country with decreases in poverty and inequality - shows a significant absolute increase in the number of undernourished people. As a consequence, South Asia has the largest number of undernourished people, including children, in the world – a total 300 million. 73 million children in three countries – India, Bangladesh and Pakistan – account for half the world's underweight children, although representing only 29% of the developing world's under-five population. Levels of child malnutrition are the world's highest. As one consequence, child mortality and maternal mortality levels are among the highest globally. Given the large numbers of people living in poverty, and the worsening income distribution, estimates suggest that almost 200 million children are growing up in income-poor families, as migrants, and/ or working as child laborers.

Human development indices have improved only marginally over the past 16 years (using 1990 levels as the benchmark), placing South Asia at an HDI of 0.628 in 2007, second lowest only after Sub-Saharan Africa. The HDI – comprising results-oriented outcome indicators - incomes, literacy and life expectancy at birth - can be unpacked into the MDGs, for which South Asia as a region is under-performing with few exceptions. In fact, South Asia is the poorest performing sub-region of Asia, and one of the poorest performing regions globally.

Progress has been achieved in increasing access to improved drinking water and sanitation, but even there South Asia's sanitation coverage remains among the lowest in the world. A few countries are on track for universal primary education, with Bangladesh and Maldives taking the lead, or for gender equality in education, which is a basic right, as well as a basis for girls' development.

Underachievement on the MDGs is the most compelling indicator of the effects of growing inequalities on the background of pervasive social exclusion, which jeopardizes equitable implementation of government-led pro-poor and social inclusion policies.

Persistent poverty, malnutrition and low social indicators in South Asia are an outcome of many factors. Many of the poor live in rural areas, where access to services is difficult because they are remote, or not functioning. Livelihoods are precarious, with many landless laborers, and even those households with access to land suffer the impact of the extremely poor productivity and lack of connectivity of rural areas. As one indicator: agricultural yields in South Asia lie far below that of other regions, and per capita output has decreased in several countries. South Asia – in contrast to its high growth rates in manufacturing and services - shows stagnation or even decreases in agricultural productivity – which in India, Nepal and Pakistan lags behind. Economic growth is also not absorbing the growing labor force, which has increased at the high annual rate of 2.1% over the last decade.

Moreover, an increasingly large number of those who do find work are working poor. In this region, four out of 10 young working people remain below the US$1 per day per person extreme poverty level, and only one in 10 young people earn enough to put themselves and their families above the US$2 per day poverty threshold.

In addition, Bangladesh, India and Nepal in particular face almost perennial natural disasters – drought, floods, and landslides. In these countries, policy-makers face difficult choices with regard to current or future national development priorities in the context of emergency recovery, and/or peace-building, rehabilitation and reconstruction. In such fragile environments, the situation of millions of marginalized and vulnerable women and children has been exacerbated, depriving them of their basic rights and entitlements.

It is obviously challenging for the countries of South Asia to achieve progress in the MDGs, given their large and growing populations. Afghanistan, Bangladesh, India, Pakistan and Nepal count as high population countries and populations continued to grow at rates above 2 % per year in many South Asian countries. But that ought not to be a reason for this poor delivery on the MDGs, given that the macroeconomic growth rates and ensuing fiscal resources could facilitate and finance far better MDGs achievement.

The following sections try to map the progress with regard to SAARC Development Goals for the South Asian region as a whole. At the cost repetition, it is pertinent to emphasize here that progress tracking is contingent upon the data availability across socio-economic indicators identified. We already have mentioned that indicators for SDGs and MDGs are overlapping and complementary, and our analysis is based on trend analysis of data sets available for MDGs.

Goals of Eradication of Poverty, Malnutrition and Hunger in South Asian Countries

Hunger is a term for which there is no single, clear, and universally-accepted definition. According to the MDG standard, the average daily energy requirement for adults undertaking light activity is 2,200 calories. But there are also varying degrees of hunger. The International Food Policy Research Institute suggests three categories: the 'subjacent hungry', who consume between 1,800 and 2,200 calories per day; the 'medial hungry', consuming 1,600 to 1,800 calories; and the 'ultra hungry', consuming less than 1,600 calories. According to FAO, on the basis of the 2,200 calorie standard about 545 million people in Asia and the Pacific are undernourished – constituting 65 per cent of the World's undernourished. Of these, 300 million are in South Asia of whom 233 million are in India.

Although the South Asia region has seen an overall reduction in both the number and prevalence of undernourished people, the average rate of reduction has fallen short of what would be required to meet the MDG of halving the undernourished population by 2015. Furthermore, while the prevalence of hunger has fallen, the number of undernourished people has increased, largely as a result of increased numbers in China and India (FAO, 2006).

Another vital indicator of hunger is the proportion of under-5 children who are underweight. Here the region has been making progress, but far too slowly. The various forms of malnutrition have enormous human costs. In Bangladesh and India, for example, more than 30 per cent of all children are born under weight, and run greater risks of dying in infancy, or of suffering stunted physical and cognitive growth. The impact of hunger is worst on girl children and women, who typically eat least and last, often surviving on left-over.

Table: Percentage of people living on less than $1.25 purchasing power parity

	1990	*1999*	*2005*
Northern Africa and Western Asia	3.5	3.8	3.8
Sub-Saharan Africa	55.7	56.3	50.3
Latin America and the Caribbean	9.7	10.8	8.0
Eastern and South-Eastern Asia	56.0	35.5	17.8
Southern Asia	**48.9**	**42.2**	**38.6**
Commonwealth of Independent States	1.9	6.8	5.4
Transition countries of South-Eastern Europe	0.1	1.7	0.5

Source: Based on Millennium Development Indicators, Database 2009; UNDP.

Tackling hunger and malnutrition is a huge and complex undertaking, but one of the most basic tasks is to ensure food security and particularly grain security. This requires grain that is nutritionally adequate and socially acceptable but also that people have full economic, physical and social access to such grain at all times.

In almost all South Asian countries, poverty gap ratio (a measure of depth of poverty) is higher than 30 percent, except for Sri Lanka. Based on international standard of 2 USD a day, the proportion of population living below poverty line is at a staggering level of 75 percent or more in South Asian countries with India (80.4 %), Bangladesh (84 %) and Pakistan (73.6 %) leading the group. Sri Lanka again here is placed at better position with ratio being 41.6 percent. Not only that majority of the population in South Asian countries well below poverty line, but they are facing the scourge of inequality as reflected in the ratio of shares in consumption of the poorest to richest deciles of the population. Here, the performance of Sri Lanka is worse than other South Asian countries.

Table: Trends in Poverty (as measured by International Yardsticks), Inequality and Shares in Consumption in Major South Asian Countries

	2005		*1990-2005*		*1990-2004*					
	GDP per Capita (PPP USD)	*HPI-1 (%)*	*Population below poverty (USD 1 a Day)*	*Population below poverty (USD 2 a Day)*	*Below Poverty (national line)*	*Share of Poorest 10% in consumption*	*Share of Richest 10% in consumption*	*Ratio Richest to Poorest 10%*	*Gini Index*	*HDI Rank*
Sri Lanka	4595	17.8	5.6	41.6	25	3	32.7	11.1	40.2	99
India	3452	31.3	34.3	80.4	28.6	3.6	31.1	8.6	36.8	128
Pakistan	2370	36.2	17	73.6	32.6	4	26.3	6.5	30.6	136
Bangladesh	2053	40.5	41.3	84	49.8	3.7	27.9	7.5	33.4	140

Source: Human Development Report 2007/ 2008, UNDP.

Relative deprivations of South Asian countries are reflected in the trends of Human Development Index produced by yearly publication of UNDP. Trend data suggests that although all SAARC countries are making progress towards raising the level of human development (a composite indicator constituted by per capita income, adult literacy and healthy life years), yet the pace of progress is far from satisfactory.

Table: Human Development Index (some recent trends)

	1975	*1980*	*1985*	*1990*	*1995*	*2000*	*2005*
Sri Lanka	0.619	0.656	0.683	0.702	0.721	0.731	0.743
Maldives	–	–	–	–	–	–	0.741
India	0.419	0.45	0.487	0.521	0.551	0.578	0.619
Bhutan	–	–	–	–	–	–	0.579
Pakistan	0.367	0.394	0.427	0.467	0.497	0.516	0.551
Bangladesh	0.347	0.365	0.392	0.422	0.453	0.511	0.547
Nepal	0.301	0.338	0.38	0.427	0.469	0.502	0.534
Afghanistan	–	–	–	–	–	–	0.312

Source: Human Development Report 2007/ 2008, UNDP.

As we have discussed earlier, lack of opportunities of gainful employment is the root cause of poverty in South Asian countries.

The proportion of employed population living below the poverty line is at a staggering level of more than 40 percent (poverty line being USD 1 per day).

Country	*1992*	*1993*	*1994*	*1995*	*1996*	*1997*	*1999*	*2000*	*2002*	*2004*	*2005*
Bangladesh	39.6				39.2			49.9			
India	68	55.5	59.4	67.6		59.3		47.7			39.1
Nepal					44.7					33.7	
Pakistan						21.4	18.7		24.7		12.7
Sri Lanka					9.8			10.9	8.4		

Source: Extracted from Data base of Millennium Development Indicators; UNDP 2009.

On account of virtual absence of remunerative employment opportunities, major SAARC countries have been unable to lift their population from the quagmire of poverty and destitution as reflected in the table portrayed below. A clear emerging trend is that the South Asian region performs quite badly vis-à-vis rest of the world, except for Sub Saharan Africa.

Table: Trends in Proportion of Population living below Poverty Line (USD 1.25 per day)

Country	*1991*	*1992*	*1993*	*1996*	*1997*	*1999*	*2000*	*2002*	*2003*	*2004*	*2005*
Bangladesh		66.8		59.4			57.8				49.6
Bhutan									26.2		
India			49.4								41.6
Nepal				68.4						55.1	
Pakistan	64.7		23.9		48.1	29.1		35.9			22.6
Sri Lanka	15			16.3				14			

Source: Extracted from Data base of Millennium Development Indicators; UNDP 2009.

From the analysis provided above, it may be clear that South Asian countries have succeeded in reducing the proportion of people below poverty line to a comfortable extent. But the present ratio, in the vicinity of 40 percent is still at an unacceptably high level. Further more, the recent increases in the price of food have had a direct and adverse effect on the poor. Poor people who do not produce their own food are the most severely hurt because a larger proportion of their expenditure is allocated to food. Higher food prices limit their ability to obtain not only food but also other essential goods and services, including education and health care. Most of the urban poor and the landless rural poor are in this position. Poor farmers, on the other hand, can benefit from higher food prices if they are able to produce

more than they consume. But many lack the resources to do so, in part because higher oil prices have raised the cost of fertilizer. Overall, higher food prices are expected to push many more people into absolute poverty, with estimates suggesting that the increase will be as many as 100 million. Most of the increase will occur in sub-Saharan Africa and Southern Asia, already the regions with the largest numbers of people living in extreme poverty.

Conflict continues to displace people from their homes and drive them into poverty. Southern and Western Asia and sub-Saharan Africa are home to the largest populations of refugees. Within the South Asian region, Bangladesh, Sri Lanka and Pakistan are facing enormous problems on the issues of taking care of these refugees.

Trends in Health and Morbidity Indicators in SAARC Region

Public health is public good, and thus by definition the government has a central role to play in the universal provisioning of quality health care services to its citizens. The loss of GDP on account of morbidity and pre mature death has been estimated to be staggering globally. Rationally speaking, the government should fix top priority to better health outcomes of the population, and until this target is achieved, all other targets can wait. Moreover, as bulk of the evidence suggest, occasional and severe private health expenditure shock is the prime factor in pushing people below the poverty, howsoever defined, and perpetuating it. Thus, addressing health related problems should be the supreme priority.

South Asian countries perform far worse than other regions on health indicators, be it maternal mortality, child survival, prevalence of fatal diseases like Malaria, Tuberculosis, or other health problems on account of unhygienic conditions and severe malnutrition.

Trends in Maternal Mortality Indicators in SAARC Region

An important indicator for measuring progress for women is the maternal mortality ratio – which is a strong indicator of the attention that is paid to health care for women. Across the region around a quarter of a million women die each year as a result of events as natural as pregnancy and childbirth, and many are left disabled or chronically ill. The target is to have reduced the maternal mortality ratio by three quarters between 1990 and 2015. Unfortunately, this important indicator is difficult to measure accurately, whether through vital registration data or through sample surveys, and few countries have sufficient data to indicate trends.

The region's overall maternal mortality ratio, at over 400 per 100,000 live births is over 35 per cent higher than the rate in Latin America and the Caribbean, and maternal deaths in South Asia for almost half of the global total. Only the countries of Sub Saharan Africa face such a grave problem of maternal health.

Table: Trends in Maternal mortality ratio in South Asia vis-à-vis other Regions of the World		
	1990	*2006*
World	430	400
Developing Regions	480	450
Northern Africa	250	160
Sub-Saharan Africa	920	900
Latin America and the Caribbean	180	130
Eastern Asia	95	50
Southern Asia	620	490
South-Eastern Asia	450	300
Western Asia	190	160
Oceania	550	430
Developed Regions	11	9

Source: World Health Report; 2008; WHO.

Another important indicator reflecting access to maternity health is the proportion of institutional delivery. The progress of South Asian region leaves much to be desired. While globally this ratio above 60, for SAARC countries as whole, this ration is only 40 which is a serious cause of concern.

Table: Proportion of births attended by skilled health personnel		
	Around 1990	*Around 2006*
World	49	62
Developing Regions	47	61
Northern Africa	45	79
Sub-Saharan Africa	42	47
Latin America and the Caribbean	68	86
Eastern Asia	71	98
Southern Asia	27	40

Source: World Health Report; 2008; WHO.

Country wise performance shows gross divergence across countries of SAARC region. Apart from Maldives and Sri Lanka, no country has made significant progress towards securing institutional births of the baby which have far reaching health implications of the mother and children.

Table: Trends in Proportion of Institutional Births in South Asian Countries				
Country	*1991-93*	*2000-01*	*2003*	*2004-06*
Afghanistan		12.4	14.3	
Bangladesh	9.5	12.1	13.9	20.1
Bhutan	14.9	23.7	56.1	
India	34.2	42.5		46.6
Maldives	90	70.3		84
Nepal	7.4	11.9		19.8
Pakistan	18.8	23		31
Sri Lanka	94.1	96		

Source: World Health Report; 2008; WHO.

Adolescent pregnancy contributes to the cycle of maternal deaths and childhood mortality. Very early motherhood not only increases the risk of dying in childbirth, it also jeopardizes the well-being of surviving mothers and their children. Young mothers frequently miss out on education and socio-economic opportunities. A child born to an adolescent mother is at greater risk of dying in infancy or childhood and is likely to be deprived of the known benefits passed down from educated mothers to their children. Reducing adolescent fertility contributes directly and indirectly to achieving the maternal health and other goals.

The starting point for improving maternal survival is close attention to women's health and nutrition status generally, including reproductive health care and good antenatal care. But any woman, however healthy or well nourished can suffer complications in pregnancy that may require emergency obstetric care. In such situations, she should have the support of a skilled birth attendant who can recognize any danger signs, take the necessary action, and refer the patient quickly to an appropriate health facility. In many parts of the World, the proportion of births with this assistance is quite high, close to 100 per cent, including developed countries and many in the Eastern Asian countries. The countries with the highest maternal mortality ratios the proportion of women who get this kind of support is often far lower. However, the cases of South Asian countries present the opposite scenario: higher maternal mortality ration as a consequence of lower access to institutional delivery.

Table: Trends in Child mortality Indicators and Status of Child Health and Nutrition

	1990	*2000*	*2007*
World	93	80	67
Developing Regions	103	88	74
Northern Africa	83	48	35
Sub-Saharan Africa	183	167	145
Latin America and the Caribbean	54	35	24
Eastern Asia	45	36	24
Southern Asia	122	94	77
South-Eastern Asia	77	47	34
Western Asia	67	47	34
Oceania	85	73	59
Developed Regions	11	8	6

Source: Based on Database of Millennium Development Goals Indicator, 2009; UNDP

Globally, child mortality globally has fallen to a record low (UNICEF, 2008), but the situation in South Asia is still of great concern. Some 3 million children in the region die before they reach the age of five. Child mortality is closely related

to gender inequality. Prevailing patriarchal norms in several countries have resulted in preferential treatment for boys over girls so that girls' standards of health and nutrition are neglected. When countries are monitoring child mortality rates, they should therefore pay close attention to the sex ratios.

As may be noted from the table given above, child mortality has registered a continual and significant decline over last decade and a half in South Asian countries, from 122 in 1990 to 77 in 2007 for which we have the latest data available. In absolute terms, the performance of SAARC countries seems impressive which recorded a 2.5 % per annum reduction in under-5 mortality. However, if we compare the performance of South Asian countries with those of Northern Africa (where under-5 mortality declined from 83 to 35) and South-Eastern Asia (from 77 in 1990 to 34 in 2007), the inescapable observation is that the performance of South Asia as a whole leaves much to be desired.

Thus, there are miles to travel to reach the destination as reflected in low child mortality rates prevailing in some developed countries. Not only are that child mortality rates unacceptably high in South Asian countries, there is some depressing trends of stagnation in progress in some of countries. For example, in Afghanistan, it has been stagnant at a high level of 257 during the last fifteen years or so. Bangladesh has been able to reduce this rate substantially from 149 in 1990 to 61 in 2007, while India and Pakistan have registered some progress at snail's pace as may be evident from the Table portrayed below. The most curious case is of Nepal which has managed to pull it down to commendably low level of 55 in 2007 which was around 142 in 1990.

Table: Children under-5 mortality rate per 1,000 live births

Country	*1990*	*1995*	*2000*	*2005*	*2007*
Afghanistan	260	257	257	257	257
Bangladesh	149	120	92	73	61
Bhutan	166	133	100	75	84
India	115	102	89	78	72
Maldives	111	85	54	33	30
Nepal	142	118	86	63	55
Pakistan	130	118	108	99	90
Sri Lanka	32	25	19	14	21

Source: Extracted from Millennium Development Indicators Database, 2009 UNDP

Antenatal care is an essential safety net for healthy motherhood and childbirth, where the well-being of both the prospective mother and her offspring can be monitored. The proportion of pregnant women in the developing world who had at least one antenatal care visit increased from slightly more than half at the beginning of the 1990s to almost three fourths a decade later. However, the performance of South Asian countries has been far from impressive on this count

and there are significant regional differences in the trends values of this indicator. As per the estimates of 2007, while Sri Lanka has been able to record antenatal care coverage (at least one visit) of 99.4 percent, Bangladesh (51.2) and Pakistan (36%) are still struggling to widen the outreach of antenatal care services to pregnant women. The case of India presents a mixed picture which has succeeded in widening the coverage of antenatal care from a figure of 49.1 % in 1990 to 74.2 % in 2007, registering an annual growth of roughly 1.5 %.

Table: Antenatal care coverage, at least one visit (%)

Country	*1991-1996*	*2000*	*2001*	*2005-2007*
Afghanistan		36.9		
Bangladesh	25.7	33.3	39.8	51.2
India	49.1	61.8		74.2
Nepal	15.4	27	27.9	60.9
Pakistan	25.6		43.3	36
Sri Lanka	80.2	94.5		99.4

Source: Extracted from Millennium Development Indicators Database, 2009, UNDP

While majority of the countries have shown gradual and consistent progress in increasing the proportion of immunized children against measles, the case of India is a cause of great concern. The immunization coverage has declined from 72 in 1995 to just 67 in 2007 as may be clear from the Table given below. However, Sri Lanka (98 %), Maldives (97 %) and Bangladesh (88%) have taken significant strides towards immunization of children against measles, perceived to be a major cause of child mortalities

Table: Children 1 year old immunized against measles (%)

	1990	*1995*	*2000*	*2004*	*2005*	*2006*	*2007*
Afghanistan	20	41	35	61	64	68	70
Bangladesh	65	79	76	81	81	81	88
Bhutan	93	85	76	87	93	90	95
India	56	72	52	58	59	59	67
Maldives	96	96	99	97	97	97	97
Nepal	57	56	71	73	74	85	81
Pakistan	50	47	56	67	78	80	80
Sri Lanka	80	87	99	96	99	99	98

Source: Extracted from Millennium Development Indicators Database 2009, UNDP.

Frequent instances, widespread prevalence and subsequent deaths on account of TB have generated much vigorous policy response across the board. New and more effective interventions, including DOTS, have been developed, and production and

distribution of key medicines have improved. Countries have also been quicker to adopt more successful strategies that would have been out of reach if less funding were available. These developments suggest that even greater strides may be made in the fight against TB in the coming years.

Table: Incidence of tuberculosis (per 100000 populations)

	1990	*2000*	*2006*	*2007*
World	122	127	128	118
Developing Regions	149	150	151	139
Northern Africa	60	50	44	42
Sub-Saharan Africa	150	253	291	234
Latin America and the Caribbean	84	67	53	44
Eastern Asia	122	105	100	100
Southern Asia	**172**	**168**	**165**	**160**
South-Eastern Asia	277	229	210	202
Western Asia	54	43	38	38
Oceania	202	191	183	158
Developed Regions	25	19	15	14

Source: Based on Data Base of Millennium Development Indicators 2009, UNDP.

An important point to note in this regard is that the incidence (new cases) of TB (per 100000 population has remained around 125 for the last 15 years or so for the World as a whole. On the one hand, countries of Eastern Asia, Latin America have made significant improvements in reducing the incidence of TB, for countries of Southern Asia the incidence has remained almost invariant at the high level of 160-170 for past decade and a half. Success in eradicating tuberculosis rests on early detection of new cases and effective treatment. Africa, China and India collectively account for more than two thirds of undetected tuberculosis cases.

We admit that South Asian countries have extent of TB incidence worse than the countries of Sub Saharan Africa. In addition, we may find, from the table portrayed below, that the performances of SAARC countries are highly unequal. On the one hand, Afghanistan, Maldives, and Bhutan have registered accelerated progress towards reduction of TB incidence during the last 15 years. While, on the other hand, Bangladesh, India, Nepal and Pakistan have recorded stagnant ratio of TB incidence.

Table: Tuberculosis incidence rate per year per 100,000 populations in South Asian Countries					
Country	*1990*	*2000*	*2004*	*2005*	*2007*
Afghanistan	247.8	208.3	175.3	168.3	161.3
Bangladesh	263.8	238.7	229.3	227	224.8
Bhutan	207.2	127.9	105.4	100.5	95.7
India	167.8	167.8	167.8	167.8	167.8
Maldives	138.5	68.9	52.1	48.6	45.3
Nepal	243	198.9	183.6	180	176.4
Pakistan	181.3	181.3	181.3	181.3	181.3
Sri Lanka	60.5	60.5	60.5	60.5	60.5

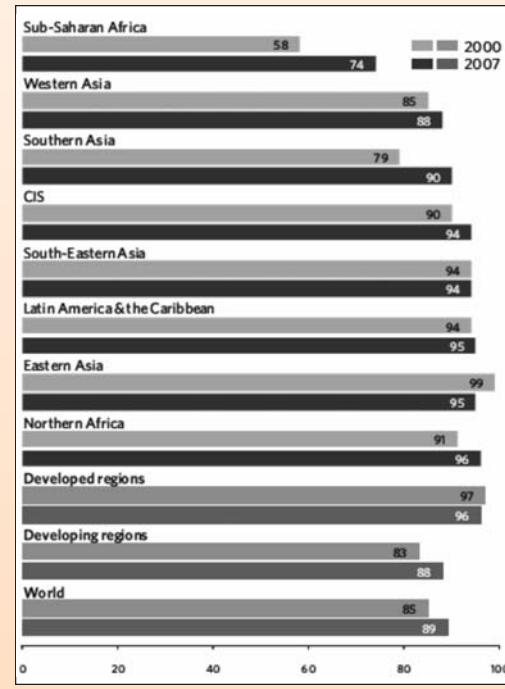
Source: Based on Data Base of Millennium Development Indicators, 2009, UNDP

The discussion presented above illustrates that South Asian countries, in general, have pathetic health records, primarily on account of under investment in primary health care services. In particular, India, Bangladesh and Pakistan are among the countries which show depressing trends in almost every health related indicators.

Taking Stock of Education, Literacy and Gender Parity related Indicators in South Asian Countries

Most South Asian countries give a high priority to education – in which they invest significant private and public resources. This effort has paid off.

Figure: Net enrolment at Primary Level (%) in South Asian Countries vis-à-vis other Regions



Source: Extracted from Millennium Development Goals Report 2009, UNDP.

Primary education is one of the region's great successes: almost all countries in the region have net primary enrolment ratios above 85 per cent and for many the ratio is approaching 100 per cent.

Table: Net enrolment ratio in primary education

	1991		*2000*		*2007*	
	Boys	*Girls*	*Boys*	*Girls*	*Boys*	*Girls*
World	87.2	76.7	87.3	82.3	90.3	87.7
Developing Regions	85.7	73.3	86.2	79.6	89.6	86.5
Northern Africa	89.7	75.5	94.0	88.4	97.4	93.7
Sub-Saharan Africa	57.5	49.5	61.8	55.0	76.1	70.9
Latin America and the Caribbean	87.5	86.3	95.1	93.5	94.9	94.8
Eastern Asia	100.0	97.3	98.6	99.7	94.9	95.6
Southern Asia	**85.7**	**57.0**	**85.7**	**71.9**	**91.7**	**87.8**
South-Eastern Asia	97.8	94.0	95.5	93.0	94.7	93.4
Western Asia	87.0	73.3	89.1	80.4	91.5	84.7
Developed Regions	97.7	98.1	97.5	97.4	96.1	96.8

Source: Based on Millennium Development Goals Report 2009, UNDP.

Though, at an aggregate level, performances on enrolment ration may be comfortable in South Asian countries, the progress of Bhutan, Nepal and Pakistan is a cause of concern. For these countries, the ratio has remained well below 75 percent. The region's performance is less impressive, however, when it comes to repetition and completion. Many children have to repeat classes or drop out of school before reaching grade five. The problems are greatest for children from poor households – reducing the prospect of education lifting them out of poverty.

Table: Proportion of pupils starting grade 1 who reach last grade of primary schooling

	1999			*2007*		
	Total	*Boys*	*Girls*	*Total*	*Boys*	*Girls*
World	81.7	84.4	78.8	87.3	89.2	85.3
Developing Regions	78.9	82.2	75.5	85.8	88.0	83.4
Northern Africa	86.6	90.4	82.6	95.1	97.0	93.1
Sub-Saharan Africa	49.9	54.2	45.6	63.1	68.5	57.7
Latin America and the Caribbean	96.6	96.1	97.1	100.4	99.7	101.2
Eastern Asia	101.8	101.5	102.1	100.7	101.2	100.3
Southern Asia	**66.9**	**73.4**	**60**	**80.6**	**83**	**78**
Developed Regions	99.2	98.6	99.9	98.6	97.9	99.2

Source: Extracted fro Millennium Development Goals Report 2009; UNDP.

The data on elementary education provide a mixed picture. Net Enrolment ratio have registered significant progress in SAARC countries, but the primary schooling completion rate provides a dismal picture. From the Table given above, it seems clear that South Asian countries have made some progress in the proportion of pupils starting grade 1 who reach the last grade of primary schooling. It increased from 66.9 in 1999 to 80.6 in 2007. In addition, there has been noticeable progress in the completion rate of primary schooling for girls which increased from 60 percent in 1999 to 78 % in 2007.

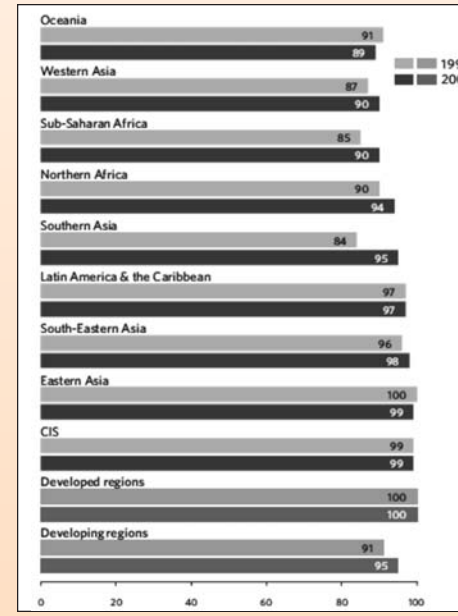
However, as is clear from the table, South Asian countries fall way behind the performances of the other regions including Northern Africa (completion rates of 95 % in 2007) and Latin America and the Caribbean (with a completion rate figure of 100.4 %).

Trends in Indicators of Women Empowerment in South Asian Countries

There is a clear balance of opinion is that a country cannot achieve its developmental targets if leaves behind the women who constitute roughly half of the population. In other words, women empowerment in arrays of fields (including livelihood issues, literacy, favorable health outcomes, and political representation) may provide a stimulus to achieve desired socio-economic goals.

As part of its success in raising the total primary enrolment rate, Southern Asia has made the most progress in gender parity since 2000 as may visible in the Figure depicted below. In 1999, girls' secondary school enrolment in relation to boys' was 84 percent, which increased to 95 percent in 2007. This is commendable achievement from the perspective of gender balance in human development opportunities.

Figure: Girls' secondary school enrolment in relation to boys', 1999 and 2007 (Girls per 100 boys)

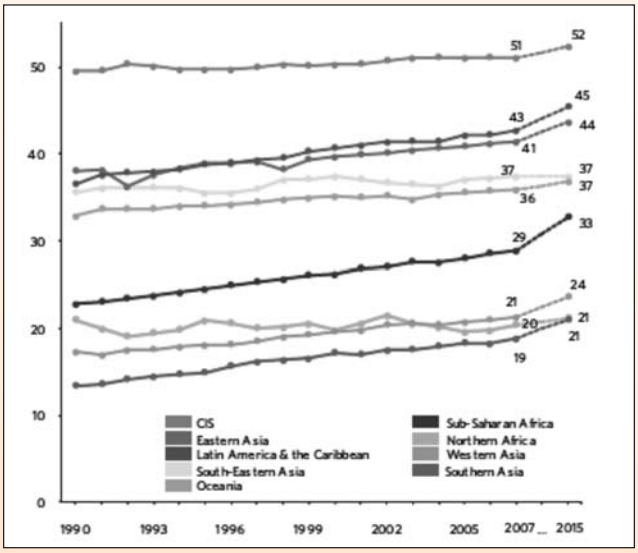


Source: MDG Report; 2009; UNDP

Though in primary schooling, gender gaps are continually declining in almost all South Asian countries, the gaps are more visible in secondary and tertiary levels of schooling.

Another important indicator of women empowerment is the share of women in non-agriculture wage employment as this indicator reflects the entitlement of women in earnings and command over physical resources. Women are also disproportionately represented in part-time, seasonal and short-term informal jobs and therefore are deprived of job security and benefits. Occupations continue to be gender-specific, and female dominated positions tend to be characterized by inferior status, lower pay and poorer working conditions. South Asian countries are among the worst performers where the share of women in non agricultural wage employment is below 20 percent; even countries of Sub Saharan Africa fares much better the countries of SAARC region where roughly one out of every 3 employees is a woman. This fact is reflected in the following graphics.

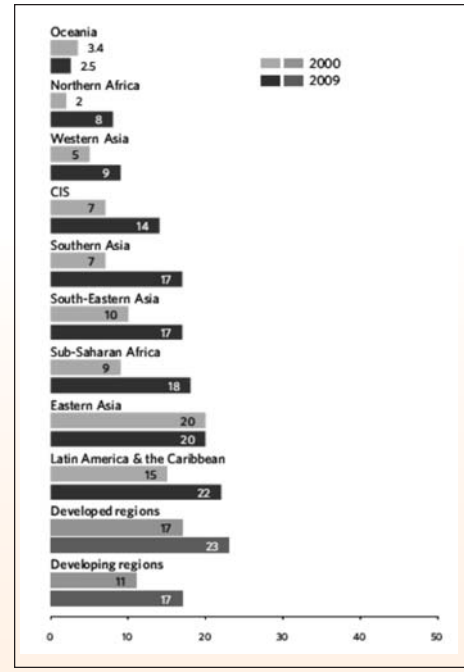
Figure: Employees in non-agricultural wage employment who are women, 1990 and 2007 (Percentage)



Source: Source: Extracted fro Millennium Development Goals Report 2009; UNDP.

Yet another important indicator representing the political empowerment of the women is their share in parliamentary seats. Women across the globe are slowly gaining ground in political decision-making, but progress is erratic and marked by regional differences. While in Scandavian and other developed countries, the share of women in parliament is roughly above 25 percent, the ration for South Asian countries well below 15 percent.

Figure: Proportion of seats held by women in single or lower houses of national parliaments, 2000 and 2009 (Percentage)



Source: Source: Extracted fro Millennium Development Goals Report 2009; UNDP.

Trends in Environment, Water and Sanitation Indicators in South Asian Countries

In 2007, the Fourth Assessment Report of the Intergovernmental Panel on Climate Change made it abundantly clear that the climate is warming and "most of the observed increase in globally averaged temperatures since the mid- 20th century is very likely due to the observed increase in anthropogenic greenhouse gas." Carbon dioxide released by the burning of fossil fuels accounts for more than half of the global greenhouse gas emissions responsible for climate change. Although rich nations still contribute towards degradation of environment, contributions of South Asian countries is too spreading thick and fast.

Table: Trends in Emissions of CO2 in SAARC Countries

Country	*1990*	*1995*	*2000*	*2003*	*2004*	*2006*
Afghanistan	2614	1239	770	389	693	697
Bangladesh	15369	22599	28051	35585	37165	41609
Bhutan	128	253	396	385	414	381
India	682137	915521	1155043	1263723	1342962	1510351
Maldives	154	275	499	587	726	869
Nepal	631	2038	3230	2951	3043	3241
Pakistan	68068	84533	106087	101626	125669	142659
Sri Lanka	3762	5796	10189	10291	11534	11876

Source: Data Base of Millennium Development Indicators 2009; UNDP.

Another important indicator reflecting environment sustainability is the proportion of area covered by forests. The situation in majority of the South Asian countries is a cause of concern. Leaving aside the case of Bhutan and India (where this ratio has remained stagnant around 22 percent of the gross land area portrayed), all other countries in this region have recorded deteriorating performance as is visible in the table below.

Table: Proportion of land area covered by forest (%)

Country	*1990*	*2000*	*2005*
Afghanistan	2	1.6	1.3
Bangladesh	6.8	6.8	6.7
Bhutan	64.6	66.8	68
India	21.5	22.7	22.8
Maldives	3	3	3
Nepal	33.7	27.3	25.4
Pakistan	3.3	2.7	2.5
Sri Lanka	36.4	32.2	29.9

Source: Data Base of Millennium Development Indicators 2009; UNDP.

Water and Sanitation

Apart form being an important in their own right, wide spread access to improved sources of water and proper sanitation facilities have the potential to reduce substantially the morbidity and mortality of preventable diseases. Access to improved drinking water facility in South Asian countries, Afghanistan, has been among the worst performers and roughly 80 percent of populations do not have access to safe drinking water.

Table: Proportion of the population using improved drinking water sources

Country	*1990*	*1995*	*2000*	*2006*
Afghanistan		21	21	22
Bangladesh	78	78	79	80
Bhutan			81	81
India	71	77	82	89
Maldives	96	95	87	83
Nepal	72	78	83	89
Pakistan	86	87	88	90
Sri Lanka	67	71	77	82

Source: Data Base of Millennium Development Indicators; 2009, UNDP.

However, access to proper and improved sanitation facilities provides a dismal picture for the South Asian countries a whole. Every two out of five people in the region have access to improved sanitation facilities with wide ranging divergences across countries. Sri Lanka (86 %), Maldives (59 %) and Pakistan (58 %) are among the better performers while India (28 %), Afghanistan (30 %), Bangladesh (36 %) belong the category of dismal performers.

Table: Proportion of the population using improved sanitation facilities in SAARC Countries

Country	*1990*	*1995*	*2000*	*2006*
Afghanistan		32	30	30
Bangladesh	26	28	32	36
Bhutan			52	52
India	14	18	23	28
Maldives		57	58	59
Nepal	9	15	20	27
Pakistan	33	40	48	58
Sri Lanka	71	76	81	86

Source: Data Base of Millennium Development Indicators 2009; UNDP.

Concluding Comments

Thus, the progress of South Asian countries in reaching the goals set under SDGs/ MDGs are far from impressive. While on the issues relating literacy, primary school enrolment ratios, and access to improved water facilities are encouraging, the region lags much behind the targets in the field of Child and maternal health, prevention of fatal diseases, access to improved sources of sanitation and gender balance and women empowerment as reflected in the trend analysis of various relevant indicators.

CHAPTER THREE

Progress and Prospects of achieving SDGs in Afghanistan

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A Brief Overview of Socio-Economic Developemnt

In December 2001, when the Interim Administration of Afghanistan assumed authority after twenty-three years of war, Afghanistan was by all measures a ruined society. Since then, Afghanistan has made impressive gains in rebuilding institutions and repairing the social fabric. With the election of the President and the parliamentary and provincial council elections in September 2005, the people of Afghanistan have demonstrated that they can and want to live in a democratic society. They want to focus on building their state after years of devastation and they want to improve their well-being. It has held two *Loya Jirgas*, adopted a new constitution establishing an Islamic democratic state, held a presidential election, and will soon hold parliamentary and provincial council elections. It has enrolled more than four million children in school, welcomed four million returning refugees, and assured that, despite the effects of drought and displacement, there has been no starvation.

Afghanistan has lost over two decades in war when most countries, particularly in Asia, made substantial economic and social progress and improved the lives of their people. In the years of war that followed, hundreds of thousands of people, most of them innocent civilians, were killed, a third of the population was uprooted and forced into exile, villages were devastated, the country's educated class and educational system were destroyed, and the modest advances made by Afghanistan's women were cruelly reversed. The country's food production fell by one half. Government ceased to be an instrument for providing even modest services to people; instead it became an instrument of control through fear and violence. Narcotics traffickers looking for new sources of supply induced many Afghan cultivators to turn to opium poppy, creating a parallel economy that funds trafficking, warlordism, and corruption.

Achieving targeted development goals in Afghanistan, therefore, is not just a desirable developmental goal, but a necessity for the security of the country, the region and the World. International research suggests that the poverty of nations

is closely linked to the threat of civil war: On average a negative economic growth shock of 5 percentage points increases the risk of civil war by about 50%. In Afghanistan we see the link more concretely where nearly 40% of the rural population cannot count on having sufficient food to satisfy their most basic hunger; 57% of the population is under 18 years of age but with little hope of employment; in much of the country over 80% of the people are illiterate; life expectancy is under 45 years; and arms supplied for decades by foreign patrons of armed groups are freely available; recruiting fighters is incredibly cheap; and some families send their sons to join armed groups in return for the guarantee that they will be fed.

Much agricultural land is deserted or mined; irrigation systems are damaged or destroyed; prices of essential goods have skyrocketed over decades as leaders both distributed foreign aid and printed money to pay armed groups; roads to market have disintegrated into dust or mud; there is limited rural credit or agricultural aid; and it is no wonder that farmers turn to the opium poppy, providing raw material for the profits of traffickers, warlords, and international organized crime.

Poverty, Hunger and Malnutrition in Afghanistan

For almost a quarter of a century, from 1978 to 2001, the people of Afghanistan endured an extraordinary sequence of events, which had a devastating impact on their economy, society and country. These events led to a near total collapse of its physical and economic infrastructure and institutions, to human rights abuses, a decline in social sector investment, and to pervasive destitution in a country that had always been poor but had always retained a degree of human dignity.

Poverty is a bundle of deprivations and in Afghanistan it is characterized by a lack of opportunities and capabilities, limited access to services, insecurity, powerlessness, a lack of voice and representation, and extreme vulnerability to shocks. On the HDI, Afghanistan is ranked close to the bottom, alongside such African countries as Burkina Faso, Burundi, Mali, Niger and Sierra Leone.

Poverty is about people and numbers often mask the human suffering and deprivation that are its manifestations. But numbers are needed to inform public spending decisions, understand the impact of policies on economic growth and poverty reduction, and track progress on achievement of mutually agreed targets.

Although Afghanistan has made great strides in raising its level of economic prosperity, along with access to health care and education, the needs of many remain unfulfilled. Afghanistan's HDI stands at 0.345, far behind those of its regional neighbors. Indeed, the index for 2007 falls slightly under that of 2004 (0.346). In terms of global rankings, this places Afghanistan 174 out of 178 countries— ahead of only four other countries, all of these in sub-Saharan Africa: Burkina Faso, Mali, Sierra Leone, and Niger. Afghanistan's poverty is even more marked in relation to its neighbors.

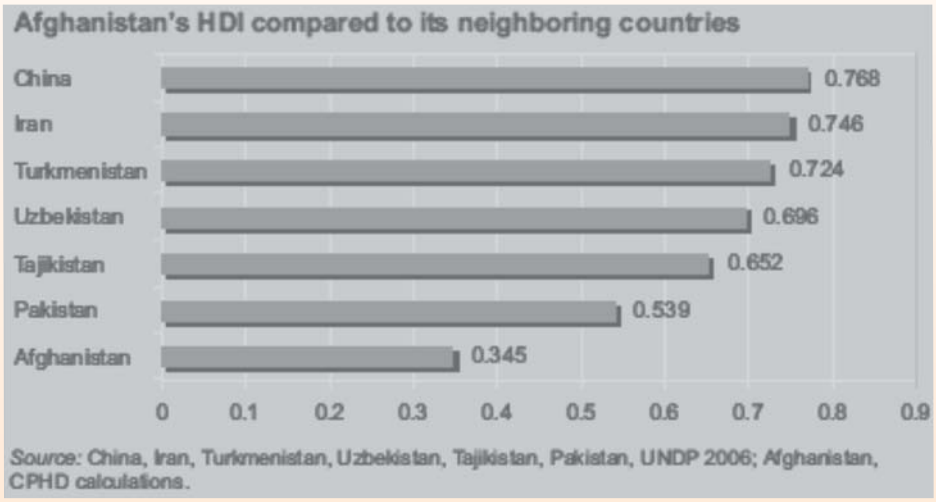
Figure: Trends in HDI for Afghanistan (2004, 2007)

Trend of HDI indicators for Afghanistan during 2004-2007 period

Indicators	*Afghanistan HDR 2004*		*Afghanistan HDR 2007*	
	Value	*Year*	*Value*	*Year*
HDI	0.346	2002	0.345	2005
GDI	0.300	2002	0.310	2005
HPI	59.3	2002	62.3	2005

Source: Based on Datasets of Human Development Indicators; Various Years.

Figure: Afghanistan HDI vis-à-vis its Neighbors



Source: Extracted from Afghanistan Human Development Report 2007; Various Years;.

GDP per capita has risen from $683 in 2002 (in PPP terms) to $964 in 2005. The gross enrolment ratio (for the primary, secondary and tertiary levels combined) has risen to 59.3 % in 2005, up from the figure of 45 % for 2002 reported in NHDR 2004. However, the percentage of girls attending school remains well below that of boys. Similarly, while levels of malaria and tuberculosis have dropped markedly, health indicators for both women and children remain exceptionally low. The female mortality rates reflect the dire conditions in which most of them live.

Although a significant increase in the number of female health workers has potentially broadened female access to health care, it can never adequately treat the effects of widespread violence against women in Afghanistan. In addition, both life expectancy and adult literacy have fallen. Life expectancy at birth is estimated at 43.1 years for 2005, compared with 44.5 in 2003. Adult literacy fell from 28.7 % in 2003 to 23.5 % in 2005.

Because reducing poverty is essential to improving human development, calculating the Human Poverty Index (HPI) is vital. In contrast to the HDI, which portrays average achievements, the HPI focuses on deprivations, specifically those that limit a long and healthy life, a decent standard of living, and lack of knowledge or exclusion from the world of reading and communication. At 62.3, the HPI for Afghanistan is one of the worst in the world. The probability at birth of not surviving to age 40 has been calculated at 0.419. The HPI for Afghanistan is even worse than that for Mali, whose HPI is 60.2. Adult illiteracy stands at 76.5 %. As many as 68 % of the population lack sustainable access to clean water, and 50 % of Afghan children under five are underweight.

Figure: Progress in the Achievement of Development Goals in Afghanistan

Some indicators of progress of AMDGs

	MDG	Indicator	Kuchi	Rural	Urban	National average
1	Eradicate extreme poverty and hunger	Proportion of population below minimum level of dietary energy consumption (%)	24	30	31	30
2	Achieve universal primary education	Net enrolment rate in primary education	9	36	53	37
		Literacy rate of 15-24 year-olds (%)	5	25	63	31
3	Promote gender equality and empower women	Ratio of girls to boys in primary education	0.5	0.6	0.9	0.7
		Ratio of literate women to men, 15-24 years old	0.9	0.3	0.8	0.5
4	Reduce child mortality	Proportion of 1-year-old children immunized against measles (%)	35	51	63	53
5	Improve maternal health	Proportion of births attended by skilled health personnel (%)	7	9	52	53
6	Combat HIV/AIDS, malaria and other diseases	Use of condoms (%)*	17	8	9	8
7	Ensure environmental sustainability	Proportion of population using solid fuels (%)	98	98	75	94
		Proportion of population with sustainable access to an improved water source, urban and rural (%)	16	26	63	31
		Proportion of population with access to improved sanitation, urban and rural (%)	0	3	28	7
		Prop. HHs with secure housing tenure (%)	28	44	83	49
8	Develop a global partnership for development	Telephone lines and cellular subscribers per 100 population	0.1	0.3	8.3	1.5
		Personal computers in use per 100 people	0.00	0.01	0.52	0.09
		Internet users per 100 people	0	0.01	0.18	0.03

Source: Afghanistan MDG Report, 2005; UNDP.

Assessment of Progress of Afghanistan with respect to Development Goals

Eradication of Extreme Hunger and Poverty

The Afghan economy has maintained an impressive rate of economic growth over the past few years. Yet this growth has failed to significantly reduce extreme poverty and hunger in the country; 6.6 million Afghans do not meet their minimum food requirements, with 24 % of households characterized by poor food consumption. Based on a minimum caloric intake of 2067 kilocalories per day adjusted by sex and age, 30 % of the population eats, on average, below their daily requirement.

Table: Population (%) below minimum level of dietary energy consumption adjusted by age and sex (2005)

Percentage	Kuchi	Rural	Urban	National
	24	30	31	30

Source: *NRVA 2005.*

Households in urban areas are slightly more food-insecure than both rural and Kuchi populations. When diversity of diet is included in the analysis, 61 % of households are likely to be below the threshold for food insecurity. Nearly 40 % of children fewer than three years of age are underweight, 54 % of children under five are stunted, and 6.7 % are wasted due to malnutrition. In general, 44 % of the population view themselves to varying degrees as food insecure. The highest percentage of households that struggled to meet their food needs lie in Nuristan province and in the central part of the country. The following Table presents facts regarding poverty, employment, hunger and malnutrition in Afghanistan. Employment to population ratio is declining in some most recent years (to be precise, it declined from 58.8 in 2005 to 55.7 in 2007). Even though there has been some improvement in employment to population ratio for men from 81.7 in 2005 to 83,6 in 2007, the overall ratio has declined on account of massive deterioration in women participation from 34.1 in 2005 to 25.6 in 2007.

Table: GDP growth, Employment and Child Malnutrition in Afghanistan

	1992	*1997*	*2000*	*2004*	*2005*	*2006*	*2007*
Growth rate of GDP per person employed (%)	3.51	2.79	4.67	6.82	-0.62	4.35	
Employment-to-population ratio(%)	55.9	55.9	56	56.6	58.8	58.4	55.7
Employment-to-population ratio, men (%)	79.7	79.9	79.9	79.9	81.7	81.1	83.6
Employment-to-population ratio, women (%)	30	30	30.2	31.5	34.1	33.8	25.6
Children under 5 underweight (%)		48	41.2	39.3			
Children under 5 severely underweight (%)			13.6	12.4			

Source: Based on Datasets of Millennium Development Indicators; 2009, UNDP

Universalization of Elementary Education and Literacy in Afghanistan

Despite marked progress in primary education, over half of school age children remain out of school. The national average for attendance of children six to thirteen years of age is estimated at 37 %. Enrollment in urban areas is considerably higher than that in rural areas, and there is almost a 1:1 ratio of girls and boys attending primary school in urban areas. Although the reasons for the greater level of attendance of girls in urban areas may be due to variations in cultural factors, it probably stems from greater access as well. Distance is often referred to as the most common reason for keeping girls out from going to school.

Figure: NER in Primary Education in Afghanistan (2005)

Net enrolment (%) in primary education (6 to 13 years old)

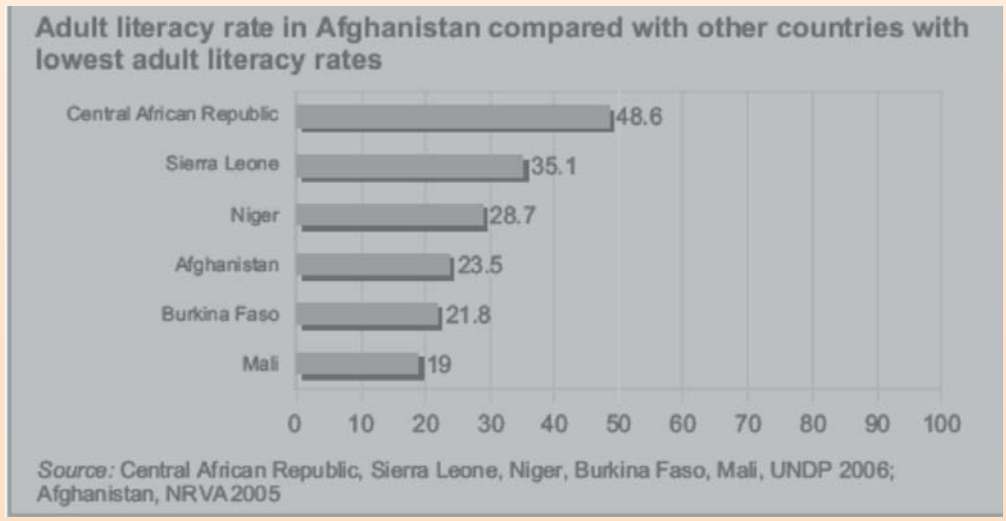
	Kuchi			*Rural*			*Urban*		
	Female	*Male*	*All*	*Female*	*Male*	*All*	*Female*	*Male*	*All*
	6	11	9	27	44	36	51	55	53

Source: NRVS 2005

Source: Extracted from Afghanistan Human Development Report 2007.

The disparity in the number of boys in school compared to girls continues to be voluminous—an issue of concern that needs focused attention and energy. Girls still face significant obstacles that prevent them from accessing education, including restricted movement, a shortage of female teachers (who comprised only 28 % of teachers in 2005), poor facilities, competing demands on girls' time and the lack of value placed on female education.

Figure: Adult Literacy Rate in Afghanistan vis-à-vis some SSA Countries in 2005



Such hurdles are more common in rural than urban areas. Provinces in the South and South-east continue to exhibit particularly low levels of enrollment for girls and boys. Zabul (1 %), Uruzgan (1%), Helmand (6%) and Paktika (9%), in the South and South-east have the lowest levels of enrollment. Insecurity has become an increasingly formidable challenge to accessing education. The number of attacks on schools, teachers, and students rose considerably into 2006.

Table: Enrolment, Gender parity and Literacy Rates in Afghanistan

	2000	*2005*
Primary completion rate, both sexes		37.7
Primary completion rate, boys		53.5
Primary completion rate, girls		20.8
Literacy rates of 15-24 years old, both sexes, %	34.3	
Literacy rates of 15-24 years old, men, %	50.8	
Literacy rates of 15-24 years old, women, %	18.4	
Women to men parity index, as ratio of literacy rates, 15-24 years old	0.36	

Source: Based on Datasets of Millennium Development Indicators; 2009, UNDP.

While the issue of access to education remains significant, the quality of education in Afghanistan remains poor and also requires concerted attention. Through its new National Education Strategy, the Government is committed to increase school enrollment with a focus on expanding the attendance rate of girls, while increasing simultaneously both access to and the quality of education. The Table given above summarizes the achievements and gaps in the achievements of Afghanistan relating to enrolment, gender parity and literacy goals. A Primary School completion rate in Afghanistan is at a spectacularly low level of 37.7 % in 2005 with massive gender gaps. While 53.5 % of enrolled boys complete their primary education, the ratio for girls is at a meager level of 20.8 percent. Youth Literacy rate in Afghanistan is 34.3 % with substantial gender gaps: youth literacy rate among female is 18.4 % while those of male is 50.8 %.

Gender Equity and Women Empowerment in Afghanistan

As has been discussed earlier, while girls' access to education has increased, particularly in urban areas, additional energy and resources must be focused on improving access to education for girls in rural areas. Enrollment rates for women at the primary, secondary and tertiary levels are almost half that of men– 41.8 % for females and 73.7 % for males. Afghanistan's adult literacy rate ranks sadly among the lowest in the world. Only 23.5 % of the population 15 years and above can read and write. More shocking, only an estimated 12.6 % of women are literate, compared to 32.4 % of men. The female to male literacy ratio is 0.4 for the entire population, far lower than in neighboring countries such as Iran (0.8) and Pakistan (0.6).

There is also a large discrepancy in the estimated earned income between females ($478) and males ($1428). Yet, in Afghanistan, 80-90 % of economic activity occurs within the informal sector. Women often work at home in agriculture, livestock management and as caregivers, but such activities, while income-generating, are not remunerated. Women continue to face a number of barriers to earning their own livelihoods, inhibiting their empowerment as well as their ability to enjoy their rights. In addition, high fertility affects women in a number of ways. Frequent pregnancy often prevents women from pursuing an education or from taking part in gainful economic opportunities.

Women's limited access to education further inhibits their productivity and ability to participate more widely in the economy. Cultural constraints on women's movement, as well as security concerns, also limit women's access to work outside of the home.

Whereas women's low literacy rate remains an urgent issue, the trend to empower women politically at the national level is encouraging. By allocating women a minimum 25 % of the seats in the *Wolesi Jirga* (lower house) of the National Assembly, Afghanistan has taken steps to bring about gender parity in the formal representation of women in decision-making.

The trends shown in the following Table makes it apparently clear that the index of gender parity in primary level of education had in fact declined from 0.55 in 1991 to 0.44 in 2004. However, the trend has reversed its direction and index moved upwards to reach the level of 0.63 in 2007. The story for gender parity in secondary level education is even more frustrating as we can observe declining trends when the index registered a significant decline from 0.51 in 1991 to 0.38 in 2007. In so far as tertiary education is concerned, the value of the index of gender parity was 0.28 in 2004.

Table: Gender Parity in Education and Political Empowerment of Women in Afghanistan

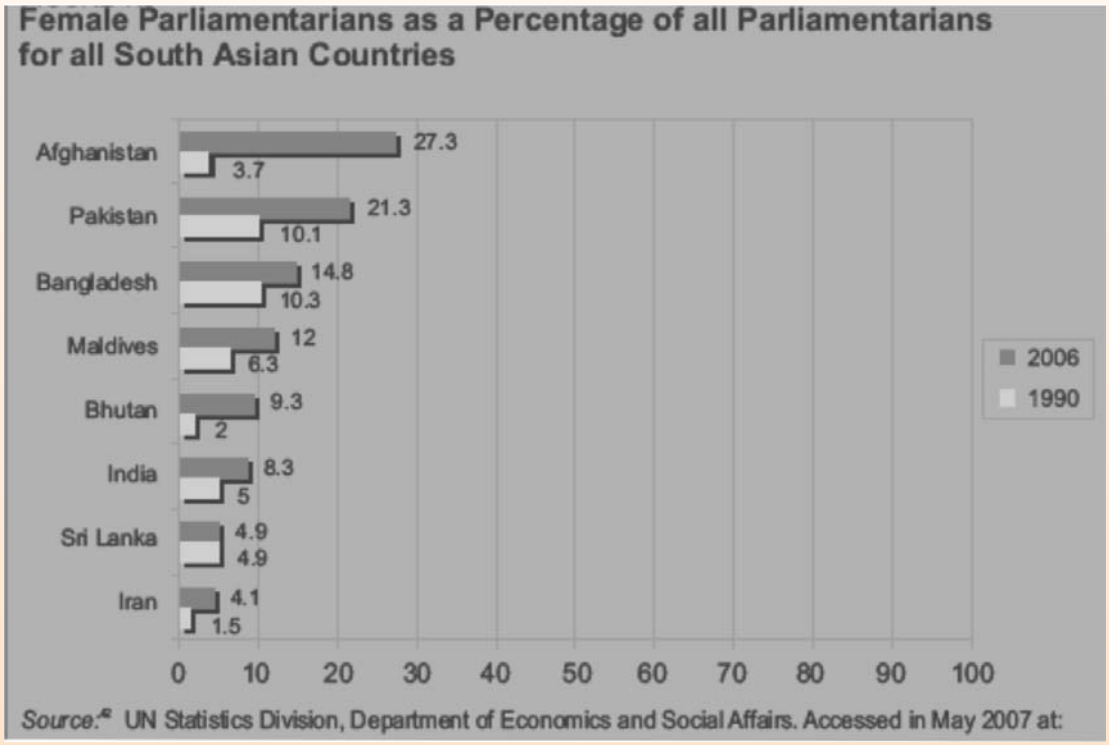
	1990, 91	*2004*	*2006*	*2007*	*2009*
Gender Parity Index in primary level enrolment	0.55	0.44	0.64	0.63	
Gender Parity Index in secondary level enrolment	0.51	0.21	0.37	0.38	
Gender Parity Index in tertiary level enrolment		0.28			
Seats held by women in national parliament %	3.7		27.3	27.3	27.7
Total number of seats in national parliament	189		249	249	242
Seats held by men in national parliament	182		181	181	175
Seats held by women in national parliament	7		68	68	67

Source: Based on Datasets of Millennium Development Indicators; 2009, UNDP.

The share of women in non-agricultural wage employment was at a low level of 17.8 % in 1990 for which we have the latest data available. Another important indicator vis-à-vis empowerment of women is the proportion of seats occupied by

women in national parliament/assemblies. In regard to the extent of women's participation in national politics, Afghanistan fares well among its neighbors as well as among the South Asian Association for Regional Cooperation (SAARC) members as may be evident from the graphics provided below. In Afghanistan, more than a quarter (to be precise, 27.3 percent) of seats of the parliament is occupied by women in Afghanistan whereas comparable figures for India (8.3 %), Bangladesh (14.8 % as per the Table,. However, female representation Parliament has declined substantially to 6.3 % in 2009) in recently held elections in Bangladesh), Sri Lanka (4.9 %) and Pakistan (21.3 %) are well below the level achieved in Afghanistan in 2006. The number of women participating in governance does not, however, reveal their decision-making power or to the extent which their voice is heard.

Figure: Female Parliamentarians in Afghanistan vis-à-vis other SAARC Countries (%)



Violence against women in Afghanistan is widely believed to have reached epidemic proportions. Yet, because the majority of cases remain unreported due to the severe restrictions women face in seeking justice or redress, limited evidence exists to confirm this perception. Women suffer from tremendous human rights violations. One example is the high level of forced and child marriages. Between 60 and 80 % of marriages in the country are forced.

In contrast to Afghanistan's neighbors, male mortality is lower than female mortality for women above 24 years. This is the likely cause of the extremely poor condition in which women in Afghanistan live. Lack of access to health care, poor nutrition, and frequency of marriage before fifteen probably all contribute to this mortality rate.

Child and Maternal Nutrition and Mortality Related Goals

The probability at birth of not surviving to age 40 is .419 in Afghanistan. This figure is the highest of any SAARC member country or of any of the countries surrounding Afghanistan.

Figure: Some Facts on Child and Maternal Health in Afghanistan

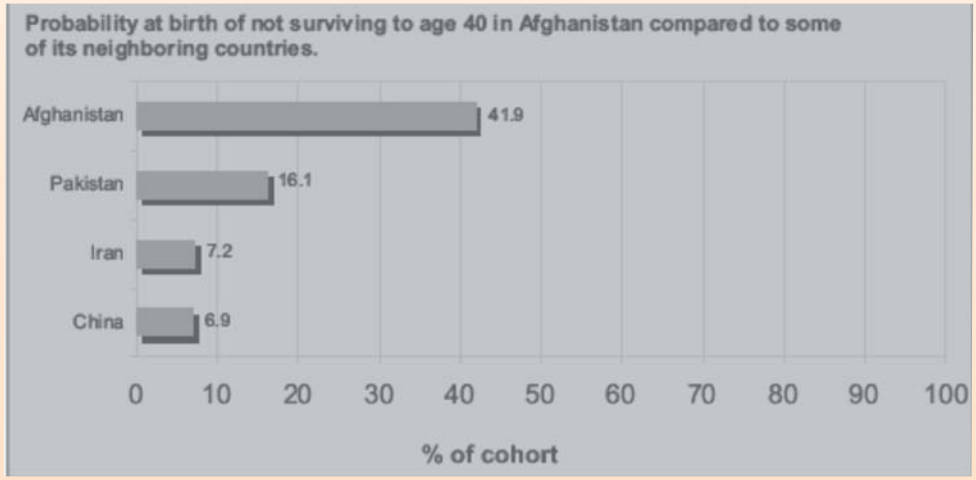
Fast facts on child and maternal health in Afghanistan:

- Infant mortality rate per 1,000 live births: 135
- Under-5 mortality rate per 1,000 live births: 257
- Probability at birth of not surviving to age 40: 0.431
- Maternal mortality ratio per 100,000 live births: 1,6000

Source: NRVA 2005; JHU 2007; UNICEF 2007

Yet notable progress is being made in improving the health of Afghan babies; the rate of Afghans dying before their first birthday has fallen from 165 to135 per 1,000 live births. This results in 40,000 more successful births each year.

Figure: % of People not surviving to age 40



Source: WHO Report, 2008.

As available data indicates, the mortality rate for children under-5 remains the world's third highest. Health indicators for Afghan women and children are a matter

of serious concern. High mortality rates stem at least in part from a lack of access to safe drinking water, food, poor access to health care services, inadequate sanitation, and low literacy. Many of the country's immunization programs have showed marked success in recent years. The measles immunization program has led to coverage for 64 % of children under twelve months of age. The proportions of children immunized against TB and Polio are 73 and 76 respectively which at par with average achievements of SAARC countries.

Figure: Coverage of Immunization against Measles, TB and Polio (2005)

Afghanistan Immunization-related facts

- 1 year-olds immunized against measles: 64%
- 1 year-olds immunized against TB: 73%
- 1 year-olds immunized against polio: 76%

Source: Based on Datasets of Millennium Development Goals Indicators

The Government initiated the Basic Package of Health Services (BPHS) in 2003 to address the greatest health problems within Afghanistan, particularly those of the most in need, including women and children. The BPHS is now essentially the basis for the primary care system in Afghanistan. A number of reforms have bolstered health services for women and children, including those in remote rural areas. The Package focuses on the main causes of morbidity and mortality in a cost-effective and affordable manner, and is now accessible to 82 % of the population. Its success thus far provides great hope and momentum for continued progress in reducing child mortality.

The presented below provides the fact sheet of Child mortality and immunization in Afghanistan.

Table: Immunization and Child Mortality in Afghanistan

	1990	*1995*	*2000*	*2005*	*2007*
Children under five mortality rate per 1,000 live births	260	257	257	257	257
Infant mortality rate (0-1 year) per 1,000 live births	168	165	165	165	165
Children 1 year old immunized against measles (%)	20	41	35	64	70

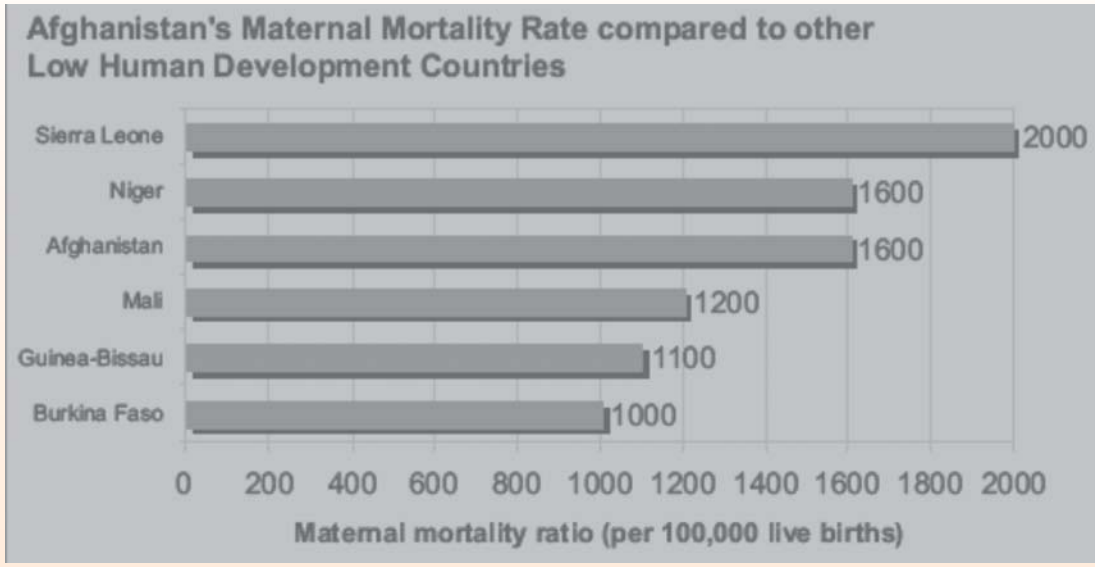
Source: Based on Datasets of Millennium Development Goals Indicators, 2009, UNDP

Even if the coverage of immunization in Afghanistan is moderate, child mortality in Afghanistan is stagnant at high level of 257 per 1000 live births. Similarly, infant (0-1 year's children) mortality is stubbornly stable at an unacceptable level of 165 in some most recent years. However, as we have noted earlier, immunization of children against measles has increased substantially from 20 % in 1990 to 70 % in 2007, with no improvement in child mortality rates.

Assessing Maternal Health Status in Afghanistan

Afghanistan's maternal mortality ratio (MMR) is estimated at 1600 per 100,000 live births. Kabul had an MMR of 400 per 100,000, and a remote rural district of Badakhshan 6,500 per 100,000 live births. This particular local rate is the highest ever recorded, even in a country with one of the highest MMRs in the world. Only a few other countries, including Angola with 1700, Malawi with 1800, and Sierra Leone with 2000 deaths per live births are comparable.

Figure: Maternal Mortality Rates in Afghanistan



Source: Based on Datasets of Human Development Report 2007/2008; UNDP.

The disparity in the number of women assisted by skilled health personnel in urban and rural areas in this regard is vast. While 52 % of mothers in urban areas are assisted by skilled personnel, only 9 % in rural areas are. This highlights that women in rural areas do not have access to any form of reproductive health care, as well as the urgent need to continue to expand and improve the provision of health care services for women in remote rural areas. Women in Afghanistan face many barriers to accessing health care. Not only does their restricted mobility inhibit their visiting health facilities; the treatment of women by male doctors is largely considered unacceptable. As indicated above, the BPHS is improving health services throughout the country, but a more concerted effort is needed to meet the needs of Afghan women, particularly in rural areas. Significant progress has already been forthcoming. Not only has the number of health care workers increased to 15,001 in 2007; 49.3 % of these are women.

Nonetheless, many challenges remain. Many of the deaths of women and children are largely preventable. Such deaths are a direct result of the young age of marriage, overall poor health, frequency of child birth as well as virtually no access

to gynecological and obstetrical surveys. As mentioned above, the majority of marriages in Afghanistan are forced, and many of these involve girls below the age of fifteen. Child marriages constitute about 40 % of all marriages. The gender gap in education also has severe health consequences.

Table: MMR, Institutional Delivery and Contraceptive Prevalence in Afghanistan

	2000	*2003*	*2005*	*2006*
Maternal mortality ratio per 100,000 live births			1800	
Births attended by skilled health personnel (%)	12.4	14.3		
Contraceptive use among married 15-49 years, any method (%)	4.8	10.3	13.4	18.6
Contraceptive use among married women 15-49 years, modern methods (%)	3.6	8.5		15.5
Contraceptive use among married women 15-49 years, condom (%)	0	0.6	1.1	2.2
Antenatal care coverage, at least one visit (%)	36.9	16.1		

Source: Based on Datasets of Millennium Development Indicators; 2009, UNDP.

Health Status and Disease Prevalence in Afghanistan and the Related Goals

Malaria is widespread in approximately 60 % of the country and is extending to higher altitudes as the climate warms. An estimated 8 % of the population is afflicted with malaria each year. Although the annual incidence of malaria is estimated to be 1,500,000 cases per year, the number of cases detected and reported is significantly lower. Malaria incidence has dropped by almost half from 2002 to 2006. In 2002, the number of reported cases was 626,839, yet the officially reported malaria incidence for 2006 is 329,754. The expansion of the BPHS has facilitated the detection and treatment of malaria cases in vast areas of the country.

But Afghanistan has one of the highest incidences of tuberculosis in the world. Among 22 high-TB burden countries, Afghanistan ranks17th. The current prevalence of tuberculosis is estimated at 228 cases per 100,000 of the population. The death rate from tuberculosis in Afghanistan is still approximately 12,000 deaths per year. Tremendous progress has been made in detecting and treating cases of tuberculosis over the past six years, resulting in a significant decrease in the prevalence of the disease. There were approximately 50,249 cases of tuberculosis in 2005, though this dropped to 41,000 new tuberculosis cases in Afghanistan in 2006. Women of reproductive age continue to be the majority of the population suffering from this disease. The increase in access to the BPHS has contributed to the detection and treatment of tuberculosis. Over 25,000 individuals were treated for tuberculosis in 2006, approximately 16,000 of whom were women.

The Table presented below shows that share of condoms in contraceptives used is at a low level of 11 percent. One important point to note here is that Afghanistan has made significant progress towards reducing the incidence (new cases) and prevalence (overall cases) of TB during the last decade and a half. Tuberculosis incidence rate per year per 100,000 populations declined appreciably from 248 in 1990 to a level of 168 in 2007. In the same way, Tuberculosis prevalence rate also reduced from 613 in 1990 to 238 in 2007. All these achievements in controlling the cases of TB incidence and prevalence may have possible on account of rising detection rates (from 8.6 in 1999 to 64.3 in 2007) and encouraging trends of success rates in the range of 85-90 %.

Table: TB incidence and Treatment Success rate in Afghanistan

	1990	*1995*	*1999*	*2000*	*2005*	*2006*	*2007*
Share of Condoms in Contraceptives used					8.1	11.8	
Tuberculosis incidence rate per year per 100,000 population	247.8	246.9	213.3	208.3	168.3	161.3	168.3
Tuberculosis prevalence rate per 100,000 population	613.8	582.9	479.1	440.4	266.6	231	238.3
Tuberculosis death rate per year per 100,000 population	70	66.8	55.3	51.6	32.9	31.8	30.1
Tuberculosis detection rate under DOTS (%)			8.6	14.9	52.4	65.9	64.3
Tuberculosis treatment success rate under DOTS (%)			86.6	85.5	89.7	84.4	

Source: Based on Datasets of Millennium Development Indicators; 2009, UNDP.

Quality of Environment and Availability of Water Supply and Sanitation Facilities in Afghanistan

The population of Afghanistan is highly dependent on environmental resources, particularly natural resources, for their livelihoods. Environmental degradation directly threatens the livelihoods of Afghans. Forest cover has been reduced by almost half since 1978, and the loss of environmental resources in Afghanistan does not appear to be reversing. From2000-2005 alone forest cover has dropped from 10,150 to 8,670 square kilometers.

Table: Trends in Progress of Environmental Indicators in Afghanistan							
	1990	*1995*	*1997*	*2004*	*2005*	*2006*	*2007*
Proportion of land area covered by forest, percentage	2				1.3		
Carbon dioxide emissions (CO2), thousand metric tons of CO2 (CDIAC)	2677	1269	1115	704	700	697	
Carbon dioxide emissions (CO2), metric tons of CO2 per capita (CDIAC)	0.21	0.070	0.057	0.029	0.028	0.027	
Carbon dioxide emissions (CO2), kg CO2 per $1 GDP (PPP) (CDIAC)				0.0335	0.0292	0.028	
Consumption of all Ozone-Depleting Substances in ODP metric tons		381.9	381.9	181.5	145.4	99.4	61.3
Consumption of ozone-depleting CFCs in ODP metric tons		380	380	177.9	141.2	94.5	55.2

Source: Based on Datasets of Millennium Development Indicators; 2009, UNDP.

Lack of access to alternatives for energy is only one of the reasons for the reduction of forest cover. The extent to which environmental resources are being depleted is further reflected by the extremely high percentage of the population that uses solid fuels (98 % rural and 75 % urban). The Table given below suggests that Proportion of land area covered by forest has declined from a low level of 2 % in 1990 to paltry level of 1.3 %. Carbon dioxide emissions (thousand metric tons of CO2 (CDIAC) has declined substantially from 2677 to 697 in 2007. Accordingly, Carbon dioxide emissions (CO2) (metric tons of CO2 per capita) has also shown a downwards trend, declining from 0.21 in 1990 to 0.027 in 2006. Consumption of ozone-depleting CFCs (in ODP metric tons) has also declined from 380 in 1995 to a level of 55 in 2007.

Table: Trends in Access to safe drinking water and sanitation in Afghanistan			
	1995	*2000*	*2006*
Proportion of the population using improved drinking water sources, total	21	21	22
Proportion of the population using improved drinking water sources, urban	37	37	37
Proportion of the population using improved drinking water sources, rural	17	17	17
Proportion of the population using improved sanitation facilities, total	32	30	30
Proportion of the population using improved sanitation facilities, urban	42	43	45
Proportion of the population using improved sanitation facilities, rural	29	27	25

Source: Based on Datasets of Millennium Development Indicators; 2009, UNDP.

Access to safe drinking water varies considerably throughout the country. Only 22 % of households nationwide have access to safe drinking water. There is wide variation among urban and rural households with regard to access to safe sources of drinking water. The proportion of households having access to improved sources

of drinking water is 37 and 17 percent, respectively. Improving access of rural populations to safe drinking water has been a focus of many development programs. Yet, the number of households with access to safe drinking water varies considerably between rural and urban areas.

Approximately 30 % of the population has access to some kind of sanitation facilities within their compounds or households. As usual, here too, we observe substantial regional variations. The proportion of households having access to improved sanitation facilities in rural and urban areas are 25 and 45 percent, respectively. On the other hand, almost whole (to be precise, 98.5 percent) urban population resides in slum in Afghanistan

Concluding Remarks:

Although Afghanistan has made significant progress towards achieving the targets of development goals, the Government and its people still face enormous obstacles to meeting these targets and to furthering human development in Afghanistan. The Government of Afghanistan, its citizens, and the international community have a unique opportunity to move forward towards these objectives.

Afghans continue to perceive security as the most striking challenge for the nation. Because security throughout Afghanistan deteriorated significantly in the past year, such opinions continue to be fuelled. The number of fatalities of Afghan civilians, security forces, as well as international civilian and military personnel, was the highest of any year since the establishment of the Interim Authority in 2001. The number of suicide attacks increased five- fold, and anti-government elements continue to demonstrate their strength amidst the ongoing insurgency.

Despite the progress made in establishing democratic institutions in Afghanistan, the Government of Afghanistan and its people still face formidable challenges to develop and consolidate the nascent state. The Afghanistan National Development Strategy (ANDS) will provide the strategy and the mechanisms to achieve the five-year benchmarks agreed upon with the international community in the Afghanistan Compact. The ANDS is also being formulated to move Afghanistan toward the achievement of the MDGs. More than any other instrument, the ANDS is the fundamental vehicle for guiding and monitoring efforts to achieve, by 2020.

Among the human development indicators, maternal mortality rates (1800 per 100,000 live births), antenatal coverage (16 % in 2003), births attended by skilled health personnel (14.3 in 2003, as per Afghanistan MDG Report, 2005), probability of birth of not surviving to age 40 years (42 %), access to safe sources of drinking water (31 %), primary school completion rates (37.7 % in 2005) and the low level of associated gender parity (0.40 in 2005), and low level of employment-to-population ratio for women (33.8 % in 2006) are among the indicators which shows dismal performance of Afghanistan. It goes without saying that the Government of Afghanistan has the responsibility of improving the health care and education facilities to bridge the gaps in targets set and performance so far, as immediately as possible.

CHAPTER FOUR

Mapping Progress and Prospects of Achieving SDGs in Bangladesh

An Overview of Socio-Economic Performance

Bangladesh is one of the most densely populated countries in the world having more than 144 million people in an area of 147,570 square kilometer. Administratively, it is divided into 6 Divisions, 64 Districts, 482 Upazillas and 4,498 Unions. Bangladesh has more than 76 percent people living in rural areas. About 18 percent of the rural population are classified as hard-core poor (Daily intake below 1,805 Kcal/person), and about 40 percent as poor (Daily intake below 2,122 Kcal/person; BBS, 2006). Poverty and rapid population growth, combined with traditional drinking water from open ponds and poor sanitary habits, contributed in the 1960s and 1970s to a high level of water-related morbidity and mortality, especially in the rural areas. The country is also highly vulnerable to natural disasters that wreak havoc on life and livelihood of the citizenry and put tremendous pressure on its economy. In the midst of continuing adversity, Bangladesh has achieved considerable progress in some of its socio-economic indicators, such as, population stabilization, sustained economic growth, reduction in infant and child mortality, success in mainstreaming women, a vibrant civil society, media and NGO sector and a tremendous progress in sanitation.

Bangladesh has made remarkable progress in terms of economic growth and yearly per capita income. Per capita GNI recently crossed the USD $500 mark and is forecasted to continue to rise. Growth has stabilized at just over six per cent in the last two years. Gross domestic product has risen to nearly USD $68 billion, while exports have grown almost 30 times from a paltry $348.42 million in 1972-73 to over $10 billion in recent years (Bangladesh Economic Survey: 2007).

With strong economic growth, gradual but palpable industrialization in rural areas, and steady accumulation of business capital, Bangladesh looks to be a booming emerging economy. Goldman Sachs in 2005 picked Bangladesh as one of the 'next 11' economies that would emerge in the next few decades, when China, India, and Brazil will have made their place among the five largest of the world.

Bangladesh has sustained positive growth rates and seen poverty reduced significantly over the past decade. However, although the proportion of people living in poverty has decreased by almost 7% during the last 15 years (SUPRO: 2007), half of its population still lives on less than $1 a day, and 83% on less

than $2 a day. 20 million people, or over seven percent of the population, are categorized by the United Nations Development Programme as ”extremely poor” (DFID: 2007).

Additionally, while the percentage of people living in poverty has decreased, the total number of poor people has increased. Between 1991 and 2005, the number of people in extreme poverty has increased to more than 4.4 million. From 2000 to 2005, the number of people living on less than 16 pence a day has increased to almost 3 million (Bangladesh Bureau of Statistics: 2005).

Inequality and disparity are seen pervasive; the top 5% receives 30% of national income; the poorest 5% receives 0.67% (Unnayan Onneshan: 2005). According to the latest household income expenditure survey, about 40 percent of Bangladesh's 140 million people are below the poverty line, according to the 'cost of basic needs' method.

It is often stated that although the proportion of poor is decreasing the absolute number of poor are on the rise across the world. About a fourth of the population of Bangladesh is considered ”extremely impoverished”, devoting nearly all of their daily income to food consumption.

The most recent global yardstick of 'a dollar a day' is therefore misleading - the World Development Report 2007, published annually by the World Bank in Geneva, states that the percentage of Bangladesh's population earning less than a dollar a day was 36 per cent in 2000. A recent study (April 2008) showed that the number of people living below the poverty line was on the rise due to exorbitant increases in food prices. The number currently stands at 90 million, up from previously estimated 60 million - or 40 per cent of the country's population. At least 40 million people of the country are currently facing extreme poverty without work and sub-standard purchasing power with their current incomes.

The Bangladeshi government defines that the people with daily food intake of less than 2122 kilo-calories technically live below the poverty line. “At least 60 per cent of the country's population currently consumes much less,” said Harun KM Yusuf, professor of Biochemistry and Human Nutrition at Dhaka University. “The high prices of food commodities are forcing the poor to cut nutrition intake.” Yusuf showed that by spending one taka on coarse rice, a consumer consumed only 120 kilo calories in December 2007, which was 50 calories less than what he or she consumed in January 2006 for the same amount of money (The New Age: 27 April 2008).

According to the latest official statistics, the country has been able to reduce the maternal mortality rate from 574 in every 100,000 mothers to 365 in recent years — far from the target of bringing down the rate to 143 by 2015. Bangladesh is also in a confusing state in attaining the most crucial goal of bringing down poverty rate to 29 per cent by the MDG deadline from 40 per cent in 2005 – the time after which, as research indicates, poverty incidence might have gone up due to impacts of the food and fuel crises.

Table: Trends in Economic Performance of Bangladesh (2004-2008)					
Economic Indicator	*2004*	*2005*	*2006*	*2007*	*2008*
Per capita GNI	410	440	450	470	
GDP growth	6.3	6.0	6.6	6.4	6.2
CPI (% change per year)	5.8	6.5	7.2	7.2	9.9
Unemployment rate (%)		4.6			
Fiscal balance (% of GDP)	-3.2	-3.3	-3.2	-3.2	-4.7
Export growth (% change per year)	15.9	14.0	21.5	15.8	15.7
Import growth (% change per year)	13.0	20.6	12.1	16.6	25.6
Current account balance (% of GDP)	0.3	-0.9	1.3	1.4	0.9
External debt (% of GNI)	33.8	29.9	31.1	30.1	

Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

Human Development in Bangladesh

The HDI for Bangladesh is 0.524, which gives the country a rank of 147th out of 179 countries with data. The HPI-1 value of 36.9 % for Bangladesh, ranks 110th among 135 developing countries for which the index has been calculated. To measure the impact of gender inequalities on human development achievement, Bangladesh's GDI value, 0.516 can be compared to its HDI value of 0.524. Its GDI value is 98.5% of its HDI value. Out of the 157 countries with both HDI and GDI values, 108 countries have a better ratio than Bangladesh's.

An Overview of Development Goals and Ensuing Debates

Bangladesh has achieved remarkable progress in the areas of primary schooling, girls' education, immunization, micro-credit, female economic participation, birth control, physical mobility and safety nets. The most remarkable achievement is in the field of primary education with the country well on its way to meet development goals relating to universal primary education. The challenge here is ensuring adequate finances to keep up the momentum and ensuring quality education for all.

Although all relevant indicators of development goals have moved towards their targets, their performances have been uneven. To understand this variation, it is important to analyse the reasons of the slowing down of the child mortality rate, the apparent plateauing of total fertility rate, the rise in youth unemployment rate, and most important of all what factors work in accelerating the pace of poverty reduction.

It is important because the main underlying factor for the slow pace of development targets achievement is poverty. Poverty permeates all sectors and holds back growth in every sense. To address this issue, Bangladesh is in the process of

completing its first PRSP. The PRSP is addressing the issues of pro-poor growth and human development, and when implemented, will accelerate the achievement of the desired development goals.

As a low-income LDC, Bangladesh is at a crossroad when it comes to achieving the UN Millennium Development Goals - eight comprehensive social and economic milestones member states of the United Nations agreed to reach by 2015. Proponents of neo-liberal economics often advocate and propagate that economic growth is the ultimate tool to development, but they do not mention that this growth and prosperity must be equitable. Even the much-hyped and glorified MDGs that have of late become the ultimate measure for development (though they require the economy to grow at a stable seven per cent) do not address the issue of equity. Economic and social inequality is manifested in the form of denial of access to basic services, such as education, health, and water-sanitation, and poor public expenditure on these essential services runs the risk of failing to reach the MDGs by the 2015 deadline.

The overall development strategy of Bangladesh, outlined in the Poverty Reduction Strategy Paper "Unlocking the Potential: National Strategy for Accelerated Poverty Reduction" has been prepared in light of reaching the Millennium Development Goals. Improvement of the quality of life of the people occupies the central position of all eight MDG targets. Although the government of Bangladesh is quite hopeful of realizing the goals by the stipulated time-frame, the issue of financing has become a grave concern. Moreover, the gradual withdrawal of the state from providing essential goods and services has become one of the tenets of aid "conditionalities" imposed by the International Financial Institutions (IFIs), including the World Bank, the International Monetary Fund, and the Asian Development Bank. It is not difficult to understand that the imposed agenda gives comfort to the so-called donor community as it ensures sustained flow of repayment of their loans, thereby reducing the pressure on government revenue. As a result, public expenditure on essential services is being squeezed day by day putting poor people at the mercy of private sector as the process involves privatizing the basic services.

The burden of public debt, both external and internal, has become a serious concern for Bangladesh, as it takes away a substantial part of public expenditure that could be invested in basic human services such as health, education etc. Currently, the government of Bangladesh spends more on external debt servicing than on health care. On an average, for every dollar in grant aid received, the government of Bangladesh pays back 1.5 dollar in external debt repayment. Bangladesh desperately needs its external debt cancelled. To finance the MDGs, every year a staggering $7.5 billion in external budget support is needed which is almost four times the amount of aid/loans currently provided by the international donor community. The present development context looks bizarre- a dollar paid in debt service seem to be a dollar lost for the MDGs.

Although the official figures show the net primary school enrolment at 91.1 per cent, not far behind the target of 100 enrolments by 2015, unofficial studies

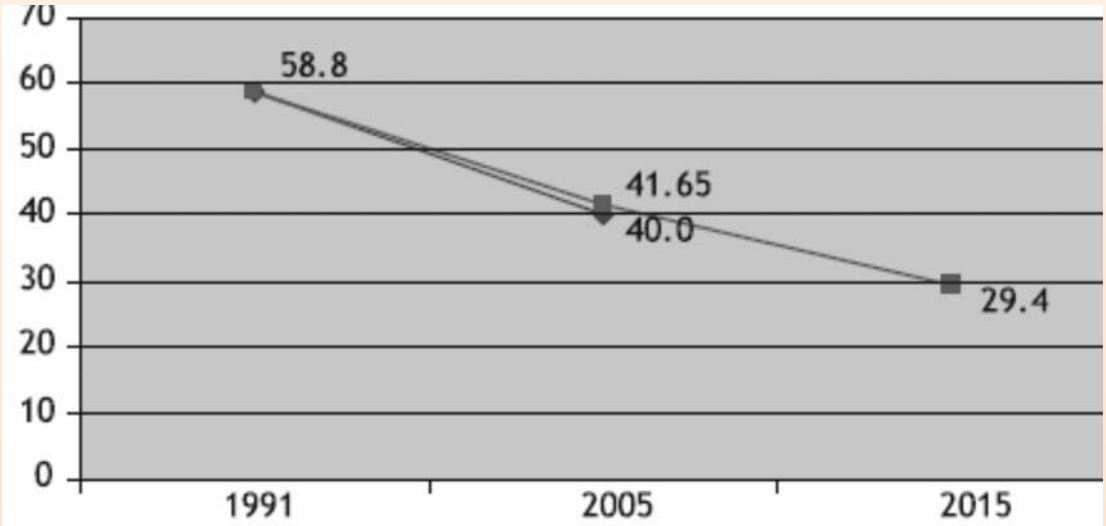
conducted by a few NGOs working on the MDGs claimed that the rate would be below 80 per cent in view of the high rate of school dropout.

Assessment of Progress of Bangladesh with respect to Various Development Goals Indictors

Eradication of Extreme hunger, Poverty and Malnutrition

Bangladesh has made good progress in reducing income poverty based on the national poverty line. The country was able to lower the overall incidence of poverty from 58.8 percent in 1991-92 to about 50 percent in 2000, or one percentage point per year. Bangladesh's good economic growth performance – with overall GDP growth averaging 5 percent and per-capita growth averaging 3.3 percent per annum during FY1992-2001 – contributed much to this progress. Since 1990, the incidence of poverty in Bangladesh has been measured in five-year cycles on the basis of the nationally representative Household Income and Expenditure Survey. The most recent survey, in 2005, found that the incidence of poverty in Bangladesh fell from 58.8 per cent in 1991 to 40.0 per cent in 2005. The trend suggests that the incidence of poverty is expected to be less than 38 per cent in 2007. The actual rate of poverty reduction per annum achieved up to 2005 was 1.34 per cent. If this trend continues, Bangladesh will halve its poverty ratio by 2013.

Graph: Poverty Reduction Trends in Bangladesh
(Blue Line shows actual while Red Line indicates Target)



Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

The Table provided below indicates that, based on the international yardstick of poverty line of USD 1.0 per day, Bangladesh has registered a moderate rate of poverty reduction. The poverty headcount ratio declined from 66.8 % in 1992 to a level of 49.6 % in 2005, roughly a reduction of 1.2 % per annum. This moderate decline in poverty ratio is associated with consistent decline in poverty gap ratio (a measure for depth and severity of poverty) from 21.1 % in 1992 to 9.4 percent in 2005. As is the case for almost all SAARC countries, there is significant variation in the level of poverty in rural and urban areas. Based on national poverty line, in urban Bangladesh, poverty ratio is 28.4, while in rural areas it is at a higher level of 43.8 %.

Table: Trends in Various Indicators of Poverty and Inequality in Bangladesh

	1992	*1996*	*2000*	*2005*
Population below $1 (PPP) per day %	66.8	59.4	57.8	49.6
Population below national poverty line, total %		51	48.9	40
Population below national poverty line, urban %		29.4	35.1	28.4
Population below national poverty line, rural %		55.2	52.3	43.8
Poverty gap ratio at $1 a day (PPP) %	21.1	17.9	17.3	13.1
Poorest quintile's share in consumption %	10	9.3	9.3	9.4

Source: Based on Database of Millennium Development Indicators, UNDP, 2009.

The poverty gap ratio is an indicator that measures the depth of poverty. It is the aggregate income deficit of the poor relative to the poverty line, and gives an idea of the resources needed to raise the poor above the poverty line. Reductions in the poverty gap ratio in Bangladesh have been dramatic. The target in 2005 was 11.8 per cent; it actually achieved 9.0 per cent in that year. The target for 2015 is 8 per cent, which the country is expected to meet well before then.

Figure: Trends in Poverty and Malnutrition in Bangladesh

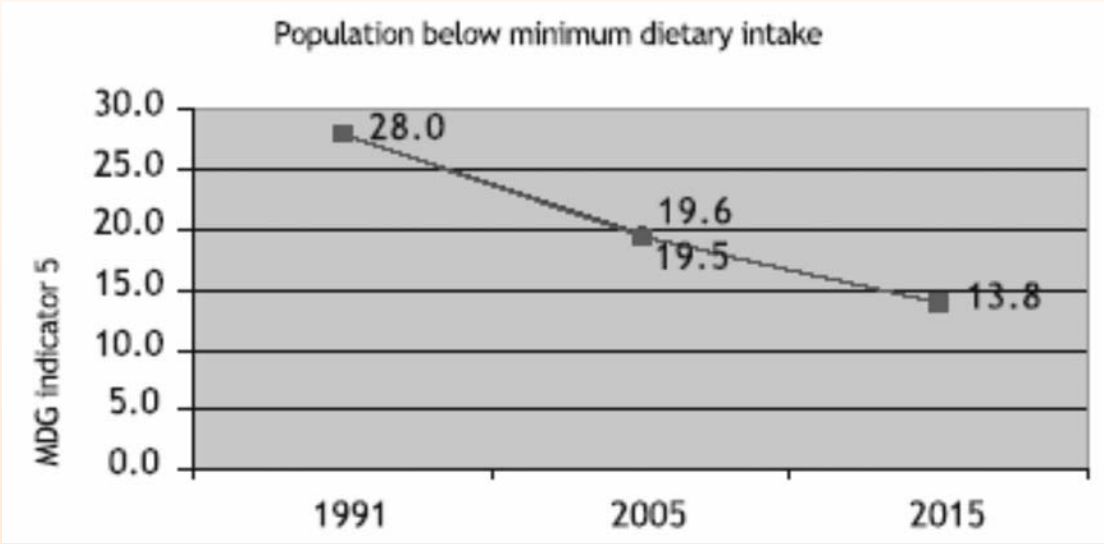
Indicators	Base Year (1991)	Current Status (2005)
1. Proportion of population below national poverty line (2221 kcal)	59%	40%
2. Poverty gap ratio	17	9
3. Share of poorest quintile in national income	6.5%	5.3%
4. Prevalence of underweight children under five years of age	67%	40%
5. Proportion of population below minimum level of dietary energy consumption (1800 kcal)	28%	19.5%

Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

As may be evident from the graphics provided above, prevalence of underweight children declined substantially from 67 % in 1991 to a level of 40 % in 2005, registering average rate of decline of roughly 2 % per annum. This is a commendable achievement.

The Direct Calorie Intake method measures the minimum level of dietary energy consumption. The Bangladesh Bureau of Statistics replaced this method with the Cost of Basic Needs method in 2000. The DCI method constructed three reference lines, of which Hard Core Poverty with the threshold of 180 kcal per capita per day is considered as the minimum level. This has been used as a proxy for the minimum level of dietary energy consumption. The proportion of population below the 180 kcal level of dietary intake fell to 19.5 per cent in 2005 against a target of 19.6 per cent for that year.

Figure: Proportion of People below Dietary Intake



Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

Future Challenges

As mentioned earlier, Bangladesh has registered impressive growth of GDP per capita in the last decade or so. But its economic growth process has not sufficiently benefited the extreme poor. Indicator 3 shows that the share of poorest quintile in national income has reduced over the years. Increasing the share of the poorest quintile in national consumption/income is a major challenge for the country and will require the benefit of economic growth to be more directed towards the poor. Bangladesh risks missing the target of 14.0 per cent if it fails to sustain the present trend of economic growth or if the extreme poor continue to get lesser benefit from economic growth. One-fourth of the population in Bangladesh lives in extreme poverty, and nearly half of Bangladesh's children are underweight. Demographic changes in upcoming years are likely to affect poverty and hunger in adverse ways.

Addressing income poverty: Promoting strong economic growth

Various empirical analyses have concluded that economic growth is the most important factor contributing to poverty reduction. Achieving and sustaining strong economic growth will require attention on many fronts such as:

- Pursuing monetary and fiscal policies that sustain macroeconomic stability.
- Improving transparency, accountability and efficiency of the Government in all key areas, including taxation, public procurement, land administration, law enforcement, and administration of justice and regulation of banking, insurance, and the credit market.
- Enhancing government effectiveness by focusing on core state functions and delivery of public services.
- Expanding national capacity to design and enforce policies, laws, and regulations that facilitate private sector investment.
- Further liberalizing the trade regime to exploit the advantages of the rapidly globalizing world economy.
- Restructuring and privatizing state-owned enterprises and business activities under appropriate incentive and regulatory schemes, and reallocating public resources to the provision of high priority public goods.
- Accelerating development of infrastructure in key areas – such as power, ports, roads, inland water transport, and telecommunications – that have been identified as constraints on the investment climate.
- Strengthening capacity for enhanced absorption of aid resources. (Mid Term Bangladesh Progress Report 2007; UNDP.)

In addition, to promote pro-poor growth in Bangladesh, the development agencies, including the government, have to focus on redistribution of income and productive assets in favour of the poor and the marginalized. The initial level of inequality of income and ownership of assets and its possible further deterioration will determine the poverty outcome. Pro-poor growth, therefore, needs to be promoted so that the positive impact of economic growth on poverty reduction is increasingly larger than the adverse impact of income inequality, and the poor are able to participate more actively in the growth process and derive increasingly higher benefits from it. Creation of more jobs and opportunities for entrepreneurship and self employment by the poor will need to be speeded up aggressively, so as to address the massive backlog of underemployment, as well as the large annual addition to the labour force on account of demographic factors. Income growth in rural areas has proven to be pro-poor in Bangladesh, and its continuation will need to be promoted pro-actively. Coordinated actions will be required to achieve these goals.

Protecting the vulnerable through widespread, effective and sustainable safety net programmes for the marginalised in poor areas should hold the key in preventing

people from slipping below the poverty line in case of an adverse income shock. The persistence of disparities in poverty and hunger warrants the evaluation of social safety net options that target particular groups and areas. Some groups of the poor and hungry are chronically vulnerable, and some face vulnerabilities that are regional or seasonal in nature. Targeted interventions will need to be designed and prioritized taking into account their financial sustainability and the country's other demands for pro-poor spending. Tradeoffs between reaching the poorest and the not-so-poor, and the distinctions between short-term palliatives and long-term measures to enhance the prospects for poverty reduction, must be recognized. (Mid Term Bangladesh Progress Report 2007; UNDP.)

Achievements and Prospects of Elementary Education and Literacy Goals in Bangladesh

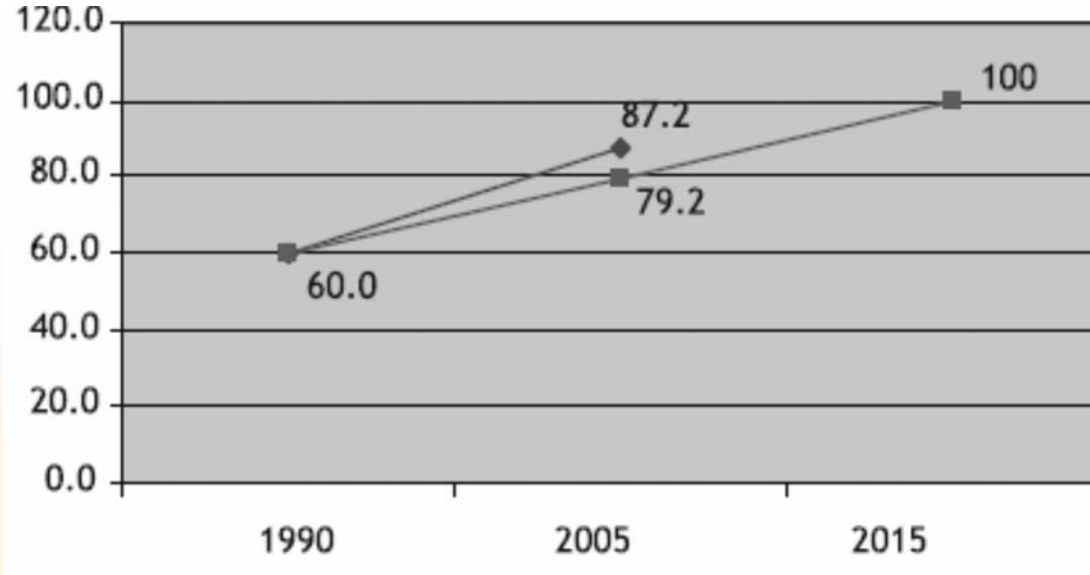
The Compulsory Primary Education Act, 1990, has made primary education (Class IV) in Bangladesh free and compulsory for all children. The Government is committed to the goals of the Dakar Framework Education for All (EFA) which aims at achieving the MDG targets by the year 2015. The National Plan of Action (NPA) also aims to achieve the six EFA Dakar goals by 2015.

Various data sources indicate that between 1994 and 2003 the primary school net enrolment rate has oscillated around 80 percent for 6-10 year old children. While the range indicates that the rates have been slightly higher for females (83-84%) compared to males (81-82%), the female rates show a plateauing trend. Improvement in the enrolment rates was due to increase in the Government's budgetary allocation for girls' education, free primary education, massive stipend programmes at the primary level, and the Food for Education Programme. In order to promote further equity and access of underprivileged children to primary education, the Government replaced the Food for Education programme with a fiveyear country-wide Primary Education Stipend Project.

Net Enrolment Ratio in Primary Education

Bangladesh has recorded remarkable success in increasing primary school enrolment. This includes creating gender balance, which is due largely to the introduction of stipend programmes, free supply of textbooks, tuition fee waiver and cash incentives provided by the government. At the primary education level, the net enrolment ratio increased to 87.2 per cent in 2005 against the target of 79.2 per cent. This is up from 60.5 per cent in 1990. If that trend continues, Bangladesh will meet its target of 100 per cent net enrolment in primary education by 2012. However, as we know, SDGs have set the target of achieving 100 % enrolment by 2010. So Bangladesh has to accelerate the pace of enrolment in primary education. High numbers of children dropping out, however, along with low rates of retention and the substantial number of out-of-reach students at the primary level may moderate this success.

Figure: Trends in NER in Primary Education in Bangladesh



Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

The indicator of primary school completion rate measures the success of the primary education system in retaining students from Grades 1 to 5, as well as maintaining internal efficiency. This is a critical area in which Bangladesh's performance is poor and marked by a lack of credible and nationally representative information. A 2005 baseline survey on primary education by the Ministry of Primary and Mass Education shows that 53 per cent of school entrants of primary school age continue to Grade 5. This figure, however, is conservative when compared with the World Bank's 2000 estimate of 66 per cent (World Bank, 2004).

The data from Millennium Development Goals Indicators suggest more progress in primary school enrolment ratio in Bangladesh. The Table given below shows that NER in primary education in Bangladesh for 2007 is 89.6, 86.3 and 93 for combined, boys and girls, respectively. Thus, we have a gender parity ratio in primary school enrolment is more than 100 percent, a unique achievement among SAARC countries.

Table: Trends in Primary School Enrolment, Completion Rate, Youth Literacy Rates and Gender Parity in Bangladesh				
	1991	*2001*	*2005*	*2007*
Total net enrolment ratio in primary education Total			89.5	89.6
Total net enrolment ratio in primary education, boys			86.7	86.3
Total net enrolment ratio in primary education, girls			92.5	93
% of pupils starting grade 1 who reach last grade of primary Total			54.8	
% of pupils starting grade 1 who reach last grade of primary, boys			52.2	
% of pupils starting grade 1 who reach last grade of primary, girls			57.6	
Primary completion rate Total		59.8	59.8	56.3
Primary completion rate, boys		57.4	57.4	54.1
Primary completion rate, girls		62.4	62.4	58.6
Literacy rates of 15-24 years old Total %	44.7	63.6		72.1
Literacy rates of 15-24 years old, men %	51.7	67.2		71.1
Literacy rates of 15-24 years old, women %	38	60.3		73.2
Women to men parity index (literacy rates, 15-24 years old)	0.73	0.9		1.03

Source: Based on Database of Millennium Development Indicators, UNDP, 2009.

Trends in Gender Parity and Empowerment of Women in Bangladesh

The youth literacy rate reflects the effectiveness of primary education programmes over time. It is often seen, therefore, as a proxy measure of social progress and economic development. Youth literacy rate (for 15-24 age group) in Bangladesh increased substantially from 44.7 % in 1991 to 72.1 percent in 2007, entailing an average rate annual growth of roughly 2 %. In addition, youth literacy for female in Bangladesh show more impressive improvement which increased from 38 % in 1991 to 73.2 % in 2007 as may be noticed from the Table portrayed above. The adult literacy rate increased from 37 per cent in 1990 to 54 per cent in 2006. Bangladesh must intensify its efforts urgently if it is to achieve its target of 100 per cent adult literacy.

Ratio of girls to boys in primary, secondary and tertiary education

Bangladesh achieved gender parity in primary and secondary education in 2005. The ratio of girl to boy students rose from 45:55 in 1992 to 53:47 in 2005 at the primary level; and from 34:66 in 1992 to 50:50 in 2005 at the secondary level. The ratio of girls to boys at primary level has crossed gender parity and now shows a bias towards girls.

Table: Percentage of Children Enrolled in Schools, 2005

Gender	Children aged 6-10 years		Children 11-15 years	
	2000	2005	2000	2005
Both Sexes	75.1	80.4	65.3	69.9
Boys	74.0	79.5	59.4	66.0
Girls	76.4	81.3	71.5	73.9

Source Household Income and Expenditure Survey, Bangladesh Bureau of Statistics

Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

Progress towards gender parity in tertiary education, however, is encouraging but less spectacular. The ratio of females to males here grew from 25:75 in 1992 to 34:66 in 2005. A marginal gender disparity still exists in the youth literacy rate. This report uses the literacy rate for the 20-24 age groups to measure progress, because of insufficient data for the 15-24 age groups. These data show that the female-male literacy ratio increased from 42:58 in 1992 to 46:56 in 2002.

Figure: Trends in Gender Parity in Education and Empowerment of Women in Bangladesh

Indicators	Base year (1992)	Current Status
9. Ratio of girls to boys in primary, secondary and tertiary education:		
Primary	45:55	53:47 (2005)
Secondary	34:66	50:50 (2005)
Tertiary	25:75	36:64 (2005)
10. Ratio of literate women to men, 20-24 years old	42:58	46:54 (2002)
11. Share of women in wage employment in the non-agricultural sector	41%	59% (2003)
12. Proportion of seats held by women in national parliament	10.3%	14.8% (2006)

Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

Table: Gender Parity in Enrolment and other Indicators of Women Empowerment in Bangladesh							
	1990	*1997*	*2000*	*2003*	*2006*	*2007*	*2009*
Gender Parity Index in primary level enrolment					1.06	1.08	
Gender Parity Index in secondary level enrolment			1.05	1.11	1.07	1.06	
Gender Parity Index in tertiary level enrolment			0.51	0.5	0.57	0.57	
Share of women in wage employment in the non-agricultural sector			24.7	21.6	20.1		
Seats held by women in national parliament %	10.3	9.1	9.1	2	14.8		6.3
Total number of seats in national parliament	330	330	330	300	345		300
Seats held by men in national parliament	296	300	300	294	294	0	281
Seats held by women in national parliament	34	30	30	6	51		19

Source: Based on Database of Millennium Development Indicators, UNDP, 2009.

The Table depicted above show clearly that gender parity in primary as well as secondary school enrolment in Bangladesh has been achieved. However, the trends in tertiary education enrolment show a retrograde position where enrolment ratio has been virtually stagnant around 57 percent. Similarly, share of women in wage employment in the non-agricultural sector paint a disappointing picture which has, in fact, declined from a low level of 24.7 percent to a dismally paltry figure of 20.1 percent.

It is quite unfortunate to note here that proportion of seats held by women in national parliament (an indicator of political empowerment of women) declined from 14.8 % in 2006 to 6.3 % in 2009. There is an urgent need for electoral reforms promoting the nomination of woman candidates by political parties.

In the health sector, women's status compares unfavorably with that of men. Although the life expectancy gap between men and women has narrowed over the last decade, Bangladesh continues to be amongst the very few countries in the world where women's life expectancy is lower than that of men: in 1990, life expectancy at birth was 56.4 years for males; 55.4 years for females. The maternal mortality rate, estimated to be in the range 320 to 400 per 100,000 live births in 2001, is among the highest in Asia. Pregnancy-related problems, including early and frequent pregnancies, are among the major causes of these phenomena. (Mid Term Bangladesh Progress Report 2007; UNDP)

Although there are no official gender-based wage differentials in the public sector, female wage in the agriculture sector is 70 percent, and in the nonagricultural sector 42 percent, of male wage. Insufficient education, training and skills, together with low productivity, often arising from poor health, contribute to women's weak bargaining power. In addition, to encourage the participation of women in the labor market, a proper working environment and facilities for women need to be established in the work place, and crèches and day care centers should also be made available.

In spite of the many initiatives undertaken in Bangladesh, progress in the area of gender equality and women's advancement remains limited. Expanded policy interventions with effective implementation; awareness building at family, institution and community levels; and better follow-up and intensified efforts for integrating gender dimensions in different programme areas are needed. Complementary efforts by civil society are crucial to the improvement of women's status at the grassroots level. (Mid Term Bangladesh Progress Report 2007; UNDP)

Child and Maternal Health Status in Bangladesh

Child mortality rate is a reflection of the care, health and nutrition status of children below the age of five years and also indicates the social, cultural, and economic progress in the country. While there has been an appreciable drop in under-five death rates from 151 deaths per thousand live births in 1990 to 91 in 2000, which further declined to a level of 61 in 2007. On the other hand, infant mortality rates in Bangladesh has dropped dramatically from a level of 105 in 1990 to a figure of 47 in 2007, registering an average annual reduction rate of more than 3 percentage points over the period.

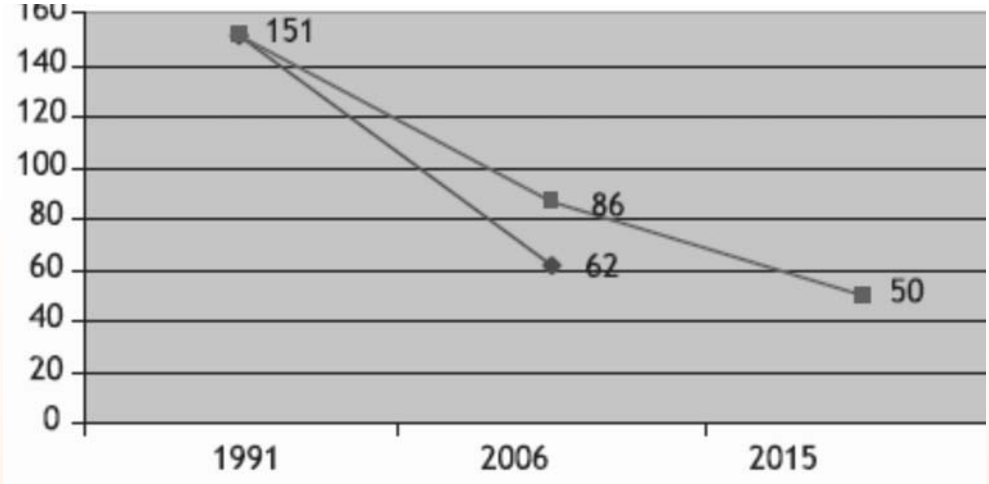
Table: Trends in Child Mortality and Immunization against Measles in Bangladesh

	1990	*1995*	*2000*	*2005*	*2007*
Children under five mortality rate per 1,000 live births	151	122	91	68	61
Infant mortality rate (0-1 year) per 1,000 live births	105	86	66	52	47
Children 1 year old immunized against measles %	65	79	76	88	88

Source: Based on Database of Millennium Development Indicators, UNDP, 2009.

In the case of under-fives, neonatal and prenatal causes contribute to 48 percent of the deaths. Other factors include very low rates of institutional deliveries (8.6%), low attendance of deliveries by skilled personnel (12%), and low utilization of antenatal care (48%). More than 71 percent of these neonatal deaths were due to non communicable diseases, mainly birth-related ailments as well as neonatal tetanus. Other major causes of under-five deaths are pneumonia (18%), diarrhea (6%), injuries and drowning (8%), and measles, with malnutrition underlying most other causes (13%). Poor care-seeking behavior and practices are also important contributing factors. (Mid Term Bangladesh Progress Report 2007; UNDP)

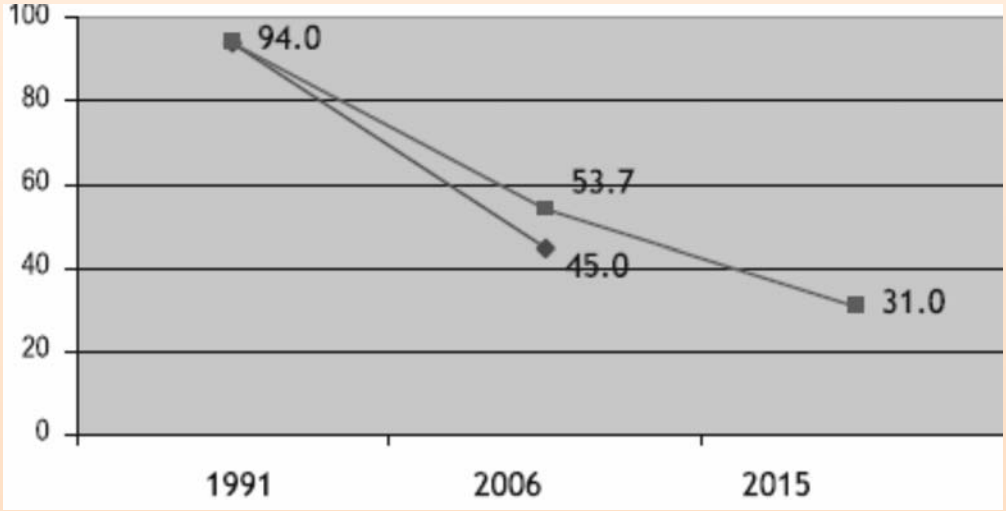
Figure: Trends in Under-5 Mortality Rates



Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

The infant mortality rate is considered a more robust estimate than the under-five mortality rate if it is drawn from vital registration statistics. The Bangladesh Bureau of Statistics measures this indicator in its regular Sample Vital Registration Surveys. Latest reports show that the infant mortality rate fell from 94 per thousand live births in 1990 to 45 in 2006. Reductions in the infant mortality rate by 2006 were almost 9 per cent ahead of schedule for that year. The average annual reduction between 1991 and 2006 was 3.07 per cent - against a target of 2.52 per cent. Child immunization against measles (a fatal disease counting majority of child deaths) have shown a consistent rising trend.

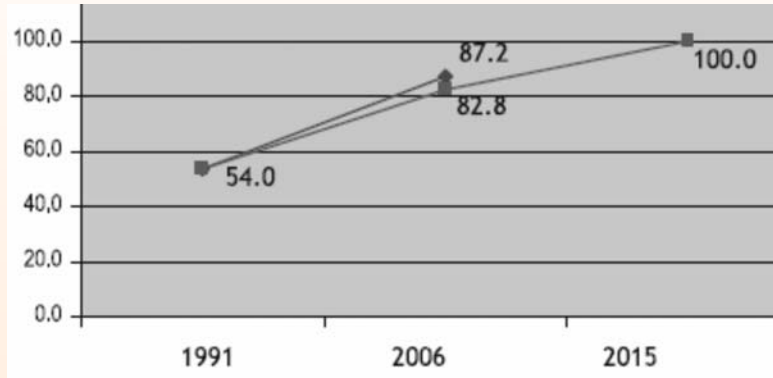
Figure: Trends in Infant Mortality Rates



Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

Immunisation plays a critical role in reducing infant and child morbidity. The government's Expanded Programme for immunisation is able to record considerable success in combating infant and child morbidity. The programme has extended its reach from less than 1 per cent of the population in 1981 to 54 per cent in 1991, increasing further to 87.2 per cent in 2006. Its very positive impact is evident in the significant reduction in child mortality. Bangladesh is often cited as one of the countries to have made the best progress in immunisation. The average increase in the coverage of child immunisation between 1991 and 2006 was 3.25 per cent: 0.65 per cent above the targeted annual rate of 2.6 per cent. The country is likely to reach 100 per cent immunisation by 2012.

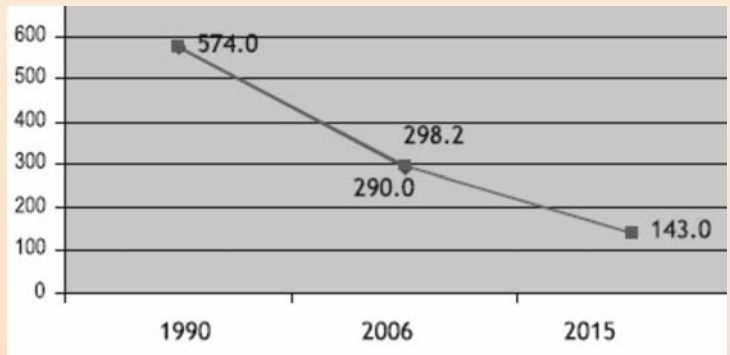
Table: Trends in Coverage of Child Immunization against Measles



Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

Bangladesh needs to reduce its maternal mortality ratio by three quarters from 574 per 100,000 live births in 1991 to 147 if it is to meet this target by 2015. There has been adequate success in reducing maternal mortality ratio (MMR) from 574 deaths per 100,000 live births in 1991 to 290 against the target of 298 in 2006. If this current rate continues, the country will be able to meet the target by 2015. The government has also undertaken initiatives to accelerate the maternal mortality reduction.

Figure: Trends in Maternal Mortality Ratio



Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

Table: Trends in MMR, Institutional Delivery, and Antenatal Care Coverage in Bangladesh				
	1994	*2000*	*2004*	*2007*
Maternal mortality ratio per 100,000 live births				570
Births attended by skilled health personnel, percentage	9.5	12.1	13.2	18
Contraceptive use (married women 15-49 years old), any method %	44.6	53.8	58.1	55.8
Antenatal care coverage, at least one visit, percentage	25.7	33.3	48.7	51.2
Unmet need for family planning, total, percentage	19.4	15.3	11.3	17.1

Source: Based on Database of Millennium Development Indicators, UNDP, 2009.

In 1990, almost all births took place at home. Only 5 per cent occurred in health centres. Traditional birth attendants assisted around two-thirds of deliveries, with the rest attended by relatives and friends. However, most obstetric complications cannot be prevented by either antenatal care or trained birth attendants during delivery. Deliveries attended by skilled health personnel increased from 9.5 percent in 1994 to 18 per cent in 2007. To meet the target, Bangladesh must increase the proportion of births attended by skilled health personnel to 50 per cent by 2015. Bangladesh needs to accelerate the present rate of progress to meet the 2015 target. Moreover, proper institutional arrangements are also required to attain the target.

Disease Control and Prevention in Bangladesh

Malaria is one of the major public health problems in Bangladesh. Out of 64 administrative districts, 13 belong to the high-risk malaria zone. A total of 14.7 million people are at high-risk and drug resistance to chloroquine and sulphadoxine-pyramethamine is posing a problem. The Malaria and Parasitic Diseases Control Unit in the Directorate General of Health Services implements control interventions based on the Revised Malaria Control Strategies viz: Early Diagnosis and Prompt Treatment (EDPT); Selective vector control; Promotion of Insecticide Treated Mosquito Nets (ITMN); Epidemic preparedness and response; and community involvement and partnerships with NGOs and private sector. The Roll Back Malaria initiative was piloted in one district and is now being scaled-up to three hill districts. There is an increasing trend of case incidence and deaths in the border districts, particularly in the hard-to-reach areas.

An estimated one million clinical cases of malaria are treated every year. During 2002, the Annual Parasitic Incidence was 4.2 in the high endemic districts, leading to 61,495 laboratory confirmed cases, and 598 reported deaths. *Plasmodium falciparum* is the predominant infection (61-71%) and *An. dirus* the principal vector. The current programme aims to reduce by 50 percent the incidence of cases and the number of deaths from malaria by the year 2015.

Figure: Trends in Various Indicators of HIV/AIDS, Malaria, Contraceptive Prevalence and Tuberculosis Incidence in Bangladesh

Indicators	Base year (1991)	Current Status
18. HIV prevalence among pregnant women aged 15-24 years	n/a	n/a
19. Condom use rate of the contraceptive prevalence rate (among currently married women 15-49 years old)	2.5%	5.5% (2004)
19.a Condom use at the last high-risk sex	n/a	n/a
19.b Per cent of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	n/a	38 (2004)
19.c Contraceptive prevalence rate	40%	58% (2004)
20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years	n/a	n/a
21.a Notified cases of malaria per 100,000 population	42	34 (2005)
21.b Malaria death rate per 100,000 population, all ages		0.35 (2005)
22. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures	n/a	n/a
23.a Tuberculosis prevalence rate per 100,000 population	n/a	406 (2005)
23.b Tuberculosis death rate per 100,000 population	n/a	47 (2005)
24.a Tuberculosis detection rate under DOTS	34%	71% (2005)
24.b Tuberculosis treatment success rate under DOTS	84%	91% (2005)

Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

Bangladesh has made some progress in combating the spread of malaria. The disease's prevalence dropped from 42 cases per 100,000 in 2001 to 34 in 2005. Malaria is endemic in 13 of the country's 64 districts. Over 98 per cent of all malaria cases are concentrated in these areas. In total, those 13 districts accounted for 48,121 laboratory confirmed cases and 501 deaths in 2005 - against 48,647 cases and 502 deaths nationally. This is down from the previous year's figures of 58,894 cases in those 13 districts (59,853 nationally) and 538 deaths (535 nationally).

Table: Trends in Incidence, Prevalence and Detection Rates of TB in Bangladesh

	1991	*1994*	*1997*	*2000*	*2004*	*2007*
Tuberculosis incidence rate per year per 100,000 population	261.2	253.4	246	238.7	229.3	222.5
Tuberculosis prevalence rate per 100,000 population	623.4	579.1	535.1	499.8	443.6	386.8
Tuberculosis death rate per year per 100,000 population	74.7	68	61.6	57.8	51.6	44.7
Tuberculosis detection rate under DOTS %			17.8	23.9	40.4	65.7
Tuberculosis treatment success rate under DOTS%			78.4	82.6	89.6	

Source: Based on Database of Millennium Development Indicators, UNDP, 2009.

As may be evident from the Table portrayed above, TB incidence (new cases) rates have been stable around 220-250 cases during the last decade or so. However, Bangladesh has achieved significant success in halting and reversing the spread of tuberculosis (TB) as reflected in the trends of prevalence rates of TB which registered a sustained decline from a level of 623 in 1991 to 443 in 2007. Detection of tuberculosis by the Directly Observed Treatment System showed accelerated increase from 17.8 % in 2000 to 65.7 % in 2007. There has been moderate progress in the successful treatment of tuberculosis from 78.4 % in 1997 to 89.6 % in 2007. This increased from 84 per cent in 2002 to 91 per cent in 2005. Bangladesh still has a long way before 100 per cent detection and successfully treating tuberculosis is achieved.

Environmental Sustainability and Status of Water and Sanitation in Bangladesh

Bangladesh has taken significant steps to incorporate sustainable environmental development into policy as well as programmes. It can report successes in reforestation, through the social forestry movement, and in increasing access to drinking water, especially in urban areas. Bangladesh is an insignificant polluter in terms of CO2 emissions, energy and CFC consumption. But the country does face challenges in meeting all environment related target, for example, maintaining its bio-diversity (especially its wetland biodiversity), increasing access to sanitary latrines in rural areas particularly, and improving service delivery in rapidly growing urban slum areas.

The very recent floods and cyclone SIDR in 2007 also draw attention to Bangladesh's need for sustainable environmental protection. The Government intends to undertake extensive programs aimed towards mitigating and coping with the after-effects of floods and cyclone. The Government's endeavors towards sustainable environmental protection come with keen interest and much appreciation by the development partners. In coming days, this interest is expected to be translated into commitment to assist the Government in all such efforts.

However, the current performance is far from satisfactory. According to the Forest Master Plan and the Forestry Policy of Bangladesh only about 769,000 hectares or six percent of the country has actual tree cover. This includes the mangrove and the planted forests. About 1.41 million hectares of former forest is now covered only by grass. Consumption of wood for fuel has contributed to deforestation and other environmental problems in Bangladesh. It is estimated that 9000 hectares of forestland are lost every year. Depletion has taken place in all major forest areas, including the Chittagong Hill Tracts, Cox's Bazar and the sal (indigenous teak) forest areas. (Mid Term Bangladesh Progress Report 2007; UNDP).

Table: Trends in Forest Cover, CO2 Emissions, Consumption of ODS and Access to Water and Sanitation in Bangladesh					
	1990	*1995*	*2000*	*2006*	*2008*
Proportion of land area covered by forest, percentage	6.8		6.8		
Carbon dioxide emissions (CO2), thousand metric tons of CO2 (CDIAC)	15528	22814	27859	41609	
Carbon dioxide emissions (CO2), metric tons of CO2 per capita (CDIAC)	0.1374	0.1806	0.1998	0.2667	
Carbon dioxide emissions (CO2), kg CO2 per $1 GDP (PPP) (CDIAC)	0.1974	0.234	0.2217	0.2383	
Energy use (kg oil equivalent) per $1,000 GDP (Constant 2005 PPP $)	163	164	149	143	
Consumption of all Ozone-Depleting Substances in ODP metric tons	202.1	291.3	816.4	217.5	192.7
Consumption of ozone-depleting CFCs in ODP metric tons	195.1	280.7	805	196.2	154.9
Terrestrial and marine areas protected to total territorial area, percentage	1.5	1.5	1.7	1.8	1.8
Terrestrial and marine areas protected, sq. km.	2777	2777	3190	3353	3353
Terrestrial areas protected to total surface area, percentage	1.4	1.4	1.6	1.7	1.7
Terrestrial areas protected, sq. km.	2563	2563	2976	3140	3140
Marine areas protected to territorial waters, percentage	0.5	0.5	0.5	0.5	0.5
Marine areas protected, sq. km.	214	214	214	214	214
Proportion of the population using improved drinking water sources, total	78	78	79	80	
Proportion of the population using improved drinking water sources, urban	88	87	86	85	
Proportion of the population using improved drinking water sources, rural	76	76	77	78	
Proportion of the population using improved sanitation facilities, total	26	28	32	36	
Proportion of the population using improved sanitation facilities, urban	56	54	51	48	
Proportion of the population using improved sanitation facilities, rural	18	21	26	32	

Source: Based on Database of Millennium Development Indicators, UNDP, 2009.

The proportion of land area covered by forest is stagnant at a low level of 6.8 %. Carbon dioxide emissions (CO2), metric tons of CO2 per capita (CDIAC) is rising slowly but is at a low level of 0.25 However, protected areas that include National Parks, wildlife reserve and game reserves, maintaining biodiversity, cover barely 2.0 per cent of the total surface area.

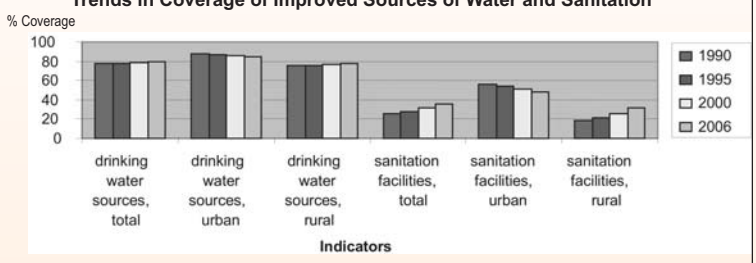
Protection of the remaining forests is a major challenge for the Government and other stakeholders. The forest sector strategies under the 1992 Environment Policy include conserving, developing and augmenting forests for sustainable ecological balance and to meet socioeconomic needs; incorporating tree plantation programs in all relevant development schemes; arresting the depletion of forestland and forest resources; and developing and encouraging the use of substitute forest products.

Bangladesh is one of the world's lowest per capita carbon dioxide emitting countries. Carbon dioxide emissions per capita (metric tons) increased to 0.3 in 2006, from 0.14 in 1990, which is still very low in the global context. Consumption of ozone depleting CFCs increased marginally to 196 in 2006 from 195 in 1990.

Issues of Water and Sanitation in Bangladesh

In the last two decades, Bangladesh has emerged as the leader in experimenting and implementing innovative approaches to rural sanitation in Asia. The turning point for the sanitation movement in the country came with hosting the First South Asian Conference on Sanitation (SACOSAN-I) in 2003 wherein the Government of Bangladesh announced its target of 'Sanitation for All by 2010', keeping its commitments to the MDG targets. This commitment has amply been reflected in the first National Strategy for Accelerated Poverty Reduction (NSAPR, 2005).

Figure: Trends in Access to Water and Sanitation in Bangladesh



Source: Based on Database of Millennium Development Goals Indicators 2009, UNDP.

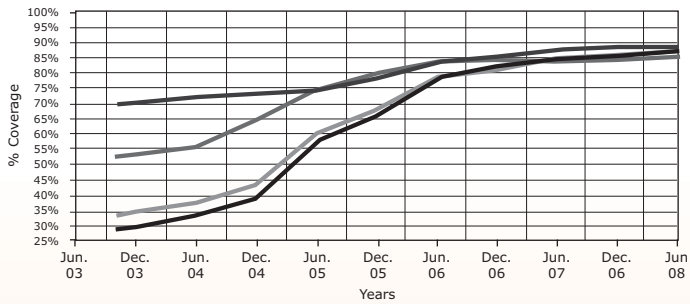
As is evident from the Table given above, proportion of the population using improved drinking water sources in Bangladesh has been stagnant around a figure of 80 percent and if this trend continues, Bangladesh will not be able to provide 100 % access to improved sources of water to households. On the other hand, the proportion of population having access to improved sources of sanitation is rising at a slow pace which increased from 26 % in 1990 to 36 % in 2006.

The sanitation issues have been adequately addressed in the second National Strategy for Accelerated Poverty Reduction (NSAPR, 2008). By 2006, the proportion of the urban population without access to safe drinking water had been reduced to 0.1 per cent. The picture in rural areas is rather different, with arsenic contamination of ground water contributing to a reversal of that trend. The proportion of the rural population without safe drinking water increased to 21.4 per cent in 2006, from 6.9 in 1991. Measures to contain arsenic contamination have been introduced by the government. The Government of Bangladesh has realized the importance of sanitation for sustainable development and put emphasis on achieving the target that will have immense impact on poverty reduction.

Bangladesh has made major progress on access to sanitation indicator. A nationwide 'Community Led Total Sanitation' campaign was launched in 2003 with the aim of reaching 100 per cent coverage by 2010. In 1991, 56 per cent of urban populations and 15 per cent of their rural counterparts had access to sanitary latrines. By June 2007, coverage had jumped phenomenally to around 88 per cent in urban and municipal areas and 85 per cent in rural areas. The World Bank estimates that more than 100 million people in Bangladesh now have access to total sanitation. The challenge now is how to extend safe sanitation to more remote areas. The country is likely to meet the target by 2010.

The progress in rural sanitation was rather slow during the 1980s and 1990s. The sanitation coverage growth rate was merely 1% per annum. In 2003 the rural sanitation coverage was only 29%. The Bangladesh Government is committed to

Figure: Trends in Sanitation Coverage Progress



Source: Extracted from Mid Term Bangladesh Progress Report 2007; UNDP.

achieving 100% sanitation coverage by 2010. In 2003, the government initiated a National Sanitation Campaign in a coordinated way together with DPHE, LGED, the local governments, the government's administrative units in upazilas and districts and NGOs. Since initiation of the coordinated sanitation campaign, also called "Community-Led Total Sanitation (CLTS) Approach" in 2003 and the government declaration of the target of 100% sanitation coverage by 2010, there has been unprecedented progress in sanitation coverage. The rural sanitation coverage in June 2008 has increased to 87 %.

Table: Access to Sanitary Facilities for Households

Area	*According to Baseline Survey, October 2003*			*Coverage upto June 2008*
	Total number of families	*No. of families using Sanitary Latrines*	*% of families using Sanitary Latrines*	*% of families using Sanitary Latrines*
City Corporations	1216424	850527	69.92	85.03
Pourashavas	1851337	983025	53.1	89.13
Rural	18326332	5272589	28.77	87.08
Country Total:	21394093	7106141	33.21	88.22

Source: Mid Term Bangladesh Progress Report 2007; UNDP.

Concluding Remarks

The details provided above shows how far Bangladesh is on track in achieving developmental goals. Bangladesh has already achieved 'gender parity in primary and secondary schooling'. It is on track to achieve the targets of 'halving the proportion of population who suffer from hunger', 'achieving universal primary school enrolment', 'reducing the under- five child mortality rate' and 'reducing infant mortality rate'. Bangladesh is also on track of achieving other targets of 'containing the spread of communicable diseases like HIV/AIDS, malaria and tuberculosis' and 'reducing the proportion of population without safe drinking water and reforestation'. Meanwhile, Bangladesh has also achieved remarkable success in female education and sanitation. However, Bangladesh is lagging behind against some other targets like 'share of poorest quintile in national income/consumption', 'reducing maternal mortality', 'completion of primary schooling', 'gender parity in tertiary education' and others. The challenges ahead of Bangladesh call for mobilising required resources and targeted interventions in the areas lagging behind. Bangladesh has already initiated the implementation of the second PRSP for the period of July 2008 to June 2011. This report will be of immense utility in the preparation process of the second PRSP and would assist the Government of Bangladesh and other stakeholders to take corrective measures regarding the off-track targets as quickly as possible.

CHAPTER FIVE

India's Progress towards SDGs

Epitomizing "One Step Forward and Multiple Steps Backwards"

General Socio-economic Overview: The Case of Grand Economic Fundamentals and Dismal Social Outcomes

India belongs to category of 'Hall of Fame' nations with registering a growth of GDP to the tune of 8 percent and above for consecutive four financial year. The spectacular growth of service sector and the boom in stock markets are being publicized with unprecedented fervor and passion. Under the cushion of monstrous stocks of foreign exchange reserves and ever rising inward flow of finance capital, the Country has all the potential to record a spectacular growth in GDP in the coming years as well, notwithstanding the mild recessionary phase being experienced on account of 'imported' financial setback.

Table: Macro-Economic Indicators

Indicator	*9th Plan (1997-98 to 2001-02)*	*10th Plan (2002-03 to 2006-07)*
GDP growth (%), of which:	5.5	7.2
Agriculture	2.0	1.7
Industry	4.6	8.3
Services	8.1	9.0
Gross domestic savings (% of GDP at market prices)	23.1	28.2
Gross domestic investment (% of GDP at market prices)	23.8	27.5
Current account balance (% of GDP at market prices)	-0.7	0.7
Combined fiscal deficit of centre and states(% of GDP at market prices)	8.8	8.4
Foreign exchange reserves (US $ billion)	54.2	165.3
Rate of inflation (based on WPI)	4.9	4.8

Source: An Approach to the 11th Five Year Plan

However, the picture is not that much rosy in the countryside. Even the majority of the urban people are still struggling to find sufficient means to procure necessities of life (food, housing, primary health care services and quality school education). In policy discussions, we tend to, presumptuously, ignore the near stagnation in agriculture sector and creeping pace of employment generation in

the face of monumental growth in GDP and constant flooding of institutional investment. In fact, the agriculture sector has become a non profitable enterprise and farmers are committing suicides even in some more prosperous States of India (e.g., Maharashtra, Karnataka, Punjab), let alone the precarious condition of farming community in some relatively poor States of Bihar, Uttar Pradesh, Chhatisgarh and Orissa. On the one hand, (Food Corporation of India) FCI food store are flooded with procured grains, per capita consumption of food grains in India is showing a consistent trend of decline during the much touted reforms era. One need not be a brain surgeon to figure out that, given the acute scarcity of employment opportunities and the virtual absence of social safety nets, people do not have enough power to purchase grains in the market which has led to decline in food consumption, which is comparable to the level of consumption during the Great Bengal Famine in 1943. As will be evident in the following discussion, despite the plethora of schemes targeting nutrition of children and women, even the countries of Sub Saharan Africa perform better than India on child nutrition and health indicators. Despite the decline in food grain consumption per capita (let us keep the fact at the back of our mind that food grain is the most important source of calorie intake, and poverty in India is calculated on calorie intake base), with no significant rise in the share of meat, milk and fish products in consumption expenditure of the household, official data sources show decline in head count poverty ration India during the 1990s and afterwards. We cannot conceive of any reasoning behind such paradoxical finding of the consumption survey and the methodology of poverty estimation in India.

Table: Incidence of poverty (per cent)

	By Uniform Recall Period (URP) Method		*By Mixed Recall Period (MRP) Method*	
	1993-94	*2004-05*	*1999-2000*	*2004-05*
Rural	37.3	28.3	27.1	21.8
Urban	32.4	25.7	23.6	21.7
All-India	36	27.5	26.1	21.8

Source: Economic Survey, 2008-09, Ministry of Finance, GoI)

Table: Per capita net availability (per day (grams)

	Cereals	*Pulses*	*Total*
1951	334.2	60.7	394.9
1961	399.7	69	468.7
1991	468.5	41.6	510.1
1997	466	37.1	503.1
2002	458.7	35.4	494.1
2003	408.5	29.1	437.6
2004	426.9	35.8	462.7
2005	390.9	31.5	422.4
2006	412.8	32.5	445.3
2007	407.4	35.5	442.8

Source: Economic Survey, 2008-09, Ministry of Finance, GoI)

This paradox of coexistence of official claims of poverty reduction poverty and the declining trends of per capita food availability is clearly visible in the tables portrayed above. On the one hand, during the period between 1993/94 and 2004/05, poverty has declined 9 percentage points, while on the other hand, per capita food grains availability declined from 510 grams in 1991 to 443 grams in 2007. In addition, the official claims that consumption patterns have shifted in favor of non-cereal items is not statistically tenable either, as can be viewed from the datasets of National Accounts Statistics of India. Given this apparent paradox, it may be suggested that methodology of poverty calculations in India seems to be flawed as has been asserted repeatedly by numerous progressive economists including Utsa Patnaik.

Table: Selected HDI for Major States

	Life expectancy at birth (2002-2006)			*Infant Mortality Rate (per 1000 live births) (2007)*			*Birth rate (per 1000)*	*Death rate (per 1000)*
	Male	*Female*	*Total*	*Male*	*Female*	*Total*	*2007*	*2007*
Andhra Pradesh	62.9	65.5	64.4	54	55	54	18.7	7.4
Assam	58.6	59.3	58.9	64	67	66	24.3	8.6
Bihar	62.2	60.4	61.6	57	58	58	29.4	7.5
Gujarat	62.9	65.2	64.1	50	54	52	23	7.2
Haryana	65.9	66.3	66.2	55	56	55	23.4	6.6
Karnataka	63.6	67.1	65.3	46	47	47	19.9	7.3
Kerala	71.4	76.3	74	12	13	13	14.7	6.8
Madhya Pradesh	58.1	57.9	58	72	72	72	28.5	8.7
Maharashtra	66	68.4	67.2	33	35	34	18.1	6.6
Orissa	59.5	59.6	59.6	70	72	71	21.5	9.2
Punjab	68.4	70.4	69.4	42	45	43	17.6	7
Rajasthan	61.5	62.3	62	63	67	65	27.9	6.8
Tamil Nadu	65	67.4	66.2	34	36	35	15.8	7.2
Uttar Pradesh	60.3	59.5	60	67	70	69	29.5	8.5
West Bengal	64.1	65.8	64.9	36	37	37	17.9	6.3
India	62.6	64.2	63.5	55	56	55	23.1	7.4

Source: Economic Survey, 2008-09; Government of India.

Not only that the claims of poverty reduction in India seem to be frivolous, other indicators pertaining to human development also show a depressing picture. As is shown in the table above, life expectancy at birth in India is on the lower side, but also there are significant variations across States in India.

While Kerala is the top performer with a figure of 74 years, Assam and Madhya Pradesh belong to the category of worse performer with a life expectancy of less than 60 years. Another related indicator is the infant mortality rates across States. Here again, Kerala is the outlier with a IMR of 13, while the States of Madhya Pradesh (72), Orissa (71) and Uttar Pradesh (69) are among the States which perform worse than the national average of IMR of 55 which in any case is a depressingly higher figure.

Despite of the fact that India Economy has registered an unprecedented GDP growth rates, the situation of hunger remains a serious cause of concern for India as is clearly reflected in the Box given below. India, despite being flaunted as the emerging economic power at the world stage, India belongs to the category of countries where the extent of hunger is alarmingly serious, though not violent.

The gradual decline in net availability of food grains has a mirror image in the extent of hunger prevalent in India. As may be clear from the figure provided below, contrary to the 'magic' figures of declining poverty ratio in India, the Global Hunger Index published by FAO places India in the group of countries, where the severity of hunger is serious and alarming, though not violent.

Table: Global Hunger Index by severity and food protests January 2007–June 2008

< 4.9 (low)	*5.0 to 9.9 (moderate)*	*10.0 to 19.9 (serious)*	*20.0 to 29.9 Alarming*	*ed 30.0 (extremely alarming)*
Non-Violent				
Argentina Brazil Jordan Lebanon Mexico	China el Salvador el Salvador South Africa Trinidad and Tobago	Bolivia Guatemala Nicaragua North Korea* Philippines Uzbekistan	Bangladesh India Madagascar Nepal	Ethiopia Niger
Violent				
	Malaysia Arab rep. Egypt Morocco Russia Thailand Tunisia	Cameroon Côte d'Ivoire Honduras Indonesia Kenya Mauritania Senegal	Burkina faso Guinea Haiti Mozambique Pakistan Yemen, rep.	

Source: Global Hunger Index, FAO 2008.

The delivery of social services (including education, health care, water supply and sanitation) in India is at best disappointing. Even though the share of education and health services in public expenditure has grown significantly in some recent most years (see Economic Survey, 2008-09), sub-par management and policy implementation meant that many programmes have failed to live up to expectations. Delivery of public services remains at best poor and leaves a lot to

be desired. This is especially true for the health sector where the government promises much but has delivered little. In a country like India where more than 3/4th of the population is struggling for sustaining their livelihood by spending less than USD 2.0 a day, private out of expenditure on health care services accounts for 75 percent of total health care spending in India while the coverage of health of health insurance is virtually blank (NHFS III, 2005-06, India). The Central and State government's annual budget for healthcare is a measly 1% of GDP and this lackluster commitment underlies the problems faced by the health sector.

The country's Tenth (2002-2007) and Eleventh Five-Year Plan (2007-2012) has been formulated to focus on and address social agendas such as education, healthcare and environmental issues amongst others. The Tenth Plan included a clear and concise outline of the national targets whilst the Eleventh Plan proposed state-specific targets. The plans were also formulated with a view to raise efficiency through decentralization such that initiatives will be implemented and governed at the state rather than at the national level. One particular feature of note in the Eleventh Plan is the acknowledgement of a lack of inclusiveness of marginalized groups in previous Five-Year plans. How well the Eleventh Plan translates into visible outcomes remains to be seen.

Livelihood SDGs in India

The Government of India has launched various new countrywide programmes for extending the benefits of its policy initiatives and demonstrated its commitment by significant enhancement of allocations for these programmes in the recent budgets. The Sarva Shiksha Abhiyan (Education for all), the National Rural Health Mission, the Expanded Midday Meal Scheme and the Integrated Child Development Mission, Sampoorna Grameen Rozgar Yojana and National Rural Employment Guarantee Scheme (NREGS) are the main programmes targeted to achieve goals akin to the Millennium Development Goals (MDGs). These programmes along with other concomitant action plans have their own instruments of assessing the impacts on the ground.

In order to realize maximum social development with a focus on optimization of scarce financial resources attracting competing claims of various sectors, the Government is focusing on several flagship programmes including, inter alia:

- Food Security Mission (for Livelihood and Food Security)
- Integrated Child Development Services (ICDS) (holistic flagship scheme targeting simultaneously health, nutritional improvement and pre-school education of the children
- National Rural Health Mission (NRHM) (to ameliorate the precarious health condition of the rural people)
- National Rural Employment Guarantee Scheme (NREGS) (for employment provisioning and Livelihood Security

- Sarva Shiksha Abhiyan (SSA) (for universalisation of elementary education)
- National Literacy Mission (NLM) (universalisation of education and to cover adults into literacy net))
- National AIDS Control Programme (NACP)
- Total Sanitation Campaign (TCS)
- Swajaldhara (for drinking water supply)
- Bharat Nirman (for rural infrastructure to facilitate rural Development)
- Jawaharlal Nehru National Urban Renewal Mission (JNNURM) (for provisioning of urban infrastructure and services, particularly attention being paid to slum area development)

Although, every rupee spent on public welfare programmes in India has potentially high marginal value, the case may be more pronounced when it is spent on employment generation activities that not only raises the purchasing power of the majority of the poor, but also has a positive impact on the economy through multiplier effects. One additional benefit of such employment schemes is that they are inherently self targeting the poor if wages are kept at moderate level as is the case with the National Rural Employment Guarantee Scheme.

Table: Provision of Guaranteed Employment under NREGS, up to July 2009.

Employment provided to households	:	4.5	Crore
Person days [in Crore]			
Total	:	216.1	
SCs	:	63.43	[29.35%]
STs	:	54.81	[25.36%]
Women	:	103.42	[47.86%]
Others	:	97.86	[45.29%]
Total works taken up	:	27.2	Lakhs.
Works completed	:	12.09	Lakhs.
Works in progress	:	15.11	Lakhs.
Note: Figures in Parentheses are percentage shares.			

Source: extracted from nrega.nic.in (Ministry of Rural Development, GoI) as on 03.07.2009.

The National Rural Employment Guarantee Act (NREGA) was notified on September, 2005. The Act provides a legal Guarantee of 100 days of wage employment in a financial year to every rural household whose adult members volunteer to do unskilled manual work at the minimum wage rate notified for agricultural labour prescribed in the State or else an unemployment allowance. The objective of the Act is to supplement wage employment opportunities in rural areas and in the process also build up durable assets.

In order to ensure means of livelihood for the rural people in distress conditions, the scheme has remarkable implications. As is evident from the table depicted above, so far, 4.5 Crores (45 million) households have been provided employment through this scheme. One important aspect of this scheme is that majority of the beneficiaries of the scheme has been from marginalized class of the society, namely, Scheduled Caste and Scheduled Tribes people who are placed at the bottom of the development ladder. More importantly, just less than half (48 percent) of the jobs have been provided to women.

Another important programme of the government is the mission to secure food and nutrition security of the people through the extensive network of Public Distribution System (PDS) across the country. PDS means distribution of essential commodities to a large number of people through a network of Fair Price Shops (FPS) on a recurring basis. The commodities distributed include: Wheat, Rice, Sugar and Kerosene.

PDS evolved as a major instrument of the Government's economic policy for ensuring availability of foodgrains to the public at affordable prices as well as for enhancing the food security for the poor. It is an important constituent of the strategy for poverty eradication and is intended to serve as a safety net for the poor whose number is more than 330 million and are nutritionally at risk. PDS with a network of about 4.99 lakh Fair Price Shops (FPS) is perhaps the largest distribution network of its type in the world. (fcamin.nic.in)

The main elements of the Government's food management policy are procurement, storage and movement of food grains; public distribution and maintenance of buffer stocks. Food grains are procured at the Minimum Support Price (MSP) fixed by the Government. Under the decentralized procurement scheme, the State Government itself undertakes direct purchase of paddy and wheat and procurement of levy rice on behalf of Government of India. Purchase Centres are opened by the State Governments and their agencies as per their requirements. The State Governments procure, store and distribute food grains under TPDS and other welfare schemes. In the event of the total quantity of wheat and rice thus procured falling short of the total allocation made by the Central Government for meeting the requirements of TPDS and other schemes, the Central Government, through FCI, meets the deficit out of the Central Pool stocks.

The government allocates procured food grains under various heads, namely, Targeted Public Distribution System (TPDS), Below Poverty Line Population (BPL), Above Poverty Line Population, Antyodaya Anna Yojana (AAY). In addition, the Government allocates food grains for various States for different welfare schemes including, Sampoorna Gramin Rojgar Yojana (SGRY), Mid Day Meal Scheme (MDM), Wheat Based Nutrition Programme (WBNP) and NPAG (Nutrition Programme for Adoloscent Girls (NPAG). For the year 2006-07, 263 Lakh Million Tonnes of food grains were allocated under the schemes mentioned above and the relevant details are as follows:

Table: Off take of Food grains from the Central Pool			
Schemes	*Off take*		
	Rice	*Wheat*	*Total*
(A) TPDS			
BPL	65.573	35.287	100.860
APL	43.334	19.724	63.058
AAY	41.121	21.192	62.313
Sub-Total (A)	150.028	76.203	226.231
(B) Welfare Schemes			
SGRY	9.251	4.062	13.313
SGRY (Spl. Comp.)	5.330	0.207	5.537
MDM	9.202	2.482	11.684
WBNP	0.869	1.758	2.627
NFFWP	1.215	0.172	1.387
EFP	0.092	0	0.092
Hostels/Welfare Institutions	1.167	0.201	1.368
ANNAPURNA	0.438	0.208	0.645
WFP	0.354	0.310	0.664
NPAG	0.105	0.044	0.149
VGBS	0.056	0.007	0.063
Sub-Total (B)	28.079	9.449	37.528
(C) Open Sale	0.087	0.012	0.099
Total (A+B+C)	178.194	85.663	263.858

Source: Annual Report, 2008-09; Ministry of Food and Consumer Affairs, Government of India.

To ensure better nutrition of the children belonging to age group 0-3 years, the government runs ICDS (Integrated Child Development Schemes) centres, where micro as well as macro nutrients are provided free of cost to the children and lactating mothers. However, given the lack of monitoring and poor governance, majority of ICDS centres, specifically in rural India, are dysfunctional, defeating the whole purpose of the scheme of the scheme (a brief sketch of ICDS is provided in the following Box).

The decision to universalize quality ICDS by setting up an 'Anganwadi' centre in every settlement (after a notice provided by the honourable Supreme Court), the introduction of an education cess of 2% on all central government revenues to finance universalisation of elementary education, the strengthening of the mid-day meal scheme, the enactment of the National Rural Employment Guarantee Act, the Right to Information Act and the Protection of Women from Domestic Violence Act, have given needed impetus to initiatives pertaining to assurance of food and livelihood security of the poor and children.

BOX. Integrated Child Development Services (ICDS)

The Integrated Child Development Services (ICDS) was launched on 2 October 1975 with the aim to (1) lay the foundation for proper psychological child development, (2) improve the nutritional and health of children up to 6 years of age, (3) reduce child mortality, morbidity, malnutrition and percentage of school drop-outs, (4) encourage families to play a greater role in child development and (5) provide a framework for coordinated approach between policy implementation between various institutions. The ICDS seeks to achieve this through the provision of nutritional supplements, immunisation against six preventable diseases, health monitoring, informal preschool education (children aged between 3-6 years) and referral services.

Under the scheme, women between 15-45 years of age are also provided with health and nutrition education, which forms part of capacity building initiatives designed to make women more self-sufficient. Financed by the Central government and implemented through authorities of the State/Union territories (UT), the ICDS operate at the village level from childcare centres called 'anganwadi'. The number of anganwadi in operation has increased by three-fold, from 249,310 in 1992 to 748,229 in 2006. Despite being in service for more than three decades, the ICDS has yet to provide coverage for the entire country. This failure was highlighted in the Eleventh Five-Year Plan with lack of funding being cited as the main reason.

Table: India Livelihood SDGs Indicators: Poverty and Employment

	Employment-to-population ratio, %	*Growth rate of GDP per person to employed, %*	*Employment-population ratio, men, %*	*Employment-to-population ratio, Women, %*	*Employed people living below $1 (PPP) per day, %*
1991	58.6		80.7	34.7	
1992	58.2	3.79	80.2	34.3	68
1993	58.2	2.4	80.3	34.3	55.5
1994	58.6	4.33	81	34.4	59.4
1995	57.6	6.85	79.8	33.7	67.6
1997	57.3	2.58	79.6	33.3	59.3
2000	56.8	3.02	79.3	32.7	47.7
2004	55.9	7.7	78	32.2	
2005	55.8	6.7	77.9	32.2	39.1
2006	55.7	7.11	77.7	32.2	

Source: Based on Datasets of Millennium Indicators; UNDP.

Eradication of Hunger Poverty

A 2006 report published by the UN Food and Agriculture Organisation (FAO) states that 12% of the world's 6.6 billion people are living in hunger and of that, 26% or 212 million of them live in India. To put this into context, 1 in 6 people in India are living in hunger every day. This is not a new phenomenon as a quarter of the Indian population in the early 1990's do not receive the minimum

recommended 2,350 calories a day in their diet Although the situation has improved at the turn of the century, it is not nearly enough when compared to the economic growth rates that India has achieved. It is important to note that food poverty is centered on the marginalised and poorest community in the country where inequality and inequity is most glaring.

To a lesser extent, the lack of food accessibility could also be a result of the shifting focus that India has undertaken in recent years from one of agriculture to that of industrial expansion. In a recent interview, M. S. Swaminathan, one of the founding fathers of the Indian Green Revolution gave a rather morbid assessment on the current state of agriculture development in the country by stating, “Unless it is a prolonged and sustained campaign, hunger-free India cannot be achieved. By 2007, we should have had substantial freedom from hunger but 2007 is over and it is a dream and not a reality.”

Implementation of the National Food for Work programme (which has been described as a prelude to the National Rural Employment Guarantee Act or NREGA) and the Total Rural Employment Scheme has provided a means for the poor and marginalised to be self-sustaining by offering manual labour (that contributes positively to overall community health, e.g. creation of basic sanitation facilities) in return for food security. Although this is a step forward towards combating food poverty, these programmes are rife with corruption, mismanagement and oversight and may be incapable of eradicating hunger poverty. In fact, National Sample survey data strongly suggest that less than 10 percent of the population are participating in government schemes meant for ensuring employment, livelihood and food security (For details, see SANSAD Booklet, Farmer Suicides in India (2009).

If the national poverty line is used as the definition, the country is generally considered to be well on track to reduce the headcount ratio of poverty, but not if the World Bank’s estimates of proportion of population below the newly defined extreme poverty line of USD 1.25 per day is considered. Besides, irrespective of the poverty estimate one uses, there is a distinct possibility that poverty levels may be higher than expected in the next couple of years till the economy resumes a faster growth path. Higher food prices would aggravate the situation and push back further the possibility of India reaching the target in Goal-I which aims at hunger eradication.

Higher food prices limit their ability to obtain not only food but also other essential goods and services, including education and health care. Most of the urban poor and the landless rural poor are in this position. Poor farmers, on the other hand, can benefit from higher food prices if they are able to produce more than they consume. But many lack the resources to do so, in part because higher oil prices have raised the cost of fertilizer.

The figures presented in the table presented above clearly suggest that employment to population ration is declining over time and every two out of five people in India is below the poverty line of $1.0 per day. This is a very disturbing trend and needs to be reversed sooner rather than later.

Hunger, Food Price Rise and Malnutrition:

The current rise in price of basic foodstuff can only worsen the situation and threatens to reverse the positive effects that these programmes have managed to generate, if any. With hunger poverty rife amongst the population, malnutrition is not far behind. The UN Children's Fund (UNICEF) recently announced that 1.5 million children in India are at risk of being malnourished as a result of the continuing food crisis. UNICEF indicated that every second young child in India is malnourished and this speaks volumes on the dire situation India finds herself in. Looking at the prevalence of malnutrition amongst the country's younger population, the percentage of children under five that are underweight for their age has only declined by 10% in 13 years and equates to just 0.8% reduction per year. Although this indicates a consistent decline in malnutrition, progress has actually slowed for the period 1999/00-2005/06 (3.5 %) compared to the (6.4 %) reduction observed in 1994-2000.

Table: Proportion of children who are underweight for their age

Indicators	*Definitions*	*1993-94*	*1999-00*	*2005-06*
Prevalence of underweight children under 5 years of age	Percentage of children under 5 years who are underweight for their age	53.4	47.0	43.5

Source: National Health and Family Survey (NHFS-3) of India, 2007

Thus, despite having one of the largest child development programmes in the world, India has a malnutrition rate that is amongst the worst in South Asia and the world. According to a report published by the World Bank (WB) in 2005, the underlying problem of child malnutrition is due to the failures of programmes in not targeting children under the age of three; the age range that the report describes nutrition interventions as being most effective. The study also pointed out that infection and inappropriate infant and children feeding practices rather than hunger are the leading causes for child undernourishment. Because of this, the report pointed out that the government's decision to tackle the issue by focusing on food supplementation rather than raising awareness amongst women of the consequences of poor feeding practices and the importance of a balanced diet, is the reason that child nutrition programmes in India are not as effective as could be.

Another reason for the high incidence of malnutrition amongst children is the declination of women's health. The inadequacy of the health sector (see also section on Health SDGs) has resulted in many women suffering from poor health and as a result, a very large proportion of children are born underweight and malnourished. Lack of accessibility to food (and therefore a balanced diet) as a result of rising food prices can only contribute to the already poor state of child malnutrition in India.

To compound matters, inflation has been the highest since 1995, with rates rising above 10%, twice that of the government's own target. Because India calculates

inflation rates based on wholesale price index (WPI) rather than the more accurate consumer price index (CPI), prices of goods are in fact higher than government estimates; this means the number of people unable to afford sufficient food and therefore becoming hungry and further malnourished is potentially higher than official government figures.

As has been discussed earlier, the official methodology of poverty calculation in India has been suggested to be flawed. The official figure of poverty indicates a consistent decline in head count poverty ratio in India. However, based on the international poverty line of USD 1.0 per day, poverty reduction trends in India show an inconsistent trend. During the period between 1990 and 2000, head count ratio of poverty India declined from 37.5 percent in 1990 to a level of 26.1 percent in 1999-00. This trend of poverty reduction, however, reversed its path in the next five year period; it increased to 33.5 percent in 2004-05 as may be noted in the Table given below.

Table: Proportion of people living below the national poverty line

Indicators	*Definitions*	*1990*	*1999-00*	*2004-05*	*2012 Target*
Proportion of population living below the poverty line	Percentage of people living below $1 per day	37.5	26.1	33.5	18.8

Source: collated based on figures provided by the Ministry of Statistics and Programme Implementation Government of India (brief MDG report 2006) and NHFS-3, 2007

Thus despite significant achievement recorded in economic growth and relative macroeconomic stability, India has not been able to manage adequate food for its people which gets reflected in high incidence of poverty and malnutrition. If this trend continues, not only will India fail to achieve development targets but the condition will deteriorate further.

Health SDGs

The total government expenditure on health in 2004 is just hovering around 1.0 % of GDP. With an extremely high ratio of private spending whilst government expenditure on health is embarrassingly low. The public expenditure on health is just 1.3% in 1990 and this has declined to 1% in 2007 compared to the 5-6% in developed countries). The government hopes to raise the public health expenditure from 0.9% to 2% by 2010 but the problem in the health sector is not only of financial inadequacy but also of one arising from poor implementation and short-sightedness.

Table: Trends in Medical Care Infrastructure and Health Personnel Related Indicators				
	1991	*2001*	*2007*	*2008*
Hospitals (Govt. Allopathic Hospitals) (in '000)	11.2	4.3	7.7	10.0
Dispensaries (CGHS) (in '000)	27.4	0.3	0.3	0.3
No.of beds (Govt. Allopathic Hospitals) (in '000)	811	421.6	492.7	482.5
Beds per Lakh Population (in '000)	95	41.0	43.7	42.2
Registered medical practitioners (in '000)	393.6	555.6	682.6	696.7
Registered medical practitioners per Lakh Population	46.5	54.0	60.5	60.9
Registered nurses (ANM+GNM) (in '000)	340.2	1195.4	1458.0	1458.0
Registered nurses per Lakh Population	40	116.2	129.2	127.4
Medical college	146	189	262	266
Annual admissions (MBBS)	12199	18168	28928	30290
Note: ANM - Auxiliary Nurse Midwives; GNM - General Nursing and Midwives				

Source: Statistical Pocket Book of India, 2008. (Available at mospi.nic.in)

The lower public spending in health care services and infrastructure has been resulted in an absolute decline in the number of Government Hospitals, from 11200 in 1991 to 10000 in 2008. Only 300 CGHS dispensaries were functional in 2008 as against the figure of 27400 in 1991. There has significant decline in the number of beds in Government Hospitals which declined to 482 thousand in 2008 from a figure of 811 thousands in 1991. If we look at figures of beds per 1000 populations, we again get a very dismal picture which reduced to paltry level of 42 in 2008 from a comparatively better level of 95 beds per 1000 populations.

Take for example an article published by Xavier et al. (2008) analysing the reasons for abnormally high numbers of patients suffering from acute heart problems in India (60% compared to 40% in the rest of the world). Essentially, the researchers realised that once at the hospital (a journey which can itself take an inordinate amount of time due to lack of ambulances, traffic congestion and vast distances to cover), it may take up to 50 minutes before a patient is seen by a practitioner, a gross amount of time when it only takes between 20 to 30 minutes for patients in the developed world to receive medical attention.

The consequences of such delays are not merely financial, but can result in a patient's death. For example, the researchers pointed out that patients suffering from a heart attack can potentially make a full recovery by taking prescribed medicine costing Rs 1,500, provided that these patients receive proper medical care within one hour of suffering a heart attack. Past the one hour time-frame and more expensive procedures that include invasive surgery may have to be performed and these can cost up to Rs 100,000. As have been mentioned, India suffers from poor programme design and implementation (geographical placement

in this case) and no amount of monetary expenditure can solve the problems it faces (unless available budget was used to overhaul the entire administration system).

In yet another example of short-sightedness, a recent article published in the Indian magazine Outlook brought to attention that the pneumococcal conjugate vaccine (PCV) which the Indian Ministry of Health and Family Welfare plans to introduce as part of its immunisation programme in 2010 was in fact, unsafe for use. The author of the said article cites a reply garnered from experts at WHO which categorically states that PCV does not prevent instances of clinical pneumonia (the most common form of pneumonia afflicting children) but instead, prevents 3.6 cases of radiological pneumonia (a rare form of the infection) per 1,000 children vaccinated. Since 2006, PCV has been marketed in India under the brand name Prevnar and cost Rs 12,000 for three doses, compared to Septran, a standard drug used to combat bacterial infections which costs just Rs 10. In light of this, it is unclear why the Ministry of Health has decided to incorporate the vastly overpriced PCV into its national immunisation programme when its cost far outweighs the marginal benefits.

India: Health and Diseases Indicators

The scarcity of financial commitments and the consequent shortages of health infrastructure, coupled with indifferent behavior of health personnel in the absence of effective regulatory and monitoring mechanisms, have resulted in dismal progress in magnitude of health indicators across the board. Infant mortality indicators show consistent decline in magnitude (from 66 in 2001 to 55 in 2007), though the pace of mortality reduction leaves much to be desired. An important indicator to capture the long term overall health status of the country is the life expectancy at birth. Though India has registered a significant increase in life expectancy (from 58.7 years in 1990 to 63.1 years in 2005), it is still well below the average level of 75 years in developed regions of the world.

Table: Trends in Birth, Death and Infant Mortality Rates in India

	1990	*2001*	*2005*	*2006*	*2007*
Crude Birth rate (per 1000 population)	30.2	25.4	23.8	23.5	23.1
Crude Death rate (per 1000 population)	9.7	8.4	7.6	7.5	7.4
Infant mortality rate (per 1000 live births)	80	66	58	57	55
Expectation of life at birth (in year)	58.7	62.5	63.1		

Source: Office of the Registrar General, India; Extracted from Statistical Pocket Book of India, 2008.

The situation of maternity care in India is even worse as reflected in the trend values of indicators presented in the table below. Maternal Mortality Rate in India is stubbornly stagnant at a high level of 450 per 100000 live births. This may be logical fall out of the limited access to institutional births and antenatal and

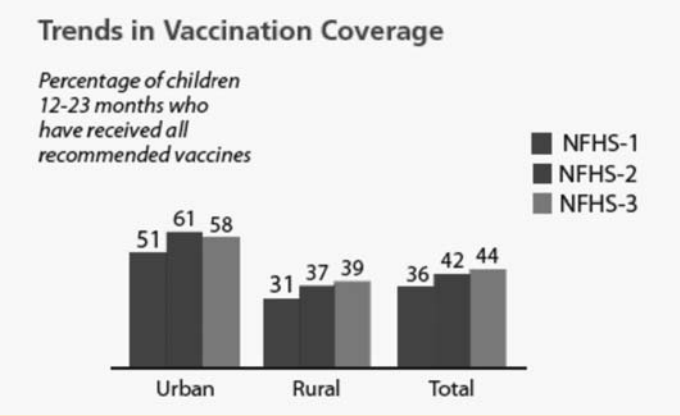
post partum care. Indeed, in Inda, the proportion of births attended by skilled health personnel is at a low level of 48 percent in 2005-06. Similarly, percentages of women who received at least one antenatal care during their pregnancy period from either public/private care providers has been stagnant at a low level of 65-67 percent in the last 12 years or so.

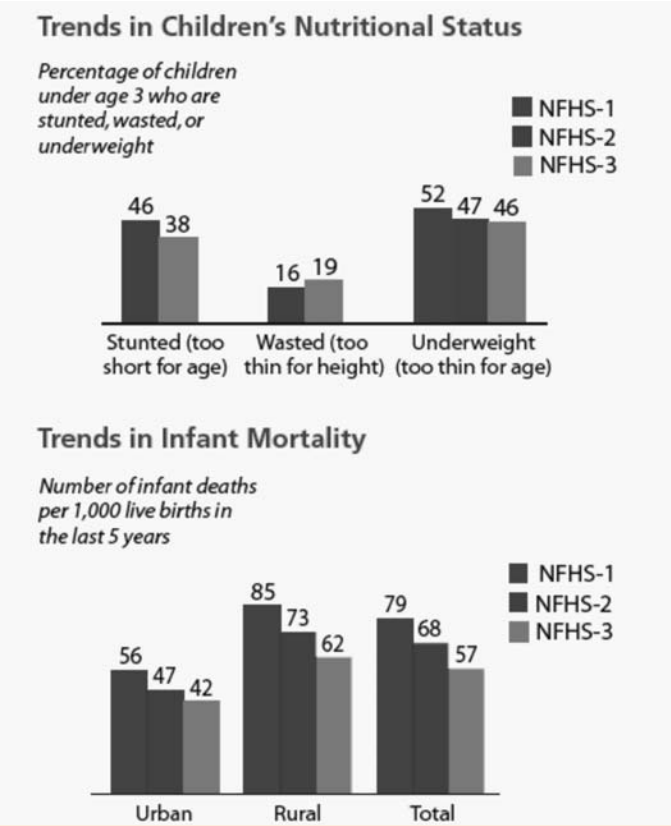
Table: Healthcare afforded to pregnant women for the period 1990-2005

Indicator	*Definitions*	*1992-93*	*1998-99*	*2005-06*	*2010 Target*
Maternal mortality ratio	No. of mothers dying due to complications of pregnancy and delivery per 100,000 live births	437	540	450	100
Proportion of births attended by skilled birth attendants	% of deliveries attended by skilled health personnel	33.0	42.4	48.3	100%
Proportion of women who had given birth and made at least one antenatal care consultation	% of women who received at least one antenatal care during their pregnancy period from either public/ private care providers	65.0	66.0	67.0	48.8

Source: National Health and Family Survey (NHFS-3) of India, 2007

Figure: Trends in Nutritional Status, Vaccination Coverage and Infant Mortality in India, 2005-06





Source: Extracted from NFHS III, 2005-06

Trends in Indicators of Child and Mother Health

Children under five mortality rates per 1,000 live births have declined significantly from 102 in 1995 to 76 in 2006. Infant mortality rate (0-1 year) per 1,000 live births shows relatively low pace of decline, the ratio declined to 57 in 2006 from 73 in 1995. Maternal mortality ratio per 100,000 live births is stubbornly at 450.

Table: Childhood mortality rates for five year periods preceding survey

Indicators	*Definitions*	*1992-93*	*1998-99*	*2005-06*	*2012 Target*
Under-five mortality rate	No. of deaths of children under 5 years of age per 1,000 live births	107	96	75	41
Infant mortality rate	No. of deaths of children under 1 year of age per 1,000 live births	77	73	57	30

Source: data obtained from the National Health and Family Survey (NHFS-3) of India, 2007 NB: data provided here was rounded up instead of given in decimal as per the original NHFS-3 report

Children 1year old immunized against measles have increased at a slow pace roughly 0.5 % per annum, from 56 % in 1990 to 67 % in 2006. Another important indicator, % of births attended by skilled health personnel, has shown a disturbing stagnant trend, increasing slowly from 42.3 percent in 1999 to 46.6 percent in 2006. Roughly half of the children in India do not access antenatal care (at least four visits). Unmet need for family planning remains a problem for roughly 12 percent of the people in 2006.

Table: Trends in Indicators relevant for Child and Maternal Health

	1990	*1993*	*1999*	*2000*	*2005*	*2006*	*2007*
Children under five mortality rate per 1,000 live births	115			89	77	77	72
Infant mortality rate (0-1 year) per 1,000 live births	82			66	58	57	54
Children 1year old immunized against measles %	56	59	50	52	64	67	67
Maternal mortality ratio per 100,000 live births					450		
% of births attended by skilled health personnel		34.2	42.3	42.5		46.6	
Current contraceptive use among married women 15-49 years old, any method		40.7	48.2	46.9		56.3	
Current contraceptive use among married women 15-49 years old, modern methods		36.5	42.8	42.3		48.5	
Adolescent birth rate, per 1,000 women	76		52.1	51	45.9		
Antenatal care coverage, at least one visit%		49.1	59.5	61.8		74.2	
Antenatal care coverage, at least four visits%						50.7	
Unmet need for family planning, total %		16.5	15.8			12.8	
Unmet need for family planning, spacing,%		9	8.3			6.2	
Unmet need for family planning, limiting %		7.5	7.5			6.6	

Source: Based on Millennium Development Indicators, 2009; UNDP.

In a survey of nearly five thousand males aged 15-49 living in urban and rural areas said on the question of why pregnant women in the house was not receiving ante-natal care, a large number of respondents (40%) answered that it was either not necessary or did not allow for the woman to receive medical consultation prior to giving birth, with costs of consultation being a secondary concern (20%).

Table: Reason offered for not receiving antenatal care			
Reason	*Urban (%)*	*Rural (%)*	*Total (%)*
Man did not think it was necessary/did not allow	38.8	40.7	40.4
Family did not think it was necessary/did not allow	20.3	14.0	15.0
Child's mother did not want check-up	10.4	9.1	9.3
Has had child before	1.5	1.6	1.6
Costs too much	14.0	20.7	19.6
Too far/no transportation	1.2	3.9	3.4
No female health worker available	0.9	1.4	1.3
Other	3.0	2.0	2.2
Don't know/missing	9.8	6.5	7.0
No. of male correspondents	756	3,944	4,699

Source: National Health and Family Survey (NHFS-3) of India, 2007.

As is evident from the foregoing discussion, performance of India in reducing child mortality is modest one when compared to even countries like Bangladesh and Nepal. In addition, apart from dismal condition of child health at all India level, there are significant inter-state variations. Infant Mortality Rates in Kerala (13), Maharashtra (34) and Tamil Nadu (35) are well below national average of IMR 55 per 1000 live births. On the other spectrum the States of Madhya Pradesh (72), Orissa (71) Uttar Pradesh (69) and Rajasthan (65) show IMR which are far above than the national figure. The trends in IMR across major States of India are presented in the Table portrayed below.

Table: State wise Infant Mortality Rates									
	1961			*2006*			*2007*		
	Male	*Female*	*Person*	*Male*	*Female*	*Person*	*Male*	*Female*	*Person*
Kerala	55	48	52	14	16	15	14	10	13
Maharashtra	96	89	92	35	36	35	41	24	34
Tamil Nadu	89	82	86	36	37	37	38	31	35
West Bengal	103	57	95	37	40	38	39	29	37
Punjab	74	79	77	39	50	44	47	35	43
Karnataka	87	74	81	46	50	48	52	35	47
Gujarat	81	84	84	52	54	53	60	36	52
Andhra Pradesh	100	82	91	55	58	56	60	37	54
Bihar	95	94	94	58	63	60	59	44	58
Haryana	87	119	94	57	58	57	60	44	55
Assam				67	68	67	68	41	66
Rajasthan	114	114	114	65	69	67	72	40	65
Uttar Pradesh	131	128	130	70	73	71	72	51	69
Madhya Pradesh	158	140	150	72	77	74	77	50	72
Orissa	119	111	115	73	74	73	73	52	71
All India	122	108	115	56	59	57	61	37	55

Source: Statistical Pocketbook of India, 2008; MOSPI, India.

The data provided in the Table given below suggest that proportion of people living with HIV (15-49 years age group), with a figure of 0.5 %, has not assumed serious proportions in India as yet. Condom use to overall contraceptive use among currently married women 15-49 years is relatively stagnant at a level of 9 % in some recent years. Tuberculosis prevalence rate per 100,000 populations has registered a significant decline from 568 in 1990 to 283 in 2007. Tuberculosis death rate has moved downwards from a figure of 42 in 1990 to 28.3 in 2007. All these improvements have been possible, arguably, on account of decent success rates of DOTS.

Table: Trends in Indicators of HIV/AIDS and Tuberculosis Prevalence in India

	1990	*1993*	*1999*	*2000*	*2001*	*2004*	*2006*	*2007*
People living with HIV, 15-49 years old, %					0.5		0.3	
Condom use to overall contraceptive use among currently married women 15-49 years old, %		5.9	6.4			9.1	9.2	
Tuberculosis incidence rate per year per 100,000 population	167.8		167.8	167.8	167.8	167.8	167.8	167.8
Tuberculosis prevalence rate per 100,000 population	567.8		500.9	464.4	429.3	322.5	299.1	282.7
Tuberculosis death rate per year per 100,000 population	42.1		41.6	41	38.3	30.2	28.2	28.3
Tuberculosis detection rate under DOTS, %			6.8	12.1	23.1	55.3	63.8	67.9
Tuberculosis treatment success rate under DOTS, %			82.4	83.6	84.8	86.1	85.9	

Source: UN MDG Country Data, 2009, UNDP.

In fact, with a purpose to ameliorate health status of rural people who constitute roughly three fourth of the total population in India, in 2005, the government launched the National Rural Health Mission (NRHM), a five year scheme to improve the quality of the healthcare system and increase accessibility of basic healthcare to rural areas. Even, though the Central Government is increasing allocation for this flagship programme continually, but the virtual freeze in the recruitment of regular health sector employees has resulted in declining absorption capacity of the health care allocations, and by corollary, reduction in access to public health care services for the poor and the marginalized.

Education SDGs

Goal 13: Access to Primary/Common School for All Children, Boys and Girls & Goal 14: Completion of Primary Education Cycle

Government of India has adopted ambitious targets related to children that are in line with, and at times more ambitious than, the MDGs. Centrally-sponsored

schemes have increased public resources to key sectors, notably the Sarva Shiksha Abhiyan in education (the national policy to universalize primary education), Mid day Meal Scheme and the Integrated Child Development Services. The challenge remains to convert these commitments and resources into measurable results for all children, especially those belonging to socially disadvantaged and marginalized communities. As the trends indicate, the importance of India to the achievement of the global MDGs and regional SDGs cannot be overstated. Some 42% of households without latrines globally are in India, and Indian children make up one-third of the world's malnourished children.

As a matter of fact, acquiring proper education remains elusive for many children in India. The Sarva Shiksha Abhiyan (Education for All Campaign) launched in 2000 is a national programme to make elementary education accessible to all. Because malnourishment affects a child's ability to concentrate, it can be assumed that the child's performance in school will suffer. The indirect effect of hunger and malnutrition could explain the low percentage of pupils that complete primary education and if not properly addressed, could pose long term threats such as reducing the nation's productivity.

Table: Gross Enrolment Ratio in Classes I-V AND VI-VIII AND I-VIII (2006-07)

	Classes I-V (6-11 years)			*Classes VI-VIII (11-14 yrs)*			*Classes I-VIII (6-14 yrs)*		
	Boys	*Girls*	*Total*	*Boys*	*Girls*	*Total*	*Boys*	*Girls*	*Total*
Andhra Pradesh	96.33	96.6	96.47	76.57	74.29	75.46	88.47	87.77	88.13
Assam	97.63	99.23	98.42	67.55	63.46	65.55	86.15	85.68	85.92
Bihar	106.34	82.32	94.67	45.8	31.54	39	83.74	63.8	74.12
Gujarat	127.93	111.3	120.12	82.46	67.48	75.44	110.6	94.64	103.11
Haryana	86.56	90.18	88.21	79.13	81.69	80.29	83.7	86.93	85.17
Karnataka	108.45	105.48	106.99	90.62	86.82	88.76	101.53	98.28	99.94
Kerala	93.06	93.8	93.42	100.97	96.82	98.94	96	94.94	95.48
Madhya Pradesh	153.71	146.9	150.41	101.6	89.98	96.03	134.1	125.76	130.07
Maharashtra	116.06	110.98	113.61	100.95	102.12	101.51	110.31	107.65	109.03
Orissa	116.36	111.66	114.07	79.13	70.26	74.79	102.01	95.6	98.88
Punjab	78.07	85.36	81.33	68.12	70.15	69.03	74.13	79.29	76.45
Rajasthan	123.14	116.92	120.17	89.67	63.65	77.35	110.62	97.16	104.22
Tamil Nadu	117.78	117.84	117.81	110.25	108.12	109.21	114.84	114.03	114.44
Uttar Pradesh	117.92	109.24	113.75	59.64	46.89	53.62	95.56	85.82	90.91
West Bengal	102.13	103.43	102.77	70.01	71.93	70.95	89.66	91.35	90.49
All India	114.42	107.84	111.24	77.41	69.51	73.63	100.25	93.32	96.92

Source: Economic Survey 2008-09, Ministry of Finance, GoI.

The Table presented above shows the gender-disaggregated patterns of Gross Enrolment Ratio (GER) across major States of India. As per indicators pertaining to overall GER, the States of Bihar (74.1%), Punjab (76.45 %), Assam (85.92 %) and Haryana (85.17 %) belong to the group of States who perform substantially the national average of 96.92 % as per the census data of 2001. There is small gap of 3 % in ratios of enrolment of boys and girls at all India level. If we look at the performance of States vis-à-vis GER for girls, Bihar (63.8 %), Punjab (79.29 %), Uttar Pradesh (85.82 %) and Andhra Pradesh (87.77 %) are among the worse performing States of India.

Table: Trends in State wise Literacy Rates

	1951	*1961*	*1971*	*1981*	*1991*	*2001*
Punjab			34.12	43.37	58.51	69.65
Haryana			25.71	37.13	55.85	67.91
Rajasthan	8.5	18.12	22.57	30.11	38.55	60.41
Uttar Pradesh	12.02	20.87	23.99	32.65	40.71	56.27
Bihar	13.49	21.95	23.17	32.32	37.49	47
Assam	18.53	32.95	33.94		52.89	63.25
West Bengal	24.61	34.46	38.86	48.65	57.7	68.64
Orissa	15.8	21.66	26.18	33.62	49.09	63.08
Madhya Pradesh	13.16	21.41	27.27	38.63	44.67	63.74
Gujarat	21.82	31.47	36.95	44.92	61.29	69.14
Maharashtra	27.91	35.08	45.77	57.24	64.87	76.88
Andhra Pradesh	21.19	24.57	35.66	44.08	60.47	
Karnataka	29.8	36.83	46.21	56.04	66.64	
Kerala	47.18	55.08	69.75	78.85	89.81	90.86
Tamil Nadu	36.39	45.4	54.39	62.66	73.45	
All India	18.33	28.3	34.45	43.57	52.21	64.84

Source: Economic Survey, 2008-09, Ministry of Finance; Government of India.

As is the case with other development indicators, there is substantial inter state variations with regard to literacy rates in India. While Kerala (91 %), Maharashtra (76.88%) and Tamil Nadu (73.45 %) are among the States who perform better than average figures for literacy at all India level. The States of Bihar (47%) and Uttar Pradesh (56.27 %) are among the worst performing States of India as may be evident in the Table depicted above.

Given precarious situation of some of the poor States including Bihar, Orissa, Uttar Pradesh and Madhya Pradesh in improving the literacy rates among youth and adult population and enrolment at various tears of education, there is need to substantial public investment in educational infrastructure and the associated human resources. However, as against the recurring promises of allocating at least 6 % of Gross Domestic Product for education, the government spending on education has remained well below 3 % of GDP (the expenditure figures relate to expenditures by the education department only.

Table: Number of Schools by Stage of Education				
	1990-91	*2003-04(P)*	*2004-05(P)*	*2005-06(P)*
Arts, science and commerce colleges	4038	8316	8756	9462
Professional / other college education				
Law	52	59	62	66
Medicine	167	313	330	361
Veterinary science	12	15	16	17
Education	110	146	154	168
Engineering, technology and architecture	243	717	755	824
Other professional colleges	42	84	88	96
Schools for general education				
Pre-Primary/Pre-Basic	1635	5059	4761	5264
Primary (I-V)	97375	128266	130763	132049
Middle (VI-VIII)	34026	48747	51245	52195
High/ Higher Secondary (IX-XII)	19057	35009	37075	38385

Source: Statistical Pocketbook of India 2008 (available at mospi.nic.in)

Even though there are significant gender gaps in literacy rates and GER between boys and girls, along with the fact that performance is far from uniform across States in India, yet it has to be realized that India has achieved substantial reduction in illiteracy and has been able to bring back lakhs of out of school children in the school premises through implementation of various schemes including Mid Day Meals which provide an incentive to the parents to send their children to schools. All this progress in elementary and higher levels of education has been concomitant with the substantial and consistent growth in the number of educational institutes across the country. The Table given above shows that, during the period between 1990 and 20005-05, the number of pre primary schools increased almost three and a half fold, from 1635 in 1990 to 5264 in 2005-06. Similarly, the number of primary schools (class I-V) increased from 97375 in 1990 to 132049 in 2005-06. Even at higher levels of education, the number of schools and institutes have increased at a accelerated pace as may be visible from the Table depicted above.

Table: Trends in Expenditure on Education by Central Government and State Governments combined (by the Education Departments only)						
	2002-03	*2003-04*	*2004-05*	*2005-06*	*2006-07 (RE)*	*2007-08 (RE)*
Total Expenditure on Education (in Rs. Crore)	71298	75607	84111	96365	1,19,199	1,33,284
Exp. on Education as % of Social Sector Expenditure	50.3	49.3	48.7	47.2	46.5	45.3
Exp. on Education as % of Total Expenditure from the Budgets of Centre & States combined	10.3	9.6	9.8	10	10.4	10.2
Exp. on Education as % of GDP	2.9	2.74	2.67	2.69	2.88	2.84

Source: Economic Survey 2007-08, Ministry of Finance; GoI..

The Table portrayed above clearly shows that expenditure on education in India, in fact declined marginally from level of 2.9 % in 2002-03 to a level of 2.84 % of GDP in 2007-08 (BE). As proportion of total social sector budget, expenditure on education declined from a figure of 50.3 % in 2002-03 to 45.3 % in 2007-08 (BE).

India Education SDGs: Enrolment, Literacy and Gender Parity

In this backdrop, it will be worthwhile to analyze the datasets of Millennium Development Goals Indicators. The data provided in the following Table makes it abundantly clear that overall NER in India at primary school level has increased from a high base of roughly 85 % in 1991 to a level of 94.21 % in 2006. What is quite encouraging is that the NER for girls, during this period, has increased heavily from 77.11 % in 1991 to 92.21 % in 2006. An important indicator, in this regard, is the proportion of already enrolled pupils who reach the last grades of primary schooling. The indicator shows a dismal performance and the ratio moved from a level of 62 in 1991 to 73 in 2006, thereby registering an average annual growth of roughly 0.7 % per annum. It may be observed that gender gaps pertaining to this indicator are slowly vanishing.

The table presented below shows clearly that there has been some noticeable increase in combined enrolment ratio from 84 percent in 2001 to 94 percent in 2006. The increase has been steeper for girl students, from 77 percent in 2001 to 92 percent in 2006. Similarly, proportion of pupils starting grade 1 who reach last grade of primary schooling have registered significant improvements: from 59 percent in 2001 to 73 percent in 2004 for boys, and from 63 percent to 73 percent for girls during the same period. Thus, India is on track to achieve education goals envisaged in its plan documents, SAARC Development Goals and MDGs as well.

The indicator of primary completion rate suggests a trend of gradual increase during the last decade and a half, from a level of 62 % in 1991 to 85.7 % in 2006. As may be seen from the Table, there was a gender gap of close to 24.4 percentage points between boys and girls in primary school completion rate in 1991. On account of special focus on retention and enrolment of girl children, along with monetary incentives in government education programmes, the said gender gap is consistently vanishing. In 2006, the gender gap declined to a level of 0.2 percent.

Table: Trends in Enrolment, Primary School Completion Rates and the associated Gender Parity in India									
		1991	*1999*	*2000*	*2001*	*2004*	*2005*	*2006*	*2007*
Net Enrolment Ratio	Combined			84.91	83.81	95.41	94.01	94.21	
	Boys			92.01	90.11	96.61	95.71	96.11	
	Girls			77.11	76.91	94.11	92.01	92.21	
pupils starting grade 1 who reach last grade of primary %	Combined		62	59	61.4	73			
	Boys		63.3	59.2	59.7	73.1			
	Girls		60.4	58.7	63.5	72.9			
Primary Completion Rate	Combined	63.8	69.9	72.3	72.4	83.8	84.8	85.7	
	Boys	75.1	77.5	79.7	78.7	86.5	87.1	88	
	Girls	51.5	61.7	64.3	65.6	80.8	82.4	83.1	
Literacy rate of 15-24 year-olds, women and men	Combined	61.92			76.4				82.14
	Men	73.52			84.2				86.74
	Women	49.32			67.7				77.14
	women to men parity index	0.67			0.8				0.89
Gender Parity Index	Primary level enrolment	0.77	0.84	0.85	0.85	0.97	0.98	0.96	
	Secondary level enrolment	0.6	0.71	0.71	0.72	0.81	0.82		
	Tertiary level enrolment	0.54		0.66	0.69	0.67	0.71	0.72	

Source: Based on Millennium Development Indicators, 2008; UNDP.

Environment SDGs

Forests have acquired increasing importance in the recent past not only for their role in meeting the material requirements but also for their ecological and environmental functions. Although it is improper to make a comparison in different assessments due to change in technology and scale of interpretation, however, it may still be observed that the forest cover of the country has remained stagnant around 20.0 % in the last two decades.

Table: Forest Cover in Different Assessments (1987 to 2003) (Area in square km)								
Year of Assessment	*1989*	*1991*	*1993*	*1995*	*1997*	*1999*	*2001*	*2003*
Forest Cover in India	638,804	639,364	639,386	638,879	633,397	637,293	675,538	678,333
Percent	19.43	19.45	19.45	19.43	19.27	19.39	20.55	20.64

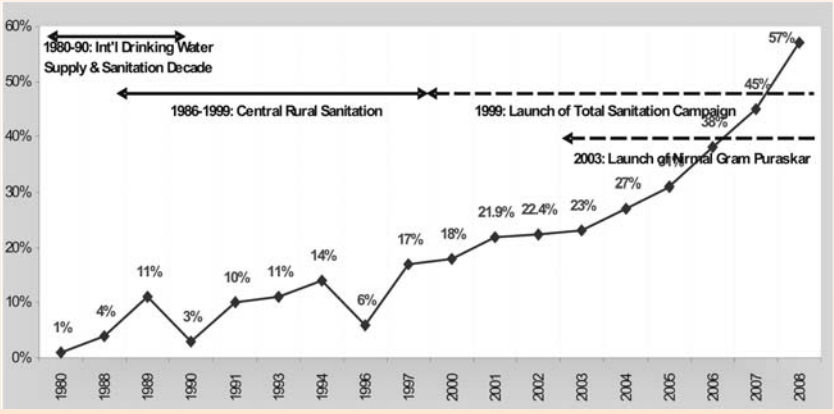
Source: Based on Official website of Ministry of Environment and Forests, Government of India.

Lack of adequate sanitation is a pressing challenge in both rural and urban India. Everyday, an estimated 1,000 children under five die in the country because of diarrhea alone, a preventable disease. Prevalence of child under-nutrition in India

(47 per cent according to National Family Health Survey III, 2005-06) is among the highest in the world and nearly doubles that of Sub-Saharan Africa. Child under-nutrition is aggravated by the prevalence of diarrheal disease, and is responsible for 22 per cent of the country's burden of disease (World Bank 2005). Some studies suggest that it affects child cognitive and motor development and undermines educational achievement. Sanitation related illnesses in both children and adults drain productivity and income, ultimately perpetuating poverty. In addition to public health implications, lack of adequate sanitation forces households into the continued indignity of open defecation, which is an acute problem especially for women and young girls. On the other hand, access to safe sanitation in schools is linked to continued education enrolment by young girls and teenage women, particularly at puberty. Sanitation, therefore, is appropriately included in the Millennium Development Goals as it has a direct bearing on initiatives to reduce poverty and improve health and literacy.

After sluggish progress throughout the eighties and nineties, rural sanitation coverage received a fillip with the implementation of the TSC. As can be seen from Figure depicted below, individual household latrine coverage has more than doubled, from around 22 per cent in 2001 to 57 per cent in 2008.

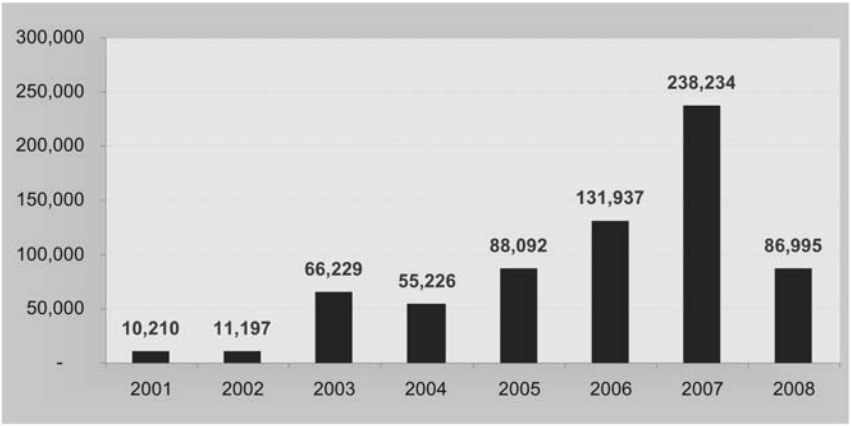
Figure: Trends in Coverage of Sanitation Facilities: Pre and Post Period of Launch of Total Sanitation campaign



Source: Extracted from SACOSAN III, India Country Paper 2008

In addition to individual household toilets, the TSC lays emphasis on school sanitation. Since inception, a total of 6, 80,000 school toilets have been constructed towards a target of 11, 80,000. The year-wise physical progress on this component is shown in Figure below.

Figure: Trends in Construction of School Toilets in India



Source: Extracted from SACOSAN III, India Country Paper 2008

It is important to note that the figures above only reflect the number of households/ schools that have a toilet and do not take into account sanitary conditions of the toilet or its usage. They also do not consider sanitation more broadly e.g. by considering improved hygiene behaviors such as hand-washing with soap. At current rates of progress (57% coverage as of 16 Oct-08), GoI will not only meet the sanitation MDG but exceed it, as more than 90% rural sanitation coverage may be achieved by 2012.

The Table presented below suggests that emission of CO2 (million metric tons) is rising in India gradually (from 682 in 1990 to 1343 in 2004), though it yet assume serious proportions. Energy use (kg oil equivalent) per $1,000 GDP (Constant 2005 PPP $) in India is declining (from 313 in 1990 to 221 in 2005) which is an encouraging trend. Consumption of all Ozone-Depleting Substances (in ODP metric tons) also presents a declining trend (from 10287 in 1995 to 5280 in 2006.The proportion of terrestrial areas protected to total surface area is also showing a stagnant trend at the level of 4.8 %. Similarly, the percentage of marine areas protected to territorial waters paints a stagnant trend in the lower range of 1.4-1.5 % during the last decade and a half in India as may be noticed in the figures presented in the Table given below.

Table: Consumption of ODS, CO2 Emissions, Energy Use, and Protection of Marine Areas in India

	1990	*1991*	*1994*	*1995*	*1999*	*2000*	*2003*	*2004*	*2005*	*2006*
Emission of CO2 (million metric tons)	682	731	860	916	1140	1155	1264	1343		
Emission of CO2 (thousand metric tons) per capita	0.793	0.832	0.920	0.96	1.11	1.1	1.15	1.2		
Energy use (kg oil equivalent) per $1,000 GDP (Constant 2005 PPP $)	313	322	302	296	270	264	239	234	221	
Consumption of all Ozone-Depleting Substances in ODP metric tons	0	0	16066	10287	21455	18696	13820	10150	4326	5280
Consumption of ozone-depleting CFCs in ODP metric tons	0	0	6387	6402	4143	5614	2632	2242	1958	3560
Terrestrial and marine areas protected to total territorial area %	4.1	4.3	4.5	4.5	4.6	4.6	4.6	4.6	4.6	4.6
Terrestrial and marine areas protected, Thousand sq. km.	144	149	155	156	159	159	159	159	160	160
Terrestrial areas protected to total surface area, %	4.3	4.4	4.6	4.7	4.8	4.8	4.8	4.8	4.8	4.8
Terrestrial areas protected, thousand sq. km.	142	146	152	153	156	156	156	156	157	157
Marine areas protected to territorial waters %	1.4	1.4	1.4	1.4	1.5	1.5	1.5	1.5	1.5	1.5
Marine areas protected, sq. km.	2691	2691	2691	2691	2892	2892	2892	2892	2892	2892

Source: Based on Millennium Development Indicators, 2009; UNDP.

Sanitation and Water

Availability of adequate water is a factor that influences demand for sanitation e.g. hand washing after defecation and flushing excreta require sufficient quantity of water. In turn, sanitation can impact quality of water e.g. appropriate technology, especially for pit latrines, is a must to prevent groundwater contamination. According to WHO 3.3 million people die every year from diarrhea diseases and at any time there are 1.5 million suffering from parasitic worm infections stemming from human excreta and solid wastes in the environment. As such sanitation is more important than water from the point of view of impact on the health, dignity, and quality of life of the poor. There is scope to address the linkages between sanitation and water quality and quantity through convergence with the Government of India flagship rural water program which is being implemented in parallel with the TSC.

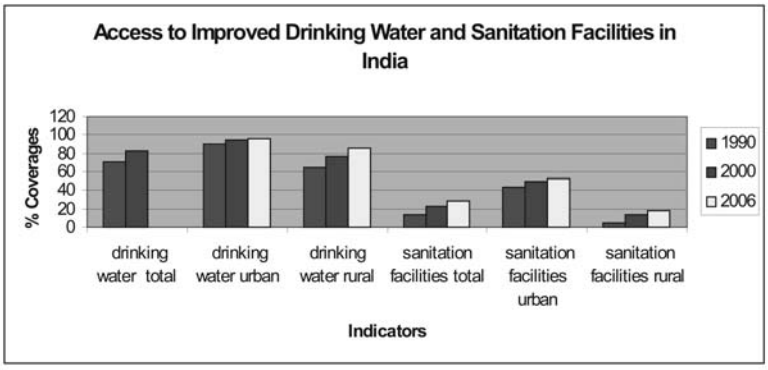
Table: India Environment Sustainability SDGs Indicators: Water and Sanitation						
	1990	*1995*	*2000*	*2001*	*2005*	*2006*
Slum population as percentage of urban	60.8			55.5	34.8	
Slum population in urban areas (million)	131			158	110	
% of the population using improved drinking water sources, total	71	77	82			89
% of the population using improved drinking water sources, urban	90	92	94			96
% of the population using improved drinking water sources, rural	65	71	77			86
% of the population using improved sanitation facilities, total	14	18	23			28
% of the population using improved sanitation facilities, urban	44	46	49			52
% of the population using improved sanitation facilities, rural	4	8	13			18
% of land area covered by forest, percentage	21.5		22.7		22.8	

Source: Based on Millennium Development Indicators, 2009; UNDP.

As may be evident from the graphics given below (and also from the Table portrayed above), the proportion of Slum population is declining in India continually, from 61 percent of total urban population in 1990 to 35 percent in 2005. The percentage of population having access to improved water sources and improved sanitation facilities have increased to 89 percent and 28 percent respectively. However, there are substantial regional differences between rural and urban India with respect to access to sources of water and sanitation. In urban India, the proportion of people having access to safe sources water increased from 90 % in 1990 to 96 % in 2006, while in rural India, the proportion increased from a level of 65 % in 1990 to 86 % in 2006.

As regards the access to safe sources of sanitation facilities in India, the proportion of urban population having access to sanitation facilities increased marginally from 44 % in 1990 to 52 % in 2006, while in rural areas it rose from a paltry level of 4 % in 2006 to 18 % in 2006. Similarly, percentage of land area covered has increased marginally from 21 percent in 1990 to 22.8 percent in 2005 as may be noticed from the Table presented below.

Figure: Trends in Access to Improved Drinking Water and Sanitation Facilities in India



Source: Based on Datasets of Millennium Development Goals Indicators 2009.

Even though India have managed to provide access to safe drinking water facilities to 78 percent of the households, there are significant interstate variations with Punjab (97.6 %), Delhi (97.2 %) and (Uttar Pradesh (87.8%) are among the better performing States while **Kerala (23.4 %),** Orissa (64.2 %) and Rajasthan (68.2 %) belong to the category of worst delivering States in India as may be visible from the Table provided below. It worth to emphasize here that the State of Kerala, which has high level of overall human indicators, is the worst performer in providing access to safe sources of drinking water to its people, It is interesting to note also that socio-economically backward State of Orissa was placed at a similar level (Orissa:- 14.6 % and Kerala:-12.2 % in 1981), but it has succeeded in improving the access to 64.2 % in 2001 while the ratio for Kerala remained at low level of **23.4 % in 2001.**

Table: Access to Safe Drinking Water in Households in India

	1981			*1991*			*2001*		
	Total	*Rural*	*Urban*	*Total*	*Rural*	*Urban*	*Total*	*Rural*	*Urban*
Punjab	84.6	81.8	91.1	92.7	92.1	94.2	97.6	96.9	98.9
Haryana	55.1	42.9	90.7	74.3	67.1	93.2	86.1	81.1	97.3
Delhi	93	62.3	94.9	95.8	91	96.2	97.2	90.1	97.7
Rajasthan	27.1	13	78.7	59	50.6	86.5	68.2	60.4	93.5
Uttar Pradesh	33.8	25.3	73.2	62.2	56.6	85.8	87.8	85.5	97.2
Bihar	37.6	33.8	65.4	58.8	56.5	73.4	86.6	86.1	91.2
Assam				45.9	43.3	64.1	58.8	56.8	70.4
West Bengal	69.7	65.8	79.8	82	80.3	86.2	88.5	87	92.3
Orissa	14.6	9.5	51.3	39.1	35.3	62.8	64.2	62.9	72.3
Madhya Pradesh	20.2	8.1	66.7	53.4	45.6	79.4	68.4	61.5	88.6
Gujarat	52.4	36.2	86.8	69.8	60	87.2	84.1	76.9	95.4
Maharashtra	42.3	18.3	85.6	68.5	54	90.5	79.8	68.4	95.4
Andhra Pradesh	25.9	15.1	63.3	55.1	49	73.8	80.1	76.9	90.2
Karnataka	33.9	17.6	74.4	71.7	67.3	81.4	84.6	80.5	92.1
Kerala	12.2	6.3	39.7	18.9	12.2	38.7	23.4	16.9	42.8
Tamil Nadu	43.1	31	69.4	67.4	64.3	74.2	85.6	85.3	85.9
All India	38.2	26.5	75.1	62.3	55.5	81.4	77.9	73.2	90

Source: India Census Data Various Issues, Extracted from Economic Survey, 2008-09, Ministry of Finance, India.

According to the Census of 2001, 30.6 million urban households which form 35.49% of the urban households suffer inadequate access to sanitation facilities and more than 37% of the total human excreta generated in urban India are unsafely disposed. Out of these 30.6 million households, 12.04 million (7.87 %) urban households do not have access to latrines and defecate in the open. 5.48 million (8.13%) urban households use community latrines and 13.4 million households (19.49%) use shared latrines. 12.47 million (18.5%) households do not have access to a drainage network. 26.8 million (39.8%) households are connected to open drains.

The status in respect of the urban poor is even worse. The percentage of notified and non-notified slums without latrines is 17 percent and 51 percent respectively. In respect of septic latrines the availability is 66 percent and 35 percent. In respect of underground sewerage, the availability is 30 percent and 15 percent respectively. 37 percent of the wastewater generated is let out into the environment untreated. Three-fourths of surface water resources are polluted and 60 percent of the pollution is due to sewage alone. Poor sanitation severely impacts public health, causes hardships and imposes huge medical expenditure, especially for the poor. The loss due to diseases caused by poor sanitation for children under 14 years alone in urban areas amounts to Rs. 5 billion at 2001 prices.

Information collected by CPHEEO, Ministry of Urban Development indicates that as on 31.03.07, about 63 % of the urban population has got access to sewerage, low cost sanitation and septic tank facilities at present i.e. about 30% population have got access to sewerage and 33% have got access to low cost sanitation and septic tank facilities.

To achieve 100 per cent population coverage for sewerage, sewage treatment and low cost sanitation facilities in urban areas during Eleventh Plan, the following steps have been identified:

Install more plants to treat, recycle and reuse sewage. Industrial and commercial establishments must reuse and recycle treated sewage to reduce fresh water demand. ULBs should amend their by-laws to make it mandatory for all residents to connect their toilets to the existing sewerage system.

Fringe areas of cities and colonies of economically weaker sections and slum dwellers be covered with low cost sanitation facilities, either on individual household basis or community basis with “pay and use system” with adequate maintenance arrangements. Necessary penal clause to be enforced effectively to stop open defecation practice as well as indiscriminate throwing of garbage/litter in public places. Targeted subsidy may be given to urban poor for taking water supply/sewerage house service connections, metering, to and construction of toilets. Comprehensive storm water drainage system is developed in all cities and towns in order to avoid water logging during monsoon.

Mumbai Slum Sanitation Program

The Municipal Corporation of Brihan (Greater) Mumbai, (MCBC) implemented the World Bank-assisted Slum Sanitation Program (SSP) as a part of the Mumbai Sewage Disposal Project (MSDP) that commenced in 1995. The Slum Sanitation Program was a component of the MSDP project and aimed at "improving the health and environmental conditions in Greater Mumbai including the slum dwellers". It was targeted at about one million slum dwellers (approximately 20 percent of the total Mumbai slum population) living on municipal land at about 10 percent of the MSDP project cost (approximately Rs.13.2 billion or US$295.6 million).

Under SSP, about 330 community toilet blocks (CTBs) with more than 51,00 toilet seats were constructed and handed over to community groups to use and maintain. Implemented over 1996-2005. This program is estimated to have benefited about 400,000 people in the slums of Mumbai. The program was unique in (a) fostering a participatory and demand-led approach in a complex metropolitan socio cultural environment; (b) supporting partnerships between the MCBM, non-governmental organizations, private construction agencies, and slum community groups; (c) initiating innovations and incentives; (d) providing superior technical specifications that help ensure improved service quality standards; and (e) responding creatively to an merging market for operations and maintenance.

IT and Communication Related SDGs Indicators: Telephone, Cellular Lines, Computers and Internet Users

Telephone lines per 100 populations in India have increased multifold, from 0.6 in 1990 to 3.37 in 2007. However, on account of increasing usages of cellular phones, the ratio is declining in some recent years. The number of cellular subscribers per 100 populations has registered a quantum jump, and increased from 0.19 in 1999 to 19.98 in 2007. A similar trend may be noticed in the table given below for the Internet users per 100 populations, which surged upwards from 0.03 in 1995 to 6.93 in 2007. We also notice a sizeable change in the number of personal computers per 100 populations, which increased from merely 0.03 in 1990 to 3.17 in 2006.

	1990	*1995*	*1999*	*2000*	*2004*	*2005*	*2006*	*2007*
Telephone lines per 100 population	0.6	1.28	2.64	3.18	4.25	4.55	3.64	3.37
Telephone lines (thousands)	5075	11978	26511	32436	46198	50177	40770	39413
Cellular subscribers per 100 population	0		0.19	0.35	4.8	8.17	14.83	19.98
Cellular subscribers (thousands)	0	77	1884	3577	52220	90140	166050	233620
Internet users per 100 population	0	0.03	0.28	0.54	3.22	5.44	6.79	6.93
Internet users (thousands)	0	250	2800	5500	35000	60000	76000	81000
Personal computers per 100 population	0.03	0.13	0.33	0.45	1.2	1.54	2.76	3.17
Personal computers (thousands)	270	1200	3300	4600	13030	17000	30909	37000

Source: Based on Millennium Development Indicators, 2008; UNDP.

Concluding Comments

In sum, we may draw the conclusion that apart from provisioning of safe drinking water facilities and raising the enrolment ratio at primary level with due gender balance, India has been lagging behind the targets set under development goals. Though the official poverty estimates suggest consistent decline in head count poverty ratio, the poverty gap ratio is high in India and it will take a Herculean fiscal effort to bring the poor people out of poverty. Moreover, by the yardstick of international poverty line of USD 1.0 per day, roughly 1 out of every 3 people is poor in India which is a source of embarrassment for 'shining' India which is touted widely as the emerging economic superpower of the world in terms of purchasing power adjusted gross domestic product. It worth emphasizing here that until and unless India manages to improve the socio-economic conditions of the laggard States of Orissa, Bihar, Uttar Pradesh and Madhya Pradesh, it will not be able to reach the targets under SDGs/ MDGs.

CHAPTER SIX

Monitoring the Progress and Prospects of SDGs in Nepal

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General Overview

Nepal is one of the underdeveloped countries in South Asia. As a result of widespread socio-political conflict and consequent insurgencies for last one decade, the country is losing its economic growth momentum for the past six years. The Official data sources indicate that the annual growth rates have remained constrained within the range of 2-3 percent over the last six years or so. A large proportion of Nepalese poor is gripped by hunger and malnutrition and progress here has been almost none since 2003. Because of arm conflict spread in the rural areas, a massive out migration of youth within or outside country took place in a massive scale. In most of village areas, remaining human resources are either women or children. Some of the families left everything and migrated to relatively safe urban areas for their survival. Consequently, limited food production lands remained either under cultivated or less productive cultivated just for the sake of cultivation. However, during the last few months, political crisis in Nepal has been diffused, and a new democratically elected government has assumed the power.

Apart from macroeconomic indicators of GDP growth and per capita income, the social sector in Nepal has received significant setback which have far reaching implications for the well being of the masses. The education and health sectors are also not moving in the desired direction. Many of trained human resources in health sector migrated to other countries for safe place to work. For example, thousands of medical doctors and nurses from Nepal migrated to America and Europe during this period. Almost all families who are able to afford, sent their children to other countries for their education. Recent years have seen schools and higher education institutions mushrooming across the country. Despite repeated claims to adhere to pro poor policies to promote socio-economic and human development of the people, the plethora of government programmes have failed to live up to expectations of common public. Delivery of public services remains poor and leaves a lot to be desired. This situation is not only in health and education but also in all sectors where the government promises much but has delivered little or none. Common people themselves were saying “we need peace and security rather than services” but government was not able to even maintain law and order in the society. At present, there is a big shifting in politics.

Gross neglect of agricultural sector is among the prominent factors which are accountable for the massive destitution in Nepal. According to the Asian Development Bank (ADB), agriculture growth in Nepal has declined from 2.4% in 2006 to 1.6% in 2007. The present reality is that Nepal is a country divided into two halves, with one half comprising the elite upper class and well-to-do middle class (centred in rapidly expanding urban areas) whilst the other is a combination of low-income group surviving in rural areas and social outcasts called *dalits* otherwise known as the 'untouchables' (centred in rural regions). A lack of inclusiveness in economic growth has certainly helped fostered such a division in the country although it is not the sole culprit fuelling the growing inequality. Instead, the deep-rooted caste system, gender bias and spatial placement underlie the overarching problem of inequality and inequity.

The country's Ninth Five Year Plan (2002-2007) was there but finished without any progress. The government could not make it functional because of unexpected security situation happened in the country. No election, royal take over, and people's movement took place during these years. The five year plan remained just on paper. The royal government tried to make Interim three years plan in 2006 but could not be implemented. At present, democratically elected government has assumed the office, and articulating ten years vision and two years interim plan but how it comes and how they implement it is not clear yet. The government has recently announced social agendas such as education, healthcare and environmental issues amongst others for the interim period. One particular feature to note about Nepal is that a clear and concise outline of the national targets at the moment is lacking. The country as a whole is extremely in transition. It is not known yet what direction this country will take in future.

Given the obscure nature of planning and the prolonged period relative political instability in Nepal, the delivery of social services (including health care, livelihood securities, and education, access to water supply and sanitation, environmental sustainability) is at best poor. As a corollary, the progress regarding indicators, reflecting achievement of SDGs/ MDGs in Nepal, is far from satisfactory as is clearly visible in the discussion pursued in the following sections of this chapter.

Progress with respect to indicators of livelihood and poverty

Eradication of Hunger Poverty

A 2006 report published by the UN Food and Agriculture Organisation (FAO) states that 12% of the world's 6.6 billion people are living in hunger and of that, 25 million of them live in Nepal. To put this into context, 1 in 10 people in Nepal are living in hunger every day**.** This is not a new phenomenon as a quarter of the Nepalese population is not receiving the minimum recommended calories a day in their diet. Although the situation has improved at the turn of the century, it is not nearly enough when compared to the economic growth rates that Nepal has achieved. It is important to note that food poverty is centred on the marginalised and poorest community in the country where inequality and inequity is most glaring.

To some extent, the lack of food accessibility could also be a result of the shifting focus that Nepal has undertaken in recent years from one of agriculture to that expansion of labour migrants to Gulf countries. It is noteworthy that unless it is a prolonged and sustained campaign for maximum agricultural production, hunger-free Nepal cannot be achieved.

Implementation of the National Food for Work programme has provided a means for the poor and marginalised to be self-sustaining by offering manual labour (that contributes positively to overall community health, *e.g.* creation of basic sanitation facilities) in return for food security. Although this is a step forward towards combating food poverty, these programmes are common with corruption, mismanagement and oversight and may be incapable of eradicating hunger poverty. The current rise in price of basic foodstuff can only worsen the situation and threatens to reverse the positive effects that these programmes have managed to generate.

With hunger poverty increased amongst the population, malnutrition is not far behind. The UN Children's Fund (UNICEF) recently announced that 0.5 million children in Npeal are at risk of being malnourished as a result of the continuing food crisis. UNICEF indicated that every five second young child in Nepal is malnourished and this speaks volumes on the dire situation that Nepal finds herself in. Looking at the prevalence of malnutrition amongst the country's younger population, the percentage of children under five that are underweight for their age has only declined by 5% in 10 years and equates to just 0.2% reduction per year. Although this indicates a consistent decline in malnutrition, progress has actually slowed for the period 2001-2006 (5.4%) compared to the 8% reduction observed in 1993-2000. Thus, despite having many child development programmes, Nepal has a malnutrition rate that is amongst the second lowest in South Asia.

According to a report published by the World Bank (WB) in 2005, the underlying problem of child malnutrition is due to the failures of programmes in not targeting children under the age of three; the age range that the report describes nutrition interventions as being most effective. The study also pointed out that infection and inappropriate infant and children feeding practices rather than hunger are the leading causes for child undernourishment. Because of this, the report pointed out that the government's decision to tackle the issue by focusing on food supplementation rather than raising awareness amongst women of the consequences of poor feeding practices and the importance of a balanced diet, is the reason that child nutrition programmes in India are not as effective as could be.

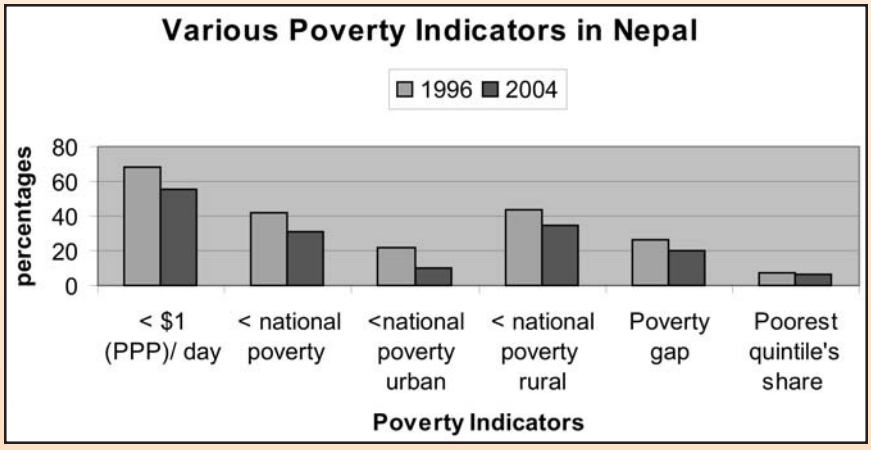
Another reason for the high incidence of malnutrition amongst children is the declination of women's health. The inadequacy of the health sector has resulted in many women suffering from poor health and as a result, a very large proportion of children are born underweight and malnourished. Lack of accessibility to food as a result of rising food prices can only contribute to the already poor state of child malnutrition in Nepal. To compound matters, inflation has been the highest since 1998, with rates rising above 15%, twice that of the government's own target. Because Nepal calculates inflation rates based on wholesale price index (WPI)

rather than the more accurate consumer price index (CPI), prices of goods are in fact higher than government estimates. This means the number of people unable to afford sufficient food and therefore becoming hungry and further malnourished is potentially higher than official government figures.

Nepal is among the poorest and least developed countries in the world with almost one-third of its population living below the poverty line. Agriculture is the mainstay of the economy, providing a livelihood for three-fourths of the population and accounting for 38% of GDP. Industrial activity mainly involves the processing of agricultural produce including jute, sugarcane, tobacco, and grain. GDP (real growth rate of is 3.2% and per capita income US$ 1,000 at 2007. Security concerns relating to the Maoist conflict have led to a decrease in tourism, a key source of foreign exchange. Nepal has considerable scope for exploiting its potential in hydropower and tourism, areas of recent foreign investment interest. Prospects for foreign trade or investment in other sectors will remain poor, however, because of the small size of the economy, its technological backwardness, its remoteness, its landlocked geographic location, its civil strife, and its susceptibility to natural disaster. It is presented that 30.9% the population is under absolute poverty line (below a dollar in a day) income. However, this percentage is taken in average. If rural areas are observed objectively, this percentage is much higher.

As may be evident from the figures provided in the graphics depicted below, population below $1 (PPP) per day in Nepal at a disappointingly high level of 55 percent. Over the period between 1994 and 2004 (the recent most year for which we have been able to extract data), poverty has declined at snail's pace, from 68 percent in 1996 to 55 percent in 2004, resulting in average annual decline of 1.5 %. The performace of on poverty reduction front is less impressive. If this slow pace of poverty reduction persists in Nepal, it will not be able to achieve the MDGs targets, let alone the issue of achieving the targets set under SDGs which envisages achievements of targets by 2010.

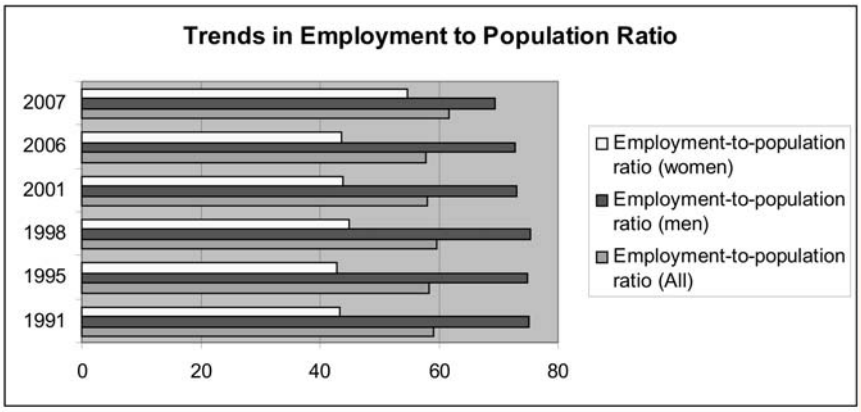
Figure: Poverty Indicators in Nepal (1996 and 2004) (%)



Source: Based on datasets of Millennium Development Indicators 2009; UNDP.

Poverty gap ratio at $1 a day (PPP), which measures the severity and extent of poverty, is at a staggering level of 19.7 percent, registering a miniscule decline of 7 percentage points over the last nine years.

Figure: Trends in Employment to Population Ratio in Nepal



Source: Based on datasets of Millennium Development Indicators 2009; UNDP.

The Table given below (and also the graphics depicted above) clearly show a downwards trends in employment to population ratio for male populations in Nepal, which declined from a figure of 75 % in 1991 to level of 69.4 % in 2007. However, this decline in male work participation is compensated by some substantial increase in employment to population ratio for women which improved from 43.4 % in 1991 to 54.6 % in 2007, thereby resulting in an marginal increase in overall employment to population ratio by 2.8 percentage points.

Table: Indicators showing Livelihood, employment and Poverty

	1991	*1995*	*1996*	*1998*	*2001*	*2004*	*2006*	*2007*
Population below $1 (PPP) per day, %age			68.4			55.1		
Population below national poverty line, total, %age			41.8			30.9		
Population below national poverty line, urban, %age			21.6			9.6		
Population below national poverty line, rural, %age			43.3			34.6		
Poverty gap ratio at $1 a day (PPP), %age			26.7			19.7		
Poorest quintile's share in national income or consumption, %age			7.6			6.1		
Growth rate of GDP per person employed, %age		1.97	-1.42	1.07	3.68	0.87	-0.91	
Employment-to-population ratio, both sexes, %age	59	58.3	60.6	59.6	58	57.8	57.8	61.8
Employment-to-population ratio, men, %age	75	74.8	76.7	75.4	73.1	73	72.8	69.4
Employment-to-population ratio, women, %age	43.4	42.8	45.5	44.8	43.9	43.6	43.7	54.6
Proportion of employed people living below $1 (PPP) per day, %age			44.7			33.7		
Children under 5 moderately or severely underweight, %age		48.7	46.9	47.1	48.3		38.6	45.6
Children under 5 severely underweight, percentage		14.4	16.1	12	12.6		10.6	10

Source: Based on datasets of Millennium Development Indicators 2009; UNDP.

Halve the Proportion of People Living in Income Poverty

Nepal's GDP has been experiencing increases over the past few years but this growth is widely seen as only benefiting the already rich upper-class and has not trickled down to the poorer communities, in particular those residing in remote rural areas. Because of this, some have said that despite the GDP growth, it is essentially a jobless growth and this is reflected by the country's unemployment rate which has gone up from 28% in 2000 to 42% in 2007. Seeing as how three quarter of Nepal's population live in rural communities, the country has a lot of annual per capita income (APCI) has risen since 1995.

The government has set up many pro-poor programmes such as the poverty alleviation fund, area development programmes, targeted community development programmes, remote area development programmes, etc. However, these programmes have brought respite to many of the poorest and are targeted at rural communities but their implementation and governance is very poor. Labour force in remained 76% in agriculture, 6% in industry, and 18% in services. It means that major labour force in Nepal is unskilled ones. They mostly go to India and Arabian countries for seasonal works. The labour force in service is 18% but GDP from service sector is expected to be 42% which is not feasible.

The most worrying aspect of the development in Nepal has been the absolute decline in employment-to-population ratio, which declined to 57.8 percent in 2006, from a level of 60.

Progress of Indicators reflecting Women Empowerment

Women's direct engagement in public decision-making has long been seen not just as a matter of democratic justice, but as a means of ensuring better government accountability to women. Quotas have been an effective vehicle for supporting women's political engagement, especially when they are backed by sanctions. But increasing the numbers of women in politics is in itself not sufficient to ensure better public sector responsiveness to women's needs. It must be linked to gender-sensitive good governance reforms – understood as inclusive, responsive, and accountable management of public affairs that increases state capacity to implement gender policies. Today there are more women in government than ever before. The proportion of women in national assemblies has increased by 8% to the current global average of 18.4% in the decade from 1998 to 2008, compared to an increase of just 1% in the two decades after 1975. Yet even at the current rate of increase, developing countries will not reach the 'parity zone' where neither sex holds more than 60% of seats until 2045.

It is quite heartening to note here that Nepal has recently enacted a legislation which mandates that among the selected representatives of the national assembly, women should be given ample representation so that the overall ratio of women to men in national assemblies is tilted in favor of women, relatively. The figures

presented in the table given below makes it resoundingly clear that the enactment of legislation has resulted in rise in proportion of seats held by women in national parliament. The ratio increased significantly from 3.4 percent in 1997 to 17.3 percent in 2008. On account of important legislation relating to reservation of seats for women (25 % of all Seats) in National Parliament in Nepal, the proportion has increased significantly to 33.2 % in 2009.

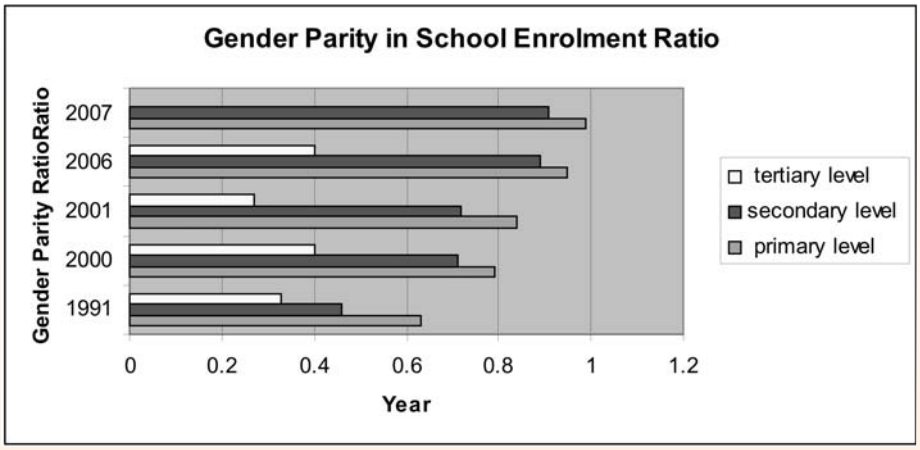


Figure: Trends in Indicators of Gender Parity in Enrolment Ratio

Source: Based on datasets of Millennium Development Indicators; UNDP.

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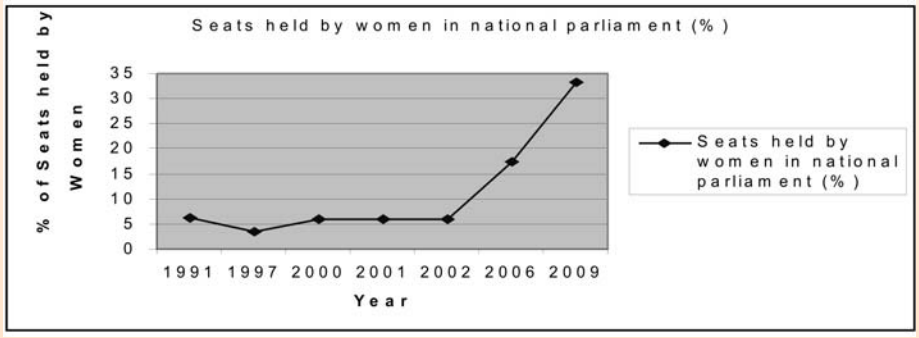

Figure: Proportion of Seats Held by Women in Nepal

Source: Source: Based on datasets of Millennium Development Indicators; UNDP.

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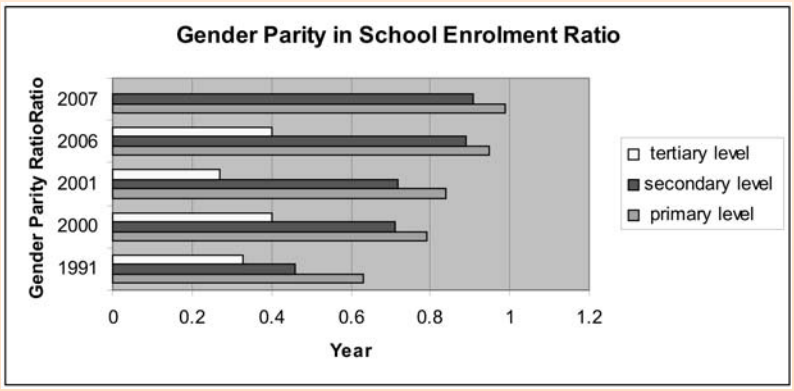
Table: Women Empowerment and Gender Parity Indicators

Women Empowerment Indicators	*1991*	*1997*	*2000*	*2001*	*2002*	*2006*	*2007*
Gender Parity Index in primary level enrolment	0.63		0.79	0.84	0.86	0.95	0.99
Gender Parity Index in secondary level enrolment	0.46		0.71	0.72	0.74	0.89	0.91
Gender Parity Index in tertiary level enrolment	0.33		0.4	0.27	0.27	0.40 (2004)	
Seats held by women in national parliament (%)	6.1	3.4	5.9	5.9	5.9	17.3	33.2 (2009)
Total number of seats in national parliament	132	205	205	205	205	329	594 (2009)
Seats held by men in national parliament	124	198	193	193	193	272	397 (2009)
Seats held by women in national parliament	8	7	12	12	12	57	197 (2009)

Source: Based on datasets of Millennium Development Indicators 2009; UNDP.

As may be evident from the Table stated above (also in the Figure depicted below), gender parity in primary level enrolment has been almost achieved in Nepal in 2007 with a value of parity index of 0.99 in 2007. In so far as gender parity in secondary level enrolment is concerned, Nepal has made substantial progress where index has increased from a level of 0.46 in 1991 to 0.91 in 2007, registering a growth of 3 percentages per annum. If this trend continues, Nepal will achieve MDGs as well as SDGs targets by 2010 in gender parity at secondary level enrolment. However, at tertiary level, Nepal has to start programmes in a mission mode to achieve gender parity in tertiary education which now is at low level of 0.40 percent in 2004.

Figure: Trends in Indicators of Gender Parity in Enrolment Ratio



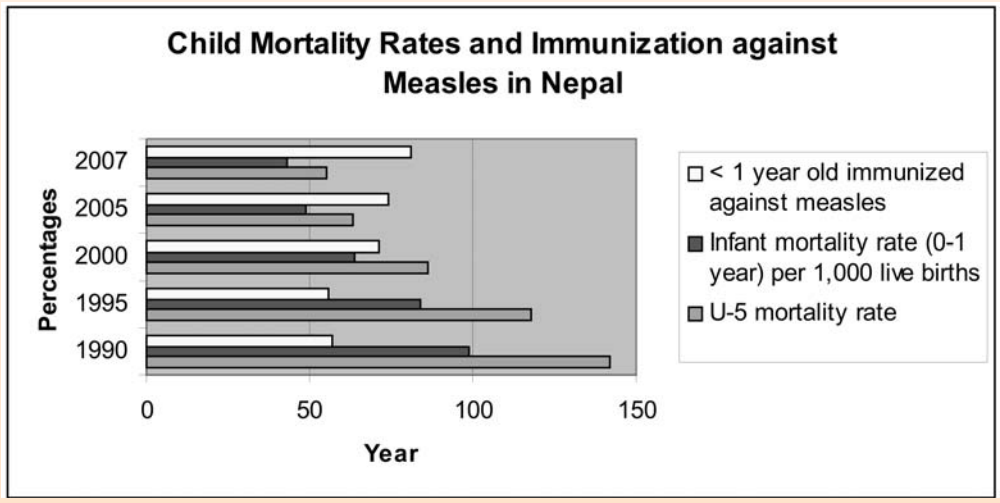
Source: Based on datasets of Millennium Development Indicators; UNDP.

Progress and Gaps in Achievement of Health SDGs in Nepal

Status of overall health care system in Nepal is very poor. Children's health status is worse in South Asian average. As per the statistics, it seems that improving child health is one of the priority concerns of the government. Nepal was making its best efforts to manage at least primary level health facilities in each of the village settlements. Number of hospitals and health workers training centres in urban cities are also increasing. However, the attention of government was completely diverted during the last insurgency decade. Normal health programme could not be in priority of the government during this time. Now, the government has announced its responsiveness upon basic service to the people including health. However, foundations required for minimum health services have already been broken. It takes much time and resource to rebuild lost foundation. It does not mean only physical foundations but also human resources. For example, many health professionals migrated to other countries because of not having good working condition and insurgencies in Nepal for last ten years. It is not possible to bring them back now. The country needs to train another set of human resources.

Children under five mortality rates per 1,000 live births in Nepal show a declining trend. Child-under-5 mortality declined significantly from a level of 142 in 1990 to 55 in 2007. Infant mortality rate in Nepal is also showing a declining trend which declined from a high figure 99 in 1990 to 43 in 2007 as is evident from the Table given below.

Figure: Trends in Child Mortality Rates and Immunization Coverage



Source: Based on datasets of Millennium Development Indicators; UNDP.

The declining ratios of infant and child mortality rates are reflected in the rising access to immunization coverage against measles, which show a rising trend, increasing from 57 percent 1990 to 85 percent in 2006.

Table: Immunisation and Child Mortality in Nepal

	1990	*1995*	*2000*	*2005*	*2006*	*2007*
Children under five mortality rate per 1,000 live births	142	118	86	63	59	55
Infant mortality rate (0-1 year) per 1,000 live births	99	84	64	49	46	43
Children 1 year old immunized against measles, percentage	57	56	71	74	85	81

Source: Based on datasets of Millennium Development Indicators; UNDP.

Maternal Health

Maternal mortality rate (per 100,000 live births) is 830 in 2006, in itself, portrays a dismal picture of health care services and health outcomes pertaining to maternal health in Nepal. However, this is not surprising given the low coverage of antenatal care and low availability of contraceptives for women. Only 43 percent of Nepalese women have access to antenatal care (at least one visits), and a quarter of women do not have access to family planning services and relevant materials.

Table: Trends in Indicators of Maternal Health in Nepal

	1991	*1996*	*2001*	*2004*	*2006*
Maternal mortality ratio per 100,000 live births					830
Births attended by skilled health personnel %	7.4	9	10.9	19.8	18.7
Current contraceptive use among married women 15-49 years old, any method %	22.7	28.5	39.3	38.3	48
Current contraceptive use among married women 15-49 years old, modern methods %	21.8	26	35.4	37.9	44.2
Current contraceptive use among married women 15-49 years old, condom %	0.6	1.9	2.9	2.9	4.8
Adolescent birth rate, per 1,000 women	89		84	106	
Antenatal care coverage, at least one visit %	15.4	23.6	27.9		43.7
Antenatal care coverage, at least four visits %					29.4
Unmet need for family planning, total %	27.7	31.4	27.8		24.6
Unmet need for family planning, spacing %	12.4	14.3	11.4		9.4
Unmet need for family planning, limiting %	15.3	17.1	16.4		15.2

Source: Based on datasets of Millennium Development Indicators 2009; UNDP.

Therefore, maternal health condition of average Nepalese is not in a progressive mode. It is not only in rural areas, the problem is even more acute among urban poor and in slum areas. Traditional practices like faith hillers and traditional birth attendees (not trained women) are still active in the cities like Kathmandu. Another reality is that women are still not able to come out from home and share their birth and pregnancy related problems to health workers. Situation of rural areas is even more difficult. Most of women think that giving birth of a child is in interest of God. It cannot be control by human efforts. If they die because of child birth related complications, that is also the interest of the God. These kinds of beliefs are still active in the society.

Control of Fatal Diseases

The data presented in the table portrayed below suggests that prevalence of HIV/ AIDS is at a low level in Nepal), roughly half percent of the population of age group 15-49 years in Nepal is afflicted with HIV/AIDS.

Condom use among married women (age group 15-49 years) is rising, though at slow pace (from 2.6 percent in 1990 to 10 percent in 2006.

Tuberculosis incidence rate is declining in Nepal, though it is still at a disappointingly high level of 173 in 2007. However, Nepal has been able to reduce TB prevalence rates by two-third during the last decade and a half (from 625.4 in 1990 to a level of 244 in 2006). Tuberculosis detection rate under DOTS has increased significantly from a paltry level of 5.2 % in 1996 to 65.8 % in 2007. Tuberculosis treatment success rate under DOTS in Nepal has remained stagnant at relatively high level of 85-90 % during the period between 1996 and 2006.

Table: Trends in Disease Prevalence in Nepal

	1990	*1996*	*1999*	*2000*	*2001*	*2006*	*2007*
People living with HIV, 15-49 years old (%)					0.5	0.5	
Condom use to overall contraceptive use among currently married women 15-49 years old (%)	2.6	6.7		3.8	7.4	10	
Tuberculosis incidence rate per year per 100,000 population	243	215.5	203	198.9	195	176.4	173
Tuberculosis prevalence rate per 100,000 population	625.4	502.4	364.5	311.4	303.8	243.9	239.6
Tuberculosis death rate per year per 100,000 population	50.8	42.3	31.9	28.1	27.5	23	22.8
Tuberculosis detection rate under DOTS (%)		5.2	44.4	57.1	58.1	64.1	65.8
Tuberculosis treatment success rate under DOTS (%)		84.7	86.8	85.7	88.3	88.5	

Source: Based on datasets of Millennium Development Indicators 2009; UNDP.

Education SDGs

Access to Primary/Community School for All Children, Boys and Girls & Goal 14: Completion of Primary Education Cycle

The expenditure pattern during the last one and half decade shows that Nepal is increasing priority to education sector. Nepalese public expenditure on education increased from 9% in 1990 to 16% of the total budget in 2003. Education expenditure as percentage of GDP is now around 3% in comparison to 2% in earlier years. However, it is still low compared to what is needed quality education to reach all school age children.

In the one hand, government has already implemented various educational schemes and projects like Basic and Primary Education, Universal Education and Education for all. Despite the efforts over last 10 years, the progress for achieving universal primary education has been observed very slow. On the other hand, private sector is heavily coming into education sector. This is good that Nepal has now more than seven Universities in comparison to one in 1990. However, these are very expensive educational institutions registered under profit making company laws. Despite of expensive, quality education from the private institutions is still questionable. They focused more on earning income than providing quality education.

Emergence of private sector in education has created two scenarios. One of the dreadful scenario is that different education systems and institutions have established for 'have' and 'have nots' in the society. It has compounded social conflicts and disharmony. The second scenario is that government owned educational institutions have made almost defunct. Most of good teachers, most of the parents having good purchasing power and good students who used to remain with government owned institutions, have been shocked by private institutions. Now the situation is that only poor people's children go to government owned schools and colleges. Sending children to private schools and universities has become a matter of prestige in the society. The present reality is that in a globalised economy and market competition, it is also not possible to control all private initiatives in education sector.

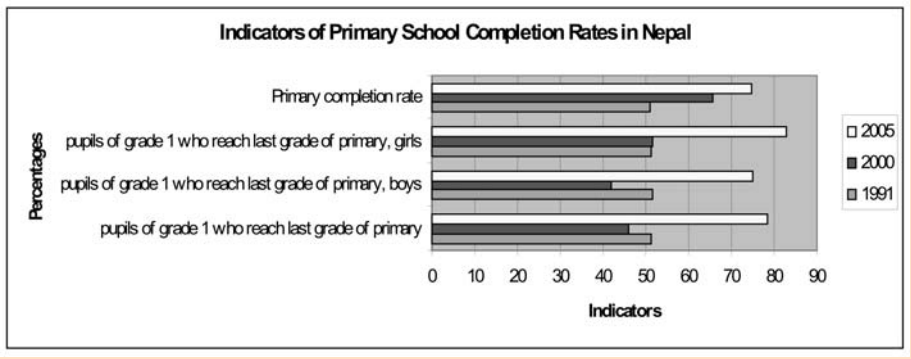
As may be evident from the Table given below, total enrolment in primary education in Nepal show an inconsistent trend in some recent years. NER at primary level declined increased from a level of 72.8 % in 2000 to 80.1 % in 2004. Hover during the period between 2004 and 2007, it declined to 76.5 %. An important point to note in this regard is that NER fro girls at primary level of education have registered a decline during the latter period and has been stagnant at a level of 74.6 %.

Table: Trends in Indicators of Enrolment, Literacy and Gender Parity in Nepal						
	1991	*2000*	*2001*	*2004*	*2005*	*2006*
Total net enrolment ratio in primary education		72.8		80.1		76.5 (2007)
Total net enrolment ratio in primary education, boys		79.8		85.3		78.3 (2007)
Total net enrolment ratio in primary education, girls		65.5		74.6		74.6 (2007)
% of pupils starting grade 1 who reach last grade of primary	51.3	45.8	77.8	60.8	78.5	
%of pupils starting grade 1 who reach last grade of primary, boys	51.5	41.9	75.4	56.6	75	
% of pupils starting grade 1 who reach last grade of primary, girls	51.2	51.6	80.8	66.1	82.8	
Primary completion rate	50.9	65.6	65.2	71	74.7	76
Primary completion rate, boys		73.9	71.3	76.7	79.6	79.6
Primary completion rate, girls		56.8	58.6	65	69.5	72.3
Literacy rates of 15-24 years old %	49.6		70.1			79.3
Literacy rates of 15-24 years old, women %	32.7		60.1			73
Women to men parity index, as ratio of literacy rates, 15-24 years	0.48		0.75			0.86

Source: Based on datasets of Millennium Development Indicators 2009; UNDP.

Overall youth literacy rate in Nepal has increased substantially from a low level of 49.6 % in 1991 to respectable level (by SAARC country standards) of roughly 80 % in 2006. Here we may notice that there is perceptible gender gap where the literacy rates among youth female (15-24 years age group) is only 73 %. This fact is also reflected in the value of women to men parity index of 0.86 in 2006.

Given the rising trends of privatisation of school education in Nepal, it is not quite surprising to note dismal trends in indicators pertaining to net enrolment ratios, primary school completion rates and the associated gender parity indexes. Total net enrolment ratio in primary education in Nepal is around 80 percent which not at par with the level achieved in other major SAARC countries including Sri Lanka,



India and Maldives. Proportion of pupils starting grade 1 and who reach last grade of primary school again show a disappointing picture. Only, 78 percent of pupils reach grade 5. Similarly, primary school completion rate is below 80 percent associated with gender gaps between boys and girl students.

Environment SDGs

Ensure Environmental Sustainability

Government of Nepal has developed a national water plan (2002-2027). This plan has summarised the increasing demands for drinking water and sanitation. This plan says that 100% population will have access to safe drinking water and sanitation facilities by 2017. Strategies and priorities for addressing urban sewerage, waste water treatment, solid waste management, pollution control, etc are articulated in this plan.

Table: Trends in Indicators of Environment, Access to Water and Sanitation Facilities in Nepal

	1990	*1995*	*2000*	*2005*	*2006*
Proportion of land area covered by forest, percentage	33.7		27.3	25.4	
Carbon dioxide emissions (CO2), metric tons of CO2 per capita (CDIAC)	0.033	0.0941	0.1323	0.1169	0.1173
Energy use (kg oil equivalent) per $1,000 GDP (Constant 2005 PPP $)	433	390	372	353	348
Consumption of all Ozone-Depleting Substances in ODP metric tons		30.1	99.2	0.1	1.2 (2007)
Consumption of ozone-depleting CFCs in ODP metric tons		25	94	0	0
Terrestrial and marine areas protected to total territorial area, percentage	6.8	12.6	16.5	16.6	16.6
Terrestrial areas protected to total surface area, percentage	6.8	12.6	16.5	16.6	16.6
Proportion of the population using improved drinking water sources, total	72	78	83		89
Proportion of the population using improved drinking water sources, urban	97	96	95		94
Proportion of the population using improved drinking water sources, rural	70	76	81		88
Proportion of the population using improved sanitation facilities, total	9	15	20		27
Proportion of the population using improved sanitation facilities, urban	36	39	42		45
Proportion of the population using improved sanitation facilities, rural	6	12	17		24
Slum population as percentage of urban, percentage	96.9		92.4		60.7

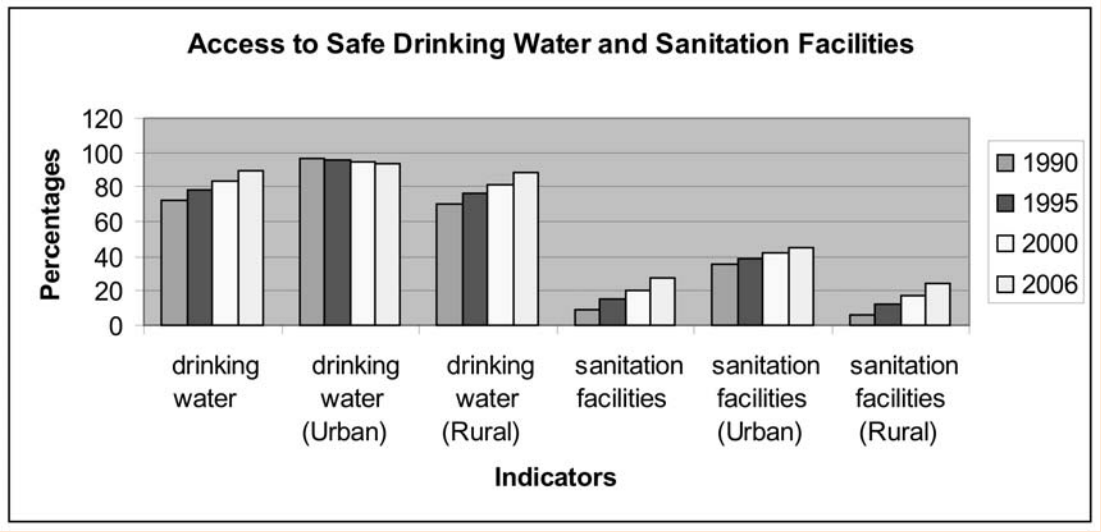
Source: Based on datasets of Millennium Development Indicators 2009; UNDP.

Community forest in Nepal has become the model in the world. Most of dry hills are slowly being converted into green and overall biodiversity is in rich mode. This is one of the sectors that Nepal has made a significant progress and has contributed to safeguard environment.

However, it pertinent to note here that proportion of area covered with forests is declining in some recent years. Roughly 33 percent of the land area was covered with forests in Nepal in 1990 which declined gradually to a mere 25.4 percent in 2005. The consumption of ozone depleting substances and emissions of CO2 in Nepal (currently at 1.2 metric tons in 2007) is well below international standards and is declining further as may be evident from the table depicted above.

Access to sanitation and improved water facilities in Nepal portrays a disappointing picture. Roughly 89 percent of the population has access to safe water and only 27 percent has the access to safe sources of sanitation as may be evident from the Figure portrayed below.

Figure: Trends in Indicators of Access to Safe Drinking Water and Sanitation Facilities in Nepal



Source: Based on datasets of Millennium Development Indicators; UNDP.

Concluding Comments

The achievement of targets of SAARC Development Goals may be visualised as positive and direct function of efforts and financial resource mobilisation to finance the schemes targeting socio-economic and human development of the people. The indicators of poverty and livelihood in Nepal show a gloomy picture where every two out five people are afflicted with destitution based on the poverty line of USD 1.0 a day. Poverty gap ratio of 19 percent shows the extent of poverty in Nepal.

Indicators of education, literacy and the associated gender parity in Nepal tells a telling story of underperformance as around one fifth of population do not get enrolled in primary education and the same fraction of people among enrolled do not complete primary schooling. There is significant gender gap in primary schooling and adult literacy which needs to done away with as rapidly as possible.

The most worrying aspect of SDGs indicators of Nepal is the high maternal mortality rates, which is around 830. As we know, access to antenatal care and institutional delivery services are inversely related with the rates of maternal mortality across the world. Thus there is an urgent need to spend heavily on maternal and child care health services so that thousands of lives could be saved.

The only encouraging fact about Nepal is that the indicators of environmental sustainability including CO2 emissions and consumption of ozone depleting substances are low by international standards and are still declining over time.

CHAPTER SEVEN

Achieving SDGs in Pakistan

Socio-economic Review of Pakistan

Pakistan's per capita income in dollar terms rose from $925 last year to $1085 in 2007-08, depicting an increase of 18.4 percent. Real per capita income in rupee terms has also increased by 4.7 percent, on average, for the last three years. The real per capita income grew by 4.2 percent as compared to 4.9 percent last year. Real private consumption expenditure grew by 8.5 percent in 2007-08 as opposed to 4.1 percent last year (Economic Survey, 2007-08; Pakistan). However, such an impressive growth performance is not matched up by the trends in indicators of human development in Pakistan. Per capita income has grown at an average rate of above 13.0 percent per annum during the last five years, rising from $586 in 2002-03 to $925 in 2006-07 and further to $1085 in 2007-08. Pakistan is the fourth most populous country in Asia and sixth in the world. Having an average annual growth rate of 2.02 percent the population of the country reached 160 million in 2007 as compared to 139 million in 2002, whereas during the said period the overall world population increased by average annual growth rate of 1.17 percent.

As per the HDR country Fact sheet (UNDP, 2008), Pakistan ranks 136 with a HDI value of 0.55, far behind the index value of countries like Ghana and Comoros. Life expectancy at birth in Pakistan is at a low value of 64.6 years, closely followed by Comoros (64.1 years) and India (63.7 years). Tin Pakistan, more than half (50.1 percent) of the adult population are illiterate, even Mauritania (48.8 %) and Timor-Leste (with adult illiteracy of 49.9 %) perform better than Pakistan. A figure of 40 percent of combined primary, secondary and tertiary gross enrolment ratio presents an even more dismal picture for Pakistan which is way behind the figures for countries like Ethiopia (42.1 %) and Papua New Guinea (40.7 %).

Children underweight for age (% ages 0-5) data of 38 percent put Pakistan in the League of Nations who performs worse than the countries of Sub Saharan Africa including Chad (37 %) and Burkina Faso (38 %). However, Pakistan, here, performs better than India where every two out of five children are malnourished.

The HPI-1 measures severe deprivation in health by the proportion of people who are not expected to survive the age of 40. The HPI-1 value of 36.2 for Pakistan, ranks 77th among 108 developing countries for which the index has been calculated. The gender empowerment measure (GEM) reveals whether women take an active part in economic and political life. It tracks the share of seats in

parliament held by women; of female legislators, senior officials and managers; and of female professional and technical workers- and the gender disparity in earned income, reflecting economic independence. Pakistan ranks 82nd out of 93 countries in the GEM, with a value of 0.377.

Given the dismal figures of socio-economic indicators of Pakistan, it is pertinent that that the Government of Pakistan should take serious actions to eliminate the developmental deficits and pursues the goals and targets as envisaged in MDGs and SDGs. It may be relevant to comment here that the Planning Commission of Pakistan has charted out a well planned Medium Term Development Framework (MTDF) wherein Human Development targets have been fixed in line with the Millennium Development Goals – MDGs 2015. In the following sections, we will examine the trends in progress towards achieving the goals and targets based on the information provided in report of MTDF and the datasets available through Millennium Development Goals Indicators.

Livelihood SDGs:

Pakistan has been able to reduce the incidence of poverty in terms of the percentage of population living below the poverty line. On the basis of national poverty line, poverty increased to 34.5 percent in 2000-01, compared to 30.6 percent in 1998-99 but high economic growth, targeted programs for poverty reduction and significant increase of pro-poor expenditure, lifted a large number of poor households out of poverty. Poverty incidence declined substantially from 34.5 percent in 2000-01 to 23.9 percent in 2004-05. Against 7.8 percentage point reduction in urban poverty during 200'1-05, the rural poverty declined by 11 .2 percentage points.

Table: Poverty Indices 2000-01 and 2004-05 (Percent)

	1998-99	*2000-01*	*2004-05*
Headcount Poverty Indices:			
Overall	30.6	34.5	23.9
Urban Areas	20.9	22.7	14.9
Rural Areas	34.7	39.3	28.1

Source: CPRSPD, Planning Commission, Pakistan.

The Government in Pakistan, as part of its strategy to intensify Pakistan's efforts for the achievement of the MDGs, has recently taken the following steps to address the urgent needs of the poor which has resulted in rapid decline in poverty ratio over the last decade:

a) First, increased the support price for wheat to encourage the small farmers to grow more wheat.

b) Second, liberalized imports to improve the supply situation of essential commodities especially duty free imports of wheat.

c) Third, instituted high level Committees to stabilize and monitor prices of essential commodities.

d) Fourth, ensured the availability of all basic food items at Utility Stores Corporation at a cheaper rate than the open market prices.

e) Lastly, provided cash assistance of Rs 1,000/per month to 3.4 million poor households under the newly created Benazir Income Support Program (BISP) with an allocation of Rs 34 billion for 2008-09 (MTDF Report, Pakistan Planning Commission, 2006).

The data portrayed in the Table presented below suggest that Pakistan has been successful in reducing the percentage of population living below the poverty line of USD 1.0 a day from 64.7 percent in 1991 to 22.6 percent in 2005. In a similar vein, poverty gap ratio, which measures the depth and extent of poverty, has declined drastically from a level of 23.2 percent to only 4.4 percent in 2005.

Table: Trends in Poverty, Inequality and Employment Ratio in Pakistan

	1991	*1993*	*1999*	*2002*	*2005*	*2007*
Population below $1 (PPP) per day, percentage	64.7	23.9	29.1	35.9	22.6	
Population below national poverty line (%)		28.6	32.6			
Population below national poverty line urban (%)		17.2	24.2			
Population below national poverty line rural (%)		33.4	35.9			
Poverty gap ratio at $1 a day (PPP) (%)	23.2	4.2	6.3	7.9	4.4	
Poorest quintile's share in consumption (%)	8.1	9.5	8.7	9.4	9.1	
Employment-to-population ratio (%)	47.6	47.9	47.8	46.9	48.7	51
Employment-to-population ratio men (%)	81.4	80.9	80.2	78.4	78.8	81.2
Employment-to-population ratio, women (%)	11.6	12.8	13.3	13.4	16.8	19
Employed people living below $1 (PPP) per day (%)	64.7	23.9	29	35.9	22.6	

Source: Based on Millennium Development Goals Indicators 2009, UNDP.

If we look at the poverty estimates based on national poverty line (see Table above), poverty had increased from 28.6 to 32.6 % between 1993 and 1999 with substantial differential between rural and urban Pakistan (headcount poverty ratio of 24.2 in Urban area while 35.9 % in rural areas in 1999). We do not have data for later periods. Apart from poverty measures, an important indicator for measuring inequality is the share of poorest quintiles in consumption (a surrogate measure for income). The ratio has moved upwards from a figure of 8.1 in 1991 to a level of 9.1 % in 2005. It may be worthwhile to mention here that the value of this ratio prevailing in Pakistan is among the best by international standards.

Table: Own account Workers, Youth Unemployment and Prevalence of Undernourishment

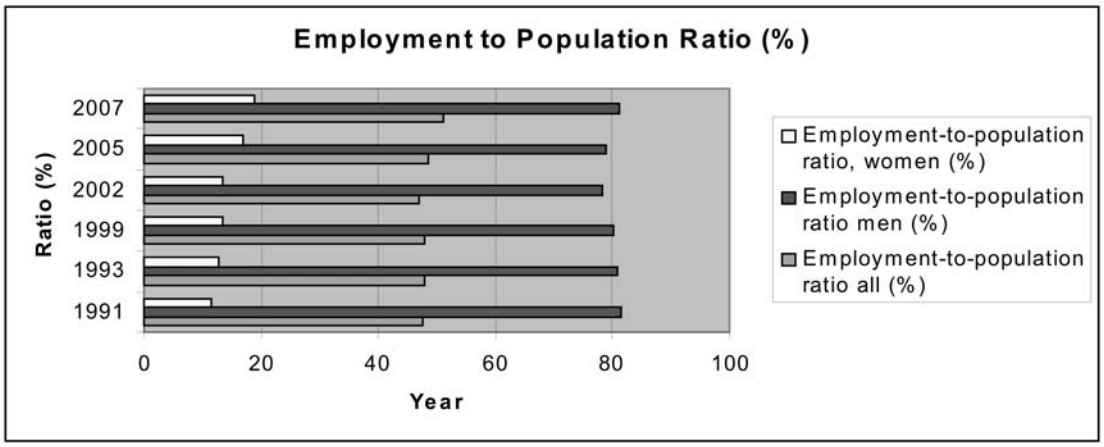
	1991	*1995*	*2000*	*2004*	*2007*
Own-account and contributing family workers in total employment (all, %)		64.9	63.6	61.2	61.8
Own-account and contributing family workers (women, %)		74.9	66.8	68.7	75.3
Own-account and contributing family workers in total employment (men,%)		63.5	63.1	59.7	58.4
Under- 5 moderately or severely underweight (%)	40.4	38.2			
Youth unemployment rate, aged 15-24, all	10.1	8.9	13.3	11.7	7.5
Youth unemployment rate, aged 15-24, women	21.8	18.1	29.2	14.9	8.9
Ratio of youth unemployment rate to adult unemployment rate, both sexes	2.4	2.4	2.7	2.1	1.8
Ratio of youth unemployment rate to adult unemployment rate, women	1.6	1.4	2.4	1.2	1
Share of youth unemployed to total unemployed, both sexes	47.5	46.2	49.9	48	43.6
Share of youth unemployed to total unemployed, women	42.7	34.2	38.5	36.4	31.3
Share of youth unemployed to youth population, both sexes	4.2	3.5	5.4	5.1	3.3
Share of youth unemployed to youth population, women	2.9	1.9	3	2.4	1.6
Population undernourished, percentage	22			23	

Source: Based on Millennium Development Goals Indicators 2009, UNDP.

As may be evident from the Table presented above, proportion of own-account and contributing family workers in total employment has remained almost stagnant in the range of 60-65 % between 1995 and 2007 with a marginal decline from 64.9 percent in 1995 to 61.8 % in 2007, led primarily by decline in proportion of own-account and contributing family workers among females from 63.5 in 1995 to 58.4 % in 2007.

Malnutrition of children has remained relatively stagnant in Pakistan over the last decade and a half. The proportion of children under five who are severely underweight has remained constant around 12-13 percent. However, the percentages of children who are moderately underweight are stagnant at an alarmingly high range of 35-40 percent. The proportion of population undernourished has remained stagnant at level of 22-23 % during the last decade and a half.

Figure: Trends in Employment to Population Ratio in Pakistan



Source: Based on Millennium Development Goals Indicators 2009, UNDP.

As may be visible from the graphics depicted above, overall employment to population ratio has increased marginally from 47.6 in 1991 to 51 % in 2007, led exclusively by increase in the ratio for women from 11.6 % to 19 % over the said time period. The ratio for men remained stagnant around 80 percent. It may be worthwhile to record here that dismal level (below 20 %) of employment to population ratio for women in Pakistan is among the worst in the world, the goals of gender parity in respect of this indicator is a distant dream.

Social Protection Strategy in Pakistan
To Reach the Poor and Vulnerable

Social Protection Strategy is the cornerstone of building a harmonious society.

The goals of the Social Protection Strategy:

- to support chronically poor households and protect them against destitution, food insecurity, exploitation, and social exclusion;
- to protect poor and vulnerable households from the impact of adverse shocks to their consumption and wellbeing that, if not mitigated, would push non-poor households into poverty, and poor households into deeper poverty; and
- to promote investment in human and physical assets, including health, nutrition and education, by poor households capable of ensuring their resilience in the medium run and of interrupting the intergenerational cycle of poverty.

The Core Instruments of the Strategy include:

- expanding the coverage of cash transfers using Conditional Cash Transfers (CCTs) supplemented with unconditional transfers, through the Food Support Program (FSP) and Zakat;
- a new public works program based on low-wage employment;
- child labour programs, and various new pilots such as (i) combination of cash transfers and basic skills development aimed at enabling the poor to qualify for microfinance and (ii) programs for bonded labour; and
- Scaling up schoolfeeding and socialcare services.

Reaching the Poorest, Short-term Measures:

- maintaining the current level of benefits and effecting a transition to better and more comprehensive systems;
- introducing new means of testing and development of databases through some pilots across chosen rural and urban areas;
- scaling up successful pilots across the country following assessment of lessons learnt;
- extension of the current level of benefits to the target population of the poorest of the poor;
- introduction of pilot CCT programs; and
- scaling up successful pilots to the whole target population.
- Speedy Implementation Requires:
- Being inter-sectoral and inter-provincial, coordination problems will require highlevel policy decisions and effective monitoring. Oversight of Cabinet Committee on Social Sectors recommended with Centre of Poverty Reduction/Planning Commission as focal institution and technical secretariat for Social Protection Policy implementation.
- Cabinet Committee on Social Sectors to meet regularly to monitor social sector policies, programs and projects.

Source: Social Protection Strategy to Reach the Poor and Vulnerable, Planning Commission June 2007

Health SDGs

This section considers several aspects of female and child health and incidence of fatal disease, in particular tuberculosis, in Pakistan and the availability of health services. The government of Pakistan accepts responsibility for providing free medical treatment and health protection to all persons in need. Public medical care units offer services to implement government policy, but resources are limited and personnel not fully oriented or totally devoted to the government's philosophy.

Pakistan is in the middle of epidemiological transition where almost 40 percent of total burden of disease is accounted for by infectious/communicable diseases. These diseases are thus widely spread in the country and there are also basic nutritional gaps in population. Here is an urgent need of a paradigm shift in the health strategy from curative services to preventive and primary health care. Health to GDP Ratio remains below 1%, strategy to reach 2 % by 2012 needs to be formulated. Out-of-Pocket expenditures in Pakistan are among highest in the world. There is also an acute for more equity in health system of Pakistan.

In relative terms the population seems to have increased faster than these facilities, but, conversely, there has been a real increase in facilities with regard to dispensaries, maternal and child health (MCH) centers, registered doctors, nurses, and lady health visitors. The scale on which health services are available for the population of the rural areas is comparatively poorer than urban areas. The disparity in availability of services in rural and urban areas has obvious implications for the health of rural females. Most women do not get any prenatal care and deliver at home with the help of indigenous midwives who are usually untrained. Abortion, which is illegal, is practiced and constitutes a serious health hazard for those who attempt it. Iron deficiency anemia is very common among women and particularly acute among pregnant women.

Achievements:

The major primary health care programs and projects are: Expanded Program of Immunization (EPI), National Program for Family Planning & Primary Health Care, Maternal, Neonatal and Child Health, T.B Control, Roll Back Malaria, Prevention and Control of Hepatitis, HIV-AIDS, Control of Blindness and Control of Avian Influenza and Improvement of Nutrition. Investment in women and child health programs has also been made to reduce maternal and child mortality and to reduce child morbidity.

During the first two years of the MTDF (2005-07), seventy new Basic Health Units (BHUs) and 10 new Rural Health Centers (RHCs) have been added, and 66 BHUs and 18 RHCs have been upgraded. Other additions during this period are: 10,000 new hospital beds,8,500 doctors,830 dentists,6,510 nurses and 9,500 paramedics. These achievements are below the target.

The National Expanded Program for Immunization (EPI) provides immunization against the 7 killer diseases i.e. childhood tuberculosis, poliomyelitis, diphtheria,

peruses, neonatal tetanus, measles and hepatitis B. During the year 2006, 5.6 million children 0-11 months old and 6.5 million pregnant women were targeted for immunization. National and sub-national immunization campaigns are being carried out and, in every round, more than 25 million children aged 5 years and below are given polio drops. As a result of this intensive exercise cases of polio are reducing yearly and restricted to a few districts in the country.

Table: Achievement in Health Indicators (Percentage)

Indicators	*2000-01*	*2004-05*	*2005-06*
Under-five Mortality rate	105	100	
Infant Mortali$ Rate	77	73	70
Infant Immunization Coverage	53	77	71
Population Covered with Tap Water	25	34	34
Population Covered with Sanitation Facility	45	54	60

Source: Pakistan Integrated Household Survey (PIHS) FBS ; CPRSPD, Planning Commission, Pakistan

As is evident from the Table depicted above, under-5 mortality in 2005 was 100 per 1,000 live births compared to 140 in 1990. The rate of maternal mortality between 350-400 deaths per 100,000 births is also high. The percentage of births attended by doctors and nurses has increased from 23 percent in 2001 to 31 percent in 2006-07. Infant Mortality Rate was 70 deaths per 1,000 live births in 2005-06 as against 73 in 2004-05. Improvements in access to safe drinking water and sanitation are on track to halve the population improved water and sanitation by 2015.

The gravest issue of concern is dismally high under-5 mortality in Pakistan. Regrettably the country is also struggling to contain its maternal mortality. It is lagging behind Asia Pacific region in addressing this problem. Presently maternal mortality ratio is 500 per 100,000 live births (however, the MDGs Database suggest a lower rate of 320 in 2005) which is the 6th highest in the region. Afghanistan leads the list with maternal mortality of 1,900 per 100,000 live births. Maternal mortality and access to obstetric care and ante-natal care coverage are inversely correlated. Pakistan has high maternal mortality on account of low coverage (ranging from 25-40 %) of antenatal care. An encouraging aspect is that the LHWs program has been successful in providing preventive health services to the targeted population. Child immunization coverage has also increased from 53 percent in 2000-01 to 71 percent 2005-06, which may result in decline in maternal and child mortality.

Table: Maternal and Child Health Status in Pakistan											
	1991	*1992*	*1993*	*1995*	*1997*	*1999*	*2001*	*2003*	*2005*	*2006*	*2007*
Maternal mortality ratio per 100,000 live births									320		
Births attended by skilled health personnel, %	18.8				18	18	23		31		38.8
Current contraceptive use among married women 15-49 years old, any method, %	11.8		21.9	17.8	23.9		27.6	32.1		26	29.6
Current contraceptive use among married women 15-49 years old, modern methods, %	9		17.9	12.6	16.9		20.2	25.2		18.4	21.7
Current contraceptive use among married women 15-49 years old, condom %	2.7		4.5	3.7	4.2		5.5	6.4		5.2	6.8
Adolescent birth rate, per 1,000 women		73.3			52.3	36.2	24.2	23.7	20.3		
Antenatal care coverage, at least one visit, %	25.6				26.4	27.6	43.3		36		60.9
Antenatal care coverage, at least four visits, %	14.2										28.4

Source: Based on Millennium Development Goals Indicators 2009, UNDP.

An important indicator from the perspective of health of children and pregnant women is the proportion of births attended by skilled health personnel. The ratio shows an encouraging trend, and has risen from a figure of 18.8 in 1991 to 38.8 in 2007. Current contraceptive use among married women (15-49 years old, any method) has also increased significantly from 11.8 in 1991 to 29.6 in 2007. The indicator value of antenatal care coverage (at least one visit) has increased substantially from 25.6 % in 1991 to a comparatively high figure of 60.9 % in 2007. Antenatal care coverage (at least four visits) has been doubled during the last decade and a half, from 14.2 % in 1991 to 28.4 % in 2007.

In so far as trends in child mortality in Pakistan are concerned, it has taken a significant, though not adequate, step forward. Both child and infant mortality have declined over the years, largely reflecting the fact that immunization coverage against measles has increased contemporaneously as is evident in the Table given below. The Table shows that children under five mortality rates per 1,000 live births declined from130 in 1990 to 90 in 2007.

Table: Child Mortality and Immunization in Pakistan						
	1990	*1995*	*2000*	*2005*	*2006*	*2007*
Children under five mortality rate per 1,000 live births	130	118	108	99	95	90
Infant mortality rate (0-1 year) per 1,000 live births	100	93	85	79	76	73
Children 1 year old immunized against measles,%	50	47	56	78	80	80

Source: Based on Millennium Development Goals Indicators 2009, UNDP.

We do not have consistent estimates of prevalence and the resulting deaths on account of Malaria and AIDS. However, the figures for TB incidence, prevalence, DOTS treatment and TB deaths are provided in the following table which clearly suggests that progress is far from impressive, though the success rates of DOTS is rising over time. Tuberculosis incidence rate per year per 100,000 populations has been stagnant at figure of 181.3 during the period between 1990 and 2007. There have been noticeable reductions in Tuberculosis prevalence rate per 100,000 populations from 427.8 in 1991 to 222.6 in 2007. Tuberculosis detection rate and success rates under DOTS have registered a significant upward movement from 1 in 1995 to 66.6 % in 2007 and 70.4 in 1995 to 88 in 2007, respectively as may be evident from the Table listed below.

Table: Tuberculosis Incidence and Treatment Success in Pakistan							
	1990	*1995*	*2000*	*2004*	*2005*	*2006*	*2007*
Tuberculosis incidence rate per year per 100,000 population	181.3	181.3	181.3	181.3	181.3	181.3	181.3
Tuberculosis prevalence rate per 100,000 population	427.8	423.6	416	336.3	292.5	260	222.6
Tuberculosis death rate per year per 100,000 population	49.1	48.8	48.2	41.1	37.1	34.5	29.0
Tuberculosis detection rate under DOTS,%		1	2.8	24.9	37.5	49.9	66.7
Tuberculosis treatment success rate under DOTS, %		70.4	74.5	82	83.3	88	

Source: Based on Millennium Development Goals Indicators 2009, UNDP.

Goal: Achieve Universal Primary Education, Completion Rates and Gender Parity in Access to Schooling

The major objectives or thrust areas in the basic and college education sector covered under MTDF are: universalization of primary education, attainment of adult literacy and gender equality. Goal 2 of MDGs reflected in MTDF, aims at ensuring that by 2015 children everywhere, boys and girls alike would be able to complete a full course of primary schooling.

These targets are assessed in Pakistan by the trends in gross and net primary enrolments, the proportion of pupils who started grade one and reached grade five, and the literacy rates of 15-24 years old. MTDF has also set the targets for the overall adult (10 years and more) literacy and participation at the secondary level, 77 percent by 2010 for these two indicators

The MTDF also aims at improving the quality of teachers, establishment of quality educational institutions including cadet colleges, revamping of science education including improving laboratory and library facilities, introduction of computer as a compulsory subject from class VI onwards, establishment of polytechnic institutes both for girls and boys, and upgradation of college education especially in science subjects by providing lab equipment, library books, furniture and qualified teachers.

However, Pakistan has a long way to go with regard to promotion of gender equality and women empowerment. There are wide gender gaps which inhibit efforts to ensure gender parity. The country is off track with regard to ratio of girls' to boys' secondary enrolment which stands at 0.7%. It is also lagging behind in another MDG gender indicator: of women's share of paid non-agricultural employment which is only 10%. Sri Lanka has 40%, India's 18% and Nepal's 15%.

Table: Trends in Enrolment, Completion Rates and Literacy Rates in Pakistan

	1998	*2003*	*2004*	*2005*	*2006*	*2007*
NER in primary education		58.5	64.5	67.2	65.6	
NER in primary education, boys		67.6	74.3	76.1	73.5	
NER in primary education, girls		48.8	54	57.8	57.3	
% of pupils reaching last grade of primary			69.7			
% of pupils reaching last grade of primary, boys			67.8			
% of pupils reaching last grade of primary, girls			72.4			
Primary completion rate, both sexes				61.5	61.8	63.3
Primary completion rate, boys				71.4	70.2	70
Primary completion rate, girls				51	52.9	56.2
Literacy rates of 15-24 years old, %	55.3			65.1	69.2	70
Literacy rates of 15-24 years old, men, %	67.1			76.7	79.1	79.5
Literacy rates of 15-24 years old, women, %	43.1			53.1	58.4	60
Women to men parity index, as ratio of literacy rates, 15-24 years old	0.64			0.69	0.74	0.75

Source: Based on Millennium Development Goals Indicators 2009, UNDP.

As the data presented in the Table above suggest, NER in primary education (for both boys and girls) moved upwards from 58.5 in 2003 to 65.6 in 2006. NER

in primary education for girl students showed a consistent improvement, though at a slower pace, from 48.8 in 2003 to 57.3 in 2006. Primary completion rate for both and girls has progressed at slow pace during the period between 2005 and 2007. For 2007, figures for primary completion rates for all, boys and girls are 63.3, 70 and 56.2 percent, respectively.

Achievements

During 2005-08, against federal and provincial allocation of Rs 58.1 billion for the basic and college education, Rs 45.4 billion (78 %) is expected to be utilized. However, the federal programs reflected higher utilization Rs 16.2 billion (89 %), against an allocation of Rs 18.2 billion. In physical terms, considerable progress has been made in the education sector. It has been estimated that in 2007, there were four million more children in primary schools as compared to those in 2001. In 2005-06, 52 percent of 5-9 years old were enrolled in primary schools, up from 42 percent in 2001, although the progress during the first year of MTDF was relatively slow. Literacy rate has also shown improvement, which increased from 35 percent in 1990-91 to 53 percent in 2004-05, and to 55 percent in 2006-07. MDG target for net enrolment rate and literacy are 100 percent and 88 percent respectively, whereas, this target was set at 77 percent for the MTDF period (2005-2010).

In the context of these targets, the recent progress in net primary enrolment as well as literacy is slow. The MDG Report 2005 has assessed that if the net primary enrolment increases at the rate of 2.5 percent per annum, it will be about 77 percent by the year 2015, well below the target of 100 percent. Only if the per annum increase more than doubles to 5 percent, net primary enrolment would achieve the MDG target by 2015.

There is need for more efforts to achieve the enrolment and literacy targets. MTDF aims to eliminate gender inequality, measured by Gender Parity Index (GPf), in primary and secondary education not later than 2015. In the last few years the gender inequality has significantly reduced but remains high. The ratio of female to male primary enrolment rates increased from under 0.73 in 1990-91 to 0.85 in 2006-07 and for secondary education it stood at 0.83 in 2004-05. But female literacy rates are particularly low; just over a third of adult females are literate, compared to nearly two thirds of adult males.

In sum, despite recent improvements in the education sector, Pakistan is behind the SDGs/ MDGs / MTDF targets in some key indicators. In total Rs 58.1 billion were allocated during 2005-08 against which Rs 45.3 billion (78 %) were utilized. Inadequate funding may be attributed as one of the principal reasons of non achievement of education indicators projected by the MTDF. Although more than the target, new primary schools and cadet colleges have been set up during the first two years of MTDF, the target of opening new colleges and addition of new classes in existing schools and colleges could not be achieved. The process of upgrading the primary schools to secondary schools and secondary schools to colleges has also remained slow.

There are three indicators relating to the Universal Primary Education (UPE) under Millennium Development Goals. Pakistan has achieved a net primary enrollment of 65 per cent, the completion survival rate of 63.3 per cent and an overall youth literacy rate of 70 per cent in 2007.

Table: Achievements in Education Sector

	2000-01	*2004-05*	*2005-06*	*2006-07*	*MTDF Target 2010*	*MDG 2015*
Net Primary ratio (%)	68	72	-	56	77	100
Completion Rate to Grade 5 (%)	68	72	-		80	100
Literacy Rate (%)	45	53	54	55	77	88
Gender Parity Index (GPI) for Youth Literacy	0.65	0.65	0.67	-	0.85	1
GPI Primary	0.82	0.85			0.94	1
GPI Secondary Education	0.75	0.83			0.9	0.94

Source: CPRSPD, Planning Commission, Pakistan.

As may be noted from the Table portrayed above, Gender Parity Index (GPI) for youth literacy rates in Pakistan has remained stagnant at a level of 0.65 between 2000-01 and 2005-06 while the MDGs target and SDGs target imply achievement of 100 % gender parity. Similarly, GPI for primary level of education has remained virtually stagnant in the range of 0.8- 0.85 during 2000-01 and 2004-05. However, GPI for secondary level of education has increased marginally from 0.75 in 2000-01 to 0.83 in 2004-05 in Pakistan. Thus it seems clear that Pakistan is not going to achieve the targets of gender parity at different tiers of education.

Promotion of Gender Equality and Women Empowerment

Goal: Progress in Promoting Gender Equality and Empowerment

At the national level GPI in primary enrollment steadily improved from 0.73 to 0.82 and to 0.82 in 1990, 2001 and 2005 respectively. However, the national estimates mark considerable inter provincial variations in GPI. Although the country has missed the preferred target year of 2005 to achieve GPI 1.0 in primary and secondary education, the rate of progress is however, steadily achievable by 2015. Considerable progress in eliminating gender disparity in primary education in the last 7 years is apparent. The numerical analysis indicates that nine districts have already attained the MDG target to parity ratio of 1.0 and another 4 districts are almost close to the target. If the past rate of progress is maintained and extrapolated into the future, another 25 districts will attain the parity ratio. However, fast track initiatives in this regard will ensure the attainment of parity in majority of the districts by 2015.

Table: Trends in Gender Parity in Education, Employment and Political Empowerment in Pakistan

	1990	*1991*	*1999*	*2002*	*2004*	*2006*	*2007*
Gender Parity Index in primary level enrolment				0.68	0.73	0.78	.82
Gender Parity Index in secondary level enrolment		0.48			0.78	0.78	.76
Gender Parity Index in tertiary level enrolment		0.58		0.81	0.8	0.85	.85
Share of women in wage employment in the non-agricultural sector	6.6	8.1	8.1	8.9	9.7	10.7	13.2
Seats held by women in national parliament, %	10.1		2.3		21.6	21.3	22.5 (2009)
Total number of seats in national parliament	237		217		342	342	
Seats held by men in national parliament	213		212		268	342	
Seats held by women in national parliament	24		5		74	73	

Source: Based on Millennium Development Goals Indicators 2009, UNDP.

Pakistan has defined four indicators for achieving the goal of women empowerment and gender balance in socio-economic outcomes. The first indicator is Gender Parity Index (GPI) for primary, secondary and tertiary education. At primary level the index in 1990-91 was 0.73 and 0.68 in 2002 which has increased to 0.82 by 2007 while the MTDF has a target of 0.94 so that the GPI at primary level is achieved by 2015. However, it seems less likely to achieve the target unless more efforts are made. At secondary level index in 2007 is 0.76 but the MTDF target is 0.90 and the target for 2015 is 0.94 and that seems less likely to be achieved. The second indicator is the GPI in literacy rate by 2015; in 2004-05 index was just 0.67, and MTDF target of 0.85 and therefore GPI of 1 by 2015 seems quite unrealistic. Third, the share of women in wage employment in the non-agricultural sector which at present is around 10 percent. It may be possible if the average targeted growth rate of GDP of 7.6 percent for the MTDF period is achieved. The fourth indicator is the proportion of seats held by women in national parliament and there has been significant improvement; from just 0.9 percent in the National Assembly and 1.0 percent in Senate, the female seats have gone up to 21 percent in National Assembly and 17 percent in Senate. The database of MDGs indicators suggest that proportion of seats held by women in parliament has increased substantially from 10.1 % in 1990 to 22.5 % in 2009. An important indicator of economic empowerment of women is their share in non agriculture wage employment. The values of this indicator have moved upwards at a creeping pace,

from 6.6 in 1990 to 13.2 in 2007 while the MTDF target of 12 percent has been envisaged to rise to 14 percent by 2015.

Trends in Progress towards Achieving the Goals of Environment Sustainability, Access to Improved Sources of Water and Sanitation Facilities

Access to improved drinking water sources especially for the poorest of the poor remains a challenge. With the launch of multibillion rupee, "Clean Drinking Water for All by 2008", Government of Pakistan has further stepped up efforts to achieve the targets. Pakistan's adaptation of MDG indicator for drinking water coverage defines it, as the proportion of population (urban and rural) with sustainable access to improved water sources i.e. Pipe and Hand Pump water. As per this definition, water supply and sanitation coverage increased from 65 per cent and 42 per cent in 200405 to 70 per cent each in 200708. Details of progress are given below:

Table: Environment SDGs Indicators

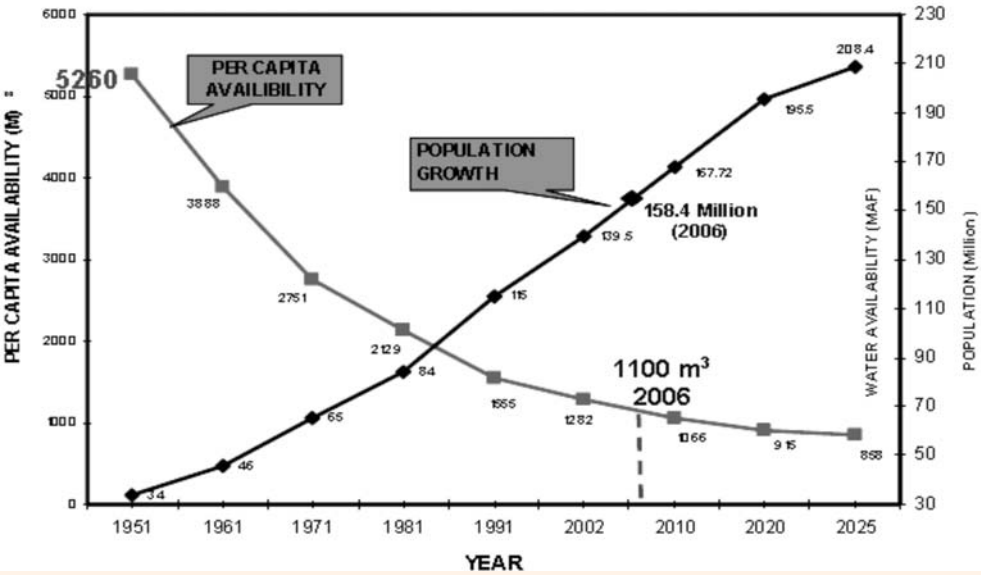
	2004-05	*2005-06*		*2006-07*		*2007-08*
	Benchmark	*Targets*	*Achieved*	*Targets*	*Achieved*	*Likely Achievement*
Forest Cover	4.9	4.9	5.1	5.1	5.2	5.2
Access to Sanitation	42	43	43	43	44	46
Access to Clean Water	65	66	66	66	68	70

Source: CPRSPD, Planning Commission, Pakistan.

Situation of Water in Pakistan

The country is water stressed - water availability on a per capita basis has been declining at a disturbing rate, and has decreased from 5,000 cubic meters per capita in 1951 to about 1,100 cubic meters per capita in 2006, verging on the international scarcity rate. It is estimated to go down to 700 cubic meters by 2025. Funding for the Environment Sector has been enhanced from Rs 0.74 billion in 2004-05 to Rs 3.1 billion in 2005-06, to Rs 6.5 billion in 2006-07 and about Rs 6.6 billion during 2007-8. Against the allocation of Rs 16.2 billion during 2005-08, Rs 12.3 billion are likely to be spent, reflecting utilization to the extent of 76 percent.

Water availability and population growth, 1951–2025 (Cubic meters)



Trends in Water and sanitation coverage

Through the 1990s progress in improving coverage in the water supply and sanitation sector was lacklustre. Since 2002/03 however, there have been marked improvements in access to water supply and sanitation services. The trend of the 1990's has been bucked by improvements in rural access, in particular in access to sanitation in rural Pakistan.

Table given below presents the changes that have taken place in water and sanitation coverage between 1990 and 2006. This data from the WHO /UNICEF Joint Monitoring Programme for Water Supply and Sanitation (JMP) shows, that while access to improved urban water supply has remained more or less static at about 95% coverage, there has been some increase in access to improved water supply in rural areas, from 81% to 87%. More striking, however, are the improvements in access to 'improved' sanitation, with urban access growing from 76% to 90% and rural access growing from 14% to 40%. Overall access to improved sanitation grew from 33% to 58%. The JMP estimates that the percentage of population that gained coverage over this period is 33% for water supply, and 40% for sanitation (with respect to median population year 1998). The reduction in open defecation from 74% in 1990 to 45% in 2006, for rural areas, is also notable (leading to an overall decline in open defecation from 54% to 31%).

With respect to sanitation coverage, it is important to also highlight the rural and urban differences. In 2006, while 94% of the urban population had improved or shared access to sanitation, only 45% of the rural population had such access,

with 55% continuing to practice open defecation or having access only to unimproved facilities. Despite strong urbanizations trends the population is as yet largely rural, and this disparity has significant impact.

Table: Changes in drinking water and sanitation coverage – 1990 and 2006

	Urban				Rural				Total			
Water supply	*Improved*	*Piped to dwelling yard or plot*	*Other improved*	*Unimproved*	*Improved*	*Piped to dwelling yard or plot*	*Other improved*	*Unimproved*	*Improved*	*Piped to dwelling yard or plot*	*Other improved*	*Unimproved*
2006	95	48	47	5	87	19	68	13	90	29	61	10
1990	96	52	44	4	81	8	73	19	86	21	65	14
Sanitation	*Improved*	*Shared*	*Unimproved*	*Open defecation*	*Improved*	*Shared*	*Unimproved*	*Open*	*Improved*	*Shared*	*Unimproved*	*Open defecation*
2006	90	4	0	6	40	5	10	45	58	5	6	31
1990	76	4	12	8	14	2	10	74	33	3	10	54

Source: JMP 2008

Table: Forest, Water and Sanitation related Indicators in Pakistan

	1990	*2000*	*2001*	*2006*
Proportion of land area covered by forest, percentage	3.3	2.7		
Carbon dioxide emissions (CO2), metric tons of CO2 per capita (CDIAC)	0.6024	0.7349	0.7236	
Energy use (kg oil equivalent) per $1,000 GDP (Constant 2005 PPP $)	240	240	240	
Consumption of ozone-depleting CFCs in ODP metric tons	751	1945.3	1666.3	626
Marine areas protected to territorial waters, percentage	1.1	1.1	1.1	1.1
Proportion of the population using improved drinking water sources, total	86	88		90
Proportion of the population using improved drinking water sources, urban	96	95		95
Proportion of the population using improved drinking water sources, rural	81	85		87
Proportion of the population using improved sanitation facilities, total	33	48		58
Proportion of the population using improved sanitation facilities, urban	76	85		90
Proportion of the population using improved sanitation facilities, rural	14	30		40
Slum population as percentage of urban, percentage	78.7		73.6	

Source: Based on Millennium Development Goals Indicators 2009, UNDP

Pakistan is committed to the target of halving by 2015 the proportion of people without sustainable access to safe and improved sanitation. Given the baseline of 33% improved sanitation coverage in 1990 (JMP figures. If 'shared' as well as 'unimproved' coverage (with baselines in 1990 of 3% and 10% respectively) are included the target rises to 73%. Recent analysis indicates that Pakistan is on-track to meeting its target for sanitation. The most recent PSLM data of 2006/07 indicates 73% of the population has access to a latrine, with 96% access in urban areas, and 62% access in rural areas. The most recent JMP report (2008) uses the slightly earlier PSLM 2005/06 data and importantly deconstructs PSLM coverage figures, into improved, shared, and unimproved access and open defecation, providing a more nuanced picture of coverage. In 2006, Pakistan had reached 58% improved coverage, 5% shared, and 6% unimproved, giving total coverage of 69% (and 31% still practicing open defecation).

The overall achievement in the Environment Sector is not encouraging. The utilization with respect to allocation has been low. The utilization in the Environment Sector, other than clean drinking water program, also remained very low against MTDF targets. Against a target of over 6,500 water filtration plants, one in each union council, not much progress reflecting output on ground has been achieved. During 2005-07, 440 water filtration plants have been established against a target of 646 plants. Recently this program has been reactivated under the Ministry of Industries, Production and Special Initiatives. In 2007-08 against the target of 6035, only 4500 plants are likely to be installed.

Concluding Comments

The analysis presented above makes it starkly clear that achievements of SDGs/MDGs in Pakistan seem a distant dream for majority of the indicators. Head count poverty ratio has declined from 64.7 % in 1990 to 22.5 in 2005, thereby achieving the targets wee before deadline. However, other indicators pertaining to extent of hunger and malnutrition, Pakistan is placed at an uncomfortable position. The Global Hunger Index suggests that the prevalence of hunger in Pakistan is serious and alarming. A maternal mortality rate, to the tune of 320 is too high a figure to be complacent. A high rate of infant and child mortality (in the range of 80 and 100) indicates the precarious situation in Pakistan in providing access to maternal and child health care facilities. The high rates of prevalence and incidence of TB in Pakistan infer that there is urgent need to invest heavily towards control of such fatal diseases. Access to proper sanitation facilities, specifically in rural areas of Pakistan is a cause of concern. The environmental indicators suggest a more satisfying situation in Pakistan, though its performance on forest cover front leaves much to be desired.

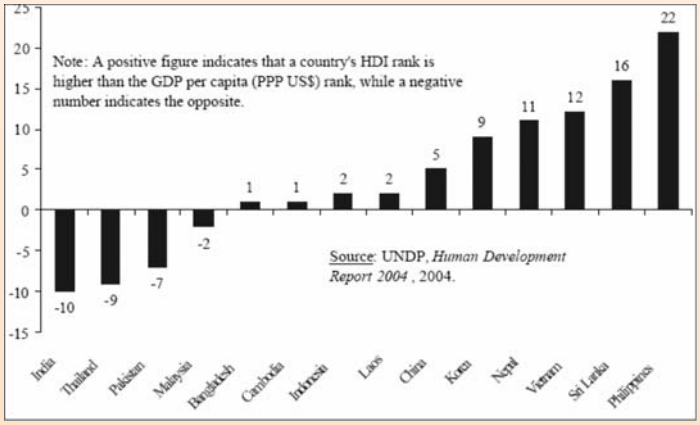
CHAPTER EIGHT

Achievements and Gaps in SDGs in Sri Lanka

Overview of Sri Lanka's Economic and Human Development Record

Sri Lanka has long been celebrated in the development economics literature as a model of low-income country- one that has achieved extraordinary success in attaining high levels of male and female literacy, school enrollments, and health outcomes despite low levels of per capita income. Only a handful of developing countries, such as China, Vietnam, Cuba and Costa Rica, can list as many achievements as Sri Lanka on the social front. Indeed, data from the UNDP's global Human Development Report 2007 suggests that Sri Lanka has one of the highest ranks of all the countries in Asia when its performance on the human development index (which is a composite index of life expectancy, adult literacy, school enrollment, and income per capita) is compared relative to its performance on GDP per capita.

Figure: Comparison of HDI Ranking of Sri Lanka vis-à-vis GDP per Capita



Source: Extracted from Sri Lanka MDG Report 2005; UNDP.

In the year 2000, the leaders of the world decided to launch a concerted attack on poverty and the problems of illiteracy, hunger, and discrimination against women, unsafe drinking water and a degraded environment.

The United Nations at the dawn of the new Millennium, leaders from virtually all countries agreed to a set of eight ambitious Goals called Millennium Development Goals (MDG). Developing countries, have been taking the lead in this campaign, particularly regarding the first seven Goals concerning direct improvements in human well-being. In addition, as has been discussed earlier, all SAARC countries decided to set their targets to achieve the developmental goals pertaining to Livelihood, health education and environmental sustainability, named as SAARC Development Goals, by 2012.

Livelihood SDGs in Sri Lanka: Progress and Prospects

Sri Lanka's impressive performance on social indicators does not mean, however, that the SDGs are irrelevant for the country. Sri Lanka's performance on income-poverty reduction – an important SDG – has lagged behind its performance on improving health and education indicators, largely because the country has generally been a slow grower during much of its past (although not its recent past). Sri Lanka has experienced diversity of outcomes even among the various social indicators. For instance, while the country has done very well in reducing infant, child and maternal mortality, it has not done anywhere as well in reducing child malnutrition. This means that the large numbers of Sri Lankan children who survive infancy and childhood end up suffering a lower quality of life, at least in terms of nutritional deprivation.

In short, it is important to analyze Sri Lanka's past performance on a variety of development indicators and assess its prospects for attaining the SDGs.

Table: Progress of Indicators relating to Poverty and Employment in Sri Lanka

	1992	2000	2002	2004	2005	2006	2007
Population below $1 (PPP) per day, percentage	15		14				
Population below national poverty line, total, percentage	20		22.7				
Population below national poverty line, urban, percentage	15						
Population below national poverty line, rural, percentage	22		7.9				
Poverty gap ratio at $1 a day (PPP), percentage	2.7		2.6				
Poorest quintile's share in national income or consumption, percentage	8.7		6.8				
Growth rate of GDP per person employed, percentage	5.42	8.37	3.5	6.69	-0.07	5.36	
Employment-to-population ratio, both sexes, percentage	50.2	52.4	50.8	50.8	51.2	54.3	55.1
Employment-to-population ratio, men, percentage	69.4	72.2	71.3	71.8	72.2	70.7	71.8
Employment-to-population ratio, women, percentage	30.9	32.9	31	30.6	31	38.6	39.2
Proportion of employed people living below $1 (PPP) per day, percentage		10.9	8.4				
Youth unemployment rate, aged 15-24, both sexes	33.1	23.6		28.9	26.2	21.6	21.2
Youth unemployment rate, aged 15-24, women	40.7	30.9		39.8	37.1	28.2	28.1
Youth unemployment rate, aged 15-24, men	28.4	19.9		22.5	20.1	17.5	17.1
Share of youth unemployed to total unemployed, both sexes	61.1	66.5	61.2	68.7	64.3	56.8	56.8
Share of youth unemployed to youth population, both sexes	15.9	10.3		12.8	10.9		

Source: Based on Datasets of Millennium Development Indicators 2009; UNDP.

Reducing poverty and alleviating deprivation have also been at the heart of Sri Lankan public policy over several decades. The country has made considerable progress on poverty reduction over the long-term, with income levels and living standards improving substantially since independence in 1948. However, more recently, Sri Lanka has encountered difficulties in its battle against poverty.

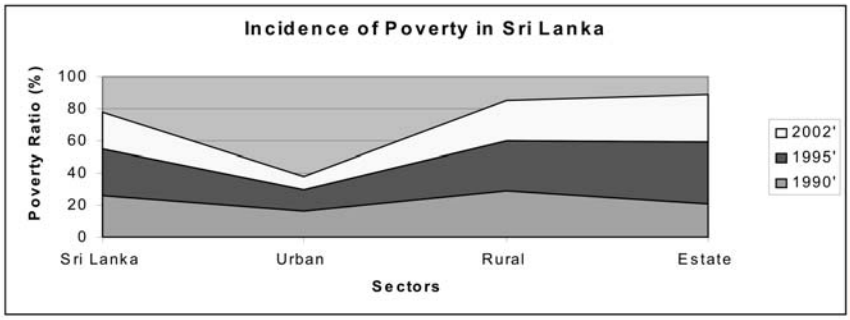
Poverty in Sri Lanka is high and widespread. About 23% of the population lives below the official national poverty line in seven of the eight provinces in the country. The highest level of poverty is in the estate sector, which comprises the plantations in the central highlands and surrounding areas. About 30% of the population in estate areas is poor. This is followed by the rural sector, where about 25% of the population lives below the poverty line. In the prosperous urban sector, in contrast, poverty levels are considerably lower – just 8%. This pattern of poverty across sectors, where agricultural areas exhibit substantially higher levels of poverty than areas which depend mainly on industry and services, is evident in virtually every country in the world.

The wider range of economic activities and more profitable economic opportunities available in cities and towns are manifested in lower poverty rates in urban areas.

The time trend of poverty shows that the proportion of people living below the poverty line rose from 26% in 1990/91 to 29% in 1995/96 and then declined to 23% in 2002. This non- linear poverty trend is seen in both the rural and estate sectors which experienced rising poverty between 1990/91 and 1995/96, followed by decreasing poverty between 1995/96 and 2002. Urban poverty, in contrast, fell continually between 1990/91 and 2002. Other measures of poverty, such as the depth and severity of poverty, show a similar time trend and sector pattern. The depth and severity of poverty increased from 1990/91 to 1995/96 and decreased between 1995/96 and 2002 in the country as a whole.

Further, this trend was observed in both the rural and estate sectors. In the urban sector, in contrast, the depth and severity of poverty declined throughout the time period 1990/91-2002. One important point to note in this regard is that Sri Lanka has the poverty at a level which shows higher poverty ratio (based on national poverty line). If we choose to accept the international poverty line of USD 1.0 a day, poverty ratio in Sri Lanka declines to a level of 15 percent. Furthermore, a poverty gap ratio of 2.6 percent shows that Sri Lanka can lift its people out of poverty with a relatively low fiscal effort.

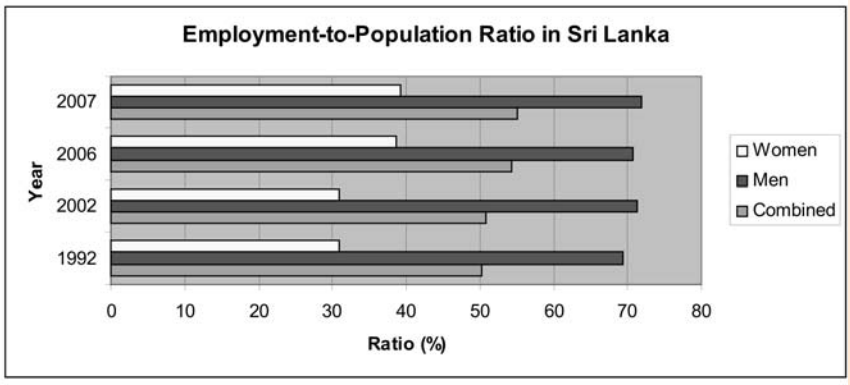
Figure: Trends in the incidence of Head Count Poverty Ratio in Sri Lanka



Source: Based on Datasets of Department of Census and Statistics, Government of Sri Lanka, 2004.

It is of interest to note here that Sri Lanka has been able to manage its poverty ratio (based on international yardstick of USD 1.0 a day) below 15 percent and the associated poverty gap ratio to miniscule level of 2.6 percent. This spectacular performance is in complete contrast to stagnant employment-to-population ratio and the adverse gender parity scenario on this account as may be visible in the Figure depicted below.

Figure: Trends in Poverty Ratio and Poverty gap in Sri Lanka



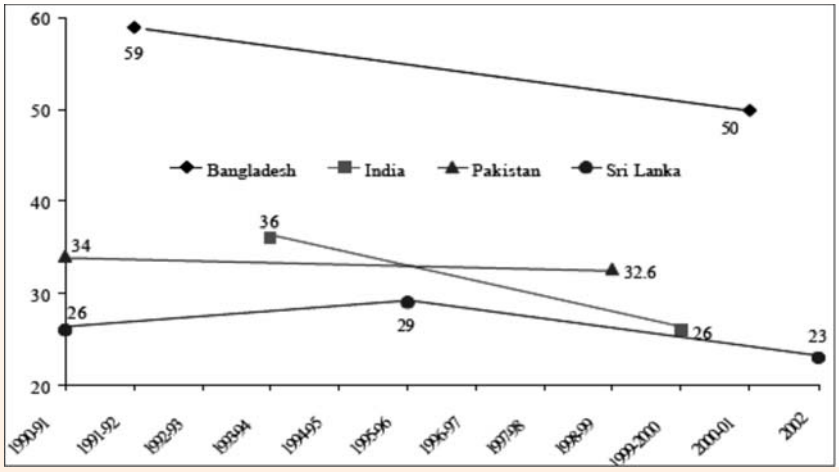
Source: Based on Datasets of Millennium Development Indicators 2009; UNDP.

Performance of Sri Lanka vis-à-vis other SAARC Countries

The figure given below clearly shows the poverty headcount ratios (based on national poverty lines) in Sri Lanka, Bangladesh, India and Pakistan at different points during the 1990s. While there are serious methodological problems in comparing poverty incidence across countries, a broad conclusion about the pace of poverty reduction can be made – viz., that Sri Lanka's overall performance on poverty reduction during the 1990s has been modest and comparable to that of Pakistan, where the poverty headcount ratio fell from only 34% in 1990-91 to 32.6% in 1998-99, but significantly short of the performance of India, where the

poverty headcount ratio fell from 36% in 1993-94 to 26% in 1999-2000 – an annual decline of 1.7 percentage points, or Bangladesh, where the poverty headcount ratio fell from 59% in 1991-92 to 50% in 2000 – an annual rate of decline of about one percentage point. In Sri Lanka, the annual decline in poverty was only about 0.25 percentage points between 1990 and 2002.

Figure: Poverty incidence (%) in the 1990s (national poverty lines), South Asia



Source: Extracted from Sri Lanka MDG Report 2005; UNDP.

Maternal and Child Health and Eradication of Diseases in Sri Lanka

Child Health and Nutrition:

Reducing child malnutrition is a key millennium development goal, as child malnutrition produces a wide and diverse range of adverse economic and social consequences. Malnutrition substantially raises the risk of infant and child deaths, and increases vulnerability to a variety of diseases in later life. In addition, malnutrition impairs cognitive ability and decreases school performance, and lowers labor productivity and lifetime earnings. Combating child malnutrition is of central importance to the future economic and social welfare of countries. Child malnutrition in Sri Lanka is very high. Nearly one in three children aged 3- 59 months is underweight, and more than one in ten children in this age group suffers chronic or acute malnutrition. An International comparison of child malnutrition rates relative to per capita national income, based on a cross section of 113 low and medium-human development countries. This is in sharp contrast to Sri Lanka's celebrated performance on other human development outcomes such as primary education enrollment, adult literacy, infant mortality and life expectancy, where the country performs well above the levels that would normally be expected at its level of per capita income.

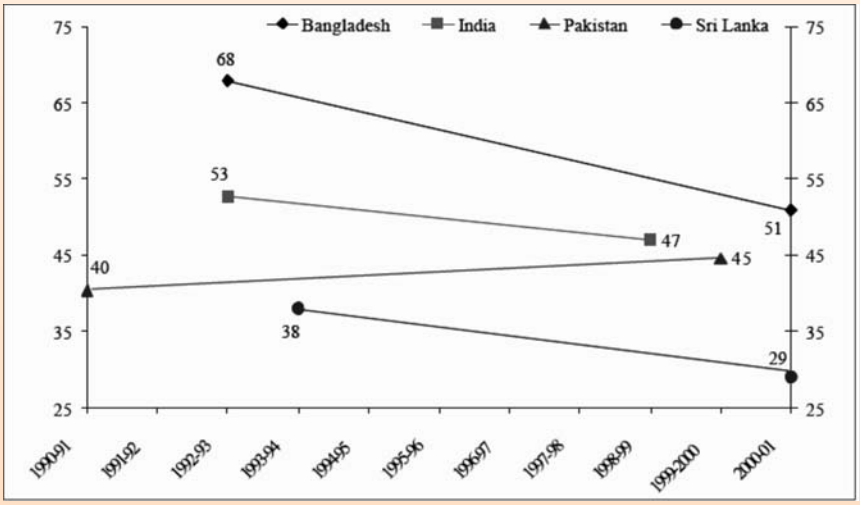
Table: Trends in Child Mortality and Measles Immunisation in Sri Lanka					
	1990	*1995*	*2000*	*2005*	*2006*
Children under five mortality rate per 1,000 live births	32	25	19	14	13
Infant mortality rate (0-1 year) per 1,000 live births	26	21	16	12	11
Children 1 year old immunized against measles, percentage	80	87	99	99	99

Source: Based on Datasets of Millennium Development Indicators 2009; UNDP.

On average, infant mortality rates for females are about 20% higher than those for males, but under- five mortality rates are almost identical. Excess infant mortality among females is observed throughout South Asia, and reflects parental discrimination against their girl children in the allocation of nutrition and medical care. The higher infant mortality for females than for males is surprising in Sri Lanka in view of the high levels of adult female literacy and extensive access to medical facilities and care through much of the country.

How does Sri Lanka's performance on reduction of child malnutrition compare to that of its neighbors in South Asia? The figure below portrays child underweight rates during the1990s in four countries of the region. The only country that performed better than Sri Lanka in terms of reduction in child malnutrition was Bangladesh, where the underweight rate fell by an average of 2.1 percentage points annually. In India, the decline was more modest- 1 percentage point each year- while Pakistan actually saw its child underweight rate increase by 0.6 percentage points annually during the 1990s. However, it should be observed that the decreases in Bangladesh occurred from a much higher underweight rate (68% versus 38% in Sri Lanka). As the underweight rate declines, it is progressively more difficult to achieve further reductions in child malnutrition.

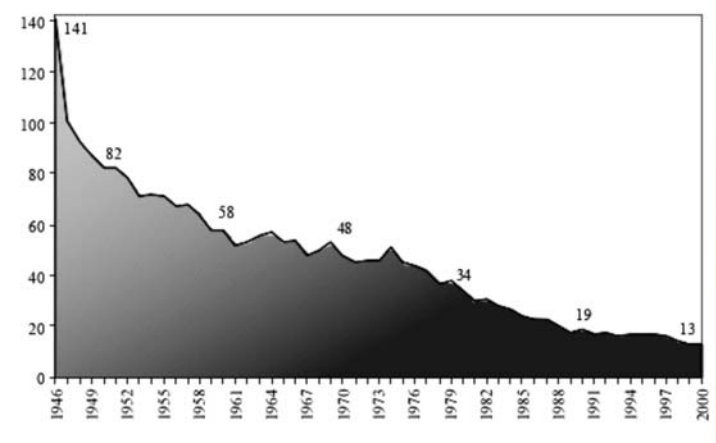
Figure: Rates of child underweight (%) during the 1990s, South Asia



Source: Extracted from Sri Lanka MDG Report 2005

Achieving low rates of infant and under-5 mortality is of central importance for social well-being and human development. Sri Lanka has been extraordinarily successful in reducing its infant and child mortality rates over the last half-century. Indeed, over the period 1946-2000, Sri Lanka has been one of the most successful developing countries in the world in terms of infant and child mortality reduction. The infant mortality rate fell from 141 infant deaths per 1,000 live births in 1946 to a mere 13 deaths per 1,000 live births by 2000 – an annual reduction of 4.2% maintained over more than 50 years.

Figure: Infant mortality rate (per 1,000 live births) during the five Decades



Source: Extracted from Sri Lanka MDG Report 2005

Maternal Mortality and Other Health Indicators

	1991	*1993*	*1996*	*2000*	*2005*	*2007*
Maternal mortality ratio per 100,000 live births					58	
Births attended by skilled health personnel, %		94.1		96		98.5
Contraceptive use among married women 15-49 years old, any method, %		66.1		70		68.0
Contraceptive use among married women 15-49 years old, condom %		3.3		3.7		5.5
Adolescent birth rate, per 1,000 women	33.2	29.9	29.1	31.6	28.0	
Antenatal care coverage, at least one visit, percentage		80.2		94.5		99.4
Unmet need for family planning, total, %				18.2		

Source: Based on Datasets of Millennium Development Indicators 2009; UNDP.

Among the SAARC countries, Sri Lanka and Maldives are outlier cases in the sense that out of 188294 cases of maternal deaths in 2005 in SAARC region, the number of maternal death in Sri Lanka and Maldives are 173 and 8, respectively.

In Sri Lanka, significant declines in maternal mortality have occurred as more women have gained access to family planning and skilled birth attendance (98.5 % in 2007) with backup emergency obstetric care. The country has achieved unprecedented decline in MMR (to the tune of just 58 in 2007) in the space of a decade. Severe shortages of trained health personnel and lack of access to reproductive health are holding back progress in all other SAARC countries as may visible in the following Table.

Table: Comparison of MMR of Sri Lanka vis-à-vis other SAARC Countries

	Number	*Ratio (Mortality per 100,0000 Live Births*
Afghanistan	22180	1800
Bangladesh	22966	570
Bhutan	55	440
India	122686	450
Maldives	8	120
Nepal	6527	830
Pakistan	13699	320
Sri Lanka	173	58
SAARC	**188294**	**497**

Source: Extracted from Sri Lanka MDG Report 2005

The most effective way to reduce maternal mortality is to have births attended by skilled health personnel. Countries with high MMRs tend to have a low proportion of births assisted in this way – 14 per cent in Afghanistan (with MMR 1800), 20 per cent in Bangladesh (with MMR 570) and nearly 96 percent in Sri Lanka (MMR being 58 in 2005).

Trends in Incidence, Detection Rate and Success Rates of DOTS for Tuberculosis in Sri Lanka

Table: Trends in Prevalence and Treatment of TB in Sri Lanka

	1990	*1995*	*2000*	*2001*	*2005*	*2006*	*2007*
Tuberculosis incidence rate per year per 100,000 population	60.5	60.5	60.5	60.5	60.5	60.5	60.5
Tuberculosis prevalence rate per 100,000 population	107.7	97.1	106.6	98.7	74.7	80.3	79.4
Tuberculosis death rate per year per 100,000 population	10.1	9.6	10.1	9.4	6.9	7.9	7.8
Tuberculosis detection rate under DOTS, %		61.9	67.3	72.4	93	84.8	85.2
Tuberculosis treatment success rate under DOTS, %		79.4	77	79.6	86.3	87.0	

Source: Based on Datasets of Millennium Development Indicators 2009; UNDP.

In so far as prevention and control of fatal diseases are concerned, Sri Lanka has been able to bring the Tuberculosis prevalence rate down to 79.4 per 100,000 populations in 2007, a remarkable achievement by South Asian standards. In addition TB detection rate under DOTS has improved significantly from 61.9 percent in 1995 to a level of 85.2 percent in 2007 as may be suggested by the figures provided in the Table portrayed above. Tuberculosis treatment success rate under DOTS have shown a gradual improvement from 79 percent in 1995 to 87 percent in 2007. We do not have adequate figures to analyze the trends in HIV/AIDS prevalence, detection and treatment.

Achieving Universalization of Elementary Education, and Gender Parity in Sri Lanka

Investment in education has been at the heart of Sri Lankan government policy to increase national income, reduce poverty and promote human development for several generations. In consequence, the country has attained high levels of primary school enrollment and completion. The impact of schooling on economic welfare and social-well being are well known. Investment in schooling constitutes an extraordinarily powerful instrument to enhance earnings, decrease poverty and promote social mobility; increase health, nutrition and life-expectancy; and produce sustained, long-term human development.

School Enrolment and Gender Parity

About 1.7 million children are enrolled in the primary grade cycle (grades 1-5). Net primary school attendance in Sri Lanka is about 96%, with approximately the same percentage of boys and girls in the age group 6-10 years attending school. Sri Lanka had already attained a high level of net primary attendance, 95%, by 1990/91. This attendance rate rose to 96% in 1995/96, and held steady through 2002, the period for which the latest datasets are available for Sri Lanka.

Table: Net Primary School Attendance Rates (%), by Sex, 1990/91-2002

	1990/91	*1995/96*	*2002*
Both sexes	95	96	96
Boys	95	96	96
Girls	95	95	96

Source: World Bank estimates based on the Household Income and Expenditure Survey; Department of Census and Statistics, 2002.

In so far as the Net Enrolment Ratio at primary education level is concerned, in 2003, Sri Lanka almost achieved the goal of Universal enrolment for boys and girls, both. This is remarkable achievement, especially the 100 percent enrolment of girl students, as reflected in the table given below. Primary school completion rate in Sri Lanka is almost universal for both boys and girls. Literacy rates for youth in Sri Lanka is at a spectacularly high level of 97.6 % in 2005.

Table: Enrolment, Primary School Completion Rates and Gender Parity in Achievements in Sri Lanka					
	1991	*2001*	*2003*	*2005*	*2007*
Total net enrolment ratio in primary education, both sexes			99.7	96.7	
Total net enrolment ratio in primary education, boys			99.4		
Total net enrolment ratio in primary education, girls			100		
Primary completion rate, both sexes	102.4			107.5	104.3
Primary completion rate, boys	102.6			107.3	104.2
Primary completion rate, girls	102.2			107.8	104.5
Literacy rates of 15-24 years old, both sexes, percentage		95.6			97.6
Women to men parity index, as ratio of literacy rates, 15-24 years old		1.01			1.01

Source: Based on Datasets of Millennium Development Indicators 2009; UNDP.

The case of Sri Lanka presents an example of most equitable society in so far as access to primary schooling is concerned. The high net primary school attendance and completion rates and near gender parity in enrollments can be attributed to a number of factors, including strong household demand for schooling and progressive government policies. The government of Sri Lanka has several policy initiatives to promote primary school attendance and completion. These include the establishment of a complete network of tuition-free public schools which provide access to primary schooling for all children within 3 kilometers (2 miles) of their homes, free school uniforms and subsidized transport to attract children to school, and enrollment drives at grade 1 to draw out-of-school 6 year olds into the school system. Strong household demand is reflected in the primary school attendance rates by consumption quintile; these data show that 95% of children from poor households and the lowest quintile attend school.

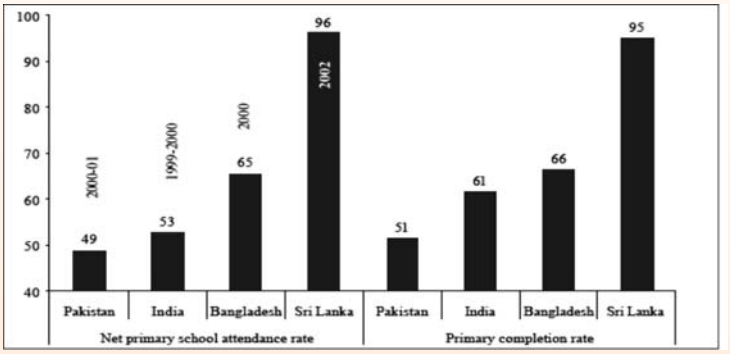
Table: Primary School Enrolment by Consumption Quintile (2002)			
Per capita consumption quintile	*Combined*	*Male*	*Female*
Bottom	95	95	95
Second	96	95	96
Third	96	96	96
Fourth	96	97	96
Top	97	97	97
All	96	96	96

Source: World Bank estimates, based on the Household Income and Expenditure Survey, Department of Census and Statistics, 2002

Performance of Sri Lanka in Primary Education vis-à-vis other SAARC Countries

As is the case with socio-economic and human development indicators, Sri Lanka outperform all other SAARC countries in providing access to primary education and ensuring gender parity in literacy and completion of education cycle. It may be observed from the picture portrayed below, the net primary school attendance rates and the primary completion rates in the four large countries of South Asia. As may be clear from the figure, Bangladesh Pakistan, and India have net primary school attendance rates that are in the 49-65% range – more than one- third below the comparable figures for Sri Lanka.

Figure: Performance of Sri Lanka vis-à-vis Other SAARC countries in Net primary attendance rates and primary School completion



Source: Attaining MDGs in Sri Lanka, World Bank (2005)

Given the high net primary school attendance and completion rates, the Sri Lankan education system faces two major challenges. First, the 4% of children aged 6-10 who do not attend school and the 5% of primary aged children who do not complete primary school have been fairly constant from 1995/96 onwards to 2002. As in other countries, the Sri Lankan government strategy is to attract these children into special and non-formal education programs. Second, the quality of schooling is important, and improving school quality has become the central focus of government policy (World Bank, 2005).

Trends in Progress towards Environment Sustainability and Access to Improved Water and Sanitation Facilities in Sri Lanka

Environmental sustainability means managing and protecting our natural resources so that they will still be available for future generations. Most of the world's rural poor depend on the natural environment for survival and are most affected by its exploitation. The Key Indicators to measure the progress towards this target include: Proportion of land area covered by forest (%), ratio of area protected to maintain biological diversity to surface area (%), Carbon dioxide emission (per capita) and consumption of ozone depleting CFCs (ODP tons).

Regardless of recent policies aiming at protecting natural resources, such as the National Forest Policy and the National Wildlife Policy, deforestation continues at an alarming rate. Forest cover decreased from 80% in 1881 to 36.4% in 1990, which further deteriorated to 32 percent in 2000. Sri Lanka is considered to be one of the biodiversity hotspots in the world. At present, 14.3% (for the latest year 2006) of land is under biodiversity protection, compared to 8% in the 1950s. Increasing carbon dioxide emissions are of great concern, especially in urban and industrialized areas. The transport sector was responsible for the highest percentage of CO2 emissions, however nowadays it is the power sector.

One indicator used to measure the loss of natural resources is the prevalence of the use of solid fuels. In Sri Lanka, 80.3% of the national population uses solid fuel, mainly in the rural and estate areas. (MDG Country Report, 2005, Sri Lanka).

Table: Trends in Indicators of Water & Sanitation Facilities and Environmental Sustainability in Sri Lanka

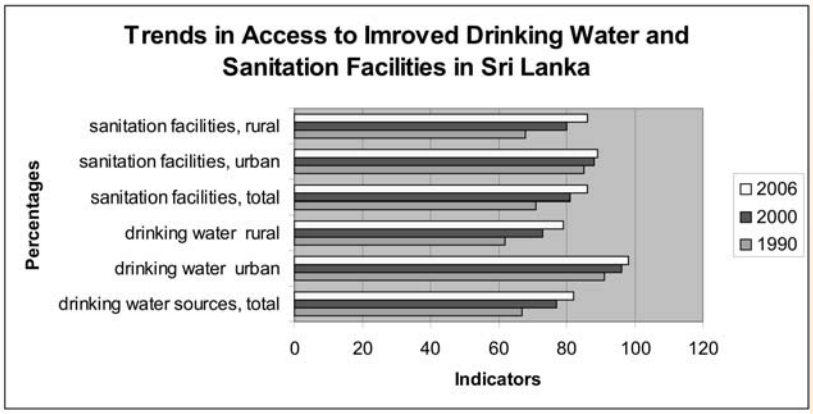
	1990	*1995*	*2000*	*2006*	*2007*
% of land area covered by forest	36.4		32.2	29.9 (2005)	
Carbon dioxide emissions (CO2), thousand metric tons of CO2 (CDIAC)	3762	5796	10160	11876	
Carbon dioxide emissions (CO2), metric tons of CO2 per capita (CDIAC)	0.22	0.32	0.54	0.62	
Consumption of all Ozone-Depleting Substances in ODP metric tons	218.2	552.2	252	117.7	77.6
Consumption of ozone-depleting CFCs in ODP metric tons	209.5	520.5	220.3	105.3	62.2
Terrestrial and marine areas protected to total territorial area, %	13	13.3	14.3	14.3	14.3
Terrestrial areas protected to total surface area, %	19.1	19.2	20.6	20.6	
% of the population using improved drinking water sources, total	67	71	77	82	
% of the population using improved drinking water sources, urban	91	93	96	98	
% of the population using improved drinking water sources, rural	62	67	73	79	
% of the population using improved sanitation facilities, total	71	76	81	86	
% of the population using improved sanitation facilities, urban	85	86	88	89	
% of the population using improved sanitation facilities, rural	68	74	80	86	
Slum population as percentage of urban, %	24.8		13.6		

Source: Based on Datasets of Millennium Development Indicators 2009; UNDP.

Access to Improved sources of Water and Sanitation

As may be evident from the table portrayed above (and, of course, in the Figure depicted below), the proportion of the population using improved drinking water sources has shown significant increase in the last fifteen years, from 67 percent in 1990 to 82 percent in 2006. The same ratio shows significant divergence between rural and urban areas. In rural Sri Lanka, the proportion of population having access to improved water sources have increased from 62 percent in 1990 to close to 79 percent in 2006, while in urban part of Sri Lanka, the ratio moved from a level of 91 percent to 98 percent over the same time period. If this trend continues for another seven or eight years, Sri Lanka may be able to manage 100 percent access to safe drinking water for its citizen.

Figure: Trends in Access to Water and Sanitation Facilities in Sri Lanka



Source: Based on datasets of Millennium Development Indicators 2009; UNDP.

Access to sanitation services increased in Sri Lanka by 15 percentage points between 1990 and 2006, benefiting in 2006, 86 % of the population. However, dichotomies are recorded, to some extent, also in this area, with rural Sri Lanka having 86 % of households with access to safe sanitation while in urban areas, the proportion is 89 percent.

Thus, in order to secure safe sanitation facilities, both in urban and rural areas, Sri Lanka has to devote more resources (human as well as financial) and efforts to achieve the goal of universal provisioning of access to improved sources of sanitation.

Concluding Comments

Sri Lanka, a small Island Country may be described as a model for state led growth and as a state that challenges the link between high income and high social indicators. Sri Lanka has high social development indicators and low incomes. Though this fact may suggest a paradox, but for our purposes this incongruity of income level and human development indicators can be treated as a proof that

greater state intervention in provisioning of public health care services and quality education with adequate focus on gender parity can lead to higher social indicators.

As may be clear from the preceding analysis of indicators of SDGs, Sri Lanka is an outlier among SAARC countries. The indicators relating to poverty ratio and poverty gap (be it international yardstick or national poverty line) place Sri Lanka at a comfortable position vis-à-vis other neighboring countries. Sri Lanka has been able to reduce the head count poverty ratio below the level of 15 percent (based on poverty line of USD 1.0 per day). Even using national poverty line as the yardstick, Sri Lanka has succeeded in keeping the ratio around 20 percent. The dramatic performance of Sri Lanka in poverty reduction can be explained by the drastic reduction in poverty ratio in rural areas where the figure plummeted to paltry level of 7.9 percent in 2002 from a high proportion of 22 percent in 1992. Not only that it has been able to manage poverty ratio at a low level, poverty gap ratio (a measure of severity and depth of poverty) is also at a startlingly low level of 2.6 percent. Only flaw that can be gauged from the perspective of livelihood security in Sri Lanka is that overall employment-to-population ratio has remained stagnant at 50 percent while those of the women around 30 percent over the period between 1992 and 2006.

Sri Lanka's celebrated performance on other human development outcomes such as primary education enrollment, adult literacy, infant mortality and life expectancy, where the country performs well above the levels that would normally be expected at its level of per capita income are exemplary by any standards. The only lacuna in this respect is that nearly one in three children aged 3- 59 months is underweight, and more than one in ten children in this age group suffers chronic or acute malnutrition.

CHAPTER NINE

Concluding Comments and Recommendations

Major Findings of the Report

This report presents an assessment of progress of SAARC countries towards realizing the development goals as envisaged in SDGs/ MDGs. The Millennium Declaration set 2015 as the target date for achieving most of the Millennium Development Goals (MDGs), which established quantitative benchmarks to halve extreme poverty in all its forms while SDGs points towards more progressive achievements of targets by 2012. The trends of poverty reduction in South Asian countries show that proportion of people living on less than $1.25 a day has been reduced from 49 % in 1990 to 39 % in 2005, reflecting an average reduction of 0.65 % per annum. If this trend of poverty reduction continues, South Asian region will achieve MDG targets of reducing poverty ratio to 24.5 % by 2025, let alone the issue of meeting the SDGs targets by 2012.

Among major SAARC countries, only the progress made by Sri Lanka is placed at a comfortable with poverty ratio at 14% on track (with a head count ratio of less than 15%). Another relevant indicator showing the depth of poverty is the poverty gap ratio. The trends in the ratio (which moved downwards from 14 % in 1990 to 10 % in 2005, USD 1.0, PPP) suggest that the region will hit the target of 7 % by 2020 if the present trend persists. Sri Lanka is placed at a comfortable position with a poverty gap ratio of 2.6 percent in 2002 (based on national poverty line).

Almost all country of South Asian region have given high priority in policy implementation (this in itself do not suggest high priority to education in public spending) to education to achieve the goals of MDGs/SDGs. To achieve this goal, countries have to enroll children in schools and ensure that they complete the full course of schooling. Measured on this yardstick, SAARC countries have performed well. Trends in NER for primary education (from 79 in 1990 to 90 in 2007) suggest an average growth in NER to the tune of 0.6 % per annum. If this trend persists, SAARC countries as a whole will be achieve universalization of primary education (achieving 100% enrolment) by not before 2020. However, it quite satisfying to note here that SAARC region has been able to achieve 90 % enrolment in primary schooling.

The central point of concern is that though progress is being made towards universal primary education. Still, more than 10 per cent of children of primary-school age are out of school. It may be noted here that nearly 32 % of the out-of-school children in South Asia have never had any contact with formal education. It may be worthwhile to record here that in many countries, improvements in school enrolment have been associated with increases in national spending on education, which could be dealt a serious blow as a result of the global economic crisis. Demographic trends may also affect achievement of the goal, since population growth usually puts increased pressure on the resources allotted to education.

The large number of out-of-school children is especially worrisome because of the impact it will have on the other MDGs. Evidence shows, for instance, that an increase in the share of mothers with a primary or secondary education is associated with a reduction in the child mortality rate, and that educated parents have better nourished children. Parental literacy also plays a role in whether children attend school. Thus, it goes without saying that that all children at the official entry age for primary school have access to education by 2010.

Access to education, however, is only part of the solution. Completion of a full course of primary schooling is necessary to achieve universal primary education. Millions of children start school but eventually drop out. In many SAARC countries, school systems are chronically underfinanced and under-resourced and often fail to deliver a high quality education. Out of every 100 out-of-school children, 63 are a dropped out children from the formal school system which suggest a dismal level of incentives for completing primary schooling. This issue is reflected in the fact that proportion of pupils starting grade 1 who reach last grade of primary schooling is 80.6 % in 2007, a low level of achievement comparable to the performances of Sub Saharan African countries.

As per MDG Report 2009, every year, 536,000 women and girls die as a result of complications during pregnancy, childbirth or the six weeks following delivery. Almost all of these deaths (99 per cent) occur in developing countries. Maternal mortality is among the health indicators that show the greatest gap between the rich and the poor- both between countries and within them. Half of all maternal deaths (265,000) occur in sub-Saharan Africa and another third (187,000) in Southern Asia. Together, these two regions account for 85 per cent of all maternal deaths. In proportional terms, maternal mortality rate has declined (from 620 in 1990 to 490 in 2007) at too slow a pace to achieve the target of 210 by 2015. Thus, achievement of target of reducing MMR by two-third in SAARC countries by 2010 as envisaged in SDGs seems to be a distant dream.

Many health problems among pregnant women are preventable, detectable or treatable through visits with trained health workers before birth. But, access to such health care facilities in SAARC countries is at a dismally low level. The progress of South Asian region in provisioning of facilities relating to births attended by skilled health personnel leaves much to be desired. While globally this ratio above 60, for SAARC countries as whole, this ratio is only 40 which is a serious cause of concern.

Globally, child mortality has fallen to a record low (UNICEF, 2008), but the situation in South Asia is still of great concern. One of the highest priorities for governments across the region must be to reduce the number of children dying before their fifth birthday. There are two main indicators here, one for infant mortality (under 12 months) and one for under-five mortality. The target is to reduce under-five mortality by two thirds. Deaths in children under five have declined steadily worldwide. In 2007, the global under-five mortality rate was 67 deaths per 1,000 live births, down from 93 in 1990. The South Asian region is moving too slowly to meet this vital goal. As the discussion pursued in previous chapters indicate, the rate for the region as a whole is still around 77 deaths per thousand live births (a significant progress from the level of 122 in 1990) – which is almost double that of Latin America and the Caribbean.

Antenatal care is an essential safety net for healthy motherhood and childbirth, where the well-being of both the prospective mother and her offspring can be monitored. The performance of South Asian countries has been far from impressive on this count and there are significant regional differences in the trends values of this indicator. As per the estimates of 2007, while Sri Lanka has been able to record virtual universalisation of antenatal care coverage (at least one visit), to the tune of 99.4 percent, Bangladesh (51.2) and Pakistan (36%) are still struggling to widen the outreach of antenatal care services to pregnant women. The case of India presents a mixed picture which has succeeded in widening the coverage of antenatal care from a figure of 49.1 % in 1990 to 74.2 % in 2007, registering an annual growth of roughly 1.5 %. If this trend rate continues, it will take at least another 17 years or so to achieve the universal coverage of antenatal care (at least one visit, keeping aside the issues of four visits or more in India. The same prediction holds good for other major countries of SAARC region except for Sri Lanka and Maldives.

Another major disease of concern across the region is tuberculosis. As in the rest of the world, both the prevalence and the death rate from tuberculosis have started to decline and most parts of the region are on track to meet the goal. As shown in previous chapters, the prevalence is around half that in Sub-Saharan Africa. While the MDG goal is to reverse the spread of TB, to give an indication of the scale of progress, the target selected here is to halve the prevalence by 2015, as set by the Stop TB Partnership. Frequent instances, widespread prevalence and subsequent deaths on account of TB have generated much vigorous policy response across the board. Given the proactive and meaningful intervention by respective governments in SAARC region, number of tuberculosis cases per 100,000 populations (excluding people who are HIV-positive) has declined appreciably from a high figure of 543 in 1990 to a relatively moderate magnitude of 268 in 2007.

On the one hand, countries like Bangladesh (from 263 in 1990 to 224.8 in 2007), Pakistan (stagnant at 181.3), India (stagnant at 167.8), Sri Lanka (stagnant at a fairly low level, by SAARC country standards, at 60.5 have made virtually no appreciable progress in reducing TB incidence, on the other hand, Afghanistan (from a high figure of 247.8 to 161.3 in 2007), Bhutan (from 207.2 to 95.7), and

Nepal (from 243 in 1990 to 176.4 in 2007) have made noticeable progress in reducing the incidence (new cases) of TB during the last decade and a half. On average, SAARC countries are on right track to achieving the SDGs as well as MDGs of reducing TB cases by half by 2010 and 2015, respectively.

The progress of SAARC countries with respect to the target of eliminating gender disparity in primary and secondary education (preferably by 2005) and in all levels of education no later than 2015 is a mixed bag of outcomes. For SAARC region as a whole, girls' primary school enrolment in relation to boys', the ratio has moved upwards from a level of 84 % in 1998/99 to 95 % in 2007. Going by this trend rate of gender parity index in primary schooling, SAARC countries will achieve the targets of SDGs and MDGs by 2010, even though the target of eliminating gender disparities in primary and secondary education by 2005 was missed.

Notwithstanding the satisfactory performance of South Asian countries in achieving perfect gender parity in primary schooling, their performance in eliminating gender differentials in secondary education enrolment is not up to the mark. The gender parity index in secondary education in SAARC region as whole increased at a slow pace, from 74 % in 1999 to 85 % in 2007, registering an annual average growth of 1.4 %. If this trend persists, these countries will be able to eliminate the said gender differential by 2017, thereby missing the MDGs target by a whisker. If more vigorous efforts are carried out, achievement of MDGs is very well within the reach, if not the target of SDGs. Women are still at a significant disadvantage in tertiary education, and in this case, the region is far from achieving gender parity.

In so far as progress of indicators pertaining to economic empowerment of women is concerned, the performance of SAARC countries may be viewed as dismal by any standards. Globally, the share of women in paid employment outside the agricultural sector has continued to increase marginally over the years. But in South Asian countries, along with those of Northern Africa, Western Asia and Sub Saharan Africa, paid employment opportunities in non agricultural occupation for women continues to expand slowly and remains meager, moving at creeping pace from 12 % in 1990 to dismal figure of 19 % in 2005.

If we look at the distribution of total employment by job status, the situation of women is even more alarming. Women remain more vulnerable on the job front, assuming the largest share of unpaid work and failing to secure paid jobs outside agriculture. As low as 16 % of women workers in SAARC countries are wage paid and salaried workers with substantial cross-country variations. Apart from Sri Lanka, for example, where the proportion is 40 per cent, across South Asia the figure is generally lower: in India 18 per cent, Nepal 15 per cent; and in Pakistan only 10 per cent. On other side, the remaining 84 % of women workers are engaged either as contributing family workers or as own-account workers. These unpaid family workers freely give their time to family owned businesses. The large share of unpaid jobs adds to the already heavy burden of unpaid work carried out by women in households which is not reflected in official labor statistics.

An important gender indicator relating to political empowerment is the proportion of women in national parliaments. Globally the proportion in single or lower houses of parliament tends to be quite low, around only 17 per cent. While in Scandavian and other developed countries, the share of women in parliament is roughly above 25 percent, the ration for South Asian countries well below 15 percent. Some countries in the region have gone beyond this – achieving more than one-quarter, for example, in Afghanistan (27.7 % in 2009), Nepal (33.2 %.) and Pakistan (from 2.3 in 1999 to 22.5 in 2009), basically on account of enactment of legislation pertaining to reservation of certain percentages of seats for women. But in other South Asian countries, the rates are surprisingly low, the relevant figures for India are (10.7 %), and Bangladesh (from 14.8 % in 2006 to 6.3 % in 2009), respectively.

It may be pertinent to emphasize here that in spite of recent improvement in system of gender disaggregated data collection and compilation at various levels, monitoring development goals from a gender perspective is hindered by the restricted number of indicators and a shortage of quality data. The only indicator on gender equality and women empowerment that has a numerical target is parity in educational enrolment. However, there in nothing in this indicator to take account of quality of learning. Despite of being a helpful indicator of women's participation in the modern sectors of the economy, the index of women's share of paid nonagricultural employment do not capture women's unpaid economic activities, which are a mainstay of the rural sector and of the care economy.

Multiple dimensions of environmental protection are becoming an increasingly critical issue for this region – whether in terms of the deterioration in the natural environment, or the lack of access to clean water and sanitation. As has been suggested in empirical research, environmental deterioration is closely linked with poverty. The continued loss of natural forests is reducing critical ecosystem services, including that of carbon sequestration. This has serious implications for global warming since globally deforestation is associated with 18 to 25 per cent of greenhouse gas emissions – a higher proportion than for transportation. Both total CO2 emissions and energy use per capita in the South Asian countries remain far lower than in developed countries. But since emissions are coupled with economic growth they are likely to rise.

In so far as halving the percentage of people without access to safe drinking water is concerned, South Asian countries have shown spectacular progress during the last decade and a half. As we know, access to improved drinking water sources is predominantly a rural problem and the region has been able to reduce the proportion of people using unimproved sources of drinking water, from 32 % in 1990 to a comfortable figure of 16% in 2006 and SAARC countries are ahead in achieving the target of halving the proportion. If this trend continues, these group countries will be able to manage 100 % coverage by 2020. The only exception in this regard is Afghanistan, the worst performer wherein roughly 80 percent of populations do not have access to safe drinking water.

The lack of clean water is closely linked to access to sanitation since the pollution of groundwater, rivers and other water sources with faeces further heightens the risks of contaminated drinking water. In the SAARC region, as elsewhere in the world, access to improved sources of sanitation is generally drastically lower than access to clean water. Notwithstanding the sterling performance of South Asian region in meeting the target vis-a-vis access to improved sources of drinking water, access to proper and improved sanitation facilities provides a dismal picture for the South Asian countries as a whole. Every two out of five people in the region have access to improved sanitation facilities with wide ranging divergences across countries. Sri Lanka (86 %), Maldives (59 %) and Pakistan (58 %) are among the better performers while India (28 %), Afghanistan (30 %), Bangladesh (36 %) belong the category of dismal performers. Apart from Sri Lanka (which already have achieved SDGs target of improved sanitation as well as MDG targets), other major SAARC countries do not have even a remote chance of achieving the targets, if this trend rate persists.

Thus it is clear from the foregoing discussion that SAARC countries, in general, are on track or pretty close to achieve the targets of achieving universal enrolment at primary school level with gender parity, reducing incidence and prevalence of Tuberculosis, and immunization of children against measles. They are also on course to achieve targets of universal access to safe drinking water and other environment related indicators such as reduction of emissions of CO2, consumption of ozone depleting substances. However, they fail miserably in moving towards the target of attaining universal enrolment in secondary education and the associated gender parity, reduction in head count poverty ratio and poverty gaps and enhancing the share of women in paid non agricultural jobs. The record card of SAARC countries are also rather unflattering with respect to targets of reduction in maternal and infant mortality rates, increasing the coverage of antenatal care and child immunization and provisioning of adequate family planning related materials.

Before moving towards the issues of charting out of a course of action needed to accelerate the pace achievement of goals, it may be worthwhile to ask whether the respective governments are committed towards achieving socio-economic development of their people? Does the social sector command enough financial resources so that existing bottlenecks are removed? Is there any trade off between social sector spending and military spending of the government? Does the government really prioritize the interests of common people vis-à-vis the interests of business class? Though this is not the appropriate place to get into a detailed examination of these issues, we can add here some facts that may provide critical insights towards the way forward.

Given the fixed pool of financial and physical resources, enhanced spending on military related items necessarily makes a dent into the resources available for civil expenditure.

Military expenditure has risen substantially, across the board. Even in South Asian countries which have to devote progressively greater resources to improve the life

chances of its people, military expenditure increased from 21.9 billion USD in 1990 to 30.9 billion USD in 2008, registering a growth of 41 % in real terms over the said period. We acknowledge that matters relating defense is tricky one and this is not the appropriate platform to assess the defense requirements of the countries. Neither we are suggesting here that defense spending is waste of resources as every dollar spent on domestically produced goods is a part of the individual's income and have a multiplier effect on national income and employment. What we intend here to highlight is that South Asian countries have to bridge the wide developmental gaps and for these gaps to filled, we need more public resources which can be mobilized by shifting a certain fraction defense expenditure towards social sector programmes.

It may be noted, however, that defense expenditure is among the items that are a drag on financial resources, but not the only one nor the biggest one for that matter. Take the case of India. India spends roughly 22 percent of the government expenditure towards interest payments (a gigantic figure to the tune of 2, 25, 00000 million rupees, far more than the spending by Ministry of defense services). It should be highlighted here that since the adoption of policy of liberalization of interest rates, interest has risen on government borrowings and there has been consequent rise in interest payments of the government. Another important aspect need to be highlighted here is that a gigantic sum (to the tune of Rs. 4000000 million) of potential government revenues are foregone through the plethora of tax exemptions to the corporate sector while food and fertilizer subsidies (Rs 1,110000 million), though much emphasized in public discussions as a significant drag on government resources, are roughly a quarter of the tax expenditures towards the corporate and business sector.

In so far as the issue of mobilization of fiscal resources for social sector (including education, health care, supply of water and sanitation, provisioning of means of livelihood etc.) are concerned, it seems, thus, obvious to claim here that interest payments and tax expenditures are a more serious drag than the spending on defense. Off course, if we are interested in disarmament for the world, spending cut in defense has to be the case, in unequivocal terms. However, if the target is to mobilize resources for human development, focus has to be shifted towards iniquitous transfers of resources towards corporate and wealthier class though the means of tax expenditure and rising interest payments should be focal point of academic attack.

Be that as it may, the truth is that SAARC countries are inflicted with severe developmental deficits, as reflected in dismal values of indicators across MDGs/ SDGs goals and urgent action is the need of the hour. To address the bottlenecks in achieving development goals in a time bound manner, we suggest following recommendations:

- ***"Five will Thrive"***: We believe that access to basic needs (including food, clothing and shelter) has to be ensured for all people. SAARC countries are struggling to keep poverty ratio below 40 %, measured on the yardstick of 1.25 USD per day. Each government of region has to allocate adequate funds

towards employment creation schemes, food for work programmes, and supply of essential commodities at affordable prices for the poor so that they can be brought out of poverty trap. For this, we recommend budgetary allocation of, equivalent to 5 % of Gross Domestic Product (GDP) towards meeting the ends of livelihood sustainability of the people.

- ***"Four will Free":*** For majority of SAARC countries (except for Sri Lanka), health indicators including TB prevalence, Maternal and child mortality rates, access to antenatal care and prevalence of institutional births present a sorry state of affairs. There is an acute need of substantial public investment in provisioning of quality health care services for all. Indeed, as the experience show, a substantial health shock pushes people hitherto non poor people into the tarp of poverty and recurring shocks keeps them marred in poverty. Hence expenditure on health can be of great help in eradication of poverty. Give this back drop, we demand that 4% of GDP should be devoted towards provisioning of public health care services for all.
- ***"Six will Fix":*** Even though SAARC countries have been able to meet the targets of enrolment ratio and the associated gender parity index, secondary and teriary education enrolment and the issue of gender parity remains serious cause of concern. Further the quality of education remains an enigma for majority of the SAARC nations. Furthermore, even at primary school level, as per official estimates, roughly 10 percent of the children are out of school, independent estimates point towards much higher figures. In the backdrop massive level of out of school children and low level of enrolment ration in secondary and tertiary education, we propose that six % of GDP should be allocated towards funding of quality education for all.
- Even though there have sufficient progress towards provisioning of access to safe drinking water facilities (except for Afghanistan) in SAARC region, access to proper sanitation facilities, both in urban and rural areas, remains a massive challenge for almost all countries in the region. There is an acute need to initiate a mission mode programme with adequate public financing.
- Education, health care services and provisioning of supply of safe drinking water and sanitation facilities are public goods which have extensive positive externalities in the sense that marginal social benefits exceed marginal social cost. If these services are privatized, there be under provisioning of these services vis-à-vis socially optimum level. Hence we oppose privatization of these services and the concept of the so-called public private partnership. Instead, we recommend that these services should be provided by the government with universal access.
- We do not buy the argument that there is a trade off among meeting different development goals. All development goals are complimentary in nature and adequate funds can be arranged without much difficulty. On the one hand, countries of the region are loitering lots of resources in the name of giving incentives to the corporate sector while on the other hand social sector

expenditure are being compressed to attain an arbitrarily imposed targets of fiscal rectitude. After the implementation of neo-liberal reforms in SAARC countries since the early 1990s, the governments have opened its market for imported products and reduced the prevailing custom duty rates to a ridiculously low level, thereby loosing enough resources from custom duty. In addition, unchecked amount of cheap imports resulted in displacement of domestically produced goods for imports which, in turn, resulted in decline in trend growth of excise duty collections. Thus, the governments have pursued fiscal and trade policies under the guidance of multilateral agencies (including the World Bank, IMF and WTO) which jeopardized the potential of revenue generation to meet the financing of developmental programmes. Given this backdrop, we urge that financing of development programmes to meet the targets envisaged in SDGs/MDGs should not be curtailed to attain the goals of arbitrary and self imposed targets of fiscal prudence. There is no such thing as limit to government financial resources (as long as it has sovereign power to tax and create new money).

- Deficit in governance is among the major factors that impede the achievement of SDGs/ MDGs in South Asian region. As a whole, the South Asian countries are unable to face the challenges ahead because of lack of "good governance". In those countries which have functioning democracies, the ruling parties often do not follow the rules of the game. Of course, countries like India and Sri Lanka had planned development (e.g., the Five Year Plans in India) and were able to achieve substantial progress. Political parties based on religion, caste, ethnicity or region follow sectarian policies. Moreover, bureaucracies tend to be status quoist, and promote corruption in league with political leaders and contractors. We demand that the government of these countries deliver transparent administration and corruption free environment so that intended objectives of developmental schemes are realized.
- Another important factor impeding the achievement of SDGs/ MDGs in South Asia is the continuing cycle of conflict and civil strife. Between 1994 and 2003, 1,905,000 people lost their lives due to large-scale conflicts in South Asia. Poverty and conflict are inextricably intertwined. Where rule of law breaks down, it is the poor who become the victims, with women bearing the brunt of the violence. There is an acute need for cooperation and partnership building among SAARC countries to achieve the developmental goals collectively.
- Gender based inequality across development indicators is rampant in South Asia, and it is a serious roadblock to achieving the SDGs/ MDGs. As we have observed, only 16 percent of women workers are engaged in paid non agricultural jobs and the rest are employed as own account/family workers which is unpaid. To ensure economic empowerment of women, enabling legislation should be enacted so that women do not face discrimination in job markets. In a similar vein, political empowerment of women may be enhanced through reservation of certain fraction of seats in national parliament as happened in Pakistan, Nepal and Afghanistan. We demand that other countries

of the SAAARC region should legislate effecting acts to increase the representation of women in national and State assemblies/ parliament.

- Strengthening of democracy through proactive and substantial decentralization of financial and political powers to local bodies may go a long way in ensuring benefits of developmental programmes permeates to the intended beneficiaries to the best extent possible. Although in various SAARC countries, enabling legislations have already been passed, yet in absence of devolution of financial powers to local bodies has meant that the concept of decentralization remain limited to rhetoric and sloganeering. We demand that all SAARC countries should transfer financial powers to local bodies. In addition, we also urge that local bodies, grass root activists and civil society organizations should be consulted in a meaningful manner in planning, implementation, monitoring and evaluation stages of developmental programmes so that visualized benefits of the programmes are realized as efficiently as possible in an time bound manner.
- As we all know, financial as well as physical resources compared to the multiple uses to which they can be put. This is much true for government financial resources. There has been unfortunate trend in the region that almost every country is increasing the size of the defense expenditure, presumably at the cost of social sector expenditure. We recommend that government should focus on ameliorating the extent of development deficits, instead of investing heavily in the imports of expensive modern defense technology that may be avoided.
- Another important issue in this regard is the loitering of potential public money in the form of tax expenditures. For example, the Government of India, foregone almost 55 % of total tax collections (gigantic figure to the tune of Rs. 40000000 million, roughly 6-7 % of GDP) through providing tax incentives, tax breaks and tax holidays to corporate sector and big firms (think of incentives provided for establishing SEZs!). This lost revenue can be utilized for financing of developmental schemes to achieve the targets envisaged in SDGs/ MDGs. We demand that Government of SAARC countries should stop providing such a blanket exemptions to the corporate sector at the cost of limiting the expansion of development programmes. Those corporate willing to set up their enterprise in remote areas can be provided such tax benefits and certainly not those who are grabbing fertile land for SEZs.

Annex-1: TRENDS IN MDGs INDICATORS IN MAJOR SAARC COUNTRIES

	Bangladesh				India				Nepal				Pakistan				Sri Lanka				South Asia			
	1990	1995	2000	2007	1990	1995	2000	2007	1990	1995	2000	2007	1990	1995	2000	2007	1990	1995	2000	2007	1990	1995	2000	2007
Goal 1: Eradicate extreme poverty and hunger																								
Employment to population ratio, 15+, total (%)	75	71	69	68	59	59	57	55	61	62	61	62	48	47	47	51	52	50	54	55	59	59	57	56
Employment to population ratio, ages 15-24, total (%)	67	58	56	56	47	47	42	39	54	53	48	45	39	36	36	43	32	30	34	35	48	47	43	42
GDP per person employed (annual % growth)	5	4	4	5	2	4	2	7	-1	1	7	0	5	5	1	2	5	6	4	4	3	4	2	7
Income share held by lowest 20%	10	9.3	9.3	9.4	..	..	..	8.1	..	7.6	..	..	8.1	10	8.7	9.1	8.7	8	6.8	..	..	..	..	..
Malnutrition prevalence, weight for age (% of children under 5)	64.3	58	48.2	39.2	..	..	44.4	43.5	..	42.9	43	38.8	39	..	31.3	..	..	..	22.8	..	..	..	..	41.1
Poverty gap at $1.25 a day (PPP) (%)	21	18	17	13	16	14	..	11	..	27	..	..	23	12	6	4	3	3	3	..	..	..	..	..
Poverty headcount ratio at $1.25 a day (PPP) (%)	67	59	58	50	54	49	..	42	..	68	..	..	65	48	29	23	15	16	14	..	52	47	44	40
Prevalence of undernourishment (% of population)	36	40	..	27	24	21	..	21	21	24	..	15	22	18	..	23	27	24	..	21	25	23	..	22
Vulnerable employment, total (% of total employment)	..	69	69	85	..	..	..	..	..	..	72	..	..	65	64	62	..	38	41	41	..	..	..	..
Goal 2: Achieve universal primary education																								
Literacy rate, youth female (% of females ages 15-2`4)	38	..	60	73	49	..	68	77	33	..	60	73	..	..	43	58	..	..	96	98	48	..	64	74
Literacy rate, youth male (% of males ages 15-24)	52	..	67	71	74	..	84	87	68	..	81	85	..	..	67	79	..	..	95	97	71	..	80	84
Persistence to last grade of primary, total (% of cohort)	..	..	65	..	..	..	59	66	51	..	46	62	..	..	..	..	92	..	..	93	..	..	60	67
Primary completion rate, total (% of relevant age group)	..	..	77	..	64	74	72	86	51	..	66	78	..	..	..	62	98	..	106	106	62	..	69	80
Total enrollment, primary (% net)	..	..	87	..	..	..	85	94	..	..	73	76	..	..	57	66	..	..	99	..	..	..	80	90
Goal 3: Promote gender equality and empower women																								
Proportion of seats held by women in national parliaments (%)	10	9	9	15	5	7	9	8	6	3	6	17	10	..	2	21	5	5	5	5	6	6	7	14
Ratio of female to male enrollments in tertiary education	..	..	51	57	..	..	66	72	..	..	40	..	..	..	81	85	..	..	..	..	..	..	65	71
Ratio of female to male primary enrollment	86	..	100	..	74	82	85	96	60	71	79	99	52	56	68	78	96	96	99	100	76	..	84	94
Ratio of female to male secondary enrollment	..	..	105	..	60	..	71	83	46	..	71	93	48	..	..	76	109	..	106	..	59	..	75	84
Share of women employed in the nonagricultural sector (in %)	17.6	23.3	22.9	..	12.7	14.4	16.6	18.1	..	..	15.1	..	6.6	7.5	7.4	10.7	39.1	44	46	44.5	13.3	14.8	17.8	18
Goal 4: Reduce child mortality																								
Immunization, measles (% of children ages 12-23 months)	65	79	76	88	56	72	54	67	57	56	71	81	50	47	56	80	80	87	99	98	56	69	57	72
Mortality rate, infant (per 1,000 live births)	105	86	66	47	80	74	68	54	99	83	63	43	102	93	84	73	26	20	18	17	87	80	72	59
Mortality rate, under-5 (per 1,000)	151	122	91	61	117	104	91	72	142	117	85	55	132	119	106	90	32	26	23	21	125	111	97	78
Goal 5: Improve maternal health																								
Adolescent fertility rate (births per 1,000 women ages 15-19)	..	151	150	124	..	99	81	62	..	127	124	115	..	69	41	36	..	29	29	25	..	102	85	67
Births attended by skilled health staff (% of total)	..	10	12	18	..	34	43	47	7	9	12	19	19	18	23	39	..	94	96	99	32	..	..	41
Contraceptive prevalence (% of women ages 15-49)	40	45	54	56	43	41	47	56	23	29	37	48	15	18	28	30	..	66	70	68	40	..	..	53
Maternal mortality ratio (per 100,000 live births)	..	..	..	570	..	..	..	450	..	..	..	830	..	..	..	320	..	..	..	58	650	..	..	500
Pregnant women receiving prenatal care (%)	..	26	67	51	..	49	60	74	15	24	27	44	27	26	43	61	..	80	95	99	47	..	..	69
Unmet need for contraception (% of married women ages 15-49)	..	18	15	..	..	17	16	13	..	31	28	25	32	..	..	25	..	..	..	..	18	17	16	14
Goal 6: Combat HIV/AIDS, malaria, and other diseases																								
% of Children with fever receiving antimalarial drugs	..	..	..	..	..	..	12	8	..	..	..	0	..	..	..	3	..	..	..	0	..	..	..	7
Condom use, (% of females ages 15-24)	..	..	..	..	..	..	..	..	..	..	..	8	..	..	..	..	..	..	..	..	..	..	..	..
Condom use, (% of males ages 15-24)	..	..	..	..	..	..	..	..	..	..	13	24	..	..	..	..	..	..	..	..	..	..	..	..
Incidence of tuberculosis (per 100,000 people)	264	251	239	223	168	168	168	168	243	220	199	173	181	181	181	181	60	60	60	60	179	177	176	174
Prevalence of HIV, female (% ages 15-24)	..	..	..	..	..	..	..	0.3	..	..	..	0.3	..	..	..	0.1	..	..	..	..	..	..	..	0.3
Prevalence of HIV, male (% ages 15-24)	..	..	..	..	..	..	..	0	..	..	..	1	..	..	..	0	..	..	..	0	..	..	..	0
Prevalence of HIV, total (% of population ages 15-49)	..	..	..	..	0.1	0.2	0.5	0.3	0.1	0.3	0.5	0.5	..	0.1	0.1	0.1	..	..	..	..	0.1	0.2	0.4	0.3
Tuberculosis cases detected under DOTS (%)	..	6	24	66	..	0	12	68	..	5	57	66	..	1	3	67	..	62	67	85	..	2	14	67
Goal 7: Ensure environmental sustainability																								
CO2 emissions (kg per PPP $ of GDP)	0.3	0.3	0.2	0.2	0.9	0.9	0.8	0.6	0.1	0.1	0.2	0.1	0.5	0.5	0.5	0.4	0.2	0.2	0.2	0.2	0.8	0.7	0.7	0.5
CO2 emissions (metric tons per capita)	0.1	0.2	0.2	0.3	0.8	1	1.1	1.3	0	0.1	0.1	0.1	0.6	0.7	0.8	0.9	0.2	0.3	0.5	0.6	0.7	0.8	1	1.1
Forest area (% of land area)	7	7	7	7	22	22	23	23	34	30	27	25	3	3	3	2	36	34	32	30	16	17	17	17
Improved sanitation facilities (% of population with access)	26	28	32	36	14	18	23	28	9	15	20	27	33	40	48	58	71	76	81	86	18	22	27	33
Improved water source (% of population with access)	78	78	79	80	71	77	82	89	72	78	83	89	86	87	88	90	67	71	77	82	73	77	81	87
Marine protected areas, (% of surface area)	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Nationally protected areas (% of total land area)	..	..	..	0.7	..	..	..	5.1	..	..	..	16	..	..	..	8.5	..	..	..	17.5	..	..	..	5.6
Goal 8: Develop a global partnership for development																								
Aid per capita (current US$)	19	10	8	9	2	2	1	1	22	20	16	21	10	7	5	14	43	31	15	29	5	4	3	7
Debt service (% of exports)	35	16	11	5	29	32	16	4	15	8	7	9	23	24	21	9	15	9	11	7	27	27	15	7
Internet users (per 100 people)	0	0	0.1	0.3	0	0	0.5	7.2	0	0	0.2	1.4	0	0	1.4	10.8	0	0	0.6	3.9	0	0	0.5	6.6
Mobile cellular subscriptions (per 100 people)	0	0	0	22	0	0	0	21	0	0	0	12	0	0	0	39	0	0	2	40	0	0	0	23
Telephone lines (per 100 people)	0	0	0	1	1	1	3	4	0	0	1	2	1	2	2	3	1	1	4	14	1	1	3	3
Other																								
Fertility rate, total (births per woman)	4.3	3.7	3.3	2.8	4	3.6	3.2	2.7	5.1	4.6	4	3	6.1	5.3	4.4	3.9	2.5	2.3	2.1	1.9	4.2	3.8	3.4	2.9
GNI per capita, Atlas method (current US$)	270	310	360	470	390	380	450	950	210	200	220	350	420	490	490	860	470	700	880	1540	378	379	444	880
GNI, Atlas method (current US$) (billions)	31	39.2	49.8	74.9	330.9	350.2	458.1	1071	3.9	4.4	5.4	9.8	45.5	59.8	67.7	140.2	8.1	12.6	16.4	30.8	422.9	470.1	602.4	1338.7
Gross capital formation (% of GDP)	17.1	19.1	23	24.5	24.2	26.6	24.2	38.7	18.1	25.2	24.3	28	18.9	18.5	17.2	22.9	22.2	25.7	28	27.2	22.9	25.1	23.5	35.4
Life expectancy at birth, total (years)	55	58	61	64	60	61	62	65	54	58	61	64	60	61	63	65	70	71	71	72	59	61	62	64
Literacy rate, adult total (% of people ages 15 and above)	35	..	47	53	48	..	61	66	33	..	49	57	..	..	43	54	..	..	91	91	47	..	58	63
Population, total (millions)	113	126.3	139.4	158.6	849.5	932.2	1015.9	1124.8	19.1	21.7	24.4	28.1	108	122.4	138.1	162.5	17.1	18.1	18.7	20	1120.2	1239.6	1358.1	1522
Trade (% of GDP)	19.7	28.2	33.2	46.5	15.7	23.1	27.4	45.7	32.2	59.5	55.7	44.4	38.9	36.1	28.1	35.3	68.2	81.6	88.6	68.8	20.1	27.1	30.1	45.3

Source: World Development Indicators database (Extracted from www.worldbank.org.in as on 25.07.2009)

Why SANSAD

For millions of people in South Asia, the twenty-first century has not bought freedom from poverty, hunger, disease or death. South Asia is home to fifty percent of the world's hungry and forty-three percent of world's poor. Today, about 540 million South Asians or forty-five percent of the population in South Asia lives Below the Poverty Line [BPL] and earns less than $1 a day! Over 278 million go without clean drinking water and over 879 million do not have any proper sanitation. Approximately, 276 million or twenty-two percent of people living in South Asia have no access to basic health facilities and over four million children die annually in this region due to hunger and poverty related reasons.

To make the situation worse, unjust global agricultural trade and agricultural policies are having a life-defining impact locally Agriculture in the region is central to all national economics. Two-thirds of the population in each country earns their livelihoods from agriculture. Agriculture determines social stability in the region and is an important engine for overall economic growth. However, governments of the region are not protecting the livelihood of farmers and rural communities. Instead, governments barter away peoples' interests to agro-business corporations whose only interest in food, agricultural production and trade is to make huge profits. In South Asia today, we are witness to declining food security, increasing starvation deaths, frequent farmer suicides, and overall sustainable livelihoods, along with unstable democratic process.

Therefore, it is increasingly being realized by Civil Society Organizations in South Asia that these issues cannot be addressed without urgent and immediate cross-country initiatives both at micro and macro levels. Given agriculture's central position in the region, civil society cannot leave matters only to governments, but needs to take advocacy actions and interventions that include efforts to influence policies, particularly on trade and agriculture, with a pro-marginalized bias-whereby governments and multilateral organizations like SAARC, WTO, G20, etc. are forced to accept the developmental needs of the region.

Hence, there is a tangible need to build a regional network and alliance of multifarious but like-minded actors who can operate at different levels with a multiskilled approach, with a shared vision to make South Asia free from hunger and poverty. South Asian Network for Social and Agricultural Development [SANSAD] is a regional level network of the like-minded voluntary organizations, academic institutions, farmers and trade associations.

Vision

To make South Asia free from hunger and poverty.

Mission

To take global and regional initiatives for sustainable agriculture, rural development and human dignity aimed at putting collective pressure on policy makers.

Broad Objectives

To catalyze, support and strengthens civil society in promoting sustainable livelihood, ecological agriculture, good sovereignty, and equitable trade with focus on human dignity of poor and marginalized people in South Asia.

To undertake training, research, publication and build capacities to promote economic, social and gender justice.

To promote a democratic, accountable and transparent system of governance and create an enabling an supportive environment for development initiatives in South Asian countries.

To build alliances and network at national and international levels in order to campaign and advocate policies for the marginalized in agriculture, agricultural trade, farming system, natural resources, ecological balance and human welfare.

Interventions for Change

SANSAD organizes mass campaigns, public debates, advocacy workshops, build alliances, and gorges partnerships between the civil society and Northern NGOs with similar objectives, on issues of agriculture, poverty, hunger, food sovereignty, and social development.

SANSAD attempts to go beyond activism to analyze policies and advocate at decision-making and implementation levels for policies and programmes in favour of the poor in South Asia.

SANSAD brings together farmers and trade associations, academic institutions, like-minded voluntary organiszations on a common platform to strengthen advocacy campaigns for policy changes with respect to hunger, poverty, agriculture and trade SANSAD makes all efforts to involve the rural communities ain all advocacy efforts.

SANSAD shall endeavour to develop strategies to defend the livelihoods of South Asia's poor and hungry.

SANSAD shall become a Resource Center that will function as nodal agency for research, documentation, collection, analysis and dissemination of information and reference materials.

South Asian Network for Social & Agricultural Development

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