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C hapter 1

Tracking the MDGs – trends and prospects

In recent years, the Asia-Pacific region, along with the rest of the world, has been assailed by a sequence of global crises, first the energy and food crises and, more recently, the economic crisis triggered by the Western financial meltdown. As a result, the region is facing additional threats to development and to the achievement of the MDGs.

This report will examine these threats in detail at the end of the chapter, but it begins by telling the story so far, using the most recent data on 21 out of the 60 official MDG indicators from the Global Millennium Development Goals Indicators Database – which generally reflect the position prior to the economic crisis (UN, 2009). To judge whether countries are on or off track to achieve the MDGs, it assesses past performance and assumes countries will continue along similar trajectories. But history is not destiny. Even in the face of crises, countries can secure their position and improve their prospects. For those that have so far made good headway, this will mean implementing policies that help them to protect their gains and sustain their progress. For countries that have been less successful, it will mean diverging from the predicted path and getting back on track to meet the MDGs by 2015.

For classifying the progress of countries and regions, this report uses the same system as in previous regional MDG reports. For selected indicators, based on trends of progress since 1990, the report places each country or country group into one of four categories:

- - **Early achiever** – Already achieved the 2015 target
- ▲ - **On track** – Expected to meet the target by 2015
- - **Off track: slow** – Expected to meet the target, but after 2015
- ▼ - **Off track: no progress/regressing** – Stagnating or slipping backwards

Based on this classification, Table I-3 presents the progress of 55 Asia-Pacific countries on selected MDG indicators. Table I-1 summarizes the data for various subregions and country groups. For details of the methodology for assessing whether countries are on or off track, please see Annex 1.

Decades of progress

Prior to the global crises, Asia and the Pacific had made impressive gains in some of the MDG indicators. As indicated in Table I-1, the region as a whole is an early achiever for a number of indicators: reducing gender disparities in primary and tertiary education; stopping the spread of HIV and AIDS and tuberculosis; ensuring a proportion of protected area to maintain bio-diversity, reducing consumption of ozone-depleting substances, and halving the proportion of people without access to safe drinking water. The region is also on track to achieve three other important targets: gender parity in secondary education, ensuring universal access of children to primary school and halving the proportion of people living below the poverty line.

Table I-1 – Country groups on and off track for the MDGs

Goal	1	2	3	4	5	6	7
	\$ 1.25/day poverty Underweight children	Primary enrolment Reaching last grade Primary completion	Gender primary Gender secondary Gender tertiary	Under-5 mortality Infant mortality	Antenatal care, at least once Births by skilled professionals	HIV prevalence TB incidence TB prevalence	Forest cover Protected area CO2 emissions ODP substance consumption Water, total Sanitation, total
Asia-Pacific Excluding China and India	▲ ■	▲ ■ ■	● ▲ ●	■ ■	■ ■	● ● ●	▼ ● ▼ ● ● ■
South-East Asia	● ▲	▲ ■ ●	● ● ●	▲ ■	■ ■	● ● ●	▼ ● ▼ ● ● ▲
South Asia Excluding India	■ ■	▲ ■ ■	● ▲ ■	■ ■	■ ■	● ● ●	● ● ▼ ● ● ■
Pacific Islands Excluding Papua New Guinea	▲ ■	■ ■ ■	● ▲ ▲	■ ■	■ ■	▼ ● ●	▼ ● ▼ ● ▼ ▼
North and Central Asia Excluding Russia	▼ ▲	● ● ●	● ● ●	■ ■	▲	▼ ● ●	▼ ● ▼ ▲ ■
LDCs Asia-Pacific	▼ ●	● ● ●	● ● ●	■ ■	▲ ▲	▼ ▼ ▼	▼ ● ▼ ● ■ ■
	● Early achiever ▲ On track ■ Slow ▼ Regressing/No progress						

Notes: 1. Asia-Pacific refers to the 55 developing members and associate members of ESCAP.
2. For the composition of country groupings, please see Annex 5.

Progress in eradicating poverty remains one of the region's greatest successes. Previously, the international poverty line, marking extreme poverty, had been set at \$1.08 (1993 PPP) per day. Now, the line has been reset to \$1.25 (2005 PPP) per day (Box I-1). Between 1990 and 2005, Asia and the Pacific

reduced the number of people living on less than \$1.25 a day from 1.5 billion to 979 million – all the more impressive given that over the same period the region's population increased by some 800 million.

Box I-1 – Revised poverty estimates

In 2008, the international poverty line – below which people are assumed to be living in extreme poverty – was revised from \$1.08 per day (1993 PPP prices) to \$1.25 (2005 PPP prices). This new line represents the average of the national poverty lines of the world's poorest 15 countries, two of which are in Asia and the Pacific – Nepal and Tajikistan.

This revision followed a 2005 expanded round of data collection in the International Comparison Programme (ICP). This gathers comparative data from more than 100 developing countries on the prices of goods and services – such as food, housing and transport. Compared with the 1993 round, the 2005 ICP round enabled a considerable improvement in poverty estimates, not just because of a more realistic poverty line, but also because of an improved survey design and the availability of a larger number of household surveys.

As before, the price levels in different countries are adjusted for purchasing power parity (PPP). This is because market exchange rates for currencies only reflect purchasing power in terms of goods that are traded internationally, while consumption, particularly by the poor, includes a proportion of non-traded goods, including services, as well as certain food staples. The \$PPP figure represents a conversion into US dollars that assures parity in terms of purchasing power over commodities, whether or not these are traded internationally.

The World Bank maintains a website, PovcalNet, which enables users to calculate poverty estimates using various poverty lines for individual countries and groups of countries. <http://go.worldbank.org/NT2A1XUWPO>.

However, even this good progress will not be sufficient to achieve all the MDGs by 2015. The Asia-Pacific region has been slow in reducing hunger, ensuring that girls and boys reach the last grade of primary education, reducing child mortality, improving maternal health and providing basic sanitation. To reach the goals, from now to 2015, countries in Asia and the Pacific need to give a big, final push – stepping up their efforts through focused MDG programmes and projects.

One issue on which it is difficult to make an accurate assessment, however, is maternal mortality – which is of particular concern given the large number of women across the region dying from causes related to childbirth (Box I-2). The reduction of CO2 emissions is one indicator on which all subregions are regressing.

Disparities between subregions and country groups

The estimates for the Asia-Pacific region as a whole inevitably mask considerable variations between subregions and country groupings. Table I-1 shows that, amongst the subregions, the greatest progress has been in South-East Asia, which has already achieved 11 out of the 21 assessed indicators and is on track for another four. Next come the North and Central-Asian countries which, as a group, have already achieved nine of the indicators. The same group of countries, excluding the Russian Federation, have achieved nine of the indicators and are on track on two more – though they are progressing slowly on another three, and regressing in another six, including those related to poverty, HIV and TB.

Box I-2 – Measuring maternal mortality

Most developing countries find it difficult to estimate maternal mortality. Indeed on this indicator even the developed countries that have the advantage of more complete systems for vital registration suffer from misclassification and underreporting.

An alternative is to use household surveys to ask about the deaths of women in that household from causes related to childbirth. But because for each family maternal mortality is a relatively rare event this requires a large sample size to produce a statistically significant result. Increasing the sample size is costly and may still result in estimates with large confidence intervals. As a result many countries, such as Indonesia, when carrying out their demographic and health surveys use the 'direct sisterhood' method – also asking women within the sampled households whether any of their sisters have died. This generates more data on maternal deaths, but those reported will generally have occurred some 6-12 years prior to the survey. Other options include, as in China, using a disease surveillance system or, as in India, a sample registration system. Whatever the method, national estimates based on surveys have wide confidence intervals, making it difficult to assess trends over time or make meaningful comparisons between countries.

To produce better quality estimates and calculate regional and global aggregates WHO, UNICEF, UNFPA, the World Bank, and UNDP have developed a methodology for adjusting national data to make them more internationally comparable. For this purpose they divide countries into three groups, which are of roughly equal numbers. The first group have complete civil registration systems and good systems for attributing causes of death so their data are not adjusted. The second group consists of countries that use a range of methodologies so the estimates for these countries are adjusted to take these differences into account. The third group comprises countries that lack appropriate data and whose maternal mortality levels have to be predicted using a statistical model. These adjusted global estimates are calculated every five years and published one or two years after the reference year.

This exercise was carried out in 1990, 1995, 2000 and 2005. The 2005 estimates used an improved methodology. While this should give more reliable results it means that the 2005 estimates are not comparable with those of earlier years. To make a comparison, a separate exercise was required using the 2005 methodology to re-estimate the 1990 data, though this was only used to arrive at global, regional and subregional figures (box figure). As a result there are no internationally comparable trend data at the national level.

The Asia-Pacific region includes the world's two most populous countries – China and India – so the region's overall achievement on poverty, as on other indicators, will be swayed by their performance. To illustrate this, Table I-1 also shows the performance of different country groupings that exclude Asia's two giants. Thus 'Asia and the Pacific excluding China and India' on some indicators has performed worse than the region as a whole: it has progressed only slowly in ensuring primary enrolment, and regressed on HIV prevalence. On the other hand, this group of smaller countries has done better on gender parity in secondary educational attainment on which it is an early achiever.

Starting from a low base on many MDG indicators, South Asia has made good progress on eight indicators, but is progressing only slowly on many others. Given the weight of India in subregional aggregates, it is also useful to consider 'South Asia without India'. This grouping is on track for poverty,

but progressing slowly on primary enrolment and the provision of clean water supplies, and regressing in HIV prevalence and forest cover.

As a group, the Pacific Island countries have been less successful – regressing or making no progress in 11 indicators and advancing only slowly in another two, those for infant and under-five mortality. Papua New Guinea is home to almost 70 per cent of the Pacific Island countries' population, so estimates for the subregion are inevitably affected by this country's performance. Table I-1, therefore, presents estimates for the Pacific Island countries excluding Papua New Guinea. This subgroup has made better progress on gender equality in education and is also moving forward, albeit slowly, on ensuring that births are attended by skilled health professionals. However, it should be noted that the accuracy of Pacific Island aggregates for many indicators is hampered by a shortage of data (Box I-3).

Box I-3 – Routes to faster MDG progress in the Pacific

The Pacific Island countries have been making slow progress on the MDGs. To some extent this reflects slow economic development in general, but it is also linked with a general weakness in institutions and a lack of capacity for management and implementation – including the ability to gather the necessary data.

Pacific Island governments want to scale up their MDG efforts and allocate resources more effectively and efficiently. For this they will need more accurate estimates of the costs of service delivery, so that they can better integrate MDGs into national budgets and development strategies. At present, most governments in the subregion base their budgets on outputs rather than on outcomes in the form of identifiable long-term improvements in service standards. Some are now altering their approaches, though it will take some time for these efforts to bear fruit.

The Pacific island countries also have difficulties in tracking the MDGs. Some of the problems arise because most of the countries have small populations. The indicator on maternal mortality, for example, for which the denominator is 100,000 live births, is difficult to apply in a country with only a few thousand people. And, for this and other indicators, a relatively small number of events can cause wide fluctuations in national rates. There are also concerns that the MDG indicators fail to address specific concerns in the Pacific. In education, for example, the problem is not so much coverage as quality.

Moreover, on many issues a lot of the necessary data remain unavailable, especially at the sub-national level. This is partly due to inadequate systems for data collection and management. In the past, national statistical offices have had quite narrow mandates – dealing mainly with censuses, national surveys, compilations of financial, trade and immigration statistics, and extracts from birth and death registries.

The MDGs, however, require many new types of data which, thanks to the wider availability of information technology, may come from diverse sources, including other government departments and line ministries. In this new information environment, the chronically understaffed and under-resourced national statistics offices face being overwhelmed or overlooked, even though they retain the power to declare information official or otherwise.

Recognizing these and other issues, in 2005 the Pacific Islands Forum Leaders adopted the Pacific Plan, which envisaged incorporating the MDGs in National Sustainable Development Strategies – using Pacific-relevant indicators. At the national level, some countries have established task forces to facilitate and monitor MDG progress. Two countries have also agreed additional goals that reflect national priorities. The Cook Islands has an MDG9 on Improved Governance, and Niue has one on Population Development.

The countries of the Pacific should also be able to rely on international support. Australia, a major donor, has reemphasized its commitment to the MDGs through a major programme of Pacific Partnerships for Development. The UNDP has also provided leadership and assistance to most countries in compiling National MDG reports and organizing national and regional workshops on MDG-based planning, costing and budgeting. A regional MDG network could also help countries share information resources and good practices.

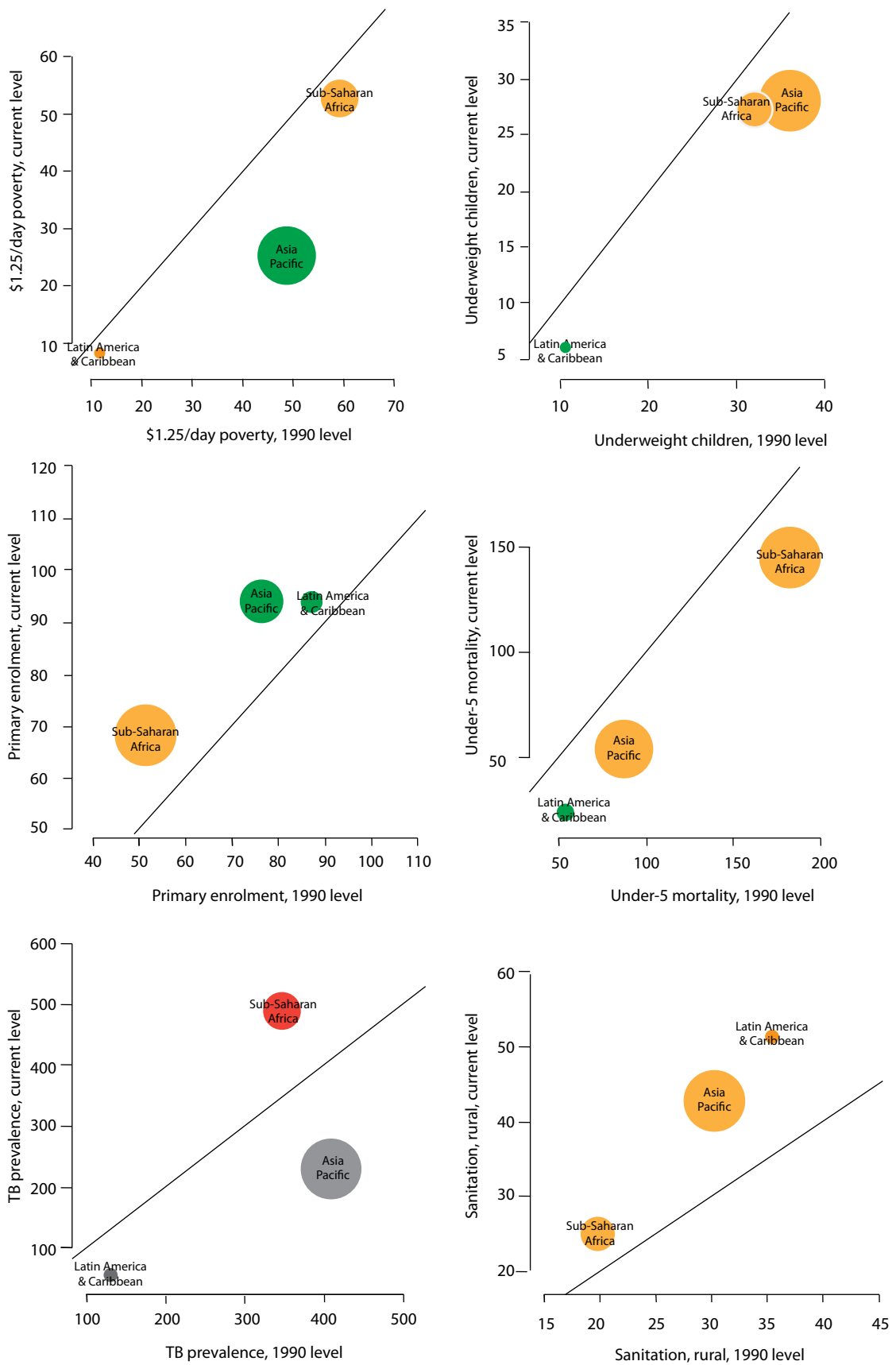
There are similar disparities between country groups. The region's 14 least developed countries have made slow or no progress on most indicators – performing well only on gender equality in primary and secondary education and on reducing the prevalence of HIV and TB.

Comparison with other global regions

The Asia-Pacific region as a whole has made more progress than Sub-Saharan Africa but less than Latin America and the Caribbean. The comparison between these three global regions is encapsulated in Figure I-1 for six indicators. In these charts, the size of the bubbles is in proportion to the population currently affected. The sloping line divides each chart into two parts: if the bubble is above the line, since 1990 the values on that indicator have increased; below the line they have decreased. The colours correspond to those of the on- or off-track progress symbols.

As these charts show, the Asia-Pacific region lags behind Sub-Saharan Africa only on under-five children underweight, but is typically behind Latin America and the Caribbean on most other indicators – coming close only for primary enrolment. The charts confirm, for example, that Asia and the Pacific is on track for reducing poverty – though the region's average poverty rate is still higher than that in Latin America and the Caribbean and the Asia-Pacific region has the largest number of poor people. Indeed these charts emphasize the reality that, because of its larger population size, on most indicators, Asia and the Pacific has the greatest numbers of people affected – a particularly serious situation for underweight children, under-five mortality and rural sanitation, for which the region as a whole is off track.

Figure I-1 – Asia and the Pacific compared with Sub-Saharan Africa and Latin America and the Caribbean

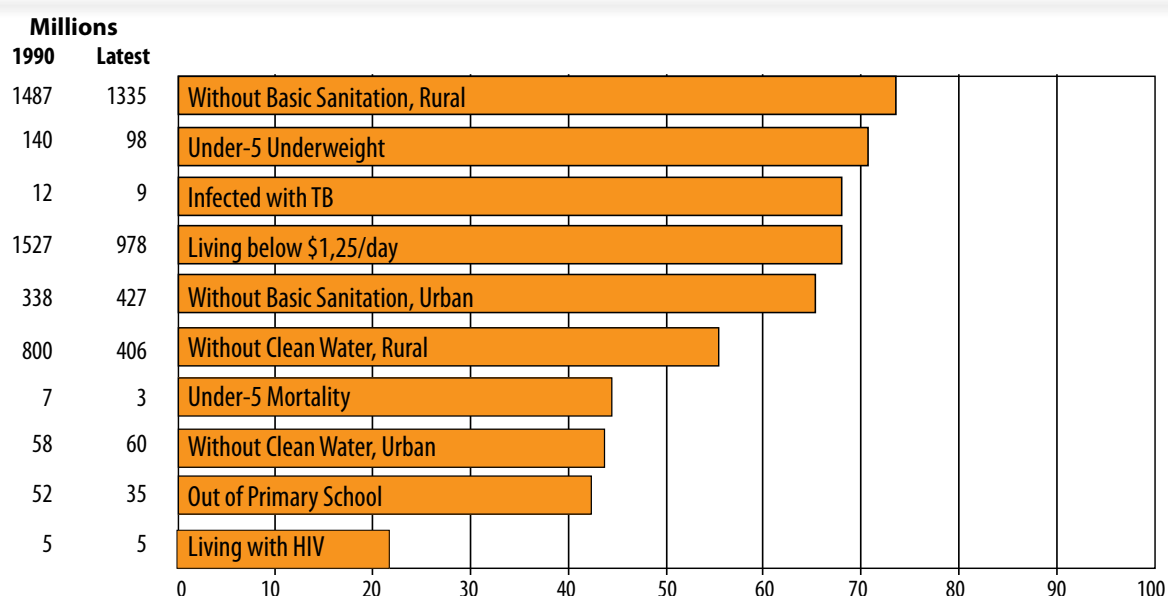


In the case of rural sanitation, for example, the Asia-Pacific region has more than 70 per cent of the developing world’s people who are affected – which in 2006 amounted to more than 1.3 billion people. This is illustrated in Figure I-2 for this and other selected indicators, showing that Asia and the Pacific is also home to over 70 per cent of the world’s under-five children underweight, 68 per cent of people infected with tuberculosis and the same proportion of those living in extreme poverty. Even on indicators for which Asia and the Pacific has made significant progress, it still has a large number of people who live in deprivation. When it comes to providing people in rural areas with access to clean water, for example, the region

is an early achiever but still has 406 million people deprived.

For most indicators, the slow progress or setbacks in achieving the MDGs will have serious gender implications. When resources are short, women and girls are typically hit hardest – and shoulder most of the burden for coping with any additional pressure on the household. By the same token, however, achieving the Goals will have particular benefits for women, providing them with more opportunities and greater security, while enabling them to strengthen their capabilities (Table I-2).

Figure I-2 – The Asia-Pacific region’s share of the developing world’s deprived people, selected indicators



The latest years are: 2006 for primary enrolment, clean water rural and urban, \$1.25/day poverty, basic sanitation in rural and urban; and 2007 for HIV prevalence, under-five mortality, TB prevalence, and underweight children.

Table I-2 – Gender implications of failing to attain MDG targets

MDG indicators	Gender dimensions
Extreme poverty	Poverty has a greater impact on women, since they have to cope with the effects on the family. Poverty is one of the principal causes of gender inequality.
Education, primary secondary and tertiary	Failing to hit gender targets on education will not just deprive women of their rights it will also affect the prospects of their children. When women are empowered through education they are likely to have fewer children. They are also in a stronger position to ensure that their children are healthy and well nourished and go to school.
Infant mortality	Globally more boys die during infancy than girls, but in some Asian countries, notably China and India, the situation is reversed. South and East Asia have also seen a new form of female disadvantage in the form of sex-selective abortion.
HIV and AIDS	Women, and especially those who have little power in sexual relations, are more vulnerable to HIV infection.
Rural water supplies	Women and girls can spend hours each day fetching water. Better access to safe water will free them for other activities.

Source: UNIFEM 2008a, 2008b

Just as setbacks in each of the MDGs can have repercussions on women's welfare and empowerment, so the lack of progress in gender equality will also have a critical impact on the achievement of other MDGs. Conversely, gender equality helps accelerate the achievement of the MDGs, and progress in gender equality in one goal

often contributes towards progress on a number of others. (UNIFEM, 2008a, 2008b). Unfortunately, apart from some progress in achieving gender parity in education, many countries have a considerable distance to go before achieving true gender equality (Box I-4).

Box I-4 – Gender equality and its impact on MDG achievement

Improvements in maternal health can make a significant contribution to a nation's economic growth and – and help reduce, poverty, malnutrition and child mortality. Yet a significant proportion of women continue to lack access to reproductive health care. The proportion of deliveries attended by skilled staff was as low as 11 per cent in Nepal, 19 per cent in Lao People's Democratic Republic, 23 per cent in Pakistan, and 43 per cent in India. However, there has also been some notable progress: in countries such as Viet Nam, Sri Lanka, and China, the figures reached 85, 87, and 87 per cent, respectively (UNIFEM, 2008b).

Women's education is strongly associated with having fewer children, fewer of these children dying in infancy or childhood, better nutrition for children, and a greater likelihood that children will be sent to school. Gender equality is therefore both a goal in its own right, and a prerequisite for the achievement of the other MDGs.

Unfortunately, the only target under MDG3 focuses on eliminating gender disparity in education. Two other indicators, gender disparity in wage employment and participation in national parliaments, cover the broader aspects of gender equality, but the lack of concrete targets has hampered progress.

Not surprisingly, many women continue to face discrimination in the formal sector through lower earnings and fewer benefits, and are forced to work in the informal sector where earnings are low and working conditions poor (UNIFEM, 2008b). In East Asia and the Pacific, around 60 per cent of women are in vulnerable employment; in South Asia, the proportion is much higher at 84 per cent (ILO, 2008). Meanwhile, in subregions such as South Asia, women's share of waged non-agricultural remains dismal – for every four men only one woman has a non-agricultural paid job (UNIFEM 2008a).

The share of women in parliaments has now reached 15 per cent in South Asia and 11 per cent in East Asia and the Pacific, Nevertheless, the region is still unlikely to reach the critical mass level of 30 per cent by 2015, and without major efforts will take decades to reach parity levels of 40 to 60 per cent (UNIFEM 2008a).

Disparities between countries

Asia and the Pacific is a huge and diverse region with countries that vary greatly in size and level of development: it has three of the world’s most populous countries, but also many Pacific Island states that have only a few thousand people. This makes it difficult to present meaningful inter-country comparisons across the whole region. The best approach therefore is usually to look at contrasts across subregions within which neighbouring countries might be expected to have some similarities. For this purpose, a convenient measure for comparison is the proportion of indicators for which each country is off track – though this also needs to be considered in conjunction with the proportion of the 21 indicators for which the country can actually provide sufficient data for assessing trends.

South and South-West Asia

The data for this subregion are summarized in Figure I-3. All the countries except Afghanistan and Maldives have reported on more than 80 per cent of the 21 indicators assessed in this report. However, more than half the countries are off track on at least 40 per cent of these indicators.

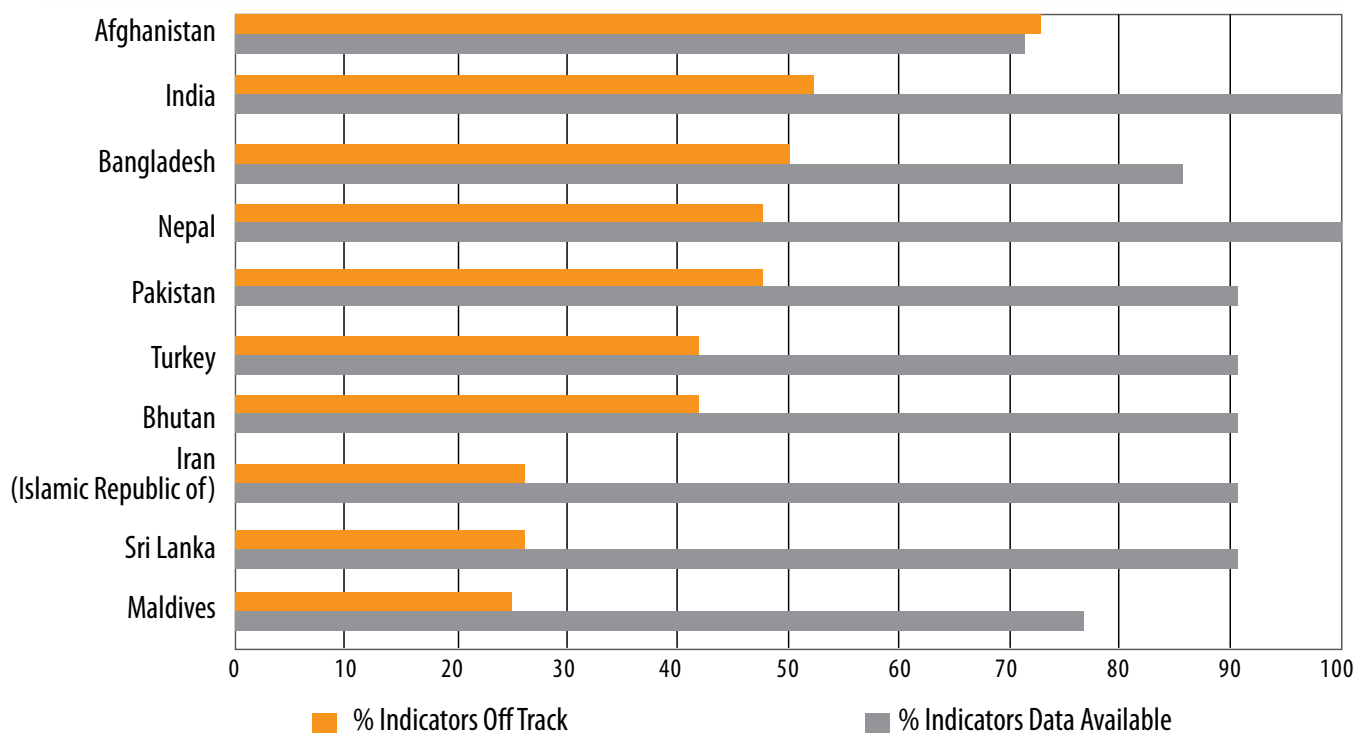
The country with most scope for improvement is *Afghanistan*, which is off track on more than 70 per cent of its reported indicators – and the indicators missing include those on poverty and education on which it would probably not fare well either.

India has reported on all 21 indicators, but is off track in more than half of these – making slow progress towards the goals of eradicating extreme poverty and hunger, completion of primary education, gender equality in tertiary education, reducing child mortality, improving maternal health or extending basic sanitation. In 2005, the country had 471 million people living on less than \$1.25 a day, and in 2006 had 318 million people without basic sanitation.

Bangladesh reports on more than 80 per cent of the indicators but is off track on half of these – with slow or no progress on poverty reduction, on education, on improving maternal health, on forest cover or on extending services of clean water and basic sanitation.

Nepal has also reported on all indicators assessed in this report, but is off track in almost half of these,

Figure I-3 – South and South-West Asia, proportion of reported indicators for which countries are off track



¹ However it should be noted this is not the case, if one uses poverty data based on national poverty line

including those on reducing extreme poverty and hunger, on providing universal primary education, on improving maternal health and on providing basic sanitation.

Pakistan is in the same position as *Nepal* in aggregate terms – though the composition of indicators covered and the corresponding achievements differ. The country has been successful on poverty, on which it is an early achiever¹, and is on track for basic sanitation. On the other hand, *Pakistan* has made no significant progress on child malnutrition and is moving only slowly on under-five mortality, and on maternal health. It has also made slow progress on halving the proportion of people without sustainable access to safe drinking water.

Turkey and *Bhutan* are off track on more than 40 per cent of their reported indicators, while the *Islamic Republic of Iran* and *Sri Lanka* are off track on one third. A commendably strong performer is the *Maldives*, which despite being one of the subregion's five LDCs is an early achiever on 9 of 16 reported indicators and on track on another three.

North and Central Asia

Most countries in this subregion have reported data on more than 90 per cent of the indicators. The exceptions are the *Russian Federation* and *Turkmenistan*, which report on 85 and 50 per cent of the indicators respectively – and are off track on half of these, including those on child mortality (Figure I-4). It should be noted, however, that on most of these indicators the *Russian Federation* already had quite starting levels in 1990.

Kazakhstan and *Tajikistan* are off track in 50 per cent or more of the indicators – making slow

progress on child mortality, for example, and none on health. *Uzbekistan* is in a better position, but on poverty has actually regressed: between 1998 and 2003 the proportion of people below the poverty line increased from 32 to 46 per cent.

Other countries in the subregion appear to be doing better, but their records are still mixed. For poverty, *Azerbaijan* is an early achiever and *Armenia* is on track, but neither has made progress on child malnutrition. On the other hand, for child malnutrition *Kyrgyzstan* is an early achiever and *Georgia* is on track, but both are regressing on poverty.

Pacific Island countries

Here it is especially difficult to assess progress because of a shortage of data. For example, no country has sufficient information on poverty, and only a few have data on education or HIV. On the basis of the available data, *Papua New Guinea* has made less progress – off track on almost 70 per cent of reported indicators – and those missing include those on poverty, education and gender equality (Figure I-5). The country is, for example, making slow progress on child mortality, clean water and basic sanitation. However, most countries in the subregion that offer sufficient data have made slow progress on child and infant mortality, and slow or no progress on providing their people with clean water and basic sanitation.

South-East Asia

Most countries in South-East Asia have reported data on more than 80 per cent of the indicators (Figure I-6). The exceptions are two wealthy countries, *Brunei Darussalam* and *Singapore*, and two LDCs, *Timor-Leste* and *Myanmar*.

Figure I-4 – North and Central Asia, proportion of reported indicators for which countries are off track

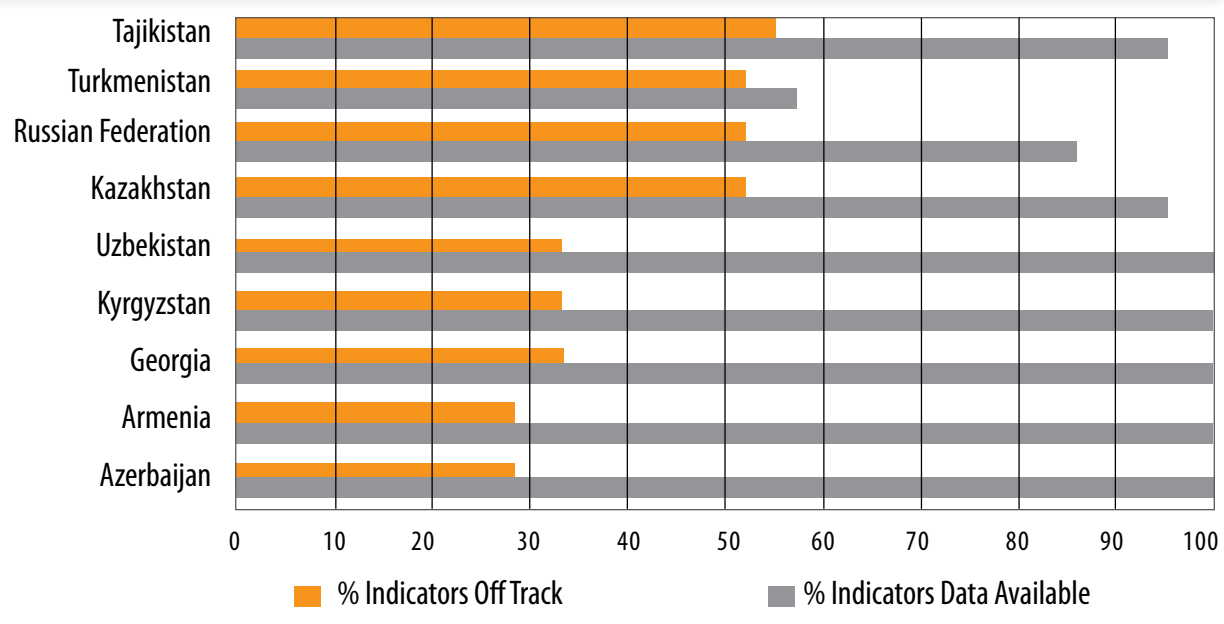


Figure I-5 – Pacific Islands, proportion of reported indicators for which countries are off track

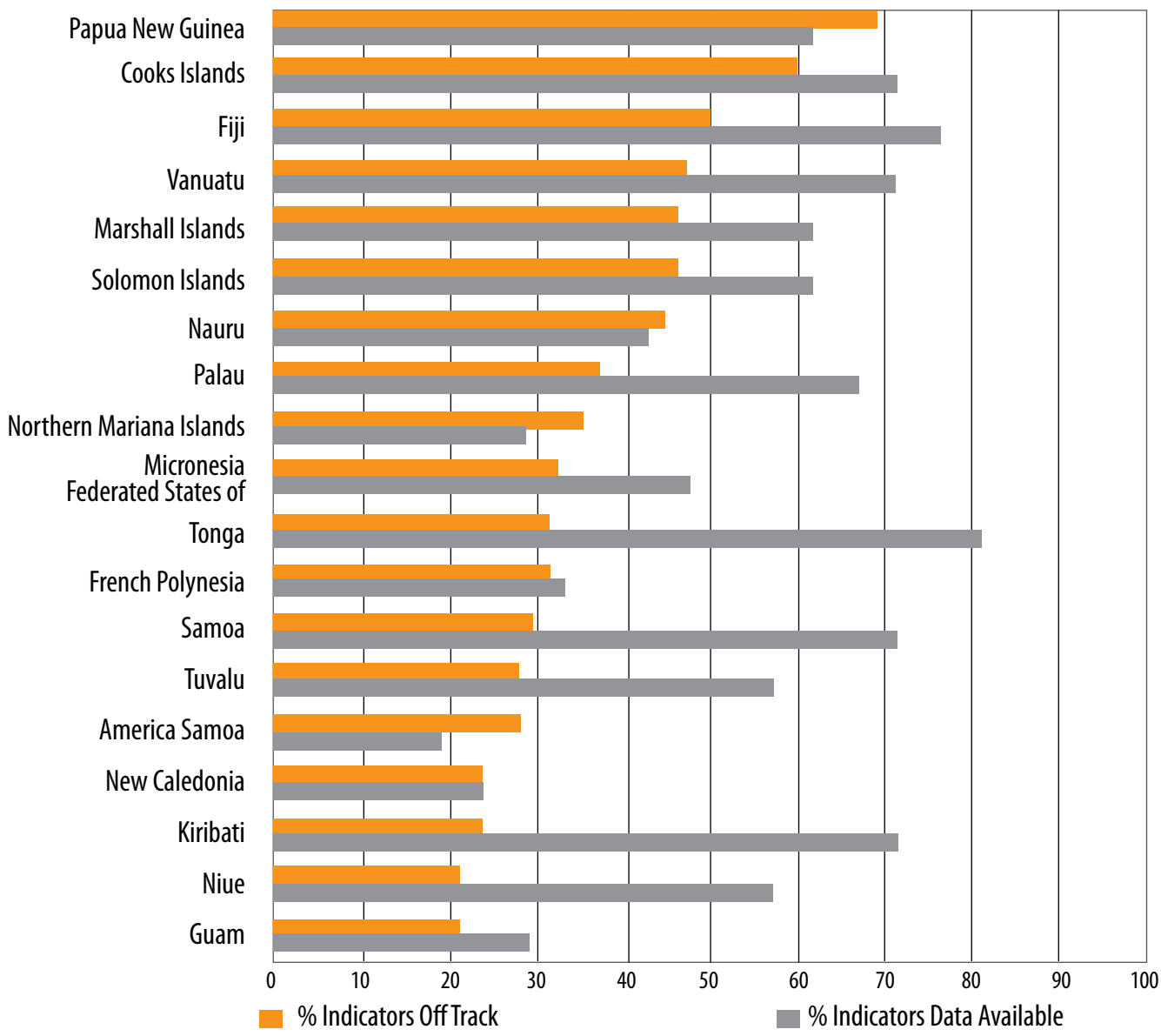
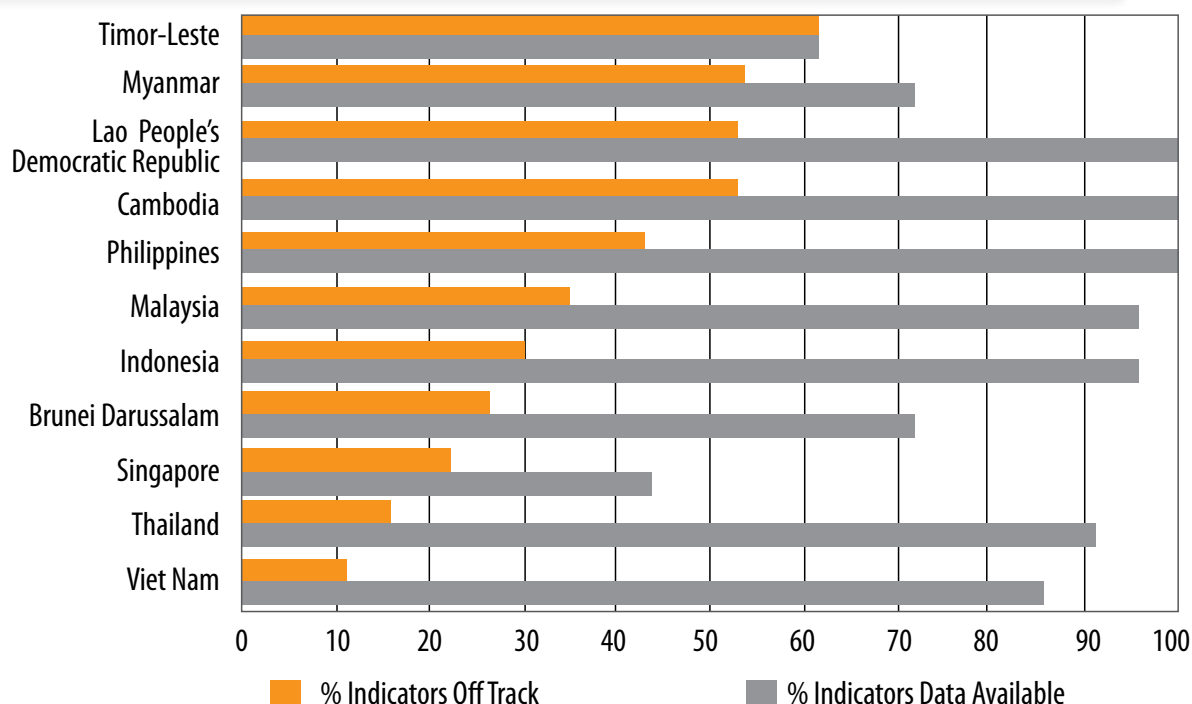


Figure I-6 – South-East Asia, proportion of reported indicators for which countries are off track



As might be expected, the countries off track on the highest proportion of indicators are the LDCs. The *Philippines* is also off track in more than 40 per cent of the 21 indicators, including poverty, hunger, infant mortality and maternal health. *Malaysia's* performance may appear similar, but this is only because on indicators such as access to improved water sources and basic sanitation the country had already achieved high levels – more than 93 per cent.

Indonesia's main challenges towards achieving the goals are in reducing hunger, halting the spread of HIV, forest cover and providing safe drinking water and basic sanitation. The country has made very good progress in ensuring that boys and girls reach the last grade of primary education – between 2001 and 2006 the proportion increased from 86 to 95 per cent. It has also substantially reduced the under-five mortality rate, which between 1990 and 2007 fell from 91 to 31 deaths per thousand live births.

A positive note is also struck by the good performance of *Thailand* and *Viet Nam*, which are off track on less than 20 per cent of the indicators. On poverty, for example, Viet Nam between 1993 and 2006 reduced the rate from 64 to 22 per cent, and between 1994 and 2006 reduced the proportion of under-five children underweight from 45 to 20 per cent. Thailand had good levels

on most indicators even in 1990, and was still able to maintain progress.

East and North-East Asia

The data for East and North-East Asia are summarized in Figure I-7. This offers a somewhat misleading picture for the Republic of Korea, which started in 1990 with its indicators at high levels, leaving less scope for further advances. However, it can be noted that the *Republic of Korea* has made slow progress in gender equality in tertiary education: between 1991 and 2007 the ratio of female to male students rose from 49 per cent only to 67 per cent.

Macao, China has low indicators coverage, less than 40 per cent, and it is off track on half of them. It is also one of the only two ESCAP members, the other is Papua New Guinea, to have regressed in gender equality in primary education: between 1991 and 2007 the ratio of girls to boys fell from 96 to 92 per cent. Data availability is also weak for *Hong Kong, China*, with coverage of a little over 40 per cent, and it had regressed in primary education: between 2001 and 2005, enrolment fell from 97.5 to 94.9 per cent.

Mongolia reports on all the indicators. It also has one of the best records on gender equality in education, with more girls than boys in primary, secondary and tertiary education, but it has made slow progress in reducing poverty and infant

mortality and in providing access to clean water and basic sanitation.

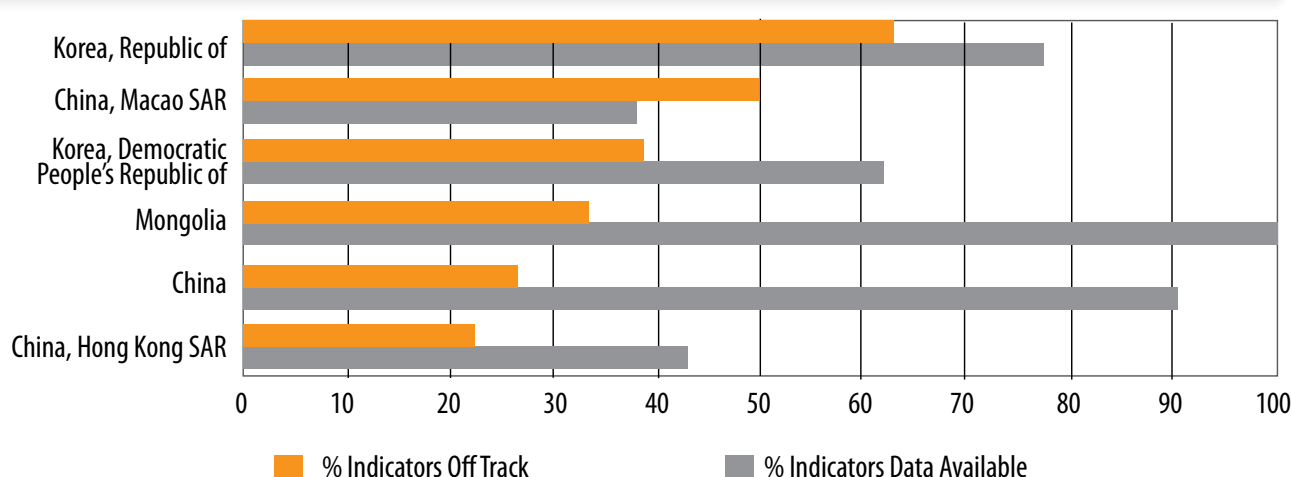
It is difficult to assess the progress of the *Democratic People's Republic of Korea* since, although it reports on more than 60 per cent of the indicators, these do not include those on poverty, education, or gender equality. For its reported indicators, the country has not made progress on reducing child and maternal mortality or on providing basic sanitation.

China has demonstrated some of the subregion's greatest advances, especially in poverty: between 1990 and 2005 the poverty rate fell from 60 to 16 per cent. On the other hand, China has made slow progress in reducing child mortality and in providing basic sanitation.

environment (Box I-6). Although almost all Asia-Pacific countries have managed to reduce national levels of under-five mortality, they have been more successful in some locations than others. One of the most consistent disparities is between rural and urban areas. This is illustrated in Figure I-8 for selected countries that have suitable DHS data. In Armenia, for example, while the under-five mortality rate came down in both rural and urban areas, it did so by a greater proportion in the urban areas and, as a result, the ratio between the urban and rural rates increased – from 1.59 to 1.62. Indeed the ratio increased in almost all these countries – clear evidence that many rural children are dying needlessly.

The greatest increase in the ratio was in Viet Nam

Figure I-7 – East and North-East Asia, proportion of reported indicators for which countries are off track



Disparities within countries

Most of the MDG indicators are reported as national averages. Only few – typically those related to gender – attempt to reflect the many important disparities within countries. This section therefore moves beyond national averages and looks at various types of disparities – based not just on gender (Box I-5), but also on rural or urban location, or on wealth. For this purpose it uses two indicators – under-five mortality and the proportion of under-five children underweight – for which many countries can offer disaggregated data via demographic and health surveys (DHS).

Under-five mortality

Under-five mortality is one of the most sensitive indicators, not just of health but also of poverty conditions generally since young children are less likely to survive a poor socio-economic

– from 1.51 to 2.20. This is also a country that demonstrates wide geographical disparities – with infant mortality rates, for the ten-year period preceding the 2002 DHS, varying from 16 per thousand live births in the Central Coast region to 52 in the Northern Uplands.

On the other hand, in India the story is more positive: the ratio fell from 1.70 to 1.59. This probably reflects the success and reach of national-level government programmes like the Universal Immunization Programme and the Integrated Management of Neonatal and Childhood Illness strategy which have been implemented successfully in many rural areas. Papua New Guinea also reduced the rural-urban ratio – from 2.56 to 2.00 between 1996 and 2006, though of these countries it still has the second-highest ratio.

Box I-5 – Gender disparities in MDG progress

Although many countries do not regularly report sex-disaggregated data that would help track the gender dimensions of MDG targets and indicators, the available data on outcome indicators of poverty, such as education, poor nutrition, and poor health, and evidence from case studies, suggest that gender disparities persist.

In the case of nutrition, for instance, case studies show that women are more likely to suffer the consequences of hunger and malnutrition – since in most societies households tend to distribute food first to the male breadwinner, then to the boys, and finally to the girls and women. Women also tend to bear the burden of feeding the family; empirical evidence shows that women in poor households typically take on the responsibility of making food available, either by producing or purchasing it (UNIFEM, 2008b).

In education, discrimination, coupled with programmes whose design and delivery are gender-insensitive, has reduced the opportunities for girls' education. Parents and society in general often attach little value to girls' education, a trend which is exacerbated by the imposition of user-pay policies and other education fees. When faced with a difficult choice of whom to send to school, poor families will typically favour boys over girls. For the region as a whole gender differences in enrolment and literacy ratios these have narrowed, but in a number of countries the disparities remain significant. While gender differences have been narrowing at the primary level, progress has been slower in secondary and tertiary education (UNIFEM 2008a, 2008b).

In combating HIV and AIDS, recent estimates show that there has been a steady increase in the number of HIV-positive women. In Asia, the female proportion of adults living with AIDS nearly doubled between 1990 and 2007 – reaching 29 per cent (UNIFEM, 2008a) The 2008 AIDS Commission Report for Asia has estimated that 50 million women are at risk of contracting HIV from partners or husbands who engage in unprotected multiple sexual relations or who are injecting drug users. Meanwhile, a 2008 study by UNIFEM of four South-East Asian countries found that the pandemic is increasingly assuming a woman's face; in Laos in 2006, men constituted 57 per cent and women 43 per cent of the people living with HIV and AIDS, while in Cambodia between 1997 and 2006 the proportion of those living with HIV who were women increased from 38 to 52 per cent. It also found that more new infections resulted from women contracting HIV from their spouses and partners; in Thailand, for example, between 1990 and 2007, for women the proportion of new infections from partners or spouses increased from 37 to 38.7 per cent, while for men in 2007 the proportion of new infections coming from partners or wives was only 9.6 per cent.

Finally, on environmental sustainability, anecdotal evidence indicates that since women often ensure food security, and do the bulk of water and household fuel collection, so their time burdens are likely to increase if the supply and quality of natural resources are undermined by environmental degradation and climate change (UNIFEM, 2008a).

Box I-6 – Children at risk

During an economic crisis those most at risk of permanent damage are children. Adults who come under stress will suffer, but their children may die. Adults who go hungry can later recover, but their children may be permanently stunted. Adults who lose their job may find other work, but if their children drop out of school they may lose their chance of education forever. It is also worth noting that in some households where adults lose their jobs, children are forced into economic activity to supplement the loss in household income. Consequently, they may drop out of school altogether or combine school and work, in which case their education performance suffers (ILO 2009c).

Some of the education effects were evident in the 1997 Asian financial crisis. In Indonesia, enrolment in secondary education fell by up to 11 per cent and dropouts increased, especially among the poor. In Thailand, many children failed to make the transition between elementary and middle school or between middle school and high school. And in the Republic of Korea many children dropped out of school or moved from the private to the public education system, placing further stress on overcrowded facilities (UNESCO, 2000).

A recent study estimates that, if unaddressed, the current crisis could increase rates of maternal anaemia by 10–20 per cent, the prevalence of low birth weight by 5–10 per cent, childhood stunting by 3–7 per cent, and child wasting by 8–16 per cent. In severely affected countries, the overall under-five child mortality could increase by 3–15 per cent. (Bhutta, 2009)

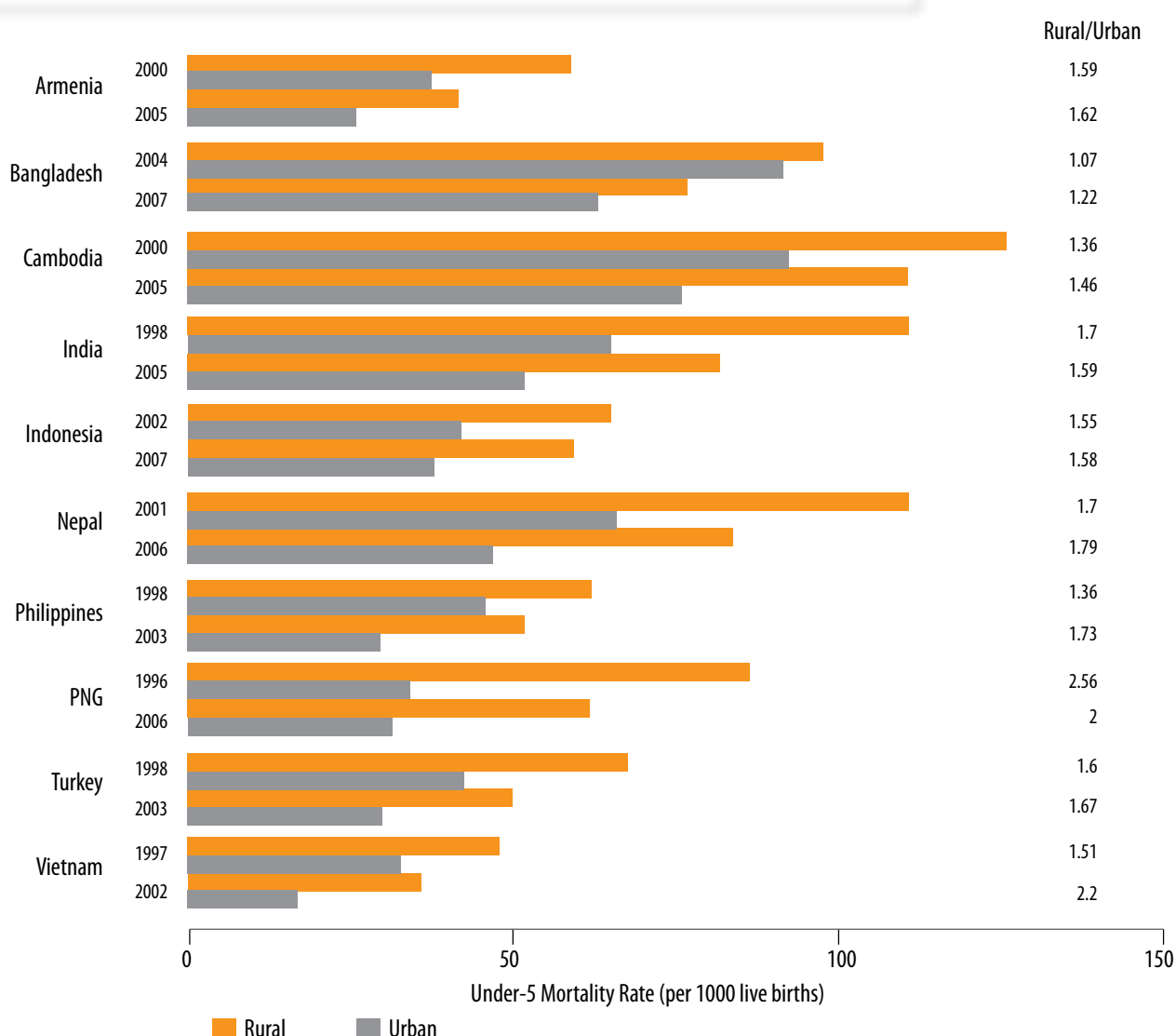
Source: Patel (2009)

Nevertheless, advances in equality cannot be taken for granted. Bangladesh, for example, between 1996 and 2004 managed to reduce the ratio considerably, from 1.40 to 1.07, only to see it rise again in 2007, to 1.22.

Another persistent disparity in child mortality is between boys and girls. This is illustrated in which compares infant mortality rates in India for male and female children in rural and urban areas.

In 1998-99, in rural areas there were 117 deaths per thousand live births for girls, compared with 106 deaths for boys – a ratio of 1.10. By 2005-06, the rural gender disparities had widened – with rates of 89 for girls and 76 for boys – a ratio of 1.17. On the other hand, by 2005-06 in urban areas the situation was more balanced; indeed the rates for girls were below those of boys. Wide gender disparities generally reflect different forms of social discrimination (Box I-7).

Figure I-8 – Under-five mortality – rural-urban rates and ratios, selected countries

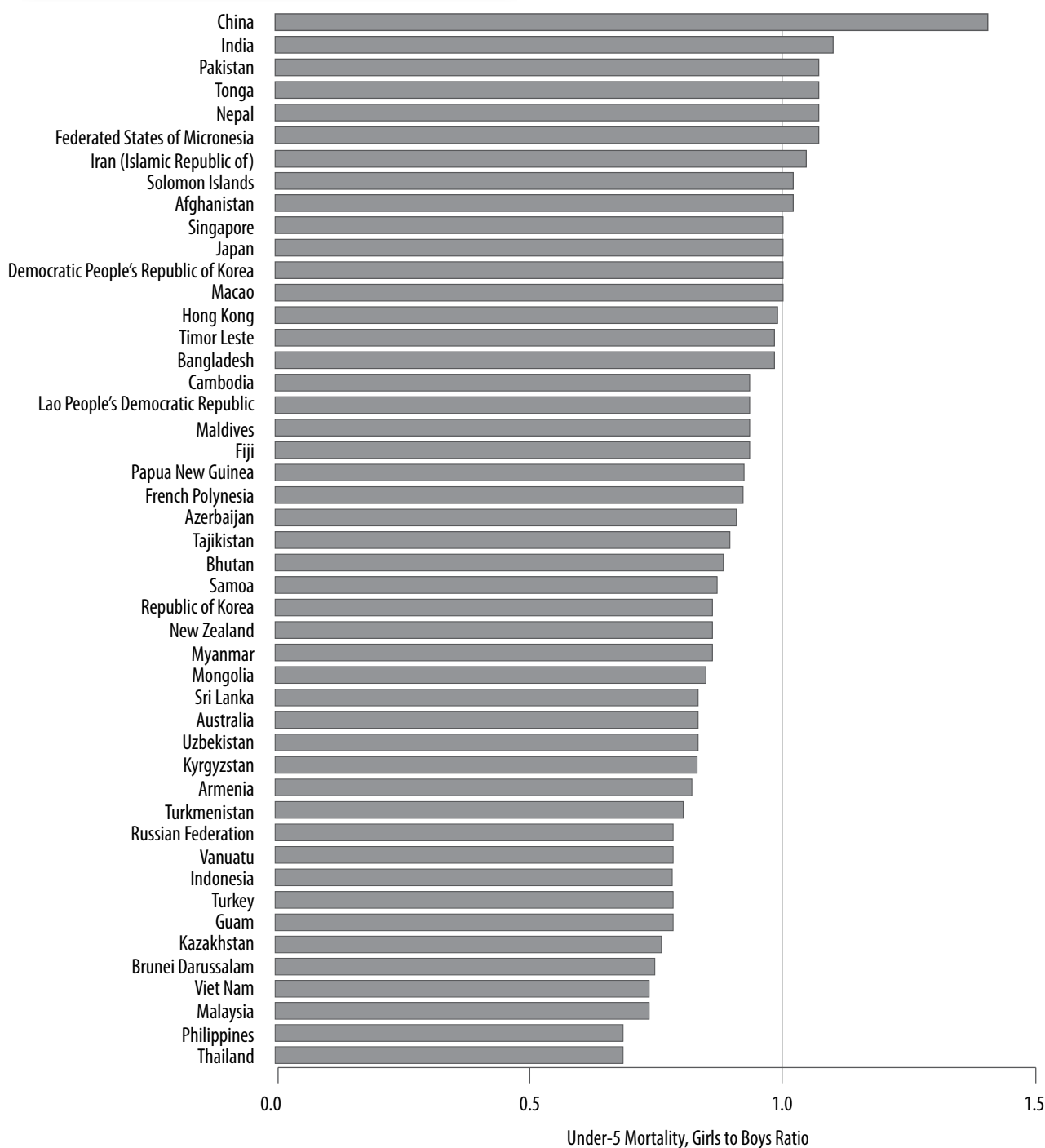


Note: Years indicate the year of DHS. Data for Papua New Guinea have yet to be officially released.

Box I-7 – Gender and child mortality

Girls have a biological advantage which should make them better able to survive the early years than boys. As a result, other things being equal, the ratio between the under-five mortality rates for girls and boys should be less than one – in Australia and New Zealand, for example, the ratios are 0.83 and 0.85, respectively. But in 16 countries in Asia and the Pacific the ratios are 0.99 or greater. The highest are in China (1.41), India (1.10), Pakistan (1.08), and the Federated States of Micronesia, Nepal and Tonga (1.07).

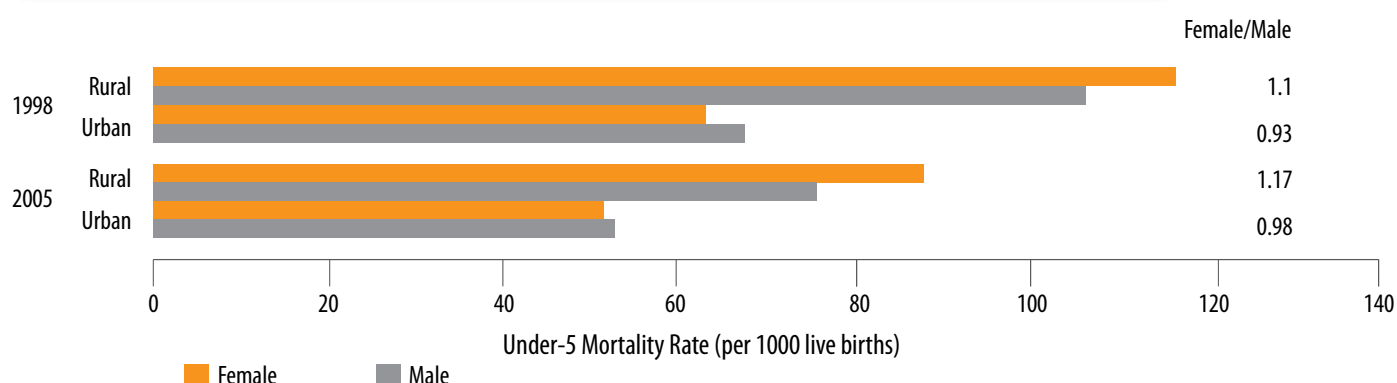
Ratio of under-five mortality rates, girls to boys



Source: ESCAP staff calculations based on World Population Prospects: the 2008 Revision using the medium variant, 2000-2005. (United Nations, 2007).

High mortality of girls in these subregions is often a reflection of patriarchal norms – which result, among other things, in strong patterns of son preference and the neglect of young girls. A recent study in India, for example, found that girls were five times less likely than boys to be hospitalized for a childhood illness. The imbalances in the Pacific, on the other hand, are more difficult to explain, since this subregion does not generally exhibit strong patterns of gender discrimination. In these and other countries, it will be important therefore not just to monitor overall child mortality rates, but also the gender balances, and address the social factors that contribute to high death rates of girls. A high proportion of these deaths occur in the neo-natal period, and child mortality is also closely linked to maternal mortality. So reducing the gender discrimination that contributes to the deaths of women will also help more infant girls survive (ADB, 2006).

Figure I-9 – India, under-five mortality, by rural and urban areas and by sex, 1998 and 2005



Note: Boxed figures are the female-male ratios

Child mortality also varies significantly according to household wealth. This is illustrated for a selection of countries in Figure I-10, which shows the mortality rate for each wealth quintile – from the poorest to the richest 20 per cent of the population. Generally,

the richer quintiles have lower rates than the poorer ones. The largest difference between the poorest and the richest quintiles is in the Philippines – 66 deaths per thousand live births compared with 21.