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Nirupam Bajpai, Jeffrey D. Sachs, and
Nicole H. Volavka

CGSD Working Paper No. 17
July 2004

Working Papers Series
Center on Globalization and
Sustainable Development

The Earth Institute at Columbia University
www.earth.columbia.edu

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Nirupam Bajpai, Jeffrey D. Sachs and Nicole H. Volavka²

July, 2004

Abstract

The United Nations Millennium Development Goals (MDGs) set the stage for developing countries to reduce extreme poverty and the problems that accompany it, such as hunger, high rates of infant, child and maternal mortality, insufficient disease control, lack of education, illiteracy, gender disparity and environmental degradation. Each goal has a specific target level for progress, such as halving poverty or reducing infant mortality rates by two thirds. All goals are to be reached by 2015, using 1990 as the benchmark year. By setting a time frame and specific levels of reductions for a variety of indicators, progress towards the goals is measurable, if data on indicators is available. Tracking progress is an essential step towards meeting the goals, as problem areas can be identified only through monitoring and evaluation, and interventions and strategies can then be developed to target them.

South Asia as a whole seems likely to halve poverty levels by 2015, due in large part to India's progress on this MDG indicator. However, the situation is not as promising in other areas, such as reduction of high rates of infant, under-five and maternal mortality. There are wide inter-country, inter-state and intra-state differences in levels of progress towards the goals throughout South Asia. In a country as large and as populous as India, tackling problems such as high maternal mortality rates at the state and even at the district levels could determine whether India as a whole achieves the MDGs. Over one billion of the roughly 1.37 billion residents of South Asia reside in India, which means that India's achievement of any of the goals brings South Asia as a whole a step closer towards regional goal attainment.

For South Asia as whole and for India in particular, public spending must be increased in the areas of health, education, rural infrastructure and agricultural research and development. The Indian government under-invests in all of these areas. Not only must public spending be increased, but spending must be accompanied by reforms. Decentralization would lead to greater control and oversight, conditions necessary for accountability.

There are only 11 years remaining to meet the MDGs. It is time for South Asian governments to focus on problem areas related to extreme poverty in the region, such as high rates of infant and maternal mortality, low primary school enrolment and completion rates, poor rural infrastructure and low rates of access to safe drinking water and sanitation, especially in rural areas.

Nirupam Bajpai presented this paper to His Excellency, Dr. A P J Abdul Kalam, President of India, the Honorable Dr. Manmohan Singh, Prime Minister of India, P Chidambaram, Finance Minister of India, and Dr. Montek Singh Ahluwalia, Deputy Chairman, Planning Commission during his two day visit to New Delhi on August 5 and 6, 2004.

¹ This paper is a revised version of the background paper prepared for discussion at the United Nations Millennium Project Task Force 1 meetings in Bangkok on June 24 & 25, 2004.

² **Nirupam Bajpai** is a Senior Development Advisor and Director of the South Asia Program at the Center on Globalization and Sustainable Development, (CGSD) Columbia University. **Jeffrey D. Sachs** is the Director of The Earth Institute, Quetelet Professor of Sustainable Development, and Professor of Health Policy and Management at Columbia University. He is also Special Advisor to United Nations Secretary General, Kofi Annan. **Nicole H. Volavka** is a Research Coordinator with the South Asia Program at CGSD, Columbia University.

Reaching the Millennium Development Goals in South Asia

Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan and Sri Lanka comprise the countries of South Asia (see Figure 1). All of them have endorsed their commitment to achieve the Millennium Development Goals (MDGs) at the Millennium Summit held in New York in 2000. The pledge was to halve the proportion of people living on less than a dollar a day and those who suffer from hunger by 2015. Additionally, governments agreed to achieve significant progress on other indicators as well, such as achieving universal primary education by 2015, promoting gender equality and the empowerment of women, and reducing by two thirds the mortality rate among children under five.

The sheer size of the population in the South Asian region, along with its growth, act as major brakes on poverty reduction in the area, where the income generating opportunities and equity promoting measures have lagged far behind the essential requirements of population. The seven countries put together had a combined population of roughly 1.37 billion in 2002, that is, about one-fifth of the world population. Of course, India alone accounts for a little over a billion people in South Asia. In all countries, population in 2000-01 was much higher compared to 1990-91, though annual population growth rates during the decade of 1990-2000 are lower than the ones from the preceding decade.

In 1990, just over 40 percent of people in South Asia were living on less than one dollar a day. This decreased to about 30 percent by the year 2000 and if poverty levels keep declining at the current rate, part of the first Millennium Development Goal (MDG)—to halve extreme poverty by 2015—is likely to be met, and possibly even surpassed (developmentgoals.org).

By 1999-00, India was over the halfway mark in terms of reducing by half the number of people living below poverty line by 2015.³ However, Bangladesh and Pakistan, the two other most populated countries in the region, are off track in terms of achieving this goal. Should the goal be accomplished for South Asia as a whole, as is expected, the bulk of the region will be riding the tails of India's success, but individual countries will be left with the reality of high levels of stark poverty within their borders.

Basic health is improving in the region, but maybe not quickly enough to meet the fourth MDG—to reduce by two-thirds, between 1990 and 2015—the under-five mortality rate. In 1990, there were about 130 deaths per 1000 children under five in the region and in 2001, the number of deaths per 1000 children declined to about 100. If the region were on track, this number should have been under 90.⁴ India, Pakistan and Bangladesh are all

³ The poverty ratio in India fell from 37.5 percent in 1990-91 to 26.1 in 1999-2000.

⁴ 90 is the linearly projected “on-track” value for 2001 towards achieving the MDG target value of 43 by 2015. Should progress continue at its current rate, the under-5 mortality rate in South Asia will be 58 in 2015.

off track in terms of achieving this goal. The only South Asian country that has made significant progress in this area is Nepal. Sri Lanka's under-five mortality rate was already low in 1990 at 23, in comparison to other South Asian countries.⁵

An unacceptably high number of women died for every 100,000 live births in South Asia in 2000, a very high maternal mortality ratio (MMR) that was surpassed only by Sub Saharan Africa (developmentgoals.org).⁶ In 1991, India's MMR was 437, compared to Pakistan's 200 and Bangladesh's 480 in 1990. In 1995, Bhutan's MMR was 500 and the Maldives' was 390. Nepal's MMR was 540 between 1985 and 2001. Sri Lanka's ratio was the lowest in the region in 1995, at 60. Since the starting numbers are so large, especially for the highly-populated India and Bangladesh, it will take a lot of work for the region to achieve the fifth MDG of reducing the maternal mortality ratio by three quarters by the year 2015.

Primary education completion rates are improving in the region, but not nearly fast enough to meet the goal of ensuring that all children will be able to complete primary schooling by 2015 (MDG 2). In 1990, the primary completion rate for South Asia was 69 percent and in 2000 it had only climbed to about 74 percent. For the region to be on track to reaching the goal of 100 percent by 2015, over 80 percent of children should have completed primary school by 2000. Better progress has been made in terms of achieving the goal of a one-to-one ratio of girls to boys in primary and secondary education by the year 2015, but the region is still significantly off track. In 1990, the ratio of girls to boys was .65 and in 1999, the ratio should have been up to .87. Instead, it was under .80 (developmentgoals.org).

As mentioned earlier, because of its sheer size, the progress in India towards meeting the MDGs will significantly affect the entire South Asian region's standing in terms of the goals. The continuing structural change in India's industrial, trade and financial sectors, among others, have contributed meaningfully to higher productivity of the economy. This reinforces the probability of the country registering sustained high levels of economic growth. Indeed, there is potential for GDP growth of the order of 8 to 9 percent per year. However, in order to attain and sustain such high levels of growth, it is necessary to move swiftly to complete many of the reforms which are now underway. If India does grow consistently at around 8-9 percent per year, this is likely to push up its domestic savings in the next few years. Besides, stronger growth should attract more foreign savings, especially foreign direct investment, and thus raise the overall investment rate.

The other relevant demographic variables, such as crude birth rate, crude death rate, total fertility rate (and preventive measures to control population i.e. contraceptive use, etc) show shifts in a positive direction. Since the crude death rate is declining faster than the crude birth rate, the overall growth of population continues to negate at least a

⁵ For comparison, the average under-five mortality rate for high-income OECD countries was 7 in 2001 and for developing countries the average was 89 (HDR, 2003).

⁶ For comparison, the average maternal mortality ratio for high-income OECD countries was 12 in 1995, and for developing countries the average was 463 (HDR, 2003).

part of the development gains when viewed in per capita terms, and hence the less-than-expected decline in the incidence of poverty in the region.

The changing population structure, however, offers some potential opportunities for poverty reduction which most of the South Asian countries have not been able to harness, except perhaps India, to a certain extent. The ‘dividends’ of demographic transition, that is, when large population groups are comprised of young adults who could engage in productive activities, could potentially be seen as an advantage throughout the region. Roughly 62 percent of the South Asian population is in what is called the economically active age group between the ages of 15 to 64. Consequently, dependency rates of children are low, and so is the proportion of dependents. The real challenge in South Asia is to create large-scale employment opportunities outside of the government/public sector.

Population below poverty line

Poverty is widespread in the region. While in Bangladesh half the population was below poverty line during the year 2000, in the rest of the countries (except Maldives) the proportion of population below poverty line ranged between 26 percent (India) to 38 percent (Nepal). However, the positive feature of the above-indicated poverty situation is that in the countries of the region, there has been a visible decline in the extent of the population living below poverty line since 1990. The only exception is Pakistan where the extent of total as well as rural and urban population below poverty line has increased since 1990.

With respect to Millennium Development Goal 1, to halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day, Bangladesh, India, Pakistan and Sri Lanka were at different places between 1990 and 2001.⁷ Out of these four countries, Bangladesh had the highest proportion of people living under these conditions—36 percent, compared to 6.6 percent in Sri Lanka. In India, the situation was similar to the one in Bangladesh, as 34.7 percent of its population lived on less than \$1 per day, while in Pakistan 13.4 percent of the people faced this difficulty (Human Development Report, 2003).

While measuring the proportion of population living below \$1 a day can be useful in the sense that it is a standard measurement, the proportion of people living below poverty line should also be measured and studied, as in many cases, it differs substantially from the proportion of people living on less than \$1 a day. In 1990, 37.5 percent of Indians were estimated to be living below poverty line. In the same year, 59 percent of Bangladeshis and 42 percent of Nepalese were reported to be living below poverty line. In Pakistan, between 1994 and 2000, an estimated 33 percent of people were below poverty line. Perhaps the most striking example of the contrast of poverty

⁷ Unfortunately, there are no separate measurements of this indicator, but rather a lump percentage spanning over eleven years. The percent of undernourished people as a share of total population in each of these four countries was measured and is available for 1990-1992 and 1998-2000, so this indicator gives a better sense of progress in the area of hunger eradication.

line data versus below \$1 a day data is that of Sri Lanka. As is mentioned above, only 6.6 percent of Sri Lankans were reportedly living on less than \$1 a day in 1990, while it is estimated that between 1995 and 2001, 25 percent of that population was living below poverty line (World Bank Group, 2003).

Of the four above-mentioned countries, the proportion of undernourished people was highest in India in 1990 at 62 percent (World Bank, 2004) and lowest in Pakistan at 25 percent (HDR, 2003).⁸ During the same time in Sri Lanka, 29 percent of its population was undernourished. This proportion remained unchanged at 35 percent in Bangladesh between 1998 and 2000, and decreased by only one percentage point in India, to 24 percent. Between 1990 and 2001, the share of the poorest 20 percent of the population of national income or consumption was very close in all four countries, ranging from a low of 8 percent in Sri Lanka to a high of 9 percent in Bangladesh.

In examining the weight and meaning of different indicators it is again interesting to note the case of Sri Lanka. Even though only 6.6 percent of Sri Lankans were living on less than \$1 a day between 1990 and 2001, as opposed to a whopping 36 percent of Bangladeshis living in the same predicament, the share of the poorest 20 percent in national income or consumption during the same years differed by only one percentage point (8 percent in Sri Lanka vs. 9 percent in Bangladesh). Also, the proportion of undernourished Sri Lankans, as opposed to Bangladeshis in 1998-2000 was not as different as one may expect, given the much smaller share of people living on less than \$1 a day in Sri Lanka, revealing the important roles of a number of different indicators, such as poverty line data. It is clear from a number of indicators mentioned above that Bangladesh needs a great deal of attention focused on MDG 1 in terms of eradicating hunger, as it has not progressed in this area.

Yet another significant dimension of the poverty situation in the region relates to income distribution. In the bulk of the cases covering rural and urban areas separately, as well as combined in 1990 and 2000, the income share of the bottom groups ranged between 6 and 8 percent. In India the range was slightly higher. On the other hand, the income share of the top 20 percent ranged between 42 to 62 percent. India differed again in terms of range, in that it was somewhat lower there. This partly corroborates the fact that increased inequalities accompany economic development in the region, and that development gains fail to percolate to the bottom. Different South Asian countries are endowed with rich and diverse (above ground and under ground, and in sea) natural resources. However, these resources are either over-extracted or remain underutilized. Both ways, the situation leads to persistence of poverty and inequality.

⁸ The large variation between the proportion of undernourished people in India relative to other countries may be attributed to the differing sources and their definitions and methods of calculation. For India, The World Bank (2004) used the normative age-specific calorie requirements recommended by the Planning Commission Task Force (GOI, 1979), with adjustments for heavy, moderate and sedentary workers aged 19 and above. Human Development Report (2003) reported that 25 percent of Indians were undernourished in 1990 and 24 percent were undernourished in 1998-2000. The discrepancy could be due to different definitions of undernourishment. The HDR's definition of undernourished people is "people whose food intake is chronically insufficient to meet their minimum energy requirements."

In terms of economic growth, pockets of medium to high growth exist in India, and medium to low growth in the rest of South Asia. In India, for instance, the high growth regions are in the western states of Gujarat and Maharashtra, and the southern states of Tamil Nadu and Karnataka. A more disaggregated, region-wise picture of poverty (head count ratio) shows that, to a significant extent, there are heterogeneities in each of the Indian states except perhaps Bihar, which is uniformly poor. Sharp contrasts are witnessed in Andhra Pradesh, Karnataka and Maharashtra, though variations can be seen in smaller states like Haryana, and Punjab as well.

The National Sample Survey in India segregates these regions by low (up to 20 percent), medium (21-40 percent), high (41- 60 percent) and very high (more than 60 percent) levels of poverty. Southern Bihar, southern Orissa, southwestern Madhya Pradesh and southern Uttar Pradesh fall in the very high poverty bracket. These regions are composed of the districts of Chotanagpur and Santhal Parganas in Bihar, Koraput and Phulbani districts in Orissa, the Jhansi region in Uttar Pradesh and Betul, Hoshangabad and Khandwa in the south west of Madhya Pradesh, adjoining Maharashtra. Two peculiar features of these regions are, that either they are mainly tribal (except Jhansi) or rocky and dry, yet densely populated because of their agro-climatic features. The one major inference drawn here is that tribal areas are predominantly and distinctly poor.

The high poverty (41-60 percent) areas are in Bihar, portions of Madhya Pradesh, inland Maharashtra, northern Tamil Nadu, eastern and central Uttar Pradesh, and parts of West Bengal. The reasons here are similar; tribal, thickly populated semi-arid areas, and those which have been neglected historically, are poor. Parts of West Bengal have made strides in poverty alleviation. Medium level poverty persists in regions of western states; a few regions have made more progress than others, compared to the eastern ones where there is uniform poverty. Typical examples are Madhya Pradesh, Maharashtra, Tamil Nadu and Uttar Pradesh. Lastly, the western coastal regions, all of Andhra Pradesh and Punjab, as well as parts of Madhya Pradesh and Rajasthan, which are a continuum of a north-south belt that experienced a green revolution, are pockets of low poverty.

Despite a gradual decline in its relative contribution to GNP from 1980 to 2000, agriculture accounts for a substantial proportion of GNP in different countries (except in Maldives). In most of the countries, agriculture's share was over 50 percent of GNP during 1980s and about a quarter of GNP between 1990 and 2000. This suggests that despite the above shifts in sectoral contributions to GNP, agriculture serves as a major contributor to GNP, as well as a source of employment and sustenance to the bulk of the countries' population. Broad-based agricultural growth in the region has helped reduce poverty. During the 1990s, agricultural performance in most of the countries is reflected by an increase in wheat and rice output, percentage of area irrigated, use of chemical fertilizers, and even an increase in net and gross sown areas in many countries.

The annual compound growth rate of agricultural production in the South Asian countries was 3.7 percent in the 1990s as against 3.2 percent in the 1980s. Besides high yielding varieties of wheat and rice, higher agricultural growth is attributed to

diversification in favor of high value commodities, especially fruits and vegetables. In part, this is due to government policies and the fact that South Asia is diverse in climate, soils and other agro-ecological features. Among the South Asian countries, Bangladesh, Bhutan and Nepal show less diversity as compared to the rest of the countries in the region. Bangladesh has specialized in rice and has more than three-fourths of the area under rice cultivation, but the remaining one-fourth is highly diversified. Bhutan and Nepal, on the other hand, are aiming at higher degree of self sufficiency in basic food grains and are hence concentrating more towards cereals, particularly rice, wheat and maize (Joshi et. al 2004).

The natural setting and resource base of the South Asian countries have quite varied potential for development and poverty reduction if properly harnessed. Because of rather extractive modes of management, inappropriate technologies and incentive systems, fuller gains of rich natural resources are not realized. On the contrary, over-extraction of natural resources, including deforestation and degradation of farm land has contributed towards increased poverty in many areas. More importantly, different natural hazards such as floods, droughts, and earth quakes bring major setbacks to activities contributing to poverty reduction.

Resource Allocation to Social Sector

An important indicator of a state's ability and priority for reducing poverty is the level of investment in education, health and related activities. If Bhutan and Maldives are excluded, the ratio of public expenditure on education was less than four percent in any of the countries during 2002. The corresponding allocation to the health sector was much lower; it was less than two percent in most cases. In 2000, India, Pakistan and Nepal each spent less than one percent of their GDPs on health. Sri Lanka, which is poorer than India, spent 1.8 of its GDP on health.

The difference in education and health-sector spending is partly explained by: higher visibility, easy feasibility, increased public demand, lower initial and operational cost and higher employment generating potential of lower level school facilities, etc. associated with the education sector, relative to health-sector projects.

India has one of the highest proportions of private expenditure on health care anywhere in the world. Primary health care is in principle 'free,' yet households incur substantial out of pocket expenses on medical care. The poor spend a very high proportion of their household income on treatment of illness compared to the rich. For the poor, an episode of illness can mean a plunge into poverty. This is also true for those above the poverty line. Health insurance and risk pooling mechanisms are conspicuous by their absence. To pay for medical care, people often borrow at high interest rates and/or sell productive assets. This pushes them deeper into poverty from which recovery is often very difficult.

Health-indicators

The infant mortality, child mortality and maternal mortality rates are very high in the South Asian countries. Except in Sri Lanka and Maldives, in 1980 the infant mortality rate (number of deaths under one year of age per 1,000 live births) ranged between 101 and 124 in South Asia. Bangladesh, India, Pakistan and Sri Lanka have all made progress in terms of reducing child mortality (MDG 3, Goal 4). In 1990 and in 2000, two measurement years for the infant mortality rate (IMR) and the under-five mortality rate (per 1,000 live births), Sri Lanka had the lowest IMR of 18.5 and 15 and an under-five mortality rate of 23 and 17.9, respectively.

The situation in Bangladesh, India and Pakistan has not been as rosy. In Bangladesh, the IMR did drop by almost a third—from 94 to 66 between 1990 and 2001 and the under-five mortality rate decreased slightly from 108 to 94. India and Pakistan also saw a reduction in IMR, as it dropped from 80 to 66 in India and from 96 to 84 in Pakistan between 1990 and 2001, respectively. Under-five mortality also decreased in India from 123 to 93 and from 128 to 109 in Pakistan between the same years.

Similarly, maternal mortality rate (number of maternal deaths in the age group of 15 to 49 per 100,000 live births) on average ranged between 350 and 540 in countries of the region (except Sri Lanka) between 1985 and 2001.

The other health indicator with long-term consequences is the high extent of under nourished children (below 5 years of age) in most of the countries. The life expectancy, though low, improved slightly for both males and females in all the countries in the year 2000, compared to 1980. An equally serious phenomenon is the high incidence of diseases like tuberculosis (21 to 211 cases per 10,000 people) in the South Asian countries in the year 2001. The corresponding incidence of respiratory diseases ranges from around 2,500 to 16,400 per 100,000 people.

The high incidence of major curable diseases (such as tuberculosis, malaria, respiratory diseases) coupled with the high proportion of undernourished young children (below 5 years of age), are major indicators of deprivation in the countries of the region. To this one can add the low nutrition of women and their required protection/preventive measures against vulnerability to chronic diseases such as anemia, or their ability to bear and nurse children. Women's exposure to risks during pregnancy and childbirth is very high, especially in poor communities and remote areas. In several cases there are no data on relevant indicators, while in others (except Sri Lanka) only half or fewer women have access to protective and preventive facilities. Furthermore, facilities and support systems to address health problems in general are quite low on the health infrastructure front.

Given the weight India carries in the world population and the very large share India has in the global burden of disease, any stride forward it makes in the field of health will also take the whole world a lot closer towards the attainment of the MDGs.

Education

Besides poor health and mortality risk, the other factors exposing the poor to persistent poverty are their limited capacities, and absence of solid foundations for, enhanced earning. The latter are reflected through the educational status and ability to acquire education and other skills. Despite improvements in adult literacy rates between 1980 and 2000, 40 to 73 percent of the adult population is still illiterate in the South Asian region, except in Sri Lanka and the Maldives. Similarly, the net enrolment ratio for relevant age groups, despite improvement during the two decades, is quite low. This is particularly so for secondary level age groups, where 34 to 54 percent of the children do not go to school.

In terms of achieving universal primary education (MDG 1, Goal 2), in 2000-01 Sri Lanka lead India, Bangladesh and Pakistan with a net of 97 percent of its children enrolled in primary school. India had the lowest net enrolment, at a strikingly low 52.5 percent; Pakistan had 72 percent enrolment and Bangladesh had 75 percent enrolment.⁹ Given the high enrolment rates, it is not surprising that Sri Lanka boasted an impressive youth literacy rate (age 15-24) of 95.1 percent in 1990 and 96.9 percent in 2001. What is surprising is that although 75 percent of Bangladeshi children were reportedly enrolled in primary school in 2000-01, the youth literacy rate there for that time was only 49 percent (up from 42 percent in 1990), indicating that there is a high dropout rate in Bangladesh. India's youth literacy rate increased from 64.3 percent in 1990 to 73.3 percent in 2001, while Pakistan's youth literacy rate went from 47.4 percent to 57.8 percent during the same time period.

The problem of children enrolling but then dropping out of school is significant, as dropout rates are as high as 33 to 40 percent in Bangladesh and India. But in all the countries in the region, the situation was better in 2000, compared to 1980. Lack of resources and engaging children for work are important reasons for this phenomenon. Natural disasters such as drought, flood etc. play a periodic role in this phenomenon as well.

In India, public expenditure on education has been rising over time. After the District Primary Education Program (DPEP) was launched in 1994, the federal government launched the Sarva Shiksha Abhiyan (SSA) in 2001 with the goal to universalize primary education (grades one to five) by 2007 and elementary education (grades one to eight) by 2010. Unlike the DPEP, SSA is funded entirely by domestic resources and provides the states with a strong initiative backed by funding to tackle illiteracy among the young members of their population. In India, another policy that has been very successful in increasing enrolments, attendance and retention of students in primary schools is that of the provision of mid-day meals. There are lessons to be learnt from the diverse experiences of Indian states in terms of their achievements in literacy. While in Kerala, strong social intermediation by the government has proved successful,

⁹ For India, the data is given for 1999-2000.

in Tamil Nadu, mid-day meal schemes have reduced drop out rates. In Himachal Pradesh, social capital and community participation seem to have led to similar success.

Country Studies

India

India is the largest and most populous country in South Asia, home to over one billion people in 2001, in a land area of 3,287,590 square kilometers (HDR, 2003). The country is well on track to cut poverty within its borders in half by 2015 (MDG 1). As mentioned earlier, this will significantly improve the entire South Asian region's chances of meeting the goal of halving poverty by 2015. In 1990, 37.5 percent of India's people lived below poverty line and in 1999-2000, this had decreased to 26.1 percent, as opposed to the 30 percent that would be necessary to say that the country was "on track" to achieve the goal (Table 1). Part of this early success could possibly be attributed to the Indian economy sustaining an annual average GDP growth of over 6 percent since the initiation of economic reforms in the country. Additionally, the Government of India has set more ambitious goals for poverty reduction. In its Tenth Five-Year Plan (2002-07), the government set out to reduce the poverty ratio by five percentage points by 2007 and by 15 percentage points by 2012 (GOI, Economic Survey 2001-02). The government has thereby set a significantly more ambitious aim to reduce the poverty ratio to about 11 percent by 2012, versus the MDG target of 18.75 by 2015.

Historically, the experience of India in terms of growth acceleration is also similar to that of countries in East Asia and China. The decadal average annual growth rate of the Indian economy, after fluctuating around 3.5 percent for the decades of the 1950s, 1960s and 1970s, took a quantum leap to 5.6 percent in the decade of the 1980s. Similarly, after hitting a low of 1.3 percent in 1991-92 in the aftermath of the balance of payments crisis, the annual rate of growth has rapidly accelerated in the second half of the 1990s, reaching a high of around 8.2 percent in 2003-04. As a consequence, the poverty ratio for India has declined from 37.1 percent in 1990-91 to 26.1 percent in 1999-2000.

Sundaram and Tendulkar (2003a) and (2003b) analyze in detail the movement of five indicators of income poverty between 1983 and 1993/94 and between 1993/94 and 1999/00: headcount ratio, poverty gap index, (reflecting depth dimension) squared poverty gap, Sen Index (the two indices representing severity dimensions) and absolute size of the poor population. The authors give two estimates for 1993/94, one with uniform recall period (URP) comparable to those for 1983, and another with mixed reference period (MRP) comparable to those for 1999/00. The authors find clear evidence of decline in absolute income poverty in terms of all the five indicators in rural India and in the country as a whole. In urban areas, however, this is true for four out of five indicators, the only exception being the absolute size of the urban population.

Between the pre and post reform periods, the relative pace of decline in poverty is found to be higher in the 1990s (post-reform period) than in the pre-reform period. Between 1983 and 1993/94, an average annual decline of 0.64 million for rural

population was offset by 0.65 million increase in the urban population, with absolute size of the poor population remaining almost unchanged for the country as a whole. However, in the post reform period, an annual average decline of 2.47 million in the number of rural poor more than offset the annual average increase in urban poor of 0.30 million (representing less than half the corresponding pre-reform increase) leaving thereby 2.17 million net annual reduction for the country as a whole.

The prospect of halving hunger in India by 2015 does not look as good as halving poverty. In 1990-92, 62.2 percent of all Indians consumed fewer calories than required and in 1993-94, the proportion of the undernourished decreased to about 53 percent (World Bank, 2004).¹⁰ If India were on track to meet the goal of halving hunger, about 50 percent of its people would have been undernourished in 1999-2000 (Table 1). This three percentage point difference may not seem that large, but if the decrease in hunger continues at its current rate, it is projected that 39.2 percent of the population will consume fewer calories than required in 2015, as opposed to the MDG target value of 31.1 percent, which still leaves almost one third of the population suffering from hunger. The proportion of malnourished children was a remarkably high 54 percent in 1990 (National Family Health Survey II 1998-99).

There is wide inter and intra state variation in hunger poverty. In 1999-2000, an astounding 78 percent of residents of Assam were calorie-deficient, followed by other northeastern states such as Meghalaya and Sikkim, where over 70 percent of the people fell into this category. Andhra Pradesh and Goa were also among the major hunger-poor states, where over 65 percent of their populations were calorie deficient. Jammu and Kashmir, Rajasthan and Uttar Pradesh were at the better end of the spectrum; less than 38 percent of their populations had deficient calorie intake. Intrastate variation is most marked in Gujarat, where the proportion of calorie-deficient people in 1999-2000 ranged from 48 to 75 percent. Surprisingly enough, the lowest rates of hunger were in the arid areas and the highest in the southern plains (World Bank, 2004).

Agriculture plays a dominant role in determining calorie deficiency among the Indian population. In 1999-2000, people living in households cultivating 1.5 hectares or more of land had calorie deficiency rates that were two thirds lower than those who lived in households without land. Furthermore, when 75 percent or more of land under cultivation was irrigated, the risk of calorie deficiency for individuals was as low as 40 percent, versus 58 percent for those without irrigated land. Landless agricultural laborers were found to be more at risk for hunger poverty than land owners and people living in districts with higher food grain per capita production were less likely to be hunger poor (World Bank, 2004).

¹⁰ The World Bank (2004) used the normative age-specific calorie requirements recommended by the Planning Commission Task Force (GOI, 1979), with adjustments for heavy, moderate and sedentary workers aged 19 and above. Human Development Report (2003) reported that 25 percent of Indians were undernourished in 1990 and 24 percent were undernourished in 1998-2000. The discrepancy could be due to different definitions of undernourishment. The HDR's definition of undernourished people is "people whose food intake is chronically insufficient to meet their minimum energy requirements."

India is far behind in achieving universal primary school enrolment. In 1999-2000, the net primary enrollment rate was only 52.5 percent—a long way off from the goal of 100 percent enrollment by 2015 (World Bank, 2004). Primary completion rates rose slightly between 1993 and 2000, from 58.7 percent to 61.4 percent, but dropout rates are clearly still very high. Although more than 90 percent of Indians have a primary school located within one kilometer of their residence, the quality of the teaching and the lack of facilities, such as classrooms and basic water and sanitation, lead to a lack of functional literacy in many of the children who manage to complete school (Bajpai and Goyal, 2004). Another factor affecting student enrollment in and completion of primary school is teacher absenteeism. Data from a 2003 World Bank survey indicate that about 25 percent of teachers were absent on any given day they were supposed to teach. India's Tenth Five-Year Plan sets out to have all children in school by 2003, to have all children complete five years of schooling by 2007, to increase the literacy rate to 75 percent by 2007 and to reduce gender gaps in literacy and wage rates by at least 50 percent by 2007. While it is extremely promising that the government itself has laid out these goals, which go beyond the MDGs, it remains to be seen whether any of these will be met.

The literacy rate of 15-24-year olds increased from 64.3 percent in 1990 to 73.3 percent in 2001. Also, India has performed extremely well in terms of improving the ratio of girls to boys in primary education from .71 in 1990-91 to .96 in 2000-01, putting it on track in terms of eliminating gender disparity in primary education (MDG 3, target 4) (Table 1). In secondary and tertiary education, there is more room for improvement, as in 1999-2000, the ratio of girls to boys in secondary school was .67 and in tertiary school it was a mere .51 (HDR, 2003).

As mentioned earlier, among other factors, the provision of midday meals for school children has been seen as a key element in increasing enrolment and retention of students. Historically, Tamil Nadu has been successful in using the midday meals scheme to enhance rates of enrolment and retention over time. In Tamil Nadu in 1986-87, the total primary school dropout rate (girls and boys combined) was 22.9 percent and by 1996-97, it had decreased to 15 percent. The dropout rate for girls during the same period was reduced by almost one-thirds, from 25 percent to 16.2 percent.¹¹ At the same time, the dropout rate for boys decreased from 19.86 to 14 (Government of Tamil Nadu, 1997-98).¹²

It is estimated that 1.72 million children die in India before reaching their first birthday, representing a tremendous waste of human potential and a pressing need to meet the millennium development goal to reduce child and infant mortality by two-thirds by 2015 (World Bank, 2004). Unfortunately, if reduction of child and infant mortality continues at its current rate, India is not likely to meet this goal. The under-five mortality rate (per 1000 live births) in India was 123 in 1990 and decreased to 93 in 2001. If India

¹¹ The dropout rate for girls in 1983-84 was 29.76 percent, so by 1996-97, this had been reduced by almost half.

¹² The total expenditure for the midday meal program in Tamil Nadu in 2002-03 was Rs. 8.27 million, of which over half, or Rs. 4.74 million was spent on children in the 5 to 9-year age group (The World Bank Group Case Studies, 2004b).

were on track to reduce this mortality rate by two thirds by 2015 (MDG 4, target 5), the 2000 rate should have been 87, not 93 (see Table 1). The IMR (per 1000 live births) in India is also high. In 1990, it was 80 and in 2000 it was 66. If India were on the right track to reducing this by two thirds by 2015, the IMR should have decreased to about 57 by 2001 to meet the MDG target of 27. The Indian Government's IMR goals are to reduce it to 45 by 2007 and to 28 by 2012. In 1991, India's MMR (per 100,000 births) was a high 437 and by 1998, it had decreased only to 407, instead of 332, which would have put it on track to reducing the rate by three fourths by 2015 (MDG 5) to a level of 109. The Government of India's goal is to reduce MMR to 200 by 2007 and to 100 by 2012. Clearly, there is a lot of progress needed on this front in order to meet the MDGs and the government's own goals.

Infant mortality rates vary widely between and within states. In 2000, IMR in Kerala was 14 (per 1000 live births), as opposed to a staggering 96 in Orissa. The low IMR in Kerala is an exception in India. Maharashtra's IMR — the second-lowest in India—was 48. Orissa's high IMR is followed by Madhya Pradesh and Uttar Pradesh, with IMRs of 88 and 83, respectively. Given the huge differences across states, it is not unreasonable to suggest that the MDGs to reduce IMR in India as a whole could be applied to individual states. Together, Uttar Pradesh, Madhya Pradesh, Bihar and Rajasthan account for slightly over half of all infant deaths in India. Given that these states also have higher fertility and population growth rates than others, they face an even greater challenge in reducing IMRs. Even if Orissa succeeds in reducing its IMR to a MDG target of 41 by 2015, the state will still have a significantly higher IMR than the all-India MDG target of 27 (World Bank, 2004).

With regard to intra-state variations, in Kerala, the infant mortality rate in the north (19) is nearly twice as high as in the south (7.8). The IMR in Karnataka ranges from a high of 76.5 in the inland southern region to a low of 38.8 in the coastal and Ghats region. In general, the interior region of the country has higher IMRs than the coastal regions (World Bank, 2004).

Nearly two-thirds of infant deaths occur within 11 months of birth and about one half of under-five deaths occur within the first month of birth — the neonatal period (NFHS II). Infanthood death constitutes over 70 percent of under-five mortalities.¹³ Given the overlap of the two indicators, it is not surprising that the relationship between IMR and U5MR in states across India is almost a perfect fit (World Bank, 2004). Therefore, many of the causes of infant mortality and interventions to prevent it carry over to under-5 mortality.

It is probable that many neonatal deaths result from maternal malnutrition and post-delivery complications, but this data is not readily available. The available data indicates that in poor states, IMR is almost double when the mother has not received

¹³ This begs the question as to whether under 5 mortality rates should be measured between the ages of one and five, instead of zero to five for it to be a more meaningful indicator.

tetanus shots during pregnancy (World Bank, 2004).¹⁴The infant mortality rate is also almost halved when a mother receives antenatal care. Professional medical attention at birth also significantly reduces IMR.

There is a positive association in poor and non-poor states between the proportion of underweight children aged 0-35 months and under-five mortality rate. Poor nutrition can result from premature termination of exclusive breastfeeding to supplementary but inadequate feeding, but can occur while a woman is breastfeeding as well if she is malnourished herself. In 1998-89, about 37 million children – almost one half of children aged 0-35 months— were chronically undernourished or stunted (NFHS II). Approximately 18-23 percent of children were severely underweight or stunted. This data suggests that children suffer from both acute short term food deficits in that they are underweight and from long term chronic malnutrition, in that their growth is stunted (World Bank, 2004).

Child immunization is critical in reducing infant and child mortality. The fact that there is a separate MDG for child immunization against measles underscores the importance of immunization. In 1998-99, only 50.7 percent of children had received the measles vaccine and an underwhelming 42 percent of children had had a complete set of vaccinations (NFHS II).¹⁵ Measles immunization rates have increased slowly, from 42 percent in 1992-93 to 51 percent in 1998-99. Measles vaccination fell in Madhya Pradesh, Rajasthan and Assam over the same six-year period. Tetanus immunization rates for children vary widely across India, with only 16 percent of one-year olds vaccinated in northern Bihar in 1998-99, as opposed to 100 percent immunization rate in eastern Maharashtra (NFHS II).

As mentioned above, maternal mortality rates are extremely high in India, with 407 deaths per 100,000 births in 1998. Programs for maternal health have, in name, been in existence since the 1960s, with the establishment of primary health centers (PHCs) and sub-health centers. International agencies, such as the WHO, the World Bank and UNICEF have all tried their hand at improving maternal health (and obviously decreasing MMR) but, for a number of reasons, including poor strategies devised by poor management capacity, these schemes failed. Strategies for reducing MMR in the 1980s and 1990s have, for the most part, focused mainly on improving antenatal care, traditional birth attendant training and tetanus immunization. In the early to mid 1990s, it was recognized that improving emergency obstetrical care (EmOC) could be more effective in reducing maternal mortality, but this essential component of maternal care was not implemented properly. As stated earlier, Sri Lanka has the lowest MMR in South Asia, at 60 deaths per 100,000 births in 1995. This low MMR can in part be attributed to programs beginning in 1968 that first focused on the development of skilled birth

¹⁴ Neonatal tetanus is a major global public health problem, with an estimated 500,000 incidences each year. Neonatal tetanus, the most common form of tetanus in developing countries, is caused by contamination of the umbilical stump when it is cut by a non-sterile instrument or when dung is applied to the cord. To protect the newborn, women should receive at least two doses of tetanus toxoid vaccine at least four weeks apart (www.who.int/vaccines/en/neotetanus.shtml).

¹⁵ Vaccinations include BCG, DPT (3 doses), Polio (3 doses), measles.

attendance through rural midwives and later on institutional deliveries and EmOC. Not only did Sri Lanka have the correct strategies in place, but it was able to implement them (World Bank Case Studies, 2004a).¹⁶

India's public spending (federal, state and local governments) in the health sector is a mere 0.9 percent of its GDP. With the exception of Indonesia, Pakistan and Nepal, India spends less than other Asian countries. India also spends significantly less than the three-percent average that developing countries spend on health as a percentage of GDP.¹⁷ In terms of health outcomes, it is recognized that preventative care, which includes child immunization and communicable disease control, is more effective than curative, or hospital care. Public spending on preventative measures, such as immunizations, is also found to be more pro-poor than hospital services. In India, most of the public expenditure on health is spent on hospital health services and relatively little is spent on preventative care. Between 1981 and 1999, government spending on public health in most states declined, while the share of spending on medical, or hospital services increased (World Bank, 2004).¹⁸

In terms of coverage of health centers, in 1998, there were 137,006 sub-centers, 23,179 PHCs and 2,913 community health centers in India. There were 665,639 hospital beds or 6.9 hospital beds per 10,000 persons. Based on data collected by the NFHS II, in terms of population coverage, only 13 percent of rural residents had access to a primary health center, 33 percent had access to a sub-center, 9.6 had access to a hospital and 28.3 percent had access to a dispensary or clinic (Bajpai and Goyal, 2004).¹⁹

Even in existing hospitals and PHCs, there are problems with facilities and service delivery. Difficulties arise with doctor and paramedic absenteeism, poor physical infrastructure and cleanliness of hospitals and centers. Lack of oversight and accountability can lead to these problems.

In 1994, the *Rogi Kalyan Samiti* (Patient Welfare Committee) Project was set up in Madhya Pradesh with the concept of managing public hospitals through community participation to improve the efficiency and quality of services. The RKS model is a local response to problems, uses a needs-based approach and its General Body is comprised of local government officials, political leaders, people's representatives, donors, professionals, and community leaders. The General Body is responsible for policy formulation and decision-making, and the Executive Body (elected by the General Body) is responsible for implementation. The RKS is not deemed as a government agency, but is seen almost as an NGO with the freedom to determine user fees on the basis of local circumstances. The use of any money generated from these fees is determined by the

¹⁶ Sri Lanka's public expenditure on health in 2000 was 1.8 percent of GDP (UNDP, 2003).

¹⁷ High-income countries spend an average of five percent of GDP on health.

¹⁸ The share of spending on public health did not decline in Maharashtra, Tamil Nadu and Kerala (World Bank, 2004).

¹⁹ Relative to health coverage in India, 28.36 percent of Chinese villages had health clinics in 1998. In 2000, however, this had decreased to 22.8 percent (UNDP, 2004).

RKS committees, and is not deposited in the state exchequer. (World Bank Case Studies, 2004). It is essentially a model for decentralized hospital management.

The RKS concept has since been standardized by the state government of Madhya Pradesh and has been replicated in 43 district hospitals, 57 civil hospitals and 321 community health centers. Along the same vein, an econometric study of over 1,500 villages, based on a nationwide survey of 33,230 households in 1994, found that under-five mortality rates were significantly lower in states where health services had been significantly decentralized relative to states where no decentralization had occurred (Mahal et al, 2001).²⁰

India accounts for almost a quarter of Tuberculosis (TB) cases in the world, with 2 million cases of this completely curable disease occurring on average per year in the country. TB causes more deaths annually in India – 421,000 deaths per year—than malaria, hepatitis, meningitis, nutritional deficiencies, sexually transmitted diseases, leprosy, and tropical diseases combined (WHO, 1999). Ineffective plans of the past for treating TB have been replaced by a revised plan, which puts into place the WHO's recommended Directly Observed Treatment, Short Course (DOTS) program. With widespread implementation over the years, this intervention program has increased successful treatment of TB cases from three out of 10 cases in 1993 to eight out of 10 in 2001 (Khatri and Frieden, 2002). However, with rising rates of HIV infection, the number of TB cases is likely to rise, as people with HIV are more susceptible to TB (Narayan et al, 2003). In 2001, it was estimated that .79 percent of the adult population (age 15-49) was living with HIV/AIDS and that 170,000 children (age 0-14) were living with the disease as well. There were 2.09 malaria cases and 946 malaria-related deaths in 2000.

The Government's Plan aims to ensure that all villages have sustained access to potable drinking water by 2007. This is again more ambitious than the MDG target value for this measure, which translates into 80.5 percent of rural population with access to improved water by 2015. Since 1990, the proportion of population with sustained access to an improved water source has been increasing in both rural and urban areas and if the rate of improvement is sustained, it is likely that India will meet the goal of halving the proportion of people without sustainable access to safe drinking water by 2015 (MDG 7, target 10). In 1990, 61 percent of the rural population had sustainable access to an improved water source, and by 2000, this was up to 79 percent. The proportion of the urban population with sustainable access to improved water grew from 88 percent in 1990 to 95 percent in 2000. Access to basic sanitation has also improved significantly in urban areas, from 44 percent in 1990 to 61 percent in 2000.²¹ If progress continues at this pace, it is likely that the MDG target value of 72 percent will be met by 2015 (Table 1).

Since India's economic reforms were launched just over a decade ago, the Indian economy has sustained an annual average growth of over six percent. This average

²⁰ States in this study where decentralization had occurred were: Gujarat, Maharashtra, Kerala, Karnataka and West Bengal. The study controlled for mean household income, income inequality, access to transport and availability of health infrastructure.

²¹ There is no data available for rural sanitation access.

actually masks much faster progress in the west and south of India, where the growth in the nineties was comparable to that of the Southeast and East Asian Tigers in their prime. Even though 2002-03 was a drought year, GDP growth exceeded four percent. In 2003-04, GDP growth is expected to be a little over eight percent. India's strong economic growth is succeeding in bringing people out of poverty, though India still has a long way to go before it can eradicate poverty from the country. However, it increasingly appears that the ingredients of rapid poverty eradication are falling into place.

India's foreign exchange reserves are nearly US\$ 120 billion. The current account deficit turned into a surplus over the last four years. This was achieved through non-debt creating flows, so that India's external debt has remained virtually static in nominal terms. The debt servicing and debt GDP ratios have fallen sharply. In fact, India is now repaying foreign debt ahead of schedule. During 2003-04, the government has prepaid about US\$ 3 billion. From a food deficient country, India has moved to a self-sufficient one. During 2003-04, close to US\$ 7 billion of agricultural products were exported. Though impressive, these aggregate figures do not fully capture the quiet transformation that is taking place at the level of enterprises and individuals. Indian enterprises are reaching global scales in quality and output. Corporations from all over the world are coming to India for manufacturing or services, though the total foreign direct investment flows into the country are still quite small.

India is becoming a production base and an export hub for diverse goods, from agricultural products to automobile components to high-end services. Indian firms are now part of global production chains – importing sub-assemblies, adding value to them and re-exporting them. Taking advantage of its pool of high-quality scientific talent, international corporations have established R & D centers in India. All these strengths have resulted in a greater integration with world trade and India's trade has risen from 21 percent to 33 percent of GDP in a decade.

Information technology is transforming rural lives. In a quiet revolution that has linked rural credit with modern technology, 30 million farmer credit cards have been issued in the past six years. From roads to telecommunication, the country is seeing the beginning of a qualitative change and growth in infrastructure. Since April 2003, India has been adding nearly 2 million mobile connections every month. In 1990, there were only six telephone mainlines per 1000 people and in 2001, this number had increased over six-fold, to 38. The enormous successes of India's IT professionals and the new successes of IT enabled services have been made possible by the fact that the data and voice carrying capacity in India is 75 thousand times what it was just 5 years ago.

India's software industry has been growing quite rapidly. The competitive edge of India's IT industry is being enhanced by value-addition in software and by India's rapid advances in the hardware industry. The balance between volumes and value has added strength to the IT industry. India is meeting almost 70 percent demand of the worldwide business process outsourcing (BPO). Operating through satellite links, Indian programmers are providing IT support to U.S. and European firms in areas ranging from software development and maintenance, back-office operations, medical data

transcription and transmission, telemarketing, and in many other areas. Additionally, India is also providing services in the areas of remote diagnosis, engineering design work, market research, updating annual audits, processing insurance claims, filing tax returns, and desktop publishing, among several other areas. U.S. and European firms in the health, insurance, and banking sectors to mention a few are also increasingly resorting to the BPO route to cut their costs. In India, unlike The Philippines, China, Ireland, Israel, or Russia, BPO is sought after by the MNCs not just on cost considerations, but for better quality as well (Bajpai, et al., 2004).

The government has launched an ambitious project for a highways network, which would link the country's major metropolitan centers and provide improved connectivity to rural areas. Between 1990 and 1999, over 1.3 million km of roads were added in the country, bringing the total network up to over 3.3 million km. These roads are already transforming the Indian economy.

Opportunities are also multi-fold in biotechnology. Research & Development has opened a wide avenue of growth in health support systems. Clinical research is breaching new frontiers in medicine. Advances in biogenetics reach out into agriculture and food-processing chains, which will help provide livelihood security for the masses.

Pakistan

Pakistan has a land area of 803,940 square km and in 2001, it was home to 146.3 million people (HDR, 2003). After much debate, Pakistan still does not have an official national poverty line, but available data indicates that from 1994-2000 and from 1997-2003, the proportion of the population living below the poverty line was the same: 33 percent (Table 2). In absolute terms, therefore, the number of poor people in Pakistan has been growing over the years, as population has increased. Clearly, the country is not on target to halve poverty levels by 2015 (MDG 1). The need for the government to agree on a national poverty line as soon as possible is essential. Accurate monitoring of poverty levels without a benchmark or standard definition of poverty is difficult, if not impossible and any efforts aimed at poverty alleviation must first have a target population, which must be defined.

The goal of achieving universal primary education by 2015 (MDG 2) will probably not be met in Pakistan. The little data available indicates that in 1998-99, the primary school net enrolment rate was 71 percent and in 2000-01, this had gone up merely by one percentage point to 72 percent (Table 2). In 1990, the ratio of girls to boys in primary education was .48 and in 2000-01 it was .55. Sixty percent of boys over the age of 10 were literate in 2000-01, while only 34 percent of girls were in this category for the same year (Government of Pakistan). A tremendous amount of work needs to be done in Pakistan to improve the education system and gender equality within it in order to ensure primary education for all by 2015.

Pakistan is off track in terms of reducing child mortality by two-thirds by 2015 (MDG 4). In 1990, the under-five mortality rate was 128 and in 2001, the rate was 109. If

the country were on track towards the target number of an under-five mortality rate of 43 in 2015, the rate should have been reduced to 90.6 by 2001. The situation is no better with Pakistan's IMR. In 1990, the IMR was 96 and in 2001 it was 84. The IMR should have been reduced to 67.8 by 2001, if the country were on track towards reaching the target of 32 by 2015.

The malaria-related mortality rate in Pakistan in 2000 was four (per 100,000), while there were 58 cases (per 100,000) reported. The TB-related mortality rate in 2001 was 45 and there were 178 cases (per 100,000) of TB reported (HDR, 2003).

The proportion of the population with sustainable access to an improved water source was 86 percent in 2000-01, while the proportion of the population with sustained access to sanitation was 62 percent. Between 1990 and 2000, the proportion of the rural population with sustained access to improved water rose from 77 to 87 percent, while urban access decreased from 96 to 95 percent. It is troubling that the numbers indicate that the urban population's access to a sustained water source decreased, though marginally, perhaps as a result of large migration to urban areas. At the same time, it is clear that most work will have to be done in rural areas, as the lower national average can be attributed to the lack of sustainable access to improved water sources there.

Bangladesh

Bangladesh is the third most populous country in South Asia, with one of the world's highest population densities, at 1,052 people per square km. In 2001, it was home to 140 million people in a land area of 133,910 square kilometers (HDR, 2003). In 1990, a strikingly high 59 percent of its people lived below the national poverty line and although this number decreased to 50 percent by the year 2000, Bangladesh needs to make much greater strides if it is to cut its poverty in half by 2015 (Table 3).²² If the country were on track towards reaching MDG 1, the proportion of people living below poverty line in 2000 should have been about 47. If the rate of poverty reduction continues on its current course, it is projected that in 2015, almost 37 percent of its people will still be living below poverty line, as opposed to the MDG target value of 29.5 percent.

The prevalence of underweight children (percent under five years of age) is decreasing at rate that, if sustained, will most likely lead it to meet, if not surpass, the goal of halving the benchmark 1990 number of 67 percent by the year 2015. However, the proportion of undernourished people as a percent of the total population did not diminish between 1990 and 2000, staying at 35 percent. As population has increased over the years, so has the number of the hungry in Bangladesh.

In terms of achieving the goal for universal primary education (MDG 2), Bangladesh is on track with its increasing level of primary school enrolment. The net enrolment ratio in primary education in 1990 was .56 and in 2000, the ratio had sharply

²² Human Development Report reported that between 1990 and 2001, 36 percent of the population lived on less than \$1 a day. This discrepancy demonstrates the potential need to establish poverty line reporting, where possible, as a norm for assessing MDG progress.

increased to .75. If progress continues at its current pace, it is likely that all children will be enrolled in primary school by 2015. However, primary school completion rates should be monitored as well, as enrolment does not translate into completion.

The ratio of girls to boys in primary and secondary education is very promising, in terms of eliminating gender disparity in primary and secondary education (MDG 3, Target 4). In the 1990-91 school year, the ratio of girls to boys in primary education was .81 and in 2000-01, this ratio had gone up to .96. In secondary education, the ratio was even better at .99 in 2000-01.

Bangladesh is on track in terms reducing the infant mortality rate (IMR), but is significantly off track in terms of reducing the under-five mortality rate and the maternal mortality ratio. The IMR was 94 in 1990 and went down to 66 in 2001 and if progress continues at its current rate, the goal of reducing the IMR by two-thirds to a target of 31 will most likely be met (MDG 4, Target 5). The under-five mortality rate was 108 in 1990 and 94 in 2001. Given the current rate of decline, the goal to reduce this mortality rate by two thirds—from 108 to 36—by 2015 will most likely not be met. If the reduction were on track, the under-five mortality rate should have been about 72 in 2001. Bangladesh is on track in its progress towards decreasing, by three-quarters, the MMR (MDG 5, Target 6). In 1990, the MMR was 480 and in 2000, this had decreased to 320, which was even lower than the on-track value of 336.

Tuberculosis and malaria-related mortality rates (per 100,000) are decreasing in Bangladesh. In 1996, the T.B.-related mortality rate was 21.9 and in 2000, it had dropped by almost half, to 11.3. Malaria-related mortality rates between 1999 and 2000 decreased from 1.2 to .64 (HDR, 2003).

The goal to halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation will most likely be met in Bangladesh (MDG 7, Target 10). In 1990, 93 percent of the rural population had sustainable safe-water access and in 2000, this was up to 97. Urban access to safe water started with an even higher benchmark of 99 percent in 1990, and was the same in 2000 (Table 3). Despite these encouraging numbers, Smith, Lingas and Rahman (2000), said of arsenic poisoning, “It is estimated that of the 125 million inhabitants of Bangladesh between 35 million and 77 million are at risk of drinking contaminated water.” Basic sanitation access is improving in Bangladesh. In 1991, only 21 percent of the urban population had access to basic sanitation and in 2003, this had more than doubled, at 48 percent. If progress continues at its current pace, it is likely that almost three quarters of urban Bangladeshis will have access to basic sanitation by 2015.

Nepal

Nepal is a landlocked country with a land area of 140,800 square km and a population of 24.1 million (HDR, 2003)). In 1990, 42 percent of the population lived below poverty line and in 2000, this had declined very little, to 38 percent (Table 4). If Nepal were on track towards halving its poverty levels by 2015 (MDG 1), the proportion

of people below poverty line in 2000 would have been about 33.6 percent. Nepal is not on track to halve the proportion of people who suffer from hunger either (MDG 1, Target 2). In 1990, 57 percent of children under five were underweight and in 2000, this had decreased to 48 percent. At the same time, the proportion of undernourished people was 19 percent for both 1990 and 2000, meaning that in absolute terms, the number of people suffering from hunger grew.

In 2000-01, 72 percent of children were enrolled in primary school. Although no earlier data on primary school enrolment could be found, it is clear that in order to have 100 percent enrolment by 2015, a significant effort will have to be made. Also, as mentioned earlier, primary completion rates should be monitored as well, as enrolment does not translate into completion (MDG 2, Target 3). The literacy rate of 15-24-year olds increased from 46.6 percent in 1990 to 62.7 percent in 2002. The ratio of girls to boys in primary education in 1990-91 was .56 and in 2000-01, it was .79, putting it on track in terms of eliminating gender disparity in education by 2015 (MDG 2, Target 4).

Nepal is well on track in terms of meeting the goal to reduce the child mortality rate by two-thirds between 1990 and 2015 (MDG 4). In 1990, the under-five mortality rate was 145 and in 2001, it was 91. The country is also on track to reduce the IMR by two-thirds by 2015. In 1990, the IMR was 100 and in 2001 it was 68.6. The MMR in Nepal between 1985-2001 was 540 (HDR, 2003).

The malaria-related mortality rate (per 100,000) in Nepal was 8 in 2000 and the number of malaria cases (per 100,000) was 33. The TB mortality rate (per 100,000) in 2001 was 28 and in the same year, there were 207.6 cases of the disease (per 100,000).

Nepal is doing well, for the most part, in terms of halving, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation (MDG 7, Target 10). In 1990, 64 percent of the rural population had access to safe drinking water and in 2000, 87 percent had access. This already surpasses the MDG target of 82 for this indicator. In 1990, 93 percent of the urban population had sustainable access to safe drinking water and this increased by one percentage point, to 94 percent, in 2000. The proportion of the total population with access to a safe water source was 67 percent in 1990 and 88 percent in 2001, which shows how strongly these numbers correspond with the situation of the rural population. In 1990, 69 percent of urban population had access to improved sanitation, but in the same year, only 20 percent of the total population had access. In 2000, the situation had improved for the urban population, which was almost on-track with 73 percent with basic sanitation access, but the proportion of the total population with access to improved sanitation increased only to 28 percent, which was off-track.

Sri Lanka

Sri Lanka is a small island nation with a land area of 65,610 square km and a population of 19.6 million in 2001 (HDR, 2003). Between 1995 and 2001, about 25 percent of its population lived below poverty line (World Bank, "Sri Lanka at a Glance,"

2003). Between 1990-92, 29 percent of its people were undernourished and in 1998-2000, this had decreased to 23 percent, putting the country on track to reducing by half the proportion of people who suffer from hunger between 1990 and 2015 (MDG 1) (Table 5).²³

The primary education system seems fairly advanced in Sri Lanka, as primary school completion rate was 100 percent in 2001. In the 2000-01 school year, the net enrolment ratio in primary education was 97 percent. In 1990, the literacy rate of 15-24-year olds was 95.1 percent and in 2001, it had increased to a high 96.9 percent, with a female to male ratio of one. The ratio of girls to boys in primary education was .93 in 1990-91 and .94 in 1998-99. Even if the ratio increases by only point one of one percentage point per year, by 2015, it is likely that Sri Lanka will have eliminated gender disparity in primary education.

In 1990, the under-five mortality rate in Sri Lanka was 23 and in 2000 it was 17.9. These rates are much lower than those of other South Asian countries, but technically, Sri Lanka's under-five mortality should have been 17 for it to be on track to reducing this rate by two-thirds between 1990 and 2015 (MDG 4). Similarly, the IMR in 1990 was 18.5, much lower than that of its neighbors. If Sri Lanka were to reduce this rate by two-thirds by 2015 to 6, its IMR would be lower than that of high-income OECD countries in 2001, which was 7. The MMR in Sri Lanka was 60 in 1990 and did not change in 1995. This puts Sri Lanka off track in terms of reducing the MMR by three-quarters between 1990 and 2015.

Malaria in Sri Lanka is widespread. In 2000, there were 1,110 cases (per 100,000) of the disease and the malaria-related mortality rate was nine (per 100,000). In 2001, there were 50 TB cases (per 100,000) and 11 TB-related mortalities (per 100,000) (HDR, 2003).

Sri Lanka is very much on track in terms of halving, by 2015, the proportion of people without sustainable access to safe drinking water and sanitation (MDG 7). In 1990, 68 percent of all Sri Lankans had access to safe water and in 2000, 77 percent had access. The numbers are much higher for the urban population; 91 percent had access to safe water in 1990, and 98 percent had access in 2000. At the same time, 62 percent of the rural population had sustainable access to safe drinking water in 1990 and 70 percent in 2000, which reflects the disparity between rural and urban access to population. The proportion of all Sri Lankans with access to improved sanitation was 85 in 1990 and 94 in 2000. In the same years, the proportion of the urban population with access to sanitation was 94 percent and then 97 percent. As is mentioned earlier, the rural areas need the most attention in terms of improving basic water and sanitation access, as these areas are pulling down the national average for these indicators.

²³ It is not possible to determine whether Sri Lanka is on track to reduce poverty by half, as there is no benchmark year data available.

Bhutan

Bhutan is a small, landlocked country, situated between China and India, with a land area of 47,000 square kilometers. In 2001, its population was 2.1 million (HDR, 2003). The country does not have a poverty monitoring system or a national poverty line and relatively little is known about the extent of poverty there (UNDP). Initial surveys indicate that the average per capita household income is below \$1 a day, and one quarter of Bhutan's population lives on less than 46 cents a day (UNDP).²⁴ Because poverty monitoring systems are not in place, it is not possible to track Bhutan's progress in terms of halving extreme poverty by 2015 (MDG 1).²⁵

The primary school completion rate in 2000 was 40.66 and in 2002, it was 43.7 percent (HDR, 2003). The ratio of girls to boys in primary education in the 2000-01 school year was .86. Even though 1990 data is not available for these indicators, it is clear that significant progress will have to be made to meet the goal of ensuring that all children, boys and girls alike, will be able to complete primary school (MDG 2).

The under-five mortality rate in Bhutan was 166 in 1990 and this decreased to 95 in 2001 (WDI, 2003). This is quite a dramatic decline and it puts Bhutan well on track to achieve the goal of reducing by two-thirds, the under-five mortality rate by 2015 (MDG 4).²⁶ In 1992, the IMR was 75 and in 2001, this had gone down only by one, to 74. If Bhutan were on track to reducing the IMR by two thirds by 2015, the IMR should have been down to about 67 by 2001. In 1995, the maternal mortality ratio was 500.

The malaria-related mortality rate (per 100,000) was 5 in 2000 and the number of malaria cases (per 100,000) was 285. The TB-related mortality rate (per 100,000) in 2001 was 24 and the number of cases (per 100,000) was 114 (HDR, 2003).

In 2000, 60 percent of rural Bhutanese and 86 percent of urban Bhutanese were living with sustainable access to an improved water source. Sixty-five percent of the urban population had access to improved sanitation. Again, since there is only one year of measurement available for these indicators, it is impossible to assess Bhutan's progress in terms of reaching the MDGs.

Maldives

The Maldives is a nation made up of over 1000 tiny islands, stretching from the southern tip of India to the equator. The total land area of Maldives is only 300 square km and its population in 2001 was 300,000 (HDR, 2003). The islands are low-lying and extremely poor in both commercial natural resources, such as minerals, and basic natural

²⁴ This information is from the UNDP web page (http://www.undp.org.bt/Poverty_reduction.htm) and there is no date given for when these initial surveys were taken or who conducted them.

²⁵ When poverty monitoring systems do come into use, it is unclear as to how progress would be tracked from 1990 onward.

²⁶ No information was found as to what led to this significant decline.

resources such as water and arable land. Few of them are larger than one square km and only 199 are inhabited. Despite the constraints of isolation, population dispersion and lack of natural resources, the country has made great strides in economic and social development since the 1980s. Throughout much of the 1980s, the archipelago's GDP growth exceeded 10 percent per year and this declined to a more sustainable 6.2 percent growth in 1996-97 (Shaljan, 2004). Much of the growth has been attributed to the exploitation of the islands' marine resources, with fishing and tourism now deeply rooted in the domestic economy. There is no poverty data available for this country.

The literacy rate of 15-24 year olds in 2001 in the Maldives was a very high 99.1 and the ratio of girls to boys in primary school for the same year was .95. The ratio of literate males to females was 1 in both 1990 and 2001 (HDR, 2003).

The Maldives is on track in terms of reducing child mortality by two-thirds between 1990 and 2015 (MDG 4, Target 5). In 1990, the under-five mortality rate was 115 and in 2001 it was 77. The IMR in 1990 was 80 and in 2001 it was 58. The maternal mortality ratio was 390 in 1995.²⁷

One hundred percent of the population in the Maldives had sustainable access to an improved water source and basic sanitation in 2000.

Economic and Social Challenges in South Asia and Policy Responses:

Whether they are the developing countries in South Asia, Africa or in Latin America, they are all faced with the task of building the two basic pillars of economic development. Broadly speaking, these are human development and economic growth. Human development signifies the ability of all individuals to reach their full potential as healthy and educated citizens. This in turn requires major government commitments to health, education, and political participation of all citizens in the country – with equal opportunity for all, and without discrimination by gender, caste, or region. Economic growth signifies the broad-based and sustained increase in per capita GNP. Sustained economic growth depends on favorable business conditions, high levels of private-sector investment, technological upgrading, and successful integration into global markets.

Undoubtedly, there can be no sustained economic development without strong successes in both human development and economic growth. Development strategy therefore requires major public commitments to social sectors (especially health and education) and to improvements in the business environment in order to promote large-scale private investments needed for economic growth.

From a budgetary point of view, government resources in South Asian countries need to be shifted towards investments in human development, leaving the private sector with the major responsibilities for increased economic growth. The government at both federal and state/province levels in these South Asian countries should commit much greater resources to public health and education. At the same time, the government

²⁷ No other MMR data was located.

should turn over major infrastructure investments (in ports, airports, telecommunications, internet, electricity, large-scale water and sanitation facilities, and major roads) to private investors who can finance these projects using private capital.

Briefly put, only government spending can promote the needed improvements in primary health and education. And similarly, it will largely be private spending that can promote the needed improvements in infrastructure and productive enterprises. Of course, to the extent possible, public investment should supplement private investment in improving infrastructure. The major budgetary challenge facing the South Asian economies is to shift government spending away from low-priority areas (such as untargeted subsidies, excessive bureaucracy, and investments that can better be left to the private sector) towards high-priority areas, such as primary health and education, that can only be met by public spending. Countries of the region should also mobilize international financial support for achieving their development targets. This includes larger aid flows for human development as well as much greater flows of private investment to speed economic growth.

Meeting the Human Development Challenge in South Asia

Barring Sri Lanka, South Asian countries have not yet met the human development challenge. Adult illiteracy remains almost 50 percent, and up to 60 percent for women. Almost half of all children do not finish primary school. Only around 20 percent are in secondary school. Infant mortality rates are high by international standards, and life expectancy at around 63 years is much lower than in other countries in East Asia, and the advanced economies. Fertility rates are still very high, and the population continues to grow rapidly, pressing hard on the region's fragile ecosystems and natural environment.

The shortfalls in health, education, and population control are of course mutually interactive. Illiterate mothers are much more likely than literate mothers to suffer the deaths of young children due to disease, since literate mothers are more effective at care giving and at seeking out medical help in emergencies. High infant mortality rates promote high fertility rates, since households have many children to compensate for the risks of childhood deaths. High fertility rates, in turn, promote a social bias against educating young girls, since parents lack the resources to provide a quality education for all of their children, and therefore invest scarce resources in boys, for whom the market returns to investment are higher.

As mentioned earlier, South Asian countries dramatically under-invest in both public health and education and so do many other developing countries. In India, for instance, in the area of health, the government (central and state-level) spends less than 1 percent of GNP for health, compared to an average of around 3 percent for all developing countries, and more than 5 percent for high-income countries. The public health services are broken down, especially at the primary level. Study after study shows that the primary health centers (PHCs) fail to provide an adequate set of services for the population. The poor in India are left with almost no health services, besides the very meager services that

they can pay for out of pocket. The situation in health will get worse, not better, if there is no increase in public investment in health. The AIDS epidemic threatens to rise dramatically in the region, especially in India in the coming years. Malaria is resurgent, as is tuberculosis linked especially to AIDS.

South Asian governments need to put together a bold strategy for universal education, at least through age 14, similar to the strategy that India has adopted. Special attention is needed to ensure the education of girls on the same basis as boys, and to ensure the continuation of children in school through the ninth year. Public spending in education should rise from the current level of around 3 percent of GNP to at least 5 percent of GNP (and probably more) to meet these goals. This money should be spent mainly by state budgets, but with local responsibility for overseeing the effective operation of schools. In the Indian state of Madhya Pradesh, for example, panchayats are given responsibility for ensuring school performance at the local level, including the right to withhold teachers' salaries in the event of poor teacher performance.

Studies have shown that more parents would like to send their children to school, but are dissuaded from doing so because of school fees, the poor quality of education in many schools, and great distances from home to school in rural areas. The large distances to schools especially hinder the attendance of girls. Part of the budgetary increase at the state level should therefore be to ensure the availability of schools within close proximity to every village.

One of the most effective ways to increase student enrolments, as mentioned earlier, is through the provision of free school meals (e.g. school breakfasts or mid-day meals, or both). The Indian state of Tamil Nadu has been very successful in implementing school meals program, and this example should be generalized not only throughout India, but also throughout the South Asian region. International donors, especially the United States, may be prepared to contribute to such a large-scale program, especially if the governments of the countries in the region can demonstrate that such a program is an integral step in achieving universal primary education. School meals not only improve school enrolments and attendance, but also childhood nutrition. Regular school meals can be augmented with nutritional supplementation, such as Vitamin A tablets on a six-month basis.

In addition to formal education in schools, the governments should promote programs of adult literacy. Students and literate family members can be encouraged to help teach their illiterate parents how to read. Small financial incentives can be organized to promote adult literacy. This would also enable the private sector to open private enterprises to promote adult literacy, with income generated by financial incentives provided by the government.

The social agenda should focus most urgently on health and education, but it should also include other social initiatives, such as increased political participation at the village level (through village councils or panchayats), and greater social and political equality for girls and women.

Growth Strategies for the Coastal and Interior Regions

Investments in health and education will have direct and beneficial effects on economic growth, by fostering a healthier, better educated, and therefore more productive labor force. But social investments are not enough. Social investments must be combined with a large improvement in the business environment in these countries in order to promote a more rapid rate of economic growth.

Export-led Growth – coastal regions

History has shown that export-led growth is a crucial component of overall economic growth. Without rapid export growth, there cannot be rapid growth of imports. But imports are necessary in order for the South Asian countries to obtain the modern technologies that have been developed abroad. Thus rapid export growth is a sine qua non for rapid economic growth. In South Asia, five of the seven countries in the region can become major platforms of labor-intensive manufacturing exports – Bangladesh, India, the Maldives, Pakistan, and Sri Lanka.

Rapid export growth can only be achieved in areas of comparative advantage in each of these five countries. These include labor-intensive manufacturing sectors such as apparel and textiles, automotive components, footwear and leather goods, jewelry, processed foods, and electronics assembly. In the Indian context, they also include high-technology areas in information technology and biotechnology (e.g. pharmaceuticals) that rely on India's tremendous scientific and engineering capacity.

There are several barriers to more rapid export growth. Fortunately, most of these barriers can be overcome by regulatory changes and private investments rather than public money. Some of the crucial steps needed for a faster growth of exports include:

- Reform of labor laws to ensure the right of enterprises to hire and fire workers for economic cause, subject to the normal rule of law (e.g. prevention of arbitrary dismissals in retribution for union activity). Especially relevant to India.
- Improvements of infrastructure, mainly ports, telecommunications, airports, power, and roads (discussed below).
- Elimination of remaining administrative barriers to foreign direct investment in export oriented sectors (e.g. elimination of need for government approvals).
- Much more active use of special economic zones and export processing zones as incentive schemes for export-oriented enterprises. As in India since March 2000, states and private enterprises should be free to establish export processing zones according to general legislation.

- Elimination of reservations for small-scale enterprises, especially relevant to India, in export oriented sectors but also generally in the economy

Agriculture-led Growth – interior regions

South Asian countries continue to be predominantly agrarian economies with majority of their populations depending on agriculture for livelihood. In India, for instance, agriculture contributes 27 percent to the country's GDP and employs more than 60 percent of the workforce. No wonder then that all round development of India as a nation rests on a sustained and holistic development of rural India. The predominantly rural nature of South Asian nations emphasizes the need to bring about sustainable development of the rural areas and its people. However, despite all the efforts over the years, rural areas have not kept pace with their urban counterparts. The reasons for this are many and include, besides others, historical as well as geographical marginalization.

We are of the view that South Asia's rural development in general, and India in particular would essentially require an agriculture-led growth strategy. In short, the rural development strategy for the region may perhaps focus along the following lines:

- 1) Agriculture-led growth as the main area of focus; under which, some of the key objectives may be:
 - a) Productivity improvements, including agricultural extension, research and development, and crop diversification
 - b) Bringing in larger areas under irrigation so as to reduce monsoon dependence
 - c) Enhanced focus on agricultural exports
- 2) Much greater focus on building up rural infrastructure, with specific focus on power, irrigation, roads, and availability of safe drinking water, and
- 3) Rural industrialization wherein agro-based industries could be the first order of business

In India, agricultural-productivity-led growth occurred in one major historical period, the Green Revolution, dating from 1965-66 to the early 1980s. The Green Revolution was centered on short-stemmed, high-yield wheat, and to a lesser extent paddy rice, with both crops depending on irrigation and intensive application of fertilizer. The epicenter of the Green Revolution was Punjab and Haryana, and to a lesser extent other states of the North Indian Plains (as far east as Bihar) and southward to Rajasthan, Gujarat, and Maharashtra. High-yielding rice varieties made their impact most powerfully in West Bengal and Tamil Nadu. The introduction of Mexican wheat and Philippine rice hybrids together with higher usage of agricultural inputs and mechanization resulted in India becoming surplus in food grains production. However, the Green Revolution initiated high rates of growth (pre-1980) in crop production that could not be sustained in the last two decades of the 20th century. Growth rates fell from 3.2 percent during the Green Revolution period to 1.7 percent during the 1980s and the 90s. For the most part, this decline is attributed to the sharp fall in yield growth from 2.6

percent in the 1980s to 1.0 percent in the 1990s. In short, not only is a second Green Revolution needed, but it is needed in the hugely populated states of U.P., Bihar, Madhya Pradesh, and Orissa.

One of the key factors to be looked into for raising agricultural productivity will undoubtedly be on research and development. Public spending on R & D has been a mere 0.46 percent of agricultural GDP. This is way below the average of about 1.5 percent for developing countries as a whole and about 3 percent in a developed country, such as the U.S. Stepping up the public expenditure significantly on R & D for agriculture is therefore critical for India. Additionally, the agricultural research organizations in India need to develop suitable and pragmatic research agendas, especially keeping the north Indian states in view.

Similarly, extending irrigation facilities on a much larger scale is vital. Of the 182.7 million hectares²⁸ of land used for crop cultivation in India, only about 50 million hectares is currently irrigated, leaving the rest to be totally dependent on monsoon rains. India's high GDP growth of around 8 percent in 2003/04, owes a great deal to the agricultural sector doing well, largely due to a good monsoon. Frequent droughts have played havoc with the farming community in India.

Another area for focus is agricultural sector exports. In 2000/01, India exported agricultural products worth \$6 billion, roughly 13.5 percent of total national exports in 2002/03. India's share in world production of several commodities is quite significant, but its share in their trade is very low. Exports will not only create new employment opportunities, but will also increase price realization by the farmers and thereby earn foreign exchange for the country. In order to raise agricultural exports, the necessary export infrastructure needs to be in place, such as storage, port handling facilities, and large scale processing technology, among others. Additionally, not only is raising crop productivity important, improving their quality so as to compete in the global market is equally significant.

Improvements in Infrastructure

Infrastructure conditions in all the South Asian countries is very poor. The road networks are insufficient and of very poor quality. In India, for instance, ports are completely inadequate, so most exports must be transshipped through Singapore or Sri Lanka, rather than shipped directly from Indian ports. Airports are insufficient and the airspace is reserved for just a few carriers. Telecommunications are notoriously poor in quality and coverage. Electricity supplies are irregular, scarce, and of low quality. Water supplies are scarce in many areas, and insufficient for key industries (such as chemical processes) as well as household use. And in general, neither the central government, nor the state/province level governments can afford to upgrade these infrastructure systems out of budgetary funds. Indeed, many of these sectors already impose huge fiscal costs as governments provide overt and hidden subsidies to these key sectors.

²⁸ This represents the largest acreage of cropland in the world.

Several South Asian countries, such as India, Pakistan and Sri Lanka could enjoy a major – indeed fundamental – improvement in infrastructure quality without major budgetary increases. The key is regulatory change, involving two main steps. First, regulatory and oversight responsibilities for almost all infrastructure should be devolved to the province/state level. This includes areas now under federal control, such as major ports and airports, and telecommunications. The states/provinces have a much better idea of their specific infrastructure needs than do the bureaucracies at the federal level. Second, infrastructure should be provided mainly by privately financed projects without state/province guarantees. For example, the entire cable TV industry in India has grown up without government subsidy, precisely because it was not regulated. Other key areas – telecommunications, Internet, water, power – would similarly expand dramatically if private investors were allowed to enter and compete.

Concluding Remarks:

More than a billion people suffer from abject poverty in developing countries and nearly half of them reside in South Asia (millenniumgoals.org). The Millennium Development Goals set out to halve, between 1990 and 2015, the number of people suffering from poverty and hunger and to alleviate other poverty-related problems, such as high infant and maternal mortality rates and low rates of primary school enrolment and completion. As the year 2015 draws near, the challenge of meeting the goals in South Asia is immediate and the need for more focused strategies and interventions is apparent.

There are wide inter and intra state/province variations in social, economic and demographic indicators in the South Asian region. For South Asia as a whole, and for India in particular, a targeted approach that focuses on states and even districts that have historically poor human development indicators and are lagging on the MDGs, could be instrumental in the attainment of the goals. Not only would a focused approach help individual states rise from the conditions of poverty, but taken together, progress in states will not only help India, but the region as a whole. With a population of over one billion in a region comprised of 1.37 billion, India's achievements will have a significant impact on the entire South Asian region in terms of meeting the MDGs.

In India, Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh (BIMARU) and Orissa are examples of states that could greatly benefit from having MDGs set at the state and district level. Out of India's 569 districts, the majority of the districts in the BIMARU states were the lowest ranking districts of a composite index of socioeconomic and demographic indicators in 2001 (Bajpai and Sachs, 2004). In comparison, over 90 percent of Kerala's and Tamil Nadu's districts fell into the highest category. In 1990, the IMR (per 1000 live births) in the BIMARU states ranged from 75 in Bihar to 111 in Madhya Pradesh, compared to a low of 18 in Kerala and 60 in Tamil Nadu. Orissa's IMR was remarkably high, at 123. Even if Orissa were to reduce IMR by two-thirds to 41 by 2015, its IMR would still be well above the all-India MD goal of 27. Madhya Pradesh and Uttar Pradesh are in situations similar to Orissa, in that if the states reduce their IMRs by two thirds, they will fall well below the country mean. Rajasthan and Bihar would fall closer to the mean.

India under-invests in both public health and education, spending less than one percent of its GDP on health, compared to the average three percent spent by developing countries. At \$4 per capita in public spending on health, India's health system is in a state of disrepair, as many hospitals and primary health centers have poor physical infrastructure, and have high rates of doctor and paramedic absenteeism. The high rates of infant mortality, under-5 mortality and maternal mortality are a reflection of the poor state of the health system. Study after study shows that the PHCs fail to provide an adequate set of services for the population. The poor in India are left with almost no health services, besides the very meager services they can pay for out of pocket.

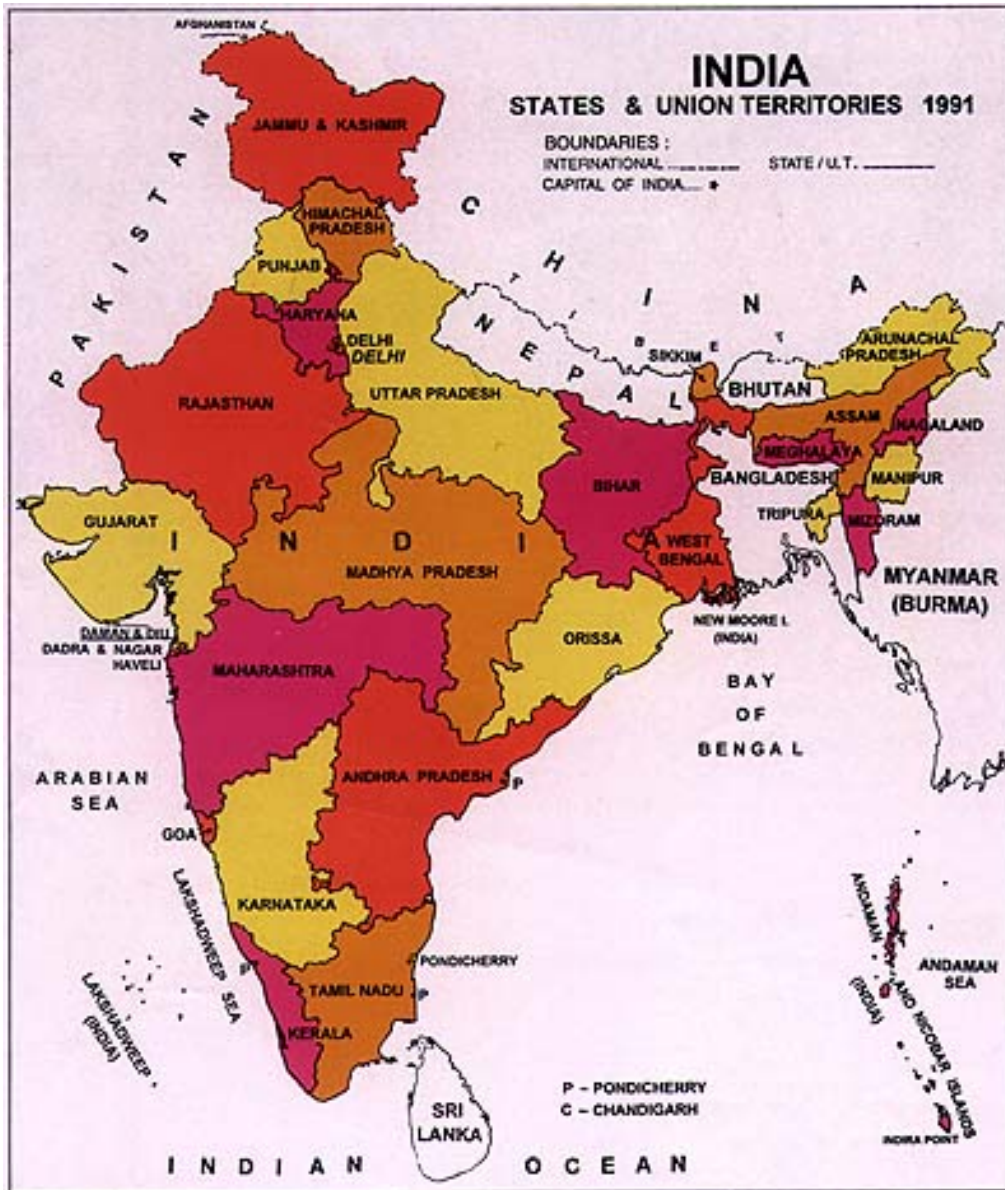
India currently spends about three percent of its GDP on education. Primary enrolment rates in the country are 52.5 percent—a far cry from the 100 percent MD goal of 100 percent enrolment. In 2000, the primary completion rate was 61.4 percent. Although over 90 percent of Indians have access to a school within one kilometer of their residence, the lack of basic facilities, such as classrooms and water and sanitation, along with high rates of teacher absenteeism are factors that decrease enrolment and completion rates.

India, like other South Asian countries, continues to be a predominantly agrarian economy. Agriculture contributes 27 percent to the country's GDP and employs over 60 percent of the workforce. Agriculture-led growth could be instrumental in lifting the rural poor from the depths of poverty. Improvements in productivity and rural infrastructure are needed to enhance growth, as well as significant increase in spending on agricultural research and development. India spends only 0.46 percent of its agricultural GDP on agricultural R&D, as opposed to 1.5 percent in developing countries and three percent in the U.S.

The Common Minimum Program (CMP) of the Congress-led United Progressive Alliance pledged to increase public spending on health to at least 2-3 percent of GDP between 2004-09 and to increase public spending on education to at least 6 percent of GDP in phases. While this is certainly encouraging, these increases too fall short of the needed public investments in these social sectors. Increasing spending in health and education is necessary to effect change, but higher spending should also be coupled with reform of the institutions of service delivery. Decentralization from the state to the local levels in these sectors could lead to better control and oversight, and ultimately, to accountability of teachers and doctors, especially in the rural areas.

Briefly put, the priority areas requiring focused attention of the South Asian governments are the elimination of illiteracy, sizeable reductions in infant, under-five, and maternal mortality rates, eradication of diseases such as malaria, tuberculosis, and polio, provision of adequate transportation facilities in the form of roads, railroads, reliable power, and universal access to safe drinking water and sanitation.

Figure 1: South Asia



Source: <http://www.censusindia.net/india.html>

Land area and population in South Asia, 2001

	India	Pakistan	Bangladesh	Nepal	Sri Lanka	Bhutan	Maldives
Land Area (sq. km)	3287590	803940	133,910	140800	65610	47,000	300
Population (millions)	1003.4	146.3	140.9	24.1	18.8	2.1	0.3

Source: HDR, 2003

Table 1: Progress towards achieving the MDGs in India

Indicator	Year	Value	Year	Value	On-track value*	Linearly projected 2015 value	MDG target value	Status
Proportion of population below poverty line (%)	1990	37.5	1999-2000	26.1	30	9	18.75	On-track
Undernourished people as % of total population	1990-92	25	1998-2000	24	20	22.5	12.5	Off-track
Literacy rate of 15-24 year olds	1990	64.3	2001	73.3	N.A.	84.7	None	N.A.
Ratio of girls to boys in primary education	1990	0.71	2000	0.96	0.83	1	1	On-track
Under-five mortality rate (per 1000 live births)	1990	123	2001	93	87	54.8	41	Off-track
Infant mortality rate (per 1000 live births)	1990	80	2001	66	56.7	48.1	27	Off-track
Maternal mortality ratio (per 100,000 live births)	1991	437	1998	407	332	405	109	Off-track
Population with sustainable access to an improved water source, rural (%)	1990	61	2000	79	69	100	80.5	On-track
Population with sustainable access to an improved water source, urban (%)	1990	88	2000	95	90	100	94	On-track
Population with access to sanitation, urban (%)	1990	44	2000	61	55	86.5	72	On-track

*The on-track value is a linear projection that reflects where the country should have been, for the last year of available data, in order to meet the MDG target value.

Source: Human Development Report, 2003; World Development Indicators, 2003; Economic Survey of India, 2002-03; authors' calculations.

Table 2: Progress toward achieving the MDGs in Pakistan

Indicator	Year	Value	Year	Value	On-track value*	Linearly projected 2015 value	MDG target value	Status
Proportion of population below poverty line (%)	1994-2000	33	1997-2003	33	N.A.	33	N.A.	N.A.
Undernourished people as % of total population	1990-1992	25	1998-2000	19	20	10	12.5	On-track
Net enrolment in primary education (%)	1998	71	2000	72	N.A.	N.A.	100	N.A.
Literacy rate of 15-24 year olds	1990	47.4	2001	57.8	N.A.	71	N.A.	N.A.
Ratio of girls to boys in primary education	1990	0.48	2000	0.55	0.7	64.8	1	Off-track
Under-five mortality rate (per 1000 live births)	1990	128	2001	109	90.6	84.8	43	Off-track
Infant mortality rate (per 1000 live births)	1990	96	2001	84	67.8	69	32	Off-track
Population with sustainable access to an improved water source, rural (%)	1990	77	2000	87	81.6	100	88.5	On-track
Population with sustainable access to an improved water source, urban (%)	1990	96	2000	95	96.8	93.5	98	Off-track
Population with access to sanitation, urban (%)	1990	77	2000	95	81.6	100	88.5	Achieved

*The on-track value is a linear projection that reflects where the country should have been, for the last year of available data, in order to meet the MDG target value.

Source: Pakistan Integrated Household Survey (PIHS), 2000-01, World Development Indicators, 2003; Human Development Report, 2003; World Bank Group, "Pakistan at a Glance," 2004; authors' calculations.

Table 3: Progress towards achieving the MDGs in Bangladesh*

Indicator	Year	Value	Year	Value	On-track value**	Linearly projected 2015 value	MDG target value	Status
Proportion of population below poverty line (%)	1990	59	2000	50	47.2	36.5	29.5	Off-track
Prevalence of underweight children under 5 (%)	1990	67	2000	51	54	27	33.5	On-track
Undernourished people as % of total population	1990-1992	35	1998-2000	35	28	35	17.5	Off-track
Net enrolment in primary education (%)	1990	56	2000	75	73.6	100	100	On-track
Primary completion rate	2000	72.49	2002	76.82	N.A.	N.A.	100	N.A.
Literacy rate of 15-24 year olds	1990	42	2000	49	N.A.	62.5	N.A.	N.A.
Ratio of girls to boys in primary education	1990	0.81	2000	0.96	0.89	1	1	On-track
Under-five mortality rate (per 1000 live births)	1990	108	2001	94	72	76	36	Off-track
Infant mortality rate (per 1000 live births)	1990	94	2001	66	66	30	31	On-track
MMR (per 100,000 live births)	1990	480	2000	320	336	80	120	On-track
Population with sustainable access to an improved water source, rural (%)	1990	93	2000	97	94.4	100	96.5	Achieved***
Population with sustainable access to an improved water source, urban (%)	1990	99	2000	99	99.4	99	99.5	Off-track
Population with access to sanitation, urban (%)	1991	21	2003	48	50	73	60.5	Off-track

*Wherever possible, country partner data was used. This data is not consistent with other data from other sources.

**The on-track value is a linear projection that reflects where the country should have been, for the last year of available data, in order to meet the MDG target value.

***This may be questionable, depending the extent of arsenic contamination and poisoning in Bangladesh. This data was reported by World Bank Country Partners in Bangladesh in the MDG Needs Assessment Bangladesh Country Study (2004).

Source: MDG Needs Assessment: Bangladesh Country Study, 2004; Country Partner; Human Development Report, 2003; World Development Indicators, 2003; authors' calculations.

Table 4: Progress towards achieving the MDGs in Nepal

Indicator	Year	Value	Year	Value	On-track value*	Linearly projected 2015 value	MDG target value	Status
Proportion of population below poverty line (%)	1990	42	2000	38	33.6	44	21	Off-track
Prevalence of underweight children under 5 (%)	1990	57	2000	48	45.6	61.5	28.5	Off-track
Undernourished people as % of total population	1990	19	2000	19	15.2	19	9.5	Off-track
Literacy rate of 15-24 year olds	1990	46.6	2002	62.7	N.A.	80.1	N.A.	N.A.
Ratio of girls to boys in primary education	1990	0.56	2000	0.79	0.74	1	1	On-track
Under-five mortality rate (per 1000 live births)	1990	145	2001	91	102	22	48	On-track
Infant mortality rate (per 1000 live births)	1990	100	2001	68.6	70	28.6	33	On-track
Population with sustainable access to an improved water source, rural (%)	1990	64	2000	87	71.2	100	82	Achieved
Population with sustainable access to an improved water source, urban (%)	1990	93	2000	94	94	95.5	96.5	On-track
Population with sustainable access to an improved water source, total (%)	1990	67	2001	88	74	100	83.5	Achieved
Population with access to sanitation, urban (%)	1990	69	2000	73	75	79	84.5	Off-track
Population with access to improved sanitation, total (%)	1990	20	2001	28	37.6	38	60	Off-track

*The on-track value is a linear projection that reflects where the country should have been, for the last year of available data, in order to meet the MDG target value.

Source: Human Development Report, 2003; World Development Indicators, 2003; UN Nepal MDG Progress Report, 2002; authors' calculations.

Table 5: Progress towards achieving the MDGs in Sri Lanka

Indicator	Year	Value	Year	Value	On-track value*	Linearly projected 2015 value	MDG target value	Status
Undernourished people as % of total population	1990-92	29	1998	23	23.2	14	14.5	On-track
Primary completion rate	1990	100.38	2001	108.1	N.A.	N.A.	100	Achieved
Literacy rate of 15-24 year olds	1990	95.1	2001	96.9	N.A.	97	N.A.	N.A.
Ratio of girls to boys in primary education	1990	0.93	1998	0.94	0.96	0.96	1	Off-track
Under-five mortality rate (per 1000 live births)	1990	23	2000	17.9	17	10.2	8	Off-track
IMR (per 1000 live births)	1990	18.5	2000	15	13.5	9.8	6.2**	Off-track**
MMR (per 100,000 live births)	1990	60	1995	60	52.6	60	15	Off-track
Population with sustainable access to an improved water source, rural (%)	1990	62	2000	70	69.6	88.8	81	On-track
Population with sustainable access to an improved water source, urban (%)	1990	91	2000	98	92.8	100	95.5	Achieved
Population with sustainable access to an improved water source, total (%)	1990	68	2000	77	74.4	90.5	84	On-track
Population with access to sanitation, urban (%)	1990	94	2000	97	95.2	100	97	Achieved
Population with access to improved sanitation, total (%)	1990	85	2000	94	88	100	92.5	Achieved

*The on-track value is a linear projection that reflects where the country should have been, for the last year of available data, in order to meet the MDG target value.

**If Sri Lanka were to reduce its IMR by two-thirds by 2015 to 6, its IMR would be lower than that of high-income OECD countries.

Source: Human Development Report, 2003; World Development Indicators, 2003; World Bank Group, "Sri Lanka at a Glance," 2003; authors' calculations.

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