2. STATUS OF THE SOCIAL SECTORS

Section 1 argues that macroeconomic performance in South Asia is on a strong growth track, but also noted that a wide range of issues may challenge the sustainability of this high growth. This section provides

- an overview of the status of education and health in South Asia, highlighting the key issues and challenges related to the nonincome MDGs (box 2.1) pertaining to education and health, as well as other aspects of education and health that affect the performance of income-related MDGs; and
- the context within which to appreciate the new opportunities and challenges posed to the social sectors by the emerging global and regional trends, which we discuss in section 3.

Box 2.1: How Far Is South Asia from Achieving the Millennium Development Goals?

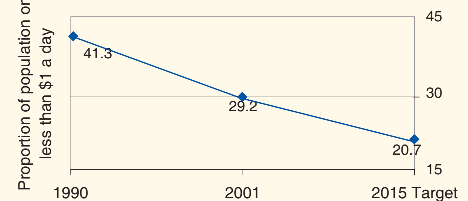
In the year 2000, nations agreed to a set of goals for building a better world. They are known as the Millennium Development Goals (MDGs) and were set for the year 2015. The MDGs promote poverty reduction, education, gender equality, maternal health, environmental sustainability, and global partnership and aim at combating child mortality, HIV/AIDS, and other diseases. The status of MDGs in the region relating to poverty, gender equality, education, and health is briefly discussed in this box.

Goal 1—Poverty reduction: Although extreme poverty is still prevalent, South Asia has reduced absolute poverty remarkably in the last decade. The number of people living on less than $1 a day dropped from 41% in 1990 to 29% in 2003. This is primarily due to accelerated growth in India, home to about 1.1 billion people. However, the decline in the proportion of people living with insufficient food is much slower, from 26% in the 1990s to 21% in 2003. Conflicts and natural disasters such as the tsunami have constrained progress in poverty and hunger in the region.

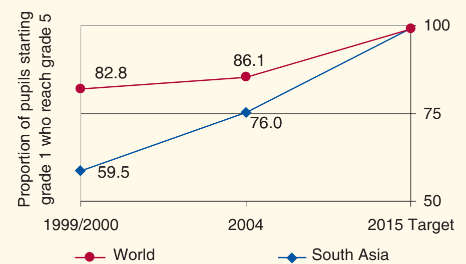
Goal 2—Universal primary education: The access to primary education has increased in South Asia, mainly due to progress in India, where the net enrollment ratio has increased from 79% in 2000 to 87% in 2004. However, completion of primary schooling remains a concern, as only 76% of grade 1 pupils in South Asia reach grade 5, compared with the global average of 86%.

Goal 3—Gender equality: Girls' access to primary education compared with that of boys has improved in South Asia from

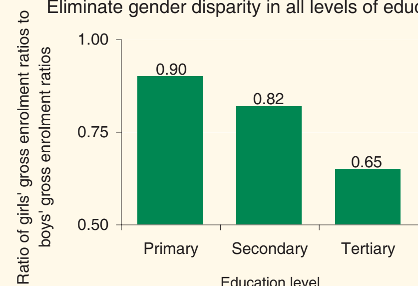
Goal 1: Eradicate extreme poverty and hunger
Halve proportion of people on less than $1 a day



Goal 2: Achieve universal primary education
Ensure completion of a full course of primary schooling



Goal 3: Promote gender equality and empower women
Eliminate gender disparity in all levels of education



Box 2.1, continued

82% in 1999 to 90% in 2004. However, gender disparities are still a concern at higher levels of education—where girls' enrollment is only about 82% of boys' enrollment in secondary education and only 65% at the tertiary level.

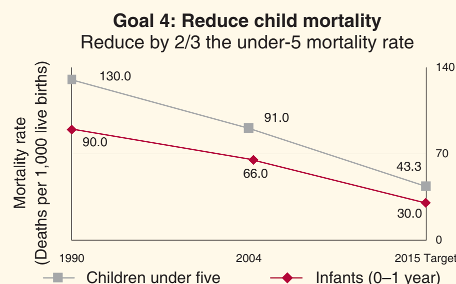
Goal 4—Reduction in child mortality: Child mortality (0–4 years old) per 1,000 live births declined from 130 deaths in 1990 to about 91 in 2004. However, significant disparities across socioeconomic groups remain a matter of concern.

Goal 5—Improvement of maternal health: South Asia still has the world's second highest maternal mortality ratio (565 per 100,000 live births), next to Sub-Saharan Africa. Maternal mortality can be substantially reduced by increasing access to reproductive health care, including family planning and skilled delivery care.

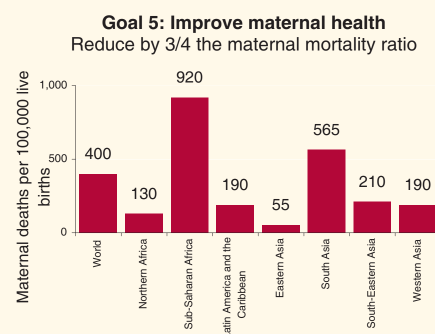
Goal 6—Combat HIV/AIDS, malaria, and other diseases: Since 1990, HIV/AIDS prevalence among adults has been increasing worldwide. HIV/AIDS prevalence in South Asia is estimated at 0.7% in 2005. To stop HIV/AIDS from spreading, strong political will is needed to promote HIV/AIDS education and prevention and for the protection and empowerment of women. Despite some progress in tuberculosis and malaria control, they continue to be major causes of chronic morbidity and mortality.

Source of data: United Nations. Millennium Development Goals Indicators Database.

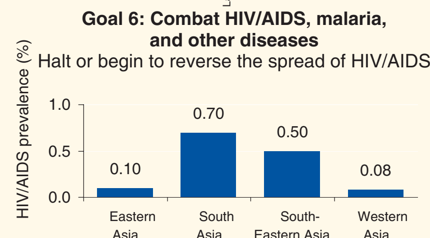
Goal 4: Reduce child mortality
Reduce by 2/3 the under-5 mortality rate



Goal 5: Improve maternal health
Reduce by 3/4 the maternal mortality ratio



Goal 6: Combat HIV/AIDS, malaria, and other diseases
Halt or begin to reverse the spread of HIV/AIDS



Education

The state of education in South Asia has improved significantly during the past few decades; nevertheless, South Asia continues to fall behind other regions of the world except for Sub-Saharan Africa

Table 2.1: Regional Comparison of Education Indicators (2005)

Region	**Public Expenditure on Education**		**Public Expenditure per Student** (% of GDP per capita)			**Gross Enrollment Ratio** (% of relevant age group)			**Primary Completion Rate** (% of relevant age group)		
	% of GDP	**% of Total Govt. Exp.**	**P**	**S**	**T**	**P**	**S**	**T**	**F**	**M**	**Total**
East Asia & Pacific	2.7	—	6.3	—	—	114	71	19	98	98	98
Europe & Central Asia	4.4	13.9	16.7	20.5	23.2	102	90	49	91	93	92
Latin America & Caribbean	4.3	15.0	12.3	14.9	31.3	118	86	28	99	98	98
Middle East & North Africa	—	—	14.3	17.5	—	103	73	22	86	92	89
South Asia	**2.9**	**12.8**	**9.7**	**12.1**	**68.6**	**110**	**50**	**10**	**77**	**86**	**82**
Sub-Saharan Africa	4.3	—	—	—	—	92	30	5	53	63	58

Note: F=female, GDP= gross domestic product, M=male, P=primary, S=secondary, T=tertiary.
Source: World Bank. 2007. *World Development Indicators*. Washington DC.

(table 2.1). World public spending on education averages 4.7% of GDP, but South Asia spends only 2.9%.

In 1965, more than three quarters of adults in Afghanistan, Bangladesh, India, and Pakistan had not completed primary education. By 1990, this percentage had been reduced substantially, and the completion of secondary and tertiary levels had increased markedly (table 2.2). Bangladesh had notable improvements: the proportion of adults with incomplete primary education was cut in half, while primary and secondary completion had grown more than threefold by 1990 (ADB 2002b and 2004e). Improvements in Afghanistan and Pakistan have been slower.

Access to primary education has improved markedly and is now quite high—gross primary enrollment ratios have reached 100% in most countries. Progress has also been made in reducing gender gaps in access to primary education, particularly in India and in Nepal. In Bangladesh, the female enrollment ratio has even exceeded that of males, which is a remarkable achievement in South Asia. Low enrollment of girls is still most evident in Afghanistan and Pakistan (table 2.3). In Pakistan, poor social sector performance is attributed the effects of elite dominance (Hussain 1999). Bourguignon and Verdier (2000) argue that less inclusive governments may tend to give less priority to education because it is perceived as stirring greater

Table 2.2: Percentage of Population (25 and older) by Highest Education Level Attained

	Less than Primary		Completed Primary		Completed Secondary	
	1965	**1990**	**1965**	**1990**	**1965**	**1990**
Afghanistan	90	86	4	9	3	3
Bangladesh	82	39	9	26	6	25
India	76	62	21	20	3	14
Pakistan	84	74	12	10	4	14
Sri Lanka	32	16	48	46	20	36

Notes: Each percentage refers to the total with only that level of schooling.
Source: ADB. 2003. *Key Indicators 2003*. Manila.

Table 2.3: Gross Primary School Enrollment Ratio (%)

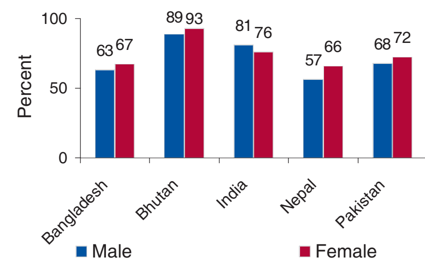
	Total	Female	Male	Year
South Asia	**110**	**105**	**116**	**2004**
Afghanistan	93	56	127	2004
Bangladesh	109	111	107	2004
Bhutan	—	—	—	
India	116	112	120	2004
Maldives	104	102	105	2004
Nepal	113	108	118	2005
Pakistan	82	69	95	2004
Sri Lanka	101	101	102	2003

Sources: ADB. 2006. *Key Indicators 2006*. Manila;
UNESCO. 2007. *Education for All Global Monitoring Report 2007.* Geneva.

demands for democracy. Other factors challenging Pakistan's efforts to provide social services are its division into linguistic, religious, and regional factions (Easterly 2001).

While most children in South Asia are able to at least start schooling, low efficiency of education (as indicated by high rates of dropping out and repeating grades) is a major concern. In addition, gender and wealth disparities in schooling achievement continue to be formidable (Filmer 2005). Too many students drop out before they complete their primary education. Less than 70% of students who enter primary school in Bangladesh, Nepal, and Pakistan ever reach the fifth grade (figure 2.1). Inefficiencies from repeaters and late entrants, as evidenced by gross enrollment ratios over 100%, have declined in the Maldives and Sri Lanka, but remain significant elsewhere.

Figure 2.1: Pupils Starting Grade 1 and Reaching Grade 5 (%)

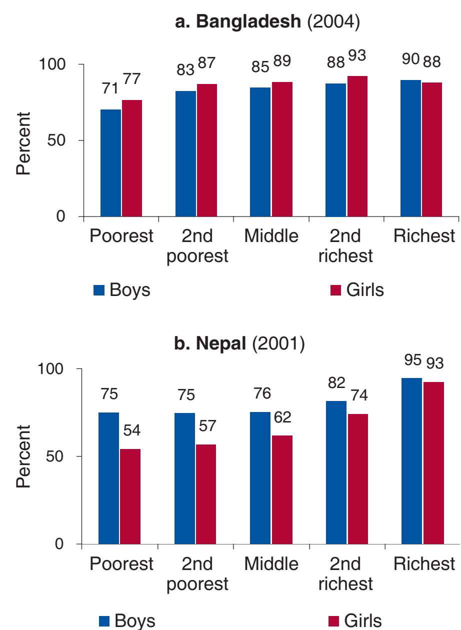


Note: Data for Nepal and Pakistan are as of 2004; for Bangladesh and India, as of 2003; and for Bhutan, as of 2000.
Source: United Nations. Millennium Development Goals Indicators Database.

Quality of primary education is also a major concern, particularly for poor and disadvantaged children in South Asia. Without quality basic education, children will have difficulty progressing to, and succeeding in, secondary and higher education (Hasan and Mehta 2006). A 2005 survey in India revealed that many primary school students are not able to read with facility or to do simple mathematical operations (MHRD 2006). In Bangladesh, pass rates in the primary scholarship examination have been increasing, but as of 2002 less than half (44%) of the test takers passed. In a national assessment conducted for grade 4 in Sri Lanka in 2003, only about 38% of students had mastered mathematics appropriate to their level, and only 37% had mastered skills in their first language (World Bank 2005). In Pakistan, school quality (as measured by various characteristics of teachers and facilities) is strongly associated with the likelihood of dropping out (Lloyd, Mete, and Grant 2006).

As with primary education, access to the secondary level has increased significantly in South Asia. Gross secondary enrollment ratios have improved the most in Bangladesh and the Maldives. Also in Bangladesh and the Maldives, the enrollment ratio for females is significantly higher than for males. Both India and Nepal have continued to reduce gender disparities in secondary education. Sri Lanka has the highest secondary level coverage in South Asia, with over 80% enrollment in 2004 (table 2.4, p.11).

Figure 2.2: Percentage of Girls and Boys Aged 6–10 Years Attending School, by Wealth Quintile



Sources: Demographic and health survey data (see pp. viii–ix).

While gender equality in access and enrollment rates has generally been improving, differentials in access to education across income groups remain a concern (figure 2.2). Children from the poorest households sometimes cannot avail of free public education due to high opportunity costs and prohibitive "peripheral" costs associated with education, e.g., uniforms, materials, and transport (ADB 2004a, 2004b, 2006a). Expenditures on such peripherals may prevent families from enrolling children even in basic education (Colclough and Al-Samarrai 2000). The opportunity costs of education increase with each school level since the ability of young people to work or do household chores increases as they mature. All these factors

Table 2.4: Gross Secondary School Enrollment Ratio (%)

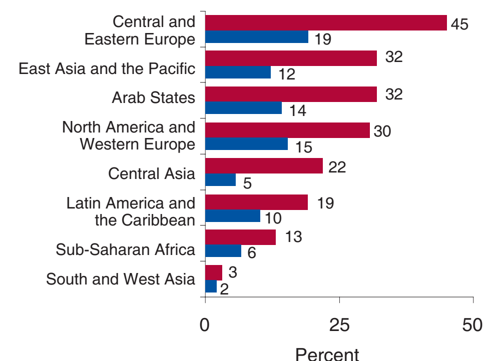
Country	1990		Latest Year		
	Female	Male	Female	Male	Year
Afghanistan	9	18	5	25	2004
Bangladesh	13	25	54	49	2003
Bhutan	—	—	—	—	
India	33	55	47	59	2004
Maldives	45	46	78	68	2004
Nepal	20	46	42	49	2005
Pakistan	15	30	23	31	2004
Sri Lanka	77	71	83	82	2004

Source: ADB. 2006. *Key Indicators 2006.* Manila.

contribute to the low enrollment of poor children in secondary school and to gender disparities, as does the greater likelihood of their dropping out during primary school (Hasan and Mehta 2006).

Enrollment in tertiary education in South Asia is low—the highest level achieved is 12%, in India (table 2.5). The causes include the high cost (direct and opportunity) and limited places available. Gender bias at the tertiary level is most evident in Afghanistan, Bangladesh, and Nepal. In the Maldives, more females access tertiary education than males. As shown in figure 2.3, South Asian enrollment in technical and vocational education and training (TVET) is very low compared to all other regions of the world (UNESCO-UNEVOC 2006).

Figure 2.3: Regional Enrollment in Technical and Vocational Education



Source: UNESCO. 2004. Higher Education in a Globalized Society. Paris.

Table 2.5: Gross Tertiary Education Enrollment Ratio (%)

	Total	Male	Female	Year
Afghanistan	1	2	0.5	2004
Bangladesh	7	9	4	2004
India	12	14	9	2004
Maldives	0.2	0.1	0.3	2004
Nepal	6	8	3	2004
Pakistan	3	4	3	2004
Sri Lanka	5	6	4	1997

Sources: UNESCO. 2007. *Education for All Global Monitoring Report 2007.* Geneva; ADB. 2003. *Key Indicators for 2003.* Manila.

Health

Despite significant improvements in the last few decades, the health services and health outcomes in the region remain suboptimal, with widespread inter- and intra-country disparities. The average life expectancy at birth in South Asia is 63 years, which is lower than the average of 71 years in East Asia and the Pacific. South Asia faces many challenges to meet the health-related MDGs. Globally, only Sub-Saharan Africa has lower health indicators than South Asia, but South Asia's indicators for malnutrition and births attended by skilled health staff (table 2.6) are the worst in the world (ADB 2001a, 2004d, 2005d, and 2005e).

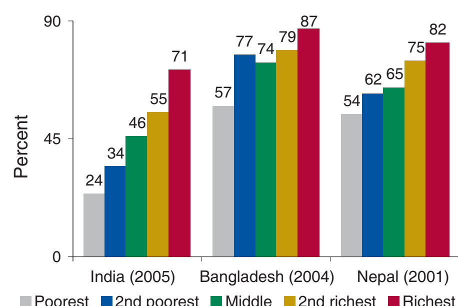
South Asia accounts for one third of maternal deaths worldwide. The lifetime risk of a woman in South Asia dying during pregnancy is 1 in 43, compared with 1 in 30,000 in Sweden. The intercountry variation of maternal mortality ratios ranges from a low of 92 per 100,000 live births in Sri Lanka to 540 in India and up to 1,900 in Afghanistan. The lifetime risk of dying during pregnancy in Afghanistan is 1 in 6—one of the highest in the world. Maternal mortality is usually preventable with appropriate medical care and management. However, South Asia's proportion of births attended by skilled health personnel increased only modestly from 30% in the 1990s to 37% in 2004. The challenges to reduce maternal deaths in South Asia remain formidable.

Child mortality remains unacceptably high in the region despite a significant reduction in the last few decades. During the past 45 years, under-5 mortality rates per 1,000 live births declined from 266 to 92, but the gains were not uniform across countries. Disparities in child deaths are pronounced both within and among countries. The lowest rates are in Sri Lanka and the Maldives and the highest are in Pakistan and Afghanistan (ADB 2002b), where access to maternal and child health services is still very limited. Preliminary findings from the recently completed National Family Health Survey in India (2005–2006) indicate that only about 50% of women had three or more antenatal care visits prior to their last birth, and only around 44% of children 12–23 months had full immunizations (IIPS 2007). Moreover, the situation is dismal among the poorest women and children (figure 2.4).

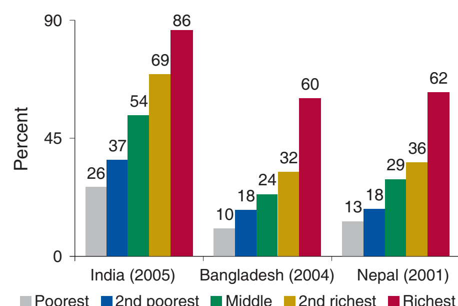
Although Asia led the decline in global poverty in the 1990s, it still accounts for two-thirds of the global burden of undernutrition, with

Figure 2.4: Wealth-Based Differentials in Access to Maternal and Child Health Services

a. Children 12–23 months fully immunized
(BCG, measles, and 3 doses each of polio/DPT, %)



b. Mothers who had at least 3 antenatal care visits for their last birth (%)



BCG=the bacille Calmette-Guérin vaccine against tuberculosis; DPT=diphtheria, pertussis, and tetanus.
Sources: Demographic and health survey data (see pp. viii–ix).

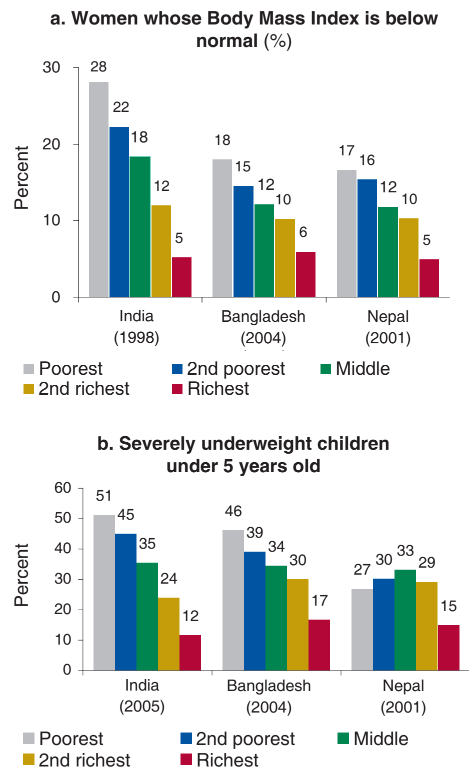
Table 2.6: Health Indicators by Region
(for the latest available year 2000–2005)

Region	**Births Attended by Skilled Health Staff** (% of total)	**Health Expenditure Per Capita** (current $)	**Out-of-Pocket Health Expenditure** (% of private expenditure on health)	**Immunization, DPT** (% of children ages 12–23 months)	**Malnutrition Prevalence, Weight for Age** (% of children under 5)	**Life Expectancy at Birth, Total** (years)	**Mortality Rate, Infant** (per 1,000 live births)
East Asia and Pacific	87	62	87.6	84	14.9	71	26
Europe and Central Asia	94	250	82.1	95	4.9	69	27
Latin America and Caribbean	87	272	74.1	91	—	72	26
Middle East and North Africa	74	103	89.7	93	14.6	70	43
South Asia	37	27	93.6	65	45.3 [a]	63	62
Sub-Saharan Africa	45	45	44.8	65	29.6	47	96

DPT=diphtheria, pertussis, and tetanus.
[a] Data from World Development Indicators online database as of April 2007.
Source: World Bank. 2007. *World Development Indicators*. www.worldbank.org/data/wdi.

nearly half of under-5 children in the region being below standards of weight-for-age (figure 2.5), especially among the poor (ADB 2001a, 2004d, 2005d, and 2005e). Rampant iron and other micronutrient deficiencies combined with overall malnutrition lead to a learning disadvantage from childhood that perpetuates intergenerational poverty. Widespread undernutrition among women, including high rates of iron deficiency anemia, is of particular concern, especially among poor women in Bangladesh and India (figure 2.5). Undernutrition among women of child-bearing age is associated with poor maternal and child outcomes and with higher rates of intrauterine growth retardation, lower birth weight, higher perinatal and neonatal mortality, and higher maternal mortality (ADB 2001a, 2004d, 2005d, and 2005e).

Figure 2.5: Maternal and Child Malnutrition, by Wealth Quintile



Note: The weight-for-age in figure 2.5b is assessed as below the -3 standard deviation z-score.
Sources: Demographic and health survey data (see pp. viii–ix).

Infectious diseases continue to be a major challenge in South Asia, and are estimated to be responsible for about 40% of all deaths in the region (Zaidi, Awasthi, and deSilva 2004). The brunt of infectious diseases is mainly borne by children, women, and the poor. Acute respiratory and diarrheal infections cause 33% of all under-5 deaths. Although access to improved water supply is claimed to have improved substantially since the 1990s, the quality and safety of water remain questionable. Waterborne illnesses continue to be a major problem. Major outbreaks of hepatitis A and E have been traced to piped water contaminated by sewage. Basic sanitation facilities in South Asia remain worse than in other regions and progress in expanding access to improved facilities for excreta disposal has been negligible.

Of the 10 countries with the largest number of tuberculosis patients, 3 are in South Asia. Afghanistan has the highest prevalence, with 661 cases and 92 deaths per 100,000 people. In total numbers, India carries the world's greatest burden of tuberculosis cases, with the situation complicated by over 2 million people who are estimated to have both HIV/AIDS and tuberculosis, and the emergence of drug-resistant strains. Multidrug-resistant tuberculosis is at least 100 times more expensive to cure than other forms of the disease. In addition, a significant proportion of the regional population continues to live in areas where malaria causes high incidences of morbidity and mortality.

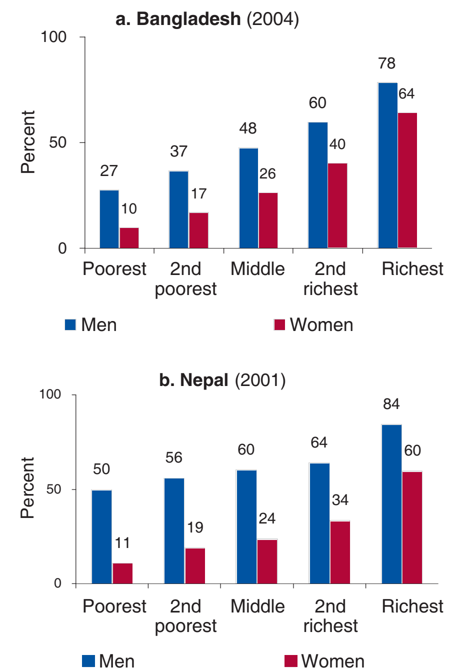
South Asia is confronted with emerging infectious diseases, HIV/AIDS being the best known (Ruxrungtham, Brown, and Phnuphak 2004; Abeysene and de Silva 2005). Others include dengue fever, Japanese encephalitis, leptospirosis, severe acute respiratory syndrome (SARS), and avian influenza (ADB 2005c). More than 5 million people in South Asia are living with HIV, and over 90% of them are living in India. Although India's HIV/AIDS rate is still low (0.9%), in absolute terms, India has one of the world's largest numbers of HIV-positive people and the disease has advanced into the generalized population (more than 1% of women attending antenatal clinics are infected with HIV) in seven states in India. Greater effort is needed to control HIV/AIDS,

as the overall awareness about its prevention is still low among the poorest, especially among women (figure 2.6).

While the challenge of communicable diseases continues, the burden of noncommunicable diseases is also increasing. Cardiovascular diseases, diabetes mellitus, and chronic obstructive pulmonary diseases have reached epidemic proportions (Nishtar 2002). India has more people with diabetes than any other country in the world. Moreover, the burden of injuries is increasing in the region; road accidents are a major cause of injuries among the working age population.

The poor quality of public health services, access to which often requires "unofficial" fees, forces the poor to seek care from private providers. Such services often must be paid in cash, which the poor often do not have. Per capita health expenditures in South Asia are very low, ranging from $10 to $11 in Bhutan and Afghanistan to $27 in India and $31 in Sri Lanka. Public expenditure on health in the region is slightly over 1% of GDP; most health expenditure is paid to private providers and out-of-pocket (i.e., with no contribution from insurance or other health schemes).

Figure 2.6: Percentage of Women and Men Aged 15–49 Who Know at Least One Way to Avoid Sexual Transmission of HIV/AIDS, in Bangladesh and Nepal
(% of population by wealth quintile)



Sources: Demographic and health survey data (see pp. viii–ix).

Conclusions

South Asia faces formidable challenges to improve and sustain universal primary education, maternal and child health, and control of communicable diseases. As noted by Ali (2007), "Persistent and growing inequalities in education and health attainments within countries are a significant concern for developing Asia, and they exacerbate income inequalities." A key theme that emerges is the widespread inequality in access to education and health services for the poor.

Other key areas indirectly related to the MDGs (e.g., secondary and tertiary education, TVET, emerging infectious and noncommunicable diseases, low public expenditure on education and health) will significantly influence South Asia's achievement of the MDGs (box 2.1), and its ability to sustain rapid and inclusive economic growth.

We are currently halfway to the 2015 date for achieving the MDGs. As income growth in South Asia has been stronger since 2000 than at any time since the 1960s, it is pertinent to assess what is constraining South Asia from meeting the MDGs related to child and maternal health and malnutrition. Malnutrition limits the development potential of children and accentuates poverty and inequality (ADB 2001a and 2004d; Walker et al. 2007). Clearly, rapid economic growth alone will not take care of human development in the region.

The current status of education and health is far from satisfactory, and global and regional trends outside the direct purview of these sectors may put additional stress on social sectors that are already overwhelmed by the current MDG challenges. Thus, section 3 examines the important matter of how global forces and recent patterns of economic growth are affecting the social sectors.