

IV. Gender Dimensions of Progress on Other Goals

Apart from Goals 3 and 5, the MDGs do not expressly address gender issues, although the Goal 2 target—ensuring that both boys and girls complete primary school—has a gender equity dimension. Even so, MDG progress reports and other studies from Asian and Pacific countries confirm the interrelationships between the gender-specific MDGs and all of the other goals, as well as the importance of including a gender perspective in any strategy to achieve these goals.

Goal 1—Eradicate Extreme Poverty and Hunger

Target 1—Reduce Income Poverty

Although poverty is widely recognized to have multiple dimensions—including diminished capabilities, insecurity and disempowerment—the target and indicators for Goal 1 measure only income poverty. Because these income poverty measures are based on household-level data, they provide little indication of the allocation of income, consumption, and assets within households, and specifically between women and men, and girls and boys. The household survey data underlying these poverty measures do permit comparisons based on the characteristics of the “head of household,” and therefore most countries in the region distinguish between male- and female-headed households in their poverty monitoring and analysis. It is often assumed that female-headed households are more vulnerable to poverty, and several MDG progress reports bear this out (including those for Bangladesh,

Kazakhstan, Kyrgyz Republic, Malaysia, Mongolia, Sri Lanka, and Tajikistan). However, this is not always the case. Viet Nam, for example, reports that female-headed households generally have lower poverty rates, perhaps because the households are smaller or because male family members are working elsewhere and sending back remittances. A recent country gender assessment for Timor-Leste also reports that male-headed households are generally poorer in terms of income poverty, although female household heads are at a disadvantage in many other respects (including access to land and employment opportunities). Female-headed households also are not a homogeneous category. In Sri Lanka, for example, the most vulnerable are female-headed households in slums, on plantation estates, and in conflict-affected areas.

Analysis of income poverty data on the basis of the sex of the household head is of limited utility. In virtually all countries, the vast majority of households are headed by men. Other techniques are needed to estimate the relative well-being of women, girls, and boys within these households. For example, a recent study recalculated poverty levels within households in Tajikistan based on various assumptions about the allocation of resources between men and women within the households.⁶¹ Time use surveys can also illuminate the constraints of “time poverty” on women, resulting from the unequal distribution of care work within households and communities.⁶² Participatory poverty assessments, country gender assessments, and other qualitative studies

For most countries in the region, poverty continues to be concentrated mainly in rural areas. However, other developments affecting gender relations include poverty and lack of social security resulting from layoffs and plant closures as well as from internal conflicts and natural disasters.

also illuminate the different impacts of poverty on women and men, as well as their different coping strategies. In Central Asian countries, for example, many women who lost formal sector jobs during the economic transition have turned to informal activities such as the “shuttle trade.” In Mongolia, many poor herding families have taken their sons out of school to help with herding activities. The Lao PDR’s national poverty reduction strategy notes that poor women in rural areas generally use a wider range of positive coping strategies than men, including reducing expenses, raising small livestock and poultry, gardening, and producing handicrafts. Other studies note that women in poor rural areas often cope with food insecurity by reducing their own food intake (eating less and eating last). An increasingly common coping strategy for poor households across the region is for one or more family members to migrate for work—either to an urban area within the country or to another country. As discussed in Section III.B.5, migration can increase household income, but invariably places strains on both the migrant and those who remain behind. Migration also poses particular risks for women, especially young women.

For most countries in the region, poverty continues to be concentrated primarily in rural areas. However, MDG progress reports also point out several “new” forms of poverty that have emerged, often with specific impacts on women. In the Central Asian countries and Mongolia, for example, massive layoffs during the economic transition left many unemployed. With few alternatives, many women turned to informal work including the “shuttle trade” and day labor. As discussed in Section III.B.5, land reform programs introduced after the transition allocated relatively little land to women farmers, and they had less access to irrigation and agricultural services. In Mongolia, many women have migrated to urban centers for work, and female-headed households in urban slums are now among the poorest groups. In several countries, the expansion of the garment-manufacturing sector over the past 10 years has provided jobs to large numbers of young women, mostly from poor rural areas. However, recent declines in global demand, coupled with greater competition from the PRC and India, have resulted in layoffs and plant closures in some countries, and more are ex-

pected. With limited education and technical training, laid-off garment workers have few alternatives, and microstudies in some countries indicate that many of them are turning to sex work to support themselves. Internal conflicts and natural disasters in several countries have also driven many people into poverty by causing death and injuries, destroying homes and livelihoods, and disrupting basic services. Both Nepal and Sri Lanka, for example, report that women in conflict areas are particularly vulnerable to poverty, deprivation of basic services and violence.

Target 2—Reduce Hunger

Gender concerns related to hunger and malnutrition operate on several levels. MDG progress reports and other studies point out that a large percentage of women of childbearing age in the region suffer from iron deficiency anemia, with rates as high as 75% in Nepal and 80% in Tajikistan. Iodine and vitamin A deficiencies are also common. These deficiencies contribute to up to 20% of maternal deaths, and maternal malnutrition also contributes to low birth weight in newborns, perpetuating the cycle of deprivation.⁶³ In response, a large number of countries in the region have introduced programs to provide micronutrient supplements to pregnant women. However, as the UN Millennium Project and others have pointed out, this type of intervention is generally too limited and too late to be effective. Broader nutrition programs, particularly those targeting adolescent girls, hold greater promise for young women and their children.

At another level, women’s awareness of healthy feeding practices for newborns—particularly the importance of breastfeeding—is a major determinant of infant health. As noted earlier, several studies also show that women tend to spend a larger portion of their income than men on food and medicines, illustrating the link between women’s economic empowerment and children’s health and nutrition levels.⁶⁴

At a third level, in countries with strong patterns of son preference, girls can have less access to nutritious food than boys, resulting in lower nutrition rates. Bangladesh, for example, reports that nutrition levels are much lower in rural areas, especially among girls. However, this is not the case in all countries. Indonesia, for example,

reports lower nutrition levels in boys. In other countries, health surveys find little difference in girls' and boys' nutrition levels. Gender-related differences in either direction underscore the need to disaggregate nutrition data by sex in order to identify gender-related patterns and develop appropriate responses.

Finally, it should be noted that several countries in the region, including the PRC, Thailand and several Pacific countries, are now confronting obesity as a major nutrition and health problem. The Pacific has some of the highest obesity rates in the world, linked to the increasing availability of high-calorie, high-fat and processed foods, mainly imports. Complications related to obesity include diabetes and heart disease. In the Fiji Islands, the obesity and diabetes rates in women are twice those in men.

Goal 2—Achieve Universal Primary Education

Goals 2 and 3 are strongly interlinked. Gender parity in education is the official target for Goal 3, and access to quality education is a key building block for women's empowerment.⁶⁵ Access to education for women also has intergenerational benefits, since higher literacy and education levels in women are associated with higher levels of enrollment and school performance in their children.⁶⁶ As discussed in Section III.B, gender parity in education only makes sense as a development objective in the context of high or rising levels of participation by both girls and boys. A scenario in which gender gaps in education are narrowing because boys' enrollment rates are falling cannot be counted as a success under Goal 3. Goal 2 therefore is an essential complement to Goal 3 in that it aims for high levels of access to primary education for both girls and boys. The Goal 2 indicators track completion as well as enrollment rates such that they also encourage attention to factors such as the quality of school facilities, teachers and teaching materials, which influence whether students remain in school or drop out. As noted in Section III.B, completion rates are also relevant to Goal 3, because the underlying objective is to ensure that girls as well as boys receive a quality education, and not simply that they are enrolled in equal numbers.

Countries' progress reports on Goal 2 con-

firm that many of the factors underlying success (or failure) in achieving universal primary education are the same as for achieving gender parity in education under Goal 3. This suggests that strategies to increase girls' enrollment and participation in primary school are likely to have spillover benefits for boys as well, especially those from poor communities, remote rural areas, ethnic minorities and disadvantaged castes. Several progress reports note concerns about the quality and relevance of education, particularly in rural areas and among disadvantaged groups. Sri Lanka reports that the worst-equipped schools are near plantation estates and in conflict-affected areas, while Cambodia and Viet Nam note teacher shortages and other problems, particularly in ethnic minority areas. The PRC reports that migrant children in urban areas have little or no access to education, and the Philippines notes the particular challenge of reaching street children. Despite exemptions from school fees, several progress reports also confirm that informal fees and indirect costs—for example, for appropriate clothing, food, transport and school supplies—are still a major barrier especially for the poorest children. Various strategies are therefore being used to extend education to hard-to-reach children, including the establishment of more community schools in remote areas; boarding schools for children from remote areas; stipends, scholarships and school feeding programs; recruitment and training of more ethnic minority teachers; and incentives for teachers posted to rural areas. Many of these strategies are also used to encourage more girls to attend school, because the girls least likely to attend are those from poor households, remote areas and socially excluded groups. However, gender-specific strategies—such as ensuring safe transport to school, providing separate toilet facilities for girls in school, and recruiting female teachers—are also needed to encourage girls to remain in school.

In their strategies to increase girls' enrollments under Goal 3, many countries in the region have recognized the need to counter gender stereotypes in textbooks and teachers' attitudes in order to ensure a positive learning environment for girls. What has received less attention is the importance for boys of promoting positive gender roles through the school curriculum and teachers' behavior. As discussed elsewhere in this

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Reducing neonatal deaths (MDG 4) and maternal mortality (MDG 5) are closely interlinked. Girl's survival and health under MDG 4 also requires attention to gender discrimination, especially in Asian countries where the death rates of girls are unusually high.

paper, patriarchal attitudes about gender roles, women's and men's capabilities, and acceptable behavior between men and women continue to be among the greatest obstacles to gender equality and women's empowerment. These norms originate and are perpetuated within families and in communities. However, primary and secondary schools also play a critical role in shaping the attitudes of the next generation. With the appropriate curriculum and sensitivity of teachers, schools have the potential to positively influence boys' as well as girls' attitudes about gender roles in the household, women's and men's rights and capabilities, safe and responsible sexual behavior, interpersonal conflicts and violence.

Goal 4—Reduce Child Mortality

Success in achieving Goal 4 is strongly linked to both of the gender-specific MDGs. As immunization programs and other interventions reduce the number of child deaths due to traditional diseases, neonatal factors have emerged as one of the main causes of death in young children. It is estimated that over one in five deaths of children under 5 years occurs in the first week of life, and is due to the mother's malnutrition, poor antenatal care, or lack of sanitary conditions and skilled assistance at birth.⁶⁷ The factors contributing to neonatal deaths are therefore some of the same factors contributing to maternal deaths. Strategies under Goal 5 to improve women's basic health and nutrition levels, and to improve pregnant women's access to sanitary and well-equipped health facilities with skilled personnel, should therefore contribute to reducing neonatal deaths as well. In their MDG progress reports, most countries in the region recognize this link. Papua New Guinea, for example, notes that poorly equipped and staffed maternity wards in health facilities and the large number of "in village" births have contributed to its slow progress in reducing infant deaths.

After birth, many of the most effective steps to ensure infants' and children's health can be taken within the household—including exclusive breastfeeding for the first 6 months; complementary feeding with energy-rich and nutritious food after 6 months; frequent hand-washing and sanitation; use of treated bednets in malaria-prone areas; and ensuring that children receive timely immunizations.⁶⁸ Because of the traditional gen-

der division of labor within most households, women are generally responsible for these tasks. Women's awareness of good childcare practices and their capacity to implement them are critical to children's health. Not surprisingly, studies have found a strong correlation between women's literacy and education levels and child survival. Several countries in the region (including Mongolia, Pakistan and Viet Nam) make this link in their progress reports on Goal 4. Women's income and savings also can provide the resources to pay for more nutritious food, bednets, and other health-enhancing expenses. Therefore, strategies under Goal 3 to strengthen women's capabilities and expand their economic opportunities have indirect benefits for their children under Goal 4.

Another critical gender dimension of Goal 4 is the issue of girls' survival and health. A very disturbing trend in the Asia and Pacific region is the persistence of negative child mortality ratios in a number of countries. On the basis of biological factors, the ratio of girls' to boys' deaths would ordinarily be much less than 1, but in 10 countries in the region the ratio is 0.99 or greater. The highest ratio is in the PRC (1.32), followed by Maldives (1.13), Pakistan (1.1), India (1.09), Nepal (1.07), Bangladesh (1.03), Vanuatu (1.0), Republic of Korea (1.0), Afghanistan (0.99), and Bhutan (0.99).⁶⁹ These results generally match the available data on sex ratios, which show that East Asia (including PRC, Republic of Korea and Taipei, China) and South Asia (including Afghanistan, Bangladesh, India, Pakistan, and Nepal) have some of the worst ratios in the world.⁷⁰ Patriarchal norms, reflected in strong patterns of son preference and neglect of young girls, are generally cited to explain girls' higher mortality rates in these East Asian and South Asian countries. A recent study in India found that girls were 1.5 times less likely to be hospitalized for a childhood illness.⁷¹ The high reported child mortality ratios for Bhutan, Maldives, and Vanuatu are more difficult to explain, because these countries do not generally exhibit strong patterns of gender discrimination. In general, it is clear that the ratio of girls' to boys' child mortality rates should be regularly monitored under Goal 4, and that specific strategies should be pursued to address the social factors contributing to the unacceptably high death rates of girls in several countries in the region.

Goal 6—Combat HIV/AIDS, Malaria, and Other Diseases

Gender factors also influence the incidence and impact of communicable diseases in Asia and the Pacific, such as HIV/AIDS, tuberculosis, and malaria. Poor women are generally vulnerable to communicable diseases because of their poor nutrition and health, and their tendency to postpone medical care because of social or economic constraints.⁷² These diseases not only diminish women's capabilities and opportunities (key aspects of women's empowerment under Goal 3), but also increase the risk of complications in pregnancy and childbirth (undermining maternal health under Goal 5). Moreover, the disabling impact of such diseases as HIV/AIDS, tuberculosis, and malaria on women also impairs their ability to care for their children and other household members. Disability of other family members by one of these diseases places a particular burden on women as the primary caretakers in most households.

HIV/AIDS. The Asia and Pacific region is increasingly threatened by rising HIV infection rates not only in high-risk groups such as intravenous drug users, mobile workers, and sex workers, but also in the general population—with the proxy indicator being the prevalence rate in pregnant women who attend antenatal clinics. As of 2004, over 8 million in the region were living with HIV and at least 540,000 had died. Prevalence rates reported in 2003 exceed 1% in at least four countries (Cambodia, Myanmar, Papua New Guinea, and Thailand), and are also high in India, Nepal, Malaysia, and Viet Nam, and increasing sharply in Indonesia. Also troubling, MDG progress reports cite much higher prevalence rates among some groups. In Nepal, for example, 17% of sex workers in Kathmandu are infected with HIV.

To date, the majority of people infected with HIV in the region are men, but the Joint UN Programme on HIV/AIDS (UNAIDS) reports that the percentage of infected women is increasing steadily, and infections have jumped from high-risk groups to the general population in several countries. In Cambodia, India, and Thailand, for example, husbands are now the main source of HIV infections in women.⁷³ This is echoed in reports for other countries: in Papua New Guinea, up to 3% of pregnant women attending antena-

tal clinics are infected with HIV; 2% of women receiving antenatal care in Nepal are infected; and in 2004 more women than men were reported to be infected in the Fiji Islands.⁷⁴ The increasing numbers of HIV infections in pregnant women also significantly raise the risk of mother-to-child transmission, especially because only a small percentage of pregnant women in the region have access to HIV testing and services to reduce the transmission risk.

Women, and adolescent girls in particular, are more vulnerable than men to HIV infection because of their physiological characteristics and limited power to negotiate safe sex and resist violence.⁷⁵ UNAIDS notes that sex workers who have been trafficked across borders—and who therefore have no power to insist that clients use condoms—are the most likely to become infected during their first 6 months in a brothel. UNAIDS estimates that the proportion of young women in Southeast Asia who work in brothels and other “high-risk” environments—such as bars and clubs—ranges from about 40% in Indonesia to over 70% in the Lao PDR. The increasing migration of young women for work and general increase in risky sexual behavior among young people also compound the risks of HIV infection for adolescent girls and young women.⁷⁶ In the PRC, Tajikistan, and Viet Nam, between 40% and 60% of new HIV infections are among young people, including young women, and in Malaysia most of the new HIV infections in women are in young women. In their progress reports, Cambodia, Nepal, and Papua New Guinea acknowledge that gender inequalities and women's lack of empowerment are major obstacles to progress in arresting the spread of HIV under Goal 6. Malaysia also recognizes the intergenerational impact of HIV infections. The increasing numbers of young people, including young women, becoming infected has created a serious burden of care for parents, and particularly for mothers.

Based on the emerging profile of HIV infections in the region, it is clear that effective prevention and treatment strategies need to reach not only high-risk groups, such as intravenous drug users and sex workers, but also the general population, including men, women, and adolescents. Any successful HIV prevention strategy must include effective outreach activities to pro-

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mote safe-sex practices among men, especially those who travel and who frequent sex workers. To reach the general population of women, the UN Millennium Project and others have strongly recommended that HIV awareness raising, testing, and treatment be integrated into the basic reproductive health programs implemented through the primary health care system.⁷⁷ Because of the widespread misinformation and stigma surrounding HIV in most countries, women are unlikely to seek out information, testing or treatment from an HIV-specific program or health facility. Through basic reproductive health programs, women are also more likely to be treated for STIs that increase their susceptibility to HIV infection. To reach adolescents, and particularly adolescent girls, sex education programs in schools are an important entry point. Reproductive health services for adolescents are also urgently needed, but the coverage level in most countries in the region is still low. Creative strategies are also needed to extend reproductive health services to hard-to-reach groups such as migrant workers.

Tuberculosis. Almost half of the high-burden countries in the world for tuberculosis (TB) are in Asia and the Pacific, and together these countries represent about 80% of the global burden of the disease.⁷⁸ Some countries have historically had high prevalence rates, while others have recently experienced resurgence in infections, including several Central Asian countries. The resurgence of TB in Thailand is linked to HIV, which increases susceptibility to TB infections, and this co-infection risk is an emerging issue in several other countries. Both HIV and TB increase the risk of complications in pregnancy and childbirth. Afghanistan reports that 70% of its TB infections are in women, while Indonesia reports that TB is a major cause of female deaths.

Malaria. The heaviest burden of malaria infections in the world—outside Africa—is in the GMS, other parts of Southeast Asia, and the Indian subcontinent.⁷⁹ However, malaria is also endemic in parts of Central Asia and in the Pacific. Despite successful interventions, such as the distribution of treated bednets and anti-malarial medications, countries' efforts to control the disease are being thwarted by increasing migration within countries and across borders, and by the

emergence of more drug-resistant strains of the disease. Pregnant women and unborn children are particularly at risk from malaria, which causes anemia and contributes to low birth weight and perinatal mortality.⁸⁰ The Lao PDR reports that malaria is one of the top three causes of maternal mortality.

Other diseases. Countries in the region increasingly face new communicable disease threats, such as avian flu and severe acute respiratory syndrome, and with expanding regional trade and migration, these diseases can spread rapidly across borders. At the same time, non-communicable conditions, such as obesity, diabetes, heart disease, and cancer are becoming increasingly common, due in large part to changes in diet, tobacco use, and physical activity. It is therefore important for countries to identify, monitor, and report on these serious challenges to both women's and men's health. For example, Pacific countries have the highest rates of obesity and tobacco use in the world. In the Fiji Islands, diabetes and heart disease are major health threats, and the incidence of obesity and diabetes among women is twice that of men. Indonesia reports that most smokers in the country are men, and that smoking has a number of negative spillover effects on women and children, including health problems from passive smoke and the waste of household resources on cigarette consumption. Alcohol and drug abuse, which is also primarily a male phenomenon, diverts scarce household resources to support the abuser's habit and frequently contributes to domestic violence.

Goal 7—Ensure Environmental Sustainability

The targets under Goal 7—related to promoting sustainable development and reversing the loss of environmental resources, improving access to safe water and basic sanitation, and improving the quality of life of slum dwellers—are closely related to the poverty and health MDGs (including Goal 5). The links with Goal 3 are indirect but no less important. Women's important roles in environmental protection and sustainable development are well recognized, notably in the outcome documents from the UN Conference on Environment and Development in Rio de Janeiro in 1992 and the World Summit on Sustainable

Development in Johannesburg in 2002. In most rural societies, women play distinct roles related to the raising of plants and animals; collection of water, fuel, fodder, and forest products for household use and economic activities; and general management of land and water resources. Their contributions to the environment are particularly noticeable in the areas of biodiversity, water resource management, and combating desertification. At the same time, the depletion of environmental resources and degradation of rural and urban environments strain women's efforts to ensure food security for their households, and diminish the health of women and their families. Women's organizations and networks in the region have introduced a number of innovative environmental programs at the local level, but they are not well represented in environmental policy making and planning.⁸¹ MDG progress reports from the region include very few explicit references to gender issues related to Goal 7, although the environmental issues raised in the reports have clear gender dimensions. In general, MDG reporting on Goal 7 would benefit from greater use of alternative data sources such as reports on urban and environmental conditions prepared by UN agencies, NGOs, and citizens' groups.⁸²

Sustainable development and environmental protection. Deforestation and contamination of water sources are serious problems in many countries in the region, as confirmed in their MDG progress reports. Illegal logging and clearing of forest areas for agricultural land and other uses deprive poor households of important sources of fuel and nontimber forest products on which they depend for food and medicine. Deforestation particularly affects women and girls in rural areas, because they are generally responsible for gathering fuel wood and other forest products, and must walk longer distances to find these products. Contamination of water sources from natural arsenic, fertilizers, pesticides, mining, industrial waste, and other pollutants takes a similar toll on women and girls in rural areas, who are mainly responsible for collecting water for household use. As discussed below, most rural households in the region only have access to untreated water from natural sources. As those sources are depleted or contaminated, women and girls must walk longer distances to collect water, or make do with the inferior water that is

nearby and suffer the health consequences. In many countries in the region, over 50% of households use solid fuels (including wood and charcoal) for cooking and heating, and the percentage is likely to be much higher in rural areas.⁸³ Cambodia and Nepal, for example, report that over 90% of households use traditional fuels. The indoor air pollution caused by the use of these fuels without good ventilation has been linked to high levels of illness and death, particularly in women and children.⁸⁴

Safe water and basic sanitation. UNESCAP estimates that over 90% of urban dwellers in the region now have access to safe water, and over 70% have access to improved sanitation. Although urban/rural gaps are narrowing, coverage levels are still much lower in rural areas, especially in remote and disadvantaged communities. Nepal, for example, reports that Dalit communities have poor access to safe water, and a recent country gender assessment for Sri Lanka notes that only 25% of workers on plantation estates have access to safe water, with similarly low coverage levels in conflict-affected areas. Even where piped water systems are in place, there can be substantial problems with water quality, particularly in Central Asian countries where water systems have fallen into disrepair. Tajikistan, for example, reports that over 50% of its water systems have completely deteriorated, and Kazakhstan reports that its poorest oblasts cannot afford to maintain their systems. Arsenic contamination of groundwater in several countries in South Asia has also rendered many tube wells unsafe. Access to basic sanitation facilities in most rural areas is still extremely low, even in Central Asian countries such as Tajikistan (only 23% coverage) and Kyrgyz Republic (only 33% coverage). Statistics on urban coverage rates for clean water and basic sanitation also mask much lower coverage levels in slum areas.⁸⁵

Improvements in access to safe water and improved sanitation under Goal 7 carry a number of gender-related benefits. Measures to provide safe water sources close to rural communities will free up women's and girls' time for other activities, including income-generating activities and school attendance. Access to safe water and basic sanitation also significantly reduces the risk of contracting waterborne and other diseases,

Environmental poverty has clear gender dimensions. The participation of women can significantly improve the outcomes of water, sanitation and slum improvement programs as well as enhance the sustainable use of natural resources and clean energy.

which are major health risks especially for pregnant women, infants, and children. In both urban and rural areas, constructing sanitation facilities closer to settlements lowers the security risks for women and girls, especially at night. Providing safe water and appropriate toilet facilities in primary and secondary schools also encourages school attendance, especially by girls.

A gender-sensitive approach to the water and sanitation targets under Goal 7 also can ensure more effective and sustainable outcomes. Women's input in the design and location of water and sanitation facilities ensures that the facilities will be appropriate and convenient to their primary users. Women's participation in community awareness raising about good hygiene practices—a key element of most water and sanitation projects—is also essential to their success and impact. In areas of South Asia where arsenic contamination of groundwater is a problem, it is particularly important to involve women and women's organizations in raising awareness and encouraging households to shift from contaminated tube wells to safer—but often less convenient—water sources.

Slums. In many Asian cities, slum areas have grown rapidly as more people migrate from rural areas and neighboring countries in search of work. Bangladesh, for example, reports that about 50% of its urban population now live in informal settlements. As noted above, slums tend to have much poorer water and sanitation facilities than formal settlements. Housing is substandard, tenure is insecure, and settlements are overcrowded and often unsafe, especially at night. Schools and health centers are often nonexistent, except for those run by NGOs. In this crowded and unsanitary environment, pregnant women and children are particularly susceptible to communicable diseases, and women and girls are at risk of harassment and violence. At the same time, the participation of women and women's organizations can significantly improve the outcome of slum improvement programs. As primary users of basic services, women are often better informed about the basic needs of slum residents. Slum dwellers' organizations, in which women are leaders and active participants, have successfully worked with municipal governments in several countries in the region to build improved housing and public toilets in slum areas,

resettle squatters, and develop innovative tenure arrangements for slum dwellers.⁸⁶

Goal 8—Develop a Global Partnership for Development

Goal 8 is perhaps the broadest MDG, encompassing targets related to trade and finance, sovereign debt, youth employment, access to affordable essential drugs and information and communication technologies (ICTs), and the special needs of least-developed countries, landlocked developing countries and small island developing states. While Goal 8 and its targets call for action mainly by developed countries, many countries in Asia and the Pacific have reported from their perspectives on one or more of the Goal 8 areas. Although not well reflected in the progress reports, several of the Goal 8 areas also have gender implications. A few of these areas are discussed below.

Development assistance. The Goal 8 target for least-developed countries calls for more generous official development assistance (ODA), and several developing countries in the region have reported on this area. Common issues raised in the MDG progress reports include the need for improved donor coordination and problems associated with aid dependency. Timor-Leste notes that the ODA it received initially could have been used to benefit more of the population. Under Goal 4, PNG also notes that the widening variation in provincial health indicators is due in part to the concentration of donor-funded health programs mainly in the more accessible provinces. Only Kazakhstan reports specifically on ODA for gender-related activities, noting that it represents only 1% of technical assistance received. Under Goal 5, the Philippines also notes the need to secure new funding for its reproductive health programs because of a phasing out of USAID support for contraceptives.

Worldwide, the Organisation for Economic Co-operation and Development (OECD) estimates that about 18% of total bilateral assistance has gender equality as either a principal or secondary objective. Within this area, ODA support is heavily concentrated in health (19%) followed by education (16%), governance and civil society (15%) and multisector activities, including traditional “women in development” projects (15%). Gender equality objectives are also in-

cluded in assistance for agriculture, water, and finance, perhaps reflecting donors' recognition of women's important roles in the agriculture and water sectors and women's high level of participation in microfinance projects. However, gender concerns are not visible in ODA for energy, transport and communications, which together account for close to a third of all bilateral assistance. In Asia, only about half of all bilateral assistance for basic health and education has a gender focus (although the proportion is much higher—close to 80%—for population and reproductive health assistance). In contrast to other regions, the gender focus in assistance to the water sector in Asia is particularly low (10%), which is especially troubling because Asia receives far more support to this sector than either Africa or Latin America.⁸⁷

Multilateral assistance to Asia and Pacific countries is provided by the UN system, World Bank, and Asian Development Bank (ADB). A recent internal ADB review found that 12% of ADB loans approved during 1998–2004 had a gender theme, and an additional 17% of loans mainstreamed gender concerns, for example, through a gender action plan linked to the loan's objectives. ADB's highest level of attention to gender concerns has been in its assistance to the health sector, followed by education and agriculture. As in bilateral ODA, the lowest level of attention to gender has been in the energy, transport, and communication sectors. In recent years, about a third of ADB's loans for water supply and sanitation projects have had a gender theme or mainstreamed gender concerns.⁸⁸

Although incomplete, these snapshots of external assistance to the region suggest that there is substantial attention to gender issues in donor support for the education and health MDGs (particularly Goal 5). However, about half of the bilateral aid to the region for basic health, 40% of aid for basic education, and 90% of aid for water supply and sanitation do not have a gender focus. Based on data for all developing regions, as much as 80% of all ODA to Asian and Pacific countries may not have a gender focus. This is problematic from the broader perspective of Goal 3. Without consistent support for gender equality across all sectors, it is unlikely that developing countries in the region—especially least-developed countries—will make sig-

nificant progress in narrowing gender gaps and empowering women.

Trade. Virtually all countries in the region are in the process of liberalizing their trade rules either as members of the WTO, through regional trading blocs or under bilateral trade agreements. Increased trade and cross-border investment are expected to contribute not only to economic growth, but also to poverty reduction.⁸⁹ It is becoming clear, however, that trade liberalization through the WTO and other trade regimes can have different impacts on women and men, depending on gender-related patterns of employment, ownership of businesses and assets, and other factors in domestic economies.⁹⁰ For example, the rapid expansion of export manufacturing in several countries has created job opportunities for large numbers of women, particularly from rural areas. However, there is substantial gender segregation in the export manufacturing sector, with women largely working in lower-skilled, lower-paying jobs, often under strenuous working conditions. These lower-level factory jobs provide little security, and tend to be the first eliminated or subcontracted as industries restructure to become more internationally competitive. Many of these jobs are in garment factories, which are facing intensive competition and uncertainty following the removal of long-standing import quotas under the WTO Agreement on Textiles and Clothing. Attention has focused on female garment workers in countries such as Bangladesh, Cambodia, Fiji Islands, and Lao PDR, which are perceived to be under greater threat from large exporting countries such as the PRC. However, low-skilled garment workers in the PRC and other countries are also subject to low wages, long working hours, difficult working conditions and job insecurity. Workers in export processing zones receive little protection from national labor laws, since these zones are typically exempt from those laws or subject to more relaxed labor standards.

Liberalization of trade is expected to provide additional markets for domestically produced goods, and a wider array of products and services for consumers. However, small farmers and producers are less likely to benefit from increased trade because of their limited access to capital, new technology, and market information, and the risk that cheaper imports may

MDG 8 has strong gender implications, for example, in the areas of development assistance, trade, access to affordable drugs, knowledge transfer and youth employment.

undercut them in local markets. In particular, women farmers and entrepreneurs tend to operate on a smaller scale due to their limited access to land, credit, and other resources, and the need to juggle business and household responsibilities. A recent country gender assessment for the Fiji Islands, for example, notes that women who produce Fijian handicrafts are being undersold by cheaper, factory-made imports.

Under WTO and regional trading arrangements, most countries in the region have substantially reduced import tariffs, particularly on manufactured goods. While this has benefited domestic consumers of those goods, it has also significantly reduced government revenues.⁹¹ The Philippines, for example, reports that reduced tariff revenues have not been offset by increased revenues from other sources, placing a considerable strain on the government budget. Without alternative revenue sources, large budget shortfalls due to lost tariff revenues may prevent governments in the region from making the substantial investments needed to achieve the MDGs, particularly in the areas of education, health, water, and sanitation.

Access to affordable drugs. The Goal 8 target of providing access to affordable essential drugs is both a health issue and a trade issue. Access to essential drugs is fundamental to all the health MDGs, including Goal 5. In Asia and the Pacific, progress in this area has been attributed to India's manufacture and export of generic drugs, as well as collaboration among governments, donors, public-private partnerships, NGOs, and others.⁹² By 2016, least-developed members of the WTO will be required to patent pharmaceuticals, and will be restricted in their ability to manufacture and import generic versions of patented drugs under the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The WHO reports that the patents on 600 or more life-saving drugs will expire between 2005 and 2010.⁹³ However, there are still concerns about developing countries' future access to affordable drugs, particularly

newer drugs and drug combinations to treat HIV and AIDS.⁹⁴ Bangladesh, for example, reports that 80% of its population previously had access to affordable essential drugs, achieved through the manufacture of drugs by a state-owned pharmaceutical firm and drug price controls. The government is now under increasing pressure from pharmaceutical firms to lift these controls, and the future of the state pharmaceutical firm after 2016 is unclear. India has already amended its intellectual property laws to conform to the TRIPS Agreement. Access to affordable drugs has a number of gender dimensions. Women in most societies in the region are the primary caretakers of sick children and other family members, and tend to spend more of their income on essential household expenses, such as medicine. For poor households, the cost of drugs can be prohibitive, and can lead to rationing in which women avoid or postpone medical care for themselves.

Youth employment. This Goal 8 target is linked to both Goals 2 and 3. Several countries in the region report high levels youth unemployment, especially in urban areas, and underemployment in rural areas. Unemployed youth represent 49% of all unemployed workers in the region, and unemployment rates are higher among young women in both South Asia and Southeast Asia.⁹⁵ Countries' ability to provide quality jobs for the large numbers of young men and women entering the workforce each year depends in part on the quality of basic education and technical training they receive. As discussed in connection with Goal 3, young women in the region who pursue postsecondary education tend toward traditional fields, such as health and education, which are also the least well paid. While there are important public policy reasons to encourage young women—especially from ethnic minority groups and disadvantaged castes—to pursue health and education careers, it is also important from the perspective of Goal 3 to encourage young women to study in nontraditional areas, such as engineering and science.

ENDNOTES

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