South Asia Economic Report

Social Sectors in Transition

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FOREWORD

We are pleased to present the second issue of the *South Asia Economic Report (SAER)*, a series of biannual reports on economic and development issues in South Asia. The *SAER* provides a biannual update on the South Asian economy and a theme chapter on an important development issue. In the first *SAER*, which was published in October 2006, the theme was "Banking, Governance, and the Investment Climate." The second *SAER's* theme is "Social Sectors in Transition: Accelerating Inclusive Growth and Human Development," and covers education and health.

This *Report* confirms that South Asia remains on a solid track of high growth. However, at the same time, South Asia is undergoing momentous changes driven by global and regional trends. The *Report* describes these transformational trends and their impact on the education and health sectors, and proposes measures to manage the social sectors through this transition.

Although South Asia has made impressive progress in human development, the region lags behind other areas of the world, and is the second poorest performer after Sub-Saharan Africa. The region faces significant challenges to meet the Millennium Development Goals (MDGs) for education and health. South Asian governments need to focus on achieving both income and nonincome MDGs, and at the same time must strategically address the emerging opportunities and risks associated with the global and regional trends highlighted in this *Report*: the "dual challenge."

Accelerated economic growth and integration into the global economy have opened new opportunities and challenges for South Asia. Technology is redefining the way social services are provided, and could be used to enhance the effectiveness and efficiency of public and private social service delivery. In the past few decades, the private sector has expanded extensively and has gained a dominant presence in almost all activities. South Asia has a 30- to 40-year window of demographic opportunity that could be beneficial provided the increasing numbers of youth and other workers of productive age have the right skills and adequate opportunity to participate in the economies. Disease patterns are undergoing an epidemiological transition, with an increasing proportion of illness attributable to noncommunicable diseases.

One of this *Report*'s key messages is that these global and regional trends tend to aggravate inequalities unless governments in the region implement policies and programs that will guarantee "inclusive" economic growth. By effective pro-poor targeting, leveraging of technology, and innovative public-private partnerships, governments in the region can make public expenditures work better for the poor, and reduce the divide between them and the wealthier segments of society.

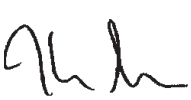
The global and regional trends have opened new opportunities based on competitiveness at a global scale. This puts higher and probably continuously evolving demands on certain labor skills and the knowledge mix. The region's education systems must be transformed for the countries to be able to adapt to the new realities. Quality education is needed at all levels, and technical, vocational, and higher education should be aligned with emerging global market demands. Early onset of lifestyle-related noncommunicable diseases is likely to affect labor productivity and increase health care costs, which could undermine the region's competitiveness.

The *Report* urges the region's governments to explore new modes of delivering social services to assure that they work for the poor. Public-private partnerships and compacts with local governments and civil societies have shown they can enhance delivery of these services. Integration of technology into social service delivery can help target education and health services more effectively to the poor. Regional cooperation on disease surveillance must be improved to reduce the likelihood of pandemics.

We hope this *SAER* will help all the stakeholders, especially senior policy makers in the governments, to appreciate the key global and regional trends and take effective proactive steps to capitalize on opportunities and mitigate risks in order to ensure accelerated inclusive growth and human development in South Asia. The Asian Development Bank (ADB) is committed to catalyze the provision of technical and financial support to the region, to ensure sustained growth to eradicate poverty.

This report is the result of efforts by numerous people at ADB. Staff and consultants from the South Asia Department of ADB prepared this issue of the *SAER*. The work was conducted under the overall guidance of Sultan Hafeez Rahman and Yukiko Kojima. The *Report* was prepared under the close supervision of Fred Roche by a team composed of Alain Borghijs, Leah Gutierrez, Ayako Inagaki, and Sekhar Bonu (team leader), with support from Caroline Patacsil, Rommel Rabanal, and Sharlene Lu-Quintana. Jill Gale de Villa edited the final report.

We thank these and numerous other colleagues who provided valuable input and comments, including Armin Bauer, Indu Bhushan, Siew Tuan Chew, Sunniya Durrani-Jamal, Rikard Elfving, Rana Hasan, Rie Hiraoka, Jesus Felipe, Walter Kolkma, Emiko Masaki, Aashish Mehta, Alessandro Pio, Narhari Rao, Jouko Sarvi, Robert Schoellhammer, Sonomi Tanaka, Norio Usui, Richard Vokes, Robert Wihtol, Ganeshan Wignaraja, and Vincent de Wit.



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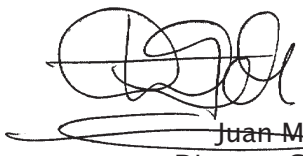

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ABBREVIATIONS AND ACRONYMS

ADB	—	Asian Development Bank
BPO	—	business process outsourcing
FDI	—	foreign direct investment
GDP	—	gross domestic product
HIV/AIDS	—	human immunodeficiency virus /acquired immunodeficiency syndrome
ICT	—	information and communication technology
MDG	—	Millennium Development Goal
MIS	—	management information system
PHC	—	primary health care
SAER	—	*South Asia Economic Report*
TVET	—	technical and vocational education and training
UPHCP	—	Urban Primary Health Care Project (Bangladesh)

Abbreviation of Country Names in Tables

AFG	—	Afghanistan
BAN	—	Bangladesh
BHU	—	Bhutan
IND	—	India
MLD	—	Maldives
NEP	—	Nepal
PAK	—	Pakistan
SRI	—	Sri Lanka
US	—	United States

Note: The symbol "$" refers to the US dollar.

EXPLANATORY NOTES

For the purposes of this issue of the *South Asia Economic Report*, the following analytical or geographical groupings apply:

- South Asia comprises Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka.
- In section 2, tables containing regional comparisons follow the regional classification of the World Bank.
- The geographic groups in figure 2.3 are derived from the *Education for All Global Monitoring Report 2007* of the United Nations Education, Scientific and Cultural Organization (UNESCO).
- In box 2.1 on progress toward the Millennium Development Goals, the regional groupings featured in the accompanying figures are consistent with the MDG regional classifications of the United Nations.

Countries in South Asia have varying fiscal years, as detailed below. The fiscal years of the Maldives and Sri Lanka correspond to the calendar year. Unless otherwise indicated, "year" refers to calendar year in the text.

Country	Fiscal Year	Caption
Afghanistan	21 March 2006 to 20 March 2007	FY2006
Bangladesh	1 July 2005 to 30 June 2006	FY2006
Bhutan	1 July 2005 to 30 June 2006	FY2006
India	1 April 2006 to 31 March 2007	FY2006
Nepal	16 July 2005 to 15 July 2006	FY2006
Pakistan	1 July 2005 to 30 June 2006	FY2006

This issue of the *SAER* uses data available as of 29 June 2007 Economic data are from the *Asian Development Outlook* (ADO), the *ADO Update*, and South Asia Department's *Economic Information System* (EIS). A detailed explanation of variable definitions, computations, and data sources is contained in the Statistical Notes of the Statistical Appendix at the end of this Report.

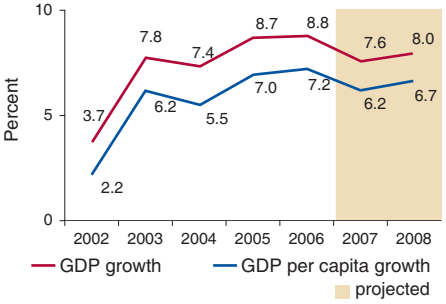
Data for figures in section 1 come from the *Asian Development Outlook 2007* (ADB 2007a) and ADB databases. Figures 2.2, 2.4, 2.5, 2.6, 3.3, and 3.7 contain data derived from country demographic and health surveys—Bangladesh Demographic and Health Survey 2004, India National Family Health Surveys 1998/99, and Nepal Demographic and Health Survey 2001, accessed through three forthcoming World Bank publications (Round II Country Reports on Health, Nutrition, Population Conditions among Poor and Better-Off in 56 Countries, by Gwatkin et al.) and India National Family Health Survey 2005/06, accessed at www.nfhsindia.org/pdf/IN_WICT.pdf. Information and data in boxes, figures, and tables that do not have sources cited are from ADB staff and databases.

1. INTRODUCTION

Recent Economic Performance and Prospects

South Asia continues to build on its recent record of strong economic performance. Growth of gross domestic product (GDP) reached a remarkable 8.8% (7.2% in per capita terms) in 2006, sustaining the impressive trend established since 2002, when annual growth averaged over 8%. South Asia is outperforming Asia as a whole, which grew at 8.3% in 2006, and remains one of the fastest growing regions in the world. With GDP forecast to grow at 7.6% in 2007 and 8.0% in 2008, the high growth trajectory is expected to be sustained over the medium term (figure 1.1).

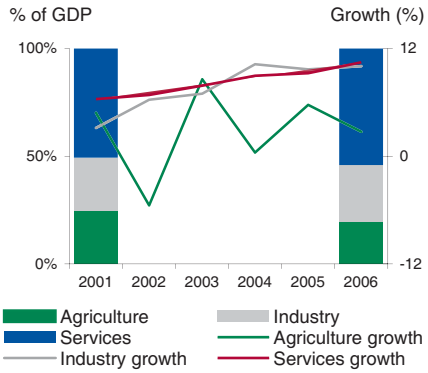
Figure 1.1: Growth in South Asia



All countries in the region grew at over 6% in 2006, except Nepal. The Indian economy maintains a robust rate of expansion with a high 9.4% growth in fiscal year (FY) 2006, which surpassed the previous year's rapid pace. Growth also accelerated in Bangladesh and Sri Lanka to decade-long highs of 6.6% and 7.4%, respectively, while the Maldives strongly rebounded from the previous year's tsunami-induced contraction by registering a 19.1% expansion. After expanding rapidly in the previous 2 years, growth in Pakistan, however, slowed to 6.6%.

Services continued to underpin economic growth in South Asia. In 2006, sectoral output expanded rapidly, by 10.5%, buoyed by vibrant trade, transport, and communications services across the region, as well as other vital subsectors such as information technology and information technology enabled services in India and tourism in the Maldives. As a result, the share of the services sector in total output increased further to 54.2% of GDP. Growth in the industry sector also remained high at 10.1%, as construction continues to expand with increased residential and commercial property building in India and Bhutan, and with reconstruction efforts in calamity-stricken countries in the region. The utilities subsector is also becoming more important due to rising hydropower generation in Bhutan and Sri Lanka. Agriculture only grew by 2.7% in 2006 (figure 1.2), although the post-tsunami recovery of fisheries in Sri Lanka is indeed a welcome development. Industry and services in South Asia are each forecast at over 7.5% annual growth in the next 2 years.

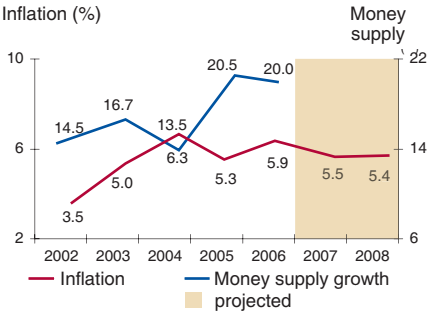
Figure 1.2: Services-Led Growth



Rising food prices due to depressed farm production, rapid money supply growth, and high world prices of oil and commodities have resulted in a significant rise in regional inflation to 5.9% in 2006

(figure 1.3). Investment requirements from the rise of manufacturing and the construction boom in India fueled credit and liquidity growth, which, combined with high food and fuel prices, pushed inflation up to 5.4%, a full percentage point higher than the previous year. Excess liquidity, plus a sharp depreciation of the taka, also raised inflation significantly in Bangladesh to 7.2% in FY2006. However, the sharpest price increases were recorded in Nepal, where inflation almost doubled to 8.0% due to low agricultural output, reduced petroleum subsidies, and a higher value-added tax rate.

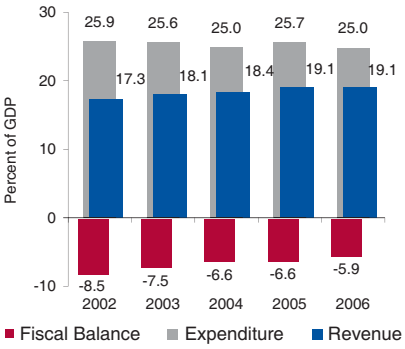
Figure 1.3: Inflation and Money Supply Growth



Monetary authorities in South Asia raised nominal interest rates in attempts to tighten liquidity but rising inflation kept real interest rates low. Thus, money supply growth in the region stabilized at a slightly lower although brisk pace of 20% in 2006. Inflation is expected to ease to 5.5% in 2007 and to 5.4% in 2008, as central banks continue the tight monetary policy stance, a strong supply response to high food prices is realized, and the world price of oil could be reduced.

The regional average fiscal deficit declined further to 5.9% of GDP in 2006, driven by a significant reduction of expenditure in India, where fiscal consolidation continues at both the federal and state levels (figure 1.4). A marginal improvement in fiscal position was also recorded in Bangladesh, while Bhutan's large budget deficit declined due to higher foreign grants and a slight reduction in capital expenditures. In general, however, fiscal deficits across South Asia remained high because of incomplete pass-through of high oil prices and higher development expenditures. Relief and reconstruction expenditures, in response to the severe effects of the tsunami in the Maldives and the earthquake in Pakistan, also contributed significantly to the high budget deficits in these countries.

Figure 1.4: Fiscal Performance



South Asia's integration with the world economy through international merchandise trade proceeded at a slightly slower pace in 2006. Total trade as a proportion of GDP increased to 36.3%, from 33.9% in 2005 and 30.8% in 2004. Export growth moderated to 19.4% in 2006, as the flow of goods from Afghanistan, India, Nepal, Pakistan, and Sri Lanka lost some momentum due primarily to real currency appreciation. However, the growth of exports accelerated substantially in Bangladesh, Bhutan, and the Maldives. Although average import growth was also lower at 22.0%, it remained above export expansion. The trade deficit thus increased to about 7.3% of GDP (figure 1.5). Large foreign exchange inflows from service exports and workers' remittances, valued at $130 billion, cushioned the current account, although the deficit still expanded to 1.4% of GDP.

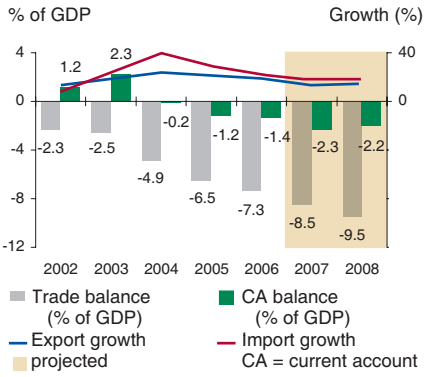
These trends are projected to persist in the next 2 years. Growth of merchandise imports is again likely to outstrip that of exports because of South Asia's rapid economic growth and low GDP growth in developed countries. Merchandise exports are expected to expand by an average of almost 15% per annum during the next 2 years, slightly lagging behind the growth forecast of nearly 18% for regional

imports. As a result, the trade deficit is projected to deteriorate further to 8.5% of GDP in 2007 and then to 9.5% in 2008. However, consistently strong performance of service exports and rising remittances should substantially compensate for the trade deficit, and help to stabilize the current account deficit at around 2.2–2.3% of GDP through 2007 and 2008.

Given its impressive economic performance in recent years and solid prospects for continued high growth, South Asia is becoming one of the more attractive destinations for foreign capital. Investor confidence is rising, with foreign direct investment (FDI) reaching over $24 billion in 2006. This builds substantially on the previous year's large inflows, which breached the $10 billion mark for the first time. India's leading role in the region's economic surge has generated the most interest among investors. About 80% of total FDI in South Asia flowed into India in 2006, amounting to $19.5 billion—almost $12 billion more than the previous year. Pakistan follows a similar trend as FDI more than doubled to about $3.5 billion in FY2006. The volume of capital inflows into South Asia has counteracted prevailing current account deficits, translating into balance-of-payments surpluses and an accumulation of gross international reserves in excess of $220 billion across the region. Prospects for sustaining rapid economic growth will become brighter as investor confidence develops and foreign capital inflows gain momentum.

Overall, South Asia is expected to experience high growth with strong domestic demand and rising investment, although economic performance may moderate somewhat in line with global trends. India will continue to set the pace with GDP growth forecast at about 8% per annum over the next 2 years. Bangladesh, Pakistan, and Sri Lanka are projected to grow at 6–7% during this period, providing strong support for the encouraging rate of progress in South Asia.

Figure 1.5: External Sector



Challenges and Opportunities

South Asia is on a track of high growth. However, growth has only been strong during the past few years, and the region has yet to prove that rapid growth is sustainable in the longer term. In addition, there is growing concern that the growth is not sufficiently inclusive and truly poverty-reducing (Felipe and Hasan 2006, 2007). Successfully tackling these challenges requires strategic choices in crucial policy areas.

In this respect, the previous *South Asia Economic Report (SAER)* highlighted the need for institutional reforms and targeted public investments required to sustain and accelerate growth. Institutional reforms need to focus on improving regulatory quality and government effectiveness. The first *SAER* also recommended that public investments be targeted at areas where infrastructure

bottlenecks are emerging. In particular, power, roads, urban infrastructure, and ports form a serious constraint to sustaining growth in the medium to long term.

This issue of the *SAER* focuses on a different, but equally important, set of challenges and opportunities for South Asia in the areas of education and health.[1] We argue that the social sectors in South Asia are increasingly confronted with a number of global and regional trends, which present both opportunities and challenges. Understanding and strategically capitalizing on these trends in order to improve social sector performance—and ultimately to sustain and enhance the inclusiveness of growth—is crucial, since South Asia continues to perform weakly in key dimensions of education and health. In section 3, the *SAER* describes six broad trends and their impact on the education and health sectors.

- First, accelerated economic growth and integration into the global economy have created new and unprecedented economic opportunities that have provided increased income for many.
- Second, rapid technological changes have redefined the nature of the services sector, resulting in unbundling and outsourcing (Friedman 2005). Among the factors that have made "offshoring" (the wholesale movement of factories to other countries) possible are advances in computer and communications technology. Technology is also redefining the way social services are provided with a potential to enhance the effectiveness and efficiency of public and private social service delivery.
- Third, labor markets in the region are in constant motion. Workers have become increasingly mobile and have generated both domestic and international migration streams. Worker remittances doubled in the region as a whole between 2001 and 2006.
- Fourth, the private sector has rapidly increased its participation in education and health. Effectively structured public-private partnerships have opened new vistas for the efficient delivery of education and health services.
- Fifth, South Asia is undergoing the demographic transition with reduced fertility rates and improved life expectancy. This will lead to a 30- to 40-year window of opportunity called the "demographic dividend."

[1] A balance between economic growth and social development cannot be found without addressing inequality issues such as income, gender, labor productivity, persistent underemployment, and growth of the informal sector. The continued existence of such inequities raises fundamental questions about the stability and sustainability of development. We acknowledge that policy and program response to the challenges posed by the broad global and regional trends, among other factors, will involve social protection, which we touch upon while referring to risk pooling and health insurance. However, a more comprehensive discussion of social protection and other aspects of improving labor productivity in agriculture and the manufacturing sectors (measures beyond health and education) for employment generation is beyond the scope of this report.

- Sixth, disease patterns are undergoing an epidemiological transition, with a lower burden of communicable diseases and an increase in noncommunicable diseases.

A thorough understanding of these trends and appropriate government responses is crucial. Ignoring the trends threatens to steer governments off course in their efforts to achieve the Millennium Development Goals (MDGs) and to improve the social sectors in general. As section 2 demonstrates, South Asia has little margin for error in this respect. South Asia continues to lag behind the rest of Asia and the world (except for Sub-Saharan Africa) in education and health outcomes. The region is progressing only slowly toward meeting the nonincome MDGs (primary education, gender equity, child and maternal health, and communicable diseases such as HIV/AIDS, tuberculosis, and malaria).

Ignoring the challenges and opportunities posed by these trends will entail substantial economic costs in terms of foregone growth and development in the region. Human development and economic growth are closely interlinked. The right investments in human development improve the likelihood of sustainable economic growth, increase labor productivity, and increase the likelihood that backward regions can catch up with better-endowed regions. For South Asia to successfully benefit from the opportunities, human resources are a key factor. A healthy and appropriately skilled workforce is crucial in attracting economic activity that will contribute to sustainable and inclusive growth (Devarajan and Nabi 2006).

Based on section 3's analysis of the crucial trends and their impact on the health and education sectors, section 4 proposes a set of key actions for governments in the region to shape the social sectors in dealing with the challenges and opportunities. Section 5 concludes the report by summarizing the strategic actions needed.

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?

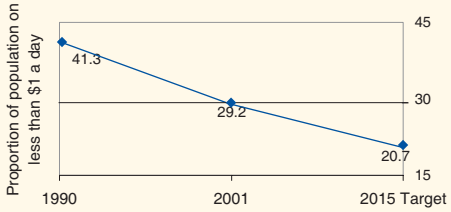
In the year 2000, nations agreed to a set of goals for building a better world. They are known as the Millennium Development Goals (MDGs) and were set for the year 2015. The MDGs promote poverty reduction, education, gender equality, maternal health, environmental sustainability, and global partnership 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.

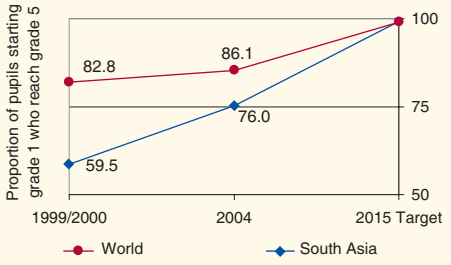
Goal 2—Universal primary education: The access to primary education has increased in South Asia, mainly due to progress in India, where the net enrollment ratio has increased from 79% in 2000 to 87% in 2004. However, completion of primary schooling remains a concern, as only 76% of grade 1 pupils in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

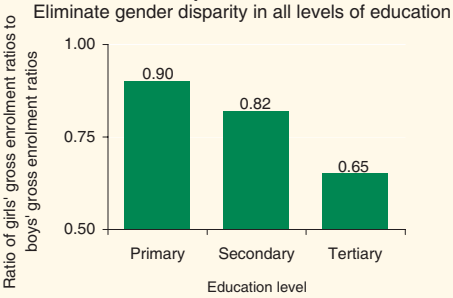
Goal 1: Eradicate extreme poverty and hunger
Halve proportion of people on less than $1 a day



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.

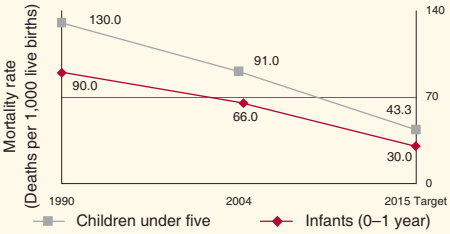
Goal 4—Reduction in child mortality: Child mortality (0–4 years old) per 1,000 live births declined from 130 deaths in 1990 to about 91 in 2004. However, significant disparities across socioeconomic groups remain a matter of concern.

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.

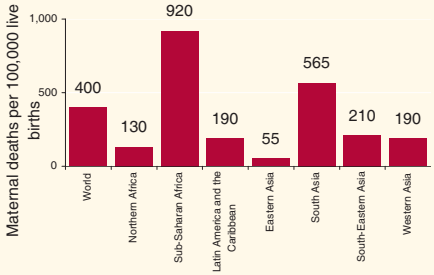
Goal 6—Combat HIV/AIDS, malaria, and other diseases: Since 1990, HIV/AIDS prevalence among adults has been increasing worldwide. HIV/AIDS prevalence in South Asia is estimated at 0.7% in 2005. To stop HIV/AIDS from spreading, strong political will is needed to promote HIV/AIDS education and prevention 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.

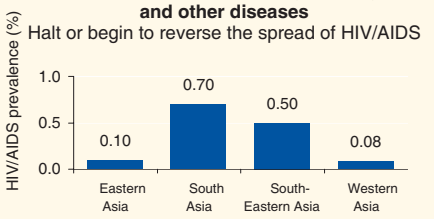
Goal 4: Reduce child mortality
Reduce by 2/3 the under-5 mortality rate



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).

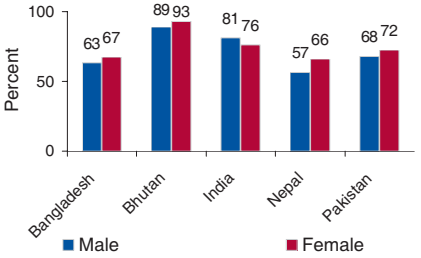
While most children in South Asia are able to at least start schooling, low efficiency of education (as indicated by high rates of dropping out and repeating grades) is a major concern. In addition, gender and wealth disparities in schooling achievement continue to be formidable (Filmer 2005). Too many 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.

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).

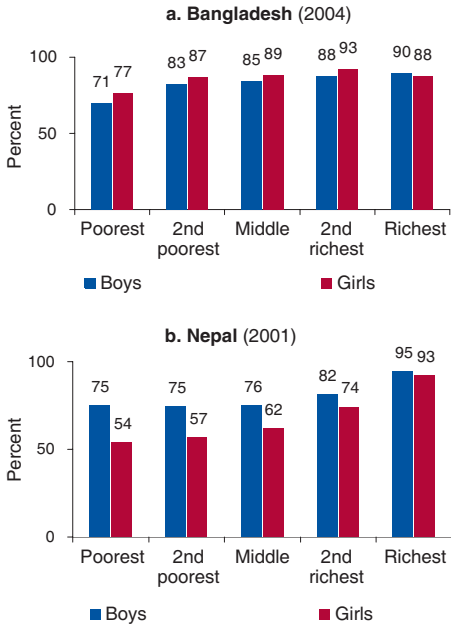
While gender equality in access and enrollment rates has generally been improving, differentials in access to education across income groups remain a concern (figure 2.2). Children from the poorest households sometimes cannot avail of free public education due to high opportunity costs and prohibitive "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

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.

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).

Table 2.4: Gross Secondary School Enrollment Ratio (%)

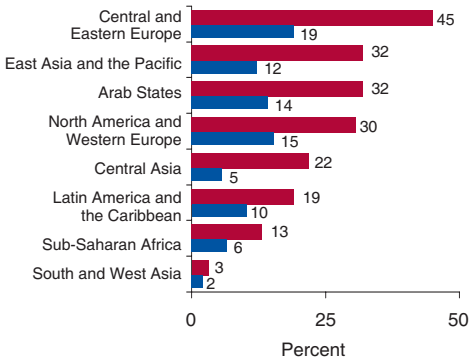
Country	1990		Latest Year		
	Female	Male	Female	Male	Year
Afghanistan	9	18	5	25	2004
Bangladesh	13	25	54	49	2003
Bhutan	—	—	—	—	
India	33	55	47	59	2004
Maldives	45	46	78	68	2004
Nepal	20	46	42	49	2005
Pakistan	15	30	23	31	2004
Sri Lanka	77	71	83	82	2004

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



Senior secondary students enrolled in technical and vocational education (%)

Secondary students enrolled 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).

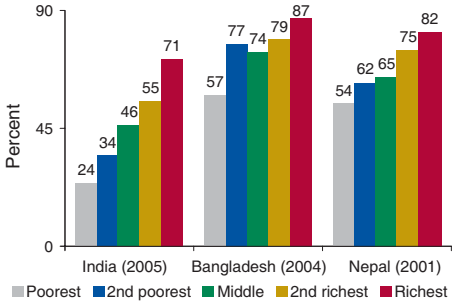
South Asia accounts for one third of maternal deaths worldwide. The lifetime risk of a woman in South Asia dying during pregnancy is 1 in 43, compared with 1 in 30,000 in Sweden. The intercountry variation of maternal mortality ratios ranges from a low of 92 per 100,000 live births in Sri Lanka to 540 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).

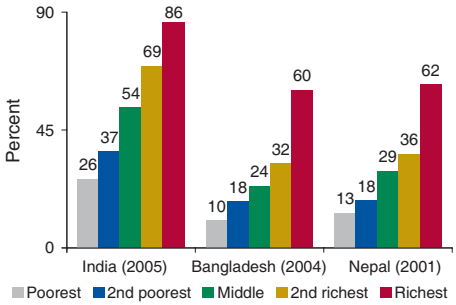
Although Asia led the decline in global poverty in the 1990s, it still accounts for two-thirds of the global burden of undernutrition, with

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.

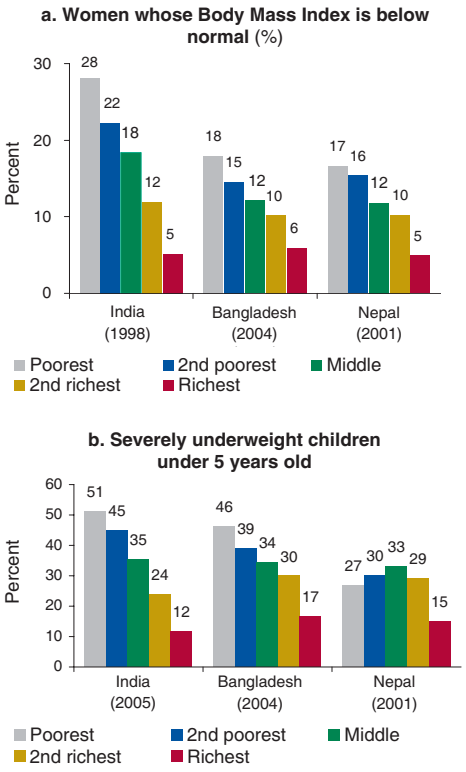
nearly half of under-5 children in the region being below standards of weight-for-age (figure 2.5), especially among the poor (ADB 2001a, 2004d, 2005d, and 2005e). Rampant iron and other micronutrient deficiencies combined with overall malnutrition lead to a learning disadvantage from childhood that 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).

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,

Figure 2.5: Maternal and Child Malnutrition, by Wealth Quintile



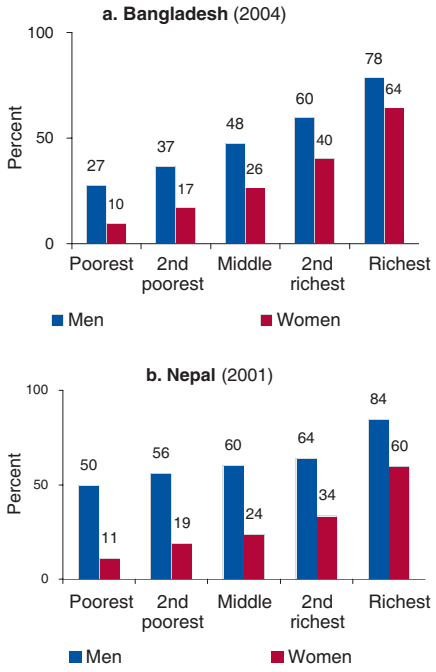
Note: The weight-for-age in figure 2.5b is assessed as below the -3 standard deviation z-score.
Sources: Demographic and health survey data (see pp. viii–ix).

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.

3. SOCIAL SECTORS IN TRANSITION

Section 2 described the challenges South Asia faces to achieve the MDGs and improve the quality, effectiveness, and efficiency of health and education. In this section, we focus on a number of emerging global and regional trends: economic growth led increasingly by the private sector, and changes in technology, labor markets, demography, and epidemiology. These trends are creating new opportunities as well as challenges for the education and health sectors in South Asia. Some of the changes are fundamental and inevitable; some opportunities, if properly exploited, can foster prosperity and improve the quality of life for the citizens in the region; some present downside risks that need to be managed with better policies and programs. Box 3.1 presents the main implications of these trends for the education and health sectors.

Box 3.1: Transition Impact Framework

Overall Trend	Implications for Education	Implications for Health
Economic Growth **Trends** • South Asia emerging as one of the engines of regional and global economic growth • South Asia increasingly integrating with the world economy **Opportunities** • New economic opportunities • Increasing purchasing power • Increased role of outsourcing **Challenges** • Accentuation of inequalities • Increasing vulnerability to global events	**Opportunities** • More resources available for public education • Increased demand for educated and skilled workers **Challenges** • While countries are still under stress to achieve good quality universal primary education, more resources are needed for secondary education • Need for good quality higher education, including technical and vocational education and training (TVET), in line with global market needs • Need for continuing education and lifelong learning to upgrade skills and knowledge to adapt to rapid changes in labor markets • Risk of widening inequalities in education	**Opportunities** • More resources for public health services and health infrastructure, including water and sanitation • Increasing business opportunities in health services—e.g., outsourcing and hospital care **Challenges** • Global trade agreements and intellectual property rights have implications for access to essential medicines and technologies • Risk of increase in health inequalities • Globalization increases threats of cross-border and faster spread of diseases and epidemics—e.g., severe acute respiratory syndrome (SARS) and avian influenza
Technological Changes **Trend** • Access to and use of information and communication technology (ICT) is increasing **Opportunities** • Anything that can be digitized is becoming tradable, facilitating outsourcing, particularly of services	**Opportunities** • Improving access and quality of education • Enhancing teaching and learning experience by using ICT • ICT as a tool for education governance **Challenges** • Technology is changing the labor skills	**Opportunities** • Improving health service provision by remotely located health workers • Technology leveraged to strengthen governance and transparency • New opportunities to strengthen disease surveillance with more

Box 3.1, continued

Overall Trend	Implications for Education	Implications for Health
• Faster spread of information can improve delivery of public services and improve governance • Communications and increasing technology-driven networking redefine ways people and governments work **Challenges** • Increasing demand for skilled and highly skilled labor • Digital divide can lead to increasing disparity in access to economic opportunities	in demand: need to reskill labor • Demand for higher education and higher skill is increasing • Need for additional investment to facilitate technology adoption in classrooms • Need to retrain education workers as the skills mix required for delivering education may change • Potential exclusion of the poor from opportunities in ICT and other markets	prompt response to outbreaks • Potential to reduce information asymmetry in health care provision • Technology-enabled unbundling and outsourcing create new business opportunities **Challenges** • Training existing health staff in using new technology • Curriculum changes in training of health workers to keep pace with changing technology • Demand for specialized health care skills to meet demands of health service outsourcing at the cost of domestic public health needs • Rapid dissemination of information on disease spread can create panic and financial market crisis
Labor Market Transformation **Trend** • Increasing labor mobility, within and across countries **Opportunities** • Domestic and international labor mobility allow for better skills match • Language as leverage for South Asians in the international labor market **Challenges** • Rapid and uncontrolled urbanization • Labor skills need to cater to global labor market requirements	**Opportunity** • Labor market includes both national and international markets **Challenges** • Increased challenge for the governments to align education and training investments in the country with both national and international labor markets • Need for higher and more diversified skills; including for English language, communication, and life skills • Migration of teachers and TVET instructors to other countries, from public to private sectors, among sectors, and from rural to urban areas	**Challenges** • Rapid urbanization further stresses weak urban primary health care systems • Growing urban slums exhibit greater vulnerability to emerging diseases • Potential worsening of human resource shortage in rural areas
Private Provision of Social Services **Trend** • Increasing role of the private sector in social service delivery **Opportunities** • Private sector setting higher bench marks in quality and consumer satisfaction • Increasing employment opportunities in the private sector • Public-private partnerships in public services **Challenges** • Aggravation of income- and skill-based inequalities	**Opportunities** • Partnerships with the private sector for provision and financing of education services • Benchmarking and competition with the private sector may improve quality in the public sector **Challenges** • Need to refine frameworks for facilitating public-private partnerships • Need to strengthen governments' capacity in regulation, facilitation, standards-setting, and quality assurance • Potential worsening of inequalities between poor and nonpoor students	**Opportunities** • New partners in provision and financing of health services • Involvement of the private sector in risk pooling and mitigation • Benchmark setting and competition provided by the private sector may improve quality in the public sector **Challenges** • Potential aggravation of inequities in health care use and outcomes • Weak public sector capacity to regulate the private sector,

Box 3.1, continued

Overall Trend	Implications for Education	Implications for Health
• Need for effective public policy to mitigate market failures and regulate the private sector • Development of innovative partnerships between public and private sectors to enhance social service delivery	• Greater demand for educated and skilled labor requires strengthening of linkages between TVET and the private sector • Potential shortage of government teachers opting for private education or lucrative nonteaching jobs	including for disease surveillance • Potential overall shortage of human resources in the health sector as people opt for more lucrative careers in the private sector • Escalation of health care cost with potential for increase in unwarranted medical procedures and use of prescription medicines
Demographic Transition **Trend** • 0–9 year age group is likely to stabilize in size by 2015 • 10–19, 20–29, and 30–39 year groups are going to increase significantly • Increasing older population in both the developed and developing countries **Opportunities** • Demographic dividend if the right skills and opportunities can be provided • Larger tax base, with increasing resource availability to governments • Lower child dependency ratio **Challenges** • Increasing proportion of old age population • Momentum of population growth is increasingly from poor households • Need to create more jobs for growing numbers of youth and working age people	**Opportunities** • Demand for primary schooling stabilizes • Education systems can focus on quality as access issues stabilize • Larger working age population increases tax revenues to improve public education **Challenges** • Increasing demand for secondary, postsecondary, and TVET education • More prospective secondary and higher education students coming from poor households • Challenge to sustain the quality and coverage of primary education while mobilizing more resources to deal with the increasing number of students entering secondary schools	**Opportunities** • Increased tax revenues to improve public health **Challenges** • Adapting the health systems to the changing demographic structure • Maintaining services for mother and child health while the health systems adjust to the needs of demographic and epidemiological transition • Increasing risk of sexually transmitted diseases, including HIV/AIDS, with current poor health status in the adolescent population • Demand for health workers and health services from an aging developed world
Epidemiological Transition **Trend** • Shift of disease burden from communicable to noncommunicable diseases **Opportunity** • Reduction in communicable disease burden especially among the better off **Challenge** • Increase in share of noncommunicable diseases, with considerably higher treatment costs	**Opportunity** • Better education outcomes with decreasing school absenteeism due to lower communicable disease burden **Challenge** • Need to integrate health education in school curricula to deal with the challenges of both noncommunicable and communicable diseases affecting mainly the young (HIV/AIDS)	**Opportunity** • Freeing-up of resources from communicable disease treatment **Challenges** • Primary health care services ill-prepared for noncommunicable diseases • Need for risk pooling (insurance) due to costly noncommunicable diseases • Potential double burden of susceptibility to both communicable and noncommunicable diseases for the poor

Economic Growth

South Asia has been recording rapid economic growth over the past few years. Provided the right policy choices are made, South Asia could emerge as an engine of Asian and global economic growth. Part of the growth is being fueled by South Asia's increasing integration with the world economy through rising trade flows (UNDP 2006). South Asia's participation in international trade, while still low compared to that of other regions, has accelerated rapidly in recent years. Economic reforms and the globalizing environment are driving the improving performance of South Asia's external sector (ADB 2007b).

This growth process has rapidly been creating and dividing winners and losers. People with the right skill mix have been able to benefit from the rapid economic expansion through employment and rising incomes. The benefits of these increased incomes from economic growth and lower trade barriers are also spreading to the wider economy through increased domestic consumption. At the same time, the growth process threatens to leave behind a large proportion of the region's population that works in traditional, low-income agricultural or nonformal occupations. For example, in India people benefiting from business process outsourcing (BPO) are "part of a small, educated elite," whereas India needs "more productive agriculture … and job creation both in labor-intensive industry and in lower productivity services" (ADB 2007a). While the overall consensus on the economic prospects and potential of the region has been generally positive, poorly managed economic integration in the world economy, including its financial systems, increases vulnerability. The flexibility with which global manufacturing and services can be shifted may increase job uncertainty. The total cost of production will be the key determinant of a producer's decision on where the manufacturing or services industry will be located. Capital deployment has become extremely mobile in an increasingly "borderless world" (Ohmae 1990). Producers, investors, and employers are growing ever more nimble. Hence, South Asia will need to become and remain globally competitive (box 3.2).

Thus, the growth trend presents several challenges and opportunities. Education systems, in particular, will need to be prepared to quickly provide new skills that are in line with changing labor market demands. People who lose their jobs or livelihoods due to the forces of globalization will require social protection between jobs (Sipahimalani-Rao 2006). The social sectors will also need to respond if the benefits of growth are to reach all strata of society. Globalization will pose new challenges to the health systems, as countries have to deal with the risk of international transfer of diseases (Frenk and Gomez-Dantes 2002).

Box 3.2: Global Competitiveness, Education, and Health

The *Global Competitiveness Report 2006–2007* ranked countries using a global competitiveness index based on nine pillars: institutions, infrastructure, macroeconomy, health and primary education, higher education and training, market efficiency, technological readiness, business sophistication, and innovation (*World Economic Forum* 2006). The components of pillars relating to education and health are as follows:

(1) Fourth Pillar: Health and Primary Education
  (a) Health
    - 4.01 Medium-term business impact of malaria
    - 4.02 Medium-term business impact of tuberculosis
    - 4.03 Medium-term business impact of HIV/AIDS
    - 4.04 Infant mortality
    - 4.05 Life expectancy
    - 4.06 Tuberculosis prevalence
    - 4.07 Malaria prevalence
    - 4.08 HIV/AIDS prevalence
  (b) Primary education
    - 4.09 Primary enrollment

(2) Fifth pillar: Higher education and training
  (a) Quantity of education
    - 5.01 Secondary enrollment ratio
    - 5.02 Tertiary enrollment ratio
  (b) Quality of education
    - 5.03 Quality of the educational system
    - 5.04 Quality of math and science education
    - 5.05 Quality of management schools
  (c) On-the-job training
    - 5.06 Local availability of specialized research and training services
    - 5.07 Extent of staff training

The report ranks 125 countries. The table below shows the rankings for five South Asian countries. India, which has the highest overall ranking for South Asia, performs poorly in pillar 4 relating to health and primary education, with only Sri Lanka ranking relatively high. For pillar 5, only India ranks reasonably high. (Afghanistan, Bhutan, and Nepal are not among the 125 countries ranked.)

Note: Lall (2001) questions the methodology used in the *Global Competitiveness Report's* analysis.

Global Competitiveness Ranking of Five South Asian Countries

	1	2	3	4	5	6	7	8	9
Pillar / **Sector**	**Institutions**	**Infrastructure**	**Macroeconomy**	**Health and Primary Education**	**Higher Education and Training**	**Market Efficiencies**	**Technological Readiness**	**Business Sophistication**	**Innovation**
Bangladesh	121	117	47	90	108	83	114	96	109
India	34	60	88	93	49	21	55	25	26
Nepal	99	122	59	102	109	105	116	108	112
Pakistan	79	67	86	108	104	54	89	66	60
Sri Lanka	82	76	110	36	81	71	83	71	53

The education sector also has to deliver the higher knowledge and skills required in the labor force as South Asia moves up the development ladder. Whether catering to international or domestic demand, skill requirements are bound to increase as manufacturing and services become more sophisticated. Governments face the dual challenges of aligning education investments with national and international labor markets, while at the same time making growth inclusive by promoting human development on the broadest possible scale. During the transition phase, more resources will be needed for secondary and postsecondary education (Devarajan and Nabi 2006). This may put countries under stress while they are still struggling to achieve universal primary education. However, in the longer run, increased income, a growing economically active population, and a growing middle class are expected to provide a wider tax base that will make more resources available for education and other social sector investments.

The Asia-Pacific Human Development Report 2006 aptly sums up the situation: "the Asia-Pacific region has embraced free trade, but free trade will not embrace the poor unless countries pursue a bold new policy agenda harnessing economic growth to promote human development" (UNDP 2006).

Technological Changes

A second trend is the ongoing development and dissemination of ICT on a global scale (UNDP 2001 and 2005). Access to and use of ICT has been steadily increasing in South Asia (table 3.1). Mobile phone use had increased dramatically to about 117 million subscribers by 2005 from a very low base in the mid-1990s. Information technology is also widespread, with a significant rise in the number of Internet users and personal computers in the region.

The technological breakthroughs have boosted outsourcing and exports of ICT-enabled services (Friedman 2005). Technology now

Table 3.1: Technology and Infrastructure Data, 1997 and 2002

Category	World		South Asia	
	1995	2005	1995	2005
Fixed Lines and Mobile Telephones (per 1,000 people)	137.8	522.6	12.1	118.9
Personal Computers (per 1,000 people)	42.0	130.4[a]	1.6	15.5
Internet Users (per 1,000 people)	8.0	136.7	0.2	49.0

[a] 2004 data.
Source: World Bank. World Development Indicators Database. www.worldbank.org/data/countrydata/countrydata.html. Accessed June 2007.

allows parts of the production process to be unbundled and shifted to locations where they can be executed at a lower cost. Anything that can be digitized and done remotely now provides an opportunity for outsourcing (*The Economist* 2007b). South Asia, with its relatively inexpensive skilled labor, has benefited from these advances. The availability of skilled, English-speaking labor and low costs have driven Asia's growth in BPO at more than 10% per annum in the last few years. India, in particular, has seen the number of outsourced jobs, mostly in ICT, grow rapidly and is the world's number one destination for them; the process has raised the incomes of the highly skilled and is contributing to the growth of some urban centers. India accounts for 40% of the global BPO market, and has had 260,000 jobs created in the sector since the beginning of the BPO outsourcing trend (*The Economist* 2005, 2006a, 2006b, and 2006d) The new technology also provides the opportunity to outsource medical services such as analyzing X-rays (*The Economist* 2004b and 2006c).

However, India is increasingly facing a supply gap of these highly skilled workers. Consequently, offered wages are increasing and employee turnover is high. The number and qualifications of graduates from the top Indian universities may not suffice to fill this gap (ADB 2007a). For India to keep its comparative advantage, more highly skilled labor is needed. India has to provide good quality, relevant education to more students—the overall quality of the education system should improve.

Technology also has a profound impact on the way education can be provided (Chittaro and Ranon 2007 and ADB 2001b and 2005a). ICT can improve access to education by remote communities and enhance the quality of teaching and learning. ICT applications can be used to improve governance and efficiency in education (although its use should be evaluated for cost effectiveness versus traditional methods). The role of teachers can be altered significantly as learning can become less teacher-driven and more student-controlled, with teachers becoming moderators or facilitators of learning. Technology can also be a key driver in improving the effectiveness of health care. ICT can be used to inform the population more effectively about health-related issues like child mortality, maternal health, and HIV/AIDS, malaria, and other major diseases. With the help of new technologies, access to health care in remote areas can be improved. Health workers with access to relevant web-based content in the local language can deliver health care for common diseases more reliably (Zolfo et al. 2006).

Labor Market Transformation

Labor markets in South Asia are being transformed by economic growth, technological change, and changes in government policies and international agreements, among other factors. Work opportunities for South Asians are local as well as international (ADB 2004e). The global and regional trends will create jobs for people who have the

right skills and education, but will not address the region's larger challenges for employment generation. (For more information on underemployment, job creation, and policy measures for economic growth that generates jobs, see Felipe and Hasan 2007.)

South Asian workers are now more mobile, moving from rural to urban areas as a result of domestic labor market changes, and increasingly seeking employment opportunities in other countries (Sheldon 2006). Shortages of highly skilled, skilled, and semiskilled workers are expected to continue. Labor markets in South Asia are now more affected by changes in international demand for South Asian products and services. Greater integration with global markets has increased competition from other countries and the vulnerability of domestic labor markets to economic recessions elsewhere. In addition, large segments of the population work in the informal sector or under informal contracts, with little or no social protection. The demand for better paid jobs in urban areas in particular skills is leading to labor shortages in rural areas for those skills or services. For example, anesthetists are increasingly in demand in urban private clinics and are therefore in short supply outside the larger towns and cities, with serious implications for maternal mortality and morbidity. Other such shortages have implications for the education and health sectors.

Demand for South Asian labor in the international market is strong, particularly in the Middle East. Foreign remittances from expatriate workers contribute significantly to South Asia's gross national product (Devarajan and Nabi 2006). The international demand for semiskilled and skilled work exceeds the supply from South Asia. For example, in 2001 Nepalese agencies sought almost 56,000 skilled and semiskilled workers, but fewer than 900 were recruited (NIDS 2003), while in 2004 Sri Lanka had over 366,000 job requests from foreign countries, but could supply less than 43% of these, and only 20% of the demand for technicians and professionals. With this demand trend for overseas contract workers likely to continue into the future, more semiskilled and skilled workers will be needed. The South Asian economies need to systematically address the expected shortfalls, lest they become constraints to sustainable economic growth (Devarajan and Nabi 2006). Demand for market-relevant TVET will continue in a wide range of sectors, from infrastructure to heath care. In addition, employers are looking for workers that have good communication skills, especially in English, and good practical skills and work attitudes.

Despite the sources of growth in labor demand, much unemployment and underemployment persists, reflecting the region's inability to meet the opportunities from international labor markets, and the mismatch of demand and supply of labor with appropriate knowledge and skills. For example, many school leavers are unable to find work in agriculture, manufacturing, and services, and are resorting to jobs with little potential for growth. The physical capacities of current TVET institutions are low compared with other regions of

the world (figure 2.3), and their ability to respond to the dynamic needs of international and domestic labor markets is also limited. For example, India has only 12,000 training and vocational institutes, while the People's Republic of China has 500,000 vocational schools (Government of India 2006). Thus, education and training represent a crucial long-term investment, and identifying the education and training strategies that will allow youth to take advantage of growing domestic and international economic opportunities is critical.

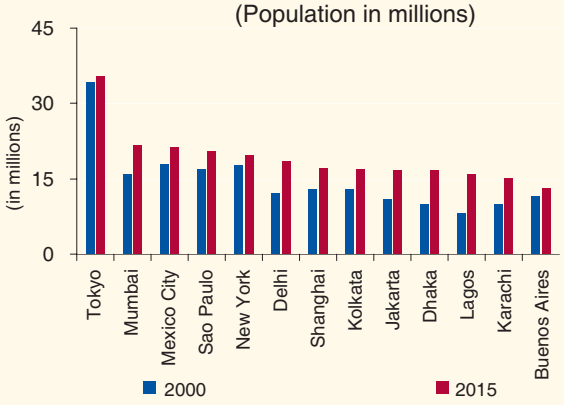
Due to rapid economic growth in urban centers combined with slower growth of employment opportunities in rural areas, many poor people are migrating from rural to urban areas (box 3.3). This migration is stretching already weak urban infrastructure. New investments are unable to keep pace with the inflow of migrants, resulting in a steady increase in urban slums (Sclar, Garau, and Carolini 2005). Overcrowded slums with minimal basic services provide a harsh physical and social environment; hence, the worst child health indicators occur in the poorest income quintile of urban households.

Box 3.3: Urbanization of the Poor

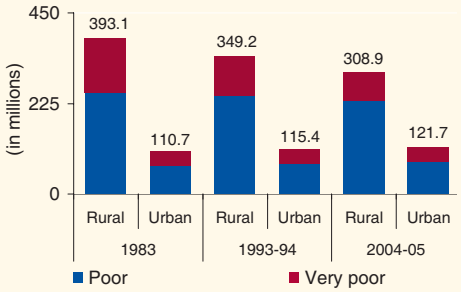
Urbanization of the poor is occurring more slowly in South Asia than in other parts of the world (Ravallion 2002, Munshi and Rosenzweig 2005); however, the increasing number of absolute poor people in urban areas has serious policy implications. The urban population in South Asia, which was close to 27% in 2000, is likely to reach 32% by 2015. According to United Nations (UN) statistics, in 2015 South Asia will have 5 of the world's largest 14 megacities (box figure 1): Delhi, Dhaka, Karachi, Kolkata, and Mumbai.

In the 2001 census, approximately 31 million people, or 23% of Bangladesh's population, lived in urban areas, and this was increasing at 6% per annum. About 25% of the urban population is very poor and lives mostly in slums. Although hardcore poverty (defined as food availability of less than 1,805 kilocalories per day per person) decreased in rural areas by 1.36 million households between 1991 (4.83 million) and 2000 (3.47 million), it increased by 0.53 million in urban areas (from 0.65 million in 1991 to 1.18 million in 2000). The absolute number of the poor and very poor in urban areas of India increased similarly (box figure 2). India's rural poor population declined by 85 million between 1983 and 2004–2005, but the number of poor increased by 11 million in urban areas during the same period.

Box Figure 1: Top 14 Megacities by 2015
(Population in millions)



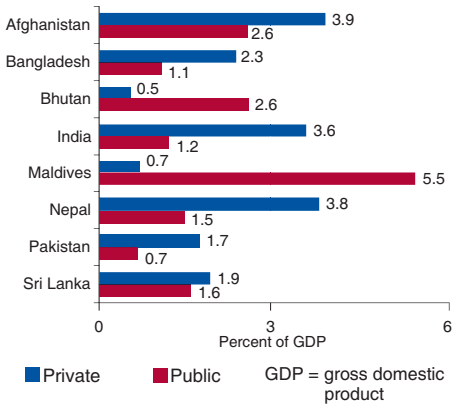
Box Figure 2: Change in Number of Poor and Very Poor in Rural and Urban India



Source: Economic and Political Weekly. 2007. Poverty and Inequality: All-India and States, 1983–2005. 10 February.

Most countries in the region have weak primary health care systems, especially in urban areas, and an extremely limited ability to respond to health emergencies. Poor people migrating to urban slums must endure dismal living conditions, severe social tensions, and other hardships.[2] With new and emerging diseases that can spread on a pandemic scale and cause large-scale human and financial disaster, urban slums may remain the weakest link in global efforts to contain diseases like HIV/AIDS, tuberculosis, and avian influenza.

Figure 3.2: Public and Private Expenditure on Health

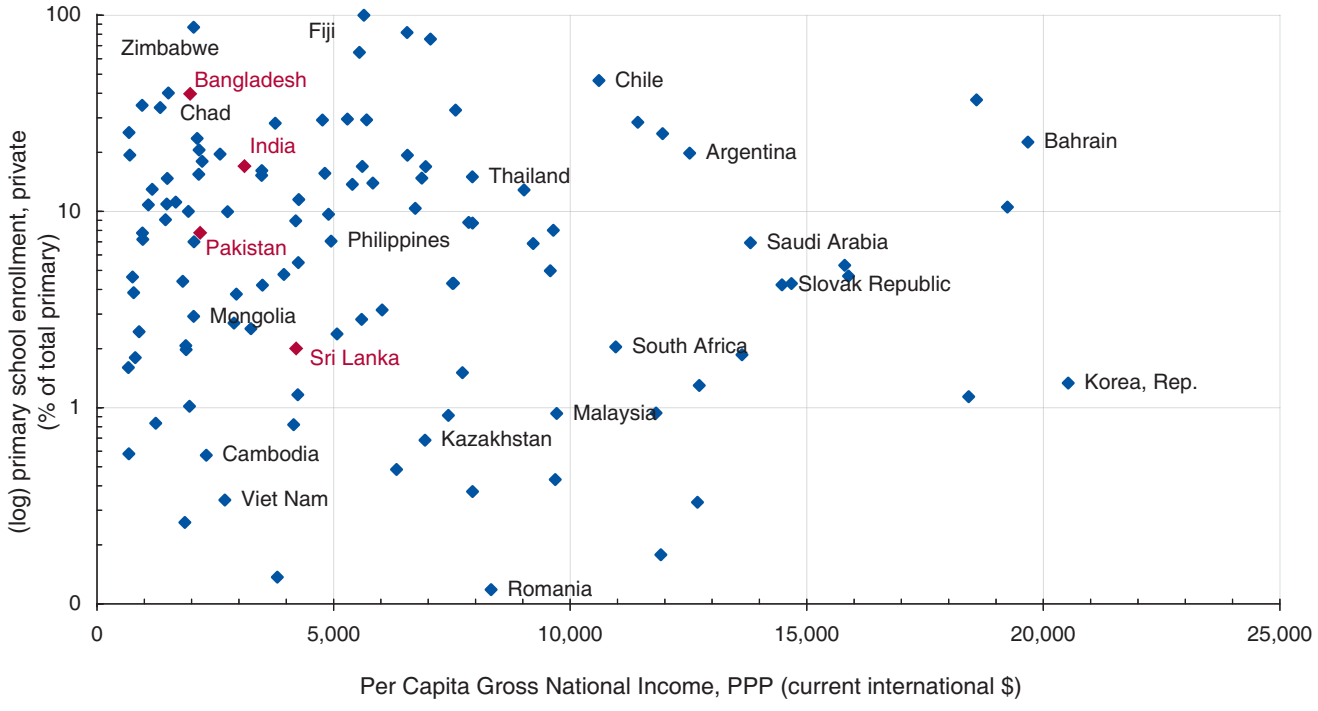


Source: World Bank. 2007. *World Development Indicators 2006*. Washington DC. (Data pertain to 2003.)

Private Sector Growth

The main engine of economic growth in South Asia has been the private sector, and more and more industries and services are dominated by it. Sustained growth of the private sector and its integration with global markets in the region will depend partly on the availability of highly trained people with relevant skills. Vocational and higher education will therefore gain greater significance (UNESCO 2004). Already, many private industrial firms are attempting to fill the gap through in-house training of new recruits. Enrollments in private schools are increasing in the region (figure 3.1), with 39% of students enrolled in private schools at the primary level in Bangladesh, followed by 17% in India. The private sector is also responding to the inadequacies of public sector health care.

Figure 3.1: Enrollment in Private Primary Schools vis-à-vis Per Capita Gross National Income



Note: Each dot represents one country, although only a few are named.
Source. World Bank. 2007. *World Development Indicators.* Washington DC

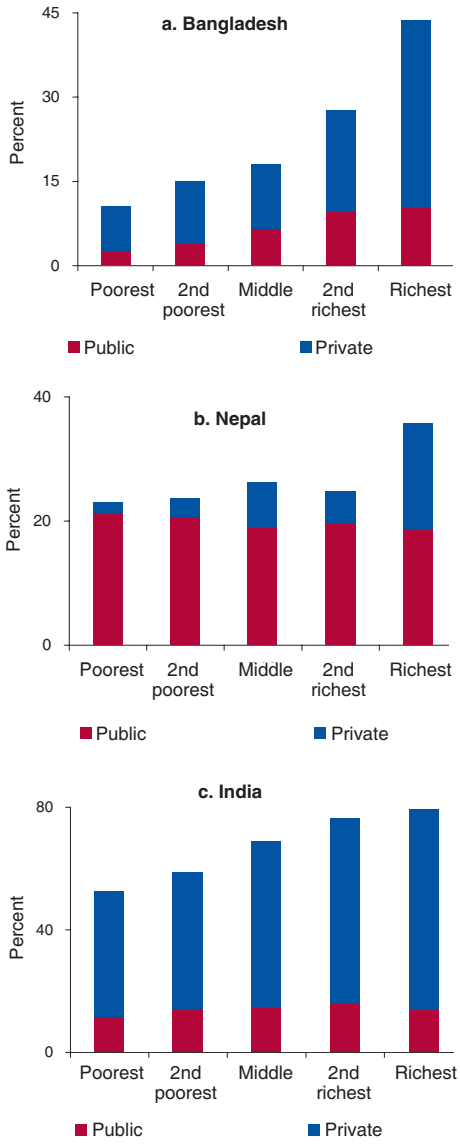
The growth of the private sector in education includes both nonprofit and for-profit provision of education and training. The choices for education and vocational training are increasing in South Asia. With economic growth and increasing incomes, more parents are willing to send their children to private schools and private coaching lessons to augment classroom learning; however, this aggravates the divide between the rich and the poor. A large number of higher education institutions are being opened in the private sector, which also raises concerns about access to higher education for the poor. Improving equity in access to quality education will become a serious concern as the private education sector increases in South Asia. With increased nongovernmental provision of education, the role of governments to facilitate, instead of provide, education will need to be strengthened. Measures to monitor the quality of education and regulate private schools will be necessary (ADB 2004f).

Health systems in South Asia are dominated by private expenditures, which tend to increase rapidly with household income (figures 3.2 and 3.3). The proportion of private health expenditure to total health expenditure in this region surpasses that of most countries in the world. The private sector is a major provider of health services—including treatment of communicable diseases such as diarrhea, childhood pneumonia, malaria, and tuberculosis. Private health systems in most South Asian countries are diverse, largely unregulated, and often not coordinated with the public health systems.

While the private sector in South Asia has made curative services more accessible to the population, unregulated private health services are partly responsible for inappropriate prescriptions of drugs, resulting in an increased incidence of drug resistance and other adverse impacts. The rich can overcome public health sector failure by availing of high-cost, high-quality private health care. However, without appropriate health financing mechanisms, the poor must either settle for the available public health care or seek lower-end, unregulated private health care.

A large share of private health services is also provided by the informal sector, mainly by pharmacists and unqualified practitioners. The private sector is less interested in the "public" good part of the health care such as childhood immunization, disease surveillance, and health promotional activities. Private providers often do not share information among themselves or with public health systems. This is a recipe for a health care disaster. Without proper information sharing, otherwise controllable situations may become full-blown epidemics, with knowledge often spread through media reporting rather than public health surveillance. Where households prefer, or only have access to, private providers, the largely government-run health services, such as childhood immunization and tuberculosis and HIV/AIDS control, are increasingly becoming less effective due to underuse.

Figure 3.3: Use of Health Facilities for Acute Respiratory Illness, by Wealth Quintile



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

Demographic Transition

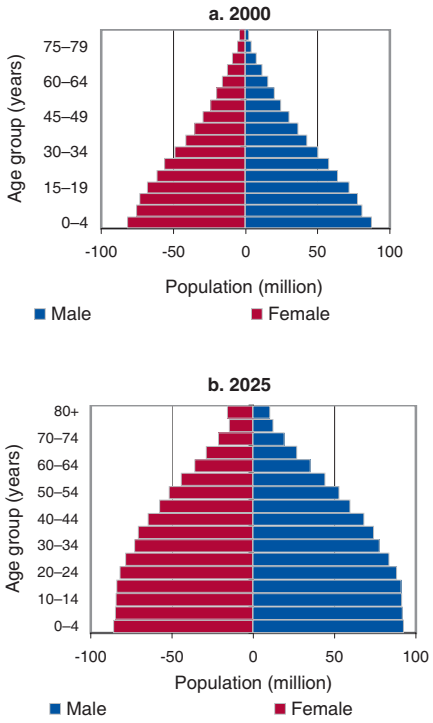
South Asia is undergoing a demographic transition from high to lower birth and death rates. As a result, during the next 4–5 decades, South Asia's population in the 0–9 year age group will stabilize, while that aged 10–39 years will increase steadily. The structure of the population pyramid is going to flatten as the percentage of young and working age people grows (figure 3.4); the population above 60 years will increase, initially slowly, but on a significant scale in South Asia after 2025.

The population in the 0–9 year age group, which was about 325 million in 2000, is likely to stabilize at around 350 million by 2015. However, the 10–39 year age group will increase significantly due to high fertility in the past. By 2025, the populations in age groups 0–9, 10–19, 20–29, and 30–39 are likely to increase by 30 million, 60 million, 90 million, and 110 million, respectively (figure 3.5), from their 2000 levels.

When a relatively large share of the population reaches the economically active years, and if the economic circumstances and social sector and labor market policies are right, economic growth can be enhanced (1) due to the higher share of the population that is working, saving, and paying taxes; (2) from the potential this offers for more rapid investment; and (3) because of reduced spending on dependents. This phenomenon, known as the "demographic dividend" (Bloom, Canning, and Sevilla 2002), arises only if the burgeoning labor force has the right skills and opportunities to contribute to economic growth. In South Asia, one result of the changing demographics and labor market opportunities is that demand for secondary and postsecondary education is estimated to increase by 20% between 2000 and 2015, and by 30% between 2015 and 2025.

The demographic changes will have a range of implications for health systems. First, a healthy population will be better able to contribute to economic growth and, hence, to realize the demographic dividend. Second, a larger working-age population will have an increased likelihood of risky sexual behavior. HIV/AIDS in large parts of South Asia has not yet spread to the general population, but the increasing number of young adults may become the tipping point for HIV/AIDS to expand from an epidemic in high-risk groups to an epidemic in the general population if effective control measures are not taken. Third, the increasing young and middle-aged population will accelerate the epidemiological transition from communicable diseases to noncommunicable diseases. Finally, by 2050, the population aged 60 years and older will increase more than fivefold from 2000 levels. Old age care will need greater attention in the next few decades. Overall, health financing needs are going to increase significantly due to these demographic changes.

Figure 3.4: Changing Population Pyramid in South Asia, 2000–2050

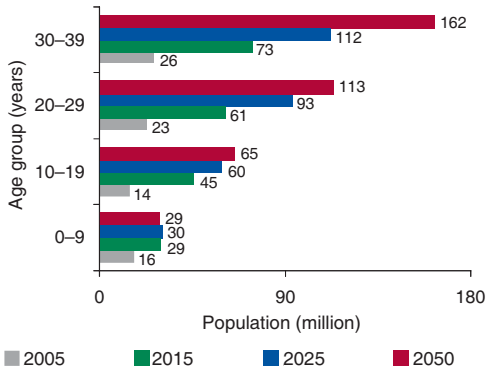


Source: Census Bureau of United States, International Data.

A large part of the demographic momentum is likely to come from rural areas and from poor households that depend on public schools and health services. Given the poor track record of public services in rural areas, much of the population entering the 10–29 age group is likely to be underskilled and unprepared to reap the benefits of an expanding economy. The rural youth need to catch up with youth from more privileged urban households or the demographic dividend will become a demographic divide, with potentially serious social and political ramifications (World Bank 2007).

Demographic changes in the developed world are also likely to create opportunities and challenges for South Asia. We are likely to witness an increasing trend toward outsourcing of medical care from the developed world (box 3.4 p. 28). An aging population in the developed world and increasing dependency ratios might lead to an increasing demand for medical personnel from South Asia. This could upset the availability of health workers in the region, a trend that needs to be carefully monitored and addressed.

Figure 3.5: Population Momentum in South Asia: Additional Children and Youth, to the 2000 Base Figures



Note: The base age group populations in 2000 are 326 million for age 0–9, 291 million for 10–19, 240 million for 20–29, and 184 million for 30–39.
Source: Census Bureau of United States, International Data.

Box 3.4: Medical Outsourcing

Medical outsourcing refers to patients traveling from abroad for medical care due to high costs and long waiting times in their own countries (Connell 2006). This trend is likely to increase with the aging population in the developed world, the increasing dependency ratio, and severe stress on social security systems resulting from increasing health care demand and costs.

Medical outsourcing has grown rapidly in India (Connell 2006; Milstein and Smith 2007; and *The Economist* 2004a, 2007a), Singapore, and Thailand in the last decade, assisted by large price differentials and highly trained doctors, privatization of health care, accelerated globalization of health care and tourism, new technologies and skills, reduced transport costs, and Internet marketing. To accelerate the growth of medical outsourcing, potential patients must be convinced that medical care and hygiene in developing countries are comparable with that in their own countries. As South Asian countries become an important global destination, they will need to upgrade technology, absorb Western medical protocols, and maintain low costs and good management.

Medical outsourcing received a boost in India following economic liberalization in the mid-1990s. Private hospitals expanded using imported technology and medical goods. As salaries improved, doctors returned from abroad with international qualifications and western experience. Global migration of doctors has also assisted medical outsourcing as patients in the developed world have become used to being treated by doctors from South Asia. About 150,000 medical tourists went to India in 2002, half of them from the Middle East. India predicts it will earn $2 billion annually from medical outsourcing by 2012.

Although medical outsourcing will give impetus to economic growth in the region, it could also distort the availability of medical care away from South Asia's poor as the health systems cater to clients from the developed world.

Epidemiological Transition

The epidemiological transition is important to South Asia for the following reasons:

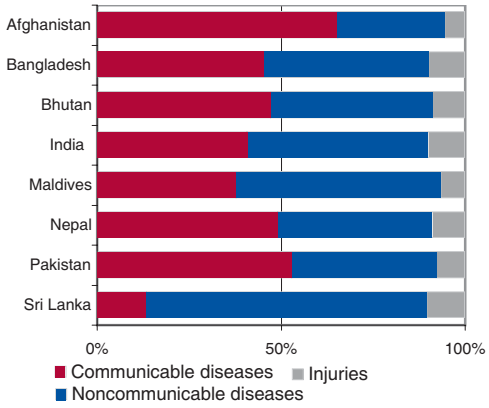
- the shift in the burden of diseases to noncommunicable diseases will increase health care costs, leading to increased catastrophic out-of-pocket health expenditures for the less well-off in the absence of health insurance;
- the poor are likely to suffer from a double burden of susceptibility to communicable and noncommunicable diseases, aggravating the inequalities they already face; and
- early onset of noncommunicable diseases can adversely affect labor productivity in the region and reduce the region's competitive edge.

Most South Asian countries are undergoing the epidemiological transition (Basnyat and Rajapaksa 2004). In South Asia, almost half of the disease burden is due to noncommunicable diseases, having risen by 10% since 1990. Moreover, as noted above, the burden of injuries is increasing in the region. Sri Lanka is in an advanced stage of the epidemiological transition, and in other South Asian countries the burden of communicable diseases is already lower than 50% except in Afghanistan and Pakistan (figure 3.6). Cardiovascular diseases and stroke are the largest sources of this burden. By 2020, the burden of disease in India from infectious, maternal, nutritional, and perinatal causes is likely to decline to 24% of the total, while the rest will comprise noncommunicable diseases (57%) and injuries (19%) (Murray and Lopez 1997). As indicated by figure 3.7, some of the risk factors for noncommunicable disease—including tobacco and alcohol consumption—are most common among the poorest population in South Asia (Ezzati et al. 2002; Room, Babor, and Rehm 2005).

By 2025, 6% of people in India and about 9% of people in Pakistan are expected to have diabetes. Cardiovascular deaths already account for 32% of all deaths in India. A third of Pakistan's adults have hypertension. Hypertension is high in South Asia due to risk factors like obesity, diabetes, smoking, and sedentary lifestyle. In India 52% of cardiovascular deaths occur among people below 70 years, whereas in the developed world it is only 22%, indicating the early onset of noncommunicable diseases in South Asia. Without effective health promotion and preventive activities to mitigate this burden, the incidence of noncommunicable diseases is likely to increase in relatively younger age groups, and much of this burden will occur during the productive middle age, adversely affecting labor productivity in the region (Danaei et al. 2006).

The treatment of noncommunicable diseases often requires expensive hospital care, which can be financially catastrophic in the absence of health insurance. Of approximately 24 million people who were hospitalized in India in 2004, about 10 million had hospital

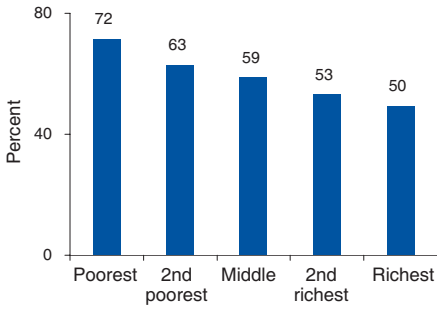
Figure 3.6: Proportion of Deaths Due To Disease and Injuries (2002)



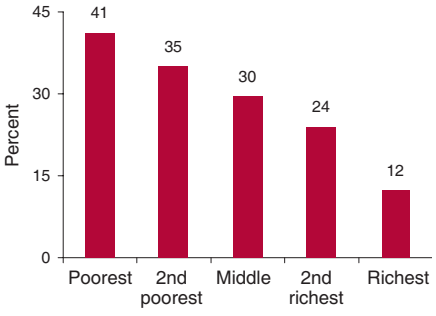
Source: World Health Organization. 2002. Global Burden of Disease Estimates. www.who.int/healthinfo/bodestimates/en.print.html. Accessed in June 2007.

Figure 3.7: Tobacco Use, by Wealth Quintile

a. Men (15–54 years) in Bangladesh, 2004



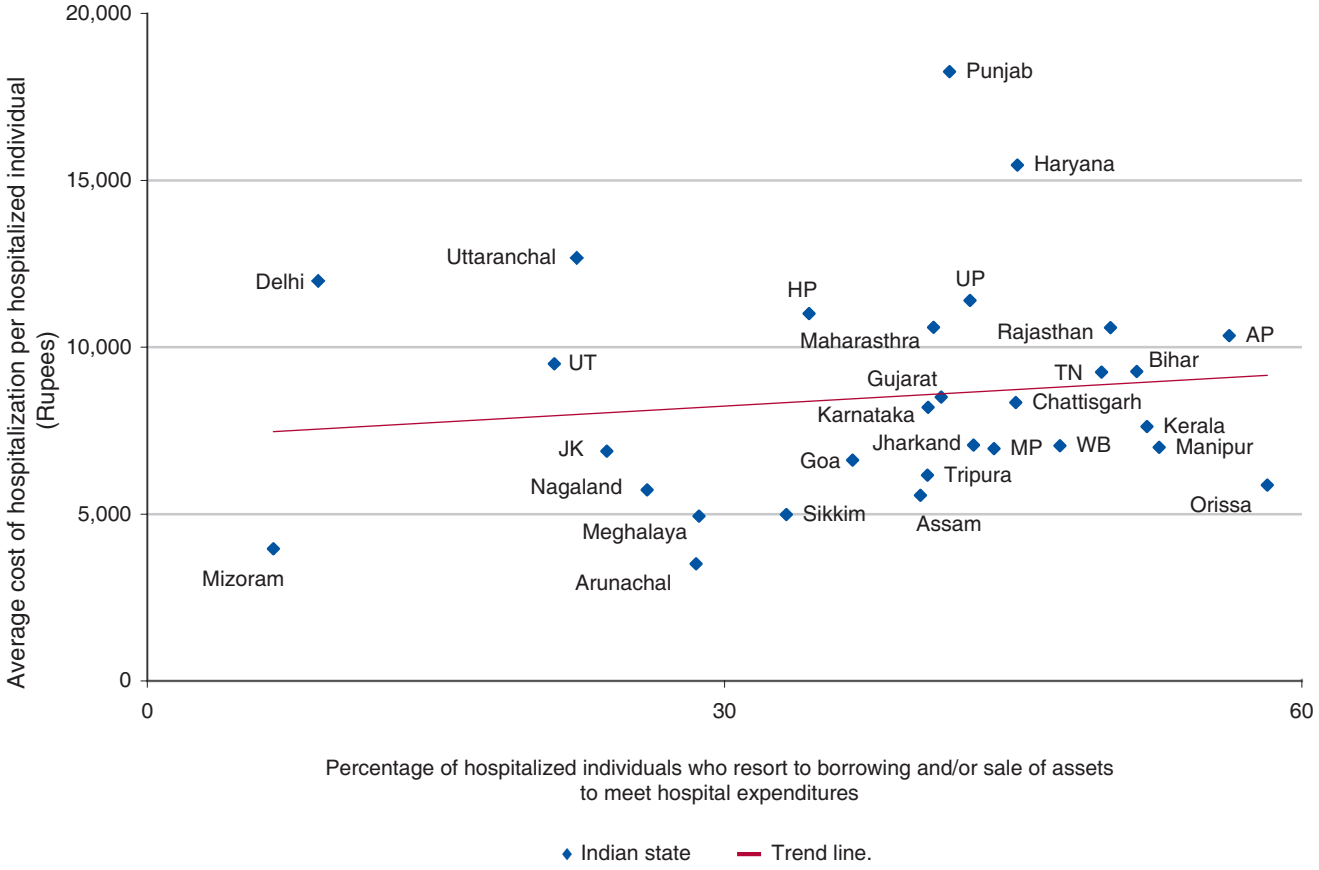
b. Women (15–49 years) in Nepal, 2001



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

expenditures exceeding 10% of their annual household expenditures. A majority of these people had to sell assets and/or borrow to meet the health care costs, increasing the likelihood of them becoming, or staying, impoverished. Figure 3.8 provides an example from Indian states, where from just below 10% to nearly 60% of hospitalized people had to borrow money or sell assets to pay hospital bills.

Figure 3.8: Borrowing and/or Sale of Assets to Meet Catastrophic Hospital Costs in Indian States (2004)



AP=Andhra Pradesh, HP=Himachal Pradesh, JK=Jammu and Kashmir, MP=Madhya Pradesh, TN=Tamil Nadu, UP=Uttar Pradesh, UT=Union Territories, WB=West Bengal.

Source: National Sample Survey Organization. 2006. Morbidity, Health Care and Condition of the Aged: NSSO 60th Round (January–June 2004). National Sample Survey Organization, Ministry of Statistics and Programme Implementation, Government of India, New Delhi.

4. MANAGING THE SOCIAL SECTORS THROUGH TRANSITION

The biggest social sector challenge the region faces, in a resource-constrained environment, is to accelerate progress toward the MDGs and simultaneously address the opportunities and risks of globalization and economic change (box 3.1). Governments in the region are already struggling to meet the MDGs and have limited financial, institutional, and managerial capacity to deal with the new, complex social sector challenges. For governments to address the dual challenge:

- first and foremost, they need to appreciate the implications of the transitional forces on the social sectors, and to acknowledge that the old ways of doing things need to be changed; and
- second, they must explore different paradigms for dealing with the dual challenge.

In the next pages, we discuss, in two parts, how South Asia can deal with this dual challenge. We first consider overall social sector strategies from the perspectives of efficiency, effectiveness, and equity. We then present indicative recommendations for the education and health sectors. It must be borne in mind that actual outcomes will be affected by factors external to the social sectors, e.g., the pace of investment in water and sanitation, which contribute to better health.

Increasing Efficiency and Effectiveness

Public and private goods: financing choices and options. Constrained by limited resources, governments have to make difficult choices in allocating financing to meet the dual challenge. The dilemma of how to allocate resources to basic and higher education, and to primary and tertiary health care, will increasingly confront governments. As a general principle, the public sector may consider focusing most on delivering the "public goods" that have significant external impacts, e.g., the control of communicable diseases. In contrast, social services that have mainly individual or private benefits, e.g., treatment of noncommunicable diseases or tertiary education, can be financed more by the beneficiaries and delivered more efficiently by the private sector (ADB 2005b). Models may be derived from transitions already made in other Asian countries, e.g., combining prudent fiscal policies with large allocations for social services, providing health insurance, and relying on the private sector for higher education and some types of health care (Mundle 1998). The desirability of ensuring access to such services by the needy

will justify some continued financing (but not necessarily delivery) by the public sector through health insurance, targeted grants, scholarships, and long-term loans.

Redefine the role of government. If private individuals and service providers are to take greater responsibility for higher education and advanced health care, central governments can focus more on their role as facilitator and regulator, including policy making, setting of service and quality standards and norms, quality assurance and accreditation, monitoring and evaluation, intersectoral coordination, and ensuring of legal and regulatory compliance. But in the areas where public financing and service delivery will continue to predominate, service quality must improve and human resource constraints must be addressed. In particular, professional management capacity is largely absent at all levels in South Asia's social sector ministries. Accountability standards for public service delivery should be just as rigorous as those set for the private sector service providers.

Build new partnerships with local governments and civil society, in addition to the private sector. Through innovative partnerships with local governments and civil society, governments can increase their reliance on the local knowledge and talent of diverse partners to improve social service delivery (Basnyat and Rajapaksa 2004). The region is witnessing many successful public-private partnerships in infrastructure, some of which may be applicable to social sector infrastructure and services (Panggabean 2006). With due support for local capacity building, decentralization can be promoted and local governments given more authority to run schools and health facilities (Behrman, Deolalikar, and Soon 2002). Central governments should also motivate the local governments to produce better results with the help of "conditional" or performance grants. With effective incentives and institutional arrangements, civil society organizations are capable of contributing to the delivery of social services in many areas of South Asia. Governments can also collaborate more with civil society and the media to promote awareness about important social sector issues, particularly in areas of public health.

Use taxation, develop strong regulatory frameworks, and ensure compliance. If South Asia's buoyant growth can be sustained, higher tax revenues will be available to fund the social sectors. "Sin taxes" on alcohol and tobacco can both raise public revenue and provide economic incentives for healthy behavior. Governments in the region can use financial incentives and legal and regulatory frameworks to ensure that the private sector effectively contributes to the social good. The private mass media should be encouraged to raise awareness about diseases of public health importance, and thereby contribute to national public health goals. Advertising of alcohol and tobacco should be restricted. Food and water safety laws should be introduced, and their compliance monitored. Workplace rules should provide a safe environment and promote healthy lifestyles.

Strengthen institutional capacity. Governance, transparency, and accountability can all be improved in South Asia, which will in turn help improve the quality of public service delivery and, thus, the efficiency of public spending (ADB 2005b). In the social sectors, a switch in public sector emphasis from provision to facilitation and regulation, and the increasing complexity of issues in the sectors require dedicated management cadres. Capacities need to be developed in managing public-private partnerships, regulation and enforcement, ICT, economic and financial analysis, and strategic decision making. Cost-effective ICT has a direct role in service delivery; ICT can also enhance efficiency and transparency and improve public disclosure.

Addressing Equity

Deal with inequalities proactively for inclusive and sustainable economic growth. As indicated in table 4.1, the transitional forces can aggravate inequalities in various ways. The result would be a sharpening of the divergence between optimistic expectations and day-to-day grinding realities that is likely to disenchant unemployed youth exposed through the media to opulence elsewhere. Relative, and in some cases absolute, deprivation might lead to social disorder (Ali 2007). Governments in the region need to make growth

Table 4.1: Potential Impacts of the Transition on Inequality

Forces of Change	How Inequities May Be Aggravated
Economic Growth and Globalization	Opportunities from globalization are based on the competitiveness of labor on a global scale. The skills and knowledge required by the global labor market are likely to keep shifting with changes in means of production. The poor are least equipped to upgrade their skills. Economic growth has led to urbanization, with rural poor people moving to urban slums, where the quality of life is low, further exposing poor migrants to environmental and social risks.
Technological Change	As more efficient means of production are driven by technology, new jobs demand a higher skill and knowledge base. The poor have limited access to ICT, which in turn may aggravate income inequalities.
Labor Market Changes	Illiterate and poorly educated youth entering labor markets will need to improve their skills and knowledge. Otherwise, they will remain at the bottom of the labor market pyramid. English language skill brings a competitive advantage, but is least accessible by youth from poor families. The poor are less equipped for life-long learning and upgrading of skills.
Private Sector Growth	Public sector failure to deliver quality education and health services has led to the emergence of private sector provision of these services. The private sector responds mainly to opportunities for profit, and will often need incentives and regulation if it is to provide services that are accessible by the poor.
Demographic Changes	Fertility rates have come down much faster among the rich than the poor. A greater proportion of population growth momentum will be from the poor. Without assuring that the poor can benefit from economic growth and employment, the existing inequities will increase.
Epidemiological Transition	The poor suffer from a double disease burden, with higher exposure to communicable disease, higher prevalence of risky lifestyle behavior (including tobacco and alcohol consumption), and lower awareness of risks relating to sexual and other health-related behavior. Catastrophic health care costs are likely to hit the poor more severely in the absence of risk pooling or community-based health insurance.

"inclusive" to ensure social stability and sustainability of the growth process. Governments should provide adequate social protection mechanisms to mitigate and reduce vulnerability, especially from global and regional economic shocks and cycles that can be detrimental in the short run (Sipahimalani-Rao 2006). Most of the poor depend on the public sector for education and health care. Improved and expanded basic education and health services of good quality, efficiently targeted to the poor, will increase the likelihood of inclusive economic growth (ADB 2004c, Devarajan and Nabi 2006, and World Bank 2004).

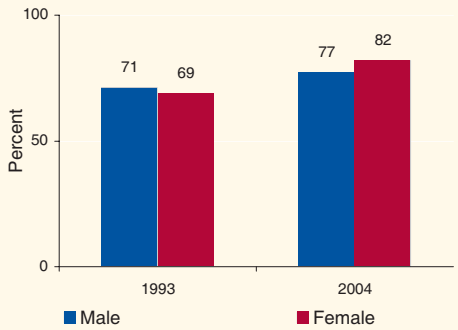
Target the poor, the disadvantaged, and backward regions: make public expenditures count. The largest progress toward the MDGs can be achieved by effective targeting of public expenditures to the poorest and most disadvantaged groups. Where malnutrition is widespread, targeted programs for maternal and child nutrition and health can help overcome demand-side barriers (Islam and Malik 1996). Where demand-side constraints are daunting, e.g., in girls' education and institutional birth delivery, direct cash transfers such as stipends and scholarships, and maternal and child health care vouchers should be designed to reach the most disadvantaged households; successful experiences from the region should be widely shared and replicated (examples are presented in boxes 4.1 and 4.2).

Box 4.1: Bangladesh: Remarkable Success in Girls' Education

In Bangladesh in 1993, girls' enrollment was significantly lower than that of boys. Between 1993 and 2004, girls' enrollment improved by 13%, more than double that of boys, reversing the gender bias in favor of girls for the first time (box figure 1).

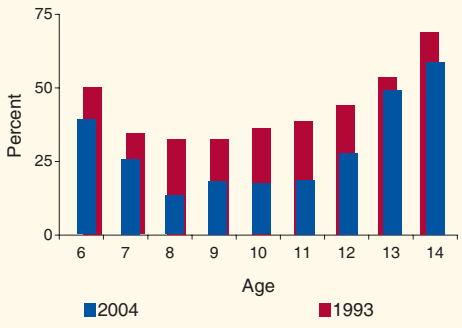
Bangladesh achieved this remarkable success by targeting the enrollment of the most disadvantaged—girls from poor families. By providing food for schooling and girls' scholarships with the aid of a vibrant civil society and nongovernment organizations, the number of poor girls not in school dropped significantly for all age groups in the country (ADB 2006b), as shown in box figure 2. ADB, along with other development partners, has provided support to the Government's stipend program.

Box Figure 1: Bangladesh School Children 6–14 years, in 1993 and 2004, by gender



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

Box Figure 2: Percentage of Girls Out-of-School by Age in the Poorest Quintile



Source: Author's analysis from Demographic and Health Surveys, Bangladesh, 1993 and 2004

Sector-Specific Recommendations

Elaborate sector-specific recommendations are beyond the scope of this report; solutions have to be contextual and a "cookie-cutter approach" is unlikely to work. Table 4.2 (pp. 41–42) lists indicative recommendations for the education sector and table 4.3 (p. 43) lists these for the health sector. We elaborate a few key recommendations separately for each.

Education

Improve the quality of primary education. With access to primary education largely addressed, the emphasis will need to move toward improvements in quality, relevance, and, thus, efficiency—equitable access to good quality education, especially for the disadvantaged groups (Hasan and Mehta 2006). Too often, "a woefully inadequate primary school system … fails to equip students with the basic skill set that they need so as to benefit from socially relevant education" (ADB 2007a). Curricula should be reviewed and updated to ensure their relevance, and textbooks and teaching and learning materials correspondingly revised. Basic school facilities (which may need to include provision of separate toilet facilities for boys and girls, and running water), textbooks, and materials should be provided in a timely manner. Teachers should also be provided with regular pre- and in-service training that reflects current pedagogical requirements. Standardized tests should be used to assess the reading, writing, mathematics, and reasoning skills at the national and regional levels.

Expand good quality and relevant secondary education.[3] As primary school participation increases and more students complete primary education, secondary education will have to expand to accommodate them (Devarajan and Nabi 2006). The Government of India notes: "The 11th Plan must … aim to progressively raise the minimum level of education to high school … level." Curricula can be updated to include ICT education, and skills and competencies required by the labor market, such as analytical, communication, and language skills (UNESCO 2005). Skills to facilitate learning at later stages in life need to be provided. Improved student guidance is important to channel students in appropriate higher education, training, and career directions. At the same time, a large number of school leavers will not be able to enroll in higher education or join the formal labor market. Opportunities for acquiring practical

[3] Devarajan and Nabi (2006) find that South Asia falls short of East Asian standards in the supply of skilled workers, and use two proxies to capture workers' skills—gross enrollment at the secondary level and average years of schooling of workers. According to them, "both of these education attributes give information about the trainability of workers. Acquiring industry specific skills to attract foreign direct investment is facilitated by a trainable work force."

employment and entrepreneurship skills can be expanded. Where appropriate, targeted subsidies can be provided to lagging and disadvantaged groups.

Provide good quality postsecondary and higher education, and technical and vocational education and training. To meet the demand for skilled and semiskilled South Asian workers for outsourcing activities, the international labor market, and the growing domestic sectors, the private sector can help ease the pressure on governments to provide more education and training places, and the governments may adapt East Asia's public-private partnerships to local conditions through firm-specific training programs (Devarajan and Nabi 2006). Given governments' limited budgets, the cost of higher education can be shared between the government and households, as the major part of its benefits accrue to the graduate. To provide equitable access to higher education, governments can use targeted subsidies for the poor and disadvantaged.

Postsecondary and higher education and TVET programs should be relevant to the needs of the labor market. For this, the capacity for teaching and research in science and technology needs to be strengthened (Hansen and Lehmann 2006). For example, the Government of India (2006) states: "We need to expand vocational training from the present capacity of a mere 2 million to 3 million to at least 15 million [people]…. Training institutes in India typically cater to around 40 skills compared with 4,000 in China." Effective quality assurance mechanisms for tertiary education programs need to be in place, including accreditation programs. In TVET, employers and related stakeholders should be actively involved at all stages, from identifying the needed training programs to developing skill standards and providing practical training. To coordinate and lend coherence to the multitude of TVET programs and providers, a national vocational qualifications framework should be considered. Skills testing and certification can address questions relating to quality and facilitate the international movement of skilled and semiskilled labor. Potentially, women comprise half of the labor force and they should be encouraged to continue their schooling and/or training.

Provide mobility between education and workplace, and lifelong learning. With rapid changes taking place in the labor market, the workplace, and society, job stability and the permanence of employment could decrease. Lifelong learning and skill training opportunities are needed to ensure that workers are able to keep up with the changes through retraining or continued education. Adult education programs are needed to provide basic skills. Coordination and mobility between education and training systems should be facilitated. Labor market information, job search assistance, apprenticeship programs, and other measures should be readily available to help ease the school-to-work transition. The availability of information and referral networks for work, learning, and training

opportunities can be improved, to help expand education and work opportunities for presecondary school-leavers.

Integrate ICT. Teaching and learning experiences can be enriched by a combination of innovative teaching methods, media, software, and information available through the Internet and digital libraries. ICT enables learning and communication, and is increasingly affordable and being mainstreamed in education systems. Education and training can be more flexibly delivered with the use of ICT. Remote communities can be served through distance education using ICT. Teachers should be trained in ICT and curricula revised to accelerate its integration. Effectively employed and improved management information systems and information networks can result in policy decisions, promotions and transfers of teachers, and students' assessments that are more transparent. With the rapid pace of change in ICT, budget allocations for hardware and software upgrades and support will need to be made regularly. As more ICT is employed in classrooms, care must also be taken to ensure that the poor, who have limited access to ICT, are not left behind.

Health

Strengthen urban primary health care. Primary health care systems in urban areas need to be strengthened (Sclar, Garau, and Carolini 2005). The Bangladesh Government is supporting urban primary health care through innovative public-private partnerships (box 4.2). Other governments in the region need to take effective steps to build public health networks in urban slums. Instead of replicating the weak model of public financing and public provision, the region needs more innovative approaches to service delivery that can provide maximum impact and value for public expenditures.

Regulate the private sector: control costs, improve quality, and share information. Without proper regulation, profit-seeking hospitals can inflate costs by (1) increasing the days of stay in a hospital, (2) increasing the number of diagnostics, and (3) resorting to costly medicines when equivalent cheaper ones are available. In the absence of risk pooling and health insurance, fewer choices are available to individual patients. Consumers in the region do not have access to performance benchmarks of various hospitals to properly evaluate and price the health services. Thus, governments need to strengthen their role as regulators and facilitators of private health care and to institute mechanisms to accredit hospitals through independent quality assurance institutions.

Integrate information and communication technology. Health departments in the region have been slow to adapt and mainstream ICT into their operations. With the help of appropriate technology, health workers in remote areas can have timely access to health care information. Using readily available cell phones, health service call centers (similar to the American "911") can provide cost-effective medical advice to the needy irrespective of where they are. Web-

Box 4.2: Meeting a Key Gap through Public-Private Partnership: The Bangladesh Urban Primary Health Care Project

A good example of how a government can address health transformation within various operational constraints and opportunities is the Bangladesh Urban Primary Health Care Project (UPHCP). The UPHCP is pioneering in many ways.

As in most of the countries in the region, urbanization has been very pronounced in Bangladesh. Prior to 1998, Bangladesh had very limited urban primary health care (PHC) facilities. In 1998, when the Government of Bangladesh decided to strengthen urban PHC facilities with Asian Development Bank (ADB) support, it had two options:

- to expand the public facilities, and/or
- to create new models of service delivery.

The Government took a bold step and opted for a public-private partnership model for the UPHCP, which has been shown to be effective (ADB 2002a).

The UPHCP provides PHC services to urban Bangladesh, and has led to a major departure from the usual model of social service delivery in South Asia—government-financed and government-provided. The UPHCP supports contracting-out of urban PHC services to nongovernment organizations—government-financed but private-sector-provided—in geographically defined partnership areas covering 200,000–300,000 people. The UPHCP is supervised by the health departments of the municipalities under the overall stewardship of the elected mayor, ensuring public monitoring and accountability of the public-private partnership model. The first UPHCP was approved by ADB in 1997 and was successfully completed in June 2005. Due to its success, the Government of Bangladesh requested a second phase of the project to accelerate progress toward the health-related Millennium Development Goals. ADB approved the second UPHCP in May 2005, with cofinancing support from the United Kingdom, Sweden, and the United Nations Population Fund. The design of the second UPHCP builds on the strong and tested features of the first, and attempts to strengthen the focus on pro-poor targeting (at least 30% of all the services under the second UPHPCP have to be accessed by pre-identified poor households).

Source: www.adb.org/Health/contracting-BAN.asp

based applications can be used for reporting disease outbreaks even from remote areas. Global positioning systems can be used to locate people who need emergency care, and track evolving disease patterns. ICT can be used to increase the citizenry's awareness of social sector issues.

Health insurance and other risk pooling. High health care costs and reliance on out-of-pocket payments expose households to financially catastrophic health spending. With the epidemiological transition taking deeper roots, the need for risk pooling and health insurance is becoming urgent. "Sickness funds" are needed, especially for the poor. Such funds can be managed by local governments or autonomous bodies that can negotiate with local providers for rates and services.

Skills planning, training, and deployment. When health service professionals with a particular skill (e.g., radiology or anesthesiology) are in short supply, the ability of health systems to deliver effectively is hampered. Projecting demand and supply for health services from the public and private sectors, from outsourcing, and from the aging developing world is a complicated task. Nonetheless, governments must devote attention and resources to training and certifying health service personnel. Special policy interventions will be necessary to ensure that a minimum standard of trained personnel is deployed in rural health systems.

Dealing with the impending noncommunicable disease epidemic. Early onset of noncommunicable diseases combined with lack of health insurance will seriously affect labor productivity and the financial well-being of many households (Nishtar 2002). Through intersectoral collaboration (education, food regulation, and media), the public and private sectors can delay the early onset of noncommunicable diseases and the associated catastrophic health expenditures. Primary health care systems have to meet the special needs of noncommunicable disease sufferers. This will require updating of in-service and pre-service training (Epping-Jordan et al. 2005, Strong et al. 2005).

Table 4.2: Actions Proposed for Managing the Education Sector through Transition

Areas of Focus	Actions
Provide Good Quality Primary Education	• Improve the quality and relevance of curricula, textbooks, and learning materials. • Ensure timely provision of basic facilities, teachers, and learning materials to all communities, including disadvantaged and distant communities. • Improve pedagogy and teacher training and management. • Improve the quality and standards of primary education teaching through specific higher education programs. • Emphasize communication, analytical, and learning skills in primary education. • Develop standardized tests to assess the reading, writing, mathematics, and reasoning skills at the national and regional levels. • Inculcate understanding and tolerance of other cultures and promote healthy lifestyles. • Improve the governance and management of primary and secondary education through effective decentralization, strengthening of capacity, and enhancement of accountability.
Expand Good Quality Secondary Education	• Modernize curricula and teaching methodologies, including introducing information and communication technology (ICT) education and using ICT and skills and competencies required by the labor market. • Improve the quality and standards of secondary education teaching through specific higher education programs. • Ensure equitable access to foreign language learning and ICT. • Provide subject options, including practical subjects, for introduction to the labor market. • Strengthen career guidance and provide linkage to the world of work in learning activities. • Improve the relevance of assessment systems to the changing needs of societies and economies. • Inculcate good citizenship, gender sensitivity, understanding and tolerance of other cultures, and healthy lifestyles. • Provide targeted subsidies, where appropriate, to girls and disadvantaged groups.

Table 4.2, continued

Areas of Focus	Actions
Provide Good Quality Postsecondary and Higher Education, and Technical and Vocational Education and Training	• Address domestic and international labor market opportunities, e.g., business process outsourcing, ICT, and other service and manufacturing industries, by expanding the provision of education and training in these areas. • Ensure that national education and training standards are accepted internationally, including assessments. • Ensure that postsecondary and higher education and TVET are in line with market demands. • Establish more linkages with employers, industries, and employment agencies. • Establish quality assurance of local university programs, e.g., accreditation. • Develop recognition and quality assurance of franchised foreign university programs. • Develop recognition of certificates, diplomas, and degrees earned abroad. • Form links with foreign institutions of higher learning and research. • Improve coordination within the education system and between education and training systems; and facilitate the mobility of students between the education and training systems, e.g., qualification frameworks and credit awards. • Strengthen teaching and research capacity in science and technology. • Expand places in higher education by involving the nongovernment and private sectors, using alternative delivery modes, and addressing cost recovery. • Encourage women to continue schooling and/or training. • Improve equitable access to higher education by providing targeted subsidies/financing to the poor.
Prepare for Lifelong Learning	• Expand opportunities for skills upgrading and/or retraining. • Expand adult and continuing education opportunities, particularly for acquisition of new knowledge, skills, and qualifications. • Expand training and education opportunities for pre-secondary school leavers. • Improve information and referral networks for learning, training, and work opportunities.
Role of the Private Sector	• Government should facilitate the involvement of the private and nongovernment sectors and civil society in the provision, management, quality assurance, and financing of education and training. • Open the provision of education and training to private providers. • Government and the private sector should set and monitor international quality standards. • Ensure that the quality of education training meets national, if not international, standards. • Open the management of government-owned education and training institutions to the private sector. • Involve employers and related stakeholders in identifying needed training programs to develop skill standards and provide practical training, etc.
Integrate ICT	• Use ICT to enhance (1) teaching and learning experiences, (2) pre- and in-service teacher training, (3) flexible delivery modes, and (4) technical support to teachers and academic supervisors. • Improve budget allocation to ICT for regular hardware and software upgrades. • Minimize any emerging digital divide. • Allocate budget for retraining in hardware and software upgrades. • Review and update the skills mix of teachers and school administrators vis-à-vis advances in ICT. • Review and update the staffing mix of schools to support students and teachers in new learning technologies. • Use ICT, including management information systems, to improve school management and the administration of the education system and improve the transparency of decisions.

Table 4.3: Actions Proposed for Managing the Health Sector through Transition

Areas of Focus	Actions
Focus on the Poor for Achieving the Millennium Development Goals (MDGs)	• The differentials between the rich and the poor in most health indicators are very high. To accelerate progress toward the MDGs, the largest gains must come from poor households. Hence, public policies and programs should shift to targeted efforts to achieve progress among the poor. • Further gains in infant and maternal mortality will take place only if the health systems cater to women in their third trimester of pregnancy and to newborn infants. To increase neonatal health and provide services to high risk pregnancies requires a health workforce with increased skills. • Young migrants from poor families moving into urban areas need to be targeted to reduce high-risk sex behavior. Awareness about HIV/AIDS and sexually transmitted diseases among the poor needs to increase. • Better public food distribution systems should target the poor to reduce malnutrition and micronutrient deficiencies. Programs such as food for work and food for schooling should be targeted where malnutrition is most prevalent.
Be Aware of the Transitional Forces and Fine Tune Public Policies Accordingly	• Transitional forces are redefining the way social services should be provided. Ignoring these forces will entail missed opportunities and an increased risk of avoidable adverse impacts and higher future costs. • Pro-poor targeting, innovative public-private partnerships, regulation of the private sector, integration of information and communication technology (ICT), and prevention of noncommunicable diseases will need appropriate public policies and programs.
Improve the Quality of Health Care by Focusing on Training for Health Personnel	• With the growth of medical outsourcing and changing disease patterns in the region, the need for more efficient hospital care is increasing. Health workers and paramedics need better skills and knowledge. Planning for the health care workforce needs to (1) consider the potential increase in demand from South Asia due to the aging population in the developed world, and (2) anticipate the future demand and ensure adequate supply so that public health service delivery, especially in rural areas, does not suffer.
Go for Bold Public-Private and Public-Public Partnerships	• Governments need to redefine their role from “provision” to “steering.” This can be done if they take full advantage of devolution and forge new partnerships. Day-to-day service delivery issues should ideally be managed by the lower levels of government or the private sector, while the central government increasingly (1) provides the framework for policy and planning, (2) regulates, (3) sets standards, and (4) assures quality.
Risk Pooling, Health Insurance, and Preventive Efforts	• With the increasing burden of noncommunicable disease, catastrophic health care costs will escalate. Risk pooling and sickness funds for the poor can reduce impoverishment resulting from high health care costs. • Through effective promotion of healthy lifestyles and disease prevention, the risk factors responsible for the largest burden of noncommunicable diseases can be reduced and the productive age groups can be protected from premature onset of noncommunicable disease. This should be a top priority in the region, and should include public awareness campaigns, improvements in school curricula, and a ban on tobacco advertisements. • Health systems and the health workforce need to be geared up for the growing noncommunicable disease burden. Curricula of pre-service and in-service training of health workers should be reviewed to mainstream control of noncommunicable diseases.
Use of ICT	• ICT could redefine the way health services are provided in remote areas and reach the most disadvantaged. Some of the seemingly intractable problems of governance and institutional capacity can be addressed by creative use of ICT. • Measures such as service quality call centers can be used to empower citizens for regular health service provision. Service to pregnant women and children can be tracked using mobile telephones and geographic positioning systems, and central health service call centers linked to ambulance services. Web-based health information systems can provide the right information in a timely manner to health workers in remote areas. Application of ICT for improving public social service delivery should be a top priority, as should operational research to leverage technology and scale up applications for improving access and quality of health services. • Health workers should be trained in using ICT; ICT should be mainstreamed into the curricula for pre-service and in-service training of health workers at all levels.

5. CONCLUSION

We conclude the report by suggesting six broad actions for the governments in the region to meet the dual challenges of accelerating progress toward the MDGs and simultaneously responding to the opportunities and risks of globalization and economic change:

- **Focus on the poor**. Faster progress toward the MDGs will be made if efforts are focused on the poor (Bryce et al. 2006) and on disadvantaged subregions in countries. Greater efficiencies in public services can be achieved through innovative partnerships with the private sector, lower tiers of governments (decentralization), and civil society.

- **Respond effectively to the new global opportunities and challenges**. Policy makers need to be aware of the implications of global and regional trends for the social sectors. We suggest using the transitional framework presented in section 3 of this report to investigate the opportunities, challenges, and policy options in consultation with the stakeholders. The capacities and resources of the region's governments are already stretched by current challenges. Hence, effective responses to new challenges will need support from the private sector and civil society, and through regional cooperation.

- **Enhance the responsiveness and agility of the social sectors.** The ongoing trends open new opportunities for the region. The opportunities provided by globalization are based on competitiveness at a global scale. Successfully adapting to the global environment will require more flexibility in labor's skills and knowledge mix, which will need to keep evolving. The region's education systems need to be transformed to adapt to the new realities. Education relevance and quality must be improved at all levels: primary, secondary, postsecondary, and tertiary (ADB 2004f). Technical and vocational education as well as higher education should be aligned with emerging global and domestic market demands. Alignment will require comprehensive sector governance and greater management capacity.

- **Proactively address the potential inequity of the transition**. The immediate global, technological, and labor market opportunities will benefit the richer sections of the society faster than the poorer ones—posing the serious risk of aggravating inequalities. Governments need to take effective pro-poor measures to ensure that the benefits of growth are equally distributed. In the long run, the most effective measures will focus on strengthening

human capabilities to enable individuals to qualify for productive and remunerative employment (Ali 2007).

- **Leverage ICT to address current and transitional challenges**. Strengthening public institutions, improving governance and the quality of public services, strengthening regulation, increasing awareness of citizens about important social sector issues, and creating the right incentives for improving public service delivery can all be addressed to some extent by effective use of ICT.

- **Prepare the social sectors for a "borderless world."** Governments have to examine policy options from the perspective of a new world with porous borders. Governments need to reach out to the private sector—both domestic and multinational—to understand the global trends so that the social sectors can capitalize on the emerging opportunities and mitigate the potential threats. New forms of regional cooperation should be forged to reconcile general national self-interest with international mutual interest and to exchange experiences dealing with common problems (Frenk and Gomez-Dantes 2002).

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STATISTICAL APPENDIX

Statistical Notes

Macroeconomic Indicators

National Accounts

Money and Prices

Government Finance

External Sector

Social Sector Indicators

Health

Education

Urbanization and Inequality Indicators

Millennium Development Indicators

Statistical Notes

Annual macroeconomic data were obtained from the *Asian Development Outlook* (*ADO*) and *ADO Update*, South Asia Department's Economic Information System, official and secondary sources, and statistical publications. Social sector data were compiled from various issues of the Asian Development Bank (ADB) *Key Indicators (KI)* and World Bank *World Development Indicators (WDI)*, and from the United Nations Millennium Development Goals Indicators database and WDI Online database.

In tables, a dash (—) indicates data are not available. Where no data are provided, and there is no dash, data are not applicable.

The Statistical Appendix is organized in two sections.

Macroeconomic Indicators. This section presents selected macroeconomic indicators for the eight South Asian countries. The tables are grouped under the following headings:

- national accounts (A1–A4),
- money and prices (A5–A6),
- government finance (A7–A8), and
- external sector (A9–A17).

Unless otherwise indicated, country data in tables A1–A17 are on a fiscal year basis (for details, see the Explanatory Notes). The majority of Bhutan's accounts are recorded on a fiscal year basis, except for its gross domestic product (GDP) data, which are recorded on a calendar year basis. Data presented in these tables are based on the statistics provided by ADB country economists for the *ADO*. For a detailed discussion of statistical sources, methodology, definitions, scope, and limitations, refer to *ADO 2007*.

Regional averages are derived using gross national incomes in current US dollars (World Bank Atlas method) as weights. Where country data are missing for a given year, regional aggregates are computed on the basis of available information only. For annual changes in exports and imports of goods and exports of services (tables A9, A10, and A12) regional aggregates are computed on the basis of a consistent sum (i.e., in cases where country data are missing for a given year, the sum of the prior year used for computing the growth rate excludes the corresponding country data).

GDP and GDP per capita valued at current market prices are presented in table A1. GDP per capita is defined as GDP at current prices divided by total population.

Annual growth rates of GDP (A2) and GDP per capita (A3) for Afghanistan, Bangladesh, and Bhutan are reported based on GDP valued at constant market prices. For the Maldives, A2 and A3 are based on constant basic prices. For the rest of South Asia (India,

Nepal, Pakistan, and Sri Lanka), A2 and A3 are based on GDP valued at constant factor cost.

Shares of the three major sectors—agriculture, industry, and services—for 2001 to 2006 are presented in table A4, based on constant prices. The agriculture sector includes agricultural crops, livestock, poultry, fisheries, and forestry; the industry sector includes the manufacturing and nonmanufacturing subsectors such as mining and quarrying, construction, and utilities; and the services sector includes trade, banking, finance, real estate, public administration, and other services.

In the case of Bhutan, previous calendar-year GDP is used as the base or the denominator for all national data presented as a percentage of GDP (A7–A8, A11–A12, A14; and A17).

Data on inflation rates presented in table A5 represent period averages based on the consumer price index (CPI) except for India, which reports the wholesale price index. The CPI for Nepal is for urban consumers only, while the CPI used for deriving inflation in the Maldives only covers the Male' region.

Except for Sri Lanka and India, liquidity growth (A6) is presented as annual percentage change in the end-of-period supply of broad money as represented by M2, which is the sum of currency in circulation plus demand deposits (M1) and quasi-money. Liquidity growth for Sri Lanka is based on M2b (M2 plus time and savings deposits held by commercial banks' foreign currency banking units), while for India broad money is represented by M3 (M2 plus other assets that are less liquid, including deposits with the Reserve Bank of India).

Tables A7 and A8 present central government finance except for India and Pakistan, which report government finance on a consolidated basis. Government revenues (percentage of GDP) generally comprise nonrepayable current and capital receipts plus grants divided by GDP at current prices. In A7, capital receipts for Afghanistan, Bangladesh, India, and Pakistan are not reported. Grants are likewise not reported in Bangladesh, India, and Pakistan. Other items included are revenues from disinvestment in India, and privatization proceeds in Sri Lanka. Expenditures (percentage of GDP) comprise all nonrepayable payments to both current and capital expenses, plus net lending divided by GDP at current prices. Fiscal balance (percentage of GDP) presented in Table A8 is the difference between government revenues and expenditures divided by GDP at current prices.

Annual changes on exports of goods (A9) are reported based on free-on-board (f.o.b.) valuation of exports. Annual changes on imports of goods (A10) are also reported on an f.o.b. basis, except for Afghanistan, Bhutan, and India as these countries report imports on a cost, insurance, and freight (c.i.f.) basis. Trade balance (A11) is the difference between exports and imports of goods.

Table A12 reports services exports and A13 reports workers' remittances. For Nepal, 2003 data on workers' remittances is from the *Macroeconomic Indicators of Nepal*, Nepal Rastra Bank, December 2003. Services export may include transport and travel services, communication, computers, and other services. Workers' remittances, broadly, are income flows sent by nonresident citizens to recipients in their respective home countries.

Current account balances (percent of GDP) presented in table A14 are based on the sum of the balance of trade for merchandise and services, net factor income, and net transfers divided by GDP at current prices in US dollars.

Foreign direct investment (FDI) presented in table A15 refers to equity capital, reinvested earnings, investment in debt securities, and other capital associated with the transactions of enterprises, net of repatriations and intercompany loan repayments. For Bangladesh, only capital investments passing through banking channels are reported.

Except for the Maldives, Nepal, and Pakistan, gross international reserves (GIR) comprise holdings of special drawing rights (SDR), reserve position in the International Monetary Fund (IMF), foreign exchange, and gold at the end of the given period (A16). GIR comprises foreign assets of the Maldives Monetary Authority; foreign currency reserves with the Nepal Rastra Bank, and net foreign reserves with the State Bank of Pakistan, for these countries.

Table A17 presents outstanding external debt (percentage of GDP) and debt service ratio (percentage of exports of goods and services). For Bangladesh, the sum of exports of goods, nonfactor services, and workers' remittances is the denominator for the ratio.

Social Sector Indicators. This section provides relevant information on social sector status, particularly in terms of health and education, of countries in South Asia, divided into the following groups:

- health indicators (A18–A19),
- education indicators (A20–A21),
- urbanization and inequality indicators (A22–A23), and
- millennium development indicators (A24–A31).

All indicators in tables A18–A22, except for mid-year population in A18, were obtained from WDI online, accessed in April 2007. Mid-year population data in table A18 are consistent with *KI 2006*. Inequality indicators in table A23 are from *WDI 2007*. Millennium development indicators in tables A24–A31 are compiled from *KI 2006* and the Millennium Development Goals Indicators database, accessed in April 2007. For detailed explanations of data definitions and sources, methodology, scope and limitations, please refer to the appropriate reference documents and data bases.

Macroeconomic Indicators

National Accounts

Table A1: GDP and Per Capita GDP (current market prices)

	GDP ($ billion)		**Per Capita GDP** ($)	
	2001	**2006**	**2001**	**2006**
South Asia	619.7	1,136.9	468.1	794.5
Afghanistan	2.5	8.4	115.1	335.3
Bangladesh	47.0	62.0	361.7	446.5
Bhutan	0.5	1.0	693.4	1266.6
India	478.3	911.2	460.8	812.1
Maldives	0.6	0.9	2,165.8	3,107.5
Nepal	5.6	8.1	241.2	311.8
Pakistan	72.0	126.9	513.3	816.6
Sri Lanka	15.7	27.0	840.8	1,288.4

Table A2: Growth Rate of GDP (annual change, %)

	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
South Asia	5.1	3.7	7.8	7.4	8.7	8.8	7.6	8.0
Afghanistan	__	28.6	15.7	8.0	14.0	8.0	12.2	10.0
Bangladesh	5.3	4.4	5.3	6.3	6.0	6.6	6.5	7.0
Bhutan	7.2	10.0	7.6	6.8	6.5	9.0	18.0	10.0
India	5.8	3.8	8.5	7.5	9.0	9.4	7.8	8.3
Maldives	3.5	6.5	8.5	9.5	-4.6	19.1	7.3	12.1
Nepal	4.8	-0.4	3.0	3.5	2.3	2.3	2.8	2.8
Pakistan	2.0	3.1	4.7	7.5	9.0	6.6	7.0	6.5
Sri Lanka	-1.5	4.0	6.0	5.4	6.0	7.4	6.1	6.0

Table A3: Growth Rate of Per Capita GDP (annual change, %)

	2001	2002	2003	2004	2005	2006	2007	2008
South Asia	3.3	2.2	6.2	5.5	7.0	7.2	6.2	6.7
Afghanistan	—	—	12.7	5.4	10.4	4.9	8.9	6.9
Bangladesh	5.2	3.1	3.8	4.9	4.6	5.2	5.1	5.6
Bhutan	4.6	7.3	4.9	4.2	4.1	6.6	15.4	7.6
India	3.9	2.1	6.7	5.8	7.3	7.9	6.5	6.8
Maldives	1.7	4.8	6.8	8.0	-6.2	17.3	5.7	—
Nepal	2.2	-13.6	13.5	1.3	0.1	0.1	0.3	0.8
Pakistan	0.0	3.0	4.8	4.3	6.7	4.5	5.0	—
Sri Lanka	-2.9	2.5	0.7	3.9	4.5	5.8	4.5	4.5

Table A4: Shares of Major Sectors (% of GDP)

	Agriculture		Industry		Services	
	2001	2006	2001	2006	2001	2006
South Asia	24.2	19.2	25.0	26.7	50.8	54.2
Afghanistan	—	30.9	—	26.2	—	42.9
Bangladesh	25.0	21.8	26.2	29.0	48.8	49.2
Bhutan	27.9	21.3	36.5	38.5	35.6	40.2
India	24.0	18.5	25.0	26.6	51.0	54.9
Maldives	9.2	8.6	14.5	15.5	76.3	75.9
Nepal	38.0	38.8	23.5	22.4	38.5	38.8
Pakistan	24.9	21.3	23.8	25.9	51.3	52.8
Sri Lanka	20.1	16.8	27.4	27.0	52.5	56.2

Money and Prices

Table A5: Inflation Rate (annual change, %) [a]

	2001	2002	2003	2004	2005	2006	2007	2008
South Asia	3.8	3.5	5.0	6.3	5.3	5.9	5.5	5.4
Afghanistan	—	5.1	24.1	13.2	12.3	6.4	5.9	5.0
Bangladesh	1.9	2.8	4.4	5.8	6.5	7.2	7.2	6.5
Bhutan	3.4	2.9	2.1	3.6	4.8	4.9	5.0	5.0
India	3.7	3.4	5.4	6.4	4.4	5.4	5.0	5.0
Maldives	0.7	4.2	-1.3	-1.7	1.3	2.7	4.0	4.0
Nepal	2.4	2.9	4.8	4.0	4.5	8.0	5.3	5.4
Pakistan	4.4	3.5	3.1	4.6	9.3	7.9	7.3	6.5
Sri Lanka	12.1	10.2	2.6	7.9	10.6	9.6	10.0	9.0

[a] CPI, except for India (WPI)

Table A6: Liquidity Growth (annual change, %) [a]

	2001	2002	2003	2004	2005	2006
South Asia	13.7	14.5	16.7	13.5	20.5	20.0
Afghanistan	—	—	50.5	41.8	14.1	21.1
Bangladesh	16.6	13.1	15.6	13.8	16.8	19.5
Bhutan	5.5	17.6	28.7	4.0	10.7	24.8
India	14.1	14.7	16.7	12.3	21.2	20.8
Maldives	9.1	19.5	14.5	32.7	11.7	20.6
Nepal	15.2	4.4	9.8	12.8	8.3	15.6
Pakistan	9.0	15.4	18.0	19.6	19.3	15.2
Sri Lanka	13.6	13.4	15.3	19.6	19.1	17.8

[a] M2, except for India (M3) and Sri Lanka (M2b). For India, M3 includes deposits with the Reserve Bank of India. For Sri Lanka, M2b includes time and savings deposits held by commercial banks' foreign currency banking units.

Government Finance

Table A7: Revenues and Expenditure (% of GDP)

	Tax Revenue		Total Revenue		Expenditure	
	2001	**2006**	**2001**	**2006**	**2001**	**2006**
South Asia	12.9	15.4	16.5	19.1	25.4	25.0
Afghanistan	—	5.4	—	15.2	—	18.9
Bangladesh	7.6	8.5	9.0	10.7	14.0	13.9
Bhutan	9.6	10.2	43.3	36.7	55.7	43.8
India	13.8	16.8	17.7	20.5	27.6	26.9
Maldives	—	—	33.0	61.5	37.7	68.6
Nepal	9.5	10.3	13.0	14.9	17.5	16.7
Pakistan	10.5	10.6	13.1	14.2	17.4	18.5
Sri Lanka	14.6	15.3	16.6	17.0	27.5	26.2

Table A8: Fiscal Balance (% of GDP)

	2001	**2002**	**2003**	**2004**	**2005**	**2006**
South Asia	-8.9	-8.5	-7.5	-6.6	-6.6	-5.9
Afghanistan	—	-0.1	-3.0	-1.2	0.9	-3.8
Bangladesh	-5.0	-4.6	-3.4	-3.2	-3.4	-3.3
Bhutan	-12.4	-5.4	-11.0	2.0	-11.0	-7.1
India	-9.9	-9.6	-8.5	-7.5	-7.4	-6.3
Maldives	-4.7	-4.9	-3.4	-1.6	-10.9	-7.1
Nepal	-4.5	-3.9	-1.5	-1.0	-0.8	-1.8
Pakistan	-4.3	-4.3	-3.7	-2.4	-3.3	-4.3
Sri Lanka	-10.8	-8.9	-8.0	-8.2	-8.7	-9.2

External Sector

Table A9: Exports—Goods (annual change, %)

	2001	2002	2003	2004	2005	2006	2007	2008
South Asia	0.1	13.6	20.8	24.0	21.0	19.4	14.5	14.8
Afghanistan	—	82.1	46.7	-13.3	9.1	5.1	7.3	5.5
Bangladesh	12.6	-7.6	9.5	15.9	14.0	21.6	20.0	18.0
Bhutan	-12.9	4.1	8.9	39.7	18.0	61.0	—	—
India	-1.6	20.3	23.3	28.5	23.4	20.9	16.0	15.0
Maldives	1.4	20.1	14.9	19.1	-10.7	39.4	15.5	—
Nepal	11.7	-20.3	-13.8	14.8	11.0	4.2	4.7	6.0
Pakistan	9.1	2.3	19.1	13.8	16.2	13.8	3.4	15.0
Sri Lanka	-12.8	-2.4	9.2	12.2	10.2	8.5	7.0	8.0

Table A10: Imports—Goods (annual change, %)

	2001	2002	2003	2004	2005	2006	2007	2008
South Asia	-1.7	8.8	22.2	39.2	30.0	22.0	18.0	17.9
Afghanistan	—	52.5	50.9	2.3	11.5	13.8	6.3	4.3
Bangladesh	11.4	-8.7	13.1	13.0	20.6	12.1	20.0	18.0
Bhutan	1.1	8.6	1.6	27.3	63.2	-3.5	—	—
India	-2.8	14.5	24.1	48.6	32.0	22.3	20.0	19.2
Maldives	1.3	-0.5	20.2	36.3	16.1	24.4	13.8	—
Nepal	6.7	-15.3	7.1	15.9	12.1	18.4	6.5	10.0
Pakistan	6.2	-7.5	20.1	20.0	37.8	31.4	8.9	13.5
Sri Lanka	-18.4	2.2	9.3	19.9	10.8	15.7	8.0	9.0

Table A11: Trade Balance (% of GDP)

	2001	2002	2003	2004	2005	2006	2007	2008
South Asia	-2.8	-2.3	-2.5	-4.9	-6.5	-7.3	-8.5	-9.5
Afghanistan	-38.0	-29.8	-41.2	-37.4	-34.6	-36.1	-32.4	-28.8
Bangladesh	-4.3	-3.7	-4.3	-4.1	-5.5	-4.6	-5.1	- 5.6
Bhutan	-18.1	-18.4	-14.9	-14.8	-29.0	-11.5	—	—
India	-2.4	-2.1	-2.3	-4.8	-6.4	-7.1	-8.7	-9.6
Maldives	-39.5	-33.2	-38.0	-49.4	-65.9	-63.7	-63.6	—
Nepal	-13.7	-12.6	-15.4	-15.6	-16.1	-18.9	-19.1	—
Pakistan	-1.8	-0.4	-0.5	-1.2	-4.0	-6.5	-5.2	—
Sri Lanka	-7.3	-8.5	-8.4	-11.2	-10.7	-12.5	-12.0	—

Table A12: Exports—Services

	Annual Change (%)						Percentage of GDP	
	2001	2002	2003	2004	2005	2006	2001	2006
South Asia	5.8	20.0	28.7	50.8	38.5	30.8	3.4	7.8
Afghanistan	—	—	—	—	—	—	—	—
Bangladesh	-10.6	14.0	2.5	4.2	27.4	10.1	1.6	2.1
Bhutan	76.0	-5.6	-15.2	25.6	48.3	31.2	7.0	7.3
India	5.4	21.1	29.4	61.0	42.0	32.5	3.6	8.9
Maldives	1.6	2.5	19.0	17.6	-36.4	46.5	59.2	51.0
Nepal	—	—	—	—	-22.5	1.5	—	4.5
Pakistan	-2.5	38.5	46.4	-2.5	32.6	23.0	2.0	3.7
Sri Lanka	42.2	-6.4	11.3	8.2	0.9	5.5	8.6	6.0

Table A13: Workers' Remittances ($ million)

	2001	2002	2003	2004	2005	2006
South Asia	19,884	23,366	31,595	30,676	35,403	41,300
Afghanistan	—	—	—	—	—	—
Bangladesh	1,882	2,501	3,062	3,372	3,848	4,802
Bhutan	—	—	—	—	—	—
India [a]	15,760	17,189	22,182	21,075	24,560	28,223
Maldives	—	—	—	—	—	—
Nepal [b]	—	—	700	794	908	1,349
Pakistan	1,087	2,389	4,237	3,872	4,169	4,600
Sri Lanka	1,155	1,287	1,414	1,564	1,918	2,326

[a] Data from Reserve Bank of India.

[b] 2003 data from Macroeconomic Indicators of Nepal, December 2005, Nepal Rastra Bank.

Table A14: Current Account Balance (% of GDP) [a]

	2001	2002	2003	2004	2005	2006	2007	2008
South Asia	0.3	1.2	2.3	-0.2	-1.2	-1.4	-2.3	-2.2
Afghanistan	—	-3.7	3.0	1.8	0.6	-2.3	-4.3	-5.1
Bangladesh	-2.3	0.3	0.3	0.3	-0.9	0.9	0.6	0.2
Bhutan	-9.8	-13.4	-15.5	-11.6	-29.7	-2.4	3.0	3.0
India	0.7	1.2	2.3	-0.4	-1.1	-1.1	-2.2	-2.2
Maldives	-9.8	-5.6	-4.5	-15.8	-36.0	-39.8	-38.3	-15.0
Nepal	4.9	4.3	2.5	2.9	2.2	2.4	1.0	1.0
Pakistan	-0.7	1.8	3.8	1.3	-1.6	-4.5	-5.0	-3.9
Sri Lanka	-1.4	-1.4	-0.4	-3.2	-2.8	-4.9	-2.5	-2.4

[a] For Bhutan, % of GDP of prior calendar year.

Table A15: Foreign Direct Investment ($ million)

	2001	2002	2003	2004	2005	2006
South Asia	7,149	6,153	5,753	7,807	10,572	24,424
Afghanistan	—	50	58	187	271	232
Bangladesh	550	391	376	385	800	675
Bhutan	0	2	2	3	9	6
India	6,130	5,035	4,322	6,051	7,722	19,531
Maldives	12	12	14	15	10	14
Nepal	0	-4	12	0	2	-6
Pakistan	286	485	798	949	1,524	3,521
Sri Lanka	172	181	171	217	234	451

Table A16: Gross International Reserves

	$ Million		Months of Import Coverage	
	2001	2006	2001	2006
South Asia	59,816	220,643	6.8	8.4
Afghanistan	—	1,838	—	4.5
Bangladesh	1,307	3,484	1.6	2.7
Bhutan	293	479	15.8	12.1
India	54,106	199,179	9.3	9.9
Maldives	94	232	2.5	2.7
Nepal	1,002	1,834	7.0	7.7
Pakistan	1,677	10,760	1.4	3.5
Sri Lanka	1,338	2,837	2.3	2.9

Table A17: External Debt

	% of GDP		Debt Service [a] (% of exports of goods and services)	
	2001	2006	2001	2006
South Asia	25.8	19.5	14.8	9.1
Afghanistan	—	19.7	—	1.3
Bangladesh	31.2	30.5	6.6	3.9
Bhutan	53.1	81.3	4.7	5.4
India	20.7	16.4	13.4	4.8
Maldives	35.1	61.9	4.3	4.5
Nepal	47.7	39.2	6.8	8.4
Pakistan	48.9	27.8	32.6	13.3
Sri Lanka	55.6	47.0	13.2	12.7

[a] Includes remittances for Bangladesh

Social Sector Indicators

Health

Table A18: Demographics

Population	Mid-year Population (million)	Population Density (people per km^2)	Population Growth (annual % change)	Fertility Rate (births per woman)	Birth Rate (crude; per 1,000 people)	Age Dependency Ratio
South Asia	1,467.7	307.5	1.6	3.1	25.1	0.6
Afghanistan	23.6	—	—	—	—	—
Bangladesh	137.0	1,089.5	1.9	3.0	26.7	0.6
Bhutan	0.8	19.5	2.4	4.2	30.0	0.8
India	1,107.0	368.2	1.4	2.9	24.1	0.6
Maldives	0.3	1,097.3	2.5	4.1	30.8	0.8
Nepal	25.3	189.7	2.0	3.5	29.4	0.7
Pakistan	154.0	202.1	2.4	4.3	27.2	0.7
Sri Lanka	19.7	303.0	0.8	1.9	18.6	0.5

km^2= square kilometer Note: Data are from 2005 except that data for fertility and birth rate are for 2004.

Table A19: Child Health Indicators

Population	Malnutrition (% of children under 5)				Treatment (% of children under 5)			
	Height -for- age	Year of Data	Weight -for- Age	Year of Data	ARI	Year of Data	Diarrhea	Year of Data
South Asia	43.5	2004	45.3	2004	21	2004	22	1999
Afghanistan	—		39.3	2004	28	2003	48	2003
Bangladesh	43.0	2004	47.5	2004	20	2004	35	2000
Bhutan	40.0	1999	18.7	1999	—		—	
India	44.9	1999	46.7	1999	64	1999	22	1999
Maldives	24.8	2001	30.2	2001	22	2001	43	2001
Nepal	50.5	2001	48.3	2001	24	2001	—	
Pakistan	36.8	2001	37.8	2002	—		—	
Sri Lanka	13.9	2001	29.7	2001	—		—	

ARI=acute respiratory infection.

Education

Table A20: Primary Education Indicators

Population	Gross Enrollment Ratio (%)	Net Enrollment Ratio (%)	Repetition Rate (% of total enrollment)	Pupil-Teacher Ratio
South Asia	110.5	87.1	4.1	40.1
Afghanistan	92.9	—	—	65.2
Bangladesh	108.9	93.8	7.0	53.5
Bhutan	—	—	12.9	37.9
India	116.2	89.7	3.2	40.2
Maldives	103.5	89.7	11.3	18.2
Nepal	113.3	78.0	21.7	39.7
Pakistan	82.1	66.2	—	37.5
Sri Lanka	97.7	97.1	5.1	22.5

Note: All data are from 2004 except as follows: Gross Enrollment Ratio, Nepal (2005); Net Enrollment Ratio, the Maldives (2002) and Nepal (2003); Repetition Rate, Bhutan (2002) and Sri Lanka (1998); Pupil-Teacher Ratio, Nepal (2005), Bangladesh and the Maldives (2003), and Bhutan (2002).

Table A21: Postprimary Education and Literacy

Population	Progression to Secondary School (%)	Gross Secondary Enrollment Ratio (%)	Gross Tertiary Enrollment Ratio (%)	Literacy Rate	
				Adult (% of people ages 15 and above)	Youth (% of people ages 15–24)
South Asia	84.8	49.3	10.4	59.5	74.3
Afghanistan	—	15.6	1.1	28.1	34.3
Bangladesh	95.4	51.3	6.5	—	—
Bhutan	82.5	—	—	—	—
India	85.1	53.5	11.8	61.0	76.4
Maldives	60.2	72.8	0.2	96.3	98.2
Nepal	75.8	45.7	5.6	48.6	70.1
Pakistan	69.0	27.2	3.2	49.9	65.5
Sri Lanka	97.0	82.5	—	90.7	95.6

Note: Data are for 2004 except as follows: Progression to Secondary School, Afghanistan, India, Nepal, and South Asia (2003); Bangladesh, the Maldives, and Sri Lanka (2002); and Bhutan (2000); Gross Secondary Enrollment Ratio, Bangladesh (2003) and Nepal (2005); and Gross Tertiary Enrollment Ratio: Bangladesh (2003).

Urbanization and Inequality Indicators

Table A22: Migration and Urbanization

Population	Rural Population (% of total)			Urban Population (% of total)		
	1965	1985	2005	1965	1985	2005
South Asia	82.4	76.4	71.5	17.6	23.6	28.5
Afghanistan	90.6	83.1	77.1	9.4	16.9	22.9
Bangladesh	93.8	82.5	74.9	6.2	17.5	25.1
Bhutan	96.6	93.8	88.9	3.4	6.2	11.1
India	81.2	75.7	71.3	18.8	24.3	28.7
Maldives	88.5	74.5	70.4	11.5	25.5	29.6
Nepal	96.3	92.6	84.2	3.7	7.4	15.8
Pakistan	76.5	70.7	65.1	23.5	29.3	34.9
Sri Lanka	82.4	82.0	84.9	17.6	18.0	15.1

Table A23: Inequality in Selected Countries in South Asia

Population	Year	Gini Index	Income Share				
			1st Quintile	2nd Quintile	3rd Quintile	4th Quintile	5th Quintile
Bangladesh	2000	33.4	8.6	12.1	15.6	21.0	42.7
India	2004	36.8	8.1	11.3	14.9	20.4	45.3
Nepal	2004	47.2	6.0	9.0	12.4	18.0	54.6
Pakistan	2002	30.6	9.3	13.0	16.3	21.1	40.3
Sri Lanka	2002	40.2	7.0	10.5	14.2	20.4	48.0

Millennium Development Indicators

Table A24: Goal 1—Eradicate Extreme Poverty and Hunger

Country	Population Below $1 (PPP) per Day Consumption, Percent			Population Undernourished, Percent	
	1990	Latest Year		1990–1992	2001–2003
Afghanistan	—	—		—	—
Bangladesh	34	30	2003	35	30
Bhutan	—	—		—	—
India	42	31	2003	25	20
Maldives	—	1	2004	17	11
Nepal	44	25	2004	20	17
Pakistan	48	20	2003	24	23
Sri Lanka	4	1	2003	28	22

PPP=purchasing power parity.

Table A25: Goal 2—Achieve Universal Primary Education

Country	Net Enrolment Ratio in Primary Education				Percent of Pupils Starting Grade 1 Reaching Grade 5			
			Latest Year				Latest Year	
	1990	2000	Data	Year	1991	2000	Data	Year
Afghanistan	27	—	—		—	—	—	
Bangladesh	71	89	94	2004	—	66	65	2003
Bhutan	14	—	—		82	91	91	2000
India	—	82	90	2004	59	59	79	2003
Maldives	87	96	90	2002	—	—	—	
Nepal	81	70	78	2003	51	46	61	2004
Pakistan	33	58	66	2004	—	—	70	2004
Sri Lanka	90	—	97	2004	92	—	—	

Note: Data for Bhutan and India in the 1991 column are from 1993.

Table A26: Goal 3—Promote Gender Equality and Empower Women

Country	Gender Parity Index in Primary Level Enrolment			Gender Parity Index in Secondary Level Enrolment			Gender Parity Index in Tertiary Level Enrolment		
	1991	Latest Year		1991	Latest Year		1991	Latest Year	
Afghanistan	0.55	0.44	2004	0.51	0.21	2004	0.48	0.28	2004
Bangladesh	0.86	1.03	2004	0.52	1.11	2003	0.20	0.50	2002
Bhutan	0.76	—		—	—		—	—	
India	0.76	0.93	2004	0.60	0.80	2004	0.54	0.66	2004
Maldives	0.97	0.97	2004	1.02	1.14	2004	—	2.37	2004
Nepal	0.63	0.91	2005	0.46	0.86	2005	0.33	0.40	2004
Pakistan	—	0.73	2004	0.48	0.73	2004	0.58	0.80	2004
Sri Lanka	0.95	0.99	2003	1.08	1.00	2004	0.55	—	

Table A27: Goal 4—Reduce Child Mortality

Country	Children Under-Five Mortality Rate (per 1,000 live births)		Infant Mortality Rate (0–1 year old, per 1,000 live births)	
	1990	2004	1990	2004
Afghanistan	260	257	168	165
Bangladesh	149	77	100	56
Bhutan	166	80	107	70
India	123	85	84	62
Maldives	111	46	79	35
Nepal	145	76	100	59
Pakistan	130	101	100	80
Sri Lanka	32	14	26	12

Table A28: Goal 5—Improve Maternal Health

Country	Maternal Mortality Ratio (per 100,000 live births)		Births Attended by Skilled Health Personnel (percentage)			
			Base Year		Latest Year	
	1990	2000				
Afghanistan	1,700	1,900	9	1990	14	2003
Bangladesh	850	380	10	1994	13	2004
Bhutan	1,600	420	16	1990	37	2003
India	570	540	34	1993	43	2000
Maldives[a]	390	110	55	1990	70	2001
Nepal	1,500	740	7	1991	15	2004
Pakistan	340	500	19	1991	23	2001
Sri Lanka	140	92	85	1990	96	2000

[a] Data in the 1990 column for the Maldives are actually from 1995.

Table A29: Goal 6—Combat HIV/AIDS, Malaria, and Other Diseases

Country	People Living with HIV (15–49 years old, percentage)		Prevalence of Malaria (per 100,000 people)	Prevalence of Tuberculosis (per 100,000 people)	
	2001	2005	2000	1990	2004
Afghanistan	—	<0.1	937	826	661
Bangladesh	—	<0.1	40	640	435
Bhutan	—	<0.1	285	371	184
India	0.8	0.9	7	570	312
Maldives	—	—	—	155	57
Nepal	0.4	0.5	33	616	257
Pakistan	0.1	0.1	58	430	329
Sri Lanka	<0.1	<0.1	1,110	109	91

HIV=human immunodeficiency virus.

Table A30: Goal 7—Ensure Environmental Sustainability

Country	Proportion of the Population Using Improved Drinking Water Sources		Proportion of the Population Using Improved Sanitation Facilities		Slum Population as Percentage of Urban Population	
	1990	2004	1990	2004	1990	2001
Afghanistan	4	39	3	34	98.5	98.5
Bangladesh	72	74	20	39	87.3	84.7
Bhutan	—	62	—	70	70.0	44.1
India	70	86	14	33	60.8	55.5
Maldives	96	83	—	59	—	—
Nepal	70	90	11	35	96.9	92.4
Pakistan	83	91	37	59	78.7	73.6
Sri Lanka	68	79	69	91	24.8	13.6

Table A31: Goal 8—Develop a Global Partnership for Development

Country	Debt Service as Percentage of Exports of Goods and Services and Net Income from Abroad			
	1990	2000	Latest Year	
Afghanistan	—	—	—	
Bangladesh	34.8	10.7	6.9	2004
Bhutan	5.3	4.7	4.7	2002
India	29.3	15.4	18.1	2003
Maldives	4.0	4.0	4.5	2004
Nepal	15.2	7.3	8.9	2004
Pakistan	22.9	20.7	22.8	2004
Sri Lanka	14.8	10.8	8.8	2004