

ACHIEVING THE MDGs WITH EQUITY IN ASIA AND THE PACIFIC

DISCUSSION PAPER¹



High-Level Meeting on Cooperation for Child Rights in
the Asia-Pacific Region
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Glossary

ASEAN	Association of Southeast Asian Nations
ADB	Asian Development Bank
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Survey
EAPRO	East Asia and Pacific Regional Office
ECCE	Early Childhood Care and Education
E7	Emerging economies (China, India, Brazil, Russia, Indonesia, Mexico and Turkey)
G7	Group of 7 developed countries (Canada, France, Germany, Italy, Japan, United Kingdom, United States)
Lao PDR	Lao People's Democratic Republic
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
NAR	Net Attendance Rate
NER	Net Enrolment Rate
PMTCT	Preventing Mother-to-Child Transmission
ROSA	Regional Office for South Asia
SAARC	South Asian Association for Regional Cooperation
SIDS	Small Island Developing States
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
WB	World Bank
WHO	World Health Organization

Contents

I. Introduction: The Asia-Pacific context	1
II. Disparities in MDG achievement.....	3
A. Poverty and hunger.....	3
B. Education	5
C. Gender equality.....	8
D. Child mortality and maternal health	10
E. HIV and AIDS	12
F. Water and sanitation.....	13
III. Underlying causes of disparity	18
A. Causes of gender disparities.....	18
B. Causes of urban-rural disparities	18
C. Causes of geographic disparities.....	19
D. Wealth-based causes of disparities	19
E. Other important sources of inequity in MDG achievement.....	20
IV. Social policy and legislative solutions.....	22
A. Equity-oriented intersectoral policies.....	22
B. Equity-oriented sectoral policies and programmes.....	23
<i>Education</i>	23
<i>Health and nutrition</i>	25
<i>HIV and AIDS</i>	27
<i>Water and sanitation</i>	29
V. Budgets and fiscal space	30
VI. Conclusions and recommendations	33
VII. Bibliography	34
VIII. Annexes	37
A. List of surveys.....	37
B. Definition of indicators	38
C. Country data by MDG	39
D. Methodology	42
E. Challenges in gathering evidence	44
F. Natural disasters	45

Executive summary

Reporting on Millennium Development Goals (MDG) achievement has usually focused on national averages and whether countries are “on track” or “off track” to achieve the goals. The worse-off: women, poor people and those living in rural areas, are often mentioned. But systematic analysis of their data is rare. Similarly, government policies that succeeded in reducing disparities are rarely reviewed. This paper focuses on left behind groups, provides a systematic analysis of disparities affecting them, and provides examples of solutions used by governments in Asia and the Pacific.

Economic progress in many countries in Asia and the Pacific has been remarkable. Hundreds of millions of people have emerged from poverty. But economic inequality has also been increasing: the rich are getting richer far faster than the poor. Rural-urban differences are growing. About 95 per cent of the poorest fifth of the population live in rural areas.

The association between poverty and low MDG achievement is very strong: In almost every country with internationally comparable data, for almost every MDG indicator analyzed, poverty was the largest underlying cause of disparities in MDG achievement. Only one other underlying cause had a similar effect on MDG achievement: geography. In many countries, the difference between the best performing region and worst performing region was similar to the difference between the richest and poorest wealth quintiles. Geography and poverty are the two largest determinants of MDG achievement.

There are also differences between urban and rural areas, and boys and girls. Gender differences are comparatively small for infants (birth registration and immunization coverage are similar for boys and girls), but increase significantly with age. There are very large differences between men and women in labour force and parliamentary participation. Discrimination based on ethnicity, religion, HIV/AIDS status, physical and mental disabilities, and in some places caste, may be very significant, but little internationally comparable quantitative data is available.

Identifying causes of disparities is important because selection of the policy solutions that are most effective depends on the causes. Disparities based on individual poverty might be best remedied by cash transfers to the poor and other social protection policies. Geographic disparities may require compensatory provincial allocations linked to fiscal decentralization, or other geographically targeted subsidies and grants. Discrimination based on identity, if associated with gender, ethnicity, religion or caste, may require legislative action.

Many of these disparities may seem inevitable and intractable. Increased inequalities are sometimes considered “transitional” or “the price of development”. This is emphatically not the case. Individual countries in Asia and the Pacific have achieved remarkable success in reducing, and often eliminating, specific disparities. This is shown in the overview chart of MDG-related disparities (figure 18) in which, for every indicator, for every type of disparity, there is always at least one country without, or almost without, disparities.

This paper is necessarily selective in presenting national examples of successful policies. Some of the examples presented may be useful to policy makers in the region. Through enhanced inter-country collaboration and improved regional level knowledge management, such as the establishment of a regional hub for networks of expertise, data and policy solutions, more policy examples could be illustrated, shared and adapted when useful. This would highlight the transition of Asia Pacific countries from aid recipients to independent development contributors as active partners for the betterment of all children.

I. Introduction: The Asia-Pacific context

Countries in Asia and the Pacific have made remarkable socio-economic progress over the last two decades. This swift progress recently included China overtaking Japan as the world's second largest economy. A recent report forecasts that the world's seven largest emerging economies (the E-7 – which includes India, China and Indonesia from Asia and the Pacific) will overtake the G-7 economies by 2020 (PwC, 2010).

While per capita income equality is still relatively distant, the increase in total output and the outstanding performance of Asia's large economies has resulted in millions of people in Asia and the Pacific emerging from extreme poverty in the last few decades (Patel, 2009).

Progress in social sectors has lagged and been more varied (see figure 1 for a breakdown of country progress towards achieving the MDGs). Early achievements in education coverage have not always been followed by improvements in quality. Health and nutrition status still lag, often visibly. Within most countries, elite groups now receive education and health services that are comparable to those available in developed countries. The poor, and those in remote rural areas, are often receiving services that are only marginally better, and sometimes worse, than those received two decades ago. The continued exclusion of some children from benefits such as education and adequate health care is more than a brake on enhanced future economic development. It is a serious threat to the development of a cohesive developed society. Governments in Asia and the Pacific have committed themselves to address these inequities (see box below).

Regional Commitments on Improving Outcomes for Children

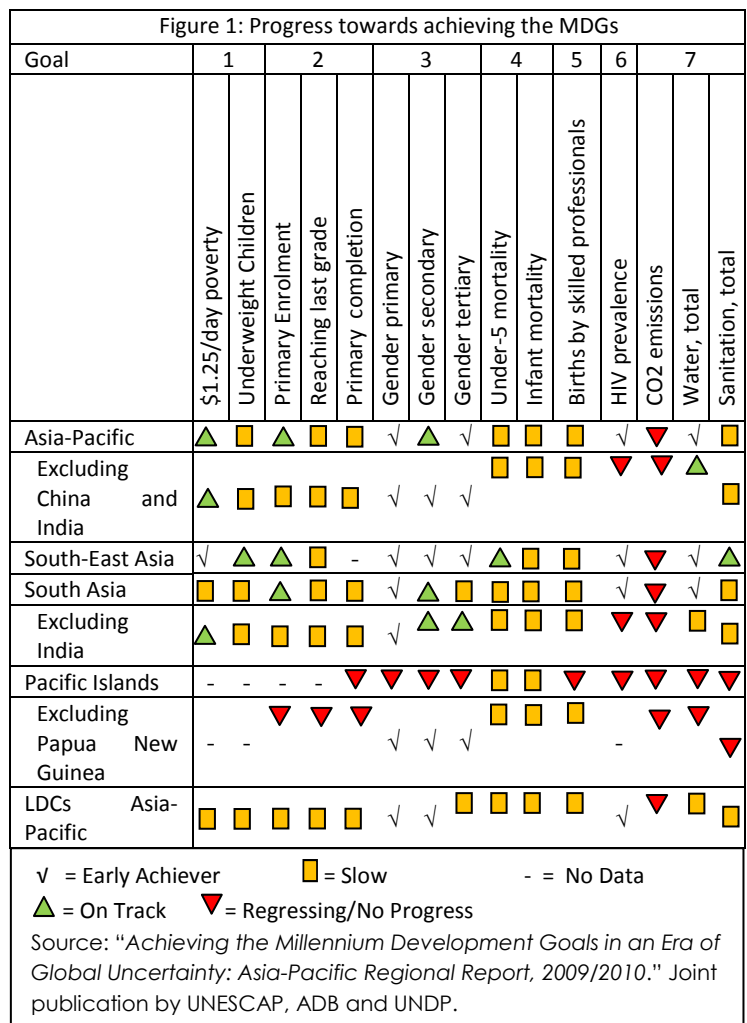
Government commitments through ratifying the [Convention on the Rights of the Child](#) include:

- *"States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services..."*
- *"States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity..."*

These recognitions, endorsed as entitlements in most national constitutions, have been echoed and supplemented by organizations promoting regional collaboration for universal and inclusive realization of these rights:

- [Association of Southeast Asian Nations \(ASEAN\)](#): "Vision and Mission Statement on Social Protection" (2001) and work programme (2000-2005) — prioritizes capacity building to develop national social protection systems that target the unreached, protect against shocks.
- [South Asian Association for Regional Cooperation \(SAARC\) Social Charter \(2004\)](#): "...attach high importance to the imperative of social development and economic growth and that their national legislative, executive and administrative frameworks provide, in varying degrees, for the progressive realization of social and economic goals, with specific provisions, where appropriate, for the principles of equity, affirmative action and public interest.."
- [The Pacific Forum Guiding Principles and Values \(2008\)](#): " ... Addressing the priority needs and rights of our most vulnerable Members, communities and people ...; ... embracing gender equality ...; and ... excelling in a caring, inclusive and innovative environment ..."
- [The Mauritius Strategy for the further Implementation of the Programme of Action for the Sustainable Development of Small Island Developing States \(SIDS\) \(2005\)](#): "development must prioritize the most vulnerable countries, communities and people. It also identifies climate change and sea-level rise as well as disasters as the most important threats to sustainable development of the SIDS ..."
- [Seventh East Asia and Pacific Ministerial Consultation on Children \(2005\)](#): "We shall reduce disparities and inequities and eliminate discrimination by reaching out to all children, young people and women, especially the most disadvantaged, vulnerable and marginalized, recognizing that this may require a greater proportion of government spending on basic social services."

In support of these national and regional commitments, and to complement routine reporting on MDGs that focuses primarily on national averages and trends, this report, using only internationally comparable governmental publications and statistics (see annexes A, B and C), analyses current disparities, their underlying causes, and presents some solutions and promising policies from countries in the region. A crucial, and too often ignored fact, is that it is more cost-effective as well as equity enhancing to extend public health based life-saving measures and basic social services to remote areas than to build up complex tertiary facilities in national capitals. In times when communications are improving rapidly, and awareness of subnational differences in levels of social investment and development is increasing, equity oriented policies and policy implementation are urgently needed.



To give due recognition to initiatives currently underway in countries in Asia and the Pacific to reduce disparities, the examples presented in this report cover a wide range of experiences. In Thailand, health care is now provided for free and universal coverage – a more complete coverage than exists in many developed countries – has already been achieved. In Viet Nam, health care is now provided free to all children less than six years of age and for the poor. In Sri Lanka, free health services, both preventative and curative, have been extended to women.

Given the brevity of this report, many initiatives have unfortunately been omitted. It is hoped this study will serve as a starting point for the exchange of experiences between countries, on problems and solutions, successes and failures, and will contribute to a true levelling up of efforts and cooperation, where

each country in the region has access to the best ideas, policies and programme models available. Building on this foundation, national adaptation and adoption of locally suitable models through South-South cooperation will result in equal opportunities for all children in the region.

Section II of this paper reviews MDG disparities; section III analyses underlying causes; section IV presents national successes; section V reviews fiscal issues, and section VI provides a few summary conclusions and recommendations.

II. Disparities in MDG achievement

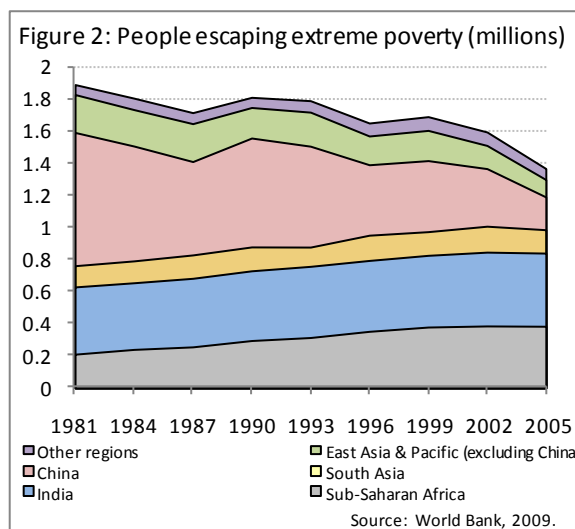
A. Poverty and hunger

MDG 1, Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than US\$1 a day

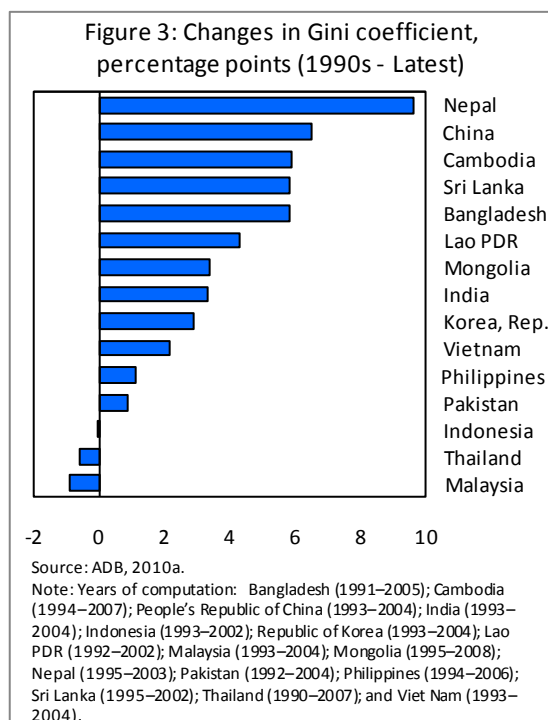
MDG 1, Target 3: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

CRC, Article 27: "States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development."

Globally, economic progress lifted over half a billion people out of extreme poverty over the last three decades. The relatively rapid growth of several countries in Asia and the Pacific more than proportionately contributed to this dramatic reduction of poverty. By far the largest contributor to this emergence from poverty was China where 627 million people crossed the \$1.25 a day threshold between 1981 and 2005 (see figure 2).



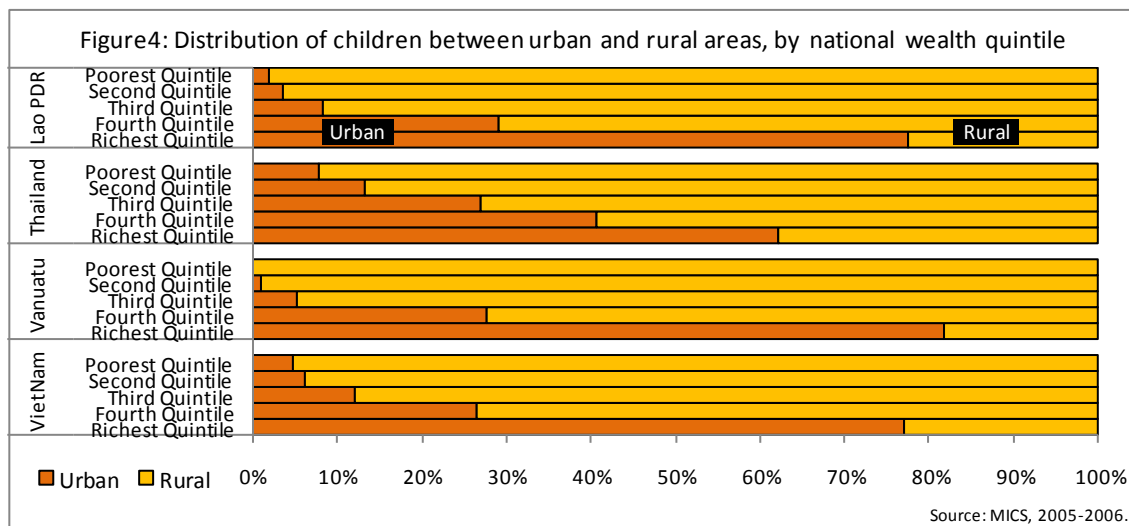
While there has been economic progress, and extreme poverty has dramatically decreased, economic inequalities have nevertheless been increasing. A widely used measure of economic inequality is the Gini co-efficient. Over the last two decades, the Gini co-efficient has decreased only in Indonesia, Thailand, and Malaysia (see figure 3). Increases in inequality of over ten percent took place in Nepal, China, Cambodia, Sri Lanka, and Bangladesh.



While the lives of the poor have improved, the lives of the rich have improved far more rapidly. Labour productivity in industry has risen much faster than labour productivity in agriculture. Since the outputs of one industry are often the inputs of another, it is efficient for industries to be located close to each other. Industrial development is therefore often clustered in urban areas. This geographic concentration of high economic productivity increases inequalities between rural and urban areas.

Governments concerned with the plight of the poor, and in some cases those anxious to avoid civil unrest, are preparing and implementing a range of targeted social protection policies and safety nets for those left behind by economic development. Relevant questions for targeted policies are: “Who and where are the poor? Is poverty largely “urban”, or largely “rural”? Extreme urban poverty is normally geographically closer to policy makers, and so more visible in that sense; rural poverty is less immediately visible. Comprehensive comparisons of urban and rural poverty that are based on numerical data are rare.

One benefit of the increasing use by Government Statistical Offices of Multiple Indicator Cluster Surveys (MICS) and Demographic and Health Surveys (DHS) is an increased availability of MDG relevant and internationally comparable national data, disaggregated by wealth quintile. Figure 4 shows the location of children in each national wealth quintile for four countries. In every case, few children in the poorest quintiles are living in urban areas. Almost all the children in the poorest quintile (top-most bar for each country) are living in rural areas (on the right of the figure). Even in the second poorest quintile, almost all children – over 90 per cent – are living in rural areas. Conversely, of the children in the fifth, or richest,



income quintile, only about 5 per cent are living in rural areas. For all four countries, almost all the rich children are living in urban areas and almost all the poor children are living in rural areas. This has policy and resource allocation implications.

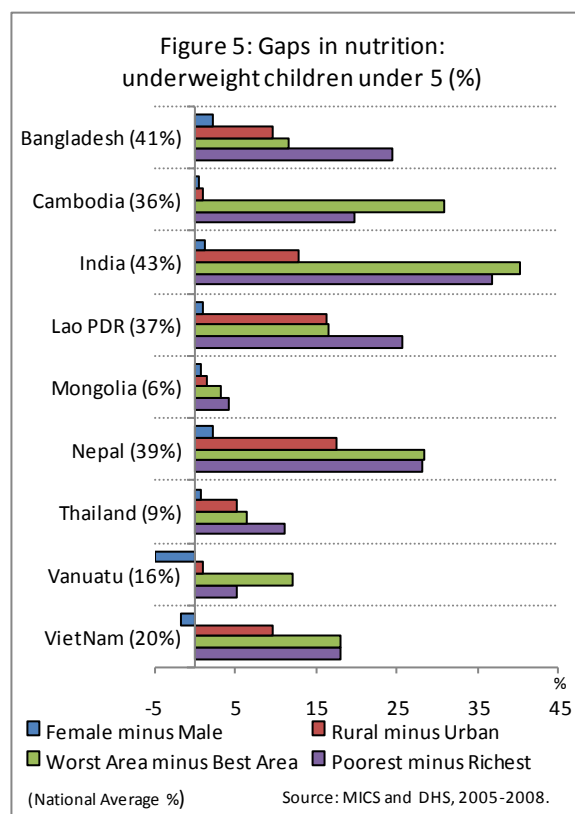
Poverty affects adults and children differently. In some countries, poverty drives families to require children to work for money, when they should be in school. Child labour is most visible on the streets in urban areas, where children sell consumer items to commuters. It is known to be invisibly prevalent in informal sector enterprises. It may also be more prevalent, though less visible, in the poorest rural households, where children work as agriculture labourers.

Many of the child-specific effects of poverty can be described in terms of MDG indicators such as those for child undernutrition, schooling, gender inequities, immunization status, mortality rates, birth attendance, knowledge of HIV and AIDS and access to improved sanitation.

Beginning with undernutrition (the MDG1 target on hunger), a systematic analysis on child-specific dimensions of poverty and associated disparities is presented through charts similar to figure 5. (For more detail on methodology see annex D.) In these figures, four types of disparities in MDG achievement are depicted: differences (henceforth referred to as 'gaps') between males and females (blue bars), between urban and rural residents (red bars),

between residents of different provinces or sub-regions within a country (green bars), and between people belonging to the richest and poorest national wealth quintiles (purple bars). The longer the bar is, the greater the disparity. This is done systematically for all MDGs, relying on select MDG indicators, ones that are most child-relevant and have the necessary disaggregation available.

In figure 5, the association between undernutrition (as measured by percentage of underweight children) and poverty is considerable. The largest disparities in undernutrition are between the rich and the poor (purple bars), although undernutrition can usually be found in all wealth quintiles. In several countries, the worst-off provinces experience high rates of undernutrition. Interestingly, gender differences in undernutrition (blue bars), while low compared to geographic and wealth disparities, go both ways. In Vanuatu and Viet Nam, undernutrition is more prevalent among boys, while in Bangladesh and Nepal, it is more prevalent among girls. This is an unexpected finding, given the cultural dominance of males in most societies in Asia and the Pacific. Geographic disparities in undernutrition, both urban-rural (red bars) and provincial (green bars) are substantial in some countries. In Cambodia, India and Nepal, provincial disparities (green bars) appear to be the starkest of all differences. These disparities indicate that geographic and poverty-based targeting of nutrition interventions could go a long way in achieving the goal on hunger and malnutrition.



Undernutrition is a complex problem. Although included with MDG1, reduction of poverty and hunger, rather than as a health goal, it is closely linked to health outcomes. Undernutrition not only increases a child's vulnerability to infectious diseases and associated mortality, but also undermines a child's physical and cognitive development, which in turn affects school performance and productivity during adulthood.

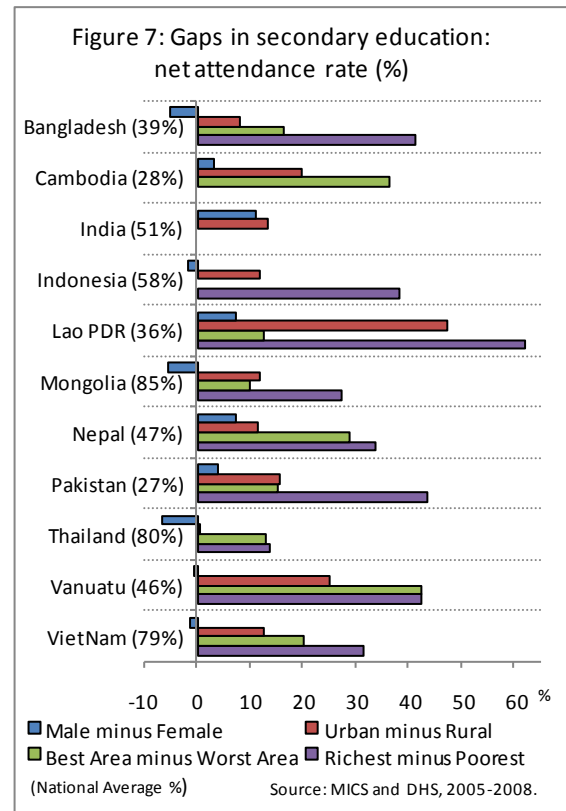
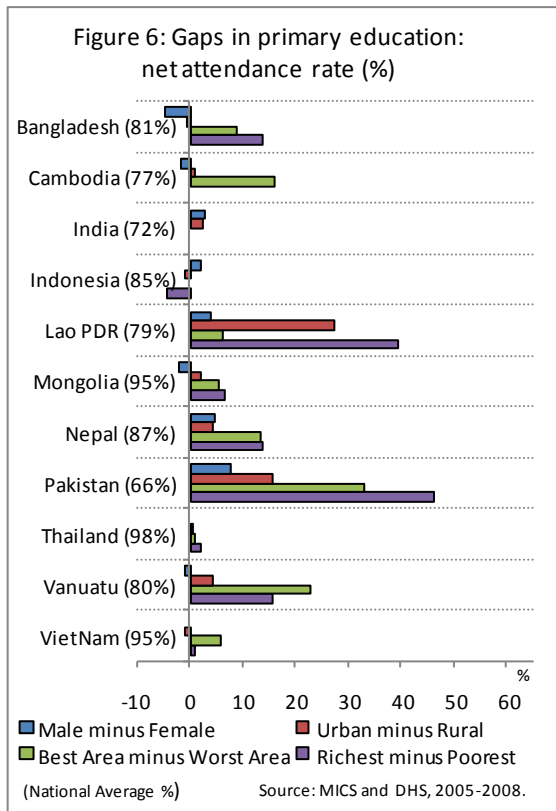
B. Education

MDG 2, Target 1: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

CRC, Article 28: "...States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular: (a) Make primary education compulsory and available free to all; (b) Encourage the development of different forms of secondary education..."

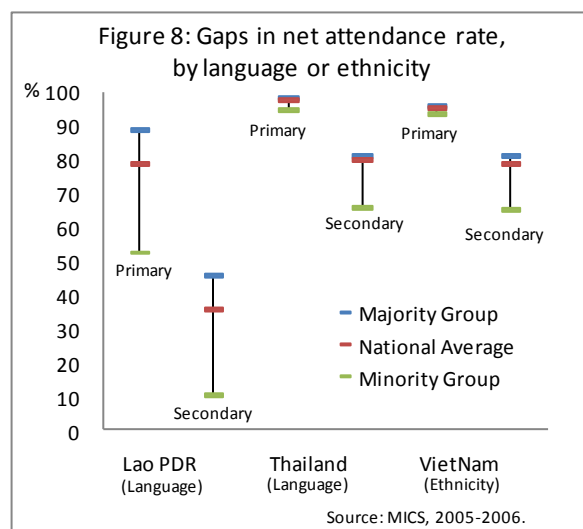
Widespread disparities in access to, and quality of, primary education may prevent many countries in the region from ensuring that all children complete a full course of primary schooling by 2015. Thirty three million children of primary school age are still out-of-school in South Asia; the number has actually increased in East Asia and the Pacific between 1999

and 2007 (UNESCO, 2010). As shown in figures 6 and 7, MICS and DHS data from the region reveal that whether children attend school is determined to a great extent by their wealth, location and gender (in order of decreasing magnitude). Children from the poorest national wealth quintile are generally much less likely to attend primary school than their counterparts in the richest quintile (green bars). Children in rural and remote areas are similarly disadvantaged (red bars). While considerable regional progress has been made in improving gender parity at the primary level, girls remain at a disadvantage in several countries (blue bars). In some other countries, less favourable outcomes are now emerging for boys. Figures 6 and 7 also show that, in all countries, patterns of disparities observed at the



primary school level are augmented in secondary school. Inequities in secondary education remain a major challenge for almost all countries.

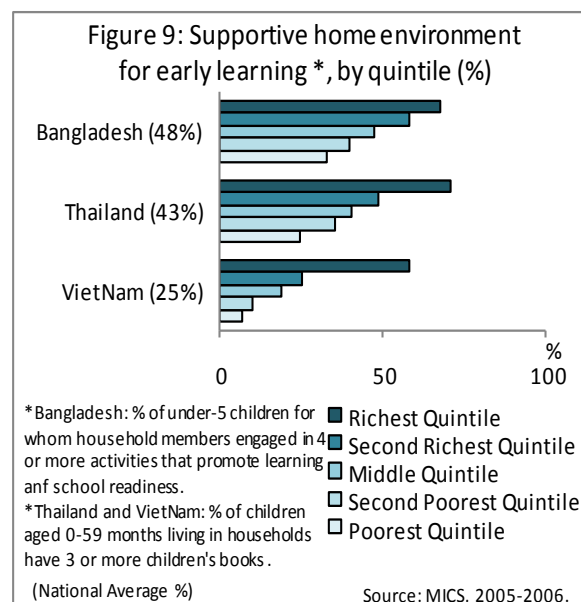
Marginalization in education due to caste, ethnic and language backgrounds is also occurring. An analysis of household survey data in Nepal finds marked disparities in primary school net attendance rate by caste, ethnic group and religion. The lowest attendance rate is observed among children from Muslim families, with only 32.1 per cent compared to the national average of 73.5 per cent (Nepal HS, 2001). In figure 8, marked differences in school attendance between majority (dominant) and minority groups are also visible in Lao PDR, at both primary and secondary levels. In Thailand and Viet Nam,



these differences are larger at the secondary level. This can be somewhat explained by the argument that even when children from minority groups, scheduled castes, or those with disabilities gain access to primary education, they face the risk of marginalization in learning achievement because their specific education needs are not met as a result of differences in culture, language or mobility. As a consequence, they are unable to complete the full course of primary education or to do so in a timely manner, let alone enrol in secondary school.

Along with disparities in access to education, disparities in the quality of education merit attention. National literacy and numeracy benchmarking tests conducted in several Pacific Island Countries point to low learning outcomes among primary school aged children, with indications that children from the most remote administrative areas perform least well. In other countries, rural-urban migration has outpaced government capacity to increase infrastructure. In Mongolia, following massive urbanization during the severe “dzud” (snow-storm), already overburdened schools in peri-urban areas are now running three shifts, with more than 40 students in each class. Quality is inevitably sacrificed.

Disadvantage in school performance starts well before the child enters first grade. Children who have attended quality early childhood care and education (ECCE) before entering grade one have a tremendous advantage in later school performance, future wage earning, social mobility and healthy habits (i.e., not smoking) than children without early learning experience (UNESCO, 2008a). In figure 9, young children in the poorest quintiles are less likely to have access to children’s books or engage in stimulating play than children in the richest homes. In Viet Nam, the wealthiest children are six times more likely to have at least three children’s books at home. In Bangladesh, wealthiest children are twice as likely to engage in activities at home that promote learning and school readiness.



Large gaps exist across Asia and the Pacific in access to organized early learning opportunities before entering first grade. In Indonesia, five year olds in western provinces and urban areas are six times as likely to attend ECCE prior to entering grade one as children in poorer eastern provinces (UNESCO, 2008b). In Nepal, children from the Dalit excluded castes are three times less likely to attend ECCE than children from other castes (UNESCO Nepal, 2007).

Nutrition plays an important role in education attainment. Iodine deficiency disorders (IDD) are the single most common cause of preventable mental disability and brain damage. Even a mild iodine deficiency in the general population can result in significant loss of learning ability and a severe decline in individual intelligence. Consequences of iodine deficiency include poor school performance, reduced intellectual ability, impaired work capacity and lower productivity in adults. Several governments have adopted legislation relating to universal salt iodization (USI) and have implemented enforcement mechanisms to

protect against iodine deficiency and its disastrous consequences. With only 73 per cent salt iodization coverage achieved in Asia and the Pacific, efforts are still needed to eliminate iodine deficiency disorders.

C. Gender equality

MDG Goal 3, Target 1: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

CRC, Article 2: "States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status."

Figure 10 shows that gender differences in secondary education are very different between countries. In Bangladesh, Mongolia, Thailand and Viet Nam, girls attend more than boys. In Lao PDR and Nepal, boys attend secondary school more than girls. Gender biases often differ between urban and rural areas. In India, there is little difference in secondary attendance between boys and girls in urban areas, but in rural areas, the differences are large: girls attend much less. Pakistan is different: in urban areas, girls attend secondary school more than boys, while in rural areas, boys attend more than girls.

These differences may reflect cultural differences between urban and rural areas, and may also be inter-twined with differences in wealth. Again in Pakistan, girls in the richest quintile attend more often than boys. In the poorest quintile, they attend less often. This pattern is also found in Vanuatu and Viet Nam. In Bangladesh, Indonesia and Mongolia, this pattern is reversed. In these countries, girls in the richest quintile attend secondary school less than boys, while girls in the poorest quintile attend more than boys.

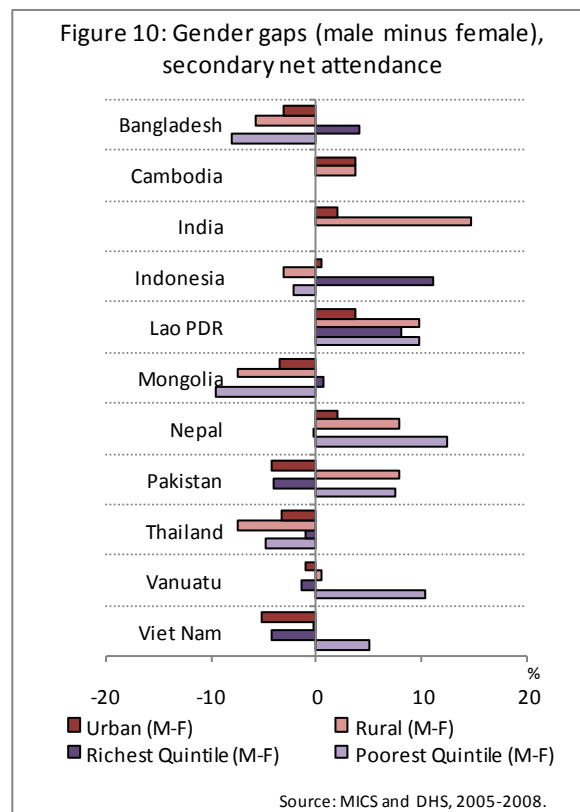
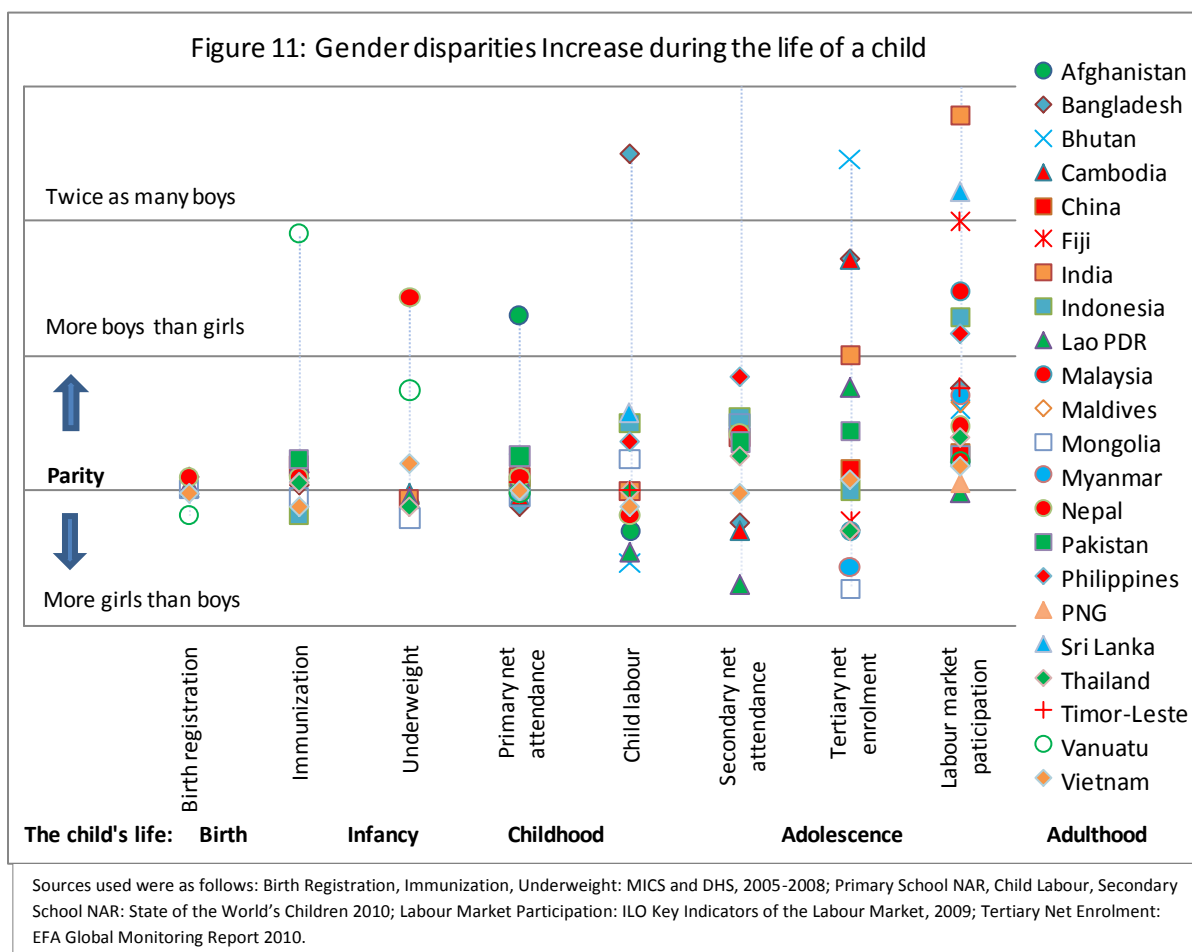


Figure 11 shows gender disparities using a life-cycle approach, infancy on the left, adulthood on the right. Each column shows one type of gender disparity that applies at a specific stage in the life of a child. The points in the columns each show the amount of disparity in one country. At early ages, gender disparities are relatively minor in most countries. Both disparities, and differences between countries, increase with age.

Starting with the birth of a child, the close clustering of points for birth registration on the "Parity" line shows small gender differences for all countries. There are slightly greater disparities for immunization. The spread is wider for undernutrition, primary school net attendance, and child labour. More points are further from, and above, the parity line, indicating greater variation between countries as well as increased discrimination against

girls. Child labour involves mostly boys in some countries; in others it involves mostly girls. Secondary and tertiary education data reflect even larger differences between countries, as well as greater gender disparities. Overwhelmingly, the labour markets are dominated by men. But there are exceptions: China, Lao PDR, Mongolia, Papua New Guinea, and Viet Nam show relatively equal levels of labour force participation rates for men and women.



Information is less widely available on wage rates and types of labour employment. Though not shown in the figure, the ratio of men to women with parliamentary seats is also telling. In Afghanistan, the country with the lowest difference between women's and men's share of parliamentary seats, there were 2.85 men per woman, compared to 99 men per woman for the country with the greatest gender inequality in seats (UNDP, 2009). This is the result of a political reservation policy aimed to overcome gender disparities in areas of Afghan life.

Gender disparities for each individual MDG indicator are typically smaller than disparities framed by household poverty or subnational geographic area of residence. The same may be true, or more so, for other frames of disparities, such as disparities between the rich and the poor, whose representation in national parliaments is likely also skewed. (No comparable data for quantification of wealth of parliamentarians was possible.) Gender-based quota systems can be equally distorting, as they are biased towards richer, well connected women and often have less to do with educational status.

Progress in reduction of gender disparities in secondary and tertiary education is recent in some countries. The frequently extreme exclusion of women in labour markets and political representation may be the result of a history of gender disparities, as well as culturally and institutionally entrenched attitudes and behaviours. According to a 2008 study conducted

by the United Nations Girls Education Initiative for East Asia and the Pacific, the gender dimensions of school to work transition are salient, with inequitable opportunities in employment outcomes for males and females due to traditional discriminatory practices and cultural stereotypes (UNGEI, 2008). If discrimination is overcome, by legislative, political or through behaviour change, there may be an increased presence of women in the labour force, and in parliaments, over the next years.

D. Child mortality and maternal health

MDG Goal 4, Target 1: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

MDG Goal 5, Target 1: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

CRC, Article 24: "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services..."

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

Countries in Asia and the Pacific have made progress towards the achievement of the MDG goals on health (MDGs 4 and 5). But large disparities in child and maternal health indicators continue to persist between and within countries.

Assistance by skilled health personnel during delivery is essential for the health and safety of both the mother and the child. Figure 12 shows that disparities in access to health service start with the very birth of a child. For the countries with internationally comparable subnational data on the percentage of births attended by skilled personnel, disparities in assistance during delivery between population subgroups range from 15 per cent to 80 per cent. Urban-rural differences are significant but are in all cases, except Bangladesh, Lao PDR, Nepal and Pakistan, less than differences between provinces or sub-regions within countries. Low population density in some provinces probably contributes to their being underserved by health facilities. In low population density areas, either the mothers or the birth attendants may have a long way to travel in the narrow window of opportunity between the onset of labour and actual delivery.

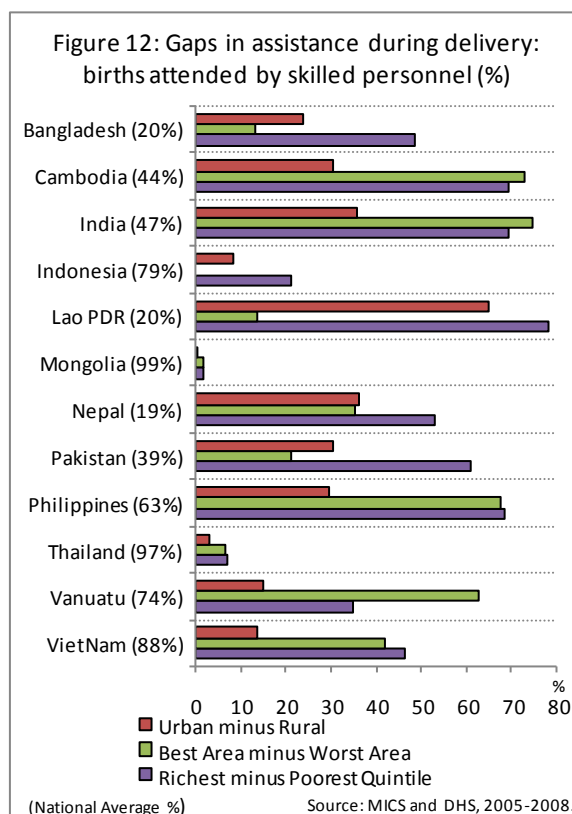


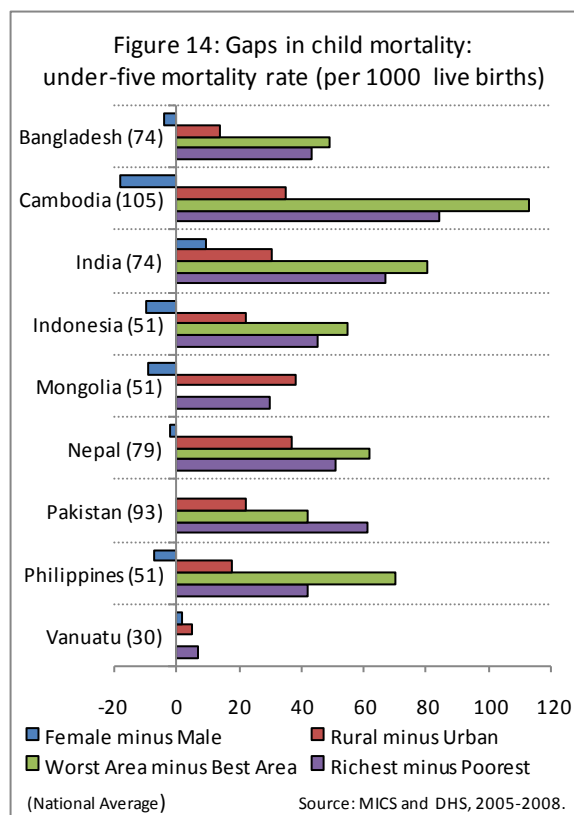
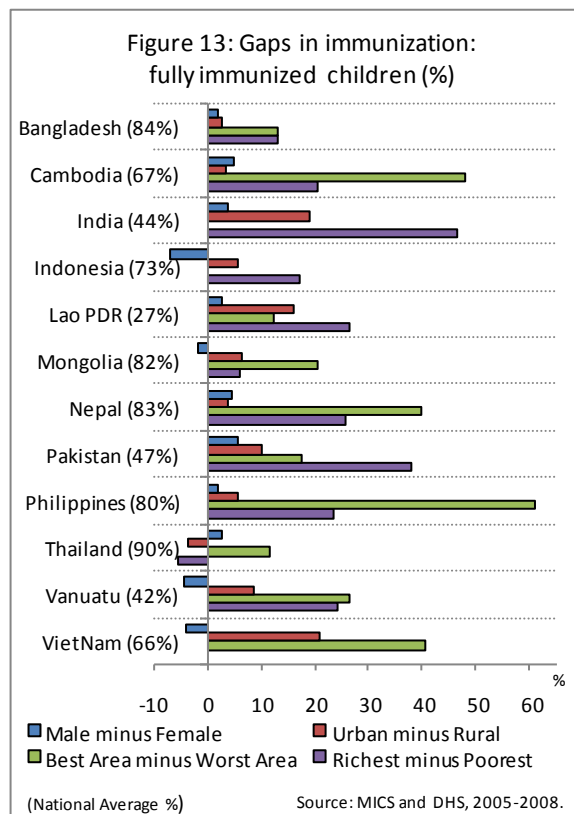
Figure 12 also reveals that poverty is an important determinant of coverage by skilled birth attendants. In some cases, poor provincial performance may simply be due to provincial poverty and resultant weak infrastructure, including lack of skilled staff, equipment and supplies. But household wealth is also a strong determinant of assistance during delivery. In

most countries, disparities between the richest and poorest quintiles are as large, or larger, than any other factor. This may largely be a reflection of differences in household abilities to pay user fees to skilled personnel for assistance during delivery. If every child is to be given an equal start to life, reducing these disparities is an urgent priority.

After birth, in the first year of a child's life, mortality can be significantly reduced by a series of vaccinations. Although the official MDG indicator is immunization against measles, this paper examines disparities in full immunization with all basic vaccinations. Figure 13 shows disparities in percentages of fully immunized children. Disparities by geographic location and wealth are far greater than gender disparities. Immunization coverage is almost equal for boys and girls. In some countries, boys appear to be slightly less likely to be immunized than girls. In semi-nomadic pastoral communities this can happen if boys are travelling with the herds and not available for immunization. It is unclear whether this is the cause of gender differences found in Asia and the Pacific.

More glaring differences exist by geography and wealth. In Cambodia, Mongolia, Nepal and the Philippines, differences by province or sub-region are greater than differences by wealth. In Lao PDR and Pakistan, wealth based disparities predominate. In Bangladesh and Vanuatu, disparities by wealth are comparable to disparities by province. The wealthy generally make better use of health services, are willing to pay user fees where applicable, and tend to ensure that their children are immunized. The children of the poor, and those living in provinces with less developed health infrastructure, or lower population density, are too often not fully immunized.

Mortality rates of children under five years of age (U5MR) are often considered a useful summary indicator of the level of development of a country and its health services. It is undeniable that Asia and the Pacific has made tremendous progress in reducing U5MR, just as it is undeniable that economic progress has generally been



impressive. But just as economic progress has been uneven, improvements in U5MR have also been uneven. Figure 14 shows that, as with the other health indicators examined, large disparities exist by wealth and geographic location.

It is also interesting to note that, where comparable data is available for both indicators, disparity trends in child mortality tend to mirror disparity trends in immunization. As with immunization, differences by province or sub-region are again larger than differences by wealth in Cambodia, Nepal and the Philippines. And as with immunization again, differences by wealth predominate in Pakistan.

Disparities in preventive measures against U5MR such as immunization are also likely to be mirrored in curative measures. While effective curative tools against pneumonia and diarrhoea (diseases that together account for more than 30 per cent of U5MR) exist, the major problem is delivering simple life saving interventions to those most vulnerable and at highest risk because they are also the hardest to reach, often as a result of a combination of geography, social exclusion, cultural beliefs, economic status and education in addition to health systems inadequacies. The application of specific programmatic strategies is required to address the gaps in service delivery and utilization to ensure universal coverage in an equitable way.

E. HIV and AIDS

MDG Goal 6, Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Committee on the Rights of the Child – General Comment No. 3, Article 25: “States parties are requested to ensure implementation of the strategies recommended by the United Nations agencies to prevent HIV infection in infants and young children. These include: (a) the primary prevention of HIV infection among parents-to-be; (b) the prevention of unintended pregnancies in HIV-infected women, (c) the prevention of HIV transmission from HIV-infected women to their infants; and (d) the provision of care, treatment and support to HIV-infected women, their infants and families.”

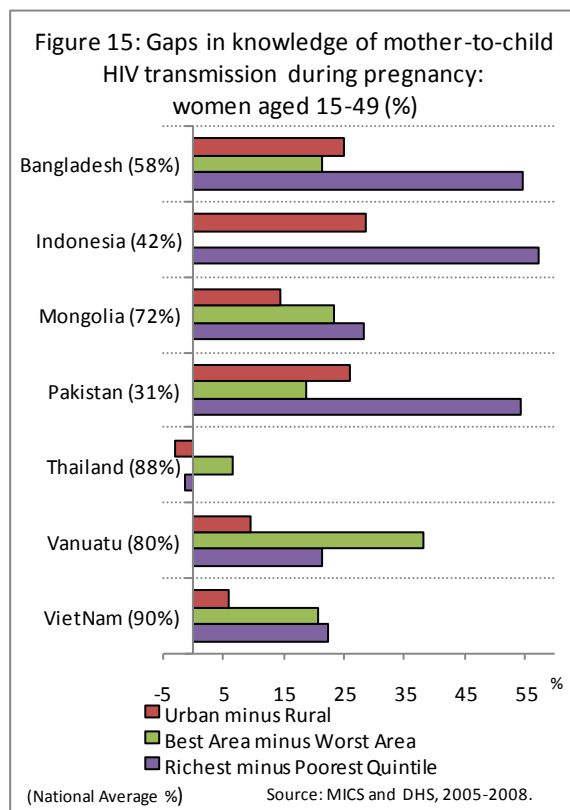
Prevention of mother-to-child transmission (PMTCT) of HIV is key to halting and reversing the spread of HIV and AIDS in children. Of the estimated 430,000 children who were newly infected with HIV in 2008, globally, over 90 per cent of them were infected through mother-to-child transmission (WHO, 2010). While disaggregated data (by subnational location and wealth) on access to PMTCT services is not widely available, the knowledge of mother-to-child transmission among women is a useful proxy indicator.

As shown in figure 15, significant gaps exist in knowledge of mother-to-child transmission during pregnancy by wealth and location of women. While women in urban areas are more likely to know about mother-to-child transmission during pregnancy than their rural counterparts in almost all countries, this urban-rural gap in knowledge is generally less severe than the differences between women from different provinces and from different wealth quintiles.

In Cambodia and Vanuatu, the province in which a woman resides is a more significant determinant of knowledge on mother-to-child transmission than wealth. In Bangladesh and Pakistan, wealth-based differences in knowledge are far greater. These disparities in knowledge of mother-to-child transmission of HIV can be expected to contribute to similar disparities in the number of infected newborns, since lack of knowledge precludes

prevention in most cases. When knowledge does exist, factors such as user fees, distance between ante-natal care facilities and HIV test sites, long waiting times for results, and transportation costs to delivery sites can lead to pregnant women, especially those from the poorest quintiles and those residing in rural and remote areas, dropping out of PMCT services.

Although not captured by the indicator discussed above, children in the region are also severely affected by a growing feminization of AIDS: the proportion of women to men living with HIV in the region rose from 19 per cent in 2000 to 35 per cent in 2008 (UNAIDS, 2009). HIV prevalence in the region tends to be concentrated among marginalized and hard-to-reach groups (sex workers, men who have sex with men, intravenous drug users, and their partners), with significant implications for equity.



F. Water and sanitation

MDG Goal 7, Target 3: Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation

CRC, Article 24: "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."

(c) To combat disease and malnutrition... through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution...

The Asia-Pacific region as a whole is on-track for meeting targets for drinking water, but intraregional differences remain. In East Asia and the Pacific, for example, almost all urban households have access to improved water, compared with about a third of rural households. In South Asia, access to improved water has declined in urban areas and improved only slightly in rural areas. Progress towards achieving sanitation targets has been less. The Asia-Pacific region as a whole is off-track, with only 36 per cent of households in South Asia and just over half of those in East Asia and the Pacific using improved sanitation sources (WHO/UNICEF, 2010).

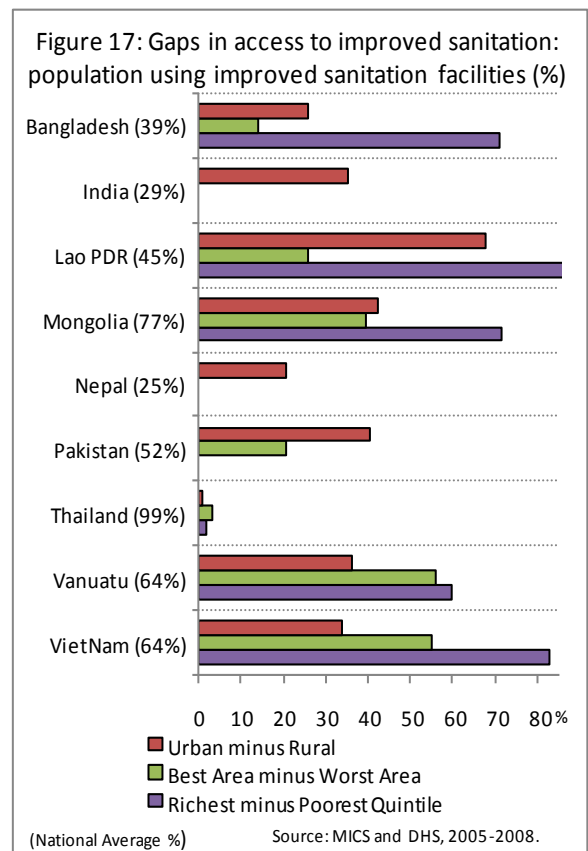
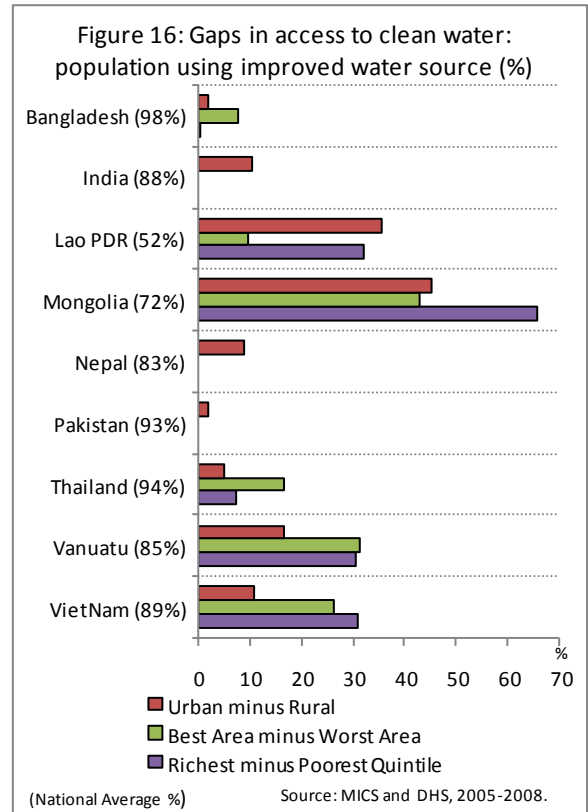
There are striking wealth-based and area-based disparities in access to safe water and improved sanitation sources. Figure 16 shows disparities in access to improved water sources

Unlike those for health and education, data for access to water do not show clear regional differences as to the significance of one form of disparity over another. Wealth (the blue bars) is an important factor in Mongolia. There is a 70 per cent gap in access between the

rich and poor. In comparison, in Bangladesh wealth is hardly significant as a basis for disparities, and provincial differences (the green bars) are far greater. In Bangladesh, Thailand and Vanuatu, disparities in access to improved water between the best and worst performing provinces are twice as large as disparities between urban and rural areas (the red bars). Location is the most important determinant for access to improved water sources in all countries except Mongolia and Viet Nam. The importance of location may be because laying water pipes and developing treatment plants is time and resource intensive. Progress has tended to be concentrated in municipal areas where there are greater economies of scale.

Patterns of disparities are clearer for access to improved sanitation. Figure 17 shows disparities in access to improved sanitation sources. For all countries, wealth is the largest determinant. For Viet Nam and Lao PDR, the difference between the rich and poor is more than 85 per cent. In Bangladesh and Mongolia, there is a 70 per cent gap between the rich and poor and access to improved sanitation sources, far greater than the 30 per cent gap between urban and rural areas in Bangladesh, and the 40 per cent gap in Mongolia.

Whether a person lives in urban or rural areas seems a stronger determinant than province-based disparities for all countries except Vanuatu and Viet Nam where disparities between provinces are almost twice as great as disparities between urban and rural areas. In Nepal, there is a 25 per cent gap in access between people living in urban and rural areas. Disparities are substantially larger in Lao PDR, where people living in urban areas are almost seven times more likely to have access to improved sanitation than those in rural areas. The great majority of people practising open defecation live in rural areas, though the prevalence of open defecation is growing in some urban areas as a result of rapid urban population growth (WHO/UNICEF, 2010).



Differences also exist in access to water and sanitation facilities at school, the presence of which have been shown to significantly contribute to improved health, nutrition and learning performance of children. According to the WHO/UNICEF *Joint Monitoring Programme 2010 Assessment*, barely half of the primary schools in Bangladesh, Nepal and Pakistan have an adequate water supply.

Roughly two-thirds of schools in Afghanistan, Bangladesh, India and Nepal lack adequate sanitation facilities for girls. In countries such as the Philippines, there is significant area based variation in coverage, from as low as 50 per cent in the Mindanao region to almost 100 per cent in Metro Manila (UNESCO, 2008c). It is difficult to extrapolate trends in disparities due to a lack of available data, but it seems gender, religion, culture and location (based on the preceding analysis) may contribute to gaps, particularly in access to sanitation facilities in schools.

Even if the MDG targets for water and sanitation are achieved, millions of children will still suffer from diarrhoeal diseases and intestinal worms because of unsafe water, inadequate sanitation and poor hygiene. Illness and disease impacts a child's ability to attend school and to learn. In Asia and the Pacific, there were about 330,000 deaths due to diarrhoea in 2008. Diarrhoea caused 11 per cent of all deaths among children younger than 5 years (Black et al., 2010). The majority of the disease and mortality burden, and the associated social and economic costs, will continue to be borne disproportionately by the poorest and most disadvantaged households.

Partial coverage of sanitation is not sufficient. Evidence imparts that for maximum health benefits, all households in a community should use hygienic toilets. A massive scaling up of technology and human and financial resources is needed to extend the MDG achievement to those left out in the region.

Overview of MDG Disparities (based on Figure 18)

Figure 18 summarizes information presented for each MDG. For each MDG indicator, three or four different types of disparities are presented. Usually these are male minus female gender disparities, urban minus rural differences, best minus worst province differences, and richest minus poorest. The further the dot for each country is from equality (the 0 per cent difference line), the worse the disparity. 100 per cent is the maximum possible disparity. In such a case, all of those in the best group would have achieved the goal, and none in the worst group.

For "negative goals" where more is undesirable, such as underweight and U5MR, the order is reversed and the values presented are female minus male, rural minus urban, and poorest minus richest. This reversal makes the chart consistent: disparities always increase in the same direction. If disparities take an unconventional form, for example girls doing better in primary school attendance than boys in Bangladesh (the blue diamond in the figure), then data points appear on the negative side of the equality (0 per cent) line.

Data for MDGs 1 and 2 show disparities that are fairly consistent across the remaining MDG indicators. Gender inequalities are present, but they are less than urban-rural differences. The greatest disparities are between geographic areas, represented as "best area minus worst area", and between the rich and the poor.

MDG 3, gender parity, has a slightly unique presentation. It is the only goal that has minimizing differences as its objective. Interestingly, the data for net attendance in secondary school shows that gender disparities at national level, in rural areas, and for the poorest wealth quintile, do not always favour boys. Almost as often, they favour girls.

The two indicators shown for MDG 4, immunization coverage and mortality of children under 5 years, follow the pattern of MDGs 1 and 2. Gender and urban-rural disparities are present, but geographic and wealth based disparities are greater.

The indicator for MDG 5, attendance of birth by skilled personnel, shows perhaps the highest disparities in the figure, and does so for every type of disparity presented: urban rural differences, geographic differences, and wealth based differences. Similarly large disparities are present for MDGs 6 and 7.

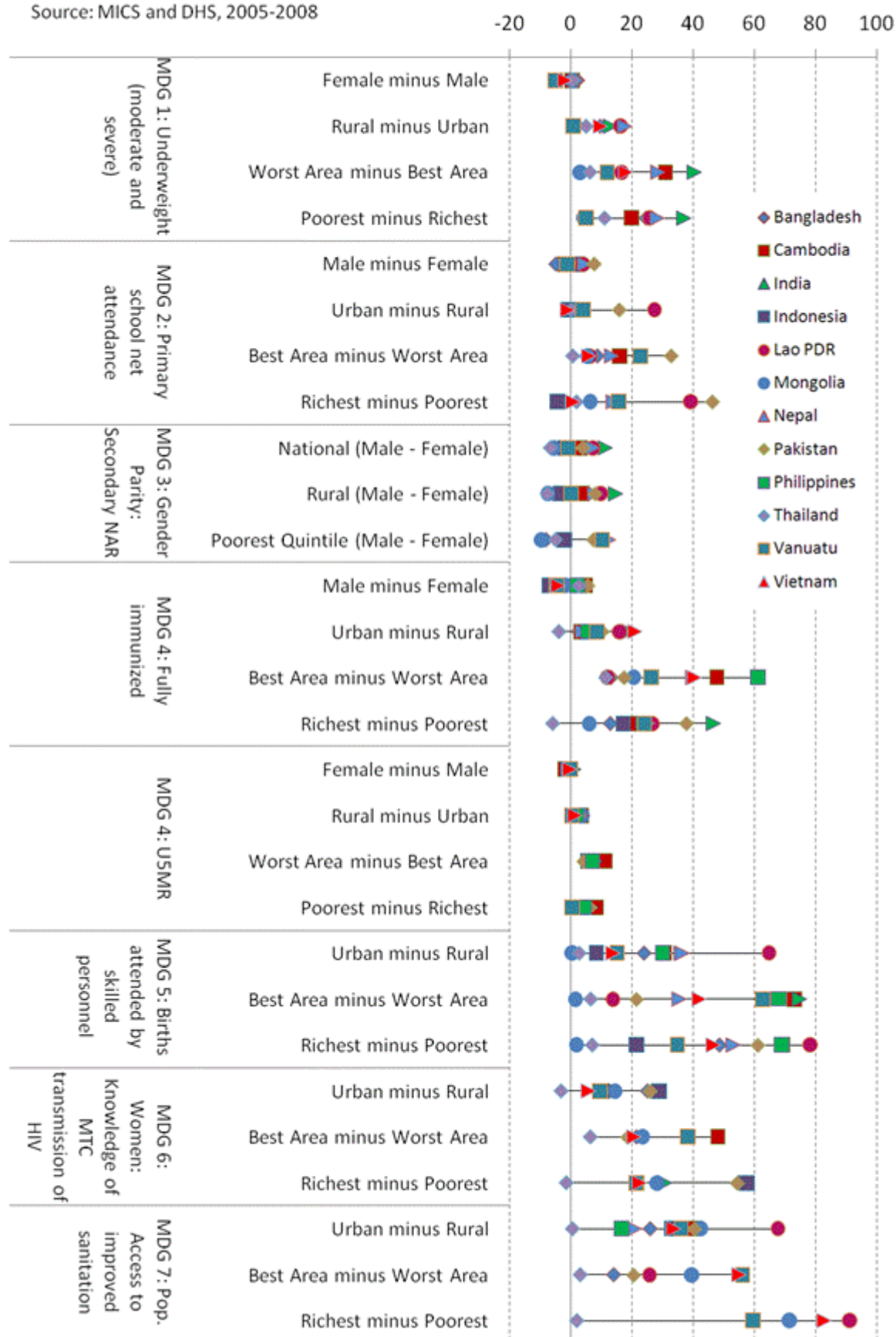
One of the most interesting features of this chart is that, for almost every indicator presented, and for almost every type of disparity measured, there is always at least one country, sometimes more than one, that has no disparity. The evidence is clear. Elimination of disparities is not impossible, depending on circumstances.

To understand better how disparities can be eliminated, it is necessary to examine underlying factors and the ways in which exclusion takes place. There are many forms of exclusion and there may be interaction between them, with the result that some groups of children may suffer from several forms of exclusion at the same time.

For policy makers, it is useful to have these underlying sources of disparities separated out from each other, as different types of exclusionary processes may well require different types of remedial governmental action. As examples, economic exclusion may require anti-poverty programmes and education, while institutional refusal of access to schools to children whose parents are migrants from rural to urban areas may require a legislative solution. Four main sources of exclusion are briefly reviewed, while recognizing that causes and solutions are both complex and highly contextual to individual countries.

Figure 18 : Largest minus smallest : Percentage gaps in MDG achievement

Source: MICS and DHS, 2005-2008



III. Underlying causes of disparity

A. Causes of gender disparities

CRC, Article 2: “No child should suffer discrimination ... irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national ethnic or social origin, property, disability, birth or other status.”

The analysis of select MDG indicators in the preceding section shows that gender differences are persistent and generally, but not always, in favour of boys or men. Gender disparities seem to be smaller than other forms of disparities early in life (birth registration, immunization, undernutrition) but seem to increase over the life cycle (secondary education, labour force participation, representation in parliament). The cross-section snapshots (of a point in time) presented may not represent the future life experiences of the current cohort of female children because societies are changing. Labour force participation and political representation of women do seem to be increasing.

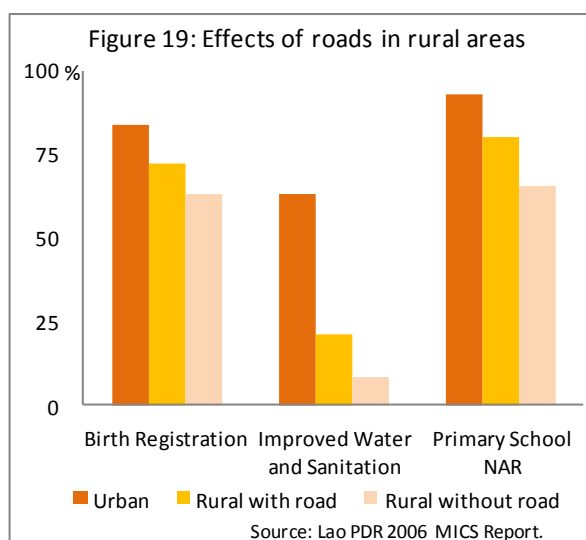
Gender-based disparities, particularly when girls or women are worse off compared to boys or men, stem from deeply entrenched cultural, behavioural, and attitudinal norms which often result in the institutionalization of discriminatory practices against females. Although most countries have some form of policy framework on gender equality in place, as part of commitments to the Beijing Platform of Action (1995), putting these policies into practice is often a challenge. Preference for a male child, patriarchal values, and socialization into gender roles give rise to a situation wherein girls and women receive fewer entitlements than their male counterparts, which is then perpetuated by their lack of political voice and economic empowerment.

B. Causes of urban-rural disparities

MDG disparities were analysed in terms of urban-rural and inter-provincial disparities. Both are geographical dimensions of disparities, and while their dynamics often overlap, there are also some important differences.

One key economic dynamic is the geographic concentration of manufacturing industries. Labour productivity in manufacturing has risen much faster than productivity in agriculture. This, together with industrial clustering in urban locations, has led to massive differences in wealth between urban and rural areas.

Another visible difference between urban and rural areas is population density. In principle, it is far easier, and cheaper, to provide social sector services to areas of high population density than those with low population density. Roads and other infrastructure tend to be concentrated in high density areas, facilitating the movement and growth of more urban populations. Figure 19 illustrates



the impact of roads on access to key basic services in Lao PDR. For all indicators presented, rural areas without roads have less access than areas with roads.

With lesser travel times reducing opportunity costs of attending a school or clinic, a larger catchment area in terms of numbers of people can be served, opening up the attractive prospect of economies of scale. Positioned at the hub of infrastructural and transportation networks, urban areas are the obvious sites for tertiary level facilities such as hospitals and universities. Yet each tertiary facility located in an urban area reinforces existing disparities between service provision there and in rural areas. Private sector services for the poor are also more common in urban areas. It is not surprising, then, that urban-rural disparities are so systematically visible in all the MDG indicators analysed.

Disparities based on wealth and service provision are the underlying factors that draw rural people to urban areas in ever increasing numbers. Children of migrants to urban areas often face special, usually unnecessary, difficulties. In some countries, national or municipal legislation denies the right of every child to education and health care by restricting access to those whose birth, or residence, is registered in that urban area. Usually, proof of birth registration is essential to eventually obtain formal urban residency. Natural and human-made disasters can also accentuate disparities experienced as a result of geographical isolation – as has been experienced recently in Mongolia, Myanmar, and Pakistan.

C. Causes of geographic disparities

Geographic area disparities presented in the analysis compare best and worst areas, based on the State, Region, or Province, as available. Differences between subnational areas have some of the characteristics of urban-rural differences, such as varied population densities, with similar implications for provision of social services. The tax and revenue base for local government may also differ greatly between provinces – accentuating the lack of services faced by the poor in remote administrative areas.

Differences between provinces are linked to differences in wealth arising from differing natural resource endowments (quality of agricultural land, minerals, communications linkages, including location, and rivers), as well as historical investment by central government. To complicate matters, geographic areas may have specific local cultures and religions, and are sometimes heavily populated by a single ethnic group, thus intertwining – and making it difficult to distinguish between – disparities rooted in identity and geography. Unique geographic disparities apply to small and remote island states, including differences between coastal areas and the interiors, as well as between locally specific cultures and livelihoods.

D. Wealth-based causes of disparities

For most MDG indicators examined in this paper, and in all countries included in the analysis, disparities between people from the richest and poorest quintiles are stark and more severe than disparities by gender and location. Differences in household wealth affect ability to afford school fees and associated costs of transport, uniforms, textbooks, and exams, as well as fees or co-payments for health care.

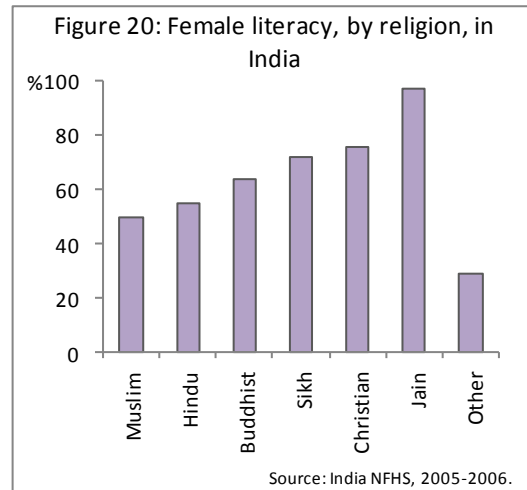
Poor households also face higher opportunity costs of school attendance, if they consider the alternative of putting children to work, and hence often have higher rates of child participation in the labour force. Economic shocks, such as the Asian Financial Crisis,

typically affect the poor more than the rich. Less educated, less well nourished, and with poorer health, the children of the poor face the daily reality of the vicious cycle of poverty know as the 'poverty trap'.

E. Other important sources of inequity in MDG achievement

While MICS and DHS can quantify inequities in MDG achievement due to gender, location, and wealth, these household surveys do not reveal sources of inequity that escape measurement due to their complex nature, where researchers either choose not to ask questions, opt not to disclose information, or are unable to quantify relevant data. (See annex E on challenges in gathering data and evidence.) The following section provides examples of these additional sources of inequity.

Identity, as represented by gender, ethnicity, caste, religion (see figure 20), political beliefs, disability and, more recently, HIV/AIDS status, is an important determinant of whether a person has access to basic services. Considerations of privacy and sensitivity have often resulted in exclusion of questions on identity and other difficult topics from household surveys with corresponding limitations on the availability of internationally comparable data on identity-based discrimination.



Migration, both rural-urban and cross-border, is widespread across the region and can often make children more vulnerable to exclusion from MDG achievement, especially in the case of irregular or undocumented migration. Without legal status and proper identification documents, children of migrants are unable to access schooling and public health services in destination cities (Bryant, 2005). Independent child migrants often migrate into exploitative situations, where their rights to health, education and protection are further compromised.

Caste based disparities in Nepal

Nepal is home to around 100 distinct social groups, differentiated by caste, ethnicity, religion, and language. Groups that rank lower in the hierarchical caste system along with ethnic and religious minorities face significant social exclusion and a correspondingly lower socio-economic position. Disparities exist in human development outcomes across every MDG. Dalits, Janajatis, and Muslims have a much lower level of wellbeing than the high-caste Brahmins and Chhetris or ethnic Newaris (BCNs). For example, Dalits are more than three times more likely to have no formal education than the BCN group. Around half of Dalit and Muslim children under 5 are underweight, which is 5 times the figure for Newar children. Likewise, Dalits, Janajatis, and Muslim families are about twice as likely to lose their child before age 5 than Newar or Brahmin families. The same is true for infant mortality but the variance is smaller, which implies that poor early childhood conditions adversely affect socially excluded communities to a greater degree than more well off communities. There is a negative correlation between under-5 mortality and income.

Poverty drives these disparities; the income gap in Nepal is very wide with Newaris earning a per capita income three times that of Hill Dalits. UNDP recently calculated a Human Development Index (HDI) for Nepal, disaggregated by caste, ethnicity, and religion. It found that caste is a more significant driver of disparity than geography. The widest gap occurs in the Tarai/Madhes region where Brahmin and Chhetris have an HDI of 0.625 and Dalits have the lowest national HDI (0.383). Social, economic, and political power asymmetries along caste, ethnic, and religious lines drive social exclusion in Nepal. These require considered policy attention. (From Bennett et al, 2008 and UNDP Nepal, 2009).

HIV and AIDS contribute to disparities in access to health and education. Pervasive stigma and discrimination in the health and education systems may limit access to essential services (UNDP, 2007). In the health sector, people living with HIV are commonly denied treatment or subjected to delays in receiving treatment. These acts of discrimination are most often attributable to discrimination by individual service providers rather than legislation or institutional policy. In the education sector, children living with HIV and AIDS, and those who have family members living with HIV and AIDS, are sometimes denied admission to schools. Children may also withdraw from school due to shaming by teachers and ostracism by peers. Family circumstances brought about by HIV and AIDS, such as increased financial burdens, caretaking responsibilities, and orphan-hood, are also highly likely to limit access to education and health services.

Children subjected to **violence and abuse** face special difficulties in growth and development which can result in them being left behind in terms of MDG achievement. Violence and abuse have lifelong consequences in the form of poorer physical and psychological health, lower levels of academic achievement, inability to form stable relationships and attachments, higher levels of drug abuse, early parenting and chronic disease (WHO, 2004). Although not directly visible as disparities in MDG achievement, these consequences translate into substantial inequities borne by children subjected to violence and abuse (as compared to their non-abused peers).

Exclusion due to **physical and mental disabilities** routinely occurs in the education sector. Schools, especially in resource-constrained settings, are often not equipped to cater to special needs of children with disabilities. Stigma and poor social treatment also result in the withdrawal of these children from education and non presentation to health systems.

In some countries, **armed conflict and natural disasters** have resulted in exclusion of children from MDG achievement. Children recruited as soldiers are denied education and often unable to access essential health services. Displacement and separation from families due to conflict or natural disasters can also cause similar deprivations. The destruction of physical infrastructure and further strains on already resource-poor health and education systems enhances the marginalization of children in affected areas (SOWC, 2006). (See annex F for additional information on natural disasters.)

The **registration** of all children at, or soon after birth, is the best way to ensure that they have a name, a nationality and are legally recognized by the state. For unregistered children, the consequences later in life can be serious. Lack of birth registration may prevent a child from receiving health care, immunization and other forms of social assistance. Undocumented children are often prohibited from enrolling in school. (Legislation restricting access of children to schools and health centres is in violation of the CRC as well as many national constitutions.) Birth registration is often the best evidence of age and identity, which is often the basis for other types of protection: against early marriage, recruitment into the armed forces or employment in hazardous occupations. It may prevent a minor, if accused of a crime, from being prosecuted as an adult. Unregistered migrants, both internal and international, whether seeking employment opportunities or asylum in areas away from home, are likely to face many hurdles – in finding employment, establishing a fixed place of residence, enrolling their children in school and accessing social services. They may have to suffer long periods of separation from their families.

Legislative failure

Disparities arising from discriminatory legislative procedures can accentuate social and economic disparities, while exclusion from education can result in perpetuation of poverty. These may in turn contribute to discriminatory perceptions of some ethnic groups. Failure of the state to provide adequate legal documentation of birth and nationality, by affecting access to education, may increase disparities and cause economic, social and cultural damage to children.

Anti-discrimination laws, employment policies, social measures for target groups, employment rights and equality measures for women and minorities help to fight social exclusion by defining common rules and principles for national and subnational authorities, institutions and courts to follow. Yet, they can also create disparities. Examples of “equal treatment before the law” of minority ethnic groups may fail to ensure translation of proceedings into an appropriate language. This can result in disparities. Special consideration is needed for some problems women face, including domestic violence. Laws affecting children that fail to distinguish them from adults, for example that result in placing children in the same prison cells as adults, can result in additional harm to children. Legal documentation is important for all people, in many areas of life. It is fundamental for establishing citizenship, which is a prerequisite for accessing many public services and other benefits and rights throughout life.

IV. Social policy and legislative solutions

A. Equity-oriented intersectoral policies

Addressing disparities will require a combination of policy measures, some sector-specific, others cross-cutting. This section touches on only a few of the wide variety of policy options available to policy-makers. Common interventions include taxation, subsidies, public-private partnerships and social protection. Social protection, which refers to programmes that reduce economic and social vulnerability of families, promises to be a useful approach to achieve the MDGs with equity. Even if quality services are free, barriers may still exist in accessing them and bottlenecks remain in delivering services to all. In addition to schemes aimed at expanding access to basic services, social protection measures such as employment guarantee schemes (see box on India) and cash transfers (see box on Philippines) have an important role to play in reducing inequity. These have the potential to improve access to better opportunities in health and education and reduce immediate poverty and hunger.

While social protection measures are useful in addressing demand-side causes of inequity, supply-side policy solutions are also needed. The law allows collection and allocation of funds for social protection. Taxation and budgeting for social protection programmes, are also regulated by law. Legal frameworks have coercive force and are especially important in the context of decentralization, or centralization, of political power and administrative and financial control over resources, directly and indirectly influencing realization of children's rights as well as MDG achievement (see box on Indonesia). Political decentralization can improve participation or damage national unity and allow local elite capture of power and resources. Administrative decentralization can increase accountability and access, or weaken formal audit and supervision. And the resultant need to replicate central skills locally can increase costs of government or result in service failures.

Decentralization in Indonesia

Indonesia has faced longstanding subnational disparities. Infant mortality rates between 1988 and 1997, ranged from 23 per 1000 in the best-performing district to 95 in the worst. The Indonesian Government began decentralizing in 2001 with the implementation of laws on regional autonomy and fiscal transfers. Subsequent laws and policies devolved power to the provinces and districts, established further clarity on the respective responsibilities and functions of government, and somewhat addressed transfer and oversight mechanisms. Though there remain challenges in effectiveness, political, financial, and administrative decentralization has been realized. Subnational governments enjoy greater political, policy-making, and fiscal autonomy. Decentralization has had a strong equity focus, though it has not yet adequately addressed provincial and intra-provincial disparities. Fiscal transfers from the central government to subnational governments, previously earmarked as grants, are designed to reduce fiscal imbalances across regions. The provinces of Aceh and Papua, historically the worst-performing provinces in terms of MDGs, and also amongst the resource richest provinces in the country, receive special funds, with the majority allocated to health and education. There is still a need for improved evidence-based local level planning and budgeting. Since several countries in the region are already undergoing the decentralization process, decentralization policies must be designed and implemented to enhance equity within countries.

Poverty reduction in India

The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) was passed by the Indian parliament in 2005, building upon a state-level scheme in Maharashtra. The act ensures paid work of up to 100 days per year per household in rural areas to those who need it. The scheme offers the national level minimum wage of 60 rupees per day to adults who are able to do manual labour, and a third of beneficiaries must be women.

The project is being implemented across different states, though unevenly. The scheme provides insurance for rural workers against unemployment; it raises wages and creates an awareness of the minimum wage. MGNREGA has been designed to allow women equity in both access to work and in wages. Women workforce participation has surpassed the statutory minimum requirement of 33 per cent. The national level is 50 per cent. Challenges remain. Beneficiaries are required to register with their local village council and this has led to exclusion and corruption. Local participation has varied, and the public utility of the types of activities people are employed for is not clear. Worker's right to demand work is often limited by the lack of reading and writing skills. Policy innovations are under way including better use of ICT to improve implementation.

Pro-poor conditional cash transfers in the Philippines

The Pantawid Pamilyang Pilipino Programme (2008) provides grants to poor households to improve health, nutrition and education, particularly of children aged 0-14. The programme has dual objectives: social assistance, to provide income assistance to the poor (short term poverty alleviation), and social development, to break the intergenerational poverty cycle through investments in human capital. A household with three children receives US\$30.2 per month; up to US\$130 per year per household for health and nutrition expenses; US\$65 per school year (10 months) per child for covering educational expenses. A maximum three children can be covered.

Health grants are given to poor households with children aged 5 years and younger and to pregnant women. Education grants are given to poor households with children aged 6-14. Households have to attend pre- and postnatal care, parenthood sessions, health check-ups, vaccinations and have 85 per cent school attendance to receive the grants. By 2009, 700,000 poor households living in 140 of the poorest municipalities and 10 cities received grants.

B. Equity-oriented sectoral policies and programmes

Education

To reduce disparities in education, actions to ensure affordability, physical access and equality in the school environment and learning outcomes for all children need to be

adopted. Although free education is a right for all children, in practice some disadvantaged groups or poorer districts will require additional funding and financial resources. These may need to be targeted unequally in order to achieve equitable outcomes. Greater investment in school feeding, grants and incentives to increase the number of trained local teachers may also be required. Hidden costs of education such as textbooks, uniforms, examination fees, and opportunity cost for families need to be considered in the design of social protection interventions. Specific needs of out-of-school children need to be addressed through policies such as indigenous language programmes and community-based schooling (see box on Bangladesh) which build on strength of the community without shifting the financial and other responsibility of the education system to already marginalized parents. Although much progress has been made in making schools child friendly, more attention is needed to make schools welcoming for all children. Efforts in curriculum reform and teaching methods must ensure that classroom practices promote equity and celebrate diversity.

Achieving Universal Primary Education in Cambodia

Cambodia has made significant progress in reducing disparities in primary education since 2000. Improvements in Net Admission Rate and Net Enrolment Rate (NER), especially between national averages and averages for remote areas, are noteworthy. In 2000, Net Admission Rate was 80 per cent nationally but about 45 per cent in remote provinces. NER was around 85 per cent nationally but only 60 per cent for remote areas. By 2008, the Net Admission Rate gap had narrowed to 92 per cent nationally and 87 per cent for remote areas. NER remained at 94 per cent and 91 per cent respectively. There has been similar progress in reducing gender disparities in primary Net Admission Rate and Net Enrolment Rate, although disparities remain by region, ethnic and economic status and for disabled children. While repetition and drop-out rates remain high and concerns remain in terms of quality,

Cambodia is on-track to achieve MDG 2 by 2015. Various efforts contributed to this success: abolishment of school registration fees in 2002-2003, school enrolment campaigns to ensure right-age enrolment, expansion of school-based and home-based early childhood education centres, scholar ships for poor children and school feeding programmes. Policy initiatives like the National Plan for Education for All 2003-2015, and success with the sector wide approach, have facilitated these interventions. The Government, through the 2007 Education Law, protected the budget for education and recruitment of new teachers during the economic crisis, as other sectors faced budget cuts.

NGO and Government cooperation for Community-Based Schooling in Bangladesh

Bangladesh's BRAC Education Programme, which started in 1985, provides literacy and lifelong learning skills to out-of-school children, adolescents and illiterate adults. BRAC is conducted in the Bengali language (Bangla) and reaches over 1.5 million learners per year in all 64 districts. BRAC helps hard to reach learners access formal education. Schools are established for non-enrolled and dropout children. The model is community based, with small classes, a flexible schedule, proximity to children's villages and a curriculum that is responsive to children's needs. Schools follow national curriculum guidelines, and many students graduate into the formal education system. Also available to graduates are continuous learning and livelihood enhancement through post-literacy and continuing education.

BRAC has a number of level-appropriate and complementary community development components. The Pre-Primary and Primary Education Programme targets out-of-school and dropout children and adolescents. The Adolescent Development and Post-Primary Basic and Continuing Education is designed to reach a range of age groups. There are also complementary community components. Reading centres target adolescent girls and create opportunities for post-literacy and life skills development. BRAC also runs gonokendros (community libraries) giving semi-literate and literate youth access to reading materials, IT literacy and livelihood training. By 2007, over 1.5 million learners were served annually by BRAC schools. The Adolescent Development Programme served over 225,000 learners and gonokendros had 610,000 members. Every year, 10,400 adolescents received life skill courses, 7,000 learners received training in IT literacy, and 8,000 received livelihood training.

Health and nutrition

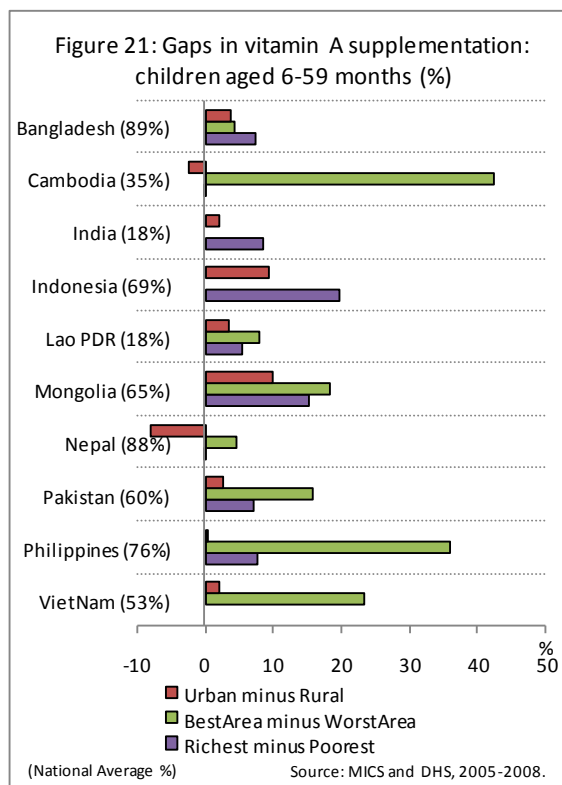
The key maternal, newborn and child health interventions that are needed to reduce disparities in children are few and relatively low in cost. Low cost high impact interventions include immunization, micronutrients for children and women (vitamin A supplementation, iron-folic acid supplementation and fortification, multiple micronutrient supplements, therapeutic zinc, and salt iodization), de-worming tablets, behavioural change for adequate infant and young child feeding and care practices. Promotion of inclusive and early initiation of breastfeeding, particularly from 0 to 6 months, is especially effective in decreasing morbidity and mortality.

Assuring high-coverage vitamin A distribution is also effective in reducing inequalities in child survival. Universal supplementation with vitamin A narrowed differentials in child death across gender and caste in rural Nepal (Bishal et al., 2005). Although several countries in the region have put in place vitamin A supplementation programmes, figure 21 shows that disparities between best and worst off areas persist in several countries.

Besides proven preventive measures effective curative tools exist against pneumonia and diarrhea, that together account for more than 30 per cent of U5MR. Policies to provide free primary care to strengthen existing primary healthcare systems and can go a long way in making the children of Asia and the Pacific live longer, healthier lives (see boxes on China and Thailand).

Skilled and motivated health workers in sufficient numbers at the right place and at the right time are critical to deliver effective health services and improve health outcomes. Yet, countries struggle to retain health care workers in rural areas due to economic constraints and preference of health workers. To retain trained health care workers in remote areas, a bundle of contextually relevant strategies are needed. Admission policies to enrol students with a rural background in education programmes must be implemented. Undergraduate students of various health disciplines should be exposed to rural community experiences and clinical rotations. Financial incentives sufficient enough to outweigh the opportunity costs associated with working in rural areas are needed to improve rural retention of trained health personnel.

Improving women's social status and improving access to nutritional support (see box on Viet Nam) and family planning services is also crucial to reduce both maternal and newborn mortality (see box on Pakistan). Innovative strategies have been developed focusing on the continuum of care (antenatal, delivery, postnatal). Examples include communicating the onset of labour by cell phone rather than messenger; bicycle ambulances to move the mother short distances; and relocation of the mother closer to the delivery centre as birth approaches. Visits by community health workers in the first hours and days following birth has



been shown to improve newborn survival and maternal health among rural populations. Examples of such initiatives follow below.

Marginal Budgeting for Bottlenecks in Pakistan

An equity focused analysis in the Pakistani state of Punjab using the 'Marginal Budgeting for Bottlenecks' is informing policy makers on the most cost-effective evidence based strategies that will accelerate progress towards MDG 4 with equity in the state, and Pakistan's progress as a whole.

Though still in its implementation stage, so far the analysis shows a combination of greater emphasis on community focused strategies such as strengthening community case management for childhood diarrhea, pneumonia and neonatal infections, and on scaling up outreach and schedulable services, such as immunization, along with other system strengthening measures will accelerate progress towards MDG 4 at a more efficient and cost effective rate than Punjab's current policies. Particular focus is placed upon reaching the most deprived populations where the highest rates of mortality exist. This is done through a combination of interventions shown to improve both supply and demand side service coverage, including conditional cash transfers and paid for performance incentives.

Together these interventions will strengthen service delivery along the continuum of care and outcomes for child health, thus strengthening the health system as a whole. The MBB approach is highly consultative and enables governments to model various intervention strategies. While some interventions may be new (introducing rotavirus and pneumococcal vaccines into government mandated immunization), other existing interventions might merely require refining existing strategies to improve cost effectiveness and achieve equitable outcomes.

Achieving MDGs 4 and 5 with equity in China

Chinese government figures indicate that the MDG target for U5MR has been achieved already, declining by 72 per cent from 61 per 1000 live births in 1991 to 17.2 in 2009. The rural-to-urban ratio of U5MR also decreased, from 3.4 in 1991 to 2.8 in 2009. China is on track to achieve MDG 5, with its maternal mortality rate (MMR) having declined from 88.9 per 100,000 live births in 1990 to 31.9 in 2009. The rural-to-urban ratio of MMR declined from 2.5 in 1990 to 1.3 in 2009.

The government achieved this progress on MDGs 4 and 5 by increasing healthcare expenditure (from 0.7 per cent to 1.2 per cent of GDP from 1990-2008); instituting a Law on Maternal and Child Health (MCH) (1994); standardising service quality in and referral practices between the three tiers of the MCH network (village, township and county); successfully implementing a unique family planning system and expanding pro-poor hospital delivery subsidies for rural women.

Health sector reforms continue, including pro-poor health financing and insurance initiatives. Reducing disparities, particularly in child mortality, remains challenging.

Nutrition Programme in Viet Nam

Viet Nam started its child malnutrition control programme in 1994 under the National Committee for the Protection and Care of Children with pilot sites in all provinces. The programme initially funded activities for pregnant women who weren't gaining weight and provided medicines and food for severely to moderately malnourished children living in poor families. The programme now includes child growth monitoring and key interventions for malnourished children and pregnant women such as guidance for mothers on appropriate breastfeeding and food preparation for children under 2 years of age and for malnourished children aged 2 to 5, Vitamin A and iron supplementation, intestinal parasite controls, provision of adequately iodized salt, ensuring food hygiene and safety, addressing food security in poor households, and development of appropriate models for child health care to prevent and treat infectious disease.

Lady Health Worker Programme in Pakistan

The Pakistan Lady Health Worker Programme (LHWP) provides basic community services to rural and urban areas in Pakistan. Lady Health Workers (LHWs) are women auxiliary health workers who offer registered households or individuals a range of preventative services, including family planning, vaccinations and other primary health care services.

LHWs work from their home, with one room a dedicated 'health house', but are attached to a government facility that provides supervision, training and medical supplies. An evaluation found that rural populations served by LHWs had better health outcomes than control populations, and had better access to antenatal services, skilled delivery at birth, contraceptive prevalence, use of preventative child health services and treatment of childhood diseases. Structural factors like uneven distribution of LHWs across regions, sometimes prevents the prioritization of those most in need. Despite this, the health care system in Pakistan accords LHWs a high level of importance, with plans to increase their numbers and improve the effectiveness of the health facilities.

Universal Health Care Scheme in Thailand

Thailand has successfully implemented pro-poor, free universal healthcare. What began as a low cost Universal Coverage (UC) scheme has been free since 2006 when the 30 baht co-payment was abolished. Thailand's UC scheme showed that it was possible to introduce equity in healthcare even when economic conditions were not entirely favourable, as a result of the 1997 Asian financial crisis.

The impact of the UC Scheme on equity has been notable. Prior to the introduction of the scheme in 2001, almost 30 per cent of Thais did not have access to healthcare; now over 96 per cent of the Thai population has access to some form of health coverage, with the UC scheme accounting for almost 80 per cent of those covered. The UC scheme also covers antiretroviral treatment for HIV/AIDS patients. The pro-poor schemes prior to the UC's introduction were biased in their coverage towards high income quintiles, as there were significant problems with targeting. With the UC scheme, 50 per cent of beneficiaries are from the lowest two income quintiles. This example shows that a lower Middle Income Country can successfully introduce free, universal healthcare.

Universalist approaches for maternal and child health in Sri Lanka

The maternal mortality ratio in Sri Lanka was estimated at between 500 and 600 per 100,000 live births, in the 1950s. Sri Lanka has halved maternal deaths (relative to the number of live births) every six to 12 years since 1935, contributing to a decline in the maternal mortality ratio from between 500 and 600 maternal deaths per 100,000 live births in 1950 to 60 per 100,000 in 2010. Skilled practitioners now attend to 97 per cent of births, compared with 30 per cent in 1940.

In the 1950s, the government of Sri Lanka made a concerted effort to extend free health services through a health network, covering both urban and rural areas and including both preventive and curative services. This includes a strong referral system from the lowest level health unit to district hospitals, and ambulances. This coincided with the emergence of free public education, resulting in a highly literate population and an average female literacy of 89 percent in 2006.

Each midwife receives eighteen months training and is supported through supervision and a referral network to district hospitals. Each midwife serves a population of 3,000 to 5,000. Midwives visit pregnant women at home, register them for care, encourage them to attend antenatal clinics, as well as work with clinic doctors. Challenges remain, Commodity shortages at community level health centers means that many people go directly to hospitals for care. There is also a trend toward increased facility based treatment, and this may increase inequality in the future.

HIV and AIDS

Addressing inequity in the prevention (and treatment) of HIV will require a multi-faceted approach, including supply-side scale up of services to the often marginalized, high-risk groups and pregnant women, as well as concerted efforts on the demand-side such as reducing stigma and discrimination associated with both the disease and the high-risk

groups it most affects (sex workers, men who have sex with men and intravenous drug users, and their partners).

Low HIV prevalence in the region also makes it a challenge to incorporate HIV testing and counselling as a routine component of antenatal, childbirth and postpartum services. Because HIV prevalence is low in the general population, testing of every pregnant woman is considered economically unaffordable, especially given other competing health priorities. To address this, strategic targeting of HIV testing and counselling of pregnant women, based on local epidemiological contexts, as well as the urban-rural and wealth quintile disparities, will be needed.

For pregnant women, stigma and fear of discrimination impact each step in the PMTCT cascade, from getting tested to following infant feeding recommendations, lowering the effectiveness of investments in this arena and the ability to reach all pregnant women and children in need of services. A modelling study showed that between 30-50 per cent of mother-to-child transmissions could be attributed to stigma in some settings. Since countries with HIV epidemics in Asia and the Pacific are characterized by a concentration of the disease among already stigmatized, marginalized and hard-to-reach groups and their female partners, combating stigma at the household, community and health facility levels in addition to offering PMTCT services could be more effective than adopting a purely medical approach (Watts et al, 2010). Addressing stigma and discrimination will enable more pregnant women to come for a test and seek treatment. It will also enable children living with HIV and those affected by AIDS to stay in school without being stigmatized or ostracized.

South Asia Region Development Marketplace: Stigma reduction through South-South Cooperation

In South Asia, the recently completed South Asia Region Development Marketplace (SARDM), co-funded by UNICEF, supported 26 implementers from six countries to pilot stigma reduction interventions (World Bank, 2010a). The grants led to considerable innovation in terms of using multiple intervention strategies, engaging marginalized groups and forming unlikely alliances such as between sex workers and the police) in combating stigma. A key lesson learned, confirming experience in other regions, is that effective stigma-reduction programming must engage multiple groups within communities to champion the effort, in particular opinion leaders, people experiencing stigma, health providers and the police, while reaching out to sensitize and educate the general community (World Bank, 2010a). The insights, resources, capacity and partnerships that emerged from the SARDM programme provide a strong foundation for addressing stigma within the context of HIV prevention in the region. This is relevant for championing the equity agenda because most grantees worked with hard-to-reach, high-risk groups. Given that the majority of cases of HIV in the region are among these highly-stigmatized groups and their partners, it is critical that stigma reduction be an integral part of HIV strategies and programmes if they are to be effective in reaching those most at risk of HIV and in stopping the transmission of HIV.

Integrated approach towards improving sexual and reproductive health outcomes among young female garment factory workers in Cambodia

The Cambodian garment sector makes up 80 per cent of national exports, employs 270,000 workers directly, of whom 85-90 per cent are women aged 18-25. Thousands more work on the sidelines of the industry, in food sales and other services to factory workers, and in sub-contracted piece work and in the supply of packaging materials. Several studies suggest these young women are potentially at higher risk of contracting HIV owing to rapid rural to urban migration, poverty and low paid employment. A five-year public-private initiative was launched in 2005 to increase these workers' access to reproductive health, HIV and STI prevention and nutrition services in 12 garment factories. Peer education and health promotion sessions were conducted, and access to information, local resources and contraceptives were supported.

A qualitative assessment of the intervention, undertaken in 2009, revealed a significant improvement in comprehensive AIDS knowledge among garment workers in intervention factories. Nearly two-thirds gained knowledge compared to only 32 per cent in a non-intervention site, and 49 per cent of respondents in intervention factories confirmed adopting appropriate personal risk assessment and health-seeking behaviours. These findings lend support to the usefulness of an integrated HIV and reproductive health approach, especially in the context of global economic and financial insecurities where job loss could trigger potential entry to sex work or transactional sex as alternate means of livelihood.

Water and sanitation

To meet the MDGs in water and sanitation, and particularly with equity, governments need to substantially increase and allocate resources for water and sanitation services, and through policy, address affordability and sustainability issues, administrative and legal constraints to ensure that quality standards are being met. Governments are often unable to do this due to capacity and resource constraints. Water supply and sanitation support, particularly in peri-urban and rural areas, is challenging, given the complexity of provision and associated cost structures. Limited access to fresh water and contamination of ground water add additional pressures.

There are a range of strategies for expanding access to quality water and sanitation services that have been tried and tested in the region. These include, using community-based approaches to encourage toilet use amongst all households (see box on Nepal); promoting community participatory mapping, action planning and monitoring; targeting water supply funding based on basic water supply facilities, rather than high-cost water supplies for those already using basic services; and strengthening geographical targeting, giving priority to areas where water supply and sanitation coverage is significantly below the national average.

Partnerships with non-state providers (NSPs) are important for expanding coverage (see box on India and Viet Nam). Governments are working with NSPs in a variety of contexts, from information dissemination and awareness building to construction, operation and maintenance of water and sanitation facilities, to service provision, and small-scale financing.

Non-State Provision of water and sanitation services in India and Viet Nam

The Gram Vikas project and International Development Enterprise are two examples of pro-poor non-state provision of water and sanitation services. Gram Vikas, based in India, provides 45,697 households with a standard toilet and bathroom, and running water supply. All community members – regardless of income or caste – are required to participate in the project to derive benefits. Costs are born by households with each household contributing an average of 1,000 rupees to the village 'corpus fund.' The poor pay what – and when – they can. The project provides comprehensive 60-day training on masonry and operation and maintenance of facilities. Youth are also trained to address minor repairs. Each village has a village fund, which earns interest from fish horticulture to pay for construction of toilet and water supply facilities, and to leverage additional funding, including subsidies from the government, amounting to 3,000 rupees per household.

The Viet Nam-based International Development Enterprise implemented a market-driven project for small-scale private sector development and marketing for sanitation in rural areas. The project targeted 54,000 households. In three years, the project created 15,000 new toilets and increased improved sanitation coverage from 15 per cent to 44 per cent in the project communes. Growth in sanitation coverage has continued to increase, despite no external financing. Sanitation coverage is now 59 per cent.

The project was effective in leveraging private investment: households invested USD \$65 for every US\$33 spent by the project (2:1 leverage ratio). The market-based approach led to significant post-project benefits, including sustainable local supply chains and increased knowledge on sanitation promotion and improvement. The project assisted providers to develop more flexible finance and payment options, including seeking credit from their suppliers and providing payment by installment options to their customers. It also developed a system of accreditation and blacklisting through local health posts that provided an annual list of accredited (trained and approved) service providers, with black listing of any providers found repeatedly in breach of the agreed service conditions.

School-community partnerships for Total Sanitation in Nepal

In 2006, the Government of Nepal (GoN), with UNICEF support, piloted a School-Led Total Sanitation (SLTS), a community-based approach to total sanitation, to facilitate scale up of sanitation facilities. It capitalizes on the role children can play as change agents and promoters of sanitation and hygiene in schools and communities. Through participatory approaches, motivational tools, flexibility for innovation and building ownership at the local level, SLTS is accelerating latrine coverage across Nepal.

SLTS begins at the school and extends to the school catchment area, generally made up of four or five communities. SLTS works with child clubs and empowers them to put their skills to use alongside community sanitation sub-committees. Child clubs are involved in surveying and monitoring sanitation quality in their community and lead in the campaign to educate their parents and neighbours about the benefits of using improved sanitation and keeping their communities clean.

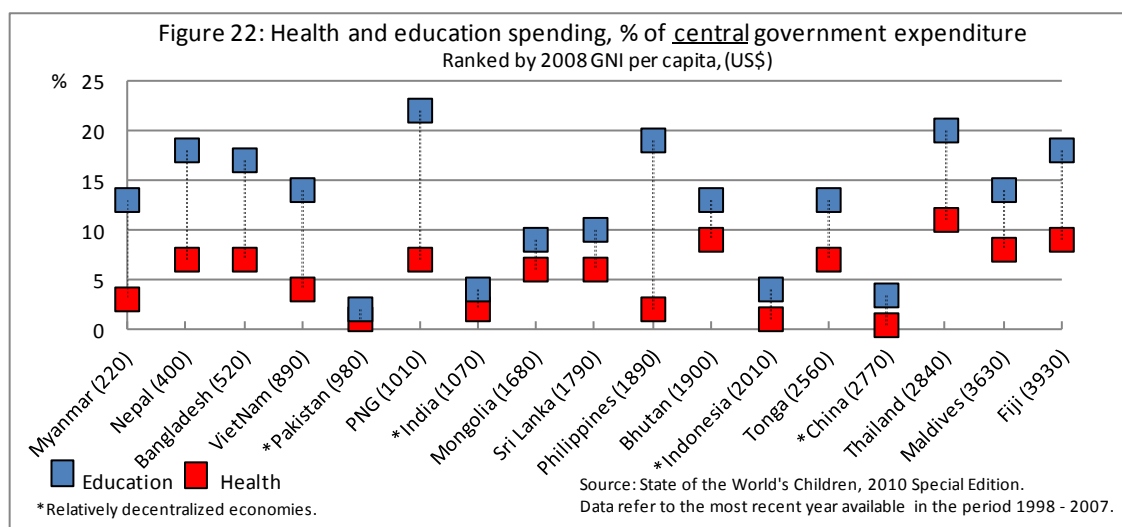
Open Defecation Free status is achieved through social mobilization using participatory approaches, advocacy and institutional capacity building at school, community and district levels. A feature of the programme's success is building school-community partnerships that enable sustainability of hygiene and sanitation facilities. SLTS has been incorporated in Nepal's Sanitation Master Plan (2009). The GoN is replicating the SLTS programme in all 75 districts. Targeted budget lines have been established for sanitation at the national and district levels. A 25 per cent additional budgetary grant is given to villages that become open-defecation-free and have a child-friendly environment and facilities.

V. Budgets and fiscal space

Article 4 of the CRC: States Parties shall undertake such measures to the *maximum extent of their available resources* and, where needed, within the framework of cooperation."

Realization of many rights of children is hampered by a lack of resources. The State's ability to fulfil their obligations can be assessed in terms of the financial and other resources allocated, as well as the fiscal space available. How budgets are allocated is ultimately a political decision. An overall constraint of fiscal space may apply, but within that space resource allocation priorities depend on national priorities and the processes used to determine them (see box on gender budgeting).

Figure 22 shows some health and education expenditures as a percentage of central government expenditure. This is a poor measure of total sectoral resource allocation, which should include expenditures by provincial, district and local governments, as well as private expenditures, but it is the most widely available measure and does offer interesting insights.



Most central governments spend more on education than health, and this is true at subnational levels as well. The largest states, China, India, Indonesia and Pakistan have some of the lowest central government expenditures on health and education: both under five percent of the total. These four countries are relatively decentralized. Subnational capacities to raise and expend resources are greater, and constitute a relatively large proportion of total expenditures. The Philippines shows the greatest difference between central education and central health expenditures. This is a very interesting example of sector-specific decentralization. In the Philippines, the health sector is more decentralized while the education sector is more centralized.

A 2010 Asian Development Bank (ADB) analysis of Asia Pacific countries revealed that at least 15 countries have fiscal space available to increase social sector expenditures - defined as a pre-crisis fiscal deficit below 3 per cent and a tax burden below 20 per cent (ADB, 2010b). Figure 23 depicts pre-crisis fiscal footprints for Cambodia and Indonesia. Both show levels of government revenue significantly below the 20 per cent suggested by the ADB. As an example, fiscal space assessments for Bhutan, undertaken by the International Labour Organization (ILO), noted that improving the revenue productivity of the tax system could increase fiscal space by 4-5 per cent of GDP (UNDP, 2010). Other resourcing options that may be available in some countries include increased official development assistance, broadly including grants, concessional loans and debt relief; reprioritizing expenditures; enhancing allocative and technical efficiency; and financing public expenditures by borrowing from domestic and international sources.

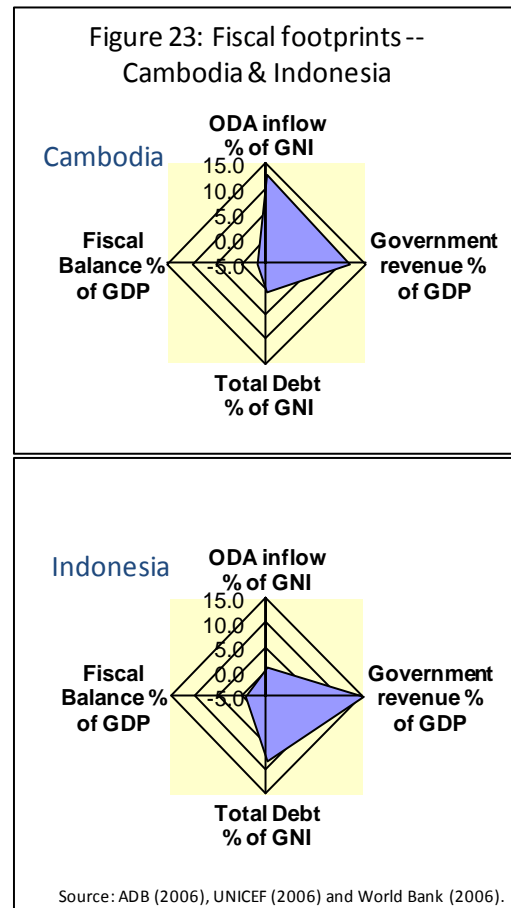
The process of defining and allocating resources and raising revenue is one of the most important political and economic tools available to governments. Tax reform requires significant political will and long-term capacity development. Other options may be more feasible, depending on the development needs and political economy of a country. Enhancing expenditure efficiency of public investments through reprioritization and transparency of disbursements is often more viable in the short-term. But merely allocating public resources does not guarantee positive outcomes if the budget institutions and framework – including planning, formulation, execution and monitoring – are flawed or not working properly.

Governance, particularly in the context of decentralization, has as much to do with effective budget processes and expenditures as the actual allocation. This includes reforming information systems and record keeping, reducing corruption, improving public financial management, strengthening benefit-delivery mechanisms, and upgrading staff skills. Even with improved efficiency and greater domestic revenue, countries may need to explore a range of options to keep pace with increasing demand and changing demographics.

If traditional fiscal policies are difficult to apply there are additional areas of active innovation in Asia and the Pacific. These include social insurance and micro-insurance, social funds and community development grants, social assistance schemes and child-benefit programmes.

'Marginal Budgeting for Bottlenecks' (see earlier box on Pakistan) is a promising approach that informs policy makers on the most cost-effective evidence based strategies to accelerate progress towards achieving the MDGs with equity. This is done through a combination of interventions that have been shown to improve both supply and demand side service coverage. These include conditional cash transfers and pay for performance incentives to strengthen service delivery along the continuum of care.

Partnerships with non-state providers (civil society organizations, faith based organizations, non-governmental organizations and the private sector) to deliver basic social services can have very useful effects, helping governments to reduce the financial and logistical burden of public service delivery, while increasing coverage.



Gender-responsive and child-sensitive budgeting for to promote equity

Gender-responsive and child-sensitive budgeting integrates the differing needs of women, men, girls and boys into budget-related processes. It is most effective when the government budget authority encourages participative discussion and involvement. In some countries, transparency is enhanced by support to civil society groups that participate in budget formulation, and also help monitor its implementation. Indonesia and Cambodia have developed some interesting initiatives in these areas (Corner, 2009).

VI. Conclusions and recommendations

This paper has summarized some of the rich data and knowledge available on some of the main MDG relevant social and economic disparities in Asia and the Pacific. These disparities in many MDG indicators include differences by wealth, geographic location and gender, and in some countries ethnicity and caste.

Governments have developed a wide range of effective responses to these challenges, though too often these responses are applied only in one country for a specific MDG. There is a strong case for governments to take advantage of the experiences of others in selecting policies that are culturally and institutionally appropriate, and validated as successful and cost-effective.

This type of collaboration has a long history, dating back to the Group of 77 and Non-Aligned Movements as its main promoters, especially in the areas of trade and finance, in the 1960s and 1970s. Regional collaboration in the social sector has developed significantly in the Latin American region, where 45 per cent of collaboration initiatives focused on improving social conditions. There is considerable potential in Asia and the Pacific, based on some of the examples summarized in this paper, for efficiency improvements through increased knowledge exchange between social sector policy makers.

Building on the analysis that has been presented, of possibilities for collaboration amongst governments in Asia and the Pacific, some preliminary suggestions are offered below. It is recommended that all channels of possible collaboration, bilateral, multi-national, and inter-institutional, including through regional inter-governmental entities, United Nations Organizations and academic institutions be explored for their potential to contribute towards reducing MDG related disparities affecting children.

It is suggested that:

- Countries in Asia and the Pacific collaborate to improve the collection and use of data and evidence that will increase understanding of disparities and their underlying causes.
- Countries with successful experiences formally assess, present and promote them, and examine successful experiences elsewhere in reducing disparities to assess the feasibility of adapting and replicating them.
- Regional level research studies examine and review in detail relevant data and literature in support of these initiatives.
- Governments explore the possibility of establishing a regional repository of knowledge, expertise and data on equity issues, perhaps modelled on the successful HIV/AIDS Data Hub and the Asia-Pacific Regional Network for Early Childhood.

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VIII. Annexes

A. Surveys used

Country	List of Surveys		Sample Size (Households)
Bangladesh	Bangladesh Bureau of Statistics, UNICEF. 2007. Bangladesh Multiple Indicator Cluster Survey (Progotir Pathay) 2006. Volume 1: Technical Report. Dhaka, Bangladesh.	MICS2006	62,463
	National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International. 2009. Bangladesh Demographic and Health Survey 2007. Dhaka, Bangladesh and Calverton, Maryland, USA: National Institute of Population Research and Training, Mitra and Associates, and Macro International.	DHS2007	10,400
Cambodia	National Institute of Public Health, National Institute of Statistics [Cambodia] and ORC Macro. 2006. Cambodia Demographic and Health Survey 2005.	DHS2005	14,243
India	International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005-06: India: Volume I. Mumbai: IIPS.	NFHS 2005-2006	109,041
Indonesia	Statistics Indonesia (Badan Pusat Statistik – BPS) and Macro International. 2008. Indonesia Demographic and Health Survey 2007. Calverton, Maryland, USA: BPS and Macro International.	DHS2007	40,701
Lao PDR	Department of Statistics and UNICEF. 2008. Lao PDR Multiple Indicator Cluster Survey 2006, Final Report. Vientiane, Lao PDR: Department of Statistics and UNICEF.	MICS2006	5,894
Mongolia	National Statistical Office, UNICEF. 2007. Mongolia “Child and Development 2005” survey (MICS-3), Final Report. Ulaanbaatar, Mongolia.	MICS2005	6,220
Nepal	Ministry of Health and Population (MOHP) [Nepal], New ERA, and Macro International Inc. 2007. Nepal Demographic and Health Survey 2006.	DHS2006	8,707
Pakistan	National Institute of Population Studies (NIPS) [Pakistan], and Macro International Inc. 2008. Pakistan Demographic and Health Survey 2006-07.	DHS 2006-2007	95,411
Philippines	National Statistics Office (NSO) [Philippines], and ICF Macro. 2009. National Demographic and Health Survey 2008. Calverton, Maryland: National Statistics Office and ICF Macro.	DHS2008	12,469
Thailand	Thailand National Statistical Office. 2006. Thailand Multiple Indicator Cluster Survey December 2005- February 2006, Final Report. Bangkok, Thailand: National Statistical Office.	MICS 2005-2006	40,511
Vanuatu	Ministry of Health, Government of Vanuatu, 2008. Vanuatu Multiple Indicator Cluster Survey 2007, Final Report, Port Vila, Vanuatu.	MICS2007	2,632
VietNam	GSO. 2006. Viet Nam Multiple Indicator Cluster Survey 2006, Final Report. Ha Noi, Viet Nam: General Statistics Office.	MICS2006	8,355

B. Definition of indicators

MDGS		MICS Indicators	Definition
MDG1	Prevalence of underweight children under 5 years of age	Indicator 6	Number of children under age five that fall below minus two standard deviations from the median weight for age of the NCHS/WHO standard (moderate and severe); number that fall below minus three standard deviations (severe)
MDG2	Primary school net attendance ratio (NAR)	Indicator 55	Percentage of children in the age group that officially corresponds to primary schooling who attend primary school.
	Secondary school net attendance ratio (NAR)	Indicator 56	Percentage of children in the age group that officially corresponds to secondary schooling who attend secondary school.
MDG3	Gender Parity Gap for secondary school net attendance ratio	Indicator 56	The difference between male net attendance rate and female net attendance rate at the secondary level.
MDG4	Under-five mortality rate (U5MR)	Indicator 1	The <i>under-five mortality rate</i> is the probability (expressed as a rate per 1,000 live births) of a child born in a specified year dying before reaching the age of five if subject to current age-specific mortality rates.
	Proportion of children fully immunized against childhood diseases	Indicator 31	Proportion of children aged 12-23 months receiving a number of vaccines before their first birthday. Immunisation protects children from vaccine-preventable diseases and is considered a priority preventative health service.
MDG5	Proportion of birth attended by skilled health personnel	Indicator 4	The <i>proportion of births attended by skilled health personnel</i> is the percentage of deliveries attended by personnel trained to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period; to conduct deliveries on their own; and to care for newborns. <i>Skilled health personnel</i> include only those who are properly trained and who have appropriate equipment and drugs. Traditional birth attendants, even if they have received a short training course, are not to be included.
MDG6	Knowledge of mother-to-child transmission of HIV	Indicator 89	Per cent of women aged 15 to 49 who know that HIV (or AIDS) can be transmitted from mother to child during pregnancy.
MDG7	Proportion of population with sustainable access to an improved water source	Indicator 11	The <i>proportion of population with sustainable access to an improved water source</i> is the percentage of the population who use any type of the following types of water supply for drinking: piped water, public tap, borehole or pump, protected well, protected spring or rainwater. Improved water sources do not include vendor-provided water, bottled water, tanker trucks or unprotected wells and springs.
	Proportion of population with access to improved sanitation	Indicator 12	<i>Proportion of the urban and rural population with access to improved sanitation</i> refers to the percentage of the population with access to facilities that hygienically separate human excreta from human, animal and insect contact. Facilities such as sewers or septic tanks, pour-flush latrines and simple pit or ventilated improved pit latrines are assumed to be adequate, provided that they are not public, according to the World Health Organization and United Nations Children's Fund's <i>Global Water Supply and Sanitation Assessment 2000 Report</i> . To be effective, facilities must be correctly constructed and properly maintained.

C. Country data by MDG

MDG 1: Prevalence of underweight children under 5 years of age										
Country	Male	Female	Urban	Rural	Best Area	Worst Area	Richest Quintile	Poorest Quintile	National Average	Data Source
Bangladesh	39.9	42.1	33.4	43	34.1	45.6	26	50.5	41	*DHS2007
Cambodia	35.3	35.8	34.7	35.7	21.2	52.2	23.1	42.9	35.6	DHS2005
India	41.9	43.1	32.7	45.6	19.7	60.0	19.7	56.6	42.5	NFHS2005-2006
Lao PDR	36.6	37.6	25.7	42	32.9	49.5	18.2	43.9	37.1	MICS2006
Mongolia	5.9	6.6	5.6	7	4.9	8	3.5	7.8	6.3	MICS2005
Nepal	37.5	39.7	23.1	40.7	21.7	50.2	18.8	47	38.6	DHS2007
Thailand	9	9.6	5.6	10.7	6.1	12.5	4.1	15.2	9.3	MICS2005-2006
Vanuatu	18.3	13.4	15.2	16.1	11.4	**23.4	13	18.1	15.9	MICS2007
VietNam	21.1	19.2	12.3	22	10.8	28.8	10.4	28.5	20.2	MICS2006

Notes: India figures for previous five years

*Using DHS because MICS2006 does not include this indicator

**Percent count has been suppressed as the figure is based on less than 25 unweighted cases.

MDG 2: Primary school net attendance rate (NAR)										
Country	Male	Female	Urban	Rural	Best Area	Worst Area	Richest Quintile	Poorest Quintile	National Average	Data Source
Bangladesh	78.9	83.7	80.9	81.5	87	78.3	87	73.4	81.3	MICS2006
Cambodia	76.4	78.2	78	77.1	83.2	67.2			77.3	DHS2005
India	73.2	70.5	73.8	71.2					71.9	NFHS2005-2006
Indonesia	85.7	83.6	84.1	85			81.4	85.7	84.7	DHS2007
Lao PDR	80.9	77	93	65.6	81.4	75.2	98.2	59	79	MICS2006
Mongolia	94.3	96.4	96.3	94.3	97.6	92.2	97.7	91.3	95.3	MICS2005
Nepal	88.8	84.2	90.5	86	92.9	79.5	94.5	80.6	86.6	DHS2007
Pakistan	69.8	62.2	77.4	61.6	75	42.2	87.8	41.5	66.2	DHS2006-2007
Thailand	97.9	97.9	98	97.8	98.3	97.5	98.9	96.9	97.9	MICS2005-2006
Vanuatu	80	80.9	83.8	79.6	93.1	70.4	89.1	73.3	80.4	MICS2007
VietNam	95.4	95.4	94.6	95.6	97.3	91.4	94.9	94.1	95.4	MICS2006

MDG 2: Secondary school net attendance rate (NAR)										
Country	Male	Female	Urban	Rural	Best Area	Worst Area	Richest Quintile	Poorest Quintile	National Average	Data Source
Bangladesh	36.2	41.4	44.6	36.5	46.5	30.1	60.2	18.8	38.8	MICS2006
Cambodia	29.9	26.7	45	25.2	45.7	9.4			28.3	DHS2005
India	56.8	45.6	60.5	47.2					51.2	NFHS2005-2006
Indonesia	57.2	59	64.8	52.9			74.7	36.5	58.1	DHS2007
Lao PDR	39	31.8	63.8	16.5	42.3	29.6	69.9	8.1	35.5	MICS2006
Mongolia	82.6	88.1	90.4	78.4	90.9	80.9	96	68.8	85.4	MICS2005
Nepal	50.4	43.1	56.6	45.2	58.2	29.5	65	31.2	46.7	DHS2007
Pakistan	29.2	25.3	37.9	22.1	31.2	16.1	52.3	8.7	27.3	DHS2006-2007
Thailand	76.6	83.1	80.3	79.6	84.5	71.5	88.5	74.9	79.8	MICS2005-2006
Vanuatu	45.4	46.1	65.2	40	66.6	24.4	69.6	27.3	45.7	MICS2007
VietNam	78.1	79.6	88.8	76.1	87.7	67.5	91.5	59.9	78.8	MICS2006

MDG 3: Gender parity of secondary school net attendance					
Country	National (Male-Female)	Rural (Male-Female)	Poorest Quintile (Male-Female)	National Average	Data Source
Bangladesh	-5.2	-5.8	-8	38.8	MICS2006
Cambodia	3.2	3.7		28.3	DHS2005
India	11.2	14.6		51.2	NFHS2005-2006
Indonesia	-1.8	-3.1	-2.2	58.1	DHS2007
Lao PDR	7.2	9.7	9.8	35.5	MICS2006
Mongolia	-5.5	-7.4	-9.6	85.4	MICS2005
Nepal	7.3	7.8	12.4	46.7	DHS2007
Pakistan	3.9	7.9	7.4	27.3	DHS2006-2007
Thailand	-6.5	-7.5	-4.8	79.8	MICS2005-2006
Vanuatu	-0.7	0.4	10.4	45.7	MICS2007

MDG 4: Under-five mortality rate (U5MR)										
Country	Male	Female	Urban	Rural	Best Area	Worst Area	Richest Quintile	Poorest Quintile	National Average	Data Source
Bangladesh	76	72	63	77	58	107	43	86	73.5	*DHS2007
Cambodia	115	97	76	111	52	165	43	127	105	DHS2005
India	69.7	79.2	51.7	82	16.3	96.4	33.8	100.5	74.3	NFHS2005-2006
Indonesia	56	46	38	60	19	74	32	77	51	DHS2007
Mongolia	55	46	31	69			30	60	51	MICS2005
Nepal	80	78	47	84	60	122	47	98	78.5	DHS2006
Pakistan	93	93	78	100	59	101	60	121	93	DHS2006-2007
Philippines	41	34	28	46	24	94	17	59	51	DHS2008
Vanuatu	29	31	27	32			26	33	30	MICS2007
VietNam	28	25	16	30					27	MICS2006

*Using DHS because MICS2006 does not include this indicator

MDG 4: Proportion of children fully immunized against childhood diseases										
Country	Male	Female	Urban	Rural	Best Area	Worst Area	Richest Quintile	Poorest Quintile	National Average	Data Source
Bangladesh	85	83	85.9	83.4	90.8	77.6	91.1	78.2	84	MICS2006
Cambodia	69	64.1	69.4	66.2	82.4	34.6	76.4	56.1	66.6	DHS2005
India	45.3	41.5	57.6	38.6			71	24.4	43.5	NFHS2005-2006
Indonesia	70.1	77.1	76.5	70.9			79.2	62.2	73.3	DHS2007
Lao PDR	28.4	25.8	40.3	24.3	32.5	20.4	44.8	18.3	27.1	MICS2006
Mongolia	80.8	82.7	84.5	78.3	90.4	69.9	87.1	81	81.7	MICS2005
Nepal	84.9	80.6	86.3	82.4	94.4	54.6	93.5	68	82.8	DHS2006
Pakistan	49.8	44.3	54.2	44	52.6	35.2	63.7	25.9	47.3	DHS2006-2007
Philippines	80.5	78.5	82.3	76.8	91.5	30.6	87.1	63.6	79.5	DHS2008
Thailand	91	88.3	87	90.7	95.4	83.9	86	91.7	89.7	MICS2005-2006
Vanuatu	39.5	44.1	48.7	40.1	57.1	30.8	49.9	25.6	41.6	MICS2007
VietNam	63.8	67.9	82	61	78.1	37.7			65.6	MICS2006

MDG 5: Proportion of births attended by skilled health personnel								
Country	Urban	Rural	Best Area	Worst Area	Richest Quintile	Poorest Quintile	National Average	Data Source
Bangladesh	37.9	14	27.3	13.9	55	6.5	20.1	MICS2006
Cambodia	70.1	39.4	86	12.9	89.9	20.7	43.8	DHS2005
India	73.5	37.5	99.4	24.7	88.8	19.4	46.6	NFHS2005-2006
Indonesia	84.3	75.9			86.4	65	79.4	DHS2007
Lao PDR	67.8	3	28.2	14.4	81.2	3	20.3	MICS2006
Mongolia	99.5	98.9	100	98.4	100	98.1	99.2	MICS2005
Nepal	50.6	14.3	40.7	5.3	57.8	4.8	18.7	DHS2006
Pakistan	60.1	29.8	44.4	23	77.3	16.1	38.8	DHS2006-2007
Philippines	77.5	47.7	86.8	19.2	94.4	25.7	62.6	DHS2008
Thailand	99.4	96.5	99.4	92.8	99.8	92.7	97.3	MICS2005-2006
Vanuatu	86.8	71.6	94.7	*32	89.9	55	74	MICS2007
VietNam	98.3	84.5	100	58	99.4	52.8	87.7	MICS2006

*Percent count has been suppressed because figure is based on less than 25 unweighted cases.

MDG 6: Percentage of women aged 15-49 with knowledge of mother-to-child transmission of HIV								
Country	Urban	Rural	Best Area	Worst Area	Richest	Poorest	National Average	Data Source
Bangladesh	75.8	50.8	69	47.6	84.9	30.2	58.4	*DHS2007
Cambodia	39.3	29.2	57.4	9.3	43.5	21.8	31	DHS2005
India	28.4	13.8			35.0	4.3	18.6	NFHS2005-2006
Indonesia	58.9	30.1			73.2	15.7	42.2	DHS2005-2006
Mongolia	78.1	63.7	80.1	56.6	82.7	54.5	72.3	MICS2005
Pakistan	48.4	22.5	34.1	15.5	60.3	5.9	31.2	DHS2006-2007
Thailand	85.6	88.6	91.6	85.1	86.9	88.2	87.6	MICS2005-2006
Vanuatu	86.5	76.9	87.2	48.9	89.1	67.7	79.5	MICS2007
VietNam	95.3	89.5	96.8	76.1	96	73.5	91.1	MICS2006

Notes:

1) Cambodia and India figures for a slightly different indicator, so not comparable with other countries. Percentage of women aged 15-49 who know that HIV can be transmitted from mother to child and its risks can be reduced by taking special drugs.

2) Thailand and Vanuatu figures for transmission of AIDS

3) Indonesia and Pakistan figures for ever-married women aged 15-49

*Using DHS because MICS2006 does not include this indicator

MDG 7: Proportion of population with access to an improved water source								
Country	Urban	Rural	Best Area	Worst Area	Richest	Poorest	National Average	Data Source
Bangladesh	99.2	97.1	99.6	91.7	99.3	99	97.6	MICS2006
Cambodia	67.3	53.7					55.6	DHS2005
India	95	84.5					87.9	NFHS2005-2006
Indonesia	80.6	54.4					65.6	DHS2005-2006
Lao PDR	70.4	35	56.7	47	72.4	40.4	51.5	MICS2006
Mongolia	91	45.9	95.1	52.2	99.5	33.7	71.6	MICS2005
Nepal	90	81.1					82.5	DHS2006
Pakistan	94	91.9					92.6	DHS2006-2007
Philippines	60.6	79.7					70.1	DHS2008
Thailand	97.6	92.5	98.1	81.5	98.0	90.5	94	MICS2005-2006
Vanuatu	97.8	81.2	98.4	67	99.8	69.2	85.1	MICS2007
VietNam	97.1	86.2	98.9	72.6	97.7	66.6	89	MICS2006
MDG 7: Proportion of population with access to improved sanitation								
Country	Urban	Rural	Best Area	Worst Area	Richest Quintile	Poorest Quintile	National Average	Data Source
Bangladesh	57.8	31.9	48.4	34.4	82.0	11	39.2	MICS2006
Cambodia	56.1	15.7					21.6	DHS2005
India	52.8	17.6					29.1	NFHS2005-2006
Indonesia	77.3	44.3					58.4	DHS2005-2006
Lao PDR	83.5	15.8	53.5	27.7	98.3	7.1	44.8	MICS2006
Mongolia	95.4	53.1	96.2	56.8	99.8	28.5	77.2	MICS2005
Nepal	42.1	21.3					24.5	DHS2006
Pakistan	78.4	38	55.8	35.3			51.8	DHS2006-2007
Philippines	75.2	58.8					66.9	DHS2008
Thailand	99.7	99	99.8	96.6	99.9	97.8	99.2	MICS2005-2006
Vanuatu	91.2	55.1	94.3	38.2	97.1	37.6	63.5	MICS2007
VietNam	89.5	55.8	87.3	32.3	98.2	15.4	64.3	MICS2006

D. Methodology

Statistical Data and Qualitative Information

This report uses national level household survey data from Multiple Indicator Cluster Surveys (MICS) and demographic health surveys (DHS). These are only household surveys implemented by Government Statistical Offices that consistently use the same MDG related indicator definitions in an internationally comparable manner are the MICS and DHS. For the purpose of being able to conduct disparity analysis, raw data from MICS/DHS, which are key government data sources (but not the only sources), have been used but national averages

stemming from these sources may not be the actual UN official or government cited MDG estimates. This analysis uses the published survey reports, which include much data that has already disaggregated. The full list of MICS and DHS surveys used is provided in the data annex above. However, the lack of availability of pre-analysed disaggregated data is a significant challenge to providing a complete picture of all disparities. The focus of this analysis is frequently determined by the availability of data, and therefore must be considered preliminary.

In some cases, supplementary information on specific categories of data (such as government social sector expenditures), or on specific countries (such as examples of specific governmental programmes, or data on a specific issue in one country) was either obtained from a key informant or abstracted from project documents, and then reviewed by key informants associated with the programme.

Indicator selection

Indicators have been selected for each MDG, and child protection, based on the availability of comparative disaggregated national data. Indicators selected have particular significance for measuring child wellbeing. These indicators may not reveal the full breadth and depth of disparities, but have been selected to provide a 'snapshot' of disparities in the region. In selecting indicators, some compromises had to be made. The "ideal" indicator was sometimes not available for a large number of countries. In those cases, a useful, but not necessarily ideal, indicator that was available for a larger number of countries was sometimes chosen. All indicator definitions are included in the Data Annex above. All the indicators represent access to services, or outcomes, that are children's basic rights. Consequently, the gaps depicted in the analysis represent a failure to guarantee children their rights. As well as a failure to guarantee rights, each gap represents opportunities missed to reach excluded children.

Analysis

The quantitative analysis in this paper operates at the *descriptive* level, consolidating statistics from the aforementioned published reports. For each indicator, disparities are analysed using a gap analysis framework across several domains, namely gender, area of location (rural or urban), subnational geographic area, wealth status (measured in quintiles), level of mother's education, caste status, and ethnic or religious identity.

There are limitations of this analysis plan. It offers descriptive statistics without calculating whether observed differences are statistically significant. Moreover, the analysis does not analyze original datasets using multivariate regression to control for the many other variables and their interaction that could affect outcomes. In short, the report does not suggest any causal relationship between demographic status and human development outcomes.

Case study selection

In addition to describing inequities, this report also describes intervention strategies that seek to address inequities. In the absence of strong evaluation data that suggest differential effects of programs, (with some exceptions) these strategies must be considered 'promising' rather than 'proven'.

Structure of the report

Section I considers the economic and political environment of Asia Pacific that dictates an increased attention to equity. Section II examines trends in disparities affecting children's rights using the MDG indicator framework in more detail. Section III considers the underlying

causes of these disparities. Section IV considers successful examples of cross-cutting and sector-oriented policies and programmes. Section V depicts governmental revenues and expenditures as well as the availability of fiscal space to reduce disparities in MDG achievement. Section VI proposes preliminary recommendations for enhanced collaboration between countries to improve the achievement of MDGs with equity.

E. Challenges in gathering evidence

Data limitations

Starting points of the search for data on disparities were statistical web sites of United Nations Organizations. Most of these sites reported on national averages, rather than disparities. UNICEF sites, especially www.childinfo.org, had useful information. Joint Government Statistics Offices (GSO) publications and data, such as MICS and DHS reports, were the most useful sources of comparable data, in most cases.

Several types of gaps in comparability emerged. Countries with MICS and DHS reports had much more information on disparities than those without. For countries with these reports, the main gaps were simply the limitations of those surveys. Information on disparities structured by ethnic group was very rarely available. Many GSOs have useful information for national planning purposes on disparities by gender, geographic area and wealth quintile. Data on proportionally small groups, such as irregular migrants, people living in informal settlements, street-based populations, residents of conflict zones, internally displaced persons (IDPs), refugees, trafficked persons, children with disabilities and street children was also missing. This occurs precisely because these extremely vulnerable populations live on the margins of society. Their lack of permanent abode, high mobility, and relative "invisibility" converge to make enumeration and surveying difficult. Further research requires gaining greater insight into the conditions in which these excluded groups live. More usage of MICS and DHS surveys would increase availability of data on disparities. Tables of internationally comparable national level data, abstracted from governmental MICS and DHS reports

With respect to children, there is a general lack of system level data available, including an absence of vital health statistics, child protection data related to child labour, juvenile justice, and birth registration. While such administrative data is not necessarily comparable intra-regionally, it would assist in a closer analysis of disparities at the local level. Unmarried adolescents are not included in household surveys such as DHS and MICS and as such, quantitative data about their reproductive health and knowledge is absent from this paper. This results in a significant data gap for a vulnerable population, especially in the context of STIs and HIV/AIDS. In this study, authors have not been able to access robust, published quantitative data about caste, ethnic, and religious disparities. However, the paper does provide a general overview of the disparities that exist across these domains of exclusion for each country in the region.

Regarding policy and program responses, a lack of monitoring and evaluation data has impeded efforts to identify successful pro-equity strategies. Even when monitoring data is available, too frequently they focus on service *outputs* rather than *outcomes* and impact. When outcome and impact data is available, too often they fail to demonstrate the *differential* impacts programs have on different population groups, delineated, for example, by gender, wealth, or ethnicity.

Knowledge gaps

The Asia-Pacific region increased its global share of scientific published articles from 13 per cent in the early 1980s, to just over 30 per cent in 2009. In science and technology, Asia is clearly a significant and growing part of the global “knowledge economy”.

The expansion of knowledge of coverage and efficacy of activities of social sector programmes is probably lagging somewhat, though there have clearly been vast improvements in the knowledge available. Culturally, Asia and the Pacific have been somewhat reluctant to embrace the discipline of programme evaluation. While Africa has about 18 national professional associations of programme evaluators, Asia has only three. Africa, Europe, Latin America and North America all have continent wide umbrella associations of professional evaluators. Asia does not have such an entity, yet.

This does not mean that Asia is inactive in the area of programme evaluation. Sectoral Ministries are normally engaged in continuous assessment of performance with varied stakeholders, including UN Agencies. These assessments include periodic dedicated studies of sector activities with documented formal methodologies. Unfortunately, the vast majority of these dedicated studies are unpublished. This problem of the “grey zone” of unpublished but often very important literature is referred to formally in meta-analysis as “the file drawer problem”.

International agencies do often maintain databases of studies in which they collaborated, but in the absence of formal government endorsement and publication, these huge collections of vital information are typically maintained only for internal access by staff only.

Asia certainly needs to publish more of its studies of social sector activities and impacts. In addition, there is a pressing need for an open access database that includes unpublished, but highly informative, examples of successful programmes and information on lessons learned on the way. This “knowledge repository”, into which researchers from all countries in the region could submit their unpublished research results, could perhaps be maintained by some inter-governmental organization.

F. Natural disasters

Asia and the Pacific is the most disaster prone area in the world, with 70 per cent of lives lost to disasters located in the region. According to the ISDR Global Assessment Report (GAR) of 2009, 75 per cent of global flood mortality risk was concentrated in only three countries: Bangladesh, China and India, while 85 per cent of cyclone deaths were in Bangladesh and India. Between 1990 and 2008, over half of South Asia's population was affected by weather-related disasters, killing 60,000 and costing US\$45 billion in damages. The SAARC Disaster Management Centre estimates GDP losses of between 2 and 20 per cent due to disasters with the ADB estimating an annual loss of US\$39.5 billion for all of Asia.

In 2005, 168 governments, UN and NGOs endorsed the Hyogo Framework for Action (HFA) to ‘build the resilience of nations and communities to disaster’. Governments and communities have responded in unique ways. The Government of Viet Nam is building flood-resistant schools and housing for one million people and is trying to relocate vulnerable populations to higher land, while improving access to basic services and has improved land tenure rights for women with the 2004 Land Law. Women are often left landless after deaths of husbands in disasters. The Land Law addresses this by making it mandatory for all Land Tenure Certificates (LTCs) to carry the names of both husband and wife to indicate joint ownership.

The Government of Bangladesh too has modified national laws. The government recently passed a National Disaster Management Act and National Disaster Management plan, which specifies policies, roles and responsibilities for addressing disasters at local and national levels. In 2004, the government developed a Natural Disaster Risk Reduction Fund to support short-term employment programmes for disaster-affected people, including the '100 day employment generation' programme initiated in 2008.

Still, progress under the HFA is not leading to an overall reduction in disaster associated risks. The 2009 ISDR Global Assessment Report (GAR) suggests that total risks are actually increasing. Climate change magnifies the extent of risks, and the uneven distribution of consequences. Unless trends are reversed, it will be difficult to achieve the HFA goals and the MDGs.