



Economic and Social Commission for Asia and the Pacific**Seventy-first session**

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Item 3 (g) of the provisional agenda*

**Review of issues pertinent to the subsidiary
structure of the Commission, including the work of
the regional institutions: social development****Key issues and challenges in achieving the social-sector-
related Millennium Development Goals****Note by the secretariat***Summary*

As the deadline for the achievement of the Millennium Development Goals draws near and the international community debates the elements of a development agenda beyond 2015, it is an opportune time to take stock of achievements in the region as a whole, with a particular focus on countries with special needs, and to identify priority areas for future action.

The Asia-Pacific region as a whole has made significant progress towards the social-related Millennium Development Goals. While the region's greatest success lies in reducing income poverty and achieving universal primary school enrolment, the reduction in income poverty has often not been translated into improvements as regards other Goals and targets, such as those on health and gender equality.

A review of the evidence also shows that many countries with special needs are performing relatively well as regards Goals 1 and 2, while progress is uneven for other Goals. Overall, least developed countries still have a long way to go to further reduce poverty, and child and maternal mortality.

Further analysis shows that addressing the following areas has been essential in achieving the Goals and will continue to be critical for sustainable development: (a) investments in social policies; (b) gender equality; and (c) inequalities.

The Commission is invited to review the issues and proposed policy recommendations in the present note and provide the secretariat with guidance for its future work in the area of social development, particularly in the light of the ongoing discussion on the development agenda beyond 2015.

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I. Introduction

1. The Millennium Development Goals (hereafter “Goals”) are a milestone in global and national development efforts, having revolutionized the development paradigm by moving the focus to specific key areas of social development.

2. In the United Nations Millennium Declaration, the international community committed itself to a set of development goals on eradicating poverty and ensuring universal access to essential social services, including primary education and maternal health services. It also committed itself to improving maternal and child health, and combating HIV/AIDS and other infectious diseases.

3. In the Millennium Declaration, member States made a strong commitment to reducing poverty:

We will spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty, to which more than a billion of them are currently subjected. We are committed to making the right to development a reality for everyone and to freeing the entire human race from want.¹

4. The Millennium Declaration also affirmed equality as one of the fundamental values of the 21st century: “No individual and no nation must be denied the opportunity to benefit from development. The equal rights and opportunities of women and men must be assured.”²

5. With six Goals out of the eight being directly related to the social sector, social development is at the centre of the development agenda. While the Goals provided a core set of objectives, other frameworks adopted at key global conferences yielded implementation plans that support their achievement. Those include the Beijing Declaration and Platform for Action, the Programme of Action of the International Conference on Population and Development, the Brussels Programme of Action for the Least Developed Countries for the Decade 2001-2010 and its follow-up programme, the Istanbul Programme of Action.

6. As the deadline for the achievement of the Goals draws closer and the international community debates the elements of the development agenda beyond 2015, it is an opportune time for the region as a whole to take stock, with a particular focus on countries with special needs, and to identify priority areas for future action.

II. Assessment of Millennium Development Goal achievement in the Asia-Pacific region

7. The Asia-Pacific region as a whole has made significant progress towards achieving the social-related Goals, but considerable unfinished business remains. The region’s largest success lies in reducing income poverty and achieving universal primary school enrolment, the reduction in income poverty has often not been translated into improvements as regards other Goals and targets, such as those on health and gender equality.

¹ General Assembly resolution 55/2, para. 11.

² Ibid., para. 6.

8. The assessment also shows that many countries with special needs are performing relatively well as regards Goals 1 and 2, while progress is uneven on other Goals. Overall, least developed countries still have a long way to go to further reduce poverty and child and maternal mortality. Most Pacific island countries have almost achieved universal primary education — but like many other countries, they are lagging behind on gender equality and all health-related goals.

A. Goal 1: Eradicate extreme poverty and hunger

9. Goal 1 seeks to eradicate extreme poverty and hunger. Related targets and indicators include halving the proportion of people whose income is below \$1.25 per day by 2015, achieving full and productive employment for all, including women, and halving the proportion of those suffering from hunger.

10. The Asia-Pacific region's dynamic economic growth has led to unprecedented poverty reduction. Although data constraints, including the lack of data disaggregated by sex, render it difficult to assess the complete picture, the most recent data show that at least 24 countries in the Asia-Pacific region have halved the percentage of people living below \$1.25 a day or are likely to have achieved this goal by the end of 2015. Achievements in China, Viet Nam and Tajikistan are most remarkable in both absolute and relative terms. China reduced the percentage of people living on less than \$1.25 a day from 60.2 per cent in 1990 to 11.8 per cent in 2010; Viet Nam from 63.7 per cent in 1993 to 16.8 per cent in 2008; and Tajikistan from 49.4 per cent in 1993 to 6.6 per cent in 2009 (see figure 1).

11. Reductions in income poverty have not always translated into reducing hunger. Several countries that have met the target of halving the percentage of people living below \$1.25 a day have not been able to halve the percentage of malnourished children. However, notable reductions in the percentage of malnourished children were made in, for example, Bangladesh (from 61.5 per cent in 1990 to 36.8 per cent in 2011).³

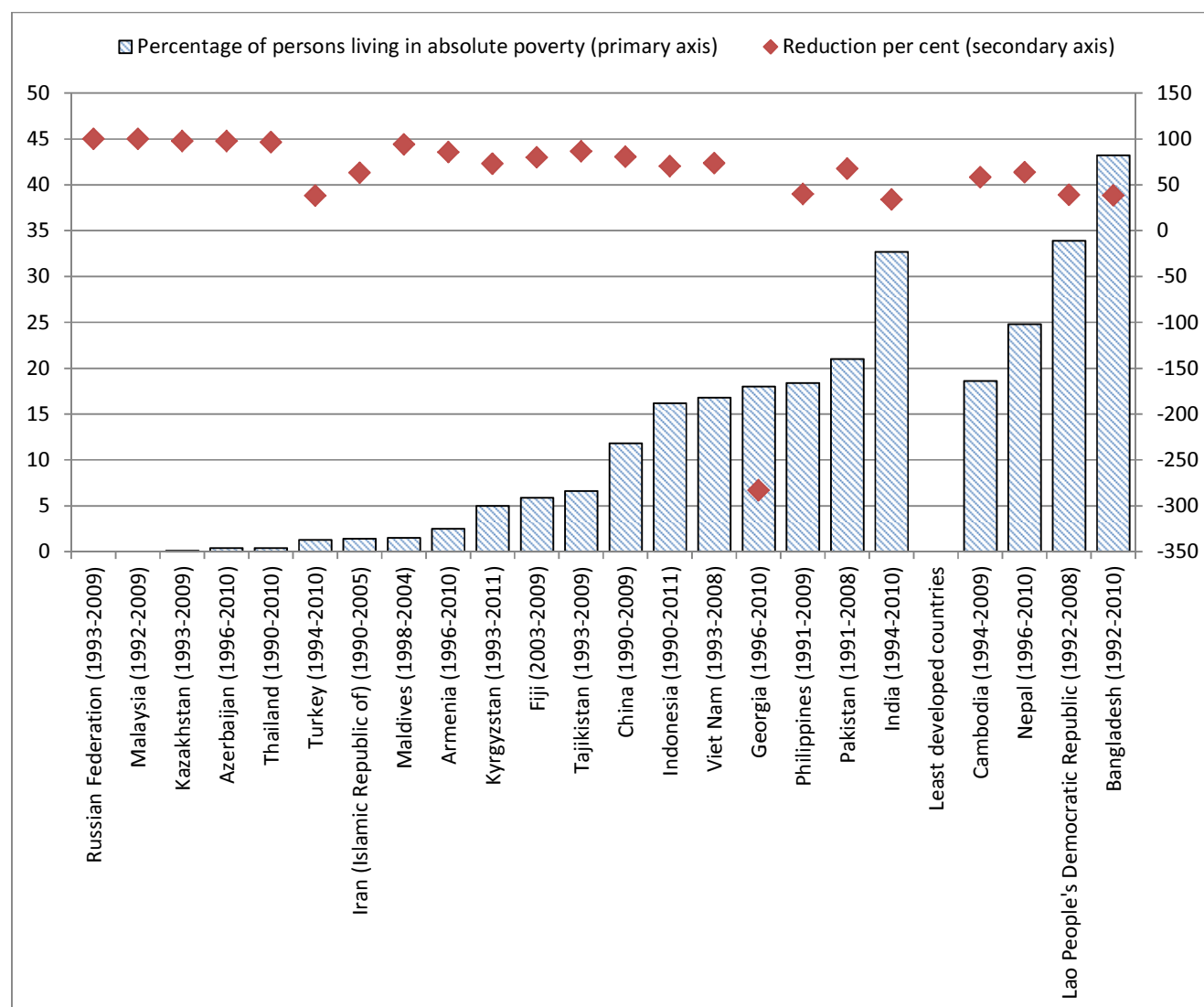
12. Overall, most of the region's least developed countries performed well in reducing poverty. Cambodia and Nepal are among the early achievers, having already more than halved the percentage of the population living on less than \$1.25 a day. Bangladesh and the Lao People's Democratic Republic are likely to meet the target. Similarly, all least developed countries in the region, except for Timor-Leste, have already halved the proportion of malnourished children.

13. As a result of the paucity in data, progress is difficult to assess in the Pacific. Fiji has successfully reduced absolute poverty from 29.2 per cent in 2003 to 5.9 per cent in 2009. Overall, absolute poverty levels, as well as food poverty, are relatively low in the Pacific. However, many Pacific island countries suffer from new forms of malnourishment, such as high obesity levels, driven by, for instance, the consumption of food high in fats and carbohydrates.⁴

³ United Nations Statistics Division, Millennium Development Goals Indicators. Available from <http://mdgs.un.org/unsd/mdg>.

⁴ World Health Organization, *Global Status Report on Noncommunicable Diseases 2014* (Geneva, 2014). Available from http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1.

Figure 1
**Percentage reduction in the percentage of people living in absolute poverty
 (between 1990 and the most recent year) and poverty levels in recent
 years, select countries in the Asia-Pacific region**



Source: United Nations Statistics Division, Millennium Development Goals indicators website. Available from <http://mdgs.un.org/unsd/mdg/Data.aspx>.

14. In spite of that success, there are areas of concern. In some countries, the situation has deteriorated. In Georgia, the percentage of people living on less than \$1.25 has increased from 4.7 per cent in 1996 to 18 per cent in 2010 (see figure 1). The percentage of malnourished children has increased in Armenia (from 2.7 per cent in 1999 to 5.3 per cent in 2011) and in Timor-Leste (from 40.6 per cent in 2003 to 45.3 per cent in 2010).

15. While poverty has dropped in absolute terms, the share of the poorest income quintile in national consumption is decreasing in many countries.³ However, poverty is still high in many countries. At least one fifth of the populations in Bangladesh, India and the Lao People's Democratic Republic still live in absolute poverty in 2015.

16. Unfinished business also remains in providing decent work and employment opportunities for all. A significant proportion of the population is still employed in vulnerable employment without social protection or decent work opportunities, particularly women and people in rural areas.

17. Progress made since the adoption of the Goals may furthermore be threatened by emerging socioeconomic developments. Rising inequalities and limited access to social protection threaten further poverty reduction. Studies have shown that growth in Asia over the past decades had a tendency to be “pro-rich”.⁵ To realize future poverty reduction, it will not be enough to rely on economic growth alone. Without social protection, it is likely that a large number of people will fall back into poverty in times of crisis. The Asia-Pacific region is also ageing without comprehensive systems of income security for older people being in place.

B. Goal 2: Achieve universal primary education

18. Another remarkable area of success for most countries in the Asia-Pacific region is in achieving universal primary education, in terms of enrolment and attendance. By 2012, at least 27 countries and territories in the region had achieved net primary enrolment rates of more than 90 per cent for girls and boys.

19. Several least developed countries have been particularly successful in relation to this Goal. Bhutan almost doubled its net primary enrolment rate from 55.9 per cent in 1999 to 90.6 per cent in 2012. Nepal increased primary enrolment rates from 60.3 in 1999 to 98.5 per cent in 2013; and primary enrolment in the Lao People’s Democratic Republic went from 74.3 per cent in 1999 to 95.9 per cent in 2012.³

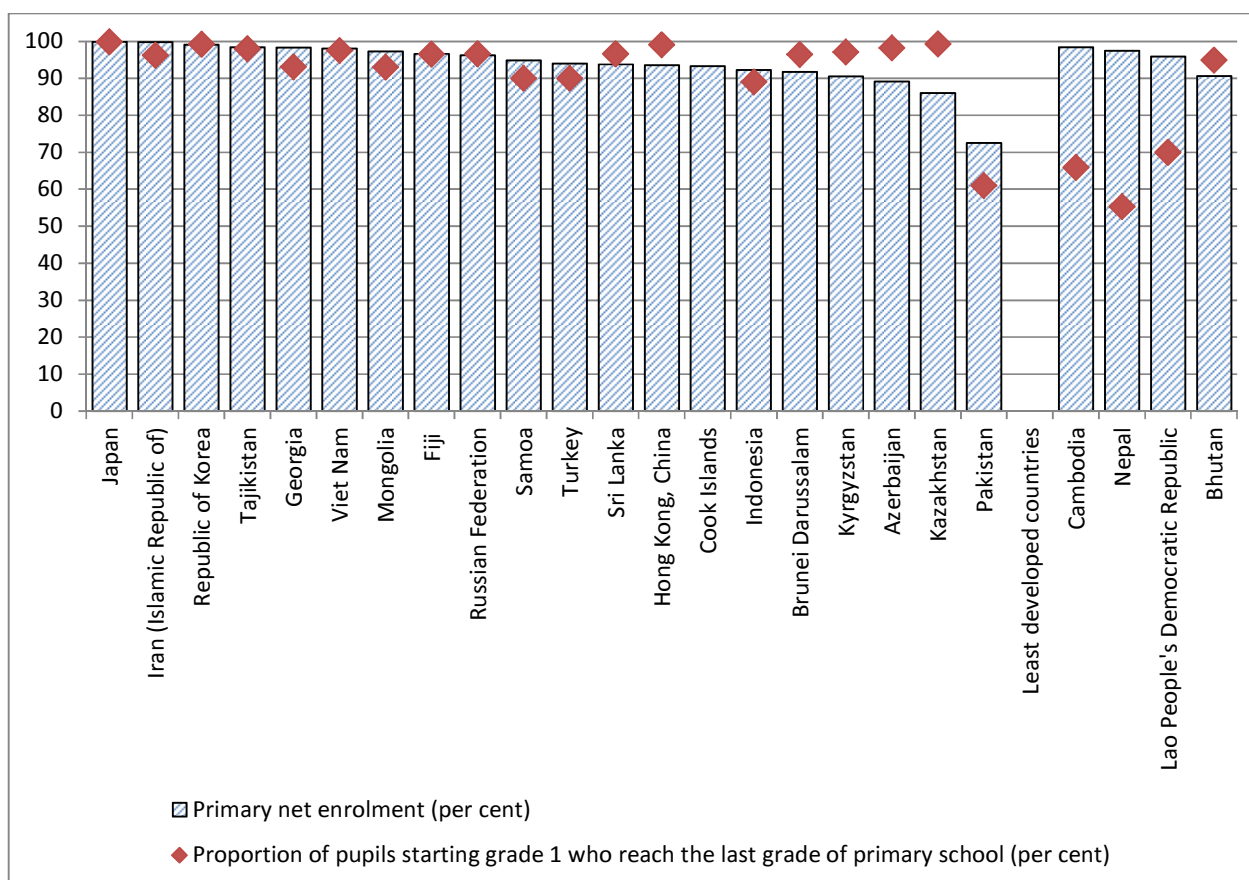
20. In some countries, such as in Azerbaijan and Tonga, however, net primary school enrolment seems to have declined. In Azerbaijan, net primary enrolment fell from 92.1 per cent in 1999 to 89.1 per cent in 2012; while in Tonga it decreased from 91.3 to 89.8 per cent over the same period.³

21. When it comes to completion of primary education, least developed countries perform less favourably. In Nepal, only 55.3 per cent of children who are enrolled in school reach at least the last year of primary school. In Cambodia, it is 65.9 per cent and in the Lao People’s Democratic Republic it is 69.9 per cent (see figure 2). Many least developed countries are implementing policies to encourage school enrolment, but lack adequate policies to ensure that children stay in school. In least developed countries, where access to social protection is still relatively limited, households are more likely to take their children out of school in times of crisis.

22. Pakistan is one of the few countries that are likely not to achieve universal primary education (see figure 2). In 2012, net primary enrolment stood at 72.5 per cent (77 per cent for males and 65 per cent for females); but of children enrolled, only 61 per cent reached at least the last grade of primary school. Thus, only 44 per cent of school-age children actually complete primary school.

⁵ David Dollar, Tatjana Kleineberg and Aart Kraay, “Growth is still good for the poor”, World Bank Policy Research Working Paper No. 6568 (Washington, D.C., World Bank, 2013).

Figure 2
Net primary school enrolment ratios and percentage of children starting grade 1 who reach at least the last grade of primary school, select countries in the Asia-Pacific region, most recent years



Source: ESCAP Online Statistical Database. Available from www.unescap.org/stat/data/statdb/DataExplorer.aspx.

C. Goal 3: Promote gender equality and empower women

23. The Goals framework seeks to measure gender equality and women's empowerment through indicators related to: (a) gender parity in education; (b) the share of women in wage employment outside the agricultural sector; and (c) the proportion of seats held by women in national parliaments. While the region is performing well in achieving gender parity in education, gender gaps remain in relation to employment and political representation.

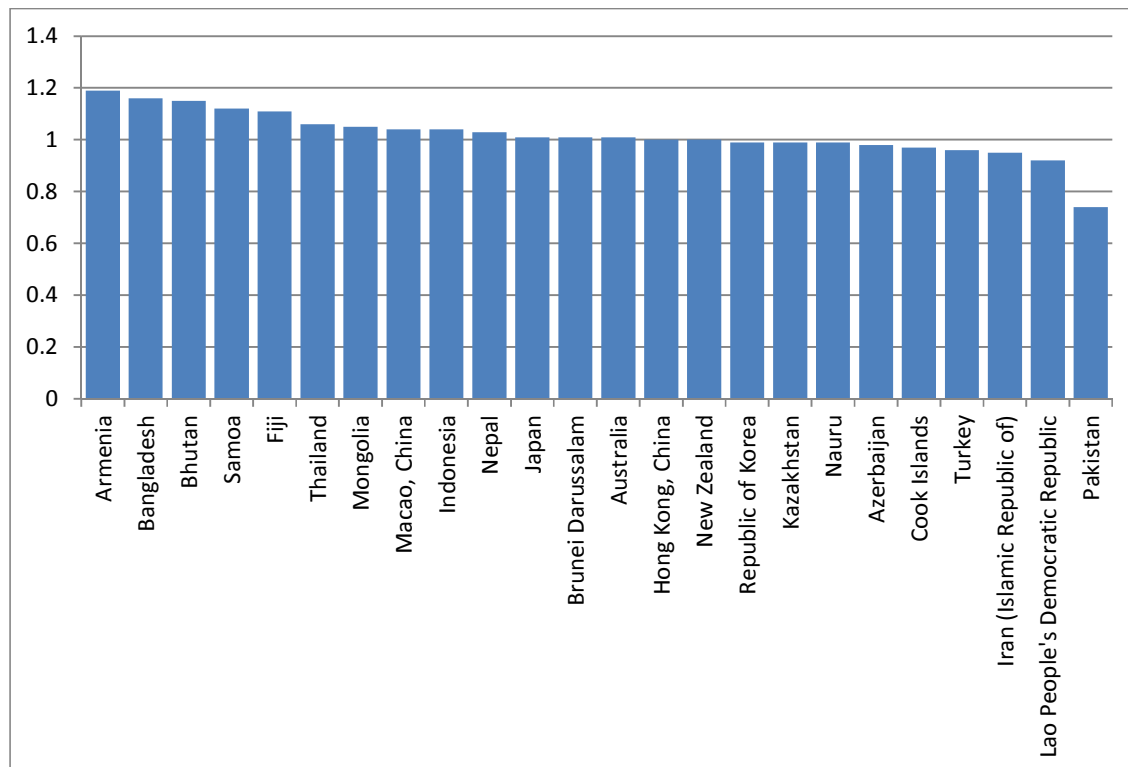
24. Since 2005, all subregions have been on track to reach the target of gender parity in primary education; almost all countries have achieved a girl to boy ratio in primary enrolment of between 0.98 and 1.03, and the ESCAP region as a whole is on track to achieve an equal ratio in 2015 (see figure 3). Of the countries where data are available, Pakistan seems to be the only country that is unlikely to achieve gender parity in primary education.

25. Similarly, the ESCAP region as a whole is in a good position to meet the target of gender parity in secondary enrolment with an overall 0.95 ratio of girls to boys. In at least 13 countries, the gender imbalance actually favours girls at the secondary level. With a ratio of 0.74 in 2012, Pakistan is the only country — of those countries for which data are available — where fewer girls than boys are enrolled in secondary school. The ratio has even deteriorated slightly in recent years.

26. Enrolment in tertiary education reveals a more diverse picture. Tertiary enrolment rates for women still lag behind those of men in all countries in South and South-West Asia, with the exception of Sri Lanka. In other subregions, young women outnumber young men in many countries. For example, in Brunei Darussalam, there are 174 young women in tertiary education for every 100 young men.

Figure 3

Ratio of girls to boys in primary education in the Asia-Pacific region (2012)



Source: ESCAP Online Statistical Database.

27. Progress in other indicators measuring Goal 3 is less favourable than the region's performance as regards education. Throughout Asia and the Pacific, women are less likely than men to be in the labour force, and are more likely to be in vulnerable employment lacking social protection.

28. For example, across the region, 24.7 per cent of women are contributing family workers, compared with 8.4 per cent of men. As contributing family workers, women do not have, or have limited, access to social protection and are restricted in their economic independence and/or autonomy within the family.

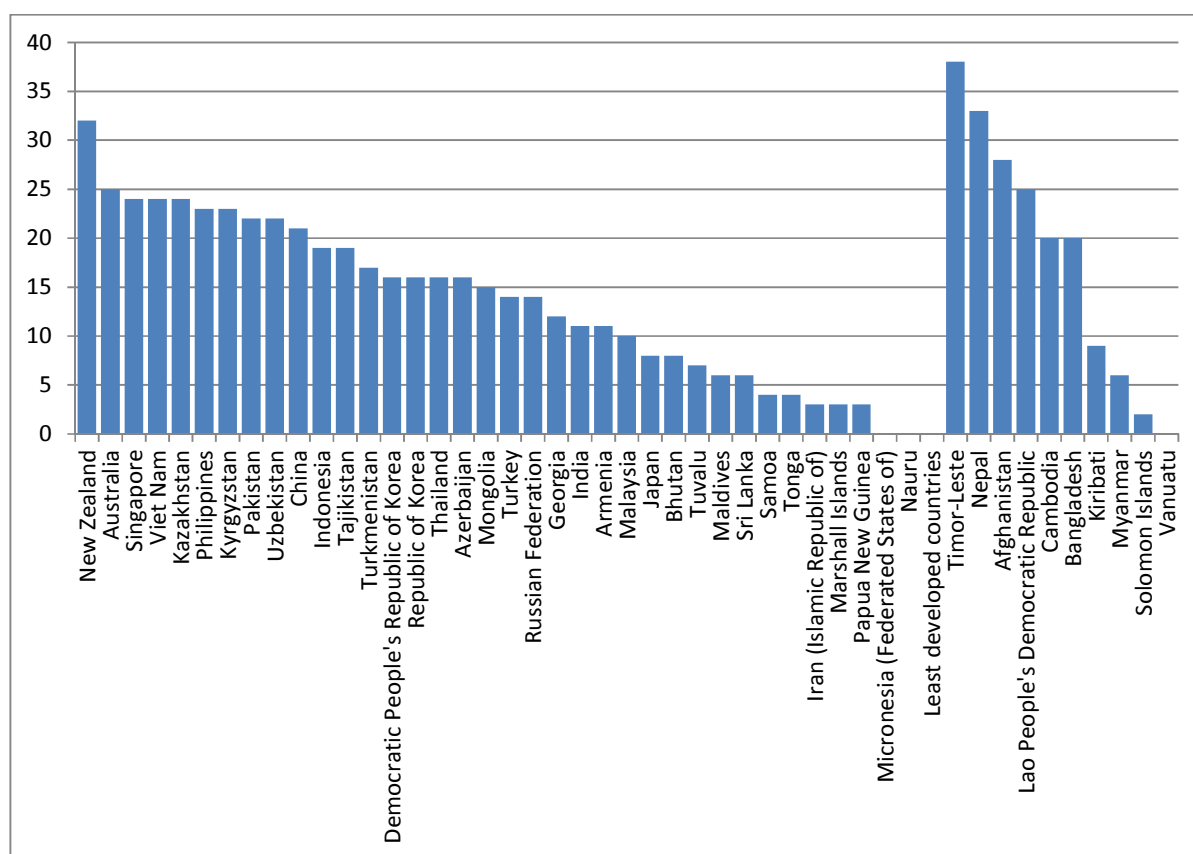
29. Only two countries or territories in the region, namely the Russian Federation and Macao, China, have achieved the target of women constituting 50 per cent of those employed in the non-agricultural sector. Furthermore, a significant number of countries are in a good position to achieve the target, with 10 countries hovering in a range of 40 to 48 per cent share of the non-agricultural labour market. Conversely, in at least nine countries in the region, women constitute less than 30 per cent of those employed in the non-agricultural sector, dropping to as low as 12.6 per cent in Pakistan.

30. In relation to the indicator on the proportion of seats held by women in national parliaments, the regional average is 18 per cent, just below the global average of 19 per cent (see figure 4). Only three countries — Timor-Leste, Nepal and New Zealand — have reached a proportional representation of 30 per cent women in national parliament. In approximately one third of countries in the region, in particular those in South Asia and the Pacific, women constitute less than 10 per cent of national parliamentarians.

31. Other statistics reveal the slow progress made in achieving gender equality in political representation. For instance, as at February 2015, among the 58 ESCAP members and associate members, there was only one female head of state (Republic of Korea) and one female head of Government (Bangladesh). In approximately half of the countries in the region, women occupy less than 10 per cent of ministerial positions. Where women serve as ministers, their portfolios tend to follow traditional gender roles, such as social, children's or women's affairs.

Figure 4

Proportion of seats held by women in national parliaments (per cent), 2012



Source: ESCAP Online Statistical Database.

D. Goal 4: Reduce child mortality

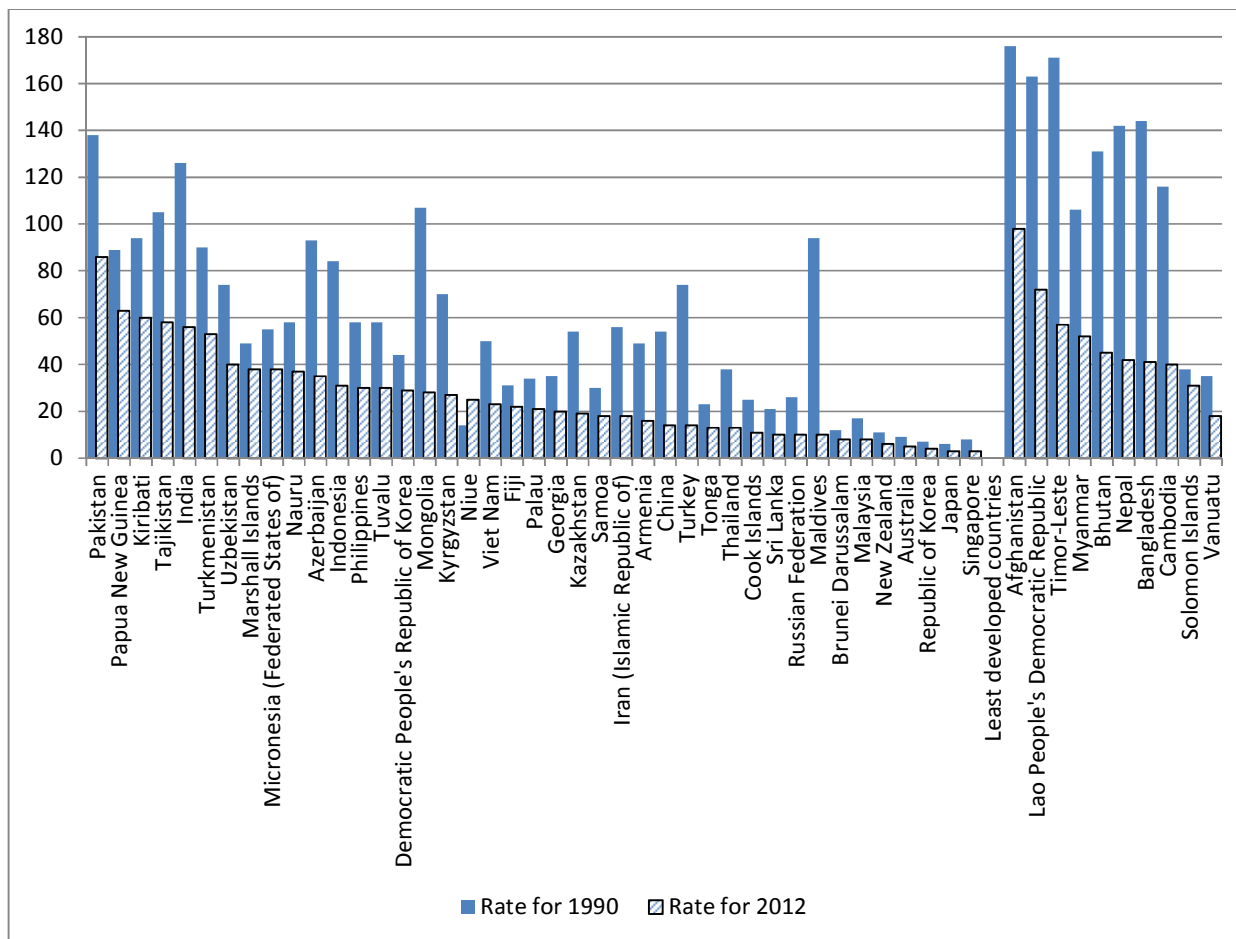
32. The Asia-Pacific region as a whole has been successful in reducing child mortality rates, with reductions in two thirds of the countries and significant improvements in immunization rates. It is to be noted that several countries in the Asia-Pacific region already had low child mortality rates at the inception of the Goals.

33. Indicators related to this Goal include reducing the infant mortality rate and the under-5 mortality rate by at least 60 per cent and achieving full measles immunization of children under 1 year of age.

34. Some countries in the region have already met these targets in advance of the 2015 deadline. For example, by 2012, the Maldives had reduced under-5 mortality by almost 90 per cent and infant mortality by 87 per cent. Similarly, Bangladesh, China, Turkey, Mongolia and Nepal had reduced both infant and under-5 mortality by more than 70 per cent by 2012 (see figure 5).

Figure 5

Under-5 mortality rates (per 1,000 live births) in 1990 and 2012 in select countries in the Asia-Pacific region



Source: United Nations Statistics Division, Millennium Development Goals indicators.

35. Least developed countries in Asia, except Afghanistan, have already achieved or are likely to achieve the goal of reducing child mortality by the end of 2015. Some of the least developed countries in Asia are among the highest achievers in reducing child mortality.

36. Overall, progress towards reducing child mortality is uneven in the Pacific. Eight countries in the Pacific are not likely to achieve this goal by 2015. Samoa and Vanuatu are the only least developed countries in the Pacific that have met the goal of reducing child mortality. The measles immunization rate in Vanuatu, however, was only 52 per cent in 2012. In Niue, the infant mortality rate increased from 12 to 21 deaths per 1,000 live births, and under-5 mortality increased from 14 to 25 per 1,000 live births between 1990 and 2012 (see figure 5).

37. Although Afghanistan and Pakistan have made progress, these two countries remain the countries with the highest child mortality levels in the region. In 2012, under-5 mortality stood at 98 per 1,000 live births in Afghanistan and at 86 per 1,000 live births in Pakistan. Although compared with 1990, under-5 mortality reduced by 44 per cent in Afghanistan and 38 per cent in Pakistan, the pace of improvement has not been enough to meet the target (see figure 5).

E. Goal 5: Improve maternal health

38. Overall, the Asia-Pacific region has seen significant improvements in maternal health, but there is still a long way to go to fully achieve the Goal. About half of the countries in the region already had low maternal mortality levels at the adoption of the Goals or have reduced maternal mortality ratios by two thirds or more.

39. Goal 5 has two targets: reducing maternal mortality ratios by three quarters and achieving universal access to reproductive health, measured by contraceptive prevalence rates, adolescent birth rates, unmet need for family planning and antenatal care coverage.

40. The countries in the region with the largest reductions in maternal mortality rates since 1990 have been least developed countries. Between 1990 and 2013, the Maldives reduced maternal mortality by 93 per cent; Bhutan by 87 per cent; Cambodia by 86 per cent; the Lao People's Democratic Republic by 80 per cent; and Timor-Leste by 78 per cent. Other least developed countries in the region, namely Bangladesh and Afghanistan, are also likely to meet the target of reducing maternal deaths by three quarters by 2015.

41. In spite of improvements in most countries, others have yet to see significant improvements in maternal health. In some countries, such as the Philippines and Tonga, maternal mortality has even increased compared with 1990.

42. There is still considerable unfinished business in improving maternal health. Although several of the region's least developed countries have been among the highest achievers when measured in relative and absolute terms compared with 1990, maternal mortality is still high in some of the region's least developed countries (see figure 6). Among the 15 countries in the region with the highest maternal mortality ratios, 10 are least developed countries.

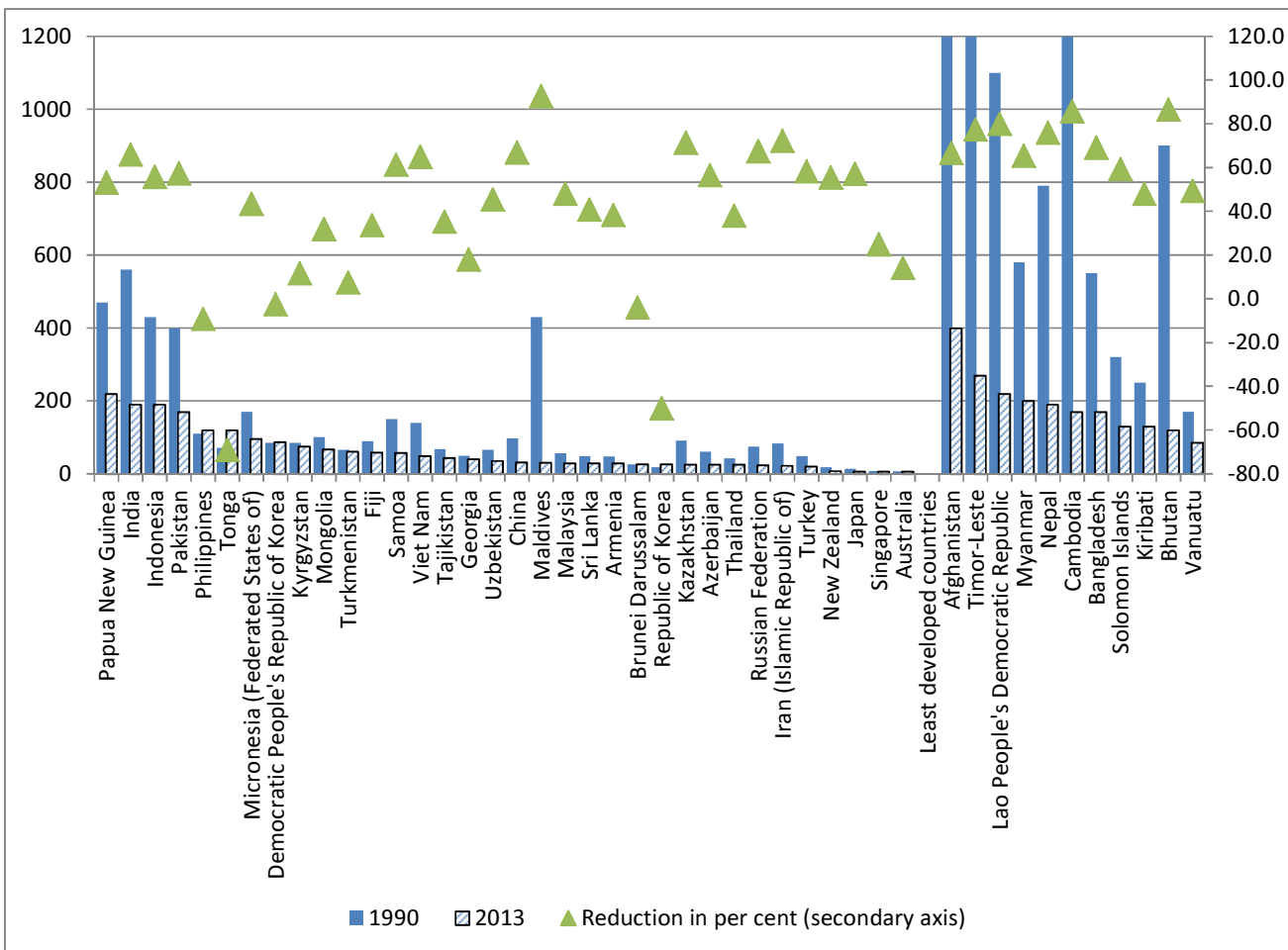
43. In some middle-income countries, maternal mortality levels are still significantly higher than their income levels would suggest. In spite of reductions of about 50 per cent in India and Indonesia, maternal mortality in 2013 still stood at 190 deaths per 100,000 live births in both countries. In Pakistan, the maternal mortality ratio is 170 deaths per 100,000 live births, at the same level as ratios in Bangladesh and Cambodia.

44. Many countries in the region still have a long way to go to reach universal access to sexual and reproductive health-care services. In Timor-Leste, 29.3 per cent of births in 2010 were attended by skilled personnel. In Bangladesh in 2011, it was similarly low at 31.7 per cent.

45. Alongside low rates of skilled personnel being present at births are low contraceptive prevalence rates. For example, in Afghanistan, only 21.2 per cent of women between 15 and 49 years of age have access to contraception; in Timor-Leste the figure is 22.3 per cent and in Pakistan 35.4 per cent. In countries in North and Central Asia, almost all births are attended by skilled

personnel, but contraceptive prevalence is still relatively low, for example, 27.6 per cent in Tajikistan and 36.3 per cent in Kyrgyzstan.

Figure 6
Maternal mortality ratios (per 100,000 live births) in select countries in the Asia-Pacific region in 1990 and 2012, as well as the percentage change during that period



Source: ESCAP Online Statistical Database.

F. Goal 6: Combat HIV/AIDS, malaria and other diseases

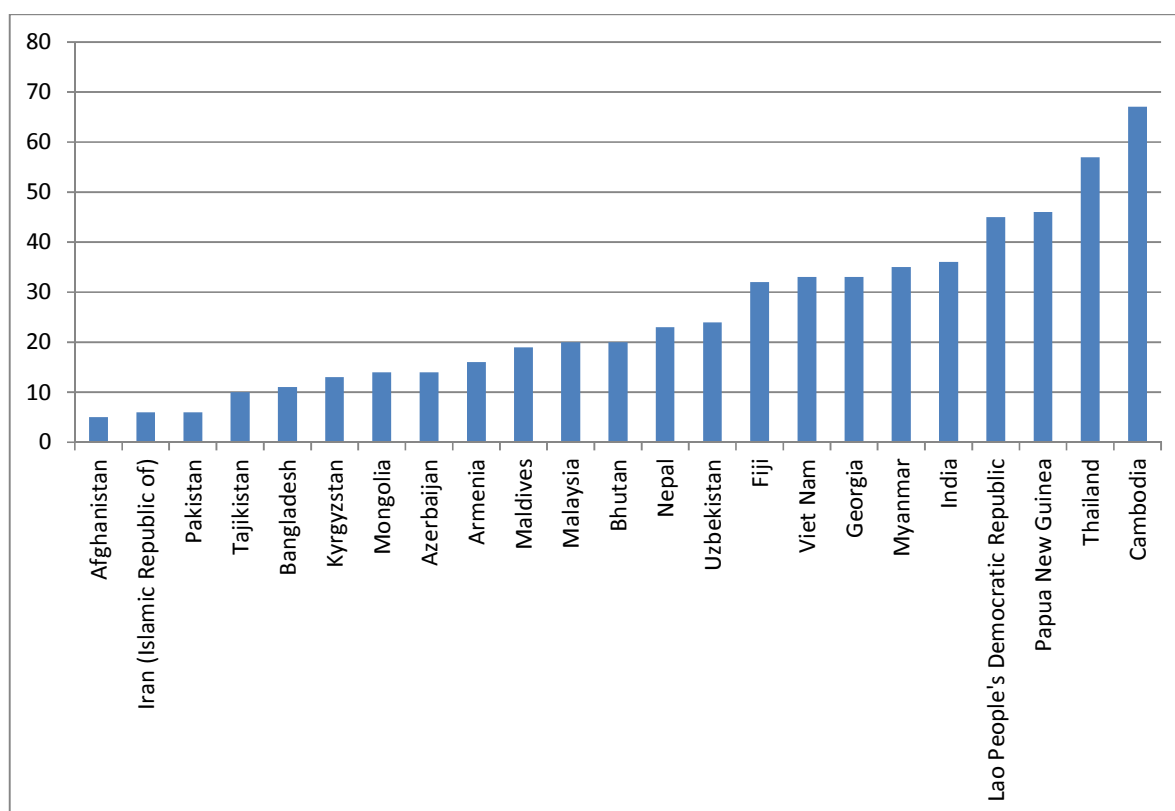
46. Progress towards Goal 6 is uneven, both across the region and by type of disease. While progress is relatively good in combating tuberculosis, with the exception of some countries, it is mixed with regard to HIV/AIDS, as well as malaria.

47. Of the 25 countries in Asia and the Pacific for which data on HIV prevalence rates are available, since 2000 the HIV prevalence rate for 15 to 49 year olds has decreased or remained unchanged in 13 and increased in 12 countries. At the same time, data showed that the number of people living with HIV increased in 17 countries in the region due to a variety of factors, including better data availability through an increase in HIV testing and access to antiretroviral therapy. HIV prevalence is higher in key populations at risk of HIV exposure.

48. Treatment coverage of people living with HIV is increasing, but it also varies substantially across the region. Moreover, in many countries, the proportion of people with advanced HIV infection with access to antiretroviral therapy did not increase. According to 2013 estimates, the total percentage of people of all ages with access to antiretroviral therapy ranges from 5 per cent in Afghanistan and 6 per cent in the Islamic Republic of Iran and Pakistan to 67 per cent in Cambodia (see figure 7). The range is between 5 and 67 per cent for those aged 15 or more and between 4 and 95 per cent for those aged under 15. Few data are available on treatment coverage in East and North-East Asia and in the Pacific. Five countries in South-East Asia have over 30 per cent coverage for those aged 15 or older, while in North and Central Asia, as well as in South and South-West Asia, only one country in each subregion provides coverage of more than 30 per cent. The antiretroviral therapy coverage of pregnant women for prevention of mother-to-child-transmission also remains persistently low in the South and South-West Asia subregion.

Figure 7

Percentage of people receiving antiretroviral therapy among all people living with HIV in Asia and the Pacific, 2013



Source: Database of Global AIDS Response Progress Reporting, prepared by the Data Team at the HIV and AIDS Data Hub for Asia and the Pacific. Available from www.aidsdatahub.org.

49. Awareness of ways of preventing the sexual transmission of HIV among young people aged between 15 and 24 is key to prevention efforts and the ability of young men and women to protect themselves from HIV. Across the region, where data are available, the awareness level for both sexes is less than 55 per cent. There are wide disparities in HIV awareness between young men and young women. Overall, young men in the Asia-Pacific region tend to have higher awareness levels compared with young women.

50. Progress is also mixed in halting malaria. While malaria is almost non-existent in East and North-East Asia and in North and Central Asia, it is still an area of concern in several countries in South and South-West Asia, South-East Asia and the Pacific. Eleven countries in South and South-West Asia and in South-East Asia have successfully halted malaria. Sri Lanka eradicated malaria in 2012. The Islamic Republic of Iran has nearly eradicated malaria, with only two cases per 100,000 people recorded in 2012 and no malaria-related deaths. Several other countries have successfully reduced malaria cases and deaths over time. Bhutan experienced a remarkable reduction within a short time; from 14,597 malaria cases per 100,000 people in 2000, to 11 cases per 100,000 people in 2012. Although reductions have not been linear, Cambodia reduced the rate of malaria cases from 1,367 per 100,000 people in 1990 to 306 cases per 100,000 people in 2012.

51. About 10 countries in the region experienced several waves of malaria within an overall decline. For example in Indonesia, malaria cases stood at 831 per 100,000 people in 1990 and, after several ups and downs, returned to 831 per 100,000 people in 2012. The Lao People's Democratic Republic initially had 512 cases of malaria per 100,000 people in 1990; this jumped to 5,195 in 2000, before falling to 275 in 2011 and then increasing again to 704 per 100,000 people in 2012.

52. Pakistan experienced an upward trend in malaria cases, rising from 72 cases in 1990 to 2,392 cases per 100,000 population in 2012.

53. The Pacific remains of particular concern in relation to malaria, with a high incidence of cases. In Papua New Guinea, the Solomon Islands and Vanuatu, malaria was particularly high between 2000 and 2005. In Papua New Guinea, the number of malaria cases has increased since 1990. In the Solomon Islands, malaria cases stood at 37,358 per 100,000 people in 1990; after several ups and downs this decreased to 10,425 per 100,000 people in 2012. Vanuatu displays a similar pattern to the Solomon Islands.

54. There is still a paucity of data related to insecticide-treated bed nets and the availability of appropriate anti-malaria drugs.

55. In the region as a whole, and particularly in East and North-East Asia, South and South-West Asia and South-East Asia, tuberculosis deaths are on a downward trend. Among the countries with the largest reductions are Bhutan, the Maldives and Turkey, with reductions of between 91 and 93 per cent from 1990 to 2012.

56. In several countries, however, particularly in the Pacific and in North and Central Asia, deaths from tuberculosis have increased over time. This is the case for Afghanistan, Armenia, Kyrgyzstan, the Marshall Islands, Nauru, Niue, the Northern Mariana Islands, Palau, the Russian Federation and Tajikistan. In the Marshall Islands, tuberculosis deaths almost quadrupled from 290 per 1,000,000 people in 1990 to 1,110 in 2012.

III. Addressing the unfinished agenda of the Goals and moving towards the development agenda beyond 2015

57. The preceding summary suggests that the region has been struggling with health-related Goals and gender equality, while the region's success story lies in achieving universal primary education.

58. As the world is moving towards the development agenda beyond 2015, which is expected to focus on eradicating poverty, addressing inequalities, providing decent work and social protection for all, among other issues, the underlying reasons for the unfinished business of the Goals has to be analysed and addressed if the development agenda beyond 2015 is to be achieved.

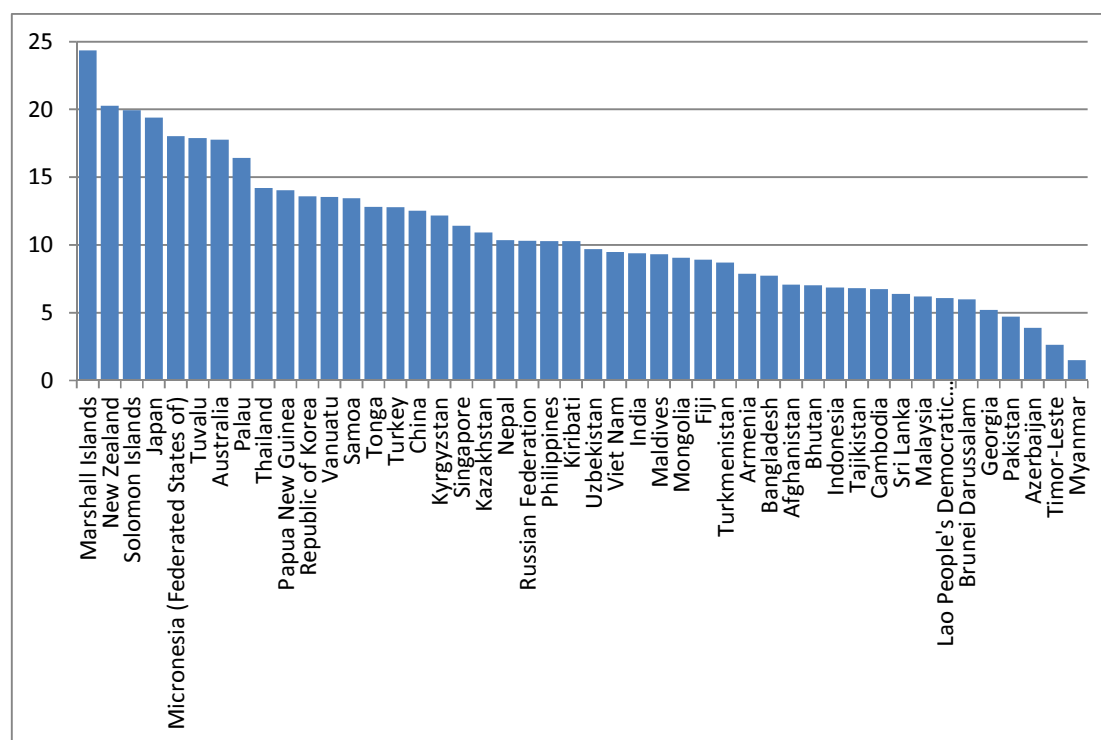
A. Investments in social policies are investments in development

59. In Asia and the Pacific, economic growth has coincided with a reduction in poverty rates in most countries, but not with improvements in areas across all social domains, including those related to health and gender equality. Strengthened social development requires effective social policies and strategies with adequate budget allocations. Social sector expenditure should be seen as an investment, and a foundation for sustainable economic growth, equality and environmental protection.

60. The experience of countries that have achieved the Goals at an early stage shows that these countries invested strongly in the social sector and continued these investments even in times of crisis. For example, Thailand has successfully achieved most social-sector Goals and, over the past decades, has shown a strong commitment to social development. This commitment is reflected in introducing a system allowing universal access to health care and committing adequate resources to it (see figure 8). Likewise, Nepal, a least developed country that has achieved most of the Goals, allocates about 10 per cent of government expenditure to health. Sri Lanka started focusing on education after independence and introduced a system focusing on primary health care and maternal health, which contributed to already having achieved universal coverage of skilled birth assistance in the 1980s.

Figure 8

Health expenditure as a percentage of total government expenditure, select countries in the Asia-Pacific region, 2012 or latest year



Source: World Bank, World Development Indicators Database, online.

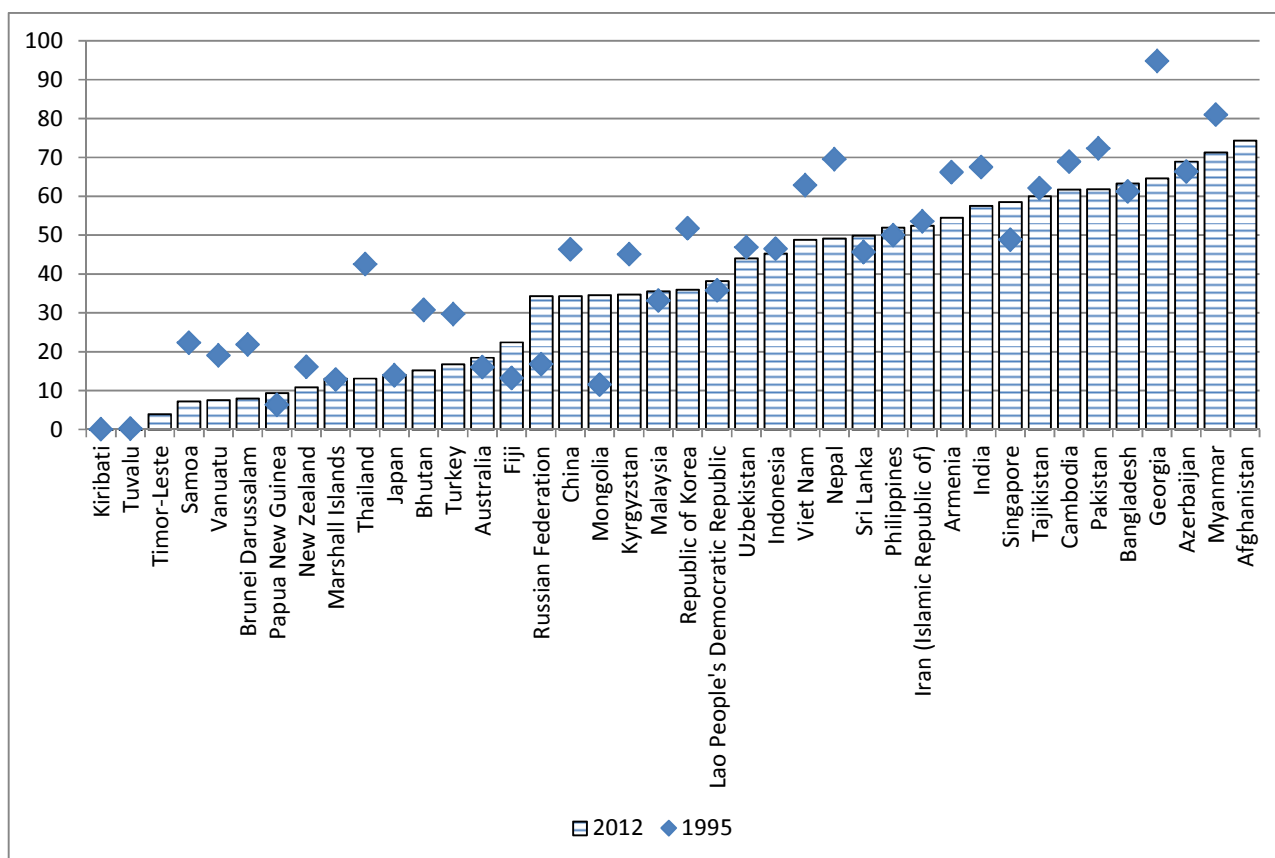
61. In contrast, health expenditure has been insufficient in many countries of the Asia-Pacific region. At least four countries in the region allocate less than five per cent of total government expenditure to health (see figure 8).

62. Private households have to bear the bulk of health costs in many countries in the region, as manifested in high out-of-pocket expenditures. In more than 18 countries in the region, more than half of all health expenditure is borne by private households (see figure 9). This implies that in many cases people may not seek medical care when necessary because they cannot afford the cost, or they have to make detrimental reductions in expenditure elsewhere, for example in nutrition or education of children.

63. Some countries in the region, such as Thailand or Bhutan, have significantly reduced the proportion of out-of-pocket expenditure between 1995 and 2012 by introducing systems enabling universal access to health care. Success in health indicators in these two countries is also a reflection of universal access to health care. But in some countries of the region, out-of-pocket expenditure has increased over time, making health care less affordable for some population groups (see figure 9).

Figure 9

Out-of-pocket expenditure as a percentage of total health expenditure, select countries in the Asia-Pacific region, 1995 and 2012



Source: World Bank, World Development Indicators Database.

64. Providing universal access to health care can be affordable for many countries. For example, Thailand is able to provide universal access to health care by dedicating 14 per cent of total government spending (or 3.2 per cent as a percentage of GDP) to health.

65. Health expenditure is not, however, always spent effectively. In many countries, health-care spending is mainly directed towards curative care with few budget allocations for preventive and basic health care including maternal and child health services, although experience has shown that the largest improvements in maternal and child health can be achieved by investing in basic health-care services. For example in Pakistan, where overall health expenditure is already relatively low, 73.5 per cent of overall health-care expenditure was allocated for curative services in general hospitals, 15.4 per cent for preventive care and only 0.3 per cent for basic health-care services including maternity and childcare in the fiscal year 2008/09.⁶ Furthermore, health spending is higher in relative terms for urban areas than for rural areas and is to a large extent absorbed by administrative costs in hospitals.

66. The situation of Pacific islands is unique. They are among the countries with the highest spending on health (as a proportion of total government expenditure), with the lowest out-of-pocket payments in the region, and yet many of them had difficulties achieving health-related Goals. Among the reasons for low achievement is the challenge of reaching outer islands and rural areas with health-care services. Health-care facilities in rural areas are poorly equipped and often lack doctors, as few doctors are willing to work in remote areas with multiple health hazards. Health-care costs are also driven up by the need to treat obesity-related diseases. Thus, there may be scope in increasing the effectiveness of health expenditure by shifting more towards prevention and health-related education.

B. Achieving gender equality is central to achieving development and equality for all

67. In spite of the progress made, the least headway has been made in Goal 3 relative to the other Goals (notwithstanding the fact that gender equality is relevant to all development goals). With women and girls comprising half the population of the Asia-Pacific region, development is only possible if attention is given to addressing the needs and interests of women and girls.

68. Gender equality is beneficial for all people, as a matter of human rights and for sustainable development. The formal education of girls has been linked to the reduced risk of child marriage and of maternal mortality. It is also linked to women having fewer and healthier children and of sending them to school, as well as enhancing employment opportunities. Investments in family planning can reduce the incidence of unwanted pregnancies and unsafe abortions, as well as reducing maternal mortality and infant mortality rates. According to a global study, increasing health expenditure by \$5 per person per year until 2035 could bring nine times that value in economic and social benefits through greater GDP, improved productivity and prevention of unnecessary deaths among women, children and infants.⁷ Gender inequality is also economically inefficient; women's restricted access to employment opportunities and decent work costs the Asia-Pacific region between an estimated \$4 billion and \$47 billion annually, and gender disparities in education result in an additional annual loss of between \$16 billion and \$30 billion.

⁶ Government of Pakistan, "Poverty Reduction Strategy Paper. Annual Progress Report FY 2008/09" (Islamabad, 2009). Available from: www.finance.gov.pk/poverty/prsp_annual_0809.pdf.

⁷ "Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework", *The Lancet*, vol. 383, 12 April 2014.

69. The synergies between gender equality and development outcomes reinforce how central and integral women's empowerment is to achieving sustainable development for all.

70. Women's equal access with men to the spectrum of social, economic and political opportunities, outcomes and resources is still restricted by imbalances in power relations, as well as discriminatory practices and patriarchal institutions and structures.

71. Violence against women is a key reflection of the power imbalances. An estimated one in three women around the world is affected by some form of physical and/or sexual intimate partner violence or non-partner sexual violence.⁸ In Asia and the Pacific, violence against women and girls remains a regional pandemic. A 2013 Asia-Pacific study indicated that between 26 and 80 per cent of men surveyed admitted to having perpetrated physical and/or sexual intimate partner violence.⁹ Gender-based violence is not only an infringement of fundamental human rights, but also undermines development.

C. Inequality undermines social development efforts

72. Future development efforts can be undermined by rising inequalities. In spite of the region's progress in reaching the Goals, there is still unfinished business in terms of eliminating poverty, child and maternal mortality and infectious diseases. In many cases, progress has not reached all population groups and all areas within countries. Overall, inequalities, which not only include income inequality but also inequality in opportunities and access to services, not only persist, but have in some cases even increased. If such inequalities are not addressed, many countries in the region will face challenges in realizing further poverty reduction, addressing the unfinished agenda of the Goals and achieving the development agenda beyond 2015.

73. Overall, efforts to increase health-care services have been more successful in urban areas more than rural areas. In rural areas, people may not be able to access the available health services due to a lack of transportation facilities. For example, a study conducted in several states of India found that 32 per cent of respondents in rural areas did not have access to an outpatient care facility within 5 km of their homes, while this was the case for only 17 per cent of respondents in urban areas. In rural areas, 63 per cent of respondents had to travel more than 5 km to access an inpatient facility, while in urban areas only 27 per cent had to travel more than 5 km to the closest inpatient facility.¹⁰ Although about 70 per cent of the population of Bangladesh lives in

⁸ World Health Organization, *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence* (Geneva, 2013).

⁹ Emma Fulu and others, *Why Do Some Men Use Violence Against Women and How Can We Prevent It? Quantitative Findings from the United Nations Multi-country Study on Men and Violence in Asia and the Pacific* (Bangkok, United Nations Development Programme, United Nations Population Fund, United Nations Entity for Gender Equality and the Empowerment of Women and United Nations Volunteers, 2013). Available from www.partners4prevention.org/sites/default/files/resources/p4p-report.pdf.

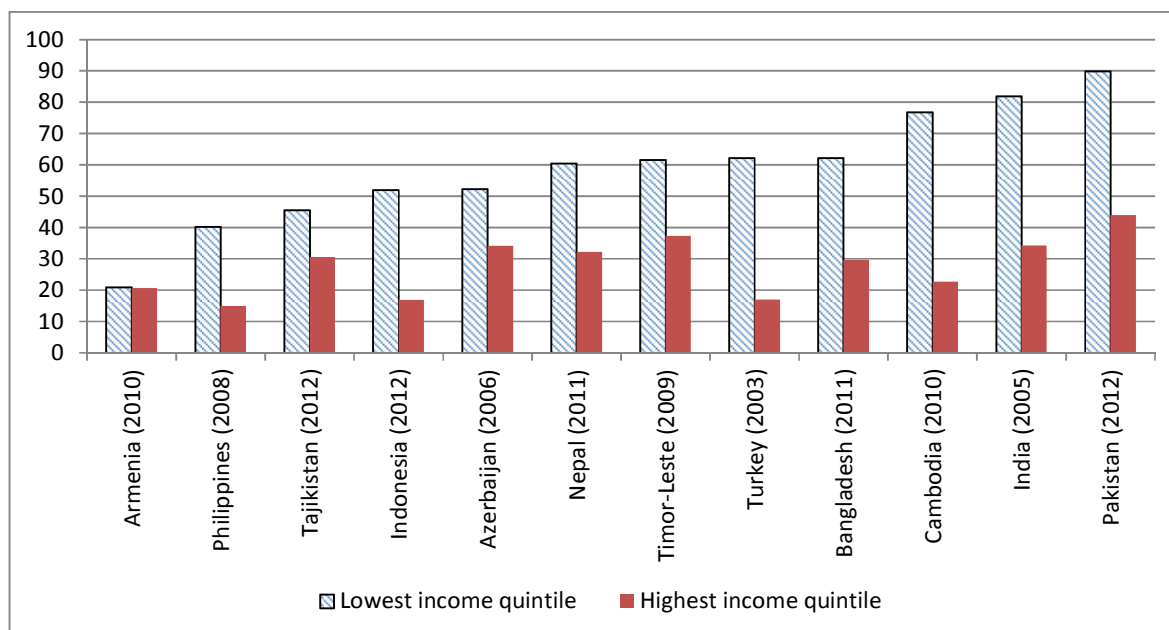
¹⁰ IMS Institute for Healthcare Informatics, "Understanding Healthcare Access in India. What is the current state?" (June 2013). Available from: www.imshealth.com/deployedfiles/imshealth/Global/Content/Corporate/IMS%20Institute/India/Understanding_Healthcare_Access_in_India.pdf.

rural areas, only 44 per cent of the major government health-care facilities are in rural areas.¹¹

74. Limited affordability of health-care services is also reflected in outcome indicators such as higher infant mortality among lower income groups. In several countries in the region, a child from the lowest income group is three times more likely to die before completing the first year of life than a child from the highest income group (figure 10).

Figure 10

Infant mortality rate (per 1,000 live births) in the lowest (Q1) and highest (Q5) income quintiles, select countries in the Asia-Pacific region, most recent years



Source: World Health Organization, Global Health Observatory Data Repository, online. Available from <http://apps.who.int/gho/data/node.main.HE-1546?lang=en>.

75. In several countries, higher income groups seem to have benefited more from increased access to health services than lower income groups. For example, access to skilled birth attendants increases with income. Moreover, in some countries, improvements over the last decades may be attributed to improvements in access for the highest income groups. For example, in Bangladesh, in the lowest income quintile, less than 5 per cent of all births were attended by skilled personnel in 2007, which shows only a small increase compared with 1996, where the figure was a little less than 2 per cent of births. The increase was significantly higher in the highest income quintile, rising from 30 per cent of births to 51 per cent over the same period. Similarly, in Nepal higher income groups benefited more from improvements to health-care provision than lower income groups.¹²

¹¹ M. Shamsur Rahman, Abu Shahin M. Ashaduzzaman and M. Mizanur Rahman, "Poor people's access to health services in Bangladesh: focusing on the issues of inequality", Workshop on Health Care for the Poor in Asia, which was held in Beijing, 5-7 December 2005. Available from www.napsipag.org/pdf/Issues_of_inequality.pdf.

¹² ICF International, DHS Program STATcompiler (online database). Available from www.statcompiler.com.

76. There are several population groups that face a number of barriers accessing health-care services. In several countries, migrant workers cannot access health-care services or, where access is permitted, encounter barriers related to issues such as language, time and transportation. Prevailing health-care systems often do not respond to the needs of persons with disabilities and/or older persons — in some cases even physical access is difficult. Young, unmarried people are often denied access to sexual and reproductive health services and key populations at high risk of HIV exposure frequently do not have access to adequate HIV prevention, treatment, care and support.

77. The combination of unequal access to opportunities, unequal outcomes and social exclusion lead to an inequality trap. The inequality trap can undermine future development efforts, as it creates the “bottom billion”, consisting of the poorest and socially excluded in each country, who are left behind in development efforts. Thus, addressing inequalities requires deliberate social policies, including universal access to social protection. Social protection plays a pivotal role in reducing inequalities and strengthening the rights of vulnerable groups, including their access to social services.

IV. Supporting countries in addressing the unfinished business of the Goals and moving towards the development agenda beyond 2015

78. The analysis above crystallizes three key areas for intervention by ESCAP that will support countries in addressing the unfinished business of the Goals and meet the goals that are likely to be agreed on in the development agenda beyond 2015. The development agenda beyond 2015 is likely to treat gender equality as a cross-cutting issue, in addition to containing a stand-alone goal on achieving gender equality and empowering all women and girls. The new global development agenda is also expected to emphasize the importance of equitable and inclusive development, reaching all areas within a country and all social and age groups. Thus, further efforts have to be made to end the inequality trap, which consists of economic poverty, social exclusion and deprivation in well-being.

79. The secretariat proposes the following key areas for intervention to address inequalities and achieve sustainable development:

(a) *Implementing the Beijing Declaration and Platform for Action to realize gender equality and women’s empowerment*: the global blueprint for realizing gender equality and empowering women is already provided in the Beijing Declaration and Platform for Action, adopted in 1995, alongside the Convention on the Elimination of All Forms of Discrimination against Women. At the regional level, countries in Asia and the Pacific are also guided by the recently adopted Asian and Pacific Ministerial Declaration on Advancing Gender Equality and Women’s Empowerment (November 2014), through which Governments committed to accelerating implementation of the Platform for Action by strengthening institutions, enhancing accountability, increasing resources, forging stronger partnerships and supporting regional cooperation;

(b) *Providing decent work including a social protection floor and addressing inequality of opportunities*: decent work and social protection has a pivotal role in reducing inequalities. When moving to a development agenda beyond 2015, providing a social protection floor, which includes universal access to health care and basic income security, will be of key importance to strengthening individuals’ and households’ resilience against falling into poverty and to further improving child and maternal health and reducing infectious diseases. In addition, universal access to health care, including

sexual and reproductive health, is crucial in reducing demand-side barriers in relation to antenatal and postnatal care, skilled birth assistance and health care for children;

(c) *Leaving no one behind*: in the development agenda beyond 2015 it will be of critical importance to ensure that currently marginalized and vulnerable people are integrated into societies and receive the support they need, in a manner that is underpinned by human rights. Without their active integration, there will always be a bottom billion left behind who are likely to remain in poverty, without access to health-care services and access to quality education or other opportunities that enable lives of dignity. These groups include, among others, persons with disabilities, key populations at higher risk of HIV and AIDS, older persons, migrants and their families, and youth. Several groups face specific barriers in accessing social services, or find that existing services do not address their needs. Thus, strengthening the rights of vulnerable groups and targeted action to enhance their access to social services will be of key importance to meeting existing targets as regards the Goals and realizing the proposed goals in the development agenda beyond 2015.

80. The key pillars of ESCAP support to member States are research and analysis, norm-setting and technical assistance in three key areas: (a) demographic and social policy trends; (b) gender equality and women's empowerment; and (c) investing in social protection and integrating vulnerable groups.

A. Research and analysis

81. Analysis of persisting and emerging demographic and social trends is essential to formulating informed and strategic policy and programmatic responses. Thus, ESCAP will monitor demographic and social trends and conduct and disseminate research, through recurrent and non-recurrent publications. This will include, inter alia, analysis of the different permutations of inequality, including gender inequalities, and their root causes and impacts; analysis of population dynamics, such as population ageing and its economic impacts; analysis of the impact of youth exclusion; analysis of existing legislation and its impact on vulnerable groups, including older persons, persons with disabilities, people living with HIV and AIDS and migrants; and analysis of the role of international migration in the Asia-Pacific region and related areas. Analysis of demographic and social trends will also guide the work of ESCAP on norm-setting and technical assistance.

82. Furthermore, ESCAP will continue to conduct research to inform frameworks on social protection, alongside documenting good practices on social policies and social protection to provide countries with recommendations and policy tools to address inequalities. Particular attention will be given to analysing the specific needs of countries with special needs and providing tailored policy recommendations.

83. To strengthen accountability systems and to monitor progress in gender equality and women's empowerment, ESCAP will intensify its efforts in building national capacity in strengthening gender statistics, including a regional core set of gender indicators to measure progress. In addition, a set of indicators will be devised to track implementation of the Asian and Pacific Ministerial Declaration on Advancing Gender Equality and Women's Empowerment.

B. Norm-setting

84. Recommendations from research provided by ESCAP will form a basis for setting norms on social policies that use a rights-based approach through intergovernmental processes. Norms and social policies are essential for the development of regional action plans on gender equality and women's empowerment and for the integration of vulnerable groups, such as persons with disabilities, older people, people living with HIV and AIDS, and migrants.

85. Monitoring existing action plans, such as the Beijing Platform for Action, the Plan of Action of the International Conference on Population and Development, and the Madrid International Plan of Action on Ageing and their regional implementation plans, will also continue to be central to the work of ESCAP on norm-setting.

86. ESCAP has also been instrumental in developing regional strategies that promote the integration and rights of vulnerable groups, such as the Incheon Strategy to "Make the Right Real" for Persons with Disabilities in Asia and the Pacific and the ESCAP road map to 2015: regional framework for action on HIV and AIDS.

C. Technical cooperation and capacity-building

87. Based on the research, analysis and norm-setting of ESCAP, the secretariat will continue to provide technical support to member States in implementing regional action plans developed in intergovernmental processes, conducting reviews of existing legislation and developing social policy frameworks.

88. The technical cooperation of ESCAP includes developing guidelines on the integration and the rights of vulnerable groups, such as promoting accessibility for persons with disabilities and developing guidelines on the rights of older people and for measuring progress in action plans such as the Incheon Strategy to "Make the Right Real" for Persons with Disabilities in Asia and the Pacific. ESCAP will also continue its capacity development work to create an enabling environment for enhancing women's economic participation, which includes supporting the development of a subregional strategy for women's entrepreneurship in the context of economic integration within the Association of Southeast Asian Nations.

89. Other elements of the technical cooperation work of ESCAP include providing a platform for the exchange of good practices in promoting gender equality and women's empowerment, investing in social protection and integrating vulnerable groups.

90. Countries with special needs will receive priority attention in the technical cooperation activities of ESCAP, with some such activities being specifically tailored to the needs of countries with special needs, including Pacific island countries.

V. Conclusion

91. Given the issues and recommendations that have been raised in this document, the Commission may wish to deliberate on the following:

(a) What policy measures are needed to ensure equal access to social services, particularly health-care services?

(b) What policy measures are needed to ensure the rights of marginalized groups, such as older people, persons with disabilities, migrants, young people and others, and their access to social services?

(c) What are the data and research gaps in the area of social protection and addressing inequalities and how could they be narrowed?
