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CAN SAARC COUNTRIES ACHIEVE MILLENNIUM DEVELOPMENT GOALS IN 2012? : A CHALLENGE FOR HUMAN DEVELOPMENT

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ABSTRACT

SAARC countries can achieve and sustain economic and human progress only if every efforts are made to eradicate illiteracy, make primary education compulsory, and ensure equitable access to good quality health care for all its people. Economic reforms in 1991 focused on expanding economic opportunity. This paper has been attempted to highlight the basic objectives of the human development in the SARRC Countries. Human development consist mainly life expectancy at birth, adult literacy rate, Gross Domestic Product per Capita, life expectancy, commitment to health, water, sanitation and nutritional status to education and poverty eradication. The SARRC Countries faced with main challenges: Quality of people's life; Balance development; Resources for investing in human capital ; Promoting basic health and education; Human development has to be participatory. The government of India and Unicef launched a five year (2008-12) action plan to help India combat the challenges of excessive malnutrition, high infant and maternal mortality rates, lack of quality education, safe water and sanitation.'with seven year to go for the realization of millennium development goals (MDGs), India is way off in terms of eradicating extreme hunger and poverty with 34.3 percent of its people still live on less than one dollar a day.' The SAARC countries have many challenges to develop the human skills in their regions to achieve the millennium development goals.

Keywords: *SAARC Countries, Millennium developmental goals, 2012.*

In the late 1970s, Bangladeshi President Ziaur Rahman proposed the creation of a trade bloc consisting of South Asian countries. The idea of regional cooperation in South Asia was again mooted in May 1980. The foreign secretaries of the seven countries met for the first time in Colombo in April 1981. The Committee of the Whole, which met in Colombo in August 1981, identified five broad areas for regional cooperation. New areas of cooperation were added in the following years.

The objectives of the Association as defined in the Charter are:

- To promote the welfare of the peoples of South Asia and to improve their quality of life.
- to accelerate economic growth, social progress and cultural development in the region and to provide all individuals the opportunity to live in dignity and to realize their full potential;
- to promote and strengthen collective self-reliance among the countries of South Asia;
- to contribute to mutual trust, understanding and appreciation of one another's problems;
- to promote active collaboration and mutual assistance in the economic, social, cultural, technical and scientific fields;
- to strengthen cooperation with other developing countries;
- to strengthen cooperation among themselves in international forums on matters of common interest; and
- to cooperate with international and regional organisations with similar aims and purposes.

The Declaration on South Asian Regional Cooperation was adopted by the Foreign Ministers in 1983 in New Delhi. During the meeting, the Ministers also launched the Integrated Programme of Action (IPA) in nine agreed areas, namely, Agriculture; Rural Development; Telecommunications; Meteorology; Health and Population Activities; Transport; Postal Services; Science and Technology; and Sports, Arts and Culture. The South Asian Association for Regional Cooperation (SAARC) was established when its Charter was formally adopted on 8 December 1985 by the Heads of State or Government of Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and India.

Afghanistan was added to the regional grouping at the behest of India on November 13, 2005, and became a member on April 3, 2007. With the addition of Afghanistan, the total number of member states were raised to eight (8). In April 2006, the United States of America and South Korea made formal requests to be granted observer status. The European Union has also indicated interest in being given observer status, and made a formal request for the same to the SAARC Council of Ministers meeting in July 2006. On August 2, 2006 the foreign ministers of the SAARC countries

agreed in principle to grant observer status to the US, South Korea and the European Union. On 4 March 2007, Iran requested observer status. Followed shortly by the entrance of Mauritius.

Services work especially when we recognize that resources and their effective use are inseparable. More effective use makes additional resources more productive and argument for aid more persuasive. External resources can provide strong support for changes in policy and practice that can bring more effective use. This is how we can scale up to achieve the Millennium Development Goals.

Services work when they include all the people, when girls are encouraged to go to school, when pupils and parents participate in the schooling process, when communities take charge of their own sanitation. Too, often, services fail poor people-in access, in quantity, in quality. But the fact that there are strong examples where services do work means governments and citizens can do better. How? By putting poor people at the centre of service provisions by enabling them to monitor and discipline service providers, by amplifying their voices in policymaking, and by strengthening the incentives for providers to serve the poor.

Freedom from illness and freedom from illiteracy –two of the most important ways poor people can escape poverty-remain elusive to many. To accelerate progress in human development, economic growth is, of course, necessary. But it is not enough. Scaling up will require both a substantial increase in external resources and more effective use of all resourced, internal and external. 'As resources become more productive, the argument for additional resources become more persuasive and external resources can provide strong support for changes in practice and policy to bring about more effective use. The two are complementary-that is the essence of the development partnership that was cemented in monetary, (Mexico, 2002) in the spring of 2002.' (World Development Report, 2004[1]). Citizen and governments can make services that contribute to human development work better for poor people and in many cases they have. But too often services fail poor people. Services are failing because they are failing short of their potential to improve outcomes. They are often inaccessible or prohibitively expensive.

But even when accessible, they are often dysfunctions, and unresponsive to the needs of a diverse clientele. In addition, innovation and evaluation so find ways to

increase productivity are rare. "Services' include what goes on in schools, clinics, and hospitals and what teachers, nurses and doctors do. They also include how textbooks, drugs, safer water, and electricity reach poor people, and what information campaigns and cash transfers can do to enable poor people to improve outcomes directly.

James D. Wolfensohn (2004) observes , "But the first few years of the 21st century bring heightened challenges. HIV/AIDS and other diseases, literacy, and unclean water threaten to dash the hopes of millions, possibly billion, of people that they might escape poverty, tragically, conflict has undermined development in many countries. Peace and development go hand in hand. And even as we learn how to make development assistance more effective, aid continues to be criticized for not being effective enough".

The multidimensional nature of poverty is also reflected in World Bank's two-pronged strategy for development – investing in people and improving the investment climate. But progress in human development has lagged behind that in reducing income poverty. The world as a whole is on track to achieve the first goal-reducing by half the proportion of people living on less than $ 1 a day – mainly to rapid economic growth in India and China where many of the world's poor live.

Focusing on the human development goals, ensuring basic health and education outcomes is the responsibility of the state. How? Do we know the outcomes of these services, either services are success or failure to improve their services. By financing, providing or regulating the services that contribute to health and education outcomes.

Table-1 reveals that life expectancy at birth is now 68.1 years, with Srilanka showing impressive gains and the tremendous potential for progress in longevity levels 72 years, which also predict the high literacy rate in Srilanka. The Human development Index value of Srilanka is 0.743 at par with world human development Index value (0.743). GDP per capita in Maldives in 5261, which shows the highest education index in SAARC countries. MDG Infant mortality rate (per 1000 five birth) was high in 1970, but decreased in 2005 in SAARC countries. Presently it is higher than high developed countries.

The table. 4 reveals that population not using on improved water resources have high rate of infant mortality rate (Table- 3) "Women and child development minister Renuka Choudhry admitted to the challenges of reaching out to children below three,

and the issue of 12 percent of India's children below six having no access to safe drinking water resulting in diarrhoea deaths' (Renuka Chaudhri-2008).[2] Poverty and children underweight percentage is high, which shows poverty is deep rooted in SAARC countries.

Literacy and Education levels:

The linkage between education levels attained by different countries population groups and their potentialities for progress have now been substantiated by numerous studies across the world. Pakistan, India and Bangladesh have the world's largest number of child labours, so that any efforts to address the phenomenon of child labour in the third world must deal with South Asia. The figures on literacy rates are consistent with the figures on school enrolment. The expansion of literacy has not kept pace with the growth in population and growth of population hindered the basic health services in SAARC countries. There is no single economic or political determinant, either among the early industrialized countries or among the contemporary developing countries where education has been made compulsory. Many countries successfully made primary school education compulsory and universal when per capita incomes were low, poverty was widespread, and parents would have employed their children had they been permitted to do so. The introduction of compulsory education was driven by changes in technology which required more skilled, educated workers. More to the point, the end of child labour and illiteracy in the workforce enabled industries to employ technologies that required higher skills. John Stuart Mill wrote that the state should compel the education of "every human being who is born its citizen` and that the state "ought not to leave the choice to accept or not to accept education in the hands of parents'.

In table 6 – we have tried to distinguish among three sets of public expenditure on education in SAARC Countries. In pre-primary and primary where the proportion of public expenditure is high in all SAARC countries. It will be noted that the highest public expenditure as percentage of GDP in Maldives (7.1) and lowest in Pakistan (2.3). In the post liberalization period expenditure on education as percentage of total government expenditure decreased. The SAARC countries have given a higher budgetary priority to the expansion of higher education then to mass elementary education: Compare to other developing countries. SAARC countries spend a smaller proportion of its GDP on primary education and a greater proportion on higher education. An investment in human resources essential to economic growth, and human development of the poor masses

Table: 1. Human Development Index trends in Countries.

	Human development Index Value 2005	Life Expectancy at birth (years) 2005	Adult Literacy rate (% aged 15 and Above 1995-2005	Combined gross enrollment rates for primary, Secondary and Tertiary education % 2005	GDP Per Capita (PPP us$) 2005	Life Expectancy Index	Education Index	GDP Index	GDP Per Capita Index
Srilanka	0.743	71.6	90.7	62.7	4595	0.776	0.814	0.639	7
Maldives	0.741	67	96.3	65.8	5261	0.701	0.862	0.661	-1
India	0.619	63.7	61.0	63.8	3452	0.645	0.620	0.503	-14
Bhutan	0.579	64.7	-	47.0	-	0.662	0.485	0.589	-14
Bangladesh	0.547	63.1	47.5	56.0	2053	0.635	0.503	0.504	0
Nepal	0.534	62.6	48.6	58.1	1550	0.626	0.518	0.458	-8
Pakistan	0.551	64.1	49.9	40	2370	0.659	0.446	0.528	-8
World	0.743	68.1	78.6	67.8	9543	0.718	0.75	0.761	-

Source : Human Development Report 2007/2008 P. 229-232

Table: 2. Human Development Index trends in SAARC Countries.

	1975	1980	1985	1990	1995	2000	2005
Srilanka	0.619	0.656	0.683	0.702	0.721	0.731	0.743
Maldives	-	-	-	-	-	-	0.741
India	0.419	0.45	0.487	0.521	0.551	0.578	0.619
Bhutan	-	-	-	-	-	-	0.559
Bangladesh	0.347	0.365	0.392	0.422	0.453	0.511	0.547
Nepal	0.301	0.338	0.38	0.427	0.469	0.502	0.534
Pakistan	0.367	0.394	0.427	0.467	0.497	0.516	0.551

Source: UNESCO institute for statistics 2003 and 2007a, data on combined gross enrollment ratio from UNESCO institute for statistics.
1999 and 2007c and data on GDP per capita (2005 PPP US$) from world bank 2007b

Table: 3 Survival: Progress and Setbacks.

	Life expectancy at birth		MDG Infant Mortality rate (per 1000 live birth)	
	1970-75	2000-05	1970	2005
Srilanka	65.0	70.8	65	12
Maldives	51.4	65.6	157	33
India	50.7	62.9	127	56
Bhutan	41.8	63.5	156	65
Bangladesh	45.3	62.0	145	54
Nepal	44.0	61.3	165	56
Pakistan	51.9	63.6	120	79

Source: UNicef 2006 and UN 2007

Table: 4. Human and Income Poverty: SAARC Countries.

	Human Poverty Index (HPI-I)		Probability at birth of not surviving to age 40 (% of cohort) 2000-05)	Adult Literacy rate (%aged 15 and others 1995-2005)	Population not using on improved water resources (%) 2004	MDG Children Under weight for age (% underage 1996-2005)	MDG (Millennium development goal) Population below Poverty line	HP1-1 Rank minus income Poverty rank		
	Rank	Value %						$1 a day 1990-2005	$2 a day 1990-2005	National Poverty line
	1	2	3	4	5	6	7	8	9	10
Srilanka	44	17.8	7.2	9.3	21	29	5.6	41.6	25.0	11
Maldives	42	17.0	12.1	3.7	17	30	-	-	-	-
India	62	31.3	16.8	39.0	14	47	34.3	80.4	28.6	13
Bhutan	86	38.9	16.8	53.0	38	19	-	-	-	-
Bangladesh	93	40.5	16.4	52.5	26	48	41.3	84.0	49.8	4
Nepal	84	38.1	17.4	51.4	10	48	24.1	68.5	30.9	11
Pakistan	77	36.2	15.4	50.1	9	38	17.0	73.6	32.6	15

Source: Column -1- determined on the basis of HPI-1 Values in Column 02 (HPI-1 ranks for 108 developing countries)

Column 2 : calculated on the basis of date in column 3-6 sec

Column 3: UN2007e

Column 4: calculate on the basis of data on adult literacy rates from UNESCO institute for statistics 2007a

Column 5: UN2006a, based on a joint effort by UNICEF and WHO

Column 6: UNICEF 2006

Column 7-9 : World Bank 2007b.

Column 10: Calculated on the basis of data in column 1 and 7

Table: 5. Inequalities in Maternal and child Health in SAARC Countries.

	Birth attended by skilled health Personnel %			One Year old fully Immunized (%)		Children under weight for age (% under age 5)		Infant mortality rate (per 1000 live birth)		Under five mortality rate (per 1000 live birth)	
	Survey years	Poorest 20%	Richest 20%	Poorest 20%	Richest 20%	Poorest 20%	Richest 20%	Poorest 20%	Richest 20%	Poorest 20%	Richest 20%
Srilanka	-	-	-	-	-	-	-	-	-	-	-
Maldives	-	-	-	-	-	-	-	-	-	-	-
India	1998-99	16	84	21	64	58	27	97	38	141	46
Bhutan	-	-	-	-	-	-	-	-	-	-	-
Bangladesh	2004	3	40	57	87	52	25	90	65	121	72
Nepal	2001	4	45	54	82	62	36	86	53	130	68
Pakistan	1990	5	55	23	55	61	33	89	63	125	74

Source: All Columns: Macro international 2007a and 2007b

Table:6. Commitment to Education in SAARC Countries

	Public expenditure on education				Current Public expenditure on education by level (% of total current public expenditure on Education)					
	As % of GDP		As % of Total Government exp.		Pre-Primary and primary		Secondary and Post Secondary non-tertiary		Tertiary	
	1991	2002-05	1991	2002-05	1991	2002-05	1991	2002-05	1991	2002-05
	1	2	3	4	5	6	7	8	9	10
Srilanka	3.2	-	8.4	-	-	-	-	*-	-	-
Maldives	7	7.1	16	15	-	54	-	-	-	-
India	3.7	3.8	12.2	10.7	-	31	-	-	-	34
Bhutan	-	5.6	-	12.9	-	27	-	54	-	20
Bangladesh	1.5	2.5	10.3	14.2	-	38	-	48	-	14
Nepal	2	3.4	8.5	14.9	-	53	-	28	-	12
Pakistan	2.6	2.3	7.4	10.9	-	-	-	-	-	-

Source: Column 1-4, 7, 9 and 10: UNESCO institute for statistics 207b

Column 5-6 : Calculate on the basis of data on public expenditure on pre-primary and primary levels of education from UNESCO institute for statistics 2007b, Column 8 : Calculate on the basis of data on public expenditure on secondary and post-secondary non-tertiary levels of education from UNESCO institute for statistics 2007b.

Table: 7 : Literacy and Enrolment in SAARC countries Literacy and Enrolment in SAARC countries

	Adult Literacy rate (% age 15 and older)		MDG Youth Literacy rate % aged 15 - 24		MDG Net primary enrolment rate %		Net Secondary and Enrolment rate (%)		MDG Children reaching grade 5 % of grade I students		Tertiary student in Science, Engineering, Manufacturing and Construction % of tertiary student
	1985-1994	1995-2005	1985-1994	1995-2005	1991	2005	1991	2005	1991	2004	1999 - 2005
	1	2	3	4	5	6	7	8	9	10	
Srilanka	-	90.7	95.6	-	97	-	-	-	92	-	-
Maldives	96	96.3	98.2	98.2	-	79	-	63	-	92	-
India	48.2	61	61.9	76.4	-	89	-	-	-	73	22
Bhutan	-	-	-	-	-	-	-	-	-	91	-
Bangladesh	35.3	47.5	44.7	63.6	-	94	-	44	-	65	20
Nepal	33	48.6	49.6	70.1	-	79	-	-	51	61	-
Pakistan	-	49.9	-	65.1	33	68	-	21	-	70	24

Source: Column 1-4 UNESCO institute for statistics 2007a. Column 5 -7 : UNESCO statistics 2007c

Table. 8 Commitments to Health in SAARC Countries

	Health Expenditure		MDG One- year olds fully immunized			Children with diarrhoea receiving oral re-dehydration and continued feeding (% under age of 5) 1998-2005	MDG Contraceptive prevalence rate (% of Married women aged) 15-49	MDG birth attended by skilled health personal (%) 1997-2005	Physician (per 100,000 people - 2000-04
	Public % of GDP 2004	Private % of GDP 2004	Per Capita (PPP US$) 2004	Against Tuberculosis (%) 2005	Against Measles (%) 2005				
	1	2	3	4	5	6	7	8	9
Srilanka	2	2.3	16.3	99	99	-	70	96	55
Maldives	6.3	1.4	494	99	97	-	39	70	92
India	0.9	4.1	91	75	58	22	47	43	60
Bhutan	3	1.6	93	99	93	-	31	37	5
Bangladesh	0.9	2.2	64	99	81	52	58	13	26
Nepal	1.5	4.1	71	87	74	43	38	11	21
Pakistan	0.4	1.8	48	82	78	33	28	31	74

Source: Column 1 and 2 : World Bank 2007b Column 3 : WHO 2007a Column 4-8 UNICEF 2006

Column 9: Calculated on the basis of data on Physicians per 1000 population from WHO 2007a

Table. 9 Water, Sanitation and nutritional status in SAARC Countries

	MDG Population using Improved Sanitation (%)		MDG Populatiop Using an Improved water source (%)		MDG Population under Nourished		MDG Children Under weight for age	Children under height for age	Infants with low birth rate
	1990	2004	1990	2004	1990/92	2002/04	1996-2005	1996-2005	1998-2005
Srilanka	69	91	68	79	28	22	29	18	22
Maldives	-	59	96	83	17	10	30	32	22
India	14	33	70	86	25	20	47	51	30
Bhutan	-	70	-	62	-	-	19	48	15
Bangladesh	20	39	72	74	35	30	48	51	36
Nepal	11	35	70	90	20	17	48	57	21
Pakistan	37	59	83	91	24	24	38	42	19

Source: Human Development Report 2007/2008, Macro International 2007a and 2007b

in SAARC Countries.

The table 7 reveals that SAARC Countries are successful in Millennium development goals for youth literacy rate but fail to achieve secondary and tertiary literacy "Pressure for action on the educational front has also come from the World Bank, which has reminded governments that poor education and poor health are barriers to economic growth, from UNICEF, which has pointed to the links between compulsory education and child labour, and from the international Labour organization, which through its International programme on the elimination of child labour has been provided funds to initiate programmes to reduce the use of child labour'. (Myron Weiner, 1996)[3]

The Table 8 – shows that health expenditure done by the Maldives of its GDP is 6.3, India 0.9 and Pakistan .4 Private percentage of GDP on health respectively by India (4.1%) Nepal (4.1%) and Srilanka 2.3%. Whenever high human development on rank countries as, Iceland, Norway, France, Germany, U.S.A., U.K. expends more than 7% of its Public GDP on health. Naturally the per capita income of developed countries exceeding more than 50 times high in compare to India and Bangladesh, people are suffering from chronic diseases in these countries and immunized services system is not reaching to the doorstep of the poor population particularly like Pakistan, Nepal and India. Peoples of these countries are not able to use the contraceptive devices. Most of the developed countries more than 70% used contraceptive, this also shows that lack of skilled health workers in SAARC countries except Srilanka and Maldives. The average numbers of doctor per lakh population in developed countries are more than 312 which is six times high compare to SAARC countries. Maximum number of doctors (591) and

minimum numbers of doctors (02) serving the one lakh people. Most of the SAARC countries have facing skilled health personnel problem, in some case low developed countries have skilled health personal.

The table reveals that Srilanka, Maldives, Bhutan and Pakistan have improved sanitation. All population using an improved water sources in compare to 1990 but population in under nourished due to per-caoita encome. The poverty fighting institution said there were 1.4 billion people a quarter of the developing world-living in extreme poverty on less than $1.25 a day in 2005. In India, the number of people below the poverty line 1.25 $ a day increased to 455 million in 2005 from 420 million people in 1981.' (Lesley Wroughton, 2008)[4].

People achievements critically depend on the available opportunities as well as on the freedoms that they enjoy to make choice. The human development reports have also introduced the human development Index that attempts to capture three essential components human life- longevity, knowledge, and basic income for a decent living standard. Life expectancy is not only an indicator of the quantity of life but of its quality as well. Increase in longevity reflect progress along multiple fronts including the income and earnings of people the prevention and control of diseases the increase of knowledge and awareness, the availability of safe drinking water and the provisioning an efficacy of health service.

Even more glaring than Saarc shortfall in its dismal performance in basic education, Saarc countries must invest in its people in their health and education. There is the issue of the resources for investing in human capital clearly, more financial resource are required if all children have to attend school if all villages must have access to a primary health care centre if all pregnant mothers have to be assured of safe motherhood.

Finally human development has to be participatory. It must be planned and managed locally by people whose lives are effected by it for this structures of local self governance must be strengthened and people's participation need to be encouraged. Saarc countries can achieve and sustain economic and human progress only if every effort is made to eradicate illiteracy, make primary education compulsory and ensure equitable access of good quality health care for its entire people.

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