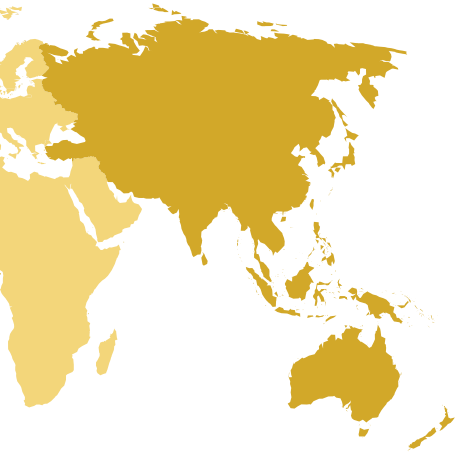

Millennium Development Goals

ACCESS TO BASIC SERVICES FOR THE POOR

THE IMPORTANCE OF GOOD GOVERNANCE

Asia-Pacific MDG Study Series

United Nations ESCAP

UNDP

ADB

Asia-Pacific MDG Study Series*

- *Promoting the Millennium Development Goals in Asia and the Pacific: Meeting the Challenges of Poverty Reduction (2003)*
- *A Future Within Reach: Reshaping Institutions in a Region of Disparities to Meet the Millennium Development Goals in Asia and the Pacific (2005)*
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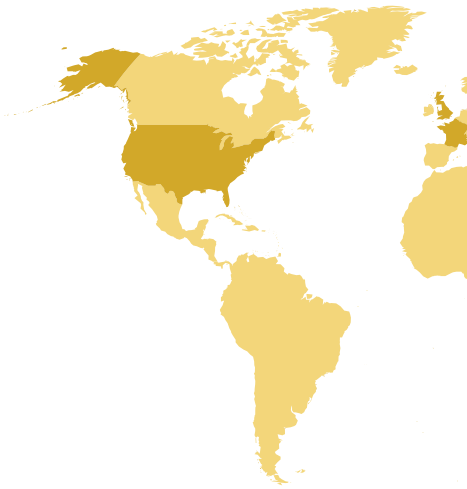
* Unless otherwise indicated, the studies in this series have been published by the UNESCAP/UNDP/ADB joint project on MDGs in Asia and the Pacific.

United Nations Economic and Social Commission for Asia and the Pacific (ESCAP)
United Nations Development Programme (UNDP)
Asian Development Bank (ADB)

ACCESS TO BASIC SERVICES FOR THE POOR
THE IMPORTANCE OF GOOD GOVERNANCE

Asia-Pacific MDG Study Series

2007



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PREFACE

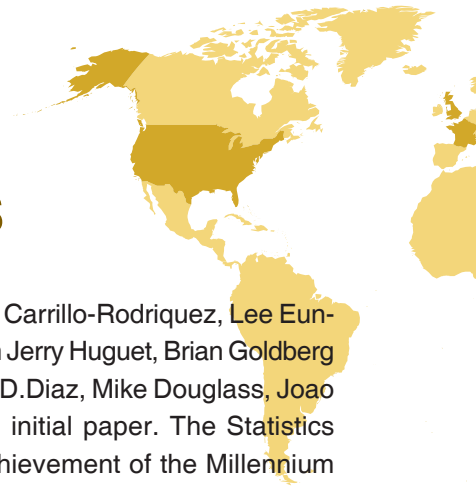
The 191 nations that signed the Millennium Declaration resolved to spare no effort to free the world from the dehumanizing condition of poverty and to create an environment conducive to development and to the elimination of poverty. The Declaration, which gave rise to the Millennium Development Goals, stresses that success in making the right to development a reality for everyone and in freeing the entire human race from want depends, *inter alia*, on good governance within each country.

This Technical Background Paper elaborates on the need for good governance to achieve the Millennium Development Goals and eradicate extreme poverty. It argues that achieving the Goals is not simply about money. It is about removing physical, legal, financial, socio-cultural and political barriers to basic services for all, in particular for the poor and disadvantaged groups.

This report presents a number of strategies for removing such barriers, including broadening the range of service providers to include the formal and informal private sector, civil society organizations and traditional institutions. Their involvement as service providers, however, requires a review and, where necessary, a revision of the framework that regulates the provision of basic services.

Paramount, however, is an adherence to good governance and the principles of inclusiveness and equity. In this respect, the paper adopts a rights-based approach to development as the guiding principle. This approach reminds governments of the need to be inclusive and to ensure that all people have access to basic services and share in the benefits of development.

This paper embodies the collaborative efforts of the tripartite regional partnership of ESCAP, UNDP and ADB to ensure a common voice on the Millennium Development Goals in the Asia and the Pacific.



ACKNOWLEDGEMENTS

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An earlier version of this paper provided the basis for Chapter 2 of the report entitled "A Future within Reach: Reshaping Institutions in a Region of Disparities to Meet the Millennium Development Goals in Asia and the Pacific" published by UNESCAP, UNDP and ADB.

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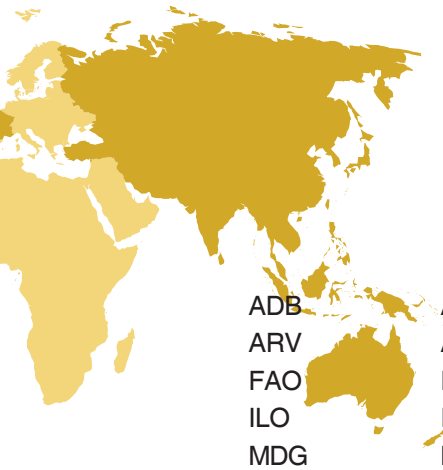


LIST OF ACRONYMS

ADB	Asian Development Bank
ARV	Antiretroviral (drugs)
FAO	Food and Agriculture Organization of the United Nations
ILO	International Labour Organization
MDG	Millennium Development Goal
MMR	Maternal mortality ratio
NFE	Non-formal education
NGO	Non-governmental organization
RBA	Rights-based approach
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WWF	World Wildlife Fund

EXECUTIVE SUMMARY

The United Nations Millennium Declaration, signed by 191 nations in 2000, resolved to spare no effort to free the world from the dehumanizing conditions of poverty. The Declaration gave rise to the Millennium Development Goals (MDGs), which are a set of targets and indicators that attempt to measure progress in achieving a significant reduction of poverty towards 2015. The progress in Asia and the Pacific by 2005 was mixed.

Some countries have achieved all of the goals and have adopted MDG+ targets. Many of the poorer countries in the region, however, achieved only part of the MDGs and it is a matter for concern that these include several very populous countries. In order to achieve the MDGs and their targets, effective provision of basic services is essential. These services include primary education and health, water and sanitation and the prevention, care and treatment of major diseases. This document examines a number of barriers holding back provision of these services and suggests a number of strategies for overcoming them.

Because the MDGs and their targets are mostly expressed in percentages, there is a tendency to try to achieve the Goals by concentrating on people that are more easily reachable. As progress is made toward development targets, it may become particularly difficult to reach those remaining un- or under-served. They include people living in remote and rural areas, ethnic minorities, people with disabilities and, sometimes, women and girls. These people also tend to be the most needy.

Several calls have been made on the governments of the world and of the region to increase their budgets to achieve the MDGs. While it is important that governments make more resources available, this paper argues that financial resources alone are not sufficient to make an impact, because many population groups face serious barriers when trying to access basic services. The barriers are physical, legal, financial and socio-cultural in nature.

The poor are not a homogenous group; different groups face different barriers and many groups face multiple barriers. Barriers include the remote location of many poor groups, the low capacity of service providers and low quality of service. The inability of the poor to pay for services is a major financial barrier to access. Some poor face legal barriers to accessing basic services if they lack birth certificates, household registration or residence permits. People who live and work in the informal sector are often excluded from all sorts of entitlements.

Socio-cultural barriers limit access to services for women, ethnic minorities, persons with disabilities, persons living with HIV/AIDS. Gender discrimination acts as a barrier against equal access to basic services by girls and women. Because women are responsible for the education and health of their children, this lack of access is a major obstacle to poverty reduction. Persons with disabilities are often denied access to basic services because of physical and social barriers, while people living with HIV/AIDS face discrimination.

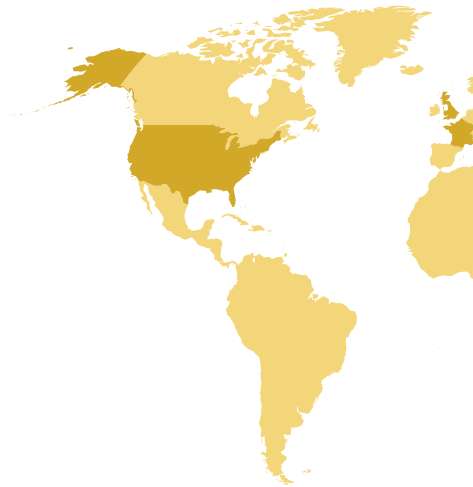
This document finds that overcoming such barriers to improving the provision of services requires a variety of strategies because different groups often confront different barriers and local conditions vary. It is important to match services to the unique conditions and needs of the users.

Governments need to broaden the range of basic services providers to include community organizations, non-governmental organizations and the private sector. In some cases, the most appropriate role of the government is to provide an enabling environment, i.e., one that promotes the involvement of a range of providers, but sets standards and monitors service provision.

Public-private partnerships combine the public interest and social responsibility of the government with the efficiency and responsiveness of the private sector. Civil society organizations provide services in the absence of State provision or promote alternative, self-help models of service provision. Broadening the range of providers does not, however, release governments from their fundamental responsibility to ensure that all people have access to basic services.

The paper argues that adherence to good governance is essential to make strategies for basic service provision and poverty reduction effective and sustainable. It considers nine principles of good governance: (1) inclusiveness and equity, (2) participation, (3) transparency, (4) efficiency, (5) effectiveness, (6) subsidiarity, (7) adherence to the rule of law, (8) accountability and (9) sustainability.

Good governance ensures that the poor and other disadvantaged groups are included in decision-making about providing services that affect their lives and about the objectives of the resulting policies and programmes. Their inclusion and involvement also empowers them to become agents of their own development and to participate in other relevant areas. The adoption of a rights-based approach to development by governments can help to ensure inclusiveness and equity.



INTRODUCTION

The regional context

1. The Asia-Pacific region, covering 58 countries and territories with a population of 3.6 billion people, is characterized by a rich diversity of landscapes, cultures, religions and political systems. It includes the world's two most populous nations as well as tiny island countries, one of the world's wealthiest countries and 14 least developed countries. People in Asia and the Pacific speak more than 3,500 different languages.

2. A range of economic and political systems governs the allocation and flow of resources, including authoritarian and democratic governments, centrally-planned and market-based economies. Some economies have experienced rapid and sustained growth, but the benefits are often not spread equally. Some of the richest people in the world live in Asia, but it is also home to 727 million people, who live on less than $1 a day.

3. Several countries have or had women heads of state or government, but even in those countries, women and girls may be excluded from access to education and health care. The maternal mortality ratio is 1,900 per 100,000 live births in Afghanistan, and 7 per 100,000 in New Zealand. Life expectancy at birth is 84 years for women in Japan and 54 years for women in the Lao People's Democratic Republic (ESCAP, no date: 25).

4. Hundreds of millions of people in the Asia-Pacific region lack access to essential services which are critical to enable the poor to overcome the deprivations of poverty. This paper will show that it is often difficult to gain access to education and health care without money, but without education and good health, it is difficult to earn a decent income. More effective provision of basic services is needed to improve conditions for the poor. Exclusion of women and ethnic or social minorities from decision-making and resource allocation minimizes their voice, causing services to be less responsive to their needs. Ethnic minorities face the dilemma of integrating into mainstream culture or being left out of development.

Poverty defined

5. Poverty has been defined in many different ways. However, a definition that limits itself to poverty's purely monetary aspects does not adequately reflect its complexity. Sen (2000) argued that lack of income is not at the core of poverty; income is merely a means to an end, namely a quality life. Poverty is a state of deprivation of capabilities to lead the life that one values. These capabilities include education and skills, good health, a social network as well as income and assets. ESCAP distinguishes three closely interrelated dimensions of poverty:

- A lack of income and productive assets
- A lack of access to essential services
- A lack of power, participation and respect

6. The Asian Development Bank defined poverty as a deprivation of essential assets and opportunities to which every human is entitled. Everyone should have access to basic education and primary health services. Poor households have the right to sustain themselves by their labour and be reasonably rewarded, as well as to have some protection from external shocks. Beyond income and basic services, individuals and societies are also poor – and tend to remain so – if they are not empowered to participate in making decisions that shape their lives (ADB, 2005: 10).

Millennium Development Goals

7. The United Nations Millennium Declaration, signed by 191 nations in 2000, resolved to spare no effort to free all people from the dehumanizing conditions of poverty. The Declaration gave rise to the Millennium Development Goals (MDGs), which are a set of targets and indicators that attempt to measure progress in achieving a significant reduction of poverty towards 2015. In order to galvanize support for the MDGs, the United Nations Secretary-General called on donors and governments to review and revise priorities, mobilize additional resources and re-allocate current expenditures for programmes that aim at achieving the MDGs.

8. With regard to poverty reduction, the MDGs deal with education, health care, water supply and sanitation, besides income. In order to achieve the MDGs and break the cycle of poverty, effective provision of basic services is crucial. The services include primary and secondary education, primary and reproductive health care, HIV/AIDS prevention, care and treatment, and adequate water and sanitation.

9. Despite government and donor efforts since the adoption of the Millennium Declaration, progress related to basic services has been mixed, as indicated below (ESCAP, UNDP and ADB, 2005):

- MDG 2 – Achieve universal primary education: most countries in the region report high primary school enrolment ratios, but discontinuation rates also tend to
- MDG 3 – Promote gender equality and empower women: progress on eliminating gender disparity in education has been good, but progress in increasing the participation and empowerment of women needs to be accelerated and some countries have demonstrated regressive trends.
- MDG 4 – Reduce child mortality: the region's achievements are mixed; some of the largest areas with high child mortality in South Asia show minimal progress.
- MDG 5 – Improve maternal health: progress across the region has been slow. Nearly one quarter of a million women still die as a result of pregnancy and childbirth, and most of these deaths could be avoided if mothers had routine obstetric care and access to emergency obstetric services.
- MDG 6 – Combat HIV/AIDS, malaria and other diseases: HIV infection rates are rising across the region, rather than being halted and reversed as called for by the target associated with this Goal.

- MDG 7 – Ensure environmental sustainability: progress in improving access to safe drinking water and sanitation is much slower in rural areas than in urban areas.

10. The MDGs have already proven valuable and effective in galvanizing international support and government action toward poverty reduction. They have also drawn attention to the enormous difficulties that many nations face in accurately measuring progress towards the MDGs and in reducing poverty. Besides the varying levels of accuracy of MDG data, it is also useful to understand the limitations of any set of indicators. By their very nature, goals and targets cover only selected aspects of the complex phenomenon of poverty.

11. The indicators on water supply and sanitation show the extent to which a service is available, but do not necessarily reflect its effectiveness or quality. For example, hundreds of millions of rural people in nine Asian countries have access to water, but over 200 million of them are at risk of arsenicosis, cancer and death from drinking contaminated water.

12. One of the targets of the third MDG is to eliminate gender disparity in education. The problem appears to require interventions primarily aimed at girls. However, if the goal is actually to increase the number of girls receiving both primary and secondary education, an expansion of secondary education for boys and girls would be more effective. In many cases, raising boys' enrolment, while maintaining the ratio of girls' to boys' enrolment would benefit many more girls than increasing girls' enrolment rates to equal the current rates for boys.

13. The MDGs do not call for the total eradication of poverty in the world. Many MDGs and their associated targets call for progress measured in terms of percentage change, to be achieved by 2015. Even if all countries achieved all the goals and targets, massive numbers of persons in the region would remain living in abject poverty. Moreover, since many goals are measured by percentage changes, a focus on achieving the MDGs by 2015 tends to target areas with the highest potential to deliver the required percentage gains and people who can be reached most easily. This can increase disparities between different population groups and regions within a country and should be a cause for concern.

14. The signatories of the Millennium Declaration realized that providing the poor with access to essential services is not just a financial or a technical issue, but also a socio-cultural and political issue. That is why the Declaration stated that good governance is critical to successfully overcoming the immense challenges that poverty poses, because good governance requires inclusiveness in both decision-making and objectives. It makes it possible for the resources to reach the poor, marginalized and disadvantaged, and to empower them to break out of the poverty cycle.

15. This paper is organized into four chapters, besides the Introduction. The first chapter identifies the need for improved provision of basic services and explores the range of legal, financial and socio-cultural barriers that prevent the poor from gaining access to them. Chapter 2 presents strategies that may overcome these barriers, but it concludes that the poor's lack of political power is the critical barrier that reinforces the other barriers. Chapter 3 argues that establishing a context of good governance is essential for making service provision effective in reducing poverty. Chapter 4 concludes that empowerment of the poor is a means to enabling more efficient and equitable service provision as well as an end in which the poor find their own solutions that respond to their needs, thus improving their ability to guide their own development.

CHAPTER 1: BARRIERS TO SERVICES

The poverty challenge

16. It is estimated that 727 million people in Asia and the Pacific live on less than $1 per day. Moreover, 652 million people in the region lack access to an improved water source and 1.9 billion people lack access to improved sanitation, resulting in poor health and possibly death. In 2005, 9 million people were living with HIV in Asia, including 1.1 million people who became newly infected in 2004 (www.unaids.org). School enrolment rates are quite high in East Asia, but parts of West and South Asia face low enrolment rates and low rates of continuation past grade 5. Poor peri-natal health care and inadequate conditions surrounding child delivery are leading causes of preventable deaths among children under the age of 5.

17. The need for vital services in the Asia-Pacific region differs among countries, within countries and across sectors. In a region that attaches great importance to education, it is not surprising that most countries have high net enrolment rates. However, the enrolment rates are low in Pakistan (59.1 per cent) and Nepal (70.5 per cent). The numbers of children continuing to grade 5 are also low in Bangladesh (65.5 per cent), Cook Islands (51.5 per cent), India (61.4 per cent), the Lao People's Democratic Republic (62.3 per cent) and Myanmar (59. 9 per cent) (Ordonez and Sack, 2005).

18. In most countries, gender ratios at primary school level are close to 1.0, with the exception of some least developed countries and some countries in South Asia (Annex table 1). There is, however, a large drop-off in school enrolment between the primary and secondary levels. The ratio of girls' to boys' enrolment at the secondary level is also 1.0 or greater in many countries in the region. The countries with low proportions of girls among secondary school students are mostly least developed countries and several countries in South Asia. Youth literacy rates reflect recent school enrolment and these rates and gender ratios are high for most countries in the region (Annex table 2).

19. Maternal mortality is rare, occurring in well under one per cent of deliveries, even in countries with relatively high ratios. The maternal mortality ratio (MMR) is, therefore, not an ideal indicator of the provision of health services. Nevertheless, table 3 (Annex) shows the very wide disparity in MMR among countries in the region. Many countries at medium levels of development have lowered the MMR to below 50 maternal deaths per 100,000 live births, but the MMR is 200 or more in Indonesia and the Philippines and well over 300 in populous countries such as Bangladesh, India, and Pakistan. Within-country disparities are also probably large in many cases.

20. Two important measures to reduce maternal mortality are having births attended by skilled health personnel and having emergency obstetric services available. However, lack of obstetric services in remote rural areas is common. In Afghanistan, Bangladesh, the Lao People's Democratic Republic and Nepal, fewer than 20 per cent of births are attended by a health professional (Annex table 3). The use of modern contraception by married women is an indicator of the provision of health care. In the more developed countries of the region and in many countries at medium levels of development, more than 50 per cent of married women aged 15-49 are using a modern contraceptive (Annex table 3). The proportion is only around one third in Myanmar, Nepal and the Philippines, and only 20 per cent in Pakistan.

21. The fourth MDG is to reduce child mortality. Child mortality is a powerful indicator of the availability of health care to a population and of people's ability to access that care. Differentials in child mortality point to problems of health-care services and to social and economic obstacles to good health. Male children naturally have higher rates of mortality and where girls have a similar or higher rate of mortality it can be inferred that there is a gender bias in care and medical treatment against girls.

22. Under-5 mortality shows the number of children (per 1,000 live births) who will die before reaching their fifth birthday and the ratio of male to female under-5 mortality rates could be expected to be about 1.1. However, it is much lower in Bangladesh, India, Pakistan and Turkey (Annex table 4), indicating differences in health care according to sex, leading to higher than expected death rates among girl children. Rural-urban disparities in child mortality are generally much greater than gender disparities. In almost all countries included in table 4 (Annex), under-5 mortality rates are at least one-third higher among children in rural areas than in urban areas and in some countries more than 50 per cent higher.

23. Female education is essential for development in a number of other sectors. Table 5 (Annex) shows the effect of mothers' education on child mortality rates. In some countries, the under-5 mortality rate is roughly two-thirds higher among children whose mothers have only a primary education than among children whose mothers received secondary education.

24. The sixth MDG is to combat HIV/AIDS, malaria and other diseases. In Asia and the Pacific, over one million people became infected in 2004 and, by 2005, 8.3 million people were living with HIV/AIDS. India, with an estimated 5.7 million people infected, now has the highest number of infections in the region. Thailand has 580,000 people living with HIV/AIDS and China has 650,000, up from 530,000 just over two years earlier. South and South-East Asia have 7.6 million infections (UNAIDS, 2006).

25. ADB/UNAIDS (2004: 9) studies show that countries must urgently tackle the enormous shortfall in finances needed to establish comprehensive prevention, care and treatment. A comprehensive response should include programmes for vulnerable groups and young people, treatment of sexually transmitted infections, promoting use of condoms and disposable syringes and the provision of antiretroviral (ARV) therapy. The

number of people receiving ARV therapy, however, is estimated to be in the range of 85,000 to 115,000, only about 8 per cent, of the estimated 1.2 million people aged 15-49 years in East, South and Southeast Asia who need the therapy (UNAIDS/WHO, 2005: 11).

26. More people in the Asia-Pacific region need access to safe drinking water and adequate sanitation than in Africa, Latin America and the Caribbean combined. To meet the MDG of halving the proportion of people without sustainable access to safe drinking water and basic sanitation by 2015, an additional 1.4 billion people in Asia need to gain access to adequate sanitation and an additional 909 million will need sustainable access to safe water. The corresponding figures for urban areas are 675 million and 619 million, respectively (UN-Habitat, no date).

Accessing basic services

27. The poor and disadvantaged face many types of barriers when trying to gain access to such essential services as primary education and health care, water and sanitation, and the prevention and treatment of HIV/AIDS and other major diseases. These include: (a) availability and quality, (b) financial barriers, (c) legal barriers and (d) socio-cultural barriers. Different groups face different barriers and many groups face multiple barriers. Women in particular face multiple barriers, owing to deeply engrained ideas about their role in society.

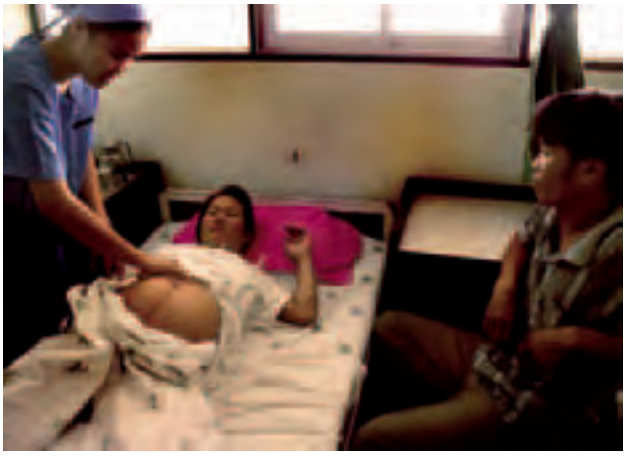
28. Women are more vulnerable to poverty than men owing to incomplete education, illiteracy, early marriage and childbearing, lack of access to employment, lower wages, lack of rights in divorce and lack of property rights. In many communities, women's participation in decision-making is minimal. Intra-household inequalities can exacerbate the vulnerabilities of women and girls to poverty. The relationship between poverty and gender is mediated by such variables as class, demographic changes and public policies. The feminization of poverty is intimately linked to the economic and social policy regime of any given society, as well as to trends in women's employment, wages, and household headship (Moghadam, 2005: 6, 31).

Availability and quality

29. Availability and quality of basic services can differ widely within a country, and affect different groups in a multitude of ways. Overall, women and girls as well as those in rural areas tend to face more limited availability and lower quality of services than other poor people. In rural areas and particularly in remote areas such as economically underdeveloped landlocked regions, upland areas away from major roads and urban centres, and small islands, primary education and health care, clean drinking water and reliable sanitation are often unavailable or only available at a considerable distance.

30. Planning the geographical distribution of facilities is a matter of economic efficiency: limited resources compel the government to set priorities, taking into account the range (i.e. the maximum distance people are prepared to travel for the service) and the threshold (the minimum number of users for a viable centre). Such planning is, however, based on a set of assumptions that apply to the average rural male, but not necessarily to women and children or to people with disabilities for whom the distance or the travel time is a serious barrier.

31. The unavailability of services affects women and men, girls and boys in different ways. Women are more vulnerable than men to reproductive health problems. They use health services on a continuous basis: to prevent unwanted pregnancies, to carry wanted pregnancies to term and to deliver safely. Similarly, distance to school is more of a problem for girls than for boys. Parents are more likely to object to their daughter going to school on the grounds of safety than out of a belief that girls do not need education. They may feel that the school is unsafe or the journey to school too long and dangerous (UNICEF, 2004: 23).



32. Women suffer particularly from inadequate water supply and sanitation, because they bear the burden of collecting and storing water, caring for children and the sick, and cooking and cleaning. In rural areas, women and girls often have to walk long distances over difficult terrain to fetch water. The provision of safe drinking water close to the home substantially reduces women's workload. It allows women to engage in economic activities to improve the household income and girls can use the time saved to attend school (ADB, 1999: 14-15).

33. A lack of safe sanitation poses serious problems for women and girls who can only relieve themselves when it is dark. They have to wake up before dawn to go to fields or roadsides to defecate, running the risks of violence against them. They often go the whole day without relieving themselves and may limit their food and water intake during the day so that they can wait until the evening. Sick and pregnant women suffer particularly from lack of adequate sanitation, while girls may not go to schools that have no toilets for girls (UNICEF/WHO, 2004: 21).

34. Halting the spread of HIV/AIDS and other major diseases by 2015 (MDG 6) requires a comprehensive response, but services normally start in urban areas where human resources and facilities are in place (UNAIDS/WHO, 2004: 15). Moreover, the availability of medicines is a more widespread issue. Market forces drive research spending, and less than 10 per cent of the funding for health research is directed at improving the health of 90 per cent of the world's population. The most common diseases among the poor attract relatively little research and development spending, hindering the development of medicines that the poor need and can afford.

35. Global investment in research on malaria in 1990 was US$ 65 per fatal case of the disease, compared with US$ 789 per asthma fatality. The past 30 years saw no major breakthrough in research and development with regard to tuberculosis. Since only a

small portion of those sick with tuberculosis can pay for treatment, industry does not perceive much incentive to invest in such research (Global Alliance). Between 1975 and 1997, only one per cent of the drugs that reached the market were for tropical infectious diseases of most relevance to the poor in developing countries (Global Forum for Health Research, 2004).

36. The presence of a facility in a location does not mean that a service is actually provided. Reports of empty schools and abandoned clinics are numerous. Construction may require a substantial one-time investment, but funding for operation and maintenance of services is often more problematic, especially if users contribute little or nothing. Staff needs to be trained and motivated, but many teachers and nurses in rural areas come from the city or have been trained there. They may have problems understanding and communicating with the local population and may lack the motivation to provide adequate services, due to difficult working conditions and low salaries.

37. Given the need to use limited resources efficiently, it is difficult to increase access to services and simultaneously improve the quality of the service. A study in rural China (Beynon and others, 2000) found that when authorities replaced incomplete village schools with centrally located, complete primary schools to enhance the quality of education and its cost-effectiveness, many poor children no longer had access to any education. The increased distance to centrally located schools and language barriers affected school attendance, particularly by girls and children from ethnic minorities.

38. Similarly, urban water supply agencies tend to stress the importance of water quality over water quantity, although both have serious impacts on health and the quality of life (Cairncross, 1999: 109-126). The large sums spent to ensure that the water supplied meets quality standards could be used to expand water supply so that more people, particularly the poor, have access to (more) water, although of a lesser quality.

39. Most countries in the region have a unitary, centrally-planned curriculum for primary education. It is often designed for children in, or familiar with, an urban environment, and may actually contain elements that conflict with local customs and beliefs. An urban bias in the curriculum complicates the task of rural teachers and makes learning more difficult for rural children, who may not see the relevance of some subjects to their own experience and life. Parents may see no point in sending their child to school if they perceive learning to be irrelevant to rural conditions. However, they may also object to a curriculum adapted to rural conditions, as they would consider such education substandard and an obstacle to future urban employment for their child.

40. The perception of irrelevance can be aggravated if the language used in school differs from the language spoken in the community or at home. The mother tongue is the best vehicle for teaching during the first years of primary schooling (see box 1). However, education in a minority language has many implications, not just educational, but also political and economic, if only because of the number of different languages spoken in some countries (FAO/UNESCO, 2003: 63, 89).

Box 1. Literacy among ethnic minorities

Throughout the region, children of ethnic minorities have the least access to education. In Cambodia, the national literacy rate is 68 per cent, but the rate is only 27 per cent in Ratanakiri, a province with many ethnic minorities. In Vietnam, the literacy rate among the Viet majority is more than 87 per cent, but is much lower among the highland minorities: 42 per cent for the Ede and 10 per cent for the Hmong. An important factor for the low literacy rates is the use of Vietnamese as the main language of instruction, which children of ethnic minority groups may not understand (UNICEF, 2003: 10).

41. Figures on coverage of water and sanitation services are no indication of the quality of the service. In many cities, water is supplied for only a few hours a day. The repeated interruptions and loss of pressure in the pipes can lead to contamination of the water by sewage. Over 200 million, mostly rural, people in nine Asian countries are estimated to be at risk of arsenicosis, cancer and eventual death from the long-term consumption of groundwater contaminated by arsenic. Arsenic has a pervasive effect on the entire body and long-term consequences for children, slowing their cognitive development and mental ability. The only sure way of prevention is to avoid drinking contaminated water.

42. Poor peri-natal health care and inadequate conditions surrounding delivery are leading causes of preventable deaths among children under the age of five. Babies born in hospitals that are marked by unhygienic practices may face the same or higher risk of infection as babies born at home. Many infections acquired in hospitals are not treatable with prescribed antibiotics. The perception that hospitals are places where children face high health risks with poor outcomes at high costs to the family negatively affects the willingness of parents to utilize available services.

43. The poor may also be reluctant to use an accessible service because of the attitude and behaviour of the providers, and turn to an alternative, less effective service or not use it at all. The poor, undocumented migrants and people without citizenship or official papers are often victims of harassment by law enforcement agents and administrative personnel and barred from services, even if they can pay (FAO/UNESCO, 2002: 31). People without official documents may avoid a public service that requires them to register, in order not to draw the attention of officials.

44. The quality of the service depends on the extent to which it takes into account the specific needs and conditions of the users. Many users of health services are women, but decision makers tend to be men who are often also urban-based. Beliefs, norms and practices concerning appropriate behaviour in matters related to reproductive health may stop a woman from seeking health care. The availability of female staff can make a crucial difference to a woman's access to health care, if she is reluctant to be examined by a male physician.

Financial barriers

45. The inability of the poor to pay for a service is a major barrier to access. Most governments recognize this problem and provide primary education and some health care services as well as water free of charge. However, all these services are expensive and even the most developed countries find it difficult to finance health care. Water, particularly clean water, is becoming a scare resource and the treatment of water to make it safe to drink is becoming even more costly. Despite considerable public and political opposition, governments are increasingly charging for the consumption of water in urban areas in order to reduce wastage. Although the cost of antiretroviral drugs has dropped in recent years, the cost of treating people with HIV/AIDS is still prohibitive for the poor.

46. When a service is available, demand tends to exceed supply, especially if it is provided free of charge, and the service provider may ration access by asking for additional payments. Teachers, often poorly paid, may ask parents for payments before admitting a child, and nurses or doctors may insist on payment before treating a patient. These payments, essentially bribes, create access barriers for the poor to free services.

47. Corruption in the form of diverting money allocated for the purchase of teaching equipment, demanding bribes from parents for school admission and better exam results and selling school material that should be distributed free, can have a particularly severe impact. The poor cannot pay the bribes, thus, corruption denies them their right to equal access to education, and consequently to one of the most powerful mechanisms to escape poverty. Exposure to corrupt practices from an early age also undermines the values of learning and personal effort in children. Corruption in education will also affect students' social environment because what they learn at school has an impact on their families.

48. If the public sector cannot, or does not want to, provide a service to the poor, the private (informal) sector may step in. Many urban poor buy water from informal water vendors and pay rates many times higher than other income groups pay for municipal water. The poor may turn to traditional healers who treat them immediately and charge them less, but do not solve their problem. As a result, the poor may have to seek further treatment incurring additional costs.

49. Besides direct costs, the poor face high opportunity costs, namely the loss of income derived from labour at home, in the fields or in other work places. The opportunity cost of time spent going to and waiting for free medical treatment, going to a distant well, spring or river, waiting in line at a public water tap or simply going to school can be considerable for a poor family. In India, the total cost of women fetching water is estimated at 150 million working days per year, equivalent to a national loss of income of Rupees 10 billion or approximately US$ 200 million (UN Water, no date: 7). If schooling is not an attractive alternative to income generation, families will not enrol their children in school and pay the direct cost of schooling such as fees, books, materials and uniforms (FAO/UNESCO, 2003: 82).

Legal barriers

50. In modern society, people need a host of official documents to access services; without such documents, they may be excluded from access to them. Exclusion starts when parents fail to register their new born child and obtain a birth certificate. If birth registration is highly centralized, costs include expenses for travel to the nearest civil registration office. The lack of a birth certificate can make it difficult to attend school, access free health care and free or subsidized vaccination programmes, get work, obtain credit, inherit property, receive welfare support and vote. If a school principal allows a child without a birth certificate to attend school, the child may not receive free books, or registration needed to sit for examinations or enter into higher education.

51. Where infant mortality is high, the incentive to pay for costly registration is low and registration may be delayed until the child has grown. Parents may not be aware of the benefits of registration and only understand the implications when they or the child are asked for official proof of age and identity. The penalty for late registration may be an additional disincentive to register. Many families lack a safe place to store a birth certificate and if it is lost or damaged, a replacement charge may have to be paid (Plan International, 2005: 29-30).

52. While some people are not registered at birth, some are also not registered at death. In many countries, there is neither a complete registration of deaths nor a medical certification of the cause of death. Maternal

mortality is measured through population surveys because of poor reporting of deaths, but the surveys require large sample sizes to produce accurate estimates. As a result, changes in maternal mortality rates are surrounded by tremendous uncertainty (ESCAP no date: 7). Undocumented migrants are by definition not registered and many questions remain about the number of foreign workers killed by the tsunami that struck countries around the Indian Ocean in 2004. Lack of reliable data makes it difficult to identify problems, develop effective programmes and monitor their impact.

53. Citizens who live and work in the urban informal sector are often locked out of recognized legal protection and the economic benefits of the formal sector. A neighbourhood may be connected to the city's water supply network, but an adjacent squatter settlement cannot be connected because squatters do not have building permits for their houses and or house registration for their occupants. Although a household may be able to pay the charges for water it consumes, it is denied access to water on legal grounds and forced to buy water from private vendors at a much higher cost, thereby increasing its poverty.

54. As urban economies grow and transport and communication costs decline, rural-urban migration becomes an essential part of a household's survival strategy. Many rural migrants are not used to having the necessary documents and registrations and may therefore be denied access to services. They may see their stay in urban areas as temporary and therefore will not transfer their civil registration from the rural to the urban area. This becomes a barrier to political participation if the rural migrant can only vote in his or her home district.

55. Groups who engage in high-risk behaviour (such as commercial sex workers, men who have sex with men, and injecting drug users) may face difficulties accessing services for the prevention, care and treatment of HIV/AIDS because their behaviour is unacceptable to mainstream society or illegal. Legal barriers hamper the distribution of condoms and clean syringes among these groups, although this could lower the risk of infection and the spread of the disease. Ironically, costly treatment in the form of providing antiretroviral drugs to people living with HIV/AIDS seems to be more acceptable than cheap prevention measures such as providing injecting drug users with clean injection tools. Even so, giving people living with HIV/AIDS access to the limited supply of expensive, life-prolonging drugs may still not be widely supported (MAP, 2004: 100-102).

Socio-cultural barriers

56. Gender discrimination remains a major barrier to accessing services that is still prevalent throughout the region and affects most people. Men tend to enjoy greater access than women to essential education and health services, water and sanitation (box 2). The socio-cultural barriers for women and girls to access these services have an impact not just on the women and girls themselves, but on society as a whole. Women represent half of the population and as mothers have primary responsibility for the health and education of their children. Access barriers to health and education for women and girls are major obstacles to poverty reduction.

Box 2. Gender disparity in South Asia

South Asia is the sub-region where gender disparities are noticeably the worst. Child mortality in countries outside South Asia is almost equal between the sexes, but in South Asia it is 30 to 50 per cent higher for female than male children. Huge variations in gender disparity also exist within countries of South Asia. Some Indian states rank among the best in the world on gender disparity, others are among the worst. Tamil Nadu and Kerala have much lower gender disparity in child mortality than the average non-South Asia countries (with a female-to-male ratio below 1), while other states have a higher gender disparity than any country in the world (Filmer and others, 1998: 26-27).

57. A strong preference for sons can lead to marked differences in what families invest in boys and girls, as reflected in the nutritional and health status of adolescent girls and young women (UNICEF, 2003: 11-12). Parity in education between boys and girls is no guarantee that they are treated equally and receive the same quality of education. Where possible, parents may be inclined to send boys to better schools than girls, and girls may be less likely to be taken to a health centre than boys. Drèze and Sen (2002: 233-234) speak of "a well-documented practice of preferential treatment of boys and neglect of female children in intra-household allocation".

58. In other words, the lack of power among the poor is not limited to the national or local political arena, but extends into the family. Women and girls may not be able to influence the allocation of resources within the household. As a result, they will receive less food and be more undernourished; they will attend school or visit health services less frequently. They are more prone to HIV infection than men because of the disadvantages they face in negotiating safer sex and in dealing with domestic violence.

59. A range of barriers blocks women from pre-natal and maternal health care services. In Dhaka, Bangladesh, these services are widely available, but studies reveal that poor urban women are not using the medical facilities but are giving birth in their homes, leading to high rates of maternal mortality. A primary reason for women not to go to a hospital for childbirth is a preference to remain with family and a strong religious and cultural aversion to the presence of male staff at childbirth (Lerner and Vilquin, 2005). Some urban poor women prefer to leave Dhaka and give birth in their villages where a larger community support network of friends and family is available.

60. Ethnic minorities, people living with HIV/AIDS and people with disabilities are often also subjected to systematic stigmatization, discrimination and marginalization and this has a significant impact on their health and education. Although the data are incomplete and not always comparable, ESCAP estimates that there are 400 million people with disabilities in the region and that over 40 per cent of them are living in poverty (ESCAP, 2002: 19). Their numbers are particularly high in post-disaster areas and in such post-conflict countries as Afghanistan, Cambodia, Timor-Leste and Viet Nam.

61. People with disabilities have the same or greater needs for health and educational services as other people, but they face more challenges in securing access due to physical and social barriers, despite improvements in disability legislation. Women with disabilities are often the most marginalized, as they have multiple disadvantages through their gender and disability. The lack of reliable data contributes to the neglect of disability issues.

62. Available evidence suggests that less than 10 per cent of children and youth with disabilities in the region have access to any form of education, compared with an enrolment rate in primary education of over 70 per cent for non-disabled children and youth. Education for children and youth with disabilities is concentrated in urban areas, while most people with disabilities live in rural areas where those services are often unavailable. Other problems faced by children with disabilities include a lack of early identification and

intervention, negative attitudes towards those with disabilities, exclusionary policies and practices, inadequate teacher training, inflexible curriculum and assessment procedures, lack of appropriate teaching equipment and devices, and a failure to modify school environments to make them fully accessible.

63. People living with HIV/AIDS suffer serious stigmatization and discrimination and this affects prevention, care and treatment. A 2004 survey (APN+, 2004) in India, Indonesia, Philippines and Thailand reported that 80 per cent of respondents experienced some form of discrimination. A quarter of the respondents told of discrimination by a health-care worker, 15 per cent had been refused treatment or care and 17 per cent had experienced delays in the provision of health care. Once their condition became known, many HIV-positive people were turned away from health centres. Breaches of confidentiality by health workers were common.

64. The fear of stigma and discrimination deters many people from taking an HIV test and hinders the use of condoms, thereby leading to a higher risk of spreading the disease. HIV-positive mothers may decide to breastfeed their child like other mothers do for fear of being identified as HIV-positive if they do not, despite the risk that they transmit the virus to the child through their milk.

65. In summary, additional financial resources are necessary to achieve the MDGs, reduce and eventually eradicate poverty, but they are not sufficient. It is equally necessary to ensure that the resources used to provide basic services actually reach the poor and that the poor benefit from them. Often, this often does not happen due to a range of physical, financial, legal and socio-cultural barriers that prevent certain groups' access to a particular service. Poverty reduction requires strategies to help the poor overcome these barriers.

CHAPTER 2: STRATEGIES TO OVERCOME BARRIERS

66. This chapter presents strategies to overcome the financial, socio-cultural and legal barriers that were identified in the previous chapter. The strategies presented, however, are not blueprints for service provision, as each strategy's strengths and weaknesses largely depend on local conditions. Whatever the strategy, it needs to be adapted to meet the specific and constantly changing conditions of the providers and users. Moreover, a single strategy will not suffice, because the poor are not a homogenous group; different groups encounter different barriers. Women, girls, ethnic minorities and other disadvantaged groups are often subject to multiple barriers, including those faced by the poor as well as those faced due to gender, ethnic or other sorts of discrimination.

Removing financial barriers

67. If services are available, an important barrier is the cost of the service to the user. Education and health care are expensive services that even the most developed countries find difficult to finance and governments are under pressure to recover at least part of the costs. The increasing competition for water between agriculture, industry and domestic users has made it a scarce and costly resource all over the region. Antiretroviral drugs are prohibitively expensive for poor persons.

68. Access to primary education and health care (including maternal and child health care) and to adequate water and sanitation tends to be considered a basic right. Article 26 (1) of the Universal Declaration on Human Rights states that "everyone has the right to education, education shall be free, at least in the elementary and fundamental stages, and elementary education shall be compulsory". The right to health care is included in article 25 of the same Declaration. Most governments try to minimize out-of-pocket payments for primary health care and to support those who are unable to pay at all. International conventions recognize, at least implicitly, access to affordable water and sanitation as a basic human right (Vision 21, no date: 5).

69. Services such as education and health care also have many positive externalities; they benefit not only the immediate user, but society as a whole. Most governments agree that cost should not be a barrier to access to the service; the services should be free or carry a nominal charge. However, the free provision of a service has disadvantages beyond the lack of cost recovery. A free service may result in wastage (e.g., water), while the recovery of nominal charges may not be worth the effort. A free service that overloads the provider may lead to informal payments by users to the provider as the latter rations the supply.

70. It is important to recognize that the poor are already paying for many services and they may see the payment of a small fee for a reliable and timely service as a considerable improvement. As they live and work in the informal sector, they may even insist on paying so that they can be considered legitimate users rather than second-class citizens. Given the range of services discussed in this paper and the diversity of circumstances, it is difficult to provide comprehensive guidelines for removing financial barriers, but some interesting practices can be mentioned.

71. Governments can charge fees to everyone but exempt the poor or they can transfer cash to the poor to pay for services (e.g. through vouchers) so that only they benefit from the subsidy. However, distinguishing the poor from the non-poor, administering cash transfers and ensuring that those most in need are covered is costly and difficult. Subsidies tend to be insufficient to cover all those in need and therefore benefit only a portion of them. Mistargeting of subsidies is a widespread problem. Subsidies often do not reach the poorest of the poor, precisely because they are invisible and difficult to reach, and benefit those who do not need the subsidy ("subsidy capture"). In Katmandu (Nepal) and Bangalore (India), 90-95 per cent of the total subsidies allocated to the water utilities are spent on subsidizing private water taps and barely 5 per cent on the public taps, used mainly by the poor (World Bank, 2003: 7).

72. There is a growing interest in "self-targeting" subsidies, which are based on the idea that a subsidy should be attached to a service (or a good) that the poor consume disproportionately. Examples are water from a public tap and the use of a public toilet. People who can afford a private facility in their house are unlikely to use the public facility to save money. Some projects make the community of users responsible for the financial management of a service. The service is provided "in bulk" to the community which appoints a person or organization to collect payments from users. This works well in cohesive communities where the somewhat better-off are ready to pay more so that the poorest can pay less, but this is not the reality in all villages and communities.

73. Some countries in the region are experimenting with community-based health insurance (Tabor, 2005). These schemes tend to be small, voluntary programmes that are organized and managed by the community in a participatory manner. They are based on traditional values of solidarity and social cohesion. Examples are the Grameen Bank in Bangladesh and SEWA in India, but they have also been introduced in Cambodia, Indonesia, Thailand and Viet Nam. Their main weaknesses are the small risk pool, poor governance and cost escalations (UNFPA, 2005: 63). Networking micro-schemes or seeking formal-sector re-insurance may remove some of these weaknesses, but require changes in the regulatory framework.

74. Opportunity costs are another financial barrier. Education and health-care facilities are usually established in a central location so that the largest number of people can use them, but the cost of travel, in terms of time and money, becomes a barrier. Although many rural people are used to walking long distances, safe, reliable and affordable public transport is an essential service to give the rural population access to basic services (and markets).

75. A technique to remove financial barriers in education is the use of conditional cash transfers designed to persuade parents to keep their children in school rather than make them work to aid household income. An evaluation found that cash transfer programmes had no significant effect on child labour but had a positive and significant impact on school attendance (Cardoso and Souza, 2004). In Bangladesh, the Government has operated a Food for Education programme since 1993. Poor families receive a free monthly ration of food grains as an income entitlement to enable a child to go to school. The family can consume the grain, thus reducing its food budget, or sell it and use the cash to meet other expenses. To be eligible, children must attend 85 per cent of classes each month. The programme has increased school attendance (Ahmed and Ninno, 2002).

Box 3. Thailand's 30-baht health-care scheme

Until 2001, one or more of six health insurance schemes covered around 70 to 80 per cent of the population in Thailand, but the schemes tended to overlap and were not very equitable. In 2001, Thailand became one of the first middle-income developing countries to introduce a universal health-care policy, extending health coverage to some 20 million people who previously were not covered. The scheme was designed to provide equal access to health care and to protect Thai citizens from financial losses due to illnesses. It also marked a shift of funding from large urban hospitals to primary health care.

The benefit package includes inpatient/outpatient treatments at a registered primary care facility and referral to secondary and tertiary care facilities, dental care, health promotion and prevention services, ambulance fees and drug prescriptions. The user fee is 30 baht per visit (approximately US$0.80), but the poor are exempted from the payment. By 2004, 60 million people had health security, representing 95.5 per cent of the population (47 million under the 30-baht scheme and the rest under other schemes) and the levels of user satisfaction were generally high.

The main difficulty facing the scheme is its long-term financial sustainability. A number of hospitals have incurred large debts because, among other things, the number of people covered by the scheme has increased much faster than the budget allocation. The Government has started to provide additional funding to cover 21 per cent of the salaries of health workers in public health facilities in order to reduce the financial burden of health-care providers and to reduce staff shortages in primary health-care facilities, especially in rural areas (Tanaka, 2004; Towse, Mills and Tangcharoensathien, 2004:103-105).

Matching services with conditions

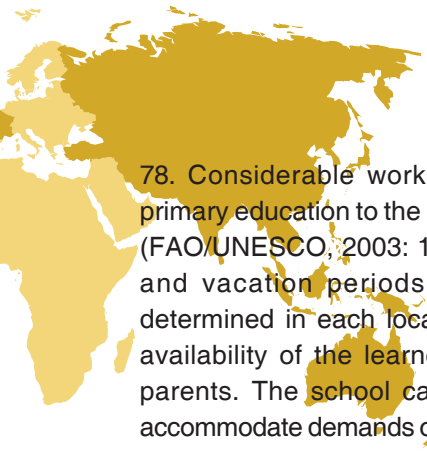
76. A key element of overcoming barriers to services is to match the service to the unique conditions and special needs and priorities of the users. National standards can guarantee that a service is provided to everyone with the same quality, but national standards that are set too high or emphasize aspects that are irrelevant to the users will not produce the expected results (Conan no date:7). Service provision must be designed to ensure access to all users rather than to meeting a standard, but losing the users.

77. Studies show that relatively simple changes can make a major difference, but those changes cannot be decided in a central location, because needs and conditions differ from place to place and from group to group. Central authorities should, therefore, set a few core standards and parameters, and allow flexibility to adapt service provision to local circumstances through needs assessments and consultations between local providers and users. Local level decision-making is essential to make service provision more effective.

Box 4. Non-formal education

In the past, the Asian Development Bank (ADB) tended to concentrate its education investments on formal education but now it intends to expand its support for innovative, responsive and flexible non-formal education as part of its overall poverty reduction strategy. Non-formal education brings education, especially basic education and literacy, to ethnic minorities and other marginalized groups that for whatever reason have not availed of formal schooling. ADB also considers assistance for governments to upgrade and mainstream Koran schools and NGO-run schools.

ADB assists the Lao People's Democratic Republic through the Basic Education (Girls) Project, which actively involves parents in village schools. Multi-grade schools are being established in villages with incomplete schools so that children do not have to travel to other villages to complete the full primary cycle. Efforts are made to recruit and train women ethnic minority teachers. Locally adapted curriculum material is developed to complement the national core curriculum and cater to the special needs of girls in the village. (Asian Development Bank, Education, Our Framework: Policies and Strategies, 2002)



78. Considerable work has been done to match primary education to the needs of the rural population (FAO/UNESCO, 2003: 107-157). Weekly schedules and vacation periods of rural schools can be determined in each locality in accordance with the availability of the learners and in agreement with parents. The school calendar can be adjusted to accommodate demands on girls' time for fetching water in the morning or selling goods at the weekly market. Enclosing the schoolyard with a fence and building separate toilets for girls can help allay parental concerns for their daughter's safety. Local recruitment may ensure that teachers know the local language and customs, and are more acceptable and accountable to the local community. The recruitment of women teachers can boost the enrolment and retention of girls in rural schools.

Broadening the range of providers

79. In order to reduce poverty and achieve the MDGs, governments should also broaden the range of providers of essential services beyond the government and recognize the effectiveness of alternative providers. Broadening the range of providers not only increases the capacity to provide a service, but also facilitates the matching of service provision with the needs, priorities and conditions of the poor, because alternative service providers tend to be more responsive to the needs of their customers.

80. Broadening the range of providers does not mean that the government can relinquish its responsibility to ensure access for all to basic services. It may not be the government's obligation to provide services, but it is obliged to ensure that they are provided. The government should facilitate and closely monitor service provision by others, and hold providers accountable for the quality and coverage of their services. Alternative providers include the formal and informal private sector and civil society as well as traditional providers such as temples, mosques and churches, and non- or semi-professionals such as paramedics.

81. Traditional institutions and non- or semi-professionals, because of their proximity to potential users, can play an important role in providing basic health care and education to under-serviced groups. Some health and education programmes make use of existing forms of traditional education, such as Koran and temple schools (box 5). A literacy component, for instance, is included in the teaching at Koran schools in some rural communities in Uttar Pradesh (India). There, schooling moves from formal to non-formal education. The informal setting of the learning environment allows parents closer surveillance over children's security, which is especially important for girls (FAO/UNESCO, 2003:134).

Box 5. Involving temples and mosques in health care

In Kirivong district of Cambodia, an NGO established a network of 91 temples and five mosques for its health care programme. Each of the health centres has a management committee (HCMC) consisting of commune chiefs, health centre staff and one male and one female representative from each temple and mosque. Each temple and mosque has a Health Action Group (HAG), which consists of two HCMC members, a monk and a nun at the temple or the Imam and two mosque volunteers.

The system promotes sound management, accountability and community ownership of the facilities, and facilitates communication between the community and the health centre. In consultation with the village chiefs, HCMCs coordinate an equity fund, managed by the temple or mosque and financed by community contributions, to exempt the poorest from user fees. HAGs encourage better utilization of preventive health-care services, lead peer group discussions and supplement their income by social marketing of home-birth kits and oral re-hydration solutions (Jacobs, 2002).

82. Paramedics can speak to rural women directly and meet their specific health and socio-economic needs (box 6). They are more cost-effective in providing health care and introducing preventive measures against diseases, such as dysentery, cholera, diarrhoea and scabies, because their training is shorter and costs less than that of a physician. In India, the Federation of Obstetric and Gynaecology Societies launched an initiative to train non-specialist doctors to provide emergency obstetric care, including caesarean sections, in order to make the service more widely available (UNFPA, 2005:59).

Box 6. Gonoshasthaya Kendra

The aim of Gonoshasthaya Kendra (GK) or People's Health Centre was to develop a system of health care appropriate to the needs of the rural poor of Bangladesh. However, its focus on delivering purely curative services to the poor was soon modified by the understanding that a person's health is conditioned by socio-economic factors. The focus, therefore, shifted to a holistic approach to health that emphasizes the well-being of a person, not only the absence of disease.

The organization now has around 2,000 staff members who operate in 12 districts of Bangladesh. It provides health care to over 800,000 people and has established 47 schools. Twenty-seven of these are in the remote Chittagong Hill Tracts where literacy rates for women in many villages are below 5 per cent. The school curriculum balances Bengali language and culture with those of the various tribal groups (Haque, n.d.).

83. The risk of employing "non-professionals", such as paramedics, is that the users will consider the service "second class" and that the providers are not valued for their work. They should, therefore, be offered career development opportunities, rotation to and from isolated rural postings, provided with good working conditions and benefits, and given the chance to work with others as part of a team. Any programme that uses such staff members to perform tasks normally performed by those with higher levels of education and training must have a good system of monitoring, evaluation, supervision and regulations to ensure high-quality service provision and to protect user rights (UNFPA, 2005: 60).

84. The service provided to the poor by a non-professional, informal or traditional provider must not be a dead-end, but a stepping stone to access more and better services. For instance, reliance on incomplete schools or non-formal education should not result in "second class education". Formal and non-formal education should be designed and managed to be complementary. Children who enrol in an incomplete school or attend non-formal education because of the unavailability of a complete school should be able to move on to formal education without problems. Similarly, the work of paramedics and medical professionals should be complementary and professionals should not look down on users of health services who first deal with paramedics. Local services must be linked to national services so that users can upgrade to these standard services if and when they want or need them.

Public-private partnerships

85. Since privatization now comes high on the agenda of agencies such as the World Bank, the role of the government in service provision has been debated. Some argue for a small government and want to leave most of what the government is currently doing to the private sector and the market. That is not the view of this paper. Broadening the range of providers does not mean that there is no role for government in service provision. Where the central or local government provides services effectively and efficiently, it should continue to do so. Where it does not provide services effectively and efficiently, it should consider involving other providers.

86. This paper contends that the government, the private for-profit sector and civil society should each do what they can do best. The roles they could play in service provision can be summarized as follows:

- The public sector tends to be better at setting priorities through a democratic political process, raising resources, regulating, ensuring equity and preventing discrimination.
- The private sector tends to be better at performing economic tasks, innovating and replicating successful experiments, abandoning unsuccessful or obsolete activities, adapting to rapid change, responding and customizing services to user demands (provided they are prepared to pay).
- Civil society tends to be best at performing tasks that generate little or no profit, demand compassion and commitment to individuals, require extensive trust on the part of customers and clients, and need hands-on, personal attention (Osborne and Gaebler, 1993: 30, 45-46, 345).

87. Public-private partnerships have emerged as an alternative arrangement for service provision by combining the public interest and social responsibility of the government with the efficiency and responsiveness to customer demand of the private sector (box 7). The central principle of the partnership is a sharing of risks, resources and responsibilities among the partners. Experience with public-private partnerships within the region and elsewhere, however, have not been encouraging. Allocating risks and rewards between the partners is not easy, as private companies base their investments on estimates of future demand that are often not accurate. Governments, on the other hand, tend to insist on regulating the price of a service and this may easily lead to political interference and disregard for the interests of the private partner.

88. There are also contrasting arguments about the impact of public-private partnerships on the provision of services to the poor. If a private company brings capital, new technology and better management, it may

be able to extend the service and improve its quality for everyone, including the poor. Examples are the private telecommunication companies that have brought access to mobile telephones to the poor. However, a profit-oriented company tends to target those market segments where risks are low and revenues are easy to generate. It sees the poor as a difficult and risky market, if a market at all, and may not even try to extend the service to the poor, unless the contract requires it to do so.

89. There are positive examples of private-sector service provision to the poor. Past sanitation programmes were ineffective because they were highly subsidized and supplied centrally designed sanitation systems. Recent programmes have a soft component (raising awareness for behaviour change) and a hard component (low-cost technologies adapted to the needs of the users). Once the population has been motivated through awareness of the sanitation-health link or through non-health concerns such as privacy, convenience and status, an effective demand for low-cost sanitation emerges. Small-scale entrepreneurs respond to the demand by supplying different types of low-cost sanitation systems. Training of numerous entrepreneurs promotes competitiveness in the market (Phan and others, 2004).

90. The existence of a market among the poor and the nature of that market have become a matter of debate. According to Prahalad (2005: 10-46), there is a market at, what he calls, the "bottom of the income pyramid", as evidenced by the often high prices the poor pay for essential services, either directly through the informal market or indirectly through time wasted and foregone income opportunities. Currently, the practices of the poor and those of private companies do not match: the latter want to collect charges in large instalments or on fixed dates, while the poor want to make daily or irregular payments and to have flexible arrangements (Conan, no date: 31). Prahalad urges private companies to adapt their products and strategies to the needs and conditions of poor consumers.

91. The provision of a service to the urban poor that requires a high investment in fixed capital (such as a piped water supply network) faces another major institutional constraint: the extra-legality of many urban poor settlements. Most urban poor do not have a legal title for their house or their land, and live under the threat of eviction. They do not form an attractive market segment for a company that has to make a high investment to serve these customers. These features do not worry the informal sector, which fills the void in service provision left by the government and operates extensively in the settlements of the urban poor.

92. Informal and small formal enterprises can operate in this environment because they have low entry costs, are close to the community and rely on informal enforcement mechanisms. The entrepreneurs often live in the neighbourhood and operate on a small scale with minimum investments in fixed capital to minimize their risks. Their knowledge of their customers allows them to tailor their services to the needs of the users, including working hours and payment schedules. Community or peer pressure enforces informal contracts and someone's reputation in the community can serve as collateral for loans. The poor use these services because they are flexible and immediately available and the management style is adapted to the conditions of the users (ADB, 2004: 55).

93. Informal-sector provision of services has its limitations. The informal sector uses simple technology and it has little capital, because commercial banks see its operations as risky, illegal and non-profitable and do not recognize its assets. The service quality may be, but not always, lower than what the formal sector can offer, while charges may be higher because the low fixed costs of the informal sector often lead to higher marginal costs. However, a study of small-scale private water providers in eight Asian cities did not find indications of profiteering or exploitation (ADB, 2004: 24, 34). On the other hand, informal entrepreneurs, like any entrepreneur, are motivated by profit and will not provide services where no profit can be made.

Box 7. Pro-poor public private partnerships

In Halgahakumbura, a squatter settlement in Colombo, Sri Lanka, 600 families used to receive their water through public stand posts. Because the water was free, the service generated no revenue for the National Water Supply and Drainage Board (NWSDB), but it encouraged wasteful use by the population. The quality of the service was poor and people wasted time queuing and carrying water home. The NWSDB considered establishing house connections costly and risky, because the capacity and willingness of the residents to pay was unknown.

In 2004, ESCAP introduced an innovative partnership among the NWSDB, the community, a small private company (without experience in water distribution) and a local NGO. The NGO organized consultations to gauge the willingness to pay of the community and to develop the community's ownership of the scheme to reduce the risk of non-payment. The private company won a concession to lay pipes in the settlement, install individual water connections and distribute water to the households.

The company sells water at the official price and buys it in bulk from the NWSDB at a lower price set by a bidding process. Because the company is small and has low operating costs, it can make profit on small margins. It has opened an office close to the community to facilitate payments and deal with customers.

The scheme required a change of attitude by all partners. The community has learned that it is beneficial to pay for the water it receives. The small private company discovered that there is a market for water among the poor. The NWSDB is paid for the water it supplies without having to collect individual charges, and sees a reduction in the wastage of water. The Government of Sri Lanka realized the possibilities of privatizing water supply.

94. Service provision to the poor by small and informal providers and traditional organizations such as temples, Koran schools and traditional healers may be unauthorized and below national standards, but its significance lies in the ability to match the service they provide to the needs, priorities and conditions of the users. Since these channels exist and have proven to be effective, it is important to explore their role in expanding services and improving their quality. The challenge is to do so in a way that keeps the activity attractive (or profitable) for the service provider, affordable for the service user and acceptable to the public interest, without making the provision ineffective.

Community-based service provision

95. In response to growing needs and declining public service provision, civil society organizations have emerged in the region to fill the gap. Some organizations provide services "in the absence of State provision"; others promote "alternative models of service provision" by supporting self-help initiatives in poor communities (Mitlin, 1999). Their usually small and flexible projects tend to produce good results, but they require long maturation periods and have limited coverage because of the need to develop trust and confidence among the service users. Many civil society organizations that provided a service in the absence of provision by the government have also come to recognize the effectiveness of participation and local ownership by the poor and the need to empower the users and are moving closer to an "alternative model".

96. Civil society organizations that advocate alternative models of service provision based on community initiatives argue that communities should not wait for the government to provide services. They should take their condition in their own hands and develop their capacity to provide services outside the control of the government (e.g. the Orangi Pilot Project or OPP in Karachi, Pakistan, discussed in box 8). However, this is, not easy as many urban poor communities have several barriers to overcome before they assume can responsibility for developing their

settlement. Once a community overcomes these barriers, often with support from a civil society organization, the results can be remarkable in both their effectiveness and sustainability. The barriers low-income communities need to overcome are:

- psychological: many people are convinced that only the government can and should provide public services;
- financial: the poor believe that they cannot afford the cost of a service;
- social: community-based service provision requires a community organization that does not always exist; and
- technical: the poor feel that they lack the knowledge and skills to arrange their own service provision.

97. This type of community-based development also has its limitations. Like informal private-sector service providers, communities lack the resources and the technology to develop more complex facilities (e.g. main drains and treatment plants in Orangi). These are not only too expensive and difficult to build, but are also less important to the population because they serve the public interest (the natural environment in the case of Orangi) rather than the individual users. Some have also criticized community-based development for providing an excuse to governments not to provide services. OPP has pointed out that communities can and should do only the internal development of their settlement; its external development should remain the responsibility of the government. However, such an ex-post-facto public-private partnership is difficult, if the government does not recognize the work done by community-based organizations in extralegal settlements.

Box 8. Orangi Pilot Project

The Orangi Pilot Project (OPP) started in response to a lack of government commitment to improve the living conditions in Karachi's informal settlements. The objective was to empower communities to manage their own development, recognizing that neither the government nor non-governmental organizations could solve the problem of poverty on the scale required, and that communities had important resources and knowledge to contribute.

Although the residents were aware of the sanitation problems in Orangi, they took no action. Only after OPP-led discussions did communities understand the limited capacity of the government and their own capacity and resources. Despite their insecurity of tenure, house owners expressed their willingness to assume responsibility for constructing and maintaining a sanitation system within their neighbourhood. The elimination of contractors and middlemen reduced construction costs.

The organization of communities in lanes of 20 to 40 houses ensured active participation by the residents, as the lanes were small enough to build mutual trust and large enough to introduce economies of scale. The communities focused on constructing sewers in lanes and toilets (internal development) and developed a sanitation system in Orangi that now benefits some 100,000 families. What the communities could not develop were the main drains and the treatment plant outside the settlement (external development).

Observers attribute the decline in infant mortality in Orangi at least partly to the construction of sewers. OPP has since evolved into an internationally known community development movement and expanded its activities into health and family planning, building technology, education, credit and income generation. Other settlements in Karachi and other cities and towns of Pakistan have adapted the model and it has influenced development approaches internationally. OPP studies have demonstrated that duplication can be avoided and government funds can be saved, if the principle of subsidiarity is applied and government contributes only that which communities cannot provide (Zaidi, 2001).

98. The experiences with pro-poor, public-private partnerships and community-based service provision show that the extralegal status of the work and assets of the poor is a major obstacle to reducing poverty. It is an obstacle when the poor want to access services provided by the government, and it is an obstacle when a private company or a community-based organization wants to provide a service in an extralegal settlement. Broadening the range of service providers and matching service provision with the needs, priorities and conditions of the users in order to reach the under-serviced poor and disadvantaged can only work if governments recognize what the poor can contribute to society. Effective pro-poor public-private partnerships reveal that the poor are willing to pay for good-quality, essential services while the Orangi Pilot Project demonstrates the value of labour and other contributions by the poor to infrastructure development.

Recognizing extralegal realities

99. Recognizing poor people's contributions to society is a critical step in formulating policies that enable broad coverage and high quality provision of essential services. De Soto estimates that the extra-legally held assets of the poor are worth over $9 trillion (de Soto, 2003: 29). However, property held in the extralegal sector is "dead capital" that cannot, or only with difficulty, be used in the formal economy. Small farmers without a solid title to the land they cultivate have problems obtaining credit. The extralegal status of urban poor settlements makes it difficult for the public or the private sector to provide services. Because a modern market economy is inconceivable without an integrated formal property system, de Soto calls for the integration of legal and extralegal property arrangements into a single codified system (de Soto, 2003: 146-188). Such integration would expand the economic opportunities of the poor and help them to escape poverty.

100. What de Soto does not mention is that the extralegal status of their assets does not prevent the poor from buying and selling property or even using it as collateral within the extralegal sector itself. In the extralegal sector, the transactions are covered by social contracts of their own making. Integration of extralegal property arrangements into a single, formal system might in fact remove the protection that informality provides and that keeps assets affordable for the poor. Any integration should, therefore, be done very carefully and start with building bridges between the legal and extralegal sectors.

101. This could be done through audits of relevant regulatory frameworks (Payne and Majale, 2004: 80-93). The aim would be to adjust these frameworks to the realities "on the ground", bring them in line with local conditions and enable more people, especially the poor, to conform to laws, regulations, standards and procedures. Adjusting a regulatory framework to the realities on the ground is simpler in some cases than in others. Box 9 presents a case where an effective service provision would require the tolerance of behaviour considered illegal or undesirable by a majority of the population.

Box 9. SHAKTI injecting drug user project

Through extensive field visits and city mapping, CARE Bangladesh identified 42 locations in Dhaka where drugs were injected and, in some cases, sold. The project started by training 12 active injecting drug users to become peer outreach workers. The focus of the training was on educating other injecting drug users on HIV/AIDS, sexually transmitted diseases and drugs-related issues, the exchange of needles and syringes and the distribution of condoms. CARE set outreach workers strict rules of behaviour: "don't inject while working", "don't carry drugs during work" and "avoid involvement in criminal activities".

By June 1999, the project reached some 2,000 injecting drug users per day, and it continued to grow until it had 11 drop-in centres and 50 peer outreach workers. It also trained 160 volunteer peer educators and 20 medicine shop sellers. After the Dhaka experience, CARE Bangladesh launched similar programmes in Rajshahi, Chapai Nawabganj and Char Narendrar (Reid and Costigan, 2002: 33).

Decentralization

102. Decentralization of decision making from national to sub-national or local levels can improve service provision by allowing at least some decisions to be made at the local level to meet the specific demands of customers. Across the Asia-Pacific region, many governments have initiated decentralization, but the results have been mixed. It is becoming increasingly clear that decentralization alone is not enough to ensure a more efficient provision of services to the poor. As with public-private partnerships, governments have often introduced decentralization without capacity building and establishing the necessary institutions and regulatory frameworks to make it work.

103. Concerns over decentralization focus on the lack of capacity at lower levels of the government to assume the delegated responsibilities, the possibilities of corruption and a lack of inclusiveness and equity in decision-making and policy objectives. There is also a lack of clarity about the appropriate balance between centralized and local decision-making. For instance, decentralization of revenue collection may reinforce existing regional inequalities within a country. This may benefit resource-rich areas most and limit the capacity of the central government to mitigate inequalities between regions by allocating resources on the basis of need.

104. Central and local governments tend to be organized along sectoral lines through ministries and departments that deal separately with education, health, water and sanitation etc. However, problems and solutions in education, health care, water and sanitation are closely related and problems in one sector may have solutions in another. People affected by the problem will not think in terms of sectors; their problems are "cross-sectoral". Once decision-making has been delegated to the local level, government should not force people to look at their problems in a sectoral manner simply because of the way its ministries and departments are organized. Local planning and decision making has to follow a holistic approach.

105. Decentralization of decision-making power to communities can generate similar problems as decentralization from central to local government. The promotion of community management must be preceded by a realistic assessment of the community's dynamics and the motives and expectations of people and their leaders to take part in the improvement of their village or settlement. The poor are not more (or less) altruistic than the non-poor, and local communities are not necessarily democratic by nature. Rural communities are known to have traditions of unequal distribution of power and resources (including patriarchal structures in families), but the same applies to urban communities.

106. Decision-making power in informal settlements is limited to local politicians and land brokers. Most urban informal settlements develop through extralegal land markets as a result of the scarcity of urban land today. The process often involves payments by the poor to politicians and local agents to obtain protection against eviction. In this way, local politicians and public administrators in many cities control the growth of the settlements. Security of tenure is often a political rather than a legal issue. Local leaders perform important functions because of their affiliation with powerful persons or parties outside the settlement who can help bring services to the settlement in exchange for votes. Private water vendors often operate under such political patronage and pass the cost on to the service users (Conan no date: 32).

107. This chapter has presented a range of strategies to overcome physical, financial, legal and socio-cultural barriers, such as broadening the range of providers to include the formal and informal private sector, traditional institutions and the communities themselves. To make these service providers effective, there is a need to make institutional changes such as recognizing extralegal realities, revising regulatory frameworks and decentralizing decision-making to lower levels of government. It is the responsibility of the government to initiate these institutional changes so that all, including the poor and disadvantaged, have access to basic services.

CHAPTER 3: THE IMPORTANCE OF GOOD GOVERNANCE

108. The strategies presented in the previous chapter have proven effective to improve service access to some extent, but they are not sufficient to ensure that all people have access to the services they need and are entitled to. The reason is that they do not address the underlying cause of the problem: the political barrier, the poverty of power. This barrier prevents the poor from influencing decision-making, from claiming access to basic services and from holding the government and the service provider accountable for the service provided. It thereby excludes them from sharing in the benefits of development.

Political barriers

109. The allocation of public budgets and the mobilization of resources for service provision are not simple, mechanical processes. Conditions have to be assessed and priorities set; policies and programmes have to be approved and plans have to be prepared and implemented. This long and complex process is influenced by numerous stakeholders who take account of a wide range of issues that include power and profit as well as the problems of the poor. Governments are responsible in principle for ensuring access for all to basic services. In practice, the competition for scarce resources makes allocation of funding for the provision of services a political process in which those with power influence the decisions and those without power remain sidelined in terms of both the process and the outcomes.

110. To overcome this political barrier, the poor need to be given the opportunities and means (i.e. power) to influence decision-making and to present their interests. However, those with power tend to be reluctant to surrender space and power to the less advantaged. Some will argue that the poor lack the capacity to use power wisely and would be better off being represented by others in the decision-making process. Empowerment therefore rarely occurs spontaneously and it cannot be left solely to the poor and disadvantaged groups to attain it; it usually requires some external intervention.

111. The government itself has a responsibility to ensure that all people, in particular the poor and needy, are able to participate actively in the political process and setting policy objectives. Such inclusion is not always in the interest of those in government. Therefore, civil society organizations often speak out on behalf of those not represented to demand that policies are inclusive and that institutional changes are made to enable the poor and disadvantaged to participate in development. Nowadays, donor agencies are also increasingly linking development assistance to empowerment, because they see that poverty reduction is not effective or sustainable without empowerment of the poor.

The rights-based approach

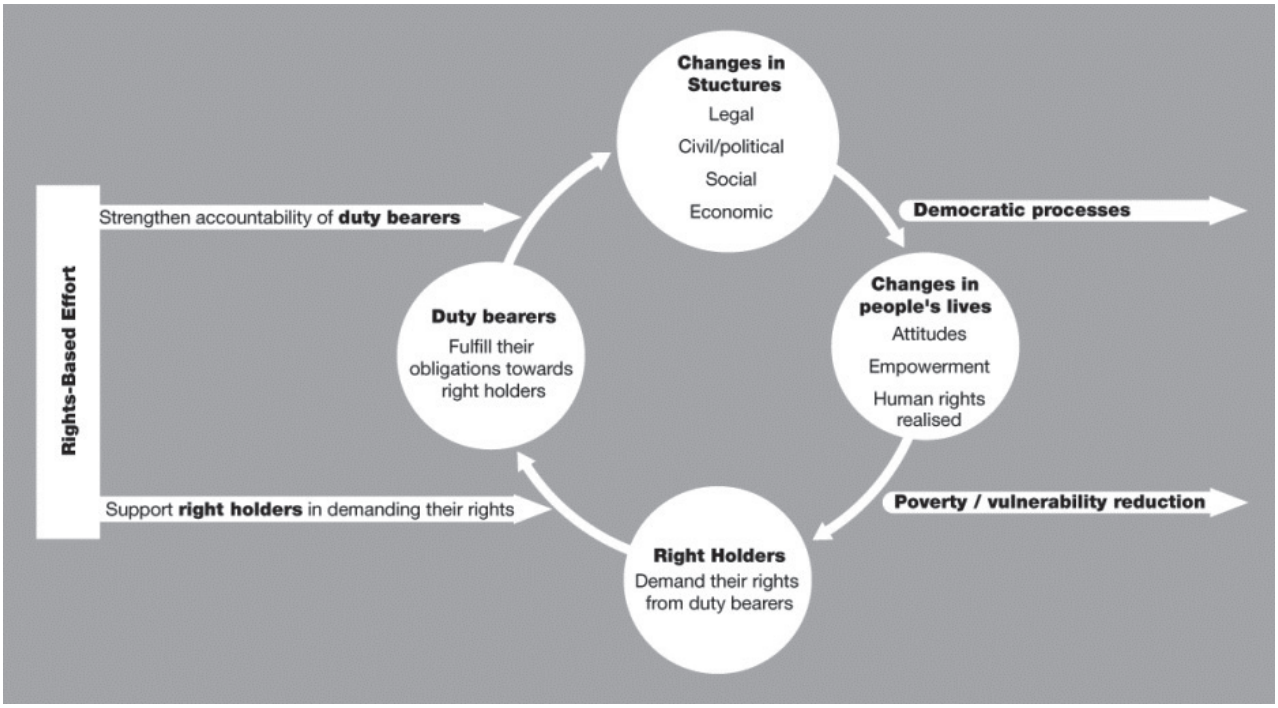
112. While most, if not all, people would agree with these principles, many have a problem visualizing ways to apply them in concrete actions. One way to do so is to adopt a rights-based approach to development.

113. Article 25 (1) of the Universal Declaration of Human Rights states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services." Article 2 states that everyone is entitled to all rights and freedoms without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Subsequent declarations and conventions have established primary education, health care and access to water as human rights. Accordingly, all people must have access to them. This provides a framework of human rights-based norms for guiding both the processes and outcomes of development interventions related to these rights. It gives direction to a government for improving the provision of basic services and reducing poverty.

114. The rights-based approach distinguishes claim-holders and duty-bearers, identifies claim-duty relationships linking individuals and institutions in these roles, and determines the gap in capacity of claim-holders to claim their rights and of duty-bearers to fulfil their obligations. This can provide a basis for actions that, together with the normative framework mentioned above, can lead to institutional changes that support the realization of human rights for all people. Furthermore, the effort reinforces itself, as processes of good governance are established and conditions of poverty are reduced (figure 1).

115. Civil society organizations use the rights-based approach to identify population groups that do not benefit from development and ask why these groups have been excluded. They remind government of the need to be inclusive and to ensure that all people share in the benefits of development by including the poor in its policy objectives and in decision-making on these policies. They also remind the government of its duty to give special attention to those who risk being excluded, to ensure that their rights are not ignored, because those who need the attention have no voice to claim their rights (Theis, 2004:5).

Figure 1. Rights-based approach to development



Source: Cecilia M. Ljungman, A Rights-Based Approach to Development, COWI, November 2004.

116. The rights-based approach recognizes four types of core obligations for duty-bearers:

- Respect rights, i.e. do not interfere with their enjoyment by everyone.
- Protect rights from abuse by others, i.e. do not allow others to interfere with these rights.
- Facilitate the fulfilment of rights, i.e. create an enabling and supportive environment.
- Fulfil the rights, i.e. support and assist those who cannot meet their own needs.

117. The rights-based approach recognizes the limitations of the real world and the difficulties involved in ensuring a full realization of all rights. It therefore introduced the concept of progressive realization, acknowledging that full realization may not be achieved in the short term. However, the acceptance of progressive realization does not take away the obligation to move as expeditiously and effectively as possible towards the goal of full realization. Thus, governments have a fundamental obligation to satisfy the minimum essential level of each right. This level cannot be determined in the abstract; it is a national task to be undertaken in accordance with human rights principles and it includes the immediate obligation not to discriminate between different groups of people (OHCHR, 2006).

118. Some proponents of the rights-based approach have argued that the Millennium Development Goals may not have done the poor a favour, if they encourage governments to reach out first to those who can be reached most easily and at a lower cost, at the expense of the most needy and difficult to reach. In a debate with Millennium Project Director, Jeffrey Sachs, Mary Robinson, a former High Commissioner for Human Rights, expressed her fear that governments and their partners withdraw funds from programmes aimed at the poorest of the poor in order to achieve the MDGs by 2015.

119. In this respect, the UNDP Human Development Report 2003 has drawn attention to some sub-national trends, even among countries that are on track to achieve the MDGs by 2015. Clearly in line with the rights-based approach, the report urges countries to take a bottom-up approach and focus first on people most in need of support to achieve sustainable and inclusive progress. The guiding paradigm in this respect is good governance.

Good governance

120. UNDP defines governance as "the exercise of economic, political, and administrative authority to manage a country's affairs at all levels and the means by which states promote social cohesion and integration, and ensure the well-being of their populations. It embraces all methods used to distribute power and manage public resources, and the organizations that shape government and the execution of policy. It encompasses the mechanisms, processes and institutions, through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and resolve their differences."

121. According to this definition, "good governance therefore depends on public participation to ensure that political, social and economic priorities are based on a broad societal consensus and that the poorest and most vulnerable populations can directly influence political decision making, particularly with respect to the allocation of development resources. Good governance is also effective and equitable, and promotes the rule of law and the transparency of institutions, officials, and transactions" (UNDP, no date).

122. In brief, good governance refers to a high quality of processes by which decisions affecting public affairs are reached and implemented. Good governance ensures that all, including the poor and other disadvantaged groups, are included and have the means (a) to influence the direction of development in particular as far as it affects their lives, (b) to make contributions to development and have these recognized, and (c) to share in the benefits of development and improve their lives and livelihoods. Good governance helps to ensure that all people have adequate access to basic services.

123. The quality of governance may be measured according to a set of principles which can be defined as follows (International Fund for Agricultural Development, no date):

- Inclusiveness and equity: the principle that no one can be excluded from the process of development on the basis of gender, race, religion etc.
- Participation: the opportunity for people affected by the decision to influence the process of decision-making directly or indirectly.

- Transparency: the degree to which the rules, standards and procedures for decision-making are open, clear, verifiable and predictable.
- Efficiency: a measure of how economically resources are used to produce the intended results.
- Effectiveness: a measure of the extent to which the intervention achieves its objectives.
- Subsidiarity: the principle that decision-making takes place at the level most appropriate for the issue (usually the lowest level possible).
- Adherence to the rule of law: the principle that every member of a society, even a ruler, must follow the law.
- Accountability: the responsibility of a decision-maker to explain and justify the decisions it made and implemented, and the results these produced.
- Sustainability: The likelihood that the positive effects of an intervention will persist for an extended period after the intervention as such ends.

Involving the poor

124. Many of the principles of good governance are interrelated and all principles are necessary in order to achieve good governance, but some have more relevance in a particular context than others. Inclusiveness and equity play a critical role in the provision of basic services to reduce and eventually eradicate poverty in line with the MDGs. Inclusiveness and equity encompass political processes (inclusion in the process of decision-making on development) and policy objectives (recognition of contributions by the poor to development and their sharing in the benefits of development).

125. Inclusiveness in political processes is not simple. The poor are not a homogeneous group, but include a wide range of groups including, for example, persons living in remote areas, ethnic minorities, women and children or persons with disabilities. To ensure that political processes are inclusive, subsidiarity is important. Subsidiarity implies that decisions should be made at the most appropriate level of government, thereby providing opportunities for people to participate in decision-making that directly affects their lives.

126. Ensuring participation by both sexes in planning, implementing, monitoring and evaluating development projects and public services, i.e. gender mainstreaming, is another essential component of inclusive political processes. This enables the users to match services to their needs, priorities and conditions.

Box 10. Women in urban local government

Representation of women in decision-making positions is an important means to improve the inclusiveness of policies and reduce gender discrimination. With support from the Government of Japan, ESCAP organized the first-ever Asia-Pacific Summit of Women Mayors and Councillors in Phitsanulok (Thailand) to review the situation in the region and discuss measures to increase women's participation in decision making.

The Summit focussed on local government, because entry at this level is easier for women than entry into central government and because local government deals with many issues that are of great concern to women. The Summit adopted a Declaration calling for further support to advance the position of women in local government.

Subsequently, ESCAP supported national summits of women mayors and councillors in Pakistan, the Philippines, Sri Lanka and Thailand, the establishment of a regional resource facility on the advancement of women in local government at the University of the Philippines (www.decentralizaton.ws/rirf) and the development of training material.

127. The result of inclusive political processes is not only more and better services for the poor and disadvantaged; the application of the principles of inclusiveness and equity, participation and subsidiarity sets in motion a process of empowerment that goes far beyond the provision of basic services towards enabling the poor to become agents of their own development.

Reaching the poor

128. Effectiveness is a measure of the extent to which an intervention achieves its objective. The need to apply good governance and be effective appears to be obvious, but there are some important issues to consider. When providing a service, in particular one that is free, governments are often only concerned that the service is available, not whether it is being used and whether it improves the conditions of the users. Once a school or clinic has been built and the water taps and toilets have been installed, governments may consider their work done and that it is up to prospective users to utilize the service.

129. This paper argues that there are many barriers that prevent prospective users from making optimum use of the service provided. Effectiveness requires that the service matches the needs, priorities and conditions of the users and that this can best be

achieved by enabling the users to be involved in the design and management of the service concerned.

130. Efficiency is a measure of how economically resources are used to produce the desired results. It means that funds are spent for the intended purpose and without waste, but it is important to define carefully the desired outcome. Efficiency means achieving the widest impact for the resources spent: e.g. the number of people reached with a standard quality of services at the lowest cost. However, the principles of inclusiveness and equity demand that the desired impact is to ensure access to basic services to all of the population on a fair basis. When stated this way, achieving anything less than 100 per cent coverage is not an efficient use of resources. If the intended purpose is to cover all people, efficiency is achieved by delivering the best quality of service for all people at the lowest cost.

131. In line with the principles of inclusiveness and equity and following the rights-based approach, governments need to acknowledge the "incrementality" in poverty reduction and the need for incremental

Box 11. Incremental housing

Article 25 of the Universal Declaration of Human Rights states that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing …" Housing was subsequently recognized as a separate human right, but most governments have wondered how to interpret the right to housing, because few, if any, have the resources to provide each family with adequate housing. Over the years, governments in the region have made substantial budgets available to house the poor, but these budgets were usually depleted after only a small number of families had been housed owing to the high cost of housing, leaving a majority of the poor without a house.

Successive governments in Hong Kong and Singapore recognized the need for adequate housing, but started small by building as many extremely small apartments as possible. The apartment provided a family with a basic shelter and access to basic services. At today's level of economic development, these housing units are considered inadequate, and the buildings are being replaced with new housing or two small units are merged into a larger one, thereby progressively realizing the right to adequate housing. This approach, however, is not affordable for most countries in the region which have a lower level of economic development and a much larger population.

Because of a lack of affordable housing, many urban poor find housing in squatter settlements, built without the consent of the landowner and without a building permit from the authorities. Squatters live under a constant threat of eviction and this makes them reluctant to invest their small savings in their informal real estate. Most governments turn a blind eye to the efforts by the poor to solve their housing problem because they cannot offer an alternative solution. A few governments have granted squatter settlements some security of tenure. They are now neither legal nor illegal, but somewhere "in between". This is good enough for the residents and as a result, they start investing in the houses. This progressive realization of the right to housing is referred to as incremental development.

Many governments are uncomfortable with the idea of providing security of tenure and with the concept of incremental development. They see incremental development as the perpetuation of slums, because investments by the poor in their housing are small and the quality of the house may be "substandard" for a long time. However, incremental development, prompted by the provision of security of tenure, is affordable to the government and the poor and matches their needs, priorities and conditions. With a sufficiently supportive and enabling environment, the poor will develop their housing to acceptable standards. Development is a process and the poor can only take small steps; the role of government is to create the conditions in which the poor can take them.

development. A journey of a thousand miles begins with a single step; poverty eradication is a long journey that cannot be achieved in a single leap; it must start with a small step. The right of access to services can be realized progressively, but the core obligation not to discriminate requires that service coverage must be constant at 100 per cent of the population, while service quality is a function of the availability of funds over time.

132. In short, inclusiveness in service provision and the right of the poor to access essential services calls for an approach that aims to reach all, even if the service can not be provided in full owing to a lack of resources or the limited capacity of the provider. A first small step makes it easier for the poor to take additional steps out of poverty, because participatory development not only brings tangible benefits in the form of basic services, but also empowers the poor. Denying them that first step until resources are available for a giant leap will leave them stranded in poverty.

133. Incrementality implies transition strategies that induce incremental improvement and scalable investments for facilities so that they can be upgraded over time. It requires a link between the incomplete services of traditional and informal providers and the complete services of the formal public and private sectors. The principles of incrementality must be incorporated in regulations, standards and procedures. A regulatory framework must serve the public interest and ensure public health and safety; it must be enforceable and enforced, and applied consistently if it is to achieve the desired results. It must also provide a predictable and relevant regulatory environment capable of adapting to the ever-changing realities on the ground.

134. Sustainability is the persistence of the positive effects of a programme or intervention after it has ended. This can be achieved by making a programme fully or partly self-funding through service charges or local support. User involvement in the design and management of services will build community ownership and enhance a sense of responsibility in the user community for their operation and maintenance. This will greatly reduce wastage and costs and increase a willingness to pay. Sustainability may furthermore be achieved by building sufficient community support for the service provided that the government feels obligated to maintain it.

Box 12. Replicating Saemaul Undong

In Cambodia, the Lao People's Democratic Republic and Nepal, ESCAP is implementing a project called "Regional poverty alleviation programme: replication of best practices on rural community development", funded by the Republic of Korea. Its objective is to build the capacity of a community to formulate and implement village improvement plans. Once a community has developed a plan, it should approach the government and request funding from its appropriate programmes. It then combines government resources and its own cash and in-kind investment to undertake village development. The approach empowers communities to hold the government accountable for the implementation of its policies.

Empowering the poor

135. Accountability and transparency are other important principles in providing basic services. The principle of accountability is rooted in the concept of the "social contract" between the government and the people governed. Philosophers such as Hobbes, Locke and Rousseau referred to the "social contract" between the government (the State) and its citizens, whereby citizens surrender their right to violent means in exchange for the right of protection and preservation as human beings by the government.

136. The inability of the poor to hold the government and the service provider accountable results from (a) ignorance on the part of the poor about their rights, (b) a lack of mechanisms to make their voice heard, and (c) intended or unintended neglect by government officials. The poor, and especially the rural poor, are also politically disadvantaged because they are usually not organized, because they do not have access to services that are essential to political participation (e.g. education, information and transport to places where decisions are being taken) and because the opportunity cost of political participation is high. Finally, the ability to hold the government accountable is constrained by lack of information about the design, the budget and the results of government programmes

137. Transparency in governance is the quality of being open, clear and verifiable with regard to the application of rules, standards and procedures. It requires that government take a pro-active approach to ensuring that the population has access to information. A lack of access to information about one's condition, one's rights and one's responsibilities is at the core of poverty because it makes it difficult, if not impossible, to seek access, remedy and justice, even if services are available. The poor and other politically marginalized groups may internalize this sense of powerlessness to the extent they are convinced that they have no right to participate in decision making or that participation will not make any difference to the outcome of the process.

138. Allowing the public to obtain information collected and prepared by government agencies is a strategy that can improve provision of essential services. An established set of procedures available to all can provide channels for citizens to access information about policies, findings from government studies, proposals

Box 13. Community construction contracts

Before 1985, the Government of Sri Lanka provided facilities such as public toilets to shanty areas without any community involvement. As a result, the facilities were often in the wrong location, were not maintained by the community and quickly fell into disrepair. Frustrated by the government's efforts, a poor urban community told officials of the National Housing Development Authority (NHDA) that it could do a better job in design and construction if NHDA provided the funds. The community designed and built a well with financial and technical support from NHDA.

This experience formed the basis for an approach now known as the Community Construction Contract. The NHDA adopted the approach followed by the Colombo Municipal Council and other urban local authorities and non-governmental organizations working with local governments in various towns of Sri Lanka. On the basis of Sri Lanka's experience, the ILO introduced the approach in Tanzania.

Having been put in control, communities made choices to find the option most suited to their circumstances. Some communities, which had been expected to hire labour within their own population, felt that for various reasons they lacked the capacity to undertake the work successfully. On their own, they subcontracted the work to another community (that had proven ability to carry out the work) or to a local contractor (whom the community knew and could closely supervise) (Pathirana and Yap, 1992: 3-14; Jayaratne, 2005).

and plans. Providing access to information also creates opportunities for governments to inform the public about how they are meeting or planning to meet the poor's specific needs. Moreover, citizens who know about plans and basic services provided by the government or its agents are more likely to make use of them.

139. Transparency and accountability also promote the rule of law. They imply that the law protects not only the rights of the rich and powerful, but also those of the poor and disadvantaged groups and that it takes into account the situation of the poor. To fulfil that role, however, laws and regulations may require amendment to cover conditions in the informal economy, in squatter settlements and in traditional villages. Amendments that recognize the informal society and economy will make it easier for the poor to claim their rights and for service providers to reach out to the poor. The rule of law must incorporate remedial mechanisms by which groups that have been excluded from, or adversely affected by, government programmes can appeal and claim their rights.

Box 14. Parivartan – A Delhi-based citizens' movement

Some cities in India have experimented with report cards on government performance in the provision of services. A report card presents the results of customer surveys assessing public services. The aim is to increase public awareness about the performance of the providers and to challenge the latter to be more efficient and responsive to their customers.

Parivartan's website starts with the statement: "India is a democracy. People are masters. Government exists to serve the people. It is the primary duty of any master to take a look at the accounts of the servant at regular intervals and hold the servant accountable. A social audit is a step in that direction." Social audits do not have legal sanction, but they create public pressure on the political establishment to take corrective steps because the findings are presented and discussed in a public meeting (jansunwai) before the entire community and stakeholders.

The Supreme Court of India ruled that the right to information is part of the right of speech and of expression, because the rights of speech and of expression cannot be exercised without information. State after state in India has passed laws granting citizens the right to question their government, inspect government records, take copies thereof and participate in day-to-day governance. The new laws make it much more difficult to be corrupt.

In December 2002, Parivartan organized a jansunwai in front of 1,000 people, including local residents, journalists and eminent persons, to discuss the public works audited. Contracts were read out and residents testified as to whether the work had been undertaken and whether it was done fully or was left incomplete. The audit found, for instance, that 29 hand pumps with electric motors were supposed to be installed, but only 14 hand pumps and no electric motors had actually been installed. Parivartan recommended that a board be placed at the site of every public work giving such information as the name of the contractor, the contract value, start and completion dates and the scope of work (www.parivartan.com/jansumwai.asp).

140. In summary, adherence to good governance is essential to make strategies for providing basic services and reducing poverty effective and sustainable. Good governance ensures that the poor and other disadvantaged groups are included in making decisions about service provision that affects their lives. Their inclusion and involvement empowers them to become agents of their own development and to participate in other relevant areas.

CHAPTER 4: CONCLUSIONS

141. Many of the region's poor are in a cycle of deprivation. They lack the capabilities to lead the life that they value. These capabilities include education and skills, good health, a social network as well as income and assets. The core of this poverty cycle is a deprivation of political power and political inclusion. Without the power to claim their rights and to pressure the government to ensure access to basic services that can develop their capabilities, they will remain stuck in poverty.

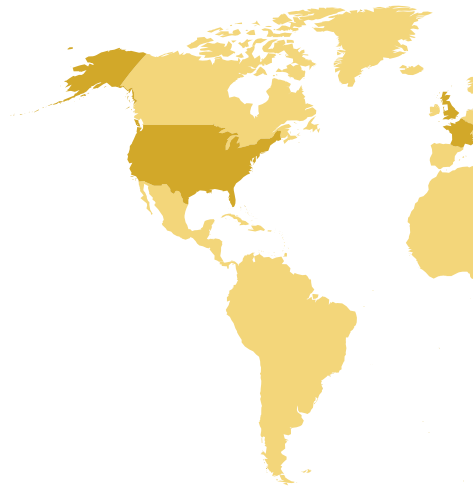
142. The main conclusion derived from the analysis presented in this paper is that mechanisms that aim to achieve good governance create cycles of empowerment that will increase the efficiency and effectiveness of services and empower the poor to become agents of their own development. Good governance is achieved when citizens cease to be passive recipients of services and become engaged in issues that matter to them.

143. Empowerment makes a community responsible for implementing its own plans. By taking responsibility for work to be done, the community can select its own approach, avoid private contractors known to divert resources and produce poor quality work, and closely monitor its progress. This will not only guarantee better work but also develop a sense of pride and ownership in the facility.

144. Adapting service provision to local conditions is only possible if mechanisms are in place for users to negotiate the issues with the provider and if the users have the capacity and all relevant information to meet with the providers on an equal footing. Parents should be able to articulate the educational needs of their children, evaluate a school and hold the service provider accountable for the quality. Users of health services need to be able to express their needs and ideas to the medical staff.

145. Good governance fosters the acquisition of new capacities, the establishment of new institutions, the promotion of new ways of working within existing organizations and the formulation of new rules for interaction. It requires the adoption of inclusive non-discriminatory values and norms and the distribution of power between social groups, so that none is marginalized and loses the right to speak and be heard.

146. An empowered community possesses the knowledge of its rights to services, familiarity with procedures and processes for requesting them, ability to express its priorities and service needs and an understanding of the ways to hold the government and service provider accountable for the provision of efficient services.



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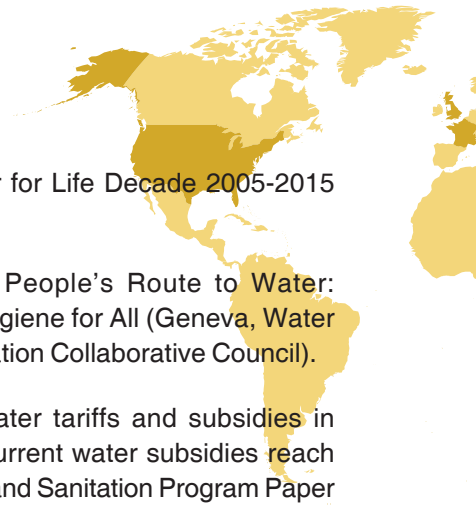

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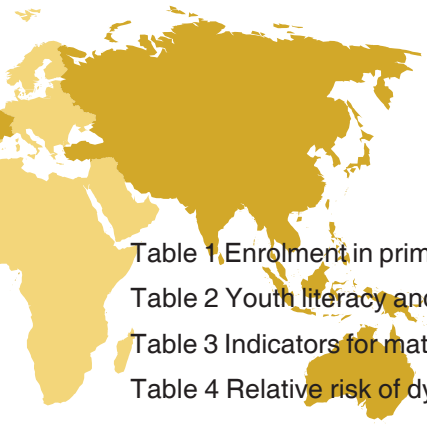


ANNEXES

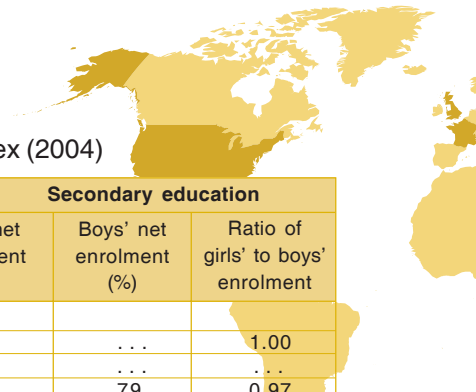


Table 1 Enrolment in primary and secondary education by sex (2004)

Region and country or area	Primary education			Secondary education		
	Girls' net enrolment (%)	Boys' net enrolment (%)	Ratio of girls' to boys' enrolment	Girls' net enrolment (%)	Boys' net enrolment (%)	Ratio of girls' to boys' enrolment
East and North-East Asia						
China	. . .	. . .	1.00	. . .	. . .	1.00
Democratic People's Republic of Korea	. . .	. . .	. . .	. . .	. . .	. . .
Hong Kong, China	90.4	95.6	0.94	77	79	0.97
Japan	100.0	99.8	1.00	. . .	. . .	1.00
Macao, China	87.8	90.5	0.92	80	74	1.04
Mongolia	84.5	83.8	1.02	88	77	1.14
Republic of Korea	99.3	99.8	0.99	88	88	1.00
South-East Asia						
Brunei Darussalam	. . .	. . .	1.00	. . .	. . .	1.05
Cambodia	95.6	99.6	0.92	22	30	0.69
Indonesia	93.3	95.3	0.98	57	57	0.99
Lao People's Democratic Republic	81.7	86.9	0.88	34	40	0.76
Malaysia	93.1[a]	93.3[a]	1.00[a]	81[a]	71[a]	1.14[a]
Myanmar	87.4	86.5	1.01	36	38	0.94
Philippines	95.0	93.0	0.99	67	56	1.11
Singapore	. . .	. . .	. . .	. . .	. . .	. . .
Thailand	. . .	. . .	0.96	. . .	. . .	1.00
Timor-Leste	. . .	. . .	. . .	. . .	. . .	. . .
Viet Nam	91.5[c]	97.1[c]	0.93	. . .	. . .	0.95
South and South-West Asia						
Afghanistan	. . .	. . .	0.44	. . .	. . .	0.21
Bangladesh	95.4	92.2	1.03	51[a]	45[a]	1.11[a]
Bhutan	. . .	. . .	. . .	. . .	. . .	. . .
India	87.0	92.2	0.93	. . .	. . .	0.80
Iran (Islamic Republic of)	88.3	88.9	1.10	76	80	0.94
Maldives	90.0[b]	89.3[b]	0.97	55[b]	48[b]	1.14
Nepal	72.7[a]	83.1[a]	0.88[a]	. . .	. . .	0.77[a]
Pakistan	55.5	76.3	0.73	. . .	. . .	0.73
Sri Lanka	98.4[a]	98.8[a]	0.99[a]	. . .	. . .	1.00
Turkey	86.8	91.8	0.94	. . .	. . .	0.75
North and Central Asia						
Armenia	95.5	92.1	1.03	90	88	1.03
Azerbaijan	83.0	84.6	0.98	76	78	0.97
Georgia	92.5	93.1	1.00	81	81	0.99
Kazakhstan	92.0	93.3	0.99	92	93	0.98
Kyrgyzstan	89.8	90.3	1.00	. . .	. . .	1.01
Russian Federation	91.9	91.1	1.00	. . .	. . .	0.99
Tajikistan	94.5	98.9	0.95	73	86	0.84
Turkmenistan	. . .	. . .	. . .	. . .	. . .	. . .
Uzbekistan	. . .	. . .	0.99	. . .	. . .	0.97
Pacific						
American Samoa	. . .	. . .	. . .	. . .	. . .	. . .
Australia	96.0	95.5	1.00	86	85	0.96
Cook Islands	77.1[d]	77.6[d]	0.98[a]	60[d]	55[d]	1.02[a]
Fiji	95.8	96.7	0.98	85	80	1.07
French Polynesia	. . .	. . .	. . .	. . .	. . .	. . .
Guam	. . .	. . .	. . .	. . .	. . .	. . .
Kiribati	97.6[e]	96.4[e]	1.03	76	65	1.22
Marshall Islands	89.3[a]	89.9[a]	0.94[a]	77[a]	72[a]	1.04[a]
Micronesia (Federated States of)	. . .	. . .	. . .	. . .	. . .	. . .
Nauru	. . .	. . .	0.99[a]	. . .	. . .	1.07[a]
New Caledonia	. . .	. . .	. . .	. . .	. . .	. . .
New Zealand	99.2	99.3	1.00	96	93	1.09
Niue	98.4[e]	98.6[e]	1.19	96[e]	91[e]	0.95
Northern Mariana Islands	. . .	. . .	. . .	. . .	. . .	. . .
Palau	94.5[d]	98.3[d]	0.82	. . .	. . .	1.14
Papua New Guinea	. . .	. . .	0.88[a]	. . .	. . .	0.79[a]
Samoa	90.6	90.3	1.00	70	62	1.12
Solomon Islands	79.0	80.1	0.97	24[a]	28[a]	0.81[a]
Tonga	89.3[e]	92.1[e]	0.95	75	61	1.08
Tuvalu	. . .	. . .	1.07	. . .	. . .	0.93[c]
Vanuatu	93.0	94.7	0.97	36	42	0.86

Source: United Nations Statistics Division, MDG Indicators Database

[a] Data refer to year 2003
[b] Data refer to year 2002
[c] Data refer to year 2001
[d] Data refer to year 2000
[e] Data refer to year 1999
[f] Data taken from UNESCO Institute for Statistics

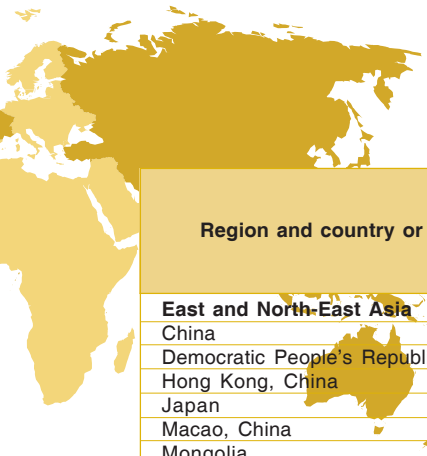


Table 2 Youth literacy and tertiary enrolment by sex (2004)

Region and country or area	Literacy of persons ages 15-24			Tertiary education		
	Women's literacy (%)	Men's literacy (%)	Ratio of female to male literacy	Women's gross enrolment (%) [f]	Men's gross enrolment (%) [f]	Ratio of female to male enrolment
East and North-East Asia						
China	98.5	99.2	0.99	17	21	0.85
Democratic People's Republic of Korea	. . .	. . .	. . .	. . .	. . .	. . .
Hong Kong, China	97.9[e]	98.5[e]	0.99[e]	32	33	0.97
Japan	. . .	. . .	. . .	51	57	0.89
Macao, China	99.8	99.4	1.00	54	84	0.65
Mongolia	98.4	97	1.01	48	29	1.64
Republic of Korea	99.8[e]	99.8[e]	1.00[e]	67	109	0.61
South-East Asia						
Brunei Darussalam	98.9	98.9	1.00	17	10	1.74
Cambodia	78.9	87.9	0.90	2	4	0.46
Indonesia	98.5	98.9	1.00	15	19	0.79
Lao People's Democratic Republic	74.7	82.6	0.90	5	7	0.63
Malaysia	97.3	97.2	1.00	38[a]	27[a]	1.41[a]
Myanmar	93.4	95.7	0.98	14[c]	8[c]	1.76[c]
Philippines	95.7	94.5	1.01	32	25	1.28
Singapore	99.6	99.4	1.00	. . .	. . .	. . .
Thailand	97.8	98.1	1.00	44	38	1.17
Timor-Leste	. . .	. . .	. . .	12[b]	8[b]	1.48[b]
Viet Nam	93.6	94.2	0.99	9	11	0.77
South and South-West Asia						
Afghanistan	18.4	50.8	0.36	. . .	2	0.28
Bangladesh	33.2[e]	50.7[e]	0.65[e]	4[a]	9[a]	0.5[a]
Bhutan	. . .	. . .	. . .	. . .	. . .	. . .
India	67.7	84.2	0.80	9	14	0.66
Iran (Islamic Republic of)	80.8[e]	91.7[e]	0.88[e]	24	21	1.11
Maldives	98.3	98	1.00	. . .	. . .	2.37
Nepal	60.1	80.6	0.75	3	8	0.4
Pakistan	54.7	75.8	0.72	3	4	0.8
Sri Lanka	96.1	95.1	1.01	. . .	. . .	. . .
Turkey	93.3	98.0	0.95	24	34	0.73
North and Central Asia						
Armenia	99.9	99.8	1.00	29	24	1.21
Azerbaijan	99.9	99.9	1.00	14	16	0.87
Georgia	. . .	. . .	. . .	42	41	1.03
Kazakhstan	99.9	99.8	1.00	56	40	1.38
Kyrgyzstan	99.7	99.7	1.00	43	36	1.19
Russian Federation	99.8	99.7	1.00	79	58	1.36
Tajikistan	99.8	99.8	1.00	8	25	0.33
Turkmenistan	99.8	99.8	1.00	. . .	. . .	. . .
Uzbekistan	99.6[e]	99.7[e]	1.00[e]	14	17	0.8
Pacific						
American Samoa	. . .	. . .	. . .	. . .	. . .	. . .
Australia	. . .	. . .	. . .	80	65	1.23
Cook Islands	. . .	. . .	. . .	. . .	. . .	. . .
Fiji	97.6[e]	98.1[e]	1.00[e]	17	14	1.2
French Polynesia	. . .	. . .	. . .	. . .	. . .	. . .
Guam	. . .	. . .	. . .	. . .	. . .	. . .
Kiribati	. . .	. . .	. . .	. . .	. . .	. . .
Marshall Islands	. . .	. . .	. . .	19[a]	15[a]	1.3[a]
Micronesia (Federated States of)	. . .	. . .	. . .	. . .	. . .	. . .
Nauru	. . .	. . .	. . .	. . .	. . .	. . .
New Caledonia	. . .	. . .	. . .	. . .	. . .	. . .
New Zealand	. . .	. . .	. . .	74	53	1.4
Niue	. . .	. . .	. . .	. . .	. . .	. . .
Northern Mariana Islands	. . .	. . .	. . .	. . .	. . .	. . .
Palau	. . .	. . .	. . .	57[b]	27[b]	2.15[b]
Papua New Guinea	64.1	69.1	0.93	. . .	. . .	0.55[d]
Samoa	98.9[e]	99.1[e]	1.00[e]	7[c]	8[c]	0.93[c]
Solomon Islands	. . .	. . .	. . .	. . .	. . .	. . .
Tonga	99.4	99.3	1.00	8	5	1.67
Tuvalu	. . .	. . .	. . .	. . .	. . .	. . .
Vanuatu	. . .	. . .	. . .	4	6	0.58

Source: United Nations Statistics Division, MDG Indicators Database

[a] Data refer to year 2003
[b] Data refer to year 2002
[c] Data refer to year 2001
[d] Data refer to year 2000
[e] Data refer to year 1999
[f] Data taken from UNESCO Institute for Statistics

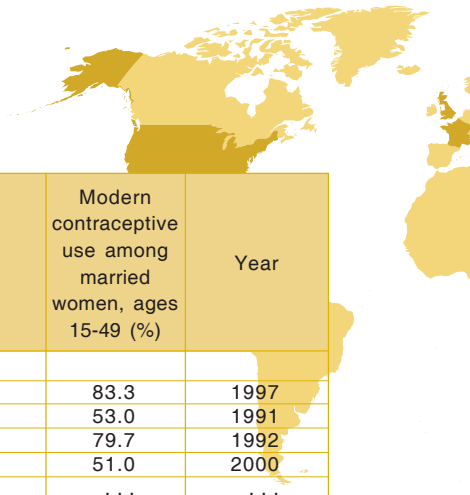


Table 3 Indicators for maternal health

Region and country or area	Maternal mortality ratio (per 100,000 live births)	Year	Births attended by skilled health personnel (%)	Year	Modern contraceptive use among married women, ages 15-49 (%)	Year
East and North-East Asia						
China	56	2000	95.9	2003	83.3	1997
Democratic People's Republic of Korea	67	2000	97.1	2004	53.0	1991
Hong Kong, China	7	1990	. . .	. . .	79.7	1992
Japan	10	2000	100.0	1996	51.0	2000
Macao, China	20	1995	. . .	. . .	. . .	. . .
Mongolia	110	2000	97.0	2003	54.3	2000
Republic of Korea	20	2000	100.0	1997	66.9	1997
South-East Asia						
Brunei Darussalam	37	2000	99.0	1999	. . .	. . .
Cambodia	450	2000	31.8	2000	18.5	2000
Indonesia	230	2000	71.5	2004	56.7	2003
Lao People's Democratic Republic	650	2000	19.4	2001	28.9	2000
Malaysia	41	2000	97.4	2003	29.8	1994
Myanmar	360	2000	57.0	2001	32.8	2001
Philippines	200	2000	59.8	2003	33.4	2003
Singapore	30	2000	100.0	1998	53.0	1997
Thailand	44	2000	99.3	2000	69.8	1997
Timor-Leste	660	2000	18.4	2003	8.6	2003
Viet Nam	130	2000	85.0	2002	56.7	2002
South and South-West Asia						
Afghanistan	1900	2000	14.3	2003	3.6	2000
Bangladesh	380	2000	13.2	2004	47.3	2004
Bhutan	420	2000	36.5	2003	18.8	1994
India	540	2000	42.5	2000	42.8	1999
Iran (Islamic Republic of)	76	2000	89.6	2000	56.0	1997
Maldives	110	2000	70.3	2001	33.0	1999
Nepal	740	2000	15.4	2004	35.4	2001
Pakistan	500	2000	23.0	2001	20.2	2001
Sri Lanka	92	2000	96.0	2000	49.6	2000
Turkey	70	2000	83.0	2003	37.7	1998
North and Central Asia						
Armenia	55	2000	96.8	2000	22.3	2000
Azerbaijan	94	2000	99.7	2002	11.9	2001
Georgia	32	2000	96.4	1999	19.8	2000
Kazakhstan	210	2000	98.9	2002	52.7	1999
Kyrgyzstan	110	2000	98.1	1997	48.9	1997
Russian Federation	67	2000	99.3	2002	. . .	. . .
Tajikistan	100	2000	71.1	2000	27.3	2000
Turkmenistan	31	2000	97.2	2000	53.1	2000
Uzbekistan	24	2000	95.6	2000	62.8	2002
Pacific						
American Samoa	. . .	. . .	. . .	. . .	. . .	. . .
Australia	8	2000	100.0	1999	. . .	. . .
Cook Islands	. . .		98.0	2001	60.4	1996
Fiji	75	2000	99.0	2000	. . .	. . .
French Polynesia	20	2000	. . .	. . .	. . .	. . .
Guam	12	2000	. . .	. . .	. . .	. . .
Kiribati	. . .	. . .	85.0	1998	. . .	. . .
Marshall Islands	. . .	. . .	94.9	1998	. . .	. . .
Micronesia (Federated States of)	. . .	. . .	87.7	2001	. . .	. . .
Nauru	. . .	. . .	. . .	. . .	. . .	. . .
New Caledonia	10	2000	. . .	. . .	. . .	. . .
New Zealand	7	2000	100.0	1995	72.0	1995
Niue	. . .	. . .	100.0	2002	. . .	. . .
Northern Mariana Islands	. . .	. . .	. . .	. . .	. . .	. . .
Palau	. . .	. . .	100.0	2002	. . .	. . .
Papua New Guinea	300	2000	41.0	2000	19.6	1996
Samoa	15	2000	100.0	1998	. . .	. . .
Solomon Islands	130	2000	85.0	1999	. . .	. . .
Tonga	. . .	. . .	95.3	2000	. . .	. . .
Tuvalu	. . .	. . .	100.0	2002	. . .	. . .
Vanuatu	32	2000	88.0	1999	. . .	. . .

Source: United Nations Statistics Division, MDG Indicators Database

Table 4 Relative risk of dying before age 5 by sex and residence (selected Asian countries)

Sub-region and country	Year	Under-5 mortality rate for female children	Male mortality rate / female mortality rate			Under-5 mortality rate for children in urban areas	Rural mortality rate / urban mortality rate		
			Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-5 mortality ($_5q_0$)		Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-5 mortality ($_5q_0$)
South and South-East Asia									
Bangladesh	1999/2000	112	1.07	0.75	0.97	97	1.09	1.44	1.17
Cambodia	2000	110	1.25	1.10	1.21	93	1.32	1.54	1.36
India	1998/99	105	1.05	0.68	0.93	65	1.62	2.04	1.70
Indonesia	1997	64	1.32	0.98	1.21	48	1.62	1.77	1.65
Nepal	2001	112	1.05	0.69	0.93	66	1.58	2.12	1.70
Pakistan	1990/91	119	1.19	0.60	1.03	94	1.37	1.60	1.41
Philippines	1998	50	1.22	1.12	1.18	46	1.30	1.51	1.36
Viet Nam	1997	40	1.56	0.72	1.28	30	1.58	1.66	1.59
Central and West Asia									
Armenia	2000	45	1.10	1.58	1.13	37	1.47	4.86	1.59
Kazakhstan	1999	53	1.31	1.66	1.35	50	1.46	1.51	1.46
Kyrgyz Republic	1997	70	1.19	0.94	1.16	58	1.30	3.18	1.41
Turkmenistan	2000	76	1.39	1.12	1.33	73	1.33	1.61	1.37
Turkey	1998	58	1.12	0.78	1.04	51	1.24	1.67	1.43
Uzbekistan	1996	46	1.37	1.66	1.42	52	1.02	1.46	1.10

$_1q_0$: probability of dying between birth and exact age 1.0
$_4q_1$: probability of dying between exact age 1.0 and exact age 5.0
$_5q_0$: probability of dying between birth and exact age 5.0

Source: *Mary Mahy, Childhood Mortality in the Developing World: A Review of Evidence from the Demographic and Health Surveys, DHS Comparative Reports No. 4 (Calverton, Maryland, December 2003).*

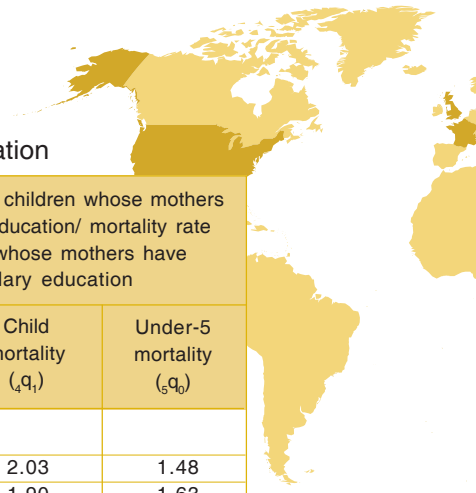


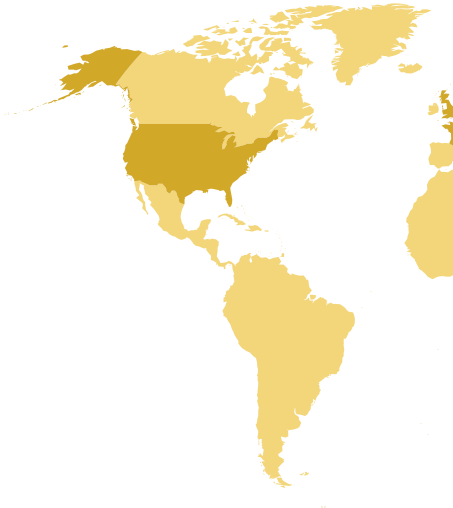
Table 5 Relative risk of dying before age 5 by mother's education

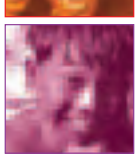
Sub-region and country	Year	Under-5 mortality rate for children whose mothers have secondary education	Mortality rate for children whose mothers have primary education/ mortality rate for children whose mothers have secondary education		
			Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-5 mortality ($_5q_0$)
South and South-East Asia					
Bangladesh	1999/2000	68	1.36	2.03	1.48
Cambodia	2000	75	1.57	1.90	1.63
India	1998/99	51	1.59	2.32	1.70
Indonesia	1997	35	2.10	2.89	2.24
Nepal	2001	50	1.56	1.16	1.46
Pakistan	1990/91	65	1.52	3.27	1.65
Philippines	1998	39	1.59	2.63	1.87
Viet Nam	1997	37	1.49	2.04	1.60
Central and West Asia					
Armenia	2000	48	1.64	3.56	1.83
Kazakhstan	1999	63	*	*	*
Kyrgyz Republic	1997	76	*	*	*
Turkmenistan	2000	88	*	*	0.34
Turkey	1998	32	1.66	2.69	1.77
Uzbekistan	1996	55	*	*	*

$_1q_0$: probability of dying between birth and exact age 1.0
$_4q_1$: probability of dying between exact age 1.0 and exact age 5.0
$_5q_0$: probability of dying between birth and exact age 5.0

* The estimate was suppressed because it was based on fewer than 250 births.

Source: *Mary Mahy, Childhood Mortality in the Developing World: A Review of Evidence from the Demographic and Health Surveys, DHS Comparative Reports No. 4 (Calverton, Maryland, December 2003).*





MDGs

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United Nations
Millennium Declaration
September 2000