

PART 2

Beyond national averages

The first part of this report assessed MDG progress at the national level – highlighting the differences in achievement between countries. Just as significant, however, are disparities within countries – between the richest and poorest groups for example, between urban and rural areas, or between states or provinces.

Intra-country disparities are especially important for the Asia-Pacific region which includes some of the world's most populous countries. The poorest 20 per cent of the populations in China and India, for example, would on their own represent the world's fourth and fifth largest countries with populations larger than Indonesia. Countries that are on track for a given indicator can thus still be leaving many millions of people behind. However, all countries, large and small, need to identify those groups and subgroups that are missing out.

This chapter looks more closely at intra-country disparities, concentrating on some MDG indicators to which the countries of the region need to pay special attention: the proportion of the population living on less than \$1 a day; under-five child mortality; under-five malnutrition, and access to improved water and sanitation.

This picture is partial since only a few countries have recent trend data by subgroup – emphasising once more the need for better data to track MDG progress. Demographic and Health Surveys are available for some Central Asian countries, though they are not very recent. In the case of the Pacific islands micro data are rarely available and when they are, they are usually not in the standardized manner needed for cross-country comparisons. Nevertheless we highlight the countries for which comparable data are available, since their experience suggests important considerations for other countries.

Growing inequality

Many countries in the Asia-Pacific region have achieved remarkable reductions in income poverty through strong economic growth. East and South-East Asia took the lead in the 1980s but subsequently countries in South Asia and elsewhere also started to grow more rapidly. In the 1980s the fruits of this growth were distributed fairly equitably, hence the reduction in poverty.

Over the past seventeen years, however, the pattern has been changing. Growth has proceeded apace but the benefits are now being skewed towards the better off. Although in many countries the poor continue to see their incomes rise, the richest have seen their incomes rise even faster and as a result, there have been significant increases in inequality.

This is clear, for example, from data on shares of national income. In many countries the poorest 20 per cent of the population have seen their share of national income drop steeply. Between 1990 and 2004, in South Asia it fell from 7.2 to 6.7 per cent and in East Asia from 7.1 to 4.5 per cent – one of the lowest proportions in the world (United Nations, 2007).

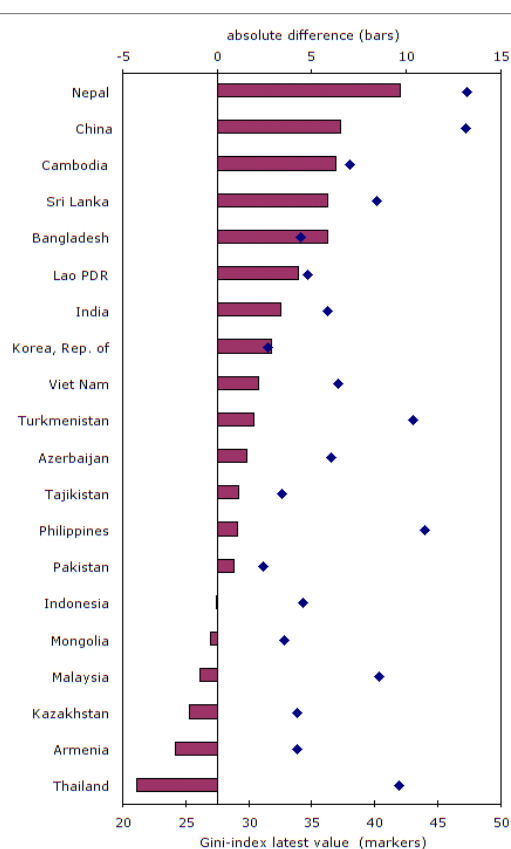
These trends are confirmed by a more comprehensive measure of inequality, the Gini-index. For any population the index takes a value between 0, corresponding to absolute equality, and 100 corresponding to one household taking everything. In the past, Ginis across the Asia-Pacific region have been significantly lower than in other parts of the world. This is no longer the case.

The bars in Figure 2-1 show that in the past decade or so, out of 20 countries in the region, 14 saw inequality rise, while only six saw it fall. The steepest increases were in Nepal, where the Gini-index increased by more than nine points, and in China where it increased by more than six points.

As the blue markers in this figure indicate, Nepal is now the most unequal of these countries, with China not far behind, both with Ginis close to 50 – approaching those in Latin America, usually among the world’s highest.

These two countries are certainly not alone in having high levels of inequality. The Philippines and Turkmenistan had smaller increases in their Ginis but these pushed the rates to quite high levels. Even Thailand, which achieved the greatest reduction, still has a high Gini at 42.

Figure 2-1
Changes in the Gini-index, 1990s–2000s



Source: ADB, 2007

It might be argued that if economic growth continues to boost the incomes of the poor an increase in inequality does not really matter, but there are three major caveats. The first caveat is that rising inequality can loosen social cohesion: conspicuous contrasts between rich and poor could lead to social or political instability and undermine future MDG achievements.

Second, it represents a missed opportunity for had these countries avoided the increase in inequality, they would have been even more successful in reducing poverty. If Nepal, for example, a strong performer on many of the MDGs, had managed to hold its Gini steady it would now have only half as many people living in poverty (ADB, 2007).

A third caveat is that uneven progress can result in vicious cycles of inequality. Educational differences – the best indicator of future income – show how disparities can endure. In India, around half of those living in a household where the head has no schooling or incomplete primary education, live in poverty, a proportion that has hardly changed since 1993. A child born into such a home is therefore ten times as likely to live in poverty as a child born to a parent with an education level higher than secondary school. Particularly important is the education level of the mother which has a strong influence on children’s prospects of receiving primary education.

The Philippines has reduced poverty at the national level, but did so more rapidly for households where the head had completed at least primary education. Hence, in 2003 three out of five people in poverty lived in a household where the head had the lowest education level, a higher proportion than at the beginning of the 1990s. In Viet Nam, two out of three living in such cohorts are poor. For both countries, however, if the head of the household holds at least a college degree their children will be able to break out of the cycle of poverty.

Table 2-1
\$1/day poverty rates by education level of household head, 1990s–2000s

	India		Philippines		Viet Nam	
	1993	2004	1994	2003	1993	2002
No schooling/ some primary	51.5	46.7	29.5	27.1	19.2	7.7
Complete primary	31.1	26.8	19.2	13.3	15.7	2.5
Complete secondary	14.5	13.1	5.7	3.8	8.1	1.0
Higher	4.9	4.7	0.5	0.5	3.9	0.1

It should be emphasized that these inequalities refer to income, which is not necessarily the most important measure of well-being. Parents living in poverty are likely to be more worried about properly feeding their children or about the quality of services at the nearest health centre. Although income is still a key indicator of these choices, the following sections broaden the picture by considering inequality in other vital aspects of human development and in those indicators for which the region has not performed that well.

Surviving the first five years

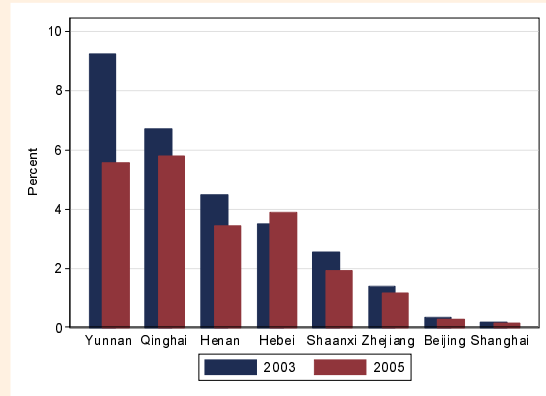
One of the most sensitive indicators of progress in human development is children’s chances of survival. Each year across the Asia-Pacific region over

Box 2-1
Health disparities in China

Between 1990 and 2004, the proportion of people living on less than \$1 a day in China fell from 33 to 10 per cent, with 250 million less people under extreme poverty. However, this growth has been accompanied by widening disparities: between 1982 and 2004 the Gini-index rose from 30 to 47.

These disparities are also evident in the nutritional status of children across provinces. Although the percentage of children underweight is close to zero in Beijing and Shanghai, in the province of Qinghai it is almost 6 per cent, and while the proportion has been coming down here and in some other provinces, in others such as Hebei the problem has been getting worse.

China, proportion of children underweight in selected provinces



Source: Ministry of Health of China, 2006

China has also made progress in reducing maternal mortality. Between 1994 and 2004, the maternal mortality ratio in urban areas fell from 44 to 26 per 100,000 live births and in the rural areas from 76 to 63 – though as a result the rural-urban ratio increased from 1.8 to 2.4 (Ministry of Health of China, 2006). Why is the health gap widening between rural and urban areas? Many cite the collapse of the Cooperative Medical System and the progressive privatization and commercialization of health insurance and medical services. In the late 1970s virtually everyone had some kind of health coverage but by 1990 the proportion covered had dropped to 55 per cent in urban areas and to 10-20 per cent in the rural areas. Health insurance coverage is especially low, at less than 5 per cent, among the poorest quintile of the population (Tandon and Zhuang, 2007).

Meanwhile medical costs have been escalating. Between 1990 and 2005, in-patient health expenditure almost tripled – exposing millions to potentially catastrophic health crises. Many poor counties and districts, short of tax revenue, now demand payment even for basic immunization and other preventive health services, including antenatal care and reproductive health care. Payments for catastrophic health costs are one of the main reasons why people fall into poverty.

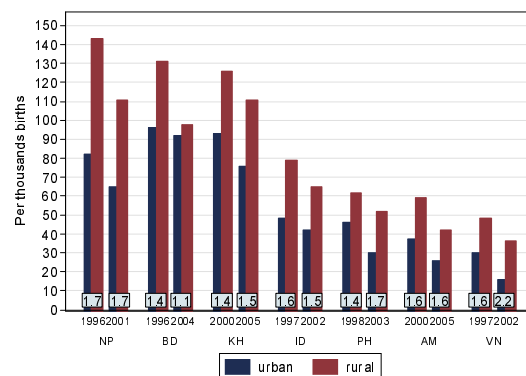
The Chinese government has recognized the urgent need to make health care more accessible and affordable and has recently taken further measures, such as improving the coverage of basic health insurance for the rural poor.

four million children die before reaching their fifth birthday. As the first part of this report has shown, the risk of early death varies significantly from one country to another. But children's chances also differ according to which part of a country they are born in and to what type of household. Even countries that are on track to achieve the under-five mortality MDG can still fall far short in rural areas and in poor households.

For those countries for which trend data are available, Figure 2-2 shows that not only are under-five mortality rates typically far higher in rural than in urban areas, by over 50 per cent or more, but that these rural-urban gaps have persisted. The ratios between rural and urban areas are indicated along the bottom of the figure. Of these countries only Bangladesh, which is on track for this goal, managed to reduce the ratio significantly, from 1.4 to 1.1 between 1996 and 2004. Nevertheless, this decline is due less to success in rural areas than to a failure to make much impact in urban areas.

Of Bangladesh's six divisions the greatest progress was in Sylhet, where 85 per cent of the population is rural and between 1996 and 2004 the under-five mortality rate fell by 30 per cent.

Figure 2-2
Under-five mortality rates, urban and rural trends

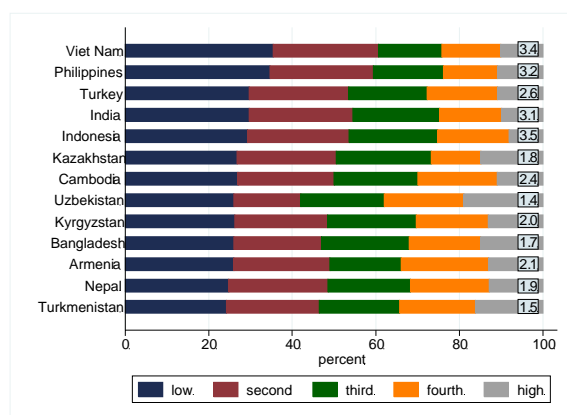


Viet Nam, on the other hand, an early achiever that is continuing to make progress, is doing so more rapidly in urban areas; as a result the rural-urban gap has widened. The Philippines too is doing well overall and is on track to meet this goal, but here too the gap is widening. In 2003, for example, in the largely urban National Capital Region, the under-five mortality rate was 31 per thousand live births, while in the largely rural region of Mimaropa the rate was 68.

Probably the most striking story is in Nepal, another on-track country. Between 1990 and 2005 the national under-five mortality rate fell from 145 deaths per thousand live births to 74, but regional disparities were still significant: in 2006 in the Eastern region the rate was down to 60 but in the Mid-western region it was 122.

Whether they are born in rural or urban areas, the children least likely to survive are those in the poorest households. This is clear from Figure 2-3 which shows that the poorest 20 per cent of households account for considerably more than 20 per cent of a country's child deaths – for Viet Nam and the Philippines around 30 per cent. The number at the end of each bar captures the greatest contrast: the ratio between the rates for the poorest and richest wealth quintiles. These comparisons and subsequent discussions are based on wealth, which is judged on the basis of the quality of housing, for example, or the possession of certain consumer durables, since it is difficult to collect quality data on household income.

Figure 2-3
Under-five mortality rate by wealth quintile and the ratio of poorest to richest quintile, latest year

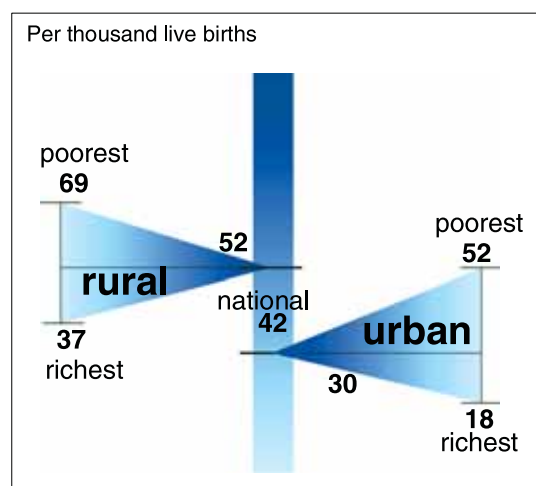


Note: The latest year refers to the latest DHS in each country (see Technical Note on page 54), except Armenia (2000) and Cambodia (2000).

For both Viet Nam and the Philippines the current ratios of under-5 mortality between the poorest to richest quintile also represent deterioration. Despite their success in achieving or moving towards the under-five survival goals, the gaps between poor and rich have been widening. In Viet Nam between 1997 and 2002 the ratio between the two rates increased from 2.8 to 3.4, and in the Philippines, between 1998 and 2003, from 2.7 to 3.2. On the other hand, for Bangladesh and Indonesia, the ratios between poor and rich decreased slightly from 1.9 to 1.7 and from 3.7 to 3.5 respectively between the 1990s and the 2000s.

These two ways of examining disparities, by residence and by income groups can also be applied in sequence, considering first the urban and rural areas and within these, looking at the rates by wealth quintile. Figure 2-4 shows this for the Philippines in 2003; although children in urban areas are more likely to survive, the experience is very different for children in poor and rich households. The greatest contrast is between the poorest households in rural areas and the richest ones in urban areas. Children in the poorest rural quintile are nearly four times as likely to die before reaching the age of five as those in the richest urban quintile.

Figure 2-4
The Philippines, under-five mortality rates by residence and wealth quintile, 2003



In addition to disparities based on income or residence, countries also have gender disparities in under-five mortality. In most cases the mortality rates are higher for boys than girls, though in some countries, such as India the rate is marginally higher for girls.

Nowadays, across the region more children are surviving to the age of five and beyond. If countries are to reduce the mortality rates still further, they will have to tackle some of the more

difficult problems. This will mean, for example, reaching out to children in the more remote rural areas or in urban slums; but it also means making greater efforts to protect the youngest children, for as under-five mortality rates come down the remaining deaths are increasingly concentrated among children aged twelve months or younger. Many infant deaths take place very early - globally one-third occur during the first 28 days of life (WHO, 2005).

One of the best ways of helping children to survive their earliest hours and days is to ensure that their births are attended by skilled personnel. More and more women are being supported by skilled birth attendants, but regional disparities remain high. While on average 61 per cent of births in Asia are attended by skilled personnel, this is the case for only 44 per cent in South-Central Asia as opposed to 71 per cent in South-East Asia.

Across the region the likelihood of receiving this vital support is far less for the poorest families. Household data from Viet Nam and the Philippines demonstrate the contrasts: for the richest quintile the proportion of births attended by skilled birth attendants is over 90 per cent, but for the poorest quintile the proportions drop to 58 per cent in Viet Nam, and 25 per cent in the Philippines. One of the most challenging places to be born, however, is in a poor household in Nepal, where only four per cent of births in the poorest quintile are attended by skilled personnel.

Ensuring that children are well nourished

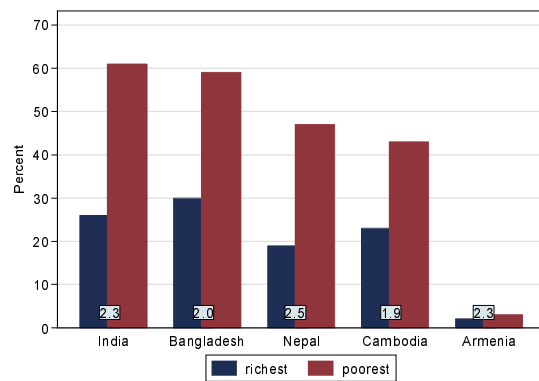
A child's death is usually directly attributable to a specific disease, such as pneumonia, diarrhoea or measles. There are, however, other preventable causes such as malnutrition: around half of under-five deaths are attributable to some extent to undernutrition, which weakens the child's resistance to disease. Despite the Asia-Pacific region's progress in reducing poverty, it has been much less successful in ensuring that its children are well nourished, as indicated by the proportion of children who are underweight. The proportion of under-five children who are underweight is around 28 per cent in Asia and the Pacific and higher still in South Asia at over 40 per cent, a rate considerably higher than that of Sub-Saharan Africa.

As with under-five mortality, the problems are typically more severe in rural areas. In Nepal in 2006, for example, the proportion of under-five

children underweight was 23 per cent in urban areas but 41 per cent in rural areas. In India, these differences by residence are also reflected by state. In 1999, while in the North-eastern state of Sikkim the proportion of children underweight was only one in five, in the Central state of Madhya Pradesh the proportion was close to three in five. According to some estimates, more than 40 per cent of all underweight children in India live in five of 28 states: Maharashtra, Orissa, Bihar, Madhya Pradesh, Uttar Pradesh (Gragnotati et. al., 2005).

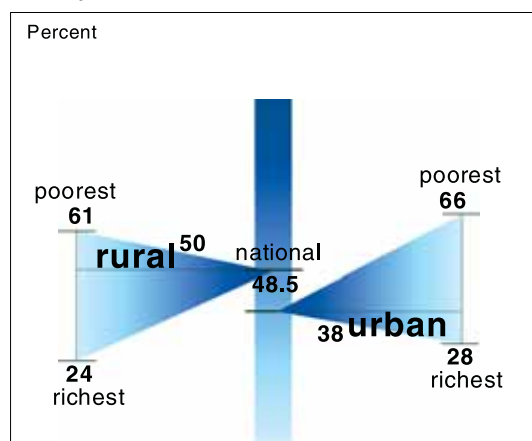
These disparities are even starker by wealth quintile. As illustrated in Figure 2-5, in India, Bangladesh and Nepal the rates of children underweight for the poorest quintiles are more than twice those for the richest quintiles. In Cambodia too, rates are over 40 per cent in the poorest quintile in contrast to only half of that in richer households.

Figure 2-5
Proportion of underweight children under-five by wealth quintile, latest year



For countries that can provide appropriate data it is also possible to break down the rates by wealth quintile within urban and rural areas. This is illustrated in Figure 2-6 for India, showing that while the overall rates are higher in rural areas, the situation is worse in urban areas where disparities are

Figure 2-6
India, underweight children under-five, by residence and wealth quintile, 1999



greater. In the poorest rural quintile the proportion of under-five children underweight is 61 per cent, while in the poorest urban quintile it is 66 per cent.

The drive for clean water

Child health and child nutrition are also closely linked to the availability of clean drinking water. Children drinking contaminated water not only suffer from diseases such as diarrhoea but also find it more difficult to absorb nutrients and thus become more malnourished. In terms of access to drinking water from improved sources the region as a whole has made progress - many countries are early achievers. But there are striking rural and urban differences, not just in overall coverage but in the sources of water. In rural areas improved sources would typically be tube wells, boreholes, protected dug wells or protected springs, while urban households may use similar sources, they are more likely to get water from public standpipes in the streets or have water piped to their homes.

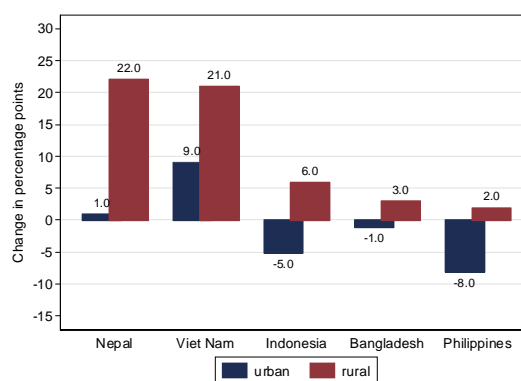
The overall rural-urban pattern, as mentioned in the previous section, shows that in urban areas access for most countries is often above 90 per cent, but with rural areas often lagging by 10 to 20 percentage points. Nevertheless there are still serious problems for urban households. In Bangladesh, Indonesia and the Philippines there are signs that as a result of urban population increase, the coverage is falling. Over the period from 1990 to 2005, all three countries saw a large influx of migrants to the cities. The proportion of the total population living in urban areas in Bangladesh rose from 20 to 25 per cent, in the Philippines from 49 to 63 per cent and in Indonesia from 31 to 48 per cent.

Many of these new urban dwellers settle in densely populated slum areas, increasing their exposure to contagious diseases, unsanitary conditions and high levels of pollution. In Bangladesh, for example, 85 per cent of urban dwellers live in slums in 2001. Governments have found it difficult to keep up with this rural-urban influx and to provide these new inhabitants with improved water supplies. Between 1990 and 2004, urban access to improved sources of water in Bangladesh decreased from 83 to 82 per cent, while in Indonesia over the same period, coverage dropped from 92 to 87 per cent; both countries are thus regressing

for this MDG target.

In some countries progress has been faster in rural areas. Nepal and Viet Nam, for example, have been able to provide rural households with access to improved sources of water more rapidly than other countries in the region, making them early achievers. Between 1990 and 2004, Nepal increased coverage in rural areas by 22 percentage points, from 67 to 89 per cent, compared with only one percentage point in urban areas. Viet Nam increased rural coverage twice as much as it did urban coverage (Figure 2-7).

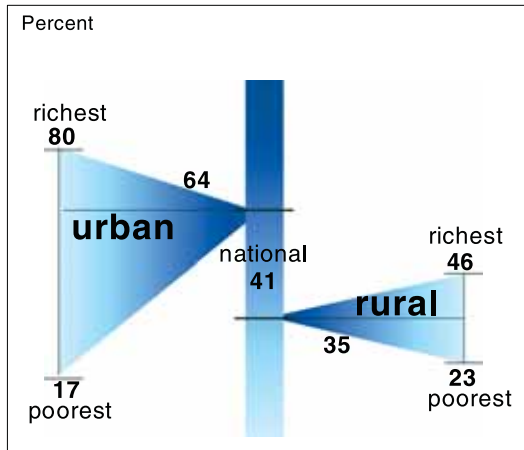
Figure 2-7
Access to improved water sources between 1990 and 2004, by residence



When countries achieve high overall levels of coverage the disparities between income groups start to narrow. In countries where coverage is still low, however, there can be wide gaps between rich and poor. Cambodia, for example, has very low coverage of water from improved sources, nationally only 41 per cent, a rate similar to that of Afghanistan. Geographical disparities are also significant since the proportion of urban households with access to improved sources of water is twice that in rural areas, where coverage is only 35 per cent. In Kandal, the region surrounding the capital, Phnom Penh, an estimated 85 per cent of the population had access to water in 2000, while in rural areas the proportion was only around one-third.

As Figure 2-8 shows, in urban areas of Cambodia where over 70 per cent of urban residents living in slums, there are much greater disparities between rich and poor. Among the richest quintile, 80 per cent have coverage, but among the poorest quintile the proportion drops to 17 per cent. Although in rural areas disparities are smaller, even for the richest rural quintile access is lower than the urban average.

Figure 2-8
Cambodia, access to improved water sources, by residence and wealth quintile, 2000



Access to improved sanitation

Access to improved sanitation is usually lower than that for improved water supplies. While families want better sanitation facilities, they tend to give a higher priority to clean water, and national political agendas rarely feature sanitation. This is despite the evident benefits: changing from unimproved to improved sanitation can lead to a 30 per cent reduction in child mortality (UNDP, 2006).

Improved sanitation includes, for example, household toilets or latrines connected to a piped sewerage system, septic tanks or pits, ventilated improved pit latrines, or composting toilets. People without these facilities might use open pits, bucket latrines, defecate in fields, or dispose of faeces in plastic bags or in rivers. Improved sanitation facilities are less common in rural areas.

For the countries included in Figure 2-9, the ratio between urban and rural provision of improved sanitation ranges from 1.3 in Uzbekistan to 2.7 in India. Even within urban areas there can be stark contrasts, with very low sanitation coverage in the poorest areas. For people in slums it can be difficult to construct even a basic toilet facility, not just because of the cost, but also because of a lack of secure tenure or of supporting infrastructure.

Within the rural areas, coverage can be analysed by household wealth. For a number of countries coverage of improved sanitation facilities for the lowest quintile is often less than one-quarter that of the richest quintile (Figure 2-10). In countries with high percentages of their total population living in rural areas, for example 84 per cent

Figure 2-9
Access to improved sanitation, urban and rural, 2004

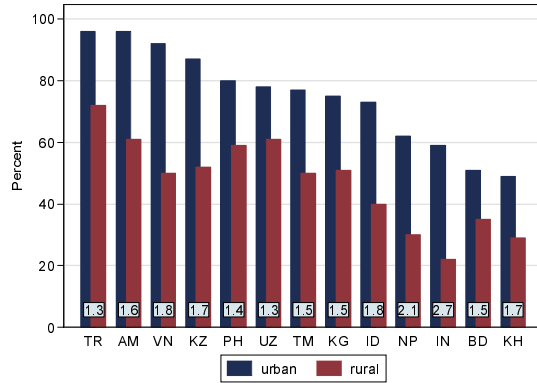
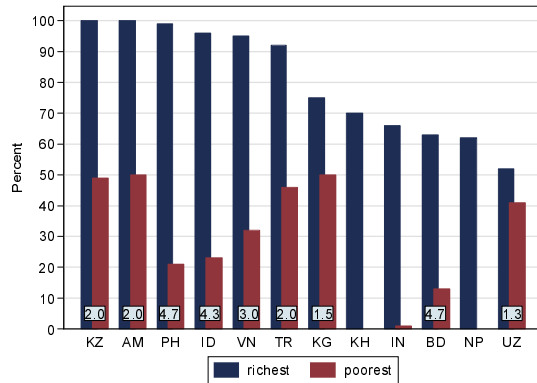


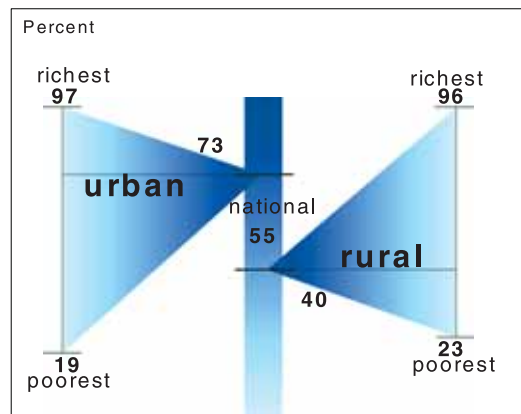
Figure 2-10
Access to improved sanitation, rural areas, by wealth quintile, latest year



in Nepal and 80 per cent in Cambodia in 2005, coverage of improved sanitation facilities for the poorest quintiles is close to zero.

The contrasts in access to improved sanitation by both urban-rural areas and wealth quintiles are illustrated for Indonesia in Figure 2-11. Indonesia is moving only slowly towards its target at the national level, and also has a low coverage in

Figure 2-11
Indonesia, access to improved sanitation, by residence and wealth quintile, 2003



rural areas. Between 1990 and 2004 access to sanitation in rural areas increased only by three percentage points over a 14-year period, moving from 37 to 40 per cent. Although the progress rate was higher for urban areas, there is still a striking gap between rich and poor. Moreover, in urban areas this gap has been widening further; between 1997 and 2002, the ratio in the access of the richest and poorest quintiles increased slightly, from 5.0 to 5.2.

For sanitation, as for the other MDG indicators considered in this part of the report, progress at the national level does not always reduce disparities between rural and urban areas, or between richer and poorer households. This emphasizes the need to adopt more inclusive strategies across all MDG target areas – to ensure that the benefits of economic growth are shared equitably, so as to reduce poverty and promote sustainable human development.