Population and Poverty: Some Perspectives on Asia and the Pacific

One key challenge is seeing that population and reproductive health programmes, and development programmes at large, confer their benefits on the poor

By Stan Bernstein*

Poverty on the international agenda

The international community has committed itself to an ambitious programme of social development for the opening decades of the twenty-first century. Attacking poverty directly — as a matter of human rights, to accelerate development and to reduce inequality within and among countries — has become an urgent global priority. World leaders have agreed on a variety of new initiatives, including the United Nations millennium development goals (United Nations, 2001).

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Some progress in reducing the proportions of people living in extreme poverty was made in the last decade (Chen and Ravillion, 2001). However, while the absolute number of the extremely income poor has decreased by over 100 million, the aggregate decline has been confined to Latin America and parts of Asia. East Asia and the Pacific registered the largest absolute decline (over 185 million fewer persons lived on less than an adjusted US$1 per day in 1998 than in 1990), but China accounted for all but 38 million of that total. Despite a declining proportion in extreme income poverty (roughly 4 per cent), South Asia registered an absolute increase of 25 million. Several countries in the region have met the goal of halving poverty, while others have seen slower progress or reversals.

socio-political conflicts and natural catastrophes have had a negative impact on several countries. Income inequality has increased in several countries, including some with rapid economic growth (ESCAP, 2002). Higher income inequality requires much higher overall growth rates to achieve progress in poverty reduction (UNDP, ECLAC and IPEA; forthcoming). The assumption that the elasticity of poverty to income gain is one that is often unwarranted.

Further, poverty is multidimensional. Income poverty is only one aspect of the deprivation of the right to essential development assets and opportunities. Education, health (including reproductive health), nutrition, water and sanitation, employment, social and political participation are additional elements of the deprivation of capability and empowerment (Sen, 1999).

The millennium development goals set targets for progress in a variety of dimensions beyond income poverty. There has been significant progress over the last decade in several dimensions, for example, educational enrolment and advancement, infant and child mortality reduction and overall longevity. However, progress in other dimensions has lagged in the aggregate and in many countries.

Population trends in the region: dimensions of diversity

Asia and the Pacific display one of the most diverse social, economic and demographic profiles. This largest of all regions contains countries at virtually all stages of demographic transition. It provides examples of the possibility of rapid change and examples of the stubborn persistence of social and demographic trends. Good overviews of recent trends are readily available in the literature (Gubhaju, Seetharam and Huguet, 2001; Westley, 2001; Leete and Alam, 1999; Leete and Jones, 2002; Asian Development Bank, 2002). For current purposes, it is sufficient to note that most reviews stress the changes in fertility rates, age structures, urbanization and migration.

Linkages between population and poverty

Recent research has reviewed the long-standing skepticism by some economists of a linkage between population dynamics and macroeconomic growth and, based on a more complete data record and improved techniques, concluded that population has a variety of effects on development at the household and national levels (Birdsall and others, 2001). A number of mechanisms have been identified.

The demographic bonus

The change from high to low mortality and fertility can create a ''demographic bonus'' for countries. Mortality declines first, followed by fertility. What happens as fertility declines is that the working-age population increases relative to younger and older dependants. That creates a one-time opportunity for growth. The opportunity can be realized if countries have made the appropriate investments, not only in family planning but in health and education generally, with special attention given to the needs of girls and women, and in employment opportunities for the new and enabled workforce. Open and responsive governance makes these adjustments possible.

This phenomenon was first analysed in the ''East Asian miracle'' of the 1980s and 1990s (Asian Development Bank, 1997). The best recent macro-level research suggests that from 1960 to 1995 about a fifth of economic growth was attributable to gains in mortality and about a fifth to reductions in fertility. External financial shocks and the failure of regulatory frameworks (like those that contributed to the 1997-1998 economic catastrophe) can impede progress. But recovery since then, although held back by continuing external problems, shows the value of the earlier demographic and social changes. The collapse hit the poor hardest and they continue to bear the brunt.

The proportion of populations in the ''working ages'' continues to increase in many countries, particularly those at an earlier stage in the demographic transition. Many countries still have time to invest to profit from their opportunity, but investments need to be made before the opportunity is squandered.

The sheer volume effects of the demographic bonus realized through the age structure changes are supplemented by the changing opportunities for women. Female labour force participation also contributes to economic growth, particularly when it is appropriately compensated, and declining fertility is linked to increased women's employment. The rising levels of women's education and increased demand for labour by a growing formal sector increase the opportunity cost of high fertility. Education and fertility declines can combine in a positive feedback in which the growth of the labour force increases faster than the growth of the labour age population alone.

For countries entering the post-transition period, increased old age dependency might act as a drag on further development if such a trend was not balanced by productivity gains. The evidence to date suggests that young age dependency has a stronger effect on economic growth than does old age dependency (Asian Development Bank, 1997), but it must be recognized that the projected pace and level of population ageing are outside the range of past experience. Without accelerated accumulation of resources for old-age support and a strengthening of intergenerational linkages the net effect could be negative.

Distributional effects

Long-term demographic and economic data from 45 developing countries show that high fertility raises absolute levels of poverty by slowing economic growth (and reducing the poverty reduction growth can help deliver) and by skewing the distribution of consumption against the poor. Fertility reduction through greater acceptance of family planning counters both of these effects (Eastwood and Lipton, 2002). Investments in improved reproductive health help to redress gender inequities and barriers to social and economic participation.

The positive redistribution effect comes from (a) the reduction of the requirement of higher outlays for basic needs and education (with lower savings and investments in child quality) of young dependants, and (b) the increased ability of poor households to increase their labour supply and savings. Women with fewer children are more able and often more willing to participate in remunerative work. They are also more likely to invest their added income in the health and education of children. Societal impacts on consumption also help poor households as the increasing scarcity of labour raises wage rates — even for families whose own fertility does not decline — and lowers demand for land (reducing the costs and slowing the unsustainable fractionalization of holdings).

These consumption effects can add substantially to the gains from growth. About half the estimated decline in poverty comes from increases in economic growth and half from the consumption side.

Timing effects

At different stages in the demographic transition these effects differ. At first, when mortality declines, particularly among infants and children, increased expenditure is needed for these young dependants and growth slows. As fertility declines and aggregate growth slow, economic growth increases.

In the early stages of transition, the gap between poor and non-poor households may increase. As poorer families join in the transition (which has

not yet happened in many societies in mid-transition), poverty and inequality reduction effects increase.

The poorer the country and the higher its initial level of fertility, the greater the effect of declining fertility on a decline in absolute poverty. The beneficial effects increase as the demographic transition proceeds. The faster the fertility decline, the larger the potential benefits of the demographic transition but the shorter the time period available to take advantage of them.

The magnitude of demographic effects interacts with the condition of markets, Governments and institutions. Where these institutions are weak, as in many pre-transition or early transition countries, the initial negative effects are magnified. The initial positive effects of fertility declines are likely to be reinforced where labour markets and school systems are working well and parents are prepared to invest in their children's education. Economic and social policies matter. Combined with access to reproductive health, they can accelerate poverty reduction.

The exclusion of the poor

While more people in a growing number of countries are becoming aware of the relative gains from smaller family size and larger investments in children's health and education, the poor may not be receiving the information or support that will allow them to recognize this (Merrick, 2001). As a result, they do not realize the benefits derived from smaller families. Public economic policies may distort labour markets, leading members of poor households to expect higher returns from child labour than are realistic. They are slow to recognize changing demographics and economic conditions which are more visible to, and more quickly affect, the less marginalized. Generally they have less access to information and fewer of the assets needed to take advantage of the opportunities that societal fertility decline produces. Where women and girls are relatively disadvantaged in decision-making and resource allocation, they bear the higher costs of high fertility but are less likely to realize the immediate gains; this undercuts their motivation to challenge the conditions that restrict their reproductive health access.

Gender inequality presents one of the most pervasive examples of exclusion of the disadvantaged. Reducing gender inequality can accelerate economic growth and have a powerful impact on poverty. Comparing East Asia and South Asia between 1960 and 1992, South Asia started with wider gender gaps in health and education and closed them more slowly. If gender gaps had closed at the same rate in the two subregions, South Asia would have increased its real per capita annual growth in gross domestic product (GDP) by 0.7 to 1.0 per cent (Klasen, 2001).

Emerging population trends: selected poverty implications

Poverty and the elderly

Elderly populations are among the fastest growing segments of the age range. Increases in life expectancy and earlier population growth have increased the total number of older persons; declining fertility rates in many countries have contributed to their increasing share of total populations. Population ageing is posing a growing challenge to formal and informal support systems. Richer countries in the region have expanded the public components of systems contributing to the care of older persons (whether through pension schemes, provident funds or various subsidies and preferences in housing and other services). As in other regions, there is also evidence, however, that increased public resources can contribute to the erosion of expectations of informal familial support.

It is likely that there will be substantial increases in the numbers of elderly persons living in poverty. The legacy of earlier low coverage in public pension systems leaves many without adequate income even as informal support weakens because of increased migration, changing social attitudes and smaller family size. While such challenges can be offset by improved public support, easier transfer of resources over larger distances and increased wealth, many will be left unhelped.

The oldest old people are overwhelmingly women and they reach their later years with significant accumulated deficits from life-long discrimination and inequality in access to resources and opportunity.

HIV/AIDS and poverty

The impact of the HIV/AIDS epidemic in severely affected countries (for example in sub-Saharan Africa) is devastating. The quality of life, prospects for economic advancement, stability of family and community social systems suffer immeasurably as the pandemic progresses. In the worst-affected countries, public servants and private sector employees are falling sick in increasing numbers; by 2020 these economies could be 20 to 40 per cent smaller than expected because of the pandemic. Damage to public services such as education and health will drive the poor further into poverty.

The prospects for the pandemic in Asia are raising increasing concern, but many countries have not yet appreciated their vulnerability. In India, more newly infected persons are being added annually than in any other country (United Nations, 2002). China is confronting the potential of a larger spread of the disease; there are acknowledged localized pockets of high prevalence, partly related to unsafe medical practices, and large-scale population movements that could readily assist the distribution of the disease. Cambodia,

Myanmar and Thailand face a serious epidemic. Prevalence in some subgroups is also high in Indonesia, Nepal and Viet Nam.

It is hard to predict what the course of the epidemic will be in Asian countries. The potential exists (between 5 and 20 per cent of adult men visit sex workers at least once a year and many of them have wives or other partners) for expansion in several countries (Brown, 2002). Various methods of transmission may spread the disease in different countries. Intravenous drug use has been reported to have increased in several Central Asian countries. Trafficking in women and girls creates additional highly vulnerable populations.

Prevention campaigns in Thailand have demonstrated that the spread of the pandemic can be stemmed. Such programmes require the investment of political will and appropriate resources. Many countries have not mobilized themselves sufficiently, either for prevention or for programmes of treatment and care.

Adult mortality impoverishes life prospects for children. Where HIV/AIDS is severe, it adds significantly to the number of orphans (beyond those created by maternal mortality and other diseases). Globally, 2 million new orphans are created each year owing to the pandemic. Maternal mortality (at some 500,000 per year in South Asia) adds some 1.5 to 2 million more. Orphanhood often has serious consequences for child poverty, health (and survival prospects), education and development, with subsequent negative poverty outcomes in later life.

Beyond national averages[1]

Attention to progress towards achieving national poverty reduction goals should not distract attention from internal differentials. Disparities in wealth, gender and geographical location will have to be reduced to improve the quality of life of the marginalized. These disparities are the result of complex processes of exclusion which tend to perpetuate them.

Infant mortality and poverty

Infant mortality is a traumatic societal burden. High infant mortality persists because of the prevalence of often-preventable communicable diseases. Vaccination programmes and improved nutrition have led to significant progress, but it has been uneven.

Poor infants and children are more likely to die than children in better-off families. In some countries, for example, the under-5 mortality rate of the poorest 20 per cent of the population is more than four times that of the richest 20 per cent (Adam Wagstaff, 2000). The differentials in infant mortality can be lower, but are still substantial.

Table 1. Infant mortality levels by wealth quintile, regional comparisons

Region	Poorest	2nd	3rd	4th	Richest	National average	Poorest/ richest
East Asia and the Pacific	56.6	46.6	40.1	30.5	20.4	41.0	2.7
South Asia	97.6	105.2	99.9	83.7	56.8	90.7	1.8
Sub-Saharan Africa	107.4	107.1	99.4	91.5	66.6	96.2	1.7
Middle East/North Africa	94.7	78.2	63.5	54.6	33.5	68.0	2.9
Europe/Central Asia	67.0	58.4	56.4	47.0	36.8	54.7	2.0
Latin America and Caribbean	68.9	59.4	50.6	40.7	29.3	52.9	2.7
Asian and Pacific region	72.8	72.1	67.3	56	41	63.6	
Total	90.9	87.3	79.9	70.5	50.7	78.1	
Quintile value/richest, total for the Asian and Pacific region	1.79 1.78	1.72 1.76	1.58 1.64	1.39 1.37	1.00 1.00		

The wealth difference in infant mortality in the Asian and Pacific region mirrors the global average (see table 1). In some regions, progress will be more difficult. In sub-Saharan Africa and South Asia, which have the highest infant mortality rates, the gap between the richest and the poorest is smaller, and even among the richest 20 per cent infant deaths are higher than the average in other regions.

Health risks to infants and children are worse in poor families with many children. Larger families are more common among the poor and their children in them are less likely to receive even basic preventive health care (Jensen and Ahlburg, 1999). If the children become ill, they are less likely to be treated. If the sick child is a girl, her risks can be even higher.

Table 2. Infant mortality levels by wealth quintile, ESCAP region

Country	Poorest	2nd	3rd	4th	Richest	National average	Poorest/ richest
Viet Nam	42.8	43.2	35.2	27.2	16.9	34.8	2.5
Philippines	48.8	39.2	33.7	24.9	20.9	36.0	2.3
Indonesia	78.1	57.3	51.4	39.4	23.3	52.2	3.4
India	109.2	106.3	89.7	65.6	44.0	86.3	2.5
Bangladesh	96.3	98.7	97.0	88.7	56.6	89.6	1.7
Nepal	96.3	107.2	103.6	84.7	63.9	93.0	1.5
Pakistan	88.7	108.7	109.3	95.7	62.5	94.0	1.4
Kazakhstan	35.1	43.7	44.3	50.2	29.1	40.7	1.2
Uzbekistan	49.5	43.8	41.5	33.6	46.8	43.5	1.1
Kyrgyzstan	83.3	73.3	67.5	49.6	45.8	66.2	1.8

Overall, in countries of the ESCAP region (table 2), some of the highest wealth differentials in infant mortality are found in East Asian countries with relatively low national averages. Further progress in infant mortality reduction will require giving greater attention to equity as levels decline. The poorest 60 per cent are often the most disadvantaged.

Poverty and reproductive health access and use: differentials within countries and regions

Some of the widest gaps within countries, and between richer and poorer countries, are in the area of reproductive health. The death of a mother in pregnancy or childbirth is hundreds of times more likely in the poorest countries. A woman's lifetime risk of dying of maternal causes is as follows: in Africa, one in 19; in Asia, one in 132; in Latin America, one in 188; but in more developed countries, only one in 2,976 (Hill, AbouZahr and Wardlaw, 2001).

This reflects both higher risk and the larger number of births. Unwanted fertility is higher in poorer settings and among the poorest of the poor. There is less information on maternal morbidity[2] but the differentials are likely to be similar, since the causes — lack of information, access, community and family support, finance, transport and provider quality[3] — are broadly the same.

Fertility levels and poverty

Achieved fertility is the resultant of preferences (demand) and the availability of means to realize reproductive choice. These combine to produce significant differences in outcomes. Wealth differentials in fertility outcomes in the ESCAP region tend to be larger than the global average (see table 3).

In the Asian countries reviewed (table 4), not all the wealthy groups have reached low fertility levels. In seven, the wealthiest have reached fertility levels at or below replacement, while the poorest are higher (between 3.1 in Viet Nam and 6.5 in the Philippines). Other countries are earlier in the transition. In Nepal, only the wealthiest had fewer than four children (2.9). In Pakistan, only the wealthiest had as few as four children; other groups of poorer women had between 4.9 and 5.1.

Family planning prevalence and poverty

The higher the level of women's overall contraceptive use, the lower the differential between women in the richest and poorest societal groups (see table 5). Once family planning use exceeds 40-45 per cent overall, the differences between wealth groups narrow considerably. Family planning acceptance becomes a social norm widely diffused throughout a society.

Table 3. Fertility levels (TFR) by wealth quintile, regional comparisons

Region	Poorest	2nd	3rd	4th	Richest	National average	Poorest/ richest
East Asia and Pacific	4.30	3.43	2.80	2.40	1.90	2.93	2.23
Southern Asia	4.80	4.38	4.08	3.80	2.80	4.05	1.77
Sub-Saharan Africa	6.91	6.35	6.10	5.54	4.25	5.76	1.72
Middle East/North Africa	5.55	4.50	3.80	2.95	2.50	3.80	2.27
Europe/Central Asia	3.98	3.35	3.08	2.75	1.73	2.93	2.33
Latin America and the Caribbean	6.51	4.93	3.88	2.98	2.07	3.84	3.17
Asian and Pacific region	4.43	3.83	3.45	3.14	2.23	3.42	
Total	6.13	5.32	4.86	4.27	3.20	4.68	
Quintile value/richest, total for the Asian and Pacific region	1.92 1.99	1.66 1.72	1.52 1.55	1.34 1.41	1 1		

In Indonesia, the Philippines and Viet Nam and some Central Asian republics, wealth differentials in contraceptive use tend to be particularly low. Differentials are largest in Pakistan, where contraceptive use is lowest (table 6).

In South Asia, the country with the lowest overall prevalence, Pakistan, at 9 per cent, 20 times as many people in the wealthiest group use contraception as in the poorest. In Nepal, with a prevalence of 26 per cent, the difference is less than three times.

Several Central Asian countries have reached overall prevalence levels close to 50 per cent, with lower differences between richer and poorer.

Recent estimates suggest that levels of unmet need for family planning in Asia (excluding China and including Central Asia) and the Pacific totals around 65 million women of reproductive age, which represents more than half of the

Table 4. Fertility levels (TFR) by wealth quintile, ESCAP region

Country	Poorest	2nd	3rd	4th	Richest	National average	Poorest/ richest
Viet Nam	3.1	2.7	2.2	1.8	1.6	2.3	1.94
Kazakhstan	3.2	3.2	2.9	2.4	1.3	2.5	2.46
Indonesia	3.3	2.9	2.6	2.5	2.0	2.8	1.65
Bangladesh	3.8	3.8	3.5	3.1	2.2	3.3	1.73
Uzbekistan	4.4	3.7	3.3	3.3	2.1	3.3	2.10
India	4.1	3.6	3.2	2.8	2.1	3.4	1.95
Kyrgyzstan	4.6	3.6	3.6	3.3	2	3.4	2.30
Philippines	6.5	4.7	3.6	2.9	2.1	3.7	3.10
Nepal	6.2	5.0	4.7	4.4	2.9	4.6	2.14
Pakistan	5.1	5.1	4.9	4.9	4.0	4.9	1.28

Table 5. Contraceptive prevalence (percentage married women of reproductive age) by wealth quintile, regional comparisons

Region	Poorest	2nd	3rd	4th	Richest	National average	Richest/ poorest
East Asia and the Pacific	37.6	46.3	49.7	50.0	47.2	46.2	1.26
South Asia	20.2	23.4	27.3	29.5	41.8	28.4	2.07
Sub-Saharan Africa	4.2	5.7	7.5	11.7	22.3	10.3	5.36
Middle East/North Africa	24.2	35.3	43.4	48.6	54.7	41.7	2.27
Europe/Central Asia	39.2	44.4	44.4	45.8	50.4	45.2	1.29
Latin America and the Caribbean	27.9	38.1	43.4	49.8	54.5	44.5	1.95
Asian and Pacific region	32.9	38.1	40.3	41.3	46.5	39.8	
Total	16.8	21.6	24.5	28.5	36.4	24.7	
Quintile value/poorest, total for the Asian and Pacific region	1 1	1.28 1.16	1.45 1.22	1.69 1.25	2.16 1.41		

developing world total of approximately 113 million (Ross and Winfrey, 2002). The levels, however, are proportionately lower for limiting births than in other regions.

Maternal care and poverty

In most regions, more than three quarters of pregnant women visit a doctor, nurse or midwife at some point in their pregnancy. Where women's mobility is more restricted, as in the South Asian countries, the figure is nearer one third. In all regions, the higher her income, the more likely a woman is to seek antenatal care. The gap between wealthy and poor families is greatest when national averages are lowest. In South Asia, the gap at the extremes of

Table 6. Contraceptive prevalence (percentage married women of reproductive age) by wealth quintile, ESCAP region

Country	Poorest	2nd	3rd	4th	Richest	National average	Richest/ poorest
Pakistan	1.2	4.1	6.1	10.7	23.2	9.0	19.33
Nepal	15.7	21.2	23.2	26.6	44.9	26.0	2.86
Philippines	19.6	26.1	32.7	32.7	29.2	28.0	1.49
India	24.9	27.5	36.1	42.0	50.6	36.5	2.03
Bangladesh	38.8	40.8	43.7	38.8	48.5	42.1	1.25
Kazakhstan	44.2	48.7	40.9	47.3	48.1	46.1	1.09
Kyrgyzstan	44.4	44.9	48.4	50.9	54.4	48.9	1.23
Uzbekistan	47.2	54.7	55.1	46.4	53.5	51.3	1.13
Indonesia	46.2	55.6	56.8	58.0	56.9	54.7	1.23
Viet Nam	47.0	57.3	59.5	59.4	55.5	55.8	1.18

Table 7. Medically skilled assisted delivery levels by wealth quintile, regional comparisons

Region	Poorest	2nd	3rd	4th	Richest	National average	Richest/ poorest
East Asia and the Pacific	30.5	53.0	68.4	80.6	93.4	60.8	3.11
South Asia	5.3	8.1	11.7	21.9	49.3	17.7	10.49
Sub-Saharan Africa	24.6	32.9	41.2	59.2	82.1	46.2	3.46
Middle East/North Africa	12.8	21.7	37.7	58.6	82.2	38.5	6.61
Europe/Central Asia	82.7	92.3	95.1	98.6	99.7	92.8	1.21
Latin America and the Caribbean	40.2	58.4	72.9	85.6	94.3	65.8	2.38
Asian and Pacific region	40.0	49.0	54.8	62.8	77.8	54.8	
Total	31.2	42.1	51.6	66.2	84.0	52.5	
Quintile value/poorest, total for the Asian and Pacific region	1 1	1.35 1.22	1.66 1.37	2.13 1.57	2.70 1.94		

the wealth distribution results from particularly high levels of care among the wealthiest.

Differences by wealth level in attended deliveries are wider (see table 7). The poorer segments of society are even less likely to have skilled assistance at delivery than to seek antenatal care.

In South Asian countries, women (in aggregate) are half as likely to have skilled attendance at birth as they are to have skilled antenatal care. Overall levels of pregnancy care are low; in the two poorest quintiles trained antenatal care is more than three times as common as trained delivery. In sub-Saharan Africa, the other region with high maternal mortality, women are two thirds as likely to have skilled birth attendants as to have skilled antenatal care and the differential in the poorest strata is less marked.

Table 8. Medical-assisted delivery levels by wealth quintile, ESCAP region

Country	Poorest	2nd	3rd	4th	Richest	National average	Richest/ poorest
Bangladesh	1.8	2.5	4.1	9.0	29.7	8.1	16.5
Nepal	2.9	5.2	6.4	9.1	33.7	9.6	11.6
Pakistan	4.6	6.6	6.0	21.5	55.2	18.6	12.0
India	11.9	18.2	30.1	47.9	78.7	34.3	6.6
Indonesia	21.3	34.8	48.1	64.4	89.2	49.1	4.2
Philippines	21.2	45.9	72.8	83.9	91.9	56.4	4.3
Viet Nam	49.0	78.4	84.2	93.6	99.2	77.0	2.0
Uzbekistan	91.9	100.0	99.3	99.0	100.0	97.5	1.1
Kyrgyzstan	96.0	98.2	98.1	99.7	100.0	98.1	1.0
Kazakhstan	99.4	100.0	98.8	100.0	100.0	99.6	1.0

Table 9. Adolescent (aged 15 to 19) fertility levels by wealth quintile, regional comparisons

Region	Poorest	2nd	3rd	4th	Richest	National average	Poorest/ richest
East Asia and the Pacific	85.3	64.7	38.0	29.3	12.7	46.7	6.72
South Asia	138.3	136.8	121.3	105.3	67.5	116.0	2.05
Sub-Saharan Africa	176.8	166.1	155.3	148.8	93.5	143.8	1.89
Middle East/North Africa	72.5	62.0	58.5	33.5	23.0	50.5	3.15
Europe/Central Asia	83.8	65.5	73.3	63.8	31.5	63.8	2.66
Latin America and the Caribbean	181.0	135.3	105.0	73.4	33.1	97.2	5.47
Asian and Pacific region	108.8	93.7	82.8	72.1	40.2	80.4	
Total	154.7	136.4	122.0	108.3	64.4	113.6	
Quintile value/richest, total for the Asian and Pacific region	2.40 2.71	2.12 2.33	1.89 2.06	1.68 1.79	1 1		

Increases in the use of skilled attendants relative to wealth (see table 8) tend to be sharper than for other basic health-care services. Antenatal care and attended delivery are more sensitive to wealth differences than oral rehydration therapy or medical treatment for diarrhoea, medical treatment for acute respiratory infections or immunization. Attendance by a doctor is the most sensitive to income (Gwatkin and Deveshwar-Bahl, 2002).

Childbirth at home or in a health facility is also strongly related to wealth. Nearly 80 per cent of births in the richest families are at a health facility, and most births in the two richest quintiles. At each lower wealth group, the proportion of home births increases. Nearly 80 per cent of the poorest quintile have their children at home.

Table 10. Adolescent (aged 15 to 19) fertility levels by wealth quintile, ESCAP region

Country	Poorest	2nd	3rd	4th	Richest	National average	Poorest/ richest
Viet Nam	51	41	27	18	11	32	4.64
Philippines	130	90	32	29	12	46	10.83
Indonesia	75	63	55	41	15	62	5.00
Pakistan	88	87	66	76	44	74	2.00
India	135	140	117	84	45	116	3.00
Nepal	143	149	132	128	90	127	1.59
Bangladesh	187	171	170	133	91	147	2.05
Uzbekistan	58	50	85	68	39	61	1.49
Kazakhstan	101	65	83	53	26	64	3.88
Kyrgyzstan	120	81	61	91	29	75	4.14

Adolescent fertility and wealth

Though adolescent fertility levels in the ESCAP region are lower than in some other major regions, the differentials between the wealth group extremes are larger: the richest attain very low levels of young fertility.

In East Asia, countries where the young are least likely to give birth have larger differences between poor and rich groups.

In Indonesia, the Philippines and Viet Nam, adolescents in the poorest segments of the population are nearly seven times as likely to have had children within the past year as their better-off counterparts. In the Philippines, poor young women are nearly 11 times as likely to have had a child. These higher levels reflect early marriage, less ability to negotiate delays in sex and reproduction and less access to family planning. In all three countries, reductions in youthful fertility are systematically related to increases in wealth. In South Asia, adolescent fertility levels are higher and only the richest quintile is regularly distinguished from less wealthy groups.

Beyond wealth

Material wealth differences are produced by disparities in physical and social infrastructure, including opportunity, resources, skills and information. They are generated and reinforced by complex social processes of exclusion. Geographical location is important: rural areas provide lower levels of services, information and opportunities than urban areas.

Some of the wealth differentials related to reproductive health services and use reflect greater poverty in more rural areas.[4] But differences can be seen within both urban and rural areas. Fewer rural residents reach the higher income levels seen in cities, but in both settings the poorest have the worst services. In India, for example, total and adolescent fertility levels, contraceptive usage and immunization levels are highly similar across the wealth spectrum in rural and urban areas. The poorest in rural areas are more disadvantaged than their counterparts in cities. Rural families, for example, have less access to safe delivery services, particularly if they involve highly trained personnel or specialized facilities. In the richest groups in both settings, the differences are minor (Gwatkin and others, 2000).

Urban areas are growing rapidly, and the poor of the world are increasingly urban (United Nations Population Division, 2001; Naylor and Falcon, 1996). This provides both opportunities and new challenges. Economies of scale and ease of access could increase coverage, but inequities in access within cities remain large. However, smaller cities, while better served than rural areas, compare poorly with larger cities (Hewett and Montgomery, 2001). The relative disadvantage of medium-sized cities in providing health quality and service is a growing problem as a larger proportion of urban dwellers come to live in them. Municipal and other local

authorities have more responsibility under the decentralization of public health administration, without the corresponding resources or revenue-raising authority. Local governments will find it increasingly difficult to fill the gaps in services.

Some ways forward

Most donor institutions are working to improve the positive impact of health (including reproductive health) interventions for the poor.[5] Health deficits for poorer populations exact a significant toll in lost productivity, human misery and missed opportunities for gender equality and accelerated development. The substantial differentials in access to information and services justify coordinated public, private and community responses on the basis of social welfare arguments and in the light of the substantial economic and social externalities. One key challenge is seeing that population and reproductive health programmes, and development programmes at large, confer their benefits on the poor. The incorporation of population considerations in emerging mechanisms for development planning (for example, in poor countries, poverty reduction strategy papers, sector-wide approaches and other elements of health sector reform) remains an important policy task. The diversity of social, demographic and economic situations in the Asian region will require the careful tailoring of policies and programmes to national realities. Important principles to be incorporated include rights-based approaches, gender and cultural sensitivity, participatory mechanisms for accelerated empowerment, quality programming, efficiency, sustainability and equity. The chart suggests some important priorities for population and reproductive health interventions with general applicability to all anti-poverty interventions.

Endnotes

1. The differentials presented here are based on the reports in the series *Socio-economic Differences in Health, Nutrition and Population in [country]* prepared by Davidson R. Gwatkin and others (2000) for the HNP/Poverty Thematic Group of the World Bank. Forty-four countries with a Demographic and Health Survey were analysed. ESCAP region countries are also aggregated in this presentation. Most of the surveys date from the mid to late 1990s. Work is under way to update and expand the database.

2. This is true of morbidity measures in general. The absence of effective registration systems and paucity of wealth or income measures even renders mortality comparisons within countries a difficult enterprise. (For discussion, see Adam Wagstaff, 2000).

3. Quality-of-care initiatives are an important component of most programmes of assistance to reproductive health care providers, but high or irregular workloads, poor compensation, staff turnover and underdeveloped systems of monitoring and supervision pose constant challenges to attaining and maintaining standards.

4. For comparative studies of the efficiency of service delivery systems, analyses need to be statistically correct for rural-urban proportions. Comparing access within countries looks at differentials within urban and rural places.

Reaching the poor: towards a pro-poor agenda

Dimension of action	Key issues	Important directions
— Attend to problems that most affect the poor — Recognize the dignity of all — Expand participation — Evidence based programme activities — Improve the quality of programmes addressing basic needs, particularly of the poor — Improve and diversify financing and ensure sustainability	— Provide basic social services with sensitivity to people's capacity, needs and cultures — Improve the accessibility of public and private services — Integrated programming — Qualitative approaches and active listening — Improve data bases on needs and situations and on effective action — Ensure the availability and use of data — Provide training for staff and information for potential beneficiaries — Mobilize demand for quality and improve systems of accountability — Make direct investments in quality improvement, recruit effective staff — Mobilize resources — Improve monitoring and evaluation — Reduce costs to the poor — Involve programme staff and beneficiaries in defining and setting priorities	— Provide governance and supporting environments for meeting people's needs — Address the marginalized – women, the indigenous, the poor, those living with HIV/AIDS, people in crisis situations — Provide programmes for adolescents — Expand resources for community and individual action and choice (including microcredit) — Involve local institutions including NGOs, cultural organizations and the private sector — Improve geographical targeting to reach those in need — Respond to expressed unmet needs (including those for reproductive health and family planning) — Advance health sector reform in ways that attend to quality and equity — Develop and improve financing systems: mobilize additional resources

Note: The general dimensions (or principles) of action that are identified in the first column are associated with the key issues presented in the second. The final column recommends particular actions that follow from this analysis.

5. See, for example, Health Systems Resource Centre, Department for International Development Health Systems Resource Centre. 2001. ''Health financing: designing and implementing pro-poor policies''; ''Which health policies are pro-poor?'' and ''Health in poverty reduction strategy papers: an introduction and early experience''. These and other papers (including national studies) can be found at <www.healthsystemsrc.org>

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