

## II. Rethinking service delivery

**If the countries of the Asia-Pacific region are to achieve the Millennium Development Goals they will need to invest sufficient resources. But funds on their own will not be enough. Just as important, countries will need to change how they do things – developing sufficient skills and capacity and ensuring that they have national and local institutions that fit the needs and aspirations of the twenty-first century. Well-functioning institutions can help to accelerate this progress towards the MDGs – especially those that are crucial for delivering health, education and other vital services to the poor.**

Achieving the MDGs ultimately depends on the efforts of communities, of families and of millions of individuals, whose determination, creativity and investment of time and resources drive countries forwards – steadily building incomes and their capacity to develop and transform their own societies. But people should also be able to rely on support from their Governments – to foster the institutions that will allow individual and community efforts to flourish while also taking responsibility for delivering or regulating the public services essential to the functioning of a modern state.

Institutions in this sense refer not just to specific organizations, governmental or non-governmental, but also to the established patterns of behaviour – cultural, economic and social – the “rules of the game”. These might be expressed formally in terms of laws or regulation or informally as accumulations of customs or conventions that have evolved to allow large numbers of people to live and work together, everything from languages to markets, from festivals to religions.

The Asia-Pacific region has all of these institutions in rich profusion – and of every conceivable character

and scale. They include the whole spectrum of economic systems from the transition economies of the Lao People’s Democratic Republic and Viet Nam to the free market economies of Singapore or the Republic of Korea. They include thousands of languages, some spoken by many millions; others by just a handful of people on small islands. And they include multiple types of relationships between men and women, from the matriarchal systems of land inheritance in Bhutan to a number of countries in Central Asia where polygamous marriages are still evident.

All of these institutions, which can both facilitate and obstruct progress towards the MDGs, have been developed according to local situations. And they are constantly evolving to meet new conditions and opportunities. In these circumstances there is no one optimum combination; rather, a complex and shifting variety. The task for a Government, whether through leadership, or advocacy or regulation is to try to ensure that these institutions change in ways that best serve the rights of all the country’s people.

At the same time, Governments themselves are institutions that have to reinvent themselves to meet their

responsibilities. This means that fulfilling the MDGs will also require playing close attention to the quality of governance. This implies openness, transparency and determination to root out corruption. In addition, many countries in the region still lack staff of the capacity or calibre needed to accelerate progress – and this along with many other factors, including weak infrastructure, limits their “absorptive capacity” – the ability to make the best use of new resources – whether generated locally, or from foreign investment or official development assistance.

Governments will therefore need to consider many types of institutional change to make the best use of funds, function effectively and more generally to fulfil the “social contract” that they have made with their citizens. This contract was echoed at the international level when all the world’s Governments signed the Millennium Declaration that gave rise to the Millennium Development Goals, committing themselves to creating an environment “conducive to development and to the elimination of poverty.”

Poverty means not just a shortage of income or assets but also a lack of what people need for full and satisfying lives – good health, for example, education, and clean water supplies and sanitation, as well as the opportunities and the power to participate in making the decisions that affect their daily life and work. All these aspects of poverty interact: without money it is difficult to gain access to education and health care, but without education and good health it is difficult to earn a decent income. And without power it is hard to claim access to services – which in turn undermines personal dignity, self-esteem and the ability to gain the respect of others.

One of the most direct ways in which Governments can address poverty – and meet the MDGs – is therefore by ensuring the availability of services, either providing them directly or sustaining a framework for provision through the private sector or civil society. This chapter, while accepting that achieving the MDGs will demand many kinds of institutional change, will therefore focus primarily on those changes required to produce services that meet the needs and priorities of all users, and especially the poor.

## **Making services available**

The first task is to ensure that services are physically in place – that there is a network of schools, health facilities, and the necessary hardware for water supplies and sanitation. All countries in the region now have the basic infrastructure. Providing this is usually more straightforward in urban areas and in the more compact countries. It is a much greater challenge where the

population is widely dispersed across difficult terrain or on small islands. In principle, a rights-based approach demands that everyone be covered; in practice there are trade-offs as Governments weight up how much they are prepared to spend to achieve a given level of coverage.

In some cases they will not extend services beyond the capital city – particularly for more sophisticated medical services, or for more advanced types of higher education. And they will also tend to initiate vital newer services such as the comprehensive response needed for the prevention, care and treatment of HIV/AIDS in the urban areas, leaving millions of rural dwellers for the time being to cope as best they can.

Extending services raises questions of economic efficiency: Governments set priorities according to the range and the threshold, the range being the maximum distance they expect that people will travel to make use of a service and the threshold being the minimum number of users, or buying power, they consider necessary to make the service viable. This may be economically and politically rational but can result in wide disparities – typically between urban and rural areas. This is evident, for example, in the case of water supplies. While in urban areas coverage of improved water supplies is typically more than 90 per cent, in rural areas it can be 70 per cent or less. In the Asia-Pacific region as a whole, 670 million people lack access to improved water sources – most of them in the rural areas.

### *Women suffer more from lack of services*

Even when services appear equally close to – or distant from – everyone in a given community, in practice inaccessibility hurts some groups more than others. Planners, who are usually men, tend to cater for an “average” consumer who is probably a healthy rural male. As a result they may locate services out of reach of young children, for example, or the elderly or the disabled – and particularly of women who have different, and often greater, needs than men for most services:

*Health* – Women tend to use health services on a more continuous basis than men. This is partly in order to care for their children – making sure they are vaccinated against common diseases, for example, and that they receive prompt treatment for the regular illnesses of childhood, from diarrhoea, to malaria to acute respiratory infections. But women will also be intensive users of services on their own account; when it comes to pregnancy and childbirth, for example, they rely on effective reproductive health services, including antenatal care, and in the case of complications in childbirth on the availability of emergency obstetric care.

*Education* – Girls also have specific requirements from schools. A common problem for girls is that schools, and particularly secondary schools, may be far from their home. Parents will worry about the risks of a daily journey for their children, but particularly for adolescent girls, and as a result are more likely to keep them at home.

*Water supplies* – Everyone needs water, but the lack of a ready supply hits hardest at women and girls because of the distribution of the workload in the household. First, because fetching water, often from long distances over difficult terrain, is typically assumed to be a woman's job. Second, because women who are responsible for cooking and cleaning are the greatest water users. Third, because it is women who have to deal with the consequences of contaminated water when children or other family members fall sick. The lack of water thus puts a huge strain on women and also absorbs time that they could use for other purposes, for earning income, perhaps, or looking after children or for leisure and rest or, in the case of girls, for going to school.

*Sanitation* – Inadequate sanitation is also a serious problem for women and girls, who need more privacy than men. Often they can get sufficient privacy by relieving themselves only when it is dark and may have to wake up before dawn to defecate in fields or at roadsides – when they also risk physical attack. Many women will limit their intake of food and water during the day so that they can wait until the evening. And in schools if there are no separate facilities for boys and girls, the girls may be kept from school.

## Quality

The fact that the physical facilities are in place, of course, says nothing about the quality of the services on offer. In some cases there may be nothing at all: stories abound across the region of empty schools and abandoned clinics. To some extent this may be because Governments find it easier to raise funds from national resources, or from international donors, to build facilities than to find funds for subsequent running costs, especially if users do not or cannot contribute. Indonesia, for example, during the 1970s and 1980s successfully established an impressive network of health centres, the *puskesmas*, but although these were numerous the quality of services or provision did not match up to the original promise (BAS-Statistics Indonesia, BAPPENAS and UNDP, 2001).

Services generally show deficiencies in terms of staff or supplies or in standards of supervision or quality control.

*Staff* – A typical problem is a lack of staff in rural areas since it is difficult to recruit people to work in remote schools or clinics. In Sri Lanka, for example, many popular schools in the urban areas have sufficient teachers, or even a surplus, while others in remote rural areas face acute shortages. But even then the low salaries on offer may force teachers to take other jobs to survive, so they can frequently be absent from their posts. One study of 3,700 schools in India found that one quarter of teachers were absent at least part of the time – and that there were no mechanisms to monitor this or punish the truants (Ordonez and Sack, 2005). Another issue is the attitude of staff to users. Government staff can be arrogant or dismissive to those whom they are supposed to serve. Or if they come from the cities they can have difficulty in communicating with rural people. There are also gender issues: in health services, for example, if all the staff are men, women will be reluctant to go there for examinations.

*Supplies* – Clinics in rural areas frequently lack even the most basic medicines. This may be because of inadequate national spending on the health system: in Myanmar, for example, per capita health expenditure is only \$26 per year (UNDP, 2004). But stocks of effective medicines are also affected by the priorities of international research efforts, which mean there are few affordable remedies for some of the commonest diseases such as malaria and TB. Globally, 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 (Global Alliance for TB Drug Development). Between 1975 and 1997, only 1 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).

*Maintenance* – A regular quality problem is that buildings or infrastructure are poorly maintained. Again this may be due to a lack of investment. But it can also reflect a lack of local participation. At some point a local committee may have been established and trained to supervise a piped water supply for example. But if the committee members are not well motivated, or if they move from the area and are not replaced with newly trained people, water systems can become contaminated or fall into disrepair.

*Standards* – Poorly motivated staff and a lack of resources can also lead to low standards of service. For example, childbirth should be safer in hospitals than at home without a trained attendant, but often it is not, either because of low standards of hygiene, or the risks of hospital-acquired infections that are resistant to antibiotics. Similarly, standards of teaching can be

inadequate. Classrooms are often overcrowded and hours are few. In Bangladesh, for example, average class size in primary schools is 59 children and contact time with pupils is around only two hours per day (Government of Bangladesh and United Nations, 2005). In addition many countries in the region rely on rote learning with children chanting from the blackboard, rather than being encouraged to think for themselves or to solve problems. Water supplies too can be of low quality or contaminated with substances like arsenic – a problem that affects over 200 million people in nine Asian countries. In urban areas of Asia more than half of water supplies also operate only intermittently which heightens the risk of contamination (WHO and UNICEF, 2000).

*Matching local needs* – Another common issue is that services designed or determined centrally may not be appropriate to local needs. Children in minority ethnic groups, for example, often have to learn in what might be their second or even third language. Thus, in Viet Nam, the main language of instruction is Vietnamese, which children in minority groups may not understand. In addition teachers in many countries work from a centrally planned curriculum with elements that either conflict with local customs or needs, or teach academic subjects that are irrelevant to local conditions rather than equipping children with vital life skills – and the ability to do the work needed in the rural areas.

#### *Expanding services while ensuring quality*

With limited resources, Governments often face the difficult problem of balancing the quantity and quality of services. In the case of services that affect health, there should be no compromise in the quality of essential services. But for some other services the situation may be different: attempting to achieve very high standards can be wasteful and prevent wider coverage. A study in rural China, for example, found that when the authorities decided to replace village schools that were convenient for children and taught in local languages but did not teach the full primary course, with more distant, complete schools this effectively excluded many poor children, and those from ethnic minorities, particularly girls (Beynon and others, 2000).

Similarly in the case of water supply it is possible to distinguish between the various purposes for which water is needed. Not all water requirements are for drinking. The bulk water needs in a household are for washing and cleaning, for which use of potable quality water may be wasteful. Water providers will understandably want to offer high-quality supplies but in doing so may spend large sums that could have been used to provide less pure water to a larger number of people (Cairncross and others, 1999).

This suggests that what is required is a flexible approach that can bring suitable services within reach of scattered populations. Bhutan, for example, despite its dramatic and vertiginous terrain, has managed to extend health services to 90 per cent of its population by creating a network of hospitals, basic health units and monthly clinics run by health workers who can within a day's walk reach them, complemented by village health volunteers. This still misses out some people such as yak herding families high in the Himalayas, but most of the sedentary population have some access to health care.

#### **Financial barriers**

Many people will be unable to access services because they cannot afford them. This is most evident in the case of services provided by the private sector, where companies will want to recover costs and earn a profit – those running transport systems, for example, or private clinics or schools.

But even government-provided services that are ostensibly free can turn out to be expensive. Thus while primary education is free in most countries, parents will find themselves paying supplementary charges. In the Lao People's Democratic Republic, as in many other countries, although parents do not have to pay fees they do have to find money for uniforms, books and supplies. Similarly in Kyrgyzstan parents and children are often subject to informal and unregulated charges for textbooks and other materials (Government of Kyrgyzstan, 2003).

Patients in the “free” health systems may also have to pay fees to nurses or doctors to receive treatment. Or discover that doctors will offer only a limited service in the public clinics that they will offer to supplement from their private practices. In China, for example, health-care providers get limited funding from the Government and in order to earn a living wage health-care workers rely heavily on charging user fees to patients (Bekedam, 2004). People living with HIV/AIDS can also face severe problems since although the cost of antiretroviral treatment has come down it is still out of reach for the poor. Even urban water supplies, long thought of as a public good requiring essentially free provision, are increasingly being charged for.

In addition to direct costs, there are also opportunity costs. If people have to travel a long distance, for example, or queue for hours to use a free service they will lose valuable income-earning opportunities or work time. Similarly, if people have to walk a long way to fetch water they will use up time that could be put to better use. In India, for example, women are thought to spend around 150 million working days per year carrying water, equivalent to a loss of around \$200 million.

Poor families will also have to take into account the opportunity cost of sending their children to school. Households in many countries in the region rely on children to care for younger siblings, to do household chores such as fetching water and fuelwood, to work in the family fields or to engage in casual labour to supplement household incomes. In these circumstances, sending them to school will imply significant short-term financial sacrifice.

## Legal barriers

Many of the poorest families can have difficulty getting access to services because they do not have birth certificates. UNICEF estimates that in East Asia and the Pacific 19 per cent of births are unregistered, while in South Asia the proportion rises to 63 per cent. Generally, rural parents are much less likely to register: in India the proportion of children registered in urban areas is 54 per cent but in rural areas it is only 29 per cent (UNICEF, 2005).

Parents may fail to register births simply because they are unaware of the importance of this. But they can also be dissuaded by the costs if the system is highly centralized and they have to travel to a registration office. This may cause them to delay the process until they are convinced that the child will survive, or to miss it altogether. Then if they later discover that they should have registered their child they can be further discouraged by the prospect of paying a fine. However, there can also be political reasons for non-registration. Ethnic minority parents who distrust the central Government may not wish to have their details known. Even when children originally had a birth certificate, poor or migrant families may not have anywhere to store it, so it can become lost or damaged and require an expensive replacement.

The lack of a birth certificate can prevent children from getting access to school or to free health services. In Nepal, for example, a birth certificate is not officially mandatory for a child who wants to enter school, but school principals frequently insist on this. And even if a school principal allows a child without a birth certificate to attend school, he or she may not allow the child to use free books, or to sit examinations or attend higher education (Plan International, 2005).

The lack of vital registration systems can also have implications for the planning of services. If the age of the child population is unknown this makes it difficult to plan education services effectively. Also, many countries in the region do not have efficient systems for registering deaths. This makes it more difficult to know, for example, what maternal mortality rates are – and thus to estimate how much will need to be invested

to save women's lives. Similarly with many immigrants unregistered it is difficult to assess the scale of their needs; following the Indian Ocean tsunami, for example, it will probably never be known even how many unauthorized immigrant workers died.

In increasingly complex urban societies, families now need a host of other documents in their daily lives. If they do not have citizenship or other official papers they may not only be harassed by law enforcement officials but be denied access to services. Thus unregistered squatter families who lack building permits will find that they cannot be connected to an urban water supply, even though they could afford to pay. Among those least likely to have sufficient documents are rural-urban migrants. This may be because they think they are only staying temporarily and do not wish to transfer their registration, but even those who intend to stay can have problems. In China, for example, millions of immigrants to the largest cities lack the permits that would allow them full access to services. In Mongolia too, migrant women have difficulty gaining access to health services (Government of Mongolia, 2004).

In practice, however, security of tenure is frequently less a legal issue than a political one. Often the only way for many people in informal settlements to protect themselves against eviction is to pay politicians or hired thugs. Similarly, the way to get services may be for local leaders to ally themselves with powerful people outside the settlement, promising votes in exchange for services. Local service providers, such as water vendors, may also have to seek patronage or protection and will pass the costs on to users.

## Sociocultural barriers

Services in principle are available to all, but certain groups typically get inferior treatment, or are excluded altogether.

### *Gender discrimination*

The largest category facing discrimination, though they can scarcely be considered a "group" since they constitute half the population, are women. Females even from birth can be excluded from health services in countries that show a strong preference for sons. In South Asia, for example, infant mortality rates for girls are 30 to 50 per cent higher than those for boys – a result in many cases of parents giving girls less care within the home and also of their being slower to seek medical attention for girls when they fall sick. One study in India, for example, found that for childhood illnesses, girls are 1.5 times less likely to be hospitalized than boys (WHO, 2005). Girls can also be poorly fed

and grow up to be undernourished mothers who deliver underweight babies in an intergenerational cycle of malnutrition.

Girls, too have historically been less likely to be sent to school – in some cases because parents consider them a less worthwhile investment, since they can have a lower earning capacity, and in any case will leave the family home at marriage. While most countries have reduced the educational disparities between boys and girls at the primary level, disparities persist in a number of countries at the secondary level: in Tajikistan in 2001, for example, while 63 per cent of boys completed secondary school, only 38 per cent of girls did so (Government of Tajikistan, 2003).

#### *Ethnic minorities*

Many countries in the region have ethnic minorities who have less access to services than the rest of the population. In Viet Nam, for example, primary education enrolment rates of children from ethnic minorities have on average been almost 10 percentage points lower than those of the majority ethnic Vietnamese population and the disparities rise the higher they go up the education system (Government of Viet Nam, 2002). Similarly in Cambodia, while the national adult literacy rate is 68 per cent it is only 27 per cent in Ratanakiri, a province with many ethnic minorities (UNICEF, 2003).

#### *People living with HIV/AIDS*

Even people within the mainstream population who have contracted HIV/AIDS can face discrimination when it comes to the use of public services. A survey in 2004 in Indonesia, the Philippines and Thailand found that one quarter of respondents told of discrimination by health-care workers, 15 per cent had been refused treatment or care and 17 per cent had experienced delays in the provision of health care. And many people found that once their condition became known they were actually turned away from health centres (APN+, 2004). One major concern for people living with HIV/AIDS is that health-care workers will not respect their right to anonymity – and thus deter them from being tested or receiving treatment. Some HIV-positive mothers, who know they may transmit the virus to their babies, will nevertheless breastfeed them to avoid being identified as HIV-positive. Discrimination is also common with education systems – both for pupils and teachers.

#### *People with disabilities*

Over 200 million people in the region are thought to be living with disabilities, of whom over 40 per cent are living in poverty (ESCAP, 2002). Their numbers are

particularly high in post-disaster areas and in post-conflict countries like Afghanistan, Cambodia, Timor-Leste and Viet Nam. People with disabilities have the same needs for health and educational services as other people, but face more challenges in securing access due to physical and social barriers. Despite improvements in legislation, people with disabilities often experience discriminatory practices and deep-rooted stigmatization. In Afghanistan, for example, at least 4 per cent of the population are disabled and are generally marginalized and among the poorest sections of the population (Government of Afghanistan and UNDP, 2004). Women with disabilities are among the most marginalized of all, as they have multiple disadvantages through their status as women and as people with disabilities.

Available evidence suggests that fewer 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. Most education facilities for children and youth with disabilities are concentrated in special schools in urban areas, while most people with disabilities live in rural areas. Other problems include a lack of early identification and intervention, negative attitudes, exclusionary policies and practices, inadequate teacher training and inflexible curricula and classes. Accommodating children with disabilities in regular schools means removing physical obstacles and arranging suitable transport. The Lao People's Democratic Republic is one of the more advanced countries in this respect with facilities in 78 schools in 12 of 18 provinces (UNESCO, 2001).

#### *Socially unaccepted or illegal groups*

Other groups that face legal barriers in getting access to services are those whose behaviour is either considered socially unacceptable or is illegal – which could include men who have sex with men, injecting drug users or sex workers. They may have difficulty getting access to appropriate health services generally, but particularly to services that could help to slow the spread of HIV/AIDS, such as the distribution of condoms or clean syringes – even though they may subsequently qualify for antiretroviral treatment.

### **Political barriers**

The responsibility for ensuring adequate services clearly lies with Governments. Citizens surrender many of their rights to Governments in exchange for the right to protection and preservation. These rights have been asserted, for example, in the Universal Declaration of Human Rights, article 25 (1) of which states: “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, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.” At the Millennium Summit, countries reaffirmed their support for upholding the respect for the rights of all without distinction to race, sex, language or religion and promised to spare no efforts to safeguard civil, political, economic, social and cultural rights.

In the past many people have, however, made a distinction between the political rights, which financially are relatively easy to fulfil, and social and economic rights, which can be much more expensive. Political rights require the State and others to desist from persecuting people so need not imply any great financial burden. Fulfilling the social and economic rights may require considerable expenditure, on education, for example, or health – which, it is argued, can only be fully delivered in richer countries, where standards of living are higher and the Government has sufficient tax revenue.

However, fulfilling the social and economic rights is not as daunting as it might seem – since it is possible to unpack the duties into several discrete components. In this view, Governments have four types of obligations: to *respect* both political and property rights; to *protect* these rights from abuse by others; to *facilitate* by building infrastructure, say, or running public health campaigns, so as to improve people’s capacity to raise their own standards of income or health; and finally to *fulfil* the rights of those who cannot meet their own needs by acting as the provider of last resort.

These distinctions help take the edge off Governments’ fears of unlimited liability. Most Governments would willingly accept the first three types of duty. And in extreme circumstances they also take on the duty to fulfil; no democratic Government can now allow any of its citizens to starve to death in public.

It is clear therefore that Governments and citizens have considerable leeway when it comes to providing or claiming services. As a result, deciding levels of service provision is essentially a process of political negotiation. On the one hand governments will decide what they can afford and choose to whom they will give priority. On the other hand citizens will either have to accept this or try to claim their rights to services which they are being denied.

Generally, however, this process of negotiation results in much better services for the rich and powerful – and also for urban dwellers, who tend to be better orga-

nized and more able to put pressure on Governments. The poorest citizens, living in remote areas, far from the seats of power and with no political or other forms of organization, are usually excluded; they may not even know what their rights are, still less be in a position to assert them. They may also internalize this sense of powerlessness, feeling that they have no right to a say. This would extend both to national-level politics, where they have no say over the budgetary process that determines what proportion of national income goes to social services and to the local level, where even elected and other assemblies are dominated by local elites.

How can the rights of the poor be fulfilled? One of the most general requirements is a high standard of governance – to ensure that public services are delivered in an efficient, transparent and honest fashion. At present that is a distant prospect in many countries. Corruption remains a major problem across the region, where bribery and favouritism can increase the cost of public works programmes by up to 50 per cent. This is common in education, for example, not just at the top level in diverting funds that should be used for buildings, equipment or supplies, but also at the local level when teachers can demand bribes from parents for school entrance or for good exam results or for books that should be provided free.

Good governance is therefore one of the primary requirements. But what other types of institutional change will be needed to extend services to the whole of the population? These can be considered under a series of headings. The first would cover the range of providers who should be delivering the services; countries are likely to deliver services more effectively if they broaden the range of options. A second would cover the various barriers to access and consider how these might be reduced or removed. A third would consider the political factors – to see how the poorest users might be empowered to demand and receive better services.

### **Broadening the range of providers**

In most countries the main provider of basic services – particularly health, education and water supplies – is the Government. Where the Government, at the national or local level, does indeed provide a good service it should continue to do so. Where it cannot do so, however, it should consider involving others, including private sector and community groups, not just to increase overall capacity but also better to meet the requirements of many different types of users. The relative strengths and weakness of each of these providers may be summarized as follows (Osborne and Gaebler, 1993).

*Public sector* – Governments are in a strong position to use the political process to set priorities, ensure equity and prevent discrimination. They can raise public funds to provide universal services – what are often termed “public goods”. However, they can also be overly bureaucratic and their staff may feel little incentive to respond flexibly to the needs of users.

*Private sector* – Private operators tend to be more efficient at economic tasks – abandoning unsuccessful or obsolete activities while also innovating and replicating successful ones. They can thus adapt to rapid change and, since they are paid by results, they have an incentive to be responsive and customize services to the needs of users. However, since they will be seeking profits they will tend to concentrate on the lucrative markets where risks are low and there are ready revenues – and thus will generally ignore the needs of the poor.

*Civil society* – Groups in civil society tend to be best at performing tasks that demand compassion and commitment to individuals, require extensive trust on the part of customers and clients and need hands-on, personal attention. Their weakness is that they tend to operate on a small scale through stand-alone projects and can be overly dependent on external, and often foreign, funds. They may also lack a strong system of accountability either to their users or to donors.

The challenge for Governments which wish to fulfil the rights of their citizens is therefore to find the optimum combination of providers who can provide the most complete and responsive service at the best price.

#### *Private sector provision*

Most countries have a range of private companies which will provide services that parallel the public ones. Often these have arisen because of deficiencies in public provision: either in quality because rich users would prefer more exclusive, high-quality treatment – or because there is no public provision at all. Although private provision is more extensive for the rich, it is also available to the poor, but only for services for which they can make small payments as they go along rather than having to pay large accumulated bills on fixed dates.

Probably the most dramatic example of private sector service provision in recent years has been the expansion of mobile telephones. Here private providers have met a need that fixed public networks could not satisfy. This has made phone services much more available to the poor, either directly if they can afford a handset, or indirectly by using the phones of individuals who have

set themselves up as mini-service providers. Grameen Phone, for example, a Bangladeshi company that is an offshoot of the Grameen Bank, is now the country's largest mobile phone provider. Poor women buy a handset with a loan from the Grameen Bank and then sell calls to users.

Private provision can also be quite extensive in health care. In Indonesia, for example, private expenditure accounts more than four fifths of total spending on health – even the poorest fifth of the population use private services more than public services (BPS-Statistics Indonesia, BAPPENAS and UNDP, 2004). Similarly, in India, 80 per cent of households use the private sector in the case of minor illnesses and 75 per cent for major ones (WHO, 2001a). There is also significant health provision through the informal sector, particularly for traditional medicine – though in a number of countries, including Bhutan and China, such traditional medicine is also provided through the public sector.

Private education is less extensive – but is growing – from kindergartens to private universities. Even in the more advanced countries of the region, private providers still account for a minority of schools: in Thailand, for example, they make up around 18 per cent of primary and secondary schools (Government of Thailand, 2004). Private provision is often greater at the higher levels: thus in the Philippines 80 per cent of college and university students attend private institutions (Tooley, 2001). Private schools need not just be for the poor. In Andhra Pradesh in India the Federation of Private Schools' Management has 500 private schools – with classes ranging from kindergarten to grade 10 – whose pupils come from poor villages and urban slums. Schools charge the pupils between Rs 25 (60 cents) to Rs 150 per month (about \$3.50) and in addition offer up to 20 per cent of their places free to the poorest students (Tooley, 2000).

In water supplies private involvement has historically been relatively limited. But in recent years there have been a series of partial privatizations of services in cities such as Jakarta, Phnom Penh and Manila. These have involved “public-private partnerships” in which the assets, including the network of pipes, belong to the State, which also sets the regulatory framework. The private sector then builds and operates the facility typically with a contract that runs over several decades and that sets out issues such as service quality and tariffs. Although these have improved water supplies for many people they have also created considerable controversy – particularly when companies have raised their tariffs – though these high tariffs have often been imposed by the Governments rather than by the private sector.

Faced with lack of services from either the Government or private utilities, especially in large urban settlements, many people have to rely on the informal sector. Small-scale entrepreneurs can provide water, often in carts or trucks to areas that have no piped supplies. This involves minimum investment in fixed capital and since the entrepreneurs are close to the community they can tailor their services to the needs of the poor and rely on informal enforcement mechanisms for payment. These more informal methods of

distribution can nevertheless operate on quite a large scale. One family business in Manila, for example, provides water to 14 areas. This works on a pyramid system in which water from the central city supply is piped to water managers in the community, each of whom covers around 200 households, selling water to them via metered pipes or in 200-litre containers. In Sri Lanka, a similar system has been used to develop water supplies for poor communities in Colombo (box II.1).

### **Box II.1. A pro-poor public-private partnership in Sri Lanka**

In Halgahakumbura, a squatter settlement in Colombo, 600 families used to receive their water through public standposts. But because the water was free, it was often wasted and the service generated no revenue for the National Water Supply and Drainage Board (NWSDB). The quality of the service was also poor and people wasted time queuing and carrying water home. Establishing house connections had been considered too costly and risky because it was not clear whether people would be willing or able to pay.

In 2004, under an ESCAP project, NWSDB entered into a partnership with the community, a small private company and a local NGO. The NGO first consulted the community to see to what extent they would take ownership of the scheme and be willing to pay. When this proved positive the company was awarded a concession to lay pipes in the settlement, install individual water connections and distribute water to households. The company now buys the water in bulk from NWSDB at a price set by the bidding process and then charges users for it at the official rate. Because the company is small and has low operating costs, it can make a profit on small margins. It has also opened an office close to the community to facilitate payments and deal with customers.

The scheme required all partners to learn new attitudes. The community 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. NWSDB has discovered a way to be paid for the water it supplies without having to collect individual charges while also wasting less water. The Government of Sri Lanka has also realized that privatization of water supplies can benefit the poor.

Informal provision has its weaknesses. Providers have little access to capital and although they have low fixed costs their labour-intensive procedures lead to higher marginal costs, so their charges can be high. Nevertheless a study of small-scale water providers in eight Asian cities did not find any indications of profiteering or exploitation (ADB, 2004c).

In addition to large-scale public private partnerships, which have had mixed results for the poor, it is also possible to create less formal partnerships, where the public sector can help to create a demand for services that the private sector can then meet. This has been demonstrated in sanitation, for example, which has a soft component in raising awareness for behaviour change and a hard component in the provision of systems. Once the Government has helped create a demand for low-cost systems the private sector can step in and meet it. In Myanmar, for example, the Government embarked on a massive social mobilization programme: between 1996 and 2000 it implemented a campaign by health workers in 174 townships, and from 1998 it has organized an annual Na-

tional Sanitation Week. In response the private sector was able to take advantage of these efforts by producing many thousands of plastic toilet pans and selling them at affordable prices. The actual construction of latrines was almost entirely the responsibility of households, which either installed them themselves or hired local builders.

#### *Civil society provision*

Responding to weak or inappropriate government-provided services, many organizations of civil society, whether community organizations or NGOs, have stepped in either to fill the gaps or to provide alternative models.

NGOs have the advantage that they are very flexible and can complement government services. However, in most countries they are typically on a small scale and offer services that are valuable but fragmented. Although some work on the basis, for example, of user payments or of types of mutual assurance often they remain dependant on external funding.

A number of Governments in the region have nevertheless recognized the strengths of NGOs and have worked in partnerships with them to extend public services. In Bangladesh, for example, the NGO BRAC works with the National TB Programme in 60 thanas covering a population of 14 million people. BRAC trains young women to become community voluntary health workers – resulting in an impressive 92 per cent completion rate for TB treatment. BRAC’s health workers have also worked with the Government to extend the reach of child immunization programmes (WHO, 2001b). In Cambodia, too, there have been successful experiments in contracting health delivery in remote areas to NGOs. These resulted not just in a greater take-up of services but in savings for the users; people in contracted-out districts lost about 15 per cent less time on illness and seeking health care compared with people in other districts (Bhushan and others, 2002).

In addition, Governments have been able to enter into partnerships with community organizations. In Sri Lanka, for example, the National Housing Development Authority provided local communities with funds and technical assistance to build public toilets and other facilities. This practice has now been adopted by local bodies – on the grounds that local people are best placed to decide on where the facilities should be and how best to look after them. If a particular community does not have the labour or skills to do the work itself it can still have it done by a contractor or by another community that has already done such work (Pathirana and Yap, 1992). Another striking example of this is the Orangi Pilot Project in Pakistan, which started with the construction of a sanitation system in an informal settlement and has since expanded to other areas with health and other services (box II.2).

### **Box II.2. Orangi Pilot Project**

The Orangi Pilot Project (OPP) was launched in 1980 by Akhtar Hameed Khan, a social scientist, to offer the 1.2 million inhabitants of the largest informal settlement in Karachi, Pakistan, more opportunities to improve their own living conditions – recognizing that neither the Government nor non-governmental organizations alone had the capacity to solve problems on the scale required, but that more progress could be made by taking advantage of the resources and knowledge of communities.

After extensive consultation, house owners in Orangi expressed their willingness to assume responsibility for the construction and maintenance of a community sanitation system that could be linked with the government-provided trunk sewers and treatment plants. They organized themselves in lanes of 20-40 houses – groups small enough to build mutual trust but large enough to introduce economies of scale – and paid for and constructed an efficient and effective system of sewerage for 90,000 families. Among other things this has contributed to a significant reduction in disease and a decline in infant mortality.

OPP has since evolved into an internationally known community development movement and has expanded into health and family planning, building technology, education, and credit and income generation. The model has also been adapted in other settlements in Karachi and elsewhere in Pakistan and it has influenced development approaches internationally. OPP has clearly demonstrated how Governments and communities can work well together by dividing their responsibilities, the Government taking on the more technically complex large-scale construction of main drains and treatment plants that are essentially public goods, while local communities and households invest in the infrastructure close by that benefits them directly.

Critics have argued that this model provides Governments with an excuse for not providing services. OPP responds that communities should only be asked to do the “internal” development, while the “external” work should be done by the Government. This requires, however, that the Government be prepared to recognize work done by community organizations in extralegal settlements.

## **Overcoming access barriers**

As well as taking a more flexible approach to service provision Governments can also attempt to address some of the barriers that deny the poor access to services – trying to reduce financial and legal barriers while also adapting services to make them more accessible to poor users.

## *Removing economic barriers*

Many people do not get services simply because they cannot pay or because the opportunity costs of using services are just too high. This not only denies the rights of individuals to services but also damages the prospects of the country as a whole – since future progress in human development depends on a healthy and well-

educated population. Most Governments accept this and agree that everyone should have access to primary education, basic health care (for example Thailand, box II.3) and adequate water and sanitation. They would also agree that costs to households should not be a barrier – since education, for example, brings benefits to the

country as a whole. ILO has, for example, calculated that over a 20-year period the economic benefits to Nepal of 100 per cent school enrolment would be double the costs of lost child labour wages (Gilligan, 2003). Nevertheless, countries find it difficult to work out the best arrangement for achieving universal access.

### Box II.3. Thailand's 30 baht health scheme

Thailand has become one of the first middle-income developing countries to introduce a universal health-care system. Previously it had six health insurance schemes that covered around 80 per cent of the population, but these tended to overlap and were not very equitable. In 2001, however, Thailand introduced a new scheme to provide all citizens with equal access to health care and protect them from financial losses due to illnesses. This also marked a shift of funding from large urban hospitals to primary health care.

Users pay only 30 baht (75 cents) per visit, though the poor pay nothing at all. The benefit package includes inpatient and outpatient treatment at a registered primary care facility and referral to secondary and tertiary care facilities, as well as dental care, health promotion and prevention services, ambulance fees and drug prescriptions. By 2004, 47 million people were getting health security from the 30 baht scheme and 13 million from other schemes – meaning that 99 per cent of the Thai population are now covered.

The scheme has proved very successful and user satisfaction is high. The main difficulty is long-term financial sustainability. Some hospitals have incurred large debts because, among other things, the number of people covered has increased much faster than the budget allocation. To reduce the financial burden and staff shortages, particularly in the rural areas, the Government has, however, started to provide additional funding to cover 21 per cent of the salaries of health workers in public health facilities.

*Free services* – The simplest option would be to supply all such services free. This may, however, result in considerable wastage – of water, for example. Moreover, even the poor may actually prefer to make some payment so as not to appear second-class citizens – especially if this entitles them to superior and timelier service. Nevertheless some services are generally free: for example, most countries do not charge formal fees for primary education.

*General subsidies* – In this case the charges are reduced for all users of the service. The charges still have to be at a significant level, since collecting small sums may cost more than the revenue. But even where charges are at a more viable level a subsidy across the board can be inefficient since it covers the whole population, poor and non-poor – and in most countries in the region the poor are actually in a minority.

*Variable subsidies* – This involves a variable tariff that increases with the number of units used, on the assumption that the poor will be low-volume users. This “increasing block tariff” has, for example, been used for water supplies in Bangalore, India, and in Kathmandu, Nepal; it helps at least some of the poor who have taps in their homes though in fact those who gain most are the non-poor (ADB, 2004c).

*Targeted subsidies* – This can be done, for example, by issuing cards or vouchers to the poor to entitle them to free or reduced services. However, it is difficult to identify the target group accurately, particularly the poorest of the poor, who may be “invisible” and difficult to reach. This is the approach typically taken with food subsidies, though the targeting is not generally very precise since vouchers and cards also finish up in the hands of the non-poor and often do not reach the poor at all. One study of the food distribution system in India, for example, found that they covered between 34 per cent and 52 per cent of the non-poor and excluded between 24 per cent and 98 per cent of the poor (World Bank, 2003).

*Self-targeting* – This involves providing a service that only the poor are likely to use. For food distribution, for example, this can be achieved by subsidizing the type of food the poorest are most likely to eat – such as the lower grades of rice. In the case of urban water supplies, one way of targeting is to make water free only from public tap-stands.

*Community-based insurance* – Wealthier patients can often buy insurance policies to meet unexpected health bills. For community health schemes, for example, this works rather like standard health insurance, except that the

schemes are small, affordable and community-managed. They have been introduced by the Grameen Bank in Bangladesh and by the NGO, SEWA, in India, as well as in Cambodia, India and Viet Nam. These provide some coverage but they can be expensive to run, suffer from poor management and also offer a small risk pool so a general epidemic in that community would soon exhaust the funds. Some of these disadvantages could, however, be overcome by networking the schemes or by linking them to formal systems.

As well as reducing the direct costs of services in these ways, Governments can also attempt to reduce the opportunity costs of services – particularly the time taken to reach them. The most direct way of doing this is by extending the network to bring services closer to communities. But it is also possible to consider mobile services, such as satellite or outreach clinics that might reach distant villages once a month. Alternatively, Governments can consider investing in better-integrated and more affordable transport networks.

Government can also address the opportunity cost of sending children to school. One option is to provide free school meals as an incentive for attendance. In India, for example, the National Mid-day Meal Programme has improved nutrition and the learning achievements of school-going children and, more importantly, their enrolment and attendance in schools (Government of India, 2002). Bangladesh has gone further with a Food for Education Programme that gives a monthly food ration to families who send their children to school; the families can either consume the food or sell it for cash. This too has been shown to boost attendance, especially by girls (Ahmed and del Ninno, 2002).

#### *Removing legal barriers*

Many poor people cannot get access because they lack the official identity papers that entitle them to health or education services. This is often the case for rural-urban migrants or for unauthorized migrants from other countries. Thailand, which is thought to have at least 1 million migrants from Myanmar and elsewhere, has addressed this through a Migrant Health Project working with NGOs and the International Organization for Migration to offer accessible and culturally sensitive health services, including treatment for TB and HIV/AIDS (IOM, 2001).

A number of countries have also engaged in birth registration drives. India, for example, has a well-established national registration campaign operating in 15 languages across almost every medium from TV spots to posters, to stickers, to billboards. The Philippines too conducts a mass campaign every February – designated “civil registration month” (UNICEF, 2002).

People in urban slum areas also have problems getting official connections to water or electricity supplies. If they cannot demonstrate ownership of a property then neither public nor private utility companies will contemplate connecting them. One option is to integrate extralegal agreements into a single formal system. However, this needs to be done carefully if it is not to undermine the existing system; as arrangements become more formal so the value of property rises and could be pushed beyond the reach of many people. Instead the aim should be to build bridges between the legal and extralegal systems, so as to draw on the benefits of both.

A useful starting point is to review the regulations on service provision to identify those elements – whether laws, regulations, standards or procedures – that tend to exclude the poor (Payne and Majale, 2004). This type of “regulatory audit” would identify the institutions involved and assess what it would cost for the poor to meet the regulatory requirements. The auditors could present their findings to all stakeholders and decision makers to explore the possibilities for adjusting the regulatory framework to the realities on the ground.

Another alternative is to work in a more flexible way when delivering services – so as to maximize the benefits for the society as a whole. Thailand, for example, has taken this approach when confronted with the HIV/AIDS epidemic. Prostitution is illegal in Thailand; nevertheless, the Government, accepting that one of the main routes of transmission was through commercial sex, ran a high-profile campaign to get sex workers and their clients to use condoms. Similarly, in Bangladesh, the NGO, CARE, while not condoning illegal behaviour has recruited injecting drug users to educate others about the dangers of HIV/AIDS (box II.4).

#### *Making services more appropriate*

Another way of connecting people better with services is to make them as appropriate as possible to local needs. While it is useful to set national standards to guarantee quality these will be counterproductive if they actually discourage people from using services. This can happen in education systems, for example, when timetables and curricula that have been set centrally do not meet local circumstances. A better approach is to mandate only some core standards and parameters while giving local schools the flexibility to adapt other lessons to local needs.

It is also important to teach children as far as possible in the language that they use at home, so it is often better to recruit local teachers who are familiar with the language and customs – and who will be more acceptable and accountable to the local community. As many teachers as possible should also be women since this will make it easier for girls to attend school.

### Box II.4. Drug users as outreach workers

The NGO, CARE Bangladesh, has demonstrated the value of employing drug users to contact other drug users to transmit important health messages. CARE identified 42 locations in Dhaka that were being used for selling and injecting drugs. Then it trained 12 of the active injecting drug users to serve as outreach workers – providing other users with information on HIV/AIDS and sexually transmitted diseases while also distributing condoms and clean syringes. The NGO stipulated, however, that the workers followed strict rules: don't inject while working; don't carry drugs while working; and don't get involved in criminal activities.

By June 1999, the project had reached some 2,000 injecting drug users per day and subsequently grew to include 11 drop-in centres and 50 peer outreach workers. It also trained 160 volunteers as peer educators as well as 20 medicine-shop sellers. After the Dhaka experience, CARE Bangladesh launched similar programmes in Rajshahi, Chapai Nawabganj and Char Narendrar.

Parents will also be more likely to send their children to school if they are being taught skills that will be useful in their daily lives – if, as well as acquiring basic literacy and numeracy, children are learning about the local environment, for example, or issues related to health, hygiene and sanitation.

Teachers and parents can also consult on the most appropriate school timetables and vacation periods which could take into account demands on children's time for fetching water in the morning, perhaps, or for selling goods on the weekly market day.

They can also discuss how to make the school a safer environment for girls, with adequate fencing and security and separate toilet facilities.

As well as making government schools more appropriate it is also possible to improve standards in other traditional forms of education as in Islamic madrasas or Buddhist temple or monastery schools. Koranic schools in Uttar Pradesh in India, for example, have introduced a literacy component.

In addition, children and young adults who have missed out on primary education should have the option of attending non-formal schools whether run by the Government or NGOs. Mostly these concentrate on functional literacy and numeracy. Non-formal education should, however, always be considered as complementary to formal primary education, rather than as a replacement for it, and children who enrol in NFE classes should then be able to move to formal education when the opportunity arises.

Health systems too can be better adapted to local needs if local people, and particularly women, are closely involved – helping to identify the health requirements, influence the range of services that are provided and take responsibility for management. Thailand and many other countries in the region train village health volunteers to provide both preventive and simple curative services.

Local medical services can also make use of paramedics. In India, the Small Scale Rural Surgical Clinics in West Bengal are usually run by a single experienced doctor who builds up a local team of paramedics (Government of India, 2002). In Bangladesh the NGO Gonoshasthaya Kendra, or People's Health Centre, has trained young unmarried women as agents of change within their own communities; they can speak to rural women directly and address their specific needs.

Employing non-professionals does bring some risks, so workers will need to be closely monitored and evaluated to ensure that they give high-quality care. To ensure that they keep working, it is also important to make the non-professionals know they are valued. They should therefore also be offered suitable salaries and good working conditions along with opportunities for career development (UNFPA, 2005).

### Empowering users

The most effective way to ensure that local services are appropriate and effective is to empower the users. But local involvement should not be seen as a way for central Government to reduce costs or to disregard its responsibility to ensure access to services for all. Rather the aim should be to develop the capacity of communities to establish their own priorities, make their own plans and then claim their entitlements from the Government.

Empowerment involves the acquisition of new capacities, the establishment of new institutions, the promotion of new ways of working within existing organizations and the provision of new rules for inter-organizational relationships. It requires changes in values and norms regarding respect and the distribution of power between social groups, so that none is marginalized and loses the right to be heard.

NGOs have often served as catalysts in this process – adopting a rights-based approach as “claim-making” organizations for the poor, arguing for better access to

services and generally for a more inclusive style of development. They can also help to organize the poor to carry out small-scale self-help projects that can help to overcome psychological barriers and build self-confidence. But this should only be a transitional phase. Eventually communities have to link all their initiatives with government policies and large-scale programmes from which they can draw financial resources and technical assistance.

Community involvement should also extend to implementation. When there are public works to be carried out, such as the building of new schools, communities should be able to adopt their own approach. They should, for example, be able to choose the contrac-

tors. This not only guarantees a better result but also generates a sense of pride and ownership. The same should apply to the running of services. As far as possible, schools for example, should be under the control of the local community, through parent-teacher associations and other groups that can work in cooperation with teachers and also hold them to account.

All this will only be possible, however, if communities have the capacity for this degree of supervision and monitoring – to be able to talk on an equal footing with teachers, for example, or medical staff (box II.5). They should therefore be able to benefit from education and other capacity-building programmes.

### Box II.5. Involving temples and mosques in health care

For its health-care programme in Kirivong district of Cambodia an NGO has established a network that includes 91 temples and five mosques. Each health centre 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, which consists of two HCMC members, a monk and a nun at temples or the imam and two mosque volunteers.

The system promotes sound management, accountability and community ownership and facilitates communication between the community and the health centre. In consultation with village chiefs, the HCMC coordinates an equity fund, managed by the temple or mosque and financed by community contributions, to exempt the poorest from user fees. The health action group encourages better utilization of preventive health-care services, leads peer group discussions and supplements their income by social marketing of home-birth kits and oral rehydration solutions (Jacobs, 2002).

One way of monitoring services is through customer surveys. Some Indian cities have experimented, for example, with sample surveys whose results can then be presented in the form of a “report card”, not just to the service providers but also

to the press, NGOs and other interest groups (Paul, 1998). The aim is to increase public awareness about the performance of providers while also challenging them to be more efficient and responsive (box II.6).

### Box II.6. Holding Indian contractors to account

Parivartan is a Delhi-based citizens’ movement that aims to promote just, transparent and accountable governance through social audits. Its website opens 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.”

Parivartan takes advantage of India’s freedom of information laws to gather data on public works. In 2002, for example, it collected copies of all the civil works done by the Municipal Corporation of Delhi in the areas of Sundernagari and New Seemapuri and asked local people what had actually happened – discovering that much of the work was incomplete or of low quality. Then it organized a public hearing (*jansunwai*) attended by over 1,000 local residents along with journalists and eminent personalities. Contracts were read out and residents testified on the results. The audit found, for instance, that although 29 handpumps with electric motors were supposed to have been installed, in fact only 14 handpumps – and no electric motors – had actually been installed.

Since then local people have insisted on monitoring construction work and in a number of cases have had it stopped because of low quality or the use of substandard materials. The Delhi Government and the Municipal Corporation have also passed orders that all contracts must now be made public before the work is carried out.

Users also need more information generally about government performance in order to hold it accountable. Efforts to assess progress towards the MDGs have highlighted the need for good data – for Governments to be able to plan their work and for the public to be able to hold them to account. It is particularly important that data be disaggregated by sex, region, income and ethnic group in order to be able to judge the impact of policies and investments on different population groups.

## Decentralization and local governance

Ultimately, all services are delivered locally so should work best if they are under democratic local control. One way of achieving this is to decentralize authority to the lowest level possible. Many Governments in the region have been carrying out programmes of decentralization. One of the most sudden and dramatic was in 2001, when Indonesia reassigned 2.2 million central civil servants to the districts and municipalities, which then took over responsibility for over 16,000 service facilities (UNDP, 2004). Here, as elsewhere the results have been mixed. As with public-private partnerships, many Governments have decentralized without establishing the necessary institutions and regulatory frameworks.

Broadly, there are three overlapping types of decentralization (Mehrotra, 2005). The first, and weakest, form is *administrative* decentralization when the Government transfers responsibility for carrying out centrally directed policies to local bodies that may simply be the local representatives of sectoral ministries. The second is *political* decentralization where those who are in charge are elected locally rather than being appointed by the centre; even so they may not have very much say over how services are delivered and may still have to follow central mandates. The third, and strongest, form is *fiscal* decentralization where an elected local body also can collect local taxes and set its own budget, which could also include freedom in the use of block grants received from the centre. In practice many programmes have not moved much further than administrative decentralization, leaving local bodies relatively little freedom to develop services in the way they see fit. Governments have a number of reservations about full decentralization:

*Exacerbating inequalities* – A centralized system allows the Government to redistribute national income so that some regions effectively subsidize others. To avoid this, a decentralized system needs a consistent way of equalizing expenditures. Viet Nam, for example, has a system of interprovincial transfers though these still need to be further refined and targeted to those in greatest need in the most isolated parts of the country (Government of Viet Nam, 2002).

*Lack of capacity* – A second concern about decentralization is that locally elected politicians or administrators may not have the skills to manage what could be quite large sums of money or the skills to supervise the work of employees in different sectors. Most decentralization programmes recognize this and include an element of capacity-building. Capacity-building is also needed higher up the system – to train people at the centre how to devolve power effectively.

*Irresponsibility* – A third concern is that local leaders may act irresponsibly – overspending while under-taxing or using funds to construct impressive buildings or infrastructure rather than for the less visible but more valuable development of services. Countering such tendencies again means ensuring an open and transparent system that empowers users, particularly women. A study of women representatives in Bangladesh, Nepal and Pakistan, for example, has shown that they have effectively mobilized resources for employment, health, sanitation, small roads and educational opportunities (ADB, 2004b).

*Corruption* – Finally there is the risk that local governments may be captured by local elites or that funds will disappear through corruption. This is true even at the lowest levels. The poor are no more or less altruistic than the non-poor.

Decentralization can thus improve delivery of services to the poor. But there is no guarantee. To ensure that it works in favour of the poor, decentralization has to be a balanced process. It needs to be accompanied by extensive capacity-building for both the local government and citizens. And it must take into account subnational inequalities in capacity and resources.

Especially important is the quality of governance at both the national and local levels. For service delivery this will also mean ensuring that a higher proportion of women are elected to what are often male-dominated assemblies.

Decentralization therefore needs to be accompanied by a realistic assessment of community dynamics and motives and an effective process of capacity-building, not just for local officials but also the communities themselves, and particularly their women members, so that they are sufficiently empowered to hold local officials to account.

## Conclusion: an adaptive approach

Conceptually at least, the simplest approach is to set national standards and then extend the corresponding government services across the country until everyone is covered. The poor, however, are not a homogeneous

group and in many countries the demands of economic efficiency would entail reaching the poor last of all. Instead, Governments should consider an adaptive approach. This will require a series of institutional changes to make essential services available everywhere while also being more flexible and responsive.

1. *Broaden the range of providers* – Governments have the responsibility to ensure that everyone has access to basic services, but they may not be the most appropriate providers. Instead, Governments should identify their own strengths and weaknesses, along with those of other providers, private and non-governmental, and plan for a combination of service deliverers. In addition to providing, Governments should also concentrate more on facilitating.

2. *Establish standards* – Governments should establish key national standards along with consultations through which service provision can be adapted to local conditions so as to provide everyone with coverage that both the provider and the user can afford without compromising quality. In the case of education, for example, this might involve incomplete schools that have one or two teachers covering a range of classes – or even a system of distance learning. However, this should not be seen as a cheap or easy option that would offer a poor service. In fact under these circumstances ministries of education would need to give extra training to teachers, who have to be highly skilled to be able to cope with multiple grades in the same classroom; they would also need to pay them more if they were working in remote communities far from home. Similarly, in health services, some rural communities would receive their first line of services from outreach clinics or paramedics who would also need commensurate training and support.

3. *Plan linkages and upgrades* – The different levels of services should always be interlinked. Thus children who are receiving non-formal education should have the opportunity to transfer to formal schools through a system of equivalency in examinations. Correspondingly, within the health services, women giving birth at home should nevertheless have access to systems of emergency obstetric care. These incremental ap-

proaches should also be set within a longer-term strategy: of replacing incomplete community schools with full primary schools; of replacing paramedics with fully trained health workers; and of replacing rural tap stands with regular piped water supplies.

4. *Devise relevant regulations* – The regulatory framework should always ensure public health and safety and be enforced and applied consistently. But it should also be relevant and realistic and sufficiently dynamic to adapt to ever-changing realities on the ground. Thus, Governments should not demand of private providers standards so high as to stifle the emergence, say, of private kindergartens or primary schools for poor children. Inevitably, as with drug abuse and sex work, for example, there will also be cases where policy objectives in one area conflict with regulations in another. This will require clear vision and decisive leadership to determine how the public interest might best be served.

5. *Keep learning* – Governments which want to ensure the best-possible service provision need to become dynamic learning institutions, constantly gathering the necessary data and experience, and disseminating and using it at all levels – local, national and international.

6. *Empower users* – The most important step, however, is to empower users to hold Governments and service providers to account. This will mean making systems and planning for service provision much more open and transparent – disclosing details of contracts for service provision, for example, and publishing statistics on coverage and quality. It will also mean devolving decision-making on services to lower levels of government that are more accessible to users – while also creating appropriate channels for public consultation and involvement.

As this chapter has illustrated, many of the obstacles to effective service delivery are not financial but institutional. Resources are vital and, as people's needs and aspirations change, public services will always be able to absorb more funds than are immediately available. But just as important is to improve the coverage and quality of services by opening them up to fresh options, attitudes and ideas.