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EQUITY

Engage and Empower the Poor

Poverty is a multidimensional concept that has evolved over time.[1] Traditional measures of poverty have relied on quantitative measures (e.g., income level, assets, calorie intake, and educational attainment). While important, quantitative measures do not fully capture the impact of poverty on the lives of the poor. Increasingly, definitions recognize that poverty also results in isolation, voicelessness, and vulnerability. To combat this, the first component of the EQUITY Framework[2] is to engage and empower the poor.

E - engage the poor
Q - quantify inequalities
U - understand barriers
I - integrate equity goals
T - target resources and efforts
Y - yield public-private partnerships

The poor and underserved groups must be engaged in each component of the framework (see box). Doing so is beneficial for programs and for people. Studies have attributed persistent poverty, in part, to a failure to effectively involve the poor in the programs intended to reach them. The poor are best able to speak to the challenges they face and provide insights to design appropriate responses. Engagement of the poor promotes dialogue with policymakers and encourages transparency, accountability, and shared ownership of initiatives.

International commitments and best practices—from the 1994 International Conference on Population and Development to the Greater Involvement of People Living with HIV (GIPA) Principle (first articulated in 1983 in Denver)—reaffirm the importance of engaging people in the programs and decisions that affect their lives and health. Engagement in itself is empowering for the poor and marginalized and can help build capacity and reduce isolation. Through engagement in the policy process, the poor and other vulnerable groups become aware of their rights and learn and apply new skills. They also gain confidence in interacting with persons of authority (e.g., policymakers, healthcare providers, law enforcement), are valued for their opinions, and are able to demand high-quality health services.

This brief presents examples of how the USAID | Health Policy Initiative, Task Order 1, has helped to engage the poor and other vulnerable, most-at-risk populations (MARPs) at each phase of the policy process to foster dialogue on improving access to high-quality health services for underserved groups.

The Policy Process: Opportunities for Engagement

Reaching the poor to involve them in policy processes requires time, effort, commitment, and resources. Efforts to engage the poor must have a clear objective and be informed by data that identify the poor and vulnerable groups, provide an overview on socio-economic characteristics, and shed light on barriers that prevent equitable access to services. The aim is to work with the poor in problem identification and throughout the process to identify challenges and potential solutions that are responsive to their needs. Building on this foundation, there are various opportunities to reach out to the poor and engage them in the policy process. Many steps of the policy process can be designed to be more participatory and inclusive. The Health Policy Initiative has outlined

illustrative strategies for bringing the poor into different stages of the policy process, including problem identification, policy formulation, policy implementation, and policy monitoring (see figure).

Engaging the Poor Throughout the Policy Process

Stage 1. Problem Identification

The policy process begins with information and data gathering during the problem identification stage (for examples, see the EQUITY series briefs on quantifying inequalities and understanding barriers). Key activities are collecting information on in-country definitions of poverty, poverty rates and trends, social and economic characteristics of the poor and other underserved groups, and inequalities in service access. It is also essential to determine underlying factors that contribute to poverty and barriers to equitable health services. Insights can be gained from direct testimonies from the poor and vulnerable groups through focus group discussions (FGDs), client interviews, community scorecards, and other mechanisms.

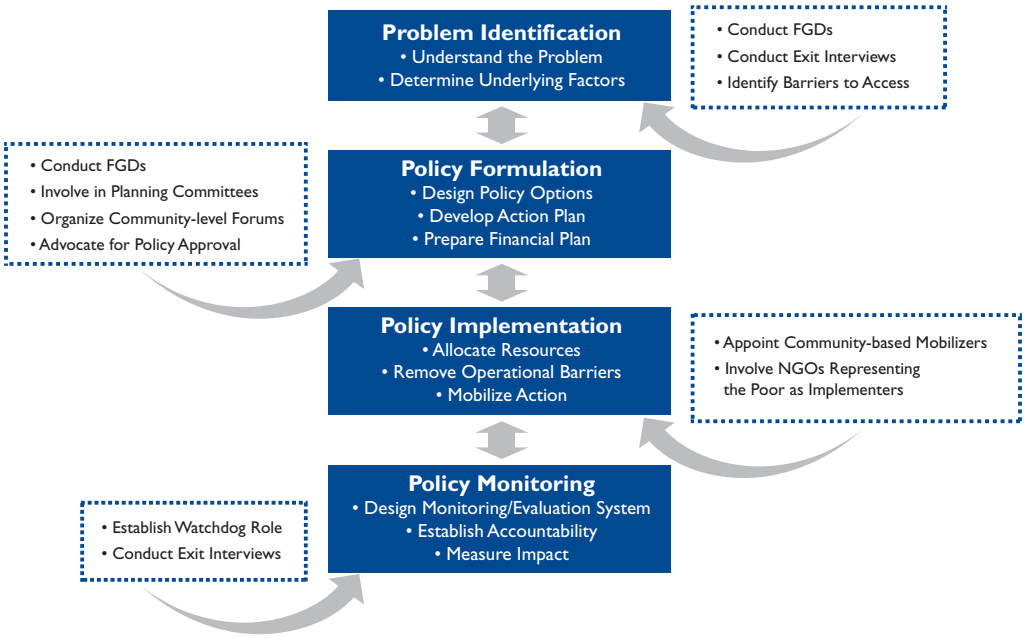
Indigenous Women Speak Out on Barriers to Family Planning in Guatemala. Through FGDs organized by the Health Policy Initiative, indigenous women described barriers to use of family planning/reproductive health (FP/RH) services, including provider bias; unsuitable conditions in clinics; lack of FP counseling and information materials in local languages; inadequate knowledge of FP/RH among community-based providers; and negative community attitudes about family planning. In response, the Health Policy Initiative worked with the Departmental Office of Health in Quiché to design guidelines on locally appropriate service delivery practices. Guatemala's Ministry of Public Health and Social Welfare recognized the importance of addressing barriers to FP/RH and decided to use the methodology of this activity in other districts. Recommendations from this work were also incorporated into the National Family Planning Strategic Plan (2007).[3]

Stage 2. Policy Formulation

Engaging the poor and other vulnerable groups in policy formulation helps to ensure that proposed strategies are responsive to their needs. These groups can play a role by advocating for increased attention to specific health issues and policy actions. They can also be engaged in the design of policies and action plans—for example, by participating in public policy dialogue, providing testimonies to policy drafting committees, and reviewing draft policies and legislation.

Community Dialogue Informs Kenya's National Reproductive Health Strategy. The Health Policy Initiative assisted in-country stakeholders to engage the poor in the formulation of Kenya's new *National Reproductive Health Strategy*. As part of the process, the project conducted FGDs with poor women and men in Nyanza Province to assess barriers to FP/RH service use. Next, findings were disseminated through meetings at the provincial level (Nyanza and Coast Provinces)

FIGURE: ENGAGING THE POOR IN POLICY FORMULATION AND IMPLEMENTATION



and community level (Kisumu, Siaya, and Homa Bay in Nyanza) to gather reactions from local health authorities, program implementers, service providers, and poor communities. During these sessions, the poor interacted with service providers and decisionmakers to discuss the challenges they face in accessing FP/RH services and pose potential solutions. The government then convened a national policy dialogue session, which brought feedback from community and provincial deliberations to national decisionmakers. Informed by this feedback and additional analyses, the *National Reproductive Health Strategy* includes clear, time-bound equity indicators and specific strategies to target resources and efforts to the poor.[4]

Stage 3. Policy Implementation

At the policy implementation stage, the poor and other vulnerable groups need not be limited to being beneficiaries of services. They can also be engaged to help put policies into practice. One approach is to train members of poor and marginalized communities as outreach workers and volunteers to provide awareness raising, counseling, referrals, and, where appropriate, services to their peers. The poor can also facilitate implementation by being engaged as experts in identifying barriers to effective service delivery.

People Living with HIV Raise Awareness of Legal Rights in Vietnam. HIV has been highly stigmatized in Vietnam—with marginalized groups and MARPs, such as injecting drug users and sex workers, being associated with laws to control so-called "social evils." In 2007, Vietnam adopted the *Law on Prevention and Control of HIV/AIDS*. The Health Policy Initiative provided assistance to develop the law and implementation guidelines. The law is based on international best practices; introduces a human-rights based approach to HIV; and involved people living with HIV (PLHIV), including MARPs, to review the draft legislation.

A key step in implementing the law is ensuring that PLHIV and MARPs are aware of their rights and have the means to redress grievances. In response, the Health Policy Initiative and in-country partners launched five HIV legal clinics and a national HIV hotline.[5] HIV-positive people serve on the clinics' advisory boards and as peer counselors in the clinics and hotline (which provides them a source of income). They play an active role in ensuring that fellow PLHIV can take advantage of the law by providing counseling (along with lawyers) to people who visit the clinics and by assisting in legal outreach and community awareness-raising activities through PLHIV support groups.

Stage 4. Policy Monitoring

Equity in health services is not possible without mechanisms to ensure accountability. The poor and vulnerable groups must have a voice in determining whether initiatives are benefiting them and operating smoothly. For example, the poor can be engaged through citizens monitoring, community scorecards, client exit interviews, or civil society "watchdog" groups and local health oversight committees. Their involvement is essential for providing first-hand accounts, from the perspective of beneficiaries, of implementation issues on the ground.

White Ribbon Alliance (WRA) Uses "Social Watch" Approaches to Promote Maternal Health in India. The global WRA for Safe Motherhood is an implementing partner of the Health Policy Initiative and works to build capacity of national- and state-level WRAs around the world. A key approach of the WRAs is "social watch," a people-centered strategy that mobilizes civil society to hold governments accountable for their commitments.[6] For example, WRA-Orissa in India conducted "verbal autopsies" of maternal deaths in 12 districts. This methodology gathers feedback from families, community members, and health workers to determine causes of maternal deaths and provide lessons learned for the future.

In addition, WRA-Orissa has organized more than 25 public hearings to provide women a chance to interact with government and health officials. Each hearing has been attended by between 500–1,300 women—resulting in more than 30,000 women, mainly from rural and underserved areas, participating in the meetings. Through this engagement, women have learned about their rights and shared their grievances directly with government authorities.

Government representatives have been responsive to the concerns raised. For example, the Chief Minister of Orissa declared that women's self-help groups would be involved in monitoring maternal health services, including identifying healthcare providers who take bribes. In Koraput District, authorities issued a directive calling for health facilities to remain open and staffed 24 hours a day. The Chief Medical Officer for Orissa also pledged to track and share data on maternal and child health services at monthly meetings.

Photo credit: WRA-Orissa

Concluding Thoughts

Engaging the poor and other vulnerable populations in policy and program design and implementation encourages local ownership and involvement for greater sustainability over time. To engage the poor, national-level decisionmakers can[7]

- Examine the situation of the poor and marginalized groups to meet their needs more effectively;
- Involve the poor and organizations representing their interests to set policy priorities and directions;
- Persuade program planners and implementers to engage beneficiaries in programming;
- Encourage local leaders to reach out to the poor and take action to address their challenges; and
- Integrate health issues into poverty reduction and national development planning efforts.

Similarly, program planners and managers can

- Engage the poor in policy formulation and program planning, implementation, and monitoring;
- Specify and monitor the adequacy of the poor's participation in development programs;
- Document and share examples of successful engagement of the poor and vulnerable groups; and
- Ensure that local poverty reduction programs integrate health issues and services.

Civil society organizations that represent the poor and vulnerable groups can

- Advocate for open policy processes with engagement of the poor and marginalized;
- Set up systems to obtain feedback from the poor;
- Build capacity of the poor to engage in advocacy campaigns and policy monitoring;
- Collect information on inequities in access to health services by underserved groups; and
- Provide information on sources of FP/RH, HIV, and maternal health information and services.

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ENDNOTES

[1] Zosa-Feranil, I., C.P. Green, and L. Cucuzza. 2009. *Engaging the Poor on Family Planning as a Poverty Reduction Strategy*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

[2] Health Policy Initiative, Task Order 1. 2010. "EQUITY Framework for Health." Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

[3] Netzer, Sara, and Liz Mallas. 2008. *Increasing Access to Family Planning among Indigenous Groups in Guatemala*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

[4] Health Policy Initiative, Task Order 1. 2010. *The EQUITY Framework: Influencing Policy and Financing Reforms to Increase Family Planning Access for the Poor in Kenya*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

[5] Health Policy Initiative, Task Order 1. 2009. "Making Policies Work for People: HIV Legal Clinics and Hotline in Vietnam Ensure that PLHIV Know and Exercise Their Rights." Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

[6] White Ribbon Alliance. 2010. "Promoting Accountability for Safe Motherhood: The WRA's Social Watch Approach for Mobilizing Civil Society to Hold Government Accountable." Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

[7] For more on these recommendations, see Zosa-Feranil, et al., 2009.