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EQUITY

Target Resources and Efforts to the Poor

Experience has shown that health interventions will not reach the neediest groups without appropriate planning and oversight.[1] Moreover, poor, vulnerable, and other most-at-risk populations may find it more difficult to access services due to myriad reasons, including lack of sufficient knowledge about health services, lack of capacity to take advantage of services offered, sociocultural or geographic barriers to access, healthcare provider bias, and high costs and fees. Therefore, the EQUITY Framework[2] highlights the need to target resources and efforts to the poor. "Targeting" is a mechanism that directs scarce resources to those most in need in a planned manner to achieve greater equity.[3]

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

In many developing countries, effective programs and interventions have successfully reduced some barriers and have improved access to healthcare services among the poor by directing a greater share of resources and benefits to vulnerable populations, such as through pro-poor financing schemes (see box). Some programs emphasize bringing health providers and facilities closer to poorer communities, for example, by establishing more facilities in rural areas, mobilizing community-based health workers, or employing mobile health vans. As described in the EQUITY brief on yielding public-private partnerships (PPPs),[4] such partnerships are a key component of targeting efforts to the poor. PPPs can help ensure that the public sector and/or subsidized nongovernmental organization (NGO), faith-based, and private sector services cater to the needs of the poor, while clients who can afford to pay for health services use the commercial sector.

No single approach can completely address the issues of low access and limited use of healthcare services by the poor. As illustrative examples, this brief presents experiences from Jharkhand, India, and Guatemala that show how well-targeted policies and interventions are improving access to reproductive, maternal, and child health services among the poorest groups.

Pro-poor Financing Mechanisms

Pro-poor financing mechanisms promote fairness in resource allocation and use. Examples include

- Designing equity-based formulae for resource allocation and applying gender budgeting approaches;
- Promoting transparency and involving underserved groups in national and local planning/budgeting forums;
- Designing and assessing the impact of alternative resource allocation scenarios by geographic area, target population, and disease burden;
- Developing appropriate strategies, such as public-private partnerships to reach the poor; and
- Implementing pro-poor financing schemes such as vouchers, conditional cash transfers, fee exemptions, and social insurance.

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Targeting Strategies for Equitable Access to Family Planning in Jharkhand, India

Improving the health of the population in India requires addressing the family planning (FP) and reproductive health (RH) needs of the urban and rural poor. The state of Jharkhand has one of the highest levels of poverty in the country. The state has lacked systematic, targeted efforts to improve basic healthcare for the poor, including efforts to address FP and RH needs. Although the poor continue to face obstacles accessing health services, evidence shows that it is possible to reach the poor with health services in a wide range of settings—by achieving higher coverage among the poor than among the better off or reducing disparities in coverage between the poor and the better off.[5] The emergence of successful strategies to reach the poor with FP services provides potential models for adaptation to the needs of the urban, rural, and tribal poor in Jharkhand.

From July 2009–August 2010, the USAID | Health Policy Initiative, Task Order 1, assisted the state of Jharkhand to develop an FP strategy that fully incorporates strategic program interventions to address the FP needs of the poor.[6] The program of activities consisted of three components: (1) analysis based on quantitative and qualitative research to better understand the FP situation of the poor in the state; (2) dialogue with state policymakers and key stakeholders on findings and implications for policy and program development; and (3) development and finalization of the Family Planning Strategy Paper for Jharkhand. The EQUITY Framework provided stakeholders with a practical, step-by-step process for ensuring that voices of the poor are actively engaged in policymaking and that pro-poor strategies are incorporated into policy design.

As a result of these activities, on August 17, 2010, the state of Jharkhand adopted an official family planning strategy for 2010–2020. This FP strategy is based on evidence from research that clearly pinpoints fertility, mortality, and contraceptive use by population sub-groups, and differentiates the data on usage between rural and urban areas. In a bold move forward, the FP strategy for Jharkhand takes the *Population and Reproductive and Child Health Policy* and specifies how the FP strategy will contribute to achieving overall policy objectives.

The new FP strategy is innovative in its targeted approach to prioritization and attention to underserved populations.

- ***First, specific overall objectives target achievements for the poor*** for increasing the modern contraceptive prevalence rate (CPR) and reducing unmet need for spacing and limiting methods by areas (rural or urban), by vulnerable sub-groups (scheduled caste [SC] and scheduled tribe [ST] populations), and by the poorest segments of the state population (see table). Specific objectives are established for overall and annual increases, but it is the focus on the poor and vulnerable that denotes this strategy as a mechanism for serious attention to addressing inequalities in FP access and service delivery.
- ***Second, strategic program interventions specifically target the poor.*** Strategies include reaching out to marginalized communities through identification and mapping of urban slums and poor populations, identifying public-private partnership mechanisms to reach urban slum populations, creating mobile medical units, deploying female link volunteers and registered medical practitioners, and identifying and training tribal women as auxiliary nurse midwives.

OBJECTIVES OF THE JHARKHAND FAMILY PLANNING STRATEGY:
INCREASES IN THE MODERN CPR AMONG ELIGIBLE COUPLES

	Current Status	Objectives (Projected)		
	2007-08*	2010	2015	2020
Overall	31.8	38.75	46.40	54.05
Average annual increase in CPR	0.4	1.53	1.53	1.53
Urban	49.9	66.3	68.6	69.2
Rural	27.8	42.0	49.8	52.7
SC/ST	21.8	35.5	45.8	50.3
Poor (lowest 40%)	23.95	38.6	47.7	52.4

*District-Level Household Survey (DLHS)–3, 2007-08

- ***Third, program interventions will start with the poor.*** The operational plan calls for the initial phase of the strategy implementation process to focus on low performing districts, selected on the basis of FP indicators for CPR and unmet need for family planning. Program resources and efforts will be targeted first to the districts most in need of attention to improve access for the poor.

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Targeting Efforts to Remove Barriers to FP/RH Service Access in Guatemala

In Guatemala, the Health Policy Initiative conducted research to identify the major barriers that limit access to FP/RH services among indigenous groups (of which, more than 70% live in poverty). The project then worked with in-country partners to design targeted operational guidelines to address the barriers.[7] The six major barriers to FP/RH services identified were (1) provider bias toward indigenous women; (2) unsuitable conditions in facilities providing FP services; (3) community beliefs regarding family planning; (4) restrictive social and familial environments; (5) lack of appropriate information, education, and communication materials; and (6) limited integration of community-based providers in the community.

To learn more about these barriers, please see the EQUITY brief on understanding barriers to access.[8]

When the findings were presented during stakeholder workshops at national and community levels, participants identified new service delivery practices that could improve access to services. These practices were then incorporated into operational guidelines that were pilot-tested in five districts in Quiché. These districts were targeted for intervention because of high maternal mortality ratios and low contraceptive prevalence.

Working with the Departmental Office of Health in Quiché, the Health Policy Initiative helped to develop a list of 10 locally-appropriate service delivery practices, such as providing services and information in the local language or through a qualified interpreter, orienting providers to local conditions, and making a private area available for FP consultations. Following collection of baseline information on the status of the 10 priority service practices, service providers were trained in the new guidelines and implementation was monitored in the five districts.

Within a month of the release of the new guidelines, four of the five districts had a system in place to ensure that a provider or translator was available to provide information in the indigenous language on FP/RH services and three districts had arranged for FP consultations in a private area, among other results. The Health Policy Initiative interviewed stakeholders to gauge feasibility and ease of implementation and interviewed program implementers to capture lessons learned and best practices.

The targeted approach resulted in a number of policy-related outcomes. The Ministry of Public Health and Social Welfare decided that understanding barriers to FP/RH was important and decided to use the conceptual framework and methodology of this activity in other districts to increase access to services. Recommendations from this work were incorporated into the development of the National Family Planning Strategic Plan. The pilot project improved coordination between major FP/RH service providers at policy and operational levels. Political commitment was demonstrated when the Director of the National Reproductive Health Program spoke of the need to remove barriers and improve equitable access to FP/RH for indigenous populations.

In developing a targeted program, health program managers should consider the following practices:

- ***Identify barriers:*** involve the targeted population in identifying barriers; interview users and non-users of services; use the local language in surveys; interview major service providers; include additional questions regarding FP users' perceptions of family planning; and ensure that focus group discussion leaders are respected by participants.
- ***Plan interventions:*** involve the targeted population in all aspects of the program design; include all stakeholders in implementation; involve community elders; develop

operational guidelines for FP services; work with community members to disseminate information and clarify myths; train all health center personnel on FP issues; and strengthen commitment of district health officials to family planning.

- ***Conduct advocacy:*** involve representative NGOs in advocacy; use a multisectoral approach; promote continuous advocacy, policy dialogue, data sharing, information gathering, and dissemination; and involve the right stakeholders to strengthen commitment to FP interventions.

Conclusion

It is important to analyze how poverty affects various aspects of development and society, namely who the poor are, where they live, what challenges or barriers they face, and what are the best strategies and policies to help alleviate these issues. Pro-poor strategies can be effective in reaching the poor and improving their access to health services. Targeting resources and services to the poor can be a useful strategy to reduce inequalities and promote greater equity in health. There are many different forms of targeting, such as targeting resources through pro-poor financing mechanisms, or targeting government subsidies or services to support high-quality services through community-based and outreach programs in hard-to-reach areas. For poor populations in urban areas, more options may be available, such as targeting government services to those who cannot afford to pay or providing vouchers to clients to use in the commercial private sector. Policy and program interventions that target the poor should be monitored to ensure that their objectives are achieved—that they contribute to improving the health of the poorest populations.

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ENDNOTES

[1] Gwatkin, D. R. 2004. "Are Free Government Health Services the Best Way to Reach the Poor?" *Health, Nutrition, and Population (HNP) Discussion Paper.* Washington, DC: World Bank.

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

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[5] Gwatkin, Davidson R., Adam Wagstaff, and Abdo S. Yazbeck. 2005 "What did the Reaching the Poor Studies Find?," pps. 47-61 in *Reaching the Poor with Health, Population, and Nutrition Services: What Works, What Doesn't and Why*, edited by Davidson R. Gwatkin, Adam Wagstaff, and Abdo S. Yazbeck. Washington, DC: World Bank.

[6] Saunders, M., H. Sethi, A.A. Jayachandran, and S. Sharma. 2010. *A Policy Response to Increase Access to Family Planning Services for the Poor in Jharkhand, India.* Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

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