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overview



“All the people we have given health cards to have come to the centre. Some people now come only because of the card. It’s important to focus more on the very poor as they need to become more aware of health issues. They get ill more as they eat bad food and eat in dirty places.”

*Shabana, Marie Stopes Volunteer,
Paris Road slum, Dhaka*

Marie Stopes Clinic Society’s participatory poverty project in Bangladesh identifies the very poorest in the community

Introduction

Indicators used to identify poverty levels and health needs in developing countries are frequently based on generalities such as national statistics, average income levels, assets indices and gross domestic product (GDP). The reality, however, can be very different. Poverty is multi-faceted and often cannot be assessed simply by how much an individual or family earns.

For international sexual and reproductive health (SRH) organisation Marie Stopes International, poverty and SRH are intrinsically linked. Poverty is not only a cause of poor SRH but also a consequence. In order to help break this destructive cycle, it is critical that the poorest are able to access affordable, quality SRH services.

For this to happen, the poor must first be identified. It cannot be presumed that an SRH centre in a slum area will automatically provide services for those who need them most. Even within a slum, there is still a poverty-based hierarchy and Marie Stopes International’s

Partner in Bangladesh, Marie Stopes Clinic Society (MSCS) wanted to ensure that the very poorest in each slum would be reached.

The tool that was developed for identifying poverty levels through this research is uniquely equitable. Local community members within the Dhaka slum research area were fully involved in the process and participated in identifying and developing their own poverty indicators. This enabled them to assess themselves and their neighbours in a genuinely fair and locally appropriate way.

Using this tool, MSCS is now able to accurately grade the poverty level of individual households and ensure that its services and information are targeted and accessible to the very poorest within the community. MSCS volunteers, known as Marie Stopes Volunteers (MSVs), who themselves come from these communities, are now able to focus their time on visiting the very poorest and ensuring that they are aware of their SRH rights and can access the free health services available.

Developing a participatory poverty grading tool

MSCS has 44 slum-based mini health centres offering a range of services including mother and child health, family planning, treatment for sexually transmitted infections (STIs) and general health. Each mini centre has MSVs drawn from the community who raise awareness among men and women and encourage them to exercise their right to good SRH by attending the centres.

Nominal fees are charged by the mini centres to help with sustainability of services and to encourage users to value them. There is considerable evidence to show that free services are often dismissed as worthless or of poor quality by users, so this nominal fee is not perceived as counter productive. However, it is critical that those who cannot even afford the nominal fee are still able to access these services, while those that pay do not feel penalised.

In order to generate support for the introduction of any poverty targeted initiative, (in this case a programme of free services for some but not all within a community), the community members themselves need to agree with both the principle and method of identifying and selecting the poorest. This research process developed an original tool for achieving just that.

MSCS commissioned the PRIP Trust, a Bangladeshi non government organisation, to carry out the participatory research in three slums in Dhaka. In each slum three focus groups were held: one of men, one of women and one mixed.

These groups defined which indicators they thought best represented poverty in their community and then allocated each indicator four grades of poverty: from very poor to rich. These indicators were combined to form a single, consistent set of 'key' indicators, representative of all slums in the study, and incorporating the range of poverty indicators identified by the participants, such as education, accommodation, facilities, earnings and nutrition.

This poverty grading tool was then used in a social mapping exercise to allocate a poverty level to each household.

The poverty grading process has enabled MSCS to target the very poorest more accurately and to allocate its subsidised treatment funds through a family health card scheme. The health card is given to very poor families who can receive free services at the mini centres. MSCS is monitoring the proportion of clients who use the health card to establish the impact on client profile. Initial feedback is positive, with the community saying that they are pleased with the scheme.

Conclusion

This research has provided the core material for the production of a poverty grading manual that can be adapted to suit any similar initiative. Marie Stopes International is already in the process of refining and replicating the poverty grading tool exercise in Yemen with the support of the World Bank to ensure that the poorest people are reached with SRH information, services and activities.

The finished manual will be an effective, participatory tool for identifying the poorest of the poor and thereby ensuring that they are reached. The manual can be used by any organisation that would like help developing a participatory poverty grading tool in conjunction with the communities in which they work.

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