Developing a participatory poverty grading tool

viewpoint

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acronyms

AIDS	Acquired Immune Deficiency Syndrome
DFID	Department for International Development (UK)
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
MDGs	Millennium Development Goals
MSCS	Marie Stopes Clinic Society
MSVs	Marie Stopes Volunteers
NGO	Non government organisation
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund

acknowledgments

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This document outlines a research project conducted in Bangladesh by Marie Stopes International's partner, Marie Stopes Clinic Society (MSCS). The project involved the development of a participatory poverty grading tool which allows the very poorest people within society, to be identified and targeted by the health programme.

This report:

- highlights why sexual and reproductive health (SRH) care needs to be targeted at the poor
- explains a participatory technique which grades poverty levels to facilitate identification of the poorest of the poor
- illustrates how the slum community in Bangladesh perceives levels of poverty
- demonstrates how SRH care can be targeted at the poor.

The Marie Stopes International Partnership strives to expand access to sexual and reproductive health (SRH) information and services worldwide. The latest research techniques and protocols are used across the partnership to generate information which helps us improve and develop programmes in response to community demand. Research findings or methods which have particular relevance to the SRH sector in general are disseminated.

Marie Stopes International

The Marie Stopes International Partnership

Marie Stopes International works with local Partners in 35 countries across the world to improve the sexual and reproductive health (SRH) of individuals, families and communities. Across the Partnership an integrated approach of raising awareness of SRH and providing services is taken. The Partnership's network of services – which range from centre-based services through to mobile clinics and outreach programmes – is designed to be sustainable, culturally appropriate and of the highest quality.

The Partnership remains committed to advancing the agenda of the International Conference on Population and Development and to supporting the achievement of the Millennium Development Goals (MDGs) to end world poverty, social injustice and ill health. Access to quality SRH services and information is essential to achieve the MDGs.

An advocacy-based approach to support people in exercising their fundamental SRH rights is used and the Partnership particularly works with underserved, unreached and marginalised communities such as young people, the poor and refugees. To ensure that services are accessible to all, affordable fees are charged and part of this income is used to subsidise services for those who are unable to pay.

Sexual and reproductive health and poverty

SRH and poverty are intrinsically linked. Poverty is not only a cause of poor SRH, but also an outcome. In order to help break this destructive cycle, it is essential to identify the poorest so that they are able to exercise their rights and access services.

Why measure poverty?

It is useful to measure poverty levels in a community in order to reach the very poor and to ensure they are not marginalised. Poverty can be measured in many different ways although many of those methods of measurement, such as assets indices or income, are costly, take time and are too general to illustrate effectively the reality of individual households and communities. In addition, poverty levels are often defined nationally or internationally, for example, living on $1 or less per day, and these levels may not effectively identify the poorest people.

This shortfall in poverty measurement can be addressed by using participatory methods to enable a community to express the reality of their poverty. Empowering members of a community to express their views allows a truly fair assessment of their poverty levels.

Key facts and figures	
Established	1976
Number of countries working in*	35
Centres*	284
Team members*	3,000
Clients served*	3.6 million
Male condoms distributed*	47,926,047
Turnover*[1]	39.3 million
Key donors	the European Community, the World Bank, UNFPA, DFID

*Statistics for 2002. [1]Marie Stopes International.

Involving the community in poverty grading

MSCS, Marie Stopes International's Partner in Bangladesh, provides SRH information and services in some of the poorest slums in Asia.

In this research, MSCS worked with local communities and another local NGO, the PRIP Trust, to accurately measure or grade poverty levels in the community. Focus groups of slum community members were held and they identified which indicators best described their own levels of poverty. These indicators were then aggregated into a poverty grading tool. Following this, more groups convened to conduct a social mapping exercise and allocate a poverty grade to households in the three slums involved, using the tool they themselves had developed.

This research was conducted between June and September 2002.

Using the participatory poverty grading tool

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.

As a result, the MSCS volunteers, Marie Stopes Volunteers (MSVs), who work with the slum communities and who themselves come from those communities, are able to focus their time on visiting the very poorest within the slums. By doing so, they ensure that those from this marginalised group have access to information, are aware of their SRH rights and can access the free health services available.

Lessons learnt

This simple, participatory approach to grading poverty can be adopted in any community and used to address any issue, from environmental health to education.

Future developments

The value of this initial work in Bangladesh has been acknowledged by the World Bank which is funding the further development and refinement of this poverty grading process through field-testing in Yemen. A practical training manual on how to replicate the poverty grading process will then be produced. This manual can then be used by organisations to help develop their own local participatory poverty grading tool in conjunction with the communities in which they work.

The field training manual will be available from Marie Stopes International in 2004.

MSCS is now able to ensure that its services and information are targeted and accessible to the very poorest within the community.

The two Millennium Development Goals relating directly to sexual and reproductive health: reducing child mortality and improving maternal health, are the two least likely to be met by 2015.

Poor sexual and reproductive health (SRH) can lead to poverty. Poverty can lead to poor SRH.

The achievement of the internationally agreed Millennium Development Goals by 2015 is critical to help eliminate world poverty. The MDGs, which were agreed by world leaders at the United Nations Millennium Summit in September 2000, are a set of goals and targets for reducing poverty, social injustice and ill health.

In the *State of world population: people, poverty and possibilities* (UNFPA. 2002.), the United Nations Population Fund (UNFPA) highlighted the key role that SRH plays in the achievement of the MDGs. However, the two MDGs relating directly to SRH: reducing child mortality and improving maternal health, are the two least likely to be met by 2015.

The disparity between the developed and developing world shown below demonstrates the need for significant investment in SRH in the developing world. Without this, the SRH status of people in the developing world, whether measured by infant mortality or maternal health, will decrease further, resulting in increased poverty.

Worldwide poverty and reproductive health: key facts and figures

	Developing regions	Developed regions
% population growth rate (2000 – 2005)	1.5	0.2
% births with skilled attendants	58	99
Infant mortality per 1,000 live births	59	8
Maternal mortality ratio	440	21

Source: UNFPA. 2002.

Sexual and reproductive health and poverty in Bangladesh

Key facts and figures

Total population (millions) (2001)	**141**
Total fertility rate (2000-2005)	**3.5**
Contraceptive prevalence rate: all methods	**54%**
% births with skilled attendants	**12%**
Maternal mortality ratio (per 100,000 live births)	**600**
Malnutrition prevalence under 5	**48%**
Female adult (15+) literacy rate	**31%**
Population living below $1 a day	**36%**
GDP per capita US$ (2001)	**1,610**
Human development index ranking	**139**

Source: UNDP. 2003.

Bangladesh is one of the world's most densely populated countries. It is also one of the world's poorest, ranked 139 out of 175 in the Human Development Index. The Human Development Index is a composite index, measuring achievement in a number of areas of human development.

The country has an extremely high rate of illiteracy, especially amongst women. This is an indicator of poverty as well as a significant barrier to accessing information about health and other issues.

The importance of the NGO sector in the provision of healthcare is critical to Bangladeshi citizens, given that two thirds of the country's annual expenditure on health comes from sources other than the government.

Overall, SRH status in Bangladesh is poor, with the latest figures from the UNFPA showing high levels of maternal mortality and morbidity, and low levels of contraceptive use. High levels of poverty are compounded by large family sizes. Malnutrition is also found in almost half of all under-five's.

Bangladesh is one of the world's poorest countries, ranked 139 out of 175 in the Human Development Index.

Marie Stopes Clinic Society

Key facts and figures	
Established	**1988**
Centres	**23**
Mini centres	**44**
Target groups	**the urban poor; homeless; young people (10-20 yrs); men; injecting drug users; men having sex with men; commercial sex workers and their clients; transgenders and factory workers**
Marie Stopes Volunteers (MSVs)	**170**
Clients served in 2002	**800,000**
Donors	**DFID, UNFPA, the Asia Development Bank and Maries Stopes International**

MSCS has developed a range of innovative projects aimed at reaching the more marginalised sections of society.

MSCS works with communities in locations across Bangladesh providing information and services. It is one of the leading SRH agencies in Bangladesh and is now also increasingly involved in training government, non-government and private service providers as part of its commitment to strengthening the country's national health capacity.

MSCS has developed a range of innovative projects aimed at reaching the more marginalised sections of society, including:

- garment factory health scheme – due to their long hours and low pay, garment workers have little time, or money, to access health services based in the community. Through its factory health scheme, MSCS provides information and free health services to employees in the workplace and over 150 factories are now involved in the scheme
- tea sellers educational project – raising awareness amongst men about SRH and key issues such as vasectomy is very difficult. MSCS worked with street stallholders selling tea, providing them with radios on which educational soap operas were broadcast to communicate effective messages about SRH
- capacity building of non-formal practitioners/traditional healers – often the first port of call when the very poorest are faced with a health problem. MSCS has worked with these providers who include herbalists and pharmacists to improve their knowledge, especially with regard to identifying sexually transmitted infections (STIs), HIV/AIDS and pregnancy complications. It has also helped them to develop their knowledge of when to refer, dispelling misconceptions and preventing the inappropriate prescription of medicines
- homeless people – MSCS takes information and services direct to homeless men and women through mobile clinics which go to the areas where they stay, for example, train stations at night. Building awareness and knowledge takes place through the use of traditional folk songs often sung by famous singers to improve the response to health messages.

"I came from my village to Dhaka but I won't go back there as I have nowhere to live. My husband is a rickshaw puller but he hasn't had any work for three to four months now. I work everyday and sell water in the market. I make about Taka 25 (under half a US dollar) a day. My husband is good and he looks after the children when I work. I can't use any other services than this as I work all day."

Ruma (above), Dhaka

Though Ruma does not know how old she is, she is probably in her mid to late twenties. She has been married for 11 years and has a seven year old son and 18 month old baby. She came to the mobile clinic (which provides services from a converted van) one evening as she had a reproductive tract infection which had not resolved despite previous treatment. She was advised to bring her husband along to the clinic to ensure they both received treatment to avoid re-infection.

The need for a fair system to grade poverty

MSCS has 44 slum-based mini centres as part of the DFID funded project: Better Health for the Urban Poor. The mini centres offer a range of services including: mother and child health, family planning, STI treatment and general health.

Each mini centre has its own network of MSVs drawn from the local community. The MSVs have been trained to raise awareness of SRH amongst both men and women, encouraging them to exercise their rights. They also have a health education and counselling role.

Mukul's story below highlights the need for continued information and service programmes in the slum, and demonstrates the need to influence all stakeholders and decision makers within the community.

"I've been coming here since the centre was built four years ago, I don't go anywhere else. I come because we get good treatment. We like it here, it's nice and it's close to our homes. There is a local doctor who I used to go to before but he was more expensive – about Taka 50 for medicine. I used to pay Taka 10 here but now I can even get free treatment.

I know the MSVs very well and they've helped us a lot. I also tell other people about MSCS. I don't have time to go to community meetings very much as I work from morning to evening.

I recently lost my baby who died 16 days after birth due to an infection in the cord. I had my baby at home with an untrained midwife who lives in the area and helps with babies. I didn't take my baby anywhere for help as everyone, my family and others, told me I couldn't do anything and I was too ill to go myself.

I want to get family planning today. I don't want any more children as two are enough; I want to be able to bring them up properly. My husband also doesn't want any more children."

Mukul, Paris Road slum

Mukul (left) is 30 and married with two children. She comes from a village outside Dhaka and has lived about 30 minutes walk from the mini centre since she got married 12 years ago. Her husband is a rickshaw puller and she works in a sari factory. She works all day so can't look after her children. Her elder daughter lives with her (Mukul's) parents in their village. Her son Rubel is seven and he will also be sent to live with her parents so he can go to school.

Nominal fees are charged for services to help with sustainability in the long term and to encourage users to value them. To ensure access for all, the poorest members of slum communities are given free services. Initially, a system was set up whereby the MSVs would grade the level of poverty of each household, but this had its limitations:

"Generally the problem we faced was that they had a lot of nice things, furniture, TV etc but no food and as a result were getting ill. So we were confused, and wondered if they actually should be graded as being in the middle or poor poverty band."

Shabana, Marie Stopes Volunteer, Paris Road slum

These limitations prompted MSCS to investigate a fair, community-focussed approach to determining poverty levels, based on the assumption that those within a community are best placed to understand their own levels of poverty.

"Understanding poverty in the community is a complex task. Through our work in the slums we have seen how poverty can vary from one slum to another and even within the same slum. While national statistics and household surveys provide a broad picture of the poverty situation in the country, these statistics and surveys have little relevance to individual communities.

To truly understand the reality of poverty levels within a community, it is vital to involve the community itself so that the poorest can be identified and reached. This is how we approached the project, working with individual communities to really understand how they define the reality of their poverty levels. Using this tool we have redesigned our strategies so that the poorest are no longer marginalised and have easy and equal access to our information and services."

Dr Yasmin H Ahmed, Managing Director, MSCS

"To truly understand the reality of poverty levels within a community, it is vital to involve the community itself."

Methodology

In order to ensure that the research was independent and to draw on expertise in participatory techniques, MSCS commissioned the PRIP Trust to carry out the research with the community. The PRIP Trust is a local NGO based in Dhaka which specialises in participatory research for development.

The slums involved

Three slums were selected to be involved in the research:

- Paris Road
- Shialbari
- Shikder.

All of these slums are in Dhaka and all have MSCS mini centres based within them.

Focus groups

In each slum a random sample of households was approached and individuals within those households invited to participate in this qualitative research.

Three focus groups made up of community members were then held in each slum; one group was made up of men, one was female and the third was a mixed group. These groups worked to define which indicators they considered important in describing poverty in their community. They then discussed the levels of these indicators which placed households in one of four poverty bands:

- very poor
- poor
- middle
- rich.

The design of the participatory poverty grading tool

The poverty indicators identified by each focus group were then aggregated to form a single, consistent set of indicators called *key indicators,* with levels within each indicator representing each level of poverty. The key indicators chosen were selected to be representative of all slums in the study; to be practical and to incorporate the range of areas identified by communities to define poverty, for example, accommodation, earnings and food.

Each key indicator was divided into four levels and a score was allocated to each level, from one for the lowest level – very poor, to four for the highest – rich. Each household was scored across all of the indicators and the total score achieved defined the household's poverty level.

This grading tool was then field tested and refinements made.

Social mapping

Once the participatory poverty grading tool had been developed, more focus groups were held to conduct a social mapping exercise. Each focus group drew a map of its own local community, highlighting each household and landmarks such as latrines, shops, mosques and schools. They then used the poverty grading tool to allocate a poverty level to each household. They also indicated if they knew whether people in the household used a MSCS mini centre.

As a result of this exercise, five maps were drawn for the Paris Road slum, four for the Shialbari slum and three for the Shikder slum.

Researchers visited households which were unknown to the focus group members in order to grade them using the poverty grading tool. A small number of households remained ungraded as they were either vacant or the occupiers could not be contacted.

Results

It should be highlighted at this point that although the households were classified according to one of the four levels of poverty:

- very poor
- poor
- middle
- rich

these levels are relative within the slums. Within Dhaka's slums the absolute level of poverty is very low. This is highlighted in the example below about nutrition where even a household classified as 'rich' might only have access to a quality meal twice a week.

Tool design

Poverty indicators

The poverty indicators identified by individual focus groups in each slum fell broadly into the same categories, although each community described them slightly differently. The outcomes for the male, female and mixed focus groups were very similar, although again, expressed slightly differently. Results between slums were also comparable.

The indicators identified by the community included:

- earnings: wage earners; household income; profession; savings and loans
- accommodation: housing structure; size of accommodation; rental/ownership status and cost
- facilities and services: cooking facilities; furniture and household assets; toilet facilities; access to water; access to electricity
- nutrition: number of meals per day, frequency of nutritious meals eaten
- other: clothing; education; child labour; access to health services.

The table below shows how the different slum communities described the quantity of food which was typically available within each poverty grade.

Key indicators
These key indicators and their levels that form the basis of the participatory poverty grading tool were selected as representative across all communities. They covered a variety of poverty descriptors, including: accommodation, facilities, nutrition and earnings and were gathered through a mixture of observation and questioning techniques.

Initially, child education was also chosen as a key indicator. During field testing however, this indicator was found to be unworkable as some households had children and others did not, which distorted scores and poverty grades. To overcome this, the child education indicator was removed from the tool. The remaining indicators described poverty from a range of angles and were applicable across all households in the slum communities.

Even a household classified as 'rich' might only have access to a nutritious meal twice a week.

Poverty indicators: nutrition

Grade	Shialbari slum (men)	Shialbari slum (women)	Shikder slum (men)
Very Poor	Can't manage a meal every day	Don't have sufficient food. Meal depends on earnings	Always have half a meal. Don't eat if no work
Poor	Don't have sufficient food	Can have meal but not sufficient	Two meals a day
Middle	Three insufficient meals a day	Have necessary food	Three meals a day
Rich	Have sufficient food	Have sufficient food	Three meals a day

Using a scoring system to grade household poverty

If a household were to have the lowest level of each indicator it would be very poor; if it were to have the second level of each indicator it would be poor. Yet households rarely have the same level of each indicator and so would not fall into specific groups in this way. To overcome this, a scoring system was developed and the poverty level of each household was graded using this system.

The poverty bands were as follows:

- very poor score between 8 – 12
- poor score between 13 – 20
- middle score between 21 – 28
- rich score between 29 – 32.

Indicator Level of indicator for poverty grade	Points	Means of verification
Living space		
Share one room with other family	1	Observation and Question
One small room for whole family	2	
Two small rooms or one large room	3	
Two or more rooms with additional space	4	
House structure		
Bamboo fence, bamboo thatched roof, polythene/kutcha floor or bamboo platform	1	Observation
Bamboo fence, tin roof, kutcha floor or bamboo platform	2	
Tin fence, tin roof, brick floor	3	
Brick wall, tin or brick roof, brick floor	4	
Rental status		
Share rent, up to Taka 500	1	Question
Rent Taka 500 to 800	2	
Rent Taka 800 to 1,200, rent out room/space	3	
Rent Taka 1,200 to 2,500, or own structure on rented/occupied land, rent out space	4	
Cooking facilities		
No separate cooking space, waste materials used for fuel	1	Observation
No separate cooking space, wood, kerosene used for fuel or electric heater	2	
Separate cooking space, stove, earthen oven, electric heater or gas oven used	3	
Separate cooking space, gas oven used, rent out gas oven	4	
Average meals per day		
One meal	1	Question
Two inadequate	2	
Two adequate or three inadequate	3	
Three adequate	4	
Frequency of quality food		
Occasionally	1	Question
Once per month	2	
Once per week	3	
Two/three times per week	4	
Type of work		
Beggar, daily labour, irregular rickshaw puller	1	Question
Regular rickshaw puller, garment or factory worker, small trader	2	
Motorised taxi driver, shop keeper/owner, tailor	3	
Businessman, driver (taxi, bus, truck, car), owner (rickshaw, taxi, small factory)	4	
Monthly income (average/household member)		
Up to Taka 300	1	Question
Taka 301 – 500	2	
Taka 501 – 1,000	3	
Over Taka 1,000	4	

Using the scoring system it was possible to grade every household. For example, Rehana's household was classified as very poor with a score of nine.

"I heard about the Marie Stopes Clinic Society mini centre from the MSVs, and I now go there for all sorts of treatment, including general health. I knew something about the pill before but was afraid to try it. However, the MSV advised me on family planning methods and injections, so I went to the centre and got it.

I didn't want to have more than three children but I went away to my village and couldn't get injections there, and as I was not careful I've now got more children. I will use family planning again but I'm not sure what I want yet, whatever is easiest. My husband has married again so sometimes he's here, sometimes not. He doesn't look after us properly. It would have been better to have less children. I have two more than I need and I have to divide the food of two amongst my four children, so they don't have enough to eat."

Rehana, Shikder slum

Rehana (above) is 35 and a housewife. She came to Dhaka four years ago and is married with four children. Her husband is a waste paper collector. Her nine year old son goes to an NGO-funded school. The room she shares is about 2.5 metres by 3 metres and there is no furniture. She has been a client of the MSCS mini centre for four years.

Grading Rehana's household

Indicator	Score
Living space – share one room with another family	1
House structure – bamboo fence, bamboo thatched roof	1
Rental status – share rent, up to Taka 500	1
Cooking facilities – no separate cooking space, waste materials used for fuel	1
Average meals per day – two inadequate	2
Frequency of quality food – occasionally	1
Type of work – beggar, daily labour, hawker, irregular rickshaw puller	1
Monthly income (average/household member) – up to Taka 300	1
Total	9
Poverty grade	Very poor

Social mapping

Following identification of the community poverty indicators, and the development of the participatory poverty grading tool with a scoring system for key indicators, more focus groups were held to undertake a social mapping exercise. In this exercise each group drew a map of their area of the slum. These maps contained the locations of all houses, water pumps, communal latrines, bathing and kitchen facilities, and other notable landmarks such as schools, mosques and factories.

As a result of this exercise, five maps were drawn for the Paris Road slum, four for the Shialbari slum and three for the Shikder slum.

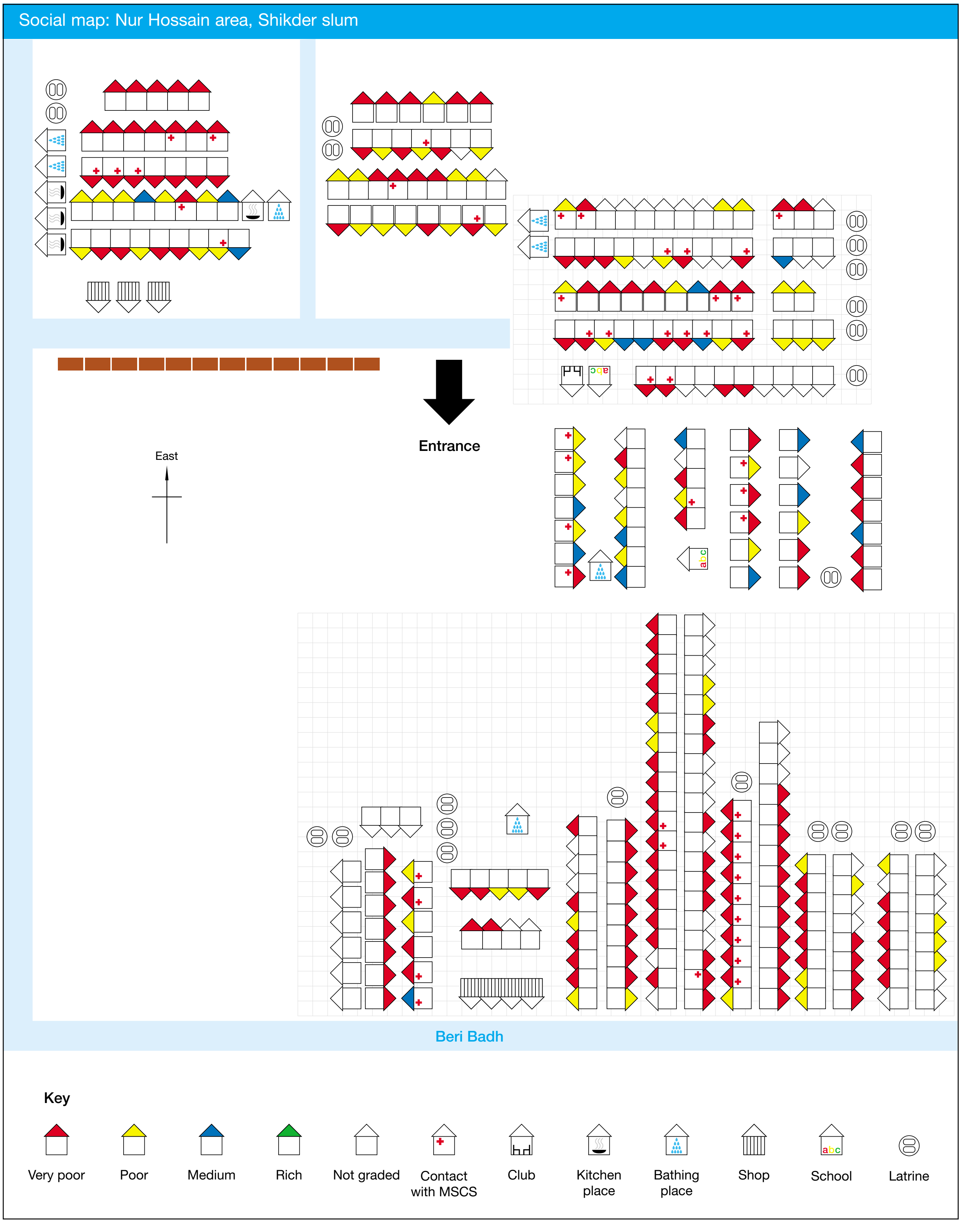
Using the poverty grading tool, the focus groups then graded each household on each of the maps, illustrating the poverty grade by colouring the roof of each house according to the following colour code:

- very poor **red**
- poor **yellow**
- middle **blue**
- rich **green.**

The mix of community members in each group meant that through discussion and consensus most households could be graded.

In order to get an initial overview of the reach of MSCS services in the slums, the groups also indicated those households where they knew the occupants were users of the MSCS mini centre. Most women were aware of their neighbours' use of the mini centre, although awareness was more limited amongst men.

The map opposite details one section of the Shikder slum.


Social map: Nur Hossain area, Shikder slum
Entrance
East
Beri Badh
Key
Very poor
Poor
Medium
Rich
Not graded
Contact with MSCS
Club
Kitchen place
Bathing place
Shop
School
Latrine

The social mapping exercise showed that people were able to describe the structure of their communities and grade the poverty levels of the households within them using the tool they had helped to develop. Below is a summary of the results of the social mapping exercise, showing the percentages of households falling into each poverty level.

There were a number of ungraded households in each slum which were vacant properties. The high proportion of vacant properties in the Shikder slum was primarily due to a large fire in the slum's Nur Hossain area a few months prior to the research taking place. Due to the fear of arsonists setting future fires, approximately one third of homes in this area were vacant. This highlights the uncertainty which many poor households face.

The poverty structure of each slum was different. Whilst the proportion of middle and rich households was fairly constant at 10% to 15%, the proportions of very poor and poor differed more markedly. For instance, the Parish Road slum was the poorest with 76% of households being very poor compared to the Shialbari slum with 43%.

The photograph above, featuring three adjacent homes, each with a different poverty grade, illustrates that it is not possible to differentiate poverty levels through observation alone.

Home	Grade
1	Very poor
2	Poor
3	Medium

Proportion of households in each poverty level

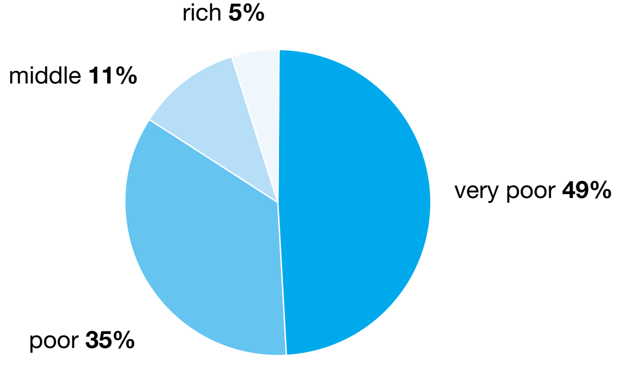
Grading using community poverty grading system						
	Very Poor	Poor	Middle	Rich	Number of households graded	Number of ungraded households
Paris Road slum	76%	14%	6%	4%	977	7
Shialbari slum	43%	42%	10%	5%	1,228	200
Shikder slum	56%	32%	12%	<1%	1,045	314
Total % of all three slums	**57%**	**30%**	**10%**	**3%**	**3,250**	**521**

Additional findings

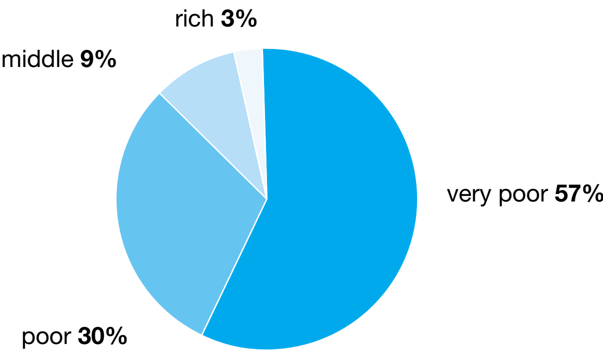
Understanding the communities' perceptions about the use of health services was an additional outcome of the study. During the social mapping exercise, the groups placed a red cross on each household they knew used a MSCS mini centre. At the time of the study, about 25% of the slum communities in this study were known to use one of the three MSCS mini centres.

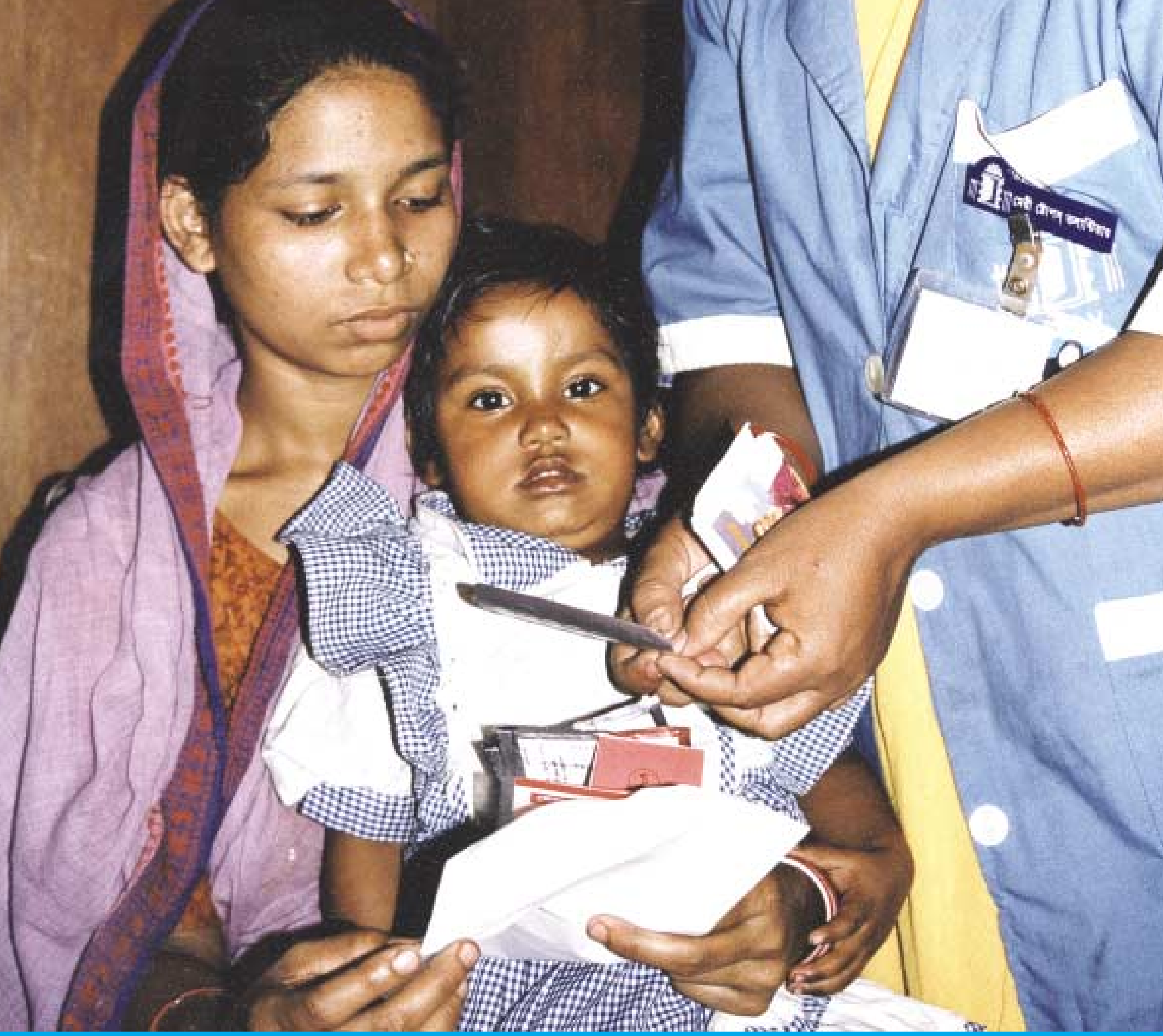
The poverty profile of the users of the three mini centres is shown opposite. Comparing this to the poverty profile of the communities shows the mini centres were reaching members of the community at each poverty level. With effective targeting of very poor households, the very poor segment of centre users can be expected to more fully reflect the proportion found in the community.

Poverty profile of known mini centre users in the three slum communities



Poverty profile of local communities





The poverty grading tool has enabled MSCS to more accurately allocate its subsidised treatment funds through a family health card scheme.

Identifying very poor households is the first step in responding to the needs of the poor. The second step is to use the information about the number and locations of very poor households to further develop the programmes designed for them.

Using the poverty grading tool has enabled MSCS, via the MSVs, to target the very poorest more accurately. It has also enabled MSCS to more accurately allocate its subsidised treatment funds through a family health card scheme.

Shabana's story below illustrates how the new poverty grading tool has become useful in a practical way to assess the households in an individual slum.

"My name is Shabana and I've been working at the mini centre for four years, since it was built.

At the beginning I faced a lot of problems because the community didn't want to listen. I was chased by one family and almost beaten. Now, after some time going to their homes, they sit and listen to me, they find it useful. Before, they didn't want to talk about STIs and family planning methods but now they open up and want to talk about these things. I tell them about infections and HIV and AIDS. They can now tell you how AIDS is prevented!

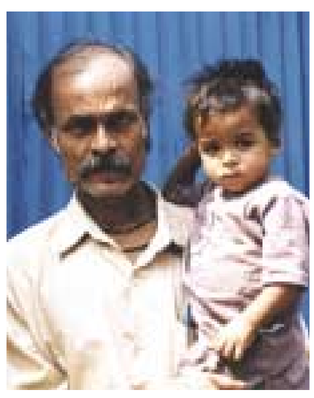
The earnings indicator [from the participatory poverty grading tool] is hard to do as people's income varies week to week. The other indicators are not difficult. Also, it can be hard making the community understand why only the very poor get free services. A lot of beggars get the health card.

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. I feel that they get ill more as they eat bad food and eat in dirty places; that's why they need to know more.

There is still a lack of understanding of family planning. Out of 100 about 25 understand, the rest think: 'Allah will look after the children, why should I do family planning?' I go to their homes more often, those who have eight or 10 children. I feel if I keep telling them enough, maybe they will understand. They don't believe in family planning for cultural reasons. The very poor haven't had a good life, they've not been educated so they can't understand the benefits of fewer children."

Shabana (above), MSV, Paris Road slum

Section 4: How Marie Stopes Clinic Society is using the participatory poverty grading tool to address the needs of the poor



Allocating subsidised treatment funds

In order to build in a component of sustainability the mini centres charge a fee for services. It is generally felt that people place a greater value on quality services for which they have had to pay. To ensure that services are accessible to all, however, subsidised treatment funds are available for the very poor. The results of this research will assure that the funds made available and who receives them can be more fairly determined.

"I have been coming here for two to three months. The MSVs came to the Muslim camp very often and we were interested in coming but we never felt the need as we weren't ill. I've been out of work for the last few months so my financial situation is bad. We often have to go without food so we can't even think about getting medical services. It wouldn't be possible to come if it wasn't free. We are happy with the staff, they are very helpful with us and very disciplined with their work."

Salar (above), Paris Road slum

Salar Hussein is 45 and is married to his second wife. He has three sons and two daughters. His first wife died. He is a stranded Pakistani whose family came here in the 1947 India/Pakistan partition. He previously worked a handloom in a local sari factory. His wife, Parvin and one of his sons, Naushad, both have a fever.

The family health card scheme

MSCS is field testing a family health card scheme as a means of allocating the subsidised treatment fund to the very poor. The health card is given to very poor families who have been identified using the poverty grading tool. All members of the family listed on the card can receive free services in the mini centres through the subsidised treatment fund. MSCS is monitoring the proportion of clients who use the health card to establish the impact on client profile and services taken up by the very poor.

Approximately 500 health cards have been distributed to very poor families in the Paris Road slum which means that approximately 2,500 individuals know about and are using the services. Initial feedback is positive with the communities saying they are happy with the scheme.

"I'd heard about this centre before but have only been coming for the last two to three months since I was given the family health card. The MSV came and told me about the free services and about family planning methods. I was asked to come to a community consultation meeting on health. I've brought my daughter as she has a bad cough. I am also here for my family planning pills as I don't want anymore children. My husband is often out of a job so we can't feed the children we have."

Nunaha, Paris Road slum

Nunaha is 23, married and has lived in the Paris Road slum for the last five years with her husband, two children, mother-in-law, brother-in-law and grandmother-in-law. She did not go to school.

Future developments

In the future, MSCS also aims to:

- involve local communities in the development of behaviour change communication materials
- refine its fee structure in order to balance ability to pay with the value placed on the service by the user
- further develop a participatory health strategy for the slum involving community consultation groups where the poorest of the poor are represented
- invest more in the subsidised treatment fund and in MSVs
- assess the effectiveness of different means of communication and the appropriateness of user fees for the very poor
- develop a system to monitor changes in poverty levels.

The results of this research have important implications for both MSCS and beyond.

Using the tool now enables MSCS to more effectively target the very poor within the community, facilitating their access to sexual and reproductive health (SRH) information and services and empowering them to understand, demand and exercise their rights. As a result, the SRH status of all sections of the community can be expected to improve irrespective of their poverty level.

The data gathered in this research can also act as a baseline study, allowing MSCS to monitor the poverty profile of the people that use its information and services to ensure the poorest are being reached.

MCSC will work with the slum communities to revisit the indicators identified in this particular poverty grading tool to ensure that they do not become obsolete over time.

MSCS invested heavily in this project both financially and in terms of time. Any future poverty grading projects can now be conducted with less investment using the lessons learnt from this experience.

The future development of the tool should be led by community members to ensure that their specific situation is considered and their poverty status is not graded solely on factors considered important by external groups.

The actual process of developing a poverty grading tool in a participatory way helps community members engage with their own health situation and that of their families and community. It also helps them form associations within civil society with the aim of improving community health.

The similarities in poverty indicators expressed by the different slum communities show a single tool can be developed for multiple communities in any country or city, as long as there is a degree of homogeneity, for example, urban slums.

All indicators should be applicable and measurable in all households to ensure simplicity in implementation.

The technique can be used for any intervention – health, education, employment – which benefits from a targeted approach and where the poorest are an important group to reach. Regardless of which intervention this technique is used for, it requires the full co-operation and participation of the community.

"I enjoy doing health education work very much. The main challenge is that I can't read the words written on the books as I only went to school for two years. I have to look at the pictures and get the idea through that and also through talking to other MSVs. I feel being illiterate helps me to communicate more as I am on the same wavelength as the community. However, it's difficult to make them understand, one or two sessions are not enough, you have to work hard, but we understand each other."

Nazma (above), Marie Stopes Volunteer, Shikder slum

Nazma Begum is about 35; she was born in the Shikder slum and has lived there all her life. She has a husband, mother and four sons. Her husband is a rickshaw puller but is not working as he is ill.

The poverty grading tool: future developments

Marie Stopes International has now taken this technique beyond Bangladesh. With funding provided by the World Bank, the organisation has further developed and refined the research process involved in developing the participatory poverty grading tool. The field-testing took place in Yemen, and a key feature of this development has been production of a field training manual for organisations to help them develop their own local participatory poverty grading tool in conjunction with the communities in which they work.

Yemen was selected due to its poor SRH status, and high levels of poverty. Marie Stopes International Yemen works with the very poor, including refugee communities. The programme in Yemen will be expanding in the near future and development and use of the tool will help it to more effectively reach its target audiences.

The researchers in Yemen were drawn from the existing Marie Stopes International Yemen team. This element ensures that programmes that use the technique in the future will be able to do so in a cost effective way by building local organisational capacity without relying on external consultants.

The finalised training manual for use in the field will be available from Marie Stopes International in 2004.

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