

HNP and the Poor: The Roles and Constraints of Households and Communities

Session 3

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1

This is the third of a series of six sessions on HNP and the poor. The session focus is on the importance of household actions and community characteristics in improving the health, nutrition, and population outcomes for the poor.

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Session Objectives

To answer the following questions:

- **Why are household and community characteristics the critical key to understanding the poor HNP outcomes for the poor?**
- **How can listening to the poor improve the design on health programs and improve monitoring?**
- **What are available quantitative and qualitative listening tools and how have they been applied to date?**

2

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Session Outline

1. Introduce two case examples

India Immunization

Bolivia Nutrition

2. Motivate Household Roles and Community Influences

3. Introduce Diagnostic (Listening) Tools

4. Application of tools in the case examples

5. Links to other sessions—health systems analysis, factors outside health sector, and public policy

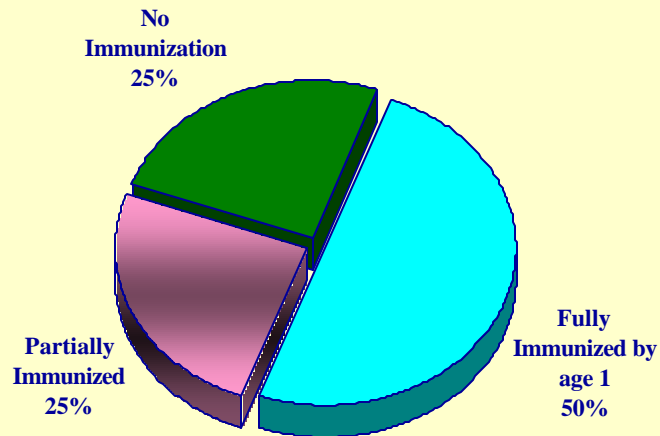
3

This session is organized to not only introduce diagnostic tools aimed at understanding the critical roles played by individuals within households and by community factors in the production of good health outcomes for the poor, but to also motivate how that knowledge can be applied. To achieve that objective, two case examples from on-going World Bank work are used. The first case example focuses on immunization in India and the second on Nutrition in Bolivia. This first segment of the session will introduce the case examples by highlighting the equity concerns.

After motivating the roles of households and communities (segment 2) and introducing the diagnostic tools (segment 3), we will return to the two case examples to show how the tools have been applied (a third case example using the Bangladesh health program will also be used in the fourth segment).

The final segment links the discussion and material presented in this session to some of the session to follow.

Some kids in India get immunized



4

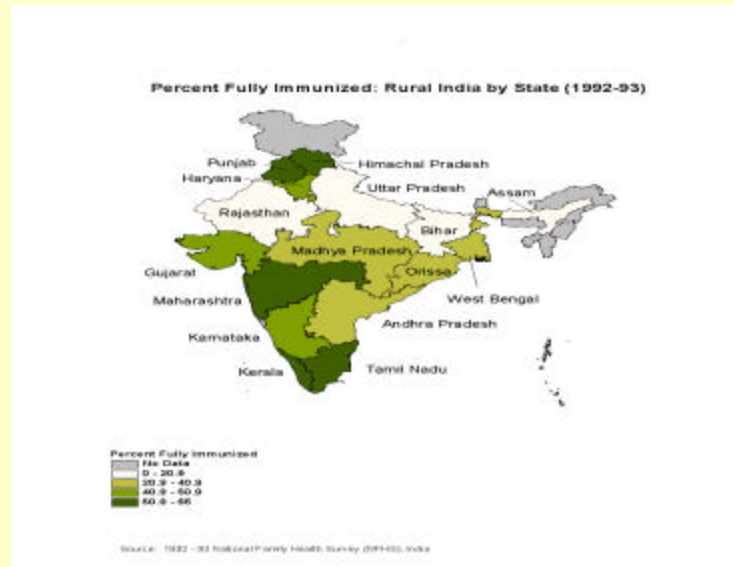
Case Example 1: Immunization in India.

The Problem:

If current trends hold, of the 25 million children born every year in India, only half are likely to be fully immunized by age one. Furthermore, of the remaining 12 million children, half are likely to receive no immunization at all.

Introduce case examples

It depends where they live ...



5

Case Example 1: Immunization in India.

The Problem (Continued):

The poorest states in India (Bihar, Uttar Pradesh, etc.) have the worst performance in immunization coverage (less than 30 percent of three-year olds were fully covered in 1993).

Introduce case examples

... and how well-off they are

1992/93 NHFS

	Poorest 20%	2 nd poorest 20%	Middle 20%	2 nd richest 20%	Richest 20%
<i>Health Outcomes: Infant and Child Mortality Rates</i>					
Infant Mortality	109.2	106.3	89.7	65.6	44.0
Under 5 Mortality	154.7	152.9	119.5	86.9	54.3
<i>Health Outputs: Immunization Coverage</i>					
Measles	27.0	31.0	40.9	54.9	66.1
DPT 3	33.7	41.1	51.8	64.6	76.7
All vaccinations	20.2	25.1	34.1	46.9	59.8
No vaccinations	44.7	38.9	28.8	18.8	11.5

6

Case Example 1: Immunization in India.

The Problem (Continued):

There is threefold difference in the child mortality rate amongst the richest fifth of households in India and the poorest fifth. The income-related differences are similar for infant mortality. Burden of disease findings link the high levels of infant and child mortality to communicable and vaccine preventable illnesses. In other words, if the children of poor families in India are dying at a much higher rate than those of wealthier families, there is a likelihood that preventive life-saving services are not reaching the children of the poor

Looking then at the health sector output that most links the system to infant and child mortality, immunization, three nationally representative household surveys in 1993, 1996 and 1998 confirm that the children of poor and socially vulnerable families in India are least likely to be immunized. The table in this slide shows the level of inequality in a number of immunization measures. While the overall level of immunization coverage appears to be very low, the level of inequality is even more stark. The last two rows in that table show that the children of the wealthiest 20 percent of households in India are four times as likely to have received some vaccinations than children of the 20 percent poorest families and three times as likely to have received all routine vaccinations

Malnutrition costs Bolivia ...

- **Malnutrition will cost Bolivia over \$1 billion between 2000-2010 (Profiles 2000)**
- **Currently, the public sector and NGOs spend about \$67 million each year on nutrition**
- **Only about 22% goes to cost effective interventions (even less for the most vulnerable groups)**

7

Case Example 2: Malnutrition in Bolivia

The Problem:

Malnutrition in Bolivia continues to be a critical issue for the well-being of a sizable portion of the population. In economic terms alone, a recent analysis using the Profiles program estimated the financial loss to the country at US\$ 1 billion for the eleven year period covering 2000-2010.

The financial response to this health crisis was also analyzed. It was estimated that about US\$ 67 was spent annually by the public sector and NGOs on the malnutrition problem but that only 22% of that spending covered proven and cost-effective solutions.

... especially for a some groups

- **40% of malnourished children are from the lowest 20% of the population (only 4% are from the richest quintile)**
- **Malnutrition is far worse in rural areas and in households where indigenous language is spoken**
- **Many Bolivian women are so malnourished that they will pass malnutrition and micronutrient deficiencies to their babies in utero**

8

Case Example 2: Malnutrition in Bolivia

The Problem (continued):

Distributional analysis of health outcomes found that poorer households shouldered a disproportional share of the malnutrition burden in Bolivia.

Malnutrition was also much worse in rural areas (than in urban areas) and among population groups where indigenous language was spoken.

As was discussed in Session 2, intergenerational factors played a role in passing malnutrition to newer generations.

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4. Application of tools in the case examples

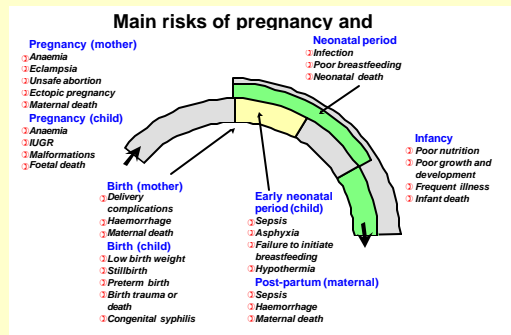
5. Links to other sessions—health systems analysis, factors outside health sector, and public Policy

9

One of the two themes emerging from the previous two examples is that *health is the outcome of a process*. The health system plays a part in this process. But it doesn't produce health outcomes by itself. Households play a key role. But as we'll see in this section, so too do communities.

Motivating roles of households and communities

Health outcomes and households



Health outcomes and health indicators by stage of lifecycle—cf. Lifecycle session

10

At each stage of the lifecycle, there are risks to health. Associated with these are health indicators. These will be familiar from session 2 on “Applying the Life Cycle Framework”.

Motivating roles of households and communities

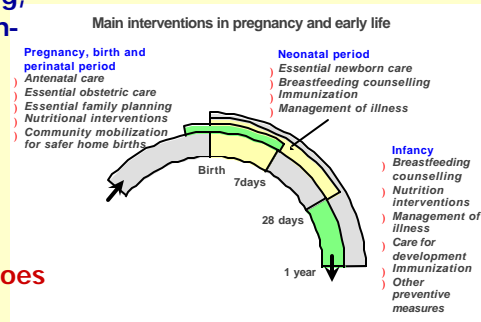
Health outcomes and households

Outcomes respond to curative measures ...

... and preventive measures—broadly defined to include: feeding and diet, hand-washing, disposal of feces, safe sex, non-smoking, etc.

Households are producers of health, and demanders of health inputs (including services)

... But what determines who does what? And who gets what?



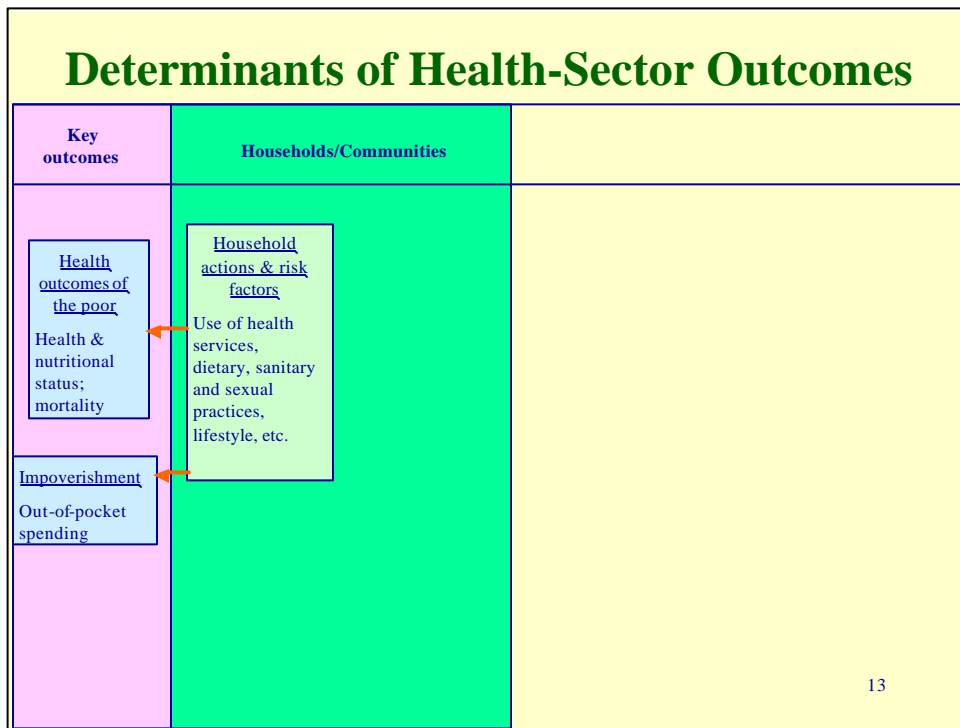
Health outcomes at each stage of the lifecycle are influenced by usage of health services—preventive and curative—and by other factors. For example, child deaths can also be reduced by better nutrition, and by better water and sanitation (see above charts). Health services have an important role to play in each case—by delivering preventive and curative services, by encouraging good nutrition, and by encouraging parents to wash hands before food preparation and to dispose of feces safely (cf. the session on “Applying the Life Cycle Framework”). But households play an important role as demanders of preventive and curative health services. They also play a role in translating information delivered through BCC programs into good health. And they play a key role in influencing access to and use of key inputs such as food, water and sanitation.

Households thus have a dual role: they are both demanders of health services (and other health inputs) and producers of health. To understand better health outcomes—especially those of the poor—we need to understand better what factors constrain households in their decisions as producers of health and demanders of health services. This is done in the conceptual framework in the next slide.

Determinants of Health-Sector Outcomes

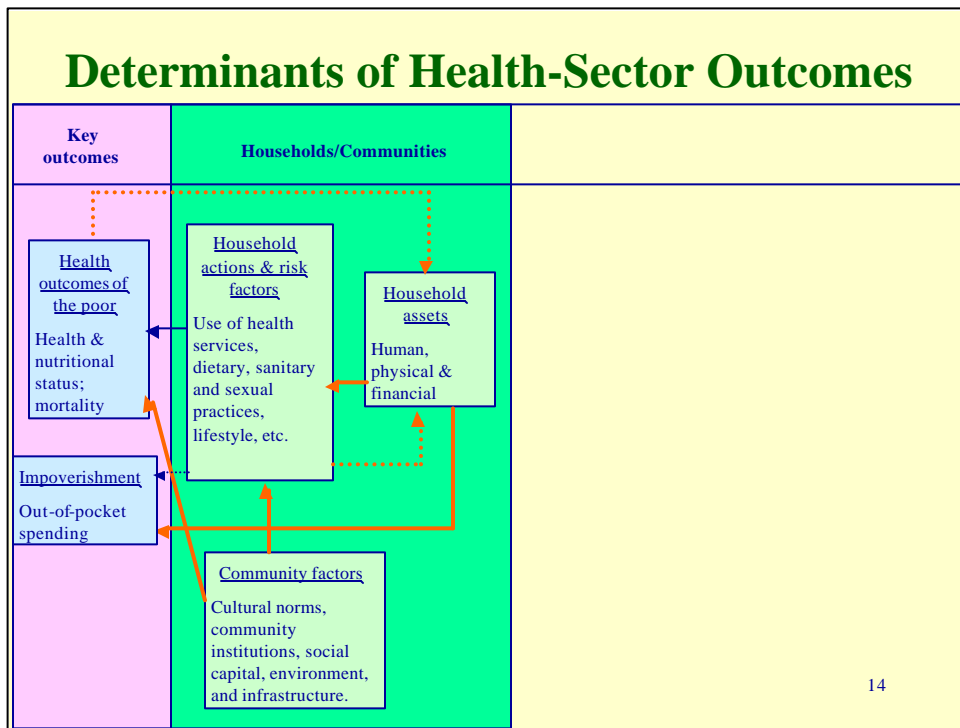
Key outcomes	
<u>Health outcomes of the poor</u> Health & nutritional status; mortality	
<u>Impoverishment</u> Out-of-pocket spending	
	12

On the left of this framework (which we saw in session1), we have the key outcomes—health, and impoverishment. We'll discuss later how to measure them and where we can get information on them from.



The things that directly affect health are indicated in the box labeled “household actions and risk factors”. They include usage of preventive and curative health services, but also dietary and sanitary practices (type and quantity of food eaten, hand-washing, disposal of feces, etc.). In adults, they would include sexual behavior, consumption of alcohol and tobacco, usage of addictive drugs, and so on. In each case, there is a biological link to the person’s health. The nature of the behavioral factors and key interventions at each stage of the lifecycle were discussed in session 2 “Applying the Life Cycle Framework”.

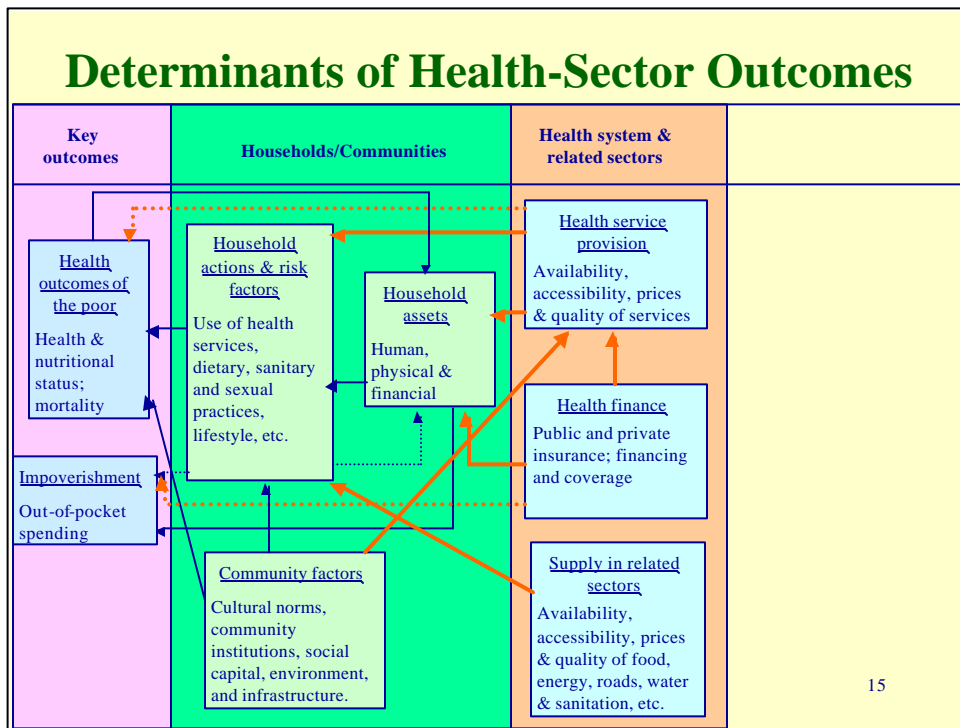
Usage of health services also influences impoverishment. High out-of-pocket spending on health services by households that are close to the poverty line may well push them below the poverty line. And spending by those already poor will push them even further into poverty.



Households are demanders of health services, as well as of the other inputs that they use to “produce” good health. Two sets of factors constraining their demand are shown on this slide.

One set is at the household level, namely household assets. Most obviously, these include financial assets. Better-off households invariably use private and public health services more. But ownership of physical assets is also important. Ownership of a bicycle or car affects ease of getting to health facilities and to market. Ownership of a refrigerator affects the household’s capacity to translate spending into good nutrition. Ownership of radios and TVs is important for receipt of BCC messages. Also crucial are human assets or knowledge—both general and health-specific.

Another set of influences shown here are those at the community level. These include intangible influences, such as cultural norms and social capital, but also tangible influences, such as environment (pollution), infrastructure (roads, water, sanitation, electricity, etc.). These influences are discussed in session 5 “Critical Factors Outside the Health Sector for Improving HNP Outcomes for the Poor”.

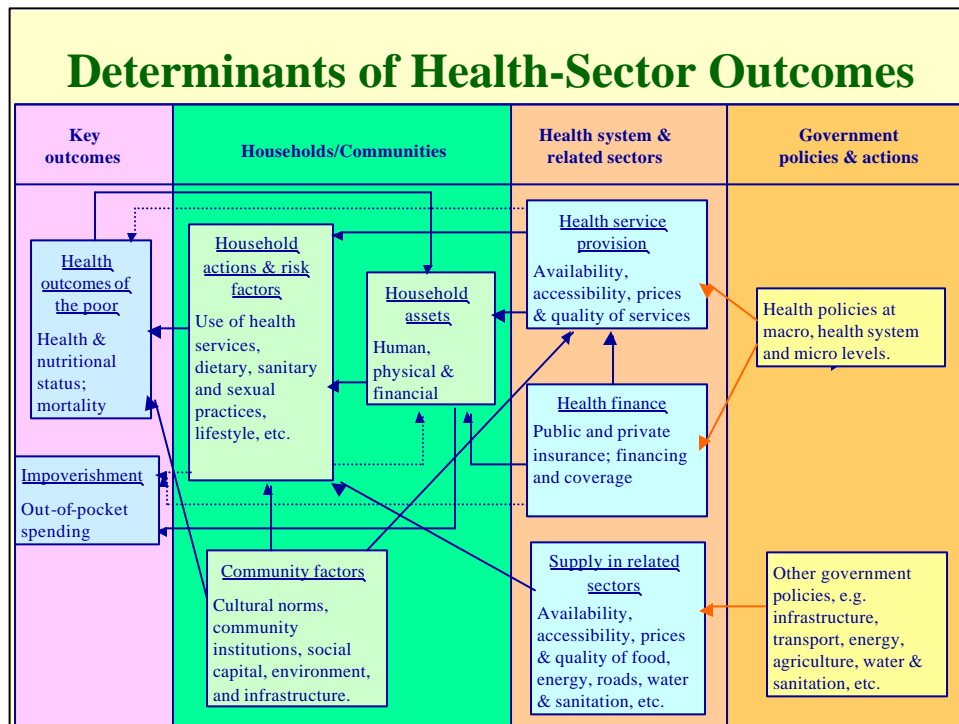


15

Of course, households’ demands for health inputs—and their ability to produce health—depend on things beyond the household and the community. The health care system is also crucial. Is it accessible? Do facilities have trained personnel? Are they stocked with key medicines and other inputs? Are they well organized and in a patient-friendly way? Do they deliver care that is of a high quality in a timely and continuous way? And are they accountable to the local community? These issues will be discussed in session 4 on “The Health System and the Poor”.

Also important is health financing. Who is covered by health insurance and for what? How much cost-sharing is there? What are the prices of services not covered by insurance? Are there fee-waivers? These issues too are addressed in the the session on “The Health System and the Poor”.

The final key set of influences on households’ demand for health inputs are in other sectors—food, energy, roads, etc. These influences are discussed in session 5 “Critical Factors Outside the Health Sector for Improving HNP Outcomes for the Poor”.



None of the influences discussed above are immune from policy. Health policies can influence health service provision, but also health financing. Other government policies influence other key sectors. Furthermore—not shown in the chart—government policies can influence household-level influences, and also community-level influences. For example, governments influence the level and distribution of household income and education. They can also influence environment and infrastructure, as well as (and less obviously) social norms and social capital.

The policy linkages are discussed in session 6 on “An Integrated Policy Framework for Improving the Outcomes for the Poor”.

Summing up so far

- **Two key health-sector outcomes—health (of the poor), and impoverishment**
- **Health responds to curative and preventive measures; households are producers of health and demanders of health inputs**
- **Household, community and health system factors influence household decisions re: (a) production of health and (b) use of services**

17

Self Explanatory slide: No text needed

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18

We have seen how households have a dual role in relation to health outcomes—as producers of health, and as demanders of health services. We have seen too the various constraints and influences that help shape the decisions that households make in each of these roles.

Our focus in this section is on tools that enable us to assess how important different household and community factors are in shaping health outcomes, whether through their impact on the decisions households make as demanders of health services, or through their impact on the decisions they make in the broader process of producing health. How can one tell whether in a particular country under-use of a particular preventive service by the poor is due largely to, say, lack of knowledge of the service's effectiveness or to their being unable to reach the facilities due to impassable roads?

We discuss two types of “listening” tools—passive (listening through the analysis of household and community survey data), and active (listening through the use of beneficiary assessments)

Diagnostic tools—What?

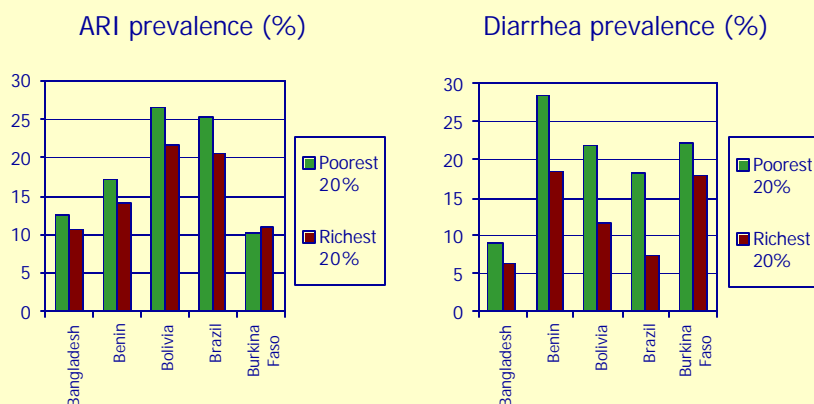
	Levels and distribution <i>What?</i> <i>(And Why?)</i>	Their effects <i>Why?</i>	
	Quantitative	Quantitative	Qualitative
Health outcomes			
Impoverishment			
Household actions & risk factors			
Household assets			
Community factors			

19

It might be helpful to think of the diagnostics in terms of peeling the layers of an onion. With the conceptual framework in mind, we start the diagnostics with the outer layer of the onion. These are “What?” questions and they relate to the two key outcomes—health outcomes, and impoverishment. Peeling the first layer of the onion away, we find the factors that directly influence our outcome variables—the household actions and risk factors. Looking at data on these gives us an idea *why* poor households may have bad health outcomes. We may find when we look at the outer layer that poor children die early and that as we peel away the first layer we find that they also have low immunization rates. This begs the question “Why do they have low immunization rates?”. Peeling away the next layer of the onion takes us to the household, community and health system factors that may account for low immunization rates amongst the poor. It might be that the health facilities serving the poor charge high fees. As we peel away the layers of the onion, we assemble data on both the levels of the variables in question and the size of the gaps between the poor and less poor.

There is another side to the diagnostics story, though. We need to know, in addition to the values of and inequalities in the variables, the strengths of the relationships between them—the strengths, in other words, of the arrows linking the boxes in the conceptual framework. It is one thing to know, for example, that facilities serving the poor charge fees. What we also need to know is whether these do indeed deter households from using facilities. Part of the “Why?” story is about variable values, but part is about the size of their effects.

Diagnostic tools—What? Health outcomes



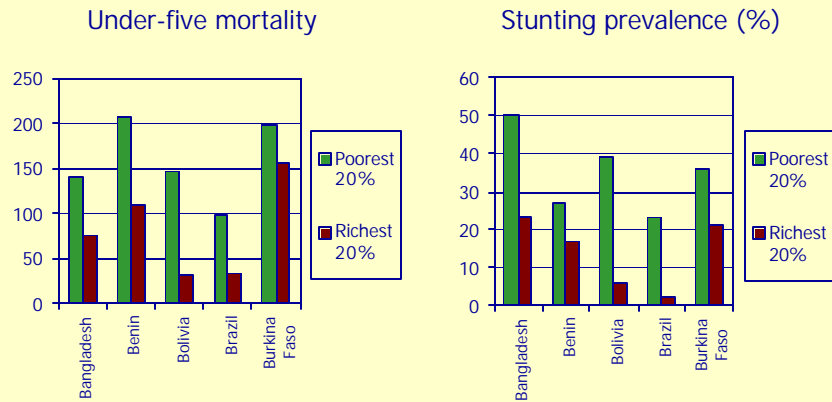
Source: DR Gwatkin, S Rutstein, K Johnson, R Pande and A Wagstaff, *Socioeconomic Differences in Health, Nutrition and Population*, HNP Network, The World Bank, 2000

20

The session on “Applying the Life Cycle Framework” (Session 2) goes through the different health outcomes at each stage of the lifecycle. Some countries have good vital registration systems, but most don’t. Many ECA countries used to, but don’t any more. Much of the data we have on health outcomes come from surveys. The survey with the largest reach in terms of countries is the Demographic and Health Survey, which focuses on maternal and child health. Outcomes have been tabulated across quintiles of a wealth index by Gwatkin et al. (2000). See the session on “Applying the Life Cycle Framework” and the website www.worldbank.org/poverty/health/data/index.htm for details. These sheets show the large gaps that exist in many countries, but that in some countries the gaps are fairly small.

These charts show prevalence rates for acute respiratory infection (ARI) and diarrhea for the poorest and richest “wealth” quintiles of the first 5 of the 44 countries for which disaggregated data are available. These illustrate how in the diagnostics for health outcomes, it is important to look not just at national averages but at rates amongst specific poverty groups.

Diagnostic tools—What? Health outcomes

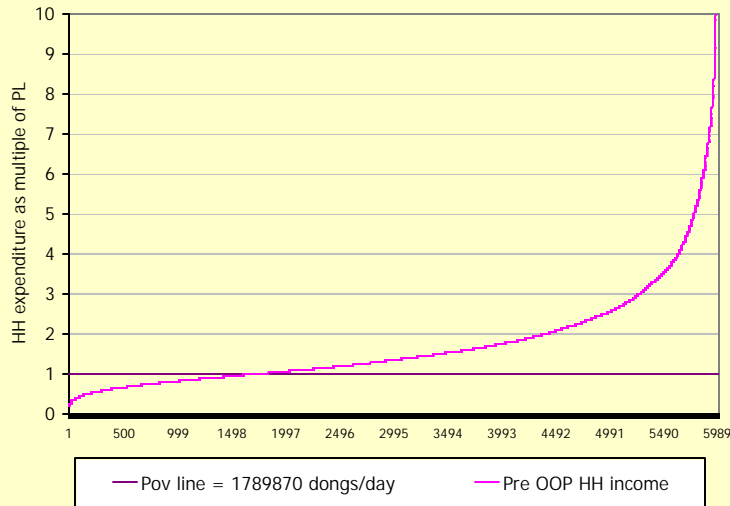


Source: DR Gwatkin, S Rutstein, K Johnson, R Pande and A Wagstaff,
Socioeconomic Differences in Health, Nutrition and Population, HNP Network, The World Bank, 2000

21

These charts show the under-five mortality rates and the prevalence rates for stunting (low height-for-age) for the poorest and richest “wealth” quintiles of the first 5 of the 44 countries for which disaggregated data are available. Again, these illustrate how in the diagnostics for health outcomes, it is important to look not just at national averages but at rates amongst specific poverty groups.

Diagnostic tools—What? Impoverishment

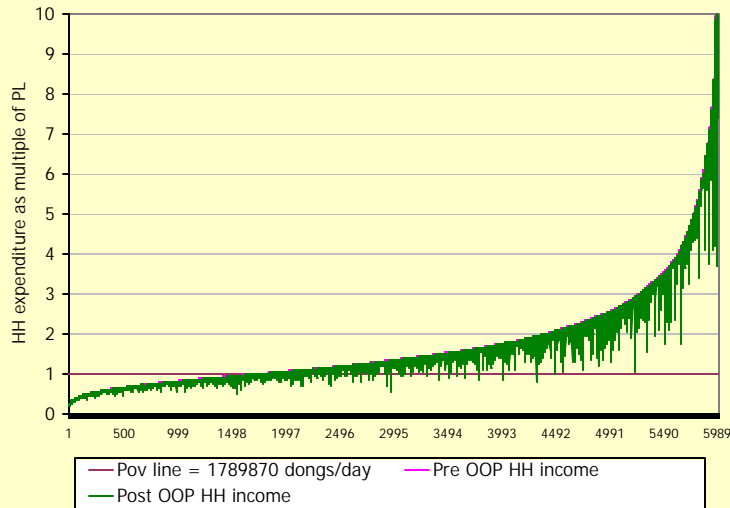


Source: A Wagstaff, N Watanabe and E van Doorslaer, *Impoverishment, insurance, and health care payments*, HNP Network, The World Bank, 2001

22

We turn now to the other key outcome of interest—impoverishment through ill health. This chart shows Pen’s parade. Households—these come from the Vietnam 1998 LSMS—are lined up by household consumption (or income if available). Their consumption (or income) is plotted on the vertical axis and their rank in the consumption (or income) distribution on the horizontal axis. By reading off at the poverty line, you can see how many (or what fraction) of households are poor. This is the *headcount*. The area below the poverty line above the parade shows the *poverty gap*—this, unlike the headcount, captures the depth of poverty. It is computed by calculating for each household the shortfall (if any) in the household’s consumption (or income) from the poverty line, and then adding these shortfalls across households.

Diagnostic tools—What? Impoverishment



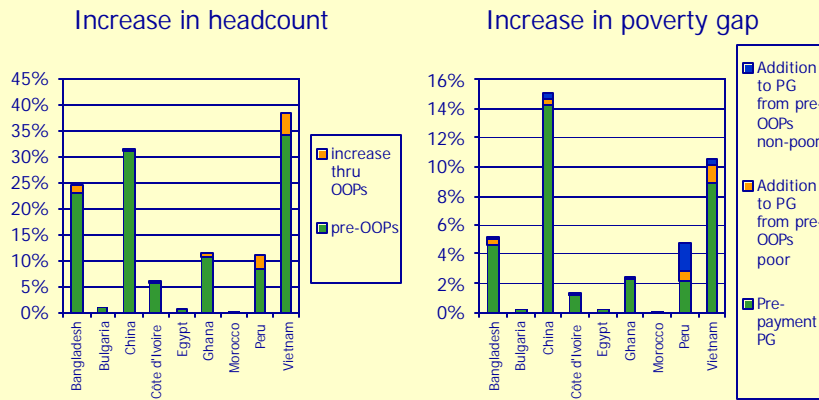
Source: A Wagstaff, N Watanabe and E van Doorslaer,
Impoverishment, insurance, and health care payments, HNP Network, The World Bank, 2001

23

The “drips” in this chart show the out-of-pocket payments (medical expenses) for each household. Some drips are big enough to take previously non-poor households below the poverty line. Some previously poor households become even poorer. Comparing the headcount and poverty gaps “before” and “after” out-of-pocket payments, gives a crude idea of the impoverishment caused by out-of-pocket payments. In this case, the headcount goes up from 34% to 38%, and the poverty gap from 9% of average income to 10.6%. Most of the latter (1.3 percentage points of the 1.6% increase) is due to deepening poverty amongst households that were already poor “before” out-of-pocket payments.

Diagnostic tools—What?

Impoverishment



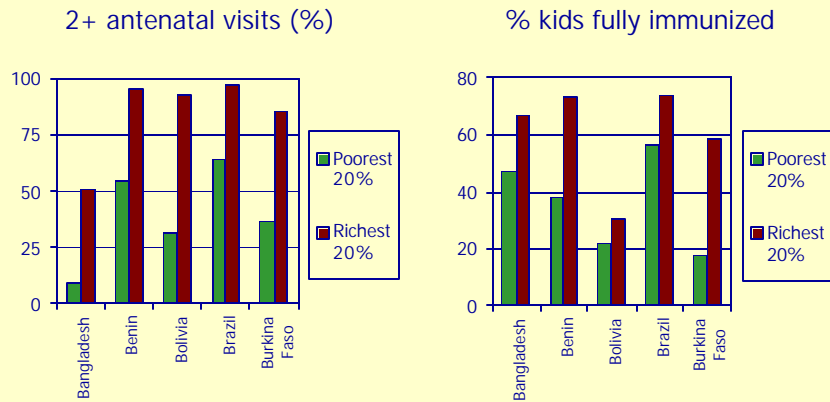
Source: A Wagstaff, N Watanabe and E van Doorslaer, *Impoverishment, insurance, and health care payments*, HNP Network, The World Bank, 2001

24

We can do the same exercise for other countries. These charts show (on the left) the headcount ratio “before” and “after” out-of-pocket payments. Countries vary in the impact of out-of-pocket payments on the headcount. In Vietnam it would have been considerably lower if households hadn’t been impoverished through out-of-pocket payments, but in China the effect seems fairly small. The right-hand chart shows the increase in the poverty gap, and breaks this down into the addition to the gap caused by households becoming poor and the addition caused by poor households becoming even poorer. In Vietnam, it seems that the increase is mostly due to poor households becoming even more poor, while the opposite appears to be true of Peru.

Diagnostic tools—What? (And Why?)

Household actions & risk factors



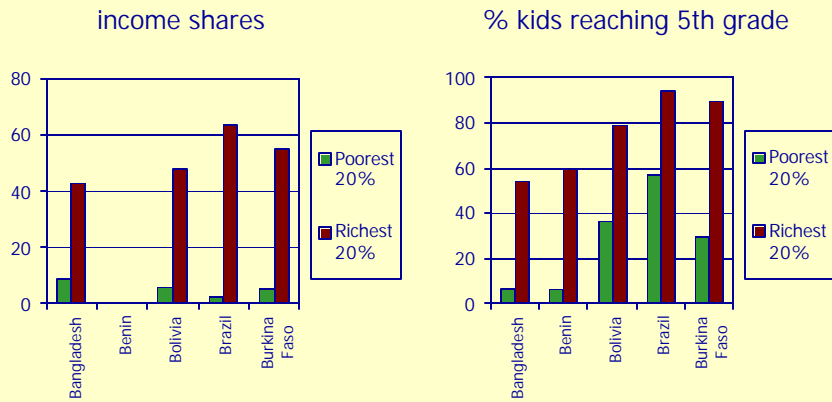
Source: DR Gwatkin, S Rutstein, K Johnson, R Pande and A Wagstaff,
Socioeconomic Differences in Health, Nutrition and Population, HNP Network, The World Bank, 2000

25

Peeling away the first layer of the onion, we come to the household actions and risk factors—the things that directly impact on health. Again, it is important to assemble evidence not just for the population as a whole, but for different poverty groups. Here there are some very large gaps, but interestingly countries with large gaps on one indicator are not always those that have the largest on the other.

Diagnostic tools—What? (And Why?)

Household assets



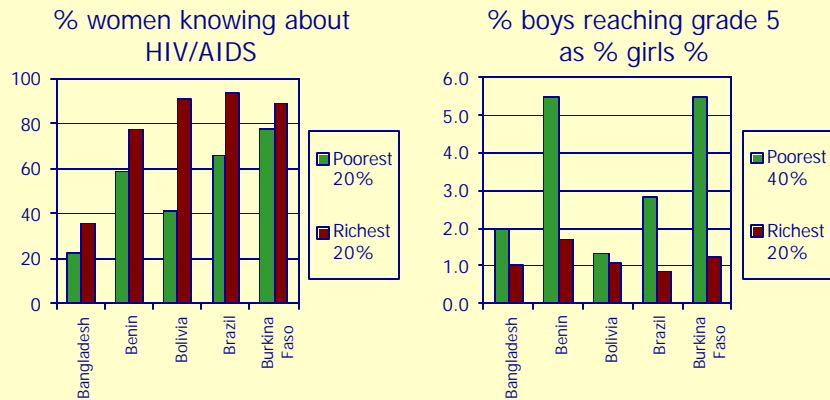
Source: World Development Report 2000/2001; Filmer, D. and L. Pritchett, The effect of household wealth on educational attainment: evidence from 35 countries. *Population and Development Review*, 1999. 25(1): p. 85-120.

26

We next peel one more layer of the onion away and in doing so come to the household factors that impact on household actions and risk factors. The gaps in income shares are striking—they are a good deal larger than the gaps in the outcomes or in the household actions and risk factors. Have you any ideas why this might be the case? The gaps in educational attainment are also striking.

Diagnostic tools—What? (And Why?)

Household assets



Source: DR Gwatkin, S Rutstein, K Johnson, R Pande and A Wagstaff, *Socioeconomic Differences in Health, Nutrition and Population*, HNP Network, The World Bank, 2000; D Filmer, *The Structure of Social Disparities in Education: Gender and Wealth*, DECRG Policy Research Working Paper #2269, 1999

27

In addition to general knowledge, health-specific knowledge is an important influence on health actions and hence on health outcomes. The chart here shows how unequal in some countries knowledge about HIV/AIDS is. In others, the gap is much smaller. Other key knowledge variables are knowledge about the signs of a sick child and knowledge about what to do with children with certain symptoms. To date, these aren't available by wealth quintile. The right-hand chart tries to get at the gender inequality question, but does so indirectly through inequalities in educational attainment rather than directly through inequalities in the household (e.g. over control over resources). For the bottom and top quintiles, the data show the percentage of boys reaching grade 5 as a fraction of the percentage of girls reaching grade 5. In Bolivia, this fraction is close to 1, so girls are only marginally less likely to reach grade 5 than boys. In Benin and Burkina Faso, boys are nearly six times as likely to reach grade 5 than girls. A question you might like to consider is whether, from your country experience, this indicator of gender equality is likely to be a useful indicator of gender inequalities in the household.

Diagnostic tools—What? (And Why?)

Community factors

Commune #1
"v. poor"
Cao Son, Lao Cai



Commune #43
"affluent"
Ninh Thanh, Thi Xa
Ninh Binh

**A tale of two
Vietnamese
communes—one
very poor, one fairly
affluent**

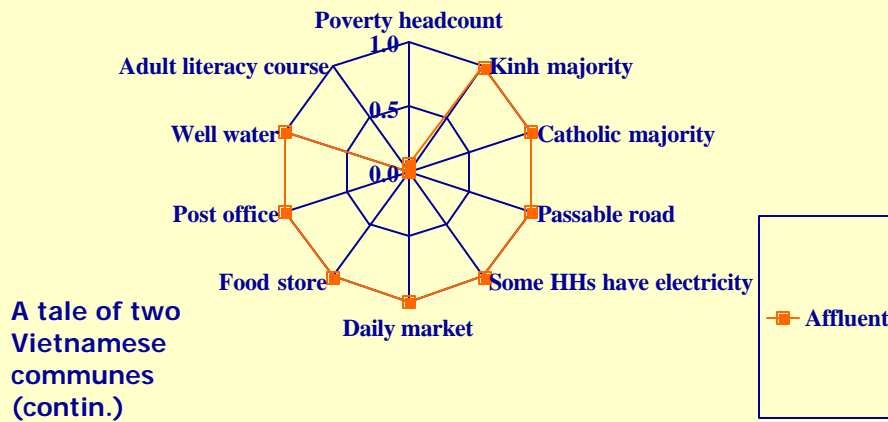
28

Household assets are a key influence on household actions and risk factors. But community influences matter too. Getting a picture of community influences can be done passively through the use of community survey data. Many LSMS surveys, and some DHS surveys, collect data not just on the households surveyed but also on the communities in which they live.

These next slides show the sort of data that one can get from the LSMS community surveys. They are from two communes in Vietnam: a very poor commune in Lao Cai in the mountains on the China-Vietnam border, and a more affluent commune in Ninh Binh between Hanoi and the sea.

Diagnostic tools—What? (And Why?)

Community factors



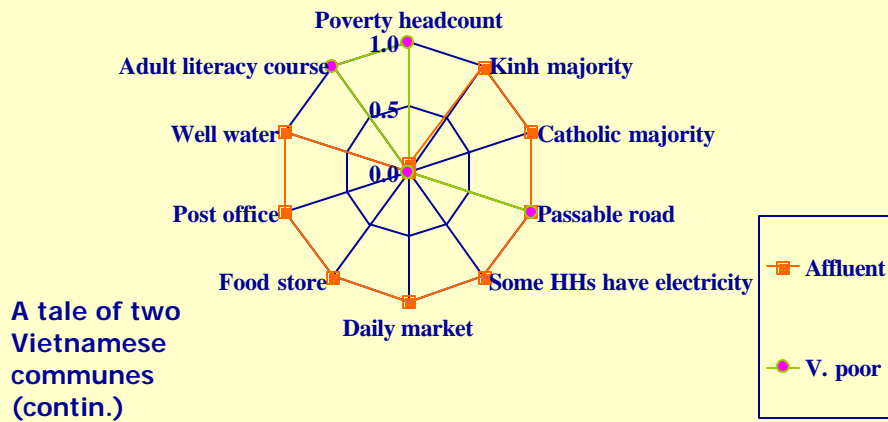
Source: Vietnam 1993 LSMS community data

29

This spider's-web chart shows at a glance how the two communes compare on certain indicators that might be thought relevant for household health actions. Starting at 12:00 on the clockface, the first ray of the spider's web shows the poverty headcount. In the more affluent commune, virtually no household falls below the national poverty line. Moving round clockwise, the next ray shows whether the commune is predominantly from Vietnam's major ethnic group—the Kinh. This affluent commune is a Kinh-majority one, and the variable takes a value of 1 and the marker is on the outside ring of the spider's web. (If it had not been Kinh-majority, the variable would have been zero, and the marker would have been at the center of the web.) Moving round further clockwise, we see that this affluent commune is also Catholic majority—a legacy of Vietnam's French imperial past. It has a road that remains passable the year round. Some of its households have electricity. There is a daily market, a food store and a post office. The commune's inhabitants get their drinking water from a well. There has been no adult literacy course in this commune in the recent past, which suggests that these courses are targeted in poor areas.

Diagnostic tools—What? (And Why?)

Community factors



A tale of two
Vietnamese
communes
(contin.)

Source: Vietnam 1993 LSMS community data

30

The circular markers on this slide show how the poor commune in Lao Cai fares on these variables. Here, 100% of the commune's inhabitants are below the national poverty line. They are mostly from one of the ethnic minorities and are not Catholic. The commune does have a road that remains passable the year round, but the commune does not have electricity, or a daily market, or a food store, or a post office. It doesn't get its drinking water from a well, but it has had an adult literacy course recently.

Data can, of course, be put together for the other communities surveyed. Comparisons might reveal much larger gaps between poor and less poor communities in some variables than in others. Or they might reveal that all communities suffer from the same problem—lack of a passable road, for example. Such an exercise ought to help identify which—if any—community factors could be principally to blame for poor health outcomes.

Communities and health services

- **Mobilizing community action and resources (e.g. community financing)**
- **Oversight and monitoring of health services**
 - **improving accountability, and**
 - **making services more responsive to community needs and preferences (e.g. Burkina Faso)**
- **Providing information and support to households on:**
 - **availability of services**
 - **preventive measures**

31

The importance of communities goes beyond the tangible things shown in the previous two slides. Community organizations can be important in mobilizing action and resources at the community level. They can play a part in overseeing, monitoring and sometimes managing local health services. Community organizations can also provide useful information on the availability of health services and on preventive care. These themes are taken up in the following sessions.

Diagnostic tools—What? (And Why?)
Where to get the data?

	Levels and distribution	Their effects	
	Quantitative	Quantitative	Qualitative
Health outcomes	DHS, LSMS, CWIQs		
Impoverishment	DHS, LSMS, CWIQs, Budget surveys		
Household actions & risk factors	DHS, LSMS, CWIQs		
Household assets	DHS, LSMS, budget surveys		
Community factors	LSMS community surveys		

32

The table above gives some sources for the different types of data discussed above. The CWIQ is the core welfare indicator questionnaire, which has the attraction—as its name suggests—of being carried out in a short space of time. Unlike the LSMS, it does not contain a vast amount of information on household consumption patterns, but instead relies on a short list of indicators of household living standards. These are coupled with questions on other aspects of household well-being including health. A list of websites—including the CWIQ website—appears at the end of the slides for this session.

Diagnostic tools—Why?

	Levels and distribution	Their effects	
	Quantitative	Quantitative	Qualitative
Health outcomes			
Impoverishment			
Household actions & risk factors			
Household assets			
Community factors			

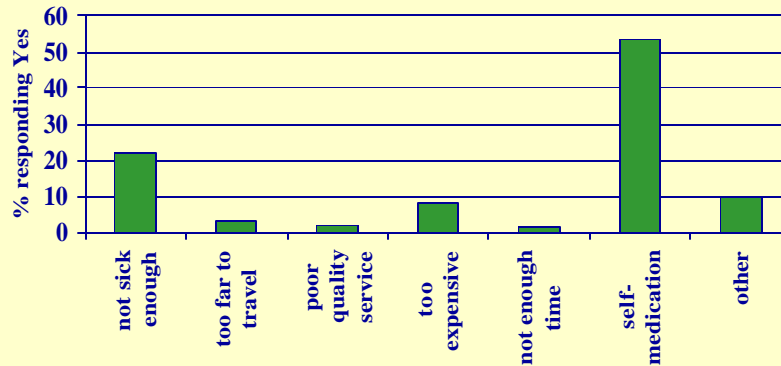
33

We said earlier that learning the values of variables and the inequalities in them between the poor and better off is only a part of the diagnostics story. One also needs to get an idea of the strength of the link between them. For example, as we said, it is one thing to know that the poor face a user fee when using services. It is another thing to know whether this actually deters them from using services. As we'll see in session 6 on "HNP and the Poor: An Integrated Policy Framework for Improving the Outcomes for the Poor", fees can indeed deter people from using services, but if by paying a fee people know the service will be good quality, they may be willing to do pay it. The general point is that knowing the value of a variable, or its distribution between the poor and the better-off, doesn't tell us how large its impact is on the variable we're interested in—whether it's an outcome or a household action and risk factor.

Getting a picture of the effects of variables on household actions can be done passively through the analysis of survey data (here called *quantitative*) or actively through focus groups (here called *qualitative*). We review each in turn.

Asking “Why?” questions in surveys

Why did you not seek care when ill?

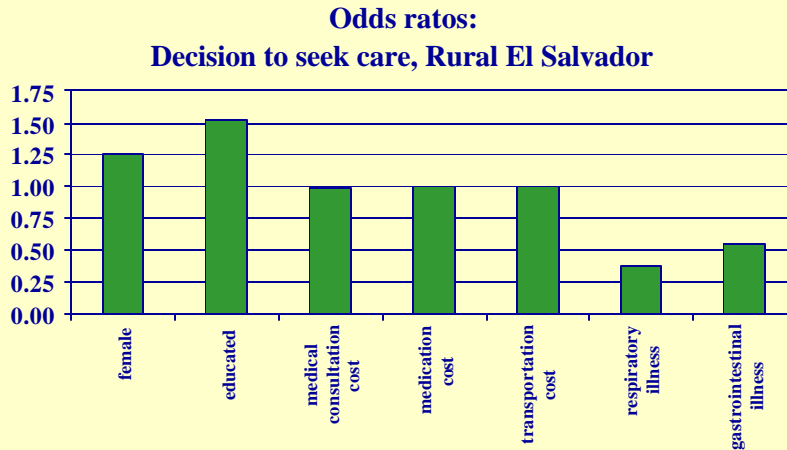


Source: Guyana 1993 LSMS household data

34

A simple approach to understanding why households make the decisions they do is to ask them why in a survey. We'll see this approach used to great effect in the India case study in a moment. This slide shows responses in Guyana to the question “Why did you not seek care when ill?”. 20% of respondents felt themselves to be insufficiently sick to merit seeking care. Of those who presumably did think themselves sick enough, nearly 10% cited expense as the deciding factor. Time costs were only a minor factor, as too was low perceived quality. The high proportion choosing self-medication raises the question of why they chose to self-medicate, since presumably this could have been due to the lower cost of this compared to seeking care from a formal provider.

Regression analysis of survey data



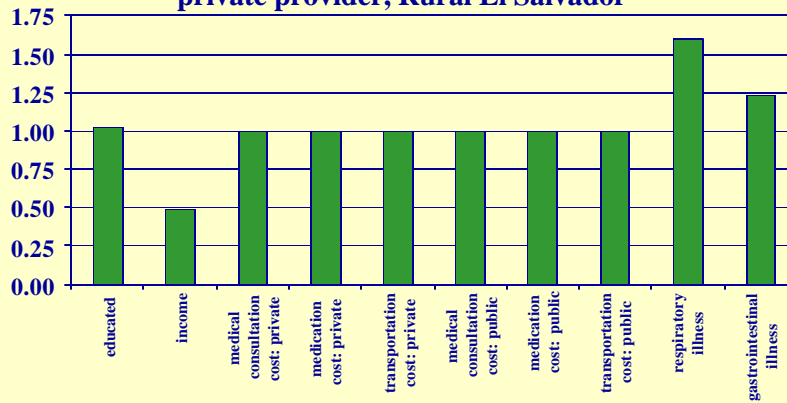
Source: Maureen Lewis, Gunnar S. Eskeland, and Ximena Traa-Valerezo
Challenging El Salvador's Rural Health Care Strategy, DECRG Policy Research Working Paper #2164

35

An alternative is to try to ascertain the various influences of different determinants of household actions through the use of regression analysis on household survey data. This chart shows the estimated odds ratios corresponding to the effects of different variables on the decision to seek care in rural El Salvador. The odds ratio on “female” is over one, indicating women are more likely to seek care than men. The same is true of educated people—the impact is greater than that of gender. None of the cost variables has any perceptible impact. Having a relatively minor illness—respiratory or gastrointestinal—makes a person less likely to seek care. Presumably these people self-treated.

Regression analysis of survey data

Odds ratios: Decision to seek public rather than private provider, Rural El Salvador



Source: Maureen Lewis, Gunnar S. Eskeland, and Ximena Traa-Valerezo
Challenging El Salvador's Rural Health Care Strategy, DECRG Policy Research Working Paper #2164

36

This chart shows regression results for the decision of whether to seek a public provider rather than a private provider. High income people tend to be less likely to seek a public provider, as do people with relatively minor illnesses. Interestingly, time and money costs do not seem to be a consideration in choosing between a public and private provider.

Regression analysis and focus groups

Focus groups in rural El Salvador

- “Health posts are good for well baby care and pre/post natal care, but not for curative care unless it is a very mild illness.”
- “The health center at La Palma is a little hospital with very good services. It is well equipped. The fee is only c/3 for consultation and sometimes medication.”
- The clinic of Malta charges c15.00. That is c/13 more than the health unit Rasario de Mora, but it is considered worth it because it is well equipped. Only one trip is necessary.”
- “Every time I go to the health unit in Jocaró, they give me only a prescription. I may as well go directly to the pharmacy and not waste my time waiting for a consultation.”

Source: Maureen Lewis, Gunnar S. Eskeland, and Ximena Traa-Valerezo
Challenging El Salvador's Rural Health Care Strategy, DECRG Policy Research Working Paper #2164

37

One of the interesting aspects of the El Salvador study was that the authors combined passive listening—regression analysis of survey data in this case—with active listening through the use of focus groups. Quotes from these reproduced here seem to lend support to the regression results. Public facilities in rural El Salvador seem to be considered useful for minor illnesses. Private facilities charge more but it is not considered exorbitant when account is taken of the higher availability of drugs and medicines. What also comes across is the fact that the time costs overall don't appear to differ much—public facilities are closer, but the waiting time is longer, and the patient still has to go afterwards to the pharmacy with the prescription.

Asking “Why?” Actively

- **Beneficiary Assessments:**
 - “... watching people in their own territory and interacting with them in their own language on their own terms”
 - Also includes direct observation, simple counting, and is expressed in quantitative terms
 - Demands close rapport between the practitioner and the beneficiaries
 - Most powerful when combined with quantitative tools (passive surveys)

38

A powerful “active” listening tool for asking the “why” questions is **Beneficiary Assessment**: Beneficiary Assessment (BA) is a method that can be used to gather information about how an activity is perceived and valued by its principal users. The use of the BA approach allows for the views of key actors and stakeholders such as the poor, service providers, NGOs, community leaders and local government officials to be heard and incorporated into project work. Consultation with local people allows projects to respond to felt needs, and provides the basis for involving stakeholders in various aspects of project design and implementation, building commitment and ultimately ownership and accountability.

BA is a qualitative, social assessment method of investigation and evaluation that consists of three kinds of data collection techniques: (i) in-depth *conversational interviewing* (with individuals or groups) around key themes or topics, (ii) *direct observation* and *participant observation* (where the individual lives in the community for a short time), and (iii) review and analysis of written documents. This methodological approach is not meant to supplant questionnaire surveys and other traditional methods for data gathering; rather it *complements* these methods with reliable and useful information for task managers and policymakers on the *socio-cultural context and perceptions* of a beneficiary/client population.

For more information see: "**Beneficiary Assessment - An Approach Described**" by **Lawrence F. Salmen**. Copies of the full paper are available from **Environment Department, Social Policy and Resettlement Division, of the World Bank, Washington, D.C. 20433, Fax (202) 522-3247.**

Asking “Why?” Actively

- **Beneficiary Assessments are not ...**
 - ... **empowerment activities. The objective is to provide decision makers policy relevant information (voicing concerns or identifying bottlenecks)**
 - ... **exclusive. You are trading off statistically significant sample sizes for in-depth qualitative information**

39

It is also important to realize what an active listening tool is not.

Such tools should not be confused with approaches designed to develop sustained empowerment to vulnerable groups. BA can be used in a health sector exercise to dig deeper into understanding the real constraints faced by poor households and individuals within households. Such information has to be policy relevant and “actionable.”

As mentioned earlier, it is important to combine quantitative and qualitative tools in order to get a representative picture of the constraints faced by the poor. The Bangladesh example highlighted later in this session shows how active and passive listening should work together.

Session Outline

1. Introduce two case examples

India Immunization

Bolivia Nutrition

2. Motivate Household Roles and Community Influences

3. Introduce Diagnostic (Listening) Tools

4. Application of tools in the case examples

5. Links to other sessions—health systems analysis, factors outside health sector, and public Policy

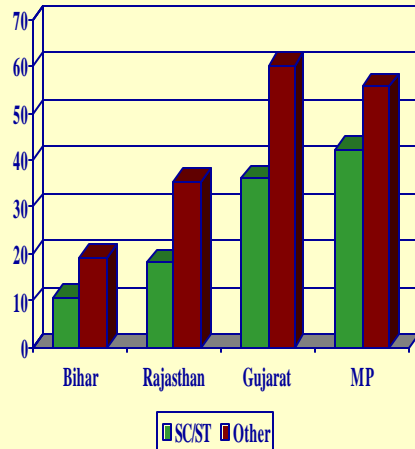
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Self Explanatory slide: No text needed

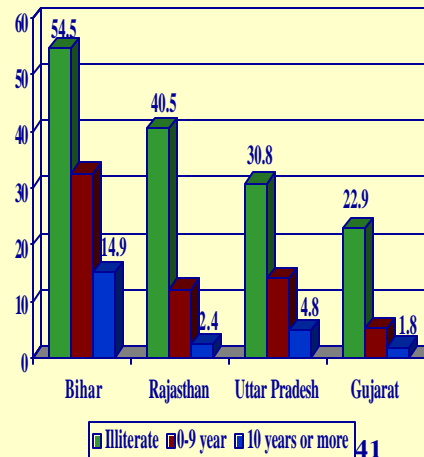
Application of tools in case examples

Immunization in India

% Children Fully Immunized



Not Immunized/Mothers Educ.



Case Example 1: Immunization in India.

Household Survey Data Allow us to better pin point problems:

Scheduled Tribes(ST)/Scheduled Castes (SC): There is a significant difference in the immunization status of ST/SC groups compared to the rest of the population. In all states they have the lowest coverage and the highest percentage of un-immunized children. While the two groups, the Tribals and the Scheduled Castes, have different characteristics, both have problems with physical, economic and social access to health services. Tribal groups tend to be located in clusters in isolated and inaccessible areas, have distinct languages and cultural practices and often poor communication with outside communities. The tribal districts being remote, have poorer facilities, a higher proportion of vacancies in health facilities and poor transportation for outreach staff. On the other hand, SCs are part of the larger communities but are socially discriminated against. They often reside at the periphery or in worse-off parts of villages. Therefore, while it may not be physically difficult for SC children to attend an immunization session taking place in the village, they may be excluded or made to feel unwelcome, possibly if it is held at the center of the village or in the house of the village leader.

Maternal Education: There is a strong association between maternal education and children's vaccination coverage. Children of mothers with low literacy have the lowest vaccination coverage levels. Further the differences in vaccination coverage levels by mother's education levels are large.

QUESTION TO PARTICIPANTS: What are the policy implications of the two graphs in this slide?

Immunization in India

- **Households need to know about immunizations and believe that they are important for child survival and well-being.**
- **Financial resources are needed for the household to seek care. Money is needed for transportation, productive time lost in seeking the provider, and payments for the provider (official or unofficial).**
- **Physical access to a provider with some element of trust in her/him.**

42

Case Example 1: Immunization in India

The critical household action needed for a child to be immunized is for the household to seek a health care provider that has the inputs needed to perform the immunization—vaccines, cold-chain equipment, training, supplies, etc.. But for the household action to take place, the following interrelated conditions should exist:

1. Decision-makers in the household need to know about immunizations and should believe that it is important for child survival and well being.
2. Financial resources are needed for the household to seek care. Money is needed for transportation, productive time lost in seeking the provider, and payments for the provider (official or unofficial).
3. Physical access to a provider with some element of trust in her/him

Immunization in India

Asking one simple “Why?” question

- **The Reproductive and Child Health Project finances an annual household survey.**
- **In 1998, Respondents with un-immunized children where asked why.**
- **30% of respondents were not aware of the need for immunization and 33% were not aware of the time and place the immunizations were to be provided.**

43

Case Example 1: Immunization in India

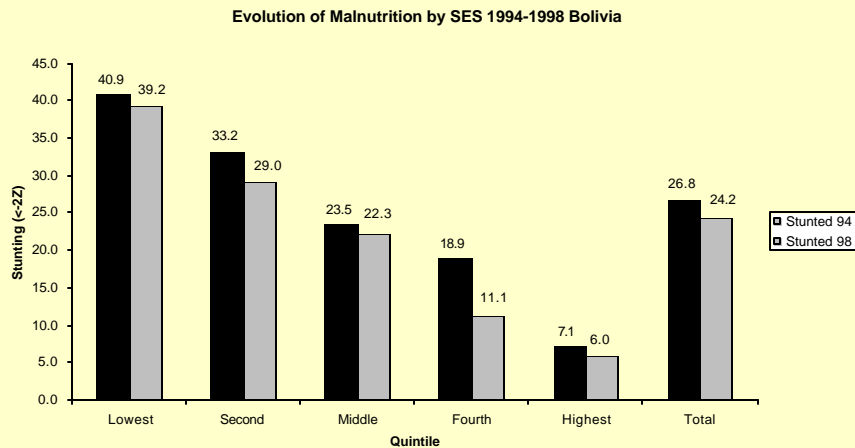
To help determine the relative importance of the three conditions in India, the 1998 household survey asked households with un-immunized children why they did not seek this life-saving preventive service. While all three conditions listed above were mentioned, two specific answers—both related to knowledge—accounted for more than 63% of responses. 30% of respondents were not aware of the need for immunization and 33% were not aware of the time and place the immunizations were to be provided.

QUESTION TO PARTICIPANTS: What are the policy implications of the findings in this slide?

QUESTION TO PARTICIPANTS: What additional information about household factors would further improve policy design?

Application of tools in case examples

Malnutrition in Bolivia



44

Case Example 2: Malnutrition in Bolivia

Over time, the poor have not benefited as much from overall economic growth as the non-poor as can be seen in this slide. Malnutrition has generally dropped as GNP/capita has risen but the nutrition of the non-poor has improved far more than that of the poor, especially in the fourth quintile.

Malnutrition in Bolivia

Causes of Malnutrition

- **Food security: availability, access, utilization**
- **Disease (vicious cycle): Diarrhea, measles, and ARI cause malnutrition and malnutrition causes immune deficiency**
- **Fertility**
- **Individual and HH behavior: Energy expenditures, birth spacing, breastfeeding, autonomy of women, psychosocial stimulation of children**

45

Case Example 2: Malnutrition in Bolivia

Malnutrition can be seen as a product of individual and family choices, cultural and natural environment, community processes, economic pressures, and national policies and programs. Each of these determinants is affected by poverty and each can be alleviated or exacerbated by policies and programs.

Food security has three dimensions and three levels: availability, access and utilization at the national, household and individual levels. If one dimension at one level is inadequate then the country lacks food security. The question for Bolivia, is which dimension and what level.

Disease is both a cause and an effect of malnutrition. Diarrhea, measles, and acute respiratory infections (ARI) cause malnutrition by reducing food intake, increasing nutritional needs, and reducing absorption of nutrients from the food that is eaten. Malnutrition, in turn, including vitamin A deficiency, causes immune deficiency and diseases are more frequent, more severe, and more prolonged as a result. Nutrition is a direct or underlying cause of 55% of under-five mortality.

One critical cause of malnutrition is high fertility. Pregnancies that occur at too early an age, too often, too closely spaced, and at too late an age not only jeopardize the nutrition of the mother, but they are associated with high malnutrition in children as well.

The keystone of improving nutrition at any income level is changing individual and household behaviors. Energy expenditure, birth spacing, breastfeeding, autonomy and self-confidence of women, child feeding behaviors, nutritional management of disease, and psychosocial stimulation of young children are all behaviors that affect nutrition. All can be changed -- consciously or inadvertently -- by public programs and policies.

Malnutrition in Bolivia

- **Different ways of asking what and why questions:**
 - **Municipal Constraints Assessment in 15 poor localities; included participatory evaluation of nutrition programs with beneficiaries and leaders**
 - **Quantitative analysis of three household surveys**
- **Main Findings:**
 - **General misunderstanding of causes and solutions (e.g. food availability is not an issue)**
 - **Nutrition knowledge at the HH and municipal level was lacking (e.g. meat and milk)**
 - **Co-targeting of intersectoral and behavioral actions**

46

Case Example 2: Malnutrition in Bolivia

The study combined active and passive listening methods. It involved consultation with government, donors, and NGOs and included a Municipal Constraints Assessment in 15 very poor municipalities. It involved participatory evaluation of the nutrition problem and nutrition-related programs by community residents, functionaries, and local leaders. The Micronutrient Constraints Assessment was health facility-oriented and carried out in nine municipalities, in four departments. Observations and interviews in three levels of health facility, in both the public system and the social security system, and focus groups and interviews with beneficiaries were included in the study. Quantitative reanalysis of the 1998 National Demographic and Health Survey (ENDSA) and of the 1993 and 1997 Social Fund evaluation in selected parts of the country were carried out as well.

Critical Findings:

- Food availability is not the main cause of malnutrition in Bolivia
- Nutrition knowledge at the HH and municipal level was lacking (e.g. There is a widespread belief that lack of milk or meat in the diet is a cause of malnutrition)
- For nutrition programs to achieve stronger results for the poor in Bolivia, an integrated approach is needed that includes intersectoral factors and behavioral actions.

Application of tools in case examples

A Further Case Example: Bangladesh

Logical Framework



Goal Improved health and family welfare status among the most vulnerable women, children and poor of Bangladesh.	<ol style="list-style-type: none"> 1. MMR reduced 2. IMR m/f reduced 3. <5 MR m/f reduced 4. Malnutrition m/f reduced 5. Communicable diseases controlled m/f (STD/HIV, TB, etc.) 6. Unwanted fertility reduced
Purpose Client-centered provision and client utilization of Essential Services Package (ESP), plus selected services.	<ol style="list-style-type: none"> 1. Increased pct of population, esp. of women, children and poor, needing ESP who receive appropriate, timely, affordable, accessible, client-centered, one-stop ESP (reproductive health care, child health care, communicable disease control, simple curative/limited care), which meet govt./community quality standards (see detailed indicator matrix) 2. 60-65% of annual public expenditure for sector allocated to ESP and 50% of donor aid allocated to ESP

14 Lenders and Donors supporting a 5-year and US\$2.9 Billion sector program

47

The World Bank is a member of a consortium of lenders, donors and technical agencies providing financial and technical assistance to the Government of Bangladesh in the health and population sector. The consortium finances a project supporting the Government's five-year Health and Population Sector Program. The focus on the poor and on improving the government's investment in the health of the poor is at the heart of the design and monitoring of implementation.

The slide shows 4 Cells from the logical Framework of the program

--Two specific issues stand out:

1. The movement away from inputs (supply side) to outputs (use of services)
2. The focus on the poor and vulnerable

--Looking at the Purpose indicators (2nd column, 2nd row), how in the world would the program be able to monitor this?

Application of tools in case examples
KISS, QQT, SMART in Bangladesh

**Solution: SDS
SERVICE
DELIVERY
SURVEY**



1. Representative Cluster Sites
2. Qualitative and Quantitative
3. Focused on Use of ESP (who is not using and why not)
4. Simple, Site-Based Household Survey
5. Related Facility Survey
6. Focus Group Data Collection
7. Quick Results (6 Weeks)
8. Cheap (US\$ 150,000/Cycle)

48

The Solution: Service Delivery Surveys

The methodological approach is based on CIET* methods. The approach combines quantitative and qualitative data from households, service users and service providers. Analysis goes beyond a description of levels of indicators: it includes a risk analysis of areas where interventions might produce useful benefits.

*CIET is an international group of epidemiologists and social scientists who bring scientific research methods to local government and community levels. By involving people in evidence gathering and analysis, CIET helps them to participate, in an increasingly informed way, in decisions that affect their lives.

Baseline Survey Findings in Bangladesh

- **Women's awareness of public services:**
 - **29 % were not aware of publicly-provided primary health services**
 - **30 % were not aware of publicly-provided secondary health services**
 - **Awareness was primarily for curative**
 - **Literacy, distance to facility, and poverty were factors in knowledge**

49

Since one of the most critical elements of the program was the use of basic services (including life-saving preventive services) it was important not only to track service use as part of the monitoring system, but to get a better understanding of the causes of low use.

The slide shows a subset of findings of the baseline survey, conducted in 1998, that highlight the low level of awareness of health services by the most vulnerable groups (poor women).

Baseline Survey Findings in Bangladesh

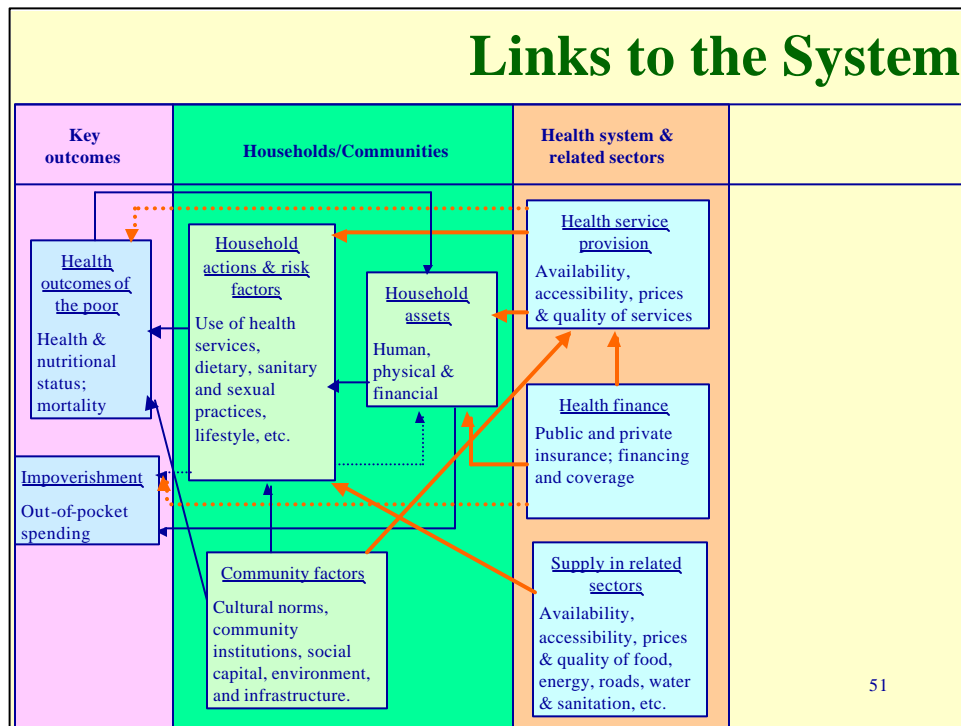
- **There are findings on:**
 - **Service and provider availability**
 - **Transport/other personal costs**
 - **Perception of quality**
 - **Problems with public services**
 - **Willingness to pay**
 - **Use of contraception**
 - **Use of preventive services**

50

The SDS Baseline survey and the follow-up survey (conducted in 2000) contain considerably more information than the few slides can highlight. You can get access to the information in the two reports by going to the CIET web page:

<http://www.ciet.org/welcome.html>

Links to the System



51

As was described in the earlier slides in this session, household influences and community factors link directly (and in some cases indirectly) to the Health, Nutrition, and population outcomes and the functioning of the health system.

Links between households and the health system will be explored further in the next session (Session 4). At issue is understanding how the health system fails the poor. A critical part of that system failure is the role of households as consumers.

Another link that will be explored in a later session (Session 5) relates to the role of households as producers of health; where inputs from the health system and other sectors are used. Constraints faced by poor communities and households may help explain the persistent gaps between rich and poor in terms of health, nutrition and population outcomes.

Links to Health Sector

- **Service Use:**
 - **Who is using (or not using the services)**
 - **Why vulnerable groups are not using**
 - **Gap between need and demand**
 - **Gap between demand and use**
 - **How to influence behavior and actions of HHs**
- **Financing services:**
 - **Real costs to vulnerable groups**
 - **Implications of the financing system**

52

This slide summarizes the areas where asking the “what” and “why” questions can help policy makers pinpoint constraints and devise operational solution.

Clearly, knowing who does, and who does not, use basic and life-saving services is an important step. When the analysis is done with a poverty focus, gaps in use motivate the need for asking the “why” questions.

An important next step, then, is to determine if the gaps in use for poor households are due to a difference between the need for the services and the household demand for these services (first gap), or are it due to the difference between the demand and actual use (second gap). As we saw in the India immunization case example, when the cause of the low immunization is lack of awareness of the importance of immunization, the policy answer needs to include convincing vulnerable families of the importance of immunizing their kids. Understanding how to influence knowledge and behavior becomes critical to successful implementation of outreach. On the other hand, in parts of India where the main cause of low immunization is the second gap (the population was aware of the need but could not physically or financially seek the service) then the policy response should focus on the barriers to use.

Another important factor that links system failure to household constraints is the understanding of the real costs to the poor of using the health system. While attention is typically given to user fees, most of the evidence (from Africa and South Asia) point to other real costs that are usually not addressed. Examples include the real costs associated to travel, forgone income from travel and waiting time (including the need for repeated visits in order to get services), and under the table payments.

Links to Other Sectors

- **Intersectoral factors impact heaviest on the poor**
 - **Water and sanitation**
 - **Education**
 - **Social exclusion**
 - **Social capital**
 - **Environmental and occupational factors**
 - **Infrastructure (e.g. roads for access)**

53

Session 5 will explore in more detail the importance of the factors listed in this slide to the achievement of better health, nutrition and population outcomes for the poor.

To take home ...

- **Health outcomes worse amongst the poor, and households impoverished through out-of-pocket expenses**
- **Dual role of households—they are producers of health, and demanders of health services**
- **Scientific literature tells us**
 - the curative and preventive measures that make for good health outcomes, but not
 - what determines who gets what, and who does what
- **Households are influenced in their actions and behaviors by**
 - household factors,
 - community factors, and
 - health system factors
- **The poor tend to be disadvantaged in all**

54

We won't reiterate the conclusions in the text of these slides. Rather we'd like you to reflect on the dual role of the household—as a producer of health, and as a demander of health services.

Consider the household as a producer of child health. What are some of the key “inputs” in this process? In the country you worked most recently on, who in the household typically makes most of the key decisions concerning health “inputs”? Does this vary—across socioeconomic groups, ethnic groups, etc.? Is this an issue in child health outcomes? Can you think of examples of inputs that improve child health but the poor use more of? Can you think of examples where policy successfully changed households’ “choices” of inputs? Which institutions were involved in this process? What influences have other groups in society had on households choices in the process of “producing” child health? Have commercial interests played a part? Is this acknowledged in policy? Do community groups play a role? Anyone else?

Consider next the household as a demander of health services. Do you have a sense—for the country you have worked on most recently—of how important household and community factors are in accounting for low utilization rates of health services by the poor? How did you develop this sense? Is the health care system in the country sensitive to these issues?

... and act on!

- **Quantitative evidence available or can be assembled on the “What?” questions:**
 - How much worse do the poor fare in terms of outcomes, and key actions and behaviors?
 - How far are households impoverished through out-of-pocket payments?
- **On the “Why” questions, we can use a combination of:**
 - direct questions in surveys,
 - regression analysis, and
 - focus groups
- **Case examples from Bolivia and India show how the major obstacles to improving health of the poor may sometimes lie:**
 - at the household and community levels, not
 - in the clinic or the hospital

Diagnostic tools
Resources

- **HNP Poverty TG website**
 - <http://www.worldbank.org/poverty/health>
 - click on [Country Reports](#) for DHS data on health outcomes, and some actions and behaviors, tabulated by quintile
 - click on [Poverty Reduction Strategy Sourcebook](#) for HNP PRSP sourcebook chapter and annexes—info on indicators, methods, etc.
- **Health System Development TG**
 - ongoing work on community financing
- **Bank's Poverty website**
 - <http://www.worldbank.org/poverty/>
 - click on [Data on Poverty](#) for links to Africa Household Database, PREM's inventory of household datasets, QWICs, LSMS, etc.

56