

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

Session 3

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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?**

Session Outline

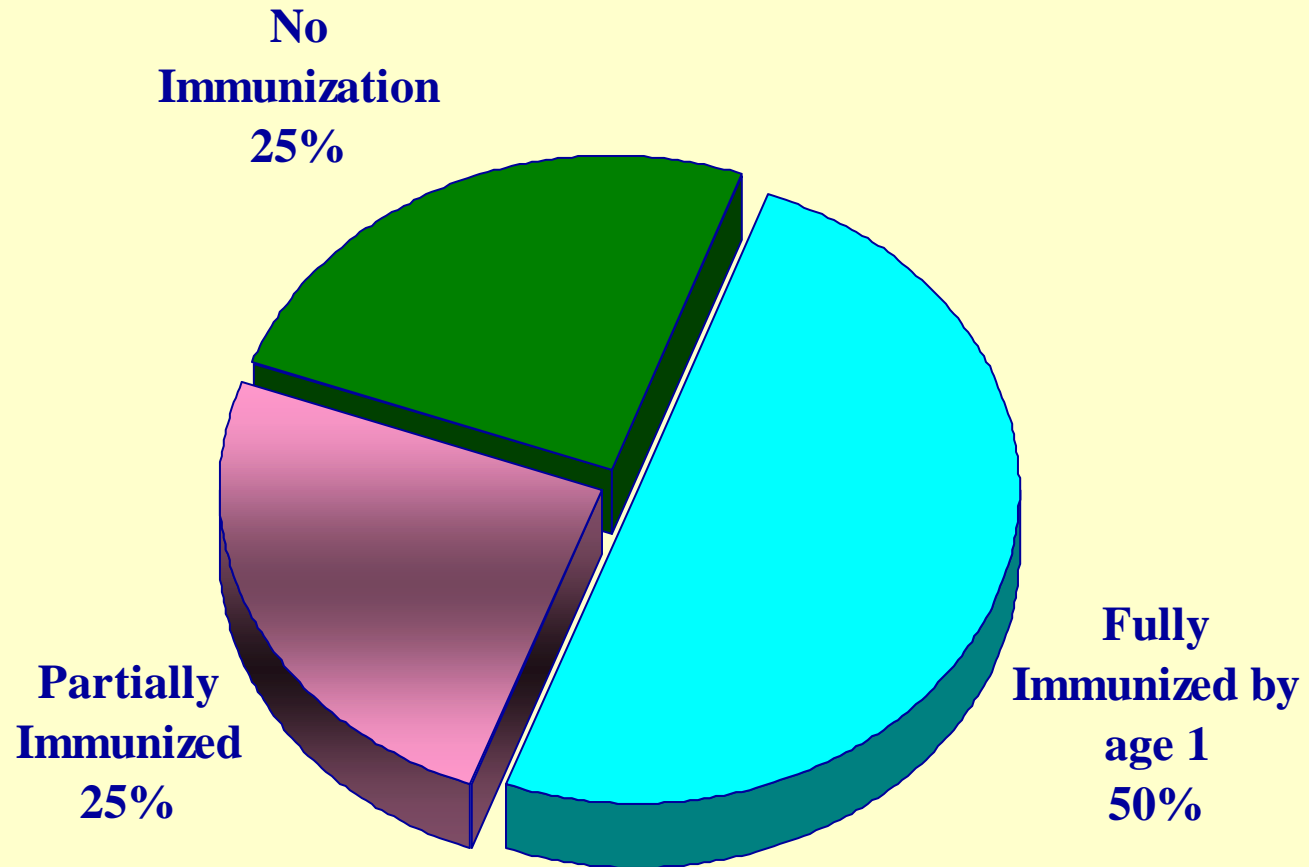
1. Introduce two case examples

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

Some kids in India get immunized



It depends where they live ...

Percent Fully Immunized: Rural India by State (1992-93)



Percent Fully Immunized

- No Data
- 0 - 20.9
- 20.9 - 40.9
- 40.9 - 50.9
- 50.9 - 66

... 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	<u>109.2</u>	106.3	89.7	65.6	<u>44.0</u>
Under 5 Mortality	<u>154.7</u>	152.9	119.5	86.9	<u>54.3</u>
<i>Health Outputs: Immunization Coverage</i>					
Measles	<u>27.0</u>	31.0	40.9	54.9	<u>66.1</u>
DPT 3	<u>33.7</u>	41.1	51.8	64.6	<u>76.7</u>
All vaccinations	<u>20.2</u>	25.1	34.1	46.9	<u>59.8</u>
No vaccinations	<u>44.7</u>	38.9	28.8	18.8	<u>11.5</u>

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)**

... 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**

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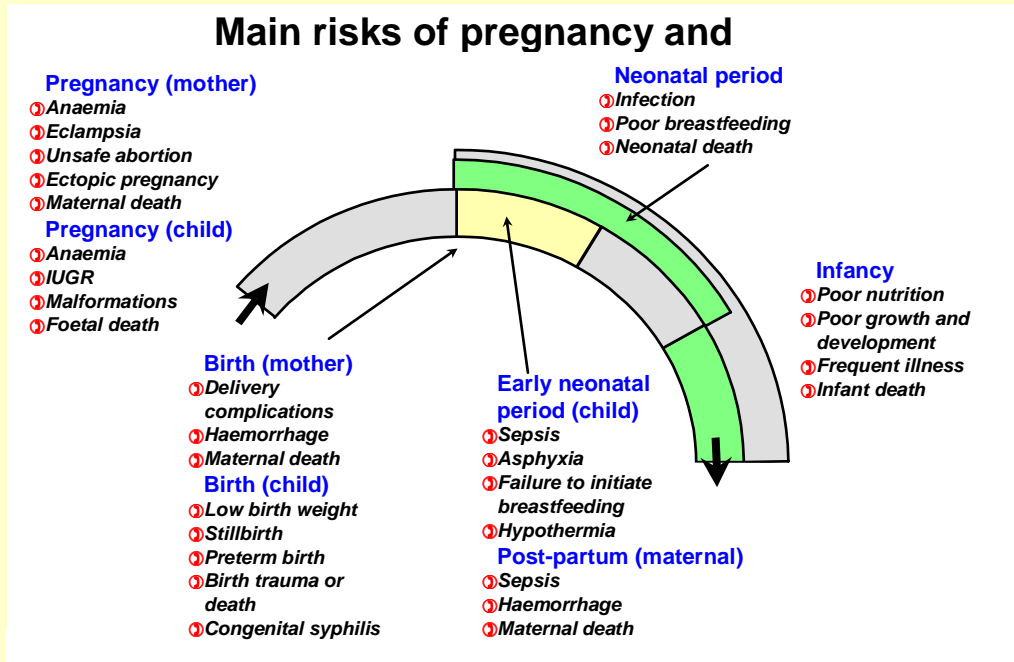
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Health outcomes and households



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

Health outcomes and households

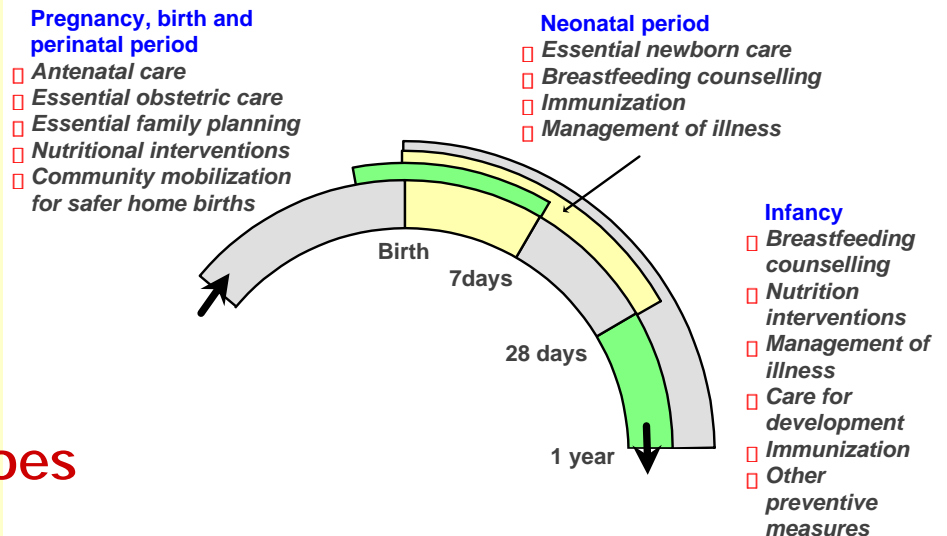
Outcomes respond to curative measures ...

... 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?

Main interventions in pregnancy and early life



Determinants of Health-Sector Outcomes

**Key
outcomes**

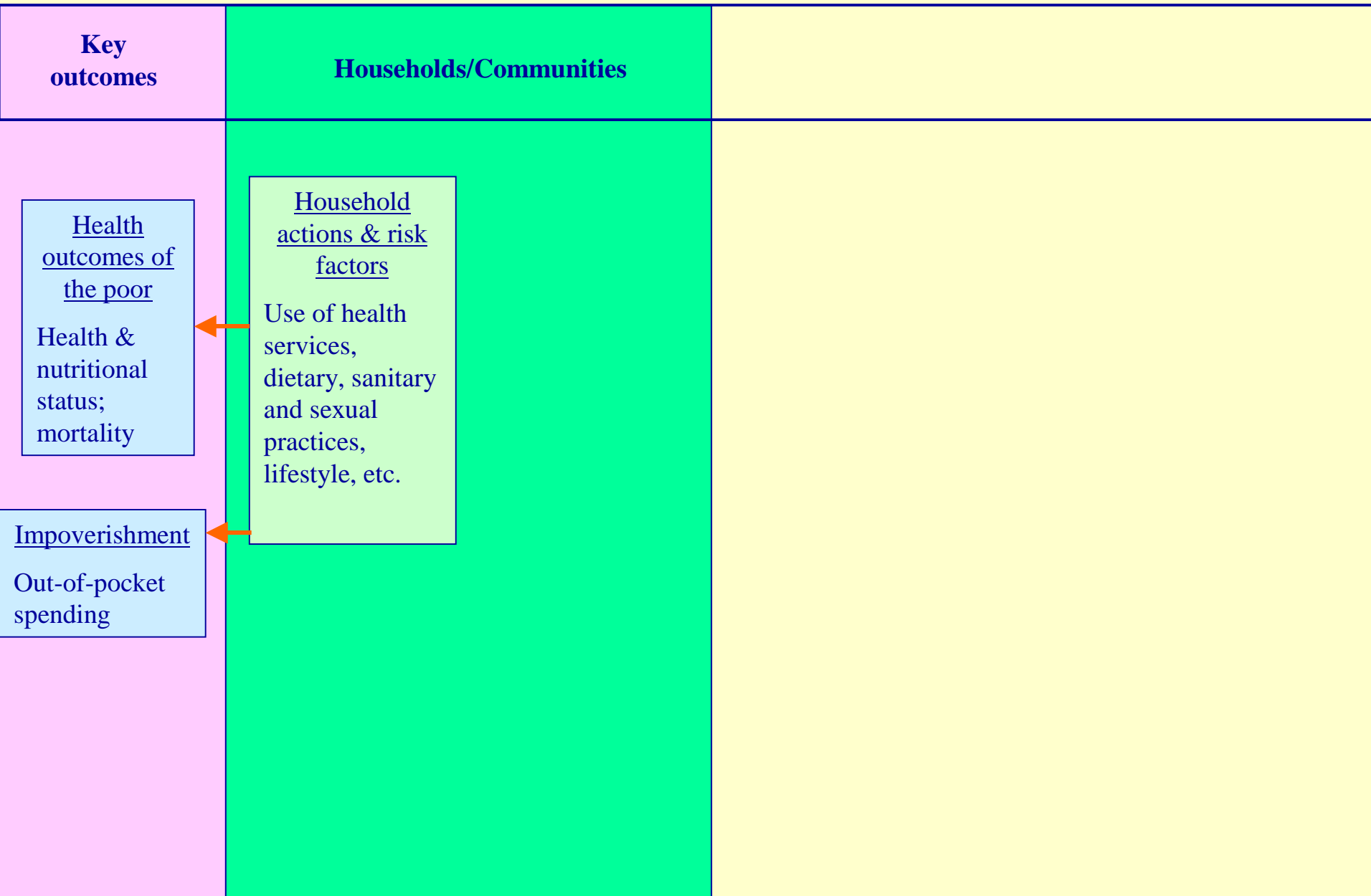
Health
outcomes of
the poor

Health &
nutritional
status;
mortality

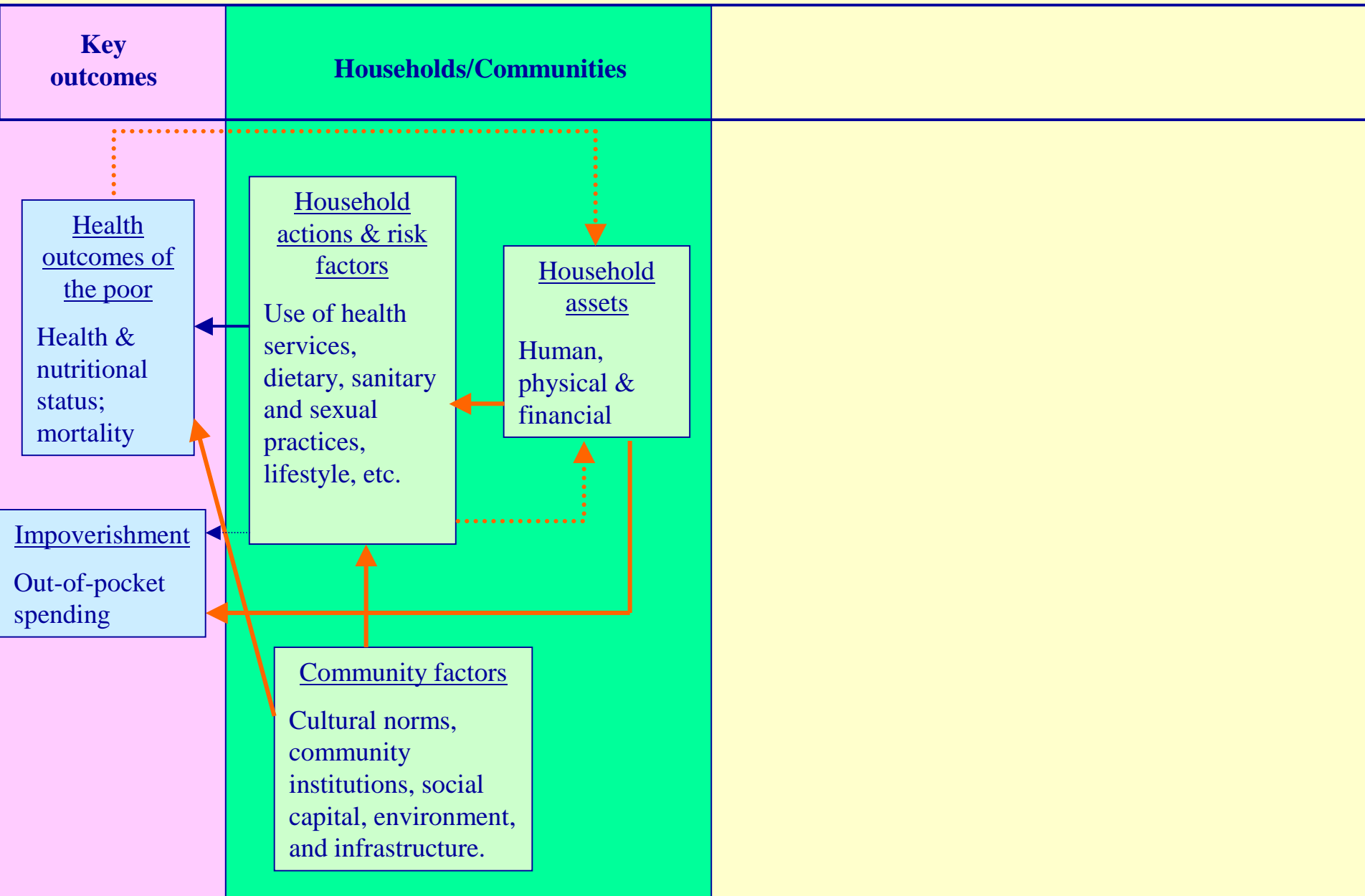
Impoverishment

Out-of-pocket
spending

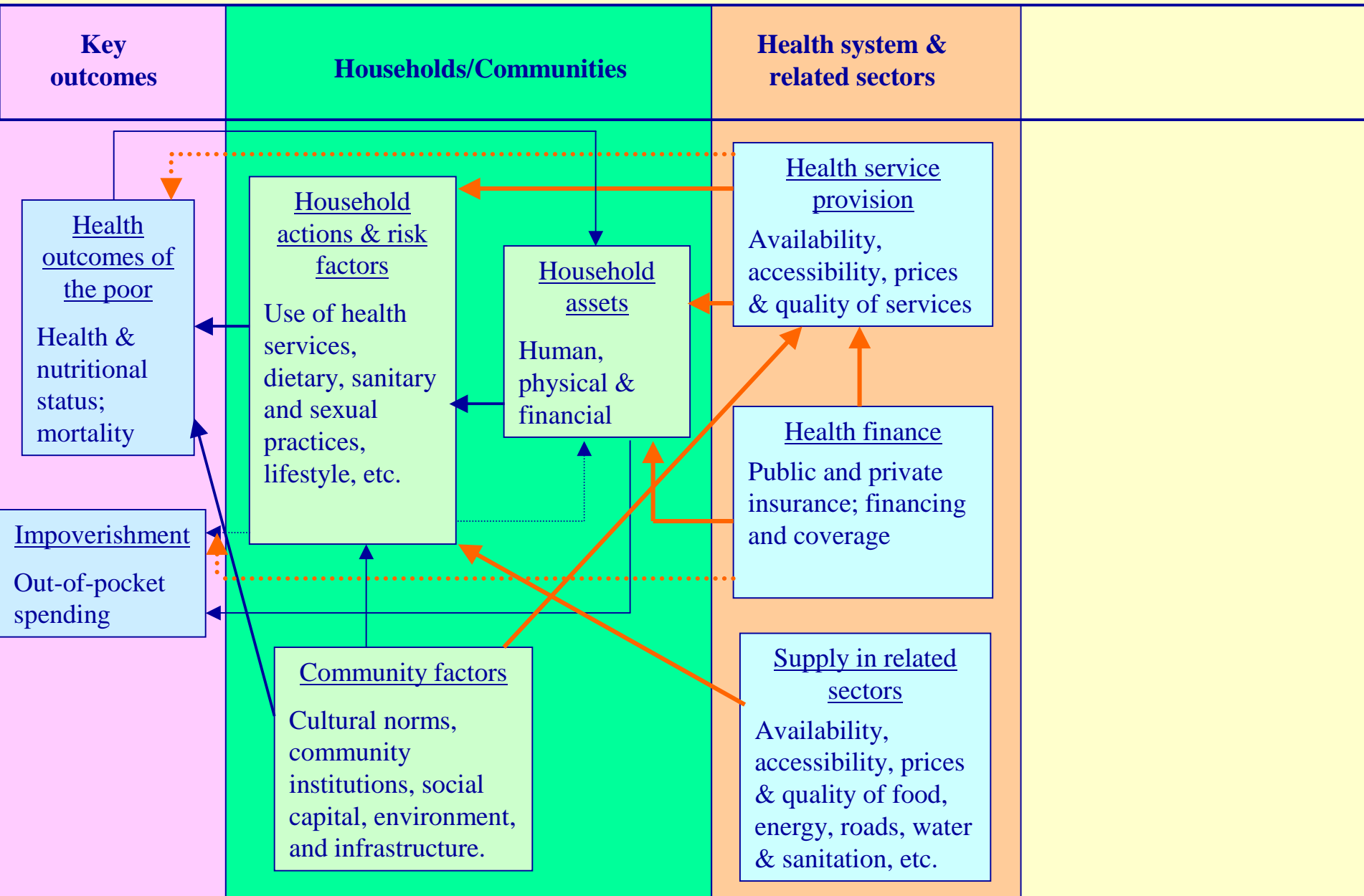
Determinants of Health-Sector Outcomes



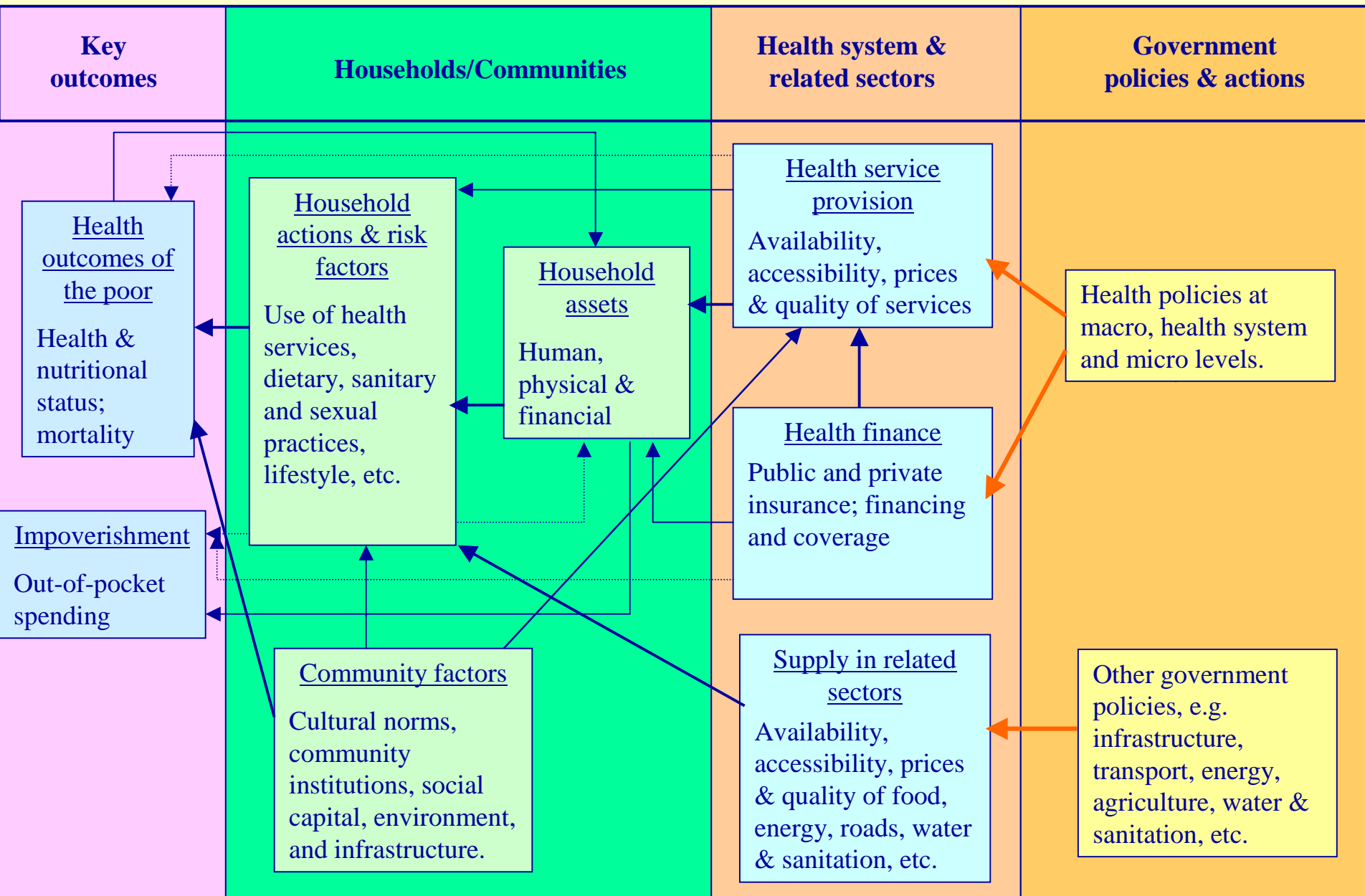
Determinants of Health-Sector Outcomes



Determinants of Health-Sector Outcomes



Determinants of Health-Sector Outcomes



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**

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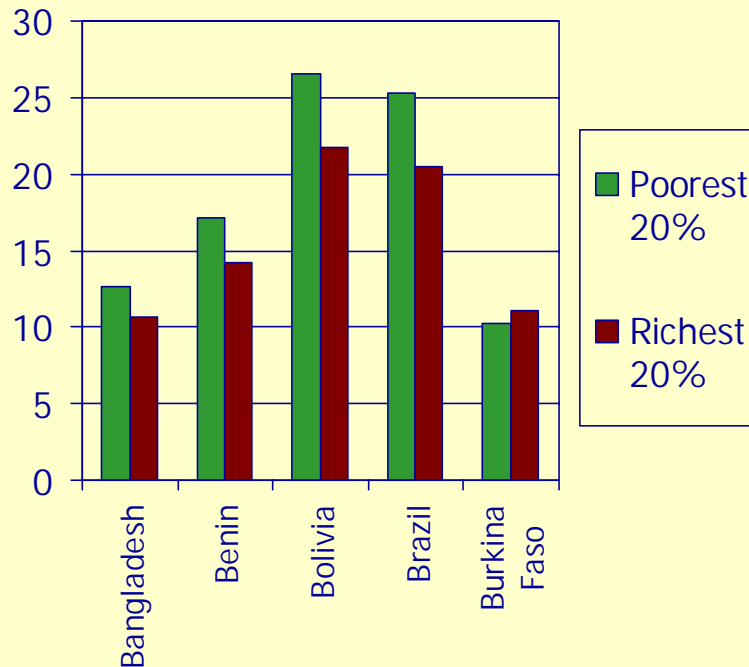
Diagnostic tools—What?

	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			

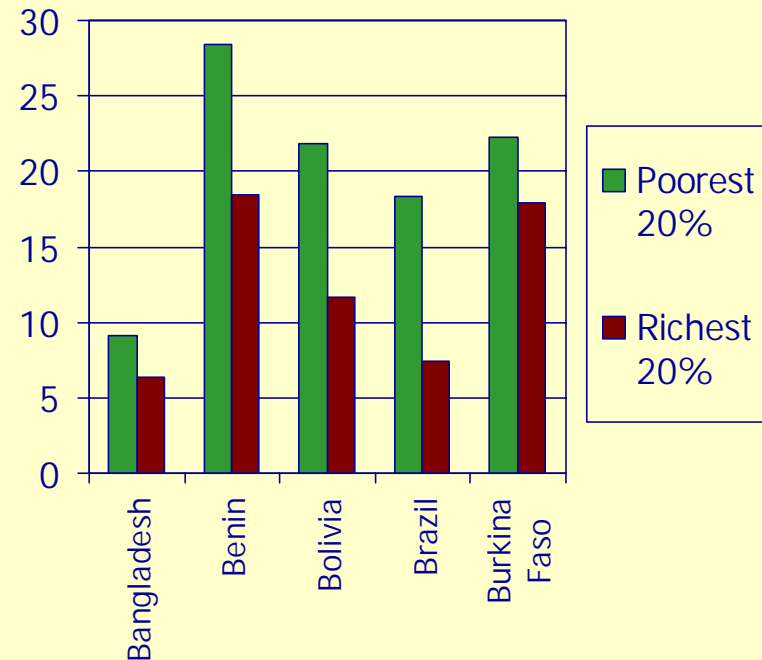
Diagnostic tools—What?

Health outcomes

ARI prevalence (%)



Diarrhea prevalence (%)

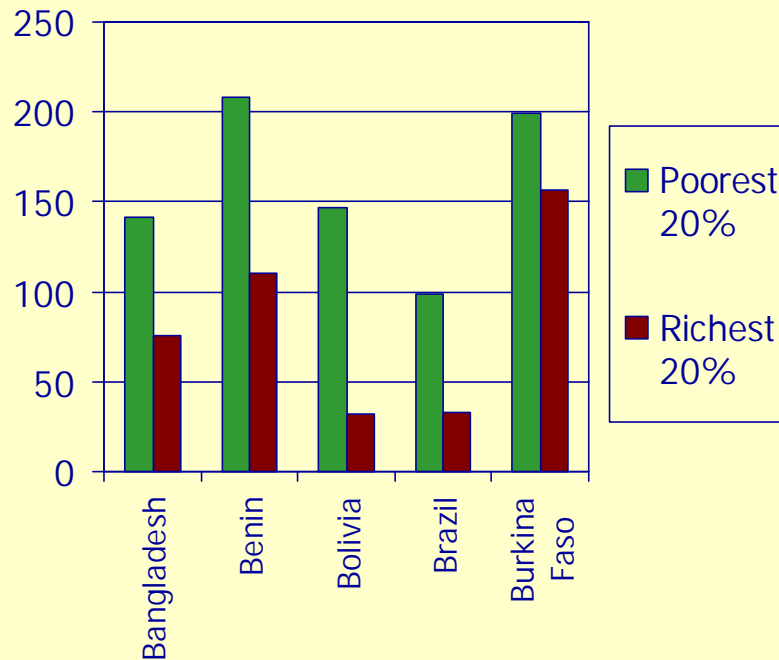


Source: DR Gwatkin, S Rutstein, K Johnson, R Pande and A Wagstaff, *Socioeconomic Differences in Health, Nutrition and Population*, HNP Network, The World Bank, 2000

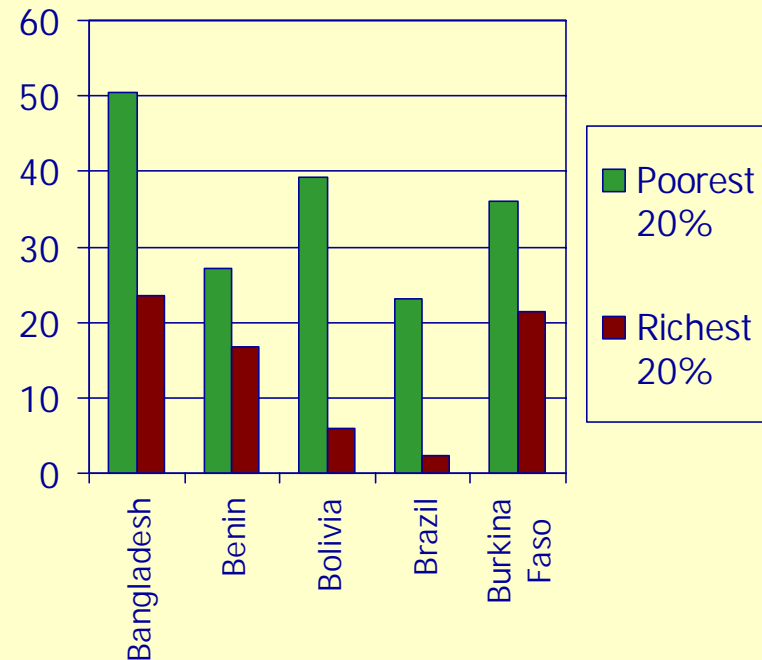
Diagnostic tools—What?

Health outcomes

Under-five mortality



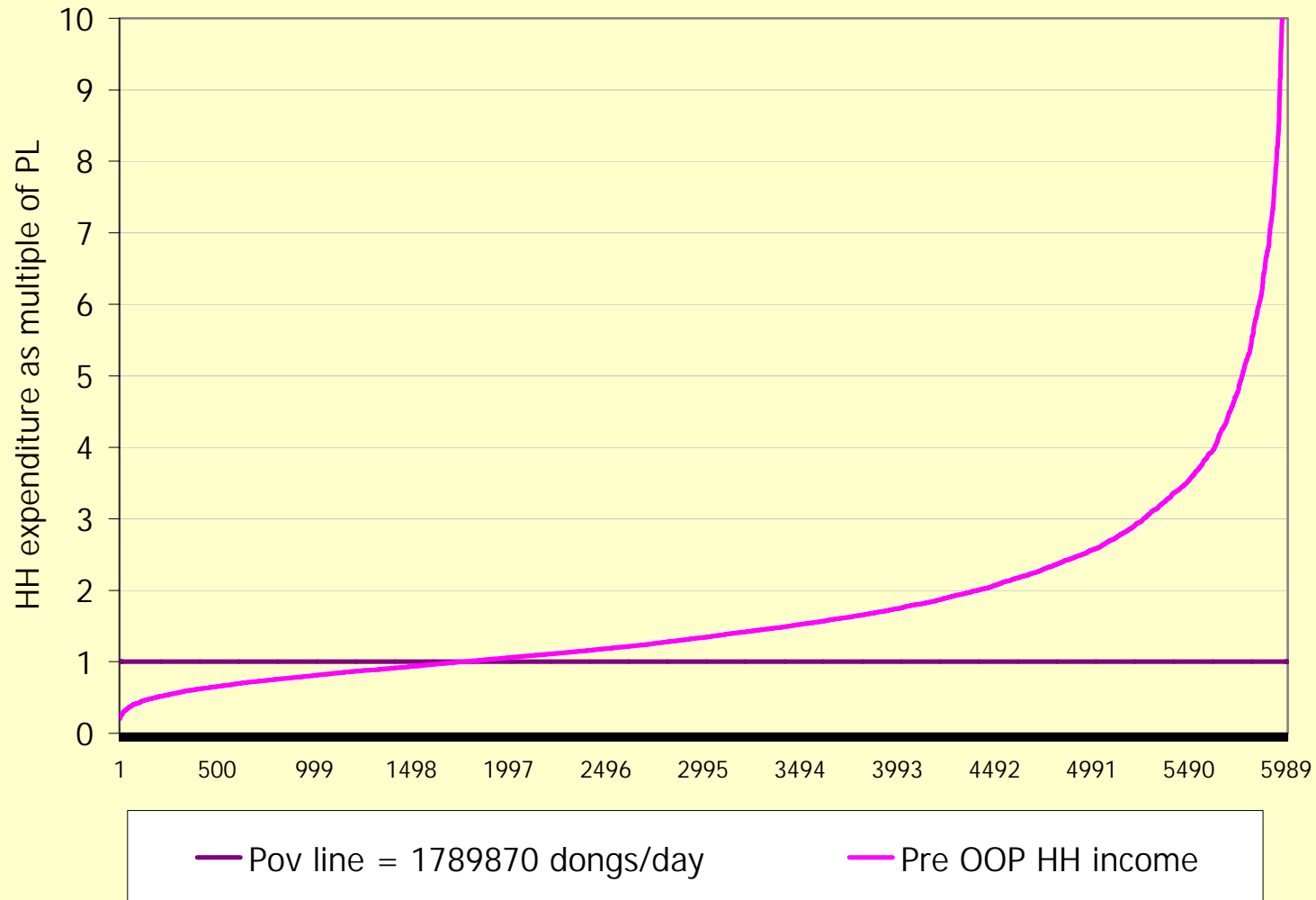
Stunting prevalence (%)



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

Diagnostic tools—What?

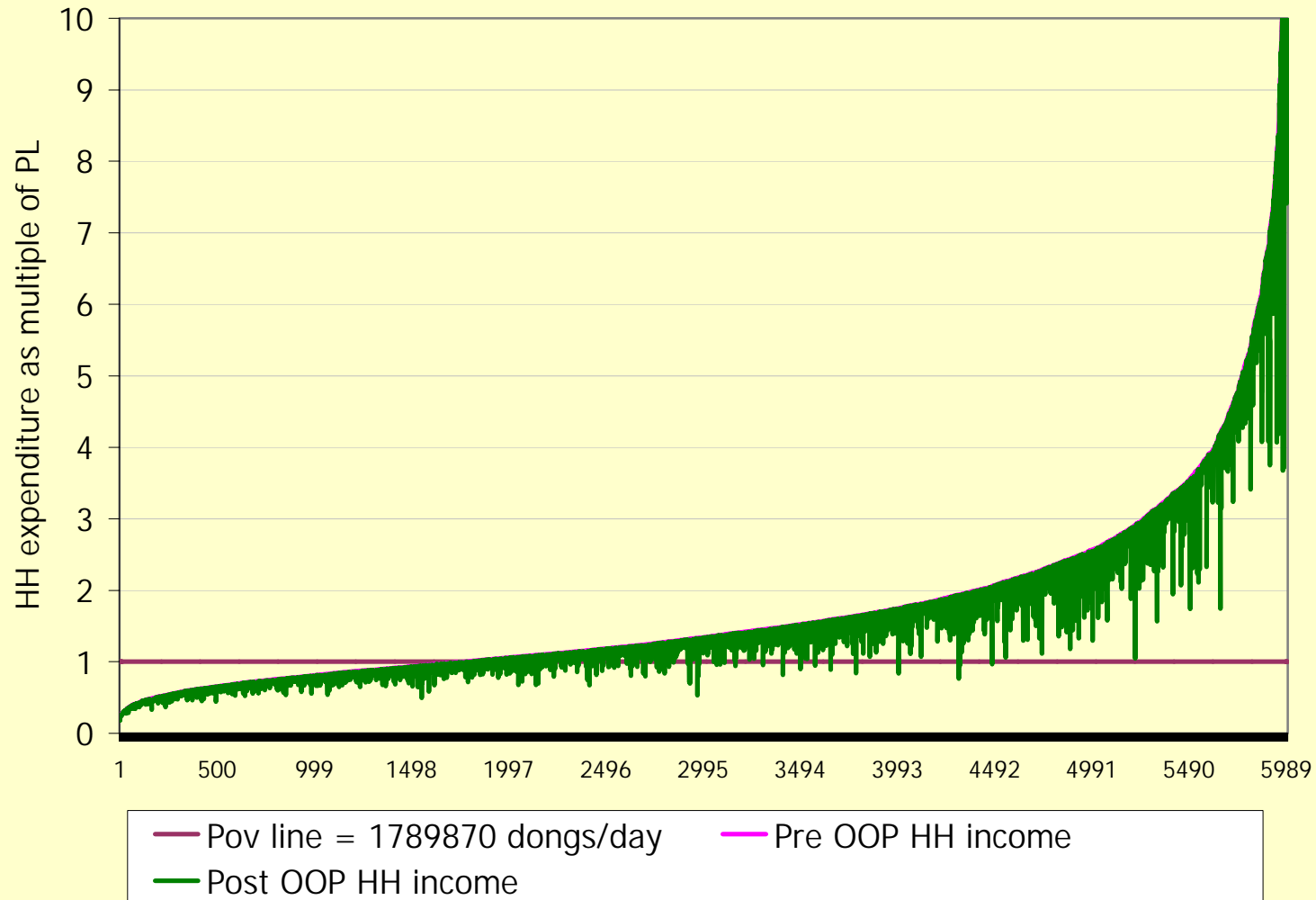
Impoverishment



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

Diagnostic tools—What?

Impoverishment

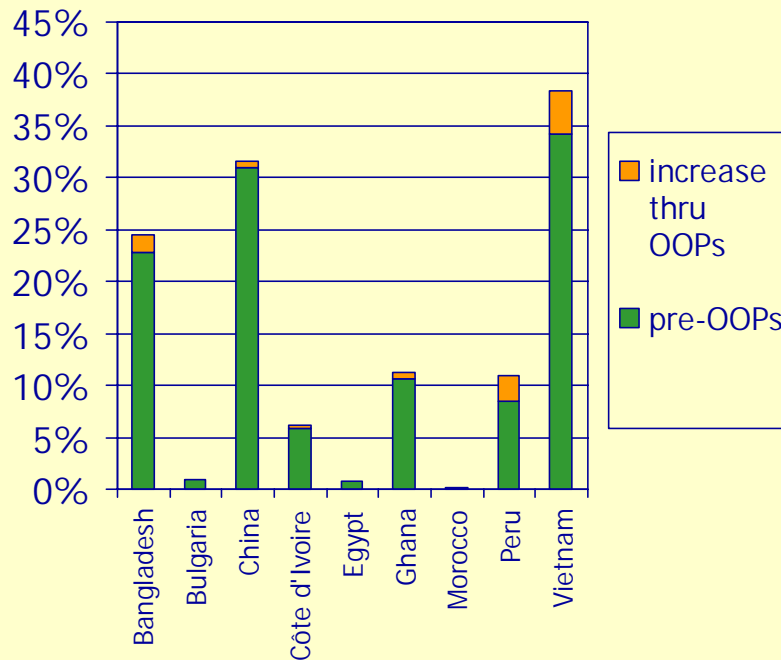


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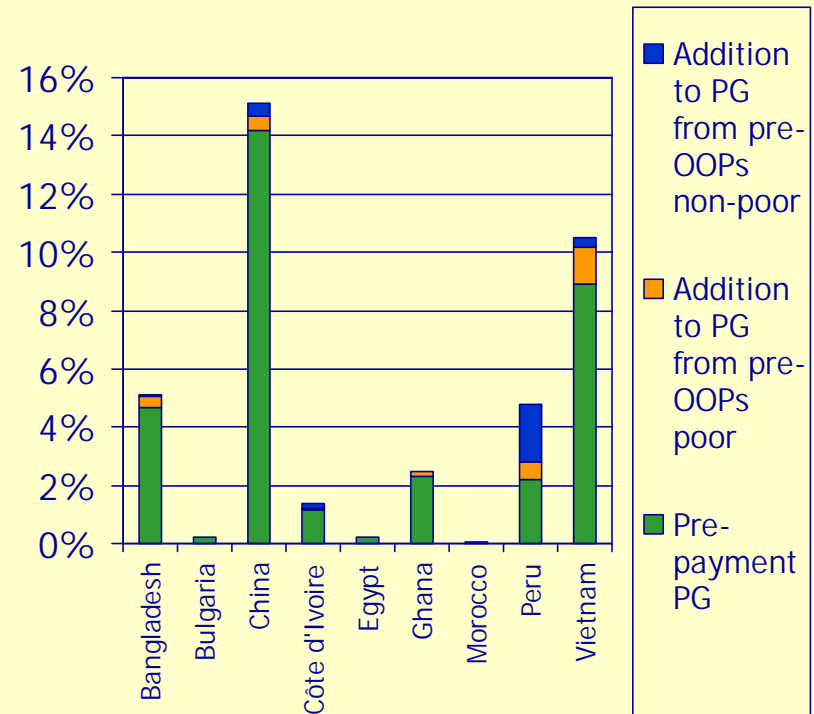
Diagnostic tools—What?

Impoverishment

Increase in headcount



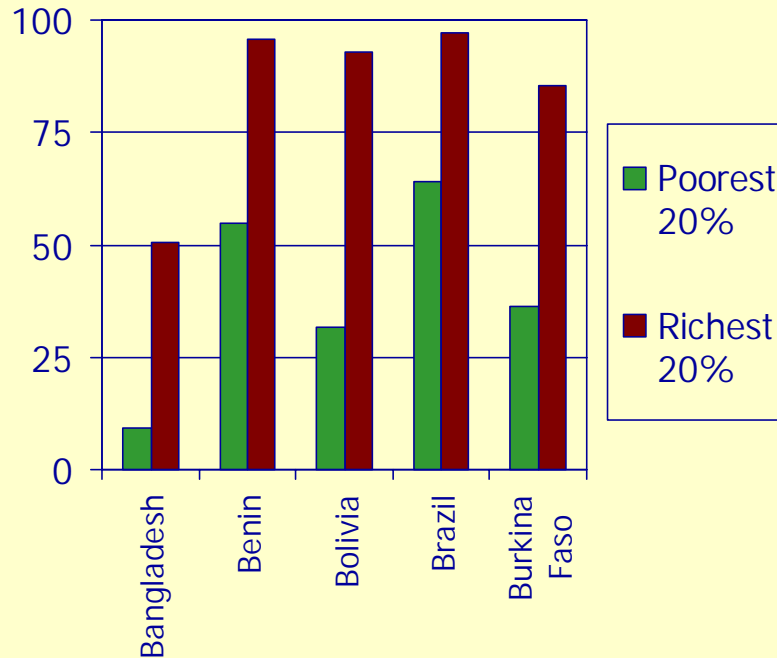
Increase in poverty gap



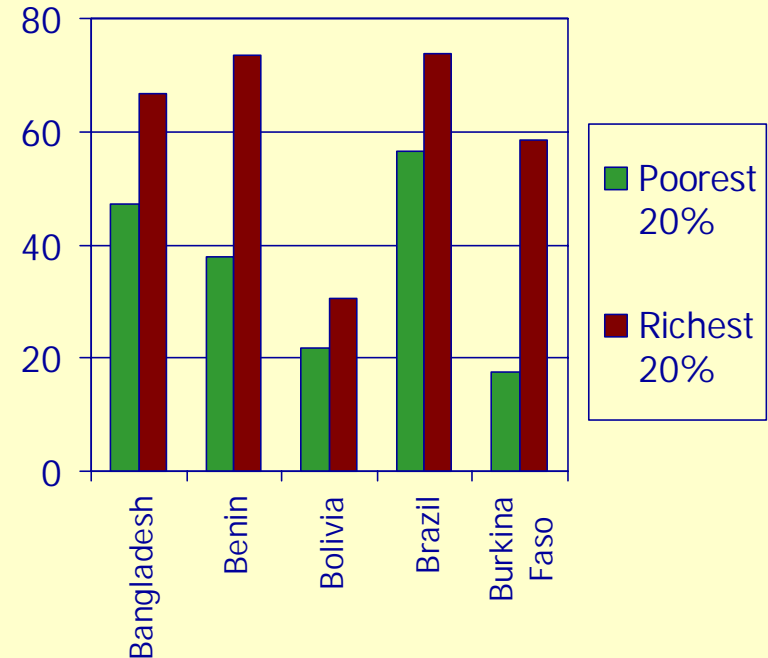
Source: A Wagstaff, N Watanabe and E van Doorslaer, *Impoverishment, insurance, and health care payments*, HNP Network, The World Bank, 2001

Household actions & risk factors

2+ antenatal visits (%)



% kids fully immunized

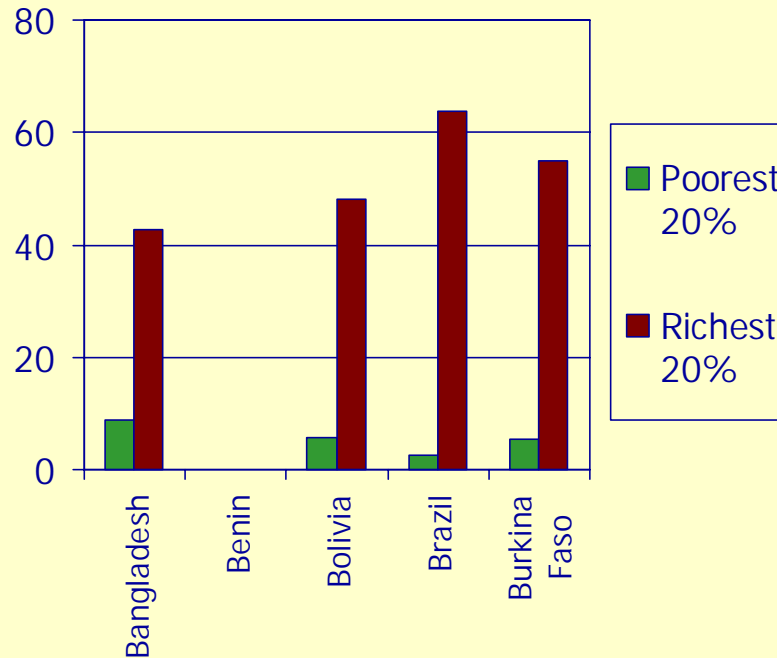


Source: DR Gwatkin, S Rutstein, K Johnson, R Pande and A Wagstaff, *Socioeconomic Differences in Health, Nutrition and Population*, HNP Network, The World Bank, 2000

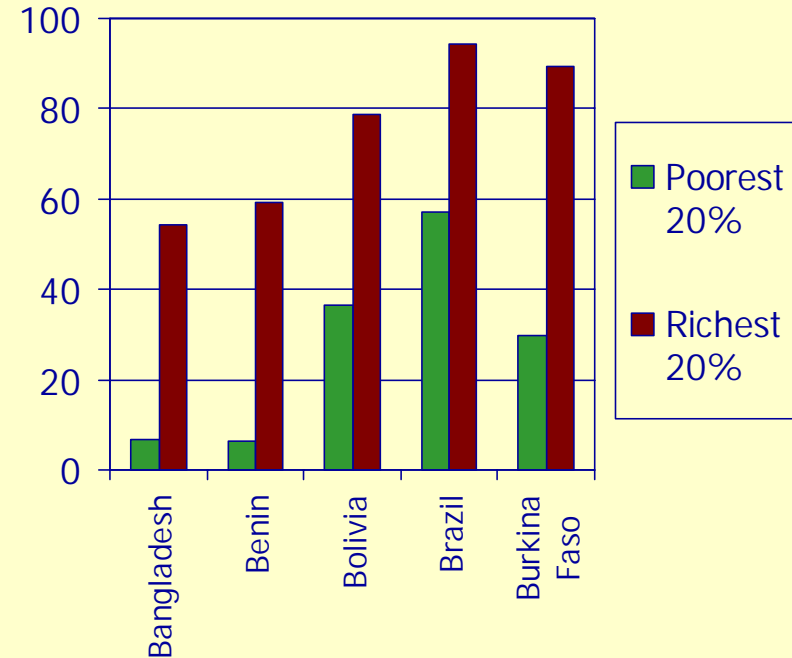
Diagnostic tools—What? (And Why?)

Household assets

income shares



% kids reaching 5th grade

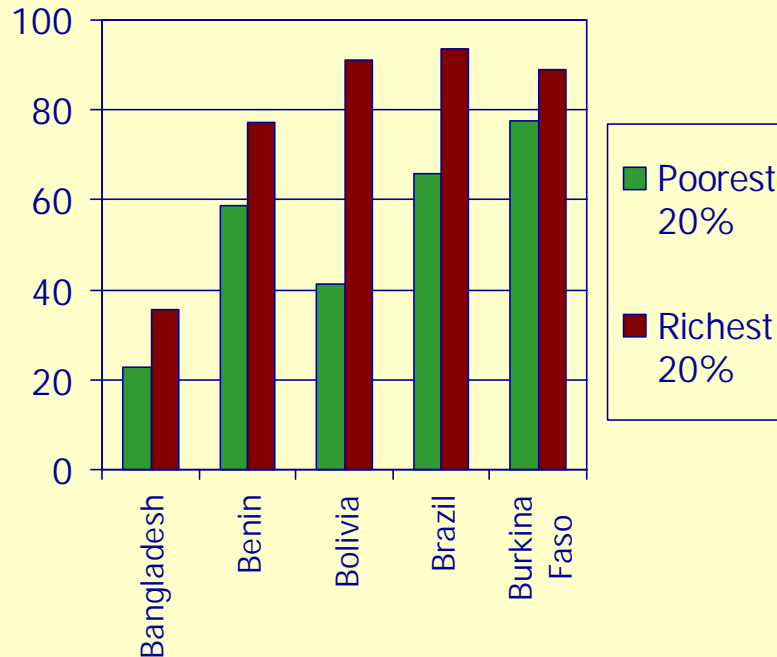


Source: World Development Report 2000/2001; Filmer, D. and L. Pritchett, The effect of household wealth on educational attainment: evidence from 35 countries. *Population and Development Review*, 1999. 25(1): p. 85-120.

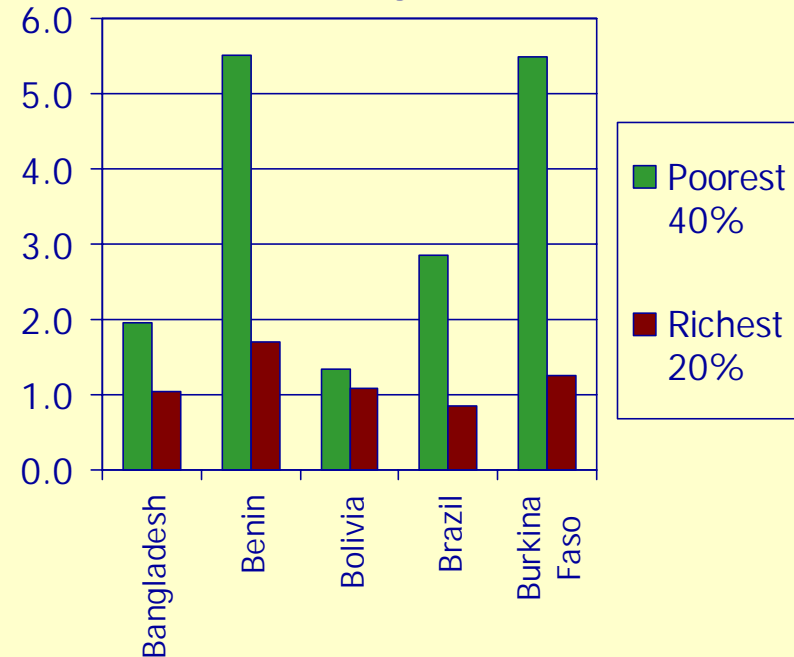
Diagnostic tools—What? (And Why?)

Household assets

% women knowing about HIV/AIDS



% boys reaching grade 5 as % girls %



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

Diagnostic tools—What? (And Why?)

Community factors

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

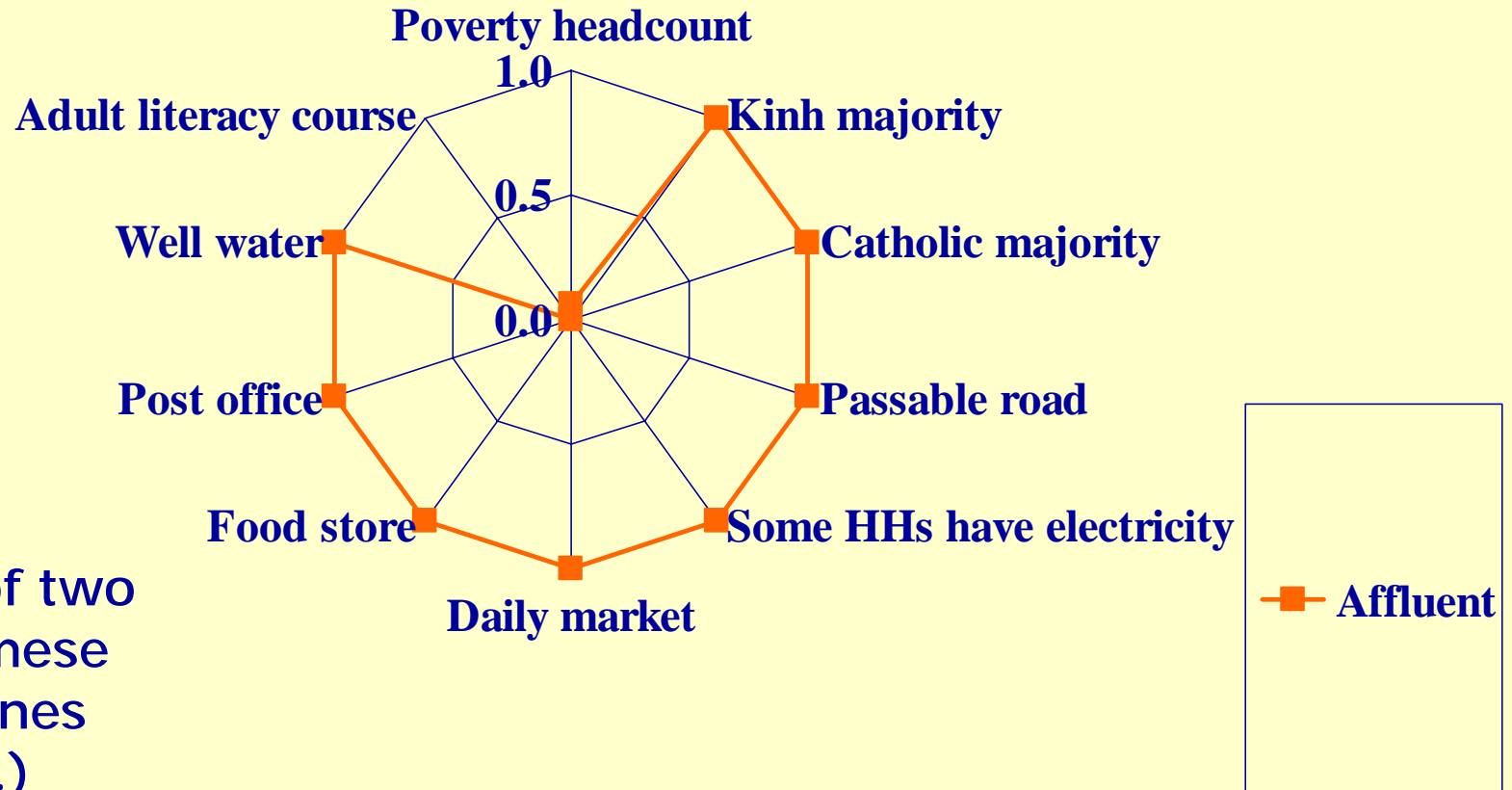


Commune #43
"affluent"
Ninh Thanh, Thi Xa
Ninh Binh

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

Diagnostic tools—What? (And Why?)

Community factors

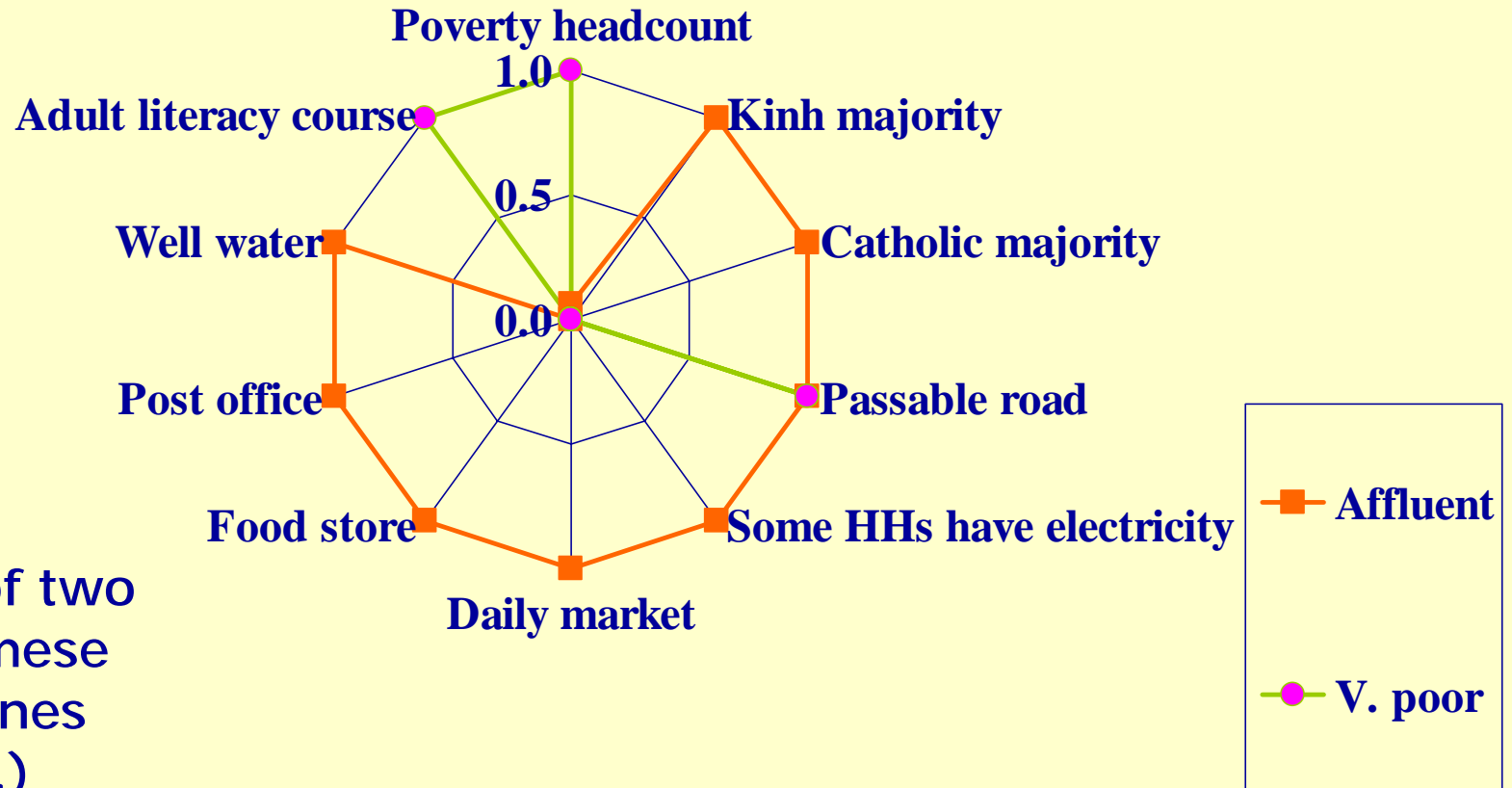


A tale of two
Vietnamese
communes
(contin.)

Source: Vietnam 1993 LSMS community data

Diagnostic tools—What? (And Why?)

Community factors



A tale of two
Vietnamese
communes
(contin.)

Source: Vietnam 1993 LSMS community data

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

Diagnostic tools—What? (And Why?)

Where to get the data?

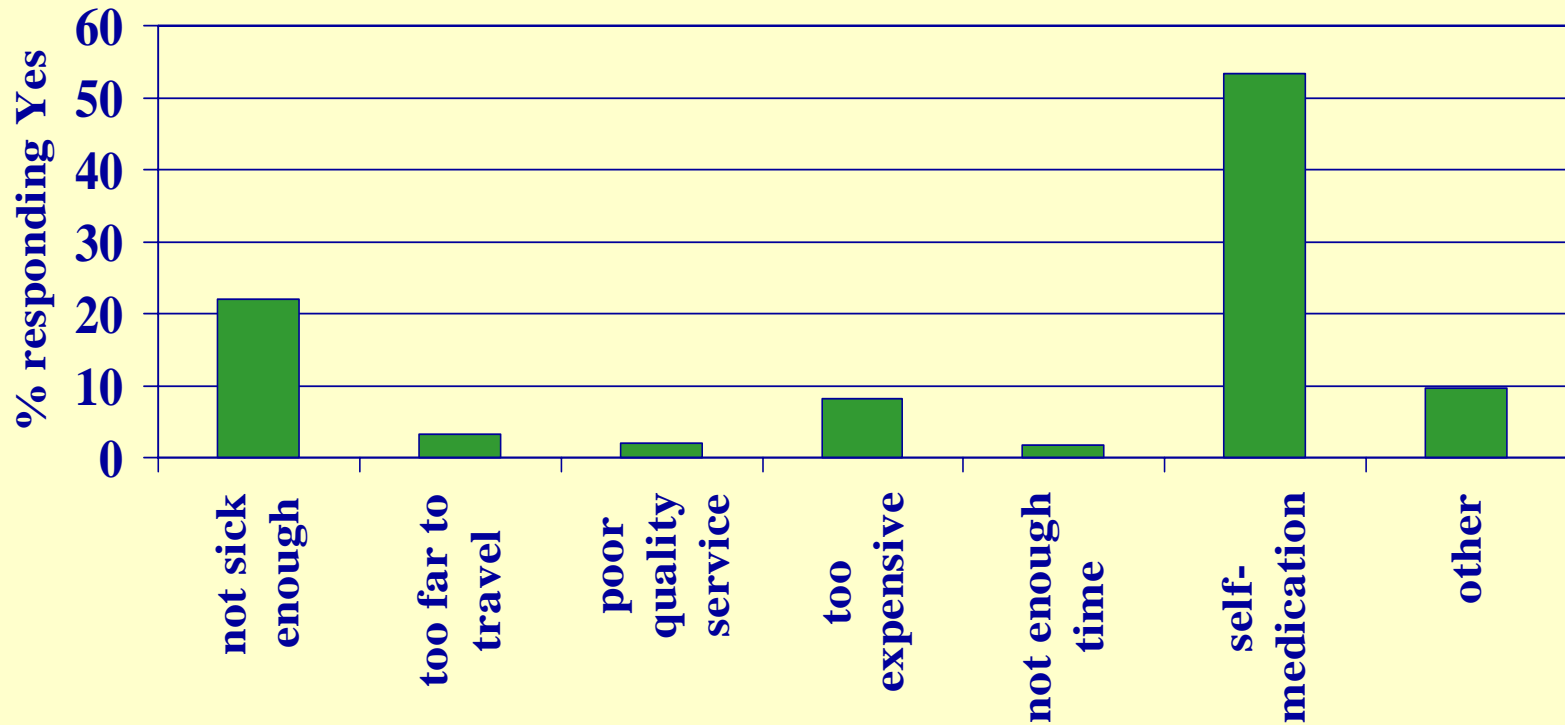
	Levels and distribution	Their effects	
	Quantitative	Quantitative	Qualitative
Health outcomes	DHS, LSMS, CWIQs	[Redacted]	[Redacted]
Impoverishment	DHS, LSMS, CWIQs, Budget surveys		
Household actions & risk factors	DHS, LSMS, CWIQs		
Household assets	DHS, LSMS, budget surveys		
Community factors	LSMS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

Diagnostic tools—Why?

	Levels and distribution	Their effects	
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Asking “Why?” questions in surveys

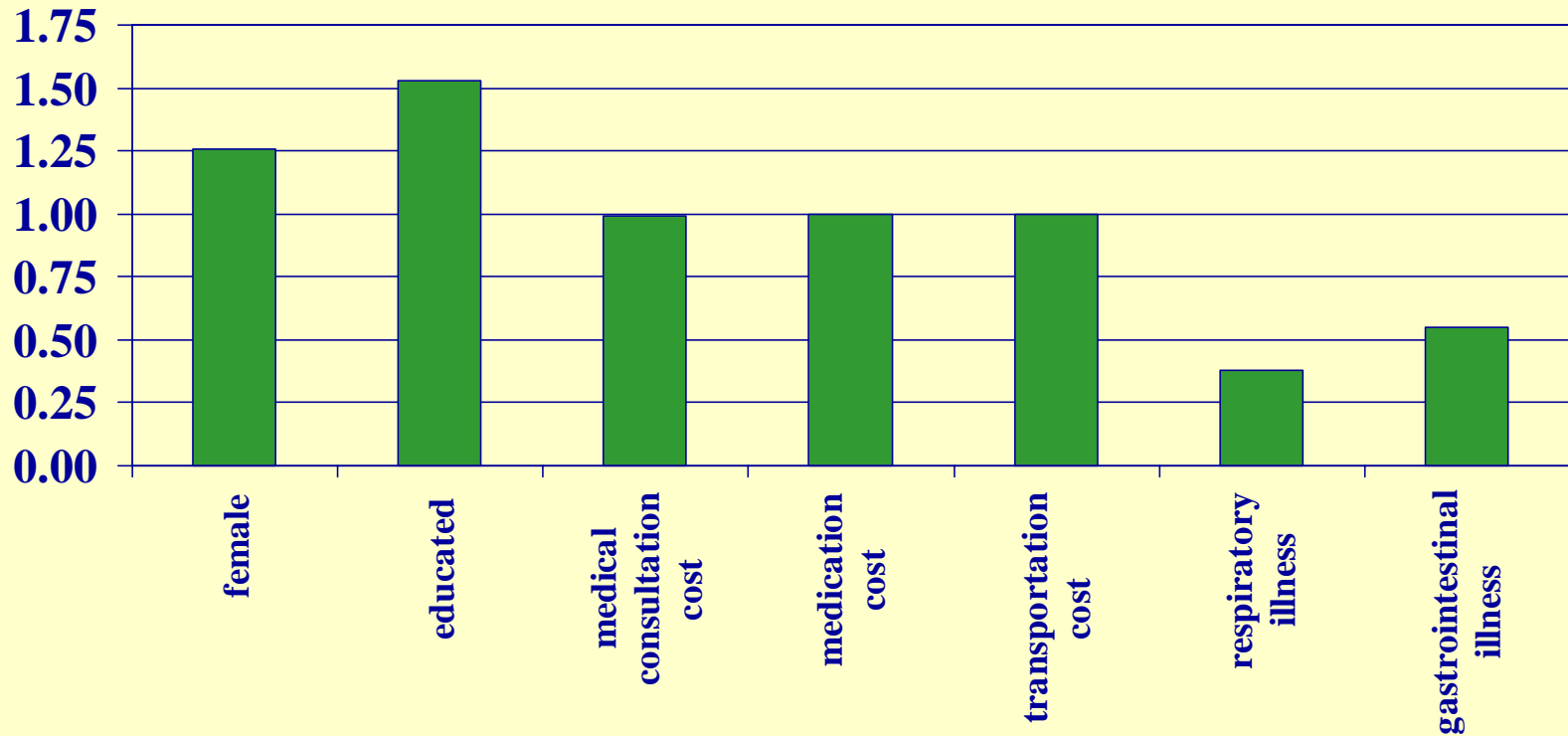
Why did you not seek care when ill?



Source: Guyana 1993 LSMS household data

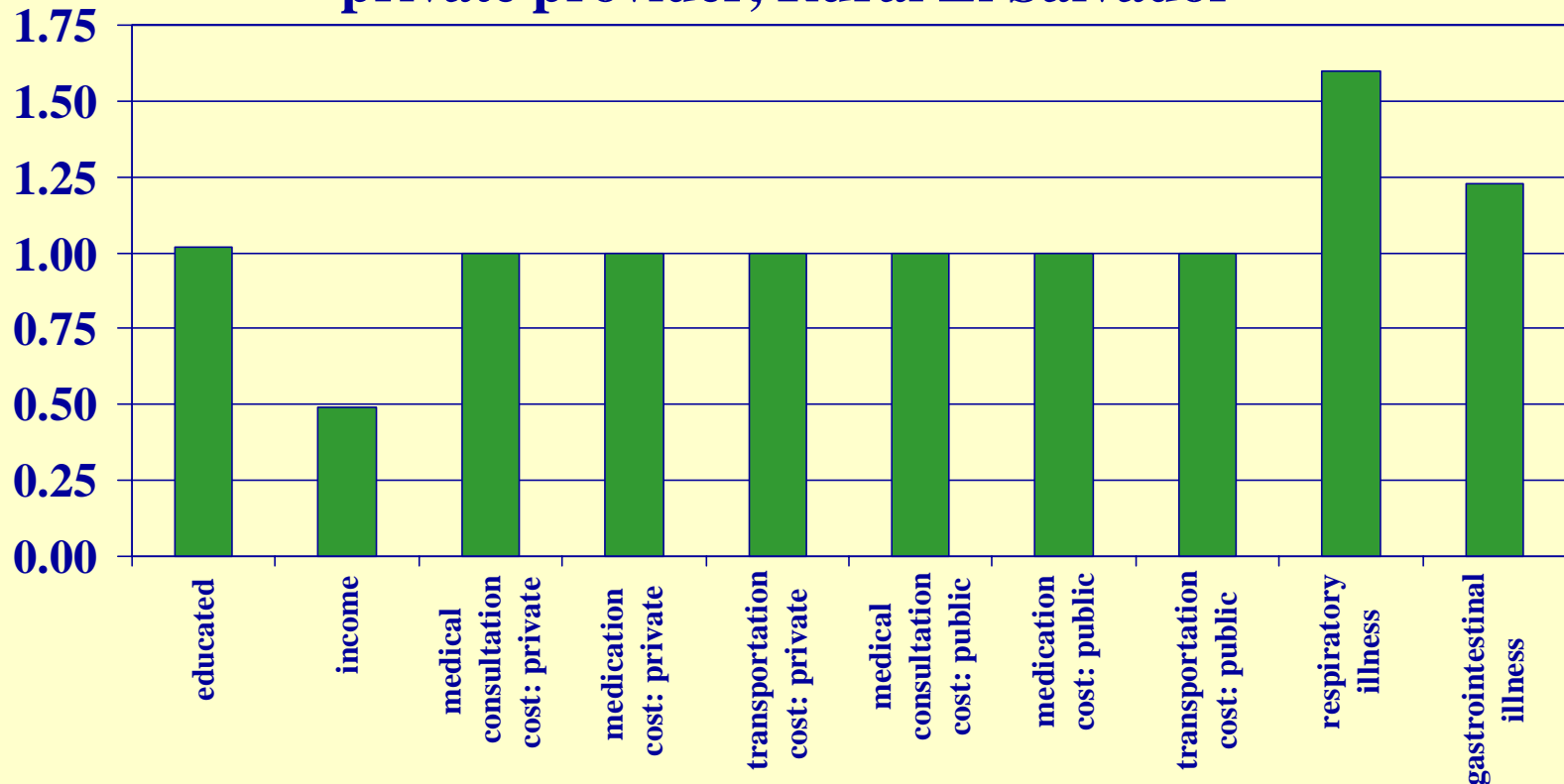
Regression analysis of survey data

**Odds ratios:
Decision to seek care, Rural El Salvador**



Regression analysis of survey data

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



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.”

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)

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

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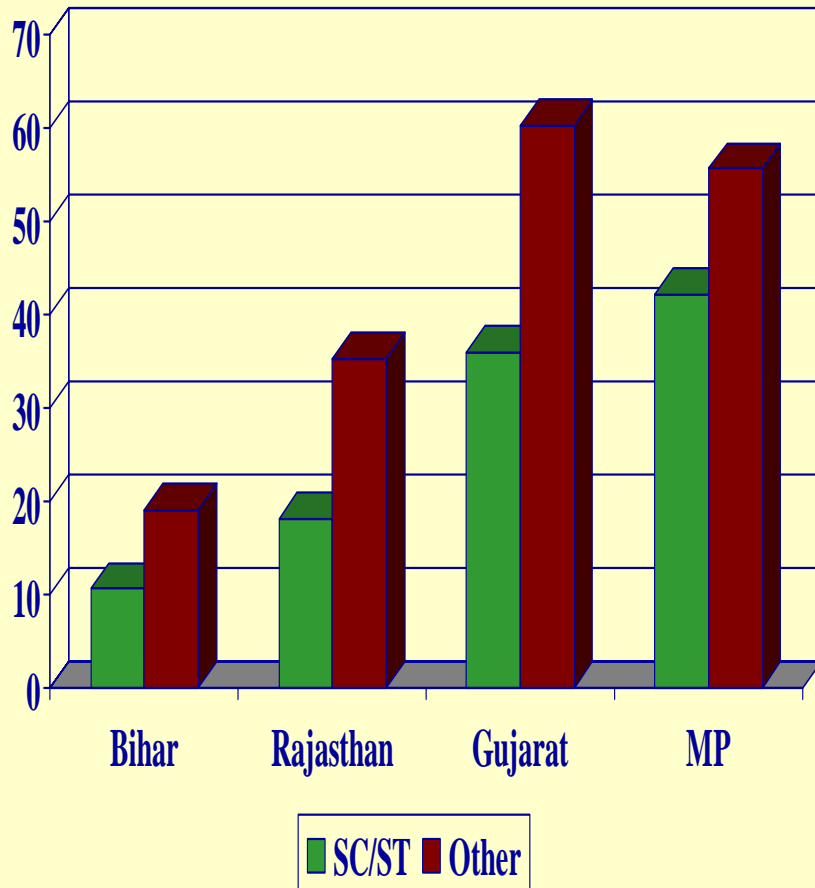
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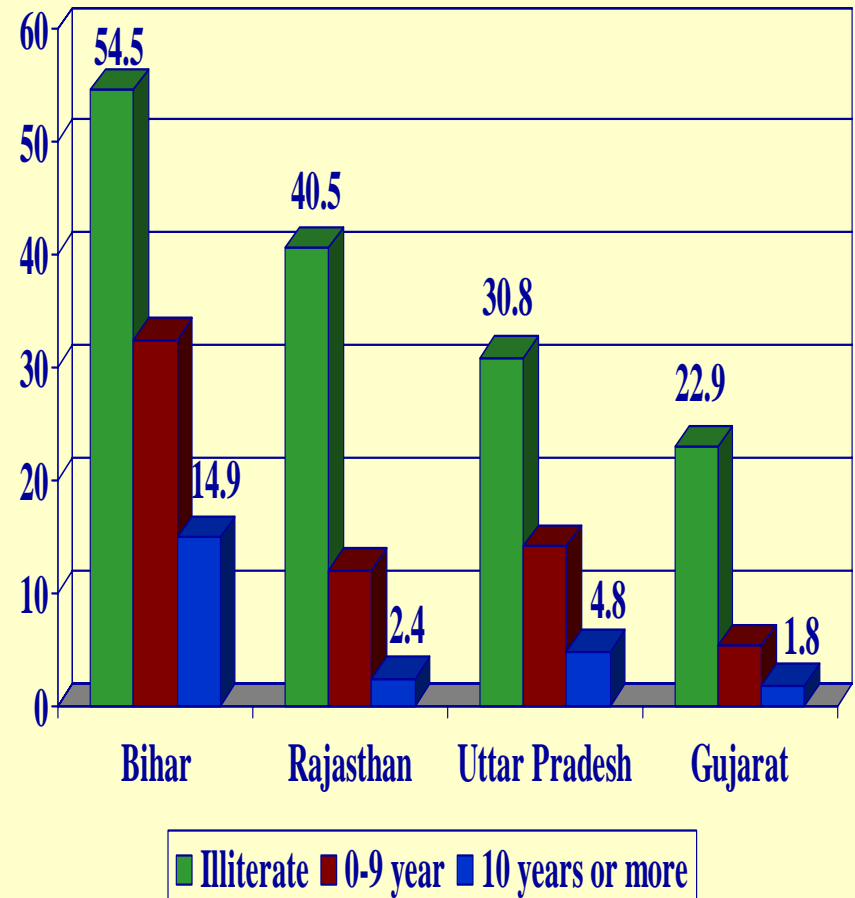
Application of tools in case examples

Immunization in India

% Children Fully Immunized



Not Immunized/Mothers Educ.



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.**

Immunization in India

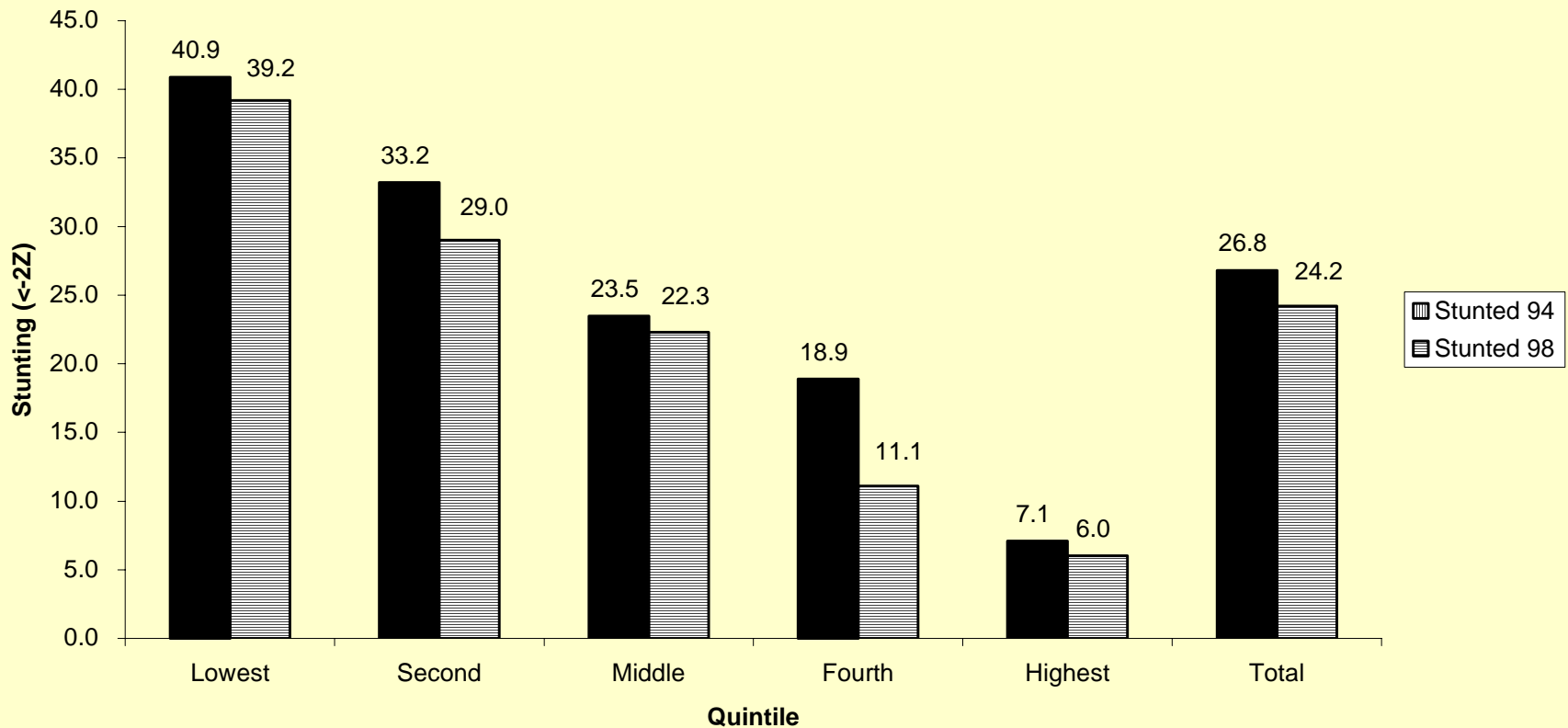
Asking one simple “Why?” question

- 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.

Application of tools in case examples

Malnutrition in Bolivia

Evolution of Malnutrition by SES 1994-1998 Bolivia



Malnutrition in Bolivia

Causes of Malnutrition

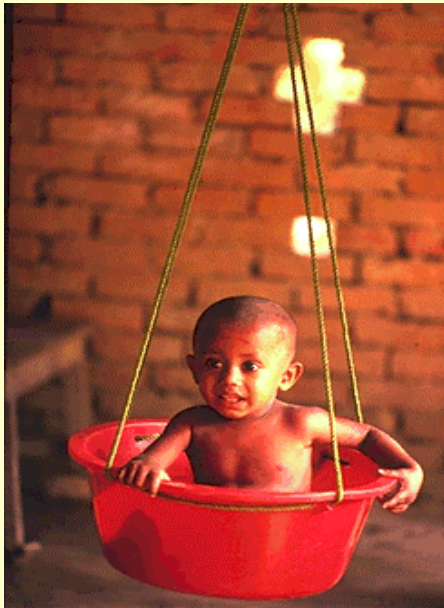
- **Food security: availability, access, utilization**
- **Disease (vicious cycle): Diarrhea, measles, and ARI cause malnutrition and malnutrition causes immune deficiency**
- **Fertility**
- **Individual and HH behavior: Energy expenditures, birth spacing, breastfeeding, autonomy of women, psychosocial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

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**

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 reduced2. IMR m/f reduced3. <5 MR m/f reduced4. Malnutrition m/f reduced5. 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**

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)**

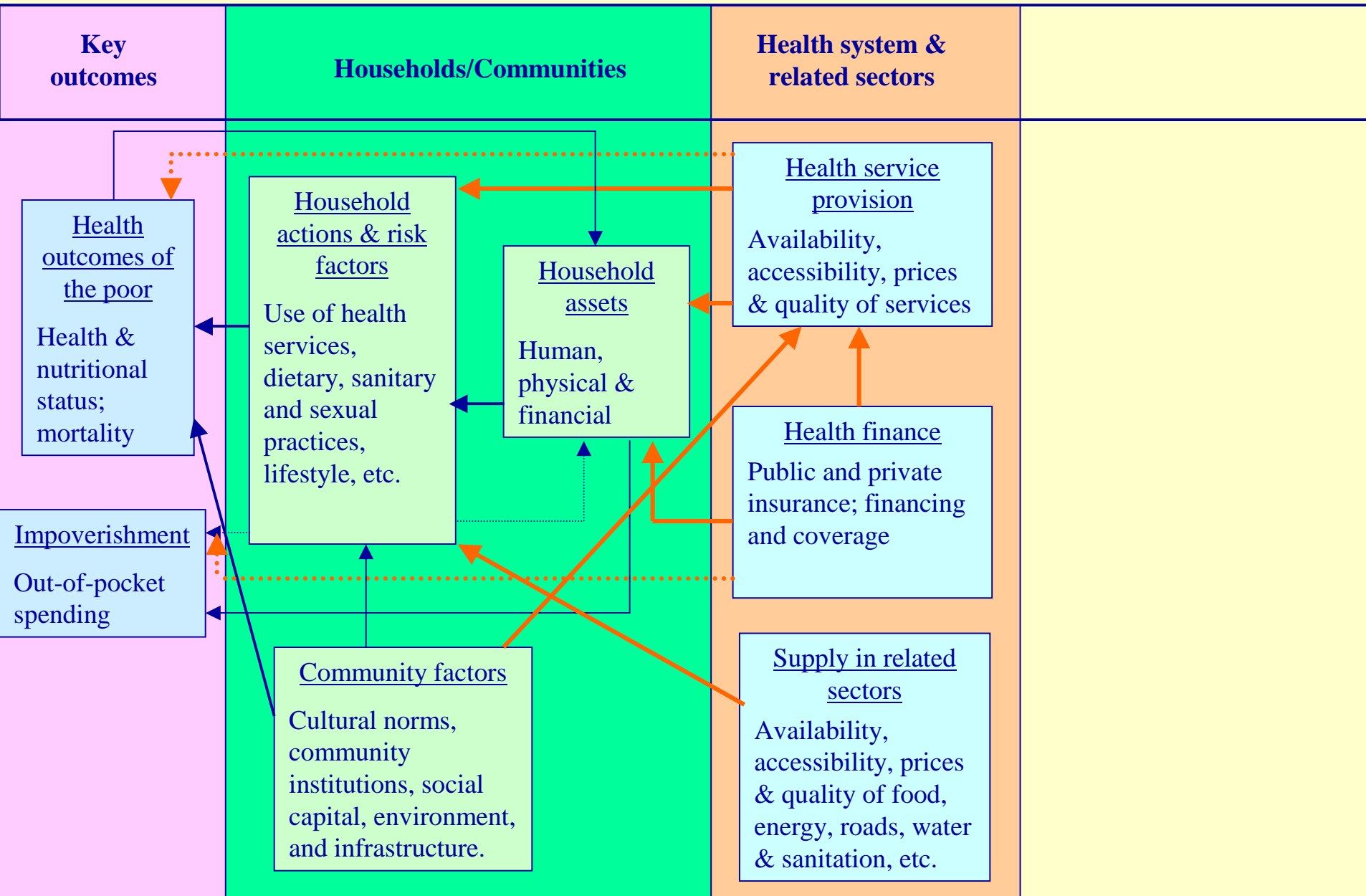
Baseline Survey Findings in Bangladesh

- **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

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**

Links to the System



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**

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)**

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**

... 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

- **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.