HEALTH SERVICES & THE POOR
Guest Editorial

BY ABDO S. YAZBECK
AND DAVIDSON R. GWATKIN

Investments in health should mean investing in the poor, but more often than not health services are most likely to benefit the better off. However, more favorable outcomes are possible. That can be seen through the cases highlighted in this special issue of Development Outreach where, through concerted effort, health services can and do reach the poor.

The studies summarized in this issue are selected from a growing body of evidence assembled by the Reaching the Poor Program (RPP), undertaken by the World Bank with support from the Bill and Melinda Gates Foundation, and from the Governments of the Netherlands and Sweden. The articles are based on presentations by RPP-supported and other investigators at a recent international conference organized by the RPP.

The evidence presented in the articles of this issue, as well as others identified by the RPP, offer hope that the poor can be reached with life-saving health services, and highlight a variety of approaches to engaging the poor and drastically decreasing inequalities in the health sector.
Vigilance

IN LIGHT OF the especially high burden of disease and malnutrition among the poor, it is not surprising that many policy makers have assumed that investing in health is investing in poor people. Unfortunately, increasing empirical evidence finds that for most health and nutrition programs in developing countries, investing in health is investing in the better off, who tend to be the principal users of health services. This is true not only of private health spending, but also of public programs typically undertaken in the name of health equity. While such an orientation of public spending is not unique to health, it has contributed significantly to large poor-rich gaps in health outcomes like child and maternal mortality. The standard assumption that the poor are the principal beneficiaries of publicly-funded health services is clearly incorrect, and must be replaced by vigilance to ensure that the traditional pattern of higher service coverage among upper-income groups does not continue.

Hope

THE PRESENTATIONS MADE at the RPP Conference provide a basis for hope that the current situation just described can be changed, by highlighting a number of successful efforts at reaching the poor with services. While not all the conference presentations showed a pro-poor pattern of service use, a clear majority did. In the same way that the earlier research found worldwide inequalities in service use, the initial rays of hope represented in this issue, as well as by other RPP-documented studies are global as well.

The first three articles provide important examples of programs with strong pro-poor reach in Latin America. The Colombia article, by Maria-Luisa Escobar, shows how an equity fund was created and financed by the government to increase health insurance coverage specifically for the poor, which in turn lowered financial barriers for service use. The article on Mexico’s PROGRESA program, by David Coady and colleagues, shows the effectiveness of an ambitious program that directly transfers cash to poor families if they seek health services. Finally, the article on community-based social funds in Honduras, Peru, and Nicaragua, by Laura Rawlings, shows how community ownership and involvement can produce pro-poor health services.

The next two articles provide instructive illustrations of pro-poor programs in Sub-Saharan Africa. The Tanzania article, by Rose Nathan and colleagues, describes the successful adaptation of private sector techniques in marketing, called social marketing, to increase the use by the poor of a critical malaria prevention product, insecticide-treated bed-nets. The second
Africa article, by François Diop and Damascène Butera, is on the success of community-based voluntary micro health insurance for rural poor population in Rwanda. By removing the financial barriers from using care, the project produced a substantial increase in the use of preventive and curative health services by the poor.

The last four articles highlight pro-poor programs in Asia—two in Cambodia, one in Nepal and one in India. The first Cambodia article, by Indu Bhushan and colleagues, shows how contracts with international NGOs that included incentives for reaching the poor led to sharply increased use of primary health services by the poor residents of underserved areas. The second Cambodia article, by Bruno Meessen and Ir Por, describes how a pilot equity fund effectively helped address the need of the poor to access hospital services by decreasing the financial barrier. The India article, by Kent Ranson and colleagues, describes how a women’s workers union improved access to reproductive health services to the urban poor, by addressing geographic and other barriers and by building trust between the community and the providers. The final article, by Anju Malhotra and colleagues, shows how participatory planning is used to ensure that youth-oriented reproductive health services serve the most vulnerable in Nepal.

Hard work

While examples like those just presented are encouraging, the wide array of approaches employed in them suggest the absence of a single, simple, universal solution. Rather, the array reflects the fact that poverty and inequality result from combinations of persistent factors that can differ widely from country to country and from region to region. In reviewing the growing experience of success and failure in reaching poor people with health services, a factor that appears to play a critical role in developing successful policies and approaches based on a solid understanding of why the poor were not getting services. Moving past the arrogance of thinking we know the answers and working hard to understand the determinants of inequalities are the obvious next steps toward policies that are customized to the needs of the poor in given settings.

This hard work of answering the ‘why’ questions and beginning to develop policies customized to different situations includes a number of analytical tools that helps policymakers understand:

1. where the poor live (critical for geographic targeting);
2. why the poor so often fail to come forward for services (because of household factors like lack of knowledge or resources, or because of community-level cultural factors like constraints on what women are allowed to do);
3. why public services typically fail to reach out to the poor (because of deficiencies in strategies, management, vision);
4. how the private (not-for-profit and for-profit) sector can be effectively harnessed to complement public services in serving the neediest.

But analytical work is clearly not enough. Policies have to be fashioned, tested and implemented in order to take advantage of the most promising opportunities and to counter those factors that constitute the most important bottlenecks identified. It will be equally important to develop ways of monitoring how well the poor have access to and use health, nutrition, and population services, in order to prevent a repeat of situations where the rich capture the benefits and the poor remain outside looking in.

In brief, a promising beginning has been made, and that provides important grounds for hope. But a beginning is only a beginning. The need for vigilance and hard work remains.


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The authors, along with Adam Wagstaff are the Coordinators of the Reaching the Poor Program.
Health Sector Reform in Colombia

BY MARÍA-LUISA ESCOBAR

BEFORE THE 1993 health sector reform, poor households in Colombia were disproportionately affected when facing health shocks. The health system was characterized by strong market segmentation, high inefficiency and badly targeted public subsidies. The Ministry of Health (MOH) was responsible for providing health care to all Colombians by constitutional mandate. In reality, only around 20 percent of the Colombian population were financially protected against the risk of health shocks.

Pre-1993 myths that supported the Colombian health sector

COLOMBIA HAD A HEALTH SYSTEM based on myths. Policy makers believed that Colombia’s public health subsidies were well targeted to the poor, publicly provided health care services were free of charge for all, and the poor did not choose private providers for their health care needs. A large portion of the Colombian health care system was financed by public funds from the Treasury and supported a large public network of hospitals and clinics through general taxation. However, out-of-pocket expenses were an important source of health care financing, and the rest was provided by insufficient and inefficient social security schemes. The poor had three alternatives when facing illness: to try to access publicly provided health care services, to go to private providers, or not to seek medical care at all. Considering that pharmaceuticals could be sold without a prescription, and deficient quality control and self-medication were common issues, the poor and less educated were more at risk when opting for self-care.

Differences between rich and poor

THE MOST IMPORTANT BARRIER to health care use before the 1993 reform was its cost. One out of every six individuals in the first income quintile who fell ill in 1992 did not seek medical care because they could not afford to pay for it (National Household Survey, 1992). The poor not only had less access to health care than the rich, but also paid out-of-pocket for health care services both by public and private providers, and paid more proportionally to their income level than the rich.

The Colombia health care system before the 1993 reform did not allocate public subsidies to upper and middle-income groups. Of those who were hospitalized in public, government-funded hospitals, only 20 percent belonged to the first income quintile, while almost 60 percent were individuals in the third, fourth, and fifth quintiles. But in 1992, 12 percent of hospitalizations and 20 percent of all surgeries done in the public sector were received by patients in the richest 20 percent group of the population. So, middle- and higher-income group individuals who could afford to use other hospital services were crowding out the poor in public facilities.

Very rarely the poor received free care in public facilities. While 91 percent of the poorest income quintile who were hospitalized in public hospitals incurred out-of-pocket expenses, only 69 percent of individuals in the richest quintile did the same. The private sector was important both in the financing and the provision of health services before the
reform. According to the National Household Survey in 1992, 40 percent of all health interventions and 45 percent of all hospitalizations were done in the private sector, although only around 20 percent of the Colombian population was insured.

The 1993 Health Sector Reform in Colombia

**LAW 100** OF 1993 mandates the creation of a new system for the financing and delivery of health care, allocating public subsidies directly to individuals instead of institutions.

The reform introduced four main elements to reach the poor:

i) a proxy-means testing index to target the allocation of public subsidies in health (SISBEN—Selection System of Beneficiaries for Social Programs—Núñez 2004);

ii) transformation of the traditional supply-side subsidies, which finance the public health care network, into individual insurance premiums for the poor subsidized by the system;

iii) an equity fund with financial flows allowing for payroll contributions and Treasury resources to cross subsidize the insurance premium for the poor; and,

iv) contracting health service delivery from both the public and private sectors.

The new system is characterized by universal health insurance coverage with two regimes. The formally employed and the independent workers who are able to contribute belong to the contributory regime (*Régimen Contributivo - RC*). Contributions are collected by the insurer of choice. The poor and indigent do not make any insurance contribution and are covered under the subsidized regime (*Régimen Subsidiado - RS*). Payroll contributions go to a national health fund (*Fondo de Solidaridad y Garantía - FOSYGA*) with four separate accounts. The fund finances insurance premiums to all in the RC with an internal compensation process, and one point of the contributions is allocated to finance the RS together with Treasury transfers to the territories. Individuals who are eligible for affiliation to the RS, but still uninsured, are called *vinculados* and should rely on public hospitals for care.

Every insured individual chooses freely an insurer and selects providers within the insurer’s network. Both regimes
have access to a basic benefit package, but the POS (Plan Obligatorio de Salud) for the contributory regime includes all levels of care, while the POSS (Plan Obligatorio de Salud Subsidiado) has to be complemented with services provided by public hospitals and financed through the existing traditional supply side subsidies. According to the Law, overtime those supply-side subsidies should be transformed into demand-side subsidies in order to achieve universal insurance coverage with the same POS in both regimes.

Although the health sector in Colombia still faces important challenges to expand insurance coverage to all the poor, to improve quality of services and to provide a more integral benefit plan for the poor, there have been important accomplishments that deserve our attention.

The results

THE REFORM BROUGHT more opportunities for access to health care to the poor. Differences between those insured and the non insured are important. Treatment rates are higher for those insured than for the non-insured in both the urban and rural areas, as well as the utilization of preventive care services. The reform of 1993 increased financial protection to all, particularly among the poor and those in the rural areas.
Health care expenditure as a percentage of income is much larger in the case of those non-insured than for those in either the Contributory or the Subsidized Regimes. Formal insurance in Colombia reduced out-of-pocket expenditures in ambulatory care between 50 and 60 percent (Bitrán et al. 2004). The poor in the RS spend around 4 percent of their income on ambulatory care, while the uninsured poor spend more than 8 percent of their income on ambulatory care (household consumption expenditure is used, see Quality of Life Survey, 2003). Out-of-pocket expenditures on hospitalization among the uninsured poor, represented in 2003 more than 35 percent of their income. The poor in the RC spend a smaller proportion of their income in inpatient care than the poor in the RS. However, the same study finds that a health shock requiring hospitalization brings 14 percent of those hospitalized and uninsured below the poverty line, while in the case of those in the Subsidized Regime, only 4 percent would fall below the poverty line when facing the same shock.

The introduction of health insurance improved access to preventive care. While 65 percent of the insured had at least one consultation with a physician or a dentist for preventive reasons and without being sick in 2003, only 35 percent of the non-insured did the same.

Regulation has given preference to children, single mothers, the elderly, the handicapped, and the chronically ill to obtain priority access to insurance enrollment in the RS. In effect, data shows that those poor and insured are less healthy than their uninsured counterparts, which could be confused with adverse selection. In reality, individuals do not decide when they can be enrolled in the RS, since annual extension of coverage depends on the availability of financial resources. There is no longitudinal data to investigate if access to health insurance among the poor has had an impact on overall health status, which would be of interest for future research. However, some inferences could be made particularly in the case of infant mortality, institutional delivery, and prenatal care.

Consistent with findings in other countries, those insured in Colombia have higher health care utilization rates and seek care faster than those not insured. This is particularly important in the case of childbirth and child and maternal health. The Demographic and Health Surveys DHS of Colombia indicate a very important improvement in access to those services particularly in the rural areas. According to the DHS (1986, 1990, 1995 and 2000), there was a 66 percent increase on child delivery assisted by a physician, 18 percent increase on institutional delivery, and a 49 percent increase in prenatal care use among rural women. The DHS 2000 shows that there is an astonishing difference between infant mortality rates among children whose mothers had access to prenatal care (P) and to institutional delivery (ID) with those whose mothers did not have access to such services.

**The challenges**

**DESPITE POSITIVE** results, the Colombian social insurance scheme receives criticism from those who would argue that the 1993 reform has not been successful because it has not achieved universal coverage yet and because the insurance for the poor scheme finances a reduced benefit plan when compared to the plan of the Contributory Regime. The slower than planned transformation of supply side subsidies, which finance public hospitals, into demand side subsidies to finance health insurance for the poor, has introduced rigidities to the expansion of the contents of the health insurance plan in the Subsidized Regime and difficulties for the extension of coverage among the poor. Several attempts to introduce legislation to change the present system to a government owed and government provided health services as the one Colombia had in 1992 have not been successful so far. However, the country faces important challenges for comple-
PROGRESA
for Progress

Mexico’s Health, Nutrition, and Education Program

DAVID P. COADY, DEON P. FILMER, AND DAVIDSON R. GWATKIN

MEXICO’S HEALTH, NUTRITION, and Education program (known by its Spanish acronym “PROGRESA”) was introduced in 1997 in order to combat the country’s stubbornly high poverty rate and to replace a set of food subsidy and other poverty programs widely considered ineffective. These programs were poorly targeted, extremely expensive, and typically inefficient, with up to one third of program costs going for administrative expenses. Further, the programs simply provided handouts, and thus only temporary relief rather than developing productive capacities that could help lead recipients out of poverty over the longer term.

Recognizing these problems, the Mexican Government changed course. It largely scrapped its earlier subsidy pro-
grams, and instituted in their place the PROGRESA initiative that was much more carefully oriented toward the poor and that replaced simple cash transfers with subsidies to household investments in human capacity development.

Beneficiary selection

IN ORDER TO ENSURE that its benefits flow primarily to poor people, PROGRESA beneficiary families are selected through a two-stage process.

First, poor villages are identified on the basis of a community score based on information available from national census data about things like educational levels, occupational composition, and housing conditions. Those villages scoring lowest in terms of these characteristics—but also within a certain distance of education and health facilities—are deemed eligible for participation.

Second, poor families within the eligible villages are selected on the basis of household-level data on factors closely associated with income. That is, household-level data on factors closely associated with income are collected through a special community census, and combined into a single scale. Those households scoring lowest on this scale qualify for inclusion. (Originally, about 50% of households in the eligible villages were included. However, in response to local protests, the PROGRESA administration adopted revised criteria that permitted participation by around 80% of the selected communities. As a result, the selection of communities ended up becoming considerably more important in determining PROGRESA’s targeting effectiveness than the identification of households.)

Benefit determination and provision

PROGRAM BENEFITS ARE DESIGNED to contribute to long-term human capital development and poverty alleviation as well as to immediate poverty relief. Thus, women in the beneficiary families are eligible to receive regular cash payments—but, unlike in the case of a traditional cash transfer program, only if they act to improve their own and their families’ education, health, and nutrition status. The benefits, referred to in the technical literature as “conditional cash transfers”, became tantamount to negative user fees that paid instead of charged program participants to attend schools and clinics.

A summary of the benefits appears in the accompanying panel. With respect to education, monthly cash payments are made for each child attending grades three through nine, with higher payments in higher grades and for girls in those grades. For health, payments are provided if family members, especially mothers and children, make a specified number of annual clinic visits. Nutritional supplements for younger children are also available.

The amounts due to each beneficiary are calculated by the PROGRESA administration on the basis of attendance information submitted electronically by school teachers and health personnel at the facilities where the beneficiary had registered upon enrollment, by submitting completed forms distributed to them by PROGRESA field staff. These amounts are paid out at local distribution points to which funds are transferred via the national telegraphic system. Beneficiaries are notified when funds are available by community volunteers, elected by the beneficiaries, who also perform a wide range of other liaison functions between PROGRESA’s administrators and benefit recipients.

Implementation challenges

THE IMPLEMENTATION OF A PROGRAM that differed so radically from those that preceding it posed many challenges. One has already been noted: the difficulty of enabling community residents to understand or accept the legitimacy of the rather complex, technocratic procedure used to identify beneficiaries. Because of this, PROGRESA’s administrators felt compelled to include more people than originally envisaged, thereby diluting (but as will be seen, by no means completely negating) its targeting effectiveness.

Another challenge has been in assuring timely payment of benefits. Initially, delays were encountered at several points: at the community level in submitting completed forms to the PROGRESA authorities; and at the central level in issuing payments once the forms had been received. A related limitation was in the number of fund distribution points, which were often quite far from
The program has been evaluated using a number of household surveys undertaken just before and at regular intervals over two years after its initiation, in 320 villages that had received services and 186 villages that had not. These and other evaluation studies suggest that the majority of program benefits have gone to poor families, and that the program has made a significant contribution to health, nutrition, education, and poverty outcomes.

PROGRESA’s record in reaching the poor is summarized in the figure. As can be seen there, almost 60% of people reached by PROGRESA belonged to the poorest 20% of Mexico’s population; 80% of beneficiaries were in the poorest 40% of the country’s population. The principal factors contributing to the highly progressive outcomes just reported were the selection of poor villages, as noted earlier; and also the linkage of benefits to education/health program participation by children (since poor people have many more children than do the better-off). The focus on poor families within villages was less important (because most of the families in the selected villages were poor—a consideration that would not prevail were the program to be introduced in higher-income areas).

In addition, the PROGRESA program produced noteworthy improvements in outcome indicators. For instance, there was a 45% reduction in the severity of poverty, a 16% increase in the annual growth rate of children 12-36 months; a 20-25% reduction in the incidence of illness among children aged 0-5 years; and an increase in secondary school enrolment for girls from 67% to 75% and for boys from 73% to 78%.

All this has been accomplished at relatively modest administrative cost. Overall, administrative expenses have been kept to under 10% of the program’s total expenditures.

References:


Do Social Funds Reach the Poor?

BY LAURA B. RAWLINGS

SOCIAL FUNDS REPRESENT a departure from traditional approaches to development led by the central government. They encourage communities and local institutions to take the lead in identifying and carrying out small-scale investments, generally in social infrastructure such as health clinics and water and sanitation systems. Social Funds appraise, finance, and supervise these grants, which then may be managed by a wide range of actors, including local governments, NGOs, line ministries, community groups, and local project committees.

Introduced in Bolivia a little over a decade ago, social funds have now absorbed close to US$10 billion in foreign and domestic financing globally, and represent international financial institutions most comprehensive experience with community-led development initiatives.

Although conceived to address the social costs of economic adjustment, social funds have more recently been used as a tool for reaching populations that public investment programs have historically underserved. Most social funds now explicitly aim to reach poor communities, though they do not target specific households. Most engage in geographical targeting, with preference for proposals from poorer communities or notional allocation targets to poorer areas based on poverty maps. Many also try to limit the types of programs financed to menus of sub-proj-
ects likely to be needed by the poor and to have positive welfare impacts.

Despite the popularity of social funds, their effectiveness as a mechanism for reaching poor populations and improving their welfare has remained largely unmeasured and hotly debated. Many have questioned social funds’ ability to reach poor communities and households given their approach that relies on demand being generated from communities, while other debates have focused on their institutional role and influence over central and local governments.

This article presents findings regarding social funds’ ability to reach the poor, drawing from a World Bank study, “Evaluating Social Funds: A Cross-Country Analysis of Community Investments,” that represents the first attempt to conduct a systematic, cross-country impact evaluation of social funds using household and other types of survey data and accepted evaluation methodologies. Evaluations were conducted of social funds in Armenia, Bolivia, Honduras, Nicaragua, Peru, and Zambia where their investments had been concentrated in education, health, water and sanitation sub-projects. Each evaluation reviewed the social fund’s poverty targeting, sustainability, welfare impacts, and costs. This article summarizes the findings with respect to poverty targeting.

**Findings from “Evaluating Social Funds”**

SOCIAL FUNDS are effective at reaching the poor and extremely poor communities and households.

To assess whether social funds reach poor communities, the six-country study reviewed the distribution of social fund investments over time and across communities ranked by their poverty status. The data show that geographic distribution of social fund expenditures was progressive in all countries studied, with poor districts receiving more per capita than wealthier districts, and the very poorest districts receiving shares exceeding their shares of the population. Moreover, geographic targeting has improved over time in all six social funds. The high levels of investment in some of the poorest areas refute the idea that such communities are systematically incapable of accessing resources from demand-driven programs (see Table 1).

Looking at household-level targeting results, the study used household survey data to measure income or consumption levels of a representative sample of social funds beneficiaries then compared their poverty rates to national poverty distributions based on the same metric. The study found that in most cases the overall distribution of resources at the household level was mildly progressive, including among the very poorest. Yet there was considerable variation across countries, reflecting the different policy orientation of the six social funds in the sample which ranged from largely urban post-earthquake reconstruction in Armenia to a concentration on poorer areas by the four Latin American social funds (see Table 2).

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**TABLE 1. Community Level Results: Cumulative geographic distribution of social fund resources by population decile (percent)**

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**TABLE 2. Household Level Results: Distribution of social fund beneficiaries by population decile (percent)**

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Source: Data used for “Evaluating Social Funds” Study (Rawlings, Sherburne-Benz and Van Domelen, 2004)

Note: The data show the distribution of the beneficiary population for the types of projects studied. In all cases these accounted for the vast majority of social fund activity. Comparable household targeting data are not available for Bolivia. Totals may not add as a result of rounding.

a. Data refer to education projects only.
Within communities, social fund investments disproportionately reached poorer households, reflecting a demand from poorer households even within mixed-income communities.

Targeting results also varied considerably by type of sub-project, as illustrated by the results from Nicaragua and Honduras presented in Table 3. Across countries, positive discrimination towards poor households was best reached by latrine and health projects and reasonably reached by education and water projects, while sewerage projects clearly benefited the better-off.

Finally, comparisons with other programs showed that social funds' geographic and household targeting generally compared favorably with that of other targeted social programs, general social spending and municipal-level transfers. In Peru the social fund had the most pro-poor geographic distribution of expenditures among the three programs compared: the social fund, another national social infrastructure program (INFES), and a targeted national nutrition program (PRONAA). In 1995 the social fund allocated 20% of its resources for educational infrastructure to the poorest district decile, compared with about 8% for PRONAA and 7% for INFES. In Bolivia, where the social fund now serves as a cofinancing agent to municipal governments, the social fund had a pro-poor expenditure pattern, while general municipal transfers were concentrated in the better-off municipalities. The poorest municipalities, accounting for 42% of Bolivia's population, received 63% of social fund expenditures in 1993-99 but only 22% of total municipal expenditures in 1996. In Armenia, several social programs—including child allowances and disability benefits—were better targeted than social fund investments, though other programs such as student stipends and humanitarian aid were less well targeted.

Beyond results on poverty targeting, the research showed that utilization increased following the social fund-financed investments in infrastructure. In health centers, increases were often found for overall levels utilization or occasionally concentrated among particular types of services, notably for maternal and infant health care. This increased utilization translated into a range of improved health outcomes in many, though not all, cases. In Bolivia, the only country where the evaluation was able to assess the social fund's impact on mortality, the social fund investment resulted in large, statistically-significant reductions in infant and child mortality of close to 50% over a 4 year period in communities with social fund-financed health investments when compared to similar communities that did not benefit from social fund projects. Positive health outcomes were also found for investments in water and sanitation across a range of countries and types of investments.

How to reach the poor: Some lessons

The findings on social funds' ability to reach the poor suggest several lessons regarding poverty targeting, especially of community-driven development initiatives.

First, the policy orientation of institutions is critical. Whereas this lesson may seem self-evident, it is clear that those social funds, which actively used strategies to reach the poor, including poverty maps, tailored menus, and promotion campaigns exhibited a more progressive distribution of social fund investments. This lesson calls for enhanced pro-activity in terms of promoting social funds' availability in poor com-

### TABLE 3. Distribution of social fund beneficiaries by population decile and type of project, Honduras and Nicaragua (percent)

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Source: data used for "Evaluating Social Funds" Study (Rawlings, Sherburne-Benz and Van Domelen, 2004) 
Note: Based on population deciles and potential beneficiaries. Data for Honduras are based on social fund expenditures; those for Nicaragua are based on the incidence of beneficiaries.

Social Funds continued on page 35
Social Marketing of Bednets in Tanzania

BY ROSE NATHAN, HADJI MPOEDA, AND HASSAN MSHINDA

MALARIA IS STILL a devastating disease in sub-Saharan Africa where it kills at least one million people every year (UNICEF 2003). Children are most vulnerable to malaria attacks, which kill more than 3,000 children every day, largely in Africa. At least 100 Tanzanian children die daily because of the disease. Another high-risk group is pregnant women. However, all other adults are also exposed to substantial risk of malaria. In Tanzania, control and care of malaria puts a huge burden on financial and economic costs both at micro and macro levels, thus translating into enormous poverty implications. As such, malaria has a potential in slowing down the achievement of the MDGs in countries where it is endemic as is the case in many parts of Tanzania.

Many efforts and resources have been invested in search of effective malaria control strategies. Among few of the strategies that have shown effectiveness are insecticide-treated nets (ITN). Such nets have been proven to be effective, feasible intervention for reducing malaria morbidity and mortality.

At the African Summit on Roll Back Malaria, African leaders signed the Abuja Declaration, with the commitment to protect 60 percent of African children with a treated net by the year 2005 (RBM 2000).

The issue of how the nets should be effectively delivered to the poor communities has been a subject of debate. Formulating effective and sustainable mechanisms that guarantee access to ITNs by the most vulnerable has been a challenge. Social marketing programs offer a way to increase demand through promotion at the same time supplying nets at subsidized prices.

The concept

SOCIAL MARKETING is an approach where the experience of commercial marketing is applied to a product which has a social benefit, with the main motivation being social improvement rather than financial gain to the marketer (Andreason, 1995).

Largely Population Service International (PSI) and Ifakara Health Research and Development Centre (IHRDC) have implemented social marketing of insecticide-treated nets in Tanzania. Here, we describe a specific social marketing program, known as KINET, for insecticide-treated nets in two rural districts of Tanzania, Kilombero and Ulanga, implemented by IHRDC. The program aimed at achieving substantial and sustainable use of insecticide-treated nets in young children and pregnant women. The purpose of the program was well in line with the philosophy of social marketing; it was therefore envisaged as the most appropriate technique to reach the target population with the insecticide-treated nets as a malaria control intervention.

Setting up the program

THE PROGRAM IMPLEMENTED delivery of treated nets in five phases. By the end of the third year of the program implementation, a population of about five hundred thousand people in 112 villages had been covered. Phase one of the implementation covered the area with a demographic surveillance system (DSS).

Community participation was made central right from the designing stage of the program. Community members were given a primary role in shaping the implementation activities. The research team in partnership with district health management team held sensitization meetings with village leaders. The meetings, in a form of open discussions included general health issues, prevention of malaria sustainability and cost-recovery. Community preference studies were conducted to identify size, quality and color of their choice. Through local market research a brand name "ZUIA MBU" (a kiSwahili phrase which means prevent mosquitoes) was identified for treated nets and insecticide.

Marketing package

Product

The nets were dark green high quality polyester in two sizes: (100 x 180 x 150 cm and 130 x 180 x 150 cm). The sizes were suitable for the local sleeping places. Insecticide water-based formulation of lambda-cyhalothrin (ICON TM) was packed in 6 ml sachet.
Promotion

Formative research was conducted at baseline to explore community perceptions of severe childhood disease. In collaboration with District Health Management Team results of the research were used to develop a range of promotional materials. Promotional materials included: billboards posted along main roads, posters, leaflets, exercise books used at primary schools, T-shirts, umbrellas, caps, and point-of-sale stickers and flags.

Information Education and Communication (IEC) seminars were held for the sales agents, and groups of specially recruited village resource people once in every six months. The resource people included village leaders, village health workers, primary school teachers and Maternal and Child Health (MCH) aides.

The distribution system

The distribution network of the ITNs included retail agents in each village and wholesalers in each division. The retailers were chosen jointly by project staff and community members; they included private shopkeepers, community leaders, health workers and priests. A reward system was used for retailers and wholesalers for reaching certain sales targets. Over time, inactive retailers were replaced. Insecticide retailers, in the initial distribution area were provided with bicycles to be able to offer door-to-door treatment services. As the area expanded, the insecticide was sold as a dip-it-yourself kit containing a pair of gloves and instructions. The kits were sold through shops (often were the same shops that sold treated nets).

The program relied on collaboration with public entities such as the district health management team and Ministry of
Health, the private sector such as international and local suppliers, local businessmen, and other non-governmental organizations involved in health.

**Price**

Price was based on what the community indicated they were willing to pay and experience from previous net projects. The prices were near to cost recovery—consumer prices were set at TZS 3000 (US$ 5.00 in 1997) for a net, and TZS 250 (US$ 0.42 in 1997) for a sachet of insecticide.

**Targeting**

The program aimed at targeting the most-at-risk group, pregnant women and young children. To achieve that, a discount system was developed. The system was based on a simple paper vouchers issued through the MCH clinics. The vouchers were given to pregnant women when they visited MCH clinics for antenatal care as well as to mothers of children under five years of age. The voucher was worth TZS 500 (approx. US$ 0.5); therefore it allowed the beneficiary to purchase a Zuia Mbu net from a retailer at a reduced price of TZS 2,500 (instead of TZS 3,000). The retailers were reimbursed on their next order with an addition of TZS 50 for each voucher as a handling charge. Implementation of voucher scheme reflected a successful public private mix.

**Reaching the poor**

KINET program had several features which qualified it as a pro-poor initiative. Those included:

- Adoption of social marketing as a strategy to deliver the insecticide-treated nets - by default SM has no motive of financial profit.
- Use of discount system facilitated access to pregnant women and young children without excluding the poorest.
- The remotest rural settlements where the poorest are concentrated were reached with the insecticide-treated nets through the established delivery system.

The program assessed the extent to which it reached the poorest in the served population. This was done through annual household coverage surveys within the DSS area. Each household was asked whether they owned a net and a similar question for other specified assets.

Using the reported ownership of assets, quality of houses, and occupation of the head of household, a statistical analysis (Principal Component Analysis) was done to categorize the households into five wealth quintiles. The survey and the analysis were done for the year of the start of the program, 1997, and three years after, 2000.

The coverage, measured by percent of households with at least one net, improved from 37 per cent in 1997 to 73 per cent at the end of 2000. Coverage among the households categorized as poorest improved from 20 per cent to 54 per cent, while among the least poor (rich) households it increased from 63 per cent to 92 per cent. The poorest/least poor ratio of the coverage increased from 0.3 to 0.6 over the three-year period (Nathan et al., 2004).

**Conclusion**

**SOCIAL MARKETING** was associated with rapid overall improvements in net coverage, and the pace of change was higher among the poorest than the least poor. It should however, be noted that this success happened in the presence of two enabling factors: the existing demand for mosquito nets, which was extremely high probably because of perceived mosquito nuisance, and the existing active private sector for nets (Nathan et al. 2004).

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Hadji Mpond, Ifakara Research and Development Center, Tanzania.
Hassan Mshinda, Director of Ifakara Health Research and Development Center, Tanzania.

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Community-Based Health Insurance in Rwanda

BY FRANÇOIS PATHÉ DIOP AND JEAN DAMASCENE BUTERA

RWANDA HAS LIVED one of the most tragic moments of its history with the genocide of 1994, which resulted in nearly one million deaths and the destruction of the social fabric of the country. Since 1994, however, the country is being rebuilt: gross domestic production (GDP) has grown at a yearly rate above 6 percent between 1995 and 2001, and social infrastructures have been rebuilt with support from the international community. Rwanda remains, however, one of the poorest countries in the world: per capita GDP is still under $300; the incidence of poverty is as high as 60 percent of the population, and reaches 66 percent in the rural areas where...
nearly 90 percent of the population live (Ministry of Finance and Economic Planning, 2002).

Mutual aid and community solidarity value systems have remained resilient traits of Rwanda’s society and continue to be translated in coping strategies in the health care area. In all local communities, associations of hamac carry the sick to health facilities. Resources are specially collected in neighborhoods and cells to face emergencies; structured tontines are more and more organized at the cell level in order to face priority needs in general, medical care needs in particular. Little attention has been paid in the past to these cultural traits of Rwanda’s society within partnership and community involvement frameworks in health development strategies. After the 1994 war, however, mutual aid initiatives have emerged in the health sector as community responses to the reintroduction of user-fees in public and mission health facilities. Building on these community initiatives, health authorities and non-government organizations have moved these emerging strategies to a deliberate strategy of building community-based health insurance schemes in the health sector.

**Community-based health insurance schemes (CBHI)**

**Building on** the experiences of mutual health organizations which have emerged in the country, the Ministry of Health (MOH) initiated in 1998 pilot experiments in the health districts of Byumba, Kabgayi and Kabutare, which played a key role in the design and organization of CBHI schemes in the country. It provided also a platform for the compilation of information to support the assessment of CBHI schemes, and to familiarize health sector actors and partners with the strategies needed to support their implementation on a large scale.

CBHI schemes in Rwanda are health insurance organizations based on a partnership between the community and health care providers. The CBHI schemes develop their bylaws, organizational structures including general assemblies, board of directors, surveillance committees and executive bureaus to regulate contractual relations between members and the mutual organization. Participation in the CBHI scheme is voluntary and is based on a membership contract between the CBHI scheme and the member. In addition, CBHI schemes develop contractual relations with health care provider organizations (health centers, hospitals) for the purchasing of health care. Bylaws of CBHI schemes and their contracts with health care providers include measures for minimizing risks associated with health insurance (adverse selection, moral hazard, cost escalation, and fraud).

The target population of individual CBHI schemes are inhabitants of the catchment’s area of their partner health center: low risk events (health center package) which are included in the CBHI benefit package are shared at the partner health center catchment’s area population. CBHI schemes in a given health district, however, establish a federation at the district level which plays a risk-pooling mechanism function for high-risk events (hospital package). The district federation also plays social intermediation and representation roles for individual CBHI schemes in their interactions and contractual relations with health care providers and external partners. Finally, the federation plays other support functions, such as training, advice and support, information, for individual schemes.

Contributions to the CBHI scheme funds are on a yearly basis. Members have the option to sign up as a family with up to seven members, which costs US$7.6 per family per year. Payment of the yearly premium entitles covered family members to a benefit package which includes all preventive, curative services, prenatal care, delivery care and laboratory exams, drugs on the MOH essential drug list, and ambulance transport to the district hospital provided by the partner health centers. With a health center referral, members also receive a limited package at the district hospital. Sick members pay a co-payment of US$0.30 for each visit at the health center. At the hospital, referred members have direct access to the hospital package without any co-payment. Health centers play a gatekeeper function to discourage the inappropriate use of hospital services (Schneider et al., 2001).

Since 1998, a cumulative process of learning in the community-based health insurance area, involving CBHI schemes of the pilot districts and CBHI schemes in other districts, has been launched in Rwanda. Such a learning environment has facilitated the emergence of innovative strategies for strengthening existing CBHI schemes in pilot districts and implementation of new CBHI schemes in other parts of the country. These local initiatives, while maintaining the technical design of the pilot phase, have built on the decentralization movement underway in the country, and partnerships between local administrative structures, grassroots associations, and micro-finance schemes (banques populaires) to strengthen local support systems of CBHI schemes and to increase enrollment in the schemes.
CBHI and the poor

CBHI SCHEMES have experienced an important growth during the past five years in Rwanda. From one CBHI scheme in 1998, to sixty in 2001. Starting in 2001, an adaptation phase drawing on lessons learned and recommendations from the pilot phase extended the number of CBHI schemes and increased enrollment rates in individual schemes: consequently, on July 2003, ninety-seven CBHI schemes, covering half a million Rwandans, were functional in the country. The development of CBHI schemes is currently in an extension phase: in 2004, two hundred and fourteen CBHI schemes have developed all over the country as a result of the combined effects of promotional activities of central authorities (Ministry of Health and Ministry of Local Affairs), provinces, districts, local health personnel, local opinion leaders and non-government organizations. In mid-2004, national coverage of CBHI schemes is estimated at 1.7 millions Rwandans: about twenty percent of the Rwanda population are currently benefiting from CBHI coverage in the health sector (Ndahinyuka, Jovit, 2004).

As a consequence of the removal of financial barriers to access to health care by CBHI schemes, members of CBHI schemes are four times more likely to seek modern health care when sick than non-members (Diop, 2000). The household survey results of the pilot phase summarized in Figure 1 have been replicated based on routine data from health centers during the pilot phase and recent results from health centers in the same pilot districts and results from health centers in the districts which have implemented CBHI schemes between 2001 and 2003 (Butera, 2004). CBHI schemes’ coverage has also increased the use of reproductive health services, including prenatal care and delivery care; they had no effect, however, on the use of family planning services.

As a result of their insurance function, CBHI schemes protect the income of their members against financial risks associated with illness through two mechanisms. First, when sick, members of CBHI schemes seek care earlier resulting in efficiency gains in the consumption of health care services. Second, sick members pay small out-of-pocket co-payments at the health centers. Consequently, out-of-pocket payments are reduced significantly among CBHI scheme members as demonstrated by the comparison of members and non-members of CBHI schemes’ out-of-pocket payments in Figure 2.

Greater access of the poor to CBHI scheme benefits is being promoted through two main strategies. First, building on partnerships between CBHI schemes, grassroots associations and micro-finance schemes (banques populaires), existing and newly formed grassroots associations are motivated to enroll as a group in the CBHI schemes under a financing scheme where the micro-finance schemes provide small loans to the associations’ members to pay for their yearly contributions to the CBHI schemes. Such a financing scheme has boosted enrollment of the poor in the CBHI schemes. In addition, it has opened opportunities for poor CBHI members for greater access to larger micro-finance loans to finance income-generating activities. Such financial arrangements developed as a consequence of the institutional arrangements between CBHI schemes, micro-finance schemes and health centers, and innovations introduced by local actors.

Second, non-government organizations and administrative districts are building on the institutional bridges between the community, the CBHI schemes and health care providers to finance the enrollment of the poorest, indigents and vulnerable groups (orphans, widows, people living with HIV/AIDS). Under these demand-based subsidy schemes, community leaders play administrative functions in the identification of the poorest and indigents and vulnerable groups, the CBHI schemes manage the consumption of health care for these groups, while the subsidies are financed by non-government organizations and administrative districts who serve as intermediaries for primary sources of finance (state, external aid).

Main lessons

WHILE THE EXTENSION of CBHI in Rwanda is still underway, the experience of the past five years provides valuable lessons for the development of micro health insurance schemes in developing countries. First, the development of CBHI in Rwanda built on an incremental approach which drew lessons from internal experiences and external experiences of pre-payment schemes in Southern Africa and mutual health organizations in Western Africa. The MOH provided the leadership to initiate the pilot phase, and secured technical assistance from USAID\Rwanda and Abt Associates Inc., which improved on the technical design and organization of CBHI schemes in the country. The MOH kept a respectable distance from the design and management of the schemes to ensure
the autonomy and the appropriation of the schemes by communities and local health providers. It generated information on the performance of the schemes and convened multiple forums for stakeholders to exchange experiences and to debate on the consequences and implications of the CBHI schemes on the Rwanda health system. Such an incremental approach provided a platform for learning and drawing policy directions for the development of CBHI in the country.

Second, as consensus built-up on the benefits of the CBHI schemes, a multi-level leadership developed in the country to provide support to the adaptation and extension of the schemes. Political leaders at the central level, starting from the Presidency, called for the mobilization of all actors to support the implementation of CBHI schemes throughout the country. Local communities were motivated by the MOH support in designing and establishing CBHI schemes; such support was boosted by the Ministry of Local Affairs involvement in promotion activities. At the province and district levels, prefects and mayors continue to play a key role in coordinating promotional activities. At the grassroots levels, cell and sector representatives are playing a key role in sensitization activities, along with health personnel and local opinion leaders. Such a multi-level leadership has strengthened the legitimacy of CBHI in the country and enabled the mobilization of intersectoral support for the development of the schemes.

Third, the involvement of decentralized entities and non-government organizations in CBHI promotion activities under a policy environment where community development was a central theme, mobilized intersectoral action, resulting in local initiatives which improved access of the poor to CBHI benefits. Partnerships between local micro-finance schemes, CBHI schemes, and grassroots associations have widened opportunities for the poor to access CBHI and micro-finance credit. Access of the poorest and indigents to CBHI benefits is being strengthened, due to the use of CBHI schemes as intermediate schemes, and grassroots associations have widened opportunities for the poorest and indigents to CBHI benefits. Such a multi-level leadership has strengthened the legitimacy of CBHI in the country and enabled the mobilization of intersectoral support for the development of the schemes.

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continued from page 9

The ideas expressed here are the author's responsibility and do not necessarily represent those of the World Bank and its affiliated institutions. The author is grateful to Panagiota Panopoulou, Ph.D., for her careful data analysis and research.

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Contracting Health Care Services for the Rural Poor

The Case of Cambodia

BY INDU BHUSHAN, ERIK BLOOM, BENJAMIN LOEVINSOHN, AND J. BRAD SCHWARTZ

Contracting NGOs to manage the primary health care system was found to be an effective means to increase service coverage and achieve a more pro-poor distribution of services in rural areas of Cambodia. In the mid-1990s, war and political upheaval had left Cambodia with limited health care infrastructure, especially in rural areas. There were sufficient paramedical and management staff, but training and quality of care were inconsistent and morale was low. The primary health care system was not able to deliver an adequate level of services. Basic services like immunization were not being provided and the child mortality rate remained at very high levels.

The “coverage plan”

To address these issues, the Ministry of Health (MOH) proposed contracting NGOs to manage at the district level of the public health care system using a results-based contract to monitor progress. The contract required the NGO to provide...
management and technical support to help the public health system efficiently, and equitably provide primary health care services to rural populations. Because of the innovativeness of the approach, this was originally done on a pilot basis.

The MOH devised a "coverage plan" which defined a minimum package of activities comprising preventive and curative services such as immunization, family planning, antenatal care, and provision of micronutrients. With financing provided by the Asian Development Bank, MOH conducted a large-scale experiment of contracting with NGOs for the delivery of these primary health care services as part of the overall coverage plan. In 1997, prior to health facility construction and procurement of equipment, a pre-contract baseline household survey was taken in twelve rural operational health districts. The five-year contracting experiment started at the beginning of 1999 and a final evaluation survey was taken at the end of 2003.

The districts included in the experiment were randomly assigned to one of three health care delivery models: i) contract-out, in which the contractors had complete management responsibility for service delivery, including hiring, firing and setting wages, procuring and distributing essential drugs and supplies, and organizing and staffing public health facilities; ii) contract-in, where the contractors worked within the MOH system to strengthen the existing district administrative structure and health care personnel with government supplied drugs and consumables, and a nominal budget supplement for staff incentives and operating expenses; and iii) government, in which the management of services remained with the government District Health Management Team (DHMT), government supplied drugs and consumables and the same nominal budget supplement for staff incentives and operating expenses provided to the contract-in districts. The three remaining candidate districts were not contracted and not formally included in the experiment. These districts continued under government management, but did not receive a budget supplement. As such, these three districts serve as a comparison group for the other nine contracted and government managed districts.

MOH used a competitive bidding process to select NGOs based on the quality of technical proposals and cost. Precisely defined, objectively verifiable health care service indicators were measured for all twelve districts using data from the baseline survey, and well-defined goals for improvement in service coverage and coverage of the poor were specified for all districts. Health service indicators included child immunization and vitamin A, antenatal care, delivery by a trained birth attendant, delivery in a health facility, knowledge and use of birth spacing, and use of health facilities for illness. An equity goal to target services to the poorest one-half of the population also was mandated for all districts.

The nine districts formally included in the contracting experiment were made up of two contracted-out, three contracted-in, and four government districts. Including the three districts not formally in the experiment, the twelve districts are spatially separated in three different provinces, and each had a population of 100,000 to 200,000. At the beginning of the experiment in 1999, the twelve districts had a combined total of more than 1.5 million people.

**FIGURE 1: INCREASES IN HEALTH CARE COVERAGE RATES (PERCENTAGE POINTS), 1997-2003**

Notes: FIC = fully immunized children; VITA = vitamin A; ANC = antenatal care; TDEL = trained birth attendant; FDEL = delivery in a health facility; MBS = modern birth spacing; KBS = knowledge of modern birth spacing; USE = use of health facility for illness.

**FIGURE 2: CHANGES IN CONCENTRATION INDICES, 1997-2003**

Notes: Negative values indicate a change toward a poorer distribution of services. FIC = fully immunized children; VITA = vitamin A; ANC = antenatal care; TDEL = trained birth attendant; FDEL = delivery in a health facility; MBS = modern birth spacing; KBS = knowledge of modern birth spacing; USE = use of health facility for illness.
Results

There were large increases in the coverage rates of health services in all twelve districts, contracted and government managed, however the contracted districts achieved much higher coverage rates than the government districts. The immunization coverage rate in the contracted-out districts, for example, increased from 25.3 percent in 1997 to 82 percent in 2003, an improvement of 56.7 percentage points (Figure 1). With only one exception (births with a trained attendant in contracted-out districts), the contracted districts achieved larger increases in coverage rates than the government districts. Government districts increased coverage rates for all health services, but these increases were smaller than in contracted districts and failed to achieve the coverage targets for vitamin A, antenatal care, trained birth attendant, and modern birth spacing. In general, the difference in the higher coverage rates achieved by contracted districts compared with lower coverage in government districts was largest for facility-based services (antenatal care, trained birth attendant, births in a facility, and use of public facilities for illness) than vertical public health programs (immunization, vitamin A, and use of modern contraceptive methods). Independent assessments of the quality of care also indicated that the contractors improved the quality of services provided at health facilities more than the government over the same period.

Benefits to the Poor

Contracted districts generally outperformed the government districts with changes in the distribution of health care services toward a more equitable or pro-poor distribution. Before the experiment, the non-poor were more likely to use public health care services in all twelve districts. Concentration indices indicate the provision of health care services in the contracted districts became more equitable or more pro-poor by the end of the five-year experiment than in the government districts (Figure 2). There was a change toward a more pro-poor distribution in contracted districts for health services with only two exceptions (vitamin A for contract-out and facility birth delivery for contract-in). Government districts, on the other hand, changed toward a more pro-poor distribution only for vertical programs (immunization, vitamin A, and modern birth spacing), and these changes were smaller than the improvements made by contracted districts. Government districts moved toward an even less pro-poor distribution for facility-based services including antenatal care, trained birth delivery, birth in a facility, and use of public facilities for illness.

Not surprisingly, the annual public recurrent expenditure per capita on NGO contracted districts was considerably higher than the public expenditure for government districts (Table 1). Technical assistance for district management provided by NGOs and salaries paid to health care workers largely account for these differences. It appears that public expenditures, however, substituted for private out-of-pocket expenditures to a greater degree in contracted districts than in government districts. At the end of the experiment, private out-of-pocket expenditures in the contracted districts were significantly lower than those in the government districts. Public expenditures in contracted-out districts, for example, were US$3.09 per capita higher than in government districts, but this higher public expenditure is associated with a US$5.57 per capita lower level of private out-of-pocket expenditure compared with government districts. For all contracted districts, on average, a higher public expenditure of about US$2.50 per capita led to about a US$4.50 per capita lower private out-of-pocket expenditure. Moreover, total public plus private out-of-pocket expenditures in contracted districts were lower than in the government districts. The larger substitution of public for private expenditures in contracted districts benefitted those with a lower ability to pay for health care services more than in government districts, and the overall efficiency of the health care system in contracted districts was better than in the government districts.

Conclusion

In summary, the results of this experiment of NGO contracting in rural Cambodia indicate that while all districts increased health service coverage rates, the contracted districts outperformed the government districts in achieving higher coverage rates and providing a more pro-poor distribution of services. In addition, private out-of-pocket health care expenditures in contracted districts were lower than government districts, which clearly benefits those who can least afford to pay. NGOs appear to be more responsive to contractual obligations to effectively and equitably provide health care services than standard government provision of services given the same goals. Overall, the results suggest contracting primary health care may be an efficient and effective means to increase health care coverage rates and better target primary health care services to the poor.

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Overcoming Barriers
Health Equity Fund
in Cambodia

BY BRUNO MEESSEN AND POR IR

IN LOW-INCOME COUNTRIES, user fees have been promoted as a strategy to tap more resources to public health facilities. But they may also constitute a barrier limiting utilization of public health services by the poor. The barrier is particularly critical for hospital care as the technicality, intensity and duration of the care delivered to an inpatient often leads to significant costs. Moreover, most of the population has no hospital in its immediate vicinity. Transportation cost also constitutes a heavy burden for the poorest.

To tackle this equity problem, most governments have decreed that the poor should be treated for free. The existing evidence shows that waivers and exemptions through regulation, in most cases, do not work: few poor can benefit from it and many beneficiaries are not the poorest. As an organization, why would the hospital accept to bear a cost without compensation? Indeed, every poor patient leads to more medical and paramedical work, more drug consumption, more catering and more troubles. On the other hand, fees are just one of the many costs for the patients. The poor traditionally live far from hospitals. In order to benefit from free medical care, they have to cover other costs such as transport. Moreover, there may be a lot of uncertainty about eligibility for waivers and exemptions. The poorest may then decide to stay at home foregoing the treatment, or seeking inappropriate care. There is also a problem at the facility level. If the hospital staff has some freedom to decide whom to waive, one can expect that people with some formal or informal connections with the hospital will manage to be among the beneficiaries. Social capital is not an attribute of the poorest.

The Health Equity Fund experience in Sotnikum, Cambodia

SOTNIKUM HEALTH DISTRICT is a poor rural area, with around 220,000 inhabitants. It is divided into 17 health areas, each of them having one public health center. The district hospital is in the small town of Damdek. It provides the full complementary package of activities foreseen by the national policy: internal medicine, pediatrics, obstetrics-gynecology and surgery.

In 1999, the Ministry of Health, Médecins Sans Frontières, and UNICEF agreed on a common approach to boost the activities in the health district. They introduced a new scheme, called the 'New Deal,' which establishes strong incentives for the hospital and health center staff to deliver quality health services to the population. Income collected through user fees was expected to finance an important part of the motivational scheme. There was however an obvious risk that the poorest would not benefit from the improvement in the service delivery. In order to avoid the pitfalls discussed above, the three partners decided to review the mechanisms dealing with hospital access.

First, a special fund was established. Both international agencies agreed to commit to an earmarked funding for enhancing access by the poor to the hospital services, the so-called Health Equity Fund (HEF). Straight from the start, it was decided that the HEF should cover all the costs the poor have to overcome to access hospital care: the user fees, the transportation cost, items for facilitating their hospital stays and some social care if necessary.

The next question was whom the HEF should be entrusted to. Both international agencies were not interested in managing it: they did not feel to have enough expertise in this domain; they were expensive and non-sustainable solutions. The other option was to entrust the HEF to the hospital itself. But some conflicts of interests were expected. In a model where a hospital staff manage such a fund, there are some perverse incentives: the most lucrative strategy for the hospital is to spend the fund, as quick as possible, in paying their own user fees, whatever the profile of the beneficiaries. Incentives for targeting the poorest and for addressing external barriers are then limited.

Henceforth, the decision was to subcontract the manage-
ment of the HEF to a local social welfare non-governmental organization (NGO). Several benefits were expected from that choice. First, one could expect some expertise and commitment to care for the poorest from this type of organization. The expertise was necessary to be able to identify correctly the beneficiaries but also to tailor the assistance. The commitment was necessary to be responsive to the needs of the poorest, including defending their rights and dignity during their stay in the hospital. Second, the local NGO was a low-cost and sustainable option. Thirdly, sponsors were concerned for enforcing some accountability mechanisms upon the fund manager (e.g. observation of leakage to non-poor should be sanctioned). Subcontracting to an agent potentially replaceable (managing a HEF has a low entry cost, there are quite a lot of local NGOs in Cambodia) was perceived as a way to guarantee actual benefit to the poorest.

Quite some freedom was given to the local NGO in the development of the strategy for recruiting, identifying and assisting the poor. Experience has permitted to progressively design the best organizational set-up. Initially, a single employee was based in an office in the hospital compound.

One year later, a second person was hired to improve presence in the hospital, follow-up of supported patients and information sharing at community level.

The recruitment of candidates for assistance was based on three ways: (1) referral by the hospital cashier who found that the patients could not pay for the admission fee and those with referral letter from the community; (2) active recruitment in the wards by the NGO welfare worker (some patients are able to pay the admission fee thanks to the assets they have sold or the debts they have taken before coming to the hospital); (3) spontaneous applicants who have heard in their community about the existence of the HEF.

Identification is done at the hospital through interviews by using a set of questionnaire. The interviews focus on information about food security, ownership of land and productive assets, housing, occupation, household size and structure, as well as social capital. Physical appearance, including clothing, often gives an indication of socio-economic status. The ‘target group’ of the HEF consists of the extremely poor, as well as the poor who risk falling into extreme poverty. No fixed criteria for eligibility are used, as poverty has many dimensions that
are difficult to measure. Some room is left for subjective judgment by the welfare worker. Judgment indeed matters: first to entitle or not the candidate, second, to tailor the assistance package according to the specific needs of those who have been entitled.

The level of financial assistance is indeed determined on a case-by-case basis, from partial payment of the admission fee to full coverage of the total cost of hospitalization, including transport, food and basic items. Presence of the social worker in the hospital compound allows frequent visits in the ward. If necessary, the support can be readjusted.

Results

In Sotnikum Hospital, the HEF assisted his first patient in September 2000. After four years, it has become an important building block for the good performance of the health system.

As shown in Figure 1, the HEF has turned the hospital into a real pro-poor health facility. On average, 40 percent of hospital inpatients received some assistance. Monitoring has constantly confirmed that beneficiaries were actual poor. Leakage to non-poor is not an issue. If there is any problem, it is one of under-coverage.

The breakdown of the HEF expenditure shows that administration costs, including management, identification and social follow-up, are under control (Figure 2). An important share of the fund goes back to the hospital through the user fees. This is of course a strong incentive for the hospital staff to provide good services to poor patients. It is important to notice that the transfer in kind to the assisted patient is much more than what is paid by the HEF. Indeed in Cambodia, a part of hospital costs are covered by the government or the donors through input financing (salaries, drugs, equipment and buildings). By paying on average US$11.5 for a poor patient, the HEFs give him an access to a benefit of more than US$48.

Lessons learned

In Sotnikum, the introduction of a HEF managed by a local NGO appeared to effectively improve access to hospital care for the poor. As long as the services delivered in the hospital are meeting the standards, one can expect a significant health outcome for the beneficiaries.

During the first year, the HEF may have mainly reduced the cost of care for people who had already chosen to access care. The years after, the steep increase in utilization indicates that a considerable number of the 'new' patients were from poor households who would not have sought care at the hospital without financial support. It is important to note that in the Cambodian context most of a household’s health expenditure takes place outside the public sector, often spent on poor quality treatment by informal private practitioners. Therefore, in terms of poverty prevention, the greatest potential of the HEF does not seem to lie in financing expenditure in the public sector, but in preventing unnecessary expenditure in the private sector, by encouraging the use of adequate public health services.

The scheme has some limitations. A better coverage would be achieved if the poor got entitled for assistance before the episode of illness (e.g. through a 'poor card'). Uncertainty on eligibility and assistance would then be removed. Some experiments with such an approach are going on in Cambodia. Another observation has been that welfare workers were quite keen on being very specific in their targeting (avoid the leakage to non-poor) but quite reluctant to deliver proximity social care to the poorest, a kind of retreat into administrative tasks.

The HEF model may be relevant to settings other than Cambodia. Similar approaches are being developed in China and some countries of Africa. Subcontracting to NGOs is
Reproductive Health Services through Mobile Camps

SEWA Experience in Gujarat

BY M. KENT RANSON, PALAK JOSHI, MITTAL SHAH, AND YASMIN SHAIKH

THE SELF-EMPLOYED WOMEN ASSOCIATION (SEWA) is a trade union of women who earn a living through their own labor or small business, started by Ela Bhatt in 1972. Headquartered in Ahmedabad (Gujarat, India), and inclusive of members from 11 of the state's 25 districts, the organization has two main goals. First, to organize women workers to achieve full employment, i.e. work security, income security, food security, and social security. Second, to make women individually and collectively self-reliant, economically independent and capable of making their own decisions.

SEWA first became actively involved in the public health
field in the early 1970s through health education and provision of maternity benefits. A focus of SEWA Health has always been to build capacity among local women, especially traditional midwives (dais), so that they become the barefoot doctors of their communities. Today, SEWA’s health-related activities are many and diverse, and include: primary health care, delivered through 60 stationary health centres and mobile health camps; health education and training; capacity building among local SEWA leaders and dais; provision of high-quality low-cost drugs through drug shops; occupational and mental health activities; and production and marketing of traditional medicines.

It has been a primary objective of these health services to provide to the very poor, particularly those living in areas not otherwise served by government or non-governmental organizations (NGOs). The services provided by SEWA Health are available both to SEWA members—of whom there are currently 468,000 in Gujarat state (calendar year 2004)—and non-members alike.

The reproductive health mobile camps

In response to demand from people in remote and underserviced areas, SEWA Health began organizing reproductive health (RH) mobile health camps for women in 1999. RH mobile camps are carried out mainly in slum areas of Ahmedabad city and villages of three districts and are funded largely by the United Nations Population Fund (UNFPA) and the Government of India. More than 35 camps are carried out per month, and the mean attendance per camp is 30 women, for a total of more than 12,500 patients per annum. Health care at the camps is provided by empanelled physicians and 50 barefoot doctors and managers. The camps are repeated in each area, on average, once per year.

Activities at the RH mobile camps include health education and training, examination and diagnostic tests (including cervical examination and Pap smears), treatment, referral and follow-up. Camps are usually held during the afternoon, and their duration is three to four hours. Those attending the camps are asked to pay a Rs. 5 (0.11 USD) contribution, and one-third of the total cost of medicines provided (although even these fees may be waived for those who are very poor).

Increasingly in rural areas, SEWA Health is conducting these camps in collaboration with the Government of Gujarat, with camps held right at government primary health centers (PHCs), which are usually located in or near small villages. These camps differ from the standard “area” camps (described above) insofar as medicines are given for free, the range of medicines available are restricted to those on the government’s formulary, and health care is provided by public doctors and nurses. Free transportation is provided by SEWA to women living in neighboring villages.

Reach among the poor

In order to assess the socio-economic status (SES) of the women using the RH mobile camps, we surveyed 376 urban and 158 rural women as they attended randomly selected camps. We then compared these women to the general urban and rural populations of Gujarat, using recent, representative surveys.

We found the RH mobile camps to be very effective at reaching poor women in Ahmedabad City. A comparison based on a composite SES index showed urban camp users to be significantly poorer than the population of Ahmedabad. Camp users (and their families) were, for example, significantly less likely to possess a motorcycle or scooter (12 percent vs. 43 percent), were more likely to rely on public (vs. private or shared) toilets (22 percent vs. 9 percent), and were less likely to use natural gas as a source of cooking fuel (35 percent vs. 66 percent). Figure 1(a) illustrates the distribution of urban camp users by deciles of the SES index score—the leftward skew of this graph indicates that camp users were more likely to be from poorer segments of the general population.
The percentage of camp users falling below the 30th decile of the SES score—which roughly approximates the poverty line in India—was 52 percent (Figure 1).

In rural areas, the camps were less effective in reaching poor women. Rural women did not differ significantly from the general, rural population in terms of their SES index score. Figure 1(b) indicates that the majority of rural camp users are from less-poor deciles of the population. Only 5.7 percent of users fell below the 30th percentile—suggesting that SEWA Health’s rural RH mobile camps do not effectively target the very poorest.

What worked and why

For the most part, the urban services seem to be effectively targeting the poor. Reasons for this success are likely to include:

- Services (especially RH mobile camps and women’s education sessions) are offered “right at people’s doorsteps”, i.e. SEWA Health takes the services to the poor, rather than trying to bring the poor to the services;
- The services are delivered by (or at least in part by) the poor themselves;
- The services are generally combined with efforts to educate and mobilize the community: for example, preceding the RH mobile camps, SEWA Health workers go door-to-door, educating people about the service, and educating people to use it;
- Costs are low (certainly relative to the private for-profit sector);
- SEWA is an entity that people know and trust.

During in-depth interviews, SEWA Health workers attributed the scheme’s success in reaching the poor to the fact that it treats poor people with respect and “warmth.” The fact that services are delivered “to their doorsteps” was also seen as contributing to the success of SEWA Health services. Finally, the fact that SEWA Health’s services are delivered largely by women, was also perceived as increasing the reach among poor women.

Our in-depth interviews with SEWA Health grassroots workers suggest that there are two main barriers that prevent poor rural women from using the RH mobile camps. First, for some, the 5 rupee registration fee prevents some from attending the camps. Second, the camps may be difficult for women to attend, as they often coincide with hours of work.

There are likely to be other, broader reasons underlying the difficulties in delivering services to the rural poor. Studies in other SEWA departments have documented similar discrepancies in the equity of utilization of rural versus urban services. For example, the poorest rural members of SEWA’s insurance scheme (Vimo SEWA) have lower rates of claims than the less poor. Reasons for this differential include:

- Problems of geographic access, both to inpatient facilities and to Vimo SEWA’s grassroots workers;
- Weaker “links” between members and local Vimo SEWA representatives in rural areas (i.e. the contact between members and the organization is less frequent, and less intensive, in rural areas);
- Weaker capacities among Vimo SEWA grassroots workers in rural areas.

Already, SEWA Health has taken steps to improve the accessibility of the rural RH mobile camps. SEWA Health waives the registration fee and the medicines fee for those who appear to be particularly poor—typically a few women presenting to each camp. Perhaps these exemptions could be granted more liberally, and in a manner more objective, for example, by providing exemption to all those who possess a below poverty line (BPL) card.

It must also be remembered that failure of a service to reach the poorest of the rural poor does not necessarily mean that the service has failed in “reaching the poor.” Even those households that fall in the higher deciles of the SES index in rural areas should be considered “less poor” rather than “wealthy.” Compared to their urban counterparts, these rural households have less in the way of cash reserves, material wealth, and thus economic security.

In conclusion, the findings of this study suggest that delivery of services through a broad-based, development-oriented union can facilitate equitable delivery of health care services. Government and donors can help to ensure that established NGOs, with an interest in providing health services, have the capacity and the resources to do so.

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Do Participatory Programs Work?

Improving Reproductive Health for Disadvantaged Youth in Nepal

BY ANJU MALHOTRA, SANYUKTA MATHUR, ROHINI PANDE, AND EVA ROCA

The world currently has its largest generation of youth ever, with over a billion young people between the ages of 10 and 19, most of whom live in developing countries (UNFPA 2004). Youth in many countries marry and begin families while still in adolescence, yet they are often denied access to sufficient information or appropriate services for prenatal care, delivery, and HIV, gaps that directly affect not only their lives but also the future well-being of their societies. The most disadvantaged—poor, rural, female youth—are least likely to have access. Yet, while this situation is recognized, little is known about what works to improve youth access to reproductive health, and, in particular, to improve the access of those who are most deprived.

Development practitioners point to participatory approaches as effective in increasing empowerment and accountability, two of the key factors in improving health services for the disadvantaged (WDR 2004). At the community level, participatory approaches can lead to increased awareness, information, social support, and client power for community members in accessing appropriate health services. Community-based participatory approaches may be particularly effective for adolescent repro-
Youth-friendly services, peer education and counseling were present in both urban and rural study and control sites, with four sites in total. Programs, activities to address social norms, and access to economic opportunities for youth. These included adult education personnel, and only 9 percent of deliveries were in a health facility, and knowledge of contraception. Rural girls in Nepal, who are typically poorer than their urban counterparts, are further disadvantaged as compared to girls in urban areas (Ministry of Health, Nepal, 2002).

**Study design**

**THE NEPAL ADOLESCENT PROJECT (NAP)** was a 5-year project conducted from 1998 to 2003, in collaboration with an international service delivery organization (EngenderHealth), an international research organization (International Center for Research on Women), and local Nepali NGOs (New ERA Ltd. and BP Memorial Health Foundation). To test the effectiveness of participatory versus non-participatory approaches to youth reproductive health, we implemented programs in urban and rural study and control sites, with four sites in total.

In the study sites, there was a focus on involving the community and actively engaging disempowered groups, such as the poor, young women, and ethnic minorities, at every stage of the program. Study site program activities took into account broader development priorities voiced by diverse members of the community. Thus, interventions aimed at improving youth-friendly services, peer education and counseling were linked with broader interventions prioritized by the community and aimed at improving the socio-economic environment and opportunities for youth. These included adult education programs, activities to address social norms, and access to economic livelihood opportunities. Consequently, the entire intervention package addressed structural, normative, and systemic barriers to youth reproductive health. Further, youth, parents, and other community members were actively engaged in implementing study site program activities through a wide variety of community-based groups set up during the project. In contrast, in the control sites, project staff designed and implemented standard reproductive health interventions that addressed only the most immediate risk factors such as STDs or unwanted pregnancies. Finally, socioeconomic disadvantages—based on gender, rural-urban residence, wealth, ethnicity, schooling status, and marital status—were a specific focus of the intervention design and approach in the study sites, whereas this was not the case in the control sites.

We measured poverty by household asset ownership. While poverty is critical, it is not the only disadvantage that can keep young people from accessing appropriate information and services around reproductive health. Thus, the study looked at multiple types of disadvantage among young people in addition to poverty, namely, gender, rural-urban residence, and education status. We chose prenatal care, delivery at a health facility, and knowledge of HIV transmission as important reproductive health outcomes for which to examine the impact of various types of disadvantage among young people. Data for this study come from baseline and endline cross-sectional quantitative surveys, as well as qualitative and participatory methods. The target age group at baseline was 14-21 year olds, so as to capture all youth who could have participated in or benefited from the project. We collected data from a total of 965 households at the baseline and 1003 households at the end-point of this study.

**Results**

RESULTS SHOW that generally, the participatory approach was more successful in reducing the gap in reproductive health out-
comes among youth with disadvantaged backgrounds as compared to those with advantaged backgrounds. Our analyses also show that for different health outcomes, different aspects of disadvantage were important. Being from a rural area or a poor household were key constraints for getting prenatal care, while gender and lack of education were the key constraints for having accurate knowledge of HIV transmission. In most cases, the participatory intervention approach was better able to overcome the impact of these constraints on reproductive health outcomes than was the more traditional approach (Malhotra et al 2004).

- Delivery in a health facility. At baseline, both the study and control sites showed substantial differences between rich and poor young women’s access to a health facility for pregnancy delivery (Figure 1). By the endline, poor young women in the study sites were closer in their access to prenatal care when compared to better-off women, but a similar change was not evident in the control sites. As Figure 1 shows, this is because the improvement in access to delivery at a health facility was entirely among the poorer 50 percent of the population in the study site, whereas in the control sites, both the rich and the poor gained.

- Prenatal care. Regression results show that before the intervention, an urban young woman in the study site was 16 times more likely to get prenatal care than her rural counterpart. By the end of the project she was only 1.2 times more likely to receive prenatal care. The control sites do not show a similar improvement of access to prenatal care among rural young women (Malhotra et al. 2004).

- Accurate knowledge of HIV transmission. In all the sites at baseline, girls were less likely to be able to correctly identify at least two modes of HIV transmission when compared with boys. In the urban study site, the intervention led to such a substantial improvement in knowledge among girls that the proportion of girls who were knowledgeable about HIV actually surpassed the proportion of boys. A similar change was not observable in the control sites. At the same time however, neither type of intervention was able to substantially reduce the difference in knowledge regarding HIV among the educated and the uneducated (Malhotra et al. 2004).

Why did the participatory approach work?

OUR EVALUATION SUGGESTS that the participatory approach succeeded because its defining characteristics lent themselves well to the problems of adolescent reproductive health.

- The participatory intervention design made the young people active players in their own health, primarily by tapping into and strengthening their existing social networks for information exchange and counseling: to an increasing extent, poor young people could rely on better informed peers rather than professional services for a number of reproductive health needs.

- The participatory intervention empowered youth and adult community members to demand accountability from providers and policymakers by building decision-making structures and coalitions. In particular, young people learned to enforce higher expectations from providers.

- The study sites focused on altering not just reproductive health outcomes, but changing fundamental social norms and institutions. This created an enabling environment for good reproductive health for youth by generating a better understanding and new mindset in the communities, and leading to a substantial increase in demand for such services, even among the disadvantaged.

Conclusions and implications

OUR RESULTS SHOW that small-scale community efforts can achieve empowerment and accountability. Specifically, participatory approaches can successfully provide youth, especially disadvantaged youth, the means to negotiate for appropriate, accessible, and accurate information and services from parents, providers and policy makers.

Equally critically, our study points to the need for broader definitions of disadvantage. There is no dispute that poverty is a key and powerful measure of disadvantage. Nonetheless, in many rural communities in the developing world, those who are most disadvantaged owe this disadvantage to complex and interwoven interactions between various contextual factors that need to be considered. Analyses of poverty as a measure of disadvantage need to be accompanied by analyses of rural-urban residence, gender, and educational access as other important markers of social, cultural, and economic differentials.

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References:


munities and setting targets for investments in poorer areas. This is important to redressing the historical underfunding of poorer areas typical of most countries. The results from Bolivia showed a correlation between improved poverty targeting over time and growing fiscal decentralization, which may hold lessons for other cases.

Second, there may be a tradeoff between improved household targeting and the use of more open menus of eligible investments. Social funds have defined menus featuring basic services more likely to be demanded by the poor as a targeting tool, a strategy supported by the household targeting results showing significant differences in outcomes among different types of projects. Should menus be further restricted to improve targeting results? That would eliminate some of the potentially positive attributes of greater choice for communities. But more open menus may allow better-off households and communities to capture benefits. At the very least, for investments that tend to benefit the better-off, developing more rigid screening criteria including introduction of data on income levels of potential beneficiary households may help to reduce leakage.

Third, there is a need to exploit complementarities among social funds, demand-side interventions, and more targeted social assistance. For example, social fund interventions could complement a demand-side subsidy enabling the very poorest parents to send their children to school as well as support the provision of nutritional supplements through health centers. Indeed access to quality supply-side investments are a prerequisite to the provision most effective demand-side approaches, with the latter being able to directly target resources to households or individuals, complementing the former’s provision of broad community benefits.

Finally, an increased emphasis on improving intra-district targeting would also be worth exploring, especially in more heterogeneous areas, such as urban centers. This initiative could explore a variety of approaches from improving poverty maps to allow for greater geographical disaggregation to engaging community members in identifying the poorer beneficiaries.

Beyond the lessons on poverty targeting, the results of the social fund impact evaluations show that although this approach has been successful in generating a range of positive welfare outcomes, social funds cannot operate effectively without well-coordinated social policy both at the central and local level.


References:
Medicinal Value of Indigenous Plants Ensures Livelihood in South African Communities

BY EMMANUEL KORO

SOUTH AFRICAN FEMALE traditional leaders are taking a groundbreaking approach towards promoting rural livelihood and development through the management of indigenous knowledge systems and sustainable exploitation of natural resources with nutritional and medicinal values.

This project was prompted by other projects that are currently being implemented in South Africa, which commercialize the use of indigenous plants to alleviate poverty and promote job creation. As long as these projects continue without a strategy that promotes conservation of these resources, there is a high risk of over-harvesting indigenous plants. Already, urban dwellers are flocking to rural areas looking for herbs with medicinal and nutritional properties that suppress the impact of HIV/AIDS-related illnesses. The female traditional leaders cited the over-harvesting of the African potato by the urban dwellers as a good case in point, to demonstrate the threat that South Africa’s indigenous plants were facing.

The traditional leaders interviewed said that indigenous plants played an important role in their daily socio-economic needs. The plants are used to cure diseases such as diarrhea, skin rash, rheumatism, and arthritis, and heal wounds, cough, and headaches. Other plants are also used as laxatives at birth. They are also sources of food for the communities, wherein lies the link between the nutritional and medicinal values of indigenous plants.

Just as medical doctors sometimes tell patients what kinds of food they should or should not eat when ill, the female traditional leaders said that this was similar to the way they administered traditional medicines in their communities. It is therefore clear that while the nutritional and medicinal values of indigenous plants are critical to the general upkeep of rural residents, they also have a huge potential to lift these communities out of poverty through sustainable commercial exploitation of the plants.

To achieve sustainable utilization of indigenous plants, the female traditional leaders said that the management of indigenous knowledge systems should link traditional and modern conservation methods.

This project is jointly funded by the Kellogg Foundation and the European Union’s CODEOSUB (Conservation and Development Opportunities from Sustainable Use of Biological Diversity in Communal Lands of Southern Africa). South Africa’s Centre for Scientific and Industrial Research (CSIR) and Resource Africa, a South Africa-based conservation agency formed a partnership in July 2004, to jointly implement the project.

The indigenous knowledge systems project also seeks to assist rural communities to protect their rich knowledge on the functions of indigenous plants from being illegally acquired and patented by western pharmaceutical and food companies.
THE SOUTH AFRICAN GOVERNMENT RECENTLY INTRODUCED A BIODIVERSITY ACT TO PROTECT INDIGENOUS KNOWLEDGE SYSTEMS

To ensure sustainability and better management of the indigenous plants, the project will focus on the female traditional leaders' role in managing the harvesting and exploitation of the plants. Through traditional fares, workshops, and media publicity, awareness could be created in the communities on the best practices to manage and sustain indigenous knowledge.

Female traditional leaders interviewed requested the South African Government's assistance to protect their indigenous knowledge systems. They said that this could be achieved through greater enforcement of the recently introduced Biodiversity Act that requires researchers investigating the values of indigenous plants to declare their intentions to do so, and also make it clear that they would enter into benefit sharing agreements with communities from where they acquire the knowledge on the values of indigenous plants.

The South African Government has a good track record for promoting the need for benefit sharing between indigenous communities and the private or public sectors, through its development agency, CSIR. About two years ago, CSIR and the San Communities signed a benefit sharing agreement with a US-based pharmaceutical company, Pfizer. The agreement regulated the sustainable and commercial exploitation of an indigenous plant, the *Hoodia Gordonii*, which contains the compound P57 that suppresses one's appetite and helps reduce fat. Under this agreement, the San Communities (the acknowledged source of knowledge on the medicinal value of the *Hoodia Gordonii*) were granted 6% of all royalties, if the product was successful. This agreement has set an important precedent that makes it unethical or morally incorrect for companies that fail to sign benefit-sharing agreements with communities to add value to products.

Meanwhile, unscrupulous pharmaceutical companies have continued to make super profits from the illegal exploitation of indigenous knowledge that establishes the nutritional and medicinal values of indigenous plants and other related resources, without benefiting the sources of that knowledge. However, the initiative by South Africa's traditional leaders to manage their indigenous knowledge system is expected to further promote benefit sharing between communities and the private sector.

Emmanuel Koro is President of Sub-Saharan Africa Forum for Environment Communicators (SAFE)

ACKNOWLEDGEMENT: This research was made possible through the Kellogg Foundation and European Union grants. The European Union is funding the project "Conservation and Development Opportunities from the Sustainable Use of Biological Diversity in the Communal Lands of Southern Africa" (CODEOSUB). The CODEOSUB Project is focused on promoting successes in Community Based Natural Resources Management (CBNRM) projects within Southern African countries that signed the UN Convention on Biodiversity and are implementing the CBD work programme within the arid and semi-arid ecosystems. The project involves building the capacity of communities and NGOs involved. The CODEOSUB Project targets eight SADC countries namely, Botswana, Malawi, Mozambique, Namibia, South Africa, Tanzania, Zambia and Zimbabwe.

This book stresses that community financing schemes are no panacea for the problems that low-income countries face in resource mobilization. They should be regarded as a complement to—not as a substitute for—strong government involvement in health care financing and risk management related to the cost of illness. The authors conclude by proposing concrete public policy measures that governments can introduce to strengthen and improve the effectiveness of community involvement in health care financing.

MEASURING EMPOWERMENT: CROSS-DISCIPLINARY PERSPECTIVES, Edited by Deepa Narayan. World Bank, 2005

Building on the award-winning Empowerment and Poverty Reduction sourcebook, this volume outlines a conceptual framework that can be used to monitor and evaluate programs centered on empowerment approaches. It presents the perspectives of 27 distinguished researchers and practitioners in economics, political science, sociology, psychology, anthropology, and demography, all of whom are grappling in different ways with the challenge of measuring empowerment. The authors draw from their research and experiences at different levels, from households to communities to nations, in various regions of the world.


This report is the second in an annual series assessing progress on the Millennium Development Goals and related development outcomes. This year's report has a special focus on Sub-Saharan Africa—the region that is farthest from the development goals and faces the toughest challenges in accelerating progress. The report finds that without rapid action to accelerate progress, the MDGs will be seriously jeopardized—especially in Sub-Saharan Africa, which is falling short on all the goals. It calls on the international community to seize the opportunities presented by the increased global attention to development to build momentum for the MDGs.


World Development Indicators presents the most current and accurate information on global development on both a national level and aggregated globally. This information allows readers to monitor the progress made toward meeting the goals endorsed by the United Nations and its member countries, the World Bank, and a host of partner organizations in September 2001 in their Millennium Development Goals. It includes over 80 tables and over 800 indicators for 152 economies and 14 country groups, as well as basic indicators for a further 55 economies. The report contains six thematic presentations of analytical commentary covering: World View, People, Environment, Economy, States and Markets, and Global Links.


Beyond the City evaluates the contribution of rural development and policies to growth, poverty alleviation, and environmental degradation in the rest of the economy, as well as in the rural space. This title brings together new theoretical and empirical treatments of the links between rural and national development. New findings are combined with existing literature to enhance our understanding of how rural economic activities contribute to various aspects of national development.
The online version of Development OUTREACH (www.worldbank.org/devoutreach) will soon feature three back issues of the magazine in translation. Over the years, international authorities in the field of development have contributed articles that “put knowledge to work for development,” as the magazine’s masthead claims. However, until now, that knowledge had been accessible only to English-speaking readers. Now three Special Reports will be available for the first time in Arabic, Chinese, French, Russian, and Spanish. The special reports are: Young People Count (Spring 2002), Sustaining the Earth (Fall 2002), and The Private Sector: Building Economic Growth (March 2003). They can be found in the online archive together with all the back issues of the magazine in English (1999-2005).

World Volunteer Web supports the volunteer community by providing a global one-stop-shop for information, resources, and organizations linked to volunteerism. It aims to represent the diversity of volunteerism in all of its cultural forms, bringing global ideals to local voluntary actions. It mobilizes individuals, organizations, and networks to help achieve the Millennium Development Goals (MDG), a set of time-bound targets to combat poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women, and to promote ties between civil society organizations, governments, and individual volunteers.

Visit: www.worldvolunteerweb.org

The Institute of Tropical Medicine is one of the world’s leading institutes for training, research, and assistance in tropical medicine and health care in developing countries. ITM is an inter-university but autonomous post-graduate institute for specialized training, research, and services provision. It carries out a wide-ranging international program of capacity strengthening and participates in activities and collaborations all over the world towards the common goal of “Health Care for All.”

Visit: www.itg.be

The Caribbean Epidemiology Centre (CAREC) works toward improving the health status of Caribbean people by advancing the capabilities of member countries in epidemiology, laboratory technology, and related public health disciplines through technical cooperation, service, training, research, and a well-trained motivated staff. It is administered on behalf of 21 Member Countries by the Pan American Health Organization (PAHO), the World Health Organization’s Regional Office for the Americas.

Visit: www.carec.org
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  UN Headquarters, New York
  
  www.un.org/events

- **11-13** Carbon Expo 2005: Global Carbon Market Fair and Conference
  
  Cologne, Germany
  
  http://www.carbonexpo.com/

  
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- **25-27** II Technical Forum on Involuntary Resettlement in Latin America and the Caribbean
  
  Bogota, Colombia
  
  jvillegas@worldbank.org

### JUNE 2005

- **1** World Bank Youth Seminar, Working for a World Free of Poverty
  
  Singapore
  
  singoffice@worldbank.org

### JULY 2005

- **5** World Environment Day
  
  San Francisco, CA, USA
  
  www.unep.org

- **6-8** G8 Summit
  
  Gleneagles, Scotland
  
  www.g8.gov.uk

- **19-21** From Reaction to Prevention: Civil Society Forging Partnerships to Prevent Violent Conflict and Build Peace
  
  New York, UN Headquarters
  
  www.un.org/events

- **21-22** International Conference on Shared Growth in Africa
  
  Accra, Ghana
  
  isser@ug.edu.gh

### SEPTEMBER 2005

- **7-9** 58th Annual DPI/NGO Conference
  
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The World Bank’s overall development strategy emphasizes two pillars for long-term growth and poverty reduction: improving the investment climate and empowering and investing in people. The Investment Climate Capacity Enhancement Program was established in 2003 jointly by the World Bank Institute (WBI) and the World Bank Private Sector Development (PSD) Vice Presidency to support the implementation of this development strategy.

The program’s objectives are:

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- To promote new thinking, share knowledge and disseminate best practices on how to incorporate investment climate issues in policy formulation.
- To enhance clients’ capacity in assessing and improving investment climate.
- To train local trainers and researchers to build capacity for policy research and training in investment climate.
- To provide direct implementation and capacity enhancement support to client countries and World Bank staff.

The target audience for the program includes: policy makers, practitioners and stakeholders in client countries, trainers and local partners, representatives from the international donor community, and World Bank staff.

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The Right to Tell: The Role of Mass Media in Economic Development contains an outstanding list of contributors from Nobel Prize winner and former World Bank chief economist, Joseph Stiglitz to Robert J. Shiller author of Irrational Exuberance and novelist Gabriel García Márquez. Contributors to this volume explore the role of the media as a watchdog of government and the corporate sector, and the policies that prevent the media from exercising that role. The Right to Tell also evaluates the media's function as transmitters of new ideas and information, an essential ingredient for markets to operate efficiently. This publication also looks at the damaging effects that an unethical or irresponsible press can cause to a society.

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Edited by Brian Levy and Sahr Kpundeh

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