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Services for the poorest: from angst to action

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What is Chronic Poverty?

The distinguishing feature of chronic poverty is extended duration in absolute poverty.

Therefore, chronically poor people always, or usually, live below a poverty line, which is normally defined in terms of a money indicator (e.g. consumption, income, etc.), but could also be defined in terms of wider or subjective aspects of deprivation.

This is different from the transitorily poor, who move in and out of poverty, or only occasionally fall below the poverty line.

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Abstract

For the poorest people, low level of access to basic services is both a cause and a consequence of their poverty and deprivation. A set of interacting factors means that supply-side and demand-side problems deny them access to health, education, water and sanitation services. Demand-side approaches to improving services (participatory planning, local health councils, user groups) offer ways forward but these need to be matched by supply-side reforms (packaging services for the poorest, effective geographical targeting, regulation of private providers, public sector reform and increased public finance). While technical changes are needed, helping the poor to access the basic services they need must be embedded in longer-term processes of progressive social and political change.

Keywords: poorest, basic services, deprivation, chronic poverty, education, health, water, sanitation, demand-side approaches, reforms.

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1 Introduction

Poverty and lack of access to basic services are inextricably related. Being poor makes it harder to access services, and not being able to access services is an important component of the processes that create, maintain and deepen poverty. Lack of access to basic services is often used as a measure of poverty and is increasingly recognised as an abrogation of human rights.

The poorest people constitute a heterogeneous group that varies greatly from country to country and region to region. They suffer from multiple and probably overlapping forms of deprivation. Major health shocks, for example, can impoverish families, but those households that are already experiencing forms of social exclusion, based on race, ethnicity, age and/or disability, for example, will find it hard to recover from shocks, and their coping strategies may draw them into deeper spirals of poverty, with few opportunities for increasing their low or declining incomes. While they are usually conceptualised as very poor 'households', it must also be noted that individuals in non-poor households can experience extreme forms of poverty because of intra-household relations. Severe deprivation harms individuals and households both in the short term and in the long term.

There are real limitations to achieving the Millennium Development Goals (MDGs) if the interests of the severely and chronically poor are not included. Achieving universal primary education is clearly impossible without including the poorest children. Many other MDG targets are unlikely to be met unless the very poorest can access basic services, as inhibited access is an important causal factor for multidimensional poverty. Those who cannot access health services, clean water and sanitation are more likely to experience hunger, higher levels of mortality and capability-damaging events, and to have incomes below the poverty line. Those who lack a basic education are likely to have lower productivity and incomes and higher rates of child and maternal mortality. Further, as argued by Grant and Shepherd (2008), poverty reduction goals post-2015 are also unlikely to be achievable unless the knowledge and capacity to ensure that the very poorest can access basic services has been created.

Service delivery inefficiencies can both drive and maintain deep and entrenched poverty. Despite pockets of excellence, state services are often mired in clientelism that excludes the poor, unresponsive to user needs and unable to provide the full service coverage required to reach the most vulnerable, discriminated or poor. Voices of the Poor tells of an 'institutional crisis' in which many poor people experience formal institutions as ineffective, inaccessible and disempowering (Narayan *et al*., 2000b: 83). This paper determines what needs to be done for services to be less supply driven and more responsive to the demands of the poorest, especially when their demands are less likely to be heard or are manipulated by more powerful interests.

2 Service provision as a driver and maintainer of poverty

Institutions can reproduce unequal relationships of power and authority, marginalising the concerns of particular vulnerable groups (Goetz, 1998; Kabeer and Subrahmanian, 1996; Narayan *et al*., 2000b: 84). These dynamics have a significant effect on the extent to which people utilise services. People often feel powerless to complain, since the consequence of complaining may be the withdrawal of services by frontline providers. Any attempts to plan and deliver services for the very poor must account for not just the formal but also the informal relationships between service provider and different users.

There are often complex sets of service delivery arrangements involving state and non-state actors as well as donors and communities themselves within specific countries and regions. State provision is important, often supported by a large bureaucracy (Turner and Hulme, 1997). The non-state sector is diverse (formal or informal, both profit and non-profit oriented, or mixed) and in many contexts has an unprecedented capacity to respond to differentiated local needs. It constitutes a significant supplement to limited government provision to reach chronically and very poor areas, groups and people (Moore and Joshi, 2004).

In practice, basic services are often purchased on the market from either/or a mix of formal and informal local providers. Complex individual and household trade-offs often underlie decisions behind choice of service provider, based on severity of need, as well as access and cost considerations. Over-reliance on expensive private sector providers often increases the vulnerability of very poor people but may be the only option available to them locally (CPRC, 2004).

Poverty and lack of access to basic services are therefore inextricably related. Being poor makes it harder to access services and not being able to access services is an important component of the processes that create and maintain poverty. The poorest often have only limited or no access to education, health, social protection, water and sanitation services. When they do gain access, these services are commonly of a lower quality than those available to less poor and non-poor people. The direct and indirect costs incurred by the very poorest in accessing such services are often higher (and sometimes very much higher) than those incurred by other groups. Their access to other services – justice, police, land administration – is often low or negative, i.e. these services are used against the poorest, as happens when the police are used to illegally clear slums.

The poor and poorest people tend to be mainly dependent on their labour power for survival. Lack of access to effective health services is a particular problem. Ill-health, especially of a ‘breadwinner’, is commonly associated with downward spirals into deep and chronic poverty, as assets are depleted to meet additional medical bills and basic household needs. Savings are liquidated, debts are taken on, land, animals and equipment are sold off and children are

pulled out of school (Pryer *et al*., 2003). Rebuilding assets after such shocks may not be possible and poverty becomes persistent.

In many developing countries, life expectancy remains very low, morbidity of preventable diseases remains high, malaria, diarrhoea and other preventable diseases account for about 40 percent of child mortality and maternal mortality is still high (Osei-Akoto, 2003). Child mortality is substantially higher in poorer households. In Bolivia, Central African Republic and Cambodia, under-five mortality rates are two to three times higher among the poorest quintile than the richest quintile (World Bank, 2003).

Many of the health problems experienced by the poor are often faecal related or water, food or vector borne (WHO, no date, in Kyegombe, 2003: 6). Convenient and safe water and sanitary disposal of human wastes are basic needs, essential to safeguarding the health of populations and their livelihood productivity. Water that is not safe for consumption spreads diseases; lack of convenient access impinges on productive time and energies; inadequate sanitation reduces the benefits of providing safe drinking water. Yet, in countries such as Morocco and Madagascar, the proportion of households from the poorest quintile that use 'improved'[1] water sources is as much as one-sixth or one-seventh that used by households from the richest quintile (World Bank, 2003).

The decline of public health systems and services means that appropriate care is rarely available, affordable or provided, and so increasing numbers continue to suffer and die from a range of causes, a large number of which (such as diarrhoea and the EPI target diseases) are preventable (Gordon *et al*., 2003: 21).

Not being able to attend school may not have such disastrous short-term consequences, but limits the life opportunities of those who do not become literate and numerate. The poor are less likely to start school, and more likely to drop out. In India, for example, almost all children in the richest quintile start school, and a negligible proportion drop out by Grade 5; in the poorest quintile, only about half of children start school, and by Grade 5 over one-quarter drop out (World Bank, 2003). In sub-Saharan Africa, 30 percent of all children are severely educationally deprived, defined as lacking any primary or secondary school education. Figures are also high for the Middle East and North Africa (23 percent) and South Asia (19 percent). These figures are starkly different between rural and urban areas, with far fewer rural children attending school. Girls are much more likely than boys to be educationally deprived (Gordon *et al*., 2003).

[1] According to the UN Children's Fund (UNICEF), a water source that provides adequate quality and quantity of water.

The returns to education are lower than returns in other assets and are much lower in rural areas than in urban (Appleton *et al*., 2003). The main economic gains from education accrue at the secondary level – this is the level at which the very poorest have very low levels of enrolment. Problems with the quality of educational services in many parts of the world mean that there are increasing doubts about the relationship between attending primary school and becoming literate and numerate. 'Years at school' may no longer be a good indicator of level of learning achieved.

3 Constraints to delivering services to the poorest

Socio-cultural, economic and political processes work in all societies to reduce the value placed on the needs or interests of certain groups. When this translates into service provision, it means that these interests and needs may be excluded or invisible to policymaking, meaning services are designed and delivered in ways that do not respond to marginalised needs and interests, with a concurrent effect on demand. Informal payments, indifferent frontline staff, institutional indifference to corruption and ill treatment of service users all combine to weaken the demand for services by the poorest. In turn, service providers require enough resources and equipment to carry out their jobs, as well as adequate facilities. Training to acquire the requisite competencies and capacity to respond effectively to the needs of the poorest and most marginal people also requires sufficient policy recognition and resources. Inappropriate service design may reflect a lack of institutional incentives to curb poor performance and corruption, and results in calls for wholesale public service reform.

The poorest commonly purchase basic services on the market from a mix of formal and informal local providers. Over-reliance on expensive private sector providers often increases the vulnerability of very poor people but may be the only option available to them locally (CPRC, 2004). A common example of this is drinking water in urban 'slums'. Poor people buy water from tankers at prices vastly higher than from standpipes (Balimunsi, 2003). Demand for services cannot be developed without reflecting the realities beneath user choices and recognising that service infrastructures, however inadequate, do already exist for the poorest people.

Goetz and Gaventa (2001) identify a number of characteristics that affect supply of services, such as the complexity of technology involved in a service and whether the service provides commonly shared goods or individually consumed products. Condensing multiple and overlapping problems into a concise and coherent framework for analysis is difficult, however, because of the variety of sectors, service providers, state contexts, types of user and so on. This section examines supply challenges associated with (1) institutional cultures and capacity; (2) cultures and capacity at the point of delivery; and (3) resource constraints.

3.1 Institutional culture and capacity

Certain people and their needs are invisible within policy debates (Bird and Pratt, 2004). This may reflect a lack of awareness or inadequate data on indigenous peoples, people with disabilities, orphans, older people and so on, but also owes to the fact that working with these groups tends to be perceived as an add-on agenda rather than central to service delivery itself. Yeo (2003) argues that, despite World Bank estimates that people with disabilities make up 20 percent of the world's poorest population, this group remains marginal to development debates. A recent Department for International Development (DFID, 2002) publication on infrastructure delivery ('Making Connections – Infrastructure for Poverty Reduction') for example makes no reference to ensuring that new infrastructure is accessible to disabled people (Yeo, 2003: 11). At other times, this exclusion is active and not possessive, as when policies deny refugees access to education or health services.

In many countries and regions, institutional capacity is limited because of the lack of trained personnel. At the national level, this is particularly common in many African countries, where trained staff (especially doctors, engineers and agriculturalists) migrate to other countries and/or have experienced high mortality rates because of HIV/AIDS. Such shortages are exacerbated in rural areas which are unattractive to urban-trained professionals.

The capacity of excluded groups to complain about the level and quality of services available to them is limited. In many cases, there are only *ad hoc* mechanisms for keeping institutions accountable for poor treatment of certain groups, and these rely on members of these groups having the capacity and/or inclination to complain, and thus tend to be ineffective for the poorest people. The World Bank (2004) identifies what it calls 'compact failures', in which clear responsibilities for outputs and outcomes are poorly communicated and enforced by the state to public bodies. These may be particularly acute where there is weak state control, particularly in countries affected by conflict, or regions of a country that are beyond the reach of government, for example. Policy-level exclusion happens in many different contexts and is not an issue only at the point of delivery itself.

3.2 Provider culture and capacity

In many developing countries, goods and services have become incredibly marketised. How the poorest manage within this market is critical, particularly within broader contexts of patronage. Bloom and Standing (2001: 3) highlight the example of personnel with health-related skills, who are willing to offer services for payment. These are rapidly increasing in many countries and include a 'wide spectrum of expertise from highly trained medical specialists to drug peddlers and a variety of quacks'. The poorest are often dependent on lower-skilled providers, as they may be more accessible in terms of costs, location and socio-cultural factors.

Pluralistic supply systems have had devastating effects on the very poorest in many countries, increasing inequality, as market-type mechanisms produce market niche-seeking behaviour by public service providers (e.g. primary care doctors seeking to avoid those socioeconomic groups most prone to illness; good secondary schools biasing their entry procedures towards the children of parents of higher socioeconomic groups) (Pollitt, 1994 in Larbi, 1999: 34). However, responses to supply-side weaknesses are often technical – job redesign, product redesign, performance-related incentives, computerisation, auditing and so on – and tend not to tackle more ingrained economic, social and political dimensions underlining behaviour. As the World Bank posits, these problems are deep, and any quick fixes that seem too good to be true probably are (2004: 57).

3.3 Resource constraints

Many countries have experienced prolonged reductions in public sector finance since the early 1980s, and the best projections suggest that resource constraints will persist, particularly in Africa (Bloom and Standing, 2001: 2). Cost recovery, usually through user fees and charges, has constituted a considerable element of structural adjustment and new public management (NPM) reforms (Larbi, 1999). It was hoped that these mechanisms would benefit the poor by drawing resources from better-off users and providing exemption systems and safety nets for the poorer users. However, these have tended to be ineffective owing to design and implementation problems, including targeting, lack of incentives and corruption, which reflect a lack of information about poorer users and high levels of discretion.

National public expenditures are often anti-poor. This can reflect political decisions that value wealthier constituents. Education spending in Bangladesh relatively favours the poorest two quintiles at primary school level, but their lack of participation at secondary and tertiary levels means that overall the poorest ‘win’ only one-third of the spending that the wealthiest quintile receives (ADB/World Bank, 2001). Public education expenditure ‘capture’ by the wealthy is typical of other developing countries. For example, in Côte d’Ivoire, the lowest real expenditure quintile received 13.5 percent of public education spending whereas the highest captured 34.8 percent (World Bank, 2001).

Public expenditure patterns within the health sector are more varied. In Bangladesh, the poorest quintile in urban areas attracts a lower rate of government subsidies than all other quintiles overall, but this is not the case for the rural ‘very poor’. Distributions differ markedly between different types of service and, for example, the second lowest quintile benefits most for curative services in urban areas and the lowest quintile for child health in rural areas.
Public health expenditure in Bangladesh is better than the strongly anti-poorest spending patterns of Ghana and Vietnam (Table 1). By contrast, Malaysia has much more redistributive expenditure patterns, from as far back as 1984, perhaps partly explaining its

progress in health indicators over the late 20th century. For publicly provided curative care, India, like Bangladesh, appears actively biased against the poorest; only 10 percent of spending on curative care accrues to the poorest 20 percent of the population, whereas the highest quintile captures 33 percent. Those who most need subsidised curative services are least likely to get them (ADB/World Bank, 2001).

Table 1: Distribution of public health expenditures across different real expenditure quintiles for various countries

Country	Year	Welfare class					
		1 Lowest	2	3	4	5 Highest	Total
Vietnam (inpatient)	1993	13	17	24	22	24	100
Vietnam (outpatient)	1993	9	14	15	23	39	100
Vietnam (community centres	1993	20	29	22	18	10	100
Vietnam (all)	1993	12	16	21	22	29	100
Malaysia (inpatient)	1984	25	21	19	20	16	100
Malaysia (outpatient)	1984	24	23	21	18	15	100
Ghana (all health)	1992	11.6	15.5	18.7	21.4	32.9	100
India (curative)[2]	1995	10.1	13.4	17.8	25.6	33.1	100

Source: ADB/World Bank (2001: 34).

Complex expenditure decisions are shaped by how priorities are influenced as well as how accessible government services are to different wealth groups *vis-à-vis* the degree to which different groups feel they can access and afford private services. The poorest do well in terms of accessing immunisation and broadly available/fair quality child health services. By contrast, they cannot access curative services very well as they lack social and political contacts.

4 Explaining low demand among the poorest

The lives of the poorest tend to by characterised by low and irregular income, low levels of formal education and knowledge, frequent ill health, lack of social and political power and

[2] For India, consumption of immunisations and outpatient care in primary health care and below (non-hospital care) appears to be pro-poor. Outpatient and inpatient hospital care appears to be pro-rich. The exact parameters of the distributions are not available at the moment.

high levels of risk and vulnerability, which all make it difficult for them to demand services and hard for agencies to help meet their needs.

Commonly cited demand-side problems are numerous, but include people's inability to meet indirect and direct service costs, lack of or exclusion from information to assess service availability and quality, poor treatment from service providers, distance from service facilities and weak capacity to articulate needs and preferences or demand accountability. Demand-side factors are categorised below as: (1) being very poor; (2) exclusions, discrimination and culture; and (3) geography and spatial poverty traps.

4.1 Being very poor

There are numerous formal and informal costs to services that limit the accessibility to services of the poorest, who are most unable to pay. Co-recovery levies through user charges, for example, often render a service inaccessible to the very poor, who cannot afford market rates. The informal costs, associated with corruption, as well as travel expenses, opportunity costs and so on, are particularly inhibitive, and difficult for policymakers to tackle. For example, in Bangladesh, malnourished children are withdrawn early from medical centres because adults simply cannot spare the time to go with them (Pryer, *et al.*, 2003). Inhibitive and excessive procedures may also increase service costs. For example, in Moldova, disabled people are often unable to afford the required payments to purchase the papers necessary to qualify for disability benefits (Narayan *et al*., 2000b: 101).

The poorest are less likely to be skilled workers and therefore salaried, or have access to sickness benefit or formal or informal health insurance. This means the most vulnerable often delay treatment until a critical point is reached, at which time treatment may be more expensive and possibly less likely to have a positive outcome (Goudge and Govender, 2000), or may lead to a chronic state of the disease (Kabir, 1998). Therefore, this group spend proportionately more of their income on health care than do middle-income or wealthier groups (Box 1).

Box 1: Costs of health care and the poorest

- In rural Nepal, the lowest income quintile spent 10 percent of their income on health, compared with an average of 6 percent for the upper quintile (Acharaya *et al*., 1993).
- Household expenditure on health in Vietnam averaged 7.1 percent of household income, ranging from 3.9 percent by 'rich' households to 19.4 percent for 'poor' households and 19.3 percent for 'very poor' households (Ensor and San, 1996).
- In a large city in northern Thailand, the health expenditure of the poorest income quintile was 21 percent of household income, whereas for the richest quintile it was 2 percent (Pannarunothai and Mills, 1997).
- In a tribal area of Madhya Pradesh, India, overall spending on health was 3.4 percent, ranging from about 2 percent of income for comparatively high income households, to 10 percent for households in the lowest income quartile (Mishra *et al*., 1993).

Source: Cited in Kyegombe (2003).

Within the education sector, free and compulsory basic education in many countries is often, in reality, far from 'free'. Government schools may not be able to charge tuition fees, but will often charge under other heads. For example, it is widespread practice to require contributions from parents towards school buildings. In India, children must provide their own text books. The poorest households are not able to pay these fees and the poorest children drop out (Govinda, 2003: 86). The opportunity costs of sending a child to school mean that pulling a child out of school is tempting and often a necessity for the poorest households.

Often, the poorest people have insufficient information or alternatives to make the most cost-effective decisions about service expenditure. Within the water sector, for example: 'The problem of lack of water services hits the poor in the slum areas of the large cities in developing countries. Often the only choice for low-income households that cannot afford a house connection is to buy water from private vendors at a relatively high price, sometimes 100 times more than that provided by public authorities' (Klugman, 2002, cited in Balimunsi, 2003: 20). For profit, service providers can actively strip assets from the poor by providing unnecessary, inappropriate or poor quality services (Hulme, 2003).

Gaining short-term access to essential services, such as emergency medical treatment or the money to pay for a school uniform, may mean taking on loans or commitments that will reduce access to services in the longer term – Wood's (2003) 'Faustian bargain'. Breaking such vicious circles will often require strong support from external agents. There is a need for policy-level support to extend microfinance services, especially credit and insurance.

4.2 Exclusion, discrimination and cultural preference

Demand may reflect local preferences, such as the need for separate toilet facilities at schools in order for girls to attend. The World Bank (2003: 12) argues that, when this is the case, local people must then have a say in service design. However, user choice or patterns of demand may reflect a series of complex trade-offs (often in terms of negative deficiencies in available options rather than benefits) rather than needs or preferences alone.

People may self-exclude because of fear or shame. Indeed, there are many people living with severe stigma which they may do their best to hide. Self-exclusion reduces the demand for health care or other services, and in effect exacerbates the original problem/deficit and can reduce policy focus on certain conditions. This might be the case with stigmatised illness, such as HIV/AIDS, leprosy (Plagerson, 2003), women's health (DeJong, 2003), mental ill health (WHO, 2001) and so on. Policies aimed at public education, however, perhaps using media to reach hard to reach groups, can have wide-ranging impacts.

The treatment of certain conditions is also inhibited by social biases. Doctors sometimes refuse to treat leprosy patients owing to the stigma attached (Plagerson, 2003). Similarly, in many societies there is a culture of silence about women's health. Severe stigma and cultural sensitivity surround particular women's health issues render them very private and therefore 'invisible' to providers. Broader issues associated with gender inequalities must be addressed through health policies in order to include these marginal issues and groups.

Strong moral judgements are attached to the behaviour of certain groups, such as sex workers, drug addicts, homeless people, groups from certain parts of a town, certain race or ethnicity and so on. The labels attached to these groups, as dirty or untrustworthy, tend to translate into the perception that they are unworthy of assistance. These groups often have little access to the democratic rights of their citizenship, sometimes lacking the right papers to access services.

The exclusion of certain people from a broad range of social, political and economic institutions leads to them experiencing low access to services in two different ways. First, exclusion directly stops the poorest from receiving services, for example when a high-caste teacher in India refuses to let low-caste children participate in 'free' mid-day meals programmes and they drop out of school (Dreze, 2004). In the case of family planning, poor women are sometimes treated without respect, their needs are not fully taken into account and they may even become victim to unethical practices or abuse (de Jong, 2003: 8).

Certain racial and caste groups are clustered at the bottom of the education ladder in South Africa and India, respectively. Increasingly, this is less in terms of physical access (measured by enrolments) but instead in terms of education quality. The social exclusion of scheduled castes and scheduled tribes in formal education in India is well documented and analysed

(see Govinda, 2003), where teaching practices, language and curricula do not respond well to the learning needs of these children, who then tend to fall behind and perform badly (Balagopalan, 2003). In South Africa, only 11 percent of Africans graduate from high school (Grade 12) compared with 63 percent of whites, even though Africans constitute 79 percent of the whole population (Subrahmanian, 2003: 2).

Second, exclusion reduces access to services indirectly by weakening the broader capacity of certain groups of people to demand that agencies fulfil their obligations to provide services, and that politicians and political parties care about their service needs. De Haan and Dubey (2003) hypothesise that differences in literacy and health outcomes between different social groups may relate to the lack of political representation of the interests of poor groups. The authors examine social groups living in different locations across Orissa state, India, and find that, in remote areas, a multiple set of factors derived from an accumulation of disadvantages, associated with location, infrastructure and social factors largely related to caste, are highly likely to be the main cause of this political neglect.

4.3 Geography and spatial poverty traps

Disadvantages operate at different levels and reinforce each other, but are exacerbated in locations that are remote from towns and service centres. Commonly, there are 'logjams of disadvantage' (de Haan and Lipton, 1998) that compound any geographical disadvantage: social and political exclusion because of ethnic status, thin and interlocked markets, poor governance and high levels of exposure to asset-depleting risks. Many of the poorest people in developing countries reside in less-favoured, rural areas that are often inaccessible and commonly experience severe environmental problems (flooding, dust storms, drought). It is in such areas that access to education, health and sanitation is worst.

> We have to cross three creeks to reach our schools. These creeks swell up to four feet during the rainy periods. When the rains come, our mother fears for our lives (school children, Philippines, 1999, cited in Narayan *et al*., 2000b: 101).

Travelling long distances to service centres requires taking time away from productive activities. Public transport costs money, while walking can be problematic for sick, old, young or disabled people. As illustrated in Table 2, medical facilities (encompassing health centres, dispensaries, hospitals and pharmacies) tend to be disproportionately located furthest away from the poorest.

Table 2: Differential distances to school and health facilities among poorest and richest quintiles

	Nearest primary school (km)			Nearest medical facility (km)		
	Poorest quintile	Richest quintile	Poor/rich ratio	Poorest quintile	Richest quintile	Poor/rich ratio
Chad 1998	9.9	1.3	8	22.9	4.8	5
Nigeria 1999	1.8	0.3	5	11.	1.6	7
India 1989/99	0.5	0.2	2	2.1	0.6	4
Uganda 1995	0.5	0.2	2	2.1	0.6	4
Central African Republic 1994/5	6.7	0.8	9	14.7	7.7	2
Philippines 1993	0.7	0.1	7	0.8	0.1	10
Dominican Republic 1991	0.6	0.4	1	6.4	1.3	5
Morocco 1992	3.7	0.3	13	13.4	4.7	3
Bangladesh 1996/7	0.2	0.1	2	0.9	0.7	1

Source: World Back (2004)

Often, geographical disadvantage is compounded by 'state failure', in that infrastructure, basic services (especially health and education) and social protection are inadequately planned. This failure may have a sub-national dimension (e.g. poorly performing provincial government), a national dimension (e.g. public expenditure focus on 'better-off' areas) and an international dimension (e.g. support from neighbouring states to an insurgency movement).

Particularly affected by their geography are the tens of millions of extremely and long-term poor who live in countries or regions experiencing violent conflict, the breakdown of the rule of law or low levels of civil and political rights, and with governments that are, at best, only weakly responsive to citizen needs and preferences. People in such areas usually have very low levels of access to education, health and sanitation/water facilities and social indicators are usually very low (as in the cases of Afghanistan and Iraq). Even when 'peace' is achieved, decades of effective action may be needed to 'catch up' with poverty reduction and service provision. A decade after peace came to Mozambique, only 36 percent of its children complete primary school, almost 20 percent of its children die before the age of five and maternal mortality runs at 980 per 100,000 live births.

5 Do demand-led approaches hold potential for the poorest?

Where exclusion and low demand interact with supply inefficiencies, it is the poorest who find themselves trapped in negative spirals that link service delivery to entrenched poverty. Supply approaches are not enough to interrupt this negative relationship. Attention to the complex underlying factors that can improve access and demand is needed.

In many countries, the central problem with service provision is that the poor are at the end of the queue (Grindle, 2002). They are the least likely to benefit from public services and the

least likely to be able to make demands on government for improvements in coverage or quality. This is even more so for the poorest, most vulnerable, excluded and discriminated groups. It is these poorest groups, however, that are expected to contribute most in terms of their time, labour and other resources in return for improved access to services (ibid). The fundamental problem with this is that these are people who are least able to contribute.

The emphasis on community participation for service provision to the poor can in fact place an increasing burden on the poorest areas, and on the most disadvantaged within those areas. Such measures in themselves are not enough either to fully understand the service needs of the poorest or to build this demand. Although community participation might be desirable, Rose (2002) warns that this approach should not be used either to shift responsibility from the state to the poor or to undermine the importance of non-state sectors. The responsiveness of service provision is not automatically determined by increasing the choice of suppliers, either with or without government subsidies. This is partly because user choice is not a simple decision but may reflect complex trade-offs (often in terms of negative deficiencies in available options rather than benefits) and not needs or preferences alone (Rakodi, 2002). Aspects of competition are relevant to service delivery but real choices must be available to the poorest people.

5.1 Accessing the views of the poorest

It is difficult for policymakers to access the views, needs and interests of the poor, and even more so with regard to the very poorest. However, there is general agreement that such an approach is important and, as Robb (2002) states, the debate has really moved on now from one of *should* the poor be included to *how* can they be included. Robb argues that participatory poverty assessment (PPA) experience to date provides some evidence to back the theory that inclusive policy dialogue broadens the constituency for reform and increases ownership in ways that mean the resulting policies are more likely to be implemented.

The premise behind participatory research for poverty analysis is, of course, that by letting the experience of poverty speak for itself, a bigger and better picture is established. This in turn enables better-informed and relevant policymaking. In both Ghana and Zambia, the PPAs have influenced the Ministry of Education's timing of school fee charges, so that they stop clashing with other household stresses but occur instead after harvests. In Ghana, the World Bank's country programme shifted in emphasis to priorities identified through the PPA, towards rural infrastructure and the quality and accessibility of education and health care (World Bank, 2003). In addition to household surveys, PPAs and other participatory approaches can therefore complement and inform service design, delivery and monitoring and evaluation processes (Narayan, *et al.*, 2000b).

Although the utility and value of these approaches are clear, they need to be introduced with caution and with an awareness of the limitations on certain sectors of the poor being involved on an equal standing. There are significant barriers to participation for some, such as ill health or simply lack of time and resources to contribute. Participation can place excessive extra burdens on struggling areas and on the most disadvantaged within those areas, and therefore bias inclusion against the extremely poor in favour of the more easily accessible, less-poor or non-poor populations. Those included/invited to participate may be able to do so only within agenda and spaces set from outside, which may in turn further limit their capacity or willingness to engage, and the findings themselves.

Ongoing efforts to reinforce the capacity of decision-making systems to become more responsive need to be supported. Support may also be necessary to change attitudes, interests and values of service providers and the local elite so that policies are more likely to be supported by them, or at least not immediately hijacked (Narayan *et al.*, 2000b: 275).

5.2 Responding to the needs of the poorest

Responding to the needs of the poorest is a critical element in building demand for services. This is very much part of the current agenda, notably in national-level poverty reduction strategy paper (PRSP) initiatives, which spur on innovations designed to increase citizens' voice and involvement in national planning. PPAs and other mechanisms can inform decision-making processes (cautions noted above), but there remain significant obstacles to uptake into decisions themselves, notably the lack of representation of the poor in national fora (Rakodi, 2002). It is important to question these 'inclusive' decision-making processes: Who makes real decisions? Are decisions based upon information generated from below ever really implemented?

Most people agree that much participation is in fact 'consultation'. However, this does not necessarily render it valueless. If this consultation does not translate into visible benefits or impacts on policy appear illusory, people will lose faith in the process and opt out of engagement. Nevertheless, well-designed consultation processes can have a major and beneficial influence on decision making, especially when they are implemented in conjunction with a democratic political system and opportunities for direct participation (Rakodi, 2002). Goetz and Gaventa (2001) conclude that, if citizen engagement is to move beyond consultation to real influence, citizen rights must include formal recognition of client groups, as well as rights to information about government decision making and spending patterns (see Box 2) and clear avenues to complain when services are not adequate or individuals are not treated appropriately.

Box 2: Management health councils in Brazil

The provision of education and health services in Brazil has long been skewed towards the relatively well-off and, despite improvements in coverage, services to the poor have been mired in poor quality. These distortions have proved difficult to correct, but there have been significant efforts. The Brazilian Constitution (1988) introduced innovative proposals for enhancing democratic alliances between the state and citizens, by instituting participation through management councils holding responsibility for health, education, social assistance and child/adolescent provision. Brazilian social movements played an integral role in demanding greater citizenship rights by contesting top-down models of governing and demanding more deliberative forms of democracy.

Management councils were initiated during the early 1990s. They have particularly taken root within the health sector, where there are now 5000 health councils (nearly one for every municipality in Brazil) involving almost 100,000 individuals and large numbers of associations. The Brazilian 'health movement' played a significant part in this success, having pushed for citizens' rights to healthcare, and is now heavily represented within municipal health councils (38 percent of citizen representatives on the councils belong to this movement). Other council members include civil society organisations, including patient associations, labour unions and private sector groups.

These councils have begun to open up broader democratic spaces in Brazil and there is much cause to be positive. However, there remain significant problems, notably in relation to lack of equality among participants and some sectors of the population still being stigmatised, unrecognised or not given legitimacy for inclusion. Prevailing institutional, social and political cultures have direct and indirect impacts on the strength of such initiatives to fully function as designed and present a clear and ongoing challenge to both policymakers and the social movements.
Source: Coelho et al., (2002)

Reforming service delivery institutions is a part of this broader task of promoting social inclusion, but service delivery institutions and their operational staff are more likely to be followers of this process than leaders. Major efforts to support the 'drivers of change' (i.e. pro-inclusion political and civil society leaders, social movements, social activists, pro-poorest elites) will be an essential component of service delivery reform activities. To achieve access to services for the poorest, teachers, health workers, administrators, engineers, magistrates, soldiers, parents of non-poor children will have to be weaned away from the discriminatory attitudes that are pervasive in so many countries.

Civil society varies enormously across different countries and societies, and the role of the most excluded within society is by nature often bypassed and further marginalised by their relations with social institutions and organisations. Nevertheless, Grindle (2002) posits that, over the longer term, the quality of public services in poor countries may well be a function of the quality of their civil society, and such potential cannot be overlooked.

Manor (forthcoming) examines the widespread proliferation of often single purpose bodies such as 'user committees' or 'user groups' and 'stakeholder committees'. These committees have been driven largely by the agenda of donor agencies, accompanied by dedicated

funding, as part of the push towards enabling local people some voice and influence in the design and implementation of development projects and services. Manor suggests that there is actually far less enthusiasm for these views by government actors at lower levels. Marking a separation between representative local politics and these user groups means that efforts to encourage increased pro-poor reform within local governance structures can be undermined.

In contrast, decentralised government bodies are more permanent and, albeit flawed, based upon more democratic representation of all citizens. Despite donor intentions, user groups often actually fragment popular participation, rather than build it, sometimes in ways that undermine the influence of poorer, low-status groups (see, for example, Jaraith, 2001).

6 Making changes to how services are delivered

There are many simple measures that can be delivered to improve services for the poorest. It is important not to neglect the small efforts that weaken the ill health–poverty relationship, (for example providing bikes to health staff), and that allow people to return to wage work and to participate more fully in domestic and social life. These may include improving access to critical drugs, such antiretroviral drug therapy, or to simple restorative equipment in cases of physical impairments, such as spectacles, crutches and hearing aids (Erb and Harris-White, 2002).

Sector policies may need to focus on basic poverty awareness training, and be linked into broader policies that aim to tackle discriminatory practices. The challenge is to determine the broader systems and mechanisms through which policymakers can work to empower the poorest constituents, identify the root of the problem and engage delivery systems that are responsive to diverse needs. Below, we briefly outline approaches to assist with this.

6.1 Linking social protection and livelihood promotion

Conventionally, poverty reduction programmes have focused either on livelihood promotion and income generation or on social protection. The former are seen as suitable for the economically active and able poor, but often fail to be of benefit to the poorest who lack the assets or opportunity to take advantage of even well-designed livelihood promotion schemes. The latter are seen as being suitable for households moving towards hunger, malnutrition and destitution, but are criticised for making poor people dependent on welfare ‘handouts’. Recent experiments seek to link these two approaches – mimicking the way in which poor and very poor households use resources for both protection and promotion (Farrington, *et al*., 2004).

In Bangladesh, the Bangladesh Rural Advancement Committee's (BRAC) Targeting the Ultrapoor Programme (TUP) is experimenting with such an approach. It provides very poor households with food aid, an asset transfer, business training and support, in an effort to help the poorest raise their assets and skills and reduce their vulnerability, so that after two years they can join a BRAC village organisation and participate in BRAC's standard poverty reduction programmes (Matin, 2002).

6.2 Packaging services for the poorest

A number of innovative programmes have made access to social grants for poor households conditional on family members taking up other services. Progresa (Box 3) has managed to achieve a 60 percent take-up rate for its services from the poorest quintile of Mexico's population and to record improvements in the nutritional and educational status of client households. It provides a social grant, which is conditional on household members using educational, health and nutrition services. In Bangladesh, the Food for Education (FFE) programme, which provides grain rations to very poor households on condition that they send their children to primary school, has improved the access of deprived children to education.

Box 3: Conditional cash transfers to reduce poverty in Mexico

Progresa, the Education, Health and Nutrition Programme of Mexico, transfers money directly to families on the condition that family members go for health checkups, mothers go to hygiene and nutrition information sessions and children attend school. The success of this programme owes partly to its ability to recognise the interdependencies between different key services – education, health and nutrition. It manages to stretch limited resources by linking cash transfers to household behaviour, and thereby influencing attitudes to education and health. Political interference in the programme is minimised through extensive publication of the programme's goals, rules, requirements and evaluation methods.

The programme has had impressive results, with almost 60 percent of transfers going to households in the poorest 20 percent of the national income distribution and more than 80 percent to the poorest 40 percent. Incidence of low height for age among children one to three years old has been reduced and there has been a substantial increase in preventive health care visits.
Source: World Bank (2003: 30-31).

6.3 Geographical targeting

In many poor countries, the very poorest are concentrated in specific geographical areas (see above). Often, these overlap with concentrations of ethnic or religious minorities and/or indigenous peoples. It is now technically feasible to identify these areas and target welfare transfers to them, thus increasing the share of public benefits available to the poorest. Innovative programmes for such areas are being implemented. These seek to avoid the

problems that many integrated rural development programmes encountered by adopting an evolutionary 'process' approach and by focusing on the mobilisation of the 'voice' of the poor. For details of the ambitious Chars Livelihoods Programme (CLP) in Bangladesh, which seeks to improve the lives of a vulnerable and underserved population in the parts of the country that are subjected to large-scale riverine erosion, see Brocklesby and Hobley (2003).

While the CLP in Bangladesh is avoiding a focus on physical infrastructure, because of the inherently unstable physical environment in which it works, a strong case can be made that major investments in transport infrastructure, to increase the connectivity of the people in remote areas to urban centres, markets and services, would benefit many very poor people.

6.4 Efforts to support particular groups and people with particular problems

Although many of the poorest are invisible to policymakers, there is a growing body of knowledge about specific groups of the very poorest and/or people who suffer particular problems and thus suffer social exclusion. Innovative efforts to help such people are called for. Most obvious, in many parts of the world, are destitutes and street sleepers in urban areas. In India, such people get minimal help from the government and non-governmental organisations (NGOs) and the country's laws create a framework that allows policemen and officials to 'tax' the destitute (Harriss-White, 2005).

Less commonly seen, but significant in numbers, are the disabled (Yeo and Moore, 2003). No low-income country has a credible estimate of the size of its disabled population and, although we know that disabled people are denied access to most services, there are no reliable assessments of benefit incidence rates for disabled people compared with the general population.

Service providers are positioned within wider contexts of social, economic and political relationships that frame the way certain groups and individuals are systematically excluded or adversely included. Teachers, for example, often simply blame parents' lack of interest in their children's education; also commonly mentioned are parents' drunkenness, failure to create a more conducive home environment or, as in the Indian case, continued dependence on traditional occupation (Balagopalan and Subrahmanian, 2003). This reasoning simply veils the underlying systematic exclusions that influence behavioural patterns, and puts the blame back on the poor.

Tackling the proximate determinants of service delivery (better teaching materials, more reliably available drugs and better trained teachers and health workers) will not necessarily alter the underlying institutional arrangements (including the informal rules and practices), but may exacerbate them. In the education sector, for example, language, admissions

policies and fees policies exert exclusionary impacts. Bangladesh's Female Secondary School Assistance Programme builds demand through scholarships, which girls receive to attend secondary school. The money is deposited into accounts set up in their own name. Scholarships are dependent upon attendance rates and passing through grades.

Discrimination and exclusions that affect particular groups of people are not easy to tackle and 'there are no macro-level, single factor solutions to the problem of wide disparities and socio-economic inequalities' (Govinda, 2003: 84). Instead of searching for the grand formulae to improve quality, one should look for specific solutions at the local level.

6.5 Regulation of private sector providers

The state must take responsibility for its regulatory and oversight role regarding private and civic service providers. Institutional reform involves government limits on private action, with civic and private groups in turn demanding state accountability (Hulme, 2003: 16). As argued above, the provision of inadequate services to the most vulnerable people not only is 'bad value for money' but also actively impoverishes people, contributing to the creation and maintenance of poverty and the redistribution of resources from the poor to the non-poor or better-off (ibid).

6.6 Civil service reforms

Civil service reform can underpin systematic improvements in service delivery by changing the working conditions of employees paid from the government (central, provincial or state) budget.

The World Bank (2004: 21) argues that 'successful services for poor people emerge from institutional relationships in which the actors are accountable to each other'. Stakeholders can themselves mobilise to reduce corruption. India's public sector unions' anticorruption network (UNICORN), for example, is supporting national initiatives to protect whistleblowers. Performance-related monitoring is a current reform initiative that holds some potential for increasing institutional interest in the service needs of the very poor, but requires very careful design (Brown, 2002).

Grindle (2002) argues that reform is about more than accountability alone; institutional arrangements are required that engender a sense of purpose and commitment. These include dimensions of organisational culture such as missions, norms, motivations, wider team dedication and an acknowledgement of successes, which are able to motivate staff to feel they are working towards solutions to important problems. While this may include accountability as a crucial element, there is more to this incentive structure than monitoring and penalty.

6.7 Financing options for service provision

While most analysis on service delivery looks at how to improve the existing use of resources, the overall level at which service delivery is resourced needs careful consideration.

Attempts to increase the resources available for service delivery by recovering costs (in part or in full) from clients are likely to lead to the very poor being screened out of access to services. Abolition of user fees has now happened in a number of countries, perhaps most prominently in sub-Saharan Africa. In the education sector, for example, user fees have been removed in Malawi (1994), Uganda (1997), Lesotho (2000), Tanzania (2000) and currently Kenya, among others. In each case, this has had a significant effect on primary enrolment (for example increasing by 50 percent in Malawi and almost doubling in Uganda within a year). Such expansions cannot be thought of as total solutions. Access does not equal quality, but does provide a useful starting point for extending service provision.

The World Bank (2004: 10) claims that, for certain sectors, there is still an important role for charging, notably for those services where the direct 'benefits are enjoyed mainly by the user', such as water and electricity provision; farmers in Andhra Pradesh, India, report that, when they pay for their water, the irrigation department becomes more accountable to them. However, critical questions remain with respect to the poorest. A broad position against the use of blanket charges seems advisable unless there is something context specific that provides conditions within which charges will not inhibit access by the very poorest (ATD, 2003).

Protecting assets, income and livelihoods is key to financing services for the poorest. Social protection policies are crucial in supporting disrupted and vulnerable livelihoods. Households and individuals can share community health risks, for example through community-based health insurance schemes, such as community health funds, in which members have access to reliable and effective health care by creating a sustainable financial mechanism (Msuya *et al*., 2003: 3). See Pryer (1993) for an example of informal health insurance schemes among urban labourers in Bangladesh. These schemes are intended to address service financing gaps and hold potential for turning latent demand for into effective demand for services (see Box 4).

Box 4: Community health insurance schemes, India

Community-based health insurance schemes pool resources to cover the costs of unpredictable health-related events and may provide a better option than national insurance schemes for the poorest, which are more open to abuse. The Self-Employed Women's Association's Medical Insurance Fund in Gujarat, India, set up an Integrated Social Security Scheme in 1992 to provide life, medical and asset insurance. The annual premium is 72.5 rupees (US$1.67), 30 rupees of which is earmarked for medical insurance. Women who pay this premium are covered to a maximum of 1200 rupees (US$28) per year in case of hospitalisation. The choice of health care provider is open and can include private-for-profit, non-profit or public facilities.

The mean household income of claimants is significantly lower than that of the general population. Reimbursement prevents 3.4 percent of claimants from falling below the poverty line. Reimbursement more than halves the percentage of catastrophic expenditure (more than 10 percent of household income) and hospitalisations resulting in impoverishment, particularly among the poorest. However, serious lag time exists between hospital discharge and payment, particularly for claimants from rural areas. Ranson (2002) suggests establishing formal links between the scheme and certain hospitals so that the hospital can submit receipts and certificates directly to the association and cut the negative effects of this time lag.
Source: *Ranson (2002).*

These schemes are not without problems. See Jowett *et al.* (2002) for a discussion of the Vietnam government's health insurance schemes, in which patients with health insurance appear to receive poorer quality care, experiencing longer waiting times and worse treatment by health workers. See also Msuya *et al.* (2003) for a presentation of the Tanzanian experience in which the poorest are excluded because they cannot afford to pay regular insurance premiums and exemption mechanisms are not working as intended.

Formal social protection for the vulnerable segments of the population is widely absent in many countries and constitutes one of the most important challenges today. It is critical to move away from resource mobilisation instruments that are based on point-of-service payments (Msuya *et al.*, 2003: 40). Rather, if pre-payment and risk sharing can be encouraged, it is likely to have an immediate direct and indirect impact on poverty. Limitations of schemes like community insurance may be overcome by broadening the risk pools, and through external financial support such as subsidies, donor funding and reinsurance. Efforts are needed to encourage greater inclusiveness within these schemes, a crucial area for attention.

6.8 Pro-poorest political change

Representative politics have a crucial role in the provision of accessible and effective services. In theory, clear political commitment from the top combined with political influence of citizen groups should provide the scope for designing effective channels for the service preferences of the poor to be expressed, and responded to. In reality, however, although many developing countries have made significant transitions to more democratic

government, certain groups are still excluded and often unable to influence public action, as political patronage prevails. The formal electoral system is often limited in its capacity to ensure responsiveness and accountability.

Central government is crucial in successful service delivery (Box 5), and not just local government and civil society, as is often asserted by decentralisation enthusiasts. Central direction must be balanced by local discretion if the benefits of decentralisation are not to be lost (Devas and Grant, 2003). However, unreformed central institutions (including central public service commissions and treasury expenditure controls, for example) can severely constrain decentralised unit capacities to deliver (Larbi, 1999: 22). What really matters is not what is in the budget but what is delivered, and this is dependent upon the effectiveness of the broader system (Devas, 2002: 3).

Box 5: Health services working for the poor, Ceara, Brazil

In Brazil's poorest northeast region, Ceara state has managed an impressive reinvigoration of health outcomes and service delivery systems, within a context of otherwise clientelistic and patronage politics, as well as poor public administration. The successful turnaround is largely attributable to the innovative efforts of a progressive state government, elected in 1987 and led by Tasso Jereissati.

Before the Health Agent Programme (Programa de Agentes de Saúde/PAS), only 30 percent of the state's 178 municípios had a nurse, let alone a doctor or health clinic. Ceara's health indicators and access to service indicators were among the worst in Latin America. Mayors might have an ambulance at their disposal and a small dispensary of prescription medicines in their homes, but these were largely exchanged in return for political loyalty.

The health programme was implemented in virtually all of the state's municípios. Health agent jobs were created as part of a subproject within a wider employment creation programme, and offered (mainly) women a minimum waged job with three months basic preventive health training. They were able to reach the rural poor, travelling to more remote and dispersed households by bicycle, donkey or canoe and are now visiting 850,000 families in their homes every month (65 percent of the state population). They used simple curative procedures (such as oral re-hydration for example) to win people's trust. Before embarking upon the preventative measures, agents have typically developed strong relationships with the people that they meet, most usually women at home during the day with their children. Vaccination coverage for measles and polio tripled to 90 percent of the child population, and infant deaths fell from 102 per 1000 infants to 65.

The strength of the central/state government has been crucial to the programme's success and to improved municipal accountability. Mayors now view the programme as a political vehicle, as state government has been proactive in rewarding municipal successes through prizes and media coverage. Extensive public information campaigns as well as public screening methods for new recruits have armed communities with the necessary information to watch over the work of personnel in their localities, such that state monitoring is largely carried out indirectly. Thus, an old patronage dynamic is being replaced by a more service-oriented one.

Source: *Tendler (1997)*

Building awareness among users of their entitlements can help build accountability for service provision, but mechanisms are also required in order to ensure they are enforced (Devas, 2002: 9-10). In Uganda, local governments, schools and clinics are required to display information about all monies received and their allocation. The media has had a significant role in enabling people then to hold their officials and representatives to account, notably via local radio (Grant, 2002).

7 Conclusion

Although information comparing the access of the poor and non-poor to services is becoming available, there is a pressing need for service delivery benefit incidence studies that disaggregate the poor. This can be done by the analysis of household economic integrated survey (HIES) datasets (an excellent example is provided by the ADB/World Bank (2001) study of Bangladesh) and/or by the examination of existing data on specific types of people who are known to experience extreme or chronic poverty (an excellent example is provided by Masset and White (2003) for orphans, the elderly, the disabled and unsupported female-headed households).

The available evidence shows clearly that the very poorest lack access to essential basic services. This is part of a two-way dynamic: they have low access to services because they are very poor, and their poverty is caused and deepened by lack of access to services.

Enhancing access to services is not just about reducing inefficiency or malpractice in delivery agencies. For the poorest countries, with the greatest concentrations of very poor people, more international support is needed for the provision of basic services. This is particularly true for many poor and fragile states where governments and people have minimal resources, but it is also the case in ‘stable’ low-income countries. By contrast, in middle-income countries, effective reforms could lead to universal service coverage.

Improving service delivery to the poorest will be supported by effective poverty reduction policies (pro-poor growth, stability and peace, good governance, effective foreign aid). It also requires major specific action on supply and demand:

- **Demand:** Major initiatives are required to promote pro-poorest social and political change across societies. The processes of social exclusion that discriminate against specific social groups (ethnic, religious, racial, orphans, cultural) and individuals (women, the impaired, older people) and obstruct their access to services are fuelled by attitudes and actions both inside and outside of service delivery institutions.
- **Supply:** Major efforts are needed to reform service delivery institutions (public, commercial and NGO) and public expenditure so that they target and reach the poorest. Reforms should focus on detailed national analyses of how to improve

institutions and treat global prescriptions of how to improve service delivery, especially decentralisation and participation, with caution.

Services can be delivered to the poorest, but this requires institutional reforms, additional international funding and political commitment.

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