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ENGAGING THE POOR ON FAMILY PLANNING AS A POVERTY REDUCTION STRATEGY

JULY 2009

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

TABLE OF CONTENTS

Acknowledgments	iv
Executive Summary	v
I. Introduction.....	1
II. Poverty: Multi-dimensional and Persistent	3
The Need to Engage the Poor in Poverty-Reduction Programs	6
Participation and Engaging the Poor.....	6
Omission of Family Planning in Poverty-Reduction Initiatives	7
III. The Interrelationship between Poverty and High Fertility	9
Population Growth and Childbearing Patterns.....	9
Effects of Fertility Behaviors on Health, Education, and Economic Well-Being.....	10
Effects Associated with Family Size	12
Effects of Early Childbearing	12
Effects of Unintended Pregnancy and Closely Spaced Birth Intervals.....	14
Family Planning as a Poverty-Reduction Strategy	15
IV. Guidelines for Engaging the Poor in FP/RH as a Poverty-Reduction Strategy	18
The Process of Reaching Out.....	18
Ensuring Genuine Representation of the Poor.....	18
Engaging the Poor in the Policy Formulation and Implementation Process.....	20
Lessons from Kenya in Engaging the Poor.....	27
V. Conclusions and Recommendations	29
Appendix A. Fertility, Family Planning, and Unmet Needs (c. 2000–2006)	31
Appendix B. Engaging the Urban Poor in Kenya: A Case Study of Kaloleni, Kisumu	33
Appendix C. Engaging the Rural Poor in Kenya: A Case Study of Lela, Kisumu	36

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EXECUTIVE SUMMARY

The purpose of this report is to

- Provide information to national and local leaders and policy champions on the potential contributions that family planning and reproductive health (FP/RH) programs can make to poverty reduction programs; and
- Suggest ways that national and local officials, development leaders, and FP/RH champions can engage the poor at any phase of the policy process to foster open dialogue on how family planning can benefit the poor.

A key theme is that policies and programs that combine poverty-reduction and family planning initiatives, as well as engage the poor, can increase the effects of both initiatives.

The first part of this paper emphasizes poverty as a multi-dimensional concept, including the absence of voice and marginalization. This discussion is followed by a summary of the latest findings on the inter-relationship between poverty and fertility. Nearly one billion people lived on less than US\$1 per person per day in 2004. In other words, almost one in five of the world's people live in severe poverty. While poverty is usually calculated based on income and assets, such measures do not reflect the other challenges the poor face, such as food deprivation, ill health, vulnerability, powerlessness, and isolation. Efforts to reduce poverty have had mixed success. Experts are advocating that governments and donors actively involve the poor in the design and implementation of poverty-reduction programs.

Worldwide, women in the poorest wealth quintile have about twice as many children as those in the wealthiest quintile. For poor families, having many children can mean fewer resources (money, time, and attention) invested in each child, leading to poor nutrition, ill health, and limited educational opportunities. One reason that women who are poor have more children than affluent women is that they are less likely to use modern contraceptive methods. Paradoxically, women in the poorest wealth quintile are more likely than those in the wealthiest quintile to report that they are not using contraception even though they want to limit or space future births.

The second major part of this report provides guidelines to national and local leaders and FP/RH advocates on ways they can engage the poor in all phases of policy formulation and implementation. Examples of involving the poor include the following:

- **Problem identification.** The poor can give insights into their day-to-day worries, factors that affect their ability to access services, and cultural norms that constrain them.
- **Policy formulation.** The poor can advise on the appropriateness and feasibility of various policy options and advocate for adoption of the policy and allocation of the necessary resources.
- **Policy implementation.** The poor can explain why programs designed by outsiders are likely to fail. Furthermore, they can take an active role in program implementation by encouraging community participation and serving as trusted sources of information and supplies.
- **Policy monitoring.** The poor can provide important feedback regarding the reach and effectiveness of policy initiatives.

In summary, the poor have a key role as expert advisers, reviewers, advocates, educators, community mobilizers, critics, and watchdogs. Concrete examples of country activities that have involved the poor in policy initiatives illustrate their valuable contributions. The guidelines in this report were tested in Kenya during meetings with community members and leaders. They are designed to be adapted to diverse groups, including the poor and other disadvantaged and marginalized groups.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ASHA	Accredited Social Health Activist (India)
CDC	Centers for Disease Control and Prevention
CEDPA	Centre for Development and Population Activities
CSC	Citizen Surveillance Committee
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
FGD	focus group discussion
FP	family planning
HD	Human Development
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
ICRW	International Center for Research on Women
IDS	Institute for Development Studies
IMF	International Monetary Fund
MDG	Millennium Development Goal
NGO	nongovernmental organization
NRHM	National Rural Health Mission (India)
OECD	Organization for Economic Cooperation and Development
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
RH	reproductive health
RNPM	National Network for the Promotion of Woman (Peru)
UN	United Nations
UNDP	United Nations Development Program
USAID	United States Agency for International Development
WHO	World Health Organization

ENGAGING THE POOR ON FAMILY PLANNING AS A POVERTY REDUCTION STRATEGY

The world is very different now, for man holds in his mortal hands the power to abolish all forms of human poverty... Inaugural address of John F. Kennedy (1961)

Poverty is me, look at me! Look at my clothes. I did not have anything this morning and I am not sure if I will eat anything today. My children are not in school and should they fall ill, I cannot afford to take them to hospital... Kibera, Nairobi resident, PRSP-Kenya report (cited by Sohani, 2005, page 4)

I. INTRODUCTION

Despite decades of economic expansion, rising incomes, greater democratization, and rapid technological progress, more than one billion people still live in severe poverty. This paper focuses on two reasons advanced by international donors, civil society groups, and population experts to explain this apparent contradiction:

1. The failure to effectively engage the poor, who are after all the intended beneficiaries of poverty-reduction schemes (McGee et al., 2002; Oxfam, 2004; World Bank 2003 and 2005); and
2. The failure to consider population growth as part of poverty-reduction initiatives (Basu, 2005; Bernstein, 2005; Gillespie et al., 2007; Fathall, 2005; Germain and Dixon-Mueller, 2005; Sinding, 2005).

International development agencies and civil society groups point to decisionmakers' lack of attention to ensuring the participation of the poor in the development and implementation of policies and programs that most affect them. In addition to demographers and reproductive health experts (Gillespie et al., 2007; Greene and Merrick, 2005), world leaders (All Party Parliamentary Group, 2007) also argue that the failure of poverty-reduction initiatives to consider the population factor can exacerbate health inequities and undermine poverty-reduction efforts.

The USAID | Health Policy Initiative, Task Order 1 prepared this report to address these policy gaps. A key theme is that policies and programs that combine poverty-reduction and family planning initiatives, as well as engage the poor, can increase the effects of both initiatives. This report

- Provides information to national and local leaders and family planning champions on the potential contributions that family planning (FP)/reproductive health (RH) programs can make to poverty-reduction programs; and
- Suggests ways that national and local officials, development leaders, and FP/RH champions can engage the poor at any phase of the policy process to foster open dialogue on how family planning can benefit the poor.

Section II of this report describes concepts of poverty and explains how they have been refined in recent years to form the basis of many development assistance programs. The section concludes by looking at the extent to which governments and donors seek the active involvement of the poor in the design and implementation of poverty-reduction initiatives and programs.

Section III discusses the interrelationship between poverty and high fertility rates. It explains the impacts of childbearing patterns on the health, education, and economic well-being of individuals as well as

families. It also provides data on differences between the wealthiest and poorest people for various RH indicators, including contraceptive use and unmet need for FP services.

Section IV provides guidelines on ways that national and local leaders and FP/RH advocates can engage the poor in advocacy and policy dialogue on family planning as a strategy for poverty reduction. This section also provides examples of country initiatives that have involved the poor in program planning, implementation, and evaluation. Local counterparts and community groups in Kenya helped validate the draft guidelines.

The guidelines were designed for use by directors, staff, and associates of national, regional, and local government agencies; nongovernmental organizations (NGOs); civil society groups; and donors, including USAID and its cooperating agencies. More specifically, the guidelines were prepared especially for FP/RH advocates and “policy champions.” Policy champions are individuals who work with political leaders and government officials to support FP/RH programs.

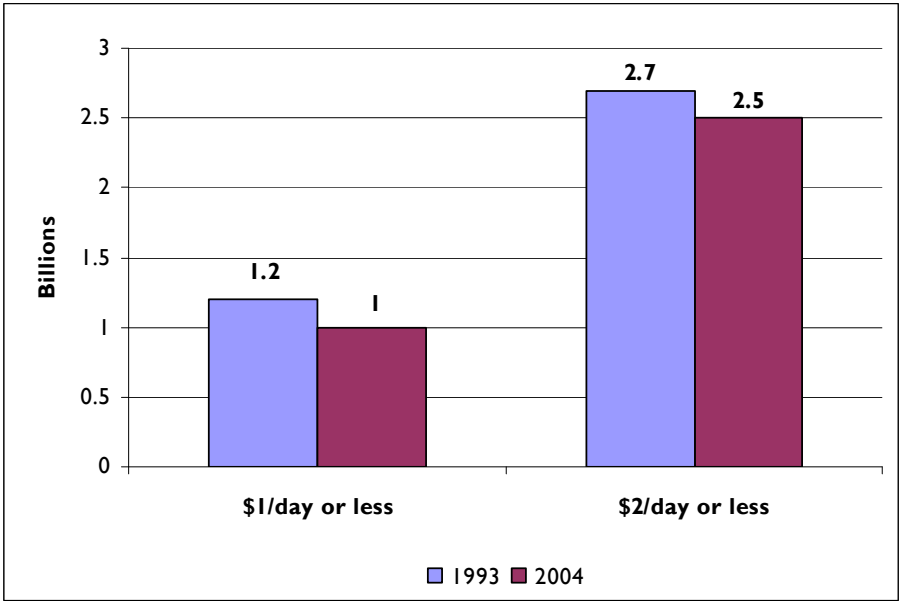
The report’s appendices include survey data on poverty, family size, and contraceptive use for developing countries (see Appendix A), as well as two case studies that describe Kenya’s efforts to engage the poor and understand their situation and views on family planning (see Appendices B and C).

II. POVERTY: MULTI-DIMENSIONAL AND PERSISTENT

Despite decades of economic expansion, rising incomes, increased productivity, and greater levels of democracy in many parts of the world, severe poverty continues to persist. While the definition of poverty differs depending on the country, absolute poverty or destitution has been conventionally defined as an income of US\$1 per person per day, while extreme poverty has been defined as US\$2 per day or less (Pritchett, 2003). A new World Bank analysis advocates raising the indicator of absolute poverty to US\$1.25 per day for 2005 (Ravallion et al., 2008).

Nearly one billion people lived on less than US\$1 per person per day in 2004, while 2.5 billion people lived on less than US\$2 per day (see Figure 1). In other words, more than one in three of the world's people live in extreme poverty (Chen and Ravallion, 2007). While fewer people live in poverty than a decade ago, progress remains slow.

Figure 1. People living on less than \$1/day or \$2/day, developing countries



Source: Chen and Ravallion, 2007.

Today, conditions surrounding food supplies and prices compound the difficulty of reducing the absolute numbers of people living in poverty. As the effects of globalization, global warming, droughts, and political upheaval reach the agricultural marketplace, the availability of basic grains is tightening and prices are skyrocketing. Despite decades of development efforts by governments, international donors, and multilateral organizations, as well as several solid decades of world economic expansion, poverty is still a major obstacle to socioeconomic development and a massive humanitarian problem.

The concept and working definition of poverty has changed considerably since donors and governments first launched major efforts to reduce it after World War II. Post-war concerns were focused on the basic subsistence and security of vulnerable populations. In 1954, when the United States established the Food for Peace Program as a central part of its foreign assistance effort, it defined **poverty** as the state of having insufficient money or assets to provide even the most basic requirements of life—mainly food and shelter. This definition, which is measured by income level, has been used through the years as donors set various “poverty lines” below which a person was deemed to be poor and in need of public assistance.

Table 1 traces the evolution of poverty concepts, explains how poverty was measured, and indicates the changing emphases over the past century. It also indicates events that marked the adoption of new definitions, principles, and program guidance by the international bodies and their government constituents. (For a more lengthy discussion, see Cornwall and Brock, 2005; Coudouel et al., 2002; Falkingham and Namazie, 2001; and Maxwell, 1999.)

Over time, poverty concepts and definitions evolved to incorporate dimensions of participation and engagement of the poor. By the 1980s, the concept of poverty expanded to include not just material resources (e.g., income or nutrition) but also non-material dimensions such as powerlessness and isolation (Chambers, 1995), vulnerability to shocks and calamity (Agarwal, 1991), sustainable livelihood (Bond and Mukherjee, 2001), human capabilities (Sen, 1987), and gender inequality (Sen and Grown, 1987). In accordance with a growing international consensus, development agencies began to introduce participatory approaches to involve project beneficiaries and increase project effectiveness. Civil society groups, however, began focusing on participation as a democratic right and an end in itself. In recent years, more emphasis has been placed on the democratic rights of poor and vulnerable groups to participate in decisionmaking on matters affecting their lives, as well as on holding authorities accountable for the socioeconomic outcomes of their governance or administration (Rudvqist, 2002).

In the 1990s, wide use of the concept of “well-being” also reflected growing recognition among international organizations about the non-material dimensions of poverty. Concepts such as “social exclusion” and the United Nation’s human development approach emerged (Sohani, 2005). In addition, world summits on population, women, environment, and social issues in the 1990s identified poverty as underlying or compounding these issues. Participating countries developed and became signatories of programs of action that resulted from these international conferences. These documents included recommendations to increase the participation of beneficiaries, especially the poor, in all aspects of development programs. At the same time, many countries began to decentralize several government functions and undertake a series of health sector reforms. These initiatives, especially decentralization, were premised on increasing local participation in government decisionmaking and management of programs. International organizations also began to use participatory methodologies (e.g., focus group discussions, etc.) in developing their projects (Narayan et al., 2000 and 2001). The World Bank/International Monetary Fund introduced their Poverty Reduction Strategy approach to help heavily indebted countries promote socioeconomic development, using a participatory bottom-up planning process and blueprints for broad-based economic growth and poverty reduction.

Table 1. Historical summary of poverty concepts and landmark events

Years	Poverty definition or emphasis	Landmark events related to a concept's introduction or adoption
1900s	The failure to meet minimum nutritional requirements	Adopted by various countries based on a minimum basket of goods
1960s	Those falling below a certain income level or some defined poverty line or threshold	<ul style="list-style-type: none"> – Income poverty adopted by donors and national ministries of finance and planning – Economic growth benefits are assumed to trickle down to the poor
1970s	<ul style="list-style-type: none"> – The failure to meet not just minimum requirements but prevailing standards of living – The lack of basic needs (health, education, and other social services) 	<ul style="list-style-type: none"> – “Redistribution with growth” introduced by World Bank – Basic needs approach introduced by United Nations, stressing human resource development and popular participation
1980s	<p>Deprivation in monetary as well as non-monetary dimensions that include</p> <ul style="list-style-type: none"> – Powerlessness, voicelessness, and isolation – Gender inequality – Restricted capabilities – Vulnerability (calamity, shocks, etc.), insecurity, and the lack of human, social, and physical assets/capital that affect the ability to cope 	<ul style="list-style-type: none"> – Participation emphasized by international organizations (USAID, Organization for Economic Cooperation and Development, United Nations, World Bank, etc.); participatory assessment tools developed by academics and NGOs – Emphasis on women in development and gender approaches; countries approve gender and development policies – Emphasis on assets and social capital – “Sustainable development” and sustainable livelihood concepts advanced by various donors
1990s	<ul style="list-style-type: none"> – Pronounced deprivation in well-being – The denial of opportunities and choices to lead a long, healthy, creative, and dignified life – Expressed in terms of how poor people view their own situation 	<ul style="list-style-type: none"> – Human development (HD) approach and HD index introduced by United Nations; countries prepare HD reports – Multiple deprivation and social exclusion a focus of poverty debates in Europe – World summits on environment, population, women, and social development emphasize poverty and participation – Decentralization and/or health sector reform initiated in many countries; cited for their potential for genuine participation – International Monetary Fund/World Bank introduced a participatory Poverty Reduction Strategy approach to heavily indebted countries to focus funds on poverty alleviation
2000s	<ul style="list-style-type: none"> – Multi-dimensional deprivation of well-being: the lack of material resources and the pain of being poor, voiceless, and powerless; having limited capabilities and low achievements in education and health; and vulnerability to external events 	<ul style="list-style-type: none"> – 180 heads of state sign the Millennium Declaration in 2000 to eradicate poverty – Country Millennium Development Goals and Poverty Reduction Strategy Papers, updates, and reviews – Poverty reduction emphasized as key part of U.S. Foreign Assistance Program – In 2008, the WHO Commission on Social Determinants of Health issued its report “Closing the Gap in a Generation” on measures to achieve health equity

Note: For more extensive discussion, please refer to Cornwall and Brock, 2005; Coudouel et al., 2002; Falkingham and Namazie, 2001; Maxwell, 1999.

Today, poverty is increasingly recognized as a multi-dimensional phenomenon—not just defined by the lack of material resources but also by vulnerability, (especially to hunger and poor health), limited capabilities, lack of economic opportunity, gender inequality, and social exclusion (see Box 1). In summary, the current concept of poverty reflects economic, social, and psychological dimensions.

Box 1. Poverty is.....

Poverty is hunger. Poverty is lack of shelter. Poverty is being sick and not being able to see a doctor. Poverty is not having access to school and not knowing how to read. Poverty is not having a job, is fear for the future, living one day at a time. Poverty is losing a child to illness brought about by unclean water. Poverty is powerlessness, lack of representation and freedom.

Source: World Bank, 2008, PovertyNet Overview, p. 1.

The Need to Engage the Poor in Poverty-Reduction Programs

The creation of the Millennium Development Goals (MDGs) has raised global awareness of the challenge of poverty reduction. Many countries—especially those in sub-Saharan Africa, South Asia, and Latin America—are falling short of their mid-term MDG targets; whether they can reach their MDG goals by 2015 is uncertain (United Nations, 2007). Referring to the progress of countries in achieving their MDGs, the 2005 *World Development Report* noted that one of the principal differences between success and failure lies in the degree to which poor people themselves are involved in determining the quality and the quantity of the services that they receive (World Bank 2004b). Civil society groups have also raised concerns that the poor—especially those trapped in poverty—are the most marginalized group in society and are rarely involved in decisionmaking about poverty-reduction programs.

At the same time, participatory policymaking and program design have been emphasized in the World Bank/International Monetary Fund guidelines for heavily indebted countries for the development and implementation of Poverty Reduction Strategy Papers (PRSPs). Various evaluations, however, indicate that many governments that have prepared PRSPs have limited the involvement of civil society groups, relegating them to a consultative role (McGee et al., 2002; Oxfam, 2004). Moreover, the PRSP process, which also serves as a framework for MDG planning, has not generated meaningful discussions outside narrow official circles. Participatory activities in countries tend to wane once PRSPs are finalized, suggesting that participation took place because donors required it rather than to strengthen local institutions and achieve systemic change to truly benefit the poor (World Bank, 2003; World Bank, 2004; Bhuyan et al., 2007).

Participation and Engaging the Poor

Engaging the poor is a key element of participatory approaches and any processes that are meant to expand the role of stakeholders in decisionmaking about development programs. This concept is implicitly recognized globally and, although difficult to implement, has become a central theme in development programming.

Since the 1950s, development assistance and virtually all overarching policies, strategies, initiatives, and project designs of international donors have included the requirement to assess the impact on the intended beneficiaries. Later, this approach was expanded to require “consulting” beneficiaries. In the past two decades, international donors and agencies, governments, and NGOs have evaluated the effectiveness of development policies and programs and found that many failed to achieve the desired objectives. Several major program weaknesses seemed to result from the failure to consult beneficiaries (see Box 2).

Box 2. Identified weaknesses in development assistance

- Country governments and citizens did not feel any sense of ownership of development efforts because external “experts” designed policies and programs that may not work locally.
- The intended beneficiaries were generally not consulted during program development and implementation.
- The policies and programs provided no mechanism for “customer” (beneficiary) feedback.
- Agencies, organizations, officials, and managers were not held sufficiently accountable to beneficiaries for program results.

In short, most development programs have been designed and implemented using a “top-down” approach, with little if any participation by those who would be affected by the programs, those who had to carry them out, and those who would presumably benefit from them. Development planners introduced the concept of “participation” or “participatory approaches” in which policymaking and program design are broadened not only within the government but also with the inclusion of civil society representatives. Civil society was defined to comprise various nongovernmental entities, including traditional nonprofit organizations, professional associations, religious organizations, political parties, community organizations, academic groups, and formal and informal labor unions.

The identified weaknesses and the need to engage the poor have been subsequently addressed in numerous international agreements, statements, and plans of action by all major donors (e.g., Rio Declaration, Principle 10, United Nations, 1992; and the Program of Action from the International Conference on Population and Development (ICPD), United Nations, 1994). As a result, major international and bilateral donors, as well as many governments, have instituted specific requirements that beneficiaries and/or their representatives participate in all aspects of development efforts (see World Bank, 2004, for an example). The premise was that the participation of beneficiaries would remedy many of the weaknesses and strengthen institutions, empower civil society in development programs, stimulate local ownership, and enhance “good governance.” Importantly, successful participatory approaches would directly involve the poor, who make up the vast majority of the intended beneficiaries of development and humanitarian programs. Therefore, engaging the poor in participatory processes around policymaking and program design should be fundamental to any development effort.

Box 3. ICPD Program of Action

“The many facets of population relate to many facets of development....There is... growing recognition that population-related policies, plans, programs and projects, to be sustainable, need to engage their intended beneficiaries fully in their design and subsequent implementation.”

Source: Program of Action, International Conference on Population and Development, 1994, Chapter on National Policies and Plan of Action, XIII.2.

Omission of Family Planning in Poverty-Reduction Initiatives

The Millennium Declaration signed by world leaders at the United Nations in 2000 was intended to stimulate an accelerated world response to poverty with measurable goals. For the eight MDGs, a total of 60 indicators were selected to measure progress in poverty reduction, education, health, gender equality, environmental sustainability, and partnership goals by 2015. None of the original indicators referred explicitly to family planning, even though it is an essential component to achieving the health targets. However, in 2007, governments adopted MDG 5B to achieve universal access to reproductive health services by 2015. Indicators for MDG 5B are increasing the contraceptive prevalence, lowering the adolescent birth rate, providing prenatal care to pregnant women, and reducing unmet need for family planning. The addition of MDG 5B gave explicit recognition to family planning and aligned the MDGs

with the ICPD goals and targets. Senegal, for example, changed Goal 5 from maternal health to “reproductive health” (UNDP 2003). In the UN Millennium Development Goals Report for 2009, MDG 5 includes indicators of family planning to emphasize its role in promoting maternal and child health (UN 2009).

Although many donors and governments recognize the importance of addressing poverty and high fertility, for the most part they have developed separate programs. Few have designed strategies or initiatives that combine, as an integrated package, programs related to poverty, fertility, and participation (McGee and Norton, 2000; World Bank, 2002). By broadening participation of the poor in poverty-reduction programs, decisionmakers may appreciate more clearly the day-to-day challenges of the poor, their aspirations, unmet needs, and perspectives on childbearing.

III. THE INTERRELATIONSHIP BETWEEN POVERTY AND HIGH FERTILITY

Population Growth and Childbearing Patterns

According to United Nations projections, roughly 2.7 billion people will be added to the world's current 6.7 billion (Haub and Kent, 2008) by the year 2050, reaching a world population of about 9.1 billion people (UN, 2007). Some of this increase is inevitable because past high birthrates have resulted in a large number of young people entering their childbearing years. Another factor is that death rates have declined faster than birthrates, thus contributing to continued population growth. Still, the main determinant of future population growth is fertility behavior—the number of children born and the timing of births.

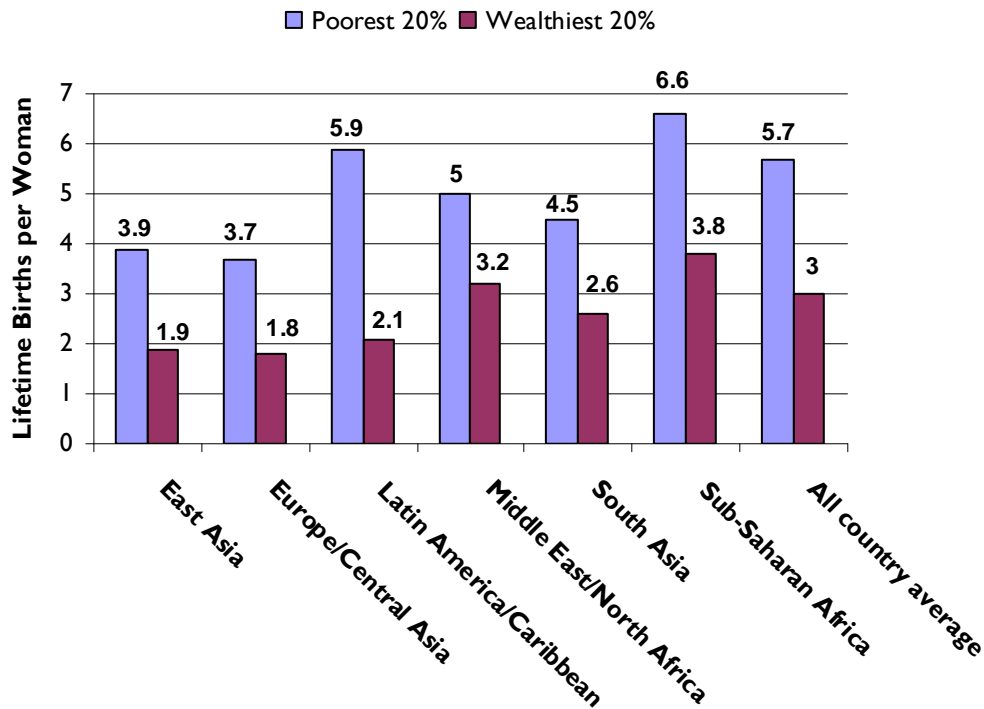
Economists and demographers have long recognized the association between poverty and high fertility but this association was based on limited data. During the past decade, more data have become available through Demographic and Health Surveys (DHS)—national surveys conducted in many developing countries. The DHS collect data on the different income or “wealth” groupings within a country. Based on household assets and characteristics, the DHS divide the population into wealth quintiles (five groups, each constituting 20 percent of the total population). The new data can be used to analyze demographic factors by wealth quintiles and compare them across different countries (Rutstein, 2000).

A World Bank analysis by Gwatkin and others (2007) compiled data from DHS in 56 developing countries. This analysis revealed a consistent pattern of high fertility among the poorest quintiles progressing to much lower fertility among the wealthiest quintile. Across all 56 countries and in all regions of the developing world (excluding China), the poorest women have fertility rates that are approximately twice the level of the wealthiest quintile (see Figure 2).

Women in the poorest quintile in sub-Saharan Africa had the highest total fertility rate¹ (6.6 children per woman), followed by Latin America and the Caribbean (5.9) and the Middle East and North Africa (5.0). In contrast, women in the wealthiest quintile have reached replacement-level fertility (2.1 children per woman—the number of children needed to replace their parents under low mortality conditions) in three regions: East Asia, Europe and Central Asia, and Latin America and the Caribbean. The difference is especially large in Latin America and the Caribbean, where women in the wealthiest quintile are having 2.1 children, compared with 5.9 among women in the poorest quintile. The gap in sub-Saharan Africa is almost as great, with women in the wealthiest quintile having 3.8 children, compared with 6.6 children among women in the poorest quintile (Gwatkin et al., 2007).

¹ The total fertility rate is the projected completed lifetime fertility per woman based on current births for women ages 15–49.

Figure 2. Total fertility rates among the poorest and wealthiest quintiles, by region



Source: Gwatkin et al., 2007, p. 31–32 (based on DHS for 56 countries, mostly conducted during 1998–2004).

Effects of Fertility Behaviors on Health, Education, and Economic Well-Being

This section summarizes research on the effects of fertility behaviors on poverty and related factors such as health and education. The discussion covers three fertility behaviors:

1. Large family size and multiple births
2. Early childbearing
3. Unintended pregnancy and short intervals between births

The key findings are summarized in Table 2. Researchers note that poverty and high birthrates are closely associated—although it is difficult to establish causality among these variables. Many studies have concluded that large family size, early childbearing, and short birth intervals are strongly associated with various adverse outcomes such as poor health, low levels of access to education, lack of economic opportunities, and restricted social mobility. While the nature of these relationships differs from country to country and region to region, most scholars conclude that poverty and high fertility are causally interconnected either directly or indirectly (Greene and Merrick, 2005; Gwatkin et al., 2007).

Table 2. Summary of the effects of fertility and childbearing on family health, education, and economic well-being

Fertility and childbearing	Effects		
	Health of mothers and children	Education of children	Economic wellbeing of household
Large family size	<ul style="list-style-type: none"> • Her lifetime number of births affects a woman's survival chances. • Large family size may affect the health of children due to factors such as early weaning due to a successive pregnancy, malnutrition (related to poverty and other factors), and spread of infections due to crowding. 	<ul style="list-style-type: none"> • Large family size affects how much the family invests in children's education or who goes to school (e.g. the oldest, the last-born, sons). • Poor parents may prefer to send sons to school; girls' schooling is at risk because they have to care for younger siblings. 	<ul style="list-style-type: none"> • Large families can create competition in household spending on children; girls are likely to be adversely affected. • Large families are more likely to live in poverty. • Smaller families are far more likely to have savings than larger families, making them less vulnerable to income fluctuations.
Early pregnancy and childbearing	<ul style="list-style-type: none"> • Strong evidence exists that very early pregnancy puts mothers at high risk of dying or suffering ill health. • Children born to teenage mothers are more likely to be born premature, have low birth weight, and/or die. 	<ul style="list-style-type: none"> • Early pregnancy or childbearing can be a reason for dropping out of school. • Children of teenage mothers are more likely to perform poorly in school (United States data). 	<ul style="list-style-type: none"> • Early childbearing can entrench women's poverty. • Low-income adolescent mothers tend to work more and earn less than other mothers.
Unintended pregnancy and short birth intervals	<ul style="list-style-type: none"> • Pregnancies that are unintended are less likely to receive good antenatal care. • Unintended pregnancies can lead to abortion complications and complications during delivery that can lead to maternal death or disability. • Women with short inter-pregnancy intervals (less than six months between giving birth and becoming pregnant) have a much higher risk of dying or experiencing medical complications during delivery. • Children whose mothers have died face higher risks of death and malnutrition. • In developed and developing countries, babies who were conceived within six months after a previous birth face higher mortality risks. 	<ul style="list-style-type: none"> • In some countries, pregnant young girls are expelled from school. • In countries at the mid- or late stage of transition from high to low birthrates, unintended children can have less education than intended children. • Large family size negatively affects educational attainment of children, especially in urban areas. 	<ul style="list-style-type: none"> • Children born as a result of unintended pregnancy, particularly those born outside of marriage, face various disadvantages.

Source: Adapted from Greene and Merrick, 2005, p. 51 (based on Table 14 and their more detailed discussions and tabular summaries).

Effects Associated with Family Size

Data from many countries indicate that larger families in developing countries are more likely to live in poverty than smaller families. For low-income couples, having many children may be a way to gain additional labor and income. Poverty can make child labor more attractive, thus reducing a child's chances to obtain an education (Skoufias, 1994). Sons can help with farming, and daughters can work in the cities but still provide for the family (see global review by Ahlburg, 1994). Parents of larger families may be able to accumulate some wealth in the long run because older children work and remit earnings to their families (Bauer et al., 1992, on the **Philippines**), but having many children becomes a burden to the family as a country becomes more developed because of the demand and greater potential returns for those with higher education and skills. In contrast, smaller families are far more likely to have savings than larger families, making them less vulnerable to income fluctuations (Knodel et al., 1990, on **Thailand**).

Furthermore, large families can create competition for household spending on children. Resources may be diluted, with each child getting a smaller share of family resources such as income, time, maternal nutrition, and attention (see global review by Lloyd, 1994). Girls are often more adversely affected (see Foster and Roy, 1997, on **Bangladesh**; Lloyd and Gage-Brandon, 1994, on **Ghana**; Shapiro and Tambashe, 2001, on the **Congo**).

In regard to women's and children's health, various studies have shown that the lifetime number of births is negatively associated with a woman's survival chances (Menken et al., 2003, on **Bangladesh**; Sen, 1999, and Anand and Morduch, 1998, on **South Asia**). Menken and others observed an extended period of higher mortality risk associated with each birth spaced within two years from a previous birth. Besides risks to mothers, children are also at risk in large family size settings. Children with many siblings have lower survival probabilities and poorer health and are less-developed physically (King, 1987). Among many potential negative effects, large family size may affect the health of children because crowding contributes to the spread of infections (see Aaby et al., 1984, on **Africa**).

Poor families with large numbers of children have less money to invest in their children's education. When families have some funds to pay for schooling, it is often the oldest sons who are able to go to school. In these settings, girls have severely limited opportunities for education. Not surprisingly, there are larger gaps in schooling between boys and girls in poor households than in wealthier ones. Poor parents may prefer to send sons to school while daughters care for younger siblings (see global review by Schultz, 1993).

Children from poor families are also much less likely to stay in school. Thomas and Meluccio (1996) show educational attainment in **Zambia** according to contraceptive use and children ever born. Lower family size is strongly correlated with educational attainment in this example. In addition, some studies have found that children from large families have poorer school performance compared with those from smaller families (see global review by King, 1987).

In summary, studies worldwide indicate that families with many children experience significant hardships. Observing this phenomenon, Desai (1995) concludes that high fertility may be one mechanism that denies the benefits of economic development to some social groups and to some family members.

Effects of Early Childbearing

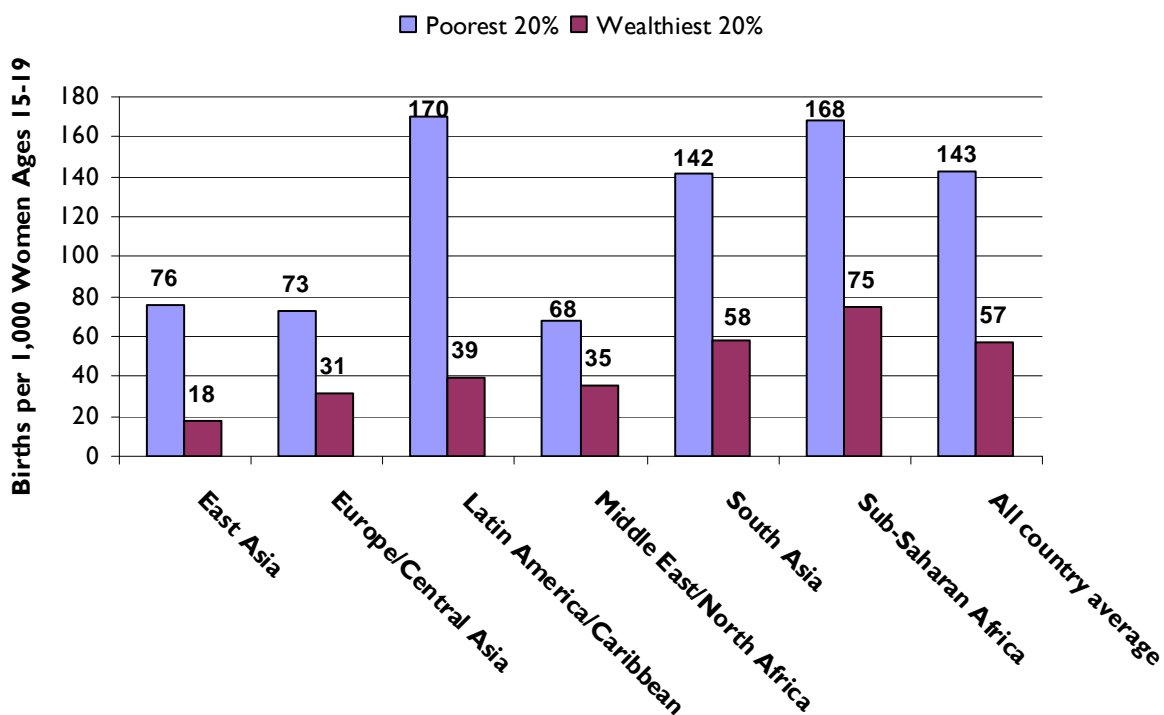
Early childbearing is common in developing countries. The highest levels are in **sub-Saharan Africa**, where an analysis of 21 countries that had national Demographic and Health Surveys conducted between

2001 and 2005 found that in 12 countries at least one in five young women ages 15–19 had already given birth (Khan and Mishra, 2008).

Within countries, women under age 20 belonging to the poorest wealth quintile have much higher levels of early childbearing than those in the wealthiest quintile (see Figure 3, based on data from 56 countries with national DHS data). The differences are striking, with the poorest quintile of young women in **Latin America** and **East Asia** having more than four times more births than those in the wealthiest quintile. In other regions, the poorest young women are having about twice the number of births of the wealthiest young women. This means that the poorest women have 2 to 4 times the risk of pregnancy-related death and illness, compared with their wealthiest peers.

Maternal and child health. Overall, there is strong evidence that very early pregnancy puts mothers at high risk of dying or suffering life-long morbidity. Pregnancy among teenage girls creates high-risk conditions for maternal and baby deaths due to obstructed labor or eclampsia. The former can occur if young mothers have not grown to their full height or pelvic size; the latter is the result of hypertension (Save the Children, 2004; Upadhyay and Robey, 1999).

Figure 3. Births per 1,000 women ages 15–19 by wealth quintile and region



Source: Gwatkin et al., 2007, p. 33-34.

Very early pregnancy can also deplete nutritional reserves because young girls need nutrients for their own growth. When pregnant women suffer from malnutrition, the risk of poor fetal development and maternal mortality increases (see King, 2003). Unintended pregnancies put young unmarried women at risk of abortion complications that can lead to death or life-long disability. Gage (1998) used data from **Nigeria** to show that that induced abortion was responsible for at least 70 percent of all maternal deaths among mothers ages 15–19. Similarly, infants born to adolescent mothers are at high risk of death due to premature birth, difficult labor, and low birth weight.

Educational outcomes. In some societies, pregnant girls are expelled from school. Girls who return to school after a pregnancy face stigma and other adjustment problems that can further affect their educational attainment. Early childbearing not only disrupts schooling but also girls' connections with mentoring adults and peers who could provide linkages to useful information and institutions (see also global review by Save the Children, 2004). Most studies cite lack of money and poor grades as the main factors causing school dropout; however, early childbearing is also a factor.

Household well-being. Many young mothers either work in the informal sector or are engaged in unpaid economic activities (see global review, Population Council and ICRW, 2004). Working in the informal sector is often the primary recourse for those with limited skills or education, but earnings are often at or below poverty levels. Low-income adolescent mothers tend to work more and earn less than other mothers. A study in **Mexico** found that having children with fathers age 17 years old or younger doubled adolescent mothers' chances of being poor (Buvinic, 1998). In summary, early childbearing is often associated with lower incomes and thus can contribute to women's poverty.

Effects of Unintended Pregnancy and Closely Spaced Birth Intervals

Unintended pregnancy is common worldwide. The Global Health Council has estimated that one in four pregnancies are unintended (Daulaire et al., 2002), which is defined by the Centers for Disease Control and Prevention as "a pregnancy that is either mistimed or unwanted at the time of conception" (CDC, 2008, p.1). Two-thirds of unintended pregnancies end in abortion (Daulaire et al., 2002). Often performed under unsafe conditions, abortions can lead to complications that can result in the woman's death or disability (global review of WHO, 1993; AbouZahr and Ahman, 1998). Risks are especially pronounced for the very young and unmarried (Africa reviews by Ahman and Shah, 2002; Ladipo, 1989; Zabin and Kiragu, 1998).

DHS data indicate that women in the poorer wealth quintiles are more likely to state that they had more children than they wanted and less likely to use contraception than women in the wealthiest quintile (Greene and Merrick, 2005). Various factors that may affect the ability of poor women to obtain FP/RH services include lack of an accessible source of FP/RH information and services in their community; the cost of services, contraceptive supplies, transportation, and other expenses; negative attitudes of health providers and substandard care; cultural and religious norms; opposition of family members; misinformation about FP/RH; and fear of side effects. Women's status may also play a role, as women in poor households often have little control over resources, limited access to information, and highly restricted autonomy.

In countries with high maternal mortality, especially those in **sub-Saharan Africa** and **Asia** and the **Near East**, unintended pregnancies expose women to unnecessary health risks. Women who are poor are likely to face higher risks of maternal mortality compared with their more affluent peers, because they are more likely to give birth without a medically-trained person present (see Table 3). Also, pregnancies that are unintended are less likely to receive good antenatal care (see global review by Acharya, 2004).

Furthermore, women with short intervals between pregnancies have a much higher risk of dying or pregnancy complications during delivery compared with other women (Conde-Agudelo and Belizan, 2003). Lamentably, children whose mothers have died face higher risks of death and malnutrition than those with living mothers (King, 2003).

Table 3. Delivery attended by a medically trained person, by wealth quintile and region

Region	Number of countries	Delivery attended by a medically trained person			Wealthy/poor difference (percentage points)
		Regional average (%)	Poorest quintile (%)	Wealthiest quintile (%)	
East Asia	4	60.7	34.4	91.7	57.3
Europe/Central Asia	6	94.4	88.4	99.2	10.8
Latin America and the Caribbean	9	67.2	45.4	93.6	48.2
Middle East and North Africa	4	60.5	39.7	84.6	44.9
South Asia	4	21.8	7.0	56.0	49.0
Sub-Saharan Africa	29	46.6	25.6	82.5	56.9
All country average	56	55.3	35.8	85.0	49.2

Source: Gwatkin et al., 2007.

Family Planning as a Poverty-Reduction Strategy

Family planning or contraception refers to any method used by women or couples in order to delay or prevent a pregnancy, including traditional as well as modern methods. According to recent DHS findings, the percentage of women using any method of family planning ranges from less than 10 percent in **Pakistan, Yemen, and 16 sub-Saharan Africa** countries to 70 percent in **Brazil** (Gwatkin et al, 2007).

In recent decades, FP use has increased in most developing countries. Several countries in **sub-Saharan Africa**, such as **Malawi, Mozambique, Namibia, Uganda, and Zambia**, have made considerable gains in the past decade. However, contraceptive prevalence rates remain low in other African countries such as **Eritrea, Ethiopia, Mali, and Nigeria**. In some **Asian** countries—**Indonesia, Philippines, and Vietnam**—contraceptive prevalence rates have stagnated in the past decade (Gwatkin et al., 2007).

The availability and use of FP services—together with socioeconomic factors such as better health, higher educational attainment, and women’s increasing economic power and greater role in family decisionmaking—help explain the differences in fertility levels and patterns between the poor and the wealthy. The average difference in FP use between wealthy and poor women is about 18 percentage points for 56 countries, with the largest gaps occurring in **Latin America, South Asia, and sub-Saharan Africa** (see Table 4). The smallest differences can be noted for women in countries surveyed in **Europe/Central Asia and East Asia**. The largest gap between the wealthy and poor is found in **sub-Saharan Africa**, where contraceptive prevalence among the wealthiest quintile is 3.5 times greater than that of the poorest quintile.

Table 4. Contraceptive prevalence rates among women, by wealth quintile and region

Region	Number of countries	Contraceptive prevalence rate (modern methods) ²			Wealthy/poor difference (percentage points)
		Regional average (%)	Poorest quintile (%)	Wealthiest quintile (%)	
East Asia	4	41.4	35.7	42.6	6.9
Europe/Central Asia	6	44.3	38.2	48.1	9.9
Latin America and the Caribbean	9	49.4	36.4	58.5	22.1
Middle East and North Africa	4	39.0	30.7	47.1	16.4
South Asia	4	33.6	24.7	45.7	21.0
Sub-Saharan Africa	29	15.2	8.1	28.0	19.8
All country average	56	28.7	20.7	38.7	18.1

Source: Gwatkin et al., 2007.

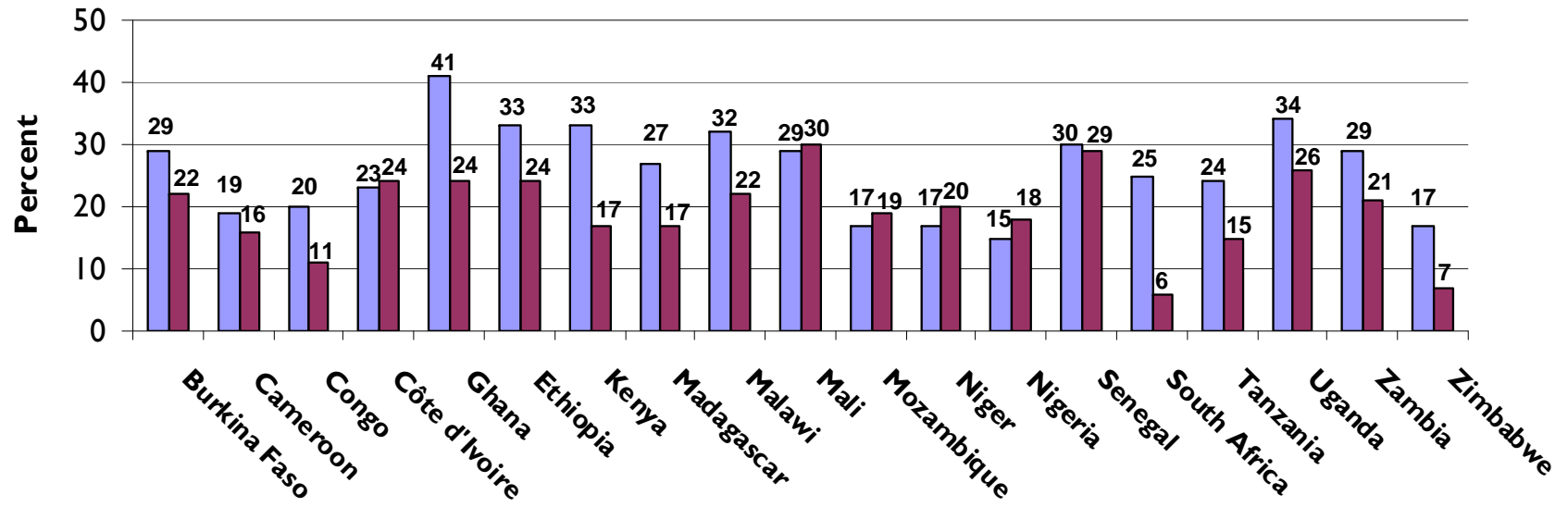
The marked differences in contraceptive use between women in the wealthiest and poorest quintiles suggest that unmet need for family planning is probably greatest for poor women (Greene and Merrick, 2005). “Unmet need” is usually measured as the percentage of currently married women ages 15–49 who are not using an FP method but who want to either delay childbearing for two years or more (to space) or stop childbearing altogether (to limit).

Westoff’s 2006 analysis of DHS data from 58 countries found that in 36 countries, unmet need for family planning was highest among women in the poorest quintile. In most of the other countries with DHS data, unmet need was similar between the lowest and highest quintiles. In most countries in **sub-Saharan Africa**, unmet need for family planning is much higher among the lowest wealth quintile than among the highest quintile (see Figure 4). The differences are especially great in **Gabon, Ghana, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Namibia, South Africa, Tanzania, and Zimbabwe**.

In summary, in most developing countries, the poorest people typically have more births, more early births, the largest number of children, the lowest use of family planning, and the highest unmet need for family planning, compared with people who are better off. These factors combine to make the poor remain poor; they severely limit families’ prospects to improve their quality of life.

² Percent of married women ages 15-49 who used any modern means of contraception.

Figure 4. Unmet need for FP among the lowest and highest wealth quintiles, Africa



Source: Westoff, 2006 (19 countries with a population of at least 10 million, based on DHS data).

IV. GUIDELINES FOR ENGAGING THE POOR IN FP/RH AS A POVERTY-REDUCTION STRATEGY

This section provides practical guidelines for national and local leaders and FP/RH champions to engage the poor on FP/RH issues during various phases of the policy process. The section starts with an overview of the process for engaging the poor, provides a step-by-step explanation of the policy formulation and implementation process, indicates key points in the policy process that can benefit from inputs from the poor, and provides examples of consultation and involvement of the poor as information sources, advisers, advocates, community mobilizers, and program monitors. This section emphasizes that engagement efforts must have a clear objective as well as be informed by data. Many examples of how the poor can be engaged are drawn from Health Policy Initiative studies and reports, especially from Kenya, where the guidelines were validated during meetings with leaders and representatives of poor communities.

The Process of Reaching Out

Engaging the poor to foster their participation in policy processes requires time, effort, commitment, and resources. First, national and local officials and FP/RH champions from the population, health, and other development sectors need to adopt an open attitude and genuinely seek to learn about the real-life situation of the poor. Second, they need to establish open communications by meeting with the poor and/or their representatives and listening to the poor describe their socioeconomic situation, major worries, childbearing experiences, and access to and use of FP/RH services. These efforts open up opportunities for joint learning and information exchange. Third, they need to work together closely to identify problems and potential solutions, as well as to develop and implement policies that are truly responsive to the needs of the poor (see Box 4).

Box 4. Essential to engage the poor in health interventions

“The design of community-level, poverty-focused initiatives requires direct consultation with the poor to learn about what they consider to be healthcare priorities in their communities. Moreover, a poverty-focused approach must recognize that interventions will be more likely to succeed if they are internalized, owned, and implemented by the poor.”

Source: Holland et al., 2000, p. 11.

Through dialogue, national and local leaders can also explain more fully the rationale behind specific FP/RH policies and programs. For example, approaches such as contraceptive market segmentation and expanded private sector involvement can ensure that the poor have equal access to FP/RH services. Given their influence in policy and decisionmaking circles, policy champions initiating the dialogue can bring the poor’s concerns to the attention of decisionmakers for appropriate action and stimulate improvements in pro-poor policies and programs. Policy champions can also create opportunities for further dialogue between other decisionmakers and those who are truly drawn from the ranks of the poor and thus open policy processes even further.

Ensuring Genuine Representation of the Poor

A targeted effort is needed to reach out to organizations that represent poor people. In general, the poor are not usually affiliated with organizations led by national and regional policymaking elites. The poor tend to belong to associations (e.g., trade unions, cooperatives, and insurance pools) related to their livelihood or employment (e.g., as sugar cane farm laborers, weavers, stevedores, peddlers, street cleaners, cargo handlers, and mine laborers). Large cities in Africa have associations of market vendors,

hawkers, and peddlers. The poor may also belong to church groups or community self-help organizations. Some civil society groups may have members and even some leaders who are poor.

It is important to recognize that not all NGOs have close ties to local communities and represent the interests of the poor. NGOs may have their own development priorities, may be preoccupied with implementing their donors' directives, or may be supporting business ventures to meet their financial needs. Some NGOs may have weak links with communities, tense relationships with government officials or community leaders, or little capacity or interest to organize and support the poor (Devas, 2004). The following agencies and organizations may have information about associations or groups representing the poor, such as listings of national or local organizations, cooperatives, or associations:

- The Interior Ministry's central, regional, provincial/state, or district offices
- The social protection or welfare ministry
- The poverty committee of parliament
- Municipal, regional, or local government or administrative bodies
- Umbrella networks, development or social action NGOs, and other civil society groups
- Multisectoral groups developing or reviewing reports about MDGs or pro-poor policy initiatives
- International development agencies and other donors working in poverty-reduction initiatives

Another approach is to use characteristics of people in poverty and then identify the organizations or associations that have them as members or beneficiaries. For example, in Kenya (see Box 5) data show that two provinces (Nyanza and Coast) have high poverty rates and proportions of poor landless farmers. Accordingly, advocacy leaders could look for organizations in the two provinces that represent landless farmers. In Latin America, indigenous people have high poverty rates; groups representing such disadvantaged groups are logical advocacy partners.

Box 5. Who are the poor in Kenya?

Data indicate that poverty rose in Kenya from 49 percent of the population in 1990 to 56 percent in 2003. The majority of the poor in Kenya are subsistence farmers. Households that are large, headed by females, headed by adults with little education, or deriving the most income from agriculture are likely to be poorer than others.

In 1997, Nyanza Province had the greatest proportion of its population living in poverty (63%) followed by the Coast (62%). More than half of the population in all other provinces except for Central (31%) were living in poverty. The poor in urban areas are concentrated in slums. Kisumu town recorded the highest prevalence of poverty (63%), followed by Nairobi (50%).

Source: Kenya PRSP IMF Country Report; Sohani, 2005.

To ensure coordinated action and the efficient use of organizational resources, it is essential for leaders who want to engage the poor to link with coalitions or networks that include groups representing the poor. The benefits of coalitions are that they can tap into the expertise and resources of member organizations, use their wide reach to identify barriers affecting development efforts, and then feed such information back to appropriate individuals or bodies. Thus, coalitions can have far greater influence collectively than their individual members would have separately.

Policymakers and decisionmakers recognize the clout of coalitions and will often invite them to comment on draft plans and guidelines. Coalitions and networks have an important "insider" role in working with policymakers and government officials, engaging in policy dialogue, and educating key decisionmakers.

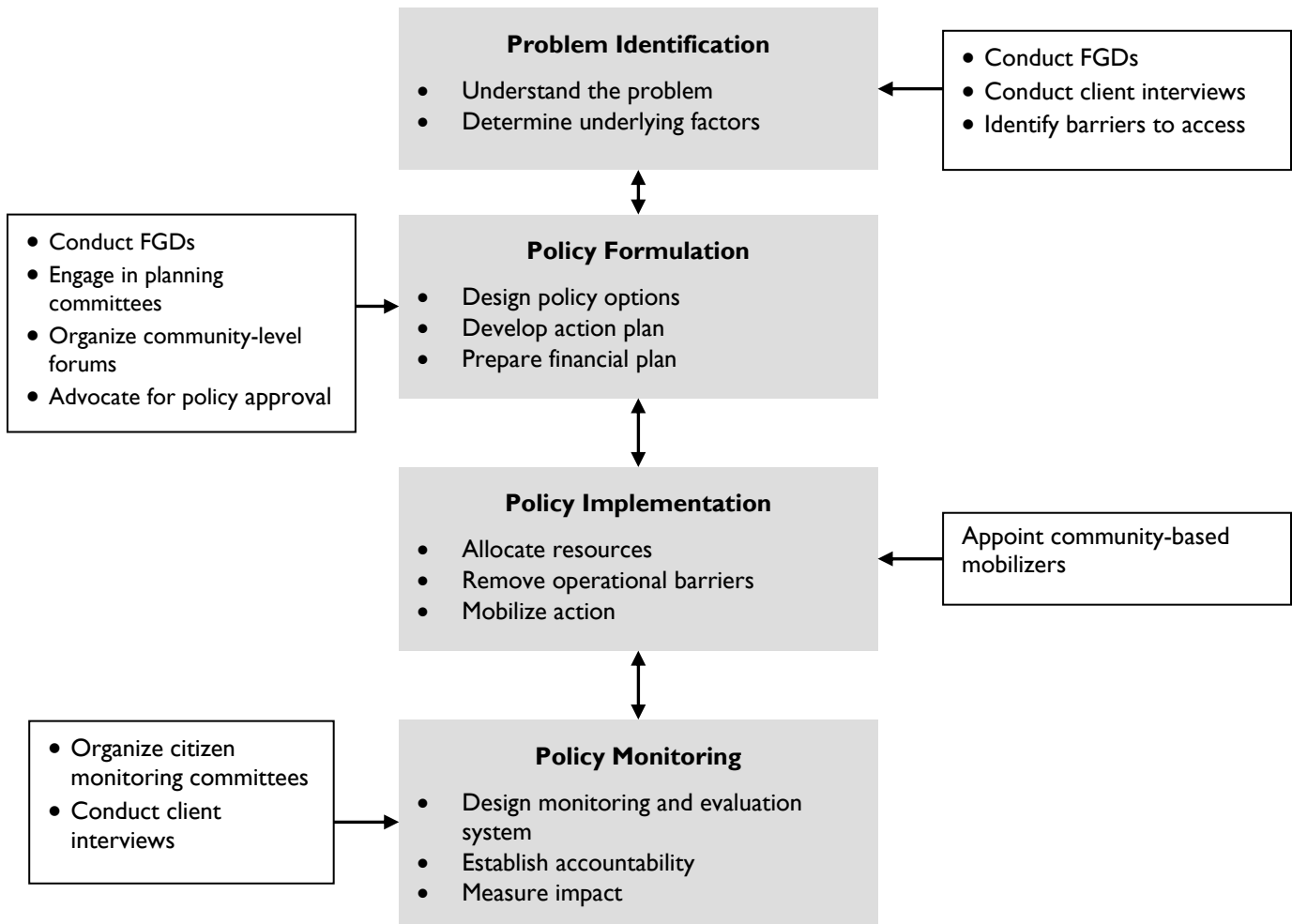
But equally important is their “public” role in raising the visibility of an issue, conveying key information through the mass media and electronic forums, and organizing public events to create greater awareness and broaden support for poverty-reduction strategies. A disadvantage of coalitions is that it can take time to forge a consensus on controversial issues. As Russell and Levitt-Dayal (2003, p. 10) note, “Compromise and mutual respect are essential to maintaining a sense of community around an issue.”

Engaging the Poor in the Policy Formulation and Implementation Process

The public policy process offers multiple opportunities for national and local officials, development leaders, and FP/RH champions to reach out to the poor, ranging from issue identification and policy development to policy implementation, monitoring, and evaluation. “Public policy” refers broadly to (1) *national* policies, laws, parliamentary acts, and legislation—such as reproductive health policies that provide the broad vision and framework for government action, and (2) *operational* policies that include guidelines, plans, budgets, procedures, and administrative norms that national and local governments use to translate national laws and policies into programs and services (Cross, 2001).

Figure 5 presents the four main stages of the policy formulation and implementation process. It should be noted, however, that these “stages” are more analytical than actual chronological steps, as it is widely recognized that the policy process is rarely linear or straightforward (Grindle and Thomas, 1991; Kingdon, 1984; Porter, 1995). Some processes overlap. Goals may be discussed even as a problem or its potential solution is identified. Ideally, policies are translated into programs for which strategic plans are developed and cost estimates are prepared to indicate their budgetary implications. However, plans are often developed without any budget data. Interest groups can alter, speed up, or subvert the policy development process at any time. Policies may be officially approved yet never implemented. Hence, an advocate or policy champion can play an important role in overcoming barriers to an approval and/or actual implementation.

Figure 5. Engaging the poor in policy formulation and implementation



Many steps of the policy process involve advocacy and policy dialogue, which can be designed to be more participatory and inclusive. Some major ways that leaders and FP/RH champions have engaged the poor are

- By meeting with the poor directly;
- Through decisionmaking assemblies or councils that include representatives of the poor (e.g., village leaders of poor communities);
- Through intermediaries such as religious leaders, RH or social welfare program managers, civil society organizations, and opinion leaders who work directly with the poor; and
- Through development projects and donors.

Concrete and practical examples of how the poor have been engaged are drawn from Health Policy Initiative documents and field reports, including those collected in February 2009 in **Kenya**, where the guidelines were validated during meetings with leaders and representatives of poor communities. Several of these examples are drawn from case studies of dialogues involving leaders and members of the Kaloleni urban poor resettlement site (see Appendix B) and the Lela rural community (see Appendix C). The two communities are located in the Kisumu District of Nyanza, Kenya's poorest province.

Step I. Problem Identification

Problem identification is often the starting point for policy action or reform. Policymakers, leaders, influential individuals or groups, advocates, and activists must perceive that a certain problem is actually or potentially affecting a large segment of society and that policy action is needed for the problem to be addressed.

Setting the objective. Before embarking on a specific course of action, national and local leaders (usually highly motivated policy champions and FP/RH stakeholders) should assess the issue as well as the policy challenge and decide on the main objective for engaging the poor on FP/RH. The objective could be any or several of the following:

- Improve FP/RH policies and/or plans by maximizing the poor's access to high-quality services
- Improve financing and resource allocation for FP/RH programs that serve disadvantaged groups
- Incorporate population and FP/RH issues into national policies, strategies, or reports on poverty reduction (including MDG and PRSP country reports)
- Ensure implementation of good policies and programs, particularly those that target the poor
- Evaluate the effects of existing services and programs, particularly related to meeting the needs of the poor

It is also worth considering at which level engagement should occur. Changing national laws or budgetary allocations often takes time, but dialogue with health service managers at the national, regional, or local levels to make FP services more accessible and affordable for the poor could produce tangible results within a few months.

Understanding the problem. To engage the poor in the policy process, policy champions and other activists need information to understand the issues and to educate others. Data are especially important during the problem identification stage. The necessary information, along with relevant questions on what data to collect, includes the following:

- **Policies and programs related to poverty reduction.** What do national policies or plans state regarding poverty? Are there specific policies in the health and social sectors that give priority to the poor (e.g., free immunizations in public health centers; provision of free voluntary counseling and testing and antiretroviral therapy to those who cannot afford them, etc.)? Information sources include government policy documents, workplans for poverty reduction programs, and reports on progress toward reaching the MDGs.
- **Definitions of poverty.** How does the country define poverty officially? Is the definition based on income, minimum nutritional requirement, or, for example, the cost to feed a family of six? What other dimensions (e.g., basic needs, human development, capabilities, vulnerability) are used to define poverty? Government reports on poverty and those of international agencies such as the World Bank and United Nations Development Program (UNDP) provide useful data and explanations.
- **Poverty rates and trends.** What proportion of the population is categorized as poor? Is the poverty rate increasing or decreasing? How does the poverty rate differ among regions of the country and urban/rural areas? Government, World Bank, and UNDP reports typically provide this information.
- **Characteristics of the poor.** Where are the poor located? Are they concentrated in rural areas or in cities, and in which geographic regions? Which socioeconomic groups are described as poor or fit the poverty definition used in the country or area? What other characteristics (e.g., gender, age, ethnicity, religion, occupation, household size, and migrant status) are associated with poverty?

Information from government and UNDP reports can be supplemented by local reports and research studies.

- **Childbearing patterns.** What are the fertility levels (completed family size) among the poor (based on wealth quintile)? What proportion of women have their first birth before age 18? Do women report that they have had unintended pregnancies? National surveys, such as the DHS, as well as local surveys provide useful data that can be disaggregated by wealth quintile and region to understand variations in fertility.
- **Family planning use.** What proportion of poor women use modern contraceptive methods? What proportion use traditional methods? What proportion of poor women say they want to limit or space births but are not using a contraceptive method (indicating unmet need for family planning)? National surveys, such as the DHS, other local surveys, and reports from FP service providers are good sources of information.

To supplement local data on poverty, it is worthwhile to seek additional information from local sources, such as well-being, welfare, happiness, or vulnerability surveys; “voices of the poor” media interviews; local community assessments; and press stories. Anecdotal reports may help to understand the concerns and daily struggles of the poor. Information on spatial distribution of the poor has been used to prepare poverty maps that organize information visually to make it easier to identify clusters of poverty, housing, water sources, location of health facilities, and other local resources.

Determine underlying factors. All these data sources need to be grounded in the direct testimony of the poor. Information can be gathered through informal and formal interviews; focus group discussions; intercept interviews conducted at the marketplace, outside a health clinic, or in some other public place; and community meetings. Person-to-person exchanges also help to understand attitudes, cultural and religious traditions, misperceptions, and inequities that may not be evident to an external observer.

In **Sierra Leone**, the Health Policy Initiative explored operational barriers to FP services among people affected by conflict (Sonneveldt et al., 2008). Through interviews, focus group discussions, and interaction with refugees and internally displaced persons, researchers learned that interest in family planning varied at different phases of the conflict, depending on whether people were preoccupied with basic survival, fleeing from danger, displaced from their home, settled in refugee camps, or traumatized and feeling insecure. People affected by conflict stated that they were unable to use family planning due to their inability to locate services, lack of funds to pay for services, provider biases regarding specific FP methods, disruption of health services, and frequent commodity stockouts. Women reported experiencing traumas, such as rape, sexual exploitation, stigma, victim blaming, and lack of family support due to deaths. These insights are useful in many countries that are seeking to provide FP/RH services to people affected by conflict.

Step 2. Policy Formulation

The problem identification phase is typically followed by discussions among stakeholders (and sometimes intended beneficiaries) about priority issues to be addressed and alternative interventions. Policy dialogue is needed to reach a consensus on policy needs. This is an important stage to engage the poor to ensure that the proposed policy will address their needs and convey some benefit to them. This stage also entails detailed planning on how the proposed policy will be implemented and what resources are needed for implementation.

Design policy options. Program planners must consider the range of policy and program options that are posited to address the key problem and determine which ones are feasible, acceptable, and affordable. In some cases, computer projections are helpful in weighing the costs and benefits of alternative

interventions. The poor and their representatives can provide useful feedback on policy options and drafts of proposed policies.

Develop an action plan. Once a course of action is decided, program planners need to prepare a detailed plan indicating how the policy will be implemented. Key elements of an action plan are (1) the targeted groups; (2) specific services, goods, or other benefits provided; (3) providers of assistance; (4) geographic coverage; (5) collaboration with public and private agencies, community organizations, and local leaders; and (6) the budget.

Prepare the financial plan. The financial as well as human and physical resource requirements to implement the action plan need to be identified. The plan also should indicate where the resources will come from and what government funds, staff, facilities, or other resources are needed.

Hold public hearings. Program planners and stakeholders should provide mechanisms such as policy dialogues, public hearings, and debates to ensure that the public, especially the poor, have the opportunity to comment on the proposed policy and understand its implications.

Advocate for approval of the policy and the necessary resources. Typically a broad coalition of stakeholders in collaboration with policy champions lead advocacy in favor of a new or revised policy. Box 6 provides an example of a local NGO in **Mali** that played a key role in advocating for the inclusion of population and FP components in the national PRSP.

Box 6. Incorporating FP into Mali's PRSP

One concrete way to introduce family planning into poverty-reduction programs is for FP/RH leaders and champions to be actively involved in the preparation of their national PRSP. PRSPs are government documents used to qualify for loans and debt relief from the World Bank and International Monetary Fund. These documents must indicate the macroeconomic and social policies that the government will adopt to alleviate poverty. Expanding access to family planning can be included as one of these policies. Advocacy groups and policy champions need to be involved not only in the process of incorporating FP into PRSPs but also in ensuring that the new policies are supported by budgets, implementation plans, and staffing. In **Mali**, the Health Policy Initiative assisted a local NGO network, *Groupe Pivot/Santé Population*, to incorporate statements about population growth and family planning into Mali's second PRSP, drafted in 2006. This initiative led to the inclusion of statements about meeting unmet need for FP and making FP services affordable for the poor. (For more information about incorporating FP into the PRSP process, see Bhuyan et al., 2007.)

The poor and their representatives often make highly effective advocates because of their dynamic personalities and/or compelling real-life experiences. Their authenticity is an integral part of their effectiveness as advocates. Nevertheless, spokespersons for the poor can benefit from training to be fully effective. Most people new to policy dialogue and advocacy could use some coaching on skills such as selecting key points, addressing government leaders, speaking before groups, answering questions in public forums, and handling press inquiries. It may also be important for spokespersons to develop leadership and community organizing skills so that they can serve in a dual role in synthesizing and prioritizing their community's needs and concerns as well as orienting policy officials and decisionmakers on these topics.

In **Nigeria**, a multi-level coalition of women's organizations worked to increase women's political participation and improve women's health. The coalition was built by bringing together leaders and representatives of 10–15 women's community organizations—often small organizations such as women attending literacy classes, a savings or credit association, a social club supporting poor members to pay

for weddings and funerals, a tribal organization, or a youth grouping. These local coalitions, known as 100 Women Groups, mobilized grassroots groups to identify and develop a consensus on priority problems and then brought these problems to the attention of local and national decisionmakers. Initiated by CEDPA in 1996 with USAID funding, the 100 Women Groups idea caught on rapidly. By 2000, the networks had 105,568 members in 686 100 Women Groups. Most of these groups were formed without external support. The strategy was particularly successful in fostering women's leadership and participation in traditional, political, and legislative decisionmaking processes. Many women became advocates for reproductive health, girls' education, and economic issues and challenged traditional gender roles. Some women were elected to local and national offices, thus taking lead roles in affecting policy change (Mangyvat et al., 2003).

Step 3. Policy Implementation

Once the proposed policy or operational guidelines have been officially approved, program implementers need to develop the appropriate systems—infrastructure, staff, management, provision of services, information, supplies, and coordination—to implement the new initiative. The poor and their representatives can be actively engaged in implementation as experts on operational barriers and community educators and organizers.

Allocate resources. Before a policy can be implemented, decisionmakers and program managers must ensure that sufficient resources are available to support the new initiative.

Remove operational barriers. Based on information obtained during the policy identification and formulation stages, program implementers must take the appropriate actions to ensure that FP/RH services are suitable for disadvantaged groups, especially the poor.

For example, in **Guatemala**, an initiative to improve access to FP/RH services for indigenous women benefited from their candid comments in interviews and focus group discussions. Researchers supported by the Health Policy Initiative identified six key barriers to use of FP/RH services by indigenous women: (1) provider bias; (2) unsuitable conditions in clinics (lack of privacy, lack of counseling in local languages, inconvenient clinic hours, and long waits); (3) lack of appropriate information materials; (4) inadequate knowledge of FP/RH among community-based providers; (5) the community's negative views about family planning; and (6) restrictive social and familial environments. To address the barriers related to service delivery, health officials identified 10 initiatives, including providing counseling and information materials in the local language, training all clinic staff and community providers in family planning; and ensuring that FP consultations would be private and confidential. The Guatemala Ministry of Health incorporated these ideas into its strategic plan for family planning and has developed operational guidelines to be applied at the department (state) level (Netzer and Mallas, 2008).

Mobilize action. In addition to ensuring that health providers and educators implement the new initiative, program managers need to develop systems for reaching out to poor communities. Community mobilization techniques are often used to help community members work through a series of steps to develop solutions to their most serious problems. This process entails gathering information, building trust with local residents, discussing their concerns, planning as a group, developing and implementing a community action plan, evaluating the outcomes, and scaling up the activity (Howard-Grabman and Snetro, 2003). The process is intended to encourage a high level of community participation so that local people, including the poor, can implement their own development initiatives without outside assistance— thus leading to increased local capacity and the prospect of sustainability (Howard-Grabman and Snetro, 2003).

Ensuring the active, sustained involvement of the poor through a community mobilization process can be challenging. Many poor people may be too busy eking out a living and caring for their family to spend time meeting and organizing. Some poor people may believe that laws and political processes do not work for them; this belief may be derived from first-hand experiences. Some people may think that their inputs will be ignored by decisionmakers. The poor may also perceive that their agendas are subordinated to those of the elite and that their goals are different from those of the well-off. In addition, many poor people lack the knowledge and education to effectively participate in policy and program deliberations and thus are dependent on spokespersons to present their views to decisionmakers. Finally, data and information systems do not generally take into account what the poor understand or consider important (de Haan and Maxwell, 1999; Kinyashi, 2006; Pasha, 2002). Nevertheless, as Box 7 indicates, most poor people are willing to participate in policy dialogue and community mobilization.

Box 7. The poor want to be involved

“A recent review of Participatory Poverty Assessment findings, along with related participatory studies on demand responses, demonstrated the expertise and willingness of the poor to engage in dialogue and identify problems and solutions in public service delivery.”

Source: Holland et al., 2000, p. 13.

In **India**, village women are actively involved in educating their communities about FP/RH. They are part of the National Rural Health Mission (NRHM) 2005–2012 which was launched to bring about dramatic improvement in the health system and the health status of the people, especially those in rural areas. The NRHM aims to achieve universal access to equitable, affordable, and high-quality healthcare and thus the goals set under the National Health Policy and the MDGs. The NRHM has sought to address large disparities in healthcare among the poor, women, scheduled castes, and tribes, especially in rural areas, by promoting access to improved healthcare at the household level. It assisted focus states to hire accredited social health activists (ASHAs) in all villages with more than 1,000 people. ASHAs are village women who visit homes in their area to educate residents about appropriate health practices. They also provide oral contraceptives and condoms, essential health supplies such as oral rehydration solution, and a set of 10 basic drugs; and also organize community action for universal immunization, safe delivery, newborn care, prevention of water-borne and other communicable diseases, nutrition, and sanitation (Government of India, 2008).

Step 4. Policy Monitoring

Program managers and policymakers can learn much from new initiatives if monitoring and evaluation systems are in place. The poor and their representatives can be helpful in determining whether the new initiative is benefiting the poor and operating smoothly. The poor can play an important “watchdog” role by providing first-hand accounts from the perspective of beneficiaries and reporting problems to program managers.

Design monitoring and evaluation system. Program managers need to design a system to assess whether the new initiative is being implemented as planned (monitoring) and is having any effect (evaluation). By monitoring outputs, important benchmarks in implementation, the response of beneficiaries, and expenditures, program managers can decide whether mid-course corrections are needed. An evaluation plan helps to set out the goals and desired results and to measure progress toward achieving them.

Establish accountability. Program managers need to assign responsibility for program implementation to specific individuals and hold these individuals accountable for achieving results. The workplan should clarify individual roles and lines of supervision and should set standards for the quality and timeliness of specific tasks.

Measure impact. Program impact is often measured through data sources such as health statistics, clinic records, and surveys. Program managers should also consider the useful role that citizen groups and community members can play in monitoring policy implementation and assessing program effectiveness.

For example, in **Peru**, the National Network for the Promotion of Woman (RNPM) sought to ensure women's access to FP/RH services and protect contraceptive users' rights. In 1999, the RNPM mobilized grassroots organizations—including rural women's associations, indigenous groups, and organizations for low-income women—to form citizen surveillance committees (CSC) in three communities. The CSCs monitored provider compliance with national FP norms and assessed the quality of FP/RH services provided to clients. They also solicited feedback from the public and local health authorities. Other communities requested assistance from the RNPM to set up their own CSCs to monitor local health programs. Since then, the CSC model has been applied to other social development initiatives (Futures Group/POLICY Project, 2003).

Similarly, in **Romania**, the leaders of women's health coalitions were effective in assessing the implementation of a new government policy that mandated the provision of contraceptives free of charge to students and women who were unemployed, receiving social assistance, or had no income. The women's health coalitions asked their members from poor and marginalized populations (e.g., Romas and other ethnic minorities) to visit public health centers and ask for free contraceptive supplies. The women reported that they could not access the free contraceptives because of onerous documentation requirements to prove poverty status. The coalition leaders reported this difficulty to the head of the FP/RH office in the Ministry of Health. The ministry amended the policy by allowing women to provide self-certification of poverty status and also increased government funding for free contraceptives (Zosa-Feranil, 2006).

In **Kenya**, women's rights champions were able to reassert women's equal right to own and inherit land. In Nyanza, which is the poorest region of the country and has the highest HIV prevalence rate, women were disinherited after their husbands died—even though the law protected women's equal right to own and inherit land. Women's rights champions held community meetings to inform poor women about their property rights and to learn of cases that violated the law. They then met with provincial- and district-level officials to inform them of these practices. Then the women's rights champions organized a dialogue among the council of elders, Land Tribunal representatives, and representatives of disinherited women. Government officials assured women of their land ownership and inheritance right and explained the process that women can use to document and reassert their legal claim or ownership (Nuong'o and Ongalo, 2005).

Lessons from Kenya in Engaging the Poor

Although **Kenya** has many pro-poor policies, recent data (see for example, IMF, 2005) reveal that poverty-reduction targets are not being met. Also, despite government endorsement of FP in 1965 and efforts to expand FP/RH services, fertility remains high (with the total fertility rate at 5 children per woman according to the 1999 Census and 4.9 as reported in the 2003 Demographic and Health Survey). In the past decade contraceptive prevalence has remained stagnant. Trend data from the 1998 and 2003 Kenya Demographic and Health Surveys showed contraceptive prevalence as unchanged at 30 percent and modern contraceptive use at 24 percent for both years.

The Health Policy Initiative is assisting the Kenya Ministry of Health to explore financing mechanisms to improve access to FP/RH services among the poor. As part of this activity, the project helped to set up community dialogues for village leaders and residents of poor communities. The purpose of these dialogues was to hear directly from the poor about the challenges they face, including those related to

childbearing and reproduction. The results of two dialogues are reported in two case studies included in Appendices B and C. The main findings were that these communities have received limited government services and resources—despite the extreme poverty of their inhabitants and the loss of adult workers due to AIDS-related deaths.

In Kaloleni, a shantytown located in Kisumu, the third largest city in Kenya, widows caring for large numbers of children—their own and others orphaned by AIDS—said that they had little food and no source of income. Some women expressed interest in using contraception, but they are unlikely to obtain FP services because the local dispensary lacks most drugs and supplies. The community leaders did develop some ideas for forming community groups and conducting health education campaigns (see Appendix B).

In Lela, a rural farming community, residents eke out a living as subsistence farmers and casual laborers. After discussing the many needs of community members, village leaders formed a community interest group to prepare proposals for funds to support two income-generating activities (see Appendix C).

The two case studies illustrate the importance of engaging the poor and focusing on family planning at various stages of the policy process—particularly to identify problems, develop policies and action plans, mobilize resources, and monitor policy and program implementation.

Another inspiring example from Kenya is an initiative by a female member of Parliament, Ms. Phoebe Asiyo, who formed committees of the poor and other disadvantaged groups in her district. After meeting with these groups to identify their problems and needs, she worked with them to lobby successfully for the approval of a law allocating 30 percent of government budgets or jobs to women. She also obtained funds for her district by meeting with donors, government leaders, and ministers and taking some of them to her district to see first-hand the problems that poor people face.

V. CONCLUSIONS AND RECOMMENDATIONS

This report examines two major factors that have received insufficient attention in the formulation of poverty-reduction policies and programs: (1) inadequate efforts to consult with the poor, the ultimate beneficiaries of such initiatives; and (2) limited attention to demographic factors, especially high fertility, that contribute to continued poverty. To compensate for these shortcomings, this report provides background information on the definitions and extent of poverty, reviews criticisms of development assistance programs that fail to consult beneficiaries, documents the relationship between poverty and high fertility, provides guidelines for engaging the poor in policy formulation and implementation, and offers examples of country initiatives to involve the poor in FP/RH programs.

The country initiatives reviewed lead to the following conclusions:

- Efforts to engage the poor are amply repaid in terms of the information and insights that they provide and their contributions as program planners, implementers, and monitors.
- The poor need to be regarded as experts in their own right and thus as essential members of policy formulation and implementation teams.
- When the poor are involved in devising solutions to problems, the resulting programs are more likely to have local ownership and involvement and hence be more sustainable over time.
- Spokespersons for the poor can be influential because of their authenticity and life experience, especially if they are supported with training and relevant background information.
- Coalitions representing the poor can be helpful in identifying necessary policy initiatives, advocating for policy change, and presenting evidence of ineffective policy implementation or unintended negative consequences.

In summary, the poor are an underutilized resource in policy formulation and implementation. National decisionmakers and government officials should

- Make a concerted effort to understand the situation of the poor and other marginalized groups in order to meet their needs more effectively;
- Involve the poor and organizations that represent their interests in setting program priorities and directions;
- Insist that program planners and implementers involve beneficiaries in all stages of program planning and implementation;
- Encourage local leaders and public officials to reach out to the poor, learn about their problems, and take action to address these problems;
- Become knowledgeable about the effects of high fertility and rapid population growth on efforts to reduce poverty; and
- Request studies on the costs of providing FP/RH services and the estimated savings in public funding for education, healthcare, and other social services.

Program planners and managers should

- Consult with the poor in order to understand the challenges they face and their childbearing experiences and intentions;
- Engage the poor in policy formulation and program planning, implementation, and monitoring;

- Monitor and evaluate the adequacy of the poor's participation in development programs;
- Encourage documentation and share examples of successful efforts to engage the poor as well as lessons learned from challenging situations; and
- Ensure that poverty-reduction programs include FP/RH services.

Organizations that represent the interests of the poor and other marginalized groups should

- Advocate for policy processes to become more transparent and open for civil society engagement, including those representing the poor and the marginalized;
- Set up systems to obtain inputs and feedback from the poor;
- Enlist representatives of the poor to participate in advocacy campaigns and monitoring of policy implementation;
- Collect information on the reproductive intentions of the poor and their ability to control the number and timing of births;
- Provide information on sources of FP/RH services and supplies; and
- Promote a culture of openness within the organization.

The authors hope that this report will inspire a greater willingness to involve the poor and other disadvantaged groups in the policy formulation and implementation process. They have much to contribute to this process.

APPENDIX A. FERTILITY, FAMILY PLANNING, AND UNMET NEEDS (C. 2000–2006)

Region and Country*	Poverty indices ¹		Total Fertility Rate (number of lifetime births per woman)			Contraceptive Use (% of currently married women using any method)			Unmet Need for FP (% not using any method but want to space or limit childbearing)		
	Population below national poverty line (%)	Population below \$1 a day (%)	Country Average	Wealth Quintiles		Country Average	Wealth Quintiles		Country Average	Wealth Quintiles	
				Poorest	Wealthiest		Poorest	Wealthiest		Poorest	Wealthiest
Sub-Saharan Africa											
Benin 2005	29	-	5.7	7.0	4.2	17	7.7	33.6	29.9	30.3	26.5
Burkina Faso 2003	45	45	6.2	7.1	3.9	14	7.6	32.4	28.8	28.6	22.4
Cameroon 2004	40	17	5.0	6.5	3.2	26	7.3	45.9	20.2	19.0	16.2
Eritrea 2002	<i>n.a.</i>	-	4.8	6.2	3.0	8	-	-	27.0	27.1	20.6
Ethiopia 2005	44	26	5.4	6.6	3.2	14.7	4.2	37.0	33.8	33.1	24.0
Ghana 2003	40	45	4.4	6.4	2.8	25.2	14.0	34.6	34.0	40.7	23.9
Kenya 2003	52	23	4.9	7.6	3.1	39.3	17.9	51.5	15.8	32.7	17.0
Lesotho 2004	<i>n.a.</i>	36	3.5	5.2	2.0	37.3	17.6	54.5	30.9	43.4	19.4
Madagascar 2003/04	71	61	5.2	6.6	3.0	27.1	9.5	51.5	23.6	26.8	16.8
Malawi 2000	65	42	6.0	7.1	4.1	32.5	25.3	40.6	27.6	31.9	21.8
Mozambique 2003	-	38	6.1	6.4	4.4	16.5	8.9	40.2	18.4	16.6	18.7
Namibia 2000	-	35	4.2	-	-	52.2**	-	-	12.7**	-	-
Nigeria 2003	-	61	5.7	6.5	4.2	12.6	6.9	30.0	16.9	14.9	18.0
Rwanda 2005	60	52	6.1	6.1	5.0	17.4	11.0	31.8	37.9	40.0	33.9
Senegal 2005	-	26	5.3	7.0	3.8	11.8	3.7	24.6	31.6	30.4	28.9
South Africa 1998	-	11	2.9	-	-	62.1**	-	-	15.0	-	-
Tanzania 2004/05	36	-	5.7	7.3	3.3	26.4	15.6	45.2	21.8	23.9	15.4
Uganda 2006	44	-	6.7	8.0	4.3	23.7	9.9	47.5	40.6	46.5	26.2
Zambia 2001/02	73	64	5.9	-	-	34.2	-	-	27.4	-	-
Zimbabwe 2005/06	35	56	3.8	5.5	2.3	60.2	48.0	72.1	12.8	20.2	7.6

North Africa/West Asia											
Armenia 2005	51	13	1.7	1.8	1.5	53.1	58.0	59.8	13.3	15.7	10.0
Egypt 2005	17	3	3.1	3.6	2.6	59.2	53.4	62.9	10.3	14.2	7.5
Jordan 2002	12	<2	3.7	-	-	55.8	-	-	11.0	-	-
Morocco 2003	19	<2	2.5	3.3	1.9	63.0	-	-	10.0	11.1	7.5
Southeast Asia											
Bangladesh 2004	50	36	3.0	4.0	2.5	58.1	53.6	62.5	11.3	13.0	8.6
Cambodia 2005	36	34	3.4	4.9	2.4	40.0	30.7	54.0	25.1	31.4	16.8
India 2005/06	29	35	2.7	3.9	1.8	56.3	42.2	67.5	12.8	18.2	8.1
Indonesia 2002/03	27	8	2.6	3.0	2.2	60.3	52.4	63.5	8.6	-	-
Nepal 2006	-	38	3.1	4.7	1.9	48.0	32.9	60.9	24.6	32.0	19.3
Philippines 2003	37	15	3.5	5.9	2.0	48.9	37.4	50.6	17.3	-	-
Latin America and the Caribbean											
Bolivia 2003	63	14	3.8	6.7	2.0	58.4	41.8	70.9	22.7	37.8	Bolivia 2003
Haiti 2000	-	-	4.0	6.5	2.1	32.0	20.0	37.6	37.5	44.2	Haiti 2000

* Data from most recent DHS.

** Data on poverty refer mostly to 1995–2001 estimates reported in the World Bank's World Development Indicators.

APPENDIX B. ENGAGING THE URBAN POOR IN KENYA: A CASE STUDY OF KALOLENI, KISUMU

A Shantytown for the Destitute

Nyanza Province is the poorest one in Kenya and also has the highest infant and child mortality rates and the highest HIV prevalence rate; 15 percent of Nyanza adults ages 15–49 were HIV positive in 2003. The province alone accounts for one-third of all HIV infections in the country. Families are getting even larger; the provincial total fertility rate rose from 5 to 5.6 children between 1998 and 2003 (Government of Kenya et al., 2004). Contraceptive use is low and unmet need for family planning is high.

Kisumu, the capital of Nyanza, is the third largest city in Kenya, with a population of 4.4 million (as of 1999). Located on Lake Victoria, Kisumu houses universities, hotels, banks, shops, gas stations, government offices, and the regional hospital. Its residential areas range from lakeside estates and villas and middle class housing complexes to grass-thatched huts and shacks made from salvaged materials.

Within Kisumu, Kaloleni is a shantytown set up by the government for resettlement of homeless people and squatters. Serviced by uneven dirt roads with large holes, Kaloleni is hot, dry, and dusty. Some residents have improved the housing shells provided by the government and now have multi-room dwellings. The newer arrivals live in dilapidated shanties with dirt floors and roofs made from salvaged materials.

Female-headed Households

Accompanied by community leaders, a local AIDS activist, and a community mobilizer (a consultant to the project), the Health Policy Initiative team visited three households:

1. The household head, a widow with nine children, explained that they were driven from their home by her husband's family after he died. They lived on the streets for months and only recently moved to Kaloleni. The widow and her two older daughters are most concerned about where their next meal will come from, where they will get money if the children get sick, and how they will stay dry if it rains. The widow supports her family by doing laundry and house cleaning for others.
2. In this one-room clay dwelling, an elderly woman who is HIV positive takes care of 10 orphans, including her grandchildren and other orphans she adopted. Most of her own children have died of AIDS. Her oldest grandson is of high school age but cannot go to school due to lack of funds. The children receive healthcare at the local dispensary; those who are HIV positive go to Lumumba Hospital for their antiretroviral therapy regimen. The family subsists on maize gruel and other foods donated by Kaloleni residents.
3. A widow with eight children, including an infant suffering from malaria and a toddler, live in a tiny lean-to shack. Older children take care of their younger siblings. The widow has run away several times. Community members found her in the streets and took her back to the dwelling.

Making Decisionmakers Aware of Community Needs

Welcomed by community members singing traditional songs, the Health Policy Initiative team met with some 30 local residents in a small community center. The audience was mostly women. The community leaders who attended were the village chief, a Christian pastor, a Muslim imam, the dispensary nurse, and the AIDS activist. The project staff explained that they were talking with community members to learn how to improve access to RH services for poor people. Upon hearing the phrase “engaging the poor,” residents said that no government official had ever met with them to ascertain their needs. They noted that

little government assistance has actually reached them—other than the funds to build the community center. They were emphatic about their lack of faith in government but unanimous in praising NGOs for helping the community. Asked how the government can engage them, several women said that this contact should be through NGOs.

Interestingly, the Kalomeni residents did not consider the village chief and the dispensary nurse as government officials or representatives but rather as community members like them. The village chief himself empathizes with residents: “If a salaried (government) worker like me can feel hunger, what more these women who have no jobs and worry every day about where their families will get the next meal.” The chief’s requests to provincial authorities to send more help to the area have been denied.

The dispensary nurse said that community members have major healthcare needs. Many people visit the dispensary for care, but she lacks the necessary drugs and supplies to treat them. Parents often lack the funds for the required co-payment at the dispensary and/or for transport to the hospital when their children are sick.

The pastor noted that religious organizations had helped the community. However, he pointed out that people hear about big donors assisting Kenya, but little of this assistance has reached Kaloleni. He recommended that donors determine where their assistance is really going, as the press report that funds for development projects are often lost to corruption.

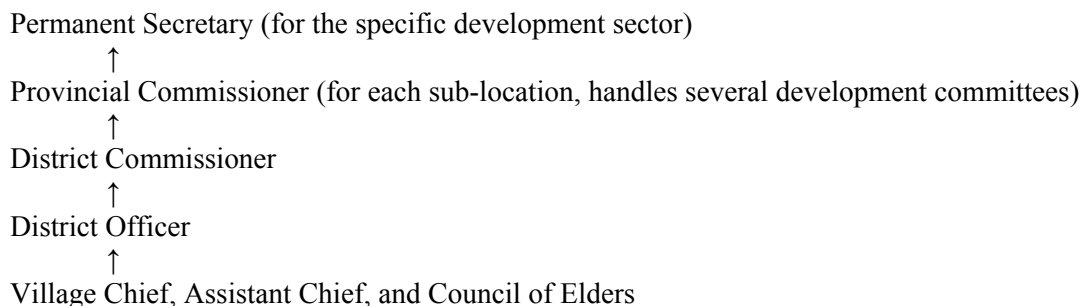
The project team mentioned that families in Kenya tend to be large, and that the poorest people tend to have the largest families. This discussion opened up the subject of family planning. One woman said that health workers had never discussed family planning with her, while another said that she had recently heard about family planning from the community mobilizer (the HPI consultant). In any case, community members who wanted to use family planning would not be able to obtain the necessary supplies from the dispensary.

The two religious leaders did not know much about contraceptive methods, but they expressed interest in learning more about family planning, especially its health benefits. The imam said that family planning is consistent with Koranic teachings on family responsibility and protecting the health of the mother and the children—although he thought that some contraceptive methods were against the Koran. The pastor said that he was also very supportive of responsible parenthood and the need to address poverty and promote women’s and children’s health.

The five community leaders agreed that they would work together to bring the plight of the urban poor community to the attention of district and provincial decisionmakers. As a unified community group, they could invite the district commissioner or higher officials to visit the community and hear directly from community members about their daily lives, lack of resources, and large family responsibilities.

Recommendations from Local Community Leaders

The project team later met separately with Kaloleni community leaders to discuss points raised in the earlier meeting. First, the community leaders presented an outline of the decisionmakers who influence funding allocations for Kaloleni:



Following are the community leaders' recommendations for bringing Kaloleni's plight to the attention of provincial commissioners:

- Community members and elders need training on development issues (e.g., poverty and fertility, family planning, male involvement, etc.) as well as on advocacy and social mobilization so that they can better articulate the community's problems to decisionmakers, form support groups, conduct community health education campaigns, and generate broad community support for key development programs such as family planning. The community leaders emphasized training in gender equity and male involvement because they believed that FP programs will only succeed if both men and women are involved.
- High-level decisionmakers and leaders need to visit the community in order to meet the poor and know what the poor really need. Poor people feel a sense of hopelessness and perceive the government as failing them. Village leaders can only do so much with the limited resources that the community currently receives. The needs of the poor are best appreciated and responded to if decisionmakers visit them in their communities.
- Groups or clubs that include government officials should be formed to facilitate direct meetings between decisionmakers and the poor. Similar groupings can be formed along chains of administration so that when government leaders develop policies or programs, or want to know what is taking place on the ground, they will know whom to contact.
- Government decisionmakers need to make regular visits to communities where the poor reside. If they are unable to visit, leaders can contact groups or clubs along the chain of command and invite the poor to their offices.

APPENDIX C. ENGAGING THE RURAL POOR IN KENYA: A CASE STUDY OF LELA, KISUMU

Economic Hardship

Lela, a farming town, is a 25-minute drive from Kisumu, the capital city of Nyanza Province in Kenya. Most of its residents are subsistence farmers. Poverty and food insecurity are endemic. Opportunities for paid labor are scarce. Most young adults, even those with a secondary education or higher, are unemployed. They take any small jobs that they can find. Many families are headed by widows who are supporting many children, including those orphaned by AIDS.

Women's Precarious Existence

Three women—a local legislative leader, a village elder, and a community organizer—welcomed the Health Policy Initiative team to Lela. This group proceeded to the local church, where they met with 25 women. The women proceeded to talk about their lives and their hardships. Most of them were farmers, tilling small plots of land. Some earned money by working as casual laborers or selling produce on the roadside.

An elderly female farmer said that she does farm work all day long but may not have enough money to buy seeds for her next crop. Another farmer, a widow, said that every day she worries about how to feed her six children. A woman who works as a casual farm laborer said that her employers sometimes give her a meal. Four women described themselves and their husbands as casual laborers. They have small lands to till, but their lands are becoming less fertile and they have no money to improve the soil and increase crop yields. Two women said they made a meager living selling potatoes and tomatoes. An elderly woman said that she takes care of many grandchildren, who were orphaned when all her children died. Two widows said their husbands died, leaving them with five children each.

The Costs of Large Families

The community meeting was expanded to include several males (the village chief, assistant chief, village elders, a local community organizer, two local youth leaders, and a Catholic Church representative) and females (a community health worker, a Christian church leader, and a local leader who is also a member of the government-constituted national body for women).

Residents were unanimous in stating that their most serious problem is their limited resources. While they recognize that education is important for their children, they do not have the funds to pay for their children's travel to school or for other necessary items. Many women are the sole support for many children. Although the government had allocated cash payments for orphans, the funds were insufficient to cover all those in need. Several caregivers of orphans said that they had never received any of these funds.

Community members had various rationales for having many children. An elderly woman explained that the poor keep having children because one does not know which child will rescue the parents from poverty. Another woman said that poor women have many children to give them something to do. Several women said that the men they married believe that women are made for procreation. A woman said that some religious denominations teach that family life is mainly for having many children. Another woman said that women end up with large families because they want to ensure that the family has a son to follow after the father. However, one woman said that having many children makes a woman sick.

Community members agreed that coping with difficult times would be easier if families were smaller. They stated that most people were ignorant about family planning. Several women said that no one has

spoken to them about family planning. A male community leader emphasized that efforts to change family size norms or promote family planning will work only if men are involved. He proposed that the community hold workshops for women about family planning and also hold separate workshops for men to make them understand their responsibilities.

Strategy for Reaching Decisionmakers

At a subsequent meeting with village leaders (the village chief, assistant chief, council of elders, and representatives of women's and youth groups), the project team learned more about the way funds are allocated at the local level. The village chief explained that funding decisions are made centrally, with allocations to each province. Provincial officials then decide on funds for each district. The district commissioner then allocates funds to the various sub-locations under his/her jurisdiction. Because the national government appoints district commissioners and village chiefs, some appointees may not be familiar with their constituents' needs.

The village leaders noted that their district commissioner has been very willing to hear about the needs of local communities. For example, when women told him about their difficulties as a result of the post-election violence, he obtained additional funds from the provincial authorities for their community. The Lela village leaders decided to form a community interest group to identify the community's needs, develop project proposals, and apply for funding from the district commissioner and other sources, including government grants. The three former village chiefs agreed to form the community interest group, get the community involved, and identify community projects that can be proposed for funding. The two main ideas for proposals were to (1) set up entrepreneurship training and microfinance funds for women (e.g., to raise goats) and (2) construct a youth center with a place for computer training so that the town's youth could learn computer skills and then earn money by training others from neighboring communities. These proposals will be submitted to the Kisumu West District Commissioner for various devolved funding mechanisms and to the council overseeing the peace and reconciliation fund (set up after the 2008 post-election violence).

REFERENCES

- Aaby, P., J. Bukh, I. Lisse, and A. Smits. 1984. "Overcrowding and Intensive Exposure as Determinants of Measles Mortality." *American Journal of Epidemiology* 120(1): 49–63.
- AbouZahr, C., and E. Ahman. 1998. "Unsafe Abortion and Ectopic Pregnancy." In *Health Dimensions of Sex and Reproduction: the Global Burden of Sexually Transmitted Diseases, HIV, Maternal Condition, Perinatal Disorders, and Congenital Anomalies*, edited by C. Murray and A. Lopez. Geneva: World Health Organization.
- Acharya, A. 2004. "Fertility and Well-Being in Developing Countries: Health and Development Impacts of Family Planning." Washington, DC: Futures Group.
- Agarwal, B. 1991. "Social Security and the Family: Coping with Seasonality and Calamity in Rural India." In *Social Security in Developing Countries*, edited by A. Ethisham, J. Dreze, J. Hills, and A. Sen. Oxford, UK: Oxford University Press.
- Ahlburg, D.A. 1994. "Population Growth and Poverty." In *Population and Development: Old Debates, New Conclusions*, edited by R. Cassen. Washington, DC: Overseas Development Council.
- Ahman, Elisabeth, and Iqbal Shah. 2002. "Unsafe Abortion: Worldwide Estimates for 2000." *Reproductive Health Matters* 10(19): 13–17.
- All Party Parliamentary Group on Population, Development and Reproductive Health. 2007. "Return of the population growth factor: Its impact upon the Millennium Development Goals." *Report of Hearings by the All Party Parliamentary Group on Population, Development and Reproductive Health*. London: House of Commons, Print Management Systems.
- Anand, S., and J. Morduch. 1998. "Poverty and the Population Problem." Pp. 9–24 in *Population and Poverty in Developing Countries*, edited by M. Livi-Bacci and G. De Santis. Oxford, UK: Clarendon Press.
- Basu, Alaka Malwade. 2005. "The Millennium Development Goals Minus Reproductive Health: An Unfortunate, but Not Disastrous Omission." *Studies in Family Planning* 36 (2). Special section on Reproductive Health and the UN Millennium Development Goals. Published online June 15, 2005, pp. 132-134. www3.interscience.wiley.com/journal/118690385/issue .
- Bauer, J., D. Canlas, M. Fernandez, and A. Mason. 1992. "Family Size and Family Welfare in the Philippines." *Working Papers Population Series* No. 87. Honolulu, Hawaii: East-West Center.
- Bernstein, Stan. 2005. "The Changing Discourse on Population and Development: Toward a New Political Demography." *Studies in Family Planning* 36(2): 127–132. Special section on Reproductive Health and the UN Millennium Development Goals. Published online June 15, 2005. Available at: www3.interscience.wiley.com/journal/118690385/issue.
- Bhuyan, A., M. Borda, and W. Winfrey. 2007. "Making Family Planning Part of the PRSP Process: A Guide for Incorporating Family Planning Programs into Poverty Reduction Strategy Papers." Washington, DC: Futures Group International, Health Policy Initiative, Task Order 1.

Bond, R., and N. Mukherjee, 2001. "Livelihood Asset Status Tracking (LAST) A Case from Rajasthan." Impact Assessment for Sustainable Development Unit, *Working Paper Series*, Institute for Development Policy and Management, University of Manchester.

Buvinic, M. 1998. "The Costs of Adolescent Childbearing: Evidence from Chile, Barbados, Guatemala, and Mexico." *Studies in Family Planning* 29(2): 201–209.

Centers for Disease Control and Prevention (CDC). 2008. "Unwanted Pregnancy Prevention: Home." Retrieved on August 22, 2008, from www.cdc.gov/reproductivehealth/UnintendedPregnancy/index.htm.

Chambers, R. 1995. "Poverty and Livelihoods: Whose Reality Counts?" *Institute of Development Studies Discussion Paper No. 347*. Brighton, UK: Institute of Development Studies.

Chen, Shaohua, and Martin Ravallion. 2007. "Absolute Poverty Measures for the Developing World." *Proceedings of the National Academy of Sciences of the United States of America* 104/42: 16757–62 (see also World Bank *Policy Research Working Paper* 4211).

Cornwall, A., and K. Brock. 2005. "Beyond Buzzwords: 'Poverty Reduction,' 'Participation,' and 'Empowerment' in Development Policy." *Overarching Concerns Programme Paper No. 10*. Geneva: United Nations Research Institute for Social Development.

Coudouel, A., J. Hentschel, and T. Wodon. 2002. "Poverty Measurement and Analysis." In *A Sourcebook for Poverty Reduction Strategies, Vol. I: Core Techniques and Cross-cutting Issues*, edited by J. Klugman. Washington, DC: World Bank.

Cross, Harry. 2001. Presentation at POLICY Project Technical Development Week. Washington, DC: Futures Group International, POLICY Project.

Daulaire, N., P. Leidl, L. Mackin, C. Murphy, and L. Stark. 2002. *Promises to Keep: The Toll of Unintended Pregnancies on Women's Lives in the Developing World*. Washington, DC: Global Health Council.

de Haan, A., and S. Maxwell. 1998. "Editorial: Poverty and Social Exclusion in North and South." *Institute of Development Studies Bulletin* 29(1): 1–9.

Desai, S. 1995. When Are Children from Large Families Disadvantaged? Evidence from Cross-National Analyses. *Population Studies* 49(2): 195–210.

Devas, N. 2004. *Urban Governance, Voice, and Poverty in the Developing World*. London: Earthscan.

Donaldson, Dayl, Himani Sethi, and Suneeta Sharma. 2008. *Vouchers to Improve Access by the Poor to Reproductive Health Services: Design and Early Implementation Experience of a Pilot Voucher Scheme in Agra District, Uttar Pradesh, India*. Washington, DC: Futures Group International, Health Policy Initiative, Task Order 1.

Falkingham, J., and C. Namazie, 2001. *Measuring Health and Poverty: A Review of Approaches to Identifying the Poor*. London: British Government's Department for International Development (DFID) Health Systems Resource Center.

Fathalla, Mahmoud. F. 2005. "The Reproductive Health Community: A Valuable Asset for Achieving the MDGs." *Studies in Family Planning* 36(2): 135–137. Special section on Reproductive Health and the UN

Millennium Development Goals. Published online June 15, 2005. Available at: www3.interscience.wiley.com/journal/118690385/issue .

Foster, A., and N. Roy. 1997. "The Dynamics of Education and Fertility: Evidence from a Family Planning Experiment." Philadelphia: University of Pennsylvania.

Futures Group/POLICY Project. 2003. "Four Workshops on Reproductive Health to RNPM Citizen Surveillance Committees" and "Citizen Surveillance Models and Human Rights Tools Used for Policy Analysis." Lima, Peru: Futures Group/POLICY Project. Unpublished (Spanish only).

Gage, A. 1998. "The Social Implications of Adolescent Fertility." Pp. 120–143 in *Population and Poverty in the Developing World*, edited by M. Livi-Bacci and G. De Santis. Oxford: Clarendon Press.

Germain, Adrienne, and Ruth Dixon-Mueller. 2005. "Reproductive Health and the MDGs: Is the Glass Half Full or Half Empty?" *Studies in Family Planning* 36(2): 137–140. Special section on Reproductive Health and the UN Millennium Development Goals. Published online June 15, 2005. Available at: www3.interscience.wiley.com/journal/118690385/issue .

Gillespie, D., S. Ahmed, A. Tsui, and S. Radloff. 2007. "Unwanted Fertility Among the Poor: An Inequity?" *Bulletin of the World Health Organization* 85(2): 100–107.

Government of India Ministry of Health and Family Welfare. 2008. *National Rural Health Mission. Meeting people's health needs in rural areas: Framework for Implementation 2005-2012*. New Delhi.

Government of Kenya Central Bureau of Statistics, Ministry of Health, Kenya Medical Research Institute, National Council for Population and Development, Centers for Disease Control and Prevention, and ORC Macro. 2004. *2003 Kenya Demographic and Health Survey. Final Report*. Nairobi, Kenya and Calverton, Maryland, USA.

Greene, Margaret E., and Thomas Merrick. 2005. "Poverty Reduction: Does Reproductive Health Matter?" *HNP Discussion Paper*. Washington, DC: World Bank.

Grindle, M. S., and J.W. Thomas. 1991. *Public Choices and Policy Change: The Political Economy of Reform in Developing Countries*. Baltimore, MD: Johns Hopkins University Press.

Gwatkin, D., S. Rutstein, K. Johnson, E. Suliman, A. Wagstaff, and A. Amozou. 2007. *Socio-Economic Differences in Health, Nutrition, and Population within Developing Countries: An Overview*. Washington, DC: World Bank.

Haub, Carl, and Mary Mederios Kent. 2008. *World Population Data Sheet*. Washington, DC: Population Reference Bureau. Retrieved on August 21, 2008, from http://www.prb.org/pdf08/08WPDS_Eng.pdf.

Holland, J., E. Fisher, S. James, and V. Walford. 2000. "Becoming Poverty-Focused: Implications for Health Actors." *Working Paper*. Swansea, UK: Centre of Development Studies, Swansea, and the UK DFID Health Systems Resource Centre.

Howard-Grabman, Lisa, and Gail Snetro. 2003. *How to Mobilize Communities for Health and Social Change*. Baltimore, MD: Health Communication Partnership.

International Monetary Fund (IMF). 2005. "Kenya: Poverty Reduction Strategy Paper." Country Report 05/11. Retrieved on May 13, 2009 from <http://planipolis.iiep.unesco.org/upload/Kenya/PRSP/Kenya%20PRSP.pdf>.

Kenya Central Bureau of Statistics, Ministry of Health, Kenya Medical Research Institute, National Council for Population and Development, Centers for Disease Control and Prevention. 2005. *Kenya Demographic and Health Survey, 2003: Final Report*. Nairobi, Kenya and Calverton, Maryland, USA: Kenya Central Bureau of Statistics and ORC Macro.

Khan, Shane, and Vinod Mishra. 2008. *Youth Reproductive and Sexual Health*. DHS Comparative Reports No. 19. Calverton, Maryland: Macro International Inc.

King, E. 1987. "The Effect of Family Size on Family Welfare: What Do We Know?" Pp. 373–411 in *Population Growth and Economic Development: Issues and Evidence*, edited by D. G. Johnson and R. D. Lee. Madison: University of Wisconsin Press.

King, J. 2003. "The Risk of Maternal Nutritional Depletion and Poor Outcomes Increases in Early or Closely Spaced Pregnancies." *Journal of Nutrition* 133: 1732s–1736s.

Kingdon, J. 1984. *Agendas, Alternatives, and Public Policies*. Ann Arbor: University of Michigan.

Kinyashi, George Frank. 2006. "Towards Genuine Participation for the Poor: Critical Analysis of Village Travel and Transport Project (VTTP) Morogoro, Tanzania." Dodoma: Institute of Rural Development Planning.

Knodel, J., N. Havanon, and W. Sittitrai. 1990. "Family Size and Education of Children in the Context of Rapid Fertility Decline." *Population and Development Review* 16(1): 31–62.

Ladipo, O.A. 1989. "Preventing and Managing Complications on Induced Abortion in 3rd World Countries." *International Journal of Gynecology and Obstetrics* (3): 21–81.

Lloyd, C. B. 1994. "Investing in the Next Generation: The Implications of High Fertility at the Level of the Family." Pp. 181–202 in *Population and Development: Old Debates, New Conclusions*, edited by R. Cassen. Washington, DC: Overseas Development Council.

Lloyd, C. B., and A. J. Gage-Brandon. 1994. "High Fertility and Children's Schooling in Ghana: Sex Differences in Parental Contributions and Educational Outcomes." *Population Studies* 48(2): 293–306.

Mangyvat, J., E. Ifenne, V. Guthrie, J. Masterson, and R. Okegbola. 2003. *Giving Women a Voice: The 100 Women Groups*. Washington, DC: Centre for Development and Population Activities.

Maxwell, Simon. 1999. "The Meaning and Measurement of Poverty." *ODI Poverty Briefing* 3. Available at: <http://www.odi.org.uk/publications/briefing/pov3.html>.

McGee, R., and A. Norton. 2000. "Participation in Poverty Reduction Strategies: A Synthesis of Experience with Participatory Approaches to Policy Design, Implementation, and Monitoring." *Institute for Development Studies Working Paper* 109. Brighton, England: Institute for Development Studies.

- McGee, R., J. Levene, and A. Hughes. 2002. "Assessing Participation in Poverty Reduction Strategy Papers: A Desk-based Synthesis of Experience in Sub-Saharan Africa." *Research Report 52*. Brighton, England: Institute for Development Studies.
- Menken, J., L. Duffy, and R. Kuhn. 2003. "Childbearing and Women's Survival: New Evidence from Rural Bangladesh." *Population and Development Review* 29(3): 405–426.
- Narayan, D., et al. 2000. *Voices of the Poor. Can Anyone Hear Us?* Vol. 1. Washington, DC: World Bank.
- Narayan, D., et al. 2001. *Voices of the Poor. Crying Out for Change*. Vol. 2. Washington, DC: World Bank.
- Netzer, Sara, and Liz Mallas. 2008. *Increasing Access to Family Planning among Indigenous Groups in Guatemala*. Washington, DC: Futures Group International, Health Policy Initiative, Task Order 1.
- Nyong'o, D., and O. Ongalo (editors). 2005. *From Despair to Hope: Women's Right to Own and Inherit Property*. Nairobi: POLICY Project/Futures Group and Kenya National Commission on Human Rights.
- Oxfam. 2004. "From 'Donorship' to Ownership? Moving Toward PRSP Round Two." *Oxfam Briefing Paper* No. 51. London: Oxfam.
- Pasha, Hafiz. 2002. "Pro-Poor Policies." Paper presented at the Fourth Global Forum on Citizens, Businesses, and Governments: Dialogue and Partnerships for the Promotion of Democracy and Development, Marrakech, Morocco, December 12–13, 2002. Regional Bureau for Asia and the Pacific, United Nations Development Programme.
- Population Council and the International Center for Research on Women (ICRW). 2000. *Adolescent Girls' Livelihoods*. New York, NY and Washington, DC: Population Council and ICRW.
- Porter, R. 1995. *Knowledge Utilization and the Process of Policy Reform: Toward a Framework for Africa*. Washington, DC: Academy for Educational Development.
- Pritchett, L. 2003. "Who Is Not Poor? Proposing a Higher International Standard for Poverty." *Working Paper* No. 33. Washington, DC: Center for Global Development.
- Ravallion, M., S. Chen, and P. Sangraula. 2007. "New Evidence on the Urbanization of Global Poverty." *Policy Research Working Paper* 4199. Washington, DC: World Bank.
- Ravallion, M., S. Chen, and P. Sangraula. 2008. "Dollar a Day Revisited." *Policy Research Working Paper* 4620. Washington, DC: World Bank.
- Rudqvist, A. 2002. *Popular Participation in Colombia*. Stockholm: Swedish International Development Cooperation Agency, Department for Latin America.
- Russell, Nancy, and Marta Levitt-Dayal. 2003. *Igniting Change! Accelerating Collective Action for Reproductive Health and Safe Motherhood*. Washington, DC, and Baltimore, MD: CEDPA/ENABLE and JHPIEGO/MNH.
- Rutstein, Shea. 2000. "Factors Associated with Trends in Infant and Child Mortality in Developing Countries during the 1990s." *Bulletin of the World Health Organization* 78(10): 1256–1270.

- Save the Children. 2004. *State of the World's Mothers 2004*. Washington, DC: Save the Children.
- Schultz, T. 1993. "Investments in the Schooling and Health of Women and Men: Quantities and Returns." *Journal of Human Resources* 28: 694–735.
- Sen, A. 1987. "The Standard of Living: Lecture II, Lives, and Capabilities." Pp. 20–38 in *The Standard of Living*, edited by G. Hawthorn. Cambridge: Cambridge University Press.
- Sen, A. 1999. *Development as Freedom*. New York: Anchor Books.
- Sen, Gita, and Caren Grown. 1987. *Development, Crises and Alternative Visions: Third World Women's Perspectives*. New York: Monthly Review Press.
- Shapiro, D., and O. Tambasche. 2001. "Gender, Poverty, Family Structure, and Investments in Children's Education in Kinshasa, Congo." *Economics of Education Review* 20: 359–375.
- Sinding, Steven, W. 2005. "Keeping Sexual and Reproductive Health at the Forefront of Global Efforts to Reduce Poverty" 2005. "The Millennium Development Goals Minus Reproductive Health: An Unfortunate, but Not Disastrous Omission." *Studies in Family Planning* 36(2): 140–143. Special section on Reproductive Health and the UN Millennium Development Goals. Published online June 15, 2005. Available at: www3.interscience.wiley.com/journal/118690385.
- Skoufias, Emmanuel. 1994. "Market Wages, Family Composition, and the Time Allocation of Children in Agricultural Households" *Journal of Development Studies* 30(25): 335–360.
- Sohani, S. 2005. "Health Care Access of the Very Poor in Kenya." Workshop on Meeting the Health-related Needs of the Very Poor. Paper No. 11. London: DFID.
- Sonneveldt, Emily, Theresa Shaver, and Anita Bhuyan. 2008. *Understanding Operational Barriers to Family Planning Services in Conflict-Affected Countries: Experiences from Sierra Leone*. Washington, DC: Futures Group International, Health Policy Initiative, Task Order 1.
- Thomas, Duncan, and John Maluccio. 1996. "Fertility, Contraceptive Choice, and Public Policy in Zimbabwe." *World Bank Economic Review* 10(1): 189–222.
- United Nations (UN). 1992. "Rio Declaration on Environment and Development." The United Nations Conference on Environment and Development, Rio de Janeiro, June 16. Retrieved April 27, 2008, from <http://www.unep.org/Documents.Multilingual/Default.asp?DocumentID=78&ArticleID=1163>.
- United Nations. 1994. *Programme of Action of the International Conference on Population and Development*. New York: United Nations Population Fund. Chapters XIII and XV. Retrieved April 27, 2008, from http://www.unfpa.org/icpd/icpd_poa.htm.
- United Nations. 2007. *The Millennium Development Goals Report 2007*. New York: UN.
- United Nations Development Program Evaluation Office. 2003. *Millennium Development Goals*. Volume 1, 2003 Reports. New York: UN.

United Nations Environment Program, the World Bank, and World Resources Institute (WRI). 2005. *World Resources 2005: The Wealth of the Poor: Managing Ecosystems to Fight Poverty*. Washington, DC: WRI.

United Nations. 2009. *The Millennium Development Goals Report 2009*. New York: UN Department of Economic and Social Affairs. Refer also to <http://mdgs/un/org>.

UN Millennium Project. 2005. *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals. Overview*. Report to the UN Secretary General. Washington, DC: Communications Development Inc., and UK design partner, Grundy & Northedge.

United Nations Population Division of the Department of Economic and Social Affairs. 2007. *World Population Prospects: The 2006 Revision and World Urbanization Prospects: The 2005 Revision*. Retrieved August 21, 2008, from <http://esa.un.org/unpp>.

Upadhyay, U., and B. Robey. 1999. "Why Family Planning Matters." *Population Reports, Series J*, Number 49. Baltimore, MD: Johns Hopkins School of Public Health, Population Information Program.

Westoff, Charles F. 2006. "New Estimates of Unmet Need and the Demand for Family Planning." *DHS Comparative Reports* No. 14. Calverton, MD: Macro International Inc.

World Bank. 2002. *Participation in Poverty Reduction Strategy Papers: A Retrospective Study*. Washington, DC: Participation and Civic Engagement Group Social Development Department.

World Bank. 2003. "Enabling Environments for Civic Engagement in PRSP Countries." *Social Development Notes* No. 82. Washington, DC: World Bank.

World Bank. 2004. *The Poverty Reduction Strategy Initiative: An Independent Evaluation of the World Bank's Support through 2003*. Operations Evaluation Department. Washington, DC: World Bank.

World Bank. 2008. "What is Poverty?" Retrieved from the World Bank PovertyNet website April 28, 2008, <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/0,,contentMDK:20153855~menuPK:373757~pagePK:148956~piPK:216618~theSitePK:336992,00.html>.

World Bank. 2009. "Trends in Poverty over Time." Retrieved from the World Bank PovertyNet website April 28, 2009. <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/0,,menuPK:336998~pagePK:149018~piPK:149093~theSitePK:336992,00.html>

World Health Organization (WHO). 2004. *Maternal Mortality Estimates for 1990 and 1995: Estimates Developed by WHO, UNICEF, and UNFPA*. Geneva: Department of Reproductive Health and Research, WHO (cited as source for the 1993 WHO review of maternal mortality causes).

Zabin, L., and K. Kiragu. 1998. "The Health Consequences of Adolescent Sexual and Fertility Behavior in Sub-Saharan Africa." *Studies in Family Planning* 29(2): 210–232.

Zosa-Feranil, I. 2006. "Networking for Policy Change: What Works" Washington, DC: POLICY Project/Futures Group.

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