

**Reaching the poorest of the poor with health services: the
case of BRAC's CFPR/TUP programme in Bangladesh**

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**Syed Masud Ahmed MBBS, PhD
BRAC Research and Evaluation Division**

Abstract

More than three decades of grassroots experience led BRAC (an indigenous Bangladeshi NGO) to the realization that regular microcredit-based intervention is not enough to effectively reach the most vulnerable section among the poor, i.e., the ultra-poor. A targeted grants-based intervention (integrating income-generating asset grants, subsistence allowance, skill training, pro-poor advocacy, and health inputs) was designed by BRAC for them under the name of *“Challenging the frontiers of poverty reduction/targeting ultra-poor, targeting social constraints (CFPR/TUP)”*. Once the grant phase is over, it is expected that they will attain the foundation for sustainable livelihoods and participate and benefit from mainstream microcredit programmes. The asset’s long term impact is enhanced by the health component of the programme which by reducing income-erosion effect of morbidity acts as a safety net and allows their productive engagement in livelihood activities. Findings from an impact evaluation study revealed substantial improvement in self-rated health and other objective indicators such as children’s nutritional status, use of contraceptives, health-seeking behaviour and capacity of health expenditure. Engaging elite support for success of ultra-poor related programmes, consumer information on locally available health services to improve accessibility, health cards for facilitated access to govt. health facilities, community mobilisation of fund for meeting costly morbidities and in-patient care are some of the tools that emerged for scaling up and replicating the model in wider environment. Thus, a combination of components that includes both health and livelihood protection measures in an intervention was found to be more effective in meeting the health-related needs of the very poor.

1. Introduction

Health has a critical role for economic development in low-income countries: better health translates into greater and more equitably distributed wealth by building human and social capital and increasing productivity (WHO, 2001). However, cost of health care itself can be a cause of poverty in these countries through loss of income, catastrophic health expenditures, and potentially irreversible crisis coping mechanisms that involve asset and savings depletion (Meesen et al., 2003; Xu et al., 2003). Of all the risks that poor households face, health risks probably pose the greatest threat to their lives and livelihoods (Krishna, 2004; Noponen, & Kantor, 2004; Russel, 2004). The income erosion effect of ill health for the poor households, especially the bottom 15-20% is also well documented in Bangladesh (Sen, 2003). Thus, enhancing poor people's ability to access quality health care at low-cost has a potential poverty-alleviating effect.

2. BRAC's CFPR/TUP Programme

BRAC, an indigenous Bangladeshi NGO, also realises the potential of high impact health services in reducing vulnerability of the poor households. To influence health outcomes of the poor, it integrates microcredit-based income-earning interventions with activities in other sectors such as human capital development, gender equities, and legal awareness besides health interventions ('credit plus' as opposed to 'credit only' approach of many other NGOs). However, more than three decades of grassroots experience showed that regular microcredit-based intervention as implemented by BRAC is not enough to effectively reach the most vulnerable section among poor, i.e., the ultra-poor¹ (around 36% of a population of 140 million) for a number of reasons. Included among these are some structural factors such as harsh discipline of the micro-credit/micro-finance institutions unsuitable to their livelihood pattern, fear of cash money transaction, and absence of a safety-net provision in the programme (Halder, & Mosley, 2004). Experiences gained from working with these population groups in recent years (Matin, & Hulme 2003; Webb, Coates, & Houser 2002) were used to develop a customized grants-based intervention by BRAC under the name of "*Challenging the frontiers of poverty reduction/targeting ultra-poor, targeting social constraints (CFPR/TUP)*". Once the grant phase is over, it is expected that they will attain the foundation for sustainable livelihoods and participate and benefit from mainstream microcredit programmes. The asset's long term impact is enhanced by the health component of the programme which by reducing income-erosion effect of morbidity acts as a safety net and allows their productive engagement in livelihood activities.

3. CFPR/TUP programme components

Once selected, the women members of the ultra poor households are provided with two or more income-generating enterprise options including poultry rearing, livestock,

¹ These ultra poor households have few or no asset base, highly vulnerable to any shock (e.g., natural disaster, illnesses requiring in-patient or costly out-patient care, death or disability of an income-earner), and mainly depend on wage-labour for survival. A household labelled as 'ultra-poor', has the following characteristics in any combination: 1) household's land-holding <10 decimals or landless; 2) female headed household and households with divorced/abandoned/widowed women; 3) adult women in the household does manual labour outside homestead for survival; 4) households where male income-earner is physically not able to work regularly; 5) households where children of school going age have to do manual labour; 6) households having negligible assets beyond the homestead they live in

vegetables farming, horticulture nursery, and non-farm activities. These are provided as grants along with customized health and other supports delivered over 18 months cycle (Table 1).

Experiences have shown that the poor, especially the ultra poor, are often not able to take full advantage of officially free services provided under existing essential health care (EHC) package (maternal health, family planning, communicable disease control, child health and basic curative care) at primary facilities (BRAC, 2001). Reasons identified include lack of access to information (on available services), lack of health awareness (unfelt need), lack of opportunity (exclusion from social and health institutions) and inability to pay (income poverty). The health component tailored specifically to overcome these barriers and acted as safety net against income-erosion effect of costly morbidities (Table 2).

Table 1: The CFPR/TUP programme components (delivered over a cycle of 18 months) and its rationale (BRAC 2004)

Component	Rationale
Integrated targeting methodologies	Effective targeting of the extreme poor
Income generating asset transfer [range: Taka 3,000-9,000 (US\$ 50-150)]	Build economic asset base
Income generation skill training and regular refreshers (e.g., poultry/livestock rearing, vegetable cultivation, shoe-making etc.)	Ensure good return from asset transferred
Technical follow-up of enterprise operations	Ensure good return from asset transferred
Provision of all support inputs for the enterprise	Ensure good return from asset transferred
Monthly stipends for subsistence [range: Taka 10 (US\$ 0.17) daily for 12-15 months]	Reduce opportunity cost of asset operations
Social development (e.g., social awareness and confidence building, legal awareness, social action on early marriage/dowry etc.)	Knowledge and awareness of rights and justice
Mobilization of local elite for support (pro-poor advocacy through seminar, workshop, and popular theatre)	Create an enabling environment
Health support	Reduce costly morbidity

Table 2: Health support under the CFPR/TUP programme with rationale (BRAC 2004)

Component	Rationale
Essential Health Care (EHC)* package, installation of sanitary latrines and tube-wells free of cost	Developing health awareness, change 'unfelt need' to 'felt need' and control disease transmission
Consumer information package on locally available health services	To overcome information barrier
Identity Card for facilitated access to health services	To overcome barrier due to social exclusion and promote use of formal health services
Financial assistance for costly morbidity (e.g., illness requiring in-patient treatment or costly lab tests) from fund mobilized by programme and community	To overcome financial barrier
Intensive supervision and assistance from community health volunteers (CHVs) and health staff to avail services; developing referral network for severe illnesses	To optimize opportunity cost of accessing and attending health care services

*health and nutrition education, child immunization, pregnancy care, basic curative care for common illnesses at cost prices (or free of cost if unable to pay), and delivery of DOTS (Directly Observed Treatment, Short course) for TB (Tuberculosis) patients

4. Impact assessment

CFPR/TUP was designed as an experimental programme to address some of the most complex economic and socio-political constraints facing the ultra poor in Bangladesh. The basic model of careful targeting, asset transfer, skills development, intensive technical assistance along with customized health support has in general worked quite well as reflected in the various assessments carried out both internally by BRAC's Research and Evaluation Division (RED) (Rabbani et al., 2006; Sulaiman and Matin, 2006) and external evaluators (Mid-Term Review, 2005).

Following intervention, majority of the participating ultra poor households improved their poverty status. By increasing capacity for health-expenditure and facilitating access to formal public sector health care facilities, the programme initiated changes in health-seeking behaviour of the ultra poor towards greater use of qualified health care providers (Ahmed et al., 2006). This happened, presumably, through activities in the intervention to overcome specific demand-side barriers (e.g., informational, financial and social barriers) for accessing health care. Findings from the impact evaluation studies also revealed substantial improvement in self-rated health (Prakash, & Rana, 2006) and other objective indicators such as children's nutritional status and use of contraceptives (Ahmed, & Rana, 2005), and improved quantity and quality of food consumption (Hassen 2006).

The research design did not allow evaluation of the individual components of the intervention e.g., the relative importance of financial vs. the non-financial components. However, authors in another study on the same group of participating women exploring

factors underlying change found that “health is a major factor in determining change in the TUP programme” (Matin, & Walker, 2004). They concluded that if participants cannot work due to poor health and nutrition, they are never likely to see significant change that is sustainable. The similar conclusion about the importance of the health component was also reached by an independent mid-term review mission of the CFPR/TUP programme (Mid-Term Review, 2005). The findings also support the assumption that a combination of components that includes both health and social protection measures in an intervention would be more effective in meeting the health-related needs of the very poor (Green 2005).

Thus, the CFPR/TUP model is a cost-effective (around US\$275 per HH per cycle) one considering the impacts on:

- livelihood which was found to be positive (improved income and asset base),
- comprehensive (economic, social and health changes) and apparently,
- sustainable (maintenance of asset growth after ‘graduation’ and joining regular microcredit/microfinance programme) (Sulaiman et al., 2006).

5. Lessons learned

Lessons learned for replication and scaling up include necessity of sensitizing different sections of the society to the plight of the ultra-poor and engaging elite support as a prerequisite for success of ultra-poor related programmes; careful identification of ultra-poor households for intervention; utility of consumer information on locally available health services in improving accessibility for the ultra-poor; utility of tools like health cards for facilitated access to public sector health facilities; necessity of community mobilisation of fund for helping the ultra-poor like installation of latrines and tube-wells and cover the expenses of moderate/severe morbidities etc.; financial support for illnesses requiring hospitalization.

Summarising,

1. Integrated methodologies for proper targeting
2. Sensitization of the society (especially elites) to the plight of the ultra-poor
3. Rights based approach to health
4. Consumer information on available services
5. Health counseling to develop awareness (‘unfelt need’ to ‘felt need’)
6. Facilitated access to formal health care services
7. Safety net to mitigate income-erosion effect of illness

6. Conclusion

Reducing poverty through specific targeting of the disadvantaged groups (such as the ultra-poor) with a pro-poor health system in a country with large out-of-pocket payments for healthcare is possible and is urgently needed in Bangladesh. In doing so, it is to be taken into account that,

- a combination of components that includes both health and livelihood protection measures in an intervention would be more effective in meeting the health-related needs of the very poor

- customized, facilitated health interventions are needed to reduce health shock on the way to sustainable livelihood

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