Research Brief Series

MARIE STOPES INTERNATIONAL

Measuring poverty for optimal FP2020 programming

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Summary

The 2012 Family Planning Summit produced a global commitment to scaling up family planning services to reach an additional 120 million girls and women across the world's poorest countries by 2020. Reaching the poor is key to achieving this goal because they inevitably have the highest unmet need for contraception. It is by reaching the poor that family planning service providers will have the biggest impact on contraceptive prevalence and health outcomes such as maternal and child mortality. Assessing the poverty profile of family planning clients is therefore a critical component of tracking progress towards FP2020 goals. In this brief, we describe how Marie Stopes International measures the poverty status of its clients and uses these results to improve women's lives. We also offer recommendations on how other family planning service delivery organisations can learn from our experience and track poverty efficiently and robustly.

Background

In 2012, heads of state and international organisations meeting at the London Family Planning Summit stated their commitment to provide contraceptive services to 120 million additional girls and women in the world's poorest countries by 2020[i]. To achieve this goal, a global partnership known as Family Planning 2020 (FP2020) was established.

The FP2020 goal to reach 120 million additional family planning users emphasises the need for family planning programmes to focus on reaching the poor[ii], as they are least likely to have access to existing contraceptive services and most likely to experience unwanted pregnancies[iii]. Moreover, by reaching the poor, service providers make the greatest contribution to increasing national contraceptive prevalence rates and reducing maternal and child mortality[iv]. Measuring the poverty profile of family planning clients allows service providers to evaluate their effectiveness in reaching this vulnerable and high risk group.

As a key service delivery partner in FP2020, Marie Stopes International provides high-quality, client-centred family planning services to the poor and the underserved in 37 countries. To achieve this core mandate, our programmes use a range of innovative approaches. These include mobile clinical outreach teams which provide free contraceptive services in remote and rural areas, and aim to reach women and men who have limited access to formal healthcare facilities and contraceptives. Other service delivery models include social franchise clinics and our own static clinics. These delivery channels exist predominantly in peri-urban and urban areas, and several of our programmes offer free or subsidised services to the poor through voucher programmes.

In this research brief, we describe how we measure the poverty status of our clients and share highlights of our

Findings at a glance

- Family planning service providers can scientifically measure the poverty profile of their clients and document their contribution towards FP2020 goals.
- We show that mobile clinical outreach programmes reach poor clients most effectively, compared to static and social franchise clinics.
- Our mobile clinical outreach programmes have grown more successful over time and are reaching more poor clients than ever before.

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results from 2011 to 2013. The brief describes how these results are used to improve programming, and offers recommendations for other family planning service delivery organisations to draw from our experience.

Selection of the poverty measurement tool

In 2010, we undertook a thorough review of poverty measurement tools to identify the most appropriate method for measuring the poverty profile of our clients. We are committed to evidence-based programming, and required a robust method to track our performance in this area. The following criteria were identified:

Based on these selection criteria, the Progress out of Poverty Index (PPI) was adopted as our primary poverty assessment tool. However, the PPI is country-specific and has not yet been developed in every country. For those countries without a PPI, the Multi-dimensional Poverty Index (MPI) was chosen as an alternative tool.

Overview of the poverty measurement tools

The PPI was developed by the Grameen Foundation. It consists of a set of 10 country-specific indicators, including household characteristics and asset ownership[v]. The questions, responses and weights for PPI measurement are derived from each country's most recent national household expenditure or income survey. Indicators are selected based on their correlation with poverty, ease of data collection, and likelihood of fluctuation over time as poverty levels change. PPI results show the proportion of clients living below a range of poverty lines, including the World Bank's $1.25 a day and $2.50 a day (purchasing-power parity) and each country's national poverty line[vi]. (For an example, refer to Ghana's PPI in the Appendix.)

Our alternative tool, the MPI, was developed by the Oxford Poverty and Human Development Initiative. It differs from traditional income-based poverty measures in that it captures the different types of deprivation people can face in terms of education, health and living standards[vii]. It uses a set of 10 indicators covering these three main areas of deprivation; an individual is categorised as 'MPI poor' if they are deprived in a third or more of the indicators[viii]. MPI indicators are not country specific.

Methods

Marie Stopes International implements its poverty assessment tool through Client Exit Interview (CEI) surveys, conducted annually by most country programmes across the three key service delivery channels – mobile clinical outreach, static clinics and social franchise clinics. CEI questionnaires are administered to clients after they have received services from Marie Stopes International sites. During the 15-minute interview, clients are asked about their service use, contraceptive history, choice of family planning methods, how they heard about Marie Stopes International, and their socio-demographic characteristics, including poverty questions. We employ two representative sampling approaches for selecting exit interview clients. Where it is possible to visit all facilities, a census of facilities is taken and a minimum of 106 clients are interviewed. Where it is not operationally feasible to visit all facilities, a stratified cluster sampling technique is used, whereby at least 30 sites (which have been sorted by service volume) are randomly selected, and a minimum of 220 clients are interviewed. With both approaches, respondents are selected through systematic random sampling.

In this brief we compared poverty results across delivery channels (mobile clinical outreach, static clinics and social franchise clinics) using data collected between 2011 and 2013. Additionally, the performance of mobile clinical outreach programmes was assessed in eight countries with data available for all three years. We used chi-squared tests and the resultant 95% confidence intervals to assess the significance of differences in the proportions of clients living in poverty, both across programmes and across years of observation.

Findings

This section presents PPI results from 67 surveys conducted over three years in 32 country programmes[2].

Comparison of service delivery channels

Our findings from 2011 to 2013 show that mobile clinical

[2] 11 MSI programmes implemented the PPI in 2011, 18 in 2012 and 20 in 2013.

outreach is the most effective delivery channel for reaching the poor, compared to static clinics and social franchise clinics (Figures 1A, 1B. On average, between 2011 and 2013, 42% of mobile clinical outreach clients were living in extreme poverty (living on less than $1.25 a day) while 75% were living on less than $2.50 a day. Although our static clinics and social franchise clinics had a significantly lower proportion of clients living in extreme poverty, on average half of their clients were living on less than $2.50 a day.

These results suggest that mobile clinical outreach is the most successful delivery channel in reaching the poor. We believe this is largely because it focuses on clients living in rural areas, who are much more likely to be living in poverty than urban clients. In contrast, MSI static clinics and social franchise clinics are mostly based in urban areas which enable them to reach out to the urban poor.

Performance of mobile clinical outreach

To assess how well outreach programmes are reaching the poor, we compared the proportion of clients assessed as poor against the proportion of the national population living in poverty. The results of this comparison are shown in Tables 1A and 1B In this analysis, changes in the performance of outreach programmes were assessed over time in eight countries that had data available for the three years between 2011 and 2013.
In 2011, the proportion of our clients living in extreme poverty significantly exceeded the corresponding proportion of the national population in five of the eight mobile clinical outreach programmes (Table 1B). This suggests that these programmes were effectively reaching out to clients living in extreme poverty. In Sierra Leone, the proportion of clients living in extreme poverty was similar to the proportion in the national population in 2011.

In 2012, four countries experienced a significant drop in the proportion of their clients living in extreme poverty (Table 1A). This was largely due to expansion to new outreach sites in 2012, which were in areas with less concentrated poverty; consequently the proportions of their clients living in extreme poverty were significantly below the proportion in the national population. In Cambodia, India and Philippines, however, the proportion of extremely poor clients significantly exceeded the proportion in the national population in 2012.
There was a general improvement among the eight outreach programmes in 2013, as all programmes' share of poor clients was at least on par with the proportion in the national population. This suggests that all eight outreach programmes were effectively reaching extremely poor clients, with the proportions served ranging from 24% to 73%.

Similarly, the eight MSI mobile clinical outreach programmes were successfully reaching clients living on less than $2.50 a day. Between 2011 and 2013, in most MSI mobile clinical outreach programmes, the proportion of clients living below the $2.50 poverty line was greater than or equal to the proportion in the national population. If the proportion of poor clients fell below the national average, for example in Ghana in 2011 and Tanzania in 2012, it increased in subsequent years.

FIGURE 1A: Proportion of clients living in extreme poverty across delivery channels

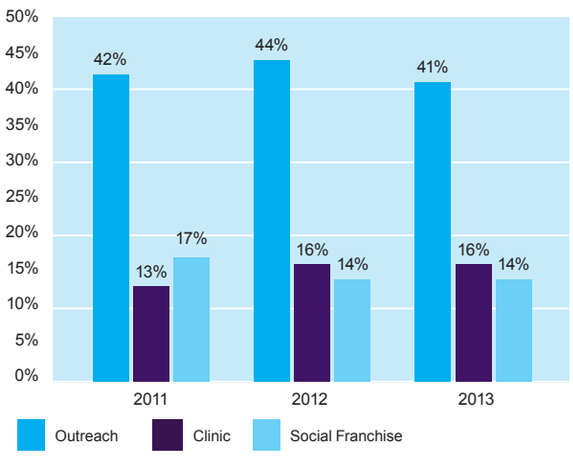
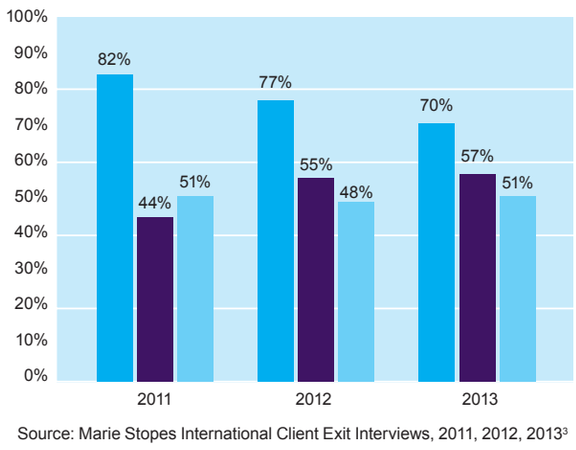


FIGURE 1B: Proportion of clients living below $2.50 a day across delivery channels



Source: Marie Stopes International Client Exit Interviews, 2011, 2012, 2013[3]

[3] The number of countries involved in the calculation of the average poverty rate differed for each channel and also for each of the years. In 2011 for instance, the average for the mobile outreach teams was computed from 12 countries, static clinics from 12 countries and social franchise from four countries. In 2012, the average for outreach was computed from 21 countries, static clinics from 25 countries and social franchise from 10 countries. In 2013, 21 countries contributed to the average for outreach, 23 for static clinics and 14 for social franchises.

TABLE 1A: Effectiveness of outreach programmes in reaching the extremely poor ($1.25 poverty line)

	2011		2012		2013		
Marie Stopes International outreach programmes	% of Marie Stopes International clients below $1.25	National and previous year comparisons	% of Marie Stopes International clients below $1.25	National and previous year comparisons	% of Marie Stopes International clients below $1.25	National and previous year comparisons	% of national population below $1.25
Cambodia	39% CI [33% – 46%]	☺	35% CI [30% – 40%]	☺	25% CI [15% – 40%]	☺	19%
India	64% CI [59% – 69%]	☺	39% CI [34% – 45%]	↓ ☺	41% CI [36% – 46%]	☺	33%
Philippines	26% CI [22% – 29%]	☺	38% CI [33% – 42%]	↑ ☺	24% CI [19% – 29%]	↓ ☺	33%
Ethiopia	38% CI [36% – 40%]	☺	26% CI [23% – 29%]	↓ ☹	34% CI [30% – 38%]	↑ 😐	31%
Ghana	17% CI [14% – 20%]	☹	22% CI [17% – 26%]	☹	29% CI [25% – 33%]	😐	29%
Sierra Leone	49% CI [45% – 53%]	😐	49% CI [43% – 55%]	😐	29% CI [25% – 33%]	😐	52%
Tanzania	71% CI [68% – 74%]	☺	58% CI [55% – 61%]	↓ ☹	73% CI [70% – 76%]	↑ ☹	68%
Uganda	46% CI [43% – 50%]	☺	34% CI [30% – 38%]	↓ 😐	73% CI [70% – 76%]	😐	38%

Source: Marie Stopes International Client Exit Interviews, 2011, 2012, 2013

TABLE 1B: Effectiveness of outreach programmes in reaching the poor ($2.50 poverty line)

	2011		2012		2013		
Marie Stopes International outreach programmes	% of Marie Stopes International clients below $2.50	National and previous year comparisons	% of Marie Stopes International clients below $2.50	National and previous year comparisons	% of Marie Stopes International clients below $2.50	National and previous year comparisons	% of national population below $2.50
Cambodia	81% CI [75% – 86%]	☺	78% CI [75% – 81%]	☺	64% CI [53% – 75%]	↓ 😐	65%
India	-	-	88% CI [86% – 91%]	☺	90% CI [87% – 92%]	☺	81%
Philippines	64% CI [59% – 68%]	☺	77% CI [74% – 79%]	↑ ☺	61% CI [55% – 67%]	↓ ☺	53%
Ethiopia	88% CI [86% – 90%]	☺	80% CI [78% – 82%]	↓ 😐	84% CI [83% – 88%]	↑ ☺	80%
Ghana	52% CI [45% – 59%]	☹	60% CI [56% – 64%]	😐	66% CI [62% – 70%]	😐	64%
Sierra Leone	85% CI [80% – 90%]	😐	87% CI [84% – 90%]	😐	87% CI [82% – 92%]	😐	88%
Tanzania	92% CI [90% – 94%]	😐	73% CI [71% – 75%]	↓ ☹	93% CI [92% – 95%]	↑ 😐	93%
Uganda	85% CI [80% – 89%]	☺	74% CI [70% – 78%]	↓ 😐	76% CI [71% – 82%]	😐	76%

Source: MSI Clients Exit Interview, 2011, 2012, 2013

Key

☹ Proportion of Marie Stopes International's poor clients is significantly less than the proportion of the poor in the national population	😐 Proportion of Marie Stopes International's poor clients is similar to the proportion of the poor in the national population	☺ Proportion of Marie Stopes International's poor clients significantly exceeds the proportion of the poor in the national population	↑ Increase in proportion of poor clients since previous year	↓ Decrease in proportion of poor clients since previous year

Evidence to Action

Putting client insights to use

We measure the poverty status of our clients to inform programming in several ways. First, we assess how well we are delivering against our mandate of providing high-quality family planning services to the poor and underserved. As demonstrated in this brief, we are meeting our mandate of reaching the underserved. Second, we are able to document our progress towards achieving the FP2020 goal. Third, country programmes use their poverty results to inform new strategies such as geographic targeting or demand-side financing to increase impact. Our pro-poor voucher projects, such as those in Marie Stopes Madagascar, have used the PPI or MPI poverty assessment tools to measure their performance (see case study below).

Case study: Marie Stopes Madagascar

In 2010, Marie Stopes Madagascar introduced a special programme which involved the distribution of family planning vouchers to clients (90% poor) at a highly subsidised price (approximately US$0.10). To ensure the programme reached the poor, the voucher distributors administered a poverty assessment tool to potential clients before giving out vouchers.

An assessment of the project in 2011 using the MPI revealed that only 76% of clients were poor. This result engendered the following actions:

- Retraining of voucher distributors to ensure proper administration of the poverty tool
- Compulsory visit to clients' homes to verify their poverty status before giving out vouchers.

In 2012, when a second assessment was carried out, it was found that the percentage of poor clients had increased to 85%. This is a clear demonstration of how MSI uses the poverty assessment tool to ensure we reach the poor and inform programme strategies.

Finally, our clients' poverty results are part of an adjusted Couple Years of Protection (CYP) metric which accounts for CYPs that go towards women living in extreme poverty, adolescents, women not currently using family planning, women choosing to change to a longer-acting method from a short-term one, and women who are receiving family planning after giving birth or having an abortion. The new metric, which we call the high-impact CYP, enables us to adjust our performance management to encompass equity, choice and health impact, in addition to scale. High-impact CYPs are a corporate metric which features in business planning and organisation strategy, supported by a performance management system.

Are you interested in measuring the poverty profile of your clients?

Our experience has demonstrated that family planning service providers can scientifically measure the poverty profile of their clients to quantify their outreach to the poor and track their progress towards FP2020 goals. Family planning service provider organisations who are interested in using the PPI should visit http://www.progressoutofpoverty.org/ for access to all supporting documents, including the poverty assessment tools, free of charge.

The way forward

Marie Stopes International is leading the way in the collection of individual-level client data via a new management information system called the Client Information Centre (CLIC). We are currently exploring the possibility of integrating poverty measurement or proxies into CLIC so that we can collect our clients' poverty data routinely. This will provide timely results on the poverty profile of our clients and help us track our progress towards FP2020 goals.

Limitations

The results presented in this brief were obtained from our CEI Survey. This cross-sectional survey provides only a snapshot, and data are only representative of clients who visited our facilities during the data collection period.

The country programmes contributing to the annual average results for each channel differ from year to year; this may have biased the result such that differences between years or across channels were obscured.

Appendix

Progress out of Poverty Index™ for Ghana

Indicator	Value	Points	Score
1. How many members does the household have?	A. Seven or More B. Six C. Five D. Four E. Three F. Two G. One	0 6 8 11 15 23 31	
2. Are all children ages 5 to 12 in school?	A. No B. Yes, or no children ages 5 to 12	0 4	
3. What is the highest grade completed by the female head/spouse	A. No female head/spouse B. None or pre-school C. Primary or middle D. Any JSS, SSS, S, L, U, or higher	0 4 7 10	
4. Is the main job of the male head/ spouse in agriculture?	A. Male head/spouse has no job B. Yes, main job is in agriculture C. No, main job is not in agriculture D. No male head/spouse	0 8 10 10	
5. What is the main construction material used for the roof?	A. Palm leaves/raffia/thatch, wood, mud bricks/earth, bamboo or other B. Corrugated iron sheets, cement/concrete, asbestos/slate, or roofing tiles.	0 3	
6. What is the main source of the lighting for the dwelling?	A. Not electricity (mains) B. Electricity (mains)	0 5	
7. What is the main source of the drinking water for the household?	A. Borehole, well (with pump or not, protected or not), or other B. River/stream, rain water/spring, or dugout/pond/lake/dam C. Indoor plumbing, inside standpipe, sachet/bottled water, standpipe/tap (public or private outside), pipe in neighbours, water truck/tanker, or water vendor	0 5 7	
8. Does any household member own a working stove (kerosene, electric, or gas)?	A. No B. Yes	0 10	
9. Does any household member own a working iron (box or electric)?	A. No B. Yes	0 6	
10. Does any household member own a working radio, radio cassette, record player, or 3-in-1 radio system?	A. None B. Only radio C. Radio cassette but no records player nor 3-in-1 (regardless of radio) D. Record player but no 3-in-1 (regardless of radio or cassette) E. 3-in-1 radio system	0 2 6 9 14	
Microfinance Risk Management L.L.C.	Total score		

This PPI was updated in March 2010. For up to date PPIs and other information on the Progress out of Poverty Index™ for Ghana and other countries go to www.progressoutofpoverty.org

Further Reading

- Marie Stopes International guidelines for poverty assessment in MSI. Available at [internal access only]: https://bestpractice.mariestopes.org/BPG/Home/DownloadAsset/1451
- Nuccio, O. and Reichwein, B. Understanding clients and achieving FP2020 goals: exit interviews help MSI deliver client-centred services. London: Marie Stopes International, 2013. Available at: https://mariestopes.org/sites/default/files/Understanding-clients-and-achieving%20-FP2020-goals.pdf

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Wumenu, J. Reichwein, B. Ngo, T. Footman, K. Measuring poverty for optimal FP2020 programme targeting. London: Marie Stopes International, 2013.

References:

i Department for International Development. *Family planning: London Summit*: https://www.gov.uk/government/news/family-planning-london-summit-11-july-2012 (accessed 18 May 2014)

ii *Family Planning 2020. Principles to support the goal of reaching 120 million additional women by 2020.* http://www.familyplanning2020.org (accessed 7th November, 2014)

iii Singh, S., Darroch, J., Ashford, L., Vlassoff, M. *Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health.* New York: Guttmacher Institute and UNFPA, 2009

iv Ibid

v Grameen Foundation. *About the PPI.* http://www.progressoutofpoverty.org/about-ppi (accessed 18 May 2014)

vi Ibid

vii Oxford Poverty and Human Development Initiative. *The Multidimensional Index.* http://www.ophi.org.uk/research/multidimensional-poverty/ (accessed 19 May 2014)

viii Ibid

ix Fry, K., Weinberger, M., Marin, C., Nuccio, O., Reichwein, B. *Adding equity into our metrics: MSI's new High Impact CYPs.* In: International Family Planning Conference, Addis Ababa, Ethiopia, November 2013