



IPPF

Western Hemisphere Region

From choice, a world of possibilities

Are we Serving the Poor?

Analyzing Client Economic Profile at IPPF/WHR

Are we serving the poor?
Analyzing Client Economic Profile at IPPF/WHR

Executive Summary

While extreme poverty is lower in Latin America than in other parts of the world, limited progress has been made towards its reduction. According to a 2002 report by the United Nations entitled "Meeting the Millennium Poverty Reduction Targets in Latin America and the Caribbean," at the current pace, 11 of the region's 18 countries will fail to reach their poverty reduction targets by 2015.

Inability to pay as well as other complex mitigating factors of poverty, operate as barriers to accessing health services, including basic sexual and reproductive health services, prenatal care, HIV prevention and care, and emergency and specialized obstetric care. Consequently, unmet need for such services is high across the region. For example, in Latin America, though unmet demand for contraceptives was reduced by 5 percent over the decade of the 1990s, when the richest 20 percent and the poorest 20 percent of the population in the region are compared, a sharp difference emerges. For example, total fertility rates remain high or very high among the poorest 20 percent of the population. In Guatemala, the fertility rate among poor women is 8 children per woman (versus 2.4 among wealthy women); and even in Brazil the fertility rate for poor women is more than double that of wealthy women (4.8 children per woman versus 1.7).⁷

Though the urgency to reach the poor and extremely poor has been identified at the highest levels of the international development policy arena, historical tensions among competing ideologies and a general shift in priorities of international donors must be mentioned to truly appreciate the myriad challenges in serving the region's poorest. Additionally, the failure of governments to provide access to services for the poor was manifest in most Latin American and Caribbean countries, no matter what the structure of their national health systems. The health systems vary in nature from highly fragmented, market-oriented (predominantly private) health systems, as in the cases of Guatemala and Mexico, to national social insurance systems (NHIS) in Colombia and Brazil that have a greater degree of participation by public sector institutions (Ministry of Health and social security) in the provision of healthcare.⁹ In each country, though, government efforts and funding have been insufficient, leaving a large share of the poor and vulnerable with no access to health care services.

Rationale for Conducting Analysis of Client Profile in IPPF/WHR

Amidst the backdrop of the development agenda, trends, and tensions, it was important for IPPF/WHR to assess the extent to which services provided in the Latin America and Caribbean region are reaching the poor and extremely poor. Many of IPPF/WHR's large Member Associations are both service providers and highly sustainable organizations. So, this meta-analysis was also conducted to better understand the relationship between sustainability and reaching the poor.

Participating Member Associations

The IPPF/WHR Member Associations (MAs) included in the analysis were BEMFAM/Brazil, PROFAMILIA/Colombia, APROFAM/Guatemala, and MEXFAM/Mexico. Together these MAs provide 76% of the services provided by IPPF/WHR Member Associations.^a (See Annex 1 for Complete Profiles of Participating Member Associations)

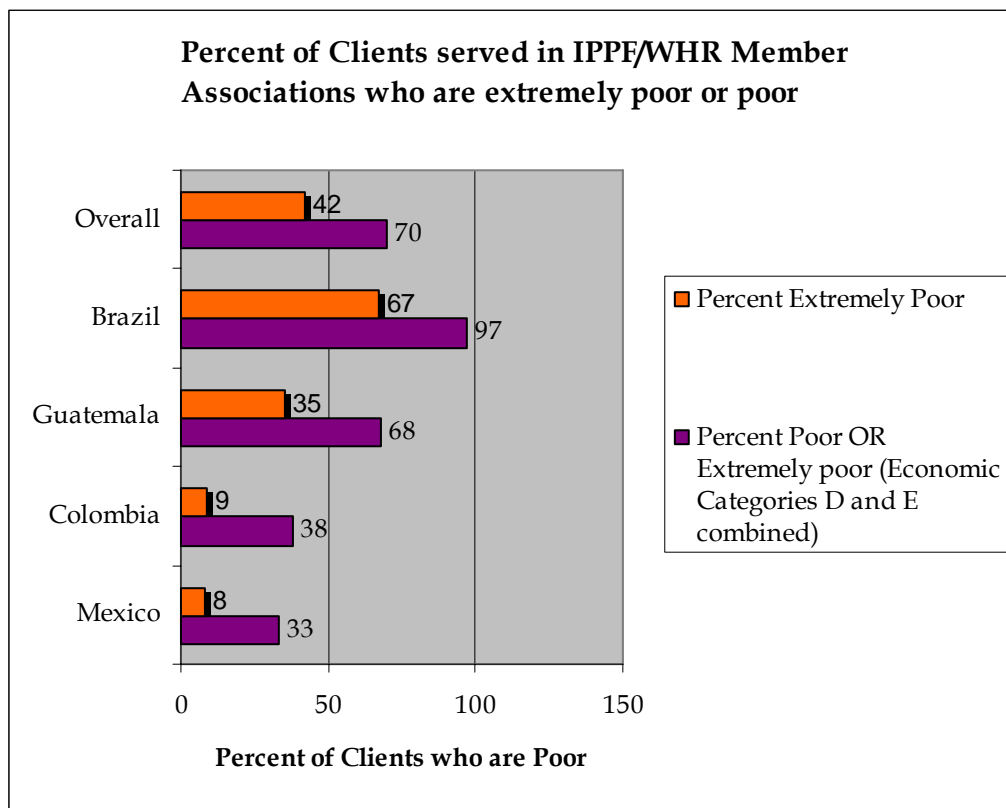
^a This includes only its grant-receiving MAs which are in Latin America and the Caribbean, excluding the MAs in the US and Canada.

Results

The analysis reveals that over 40% of services reported by Member Associations (representing 76% of WHR service volume) are provided to the *extremely poor* and over 69% of services are provided to the *poor^b* and/or *extremely poor^c*, as defined by national standards in each country. While the methodology utilized by each country to determine economic profile is not identical in each study, for the most part they are similar enough to be grouped and used for the purposes of this analysis. Additionally, though there is variability in terms of the population size across countries, the analysis still demonstrates the extent to which the poor are reached, relative to the situation within each country.

The graph below illustrates the individual country economic profiles and the weighted average of the four countries.

Graph 1: Comparison of the client economic profile in select IPPF/WHR Member Associations with the WHR Regional weighted average.



Overall, this meta-analysis reveals that a large percentage (42%) of services reported by WHR Member Associations are provided to the extremely poor. An even larger percentage (70%) of services are provided to poor clients (economic levels D&E).

^b Poor refers to clients in economic level D that corresponds to national categories of household income

^c Extremely poor refers to clients in economic level E that corresponds to national categories of household income

For BEMFAM/Brazil, which represents 38% of IPPF/WHR's reported service delivery, the results of its client profile study demonstrated the following:

- An overwhelming 97% of clients reached through BEMFAM's contracts^d with clinics fall into either the extremely poor (67%) or poor categories (30%).
- The proportion of clients reached through BEMFAM affiliated clinics that qualify as extremely poor (67%), is much higher than the proportion of extremely poor on the national level (4%). It is clear that BEMFAM specifically targets its services to the needs of the poor.

For MEXFAM/Mexico, which represents 21% of the WHR reported service delivery, the results of its client profile study demonstrated the following:

- 33% of clients reached through MEXFAM's clinics fall into the poor (25%) or extremely poor (8%) categories.
- Although extreme poverty is higher on a national level (22%) than reflected in MEXFAM's client mix (8%), it is important to note that MEXFAM's mobile health services were not included in the analysis. Furthermore, data for Mexico City were used as a proxy for national data, which would also skew the analysis toward a higher rate of extreme urban poverty.

For APROFAM/Guatemala, which represents 7% of IPPF/WHR's reported service delivery, the results of its client profile study demonstrated the following:

- An overwhelming 68% of clients reached through APROFAM's clinics fall into either the extremely poor (35%) or poor categories (33%).
- While 17% of households qualify as extremely poor on the national level, a greater proportion of APROFAM's clients (35%) qualify as extremely poor. This underscores APROFAM's efforts in improving access to high quality services for the poor. It is especially noteworthy because the programs that explicitly focus on targeting the rural poor and extremely poor, such as mobile health units, are not included and represent an underestimate of the total proportion of APROFAM clients that are extremely poor.

For PROFAMILIA/Colombia, which represents 10% of IPPF/WHR's reported service delivery, the results of its client profile study demonstrated the following:

- Overall, 29% of clients had basic needs unmet (while the national proportion is 22.4 in the same year). Based on the index of basic unmet needs, clients that were categorized as extremely poor were 9% of PROFAMILIA clients, consistent with the proportion of extremely poor people in Colombia.
- The study implemented by PROFAMILIA provided data on economic status by rural and urban zones. This revealed a much greater poverty in rural areas, with 68% of clients having basic needs unmet (compared to 29% among urban clients); and 38% of rural clients living in "extreme poverty" (compared to 9% among urban clients).
- PROFAMILIA is reaching the poorest populations in rural areas. While 68% of PROFAMILIA's rural clients have basic needs unmet, only 23% of the rural population nationally has basic needs unmet. Similarly, while 38% of PROFAMILIA's rural clients live in "extreme poverty", 33% of the national rural sample live in "extreme poverty."

^d Because BEMFAM reports service data from their contracts with government clinics, which they oversee and administrate, the study was conducted to reflect clients from these government clinics in addition to BEMFAM owned and operated clinics. Specifically, BEMFAM provides technical assistance, quality of care oversight, supplies, and training for the government clinics with which they have contracts.

Services to the Poor-The Global Analysis

- 70% (weighted average) of the total clients are poor or extremely poor, falling in the bottom two quintiles/lowest 40% (strata D and E)
- 42% (weighted average) of services delivered in the region are to the *extremely poor*^e (See Annex 2 for calculations)

Conclusions

This meta-analysis has provided the important initial first step for IPPF/WHR to begin lending insight to the question: *Are we serving the poor?* Since the results actually represent an underestimate of poor populations reached by the Member Associations, it is likely that greater than 69% of MA clients are poor and/or extremely poor. Furthermore, since the MAs included in this study represent the largest service providers (providing 76% of total service volume for IPPF/WHR), it can be concluded that as a region, IPPF/WHR is reaching the poor and very poor. This, in turn, means that Member Associations in the IPPF/WHR region are making an important contribution to poverty reduction through addressing unequal access to health care, particularly primary and preventative care.

The implications for IPPF/WHR programs and policies are that these results can be shared with donors to illuminate the landscape on the ground, especially because there is some skepticism about the ability of service providing organizations to balance sustainability and serving the poor. It is particularly essential for IPPF/WHR MAs to demonstrate that they indeed contribute to poverty reduction given the high levels of inequity in Latin America. Importantly, IPPF can also learn from the strategies utilized by the Member Associations included in this study, in terms of financing pro-poor strategies.

Additionally, the analysis generates questions for future study. That is, it has been established that the Member Associations included in this study are reaching the poor and extremely poor and are concomitantly highly sustainable organizations. The relationship between sustainability and reaching the poor should be further investigated in order to answer several pressing questions. Is it because these are highly sustainable organizations, that they can finance services to the poor at the level that they do? Has serving the poor and meeting the service delivery needs of their respective country made given these MAs a comparative advantage that has translated to increased funding? What is the relationship between a Member Association's client profile and health sector reform?

^e This assumes (a) that services per client are constant by country and (b) that the number of services used per person is the same for poor and non poor clients once access is gained.

Background

Persistent Inequities in Access to Health Care

While extreme poverty is lower in Latin America than in other parts of the world, limited progress has been made towards its reduction. According to a 2002 report by the United Nations entitled "Meeting the Millennium Poverty Reduction Targets in Latin America and the Caribbean," at the current pace, 11 of the region's 18 countries will fail to reach their poverty reduction targets by 2015.³

Just as insidious as poverty itself, however, is income inequality. Specifically, the Inter-American Development Bank notes that income inequality in Latin America and the Caribbean is strongly correlated with unequal access to health services.⁴ In most countries of the Latin America and Caribbean region, among the poorest quintile of the population, fewer than 40 percent of people have any kind of health insurance coverage, a crucial social support that is available to many at higher income levels. Development efforts, while they aim to address these inequities, often fall short. As Jeffrey Sachs, Director of Columbia University's Earth Institute and Special Advisor to the Secretary General of the United Nations, has noted, development efforts often don't reach the extremely poor: "Even when governments spend large sums on health and education...they spend little of it on poor people."⁵ Indeed, the Pan-American Health Organization (PAHO) study analyzing health care systems in Guatemala, Brazil, and Mexico, found significant pro-rich inequities in access.⁶ In most countries, direct out-of-pocket expenditures are a main source of financing for the national health care system. Inability to pay is a major hindrance for poor people who wish to access health services, preventing millions of people from receiving basic sexual and reproductive health services, prenatal care, HIV prevention and care, and emergency and specialized obstetric care.

Consequently, unmet need for such services is high across the region. For example, in Latin America, though unmet demand for contraceptives was reduced by 5 percent over the decade of the 1990s, when the richest 20 percent and the poorest 20 percent of the population in the region are compared, a sharp difference emerges. For example, total fertility rates remain high or very high among the poorest 20 percent of the population. In Guatemala the fertility rate among poor women is 8 children per woman (versus 2.4 among wealthy women; and even in Brazil the fertility rate for poor women is more than double that of wealthy women (4.8 children per woman versus 1.7) .⁷

This highlights the issue of access to sexual and reproductive health services and information for the poor as well as the health consequences and their sequelae, including unintended pregnancy, maternal death, HIV infection, untreated consequences of sexual violence - intimately linked to poverty. Therefore, greater investment in sexual and reproductive health services and information, designed to reach the poorest, is paramount.

Trends in Global Development: Health Care Reform, Organizational Sustainability, and Poverty Reduction

Though the urgency to reach the poor and extremely poor has been identified at the highest levels of the international development policy arena, historical tensions among competing ideologies and a general shift in priorities of international donors must be mentioned to truly appreciate the myriad challenges in serving the region's poorest.

Services for the poor have often found themselves buffeted by two trends vying for prominence in the global development sphere: on the one hand, efforts to increase organizational sustainability which often follow health sector reform and on the other hand, efforts towards poverty reduction (of which the Millennium Development Goals (MDGs), the United Nation's plan

to eradicate poverty, are emblematic). The first argues that the immediate priority of aid efforts should be to increase the stability of organizations by helping them become financially self-sufficient. The second proposes that reducing poverty should be the more proximal priority.

In practice, tensions between these two prevailing notions of development have complicated service-providing organizations' ability to serve the poorest. Simply, reaching the poor is often resource intensive, with the poor generating little market force, despite high demand. Organizations that reach and serve the poor, then, rely heavily on international donors as a dominant strategy for subsidizing health care delivery. Consequently, sustainability efforts aimed at reducing the reliance on donations are fundamentally at odds with efforts to serve the poorest.

In an effort to develop a systematic approach that addressed structural aspects of access to health care, health sector reform began to take shape. The original intent of health sector reform was to encourage governments to invest in access to SRH services for the general population in their countries, with an emphasis on securing access for the poorest segments of their population who had no other recourse to health care. In many countries, however, government efforts were spotty and the results underwhelming.

Governments' failure to provide access to services for the poor was manifest in most Latin American and Caribbean countries, no matter what the structure of their national health systems. The health systems vary in nature from highly fragmented, market-oriented (predominantly private) health systems, as in the cases of Guatemala and Mexico, to national social insurance systems (NHIS) in Colombia and Brazil that have a greater degree of participation by public sector institutions (Ministry of Health and Social Security) in the provision of healthcare.⁹ In each country, though, government efforts and funding have been insufficient, leaving a large share of the poor and vulnerable with no access to health care services.

Partly as a recognition of the inability of governments to provide basic services, global development efforts turned to focus on poverty reduction, which culminated in the creation of the MDGs. International donors picked up the charge, directing their funds to organizations that were making strides towards poverty reduction. This often led them to decrease funding in Latin America and the Caribbean and favoring organizations that explicitly pursued poverty reduction strategies, believing that their aid dollars would be better spent in less developed countries on other continents. The dwindling pool of funds available to Latin American and Caribbean institutions left many struggling for survival and forced them to reconsider their financial strategies. This created a dilemma for International Planned Parenthood Federation's Member Associations: should they focus on financial sustainability, which would allow them to withstand the dramatic decreases in funding that were common across the region, or should they pursue poverty reduction strategies by serving poor clients, hoping to secure sufficient donations to pay the cost?

History of Sustainability Efforts at IPPF

Historically, IPPF and its Member Associations have filled the gaps that persist despite health care reform, providing high-quality sexual and reproductive health services to those who cannot pay. But, mirroring the global trends, many of IPPF's funding efforts and that of its donors in the last decade have prioritized sustainability efforts—efforts designed to wean organizations off international development aid and increase the income they can generate locally. In order to increase their financial sustainability, Member Associations turned to a variety of strategies. Many chose to offer diversified services (non-SRH services such as dentistry, ophthalmology, and imaging services) for which they could charge more and derive a profit; others marketed their services to a population who could afford to pay for them; while others utilized these strategies in conjunction with subsidized services for the poor. Today,

IPPF's definition of sustainability emphasizes a holistic and interactive nature of the components of sustainability, and include programmatic (technical), organizational (infrastructure) as well as financial (financing strategies for programs).¹⁰ However, operationalizing this concept to ensure a measurable link between sustainability and social mission is a continued challenge.

Rationale for Conducting Analyses of Client Profile in IPPF/WHR

Amidst the backdrop of the development agenda, trends, and tensions, it was important for IPPF/WHR to assess the extent to which services provided in the Latin America and Caribbean region are reaching the poor and extremely poor. Many of IPPF/WHR's large Member Associations are both large service providers and highly sustainable organizations. So, this meta-analysis was also conducted to better understand the relationship between sustainability and reaching the poor.

Participating Member Associations

The IPPF/WHR Member Associations (MAs) included in the analysis were BEMFAM/Brazil, PROFAMILIA/Colombia, APROFAM/Guatemala, and MEXFAM/Mexico. Together these Member Associations provide 76% of the services provided by IPPF/WHR Member Associations.^f (See Annex 1 for Complete Profiles of Participating Member Associations)

Methodology

Summary

In order to assess client economic profiles across the region, IPPF/WHR conducted a meta-analysis⁹, compiling existing client profile studies from its largest service providers. The studies included in these analyses represent IPPF/WHR Member Associations (and public clinics in Brazil^h) which provide an overwhelming majority of services (76%) in the region. Prior to conducting the meta-analysis, the methodologies used in each country study were assessed for comparability. Once comparability was determined, data were quantitatively summarized; this included a sensitivity analysis to demonstrate how inclusion of data from each country contributes to the summarized data. The summarized analysis reports on the proportion of poor and extremely poor that Member Associations reach through their clinics.

Overall, the MA's studies had similar approaches to sampling (of sites and participants), data collection, and selected economic indicators for client profile. All studies were clinic based, and did not include Member Association clients reached through strategies such as mobile health units or community based distribution of contraception, information and/or education. There were differences in sample size, ranging from 801 to 7,800 participants as well as differences in the duration and year of implementation (duration of 1 month to 3 months, and years 2000 to 2004).

^f This includes only its grant-receiving MAs which are in Latin America and the Caribbean, excluding the MAs in the US and Canada.

⁹ A meta-analysis can be defined as "a statistical synthesis of the data from separate but similar, i.e., comparable studies, leading to a quantitative summary of the pooled results...The aim is to integrate the findings, pool the data, and identify the overall trend of results."¹¹

^h Because BEMFAM reports service data from their contracts with government clinics, which they oversee and administrate, the study was conducted to reflect clients from these government clinics in addition to BEMFAM owned and operated clinics. Specifically, BEMFAM provides technical assistance, quality of care oversight, supplies, and training for the government clinics with which they have contracts.

The client economic profile data were weighted by service volume in each country to attain the weighted averageⁱ for economic level E (the extremely poor), as well as the weighted average for economic levels D and E (the poor and extremely poor). Service volume is related to the number of poor or extremely poor served, and therefore was used as the weighting factor.

The key economic indicators analyzed include, (1) total percent of clients served by the Member Association that fall in the lowest economic level (E), by country and (2) total percent of clients that are in economic levels (D and E). Given differences in service provision among the MAs represented in the analysis, the percent of clients in each country in level E were weighted by service volume to produce a weighted average of level E for the four countries.

Sampling

Site Selection and Sample Size: The studies in Guatemala and Colombia included all of their clinical sites for the study. In Mexico and in Brazil, a representative sample of sites was included. MEXFAM carried out the survey with twelve of their twenty sites. In Brazil, both of BEMFAM's own clinics and the public clinics with which it is affiliated were included. Ten clinics were selected from nine areas (representing 11 states) in which BEMFAM works, for a total of ninety government clinics. Additionally, data from a separate study of six BEMFAM-run clinics (non-public) in Brazil were included.

Participant selection and Sample Size: All studies utilized stratified-sampling for selecting study participants. Clients were selected in proportion to type of service (contraceptive, other SRH, and/or diversified). The total sample size for the global analysis was 15, 510, with a range of 801 (in Mexico) to 7,800 (in Colombia), and median of 3,878. Demographic distribution of participants in each study was similar in terms of gender, being highly skewed toward women (99.4% in Guatemala to 70% in Mexico). The average age of participants ranged from 25-30^j. The majority were in union^k (59% in Mexico to 89% in Guatemala).

Survey Administration: In all country studies the client profile survey was administered by face-to-face interview. All studies were carried out during a period of one month to three months, with Mexico and Colombia implementing the study during a one month period, Guatemala over two months, and Brazil over three months.

Economic Measures

All of the country studies (except Colombia) reported on national economic levels (A-E) -based on household income. Each country has nationally defined levels that may or may not be equivalent to one another. That is, populations that reflect the earning power in economic level E for one country may not have equal earning power when compared to economic level E in another country. One available study, which provided a comparison between Mexico and Brazil, was used to formulate strata between these two countries to test the robustness of the weighted averages.¹³

In Colombia, PROFAMILIA based the economic/poverty indicator for their client profile study on an index of Basic Unmet Need^l. The index included the following categories: (a) households without basic services (water, plumbing), (b) households with inadequate housing conditions, (c) households with high economic dependence, (d) households with children between ages 7-11 who don't attend school, and (e) households exceeding allowed occupancy. Each of these

ⁱ A weighted average is "a value determined by assigning weights to individual measurements. Each value is assigned a non-negative coefficient (weight); the sum of the products of each value by its weight divided by the sum of the weights is the weighted average."¹²

^j Age data not available for Guatemala

^k Data on conjugal status not available for Colombia and Brazil

^l Based on a methodology used by the National Department of Statistics

categories includes at least two variables that correspond to a specific unmet need. Households with basic needs unmet were defined as having one or more needs unmet. Households in “extreme poverty” were defined by those as having two or more needs unmet. For the purposes of this analysis, the households in “extreme poverty” were comparable to category E in other countries and those with basic needs unmet were comparable to the next to lowest category (D/D+).

Limitations

Assumptions

There were a variety of assumptions that were made in these analyses, including the following:

- *The national economic levels defined by each country are comparable^m.* While the participating Member Associations did not use the exact same indicators, they did share a working notion of poverty, defined as the inability to live relatively comfortably; however, the amount of money, goods, and services needed to do so de-facto vary from country to country. The argument that comparisons of countries, even from one region, are invalid,¹⁵ is based on the premise that regional criteria exist or can be developed in the near future, despite formidable challenges. Indeed, regional criteria would be advantageous. Nevertheless, until these regional criteria are developed, tested, and are shown to be robust over time, individual country classifications, most often developed in collaboration between the countries’ leading statistics and economics institutes, are the mode of choice. A review of the economic levels and the methods of determining these groups were performed. Based on this review, the decision was made to allow comparisons of the countries using their internal classifications.
- *The country studies are comparable despite implementation over differing timeframes.* Survey implementation varied between one and three months. Type of service delivery, which affects the probability of a client entering the client profile survey, does not vary greatly from month to month, thus the differing implementation durations should not affect study results. Different years of implementation may have an impact on results due to economic fluctuations. A cumulative meta-analysis¹⁴ of the weighted average of the very poor using IPPF Member Association clinics, in which studies are added by year, was performed (see Results). Results showed stability over time, with the greatest fluctuation from the Brazilian data, as these data included a high percentage of the very poor.
- The unit analyzed in the client profile study in each country is the individual, while the weighted average used number of services (not number of individuals served) by each country. This assumes that each client uses about the same number of services in each country and that poor and non poor clients use the same number of services.
- The analysis assumes that BEMFAM’s data, though based largely on services provided through its contracts with public clinics, are comparable to the data from the other countries that report service data through their own clinics.
- Selection bias in the study is minimal. The percentage of non-respondents for each country’s client profile study was not tracked or quantified. Previous experience with studies conducted by IPPF shows, however, that clients of IPPF/WHR Member Associations overwhelmingly respond to these sorts of face-to-face interviews.

^m Comparability of income distribution is affected by the heterogeneity of indicators included in household surveys in different countries. This also prevents reliable transfer (of what?) into one currency.

Generalizability

Although the four countries included in the analysis are the largest service providers in the region, accounting for 76% of IPPF/WHR Member Association services, the profiles of these clients may not be entirely generalizable to the rest of the region.

- While perhaps representative of Central and South America, this sample does not include affiliates in the Caribbean.
- The analysis represents four of 34 grant recipients of IPPF/WHR.
- Member Association countries with smaller service volumes or weaker infrastructures may not have had the opportunity to conduct client profiles in part because of lack of necessary resources (financial or human) and necessary attention to service provision. These Member Associations with smaller service volume may well have clients with different economic profiles, both for the country as a whole and for those served by IPPF Member Associations.
- Furthermore, it could be argued that due to the large size of the participating MAs, they are more capable of providing and subsidizing services to the poor, particularly in the case of Brazil. Smaller organizations with fewer resources might find such cross-subsidization impossible. Client profile and financing strategies were not correlated for this study.

Results

The analysis reveals that over 40% of services reported by Member Associations (representing 76% of WHR service volume) are provided to the *extremely poor* and over 69% of services are provided to the *poor and/or extremely poor*, as defined by national standards in each country. While the methodology utilized by each country to determine economic profile is not identical in each study, for the most part they are similar enough to be grouped and used for the purposes of this analysis. That is, data collected by all countries, except Colombia, use socio-economic stratification that is based on household income and can be grouped as high, middle and low—with low representing the poor (class D) and extremely poor (class E). While there is variability in terms of the population size across countries (a large proportion of people may belong to class E as defined by country A, but those same people might belong to class D if they had lived in country B, or the poor in country A may be poorer than in country B), the analysis still demonstrates the extent to which the poor are reached, relative to the situation within each country.

For BEMFAM/Brazil, which represents 38% of IPPF/WHR's reported service delivery, the results of its client profile study demonstrated the following:

- An overwhelming 97% of clients reached through BEMFAM's contracts with clinics fall into either the extremely poor (67%) or poor categories (30%).
- The proportion of clients reached through BEMFAM affiliated clinics that qualify as extremely poor (67%), is much higher than the proportion of extremely poor on the national level (4%). It is clear that BEMFAM specifically targets its services to the needs of the poor.

For MEXFAM/Mexico, which represents 21% of the WHR reported service delivery, the results of its client profile study demonstrated the following:

- 33% of clients reached through MEXFAM's clinics fall into the poor (25%) or extremely poor (8%) categories.
- Although extreme poverty is higher on a national level (22%) than reflected in MEXFAM's client mix (8%), it is important to note that MEXFAM's mobile health services were not included in the analysis. Furthermore, data for Mexico City were used as a proxy for national data, which would also skew the analysis toward a higher rate of extreme urban poverty.

For APROFAM/Guatemala, which represents 7% of IPPF/WHR's reported service delivery, the results of its client profile study demonstrated the following:

- An overwhelming 68% of clients reached through APROFAM's clinics fall into either the extremely poor (35%) or poor categories (33%).
- While 17% of households qualify as extremely poor on the national level, a greater proportion of APROFAM's clients (35%) qualify as extremely poor. This underscores APROFAM's efforts in improving access to high quality services for the poor. It is especially noteworthy because the programs that explicitly focus on targeting the rural poor and extremely poor, such as mobile health units, are not included and represent an underestimate of the total proportion of APROFAM clients that are extremely poor.

For PROFAMILIA/Colombia, which represents 10% of IPPF/WHR's reported service delivery, the results of its client profile study demonstrated the following:

- Overall, 29% of clients had basic needs unmet (while the national proportion is 22.4 in the same year). Based on the index of basic unmet needs, clients that were categorized as extremely poor were 9% of PROFAMILIA clients, consistent with the proportion of extremely poor people in Colombia.
- The study implemented by PROFAMILIA provided data on economic status by rural and urban zones. This revealed a much greater poverty in rural areas, with 68% of clients having basic needs unmet (compared to 29% among urban clients); and 38% of rural clients living in "extreme poverty" (compared to 9% among urban clients).
- PROFAMILIA is reaching the poorest populations in rural areas. While 68% of PROFAMILIA's rural clients have basic needs unmet, only 23% of the rural population nationally has basic needs unmet. Similarly, while 38% of PROFAMILIA's rural clients live in "extreme poverty", 33% of the national rural sample live in "extreme poverty".

Services to the Poor-The Global Analysis

- 70% (weighted average) of the total clients are poorⁿ or extremely poor^o, falling in the bottom two quintiles/lowest 40% (strata D and E).
- 42% (weighted average) of services delivered in the region are to the *extremely poor*.^p (See Annex 2 for calculations)

Services to the Poor-The Global Analysis

- 70% (weighted average) of the total clients are poor or extremely poor, falling in the bottom two quintiles/lowest 40% (strata D and E).
- 42% (weighted average) of services delivered in the region are to the *extremely poor*.^q (See Annex 2 for calculations)

n Poor refers to clients in economic level D that corresponds to national categories of household income

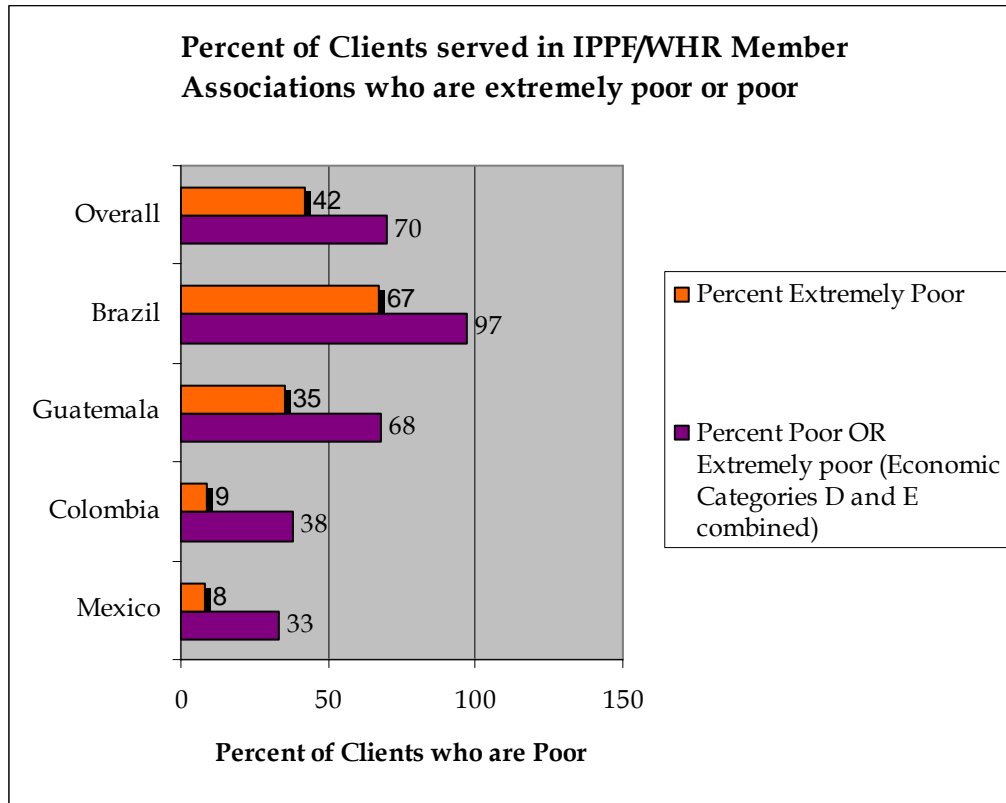
o Extremely poor refers to clients in economic level E that corresponds to national categories of household income

p This assumes (a) that services per client are constant by country and (b) that the number of services used per person is the same for poor and non poor clients once access is gained.

q This assumes (a) that services per client are constant by country and (b) that the number of services used per person is the same for poor and non poor clients once access is gained.

The graph below illustrates the individual country economic profiles and the weighted average of the four countries.

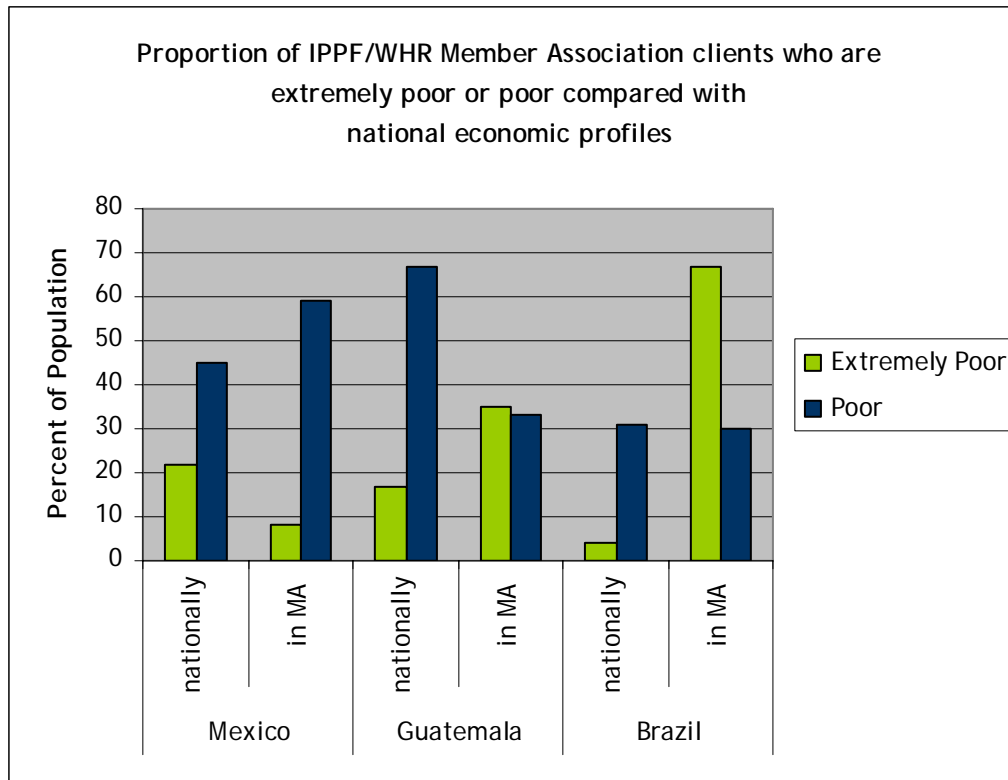
Graph 1: Client economic profile in IPPF/WHR Member Associations, by select countries and regional weighted average



Overall, this meta-analysis reveals that a large percentage (42%) of services reported by WHR Member Associations are provided to the extremely poor. An even larger percentage (70%) of services are provided to poor clients (economic levels D&E).

In addition, the graph below presents further detail related to the economic levels to which the MA clients belong, by country. National proportion of people pertaining to each economic level is also included for comparison. This comparison provides further insight into whether the client profile is a reflection of the national distribution or whether MA client mix is skewed in one direction or another in terms of economic profile.

Graph 2: Economic profile of IPPF/WHR Member Association Clients, in comparison with the national profile



In Brazil, which represents 38% of the WHR reported service delivery, the results of their client profile studies demonstrated the following:

- An overwhelming 97% of clients reached through BEMFAM’s contracts with clinics fall into either the extremely poor (67%) or poor categories (30%).
- The proportion of clients reached by BEMFAM affiliated clinics that qualify as extremely poor (67%), is much higher than the proportion of extremely poor on the national level (4%). It is clear that BEMFAM specifically targets their services to the needs of the poor.
- Client profiles differed by state in Brazil, and in each the number of interviews was proportionate to the state service delivery volume. This sampling strategy gave more weight to those states with higher service delivery. In the case of Brazil, this amounted to more clients from Rio de Janeiro being profiled, which happened to have a high proportion of clients in E.S.C (and approximately four times as many E.S.D, the poor, as E.S.E, the extremely poor). This in turn actually masks the overwhelming attention to the poor which is seen in client profiles from the more northern and less favored states. (“Brazil data”—Table 11, pg. 60)
- IPPF/WHR operates in Brazil through BEMFAM’s associated (public) clinics and Member Associations. These associated clinics accounted for 99.38% of BEMFAM’s service delivery in 2003. The associated clinics serve far more poor and very poor clients than do the MAs. Because of the marked difference in service delivery volume by clinic type, the results for the economic stratifications were weighted and then pooled.[†]

[†] Calculations based on 99% associated (public) and 1% M.A, assuming the 1% service delivery equally distributed across economic strata:

In Mexico, which represents 21% of the WHR reported service delivery, the results of their client profile study demonstrated the following:

- Of clients reached through MEXFAM's clinics, 33% fall into either poor (25%) or the extremely poor (8%) categories.
- Although extreme poverty is higher on a national level (22%) than reflected in MEXFAM's client mix (8%), it is important to note that MEXFAM's mobile health services were not included in the analysis. Furthermore, data for Mexico City were used as a proxy for national data, which would also skew the analysis toward a higher rate of extreme urban poverty.

In Guatemala, which represents 7% of the IPPF/WHR reported service delivery, the results of their client profile study demonstrated the following:

- An overwhelming 68% of clients reached through APROFAM's clinics fall into either the extremely poor (35%) or poor categories (33%).
- While 17% of households qualify as extremely poor on the national level, a greater proportion of APROFAM's clients (35%) qualify as extremely poor. This underscores APROFAM's successful efforts to improve access to high quality services for the poor. It is especially noteworthy because the programs that explicitly focus on targeting the rural poor and extremely poor, such as mobile health units, are not included. Therefore this represents an underestimate of the total proportion of APROFAM clients that are extremely poor.

In Colombia, which represents 10% of IPPF/WHR Member Association reported service delivery, the results of their client profile study demonstrated the following:

- Overall, 29% of clients had basic needs unmet (while the national proportion is 22.4 in the same year). Based on the index of basic unmet needs, clients that were categorized as extremely poor were 9% of PROFAMILIA clients, consistent with the proportion of extremely poor people in Colombia (9% are extremely poor nationally).
- The study implemented by Colombia provided data on economic status by rural and urban zones. This revealed a much greater poverty in rural areas, with 68% of clients having basic needs unmet (compared to 29% among urban clients); and 38% of rural clients living in "extreme poverty" (compared to 9% among urban clients).
- PROFAMILIA is reaching the poorest populations in rural areas. While 68% of PROFAMILIA's rural clients have basic needs unmet, only 23% of the rural population nationally has basic needs unmet. Similarly, while 38% of PROFAMILIA's rural clients live in "extreme poverty," 33% of the national rural sample live in "extreme poverty".

(For Results of the Sensitivity Analysis please consult Annex 3)

Conclusions

This meta-analysis has provided the important initial first step for IPPF/WHR to begin lending insight to the question: *Are we serving the poor?* Since the results actually represent an underestimate of poor populations reached by the Member Associations, it is likely that greater than 69% of MA clients are poor and/or extremely poor. Furthermore, since the MAs included in this study represent the largest service providers (providing 76% of total service volume for IPPF/WHR), it can be concluded that as a region, IPPF/WHR is reaching the poor and very poor.

$$\begin{aligned} \text{Economic levels D and E} &= [(M.A. \text{ Economic level D } 47.7\% + \text{Economic level E } 23.3\%) \times \\ &1\%] + (\text{Associated Economic levels D + E } 97\% \times 99\%) = 0.71\% + 96.03\% = 96.74\% \\ \text{Economic level E} &= (M.A. \text{ S.E. E } 23\% \times 1\%) + (\text{associated Economic level E } 67.4\% \times 99\%) = \\ &0.23\% + 66.73\% = 66.96\% \end{aligned}$$

This, in turn, means that Member Associations in the IPPF/WHR region are making an important contribution to poverty reduction by addressing unequal access to health care, particularly primary and preventative care.

The implications for IPPF/WHR programs and policies are that these results can be shared with donors to illuminate the landscape on the ground, especially because there is some skepticism about the ability of service providing organizations to balance sustainability and serving the poor. It is particularly essential for IPPF/WHR Member Associations to demonstrate that they indeed contribute to poverty reduction given the high levels of inequity in Latin America. Importantly, IPPF can also learn from the strategies utilized by these organizations, in terms of financing pro-poor strategies.

Additionally, the analysis generates questions for future study. That is, it has been established that the Member Associations included in this study are reaching the poor and extremely poor and are concomitantly highly sustainable organizations. The relationship between sustainability and reaching the poor should be further investigated. Is it because these are highly sustainable organizations, that they can finance services to the poor at the level that they do? Conversely, has serving the poor made them attractive to donors, and given them cache as local NGOs thus raising their profile and sustainability? Are MAs that are serving the poor subsidizing these services? What is the relationship between MA client profile and health sector reform? Finally, most of the MAs included in the study have user fees. This raises the question of whether these fees are a barrier. Perhaps a greater proportion of their client base would be poor if user fees were subsidized.

IPPF/WHR is interested in attaining a deeper understanding of how to ensure the most effective and efficient contribution to the MDGs. The results of this study are a heartening first take on this understanding.

ANNEX 1: Profiles of Participating Member Associations

MEXFAM/Mexico

MEXFAM was founded in 1965 as a pioneer organization in the field of family planning, and is currently the non-profit organization providing the widest coverage in sexual and reproductive health in the country. MEXFAM offers high-quality, cutting-edge services in the areas of family planning, reproductive health and sexual education, with a particular emphasis on the most vulnerable members of Mexican society: youth and the poor. It provides services at 15 clinics and approximately 1000 community-based distribution points.

APROFAM/Guatemala

The Guatemalan Family Welfare Association (APROFAM) was established in 1964 and provides services through 30 clinics within 18 of the 22 Guatemalan districts. The institution is the largest single provider of contraception in the country, accounting for 38% of family planning. In its clinical, community and educational programs, APROFAM operates in 23 different local languages, which is critical for providing the highest quality, culturally-appropriate services. APROFAM offers special services to youth, utilizing cutting-edge technologies, and provides services to isolated communities with mobile clinics. In addition to Spanish, APROFAM works in five Mayan languages (50% of the country's population consists of indigenous groups).

PROFAMILIA/Colombia

Founded in 1965, PROFAMILIA provides close to 50% of all contraceptive services in Colombia with its 35 clinics and rural posts. PROFAMILIA offers a variety of clinical services, such as services for youth, prenatal care, gynecological attention, men's services (through men's clinics) and lab testing, as well as legal services, psychological counseling and medical attention for victims of gender-based violence.

BEMFAM/Brazil

BEMFAM's structure and mode of operation are unique among IPPF/WHR Member Associations. It operates six clinics that are models for other services, both nationally and internationally. Additionally, through contracts with more than 1,100 municipalities in Brazil, the Association also provides contraceptives, training, technical support, monitoring and evaluation, as well as laboratory services, and integration of management information systems.

ANNEX 2: Calculations

1. Weighted average of Economic level D and E =
 (Mex. Value of D+E x weight) + (Col. Value of D+E x weight) + (Br. Value of D+E x weight) + (Guat. Value of D+E x weight) =
 $(33 \times 0.27) + (38 \times 0.14) + (97 \times 0.51) + (68 \times 0.09) =$
 $8.91 + 5.32 + 49.47 + 6.12 = 69.82\%$ in S.E.s D and E

2. Weighted average of S.E. E =
 (Mex. Value of E x weight) + (Col. Value of E x weight) + (Br. Value of E x weight) + (Guat. Value of E x weight) =
 $(8 \times 0.27) + (29 \times 0.14) + (67 \times 0.51) + (17 \times 0.09) =$
 $2.16 + 4.06 + 34.17 + 1.53 =$
 41.92% in Economic level. E

3. Cumulative meta-analysis by year

Year	Country	% Economic level. E	Service Provision	Cumulative Total	Service Provision % by year			
					'00	'02	'03	'04
2000	Colombia	29	1,917,629	1,917,629	100	61	19	14
2002	Guatemala	17	1,224,627	3,142,256		39	12	9
2003	Brazil	67	7,098,036	10,240,292			70	51
2004	México	8	3,816,977	14,057,269				27

Yr. 2000 Colombia alone = 29% in Economic level E

Yr. 2002 Colombia + Guatemala =

$$(29 \times 0.61) + (17 \times 0.39) =$$

$$17.69 + 6.63 = 24.32\% \text{ in Economic level E}$$

Yr. 2003 Colombia + Guatemala + Brazil =

$$(29 \times 0.19) + (17 \times 0.12) + (67 \times 0.70) =$$

$$5.51 + 2.04 + 46.9 = 54.45\% \text{ in Economic level E}$$

Yr. 2004 Colombia + Guatemala + Brazil + Mexico =

$$(29 \times 0.14) + (17 \times 0.09) + (67 \times 0.51) + (8 \times 0.27) =$$

$$4.06 + 1.53 + 34.17 + 2.16 = 41.92\% \text{ in Economic level E}$$

4. Meta-analysis excluding Colombian data
 (Mex. Value of E x weight) + (Brazilian Value of E x weight) +
 (Guatemalan Value of E x weight) =
 $(8 \times 0.314) + (67 \times 0.585) + (17 \times 0.101) =$
 $2.52 + 39.17 + 1.71 =$
 43.40% in Economic level E

5. Calculation of Economic level E weighted average with Brazilian and Mexican data using
 - a) Own national schema and
 - b) Mexican standard
 - a. Brazilian and Mexican each using own national schema:
 (Brazilian Value of E x weight) + (Mexican Value of E x weight) =
 Economic level E
 $(67 \times 0.65) + (8 \times 0.35) =$
 $43.55 + 2.8 = 46.35\% \text{ S.E. E}$

 - b. Brazilian data converted to Mexican standard
 (Converted Brazilian Value of E x weight) + (Mexican Value of E x weight) =
 $(97 \times 0.65) + (8 \times 0.35) =$
 $63.05 + 2.8 = 65.85\% \text{ Economic level E}$

where Brazil Economic level D + Brazil Economic level E is equivalent to Mexican E, so Brazil D of 30% + Brazil E of 67% = converted value of 97%

ANNEX 3: Results of the Sensitivity Analysis

Results of the Sensitivity Analysis

The weighted results are robust as shown by sensitivity analyses.¹⁶ (Lau, Ioannidis, Schmid) A cumulative meta-analysis, by year, demonstrates the Bayesian inferences that can be made with each successive study (see Table _ below). If the analysis had been performed in 2000 with only Colombian data, it would have been inferred that IPPF/WHR's clientele was in economic level E 29% of the time. Adding Guatemala in 2002, the clientele in economic level E would have been calculated to be 24%. The Brazilian data favor the extremely poor and bring the total to 54% in 2003. The addition of Mexico in 2004 shows the percentage of economic level E clientele served in these four countries to be 42%. (See Annex 2 for calculations) The data show what would have been known at any one year, had the meta-analysis been conducted at that time. The table below shows how estimates change over time, as countries conduct their studies and the resultant data are then incorporated into the body of knowledge.

Table 1. Cumulative meta-analysis by year, % in Economic level E

	Country(ies included)	% in Economic level E
2000	Colombia	29
2002	Colombia, Guatemala	24
2003	Colombia, Guatemala, Brazil	54
2004	Colombia, Guatemala, Brazil, Mexico	42

To test if the data follow the same trend if Colombia's economic profiles are withdrawn, as Colombia used a completely different scale in their economic calculations, a weighted average for the other three countries without Colombia was calculated, with a result of 43%. This result is clearly in line with the 42% obtained when including all four countries. (See Annex 2 for calculation)

Some researchers contend that an economic level in one country is not readily convertible to the same economic level in another country.¹⁷ They contend that Brazil's D and E levels are equal to Mexico's E. Under this scenario, it is possible to examine how the profiles change: using each country's own standards or converting them to one standard. To examine this situation, Brazil and Mexico were taken as the sample. If each country were to use its own national scale, as is performed in this paper, the regional weighted average of IPPF Member Association clients for economic level E is 46%. If Brazil's economic profiles are converted to Mexico's scale (as if it were used as a standard), the regional weighted average for economic level E is 66%. (See Annex 2 for calculations) In this case, Brazil's weight carries even more than it does in the calculations previously performed and gives a larger percentage of the very poor being served by IPPF/WHR affiliates.

Bibliography

1. United Nations Development Programme, Economic Commission for Latin America and the Caribbean, Instituto de Pesquisa Econômica Aplicada, Meeting the Millennium Poverty Reduction Targets in Latin America and the Caribbean, (Santiago, Chile: United Nations Publications, 2002)
2. Last, John M., A Dictionary of Epidemiology. Oxford. New York: University Press, 2000. 114.
3. United Nations Development Programme et al.
4. de Ferranti, David et al., Inequality in Latin America: Breaking with History? (n.p.: Worldbank, 2004)
5. Eviatar, Daphne, "Spend \$150 Billion Per Year To Cure World Poverty," The New York Times Magazine, 7 Nov. 2004.
6. Suárez-Berenguela, Rubén M., Health System Inequalities and Inequities in Latin America and the Caribbean: Findings and Policy Implications, working document prepared for the Health and Human Development Division of the Pan American Health Organization-World Health Organization, 2000.
7. United Nations Population Fund, Population Reference Bureau, "Country Profiles for Population and Reproductive Health, Policy Development and Indicators 2005 (n.p: n.p, 2005)
8. United Nations Population Fund, Population Reference Bureau.
9. Suárez-Berenguela.
10. IPPF website
11. Last, John M. 114.
12. Last, John M. 114.
13. Urquijo, Jimena., Roberto Lobl. "Social-Economic Levels in Latin America : Differences vs Similarities," ESOMAR Latin America Conference, Uruguay, May, 2003.
14. Urquijo, Lobl.

15. Lau J, Ioannidis JPA, Schmid CH. Quantitative synthesis in systematic reviews. *Ann Intern Med* 1997; 820-826.
16. Lau J, Ioannidis JPA, Schmid CH.
17. Urquijo, Lobl.