

POVERTY

REDUCTION

STRATEGY

PAPERS

PRSPs

Their Significance for Health



Poverty Reduction Strategy Papers – their significance for health

DRAFT presented to the WHO Meeting of Interested Parties
October 2002

Work in Progress

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Preliminary findings

The results of this review suggest that an important distinction needs to be made in discussion of the health component of the PRSP, between “a health strategy for poverty reduction”, and a “health strategy to meet the needs of the poor(est)” – these two objectives are overlapping, but different.

The former implies broad recognition of the need to make health investments as part of overall development strategy, based on new evidence of the role of health in reducing poverty.² It is manifest in greater health spending, and strategies to extend health services and make them more efficient and responsive. This will, undoubtedly, improve the health of many poor people, but it is based on assumptions about what works to reach the poor rather than a systematic evaluation of needs in the local situation. The latter implies an approach tailored to the country context. What are the main health problems suffered by the poorest? What are the barriers that prevent them from accessing care? How can we monitor progress to make sure that the poor are benefiting? This review shows that most PRSPs reflect the former definition, rather than the latter.

From analysis to strategy

Most PRSPs recognize that health is key to economic growth and include broad, internationally-recognized strategies which can, in principle, be categorized as pro-poor, such as expanding primary health care and increasing health spend at district level.

However, neither the analysis nor the strategy presented in the health component of PRSPs are consistently poverty focused. For example, one country reviewed outlined a detailed mental health strategy, but did not make it clear if this is an issue for the poor. There are also some significant gaps, i.e. areas which even a broad-brush strategy to reach the poor should tackle, but which PRSPs fail to address. These include:

- A lack of attention to the role of the private sector (profit and non-profit), who are often the main health providers for the poor. This is also a key criticism of Sector-Wide Approaches (SWAPs).
- Limited discussion of financial barriers to care, the difficulties associated with exemption schemes, and the impoverishing impact of catastrophic illness or accident.
- A focus on people with disabilities – often the poorest of the poor in low-income countries. Though five PRSPs identify them as in the poorest groups, there are rarely strategies to address their needs.
- Noncommunicable diseases, such as those caused by smoking, are mentioned in only two PRSPs.

In addition, many PRSPs focus on goals and targets (e.g. to reduce maternal mortality), and lack detail on *how*. This in part reflects the lack of detail in the analysis section on *why* (for example, reproductive and child health indicators are worst among the poorest groups?). Our conclusion is that, so far, **most PRSPs have not provided the evidence to justify, from a poverty perspective, many of the health strategies they outline.**

² Commission on Macroeconomics and Health (CMH), December 2001.

Moving from the health component to the overall strategy, most PRSPs recognize health as a dimension of poverty but do not explore links in detail. Despite this, health appears as a key strategic component in the majority of PRSPs. This is welcome, but it is equally important that the health components of PRSPs are built on solid foundations. **If PRSPs simply reflect the new orthodoxy that health is an engine for growth, without following through the implications for strategy, countries will not progress far in meeting poverty reduction goals.** It is notable that discussion of health as a Human Right, and of health as key to well-being, are missing from many PRSPs.

Targeting and monitoring

This study found little evidence of pro-poor targeting – or attempts to adapt national strategies to meet the needs of the poorest – in the health components of PRSPs. This is despite using an extremely broad definition of “targeting”; for example, a strategy to improve health services in rural areas was taken as an evidence of a pro-poor approach. (It is recognized that the non-specificity of this definition would not be acceptable to many working in equity/poverty.)

Lack of targeting may be a reflection of three things. First, as mentioned above, it may reflect a lack of detailed analysis. Second, it may be that targeting is not politically acceptable, because of commitments to universal coverage. Third, targeting may not be technically feasible, because of lack of disaggregated data or technical capability to collect it. Few PRSPs discuss such statistical gaps, or propose strategies to fill them

Similarly, the review assessed the monitoring indicators in PRSPs in terms of whether they monitor proposed health strategies, and secondly on whether they have the scope to monitor the impact of the health strategy on poor people. While the monitoring of specific health components was largely comprehensive, very few PRSPs built in any indicators that would monitor the impact on poor people or regions. Equally, no PRSPs contain plans to include poor people in a participatory monitoring process.

While targeting and disaggregated monitoring may be technically demanding and in some cases politically difficult, there is a growing consensus that existing health strategies are not reaching the poor. Evidence from the World Bank shows that the Millennium Development Goals can be reached without making a significant impact on the lives of the poorest. Equally, the strategies, and targets outlined in many PRSPs could be accomplished without reaching the very poor. If this problem is to be overcome – without creating a two-tier system of poor services for poor people – a much more poverty-focused approach to analysis, strategy and monitoring will be required.

What is it reasonable to expect from the health component of a PRSP?

The process of looking so closely at the health component of the PRSP has led to some important conclusions about what it is reasonable to expect from this section of the document. The initial expectations of the study team may perhaps have been too high – we searched for a systematic poverty focus in the health components, for consistency between analysis and strategy (e.g. health strategies should target the poorest regions and vulnerable groups) and for evidence of pro-poor monitoring. In reality, few national health strategies reach such levels of “perfection” or detail, so it is unlikely that PRSPs — developed much more quickly — will do so.

Will PRSPs mean more resources for health?

One widely-held expectation of PRSPs is that they will increase resources for health. This review was unable to tackle that question, as budgets presented in PRSPs are rarely detailed enough to make such an assessment. The World Bank suggests that the overall health allocations are set to increase in PRSP countries (see *box, introduction*); however, even where this is the case, the two factors may not be related. Health budgets may be increasing for other reasons, such as donor commitment to the MDGs, and not necessarily be attributable to the PRSP process.

Yet PRSPs do present some important opportunities for the health sector which, to date, few countries have grasped. PRSPs could catalyze the process of taking a fresh look at existing health plans, in order to ask: what needs to be different in order to make a real impact on poverty? To ensure that health outcomes improve for the poor? Rather than simply summarizing or drawing out the perceived pro-poor components of existing national health strategies (which many PRSPs appear to do), **health stakeholders could use the PRSP process to reassess existing health strategies from a poverty perspective.**

Following on from this, the PRSP should prompt some locally-specific analysis and poverty targeting within health. There are some examples, from PRSPs identified in this review, of strategies which can be seen as best practice in this regard. These include (no single PRSP contains all of these examples): regionally disaggregated health statistics (correlated with poverty data), monitoring of national strategies – such as vaccination – at

regional level, *ad hoc* surveys of vulnerable groups, out-reach strategies for those with the worst health outcomes, and action to address the impoverishing costs of seeking health care.

If the PRSP is to add value from a health perspective it should lead to a more detailed analysis of the how health can better contribute to poverty reduction and begin the process of making the health strategy more focused on the needs of the poorest. Many PRSPs have done this to a limited degree, but could do much more. That said, the broad statements in current PRSPs – for example on improving access to health services in “remote areas” and limiting the impact of cost recovery programmes – are a good starting point, representing policies to which governments can be held accountable.

1. Introduction

This report presents an analysis of Poverty Reduction Strategy Papers, or PRSPs, from a health perspective. It asks two distinct but related questions – to what extent is improved health seen to play a role in poverty reduction, and, to what extent does the health component of a PRSP identify, and propose strategies to meet, the specific health needs of poor people.

This review takes forward a report produced by WHO in late 2001.³ The level of interest generated by that review prompted WHO to carry out a more detailed and systematic analysis which also includes new PRSPs not analysed in the initial review. A new framework for analysis was developed (see *Annex 2*), which was then applied to 10 full and three interim PRSPs. (See *Annex 1* for list of countries reviewed.)

Why look at health in PRSPs?

PRSPs are important instruments of development policy for low-income countries (see box 1). As PRSPs are linked to accessing concessional loans, they have the potential to significantly increase funding for health programmes in poor countries. In addition, it is now generally accepted that health is central to economic growth and poverty reduction objectives, and therefore it is reasonable to expect PRSPs to include a significant focus on health.

This review also aims to facilitate an assessment of whether PRSPs include a significant focus on health and whether health is perceived to have an impact on poverty reduction. Furthermore, it gives a snapshot into the poverty focus of existing national health policies, as most PRSPs reflect or summarize these to some extent.

What is the added value of this review?

This review builds on the work of other development partners who have looked at the place of health in PRSPs, including the World Bank, the UK's Department for International Development, and Wemos. This review attempts to go further in three ways:

- It seeks to examine the poverty context from a health perspective, and the health strategy from a poverty perspective. In order to do this, it traces the poverty-health links from contextual information provided in PRSPs through to the proposed strategy. In doing so it facilitates an assessment of how far the health strategy presented in the PRSP responds to the overall poverty-health analysis, and to what extent the impact and progress indicators are appropriate to the strategy presented.
- It seeks to determine how far the health components of PRSPs aim to improve the health of the poorest groups and the poorest regions. We believe this is important because, although many of the health strategies outlined in PRSPs are implicitly pro-poor, it is possible that targets will be achieved without reaching the very poorest.
- It is based on a series of case studies of individual PRSPs, which should prove to be a useful resource for others interested in this topic. Each case study extracts from the

³ Health in PRSPs, WHO Submission to World Bank/IMF Review of PRSPs, Department of Health and Development (HDE), December 2001.

PRSP all information relevant to health (not only from the health chapter but also from other sections) and presents this in an accessible form which other researchers can use to make their own analyses. Case studies will be available on line by end 2002.

Box 1 – What are PRSPs?

Poverty Reduction Strategy Papers, or PRSPs, are national planning frameworks for low-income countries. All countries wishing to access concessional loans from the World Bank (WB) or IMF, or wishing to benefit from debt relief under the Highly-Indebted Poor Countries (HIPC) initiative are required to produce a PRSP. As of September 2002, 18 countries have produced “full” PRSPs and around 35 more have produced interim papers and are in the process of preparing a full document.

The World Bank emphasizes that PRSPs should be written and produced by countries themselves, and go beyond macroeconomic stabilization and liberalization to address issues of poverty and equitable growth.

According to the World Bank, 26 countries have reached “decision point” under the HIPC initiative, and are now receiving debt relief which will amount to \$41 billion over time (this represents 70% of total debt relief projected to be delivered under HIPC). Countries reach “decision point” once they have completed an interim PRSP which has been accepted by WB and IMF. Countries reach the “completion point” once they have implemented a full PRSP for one year.

Anticipated increased in health spending

World Bank figures suggest that social expenditure in decision point countries will increase from an average of 6% of GDP in 1999 to 9% in 2002, equivalent to an average increase of \$830 million per year. The Bank adds: “increases in education and health spending are expected to absorb about two-thirds of the total [debt] relief, with about 40% directed towards education and 25% to health care”.⁴ It is still too early to tell whether those projections will be realized.

2. Methodology and report outline

A desk review of 10 full PRSPs and three interim PRSPs was carried out using a framework (*Annex 2*) developed by a team from WHO and an external consultant. The framework addressed the following seven main areas in order to analyse the poverty-health links. This report is structured around these areas.

Poverty-health context

1. Defining poverty
2. Examining the pattern of poverty
3. Examining the links between health and poverty

Health-specific analysis

4. Health services
5. Communicable and noncommunicable diseases (including HIV/AIDS)
6. Maternal and child health
7. Health-related sectors (e.g. water and sanitation, nutrition).

⁴ *Financial Impact of the HIPC Initiative – First 26 Country Cases*, World Bank, May 2002.

The main constraint of carrying out a desk review is that it is impossible to know how far the strategies presented in PRSPs reflect reality. A “good” PRSP may be a reflection of an excellent health strategy, or it may reflect the good writing skills of the author. Nevertheless, we believe that this review provides a valuable input to further discussion on the future direction of health policy in poor countries.

3. Poverty-health context⁵

The review looked at the way in which PRSPs define and examine poverty. This included looking at the level of information given about who is poor, and the depth of analysis of the links between poverty and health. This was seen to be vital as the poverty analysis provides the basis on which the overall poverty reduction strategy, and the health component, rests.

3.1 Defining poverty

- All PRSPs acknowledge that poverty is a complex and multi-dimensional phenomenon and make the point that a person’s well-being does not rest entirely on their level of income. Non-income characteristics of poverty cited in PRSPs include: limited access to basic services such as education and health, insufficient levels of consumption, and vulnerability to disaster. This analysis implies that, as poverty is a multi-faceted phenomenon, a poverty reduction strategy will need to address an equivalent range of components.
- PRSPs use various methods to calculate poverty, including the poverty line, consumption levels, Unsatisfied Basic Needs indicator, Poverty Head Count Index and the Human Development Index. The detail given in the calculation of poverty varies across the range of PRSPs.
- Seven out of 10 PRSPs make reference to a qualitative or participatory poverty assessment (QPA - which seeks to analyse poverty means the perspective of poor people themselves), and six provide limited details of these assessments. References to QPAs are sporadic rather than systematic; only Niger used the findings to rigorously inform their health strategy. This suggests that PRSPs are not systematically based on locally-specific manifestations and perceptions of poverty.

3.2 Examining the pattern of poverty

The review assessed the extent to which the PRSPs identify the poorest regions or groups within the country. The purpose was to determine whether PRSPs establish a basis from which to apply methods of targeting the poor and vulnerable, and define indicators for monitoring the impact of the programmes on poor people. In other words, are the strategies and monitoring programmes outlined in PRSPs consistent with their analysis of poverty?

- Eight out of 10 full PRSPs identify the poorest geographical regions and provide comprehensive data in the form of statistics or poverty mapping, usually based on one or two methods of poverty analysis e.g. poverty line and consumption. All

⁵ In this preliminary draft, analysis is confined to the review of full PRSPs. It is also important to note that the study team has not yet had the opportunity to check the frameworks for consistency – i.e. to make sure that those reviewed first are scored and analysed in the same way as those reviewed last.

PRSPs state that poverty is more prevalent in the rural areas; and six say that urban poverty is widespread and/or on the increase.

- Most PRSPs make some analysis of regional disparities in poverty, but this was limited in some cases to one or two sentences, for example equating poverty with the distance from the capital city; with the incidence of armed conflict; or with the topography or environment. Inequality is flagged up as a specific problem in only three PRSPs, reflecting a lack of attention to the issue.
- PRSPs are less clear in their identification of poor groups of people, and often do not distinguish between poverty, vulnerability and social exclusion. Broad categories of vulnerable groups are identified, such as food crop farmers, female or child-headed households, specific ethnic groups and older people. Six out of 10 PRSPs specifically link gender to poverty. **In several cases, health is a factor in determining vulnerable groups**, for example the physically and mentally disabled, and families caring for someone living with HIV/AIDS. Five out of 10 PRSPs identify disabled people as poor or vulnerable.

3.3 Examining the links between health and poverty

The review sought to determine the extent to which the causal links between ill health and poverty and between good health and poverty reduction are examined. It went on to assess whether proposed health strategies are grounded in such an examination.

- Eight out of 10 PRSPs identify aspects of health in their definition of poverty (for example, high incidence of disease, lack of appropriate medical services). However, as mentioned above, any multi-dimensional analysis of poverty is limited.
- Six out of 10 PRSPs recognize **poverty as a cause of ill-health** but the analysis is usually limited to one or two sentences (e.g. "The poor are at greater risk of becoming ill"; "poverty affects access to health services"; "chronic and/or incurable diseases undermine the living conditions of those affected") rather than a rigorous analysis which would provide the basis for a poverty-focused health strategy.
- Five out of 10 PRSPs recognize **ill-health as a cause of poverty** but again the analysis is sketchy. For example: "limited access to health services causes poverty"; "poor health...exacerbates the poor's ability to climb out of poverty" "poor health has adverse affects on productivity, which contributes to poverty".
- Poverty-health links are explored in detail in just four PRSPs. This is taken to mean that the PRSP points to specific health issues relevant to poor people. This issue is taken up in more detail in Section 4.
- While causal links between poverty and ill-health are insufficiently made in the majority of the reports, nine out of 10 PRSPs state that **improving health contributes to economic growth** and all PRSPs find a prominent place for health in their overall strategies. It is notable that only one PRSP states that improving health will improve well-being, and none mention health as a human right.

Summary points

1. All PRSPs recognize poverty as multi-dimensional, and in most cases state that ill-health is one characteristic of poverty. However, the analysis of the links between poverty and ill-health is sketchy in all but a few reports.
2. In PRSPs that do provide a more detailed examination of the links, clear justification is made for health to form a key part of the PRSP strategy. However, in others this prominent place may not be justified given the level of analysis provided in the PRSP.
3. The level of detail on the geographical distribution of poverty is fairly comprehensive, although this rarely extends to a geographically-disaggregated examination of the health dimension of poverty. Rural areas are unanimously identified as poorer, although several reports maintain that urban poverty is on the increase. Broad categories of poor and vulnerable people are identified, but less statistical detail is provided.
4. Best practice in this section was demonstrated by:
 - ◇ a clear indication of the complex nature of poverty;
 - ◇ an examination of how poverty affects ill health and how ill health affects poverty;
 - ◇ an exploration of how improved health contributes to poverty reduction;
 - ◇ a breakdown of varied health needs of poor people.

4. Analysis of the health components

This section presents findings on the health components of PRSPs. It is structured around four sections: (personal) health services, communicable and noncommunicable diseases, maternal and child health and health related-sectors. Clearly the distinction between these four areas is to some extent artificial, and the division may give a false sense of verticality in programming which is not present in PRSPs themselves. However, it does allow information to be presented in a useful way and points out some important gaps.

For each country, the framework of analysis (*Annex 2*) extracts from PRSPs information and data relevant to the four areas and summarizes the strategy presented. It then provides a brief analysis of the coherence of the strategy and looks at how far it addresses the needs of the poor. The main trends, across different PRSPs, are presented below.

4.1 Health services

This section looks at information in PRSPs on health services, such as quality, access and cost of care.

Information and analysis

- Analysis of health systems constraints is most commonly concerned with geographical access to care. Niger's PRSP provides the greatest detail on this issue, including a map showing the location of health centres across the country.
- Financial barriers, such as paying for treatment, are discussed in six out of 10 PRSPs, though detail is typically limited to statements such as "certain services are not affordable to the poorest groups".

- A few PRSPs include a good analysis of other types of barriers, such as dissatisfaction with health staff, and unofficial fees. Uganda's PRSP notes that "40% of the users of public services had to pay bribes" and that "Poor people experience frustration that they see no effective mechanism to hold service deliverers accountable".
- A few PRSPs also look in detail at management constraints to the delivery of care, and patterns of health spending. For example, Honduras' PRSP notes: "The urban bias of the public health services, and the serious problems of efficiency and quality in small cities and rural areas ... continue to restrict the redistributive impact of expenditure among the poorest population groups."

Strategy and monitoring

- The essential actions needed to strengthen primary health care services are addressed in almost all PRSPs, for example through expanding infrastructure, improving drug supplies, extending coverage of basic services, and tackling human resource problems in rural areas.
- Few PRSPs mention specific poor regions, or poor groups, in their strategies to expand primary coverage, though many implicitly target the poorest areas in their intention to extend services to "all regions" or "100% of territory". Many PRSPs also mention the need to improve services in "rural areas" or "neglected communities" without naming them. Decentralization is commonly suggested as the strategy for achieving this.
- Two important exceptions to this trend are Bolivia, which focuses on improving the health of indigenous people, who are identified in its poverty analysis as among the poorest, and Mozambique, which targets service improvements on regions identified as having the worst access to care (*see box below*).
- Suggested strategies on financial barriers to care tend to be limited in detail, mirroring the brief analysis. Many PRSPs contain reference to "cost recovery strategies", usually qualified with a statement about ensuring access for the poor, e.g. "public services (will be set) at a level that can be affordable to the poor". Further detail is limited. Latin American PRSPs typically mention the need to expand health insurance schemes to include the poor.
- PRSPs rarely mention the need to improve the poor's access to hospital care – this is surprising considering the impoverishing effects of catastrophic illness and accidents. A notable exception is Mauritania, where primary, secondary and tertiary level health care is addressed along with a referral system to ensure that 'underprivileged rural and urban groups' have access to higher level care.
- Another important gap is the lack of information on the role of the private sector (profit and non-profit) in the delivery of services. Several PRSPs state an intention to promote, or further regulate, the involvement of non-state actors in service delivery. But there is typically no examination of how this will be achieved, or the potential impact – positive or negative – on the poorest regions.

- Nine out of 10 PRSPs give a distinct health budget but in most cases it is not clear whether the projected budgets are distinct from or part of the overall national health plans. Seven PRSPs break down the budget into clear project components.

Selected strategies from Mozambique's PRSP⁶ on improving access to health services

- *At the primary level, build 65 new health centres, and rehabilitate and extend at least 16.*
- *Rehabilitate and expand 6 rural hospitals in the provinces of Sofala, Zambezia and Cabo Delgado and transform eight health centres into rural hospitals in Zambezia, Tete, Manica and Sofala.*
- *Equip all health units at primary and secondary level.*
- *Increase annually the provincial funds from recurrent budgets, taking into account regional inequalities in requirements of the health network, activities developed, levels of poverty, and local conditions.*

Selected strategies from Bolivia's PRSP⁷ on improving the health of indigenous and native peoples

- *Seek greater participation on the part of small farmer, indigenous and native communities in [...] health and differentiated basic services.*
- *Improve diagnostic assessments and the information needed for decision making; a database and situation map will be developed on the small farmer communities, indigenous and native peoples in the areas of health, education, and basic services.*

Summary points

1. The majority of PRSPs outline strategies to improve coverage of primary health care, through extending a basic package or services, and improving the quality and availability of services in remote areas. This is likely to be pro-poor in its impact.
2. Financial barriers to care are addressed in six out of 10 PRSPs, though they are rarely dealt with in any detail. The problems associated with fee exemption schemes, and the impoverishing costs of catastrophic illness – both issues extremely pertinent to improving the health of the poor – are rarely mentioned.
3. There is typically very little detail about non-financial barrier to care, or strategies to target the poorest group or regions; however there are some important exceptions to this trend, suggesting that it is not an unreasonable expectation of PRSPs.
4. The analysis is concerned predominantly with the public sector, with little examination of the role of the private sector in the delivery of health services.

⁶ *Action Plan for the Reduction of Absolute Poverty (2001-2005)*, Republic of Mozambique, April 2001.

⁷ *Poverty Reduction Strategy Paper*, Republic of Bolivia, March 2001.

4.2 Communicable and noncommunicable diseases

Information and analysis

- Most PRSPs identify the “key diseases” in their country. In a few cases this is backed up with statistical evidence, but in most cases not.
- Certain countries outline very detailed disease control plans, based on rigorous analysis. For example, Mozambique includes a geographic breakdown of HIV prevalence with a correspondingly-targeted HIV/AIDS-control programme.
- In most countries, the diseases identified will also be those which disproportionately affect the poor, however even in the countries with the most detailed plans is there no detailed examination of this fact – for example a breakdown of disease burden by income quintile – nor a detailed discussion of which diseases are most likely to affect the poorest groups.
- Similarly, there is little analysis of the impoverishing effects of diseases.

Strategy and monitoring

- In most cases there is consistency between analysis and strategy, with a few notable exceptions (for example, in one country ARI is identified as the major cause of mortality, but there is no strategy to deal with it).
- All 10 of the PRSPs examined mention communicable disease control, and eight of these include some kind of monitorable indicator in their strategies.
- Eight out of 10 of the full-PRSPs address HIV/AIDS in their strategy; five of these include indicators to measure progress.
- However in only three cases for HIV/AIDS and two for communicable diseases are strategies targeted at poor and vulnerable groups,⁸ or poor and vulnerable regions. In Burkina Faso, the groups most vulnerable to HIV/AIDS are named (military, truck drivers, sex workers), and in Mozambique the specific areas where HIV/AIDS programmes need to be strengthened are named. In Mozambique, priority districts for malaria are also identified. But these are the only countries to be so specific. In other cases, the targeting is much broader, e.g. “strengthening equipment in outlying health facilities” or “enhancing ability to diagnose and treat opportunistic infections suffered by HIV/AIDS patients in peripheral health facilities”.
- Strategies to address noncommunicable diseases, and in particular smoking, represent one of the most significant gaps in PRSPs. Only one country, Albania, includes a strategy on smoking, and only Honduras mentions the rising noncommunicable disease burden.
- Links between communicable and noncommunicable diseases, and the Millennium Development Goals (MDGs) are weak – only two of the 10 full PRSPs reviewed

⁸ In the case of HIV/AIDS, in particular, vulnerable groups are not necessarily the poorest.

linked with the Goal on HIV/AIDS, and only one linked with other targets relevant to communicable diseases.⁹

Summary points

1. In most cases there appears to be consistency between the information provided and the strategies outlined. Most, though not all, PRSPs identify those diseases which are major causes of morbidity and mortality in their country, and then outline strategies to address these diseases.
2. It is possible to infer that in many cases the strategy outlined will have an impact on the poor, as the diseases addressed are those affecting poor people. However, there is no specific discussion of the need for pro-poor targeting, i.e. how to adapt general strategies to meet the needs of the poorest groups.
3. Strategies to address noncommunicable diseases are missing from most PRSPs.

4.3 Maternal and child health

Information and analysis

- All the PRSPs reviewed provided basic information on maternal mortality and infant mortality rates. Six PRSPs provided some kind of poverty breakdown for at least one of these indicators, for example by geographical region or by income group.
- Niger (*see box below*) and Mozambique stand out as PRSPs which provide clear poverty analysis. However, in neither case are interventions targeted at these identified areas.
- Very few PRSPs go beyond the presentation of statistics, for example to discuss the barriers that prevent poor women from accessing reproductive care such as distance, cost, cultural practices.

Selected information from Niger's PRSP¹⁰ on child mortality and vaccination coverage

- Mortality rates for children under five years show enormous discrepancies between urban and rural areas, and between different regions of the country. The probability that a child will die before its fifth birthday is higher among rural children (293 per 1000) than among urban children (168 per 1000), and is highest in areas where vaccination coverage is most limited.
- The Zinder region has the greatest deficit in terms of its people's poverty and vulnerability, according to infant mortality and child malnutrition indicators. At the regional level, the greatest disparities relate to infant and child mortality indicators.
- The highest infant and child mortality rates are in the regions where vaccination coverage is lowest, namely Zinder (10%) and Maradi (14%).

⁹ All targets related to communicable diseases are found under goal 6 of the MDGs: "Combat HIV/AIDS, malaria and diseases".

Strategy and monitoring

- All PRSPs have strategies to address reproductive health and child health, through interventions such as expanding immunization coverage, improved access to ante-natal care and assisted childbirth. Six of 10 PRSPs mention strategies to improve access to family planning and/or reduce fertility.
- Such activities represent pro-poor targeting in a very broad sense, as most PRSPs identify women and children as among the poor. However, the poorest women and children are not explicitly targeted, apart from in three cases. This is despite the identification, in six of the 10 PRSPs of disparities in maternal and child mortality rates between income quintiles or between regions (either named geographical areas or urban/rural).
- Where a focus on the poorest or most vulnerable groups is mentioned, it is often broad terms. For example, in Albania, there is a commitment to improve Maternal and child health “in rural areas”, in Honduras to “supporting adolescent mothers” and in Tanzania to “ensuring that quality health services are available and accessible to *all* in urban and rural areas within reachable distances”. Nicaragua’s PRSP (see box below) is a notable exception providing a detailed and targeted strategy focusing assistance on named poorest regions.
- In most cases, strategies that focus on primary level activities, though the provision of emergency obstetric care is particularly important in the reduction of maternal mortality.
- Four out of 10 of the PRSPs link their targets for improved reproductive and child health to the MDGs.¹¹
- As with other areas, the strategies outlined tend to focus on goals and targets (e.g. for MMR reduction), and lack detail on *how*. This in part reflects the lack of detail in the analysis section.

Selected strategies from Nicaragua’s PRSP¹² on improving reproductive health

- Repair the primary network, equipment, furnishings of seven health centres and posts on the Atlantic Coast.
- Repair hospitals in the regions: RAAN (northern Atlantic), RAAS (southern Atlantic), and Rio San Juan.
- Adopt alternative modalities for delivering services in faraway areas, and implement a package of services for pregnancy and infants under one year of age.
- Get a functional community reference and counter-reference system underway in order to improve follow-up to patient care in 12 municipalities.
- Support for organizing reproductive health services and work with adolescents in 40 municipalities.

¹⁰ *Poverty Reduction Strategy*, Government of Niger, January 2002.

¹¹ *The review determined that a link to the MDGs was present where an indicator reflected a similar goal or target to the MDGs to be reached by the year 2015.*

Summary points

1. The causes of mortality for poor people are rarely examined rigorously, and the barriers that prevent poor women from accessing reproductive care are typically not explored in detail. This reduces the scope for the health strategy to target appropriate programmes at those most in need.
2. There is an implicit poverty focus in many of the programmes, as women and young children are usually among the poorest and most vulnerable groups. However, there is little attempt to specifically target poor women and children.
3. Indicators for monitoring maternal, child and infant mortality are provided in every PRSP, however no PRSP identifies disaggregated indicators to monitor change in mortality among the poor.

4.4 Health-related sectors

Most PRSPs address water and sanitation independently, rather than as part of the health component. By contrast, nutrition is almost always addressed within health. Health-related information may fall either under health or under education.

Information and analysis

- In many cases, PRSPs provide information on access to water in rural and urban areas (i.e. distance to nearest source, and quality of source). Niger is an example of good practice in this regard, providing information on water needs in different geographical areas.
- In only one case (Honduras) are institutional problems with the management of water supply discussed.
- For nutrition, the information provided is usually rates of stunting or percentage of underweight children, rather than an analysis of the causes of malnutrition.

Strategy and monitoring

- All 10 PRSPs include a strategy on improving access to clean water, and most also address sanitation. In nine out of 10 PRSPs, strategies include indicators to monitor progress.
- There is a clear poverty focus in most water and sanitation strategies – with programmes being targeted at the “poorest” or “most under-served” regions in nine out of 10 cases. Three PRSPs also provide poverty-focused indicators, though these tend to be broad (e.g. increasing access in rural areas).
- Nicaragua is an example of good practice in targeting (*see box below*), as interventions clearly focus on named poor regions and vulnerable groups; indicators specific to these areas or groups are not mentioned in the PRSP; it may be that they exist but have not been included.

¹² *A Strengthened growth and poverty reduction strategy*, Government of Nicaragua, July 2001.

- Three PRSPs include strategies to privatize water provision; the likely impact on the poorest populations is not discussed.
- Eight out of the 10 PRSPs address nutrition, but only four of these focus programmes on the poorest groups. Strategies tend to be less detailed – for example including targets for improved weight-for-height but no details of *how* targets will be reached. Bolivia and Mozambique are important exceptions to this trend, including detailed programmes to provide nutritional supplements, and related information/education campaigns.
- Six of the 10 PRSPs provide indicators to monitor progress towards nutritional targets; none of these reflect poverty targeting. Programmes on the provision of health-related information are not consistently presented in PRSPs. Where they are, they are most likely to address HIV/AIDS and nutrition.

Selected indicators from Nicaragua's PRSP¹³

Increase access to water

- Increase the % of population with access to safe water and sanitation in rural dispersed areas to 39% in 2004 from 35% in 1999.
- Annual average increase of 2.4% in access to safe water in rural dispersed areas during 2000-2005

Increase rural productivity in the long run

- Set new rates and revised subsidies for extremely poor neighbourhoods
- Implement water and sanitation project for marginal sectors of Managua

Protection of vulnerable groups – design and implement interventions for social protection based on specific characteristics of vulnerability and risks

- Assistance to be provided to groups facing nutritional and educational risk
- Increase coverage of integral attention of children 0–6 years

Summary points

1. Water programmes tend to be more detailed and comprehensive than nutrition programmes. This is most likely because water provision is usually dealt with as a discrete programme, rather than as part of health components.
2. There is an explicit poverty focus in most water programmes - in many cases, expanding supply in rural areas, or in named urban slum areas. Some PRSPs contain an implicit poverty focus by aiming at universal access.
3. Nutrition programmes tend to be less poverty focused, often including national targets without specific discussion of how strategies will be achieved. Few PRSPs link their nutrition strategy to the rural development strategy.

¹³ *A strengthened growth and poverty reduction strategy*, Government of Nicaragua, July 2001.

4. The provision of health-related information (by either health or education authorities) is less commonly addressed than might be expected, given its importance as a strategy for reaching poorest groups with basic information on nutrition and sanitation.

5. Poverty targeting and monitoring indicators

A problem that recurred across many of the health components of PRSPs was the limited extent of the poverty targeting. In general, two approaches to poverty targeting were taken:

- Universal coverage which by definition would include poor as well as non-poor (used for programmes such as vaccination, coverage of health clinics).
- To target specific poor regions or groups with a specific health programme.

The latter requires information on the health issues relevant to poor people and/or regions, such as data disaggregated by socio-economic quintile. Clear mechanisms for monitoring are required to ensure that the benefits are felt by the target group. The former requires no poverty targeting as such, but experience suggests that national programmes are often very bad at reaching the poorest unless they are adapted to their needs.

- PRSPs used universal coverage more frequently than targeting of poor people. This was the case even when data and information was available to identify the most vulnerable. In some cases vulnerable groups are implicitly targeted; for example, children and women are often identified as poor or vulnerable, and thus child immunization and reproductive health programmes can be judged as “pro-poor”, but there is typically no explicit focus on poor women or poor children.
- The limited targeting ought to be viewed alongside the sketchy data and information in health components. Without the information on who is poor and what their health situation and needs are, the process of targeting is restricted, and while several PRSPs acknowledge the lack of relevant data, few strategies demonstrate a commitment to accessing required information.
- Four out of 10 reports linked their health indicators to the MDGs, where possible.
- No PRSPs outline strategies to involve the poor in participatory monitoring.

Summary points

1. Poverty targeting was limited across the range of the PRSPs. In many cases reaching the poor was possible within programmes of universal coverage (e.g. vaccination programmes), but more specific targeting of poor regions and groups of people with specific/tailored health strategies was missing. Some PRSPs did include some specific targeting but it was sporadic rather than systematic.
2. Monitoring the impact on poverty is limited. Overall indicators for, for example maternal mortality, are provided but there is no attempt to monitor specific health strategy programmes on identified poor and vulnerable people/regions.

Annex 1: Country PRSPs reviewed

Full PRSPs

- **Uganda's** Poverty Eradication Action Plan. Kampala 2000
- **Tanzania** Poverty Reduction Strategy Paper. January 2000
- **Burkina Faso.** Poverty Reduction Strategy Paper. Ouagadougou. May 2000
- **Islamic Republic of Mauritania.** Poverty Reduction Strategy Paper. December 2000
- **Republic of Bolivia.** Poverty Reduction Strategy Paper. March 2001
- **Republic of Mozambique.** Action Plan for the Reduction of Absolute Poverty. April 2001
- **Nicaragua.** A Strengthened Growth and Poverty Reduction Strategy. July 2001
- **Honduras** Poverty Reduction Strategy Paper. September 2001
- **Republic of Albania.** National Strategy for Socio-Economic Development. Tirana, November 2001
- **Niger** Full Poverty Reduction Strategy Niamey, January 2002

Interim PRSPs

- **Republic of Ghana.** Interim Poverty Reduction Strategy paper. Accra, June 2000
- Poverty Reduction and Economic Growth Program of **Georgia.** Intermediary Document. Tbilisi, November 2000
- **Azerbaijan Republic** Interim Poverty Reduction Strategy Paper. Baku, May 2001

Annex 2: Framework questions used for the review

Poverty context

- How does the PRSP define poverty?
- Is health a factor within the definition of poverty?
- Does the PRSP draw on findings from a qualitative poverty assessment (QPA)?
- Are the poorest geographical regions identified?
- What particular groups of people are identified as poor?
- Is gender identified as a social dimension of poverty?

Poverty and health

- Is poverty recognized as a cause of ill-health?
- Is ill health recognized as a cause of poverty?
- Is better health recognized as a means of poverty reduction & economic growth?
- Is better health, implicitly or explicitly, one of the principle strategies of the PRSP?

Overall objectives

- What are the overall objectives of the strategy and how are they subdivided into pillars of themes?
- Is the health strategy budgeted and what level of detail is presented?

Health components

The review addressed health issues through the following four sections extracting information, strategy objectives and indicators from PRSPs. It then analyzed this information using the questions in Box A.

1. **Communicable and noncommunicable diseases** of the poor (including HIV/AIDS, malaria, TB and other diseases)
2. **Health-related sectors** (including water and sanitation, nutrition and health-related education).
3. **Maternal and child health** (including reproductive health, population and fertility; infant and child health).
4. **Health services** (including non-financial and financial constraints to health care; quality, management and regulation; extent of non-state provision and formal health care charges).

The framework also asked, **Are there strategies in other sectors that will have an impact on health outcomes?**

(e.g. education; environment; food security; occupation/livelihood tasks). In particular:

- Does the health ministry have a role?
- To what extent are poor people targeted?

Box A: Outline of analysis

- Quantity, detail and depth of data
- Coherence and consistency of strategy
- Are the named poorest regions targeted in the health strategies?
- Are the named poorest groups targeted in the health strategies?
- Are poor women's health needs identified?
- What's missing?

BOX B: targeted health issues

- HIV/AIDS
- Smoking
- Other communicable diseases
- Reproductive health
- Child health
- Financial barriers to health care
- Improvement of water and sanitation
- Nutrition
- Reallocating resources to poorer regions
- Reallocating resources to lower tiers of health delivery system

- **In order to generate a summary information sheet, the health issues in Box B were specifically targeted for analysis through the following questions (answered yes/no):**
 - (a) Is it addressed in strategy?
 - (b) Is it targeted at poor/vulnerable groups and/or poor regions?
 - (c) Is there a monitoring indicator identified to measure progress?
 - (d) Are the indicators linked to the MDGs?
 - (e) Is the pro-poor targeting reflected in monitoring indicators?

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