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## Their Significance for Health: second synthesis report



World Health Organization

# **PRSPs: Their Significance for Health: second synthesis report**



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# Part I: Introduction

*This report presents an analysis of Poverty Reduction Strategy Papers (PRSPs) from a health perspective. It is based on a desk review of 21 “full” or “final” PRSPs, and builds on previous work by WHO in this area.*

The study had two main areas of enquiry. First, to what extent is improved health seen to play a role in poverty reduction? This involves looking at the relative priority given to health in the overall PRSP, including its budget, and examining where health fits, conceptually, within the definition of poverty. Second, to what extent does the health component of a PRSP identify, and propose strategies to meet, the specific health needs of poor people? This involves a much closer analysis of the health components of PRSPs: the targets they set, the strategies they outline, and the monitoring mechanisms they propose. See Annex 1 for a list of PRSPs reviewed.

The *purpose* of asking these questions is to assess the importance of the PRSP instrument for the health sector, and in particular its potential to advance strategies that meet the health needs of the poor. In addition, the extensive body of knowledge on the contents of the PRSP generated by this review provides WHO (and other actors in the health sector) with a good starting point to further engage with PRSP processes at country level. Thus a second purpose of this study is to inform country-level work in WHO on poverty-reduction processes in general, and PRSP processes in particular.<sup>1</sup>

The envisaged *readers* of this study are policy makers working in health and in development – particularly those interested in aid instruments and their effectiveness – based in development agencies, ministries of health, and multilateral organisations.

The main *constraint* of this study is that as a desk review, it cannot determine if the health strategies presented in PRSPs: (i) reflect country ownership, (ii) are relevant and realistic given the particular country context, or (iii) are likely to be implemented. These critical questions cannot be answered by this study. However, the study is informed by three country case studies, and by other literature on health in PRSPs. These points of reference suggest that the conclusions reached are sound.

<sup>1</sup> The PRSP is one instrument, and currently the main instrument globally, used by countries to develop poverty-reduction plans. However, some countries with poverty reduction strategies do not engage in the PRSP process.  
<sup>2</sup> [www.iphn.org/PRSPs%20and%20Health.rtf](http://www.iphn.org/PRSPs%20and%20Health.rtf)

## What is the added value of this review?

A substantial amount of literature exists on PRSPs in general, and there is also a growing body of work on health and PRSPs. Contributors to the latter include WHO, the World Bank [1], the UK's Department for International Development [2], the International Poverty and Health Network,<sup>2</sup> the Centre for Aid and Public Expenditure (CAPE) [3], and civil society organizations in the North and the South. This review attempts to go further in five ways:

- **It systematically examines the poverty context outlined in PRSPs from a health perspective, and the health strategy from a poverty perspective.** In doing so it assesses how prominently health features in the poverty analysis presented in the PRSP, and conversely how far the health strategy responds to the poverty analysis.
- It seeks to determine **how far the health components of PRSPs aim to improve the health outcomes among the poorest population groups and in the poorest regions.** This is important because, although many of the health strategies outlined in PRSPs are *implicitly* pro-poor, it is possible for targets to be achieved without reaching the very poorest.
- **It is informed by a review of individual PRSPs, which have already proved to be a useful resource in themselves.** Each review extracts from the 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 in the first quarter of 2004.
- **It allows an assessment of whether the health components of PRSPs are changing or evolving over time.** The study looks at PRSPs from 2000, 2001 and 2002 and compares later and earlier documents on a number of key issues.

- **It looks systematically at the links between the health targets and strategies set by PRSPs, and the Millennium Development Goals (MDGs), Targets and Indicators**, allowing an assessment of how far the health MDGs are reflected in PRSPs.

#### *WHO's work on pro-poor health*

This study on health in PRSPs links to a number of related work areas in WHO. Directly complementing this desk review, and helping to validate its results, is a series of country case studies on health in PRSPs. So far, case studies have been carried out in Cambodia, Azerbaijan and Uganda. There is also a growing area of work on pro-poor health policies, detailed in a 2004 paper to the WHO Executive Board: *The Influence of Poverty on Health* (EB113/12).

### *Background and approach*

This section provides background on PRSPs and discusses the conceptual issues which have informed the study.

#### **What are PRSPs?**

Poverty Reduction Strategy Papers are national planning frameworks for low-income countries. All countries wishing to access concessional loans through the Poverty Reduction Growth Facility (PRGF), or wishing to benefit from debt relief under the Highly-Indebted Poor Countries (HIPC) initiative are required to produce a PRSP. As development cooperation continues to move “upstream”, towards programme aid and budget support and away from individually funded projects, PRSPs are also becoming the framework around which some bilateral donors – notably the Nordic countries and the UK – build their cooperation programmes. As of December 2003, 32 countries have produced “full” PRSPs.

The nature of PRSP documents, and the multiple functions they are designed to fulfil, imply at least two important tensions. The first is between PRSPs as country-owned development strategies, and between PRSPs as, essentially, “funding applications” to the World Bank. The World Bank emphasizes that PRSPs should be written and produced by countries themselves, and should go beyond macroeconomic stabilization and liberalization to address issues of poverty and equitable growth. However, PRSPs must also be approved by the Boards of the World Bank and

the International Monetary Fund (IMF) before access to debt relief and concessional lending is granted. Moreover, Bank and Fund consultants often assist in the drafting of PRSPs. This suggests – and country experience confirms – that to a certain extent PRSPs must conform to Bank/Fund interpretations of “sound economic policy”.

The second important tension is between PRSPs as “advocacy” documents, and PRSPs as planning frameworks. One body of opinion argues that PRSPs should present a programme based on *need* irrespective of available resources, while others believe that PRSPs should plan around *available resources*, ensuring that these are spent to achieve maximum impact on poverty reduction. This issue will be discussed in more detail in the section on PRSP budgets.

#### **What can we expect from the health components of PRSPs?**

PRSPs are multisectoral plans and their discussion of health is therefore limited. They cannot (and should not attempt to) replace existing health-sector programmes, nor should they be expected to contain full details of a comprehensive health strategy.

This begs the question: what should the health components of PRSPs contain? The view of this study is that **PRSPs should prioritize those health interventions most likely to improve the health of the poor(est) and help to reduce poverty.**

A critique of whether or not PRSPs contain *a health strategy for poverty reduction or a health strategy to meet the needs of the poor* requires clarity on these concepts. Drawing on work in WHO [4], the World Bank, the Organisation for Economic Cooperation and Development (OECD) [5] and elsewhere, the framework developed for the review looked for:

- (1) evidence of *generic* health interventions which are considered pro-poor;
- (2) *specific targeting* of the poorest groups or geographical regions, given the country context;
- (3) interventions in other sectors which can have a positive impact on health.

In the first category, strategies on communicable-disease control, maternal and child health, nutrition and strengthening of health provision in rural areas were taken as evidence of a pro-poor approach. Work by the Commission on Macroeconomics and Health (CMH) [6] clearly shows that reducing an excessively high disease burden will have a positive economic impact. CMH estimated that an additional investment in health

of US\$66 billion annually in low-income countries will lead to economic benefits of at least US\$360 billion a year in 2015–2020, an almost sixfold return. This is strong evidence to suggest that health needs to be at the centre of any poverty reduction strategy.

However, it is also clear that national health programmes, even those tackling the diseases of the poor, often fail to reach the very poorest groups. Therefore this study also looked for evidence of a *health strategy to meet the needs of the poorest*, for example targeting of specific poor groups with outreach services, user fee exemption mechanisms, and strengthening of health services in poor districts.

Third, conscious that health status has a variety of determinants many of which are beyond the jurisdiction of the health sector, the review looked for evidence of non-health-sector activities which aimed to improve health. Examples include increases in tobacco taxes and extension of water and sanitation provision.

Different combinations of these approaches may be appropriate in different countries. In many African countries, where the number of poor is excessively high, a general strengthening of health services in rural areas and a greater focus on the conditions that disproportionately affect the poor may be appropriate (although it may neglect the urban poor). In Latin America, where health services are better established, a more targeted approach may be needed in conjunction with universal strengthening of services. In either case, a pro-poor policy needs to be based on the country context.

The review also looked at mechanisms identified to monitor progress in health, both generally and in the poorest regions or groups. This is particularly important because many health goals and targets are expressed as national averages, and could be achieved without significant improvements for the poorest populations (see Gwatkin D R [7]). The World Bank Source Book on PRSPs also encourages disaggregated monitoring: “Any results-oriented strategy, such as the PRSP, must be concerned with measuring impact. Crucial to this Monitoring and Evaluation exercise is a focus on the poor, but also a focus on other disadvantaged groups.” [8]

Typically, PRSPs follow a standard structure. They begin with a poverty profile giving an overview and analysis of the causes and characteristics of poverty in

that country. They further examine specific problems or issues that are pertinent to poverty reduction. This is framed in different ways, e.g. by sector, or by issue. The third main component is an outline of the proposed strategies (both macroeconomic and sectoral), usually divided into pillars or themes. PRSPs conclude with a budget, and by outlining a mechanism to monitor progress. Given this structure and WHO’s aims, it followed that this analysis of PRSPs should look for evidence of:

- poverty–health links;
- a description of the health needs of the poor;
- a health strategy that reflects those links and prioritizes the health needs of the poor and health interventions that will help to reduce poverty;
- a monitoring mechanism that gauges progress in poor and non-poor groups.

The analytical framework used in this study is based on this logic (see *Annex 2*).

## Methodology

WHO’s work on tracking the health components of PRSPs began 2001, with a submission to the World Bank/IMF of review of PRSPs [9]. The positive feedback generated by this report prompted WHO to carry out a more systematic review, and an initial framework for analysis was developed (see *Annex 3*) and applied to 13 full and interim PRSPs during 2002. A first synthesis report based on this work was published in October 2002 [10].

In April 2003, WHO hosted an international consultation to discuss the work to date and canvass ideas for how to move it forward. All WHO regional offices were represented, along with a number of development partners and civil society organizations. A summary report of the consultation can be found in *Annex 4*.

As a result of the meeting, a revised analytical framework was developed (see *Annex 2*). A further 11 full PRSPs were examined using this framework, and the original 10 full PRSPs were revisited. The results of this exercise are presented in the following sections.

## Part II: Findings

This section presents findings in four areas which correspond to the structure of the analytical framework used: **poverty–health links**; the analysis of health issues presented in PRSPs; the **health strategies** presented in PRSPs; and the mechanisms used to **monitor progress**.

### Conceptual overview of poverty–health links

The stated purpose of PRSPs is to foster economic growth and reduce poverty. Given this, it is fair to expect that the health strategy outlined in any PRSP should aim to contribute in some way to reducing that country's poverty. Equally, it is reasonable to expect that PRSPs justify or explain from a poverty perspective the specific health activities they include. This part of the review examined the conceptual overview of poverty presented in PRSPs and searched for links to health. In particular, it looked at:

#### 1. The examination of poverty presented in PRSPs.

How is poverty defined? What criteria are used to analyse the extent of poverty? Does the PRSP identify specific regions or groups of people who are poor or at risk of falling into poverty? What level of information and what depth of analysis are presented? These questions are important because the poverty analysis should inform the overall poverty reduction strategy, including the health component. Moreover, a thorough analysis of *who* is poor paves the way for clear poverty targeting.

#### 2. Conceptual analysis of the links between poverty and health.

Is poverty seen to contribute to ill-health, and/or vice versa? Is health seen as a way of reducing poverty, of enhancing economic growth, or both? Is health regarded as a human right? These questions aimed to examine the conceptual justification for including health sector activities in the PRSP.

#### 3. Empirical examination of health-poverty links.

What are the main health needs of the poor? What barriers do poor people face in accessing health care? What health statistics are provided that are pertinent to poverty (e.g. infant mortality rate, life expectancy). By what criteria, if any, are these data disaggregated: by region, by wealth quintile, by vulnerable group? These questions determine whether the PRSP health strategy is based on a poverty-focused analysis.

4. Whether a **multidimensional definition of poverty** was presented, which elaborated the multiple causes of ill-health.

### The examination of poverty presented in PRSPs

The review found that all PRSPs acknowledge poverty as a **complex and multidimensional phenomenon**, making the point that a person's well-being does not rest entirely on their level of income. However, further analyses beyond income poverty varied substantially, with some PRSPs presenting a much more in-depth examination than others. Despite the often-limited detail, the majority of PRSPs identify some aspects of health when describing key characteristics of poverty, e.g. nutrition levels, a high incidence of disease, lack of appropriate access to medical services. Other key points to emerge from this part of the study include:

- PRSPs draw on a range of data to calculate levels of poverty, including the poverty line, consumption levels, Unsatisfied Basic Needs indicator, Poverty Head Count Index and the Human Development Index. The majority of PRSPs identify the **poorest geographical regions**, based on one or two methods of poverty analysis. All PRSPs stated that poverty is more prevalent in rural areas.
- **Inequality** in poverty (however defined) was flagged up as a problem in several PRSPs, and most make some analysis of regional disparities in poverty. However, 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.
- PRSPs are less clear in their identification of **poor population groups**, and often do not distinguish between poverty, vulnerability, and social exclusion. The categories of vulnerable groups identified are typically very broad, for example food crop farmers, female- or child-headed households, specific ethnic groups and older people.

- Sixteen out of 21 PRSPs mention a **qualitative or participatory poverty assessment** (QPA or PPA – which seeks to analyse poverty from the perspective of poor people), but only six make comprehensive references to the QPA data collected. References to QPAs tend to be sporadic, suggesting that most PRSPs are not based on locally-specific manifestations and perceptions of poverty. Yemen (see box) is one important exceptions to this trend.

## Yemen's PRSP

*"Poor men and women were unanimous in saying that the most important effects of poverty included illness and the inability to meet the cost of treatment. Hunger and malnutrition were in second place."*

## Zambia's PRSP

*"The wealth of poor people lies in their capacities and their assets. Of these, health is the most important. A sick, weak and disabled body is a liability both to the persons affected and to those that must support them. Thus if health is an asset and ill-health a liability, protecting and promoting health care is central to the entire process of poverty reduction and human development."*

*"The poor have worse health outcomes than other economic and social groups... infant, child and maternal mortality rates are higher in poor communities"*

## Conceptual analysis of poverty–health links

Analysis of the conceptual links between poverty and health is typically sketchy and limited to comments such as: *"The poor are at greater risk of becoming ill"*; *"Poverty affects access to health services"*; *"Poor health has adverse affects on productivity, which contributes to poverty"* – rather than a rigorous analysis which would provide the basis for a poverty-focused health strategy. There are, however, important exceptions, for example Zambia (see box), where a clear justification is presented for a health component in the PRSP.

While thorough links between poverty and ill-health are insufficiently made in the majority of the reports, 18 out of 21 PRSPs state that **improving health contributes to economic growth** and all PRSPs find a prominent place for health in their overall strategies. None mention health as a human right.

## Empirical examination of poverty–health links

All PRSPs provide some national health data: at the very least maternal and infant mortality and life expectancy, but often much more. The review also looked for disaggregated health data (either regional or by income quintile) that would help in targeting poor people with appropriate health care interventions. The Gambia and Guinea stand out as examples of good practice in this regard. (see box page 10).

Five PRSPs provided no disaggregated health data at all; 16 presented health data with some form of disaggregation, of which six were rural/urban. In most

cases, these data concern health outcomes rather than health coverage, although the types of data presented vary greatly between countries. This lack of consistency in disaggregated health data is striking: there is no systematic, cross-country common approach to examining the particular health needs of the poor in PRSPs.

While it is true that most countries lack the data to present a very detailed pro-poor health profile, the majority of PRSPs studied in this review had carried out a QPA from which a substantial amount of information could have been gleaned. This represents a lost opportunity.

## Summary points:

- All PRSPs recognize poverty as multidimensional, 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.
- 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.
- The level of detail on the geographical distribution of poverty is fairly comprehensive, although this rarely extends to a geographically disaggregated

### Disaggregation of health data in The Gambia's PRSP

- Prevalence of illness among children under five years by household income quintile
- Household behaviour in response to child illness by household income quintile
- Worst indicators of health by regional divisions
- Women's health indicators by household income quintile
- Poverty versus population coverage of basic health facilities by divisions
- Estimated public provider consultations per person per year by age group, sex and poverty status (%)
- Malnutrition status among children under five years by divisions
- Micronutrient status in under-fives by division
- Distribution of stunting and wasting among school children by division
- Prevalence of goitre among school children by division
- Iron deficiency in women of childbearing age by division
- Vitamin A deficiency in women of childbearing age by division

### Disaggregation of health data in Guinea's PRSP

Information is provided by prefecture (in a map), and dates from 1999

- Number of health centres
- Ratio of population/health centre
- Number of health stations per prefecture
- Assisted delivery
- Number of physicians/dentists
- Percentage of children having taken their first dose of poliomyelitis vaccine
- Percentage of children having taken the third dose of poliomyelitis vaccine
- Percentage of population having taken the BCG vaccine
- Percentage of children having taken the first dose of diphtheria-whooping cough-tetanus vaccine
- Percentage of children having taken the third dose of diphtheria-whooping cough-tetanus vaccine
- Health sector projects financed by donors in 2001

*Regional\** Variations of the following indicators are also provided: infant mortality rate; physician- or midwife-assisted birth; children with no immunizations; children suffering from chronic malnutrition; sexually active women using contraception; composite index of fertility; access to safe water; coverage of Essential Health Services.

examination of the health dimension of poverty. Rural areas are unanimously identified as poorer, although several reports maintain that urban poverty is increasing. Broad categories of poor and vulnerable people are identified, but this tends not be backed up with data.

- Few PRSPs provide comprehensive information of data on *poor people's* health needs. In the few examples where this is provided, the type of data presented varies substantially between countries, suggesting no systematic cross-country approach to identifying the health needs of the poor in PRSPs.
- Best practice in this section was demonstrated by:
  - a clear indication of the complex nature of poverty;

- an examination of poverty–health links;
- an exploration of *how* improved health contributes to poverty reduction;
- a description (using qualitative and quantitative information) of the health needs of poor people.

### Health analysis as presented in PRSPs

This section looks at the analysis of health challenges presented in PRSPs. In most cases, PRSPs outline gaps or limitations in the health care delivery system, and provide an overview of child and maternal health issues, prevalent communicable diseases, and manifestations of malnourishment.

By discussing the limited health-care provision in isolated areas, or the most common life-threatening diseases – as opposed, say, to the lack of high-tech equipment in major hospitals – most PRSPs identify health issues relevant to poor people. However, few PRSPs begin their health analysis from the *perspective* of the poor, detailing their specific needs or the barriers they face in accessing care. One notable exception to this trend is Viet Nam (*see box*).

## Viet Nam's PRSP

*"During 1993-1997, the sickness status of the richest quintile reduced by 30%, while that of the poorest quintile remained unchanged."*

*"Migrants to urban areas have very limited access to services (including health services) and must pay more for them than registered residents."*

## Health systems

Analysis of constraints on health systems most commonly considers geographical access to care. Most PRSPs give some indication of the regions where people must travel long distances to health centres. Some, including Niger and The Gambia, present detailed maps showing the location of health centres across the country. The difficulties of delivering basic health care in rural areas (not specific to the poor) are also fairly consistently examined across PRSPs. Issues highlighted include lack of staff, management and infrastructure problems and a shortage of drugs and other resources.

Financial barriers, such as payment for treatment, are addressed in 15 out of 21 PRSPs, although any discussion is typically limited to statements such as "certain services are not affordable to the poorest groups". The PRSPs of Rwanda and Zambia stand out because they explore user fees in some detail, including the difficulties associated with fee-exemption schemes. Most PRSPs, however, assume that setting up an exemption scheme is an infallible answer to the health needs of the poor – although many studies suggest that there are numerous problems with such schemes.

A few PRSPs include a thorough analysis of other types of barriers, such as quality of care provided, 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."

Other key points to emerge from the analysis include:

- Most PRSPs identify the "key diseases" in their country. In many cases, these are likely to be diseases which disproportionately affect the poor, but rarely is there detailed examination of this fact or presentation of statistical evidence. Similarly, there is little analysis of the impoverishing effects of diseases.
- Certain PRSPs outline very detailed disease control plans, based on rigorous analysis. This is most apparent in the case of HIV/AIDS. For example, Mozambique includes a geographic breakdown of HIV prevalence with a correspondingly targeted HIV/AIDS-control programme. Zambia presents a thorough analysis of the HIV/AIDS situation and its multiple poverty impacts.
- Very few PRSPs discuss the barriers that prevent poor women from accessing reproductive care – for example distance, cost, cultural practices – although it is consistently implied that the lack of skilled birth attendants contributes to an increased maternal mortality rate and higher chance of complications at birth.

## Rwanda's PRSP

*"The cost of health services is a much more powerful deterrent than distance; it is also the cause of dissatisfaction in 80% of the cases where people are dissatisfied (followed by the failure of treatment and the long queues) ... 95% of patients in private clinics and 65% of those in hospitals come from the richest 40% of households. Patients in health centres are more representative of the population, but even here the bottom 40% of households are under-represented. Poverty therefore seems to be a constraint in accessing the health system, despite the existence of exemption schemes."*

## Water, sanitation and nutrition

In addition to health, the review extracted information on other sectors that have direct links with health, namely water, sanitation and nutrition. Most PRSPs address water and sanitation independently, rather than as part of the health component. By contrast, nutrition is almost always addressed as part of health.

## Rwanda's PRSP

*"The long distances to potable water sources represent a significant burden for time use, particularly for women and girls. This problem is particularly acute in Kibungo, Kigali Ngali, Umutara, and Butare."*

In the case of **water**, all PRSPs compare rural and urban supply, and in many cases specific regions are identified as having poor access to drinking water (e.g. Niger). Reference is made in many but not all cases to the health implications of drinking from an unsafe water source. Likewise sanitation, although considered less consistently than water and often only in urban areas, is not always discussed with reference to health.

## The Gambia's PRSP

*"25% of extremely poor households obtain their water from uncovered sources. Lack of knowledge of water and disease relationships is a major factor of water point contamination."*

Discussion of the problems that poor people face in accessing water is usually confined to physical availability. Poor maintenance of facilities, user fees, etc., are rarely mentioned. The PRSPs of Senegal (see box) and Guyana are notable exceptions; the latter draws on a consultation with poor people, which identifies poor contract work, low budgetary allocations, inefficiencies in the operations of Guyana water authority, low maintenance of drainage facilities, and faulty pumps as key issues in the supply of water to poor areas.

## Senegal's PRSP

*"In towns, poor households, who essentially have to go to standpipes for water, pay three to four times as much as households with private connections in their homes."*

Information on **nutrition** is not always included in PRSPs. Where it does appear, it is usually confined to presentation of national statistics (such as rates of stunting or percentage of underweight children) rather

than an analysis of the causes of malnutrition. Nevertheless there are exceptions: the PRSP of The Gambia, for example, associates malnutrition with low literacy levels, high population growth, environmental degradation, and rural–urban migration. It also notes that the majority of women are in a constant energy-deficient state as a result of poor dietary intake, heavy workload, and high infection rate. The issue of food safety is rarely addressed in PRSPs.

## Zambia's PRSP

*"The main nutritionally vulnerable groups include: the elderly, the physically and mentally handicapped, street children, the chronically ill, young children and women of child-bearing age. [...] In both urban and rural areas it is the poor who are most nutritionally affected."*

### Other sectors

Beyond water, sanitation and nutrition there is very little discussion of the links between health and other sectors. In other words, health issues are discussed almost exclusively in the section on health, despite the obvious links with other sectors such as transport and the environment. The exception to this trend is education, which is consistently recognized as having a significant bearing on health status.

## Albania's PRSP

*"The infant mortality rate seems to increase when the health and educational level of the mother is low."*

Where detailed cross-sectoral analysis does occur, it is most typically in relation to HIV/AIDS. Zambia and Malawi both present broad-based discussions on how the HIV/AIDS epidemic impacts on many aspects of people's lives, including education, work, and savings.

## Viet Nam's PRSP

*"20-30% of disadvantaged communes have no roads leading to commune centres and their services."*

## The Gambia's PRSP

*“Extensive use of chemicals and pesticides and other related substances to boost production brings both environmental and human health problems which in turn have significant bearings on the level of poverty of the Gambian farmer.”*

Other links with health are made sporadically rather than systematically. These include: transport (e.g. in Vietnam); the environment (e.g. in Honduras); occupational health (e.g. in Tajikistan); gender-based violence (e.g. in Malawi); and renewable energy (e.g. in Zambia).

### Summary points:

- The information on health presented in the majority of PRSPs demonstrates an *implicit* rather than *explicit* poverty focus. For example most PRSPs identify those diseases which are major causes of morbidity and mortality in their country. However these are not always specifically identified as being the key diseases of the poor. Equally, the barriers that prevent poor women from accessing reproductive care are typically not explored in detail. However there are a number of important exceptions – particularly in more recent PRSPs – which suggest that poverty is becoming a more important feature of the health analysis.
- Health systems constraints in rural areas are examined fairly consistently across the range of PRSPs, and a few look in some detail at quality of care.
- Financial barriers to care are highlighted in the majority of PRSPs, although they are rarely dealt with in any detail. Only two PRSPs mention the problems associated with fee exemption schemes.
- Information on the links between health and other sectors is sporadic and varies in detail. Information on water tends to be more comprehensive than that on nutrition and sanitation. Beyond these sectors, only education is consistently mentioned as a sector of importance to health. There are some holistic, cross-sectoral discussions on HIV/AIDS.

### Health strategies as outlined in PRSPs

This section reports on the health strategies proposed in PRSPs. The study found that the overwhelming majority include strategies that can be characterized as “pro-poor”. For example:

- All of the 21 PRSPs reviewed include strategies on communicable disease control, maternal and reproductive health, child health (typically immunization), and improvement of water and sanitation.
- Twenty out of the 21 include a focus on strengthening basic health care in rural or poor areas, or improving access to services for poor people.
- Seventeen out of the 21 include an HIV/AIDS strategy, and 16 include a nutrition strategy. Roughly three-quarters, 15 out of 21, include some programme to reduce financial barriers to care among the poorest groups.
- Eighteen out of 21 include a statement on improving the *quality* or strengthening the management of health services. Often, this is through improving available human resources for health, e.g. by offering incentives for staff to work in rural areas.

It is important to point out that the level of detail varies considerably between PRSPs – in some cases a single objective is stated (e.g. to reduce maternal mortality); in other cases there are layers of description, with intermediate and final outcome targets.

One key gap is that strategies to tackle the impact of catastrophic ill-health or accidents, which can have a devastating financial effect on the poor and push the near-poor into poverty, are missing from most PRSPs. There are some important exceptions to this general rule. Mozambique, for example, plans to rehabilitate and expand rural hospitals in six specific districts. A second important gap is that the role of non-government service providers (for-profit and not-for-profit) is rarely discussed, aside from an acknowledgement that they are an important provider of health care.

### Evidence of poverty targeting

As mentioned above, the health strategies outlined in PRSPs are often implicitly focused on poverty, as they deal with diseases and conditions that are common among the poor. The study also looked for evidence of targeting – either geographically or through the identification of particular vulnerable groups.

Overall, this was difficult to find. For example, of the 21 PRSPs reviewed that addressed communicable diseases (other than HIV/AIDS), only one explicitly targeted poor populations or regions. Similar results were found in other areas. Water and sanitation is the

one exception to this trend, with half the PRSPs reviewed employing explicit targeting mechanisms.

The study team identified four major ways in which poor populations could be targeted. The first, and most common, was targeting on a rural/urban basis. Twenty different health activities across a number of PRSPs targeted rural communities, half of which are accounted for by water and sanitation projects.

The second and almost as common way of targeting vulnerable populations was by region or district, i.e. by delivering a certain programme to a particular poor district. Regional targeting was used for 15 different projects across five PRSPs. Examples include Guyana, where there is a focus on improving quality health care in “Hinterland” regions and Viet Nam (*see box*) which is committed to strengthening health services in mountainous and poor regions.

Third, and used considerably less than other forms of targeting, is targeting of the poor(est) people. This was used in only eight cases, four of which were programmes to reduce financial barriers to health care (which is implicitly pro-poor in any case).<sup>3</sup> A further two programmes concern improved access to water and sanitation, and two more focus on strengthening health services for poor people as part of a rural development project in two particular poor regions of Guyana.

### Viet Nam

A key component of the health strategy in Viet Nam's PRSP is to **consolidate and develop health services in poor regions**. This includes:

- drafting a specific health policy for mountainous and remote regions;
- providing on-site training of local ethnic health staff in mountainous, remote and disadvantaged areas;
- a package of incentives (including salaries, shift allowance and social insurance) to attract staff to remote regions.

Importantly, these strategy areas are linked to measurable targets:

- By 2005, 50% of *communes in mountainous areas* will have a doctor; by 2010 this figure will rise to 60%.
- By 2005, 80% of *poor communes* will have basic infrastructure (including health stations); by 2010 this figure will rise to 100%.

Finally other miscellaneous methods were used, such as those targeting women or indigenous groups. There are 10 such examples from eight countries in the PRSPs reviewed. One example is Bolivia, where the PRSP notes plans to expand the Health with Identity Programme (a health programme for indigenous people), and to measure the proportion of the indigenous population covered by basic health services (though no targets or base-lines are given).

In conclusion, no consistent method of pro-poor targeting – whether rural/urban, regional or quintile – is used within the health strategies of PRSPs. Water and sanitation programmes, which do not fall under the jurisdiction of health, are different, and are often targeted on a rural/urban basis.

### Is the poverty focus in health changing over time?

The study suggests no discernible trend in either implicit or explicit poverty focus over time. Of the sample group of 21 PRSPs, four were published in 2000, five in 2001 and 12 in 2002. In all three years, the majority of PRSPs included strategies to tackle communicable disease, and improve maternal and reproductive health, and child health. The exception is consideration of financial barriers to care, which is much more likely to be dealt with in later PRSPs.

The trend is the same for explicit poverty focus (as described above): in all three years, roughly a quarter of PRSPs reviewed included some form of explicit poverty targeting either in their HIV/AIDS, or maternal health and child health programmes. Equally, there is no increase over time in the proportion of PRSPs with pro-poor monitoring indicators.

### Consistency between analysis and strategy

One of the main shortcomings of PRSPs appears to be a lack of consistency between analysis of the health needs of the poor and the strategy presented. For example, Niger and Mozambique both provide disaggregated health data which show enormous disparities in health levels between districts. However, in neither case is the health strategy particularly targeted at these regions. Conversely, there are eight examples of health activities that are explicitly targeted at certain groups or regions, without any indication that these are the poorest.

Zambia's HIV/AIDS programme, as presented in its PRSP, is an example of good practice on this issue.

<sup>3</sup> Other programmes on financial barriers to care were not expressly pro-poor: for example, they mentioned the need to improve the affordability of health care overall, rather than for the poor.

It identifies a number of specific challenges associated with the HIV epidemic, including the economic impact on families, the lack of STI management, and lack of facilities for HIV testing. The strategy section tackles all these issues, and presents a range of associated intermediate and outcome indicators to monitor progress. However, Zambia is also an example of the “disconnect” between analysis and strategy. The PRSP provides a list of regional health actions recommended by poor people during the participatory poverty assessment. For example, people in the Central Region advocated the need for more health facilities, “adequate” staff, and improved drug supply, while those in Luapula region asked for improved drug supply and a scaled-up HIV/AIDS campaign. There is no indication in the PRSP health strategy of how these recommendations will be followed up region by region.

### Cross-sectoral policies

One of the potential benefits of the PRSP process – or any multisectoral planning process – is that it could provide an opportunity for different sectors to come together, discuss synergies and common challenges, and undertake joint planning of cross-sectoral activities. The study looked for evidence of this potential benefit being realized – i.e. of health goals or activities being reflected in related sectors.

The results are surprisingly disappointing. While the information/analysis section of PRSPs often provides information to suggest that cross-sectoral action for health might be useful, there is little evidence of this being taken forward in any sectoral strategy. For example, while a number of PRSPs acknowledge the importance of education for health, few link these sectors in their strategies; even fewer make the link between food security and nutrition/health. The overwhelming emphasis is on **government delivery of health services to reach health goals**. Notable if rare exceptions to this trend include:

- Zambia, where the energy sector proposes to fit rural health centres with solar panels;
- Burkina Faso, where sanitation facilities will be built in schools;
- Ethiopia, which is developing rural electrification and telecommunications schemes to meet the needs of health services.

Most often, however, cross-sectoral activities are linked to the HIV/AIDS strategy. This is not altogether surprising as National HIV/AIDS programmes are

often located outside ministries of health and are mandated to work across sectors.

### A new “pro-poor” approach to health?

The majority of health strategies presented in PRSPs represent a strengthening of basic health care. There is an assumption that provision of an essential package of services, combined with expansion of health services in rural areas, is pro-poor. While this is welcome, there is too little attention as to why these strategies have so far failed to reach the poor.

This lack of analysis may reflect the relatively short time period in which PRSPs are prepared, and/or a continuing commitment to strengthening primary care in low-income countries. Looking at PRSP documents in isolation, it is not possible to distinguish specific or additional “PRSP health activities” from other, existing, health sector activities. Rather, the health strategies presented in PRSPs appear to be taken from pre-existing national policies and plans, and thus cannot respond to specific issues raised in the analysis section.

As in other cases, there are exceptions to this general trend. Yemen and Ethiopia stand out as two countries which examine the limitations of previous health policies in some detail and which include a strong and detailed focus on strengthening health systems in rural areas (*see box page 16*).

If, as this study suggests, PRSPs have helped to catalyse a poverty-focused approach to the analysis of health challenges, this may create an opportunity for future health sector plans and strategies to include a much more explicit emphasis on meeting the health needs of the poor.

### Summary points:

- As with WHO’s previous review of health in PRSPs, this review found that all health strategies in PRSPs focus on interventions which should benefit the poor, such as improved maternal and reproductive health and immunization. These strategies are consistent with a primary health care approach, and presumably have been pursued in the countries concerned for many years. But few PRSPs examine the difficulties they have faced in the past in reaching the poor.
- There are few examples of PRSPs targeting health programmes specifically at the poorest groups or regions. However, these do exist, suggesting that there is some “good practice” to learn from.

### *Ethiopia's PRSP identifies these problems with the delivery of basic health services:*

- An unyielding preference for curative services by professionals, the public and the decision-makers at all levels.
- Poor performance of routine immunization services; token attention given to the promotion of personal hygiene, clean environment and integrated family health.
- The quality of the curative services, as well as the ethics of health professionals.
- Critical shortages of some key professionals, such as midwives and front-line health workers. This is also a result of mismatch of human resource need and human resource deployment, including inappropriate management.
- A combination of slow budget approval, disbursement processes and inadequate budget at health facility level has resulted in underutilization of some resources.
- Limited and inefficient management capacity at zonal, *Woreda* and health-facility level.
- Lack of monitoring and evaluation mechanisms and weak activity and financial reporting at each level of the health delivery system.
- Sporadic/seasonal shortage of drugs at facility level owing to a combination of delay in international drug procurement and inadequate management.
- Inability to optimize partnership with non-governmental organizations and the private sector in the expansion and provision of health care services.

- In general, the health strategies of PRSPs are not becoming more or less “pro-poor” *over time*, either in terms of explicit or implicit poverty focus. The exception is programmes to reduce financial barriers to care, which are more likely to appear in more recent PRSPs. In addition, it appears that the health components of PRSPs are becoming more detailed over time.
- The overwhelming emphasis is on public health sector interventions to reach health goals. There is very little examination of the role of non-government providers, and – beyond water and sanitation – very few examples of other sectors which include health activities or goals.

### *Health budgets as presented in PRSPs*

A key question for the health sector is: will PRSPs mean more money for health? The IMF has done some work looking at projected increases in health spending in PRGF-supported programmes. It shows that health spending as a proportion of GNP is projected to rise in these programmes, but only very slightly: from 1.8% of GNP in 1999 (actual spend), to 2.1% of GNP in 2001-2 (projected rise)[11]. Other work by the IMF also suggests that “Poverty-reducing spending has increased, on average, both in relation to GDP and to total spending for the 14 PRSP countries where data is available ... Between 1999 and 2001, poverty-reducing outlays increased, on average, by 1.4% of GDP in these 14 countries.”<sup>4</sup>[12]

These figures are impossible to validate by looking at PRSP documents themselves, as the majority do not contain information on health as percentage of GNP. Rather, they show absolute increases in health spending, and changes in health spending as a proportion of either the overall fiscal budget (two countries: Yemen, Rwanda) or as a share of a budget for priority sectors (11 countries). This information is presented in Table 1.

In absolute terms, health spending is rising in all countries, and quite dramatically so in some cases. However, this may not always represent a ‘real’ increase, because of inflation, the value of the currency, etc. Equally, health spending as a share of priority spending is not rising dramatically, and where health spending is shown as a proportion of GDP, the projected changes are typically quite small.

Of the 11 countries showing health as a share of priority spending, five indicate that the share of health will decrease over the PRSP period (three cases) or remain the same (less than 1% change). In four of the six cases where the percentage increases, the projected rise is less than 3%. In the two countries providing the overall fiscal budget, the health budget stays the same, fluctuating by less than 1%.

In the absence of information on the overall size of the priority sector budget – and bearing in mind that different countries identify different sectors as priorities – it is difficult to draw firm conclusions about what is happening to health spending in these countries. However, it is clear that within the identified priority

sectors, health is not gaining greater prominence. Further, the IMF figures suggest that PRSPs are not going to deliver steep increases in health spending, of the kind advocated by the Commission on Macroeconomics and Health or the Millennium Project.

Underlying this question of whether or not the PRSP process will result in increased funds for the social sector is a debate around the *purpose* of PRSPs – are they essentially fund-raising or planning instruments? As mentioned in the introduction, there are two distinct – and opposing – views on this matter. One body of opinion believes that PRSPs should present budgets based on *need* – what would it cost (unit costs plus overheads) to reduce poverty and meet the MDGs in a given country? The opposing view is that PRSPs should focus on ensuring the best use of *available resources*, ensuring the greatest impact of poverty. It is interesting to note that some more recent PRSPs, for example Rwanda (see box) contain two budget

### Rwanda's PRSP

The Rwanda PRSP presents two scenarios for a proposed expenditure programme. The first scenario represents the total unconstrained expenditure required to 'fully meet the needs of poverty reduction.' It represents a broad range of expenditures, based on the submissions of ministry costings. The second scenario is constrained to an additional expenditure of Rwf50 billion on current spend, and highlights the PRSPs financial priorities.

scenarios: one for a "constrained" environment, and one for an "unconstrained" environment, suggesting that some countries are attempting to combine the two purposes of planning document and fundraising instrument.

Table 1: Allocation of Resources to Health in PRSPs

Country	Absolute change in health spending	Projected increase in health budget as a % of priority budget	Health budget as a % of GDP (where available)
Burkina Faso (billions of CFAF)	(2000) 5.04	33.92%	
	(2003) 11.64	35.76%	
Ethiopia (million birr)	(2002/3) 2268.6	14.39%	
	(2004/5) 2275.7	12.17%	
Gambia	(2000) 91.3	7.65%	1.70%
	(2005) 240.2	10%	2.60%
Honduras (million USD)	(2001) 13.8	17.2%	
	(2005) 35.0	13.4%	
Mauritania (millions of UM)	(1996) 2638	24%	1.7%
	(2004) 8823	26.1%	2.8%
Mozambique (billion Meticals)	(2001) 2302.8	11.8%	
	(2005) 3528.3	15.3%	
Nicaragua (million USD)	(2001) 19.9	9.1%	
	(2005) 29.8	11.8%	
Niger (billion CFAF)	(2002) 67.21	17%	
	(2005) 74.92	17%	
Rwanda (unit unclear)*	(2001) 12.9	5.18%	
	(2004) 14.6	5.8%	
Senegal (millions CFAF)**	(2002) 19 064	9.2%	10%
	(2005) 21 616	10%	14%
Tanzania (million T. shillings)	(1999/2000) 53 870	19.1%	
	(2002/3) 105 761	18.14%	
Uganda (billion shillings)	(1999-2000) 28.2	8.4%	8.4%
	(2002-3) 98.1	16.8%	16.8%
Yemen (million YR)***	(2003) 9561	4.63%	
	(2005) 12 847	4.83%	

\* Rwanda does not give priority budget figures; figures show here are as a proportion of the total fiscal budget.

\*\* Unclear whether number given is overall health budget or increase in health budget for PRSP

\*\*\* Yemen also gives a total budget: in 2003 health will be 1.5% of the overall budget, in 2005 it will be 1.9% of the overall

The level of budget detail on health in PRSPs varies extensively. All but two of the PRSPs reviewed provide some set of figures on health spending and 12 give a breakdown of how the spending will be distributed among various health programmes. The detail of this breakdown ranges from a description of each individual programme to simple differentiation between primary and secondary health care. In the clearest cases, for example Yemen, projected expenditure is allocated to each activity under each objective, and in addition a breakdown is provided showing the source of revenue (e.g. government, external, self financing).

### HIPC resources

It is not always possible to distinguish how fiscal funds released by debt relief will be spent. Of the countries reviewed, 17 were HIPC countries. Of these, five (Republic of Guinea, Federal Republic of Ethiopia, Guyana, The Gambia and Nicaragua) indicated how resources released by HIPC would be allocated. For example, Ethiopia shows that 138.4 million Birr (US\$2 million) will be allocated to health from HIPC resources over three years. In six further cases, the level of HIPC funds committed to the PRSP effort are shown, but it is unclear which sectors or projects will benefit. Two countries of these six state that HIPC funds will go to the programmes or sectors “in the most need”, while the others simply show the level of resources available. It must be noted that countries are at different stages in the debt relief process, and not all have yet received full debt relief.

### Summary points:

- Projected spending increases in health suggest that health is not gaining significantly in priority as a sector. Moreover, the steep increases in health spending which many feel are necessary to reach the MDGs are not likely to be realized through the PRSP process.
- Many PRSP budgets are only loosely related to the broad programming plans listed in the health strategy. Especially with reference to the HIPC funds, there is surprisingly little detail on how funds will be used.

### Monitoring the health component of PRSPs

PRSPs present a range of indicators to monitor their health strategies. These include both intermediate indicators (e.g. distance to a health facility, number of

health personnel per head of population, drug availability), and outcome indicators which measure changes in health status. Further indicators monitor the progress of specific programmes, e.g. “the Indigenous Development Plan will be in place by 2003” (Bolivia). This review assesses the extent to which PRSPs presented health indicators that:

- could monitor the activities that were part of the strategy;
- could monitor the impact of the strategy on the health of poor people;
- are linked to the Millennium Development Goals (see Annex 5 for a list of health-related MDGs).

### Monitoring the health strategy

The review found that in the majority of cases indicators were provided to monitor the key components of a health strategy presented (*see Table 2*). Most commonly, these are maternal and infant mortality (relating to maternal and child health programmes, but also serving as general indicators of health status), and HIV prevalence. Most PRSPs also include some intermediate health coverage indicators (*see box on Malawi for an example*), and a few also include indicators related to human resources. For example, in Tajikistan a programme to strengthen human resources for health has an associated indicator on the percentage of staff trained and retrained.

However, there were often glaring gaps where whole components of the health strategy lacked any means of monitoring. Most typically, these were components related to strengthening the quality of care, improving management, strengthening data collection, etc. In many cases, also, no quantifiable targets are associated with the indicators: for example the PRSP may indicate that the number of doctors per head of population will be monitored, but it is not clear what the baseline situation is, or what change the PRSP hopes to achieve. Moreover, it was noted that certain PRSPs presented very modest targets (e.g. Malawi aimed to train 60 doctors in three years) although this was not a factor that the review specifically set out to assess.

One gap, which was fairly consistent across PRSPs, was the failure to provide for monitoring of activities to reduce financial barriers to health care. Although 15 PRSPs addressed this issue, only three presented indicators that could be monitored.

### Selection of indicators from Malawi's PRSP:

- Malaria-related mortality in children under five (among children in rural hospitals) to fall from 34% in 2000 to less than 18% in 2005.
- Percentage of households with mosquito nets in priority areas to rise from 70% in 2000 to 80% in 2005.
- Number of people reached by information and sensitization campaigns on HIV/AIDS to rise from 16.4% (2001) to 17% (2005).
- HIV prevalence rate to go from 16.4% in 2001 to 17% in 2005.
- Inhabitants per health unit, levels I and II to decrease from 14 345 in 2000 to less than 11 000 in 2005.
- Institutional delivery coverage rate will increase from 40.3% in 2000 to 46% in 2005.

### Monitoring the impact on the health of the poor(est)

Few PRSPs attempt to monitor the impact of their health programmes on the poorest members of the population (*see Table 2*). Given the inconsistency of explicit poverty targeting within the health strategies, and the often sketchy data available to monitor poverty itself, this is not entirely surprising. Nevertheless, it is disappointing that little attempt has been made to monitor specific regions or groups identified as poor. For example, out of the 21 country health strategies that

address communicable diseases, only one presented *poverty-focused* indicators to monitor the programme. The figures are the same for reproductive and maternal health programmes, although slightly improved for HIV/AIDS (three) and child health (two). It is notable that the water and sanitation sector provides poverty-focused indicators in 11 cases.

It has been well argued that health programmes focused on the needs of the poor will not necessarily reach the poorest groups. Poverty-focused monitoring indicators are thus a key tool for assessing the impact of health programmes on poor people – a tool which most PRSPs fail to employ in their health strategies.

### Links with the Millennium Development Goals

PRSPs fairly consistently reflect the *goals* of MDGs, but they do not necessarily reflect the quantifiable *targets*. For example, Goal 4, to “reduce child mortality” is addressed in all 21 strategies and monitored likewise. However, none of the PRSPs refers to the quantifiable target – a three-quarters reduction in maternal death – and, because of data inconsistencies, it is impossible to judge whether the targets set in PRSPs correspond to this magnitude of reduction (*see box, page 20*).

Similarly, 20 out of 21 PRSPs link their strategy for safe water to the respective MDG, but few make reference to the target of halving the numbers of people without sustainable access to an improved water source.

Table 2: Summary analysis of the health components of PRSPs  
N=21

	Addressed in the health component of the PRSP?	Targeted at poor people?	Are indicators identified to measure progress?	Pro-poor monitoring reflected in the monitoring indicators?	Disaggregated data provided?
HIV/AIDS	17	7	13	3	7
Other communicable diseases	21	10	15	1	2
Maternal and reproductive health	21	10	21	1	5
Child health	21	13	21	2	7
Financial barriers to health care	15	12	3	–	1
Improvement of water and sanitation	21	17	19	11	13
Nutrition	16	9	12	3	6
Strengthening health services in rural or poor regions	20	9	3	1	4

### Do PRSPs aim to meet the maternal mortality target?

Target 6 of the MDGs is to reduce maternal mortality by three-quarters between 1990 and 2015. Nineteen of the 21 PRSPs present quantifiable targets for their strategy to reduce maternal mortality. However, using WHO data it is difficult to determine whether these PRSP targets correspond to a three-quarters reduction. This is because the current and projected maternal mortality rates presented in PRSPs are typically drawn from national data, which are often very different from WHO data. Thus it is impossible to compare a 2015 target for maternal mortality in a PRSP with a 1990 WHO baseline.

The study also looked for links between PRSPs and the specific indicators associated with the MDGs (see Tables 3 and 4). This is important because it has implications for the reporting burden placed on countries: if the indicators in PRSPs are very different from those in the MDGs, this implies a higher reporting burden, as all countries are asked to produce annual MDG reports. Roughly one-third of PRSPs will report on the MDG indicators for nutrition, access to essential drugs, and attended birth. However, only three of the 21 PRSPs reviewed include the specific MDG indicator on HIV/AIDS, and only four include the measles immunization target. However, in both cases most PRSPs contain a closely related indicator, such as DPT immunization.

Table 3: Coherence between MDG targets and PRSP health targets  
N=21

	Infant mortality rate	Maternal mortality ratio	Proportion of population with sustainable access to an improved water source, urban and rural
Is this indicator mentioned in the strategy	21	21	20
Is there a quantifiable target associated with it?	18	21	16
If there is a quantifiable target, is it linked to the MDG target (e.g. a 2/3 reduction)?	6*	9*	7

\*Based on WHO figures for 1990 and targets listed in PRSP, which may be a different data source

It is suggested, on the basis of the review, that the health MDGs have influenced the inclusion of certain goals and strategies in the PRSPs. However, there is limited reference to specific targets and indicators associated with the health MDGs – although many (including the World Bank) see the PRSPs as the key vehicle for achieving the MDGs.

### Responsibility for monitoring

The responsibility for monitoring PRSPs tends to rest with official bodies. In every PRSP reviewed except one (Senegal), some sort of official monitoring system and organization of duties is spelled out. Proposed mechanisms include:

- designation of a coordinating ministry to direct the actions of the ministries and other actors;

Table 4: Coherence between MDG indicators and PRSP health indicators  
N=21

	Prevalence of underweight children (under five years of age)	HIV prevalence among 15-24 year old pregnant women	Proportion of one-year-old children immunized against measles	Proportion of births attended by skilled health personnel	Proportion of population with access to affordable essential drugs on a sustainable basis
Is this indicator mentioned in the strategy?	8	3	4	8	8
Is a closely-related indicator mentioned in the strategy?	3	11	7	–	7
Is there a quantifiable target associated with it?	8	10	7	8	5

- establishing a coordinating body outside the ministries to ensure interdepartmental cooperation and manage monitoring activities;
- monitoring through national surveys.

Nongovernmental organizations and academic institutions are mentioned as monitoring partners in just three countries: Zambia, Honduras and Albania. Some other PRSPs do mention activities designed to gather opinions from poor people as part of their PRSP monitoring. For example, Malawi conducts annual stakeholder workshops as well as broader district level surveys and Uganda will receive input from the Participatory Poverty Assessment Project. Ethiopia has also recognized a need for a PPA, and Guinea will ensure that qualitative data is included in all its surveys. Fundamentally, however, monitoring remains in the hands of government structures and institutions with little external assistance or input.

### Summary points:

- Although the majority of PRSPs present a range of indicators to monitor the health strategy, they are not always comprehensive or quantifiable. In some cases they also lack clarity.
- There is little evidence of indicators that *explicitly* monitor the impact of the health strategy on the poor regions or groups identified.
- There are strong links between the PRSPs and the MDGs in terms of focus, but not necessarily in terms of quantifiable targets or indicators. This suggests that PRSPs are not adopting the health MDGs in their entirety, but rather adapting them to specific country circumstances.

# Conclusions

PRSPs are potentially very important instruments for the health sector, for a number of reasons:

- There is now a firm recognition that human capital development – including improved health outcomes – is central to poverty reduction and economic growth. Moreover, better health is important to the achievement of other human capital objectives (e.g. improved health is crucial to primary education goals). PRSPs present an opportunity to transform this recognition into strategy.
- The PRSP process can help to improve dialogue between ministries such as finance and planning (which typically have oversight of the PRSP process) and the ministry of health. This provides an opportunity to increase understanding in upstream ministries of the role of health in development, in turn strengthening the case for more resources for the health sector.
- By bringing a poverty reduction lens to the health sector, PRSPs could catalyse a more pro-poor analysis of the health challenges that low-income countries face, including an examination of why existing policies are failing to reach vulnerable groups.
- Building on this analysis, PRSPs could help to reorientate national health plans and strategies to focus on the needs of the poor and those health actions most likely to reduce poverty, while strengthening donor harmonization efforts.

However, it is clear from WHO's analysis that in most cases PRSPs are not delivering on this potential. Over time, a more detailed analysis of poverty–health links may be emerging in PRSPs, but – with some notable exceptions<sup>5</sup> – this remains far short of comprehensive. In the main, PRSPs do not systematically identify those health issues which are the biggest contributors to poverty or the greatest brake on economic growth, and then set out to tackle them. Nor do they look systematically at the health situation of the poor – beyond noting that they tend to have the worst health outcomes and are unable to afford health care fees.

In their strategies, most PRSPs suggest expanding health provision without a clear discussion of whether

this is the best course. Typically, this includes widening coverage of a “basic package” of health interventions and introducing (or continuing) fee exemptions for the poor. In very few cases is there an analysis of the successes and failures of this approach in the past.<sup>6</sup> It is likely that this approach is drawn from existing health strategies – although this cannot be verified by this review.<sup>7</sup>

A further important point is that PRSPs do not deliver on their potential to stimulate cross-sectoral action for health. PRSPs should take a holistic, cross-sectoral approach to poverty reduction, providing an opportunity to put health goals on the agenda of other sectors. However, our analysis suggests that cross-sectoral activities for health are, in the main, traditional and unimaginative: water and sanitation, nutrition, and in fewer cases health education. As always, there are important exceptions to this trend – such as Zambia's plan to fit solar panels in health centres in rural areas as part of its energy strategy. But in general the possible role of sectors such as roads, transport, and of fiscal policy (e.g. by introducing tobacco taxes) in improving health is not discussed. Rather, PRSPs focus on health sector delivery of health services.

Finally, it is clear from the budgets presented in PRSPs – and from independent analysis performed by others – that PRSPs will not result in large increases in resources available for health.

## Moving forward in the health sector

If PRSPs are not delivering on their potential for health, what can be done?

First, the health sector must engage with the PRSP process to ensure that future PRSPs better reflect health concerns. This will require a **strengthening of health sector capacity on poverty issues**, including a better analysis of poverty–health links and the creation of strategies that put health at the centre of poverty reduction efforts *and* respond to the needs of the poorest. It will also require the identification of key actions in other sectors, and the establishment of monitoring mechanisms which distinguish between

<sup>5</sup> Zambia stands out as one country which discusses the economic impact of HIV/AIDS in detail, and then proposes a multipronged, multisectoral strategy to mitigate this impact.

<sup>6</sup> Yemen and Ethiopia are two countries which do provide such an analysis.

<sup>7</sup> The three country case studies on PRSPs carried out by WHO also confirm that the health strategies proposed in PRSPs are drawn from existing health sector plans.

poor and non-poor. This approach will not only allow the ministry of health (MOH) to take a more proactive role at the PRSP table but will also – more importantly – assist the development of a poverty-oriented health strategy. Achieving it will require technical support from health development partners, including WHO, to develop tools and build capacity for health sector assessment, strategy design, public expenditure management, and monitoring and evaluation.

Yet, targeting the MOH in isolation will have its limits. In most countries, the MOH does not have a strong track record in responding to the needs of the poor or pursuing improved health outcomes through non-health inputs. The creation of a new planning instrument is unlikely to be received with enthusiasm in any quarter. But faced with conservative and insufficiently detailed health strategies in PRSPs, new approaches may be required.

One way forward is to **improve links between the PRSP and other processes which can help improve the poverty focus of the health component**. One such process is the Participatory Poverty Assessment (PPA). This often figures quite strongly in the overall analysis presented in PRSPs, but is rarely cited in the health component – even though it frequently contains a wealth of information on health from the perspective of poor people. Health partners could make much better use of PPAs in the design of health components of PRSPs.

Another such process is the development of Health Investment Plans, proposed as part of the follow-up to

the CMH process. These aim to identify key health issues for the poor and discuss different costing scenarios for the interventions required to address them. Ministries of finance are engaged in developing plans which envisage an increase in health spending of 1–2% of GDP by 2007. They could provide an important source of information, as well as political momentum, for the creation of health strategies with a greater poverty focus.

Equally, where mechanisms exist to coordinate the health development partners – such as the Sector-Wide Approach (SWAp) process – these need to engage in the PRSP process and should be reflected in PRSP documents. Debates around aid effectiveness and donor coordination tend to be missing from PRSPs as a whole (and are certainly very rarely discussed in relation to the health sector). Yet, the PRSP process is intrinsically concerned with resource management, donor harmonization and coordination. An explicit discussion in PRSPs of the challenges associated with public expenditure management, including effective delivery of donor assistance *for health*, could well contribute to more effective implementation of PRSPs.

In conclusion, PRSPs are an important entry point for tackling poverty–health challenges in low-income countries. However, PRSPs alone will not create capacity or commitment to poverty issues in ministries of health. Greater support from health development partners, links with other processes, and continuing advocacy with higher levels of government, remain essential to achieve this end.

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## List of Acronyms

CMH	Commission on Macroeconomics and Health
DPT	diphtheria, tetanus and pertussis
HIPC	Heavily Indebted Poor Country
HIV/AIDS	human immuno-deficiency virus/acquired immune-deficiency syndrome
IMF	International Monetary Fund
MDGs	Millennium Development Goals
MOH	ministry of health
OECD	Organisation for Economic Cooperation and Development
PPA	Participatory Poverty Assessment
PHC	Primary health care
PRGF	Poverty Reduction Growth Facility
PRSP	Poverty Reduction Strategy Paper
QPA	Qualitative Poverty Assessment
STI	sexually transmitted infection
SWAp	Sector-Wide Approach

*Annex 1: List of PRSPs reviewed*

Albania  
Bolivia  
Burkina Faso  
Ethiopia  
Gambia  
Guinea  
Guyana  
Honduras  
Malawi  
Mauritania  
Mozambique  
Nicaragua  
Niger  
Rwanda  
Senegal  
Tajikistan  
Tanzania  
Uganda  
Vietnam  
Yemen  
Zambia

## Annex 2: Framework of analysis used for the 2003 review of PRSPs

### Structure and Finance

- Overall objectives of the PRSP
  - Where does health fit within the strategy?
- Budget
  - Is the health strategy budgeted and what level of detail is provided?
  - Is the health budget shown to be increasing over the PRSP period?

### Poverty context

- How does the PRSP define poverty?
- What criteria are used to identify the poorest communities?
- Are the poorest geographical regions identified?
- How is the poverty monitoring mechanism organized?
- Does the monitoring mechanism enable disaggregation between poor and non-poor?

### Poverty and health context

- What conceptual links are made between poverty and health?
  - Is poverty a cause and/or a consequence of ill-health?
- Is better health recognized as a means of poverty reduction and economic growth?
- What are specifically identified as the main health problems/needs of the poor?
- What disaggregated (regional and quintile) health statistics are provided, if any?

### Health components of the PRSP–Information

- What information is provided on the health situation in the country?
  - To what extent is the health situation of the poor discussed?
  - What are the main indicators of the health situation in relation to:
    - a. health services
    - b. health financing and expenditure
    - c. health outcomes (poor and non-poor).

### Health components of the PRSP – Objectives, strategies and indicators

- What strategies are identified for improving health and health care?
- Are they targeted at poor people?
- Are indicators identified to measure progress?
- Are the indicators linked to the MDGs?
- Do the monitoring indicators reflect pro-poor targeting?

### Beyond the health sector – Health strategies in other sectors

- Are there strategies in other sectors that explicitly address issues of health and health care?
- Are they targeted at poor people?
- Are indicators identified to measure progress?
- Are the indicators linked to the MDGs?
- Do the indicators reflect pro-poor targeting?

**Box A:**  
*Other sectors may include:*

- Food security
- Water and sanitation
- Nutrition
- Environment
- Transport
- Education and literacy
- Rural development.

## Analysis

- Quantity, detail and depth of data
- Coherence and consistency of strategy
- Level of poverty focus
  - Are the named poorest regions and groups identified?
  - Are poor women targeted explicitly?
- Extent of cross-sectoral activities in addressing health issues

## Summary table

In order to generate a summary information sheet, the health issues (*see box*) were specifically targeted for analysis through the following questions (answered yes/no):

- Are they addressed in the health component of the PRSP?
- Are they targeted at poor people?
- Are indicators identified to measure progress?
- Are the indicators linked to the MDGs?
- Do the monitoring indicators reflect pro-poor targeting?

### *Box B: Health issues*

- HIV/AIDS
- Other communicable diseases
- Maternal and 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 the health delivery system.

## Annex 3: Framework of analysis used for the previous WHO review of PRSPs (2002)

### 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 and economic growth?
- Is better health, implicitly or explicitly, one of the principal 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 analysed 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?
- 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 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?

#### 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.

## **Annex 4: Summary report of international consultation on WHO's work on health in PRSPs: Key areas for future partnership and collaboration in WHO's work to monitor the health component of Poverty Reduction Strategy Papers (PRSPs)**

### **Background**

On 10-11 April 2003, WHO hosted a Consultation to Review its Analytical Work on Health in PRSPs. Participants included representatives from HIPC II countries, WHO regional offices, the World Bank, IMF, the European Commission, Overseas Development Institute, the Office of the UN Special Rapporteur on the Right to Health, civil society, as well as several departments and outposted offices from WHO headquarters.

In the final session, participants discussed opportunities and possible new directions to take the PRSP work forward. This paper summarizes that feedback and suggests some steps for operationalizing the next stage in the monitoring programme. It also reflects a key message from participants that, in addition to monitoring the place of health in PRSPs (the focus of the meeting), WHO has a crucial role to play in supporting the development and implementation of PRSPs at country level. Of particular importance is work to strengthen the poverty–health diagnosis and to elaborate priority pro-poor health strategies within PRSPs.

### **General remarks on PRSPs**

In addition to being a vehicle to attract new funding for health, PRSPs are *potentially* an important instrument for:

- promoting a pro-poor agenda in the MOH;
- streamlining donor support for health;
- promoting partnership and coordination between government, civil society and development agencies.

However, an important discussion point at the meeting was that PRSPs are not achieving these aims in all countries. Continued monitoring of the health content of PRSPs is therefore important to ensure that they optimize the potential contribution of health to poverty reduction.

### **Future WHO tasks identified at the meeting**

#### **1. Revise the mechanism used by WHO to monitor the *content* of health in PRSPs**

WHO aims to accelerate its monitoring work so that each PRSP is analysed soon after it is produced. The results of each desk review will also be made available on a publicly-accessible electronic database.

Participants put forward the following suggestions on how the framework could be revised:

- Make it shorter and focusing on key questions relevant to the health of the poor and the diagnosis/strategy/monitoring continuum;
- Identify key gaps in available data;
- Include a mechanism to monitor progress reports;
- Examine links with the Millennium Development Goals (MDGs);
- Simplify current categorizations and divisions used in the framework. This change will be made, bearing in mind the usefulness of looking into the *detail* of health strategies contained in PRSPs.

It was suggested that the desk review of PRSPs be linked with a review of other relevant documents, in particular the health sector strategy (including the sector budget and monitoring plans), and decentralization strategies. An issue raised by participants was that the PRSP is not a substitute for the health-sector strategy. Rather it is a means of focusing on priority health issues from a poverty perspective and emphasizing the multisectoral nature of health determinants.

## **2. Review and revise the mechanism used by WHO to monitor the *process* of PRSP development**

Many participants commented that the WHO case studies of PRSP development were a critical component of the review process, and encouraged the Organization to conduct more. The case studies involve a week-long country visit to gathering information on the process of PRSP development and WHO's role.

Some participants suggested that an intermediate approach which went deeper than the desk review, but was also less resource-intensive than the case studies, could help broaden the range of information available on PRSP processes. This could take the form of a short questionnaire – possibly linked to the desk review of each country's PRSP – to gather feedback on the role of WHO country offices/ministries of health in PRSP development and implementation.

## **3. Expand work to support preparation of the sector budget and to monitor financial flows to health in PRSP countries**

Participants agreed that more work needs to be done to monitor resource flows to health in PRSP countries. The key questions were defined as:

- (1) Is the overall health budget increasing in countries with PRSPs?
- (2) Is there evidence of increased pro-poor spending within the health budgets of these countries?

Making a link between the resource flows and implementation of PRSPs is crucial, i.e. comparing the sector budget with priorities outlined in PRSP documents, and retrospectively looking at actual versus projected spending (particularly on health interventions and programmes targeted at the poor). Improved collaboration between WHO and other partners, including the IMF, who already have extensive data on projected health spending in PRSP countries, is key to this objective.

Other key questions on financial monitoring which emerged during the discussion include:

- How to define “pro-poor spend”? – Participants agreed that using primary health care as a proxy is inadequate. The challenge will be to define a measure that is both meaningful and simple.
- How to distinguish between investing in health (which has multisectoral determinants) and investing in the health sector?
- How to capture off-budget donor spending when looking at resource flows in health, as the overall envelope for health may be increasing while spending through the government budget decreases.
- In what circumstances is it possible to track allocation of HIPC funds, and where is it only possible to look at overall increases in health spending in PRSP countries (which may not be attributable to HIPC)?

## **4. Strengthen links between the analytical work and guidance and capacity-building**

Many participants made the point that WHO, as one of the key players for health, needs to better link the information and insights emerging from the PRSP desk review with support for PRSP design and implementation at country level.

Some participants interpreted the framework used in the desk review as a “blueprint” or checklist for the health chapters of PRSPs. Though it is not designed to fulfil this function, WHO does need to accelerate work on developing tools and guidance which are useful at country level, including tools which countries can use to monitor progress in the implementation of PRSPs. Such guidance should look beyond health to other sectors (education, transport, water, etc.) and be linked to existing and MDGs and work to build an evidence-base on health and poverty determinants at country level (e.g. through the World Health Survey). Participants also stressed that tools and guidance should be linked to capacity-building and advocacy at country level.

The case study approach (discussed above) can be a powerful vehicle to link analytical work (review of PRSP content and process) and capacity-building in countries, with the aim of combining analysis, advocacy and advice and, over time, providing a structured input to tools and guidance on pro-poor health policy. To this end, the case studies should link opportunistically to other capacity-building processes at country level.

### Next steps (external distribution)

Many participants mentioned the need for strengthened links between the United Nations and Bretton Woods institutions on PRSP issues, and in particular for a strengthened PRSP-MDG axis. Moving forward on this issue within the health sector could help to strengthen collaboration across sectors. There is also ongoing work to frame and monitor PRSPs from a human rights perspective, and in many civil society organizations. It will be important to ensure information exchange between these initiatives and WHO's work.

It was proposed to establish an advisory or reference group to help **improve links within WHO, and between WHO and other partners working on health in PRSPs**. Most participants agreed that such a group would be useful, and suggested that its representation be broad. Members could include staff from WHO regional offices, the World Bank, development agencies, ministries of health, ministries of finance and planning, human rights experts, and civil society groups.

In the short term, the main purpose of the group would be to provide technical input and serve as a "sounding board" for tasks 1-3, mentioned above. Over time, it could also provide input and guidance on task 4. Immediate tasks for the group could include:

- Providing input on the next draft of the framework.
- Identifying countries for follow-up case study work.
- Helping to establish stronger collaboration between WHO, the IMF, and other donor groups and organizations doing similar work on financial monitoring of PRSPs. One way forward could be to hold a meeting in Washington between the WHO National Health Accounts team and the IMF to: (i) establish mechanisms to improve sharing of data and resources; and (ii) further explore the issue of how to define pro-poor health spending.

WHO, Geneva  
29 April 2003

## HEALTH IN THE MILLENNIUM DEVELOPMENT GOALS (MDGs)

Goals, targets and indicators in the MDGs focused on health

<b>GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER</b>		
Target 1	Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	
Target 2	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children under-five years of age 5. Proportion of population below minimum level of dietary energy consumption
<b>GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION</b>		
Target 3	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	
<b>GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN</b>		
Target 4	Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015	
<b>GOAL 4: REDUCE CHILD MORTALITY</b>		
Target 5	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of 1-year-old children immunized against measles
<b>GOAL 5: IMPROVE MATERNAL HEALTH</b>		
Target 6	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel
<b>GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES</b>		
Target 7	Have halted by 2015, and begun to reverse, the spread of HIV/AIDS	18. HIV prevalence among 15-24-year-old pregnant women 19. Condom use rate of the contraceptive prevalence rate 20. Number of children orphaned by HIV/AIDS
Target 8	Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases	21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)
<b>GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY</b>		
Target 9	Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	29. Proportion of population using solid fuels
Target 10*	Halve, by 2015, the proportion of people without sustainable access to safe drinking water	30. Proportion of population with sustainable access to an improved water source, urban and rural
Target 11	By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	31. Proportion of urban population with access to improved sanitation
<b>GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT</b>		
Target 12	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system	
Target 13	Address the special needs of the least developed countries	
Target 14	Address the special needs of landlocked countries and small island developing States	
Target 15	Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	
Target 16	In cooperation with developing countries, develop and implement strategies for decent and productive work for youth	
Target 17	In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries	46. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18	In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	

\* At the World Summit on Sustainable Development in Johannesburg in September 2002, Member States adopted an equivalent target for sanitation, "to halve, by the year 2015, the proportion of people who do not have access to basic sanitation."

Annotation: For WHO's operational activities in monitoring and reporting, MDG health indicators representing more than one measure (i.e. TB and malaria) have been broken down into their single measures. Additionally, the HIV-related indicator has been reformulated to incorporate the corresponding footnotes of the initial MDG indicator list.

Sources: "Implementation of the United Nations Millennium Declaration", Report of the Secretary-General, A/57/270 (31 July 2002), first annual report based on the "Road map towards the implementation of the United Nations Millennium Declaration", Report of the Secretary-General, A/56/326 (6 Sept 2001), Johannesburg Plan of Implementation, September 2002; United Nations Statistics Division, Department of Economic and Social Affairs, United Nations