Poverty Reduction Strategy Papers: An Overview of Health Components

* *Dr Benjamin Nganda*

Introduction

Poverty Reduction Strategy Papers (PRSPs) are documents prepared by national governments in poor countries through a participatory process involving civil society and development partners, including the World Bank (WB) and the International Monetary Fund (IMF). They describe a country's macroeconomic and social policies for promoting growth and reducing poverty. The World Summit on Social Development (WSSD) 2015 Agenda, endorsed by the highly indebted poor countries (HIPC)-PRSP process, supported an ambitious development programme focused on improving social indicators–education, health, water, sanitation. Each country is invited to formalize its commitment to this agenda by preparing a PRSP to be submitted to the Boards of the IMF and World Bank. The WSSD 2015 Agenda was turned into the Millennium Development Goals (MDGs), aiming to halve poverty between 1995 and 2015, with eight specific goals, 18 targets, and 48 indicators.

The MDGs give prominence to health: four out of the eight goals, nine out of the 18 targets spread over six of the goals, and 18 out of the 48 indicators directly relate to health sector. The WHO Commission on Macroeconomics and Health (CMH), set up in 1998 released a landmark report in 2001 detailing the negative effects of the high disease burden on economic development, especially in least developed countries (LDCs). The report made strong recommendations for scaling up domestic and international finances to tackle ill-health in poor countries, most of which are in Africa.

There are no set guidelines or rules to write Poverty Reduction Strategies (PRSs) or PRSPs that give health the prominence it receives in the MDGs. However, there is an obvious advantage in learning from what has been attempted. This article reviews the approaches proposed or used to assist countries in scaling up the health component of PRSs, including PRSPs, i.e., ensuring that the health of the poor is given prominence through analytical work that leads to pro-poor policies, actions and expenditures. These approaches largely address the question, "What is the basic relationships between poverty and health, nutrition and poverty, and how do they influence one other?"

A World Bank approach

The World Bank and the IMF, in response to criticism of their structural adjustment programmes (which left many low income country economies in shambles and with increased poverty burdens), introduced a new framework that sought to enhance the poverty impact of country actions and development assistance. The framework focused on a long-term operational approach to poverty reduction and comprehensive development. The World Bank prepared a document to help those working on the health component of the PRSP. It suggested five functions and activities to consider: a discussion of poverty and health; a discussion of "Best Buys", health sector analysis, building blocks for the full PRSP, and a checklist for interim PRSP (iPRSP) authors and reviewers to ensure that new investments occur in areas that actually reach the poor.

The document outlines an analysis of the interaction between poverty and health and summarizes the arguments for investment in health as critical poverty reduction activities. The health sector analysis helps iPRSP authors base their policy recommendations on sound empirical findings. It recommends the analysis of available data to assess the health outcomes of the poor at country level, analyse the interactions between poverty and health, revisit and revise the core set of packages to ensure that diseases affecting the poor are adequately included and prioritized for sustained funding; assess the coverage of the poor with the key interventions selected; and identify gaps in serving the poor and providing these services.

A logical framework, summarized by four broad questions that lend themselves to the choice of analytical and participatory activities is suggested:

- What are the health and nutritional conditions for the poor and how do they compare with those of the better off? Focuses policy and resources on the epidemiological needs of the poor.
- Why do poor households and communities suffer more than the better off and what are the barriers faced? Recognizes that poverty is a household and community characteristic

[1]World Bank, 'Rapid Guidelines For Integrating Health Nutrition and Population Issues in Interim Poverty Reduction Strategy Papers of Low-Income Countries, New York, World Bank, 2000. See the document at: http://www.worldbank.org/poverty/strategies/chapters/health/hnpguide.pdf

and that individual actions are critical in the improvements of health and nutritional outcomes.

- How does the health sector fail the poor and the socially vulnerable? Leads to policy changes within the health sector that would improve the interface between the poor and the health sector as well as improve the advocacy role of ministries of health.
- What set of public policies can be delivered to improve the equity performance of the health sector? Prioritizes the selection of interventions.

More recently, the Bank has compiled the PRSP Sourcebook which provides guidance both on process aspects of building a poverty reduction strategy, and on practical aspects, such as poverty diagnostics, specific sectoral challenges with respect to poverty reduction objectives, etc., It can be found on the World Bank website.

WHO approaches

In recognition of the prominence given to health in the MDGs, WHO initiated a programme of work to systematically monitor the place of health in PRSPs (see the WHO website). The project analyses the health component of the PRSP from a pro-poor perspective; it looks at how far the overall PRSP document recognizes investments in health as important to poverty reduction. The overall aim is to examine whether the PRSPs are leading to the creation of more pro-poor health policies in low-income countries. A comprehensive desk review of PRSPs in ten countries from all parts of the world to see whether health had been given the MDG equivalent prominence revealed gaps in four major areas. First, the ministries of health, critical stakeholders in developing the health component, were largely marginalized during the PRSP formulation process. Second, the contents of the PRSPs were dominated by macroeconomics jargon, neglecting key social issues. Third, there was no analytical framework linking deficits in social indicators to causative factors. Lastly, there were no indications of how the gap (between the resources expected from the HIPC-PRSP mechanism and what was needed to meet the MDGS) will be closed. The review uses a standardized analytical framework that addresses seven main areas in order to analyse the poverty-health links in the document:

Poverty-health context

- Defining poverty
- Examining the pattern of poverty
- Examining the links between health and poverty

Health-specific analysis

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

The framework systematically examines the poverty context outlined in the PRSPs from a health perspective, and the health strategy from a poverty perspective. In so doing, 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. Second, it seeks to determine how far the health components of the 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 the PRSPs are implicitly pro-poor, it is possible to achieve the MDG targets without reaching the very poorest. Third, the framework is informed by a review of actual country PRSPs which have already proved to be useful resources. Fourth, it allows an assessment of whether the health components of PRSPs are changing or evolving over time. Finally, the framework looks systematically at the link between the health targets and strategies set by PRSPs, and the MDG targets and indicators, allowing an assessment of how far the health MDGs are reflected in PRSPs.

During the fifty-second session of the WHO Regional Committee for Africa, a proposal for enhancing the health component content of PRSPs in the Region was tabled and approved. It provides countries with the means for: (i) diagnosing health related development issues; (ii) analysing the linkages between poverty and health; (iii) elaborating pro-poor health policy interventions in the overall context of the PRSP, including the monitoring of outcomes; and (iv) costing the financial requirements of the health component, including a test for feasibility and sustainability of the level of resources. The rest of this article highlights the key aspects of this framework for enhancing the health component of PRSPs.[2]

Analytical framework

The analytical framework involves a four-step process: (i) diagnosis of the current health situation, (ii) analysis of poverty and health linkages with a view to identifying key areas of policy intervention, (iii) quantitatively costing the health component of the national PRSP, and (iv) testing for short term feasibility of the proposed component, and for sustainability in the long term.

Current health situation

The diagnosis of the current health situation reveals the linkages between poverty and health; it should be carried out at three levels. First is a diagnosis of the overall economic performance, which determines overall indicators such as infant and maternal mortality rates and access to clean water and sanitation. This process documents health expenditures, services and outcomes and relates the indicators of expenditures and services to health outcomes, thereby helping to evaluate the effectiveness or impact of public health expenditures on health.

[2]Details of the suggested framework will appear in a guide for authors of the health chapter of PRSPs/PRSs being prepared for the WHO-African Region.

Figure 1: **Health sector matrix**

	Trend analysis of past performance and resource allocation	Current situation of the main indicators[1]	Documentation of physical-financial relationships	Projecting desirable quantitative objectives
What is the current situation in terms of strategies, policies and interventions?	Trends over the past 10-15+ years of key health performance indicators	Illustrated health indicators for the past 10-15+ years[2]	Trends analysis of financial and physical aspects to infer/highlight linkages	Desirable objectives consistent with the expected resources
What are the objectives and what is the main orientation of health policy actions?[3]	Analysis of gaps between expected and achieved outcomes; clear explanations[4]	Analyses of recent changes of indicators with respect to resource availability and their geographic allocations	Extent to which different elasticities can be inferred or worked out on the basis of the trends to back a more efficient resource allocation and pro-poor budgeting	Analysis of consistency between planned objectives and other indicators[5]

[1]Life expectancy at birth
[2]Infant mortality rate, maternal mortality rate
[3]Primary health curative care
[4]Policy choices, global economic environment, resource scarcity
[5]Absorptive capacity, changes in budget patterns

Policy intervention

Such analyses permit the design of accurate policies based on situation analyses. The purpose is to identify key areas of policy intervention. Several of interventions should be considered: alleviating the burden of disease, increasing the supply of services in the social sector, strengthening communities, involving beneficiaries in health action and protecting household incomes. Poverty profiling shows the extent and depth of poverty: how many are poor, what are their characteristics, how poor they are, and where they are to be found.

A diagnosis of the health sector produces an epidemiological profile with statistics on the burden of diseases of the poor (malaria, TB, childhood illnesses and HIV/AIDS). This culminates in a matrix of analysis and framework of policy interventions for the health sector *(Figure 1)*.

Quantitative costing of the PRSP health component

It is essential to determine the cost of the health component of the national PRSP in absolute terms, relative to government budget and in percentage terms relative to gross domestic product (GDP) which can be used to measure sustainability of the planned national effort to deliver adequate health care to all, especially the poor. It also helps determine feasibility in the short term and sustainability in the long term. It can be used by the Ministry of Health to defend its budget within the government budgetary process. The costing approach uses two types of variables related to population and health expenditure.

Population-related variables

P Total population in the country
I Incidence of poverty–proportion of poor in the population
N_P Absolute number of poor people in the population; calculated as N_P=P*I. This forms the basis for calculating the cost of scaling up investments in health. It gives the number to which the per capita expenditures gap will be applied, hence the required resources (R).

Health expenditure variables

H_{PC} Current per capita health expenditure
H_{RP} Required per capita health expenditure
G_{PC} Gap in health expenditures per capita; calculated as $G_{PC} = H_{RP} - H_{PC}$
TC Total cost of resources required for up scaling the health component of the PRSP; calculated as $TC = G_{PC} * N_P$.

Testing for feasibility and sustainability

A feasibility test considers all available types of expenditures, sources and allocations. It seeks to establish whether they will be available over the period under consideration and checks for consistency with the country's macroeconomic framework. Feasibility is evaluated in terms of the available national resources (percentage of GDP), proportion of public health expenditures vis-à-vis total government budget (e.g. per capita health care expenditure as percentage of the government annual budget) and the proportion of public health expenditures available to expected HIPC resources. It seeks to answer the question "Can the country afford to put so much of the available resources into health'?

A sustainability test looks at the implications of the proposed health component over the long term, based on present circumstances, and seeks to answer the question, "Given the percentage of GDP devoted to health in the past, is the model realistic or achievable?" An affirmative answer suggests that implementation of the proposed component is feasible. An answer to the contrary would mean that the country is being asked to put in a disproportionately higher proportion of its available resources into health. This might imply diverting resources from other sectors in order to implement the health plan. In such cases, the final action may rest with the political leadership.

Conclusion

The health sector, from the MDGs perspective, has a central role to play in reducing poverty. Countries designing poverty reduction strategies need a framework to incorporate health concerns into their policies and plans. This article has outlined a simple approach to doing just that.

**Dr Nganda is the Regional Advisor for Poverty and Ill-health at the Regional Office.*