
Agnes Soucat, Abdo Yazbeck,
Rudolf Knippenberg, Francois Diop,
Mark Wheeler, Shiyan Chao,
and Sergiu Luculescu

Africa Region
The World Bank
The authors of this book, Agnes Soucat, Abdo Yazbeck, Francois Diop, Shiyan Chao, and Sergiu Luculescu are from the World Bank; Rudolf Knippenberg is from UNICEF; and Mark Wheeler is from the World Health Organization. The views expressed herein are those of the authors and do not necessarily reflect the opinions or policies of the World Bank or any of its affiliated organizations.

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Improving health, one of the key non-income dimensions of poverty, is increasingly seen as an integral part of the broader goal of poverty reduction. A complete view of poverty includes deprivations not only of monetary income, but also of financial and physical security, growth opportunities and participation in key aspects of social life. Poverty is also seen as a lack of basic human development indicated by poor health, malnutrition, and low educational attainment. But even prior to the international recognition that poverty is multidimensional, it was widely recognized that the benefits of good health go far beyond the intrinsic benefits. There is increasingly available evidence that healthy populations are productive populations, and that as a result, good health translates into higher per capita incomes. Also, additional evidence seems to show that better health outcomes translate into lower levels of income poverty.

Over the last two years the World Bank and its partners have supported the development of comprehensive poverty reduction strategies in many of the poorest countries of the world, i.e., those eligible to receive debt relief under the Heavily Indebted Poor Countries’ (HIPC) Initiative. The development of these strategies represents an opportunity for these countries to revisit their health strategies in light of the broader goal of poverty reduction as well as to pave the way for more pro-poor allocation of funding in the health sector. Over the last 20 years public expenditures on health have stalled in Africa. The impact of this stagnation in funding, combined with a need for more pro-poor focusing of existing expenditures and the devastating impact of HIV/AIDS, has led to an alarming deterioration of basic health indicators, especially since the mid-1990s. The HIPC Initiative offers an excellent opportunity to start improving the situation by ensuring that countries benefiting from this Initiative increase their public spending on health, education and other services targeted to disadvantaged populations. For example, the plans reported in the HIPC documents show that public spending on social services in the 18 African countries that had reached the “decision point” by the end of 2000 is expected to rise from an estimated US$2.5 billion in 1999 to an average of US$3.4 billion annually during 2001 and 2002. This corresponds to an increase in spending from 4.4 percent of GDP to 5.1 percent, or an increase in spending from 29.6 percent of government revenue to 32.4 percent.

In this context of fiscal expansion, it appears particularly important that countries be equipped to seize the opportunity to fully integrate health within the poverty reduction framework. These guidelines were developed jointly by the World
Bank with WHO and UNICEF while assisting countries in developing their Poverty Reduction Strategy Papers. The analysis sets the stage for initiating the reorientation of policies, strategies and budgeting to better serve the poor. It is hoped that this report will help Ministries of Health better delineate the relationship between health and poverty in low income countries and understand how their health systems and public expenditures frameworks can be made better.

Birger Fredriksen
Sector Director for Human Development
Africa Region
World Bank

These guidelines were written by Agnes Soucat, Abdo Yazbeck, Francois Diop, Shiyan Chao and Sergiu Luculescu (World Bank); Rudolf Knippenberg (UNICEF); and Mark Wheeler (WHO). They were later adapted on the basis of comments received from the participants of the Francophone Health, Nutrition and Population and Poverty Reduction Strategy Paper workshop which was held in Dakar in May 2001. We would like to thank the Norwegian HIPC Trustfund for fully funding this publication and dissemination to African countries.
A new framework for action has been developed to enhance the impact of country actions and development assistance on poverty. In this approach, countries prepare poverty reduction strategies that would serve as a basis for external assistance and debt relief. Country-specific Poverty Reduction Strategy Papers (PRSPs) will be developed, based on wide consultations with civil society and on critical analytical work that investigates the failures of programs to reach the poor and vulnerable.

While the thinking behind this new framework was focused on a long-term operational approach to poverty reduction and comprehensive development, debt reduction introduces an urgency for highly indebted poor countries (HIPC). The need to access debt reduction funds quickly makes it difficult for many HIPC countries to provide the time and resources needed for the development of a consultative full PRSP. In those cases, Interim Poverty Reduction Strategy Papers (I-PRSPs) are designed to address the need to access debt reduction funds and at the same time to build towards a full PRSP with adequate consultation and analysis.

Debt relief creates the opportunity for additional spending on the social sectors, including health. The PRSP should make the case for health sector spending and, more importantly, identify investments and reforms that would improve the health of the poor. This document’s audience is the authors and reviewers working on the health sections of PRSPs (including nutrition and population programs). It is closely linked to the PRSP Sourcebook for full PRSPs but recognizes the time, data, and resource constraints facing authors of PRSPs. Anticipating the dynamic process of elaboration and updating of the PRSPs, this document provides authors working in the health sections with a tool for strengthening a pro-poor health reform agenda over time within the country’s poverty reduction strategies.

This paper focuses on five functions and activities PRSP authors may want to consider in developing the poverty reduction strategy papers. The next section, Section 2, Establishing the two-way link between health and poverty, summarizes the arguments for investment in health as critical poverty reduction. Section 3, Enhancing the pro-poor impact of health sector interventions, presents (a) key questions to be addressed by in-country analytical and consultative activities that support the PRSP process, and (b) the latest scientific knowledge on good public health buys as identified by the World Health Organization, UNICEF, the World Bank, and other technical and bilateral agencies. Section 4 highlights health sector analysis to help PRSP authors base policy recommendations on empirical findings. Section 5, Managing inter-temporal tensions in policy development, identifies key issues to be taken into consideration when building
blocks for the full PRSP. Debt reduction is expected to make more resources available for the social sectors. For the health sector, an important risk with new resources is that investments such as tertiary hospitals will divert resources from investments that reach the poor. Consequently, new policy and investment measures should be submitted to the “do no harm” test. Section 5 provides a checklist for PRSP authors and reviewers to identify and mitigate such risks.
An important responsibility for country teams preparing the health sections of PRSPs is to make the case that investments in health are a poverty reduction tool. A growing body of evidence points to sizable differences in health status between rich and poor countries and between the rich and poor within most countries (Gwatkin et al. 2000). These differences underline the complexity of the two-way relationship between health and poverty described briefly in this section (Claeson et al. 2000).

Poverty leads to poor health

A number of factors typically associated with income poverty are also determinants of ill-health, malnutrition, and high fertility. These include high level of female illiteracy, lack of access to clean water, unsanitary conditions, food insecurity, poor household caring practices, heavy work demand, and lack of fertility control (Eastwood and Lipton 2000), as well as low access to preventive and basic curative care. (See Figure 1). Typically around 70 percent of variance in infant mortality can be attributed to across- and within-country differences in income. Communicable diseases represent most of the burdens of illness of the poor. Consequently, ample evidence shows that increased use by the poor and other vulnerable groups of a basic package of cost-effective health interventions can significantly improve their health and general welfare.

Adverse health outcomes contribute to income poverty

Ill-health, malnutrition, and high fertility are three main reasons why households become or remain poor. They cause poverty through diminishing productivity, reducing household income, and increasing health expenditures. The data are particularly strong concerning the affect of nutrition (height) on work productivity and income (Strauss and Thomas 1998:766-817). In Asia, the proportion of household income spent on health services is typically higher in low-income groups than in higher income groups. Catastrophic illnesses often precipitate near-poor households into major economic difficulties (Narayan et al. 1999). For example, studies in East Asia showed that 50 percent of financial crises in poor families are triggered by catastrophic illnesses including TB, HIV, and severe malaria. A study conducted in Tanzania showed that AIDS in a household causes a drop in that household’s income for about two years. Recent studies attribute a 20 percent loss of GNP in Sub-Saharan Africa to malaria. HIV is increasingly seen as reducing growth in high prevalence areas such as southern Africa and is particularly affecting the lowest income groups. Hence, the introduction of policies that cushion households from the impoverishing effects of ill health, malnutrition, and high fertility—such as subsidies to essential services, health insurance, fee waiver schemes, and other safety nets—are likely to reduce income-poverty (World Bank 1997).
Poor health, nutrition and population outcomes are a key aspect of poverty

A more complete view of poverty includes deprivation, not only of monetary income, but also of human development, financial and physical security, expanding opportunities, and especially participation in key aspects of social life. Poverty is also seen as a lack of basic human development indicated by poor health, malnutrition, and low educational attainment. Improving the health of the poor and actively involving them in these efforts are therefore major components of poverty reduction strategies. Responsiveness of the health sector to the needs of the poor and accountability to social goals are therefore essential. Experiences such as the Bamako Initiative and community based nutrition services show that many countries consider that participation of the poor in the design, planning, and monitoring of health services is a key development strategy. Furthermore, it is critical to the rational use of available public services and to long-term sustainability to empower the poor—though communications for behavior change—to do as much as possible at the household level with available resources.

1. Including dietary and sanitary practices
2. This is not true in all countries but most likely reflects non-expressed demand because of various obstacles to use.
In addition to making the case for health, PRSP authors can identify pro-poor investments in the health sector (broadly defined to include nutrition and population) and policies that improve the equity performance of the sector. Authors of the PRSP can take advantage of a body of work by technical and multilateral agencies and adapt it to country conditions and needs. The first part of this section presents key questions that could be addressed through analytical and consultative activities supporting the development of the PRSP in order to reach a better understanding of the relationships between poverty and health in the country. The second part of the section summarizes some of the available knowledge on best buys in public health that are linked to the burden of disease of the poor.

**PRSP and the health sector: Key questions**

The PRSP Sourcebook chapter on health presents a logical framework for selecting analytical and participatory activities. This framework can be summarized by four broad sets of questions:

1. **What** are the health and nutritional conditions for the poor, and how do they compare to those of the better off? How do some of the poor manage to have higher levels of health and nutrition than others? Answering these questions is critical for focusing policy attention and public resources on the epidemiological needs of the poor and for setting targets for poverty reduction.

2. **Why** do poor households and communities suffer more than the better off and what are the barriers they face? Asking this question is a recognition that poverty is a household and community characteristic and that individual actions are critical to improvements in health and nutrition. Analytical work has consistently found that household constraints such as low levels of education (especially of mothers) and of income are basic determinants of health and behavior. It is also known that community factors outside the health sector have measurable impact on the community’s health and nutritional status. Achieving local understanding of these household and community barriers is critical for long-term and sustainable improvement of the health of the poor and for poverty reduction.

3. **How** does the health sector fail the poor and the socially vulnerable? Decisions on resource allocation, investments, and pricing lead to increased or decreased the access to life saving-health services for the poor. The health sector may also fail to recognize the importance of external determinants (for example, water and sanitation or the gender dimension of family dynamics) and therefore fail to advocate policy changes or information sharing. Answering this question can lead to policy changes within the sector that would improve the interface between the poor and health sector as well as improve the advocacy role of ministries of health.
4. What set of public policies can be devised to improve the equity performance of the health sector? Recognizing that in most countries resources are limited, it is important to be selective in setting priorities for interventions.

Before turning to specific targets of opportunity (best buys), it is useful to consider a framework for evaluating investments and policies for improving the health of the poor. The framework \(^1\) summarized briefly below focuses on improved targeting, responsiveness, and accountability of the health sector and also addresses factors outside health services delivery. Combined with the more detailed checklists provided in section 6, this framework provides an assessment tool for both authors and appraisers of PRSPs for health, nutrition, and population.

**Health sector:**

- **Focusing on the health problems of the poor and ensuring that health systems serve the poor.** As the best buys list in Table 1 shows, focusing on these problems typically means targeted interventions in communicable diseases, nutrition, and reproductive health. This area also contains a complex set of issues that relate not only to the supply-side barriers to the poor’s access to health services (for example, placement of facilities, quality and availability of inputs), but also to factors limiting the poor’s demand for life saving services (such as knowledge and real costs) and to the ability of markets to meet needs at an affordable price (particularly for food and drugs).

- **Protecting the poor by limiting the impoverishing effect of health expenditures.** This can be done through pricing revisions, cross-subsidization, and prepayment mechanisms for risk sharing.

- **Ensuring system accountability towards the poor.** Policies in this area include co-management, community-based delivery and monitoring, and incorporating empowerment and listening activities into the design of programs.

**Beyond the health sector**

- **Acting on the determinants of better health for the poor.** Many of the determinants of good health, such as water and sanitation, lie outside the health sector. This is especially true for the poor. Interventions may involve improving access to basic services for the poor by working inter-sectorally. Impacts on health and nutrition of such interventions should be mentioned in order to assess relative cost-effectiveness of alternative approaches to improving the health and nutrition of the poor.

- **Reducing the risks faced by the poor.** This is the most difficult element of the framework because it focuses on risk factors such as natural disasters and economic downturns that can influence the health of the poor disproportionately but are difficult to predict. Interventions may include some risk management measures and targeted safety nets.

**PRSP and the health sector: Functional systems to deliver “best buys”**

Debt relief is expected to increase the availability of domestic resources for the social sectors following the implementation of the Highly In-Debt-Poorest Countries Initiative. It is important therefore for PRSP authors to identify investments that address the needs of the poor in their countries. One way to target health sector investment that is likely to reduce poverty is to focus on the diseases that continue to plague the poor. While the poor suffer disproportionately from almost all illnesses and injuries, some diseases, such as most communicable ones, are largely concentrated among the vulnerable. Since food accounts for more than half of the expenditure of poor households, modulating food prices is an important mechanism for improving food security of the poor. High levels of malnutrition and maternal mortality are also more likely to afflict the poor. Table 1 lists some of the best buys that are both cost-effective and likely to address the needs of the poor. The list is based on the work of technical groups at the World Bank and WHO documentation.
It is important not only to select the most cost effective interventions, but also to ensure the capacity of the health sector and other sectors to deliver those interventions. In many countries, that capacity has been compromised by chronic under-funding. With the prospect of additional funding available from the proceeds of debt relief, and in some cases from additional external sources, it is important to apply these resources to relieve key constraints.

Among the key constraints are insufficient drugs, vaccines and supplies; poorly motivated staff; weak supervision and support of primary care providers (or none at all); and poor communication and education systems to deliver essential interventions. Often the procurement and distribution systems for drugs, vaccines and supplies must be resuscitated and reformed before the public provider system can be revitalized. Investment may be needed in both physical assets (storage, refrigeration, transport, comput-
ers) and institutional capacity (essential drugs lists, procurement techniques, use-related ordering systems, revolving funds, rational prescribing/treatment protocols). Closely related is the need to invest in the repair and replacement of medical and transport equipment; to develop procurement, maintenance and repair capacity; and to establish this capacity as a permanent claim on system resources.

While it has long been widely recognized that chronic under-funding tends to squeeze out non-salary expenditures, it is now understood that salary expenditures have been badly distorted also, as is evident in secular declines in real wages, the severe compression of differentials, and the widespread resort to “survival strategies”. It is clear that increased expenditure on human resources is a legitimate claim on incremental resources, but almost certainly it will not be efficient to apply across-the-board increases in salary scales. A context-specific comprehensive review of the labor contract is needed as a first step in a carefully targeted effort to re-establish the link between performance and reward. Active management of the labor force is a crucial ingredient to the capacity to deliver “best buy” interventions.

Regeneration of capacities of the health sector and other crucial sectors (such as education and communication) must advance on a broad front because almost every reform both depends on and enhances the effect of other reforms. Improving supply logistics and developing incentives to motivate workers not only complement each other but are also powerful supports to improved supervision. Without attention to these systems capacity issues, the best selection of cost-effective interventions will remain have no effect.

To assist in selecting country-appropriate interventions for the PRSP, it is also important to conduct analyses of available data. In most countries data are available for the following steps:

- Assessing the health and nutrition status of the poor at country level
- Analyzing interactions between poverty and health/nutrition
- Revisiting the core package of services to ensure that health and nutrition problems affecting the poor are adequately included and to prioritize key interventions for sustained funding
- Assessing coverage of the poor, selecting with key interventions selected
- Identifying gaps in serving the poor and providing these interventions.

The remainder of this section will briefly describe the types of analysis recommended for each of the five steps. To highlight the feasibility and usefulness of conducting these analyses, sources of data or examples from the ongoing work on PRSPs in Africa appear in each step description.

Conducting the analytical activities to support the PRSP process would typically provide information to support the development of a pro-poor health policy agenda. However, these analyses would reveal gaps in knowledge and information regarding the key questions set out in Section 3 that cannot be filled within the time constraints of the initial phase of the PRSP process. Such gaps could provide direction for the analytical work needed for policy design, implementation, monitoring and evaluation as well as for updates of the PRSP.

Assessing the health and nutrition status of the poor at the country level

The purpose of this analysis is to gain a better understanding of where the country stands compared to other countries, as well as to assess to what extent the health and nutrition of the poor and the non-poor differ. At the national level, the health indicators of any given country can be compared to those of neighboring countries and to those with comparable levels of economic and health system development (Table 2).

In addition to country level averages, data are increasingly available on health, nutrition, and family welfare status disaggregated by socio-economic characteristics, especially relative income or wealth level. Country managers can look at Demographic and Health Survey (DHS) data, using Poverty and Health Fact Sheets developed by the World Bank (Gwatkin and others 2000) when they are available. (They are currently available for more than 40 countries.) The analysis of the health of the poor could cover various health, nutrition, and pop-
ulation indicators. For instance, in most countries, mortality between the ages of one and five typically displays wide disparities between the poor and the richest income groups. These disparities in child mortality are generally associated with wide disparities between the rich and poor in nutrition and access to key health services between the rich and the poor. Higher adolescent fertility levels among the poor than among the rich are generally associated with lower opportunities for education for girls. This disparity also increases the health risks for young mothers and children in the poorest sections of the population.

Although within-country variability in maternal mortality would normally be difficult to analyze from single source data, many countries may have local demographic and health data collection systems, such as the ones supported by European research institutions, that provide maternal mortality estimates for poor rural areas. Documenting the variability of maternal mortality based on reports of these systems could provide insight on the heavy burden of maternal deaths borne by the poorest segments of the population.

Examples such as the one presented for Cameroon (figure 2) are particularly helpful in showing that infant and under-five mortality rates are highly correlated to income. These indicators vary largely according to regions and residence (urban/rural) and according to ethnic group.

In some countries, this type of analysis can also show the importance of factors other than revenue in affecting health indicators. In Burkina Faso, for example, health indicators are not correlated to income in an incremental way (figure 3). The pattern shows a large gap between the richest 20 percent and the remaining 80 percent of the population. Clearly, other determinants beyond income, including environmental and household factors, strongly affect the health of the population.

### Table 2
Example of health indicators of Mauritania compared with other countries in Sub-Saharan Africa (1990-1996 averages)

<table>
<thead>
<tr>
<th>Countries</th>
<th>Life expectancy at birth</th>
<th>Infant mortality (per 1000 live births)</th>
<th>Under five mortality rate (per 1000 live births)</th>
<th>Maternal mortality rate (per 100,000 live births)</th>
<th>Fertility rate (number of children per woman)</th>
<th>HIV prevalence (%)</th>
<th>Child malnutrition (weight for age – %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>52</td>
<td>91</td>
<td>151</td>
<td>822</td>
<td>5.6</td>
<td>8.0</td>
<td>32</td>
</tr>
<tr>
<td>Mauritania</td>
<td>53</td>
<td>92</td>
<td>140</td>
<td>930</td>
<td>5.5</td>
<td>0.5</td>
<td>23</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>46</td>
<td>105</td>
<td>219</td>
<td>484</td>
<td>6.8</td>
<td>7.0</td>
<td>33</td>
</tr>
<tr>
<td>Guinea</td>
<td>46</td>
<td>122</td>
<td>220</td>
<td>880</td>
<td>5.7</td>
<td>2.0</td>
<td>24</td>
</tr>
<tr>
<td>Madagascar</td>
<td>58</td>
<td>96</td>
<td>162</td>
<td>596</td>
<td>6.0</td>
<td>0.5</td>
<td>36</td>
</tr>
<tr>
<td>Mali</td>
<td>50</td>
<td>120</td>
<td>192</td>
<td>577</td>
<td>6.7</td>
<td>1.5</td>
<td>31</td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>55</td>
<td>88</td>
<td>138</td>
<td>597</td>
<td>5.6</td>
<td>10.0</td>
<td>24</td>
</tr>
<tr>
<td>Ghana</td>
<td>60</td>
<td>71</td>
<td>110</td>
<td>740</td>
<td>5.0</td>
<td>3.6</td>
<td>27</td>
</tr>
<tr>
<td>Uganda</td>
<td>40</td>
<td>99</td>
<td>141</td>
<td>506</td>
<td>6.7</td>
<td>8.3</td>
<td>26</td>
</tr>
</tbody>
</table>
in this country. These factors will have to be further explored and taken into account if the government is to make a difference in child health.

Analyzing interactions between poverty and health

Assessment of the health and nutrition of the poor at the country level would reveal gaps between the poor and the better-off sections of the population. These gaps may result from the interactions of the impact on the health of the poor of the environment, of the household caring capacity, and of access to preventive and curative health services. These factors need to be investigated further for a better understanding of the links between public policies and the health of the poor (figure 3).

Analyzing the impact of the environment on the health of the poor

Household surveys, such as DHS and Living Standard Measurement Surveys (LSMS), or income and expenditure surveys often provide information on the relationship between the environment and level of poverty on the one hand, and health status on the other. The Mali example (figure 4) analyzes the rate of diarrhea and acute respiratory infections (ARI) among children in different socio-economic groups. Both ailments are linked to the quality of water supply, sanitation, and air. This analysis helped pinpoint the fact that children belonging to the richer 20 percent are less subject to infections, probably because of better environmental conditions. Policies may therefore focus on addressing environmental factors in the poorest groups.

Analyzing the caring capacity at household

Household members’ knowledge and information on health are among the key resources that deter-
mine household caring capacity and health-seeking behavior patterns. In addition, providing information to effect behavior changes is one of the key interventions in the health sector. DHS surveys provide a wealth of information on adults’ knowledge of diverse health issues, including health problems of the poor. In the Mali and Senegal examples presented below (figure 5), there is clearly an income gradient of knowledge about the transmission of HIV/AIDS, which suggests that the better-off segments of the population have better access to information on HIV/AIDS.

Information on household members’ knowledge on child health, reproductive health, and communicable diseases among the poor can be compiled from DHS surveys or other KAP (Knowledge Attitude Practice) surveys. Such information could be combined with information on which channels the poor rely on for information on health issues to assess their access to information.

Key indicators of household health caring practices can also be obtained in most of the countries from various survey tools including the DHS and UNICEF’s multi-indicator surveys (MICS). Rates of exclusive breastfeeding, utilization of ORT (Oral Rehydration Therapy), for example, are good tracers of the household capacity to make decisions favorable to health. In the Guinea example below (table 3), higher education of mothers and urban residence are associated with poorer breastfeeding practices and do not seem to influence caring practices of children with diarrhea. On the other hand, higher socio-economic status of men is strongly associated with the utilization of condoms. The caring capacity is probably best assessed, however, through qualitative studies and through “Trials of Improved Practices, which have been used effectively to test nutrition counseling messages in many countries.

**Analyzing exclusion of the poor from access to preventive and curative health care**

Analysis of health-seeking behavior patterns and reasons for non use of services can be very revealing. Some DHSs and LSMSs provide information on this issue. Yet most of the time, these are obtained from specific health-seeking behavior surveys. These surveys can provide insights about the pattern of use of services. In Benin, for example, richer

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**Table 3**

<table>
<thead>
<tr>
<th>No education</th>
<th>Primary education</th>
<th>Secondary education</th>
<th>Rural areas</th>
<th>Urban areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average duration of breastfeeding with water supplementation only</td>
<td>6.4%</td>
<td>3.7%</td>
<td>0.6%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Treatment of diarrhea by increased liquids whether at home or in health services</td>
<td>51.7%</td>
<td>61.4%</td>
<td>55.4%</td>
<td>51.4%</td>
</tr>
<tr>
<td>Percentage of men that have ever used a condom</td>
<td>17.4%</td>
<td>44.9%</td>
<td>64.5%</td>
<td>22.8%</td>
</tr>
</tbody>
</table>
groups use public services more than poorer groups. Yet the utilization differential is higher for private services (figure 6).

Indicators of the utilization of different types of services (prenatal care, delivery, immunization, and curative care) could be combined to provide a better summary of the poor’s access to health services. In specific settings, depending on how health services are provided and financed, the access of the poor to health services may vary from one type of service to the other. Similarly, the reasons for not using health services may vary from one type of service to the other.

In addition to information that can be obtained from DHS or LSMS-type data, other surveys and research provide additional information on different types of exclusion. Patient exit interviews, where they have been implemented, provide information on partial exclusion associated with the lack of ability to pay for the full treatment prescribed when sick. Moreover, it will be useful to complete this information with results from qualitative studies on the use of health services covering different aspects of exclusion.

The reasons for non-utilization of services may help to understand the key factors hampering the increase of demand for essential services. In many cases, one goal of health education campaigns is to empower families to take care of health and nutrition at home and thus increase rational demand for health services. In Honduras, for instance, a community-based growth promotion program reduced the number of cases of non-serious diseases (due to treatment in the household and community) and enabled health care providers to concentrate their efforts on more serious illness that required advanced medical training. In Burkina Faso (figure 7), the question about non-utilization of service revealed that about a quarter of people not using services refrained because of high prices. Other reasons included distance and perception of the diseases as not being serious enough to justify a visit.

LSMS and consumption surveys typically provide typically information on household health-related expenditures (see table 4). In addition to the overall level of household expenditures, the information can be disaggregated by types of expenditures (consultation, drugs, and so on) to help identify variable patterns of health related expenditures among the poor and the better-off segments of the population. The burden associated with these different types of expenditures on the poor may vary according to current cost-sharing policies and drug policies in different countries.

**Revisiting the core package of services**

Most countries have defined a core package of services to be delivered to the population. This package has usually been defined on the dual basis of the burden of diseases affecting the overall population and the existing population demand for relief from suffering. This package can be revisited more specifically in light of the burden of diseases of the poor and best buys. Some interventions may need to be added, such as micronutrient supple-
mentation. The package may have to be modified along the changes in mortality patterns. Some interventions already included may be re-discussed. In most low-income countries, the best buys identified in Section 3 would have to be part of this package.

Assessing the coverage of the poor with selected key interventions

Once there is a clear agreement about which key interventions should be made available and accessible to the poor, it is important to look at the pattern of use and effective coverage for these specific interventions.

The example highlighted in figure 8 shows how utilization of essential services, including vaccination, Antenatal Care (ANC2, or coverage of pregnant women with two antenatal care visits) and assisted delivery, varies drastically according to socio-economic status in Burkina Faso. This pattern of use does not mirror the pattern of mortality but seems more in line with gaps in supply of services to the poor. It is also important to conduct this analysis by region or province in order to be able to link these results with an analysis of the health sector’s performance in actually reaching the poor. Once again the goal should be rational use of health services – treating problems correctly at the appropriate level. For instance, all children under two should be covered by growth promotion activities to prevent malnutrition. This should be carried out at the household and community level and not be facility-based, in order to assure regular attendance regardless the state of health of the child.

Identifying gaps in serving the health needs of the poor

Shortcomings in getting the best buy interventions most likely to affect health to the poor may be linked to a lower level of essential services. These gaps in coverage may reflect three different issues: reaching the poor with essential interventions, making financing more equitable, and improving social accountability of the poor.

The analysis of these gaps should be completed with an assessment of what is currently being done to fill these gaps and what major constraints face the health sector in specific areas. For example, the analysis of the distribution of human resources may reveal chronic gaps in the availability of midwives in poor remote areas while better-off areas benefits from levels of availability well beyond standards set by the ministry of health. Such gaps may result from current human resource management policies, including a weak midwife training capacity in the country, that need to be revisited if the country is to improve the poor’s access to essential health care. Linking the service gaps to current policies and implementation constraints would help answer the fourth broad question in developing the health section of the PRSP: “What set of policies can be devised to improve the equity performance of the health sector?” (see section 3).
Access of the poor to essential health care:

- Geographical access to minimum care package: Health policy-makers and managers can examine whether the poor have less access to health services (PHC/MCH centers), safe water, sanitation, health information, or community-based activities. The proportion and number of poor living beyond a reasonable distance from basic services can be measured. The provision of appropriate services at the community level must be taken into account as well. In addition, the number of services and service providers in relation to the population of the country and per region can usually be computed easily.

- Availability of essential resources: The distribution of human resources (multipurpose trained health staff) and availability of essential drugs and equipment can be examined between regions, provinces, and communities with different economic development. The existence of efficient national drug supply systems and of appropriate essential drugs and human resources policies may support continuous availability of basic services for the poorest in remote areas. As a case in point, Niger (figure 9) shows a very large inequity in the distribution of health staff with one medically trained staff person per 400 people in capital city of Niamey, compared to one staff person staff for 4000 in the most remote rural areas.

- Services units provided to the poor: Performance of the different sectors in producing specific pro-poor outputs can be measured for different regions and provinces, residence or socio-economic status. Activities include immunization visits, vitamin A supplementation, treatments of ARI, IMCI (integrated management of childhood disease) visits, full treatment of TB, impregnated bed-nets, and quality treatment for malaria. In Mozambique, for example, specific indicators of production of most essential services are measured over time and could be compared between provinces (see figure 10). Aggregated outputs, however, can hide inequities where the poor do not receive services.

- Continuity of care: Poor groups may benefit less from continuous and quality care (TB treatment courses finished, children fully immunized, respect of standards of care for treatments, and so on). A simple indicator to measure inequity in receiving continuous quality care can be to measure the drop-out rate for immunization between DTP1 and DPT3 per socio-economic group. Where ethnic groups have a high probability of being poor, disaggregating service figures by ethnic identity can also help identify inequitable situations.

These various gaps can then be examined in relation to each other. One option is to plug the different indicators on a common scale and examine at

Figure 9
Population per medically-trained health worker, per region – Niger 1997

Figure 10
Evolution of the number of essential health outputs produced – Mozambique 1993-1999
which level the bottlenecks to performance are the largest. In the example given in figure 11 for IMCI in Mauritania, the largest bottleneck appears to lay at the level of utilization of services. Yet access and availability of personnel and essential drugs are unsatisfactory and contribute to the insufficient level of continuous and quality care utilization. This kind of structural analysis can be conducted for different provinces. Differences in the level at which the largest bottleneck is found may hint at key factors hampering use of services in different socio-economic settings.

Gaps in making financing mechanisms more equitable:

- Equity of public expenditures: Comparing performance between countries can be very revealing for decision makers, when comparisons show that performance in terms of indicators is not always linked to the dollar amount injected into the health sector (see figure 12). Madagascar, for example, has a reasonable level of performance given the very low amount spent on health by both the government and donors. Other countries have a similar or higher level of under-five mortality with a higher level of health expenditures.

Figure 11
Gaps in services provision of IMCI – Mauritania 2000

Figure 12
Relationship between public expenditures and under-five mortality rates in Sub-Saharan African countries

One issue is that it is extremely difficult to obtain accurate figures on expenditures on nutrition because these are often hidden within several ministries’ budgets. Detailed public expenditure reviews are needed.

Government financing per capita in poorer (e.g., rural remote) versus rich (e.g. urban) areas can also be examined

In countries where different levels of government (central and local) contribute in the financing of health services, data on public expenditure per capita by source may provide valuable information about the impact on the equity in public expenditure of (a) local government capacity to pay and (b) central government transfer mechanisms. In addition to showing the current patterns of public expenditure, analysis of formulas underlying the allocation of public resources in the health sector may reveal structural biases against poor and remote areas. These biases would need to be addressed if financing mechanisms more are to be made more equitable. Measuring the equity of spending per capita in different socio-economic settings provides information on how resources are effectively shared among the different areas of a country.

- Allocative efficiency. Measurement of allocative efficiency will allow one to look at whether those
interventions that are most likely to address the burden of diseases of the poor benefit from sufficient levels of funding. This can be estimated by:

— Measuring the level of funding of interventions responding to ailments affecting the poor, such as communicable diseases. Gaps in funding of TB, vaccination, malaria or HIV control, for example, usually mean that the poor not protected against these diseases.

— Measuring the adequacy of funding for services that serve the poor at minimal cost, such as primary care, community-based agents, and basic surgical services.

• Affordability: Issues such as pricing, subsidies, exemptions, pre-payments and risk-sharing are often more difficult to assess. Yet studies may have been conducted in countries to examine the equity and affordability implications of the financing mechanisms in place. To simplify the analysis, health policymakers may want to focus on examining mainly the financial obstacles to provision and use of best buy interventions; for example, obstacles to use and continuity of IMCI and maternal services, as well as prevention and treatment of communicable diseases. A tracer intervention can be used to help conduct the analysis: e.g., the different obstacles to provision of TB treatment or immunization. One of the

Assessing the equity implications of health services pricing schemes

Payment for services whether through user fees or through prepayment can have a deterrent effect on utilization of services identified as "best buys", especially by the poorest. Many of these interventions meet the standard conditions which justify free or subsidized provision regardless of distributional considerations, in that they generate important external benefits by reducing the pool of infection in the case of communicable diseases. Yet the demand for those services may be more elastic than for less essential services. In Burkina Faso, for example demand for child health services was shown to be more elastic than for adults. Provision of IEC services is a public good. Even those services of a private nature, such as delivery care and nutritional supplementation have inter-generational effects and important educational impacts. The arguments for enlarging access to poor consumers who would be excluded by user charges are additional to the efficiency arguments advanced above.

A useful guide to good practice in this area is the "Addis Ababa Consensus on Principles of Cost Sharing in Education and Health" United Nations Economic Commission for Africa, 1997, which was endorsed by representatives of both the World Bank and the World Health Organization. The Consensus recognizes the severity of financial pressures on the budget, leading to attempts to finance essential services from other sources, but it is clear that user fees are a less preferred financing source, and it proposes several limitations on their application in order to minimize their most damaging effects. Differential pricing and categorical exemptions are advocated.

Experience with the Bamako Initiative in West and Central Africa show also that the deterrent effect of user fees can be counterbalanced when those fees are used in the context of community based and managed systems in which fees are invested into making services more accessible to the poor on a sustainable basis. Such systems were shown to minimize interruptions of supply due to difficulties in top-bottom transfers. Again modulated pricing and cross subsidies to lower the cost of essential care were shown to be essential to preserve access to services for the poor in these contexts.

Two specific issues need to be kept in mind when examining the equity implications of formal payments for health care. One is the widespread practice of shifting the financial responsibility for financing non-salary costs onto patients by simply not providing services. This often occurs when consultations are nominally free or highly subsidized, but patients have to buy prescribed drugs from commercial pharmacies. In many instances, patients have to buy in advance all the materials for surgical operations, including anesthetics. Because consultations and drugs, or operations and anesthetics, are joint products, the true level of cost sharing can only be assessed by taking account of out of pocket expenditures for both components. When viewed in this way, it is apparent that the burden of cost sharing will often exclude all but the better off or resourceful among the poor.

The second issue is unofficial fees, which are widely required as a condition of access to services, and which (in replacement or together with a significant proportion of official fees) are used to supplement sub-subsistence official salaries. Unofficial fees very often totally thwart the intentions of official exemption policies. The reduction or elimination of unofficial fees is a difficult and complex task, which certainly cannot be addressed by punitive regulation alone. A concerted effort linking higher official remuneration, better supervision, transparency in charging and patient empowerment appears to have the best chances of success.
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*LSMS: Living Standards Measurement Surveys
**LCMS: Living Costs Measurement Surveys
***PER: Public Expenditures Review
****CS: Consumption Survey
most expensive nutrition interventions – feeding programs – is also one of the least effective. Special effort must be made to focus expenditures on effective programs that reach the poor.

Gaps in improving social accountability, involvement and participation of the poor

The analysis of involvement and participation of the poor in the health sector should go beyond the assessment of legislative or regulatory measures taken by governments. The gaps between the intended policies and the reality of participation could be assessed based on the involvement of community organizations in health promotion activities, preventive health activities, and the management of health services. Gaps in social accountability of the health services can be identified through (a) participatory planning and budgeting processes at the local levels, (b) feedback mechanisms to community organizations on health service management by health personnel and health committees, and (c) regular reporting to health administration authorities and local government bodies.

- Responsiveness and social accountability in the health sector can be measured by the existence of associations of communities or consumers, or the involvement of users in planning, monitoring or managing health services. The proportion of facilities or communities with associations of patients (such as people living with HIV), citizen representation in local health boards, or community health committees in the Bamako Initiative context can be computed.

- Representation and involvement of the poor in these boards, associations and/or committees can also be assessed by measuring, for example, the proportion of these groups that include women and minorities, poor people, representatives of chronic patients and so on.

- Experiences with participatory monitoring, community co-management, and co-financing may be assessed by measuring whether community and client structures have regular meetings, produce health plans, implement activities, produce results, and so on.
Driven by the debt relief motive, PRSPs can identify some activities and highlight simple policy directions. Yet sustainable poverty reduction and improvement of the health of the poor require a deeper understanding of systemic bottlenecks. This includes the ways health systems fail to reach the poor as well as the household and community constraints limiting the ability of the poor to help themselves. The continuous process of the PRSP indicates that the I-PRSP and full PRSP will be followed by updates as countries continue to articulate, implement, and monitor their poverty reduction efforts. As a practical step, then, it would be useful to outline what is needed to implemented, monitor and update the PRSP. The first subsection identifies some of the technical activities recommended to be the building blocks for the refining of the Poverty Reduction Strategy framework. The second subsection suggests a checklist for ensuring that new measures in the health sector do not harm the poor.

Building blocks for more poverty-oriented work in health, nutrition and population

The health sector chapter of the PRSP Sourcebook outlines listening and analytical tools that can be used to reach country-specific conclusions on the critical bottlenecks. The Sourcebook chapter also provides a multi-leveled set of policy actions that could be the result of the analytical and consultative activities.

PRSP authors do not have always have the time to carry out many of the activities recommended for the development of the health and poverty component of the PRSP; However, they can map out analytical and consultative activities to be undertaken to develop poverty and health analytical work, as well as monitoring and evaluation of the implementation of the poverty reduction strategies. This will set the stage for future revision of the PRSP. As suggested in section 3 above, these activities could address the following key questions:

1. **What** are the health and nutritional conditions for the poor and how do they compare to those of the better off? How do some of the poor achieve better health and nutrition than others?

2. **Why** do poor households and communities suffer more than the better off and what are the barriers faced?

3. **How** does the health sector fail the poor and socially vulnerable?

4. What set of public policies can be devised to improve the equity performance of the health sector? Once the first three questions are answered (the what, why and how), policy makers can develop policies at three levels (table 6).

This would ensure that work is done to address the long-term issues of systemically improving the
Do No Harm

PRSP authors and reviewers have a responsibility to ensure that the easing of time and fiscal pressure created by debt relief does not lead to investments that do not reach the poor. Moreover, it is important to ensure that new investments do not lead to skewing long-term budgetary directions away from proven pro-poor and cost-effective activities. International experience also shows that increasing health spending does not always lead to improving outcomes, especially among the poor. Proposed “therapeutic measures” for the health sector should therefore pass the “do no harm” test. A checklist to avoid potential poisonous effects of injecting additional funding into irrelevant, unsustainable or pro-rich health sector activities may therefore include checks on targeting, functioning costs and affordability. The targeting check verifies that proposed measures are effectively pro-poor or at least not directly pro-rich.

- Targeting pro-poor health interventions: Do resources flow to address the burden of diseases of the poor, including the burden of communicable diseases?

- Targeting pro-poor health services: Do these resources purchase services such as preventive and basic curative services as well as health promotion that benefit the poor to a larger extent than the rich? Are resources flowing to basic social services, primary health care, and essential surgery services? Are the recurrent costs?salary and non-salary? of these services covered? Do the resources mobilized allow increasing the proportion of personnel working for those services?

- Targeting poor areas: Are resources flowing to regions with the most health needs and highest level of poverty? Are resources flowing to under-served areas, such as rural areas or urban slums? Do health workers receive adequate incentives to work in poor, remote areas? Are marginalized ethnic groups being reached?
• Targeting poor households and communities: Are resources flowing directly to low-income communities and households? Do the resources benefit a large proportion of these poor communities and households? Are the proposed transfers fair, given the country’s poverty profile?

The functioning cost check helps to ensure that no major spending in the health sector will be made in vain, that is, without a guarantee that attached functioning costs will be financed.

• Check the recurrent costs of investment: Often, large one-time amounts can be mobilized to finance investments, yet recurrent costs of such investments can be very expensive and consume a disproportionately large share of the health sectors’ recurrent budgets. This is particularly the case of tertiary and training hospitals, whose recurrent costs are financed, in many low-income countries today, at the expense of peripheral services. Additional resources should help correct rather than aggravate this situation.

• Check the balance on inputs: For health programs to be implemented effectively, the right mix of human and material inputs must be achieved. It is necessary to check the balance between the wage bill and non-salary recurrent costs, first, to ensure efficient use of costly technical staff who require adequate budgets to work with, and second, to make sure that human resources are not strained to the point that the size of operations must be reduced.

• Check the structure of the wage bill: Modes of health staff recruitment and management can also significantly affect the way the needs of the poor will be served. Simply increasing salaries and recruiting health staff, without linking remuneration to performance and working conditions is likely to increase the wage bill with little gain in efficiency. On the other hand, using funds to establish an incentive framework for staff to increase performance of services aimed at reaching the poor is likely to help increase the efficiency of the overall spending on salary costs.

The affordability check helps to look at the cost impact on both household and government budgets of proposed measures to improve the functioning of the health sector.

• Check the affordability of basic services to poor users: User fees for basic health and nutrition services have been shown to improve equity of utilization when accompanied by subsidies and minimization of service costs for essential services; local retention of funds; community ownership; community co-management; and investment of local revenue to improve the availability, access, and quality of preventive and basic services for the poor. In many low-income countries, community financing schemes helped restore access to and availability of essential services by introducing demand side incentives for better functioning of services. On the other hand, implementation of user fees to supplement or replace the government budget has proved regressive in most contexts. So while local community financing schemes – which may encompass some user fee component – can be pro-poor, the setting-up of national user fees schemes should be accompanied by strong mitigating measures, including affordable pricing, subsidization, exemption mechanisms, and pre-payments, so that the poor will not be deterred from using the services.

• Check affordability of services to government budget: Numbers matter. Governments with strained resources may not always be able to afford effective and pro-poor services. Typical examples are malaria treatment in hyper-endemic countries, food supplementation, or prevention of mother-to-child HIV transmission. While these interventions are proven to be highly cost-effective and will benefit economically fragile families, government domestic budgets cannot fully subsidize these interventions in countries where a very large number of patients are affected by these diseases. The interventions could consume too large share of the government budget. Full subsidies of such best buys may therefore not be possible.
In conclusion, a large range of factors play a role in determining the existing levels of health. The relationship between these factors is complex, and to improve health outcomes, factors beyond the health sector’s interventions must be addressed. Most of these factors are tied to poverty. Some factors, such as the education of girls, are playing such a large role that they may outweigh the role of the entire health services sector. On the other hand, health sectors contribute not only to improved health, but also to other health- and nutrition-related improvements, such as the protection against catastrophic expenditures and greater participation by the poor in health-related decision-making. We have reliable evidence on what constitute “best buys” both within and outside of the health sector, Debt relief is a unique opportunity to finance these “best buys” while placing them in the broader context of poverty reduction, and allowing public action to tackle aspects that go beyond the health sector. This requires governments to consider health activities as a priority in terms of poverty reduction, and to appropriate budgets to reflect that priority.
Whether or not a sector-wide approach (see annex 2) is adopted, the production and periodic updating of a projection of health sector expenditure is a powerful planning tool. Also known as resource envelope projections, the basic idea is to take account of all sources and applications of funds for a medium-term period, typically three to five years, in a single consolidated display.

Although the use of the shorthand expression “health sector expenditure” is widespread, in practice the exercise is normally confined to the publicly funded health provider system. Left outside the conceptual boundary of the health sector are private providers, whether traditional or modern, NGOs, and sometimes publicly funded provisions which are not available to the general public, such as military hospitals. It also excludes health-related services such as water supply and sanitation, which influence health but are not a direct responsibility of the ministry of health. The treatment of church-related health services is variable. In most cases, they are viewed as providers with a public service mission. In some countries, they are heavily subsidized and are treated as part of the public provider system. In other countries, some units are subsidized while others are not, and in some very poor countries, little or no subsidy reaches any church-related providers. Depending on attitudes and the extent of transfers of public funds, church-related facilities may be wholly included in the expenditure framework, included only to the extent of the subsidy element, or wholly excluded.

The justification for this restricted treatment of the health sector is essentially a pragmatic one: the publicly funded provider system is the part of the whole that the ministry of health knows about and has the power to control. The private medical care system goes largely unrecorded, and few ministries of health in poor countries have the means (the legal authority and the supervisory personnel) or the interest to attempt to influence the conduct of the private sector.

The principal sources of funds are likely to be (a) the central government budget, typically divided into recurrent and capital allocations, (b) local government general revenues, (c) grants and loans from external aid agencies, and (d) user fee revenues, which are often retained at the facility level and are sometimes excluded from the expenditure framework because there is no reliable reporting of sums collected or their application. The proceeds of debt relief will normally be included in (a) above and will not be separately identified. However, there may be cases where specific funds are created inside or outside the regular budget framework, and there may then be allocations from these specific funds. On the expenditure side, a great variety of classifications are possible and should be deployed for different planning purposes, but it is suggested that the main vehicle that should be used is that of the government budget.

The great advantage of producing an expenditure framework is that it requires all parties to be more explicit about their future intentions. The contribu-

Annex 1

Medium-term expenditure frameworks
tion of central government revenue needs to be negotiated with the ministry of finance and will, of course, be consistent with the macroeconomic projections the government will be negotiating with the World Bank and IMF as a component of the global PRSP. External donor partners are obligated to be more explicit about their future aid, as to both scope and timing of actual disbursements. It is important to be clear that donor-provided figures often include elements that are outside the ministry of health’s conceptual border (for example, grants to NGOs or the costs of aid administration) and that use valuations derived from metropolitan country price levels rather than those of the recipient. It is also prudent to assume some delays in the disbursement schedule set out in the formal terms of the aid agreement.

An expenditure framework also obliges the ministry of health to be explicit about its expenditure plans. In a situation where more resources available and there is also a heightened emphasis on poverty reduction, all funders want to know how resources will be deployed and what the expected outcomes will be. There is likely to be a direct connection between the ability of the ministry of health to present attractive and coherent expenditure proposals and the amounts that both the government and external donors are willing to provide to the health sector. To demonstrate both the policy attractiveness and the feasibility of its expenditure proposals, the ministry of health can provide alternative displays of its expenditure. For example, alternative displays might show changing proportions over time on expenditure in different geographic regions, on different tiers of the provider system, or in different program areas. The feasibility of spending plans might be demonstrated not only by the overall balance of sources and applications of funds, but also by trends of outlays on key inputs, such as essential drug purchases, equipment maintenance, or phased replenishment of the vehicle fleet. In many countries, plans to improve real wages of health employees, if linked to realistic measures to improve accountability for performance, would merit a high priority.

The construction of the expenditure framework is essentially a reiterative process, with successively refined versions being produced as uncertainty is reduced. Uncertainty arises from two sources. Some figures are initially unknown because they are subject to future negotiations. Some figures are known but are subject to unreliable data reporting. In both cases, the recommended procedure is to insert into the tabulation the current best estimate of the true value, with a footnote referring to its uncertain status, and to initiate either the negotiations that will result in a more definite figure, or an enquiry into weak data collection. In principle, the total planned expenditure has to match the total resources on a year–by-year basis. The process of drawing up the first version of the expenditure framework could begin either with projections of sources or with planned expenditures. Any funding gap that initially appears can be eliminated either by negotiating additional funding or by rephasing expenditures to fit anticipated resources. If there is no success in negotiating additional resources, expenditure adjustment ultimately becomes inevitable. Following the production of a full PRSP, the ministry of health should have a framework that shows what resources it expects to be available and how it proposes to deploy them within the publicly funded provider system.

An important constraint in the construction of the expenditure framework must be kept in mind: Some sources of funds are available only for very specific applications. For example, budget regulations may require that only capital goods may be purchased with the government’s development budget, while external donor project funds may be rigidly tied to particular locations and program activities. Local government revenues are normally available for use only in the jurisdiction in which they are raised, and user fee income may be limited not only by location but by input category as well. The expenditure plan must satisfy these constraints, which may well result in sub-optimal allocations, and must also match sources to applications overall.

By the nature of any projection, including the government budget, what is proposed in a health-sector expenditure framework may well not be what is eventually achieved. On both sides of the account, there may be significant shifts between estimates made in advance and achieved outcomes. Funds received may be less than expected (but sometimes more), programs may cost more than
expected, or new needs may arise. The expenditure framework should therefore be periodically updated to take account of actual experience and revised expectations and rolled forward so that there is always a projection for three to five years ahead. This revision should take place twice, or at least once, a year, at a suitable point in the budget cycle and in the cycle of discussions with external donors.
he sector-wide approach, or SWAP, is increasingly being adopted as an arrangement to improve the effectiveness of external aid. The move to SWAPs is prompted by an increasing degree of dissatisfaction with the consequences of channeling aid into donor projects. These consequences are thought to include:

- very uneven developments within the sector (islands of excellence in a sea of mediocrity);
- pressure for vertical programmes;
- pressure for capital rather than recurrent expenditure;
- partition of a country into donor zones of influence;
- the inability of government to make a coherent plan for the sector because so many resources are outside its knowledge and control;
- the excessive use of very expensive and frequently uninformed foreign consultants;
- the diminution in the real value of aid due to procurement-tying;
- the enticement of the most able civil servants into donor aid administration offices; and
- the administrative burden on the Ministry of Health of conforming to each individual donor’s requirements for aid negotiation, project implementation, reporting, and monitoring according to the donor’s aid and budget cycles.

Cumulatively, these negative consequences meant that even when individual donor projects were successful, collectively their effect was to derogate from national sovereignty and to erode institutional capacity.

In reaction to these negative consequences, an alternative, the sectoral program, was devised. The essence of the SWAP is a bargain whereby donors agree to channel aid money alongside budget money in support of a common expenditure program that is proposed by government, but which donors are entitled to discuss and influence. This arrangement is perceived as both more efficient and more supportive of national institutional capacity than financing specific aid projects. (Note that, as with medium-term expenditure frameworks, although the usual term is “health sector” program, the actual scope is limited to the publicly funded provider system.)

Potential advantages and corresponding disadvantages arise for both parties from the move from project to sectoral support. The deal from the donor standpoint is that they give up extensive control of a small part of the sector—the specific project(s) they finance—in exchange for a say in the management of the sector as a whole. The deal for the recip-
ient countries is that they sometimes get more money, and certainly get money in a more useful form, in exchange for allowing the donors to participate in the broadest policy deliberations. A considerable amount of trust is required on both sides: the donors trust that money placed in government hands will be well used, and the recipients trust that donors will not abuse their financial leverage to the extent of imposing unwelcome policies.

While SWAPs vary in detail, agreements between a ministry of health and its external partners share some common features. These usually include:

- An agreed statement of policies, setting out a vision of objectives for the improvement of health of the population, sometimes a set of explicit targets, and the main strategies for reaching the objectives.

- A reasonably detailed program of work, showing how those strategies will be implemented over a specified time frame, typically three to five years.

- A medium-term expenditure framework, showing the contributions of the financing partners and proposed expenditures consistent with the policies and strategies enumerated above.

- An understanding that common procedures, which in practice means government procedures, will be used for implementation of the program of work. There may well be need for transitional arrangements while government institutional capacity is strengthened.

- An understanding concerning monitoring and evaluation of the program of work against predetermined objectives.

- An understanding concerning the conduct of the parties to the agreement, often embodied in a formal Memorandum of Understanding, which can be annexed to individual aid agreements.

It must be clearly understood that, although the pioneering examples were developed in the context of reforming health systems, the only reform specific to SWAPs is the reform of the donor relationship. It should also be acknowledged that to date the record of SWAPs is mixed. They are not a panacea for all the problems of the health sector, and all the health SWAPs that have been developed have encountered problems to some degree. They are not necessarily suited to all countries; the fit is probably best with those countries that are heavily dependent on aid and that have a large number of donors to the health sector. Donors will only be willing to use government procedures for financing, procurement, accounting, and auditing when these procedures are fair, efficient, and transparent (or at the very least, when the government has indicated a willingness to pursue reforms that will result in these conditions being met).

An absolute pre-condition for a SWAP is that government and donors can reach broad agreement on the principal sectoral policies concerning objectives and the means of achieving them. This may well take a considerable time and call for some delicacy and restraint by all parties. In the past, the principal issues of debate were the design of institutional reforms, motivated primarily by efficiency concerns. In the future, more attention will probably be given to the distributional aspects of health-sector policy. The convention has developed that government should take the initiative in drafting the key documents (the statement of policies, the program of work, and the expenditure framework), and that, where there are unresolved policy differences between government and donors, donors should defer to government preferences in the last resort. In the extreme case, individual donors can withdraw from funding the sector if differences remain irreconcilable.

While there is yet insufficient experience to make definitive judgments on the utility of SWAPs, the arguments for the potential benefits of a different pattern of external aid are compelling.


