HEALTH/NUTRITION/POPULATION AND POVERTY SEMINAR REPORT

Topic: Poor-Rich Differences in Health, Nutrition, Population Status and Service Use within Developing Countries: Introduction to a New Source of Information for Project Development and Economic Sector Work

Presenters: Dave Gwatkin, Rohini Pande, Fadia Saadah, Mariam Schneidman, Abdo Yazbeck

Date and Time: 12:30 – 2:00 P.M., May 16, 2000

The seminar was the twentieth in a series sponsored by the hnp/poverty thematic group. Approximately forty people participated. Health, Nutrition, Population (HNP) Sector Manager Helen Saxenian served as moderator.

The seminar objective was to introduce participants to the country hnp/poverty information sheets, which have recently become available. Dave Gwatkin and Rohini Pande began by describing the sheets. Following them were three presentations by Bank staff members, who illustrated how data from the sheets can be used at the country- or regional-level work by describing their experiences: Miriam Schneidman, who had used the Haiti data in her discussions with policy makers in that country; Abdo Yazbeck and Rohini Pande, who are investigating the implications of the data for immunization policy in India; and Fadia Saadah, who drew upon the data in an East Asia HNP sector review that she and her colleagues have just completed.

- Dave Gwatkin began by explaining that objective of the hnp/poverty sheet project is to provide hitherto-information specific to the poor within countries, thereby making it possible to move beyond country averages in designing poverty-oriented hnp activities. The information used in the sheets, he said, came from household data sets collected through the USAID-initiated Demographic Health Survey (DHS) program, which conducted comparable studies on maternal/child health, fertility, and related issues in approximately 45 developing countries.

The studies had not collected information about household income or expenditures; but the study instrument did include a number of questions about household possessions or assets, like the nature of flooring and roofing, and the availability of electricity and water. Bank econometricians Deon Filmer and Lant Pritchett had found a way of combining responses to such questions into an asset or wealth index by using principal components analysis, and had shown that the using the index to rank households produced results quite similar to the use of expenditure or income data.

Thus, in constructing the sheets, the socio-economic status of household members was defined in terms of asset index score; and, in each country, household members were divided into quintiles on the basis of that score. For each quintile, values were calculated for approximately thirty hnp status and service use indicators. HNP status indicators included infant mortality, stunting, and total fertility. Illustrative service use indicators were immunization rates, rates for the use of oral rehydration therapy and for medical treatment of acute respiratory infections, and contraceptive prevalence.

- Rohini Pande presented illustrative findings from some of the sheets. The principal theme of her presentation was the existence of large variations in both the average level and the degree of inequality observed, both across countries for any given indicator, and across indicators.
within any given country. For example, under-five mortality was very high among all socio-economic groups in Burkina Faso; low among all groups in Colombia; high among the poor and low among the rich in Bolivia. Similar variations appeared with respect such other indicators as child and maternal health service use, childhood nutrition, and the use of public and private health facilities.

- Miriam Schneidman indicated that she and her colleagues had reviewed the data for Haiti in preparation for their dialogue with the health policy leaders. They had found that most Haitian poor-rich differences, while important, were not notably larger than for other countries of Latin American and the Caribbean. The principal difference between Haiti and other countries in the region was the lower level of accomplishment overall, in every socio-economic class. Thus, the emphasis in discussion with government officials was on improving service use at all socio-economic levels.

- Abdo Yazbeck reported on a presentation of Indian immunization data that he had made to a high-level government official. The official was reluctant to accept the findings, which showed very large poor-rich differences, for three reasons. One was that the data were rather old. The second was that they dealt only with India as a whole rather than separately with the individual Indian states that bear primary responsibility for immunization program implementation. The third was that the data failed to distinguish between rural and urban settings. To deal with these concerns, Abdo and Rohini Pande have begun further analyses of the information sheet figures – analyses they plan to extend to data from a new DHS study that is currently nearing completion. Rohini presented the initial results of their efforts, which point to very large state-to-state differences in the degree of inequality in immunization coverage.

- Fadia Saadah indicated that she and her colleagues had made extensive use of the poor-rich data, both for hnp status and for hnp service use, in preparing their recent hnp strategy paper for the Bank’s East Asia and Pacific (EAP) region. They had found to poor-rich differences to be much larger than they had expected in the three EAP countries for which sheets are available (Indonesia, the Philippines, Vietnam). However, the value of the data was limited by the small number of countries covered by the project. She thus advocated an effort to prepare sheets for other countries with suitable household data sets.

The discussion following the presentations dealt with several issues. Among them were:

- The feasibility of strengthening the health content of the Bank-assisted Living Standards Measurement Survey (LSMS) studies, so that they could serve as a basis for comparable information sheets in other countries. The instrument used in the LSMS studies, which cover approximately 25 countries, contains much more information about expenditures and consumption that the DHS instrument; but it is much weaker with respect to health. Work on strengthening the LSMS health content was reported to be under way, but details were not available.

- The feasibility of using information about hnp status and service use among the poor at different points in time for measuring progress toward achieving Poverty Strategy Reduction Paper (PRSP) objectives. Many developing countries are being asked to prepare PRSPs that are to include, among other things, a commitment to bring about specified improvements in social conditions, especially among the poor. Failure to achieve such improvements would be grounds for a reduction in external assistance. Trend data for, say, infant mortality among the
poor collected immediately before and some time after a PRSP’s preparation could indicate more accurately than national averages the amount of progress being made in dealing with poverty. While such an approach was accepted as highly attractive in principle, reservations were expressed about applying it in practice, because of the imprecise nature of the information sheet estimates.

- The implications for hnp program strategy. Concern was expressed that data like that for immunization in India might provide an impetus for dedicated, single-purpose campaigns that could work against the longer-term objective of establishing integrated health care networks. There was no response to this concern, which participants appeared to consider valid.

The discussion also produced several suggestions for further development, analysis, and dissemination of information sheet data, which are to be pursued.

Note: An illustrative summary information sheet, for India, is presented in annex A; annex B is a list of all countries covered by the information sheet project. Hard copies of full country reports, containing the information sheets and technical notes, are currently available for six countries: Bolivia, Côte d’Ivoire, India, Indonesia, Kyrgyz Republic, and Morocco. Reports for the remaining countries listed in annex B will be available within the next few weeks. Also, the reports will be soon appearing on the Bank’s hnp/poverty website: [www.worldbank.org/poverty/health](http://www.worldbank.org/poverty/health). In the meantime, copies of the available reports may be obtained from Rohini Pande, ext. 87600 (202-458-7600 if calling from outside the Bank), e-mail address rpande@worldbank.org.