

**A Review of Population, Reproductive Health,
and Adolescent Health & Development
in Poverty Reduction Strategies**

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Acronyms

AHD	Adolescent Health and Development
AIDS	Acquired Immune Deficiency Syndrome
CAS	Country Assistance Strategy
CDF	Comprehensive Development Framework
CH	Infant and Child Health
DHS	Demographic and Health Surveys
ESW	Economic and Sector Work
GNI	Gross National Income
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Virus
HNP	Health, Nutrition and Population
IBRD	International Bank for Reconstruction and Development
ICPD	International Conference on Population and Development
IDA	International Development Association
IMF	International Monetary Fund
I-PRSP	Interim Poverty Reduction Strategy Paper
JSA	Joint Staff Assessment
MDG	Millennium Development Goal
MTEF	Medium Term Expenditure Framework
NGO	Nongovernmental Organization
Pop	Population
PRS	Poverty Reduction Strategy
PRSC	Poverty Reduction Support Credit
PRSP	Poverty Reduction Strategy Paper
PSIA	Poverty and Social Impact Analysis
RH	Reproductive Health
STI	Sexually Transmitted Infection
UN	United Nations
UNFPA	United Nations Population Fund
UNIFEM	United Nations Fund for Women
WHO	World Health Organization

1. Introduction

1.1 Background on the Poverty Reduction Strategy Process¹

In 1999, the World Bank and the International Monetary Fund (IMF) proposed the Comprehensive Development Framework (CDF), a holistic approach that integrates the social, structural, human, governance, environmental, economic, and financial aspects of development. Later that year, they initiated the use of Poverty Reduction Strategy Paper (PRSPs), nationally-owned poverty alleviation strategies based on a highly participatory development process and corresponding to the key principles of the CDF. The PRSPs were to serve as the basis for concessional lending for 81 International Development Association (IDA) countries and for debt relief to 42 heavily indebted poor countries (HIPC) under the enhanced HIPC framework².

Core strategy principles. According to the World Bank, poverty reduction strategies should: be country-driven; focus on results benefiting the poor; be holistic in addressing the multiple determinants and outcomes of poverty; incorporate collaboration with development partners; and demonstrate a long-term perspective for poverty reduction.

Major PRSP components. The World Bank suggests that PRSPs should include the following four major components: a description of the participatory process during PRSP development; a diagnosis of who suffers from poverty and the key factors leading to poverty; a list of proposed policies to reduce poverty; and plans for monitoring and evaluating progress toward reducing poverty.

Process. Eligible countries submit PRSPs to the Executive Boards of The World Bank and IMF approximately every three years. A Joint Staff Assessment (JSA) accompanies the PRSP to the Executive Boards of the World Bank and IMF. This document is an assessment of whether or not the strategy presented in the PRSP constitutes a sound basis for concessional assistance and debt relief from the World Bank and IMF. While preparing to submit full PRSPs, in order not to delay World Bank assistance, countries may submit Interim PRSPs (I-PRSPs) (see Figure 1.1).

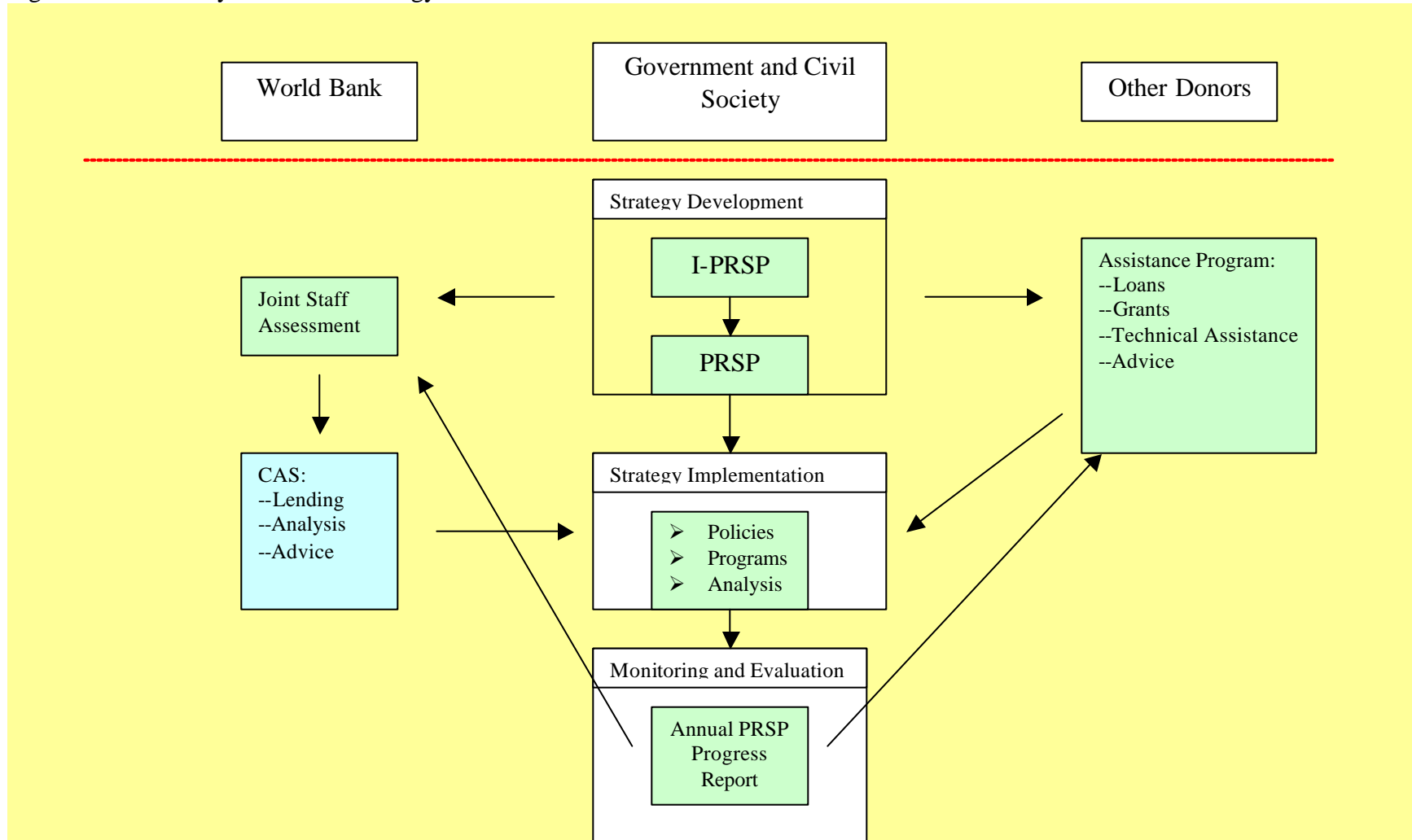
Monitoring. Countries are required to submit annual reports of progress towards achieving success. Progress reports are expected to be used to determine adjustments in countries' PRSP policies and expenditure frameworks as well as World Bank and IMF financial supports.

Link to World Bank operations. The PRSP/JSA underpins the Country Assistance Strategy (CAS), which is the Bank's business plan for each client country. As such, the PRSP/JSA process is key to the entire range of instruments that the Bank uses to support its work—loans, credits and grants, economic and sector work (ESW) as well as analytical and advisory work (AAA). This array includes a new instrument for annual budget support, the Poverty Reduction Support Credit (PRSC). Where applicable, the CAS is timed to follow the PRSP and its accompanying JSA. Beginning in July 2002, all CASs in IDA countries are based on a PRSP.

¹ World Bank, 2003a. For more information about PRSPs, visit <http://www.worldbank.org/poverty/strategies>.

² For more information about IDA and the HIPC initiative, visit <http://web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/IDA/0,,pagePK:118644~theSitePK:73154,00.html> and <http://www.worldbank.org/hipc/index.html>.

Figure 1 The Poverty Reduction Strategy Process



1.2 Links between Population, Reproductive Health, Adolescent Health and Development and Poverty Reduction

Although the relationships among fertility, population growth and poverty have been debated for decades (Merrick, 2002), emerging evidence that takes into account changing population age structure strengthen these theoretical links (Bloom et al, 2003). Lower fertility and slower population growth, in combination with decreasing mortality—i.e. the demographic transition—increases the proportion of productive individuals relative to dependents. This change creates a “window of opportunity” conducive to economic growth. Countries that exploit this “demographic dividend”—through investments in the education, skills and health of the working-age population while simultaneously creating a favorable macroeconomic policy climate—can experience economic growth and reduction in poverty. Such investments are particularly important in light of the unprecedented numbers of young people now entering their reproductive years. Of the more than 1.7 billion youth aged 10-24, 86% live in developing countries. Investing in the human and social capital of these young people is key to ending the cycle of poverty.

Evidence at the household level shows that the combination of poverty and large family size is detrimental to child health and development and to overall family welfare. Children in large families have worse nutrition, health outcomes, and physical and mental development and are less healthy as adults than are children from smaller families. These conditions combine to reduce the overall human capital available in poor households and perpetuate an intergenerational cycle of poverty. A revealing illustration of this vicious cycle is the disproportionately large share of the reproductive health disease burden borne by poor women (World Bank, 2002b). Poor women have the highest fertility rates, the highest level of reproductive health problems, the least amount of knowledge of how to deal with their needs, and the worst access to appropriate reproductive health care services.

Given the aforementioned relationships, the Poverty Reduction Strategy framework provides a critical opportunity to integrate Pop/RH/AHD in national poverty reduction plans and to help accelerate progress toward achieving the Millennium Development Goals (MDGs), internationally agreed upon goals for global development. Investments in maternal, child and adolescent health can reduce household poverty while also creating the conditions that produce the demographic dividend. When fewer children are dying, families are less likely to have large numbers of children to replace those they may lose to premature mortality. This fuels the demographic transition and helps to open the demographic window of opportunity. Governments can take advantage of these changes in population age structure by investing in appropriate and relevant programs to build human capacity and encourage growth.

1.3 Purpose and Scope of this Review

This review examines how poverty reduction strategies are addressing population (Pop)³, reproductive health (RH)⁴, and adolescent health and development (AHD)⁵ issues. We analyzed

³ The review considers population-level characteristics that affect and are affected by reproductive health and adolescent health and development, including population size, population growth rate, population momentum, life expectancy, age structure and urbanization rate.

⁴ We observe the International Conference on Population and Development (ICPD) definition of reproductive health, which may be found in the ICPD Programme of Action, paragraph 7.2 (ICPD, 1994).

twenty-one Poverty Reduction Strategy Papers (PRSPs) and associated documents, and conducted interviews with Health, Nutrition, and Population (HNP) staff at the World Bank involved in the poverty reduction strategy process. Based on this review, we recommend actions that the Bank, other donors, government counterparts, and civil society groups can take to better support countries to address Pop/RH/AHD issues in their poverty reduction efforts.

Population, reproductive health, and adolescent health and development issues are closely interrelated in cause, consequence and policy implications. To maintain a stronger focus on these three issues, we chose not to analyze related concerns such as gender, nutrition, and education—all essential components of the multisectoral approach advocated by the Cairo Programme of Action (ICPD, 1994). Other reviews have examined these related issues in greater depth⁶.

This paper complements a growing body of work reviewing the application of the PRS framework to poverty alleviation in low-income countries. Compared to previous health and related sector reviews, it provides a more in-depth look at Pop/RH/AHD issues, examines documents related to the PRSP such as the JSA and CAS, and incorporates interviews of key actors with Pop/RH/AHD expertise involved in the PRS process. This review is meant to complement findings from other reviews of the PRS process that focus on broader issues of relevance to all sectors (see for example IMF and IDA 2003). Our analysis relied on several of these relevant internal and external reviews, including in-depth reviews of gender, the health sector, nutrition, and population and development issues (see reference list).

1.4 Review Methodology

In addition to the twenty-one full PRSPs approved as of December 31, 2002 (see Box 1.1) we also examined associated documents that are important to the implementation and monitoring of the strategy. These include the Annual Progress Reports prepared by countries; JSAs carried out by Bank and Fund staff; the CAS, the Bank's business plan developed in accordance with the PRSP; and the Poverty Reduction Strategy Credit (PRSC), a new Bank lending instrument for annual budget support. Interviews with Bank HNP country staff involved in the PRS process helped us to gain more in-depth information on the process of PRSP development; the role of HNP staff in the poverty reduction strategy process; and how the policy dialogue is moving ahead post-PRSP.

⁵ “Adolescent health and development” refers to the “range of inter-related knowledge and skills that will allow [adolescents] to lead fulfilled and productive lives. These skills are critical to helping young people stay healthy, learn, obtain a job or livelihood, and participate fully in society” (Rosen, forthcoming). For this review, “adolescents” are considered youths between the ages of 10 and 24. Education is not considered in this review. Labor/employment is considered only with respect to unemployment rates among 15- to 24-year olds.

⁶ For a list of both internal (to the World Bank and IMF) and external reviews, visit <http://www.worldbank.org/poverty/strategies/review/extrev.htm>

Box 1—Reviewed PRSPs, by World Bank region

Sub-Saharan Africa (SSA)

Burkina Faso Niger
Ethiopia Rwanda
The Gambia Senegal
Guinea Tanzania
Malawi Uganda
Mauritania Zambia
Mozambique

Latin America & the Caribbean (LAC)

Bolivia
Guyana
Honduras
Nicaragua

East Asia & the Pacific (EAP)

Vietnam

Middle East & North Africa (MENA)

Yemen

South Asia (SA)

None

Europe & Central Asia (ECA)

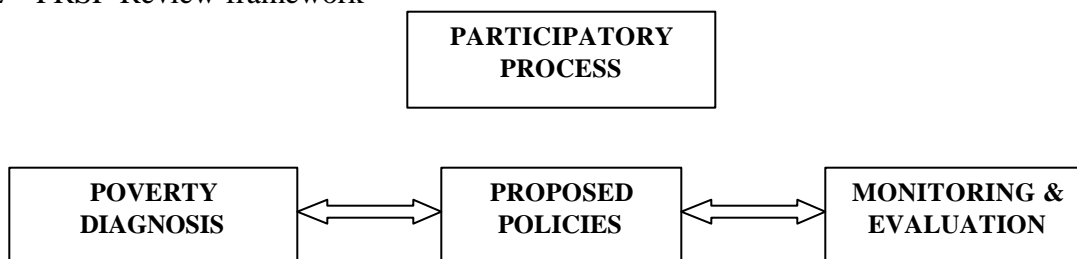
Albania
Tajikistan

2. Findings

2.1 Findings from the review of the PRSPs

Our review framework⁷ incorporates questions that address the four major sections of the PRSPs: participatory process, poverty diagnosis, proposed policies and strategies, and monitoring and evaluation targets (Box 2). The analysis below follows this framework and looks at how well poverty reduction targets correspond to the MDGs.

Box 2—PRSP Review framework



Overall key finding: *Despite having to cover many topics, the PRSPs pay a reasonable level of attention to Pop/RH/AHD issues. However, the scope and quality of the inclusion varies enormously.* With respect to overall quality, there is no exemplary PRSP as it relates to Pop/RH/AHD issues. Some PRSPs are quite strong in reproductive health and weak in population and adolescent health and development. Other PRSPs are strong in target setting and

⁷ The review framework borrows from an internal review of nutrition issues undertaken by the Nutrition Cluster of the Health, Nutrition and Population anchor (World Bank, 2002).

linkage⁸ but weak on the quality of their diagnostics and policies. A PRSP may do a good job in describing the links between poor reproductive health and poverty, but fail to detail adequate policies or lay out a follow-up monitoring and evaluation plan. The main lesson is that *all* countries can improve the way in which their PRSPs address these issues. Another general finding of our review is that reproductive health and population issues receive more and higher quality coverage in PRSPs than AHD issues.

2.1.1 Participatory Process

Because PRSPs are intended to be holistic in their approach to poverty, involvement by stakeholders representing a range of issues and viewpoints is critical to ensuring that PRSPs address all the issues relevant to a given country's situation.

Key finding: The participation of key Pop/RH/AHD stakeholder groups in the PRSP process is uneven, and the process can better represent the interests of women, youth and poor people.

It is difficult to gauge the true level of Pop/RH/AHD stakeholder involvement in and influence on the PRSP using information from PRSPs alone. Nonetheless, we can conclude that most countries include participation from at least one relevant stakeholder group aside from the government. The vast majority of countries mention participation from NGOs and donors (eighteen and nineteen, respectively), while two-thirds (fourteen) specifically mention involvement by women. Still, less than half (nine) mention participation by youth and one-third (seven) mention involvement by professional groups such as physicians' or nurses' associations. Nine countries note participation by other groups such as religious organizations or business leaders.

Our analysis confirms findings from other studies showing that the PRSP participatory process can be strengthened and should give more voice to poor people and to civil society. An internal review of nutrition issues in PRSPs and two external reviews of gender issues have put forth similar findings regarding the lack of involvement of civil society (World Bank, 2002a; Whitehead, 2003; UNIFEM, 2001). Curtain's (2003) review of 31 PRSPs found that only about half of countries consulted youth in the development of the strategy. A review by Save the Children UK (2001) found a similar lack of participation by youth. A WHO (2001) review found that lines ministries like health are often marginalized during the PRSP process.

2.1.2 Poverty Diagnosis

To formulate effective poverty reduction policies and programs, countries need an understanding of the causes and consequences of poverty. Furthermore, good knowledge of the levels and patterns of poverty can inform targeting of programs and resources, and provide baseline statistics for future monitoring and evaluation of interventions. Our review looked at how well the PRSP describes the relationship between poverty and Pop/RH/AHD; the extent to which PRSPs include discussion of existing Pop/RH/AHD policies or programs; the types and numbers of Pop/RH/AHD indicators countries included in poverty assessments; the level of indicator

⁸ "Linkage" refers to correspondence or a logical flow among poverty diagnoses, proposed policies and targets, e.g. whether there is a policy designed to impact a particular target, or whether a policy addresses a particular poverty diagnosis.

disaggregation; and the extent to which countries place their poverty indicators in a regional or global context.

Key finding: The quality of the poverty diagnosis as it relates to Pop/RH/AHD varies widely among PRSPs.

Seventeen of twenty-one countries have at least a minimal discussion of the relationship between poverty and Pop/RH/AHD outcomes. However, the quality and depth of the analysis can be greatly improved. Some countries do highlight the relationship between Pop/RH/AHD and household poverty, and a few mention links to macroeconomic growth (or lack thereof). Honduras, for instance, links high fertility with increased vulnerability among women which leads to low human capital and productive capacity; Bolivia associates limited economic progress in rural areas with the changing rural age structure (i.e. a decrease in the number of working-age individuals) resulting from rural-urban migration; Niger points to high population growth leading to increased demographic pressure on land.

Knowledge and assessment of current Pop/RH/AHD policies and programs is important to understanding current health outcomes and for planning purposes. The review found that only eleven countries provide some discussion of existing programs and policies addressing Pop/RH/AHD issues. Three additional countries include a discussion of general health policy context. Of the eleven countries providing some Pop/RH/AHD policy context, only a few give an *in-depth* assessment of existing Pop/RH/AHD policies and programs. Bolivia, for example, discusses both the characteristics of and progress achieved by a maternal and child health insurance scheme initiated in 1996; Ethiopia reviews its last Health Sector Development Program, discussing priorities, outcomes and operational problems. Other reviews, both of specific sectors such as nutrition (World Bank, 2002a) and of the overall PRSP initiative (Klugman, 2002) have found similarly low levels of discussion of existing policies.

Countries include a fair number of Pop/RH indicators, but indicators are not well-defined, different PRSPs use different ways of measuring similar outcomes, and PRSPs seldom disaggregate indicators in a manner necessary to assess poverty among different groups. In all, the PRSP poverty assessments mention eleven different population indicators, thirty-eight different RH indicators, and six different AHD indicators. The number of Pop/RH/AHD indicators contained in individual PRSPs ranges from four (Uganda) to twenty (Burkina Faso and The Gambia). All PRSPs include at least two reproductive health indicators and at least one population indicator. Seven countries have one AHD indicator each while fifteen countries have no AHD indicators. Box 3 lists the indicators that appear most often in the PRSPs. Although a few well-chosen indicators likely are more useful than a long list (see Klugman, 2002), some key Pop/RH/AHD indicators are conspicuously absent from the poverty diagnosis. These include indicators such as availability of basic and essential obstetric care and perinatal mortality rate, as well as most of the important adolescent health indicators. This lack of attention to adolescents is also noted in reviews by UNFPA (2002) and Curtain (2003).

Box 3—Indicators appearing most often in poverty diagnoses (# of PRSPs)

Population

- Life expectancy (18)
- % Urban population (11)
- Population growth rate (10)
- Population size (9)
- Human development index (8)

Reproductive Health

a) Maternal health and family planning

- Maternal mortality rate (16)
- Total fertility rate (11)
- Antenatal care coverage (various definitions) (8)
- Contraceptive prevalence rate (any method) (7)
- Births attended by skilled personnel (5)

b) STIs/HIV

- HIV prevalence (11*)
- Knowledge of HIV-related prevention practices (3)
- Number of AIDS orphans (2)

c) Infant and child health

- Infant mortality rate (19)
- Child mortality rate (16)

Adolescent Health and Development

- HIV infection rate, 15- to 24 year-olds (2)
- HIV infection rate, pregnant 15- to 24 year-olds (1)
- Adolescent fertility rate (1)
- % of women with first birth at 12- to 15 year-olds (1)
- % of women with first pregnancy at <19 year-olds (1)
- Unemployment rate, 15- to 24 year-olds (1)

Even when including relevant indicators, PRSPs tend to do a poor job of disaggregating indicators by income group, region, gender, and age. Across the twenty-one PRSPs, only 21% of reproductive health indicators, 14.7% of population indicators and 16.7% of AHD indicators are disaggregated by at least one of those four categories. Other PRSP reviews have found a similar lack of disaggregation, especially with respect to gender and socioeconomic group (WHO, 2001; World Bank, 2002a; UNFPA, 2002; UNIFEM, 2001).

2.1.3 Proposed Policies, Strategies and Specific Interventions

Each PRSP lays out policies to address poverty reduction. We looked at how well these policies address Pop/RH/AHD concerns.

Key finding: The degree to which the PRSPs propose specific Pop/RH/AHD policies and the quality of policies is mixed and can be strengthened in a number of ways.

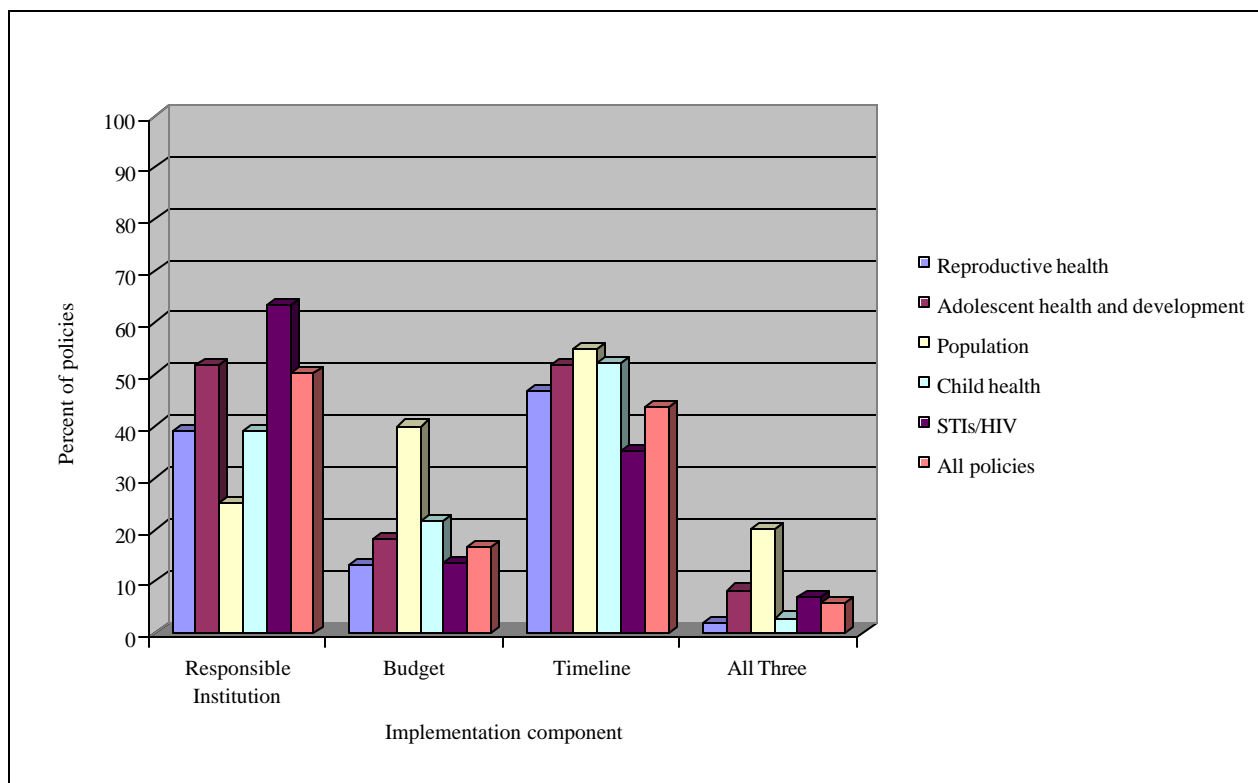
Generally, the PRSPs do a good job of mentioning policies related to Pop/RH/AHD. Every country except Uganda includes at least one policy related

to reproductive health, all but two (Tajikistan and Uganda) include policies directed at child health, and all but three (Nicaragua, Tajikistan and Yemen) include STI/HIV policies. Most surprisingly, given the relative lack of attention to AHD in the poverty diagnosis, twelve countries include policies on AHD. By contrast, just seven countries include population policies, a smaller than expected result when compared to the attention paid to population in the poverty diagnoses.

Although PRSPs are not implementation documents, our review found that many basic implementation elements are missing from Pop/RH/AHD policies. As shown in Chart 1, half of the recorded policies specify an institution responsible for implementing the policy, 44% of policies denote a basic timeline for implementation (generally, a range of years over which the policy will be implemented) and 17% of policies have a budget. Few policies (under 6%) include all three elements. Furthermore, although Pop/RH/AHD are all cross-sectoral issues, only HIV

and population policies have a significant multisectoral component, with about one-third of HIV and population policies being multisectoral.

Chart 1—Implementation plans (% of policies that indicate a component)



2.1.4 Monitoring and Evaluation Framework

Clearly defined targets⁹ are important to monitoring the progress of policy implementation. In addition to whether PRSPs are including Pop/RH/AHD targets, the review also examined the quality of such targets. A high-quality target should be disaggregated by income, region, gender and/or age to verify that policies are reaching those in need. Furthermore, targets should have an associated baseline value, goal and proposed date for achievement.

Key finding: The monitoring and evaluation section of the PRSP is irregular in its treatment of Pop/RH/AHD and especially needs improvement for AHD.

For the most part, PRSPs do include monitoring and evaluation targets addressing population, reproductive health, infant and child health, and STIs/HIV (See Box 4). Every country includes at least one reproductive health target (usually maternal mortality rate) and one infant and child health target (usually infant mortality rate). Sixteen countries include population-related targets, and fifteen countries include targets for STI/HIV-related outcomes. AHD targets, however, are conspicuously absent.

⁹ To be consistent with the terminology used in the PRSP and MDG initiatives we use the term “targets” to refer to goals or objectives outlined by the poverty reduction strategy. Use of the term “targets” in no way endorses the “target approach” sometimes associated with coercive population policies.

Box 4—Targets included most often in monitoring and evaluation plans (# of PRSPs)

Population

- Life expectancy (10)
- Immunization rate (4)
- Population growth rate (3)

Reproductive health

a) Maternal health and family planning

- Maternal mortality rate (21)
- Contraceptive prevalence rate (7)
- Fertility rate (6)
- Antenatal care coverage (4)
- % of childbirths handled institutionally (4)

b) STIs/HIV

- HIV prevalence (7)
- HIV prevalence, 15-49 year-olds (2)
- HIV prevalence, pregnant women (2)
- HIV transmission rate (2)
- # of people reached by education campaigns (2)

c) Infant and child health

- Infant mortality rate (20)
- Child mortality rate (14)
- % Children with low birth weight (4)
- Immunization coverage for children <1 year old (3)

Adolescent Health and Development

Seven targets appear once each. These include:

- Assistance to pregnant adolescent women
- Delay first sexual debut at 15 years old

Monitoring and evaluation targets lack standardization, and just 6% are disaggregated by income, region, gender or age. Other reviews of PRSP coverage of the health sector, nutrition, population and development, and gender point out a similar lack of disaggregation (WHO, 2001; World Bank, 2002a; UNFPA, 2002; UNIFEM, 2001). By contrast, countries do fairly well in describing target baselines (63% of targets), goals (77%) and target dates (71%).

2.1.5 Linkage

Good poverty reduction strategies have a logical flow, or “linkage,” between determinants of poverty, policies to address poverty, and monitoring and evaluation targets. Our review examined the extent to which this linkage exists for Pop/RH/AHD issues.

Key finding: Linkage—from diagnosis to policy to targets—is adequate in some respects but could be improved in others.

In general, linkage is good between poverty diagnoses and proposed policies, but breaks down in the transition from policy to target setting. Over 80% of Pop, RH, CH, and STI/HIV policies have a corresponding diagnosis. However, the proportion of policies that have associated targets is much lower, between 10% and 35%. Linkage is particularly poor for AHD and population policies, with only 10% of such policies

having both a corresponding diagnosis and a corresponding target. To some extent, the poor linkage reflects the lack of prioritization that is a generalized problem in the PRSPs (Klugman 2003). Rather than including an exhaustive list of policies, PRSPs should be selective based on identified needs and constraints. Unfortunately, our review found too many cases of policies that “float” without connection to either poverty diagnosis or targets.

2.1.6 Correspondence with Millennium Development Goals

We examined the extent to which the Pop/RH/AHD targets chosen to assess PRSP implementation and progress correspond with the MDGs and the proxy indicators suggested by the United Nations (UN) system.¹⁰

Key finding: Correspondence with the maternal mortality MDG target is excellent, but inclusion of other MDG targets in the PRSPs is less common. All twenty-one PRSPs include reduction of maternal mortality as a target for monitoring and evaluating PRSP implementation progress. However, just seven countries include contraceptive prevalence rate, seven countries include either proportion of births attended by skilled personnel or proportion of births handled institutionally, and one country includes proportion of people with sexually transmitted infections who are appropriately diagnosed and treated. This lack of correspondence may signal a lack of knowledge regarding the MDGs, difficulty in translating MDGs to measurable indicators, lack of relevance of some MDGs to the contexts of the review countries, and/or a lack of support for the MDGs by the review countries. A recent internal review of MDG and PRSP indicators and targets was somewhat more optimistic, finding that PRSPs “encompass most of the MDGs, although the targets and actual data required for monitoring are often different” (World Bank, 2003d).

2.2 Findings from the review of associated documents

To enrich our assessment of the PRS process we also set out to trace how Pop/RH/AHD issues are being treated at important junctures in the aftermath of the PRSP.

2.2.1 Progress Reports

Governments submit Annual Progress Reports within 12 months after preparation of a PRSP to assess progress toward poverty reduction strategy goals and intended policy and program reforms. These reports also allow governments to adjust PRSPs in response to changing macroeconomic conditions, etc. We reviewed 9 progress reports for the following countries¹¹: Burkina Faso (2 reports), Malawi, Mauritania, Mozambique, Tanzania (2), and Uganda (2). We hoped to gauge the degree to which they address Pop/RH/AHD issues, whether a country had strengthened its attention to Pop/RH/AHD issues over time, and how monitoring plans specific to Pop/RH/AHD issues have worked out.

Key finding: As we found in our review of the PRSPs, the Progress Reports include a reasonable amount of information on Pop/RH/AHD issues. Coverage of AHD in particular appears to have improved from the levels seen in the PRSPs. At least one country, Uganda, appears to have increased its attention to Pop/RH/AHD issues. Few Progress Reports, however, give specifics on monitoring and evaluation of Pop/RH/AHD issues.

¹⁰ Two of the PRSPs we reviewed were finalized prior to and nineteen PRSPs were finalized after the September 2000 announcement of the MDGs.

¹¹ Some countries have already produced more than one progress report.

2.2.2 Joint Staff Assessments of PRSPs and of PRSP Progress Reports

We reviewed 7 JSAs of PRSPs, for Albania, Guyana, Malawi, Mauritania, Mozambique, Nicaragua, and Vietnam; and reviewed 12 JSAs of progress reports for Albania, Burkina Faso (2), Malawi, Mauritania, Mozambique, Nicaragua, Tanzania (2), and Uganda (3). Our main interest was in finding out whether the JSAs provide feedback on Pop/RH/AHD issues and, if so, whether the feedback is useful and constructive.

Key finding: In general, feedback from the JSAs on Pop/RH/AHD issues is sparse.

Suggestions are very general and refer to sectors overall; JSAs make few specific suggestions for particular sub-sectors. Where JSAs have commented specifically on Pop/RH/AHD issues, the comments have been constructive and useful. For example, staff advises several countries, including Malawi and Mozambique, to develop more overarching HIV/AIDS strategies to meet needs across all sectors. Some JSAs suggest better monitoring and reporting of general health sector expenditures and comparisons of budgeted vs. actual expenditures. The JSA for Burkina Faso's first Progress Report suggests greater involvement by women in poverty reduction planning, budgeting and evaluation exercises.

2.2.3 The influence of the PRSP on the CAS

The CAS is the basis for Bank activities in a client country. We reviewed CASs in five countries (Burkina Faso, Guyana, Tanzania, Uganda, and Vietnam) to determine whether the CASs address Pop/RH/AHD issues and how well CASs incorporate the PRSP findings and recommendations directly related to Pop/RH/AHD.

Key finding: The CASs we reviewed address Pop/RH/AHD issues, but in less detail than in the PRSPs. One exception is for Niger, where the CAS has placed greater emphasis on Pop/RH concerns than was seen in the PRSP. This increased emphasis, in large part due to timely sector analysis on population issues, will likely lead to the incorporation of a reproductive health component in the new health loan in Niger. A recent general review of 20 CASs prepared in support of PRSPs finds that CASs are increasingly aligned with PRSPs in terms of vision, diagnosis, program, and results (IMF and IDA 2003).

2.2.4 PRSCs

The Poverty Reduction Support Credit (PRSC) is a new Bank lending instrument for annual budget support. We reviewed PRSCs in the six countries where, as of December 2003, PRSPs had been followed up with by Bank lending operations in the form of a PRSC. These countries include Albania, Burkina Faso (2 PRSCs), Guyana, Nicaragua, Uganda (2), and Vietnam. Our review aimed to find out whether PRSCs are addressing Pop/RH/AHD issues and, if so, how well PRSCs relate to the findings and recommendations of the PRSP.

The PRSCs appear to be fairly well aligned with PRSPs on Pop/RH/AHD issues. The PRSCs generally discuss Pop/RH/AHD with respect to improving the quality of life of the poor, which is usually one "pillar" or focus area in the PRSPs. It appears that coverage of Pop/RH/AHD issues in PRSCs parallels the coverage of these issues in PRSPs. The following Pop/RH/AHD issues are included most often in PRSCs: infant mortality, maternal mortality, and HIV/AIDS. There is much less discussion of AHD issues, but a few countries (e.g. Guyana and Vietnam) do discuss

issues such as vocational training for youths and child labor. PRSC targets are similar to those included in PRSPs (for example, impact measures such as infant and maternal mortality and HIV prevalence).

2.3 Overall Conclusions

Two important considerations shape the interpretation of our findings. First, any review of the poverty reduction strategy process that focuses on a single sector (or sub-sectors, as is the case of the present review) must be realistic in its expectations. As the most recent internal PRSP progress report (IMF and IDA 2003) highlights, it is very difficult for PRSPs to be both comprehensive and deep within the space, time and capacity limitations of the PRS teams. Thus, neither the PRSP nor related documents are the best vehicle for in-depth treatment of Pop/RH/AHD issues. A second consideration is that more on a particular topic is not necessarily better. Although we are concerned that such poverty reduction strategies do an adequate job of addressing Pop/RH/AHD, a long laundry list of diagnostics, policies, and targets without prioritization is not helpful. It is more important that strategies ensure adequate resource allocation once priorities are identified.

With these considerations in mind, the main message of our review is that the poverty reduction strategy process is paying a reasonable degree of attention to Pop/RH issues—to a degree greater than we thought when we first set out to complete this review. However, the emphasis is on the reproductive health aspects with little focus on population issues as a factor in perpetuating or reducing poverty. As our findings on linkage show, many countries are not making tight connections between the identification of a problem, policies to address the problem, and monitoring and evaluation of policy implementation. This indicates a need to better prioritize, a problem that HNP Task Team Leaders (TTLs) have noted and that affects all sectors covered by the PRSP.

A second clear message that emerges is that the process has a limited focus on AHD. Although to some extent this reflects the broader lack of attention to adolescent concerns, nonetheless it is worrisome. The largest generation of young people ever is entering the crucial transition years between childhood and adulthood. More than ever, developing countries need to focus attention and resources on this group, particularly with HIV/AIDS continuing to spread rapidly.

A third message is that quantity is not necessarily related to quality. Although the PRSPs of several countries are notable for the number of Pop/RH/AHD indicators in the poverty diagnosis, they are not necessarily of high quality or useful to the analysis. Similar results emerge with respect to the number of Pop/RH/AHD policies proposed and the monitoring and evaluation targets.

A fourth overall message is that the PRSPs are indeed important in setting the tone for subsequent actions by governments and donors. If the PRSP includes clear descriptions of Pop/RH/AHD issues, policies, and targets, this inclusion will influence both the government's program and the Bank's lending activities. Better prioritization and clearer implementation plans—especially with regard to budget—will enhance the chances of implementing Pop/RH/AHD programs as part of poverty reduction plans. As HNP TTLs have noted, this kind of prioritization is critical particularly as the Bank moves from PRSP to CAS and to instruments

such as the PRSC that transfer resources to governments for poverty reduction. Maintaining this focus on Pop/RH/AHD issues in the aftermath of the PRSP is critical.

Given all the sectors the poverty reduction plans must address, it is encouraging that strategies are paying a reasonable amount of attention to Pop/RH/AHD issues. However, weaknesses remain with respect to Pop/RH/AHD strategy development, implementation, and monitoring and evaluation. To address these weaknesses, we suggest some concrete actions in the recommendations section that follows.

3. Recommendations

The poverty reduction process has many actors. All can play a role in better supporting the efforts of countries to address Pop/RH/AHD issues in their poverty reduction plans. Our recommendations are aimed at four main groups of actors: World Bank staff; other multilateral, bilateral, and private donors; government teams working on poverty reduction strategies; and civil society groups.

3.1 Recommendations for World Bank Staff

The PRS process is country-owned but often relies on support from the World Bank. Two key groups providing support on Pop/RH/AHD issues within the Bank are HNP sector staff (including staff assigned to work in particular regions and countries as well as those staff in the HNP central unit that supports country operations) and the Bank's task team leaders who manage the PRSP process.

HNP Sector Staff should be taking the lead, together with colleagues from other sectors within the Bank and in partner organizations, to better articulate the links between Pop/RH/AHD, poverty reduction, and macroeconomic growth. More analytical work is needed in this regard, particularly when it comes to links between AHD and poverty reduction. At the same time, HNP staff should be taking better advantage of the existing body of analytical work linking Pop/RH/AHD with poverty reduction. One way to do this is through better dissemination of such analyses within the international development community and to key government officials. It is especially important that HNP staff encourage RH-focused and youth-focused civil society organizations to get involved early in the country PRS process.

To improve both poverty diagnostics and monitoring and evaluation, HNP staff should encourage countries to select Pop/RH/AHD indicators that are contextually relevant, measurable, and that adhere to globally-accepted definitions. HNP staff can also work towards building in-country capacity for data collection within both the public and private sectors, including the ability to obtain disaggregated indicators (at the very least by age and sex) for enhanced poverty diagnoses and policy formulation. One important way to do this is for HNP staff to take the lead in revising the PRSP Sourcebook to strengthen and clarify guidelines related to Pop/RH/AHD. This could be done within the context of the existing chapter on health, nutrition and population as well as within a new chapter on youth.

It is also critical for HNP staff to advocate for, support, and participate in the range of country-level analytical work to support the PRSP process. Such analyses include health sector reviews;

public expenditure reviews for the health sector that include Pop/RH/AHD; poverty analysis that studies the impact of poverty reduction policies and programs on the poor and other vulnerable populations and that specifically include Pop/RH/AHD; and vulnerability studies to identify groups of women or youth requiring special protective measures. HNP staff should coordinate such studies with other sectors of the Bank and with other donors and stakeholders willing to provide financial and technical assistance.

After completion of a PRSP, HNP staff can continue to actively ensure that implementation of poverty reduction strategies gives proper attention to Pop/RH/AHD concerns. HNP staff should be involved in the CAS process to monitor whether the Bank's business strategy translates PRSP priorities relevant to Pop/RH/AHD to action items such as loans and analytical work. HNP sector staff can also commit financial and technical assistance to build the capacity of civil society groups to implement policies.

Another key role for HNP staff is to advocate for and support government efforts to better track spending on Pop/RH/AHD. The Bank and other donors should build government capacity to track spending and to provide and develop tracking tools. One concrete step is to ensure that the medium-term expenditure framework (MTEF) includes adequate examination of spending on RH/AHD. The MTEF—typically a three to five-year budget—links government policy, planning and budgeting to better allocate resources to the nation's strategic priorities and to ensure that these allocations are consistent with overall fiscal objectives. Because many of the interventions to address RH/AHD have a strong public good component, they are prime candidates for public financing. Such analysis should be carried out under public expenditure reviews. Enhancing the focus of the MTEF on RH/AHD should occur within overall efforts to strengthen costing of specific measures in the PRSPs and their integration into MTEFs, as recommended in the recent internal PRSP progress report (IMF and IDA 2003).

HNP staff have a key role in improving monitoring and evaluation of poverty reduction strategies. HNP staff should work with development partners around the globe to encourage countries to commit the necessary resources to monitor appropriate Pop/RH/AHD indicators. While this process is moving forward globally, HNP staff also have a role in tracking key Pop/RH/AHD indicators in PRSPs and CASs. Such indicators should include, for example, the 10 indicators on the CAS watch list that is laid out in the Bank's population sector strategy (World Bank, 2000). Bank staff should also work with other donors and stakeholders to support country capacity to better track Pop/RH/AHD indicators. This includes integrating and improving existing—and, when necessary, introducing new—monitoring and evaluation systems that allow tracking by income, region, gender and age, or other relevant subgroup.

PRSP Task Team Leaders are based in the Bank's Poverty Reduction and Economic Management (PREM) unit and typically are economists, not sector specialists. As such, it is important that they have a basic understanding of the latest research linking poverty and Pop/RH/AHD, population growth issues, and programming for reproductive health and adolescent health and development. Moreover, as facilitators of the PRSP process, they should encourage governments to allow meaningful participation by groups typically disadvantaged or more vulnerable with respect to poor Pop/RH/AHD outcomes. These include poor women and youth, and organizations representing the interests of these groups. In addition, they should encourage governments to involve a range of health providers in PRSP discussions, including

representatives of licensed professional organizations as well as traditional or alternative practitioners.

The actions described above require more staff and consultant time devoted to Pop/RH/AHD issues as well as specific training for HNP staff. Managers in the HNP and Human Development sectors of the Bank should recognize these additional needs and budget appropriately. The additional resources allocated to Pop/RH/AHD issues within the PRS strategy process could also help to highlight areas where other donors could contribute.

3.2 Recommendations for Multilateral, Bilateral, and Private Donors

Besides the World Bank, many other donor organizations have the interest and the resources to support the poverty reduction strategy process and to ensure that Pop/RH/AHD issues get adequate attention.

During PRSP development, donors should signal to the Bank and the government their interest in supporting and tracking the PRSP process and should engage throughout the process. Donors can play a key role in supporting operationally relevant research, such as studies to clarify linkages between macroeconomic processes, population dynamics and poverty, including the inter-generational transmission of poverty. Donors can also support PRSP preparation directly by organizing dialogues or exchanges on key Pop/RH/AHD themes or, indirectly, by contributing to the Poverty Reduction Strategy Trust Fund (PREM and TFO, 2003), a World Bank-administered fund set aside specifically to strengthen the preparation and implementation of PRSPs. All stakeholders involved in the poverty reduction strategy process, including those in civil society, are entitled to apply to the trust fund. Donors should also engage in dialogue on Pop/RH/AHD issues with the line ministries such as the Ministry of Health that are natural counterparts as well as with finance and planning ministries.

Once the PRSP is complete, donors should continue the trend towards increased coordination of their support based on the PRS process. One aspect of this coordination is to emphasize the importance of Pop/RH/AHD issues in CAS discussions, during which the Bank often consults with partners in the donor community. Donors can also help to ensure that other national development plans and donor strategies such as MDG reports, Common Country Assessment / United Nations Development Assistance Frameworks (CCA/UNDAFs), and sector wide approaches (SWAPs) are harmonized with the PRSP. Moreover, some donors are well placed to implement certain aspects of the PRSP action plan, for example monitoring systems.

3.3 Recommendations for Government PRSP Teams

Governments are ultimately responsible for the substance of the poverty reduction strategy and for its implementation. The government teams responsible for developing the strategy can take a number of steps to better address Pop/RH/AHD issues. One step is to draw on the rich variety of existing research to explore the potential impacts of proposed poverty alleviation strategies on women, youth, and other vulnerable populations. Furthermore, where PRSPs propose Pop/RH/AHD policies, they should, at minimum, specify the institutions responsible for implementing policies, timeline, and a budget. Government teams also need to infuse Pop/RH/AHD policies with a more multisectoral approach, and consider interventions that cut sectors other than health, for instance education or transport. While it is important to address

issues raised in the poverty assessment, PRSPs should prioritize policies and sharpen monitoring and evaluation targets, focusing on a smaller number of high-quality indicators that are measurable and realistic. At the same time, it is important for governments to improve and integrate existing monitoring systems.

3.4 Recommendations for Civil Society Groups

NGOs and other civil society groups can play important roles in strategy development and, to a certain extent, in carrying out and monitoring the poverty reduction plan. They also have unique service delivery expertise in reproductive health and AHD that, in many countries, surpasses that of the government.

Civil society groups should continue their advocacy and support for the participation of under-represented groups such as youth. Civil society groups that already do their own poverty assessment and monitoring should integrate such efforts into the PRS process to ensure that Pop/RH/AHD issues are adequately addressed. Of equal value is tracking progress on poverty reduction after the PRSP has been completed, through tracking the PRSP progress reports, analyzing government programs, and examining how the Bank and other donors orient their assistance programs. In this regard, it is important for civil society groups to take part in public comment on the draft CAS.

Civil society groups must budget adequately for the time and effort involved in participating in the public consultations during the development and vetting of the PRSP, and in ongoing involvement and tracking. Groups planning to in-depth analysis and monitoring may want to consider accessing the Poverty Reduction Strategy Trust Fund (PRSTF).

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