

# **Rapid Guidelines For integrating Health Nutrition and Population issues in Interim Poverty Reduction Strategy Papers of Low-Income countries <sup>1</sup>**

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### ***I. Introduction:***

A new framework for action has been developed to enhance the poverty impact of country actions and development assistance. This approach centers around the preparation by countries of poverty reduction strategies, which would then be a basis for external assistance and debt relief. The operational side of this new framework centers around the development of country-specific Poverty Reduction Strategy Papers (PRSPs) that are based on wide consultations with civil society and on critical analytical work that investigates the failures of programs in reaching 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). For many HIPC countries, the need to quickly access debt reduction funds makes it difficult to provide the time and resources needed for the development of a consultative full PRSP. Interim Poverty Reduction Strategy Papers (I-PRSPs) are then designed to address the need for accessing debt reduction funds and at the same time building towards a full PRSP with adequate consultation and analysis.

Debt relief creates the opportunity for additional spending on the social sectors, including health. The I-PRSP should make the case for health sector spending and, more importantly, identify investments and reforms that would improve the health status for the poor. This document is targeted to the authors and reviews of I-PRSPs working on the health sector (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 I-PRSPs.

The organization of this paper centers around five functions and activities I-PRSP authors may want to consider in developing the interim papers. The next section, Health and Poverty, summarizes the arguments for investment in health as critical poverty reduction activities. Best Buys (section III), presents the state-of-the-art 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 IV highlights quick health sector analysis to help I-PRSP authors base policy recommendations on empirical findings. Section V identifies building blocks for the full PRSP which would be based on poverty-focused analysis and wide consultations. Debt reduction is expected to make more resources available for the social sectors. An important risk with new resources for health relates to investments (such as tertiary hospitals) that will take away resources from investments that reach the poor. Section VI, Do No Harm, provides a checklist for I-PRSP authors and reviewers to identify and mitigate such risks.

## ***II. Health and Poverty***

An important responsibility for country teams preparing the health sections of I-PRSPs is making the case for investments in health as 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<sup>2</sup>. These differences underline a complex relationship between health and poverty described briefly in this section.<sup>3</sup>

***Poverty leads to poor health outcomes.*** 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<sup>4</sup>, heavy work demand, lack of fertility control<sup>5</sup>, as well as low access to preventive and basic curative care. Typically around 70% 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 utilization by the poor and other vulnerable groups of a basic package of cost-effective health interventions can significantly improve their health status 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. In Asia, the proportion of household income spent on health services is typically higher in low-income groups than in higher income groups.<sup>6</sup> Catastrophic illnesses often precipitate near poor household into major economic difficulties.<sup>7</sup> For example, studies in East Asia showed that 50 percent of financial crisis 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 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

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<sup>2</sup> D. Gwatkin, and others the poverty information sheets.

<sup>3</sup> M. Claeson, C. Griffin, T. Johnston, M. McLachlan, A. Soucat, A Wagstaff, and A. Yazbeck (2000) "HNP Sourcebook for Poverty Reduction Strategy Paper" Health, Nutrition and Population, World Bank, Washington DC.

<sup>4</sup> Including dietary and sanitary practices

<sup>5</sup> R. Eastwood and M. Lipton (2000) "the impact of changes in human fertility on poverty" journal of Development Studies, forthcoming

<sup>6</sup> This is not true in all countries but most likely reflects non expressed demand because of various obstacles to use

<sup>7</sup> Narayan, D, et al (1999): Global Synthesis: Consultation with the Poor. 1999, World Bank: Washington DC.

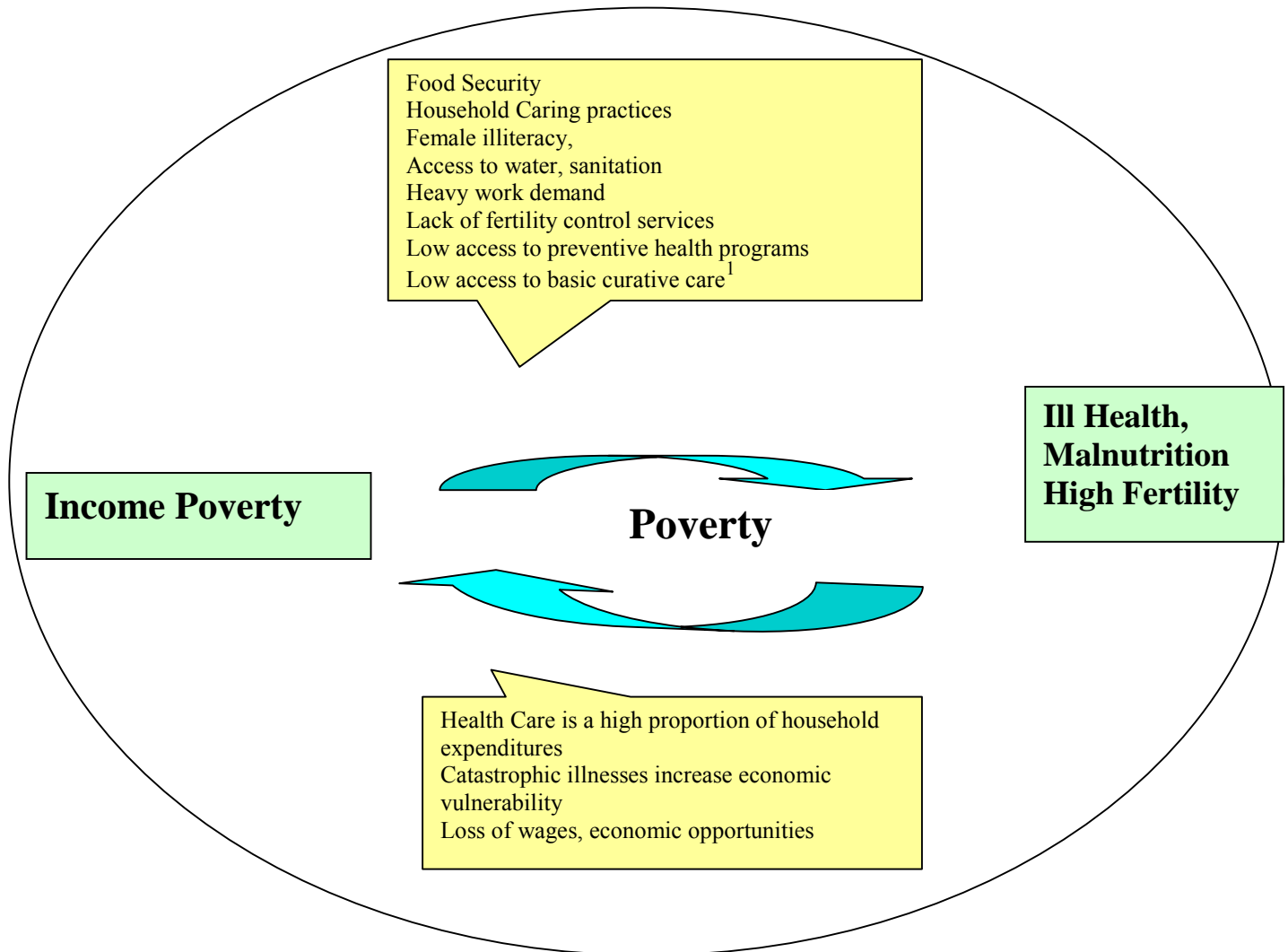
essential services, health insurance, fee waiver schemes and other safety nets--are likely to have beneficial effects on income-poverty reduction.<sup>8</sup>

***Poor HNP outcomes are a key aspect of poverty.*** A more complete view of poverty includes deprivations from not only money income, but also 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 health outcomes and involving the poor actively 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. Participation of the poor in the design, planning and monitoring of health services has been seen as a key development strategy in many countries, through experiences such as the Bamako Initiative, or community based nutrition services.

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<sup>8</sup> World Bank (1997), *Health, Nutrition and Population Sector Strategy*

**Figure 1: Summary of relationships between Income Poverty and Ill-Health**



### **III. Best Buys**

In addition to making the case for health, I-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 can take advantage of a body of work by technical and multilateral agencies and adapt them to country conditions and needs. This section summarizes some of the available knowledge on best buys in public health that are linked to the burden of disease of the poor.

Before turning to specific targets of opportunity (best buys), it is useful to keep in mind a framework for evaluating investments and policies for improving the health of the poor. The framework<sup>9</sup> summarized briefly below focuses on improved targeting, responsiveness, and accountability of the health sector as well addressing factors outside health services delivery. Combined with the more detailed checklists provided in section VI, this framework provides an assessment tool for both authors and appraisers of I-PRSPs for health, nutrition, and population.

#### I. Health Sector:

1. *Focusing on the health problems of the poor and ensuring that health systems serve the poor.* As the best buys list shows below, this typically means targeted interventions in communicable diseases, nutrition and reproductive health. This area also contains a complex set of issues that not only relate to the supply-side barriers to access to health services by the poor (e.g. placement of facilities, quality and availability of inputs), but also look at factors limiting the demand for life saving services by the poor (e.g. knowledge and real costs).
2. *Protecting the poor to limit the impoverishing effect of health expenditures.* This can be done through pricing revisions, cross-subsidization, prepayment mechanisms for risk sharing.
3. *Ensuring system accountability towards the poor.* Policies in this area include co-management, community-based monitoring, and other empowerment and listening activities.

#### II. Beyond the health sector :

4. *Acting on the determinants of better health for the poor.* Many of the determinants of good health lie outside the health sector (e.g. water and sanitation). This is especially true for the poor. Interventions may involve improving the access to basic services for the poor by working inter-sectorally.
5. *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

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<sup>9</sup> Based mainly on a framework documented in “Health: A Precious Asset”, WHO 2000.

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.

Debt relief is expected to increase the availability of domestic resources for the social sectors. It is important therefore for I-PRSP authors to identify investments that address the needs of the poor in their countries. One way of targeting investment in the health sector to increase the likelihood of poverty reduction is to focus on the diseases that continue to plague the poor. While the poor suffer disproportionately from almost all illnesses and injuries, some disease, such as most communicable disease, are largely concentrated among the vulnerable. High levels of malnutrition and maternal mortality are also more likely to afflict the poor. Table 1 lists some of the best buys that combine efficiency as measured in terms of cost-effectiveness and are likely to address the needs of the poor.

**Table1: Selected Best Buys<sup>10</sup>**

Outcome	Conditions and Services	Interventions
Reduction of IMR and U5MR	Integrated Management of Childhood Illness Immunization (EPI Plus)	Case management of ARI, diarrhea, malaria, measles and malnutrition; immunization, feeding/breastfeeding counseling, micronutrient & iron supplementation, antihelminthic treatment, and referral BCG at birth; OPV at birth, 6,10, 14 weeks, DPT at 6, 10, 14 weeks, HepB birth, 6 and 9 months( optional), Measles at 9 months TT for women of child bearing age
Reduction of maternal mortality and fertility	Reproductive health/ Safe motherhood	Family planning, prenatal delivery care, clean/safe delivery by trained birth attendant, post partum care, and essential emergency obstetric care for high risk pregnancies and complications
Control of communicable diseases	Family Planning Treatment of Sexually Transmitted Diseases (STD) HIV/AIDS prevention program Malaria Treatment of Tuberculosis	Information & education and availability and correct use of contraceptives Case management using syndromic diagnosis and standard treatment algorithm  Education on safe behavior, condom promotion, STD treatment, safe blood supply, prevention of Mother To Child Transmission Case management ( early assessment and prompt treatment), and selected preventive measures (e.g. impregnated bed-nets, presumptive treatment) Direct Observed Treatment Short-course; Case detection by sputum smear microscopy among symptomatic patients. Standardized treatment regimen of 6-8 months. Directly observed treatment for at least initial 2 months.
Improve nutrition	School health program Child Protein Energy Malnutrition Anemia and Vitamin A Deficiency Iodine Deficiency	Health education & nutrition intervention(s), e.g. deworming, micronutrient supply, school feeding Promotion of Breast feeding with appropriate complementary feeding, IEC (communications for behavior change) Iron and folic acid supplementation, Vitamin A supplementation, IEC (communications for behavior change) Salt iodization, IEC (communications for behavior change)

#### ***IV. Quick Analysis***

To assist in selecting country-appropriate interventions for the I-PRSP, it is also important to conduct quick and simple analyses of available data. In most countries there is data that would allow for the following simple steps:

1. Assessing the health outcomes of the poor at country level
2. Analyzing interactions between poverty and health

<sup>10</sup> The list is based on the work of technical groups at the World Bank and WHO documentation.

3. Revisiting the core package of services to ensure that diseases affecting the poor are adequately included and to prioritize key interventions for sustained funding
4. Assessing coverage of the poor with key interventions selected
5. 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. In each step, sources of data or examples from the ongoing work on I-PRSPs in Africa is shared to highlight the feasibility and usefulness of conducting quick analysis.

### 1. Assessing the health outcomes of the poor at country level

The purpose of this analysis is to gain a better understanding of where the country stands in comparison to other countries, as well as to assess to what extent the health outcomes of the poor are different from those of the non-poor population. 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).

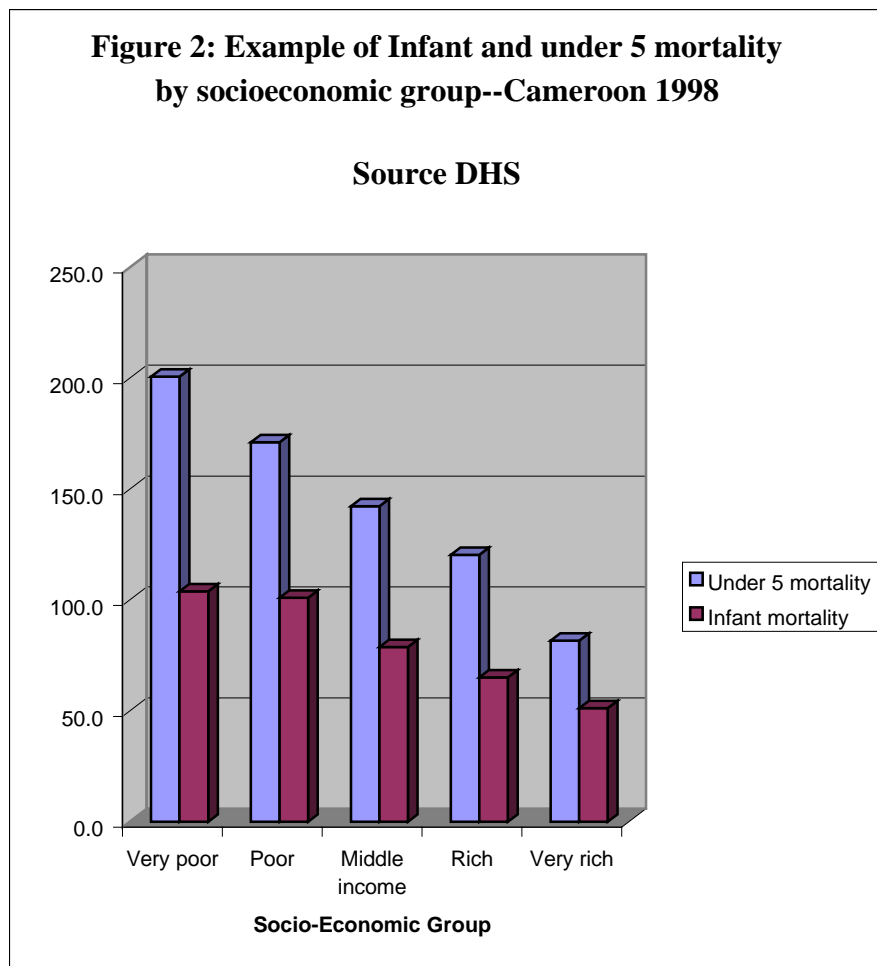
**Table 2: Example of Health Indicators of the Country in Comparison With Sub-Saharan Africa<sup>11</sup>**

Countries	Life Expectancy at birth	Infant Mortality (per 1000 live births)	Under Five Mortality Rate (per 1000 live births)	Maternal Mortality Ratio (per 100,000 live births)	Fertility Rate (number of children per woman)	HIV Prevalence	Child Malnutrition (weight per age)
<i>Countries</i>							
<i>Africa</i>	<b>52</b>	<b>91</b>	<b>151</b>	<b>822</b>	<b>5.6</b>	<b>8%</b>	<b>32</b>
<b>Mauritania</b>	<b>53</b>	<b>92</b>	<b>140</b>	<b>930</b>	<b>5.5</b>	<b>0.5%</b>	<b>23</b>
<i>Burkina Faso</i>	46	105	219	484	6.8	7%	33
<i>Guinea</i>	46	122	220	880	5.7	2%	24
<i>Madagascar</i>	58	96	162	596	6.0	0.5%	36
<i>Mali</i>	50	120	192	577	6.7	1.5%	31
<i>Cote d'Ivoire</i>	55	88	138	597	5.6	10%	24
<i>Ghana</i>	60	71	110	740	5.0	3.6%	27
<i>Uganda</i>	40	99	141	506	6.7	8.3%	26

In addition to country level averages, data is increasingly available for health, nutrition, and family welfare outcomes desegregated by socio-economic characteristics, especially by relative income or wealth level. Country managers can look at DHS data, using Poverty and Health Fact Sheets developed by the World Bank (Gwatkin et al, 2000) when they are available (currently available for more than 40 countries). The ability to

<sup>1</sup> 1990-1996 averages for Africa.

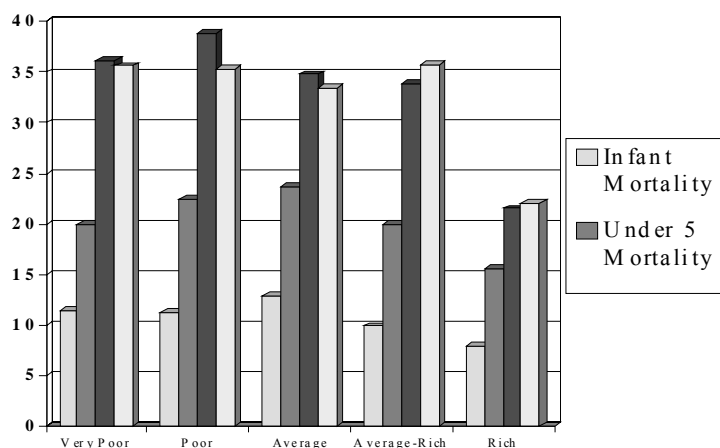
document the gaps in outcomes between the rich and poor within a country gives policy makers the ability to better target resources to improve equity and alleviate poverty. Examples such as the one presented below for Cameroon (figure 2) are particularly helpful in showing that infant and under 5 mortality rates are highly correlated to income. These indicators vary largely according to regions and residence (urban/rural).



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% and the remaining 80% of the population. Other determinants beyond income, including environmental and household factors, clearly strongly affect the health of the population in this country. These factors will have to be further explored and taken into account if the government is to make a difference on child health outcomes.

**Figure 3: Example of Under 5 mortality by income group or per region- Burkina Faso 1996**

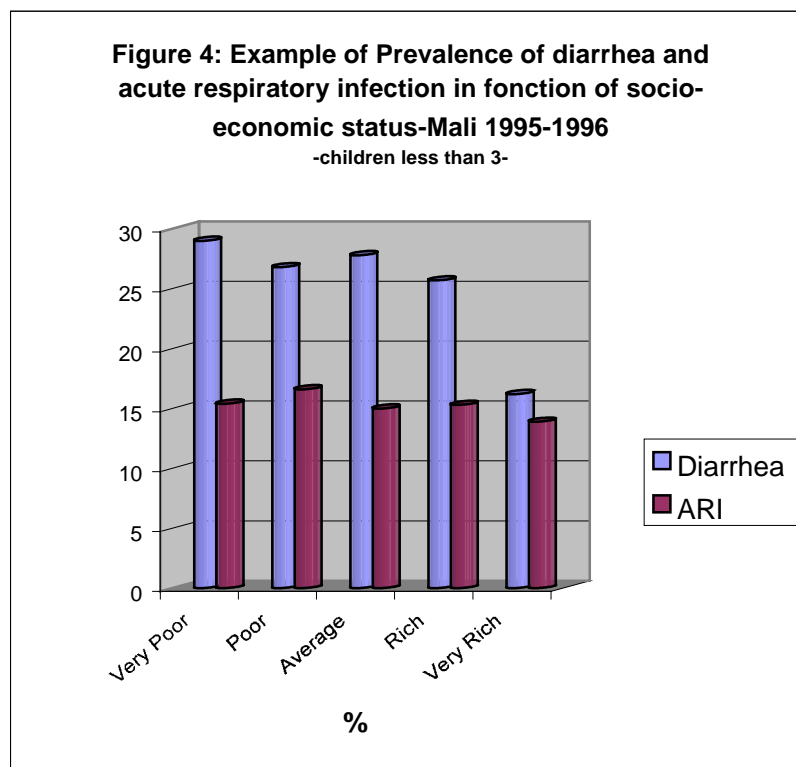
Source: DHS



## 2. Analyzing Interactions Between Poverty and Health

### 2.1 Analyzing the Impact of the *Environment of the Poor on Health*

Household surveys, such as DHS and Living Standard (LSMS), or Consumption Surveys often provide information on the relationship between the environment and level of poverty, and health status. In the Mali example (figure 4, below), the rate of diarrhea and respiratory infections among children -both ailments linked to the quality of water supply, sanitation and air- is analyzed among different socio-economic groups. This analysis helped pinpointing the fact that children belonging to the richer 20% are less subject to infections, probably because of better environmental conditions. Policies may therefore focus on addressing environmental factors in the poorest groups.



## 2.2. Analyzing the *Caring Capacity at Household Level*:

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. Rates of exclusive breastfeeding, utilization of ORT, for example, are good tracers of the household capacity to take decisions favorable to health. In the Guinea example below, 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.

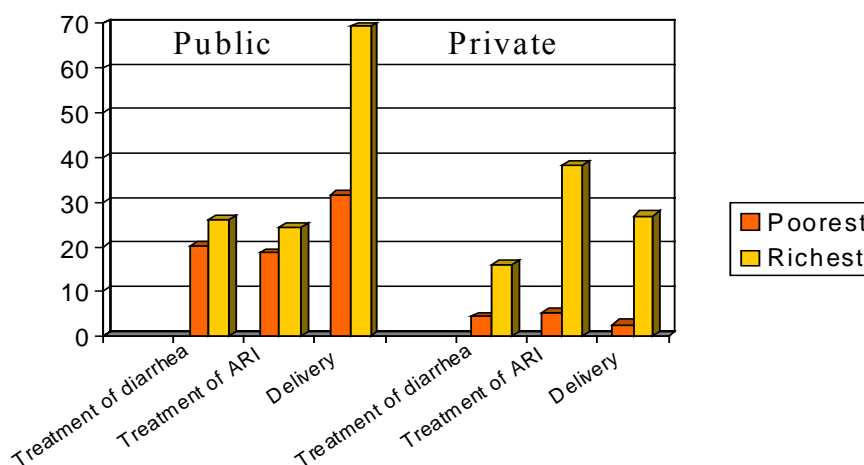
**Table 3: Example of Household Caring Practices in Guinea -1999**

	No education	Primary Education	Secondary Education	Rural areas	Urban areas
Average duration of breastfeeding with water only (in months)	6.4%	3.7%	0.6%	6.4%	3.8%
Treatment of diarrhea by increased liquids whether at home or in health services	51.7%	61.4%	55.4%	51.4%	57.9%
% men having ever used a condom	17.4%	44.9%	64.5%	22.8%	56%

### 2.3. Analyzing Exclusion of the Poor from Access to *Preventive and Curative Health Care*

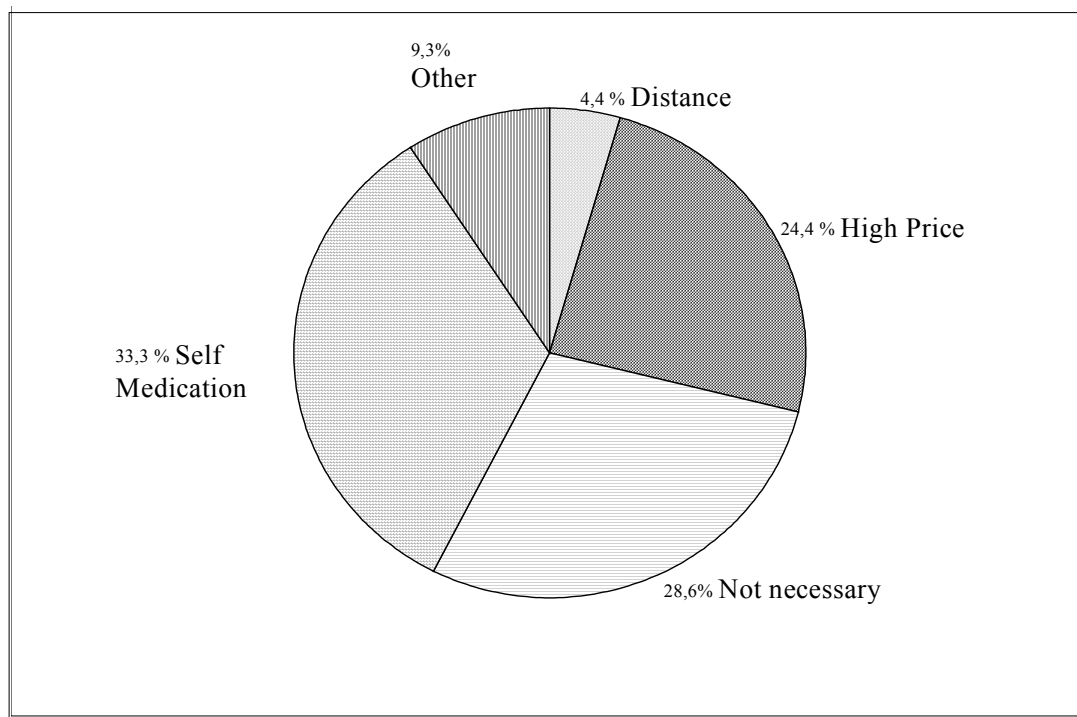
Analysis of health-seeking behavior patterns and reasons for non use of services can be very revealing. Some DHSs and LSMSs provide information on this issue. Yet most of the time these are obtained from specific health-seeking behavior surveys. These surveys can provide insights about the pattern of utilization of services. In Benin, for example, richer groups use public services in larger extent than poorer groups. Yet the utilization differential is higher for private services (figure 5).

**Figure 5: Example of Utilization of public and private services by Socio-Economic Status- Benin 1996**  
Source: DHS



The reasons for non-utilization of services may help to understand the key factors hampering the increase of demand for essential services. In Burkina Faso (figure 6) this question revealed that about a quarter of people not using services refrained from doing so due to the high price factor. Other reasons included distance and perception of the diseases as not being serious enough to justify a visit.

**Figure 6: Example of Reasons for Non-Utilization of Services in Burkina Faso-1998**



#### 2.4 Analyzing the Impact of Health Expenditures on the Incomes of the Poor

Beyond the well-documented impact of ill-health on the poor, communicable and other diseases drain household resources because of direct and indirect household expenditures. This can be analyzed by measuring the household health expenditures by socioeconomic group. In Burkina Faso, the data showed that the poor spend on average less than the rich on health care, both in absolute amounts and as a proportion of total income. This likely reflects the fact that the poor in this country do not use health services -whether private or public- due to lack of access and availability, leaving a large reservoir of unmet demand. As a consequence, the pattern of health spending as a proportion of income can be seen unduly as progressive. In Burkina Faso (table 4), as in many comparable countries, health managers seemed to conclude from this analysis that the lack of supply of basic social services was a bigger problem than the impoverishing effect of health expenditures.

Table 4: Example Household Expenditures on Health- Burkina Faso 1998

	Burkina	Urban	Rural	Rural North	Rural other
Annual Expenditures per capita in CFAF	4900	94900	3000	1300	2250 to 3700
Dépenses annuelles par habitant en US\$	8	15.8	5	2	3.8 to 6.2
% of total income spent on health	10%	14.1%	9%		

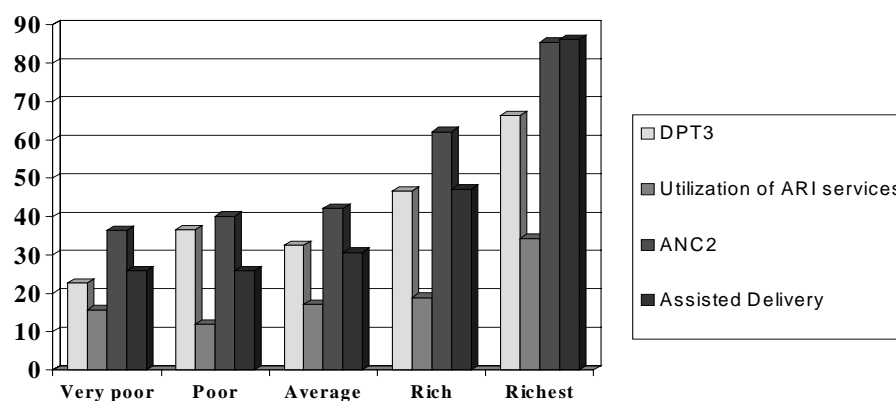
### 3. Revisiting the Core Package of Services

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 (e.g., micronutrient supplementation). Others already included may be re-discussed (e.g., cardiologic services). In most low-income countries the best buys identified above (in Section III) would have to be part of this package.

### 4. 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.

**Figure 7: Example of Utilization of Essential Services per Socio-Economic Group in Burkina Faso**



The example highlighted in figure 7 shows how utilization of essential services, including vaccination, ANC and assisted delivery, varies drastically according to socio-economic status in Burkina Faso. This pattern of utilization 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 performance of the health sector in actually reaching the poor.

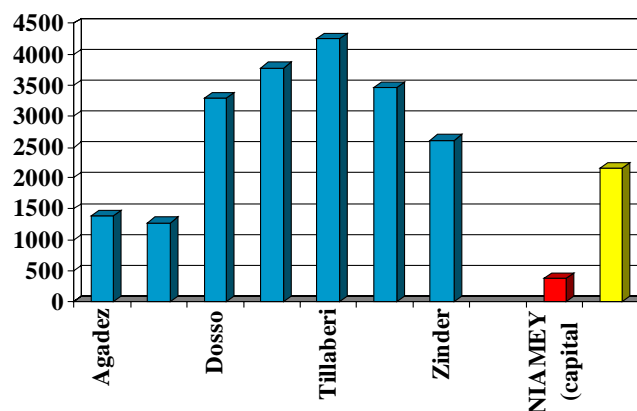
## 5. Identifying Sector Gaps in Serving the Health Needs of the Poor

Lower coverage with essential services may be linked to sector gaps in getting the best buy interventions most likely to affect health to the poor. These sector gaps may be of three natures: *reaching the poor with essential interventions, making financing more equitable, and improving social accountability of the poor.*

### 5.1 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.

**Figure 8: Example of Population per Medically Trained Personnel, per region - Niger 1997**



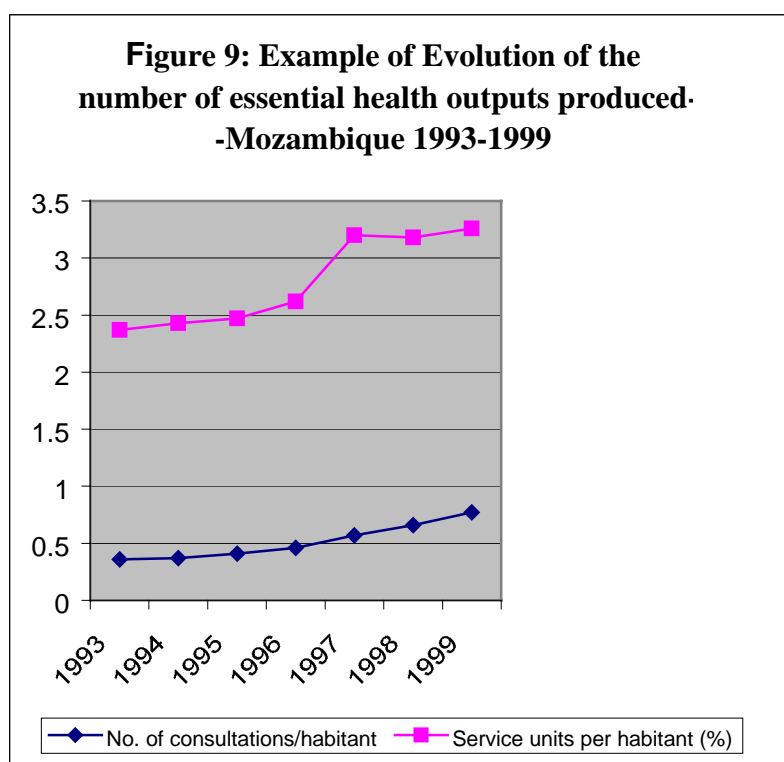

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The proportion and number of poor living beyond a reasonable distance from basic services can be measured. In addition, the number of services and service providers in relation to the population for the country and per region usually can be computed 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 and provinces with different economic development. The existence of efficient national drug supply systems, and of appropriate essential drugs and HRD policies may support continuous availability of basic services for the poorest in remote areas. As a point in case, Niger (figure 8) shows a very large inequity in the distribution of health staff with about 1 medically trained staff per 400 people in capital city Niamey, in comparison to 1 staff for 4000 in the most remote rural areas.

- Services units provided to the poor: Performance of the different sector in producing specific pro-poor outputs can be measured for different regions and provinces, residence or socio-economic status: E.g., immunization visits, vitamin A supplementation, treatments of ARI, IMCI visits, full treatment of TB, impregnated bed-nets and quality treatment for malaria . In Mozambique for example, a specific



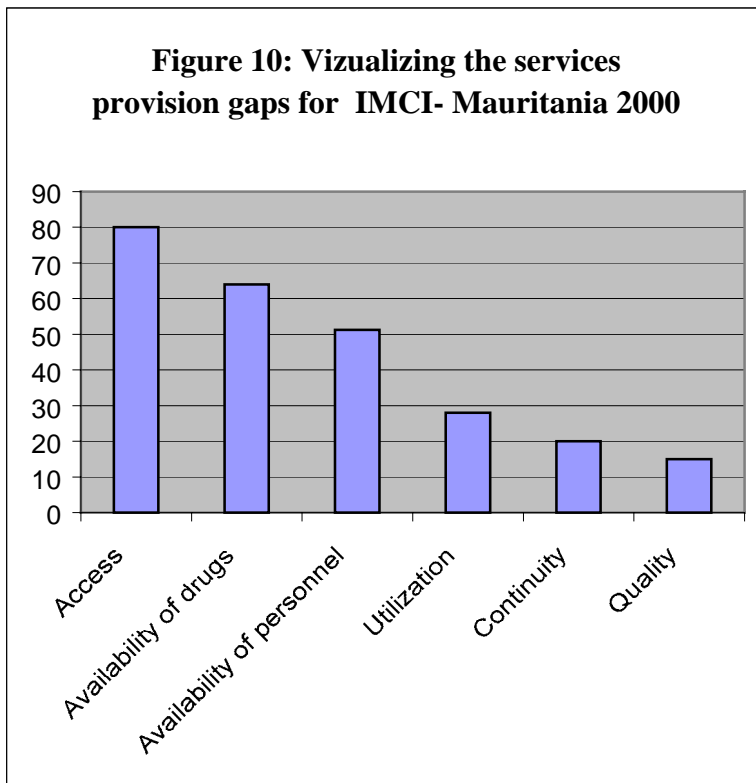
indicators of production of most essential services is measured overtime and could be compared between provinces. (see figure 9)

- Continuity of care: Poor groups may benefit less from continuous and quality care (e.g., TB treatment courses finished, children fully immunized, respect of standards of care for treatments etc.). 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.

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 which level the bottlenecks to performance are the largest. In the example given in figure 10 for IMCI in Mauritania, the largest bottleneck appears to lay at the level of utilization of services. Yet both access and availability of personnel and essential drugs both 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 and differences in the level at which the

largest bottleneck can be found may hint for key reasons hampering use of services in different socio-economic settings.

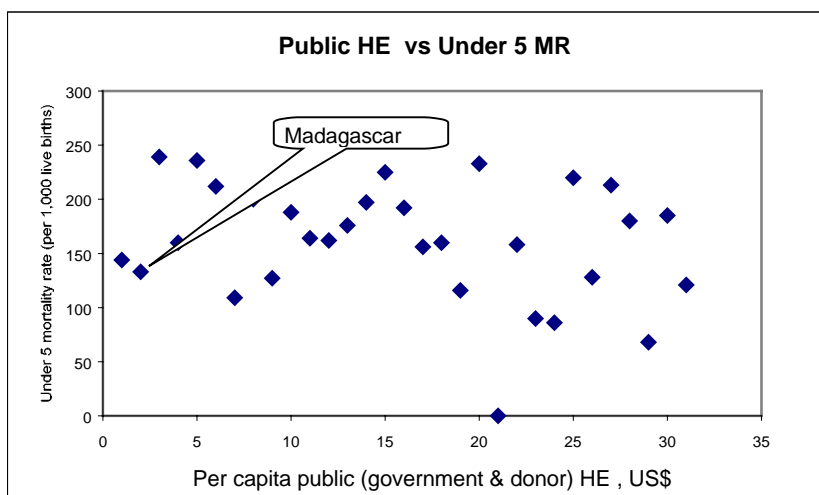


5.2 Gaps in Making Financing Mechanisms More Equitable:

- Equity of public expenditures: Comparison of performance between countries can be very revealing for decision makers, when they show that performance in terms of indicators is not always linked to the dollar amount injected in the health sector (see figure 11). 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-5 mortality with a higher level of health expenditures.

**Example Figure 11: Relationship between Public expenditures and Under5 Mortality Rates in Sub-Saharan African countries**



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

- Allocative Efficiency. 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 have direct implications in having 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 and basic surgical services
  - ✓ Measuring the equity of spending per capita in different socio-economic settings.
- Affordability: Issues such as pricing, subsidies, exemptions, pre-payments and risk-sharing are often more complex 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.

### 5.3 Gaps in Improving Social Accountability, Involvement and Participation of the Poor:

- Existence of associations of communities or consumers, or users' involvement in planning, monitoring or managing health services can be used as a way to measure responsiveness and social accountability in the health sector. The proportion of facilities or communities with associations of patients (for example people living with HIV), citizen representation in local health boards, or community health committees Bamako Initiative contexts 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 including 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, implementing activities, produce outputs and so on.

## 6. Summary of Useful Studies for the Analysis of Poverty and Health Issues

		<b>Example</b>	<b>Tools</b>
<b>Health outcomes and poverty</b>	Analysis of equity of outcomes	<ul style="list-style-type: none"> <li>Analysis of mortality, nutrition status and fertility rates, incidence of diseases by income, region, residence</li> </ul>	DHS Multi-indicator surveys
	Analysis of underlying determinants of health outcomes	<ul style="list-style-type: none"> <li>Access to water, basic education, sanitation, food security</li> </ul>	LSHS LCHS CS
<b>Private expenditures and poverty</b>	Analysis of impact of health expenditures on income and purchase of essential services	<ul style="list-style-type: none"> <li>% of income spent on health</li> <li>Per capita expenditures on health</li> <li>Expenditures per source of care</li> <li>Expenditures per income group</li> </ul>	LSHS LCHS CS Health seeking behavior survey
<b>Health outputs and poverty</b>	Analysis of equity of health outputs	<ul style="list-style-type: none"> <li>Utilization of essential health services (EPI, ANC, assisted delivery),</li> </ul>	DHS Multi-indicator surveys
	Analysis of determinants of health outputs	<ul style="list-style-type: none"> <li>Physical access, availability of essential consumables, financial access, quality</li> </ul>	EPI surveys Health services mapping Health surveys with reasons for non utilization
<b>Public expenditures and poverty</b>	Analysis of allocative efficiency and equity of PER	<ul style="list-style-type: none"> <li>% of GDP/public budget allocated to health</li> <li>% health budget allocated to primary care, communicable diseases</li> <li>Per capita expenditures per region, per income groups</li> </ul>	PER Benefit incidence studies
<b>Service delivery strategies and poverty</b>	Analysis of strategies to respond to health problems of the poor	<ul style="list-style-type: none"> <li>Strategies to address communicable diseases (malaria, HIV/AIDS, TB, leprosy, onchocerciasis etc)</li> <li>Strategies to address U5MR and MMR</li> <li>Strategies to minimize impoverishing aspect of health expenditures</li> <li>Strategies to ensure participation of the poor in design, planning and management of health services</li> </ul>	Review of current health strategies including health sector reform

## ***V. Building Blocks for the Full PRSP***

Driven by the debt relief motive, I-PRSPs can identify some quick activities and highlight simple policy directions. Yet sustainable poverty reduction and improving the health of the poor requires 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 help themselves. The interim nature of I-PRSPs indicates that a full PRSP will be completed at a later date. As a practical step, then, it would be useful to outline what is needed to develop the full version. This section identifies some of the recommended technical activities.

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.

I-PRSP authors are limited by time from engaging in many of the activities recommended for the development of the Full PRSP. The I-PRSP, however, is an opportunity to start building the blocks needed for completing the analysis. Specifically, I-PRSP authors can map out analytical and consultative activities to be undertaken in order to develop a Full PRSP.

Analytical and consultative activities can be implemented in the period between the completing of the I-PRSP and the development of the Full PRSP. A logical framework for selecting activities is presented in the PRSP Sourcebook chapter on health and can be summarized by four broad questions that lend themselves to the choice of analytical and participatory activities.

1. ***What*** are the health and nutritional conditions for the poor and how do they compare to those of the better off? Answering this question is critical for focusing policy attention and public resources on the epidemiological needs of the poor. Moreover, it is critical for setting targets for poverty reduction.
2. ***Why*** do poor households and communities suffer more than the better off and what are the barriers faced? Asking this question is a recognition that poverty is a household and community characteristic and that individual actions are critical in the improvements of health and nutritional outcomes. Analytical work has consistently found household constraints such as low levels of education (especially of mothers) and income as basic determinants of health and health seeking behavior. There is also substantial knowledge on the importance of community factors outside the health sector that have measurable impact on the health and nutritional status. Achieving local understanding on these household and community barriers is critical for long-term and sustainable improvement of the health status of the poor and for poverty reduction.

3. **How** does the health sector fail the poor and socially vulnerable? Decisions on resource allocation, investments, and pricing lead to increasing or decreasing the access to life saving health services for the poor. The health sector may also fail in recognizing the importance of external determinants (e.g. 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 prioritize interventions. Once the first three questions are answered (the What, Why and How), policy makers can develop policies at three levels (see table below).

**Table 5: Levels of Action for PRSP Contributors**

	<b>Problem Area</b>	<b>Issues</b>	<b>Actions</b>
1.	Public spending (macro level)	<ul style="list-style-type: none"> <li>• Reallocations to improve targeting and efficiency of spending</li> <li>• Adequacy of total resources devoted to health</li> <li>• Who benefits from health, nutrition, and population spending</li> </ul>	<ul style="list-style-type: none"> <li>• Three- to five-year plan for spending changes, taking into account reallocations and new resources</li> <li>• Equity-enhancing expenditure changes</li> </ul>
2.	Making the health system function better (system level)	<ul style="list-style-type: none"> <li>• Increasing effectiveness, quality, and outputs through improved system performance</li> <li>• Improving receptiveness of the system to poor and excluded populations</li> <li>• Increasing responsiveness to clients</li> </ul>	<ul style="list-style-type: none"> <li>• Systemic reforms to address bottlenecks and manage problems through changed incentives, contracting, ownership of assets, insurance coverage, and coordination among partners</li> <li>• Pilot testing of reforms with evaluation</li> <li>• Knowledge dissemination, training, and communication about changes</li> </ul>
3.	Targeted interventions that work (intervention level)	<ul style="list-style-type: none"> <li>• Need for relatively simple, easy-to-implement, focused interventions for the poor</li> <li>• Need for programs with measurable outcomes with built-in learning</li> </ul>	<ul style="list-style-type: none"> <li>• Projects and pilots as the leading edge of system improvement</li> <li>• Targeted maternal and child health, reproductive health, nutrition, and public health programs</li> <li>• Better coordination of projects by different agencies and donors</li> <li>• Evaluation</li> </ul>

Answering this last question would be the outcome of the Full PRSP, but the activities for answering the first three questions can be mapped out in the I-PRSP. This would ensure that work is done to address the long-term issues of systemically improving the health and nutritional outcomes for the poor and contributing to poverty reduction.

## VI. Do No Harm

Interim-PRSP authors and reviewers have a responsibility to ensure that the time-pressure and fiscal space 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 in irrelevant, unsustainable or pro-rich health sector’s activities may therefore include *targeting, functioning costs and affordability checks*.

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 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?
- Targeting *poor households and communities*: Are resources flowing directly to low-income communities and households? Do these flows benefit a large proportion of these poor communities and households? Are proposed transfers fair in regard to the country’s poverty profile?

The **functioning cost check** helps to ensure that no major spending in the health sector would be made in vain —i.e., without 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 correcting rather than aggravating 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. Checking the balance between the wage bill and non-salary recurrent costs is needed to ensure an efficient use of costly technical staff who require adequate budgets to work with and make sure that human resources are not constrained to the point of reducing the size of operations.
- *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 gains in efficiency. On the other hand using funding for establishing an incentive framework for staff to increase performance regarding 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 of proposed measures to improve the health sector's functioning on households and government budgets:

- *Check the affordability of basic services to poor users:* user fees in basic health services have been shown to improve equity of utilization when accompanied by minimization of service costs and subsidies to essential services, local retention of funds and community ownership, community co-management, and investment of local revenue in availability, access and quality improvements 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, to limit the deterring effect on poor people's utilization of services.
- *Check affordability of services to government budget:* Numbers matter, so cost effective and pro-poor services may not be always affordable for resources-constrained governments. Typical examples are malaria treatment in hyper-endemic countries, 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 support the subsidization of 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.

