Poverty reduction is at the core of international and national development objectives. Countries are developing poverty reduction strategies, reflected in Poverty Reduction Strategy Papers (PRSPs), to describe action in all sectors. The PRSP also sets out how funds released by the international debt relief initiative for the Heavily Indebted Poor Countries will be invested in pro-poor initiatives, including in health and education. This paper outlines how health policy and strategy are addressed in PRSPs, and suggests roles for external partners, in the country-owned PRSP process.

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Issues paper

Health in Poverty Reduction Strategy Papers (PRSPs):

an introduction and early experience

Veronica Walford

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The DFID Health Systems Resource Centre (HSRC) provides technical assistance and information to the British Government's Department for International Development (DFID) and its partners in support of pro-poor health policies, financing and services. The HSRC is managed on behalf of DFID by the Institute of Health Sector Development (IHSD).

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Title: Health in Poverty Reduction Strategy Papers (PRSPs)
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CDF	Comprehensive Development Framework
CSO	Civil Society Organisations
DFID	Department for International Development, UK
ESAF	Enhanced Structural Adjustment Facility
HIPC	Heavily Indebted Poor Countries
HNP	Health, Nutrition and Population
HSRC	DFID Health Systems Resource Centre
IDA	International Development Association of the World Bank
IDS	Institute of Development Studies, University of Sussex
IFI	International Financial Institutions (here, IMF and WB)
IMF	International Monetary Fund
IMR	Infant Mortality Rate
I-PRSP	Interim Poverty Reduction Strategy Paper
JSA	Joint Staff Assessment
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NGO	Non Governmental Organisation
NPRAP	National Poverty Reducation Action Plan
ODI	Overseas Development Institute, UK
PEAP	Poverty Eradication Action Plan
PFP	Policy Framework Paper
PHC	Primary Health Care
PRGF	Poverty Reduction and Growth Facility
PRSC	Poverty Reduction Support Credit
PRSP	Poverty Reduction Strategy Paper
SWAP	Sector Wide Approach
WB	World Bank
WHO	World Health Organisation
WHR	World Health Report 2000

Purpose of this paper

This paper aims to provide a briefing on the Poverty Reduction Strategy Paper (PRSP) process and how health is addressed in PRSPs. The paper discusses the role of PRSPs, reviews the guidance on PRSP preparation related to health, and reviews some recent experience. It ends with a bibliography of key documents.

1 What is a PRSP?

1.1 Role of country PRSPs

The Poverty Reduction Strategy Paper (PRSP) idea was initially conceived as an operational plan linked to the country-level Comprehensive Development Framework (CDF). The World Bank (WB) and International Monetary Fund (IMF) argue that: ‘The PRSP will translate the principles of the CDF into a plan of action’.

The PRSP was then linked to debt relief under the enhanced Heavily Indebted Poor Countries (HIPC) initiative. Countries are expected to have a poverty reduction strategy, reflected in a PRSP, to show how they would use the funds released by debt relief to relieve poverty.

In September 1999 it was agreed that a PRSP would become the basis for all WB and IMF concessional lending as well as for debt relief. WB concessional funding is International Development Association of the World Bank (IDA). The WB has a new IDA funding mechanism called the Poverty Reduction Support Credit (PRSC), and the European Commission has said it will co-finance these selectively. The IMF has changed the name of its concessional lending, formerly known as Enhanced Structural Adjustment Facility (ESAF), to Poverty Reduction and Growth Facility (PRGF), to indicate its emphasis on poverty reduction.

The concept is that the country government will lead in the production of the PRSP. ‘The PRSP’s aim is clear: to strengthen country ownership of poverty reduction strategies; to broaden the representation of civil society – particularly the poor themselves – in the design of such strategies; to improve coordination among development partners; and to focus the analytical, advisory and financial resources of the international community on achieving results in reducing poverty.’ (WB, March 2000).

The process of preparing a PRSP is time consuming, in part because of the emphasis on participation by civil society and representatives of the poor. It was realised that this was delaying decisions on debt relief under HIPC. It was therefore agreed that countries could have an interim PRSP (I-PRSP) if not a full PRSP by the ‘decision point’ (when it is decided whether a country qualifies for assistance under the HIPC initiative and some initial debt relief is provided). The country should have a full PRSP adopted and under implementation for a year by ‘completion point’ (for irrevocable debt relief). Countries also require an I-PRSP for access to PRGF funds.

The PRSP is presented to the WB and IMF executive boards with a Joint Staff Assessment (JSA) reviewing and recommending endorsement or rejection. The

executive boards review and ‘broadly endorse’ the PRSP, but do not ‘formally approve’ it ‘as it is a country-owned document’.

1.2 Scope of PRSPs

Poverty reduction strategies (PRS) should include plans for rapid economic growth, macroeconomic policies, structural reforms and social improvement, and lead to outcomes of the poor sharing in the benefits of growth and having reduced vulnerability to risks. Three main steps are identified in the process of defining poverty reduction strategies:

- understanding the nature of poverty within the country;
- selecting public policies and actions which will have the most impact on reducing poverty;
- identifying and monitoring outcome indicators (which may reflect the international development goals).

The PRSP should summarise the PRS. WB and IMF papers emphasise that there is no blueprint for a PRSP, but they expect the PRSP to contain:

- diagnosis of obstacles to poverty reduction and growth;
- policies and targets for poverty reduction, including institutional and structural reforms;
- monitoring arrangements;
- external assistance requirements, and assessment of the impact of more or less assistance;
- description of the participatory process used and its findings.

It is expected that PRSPs will be produced on a three-year cycle, with annual progress reports for intervening years. Progress reports could include modifications to the strategy.

I-PRSPs used for the decision on debt relief under HIPC should:

- make a commitment to poverty reduction;
- outline the strategy;
- have a three-year policy and macroeconomic matrix;
- give the timetable and participatory process for completing the PRSP.

1.3 Progress on PRSPs by April 2001

According to the 18 April 2001 joint progress report by WB and IMF staff, by the end of March the WB and IMF boards had considered 32 I-PRSPs and four full PRSPs (for Uganda, Burkina Faso, Tanzania and Mauritania). In all 21 full PRSPs and 52 I-PRSPs were expected by end 2001.

22 HIPC countries had reached ‘decision point’ for debt relief by the end of December 2000, with a total commitment of $20.3 billion debt relief in net present value terms. The impact is that debt relief payments are reduced, on average, by one third.

I-PRSPs and PRSPs can be accessed on the web at:
http://www1.worldbank.org/prsp/PRSP___Country_Documents/prsp_country_documents.html

Some countries are not preparing PRSPs – India and China are examples at present. They are not eligible for HIPC. Apparently India has argued that its existing strategy documents and plans should be sufficient.

2 Sources of guidance

2.1 The PRSP sourcebook

The sourcebook was prepared jointly by the WB and IMF. It is ‘designed as a compilation of useful resources and international best practice rather than a “how to” guide for PRSP preparation, since there can be no single blueprint for a good PRSP’ (PRSP Progress Report, 13 April 2000). The sourcebook is available in draft on the web at www.worldbank.org/poverty/strategies/sourctoc.htm. The WB is asking for feedback from partners and countries as part of the development of the sourcebook, including on the health, nutrition and population (HNP) chapter.

The sourcebook contains a series of papers with accompanying technical notes on the following topics: organising participatory processes; poverty data and measurement; monitoring and evaluation; public spending; macroeconomic issues; rural poverty; social protection; HNP; education; private sector and infrastructure (separate papers on energy; urban; transport; water; and micro, small and medium enterprises); governance; community-driven development; gender; environment; trade; and statistical capacity building. Note there is no chapter on HIV/AIDS, although this is discussed as a cross-cutting issue and as a communicable disease in the technical notes for the HNP chapter.

The HNP chapter of the sourcebook on the web is the second version, still called ‘Draft for comments’, dated June 2001. It is 35 pages long with 123 pages of technical notes. The second version is better than the first in that it is more clearly focused on assessing performance of the health sector related to poverty. However, it is thin on solutions in terms of policies that are pro poor or methods to target the poor.

It is encouraging to see that two dimensions that link health and poverty are emphasised in diagnosing performance of the health sector:

- health outcomes and how these vary between the poor and less poor people;
- how far households are at risk of poverty because of payments for health care.

Section 6 discusses options and ideas on policy and priorities. The main points are:

- prioritise public funding, particularly to public goods, activities with externalities or targeted to the poor;
- equitable allocation in geographical terms;

- ensure an appropriate balance of funding to improve quality, e.g. the balance of labour costs to supplies and maintenance;
- essential drug lists and encourage use of low cost drugs and supplies;
- subsidise public health, preventive and promotive services as much as possible and avoid financial barriers for the poor to other services even where fees are necessary (e.g. by exemptions from fees, credit etc);
- review insurance and risk-pooling arrangements to encourage cross subsidies between poor and richer groups and to regulate private or community insurance schemes;
- public information to improve health service use by the poor and protect consumers;
- consider more contracting for services from private and non governmental organisation (NGO) providers and whether contracts can be modified or extended to serve the poor better;
- government's stewardship role, including regulation, coordination, information and monitoring;
- consider whether involving the poor in decisions and monitoring at facility level will improve performance of services;
- address physical access for the poor, taking into account NGO and private service availability;
- core packages for each level of facility can be effective if they reflect the disease burden of the poor;
- monitor women's needs and access and the poor's use of and views on services.

Whilst these policies make sense in general and reflect recent thinking (e.g. the World Health Report, 2000) there is some over-simplification of financing issues.

The technical notes contain a series of papers on various topics, which mainly summarise experience and provide examples of analytical tools. Technical note 3A sets out the life-cycle approach and summarises the main interventions and suggested indicators for each stage. Two notes give spreadsheet tools for analysing heath expenditure (5C) and for linking burden of disease, cost effectiveness and public expenditure (5D). There are also short notes suggesting how to approach aspects such as stakeholder analysis.

It is not evident that much use is being made of the sourcebook in general or the HNP section in particular.

2.2 The guidelines for JSAs of a PRSP

The JSA guidelines are intended to provide guidance to WB and IMF staff on preparing JSAs. They also help partners to know what the WB and IMF are looking for when they assess a PRSP.

The guidelines recognise that different countries have varying levels of institutional capacity to prepare PRSPs. The technical points in the guidelines are thus not expected to be met by all PRSPs; rather the PRSP is expected to identify priority areas for further work. But the PRSP should be clear about priorities.

The overarching question for the JSA to address is: 'does the PRSP (including the intended use of concessional resources) provide a sufficient and credible basis for ensuring sustainable improvements in the lives of the poor?' Then the JSA is meant to:

- describe the participation process;
- assess whether the PRSP is built on a comprehensive analysis of poverty;
- assess whether the PRSP establishes appropriate targets and indicators and systems for monitoring progress;
- assess whether the PRSP presents appropriate and costed priorities for public action. This includes assessing whether sectoral policies address the key constraints to poverty reduction and will improve the distribution of public services between regions and socioeconomic groups, and assessing whether plans to improve governance and public sector management will help with poverty reduction;
- assess whether the PRSP has a credible financing plan (including external resources).

There is no specific guidance on assessing health issues or strategies in the PRSP, beyond mentioning health in terms of cross-sectoral linkages (e.g. health care and reducing household vulnerability to shocks).

JSA guidelines for I-PRSPs are also available on the WB website. They set out three main questions for review of I-PRSPs:

- how appropriate/adequate is the government's assessment of the current poverty situation and its strategy to reduce poverty?
- how realistic is the government's plan to produce a PRSP?
- what assistance will the WB and IMF provide to improve the analysis, support the participatory process, cost priority strategies etc?

3 Some experience in the PRSP development process

3.1 Responsibility for preparing the PRSP

I-PRSPs and PRSPs are generally being written by a central group, e.g in the president's office, with limited input of sector ministries. This is true, for example, of Tanzania, Albania, Georgia, Kyrgyz Republic, Honduras and Nicaragua. A study in eight African countries found that the PRSP process has typically been handled at a senior level and has led to a shift in responsibility for poverty issues to the Ministry of Finance, an upgrading in most cases, which has improved the potential to link poverty work to broader resource allocation decisions (ODI, 2001).

The involvement of the sector ministries such as health tends to be limited. Often the paper is written by locally trusted consultants or academics, who may have some knowledge of health, but equally may not. For example, in Honduras there was no health sector specialist on the team and the Ministry of Health (MOH) was also not involved. The impact of this is apparent in the document, which does not reflect existing analysis and strategies for the health sector. On the other hand, some countries have established working groups which include the health experts or MOH representatives; for example Nicaragua's team included a health specialist and its I-PRSP is more specific on health issues. The Department for International Development (DFID) may be able to encourage appropriate health sector technical inputs to PRSP preparation.

The timing issue is difficult. There is pressure to get on with producing a PRSP, or at least an I-PRSP, in order to move ahead on debt relief and/or PGRF funding. There is a risk that WB and IMF staff (or their consultants) will draft PRSP chapters in order to speed up the process. Yet experience has shown that rushing ahead to produce a strategy with inadequate ownership will risk delays and failure in implementation, and this is clearly recognised in the original WB and IMF thinking on CDFs and PRSPs. DFID has recognised that it can help by supporting local inputs to developing the strategy and documents, rather than allowing the preparation of a strategy to be driven by external agency staff and foreign consultants.

3.2 Ownership and participation

In principle, participation in PRSP development is expected to include civil society, elected institutions, other national stakeholder groups and consultation with representatives of the poor. This is expected to improve the design and support

implementation of the national PRS. Civil society is also expected to assist in monitoring of strategy implementation (WB and IMF, Operational Issues, December 1999). In addition the aim is for all donors and multilaterals, including UN agencies, to participate in the preparation process and it is hoped that they will use the PRSP to avoid overlapping or conflicting resources and conditionalities.

The experience to date suggests that the quality of participation is very variable between countries (EURODAD, 2001). Many Civil Society Organisations (CSOs) and NGOs are disappointed with the extent and nature of participation. The recent World Development Movement Report (WDM, 2001) records examples. It is apparent that part of the problem is that the participatory processes are new and not well developed for policy-level discussions. For example:

- the ODI study in eight African countries noted that non-government interest groups are poorly organised for such policy level inputs;
- in Albania, efforts to organise a consultative workshop with NGOs had various shortcomings in terms of the range of organisations invited and the way the workshop was conducted, leading to limited benefits from the exercise (Holland and Pinder, 2000);
- in Honduras the consultation with local government mayors involved circulating draft papers and asking for their comments, although many of them have low literacy levels and little experience of dealing with complex technocratic documents;
- in Cambodia, NGOs/CSOs were not able to contribute to the initial setting of priorities as they were not consulted in the early stages of I-PRSP development. None of the eight drafts of the I-PRSP were available in the Khmer language, limiting the scope for local input and discussion (WDM 2001);
- in Tanzania, NGOs and CSOs felt their involvement was superficial and at best consultative rather than allowing genuine participation in drafting the paper (WDM 2001);
- however in Uganda, the NGO response was much more positive (WDM 2001), and NGOs are involved in the PRSP monitoring process (DFID adviser).

In general, it appears that participation is having a limited impact on the PRSP content. Despite the limited impact, the efforts at participation can be seen as a good start and an introduction to participation, especially where there is little tradition of dialogue with civil society. However, there is a concern that there may be a risk of ‘consultation fatigue’ if communities and groups are frequently consulted but see little happen as a result (e.g. Guatemala) or feel their views are not taken on board.

Another concern is the view of many NGOs that there was only 'consultation', where the views and ideas of civil society are solicited, rather than full participation, where civil society organisations share in decision making. They argue that there is a danger that 'consultation' will be used to legitimise a strategy which civil society has not really

influenced. It is clear that participation processes will need to evolve if they are to meet more of the expectations of the CSOs.

It is interesting to see the current debate in Malawi, where the NGOs have criticised the extent of participation allowed for in the PRSP development process as inadequate, arguing that the timetable for the PRSP production is too short for meaningful inputs by civil society and communities. They have posted comments on this on an international PRSP discussion forum[1] entitled 'Malawi PRS process is a joke'.

Another critical issue is the extent of political input, including whether opposition parties and parliament are consulted and agree the PRSP. Again, this seems to be limited in practice in many countries: for example, in Bolivia there is no support from the main opposition party for the PRSP. In the eight African countries reviewed by the ODI study, the limited role of parliament was noted as an issue for further study. There is of course a question of how realistic it is to expect there to be a broadly owned national strategy for poverty reduction, agreed by different parties and interest groups, when there are conflicting interests.

3.3 The relationship with existing poverty strategies and sector plans

The relationship between the PRSP and existing poverty reduction plans is not always clear. For example, in Zambia there was already a national poverty reduction action plan (NPRAP) prepared (with participation) in 1998-99. The I-PRSP indicates certain questions as to how this would relate to the PRSP, although it seems to conclude that the PRSP will be a more financially realistic version of the NPRAP. Meanwhile, in Uganda the existing poverty eradication action plan (PEAP) effectively became the PRSP, and the PRSP document is a summary of the PEAP. Seven of the eight African countries studied in the ODI study already had some poverty reduction plans (Rwanda was the exception). However, it is noted that generally these had been developed with specific activities and structures in mind, with a view to project-type funding, rather than being strategies for the overall use of public expenditure.

For the health sector, many countries already have health sector policy documents and plans; some have sector-wide programmes with planned resource allocations and/or have a medium term expenditure framework (MTEF) for the sector. It would be highly desirable for the PRSP process to build on these existing efforts to address the priorities and plans for the sector, rather than to start afresh. While this is presumably intended, it is not explicit in the materials produced so far.

It is suggested that the development of the health component of a PRSP would involve a review of the existing sector plans to:

- check that they are adequately poverty focused, and if not, work on this aspect;
- check that the plans are consistent with the resource levels available given the

expected amounts of debt relief and other assistance, and consistent with other developments such as civil service reforms;

- analyse the key institutional constraints to improved service delivery at national and local levels, and assess policy options to address any institutional constraints;
- consider whether if additional resources are becoming available, it might be worth costing increased coverage of key services and demonstrating that the health sector could deliver these services;
- ensure that there are mechanisms for monitoring progress in reaching the poor and improving their health – ideally involving civil society.

It is noticeable that the existing PRSPs and I-PRSPs usually do not refer directly to the existing sector policies and agreements with funding agencies. For example, Tanzania has a health sector programme developed and agreed over several years, but this is not referred to in the PRSP, while the paper says that the health strategies listed are to be developed and costed. It may be that the activities and budget allocations are entirely consistent with the existing plans, but they have not mentioned them (apart from the malaria control plan). In contrast, Uganda's PRSP does refer to the health sector strategy.

Note

1 EURODAD (European Network on Debt and Development) PRSP-Watch. To subscribe to PRSP-Watch, send a blank email to nthomet@eurodad.ngonet.be with 'Subscribe PRSP-Watch' in the subject line.

4 The health-related contents of selected existing PRSPs and I-PRSPs

4.1 Health sector sections

The existing I-PRSPs and PRSPs all have a section on health, as well as health strategies set out in the policy matrix (in I-PRSP) and logframe (in PRSP). The health section in the text is short, typically up to one page. Obviously there is a limited amount that can be said in such a section and the statements tend to be fairly broad. For example, from Tanzania, they comprise a list of strategies to be developed and costed, including: provision of quality health service through essential package delivery; personnel training; promotion of nutrition education, especially to mothers etc.

There are some quantified targets. In Tanzania's PRSP, most relate to health status indicators (life expectancy, IMR, MMR) but also increasing immunisation rates and access to safe and clean water. In the I-PRSPs there are broader strategies reflected in the policy matrix. For example, Cambodia has six statements of strategy for health, such as 'Expand the network of health centres and referral hospitals' and 'Introduce cost-sharing partnerships with local communities through user fees and expand access … for the poor through a well monitored system of user fee exemptions'. Zambia's I-PRSP is unusual in having a quantified strategy (which pre-dates the I-PRSP); to allocate 40 per cent of the sector budget and releases to district health boards for essential services by 1999, rising to 60 per cent by 2001.

Whilst some countries identify HIV/AIDS as an important issue in the analysis of poverty trends and issues, the papers do not typically identify specific strategies to address AIDS except where it features in health plans. Malawi is an exception, explicitly referring to the objective of implementing the HIV/AIDS strategic plan in its policy matrix, while Tanzania has an explicit budget allocation for HIV/AIDS work. This gap has been noted in the JSAs and the April 2001 World Bank and IMF joint progress report.

Thus, the health sections of the papers reviewed are brief and contain standard types of statements of policy and strategy. The limited space available does not provide an opportunity for detailed discussion of the poverty focus or the rationale for strategies. Without knowing the countries' previous plans and strategies it is not possible to assess whether any of their strategies have changed as a result of the PRSP process, but in the cases which are known, they have not changed, but rather reflect existing strategies.

As discussed further below, this need not be wrong. The development of health policies usually takes place over a longer time scale and with a depth of analysis and breadth of debate and consultation that is not allowed for in the PRSP process (for example, in the development phase of a sector wide approach (SWAP), which typically takes place over several years). If the resulting health policies and strategies are judged to be pro poor in the country context, then it would not be appropriate for the PRSP to change them, and the PRSP should simply summarise the agreed strategies.

The strategies focus on development of health services and disease control programmes. There is little on the issue of expenditure on health care as a major cause of poverty (except for Cambodia's mention of exemption mechanisms to ensure access). Yet the poverty analysis often highlights the fact that paying for health care, especially hospital admission, is a cause of poverty and debt, and a priority concern for the poor. This may simply be a reflection of the limited space available to discuss health strategies, but it may also be that the wider community should think more about whether the existing solutions (essential packages, more resources to rural PHC) give adequate attention to this issue.

The PRSP should include the resource allocation for health and this should provide an opportunity to get agreement from central decisionmakers and the multilateral agencies on the level of funding and spending priorities within the sector. This could have taken place in the process of agreeing a MTEF, in which case the PRSP could be expected to reflect MTEF allocations. However, there is very little on allocations in the recent I-PRSPs. An exception is Georgia's PRSP, which says they will shift resources from defence and interior sectors to social sectors (health, education and pensions). The PRSPs have more detail on public spending plans. Uganda's PRSP shows the MTEF figures, with the health budget broken down into 10 components (by level of care, type and source of spending). Tanzania's shows only the allocation for health and within health for primary health, demonstrating a rising proportion of spending for primary health non-personnel costs. This raises the issue of how much detail should be expected in costings to support PRSPs.

4.2 Health-related sections of PRSPs

Other elements of PRSPs and I-PRSPs can have a major influence on health status and health services. Recognising the critical importance of education, microcredit, economic strategies, empowerment and civil rights, access to land, water and sanitation etc. in actually improving the health of the poor, we focus here on those issues which will influence the performance of the health sector and access to services.

Issues which might have an impact on health sector performance include:

- geographical resource allocation (e.g. more resources to poorer areas or districts);
- sectoral resource allocation (e.g. more resources for social sectors);

- performance of the public service (e.g. improving pay, rationalising numbers of civil servants);
- management of the public sector (e.g. strengthening financial management or the budget process; decentralisation to achieve local decision making);
- regulatory framework for employment (e.g. provision of health care for low income workers in commercial farms or mines; health insurance requirements);
- addressing corruption and governance issues.

The I-PRSPs and PRSPs address these types of issues to varying degrees. For example, Zambia's strategy is to reduce the overall public sector wage bill to 25 per cent of expenditure, and allocate 36 per cent of spending to the social sectors. In Tanzania, there is the creation of an equalisation fund for disadvantaged areas and development of anti-corruption plans, including for the health sector. Cambodia's paper has measures to strengthen budget management so priority expenditures are released, and to adopt and implement a plan for civil service reform. Uganda refers to changes in procurement and civil service pay and staff management reforms.

What is noticeable in most cases is the lack of quantification and hence any way of estimating the likely impact on the health sector. This is due to the limited amount of detail (especially in I-PRSPs) and there being few targets or measurable indicators. Presumably there are more detailed estimates and figures backing up the papers. It is during the PRSP preparation process that these estimates can be reviewed and health sector actors can try to influence decisions and to take these cross-sectoral plans into account in sector planning.

There has also been pressure, notably from Oxfam, for the IMF and WB to carry out poverty impact assessments as part of the analysis of PRSPs and subsequent loans. The IMF and WB have agreed to do these but none have taken place yet. These would provide an opportunity to consider the impact of economic and public sector reforms on health.

4.3 Indicators and monitoring

As noted above, there are few measurable indicators, and targets have been set in terms of outcomes, e.g. Tanzania and Uganda both use mortality rates. Whilst there may be a longer term need to monitor mortality rates, they are not likely to be a useful indicator of performance either in the short term of one-year appraisal of progress against the PRSP, or the three years for the whole PRSP, and neither will they be measured this often.

Malawi is perhaps the best example among the papers reviewed of defining activity indicators (with dates for completion) in such a way as to make it mostly easy to establish whether or not they have taken place (e.g. introduce revolving drug funds; implement central medical stores reforms; establish paying wards at district hospitals;

integrate AIDS and TB control programmes) although some will be more difficult to assess (e.g. introduce essential package; ‘implement management and incentive reforms’ to address staff shortages). These could all be more clearly defined as a basis for subsequent monitoring.

Uganda has identified process indicators: the DPT3 immunisation rate; the percentage of health centres with qualified staff; the percentage of health units without stock-outs; and perceptions of services. There are also some more direct outcome indicators relating to the prevalence of AIDS and malaria.

This could be an area for support and encouragement to make the indicators more useful as measurements of progress in two respects: first, whether the planned strategies have actually been introduced, and second, whether they are reaching intended targets, e.g. whether services are being used or exemptions granted in poor rural areas.

The strategy papers are not highly specific about the monitoring approach to be used, although there is a tendency to plan for household surveys. It is an important question for the health sector as to how far to rely on cross-sectoral efforts such as integrated household surveys and poverty monitoring versus how far to carry out specific studies. This does not seem to have been addressed in the PRSPs so far, but the need to analyse poverty and then monitor PRSPs may lead to useful developments of statistical capacity and methods which will provide helpful information to the health sector.

5 Roles PRSPs can be expected to play in health and how to support them

5.1 Potential roles for the PRSP process

The experience to date suggests that development of PRSPs has not led to radical improvements in health policy or budget allocations. Since the papers are so unspecific, they do not clearly establish priorities or force hard decisions over what will remain undone. It is too early to tell whether they will have a positive impact in practice (this will require monitoring). This raises the question of whether the PRSP is more than just another hurdle for countries to jump in gaining debt relief or concessional funds.

Arguably, there are valuable aspects of the PRS process which can be encouraged and supported. First, the PRS process can serve as **a way to bring poverty up the national agenda**. For example, one agency adviser said that in Nicaragua the process has got people talking about poverty in a way that they were not before.

Second, the PRS process provides **an opportunity for a health sector which has developed policies and strategies that are pro poor, to communicate these** to central ministries and politicians and get them reflected in budget allocations. Where there is an MTEF which has plans for improved resource allocation, the PRSP can help to communicate and institutionalise the findings from the MTEF.

Third, the PRS process provides an opportunity to reopen areas of health policy or budget allocations where there is no pro poor strategy in place: for example, if the allocation for preventable diseases suffered by the poor is low or the exemption system is ineffective, these issues could be raised in the context of the PRS development.

Fourth, if health players are involved in broader social sector or human resource development discussions or have opportunities to present their case, the PRS process may provide **an opportunity for lobbying central government and key partners on critical issues** that affect the health service and health, such as unacceptably low civil service salaries, the need for special measures to attract staff to work in poor rural areas or the case for increasing the budget allocation to sanitation. There may also be useful communication between sectors; for example, Zambia's use of community monitoring of health services might be a model applicable in education.

Fifth, the PRS process provides **an opportunity for the external development partners to coordinate their efforts** and for the focusing and monitoring of their support.

Finally it provides **an opportunity to agree on some key milestones and indicators** for sector progress and priorities. At present this is not happening much, but further work on realistic indicators and milestones could be usefully built into the substantial number of PRSPs developed in 2001.

Thus, there are aspects of the PRS process that can be helpful, even if the PRSP itself is somewhat limited in scope and content. On the other hand there is a concern to ensure that a reasonable level of effort is devoted to this exercise by key senior officials. It is suggested that governments and agencies should be strategic about the aspects or opportunities which will be most useful at country level, and focus efforts on these.

One issue is the implications for the PRS process of major international initiatives such as the proposed Global Fund on Health and AIDS which is likely to focus on malaria, TB, AIDS and GAVI. It is important that activities arising out of any of these initiatives are integrated into country health strategies and MTEFs for the health sector. The PRSP could be a vehicle for this integration.

5.2 Implications for supporting the health PRSP process

Working on the assumption that the PRSP will become a useful tool for agreeing between donors, government and civil society on directions for policy and priorities for spending, it is suggested that agencies and ministries of health should engage with the process at an early stage.

Development partners may want to:

- encourage and emphasise building on the existing policy documents, plans, work programmes and the MTEF, with the MOH taking the lead rather than making the PRSP development a totally new exercise;
- feed into the debate about which aspects (if any) of the existing policies, strategies and resource allocation merit review in the light of poverty analysis;
- provide support (e.g. local consultants) to help develop strategic options on key issues and/or to cost expansion of service coverage;
- provide clear information on planned levels and types of support to the health sector;
- use the PRSP as a coordination mechanism for donor support, where this is not already in place, through a SWAP or other mechanisms;
- support national efforts to develop effective poverty analysis and monitoring, including of health strategies.

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Annex 1: Country information on PRSPs

Country	I-PRSP	Full PRSP	PRSP report
Albania	Complete	March 2002	
Angola	December 2001	July 2002+	
Armenia	Complete	July 2002+	
Azerbaijan	Complete	June 2002	
Benin	Complete	December 2001	
Bolivia	Complete	Complete	
Bosnia and Herzegovina	December 2001	July 2002+	
Burkina Faso	Complete	Complete	December 2001
Burundi	December 2001	July 2002+	
Cambodia	Complete	June 2002	
Cameroon	Complete	March 2002	
Central African Republic	Complete	December 2001	
Chad	Complete	December 2001	
Congo, Democratic Republic of	March 2002	July 2002+	
Congo, Republic of	June 2002	July 2002+	
Cote d'Ivoire	December 2001	July 2002+	
Djibouti	December 2001	July 2002+	
East Timor	June 2002	July 2002+	
Eritrea	March 2002	July 2002+	
Ethiopia	Complete	June 2002	
Gambia	Complete	March 2002	
Georgia	Complete	March 2002	
Ghana	Complete	December 2001	
Guinea	Complete	December 2001	
Guinea Bissau	Complete	June 2002	
Guyana	Complete	December 2001	
Haiti			
Honduras	Complete	Complete	
Indonesia	June 2002		
Kenya	Complete	December 2001	

Country	I-PRSP	Full PRSP	PRSP report
Kyrgyz Republic	Complete	July 2002+	
Lao PDR	Complete	July 2002+	
Lesotho	Complete	July 2002+	
Macedonia	Complete	March 2002	
Madagascar	Complete	December 2001	
Malawi	Complete	March 2002	
Mali	Complete	December 2001	
Mauritania	Complete	Complete	March 2002
Moldova	Complete	March 2002	
Mongolia	Complete	July 2002+	
Mozambique	Complete	Complete	
Nepal	December 2001	July 2002+	
Nicaragua	Complete	Complete	
Niger	Complete	March 2002	
Nigeria	September 2001	July 2002+	
Pakistan	December 2001	July 2002+	
Rwanda	Complete	July 2002+	
Sao Tome and Principe	Complete	June 2002+	
Senegal	Complete	March 2002	
Sierra Leone	Complete	July 2002+	
Sri Lanka	June 2001	December 2001	
Tajikistan	Complete	December 2001	
Tanzania	Complete	Complete	December 2001
Togo	December 2001	July 2002+	
Uganda	Complete	Complete	June 2002
Vietnam	Complete	June 2002	June 2002
Yemen	Complete	December 2001	
Zambia	Complete	December 2001	

Source: ODI and World Bank. These dates are provisional only, and are based on World Bank expectations as of October 2001. For more information, see World Bank progress report, September 29, 2001.