

Poverty Reduction Strategy Papers (PRSP) and the Health Sector*

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Abstract: The objective of this paper is to introduce the reader to the sector-specific application of Poverty Reduction Strategy Papers (PRSPs), namely health. In order for advocacy action to be successful, agents working for increased efficiency of the PRSP process need to know the opportunities and difficulties pertaining to this important sector of societal development. Each sector has its own specific realities and corresponding analytical and theoretical underpinnings. This article provides an overview of key actors' approaches to the improvement of health services delivered to the poor within the context of PRSP processes.

Keywords: PRSP, health sector, international organisations, poverty reduction

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“The idea of social and human development has become the ‘step-child’ of international priorities and that, rhetoric aside, development does not always take into account human values and social goals; rather, development is often confused with economic growth”

(Rodolfo Stavenhagen, at the UNRISD Conference on *Taking Social Responsibility for Social Development*, 29 June 2000, Geneva) (Stavenhagen, 2003)

Introduction

Each section of this article begins with a presentation of leading development agencies’ views on PRSPs. This is followed by a discussion of the World Bank’s objectives and actions as well as the position taken by other IOs (Intergovernmental Organisations) and NGOs (Non-Governmental Organisations) active in the areas of poverty reduction and health sector. Following each perspective is a summary of their view points on the progress made by developing countries in achieving the Millennium Development Goals (MDGs) relevant to the health sector, as well as a prescription for future improvements needed to implement successful PRSPs and come closer to achieving the MDGs by 2015.

Discussion in this paper is meant to be an introduction of a complex situation and the issues surrounding the PRSP process. For more detailed information regarding PRSP and the link to health development, the reader is encouraged to deepen his or her understanding of the complexities and challenges confronting the worldwide effort in poverty reduction by visiting the suggested sites at the end of this article.

PRSP: Its Historical Context¹

Poverty Reduction Strategy Papers (also known as PRSPs) are

¹ PRS Entry Points, Module 2; pp 3-4 in *Decent Work and Poverty Reduction Strategies (PRS): An ILO Advocacy Guidebook for staff and constituents*; ILO, 2005

intended to improve the situation of the poor in low-income developing countries. PRSPs represent different strategic intentions such as: a primary policy device of international development institutions to achieve reduction of poverty through social inclusion;² a policy framework to coordinate bilateral and multilateral development assistance; and a driver to integrate the low-income countries into the global financial and trade architecture (Craig and Porter, 2003).

The origins of PRSPs lie substantially with the civil society movements – e.g., Jubilee 2000 -- that forced the issue of debt reduction onto the international agenda in the late 1990s (Whaites, 2002b). At the Annual Meeting of the World Bank and IMF in September 1999, it was announced that a new poverty focus would be part of all of the international financial institutions' (IFI) work in low-income countries. This policy put poverty reduction, as embodied in the 2015 social targets of the Millennium Development Goals (MDGs) at the heart of the overall development policy framework for low-income countries.

In December 1999, the Boards of the World Bank and the IMF approved the PRSP approach to reduce poverty in low-income countries (World Bank, 2001d). Since then, a PRSP has become the prerequisite for debt relief and concessional lending. Major donor agencies are expected to endorse the participatory process prescribed by the poverty reduction strategy (PRS) process and the PRSP as a pre-condition for financial support. In other words, a PRSP is now supposed to be the basis for all donor and creditor relationships with a low-income country.

The PRSP idea was first conceived as an operational plan linked to the country-level Comprehensive Development Framework (CDF) that was designed and implemented by the World Bank. The new IFI approach has linked PRSPs to debt relief under the enhanced Heavily Indebted Poor Country (HIPC) initiative. Countries are now expected to have developed a poverty reduction strategy, reflected in a PRSP, to show

² Social inclusion, in contrast to social exclusion, stresses equal access to education, health, housing, and employment.

how they would use the funds released by debt relief to alleviate poverty in their countries.

The World Bank's concessional funding is channeled through the International Development Association (IDA) of the World Bank. Consequently, the World Bank has set up a new IDA funding mechanism called the Poverty Reduction Support Credit (PRSC). The IMF has also changed the name of its concessional lending, formerly known as Enhanced Structural Adjustment Facilities (ESAF), to Poverty Reduction and Growth Facility (PRGF) to indicate its emphasis on poverty reduction (Walford, 2002:5; Roberts, 2003).

There are three main Board papers that set out the vision of the World Bank and the IMF on what a PRSP is about. They are:

- World Bank and IMF joint document: *Poverty Reduction Strategy Paper – Operational Issues* (10 December, 1999)
- IMF: *The Poverty Reduction and Growth Facility (PRGF) – Operational Issues* (13 December, 1999)
- World Bank: *Poverty Reduction Strategy Papers – Internal Guidance Note* (21 January, 2000)

The key point of departure from the other pre-PRSP development instruments is that PRSPs embrace a high level of civil society participation along with a stronger national ownership.

PRSPs and Health

How Does Health Underlie the poverty phenomenon?

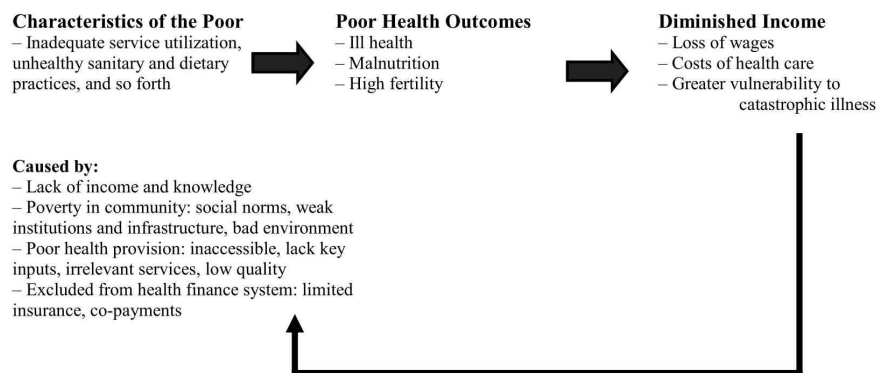
The lack of health has been identified as a key indicator reflecting poverty. It is a complex determinant, since “*poverty is both a consequence and a cause of ill health*” (World Bank, 2002k, Vol., 2, Ch. 28:203).

Poor households generally reflect poor health. Infectious diseases, malnutrition, high mortality rates and low life expectancy are among the

many maladies that reveal and aggravate poverty. The picture becomes more acute when this poor health profile impedes work. Unable to work, a sick person cannot buy medicines, obtain treatment and recover. Further, “the illness of a household breadwinner and the consequent loss of income can undermine a poor household’s ability to cope financially” (World Bank, 2002k, *ibid.*).

This so called “Poverty Cycle” is displayed below, showing the vast amount of health and poverty linkages.

Figure 1. Health and Poverty Linkages



Source: World Bank, 2002k, Ch.18:203.

This diagram displays the painful effects of the poverty-health trap for a majority of impoverished citizens in developing countries. Multiple reasons have prohibited and excluded the poor from participating gainfully in the economic system. The poor lack the financial resources necessary to lead healthy lifestyles and have access to such social securities as quality health care systems, education on prevention of illnesses, as well as decent infrastructure such as clean water and proper sanitation. Thus poverty and lack of health create a vicious cycle, where illness reduces the chances of overcoming poverty, and this in turn contributes to poor health outcomes.

In 20 Least Developed Countries (LDCs), for example, only around 62 per cent of the population had access to safe drinking water in 2004

and only 40.1 per cent had access to proper sanitation facilities. However, these statistics do not fully express the inequality divide between rural and urban areas. Out of the 20 countries reviewed, only five countries had more than 50 per cent of the urban population lacking access to proper sanitation facilities, while 17 countries had less than half their populations without access in the rural areas (United Nations, 2007a).³ This inequality shows the burden of the poor, who are generally congregated in the rural areas, where the lack of proper sanitation and water facilities creates an environment for poor health and therefore greater poverty.

In these same 20 countries, the average adult economic activity rate was 73.16. For men it was 85.74 and for women it was 60.53 (United Nations, 2007a).⁴ The average school life expectancy (in years) from primary to tertiary during the period of 2000-2005 was 8.53 years of age. For men it was 9.33 and for women 7.69 (United Nations, 2007a).⁵ It is therefore also apparent that not only are the physical and social environments of the poor effecting the poverty and health status of these LDCs, but that the gender divide still poses a huge threat to the reduction of poverty. This issue will be addressed further throughout this paper.

The ILO has adopted a life-stage model to pinpoint when people are vulnerable to falling into poverty and as the starting point for understanding the dynamics of life and work of poor community. Below are some of the key issues identified by the ILO (ILO, 2003: 22):

³ See Appendix 1 for list of countries reviewed and data.

⁴ The adult economic activity rate shows the percentage of the population over 15 years of age who are economically active. The UN defines as 'economically active all employed and unemployed persons, including those seeking work for the first time. It covers employers operating unincorporated enterprises, persons working on their own account, employees, unpaid contributing family workers, members of producer's cooperatives and members of the armed forces' (UN 2007a). See Appendix 2 for list of countries reviewed and data.

⁵ See Appendix 3 for list of countries reviewed and data.

Vulnerable Groups and Pathways to Poverty

- child labour and school attendance;
- youth unemployment;
- gender inequality;
- low incomes from agricultural; work
- insecure livelihoods in urban informal; economies
- poor health and hazards at work; the elderly.⁶



Lack of basic education, basic nutrition, gainful employment and minimum assets are some of the root causes of this vicious poverty cycle. At the macro level, similar cycles exist. It is often called the “development trap.” Low income leads to a low savings rate and low consumption. A low savings rate leads to low investment, which retards productivity gains. Underpinning this development trap is poor human capital and the lack of widespread income distribution. Therefore, it is imperative to examine the triad of failures - structural, government, and market - in order to identify appropriate and effective interventions to liberate poor countries from development traps and poverty cycles.⁷

Globalization has exasperated and widened the divide between the rich and the poor as individuals and as communities and countries. More and more individuals and societies are falling behind and suffer the negative consequences due to globalization and the ensuing economic and labour insecurity. The issue at stake is not about stopping the globalization process but rather striving toward a “fair” globalization that “leaves no one behind” (ILO, 2003: 7).

Poverty needs to take the gender dimension into consideration. Women constitute the majority of the poor and have the least access to resources, education, employment, and property rights. Various forms of religious suppression and customary deprivation often leave many

⁶ Text taken from CSEND, Module 2; 9.

⁷ Saner, R; Yiu, L. (2006), Poverty Reduction Strategy Paper (PRSP): Seen from a Sector Perspective; pp. 4-8; CSEND, Geneva.

women vulnerable, both in peaceful and in turbulent times. “Women in poverty” as a theme requires in-depth analysis and treatment.

Poverty Indicators in Health

Among the international concerted initiatives of poverty reduction, the *Millennium Declaration* (2000) and its resulting Millennium Development Goals (MDGs) has recognized the importance of health. There are three relevant MDGs targeting poverty from a health perspective. These are:⁸

Table 1. MDGs Targeting Poverty From a Health Perspective

Goals and Targets	Indicators for monitoring progress
Goal 1: Eradicate extreme poverty and hunger	
Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger (i.e. malnutrition)	4. prevalence of underweight children under five years of age 5. Proportion of population below minimum level of dietary energy consumption
Goal 2: Reduce child mortality	
Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of one-year-old children immunized against measles
Goal 3: Improve maternal health	
Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel
Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	18. HIV prevalence among 15-24 year old pregnant women 19. Condom use rate of the contraceptive prevalence rate 20. Number of children orphaned by HIV/AIDS 21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)

⁸ For information on the Millennium Development Goals, please visit: <http://www.un.org/millenniumgoals/>

These MDGs, through their respective targets and indicators, are particularly useful in poverty reduction. They measure levels of health. They allow monitoring of progress, as well as an evaluation of the results of a Poverty Reduction Strategy with a health component.

MDGs and their Future Outlook

Although some progress has been made in incorporating the health components of the MDGs into the construction of PRSPs, there is still a great deal to be done.

Goal 1 - Eradicate Extreme Hunger and Poverty:

The United Nations Millennium Development Report of 2007 predicts that if the rate of poverty reduction continues, MDG 1 will be achieved globally and for most individual regions. 'The proportion of people living in extreme poverty fell from nearly a third to less than one fifth between 1990 and 2004' (United Nations, 2007b; 4). However, certain regions are far from their goal; specifically in Sub-Saharan Africa and Western Asia, where the poverty rate is actually increasing. In Sub-Saharan Africa, the poverty rate (the amount of people living on less than \$1 a day) went from 46.8 per cent in 1990 to 41.1 in 2004. In Western Asia, the poverty rate increased from 1.6 per cent in 1990 to 3.8 per cent in 2004 (United Nations, 2007b; 6).

Also, despite the decrease in the amount of global poverty, the economic divide in individual developing countries has continued to grow. In Eastern Asia, the share of the poorest quintile in national consumption went from 7.1 per cent in 1990 to 4.5 per cent in 2004. Sub-Saharan Africa, Latin America and the Caribbean have remained stagnant, with the percentage remaining at 3.4 per cent from 1990 to 2004 for Sub-Saharan African and a 0.1 percent decrease (2.8-2.7) for Latin America and the Caribbean (United Nations, 2007b; 8). This displays a need for greater incorporation of pro-poor targeting strategies

in the PRSP process, as well as an increased emphasis on equity in conjunction with efficiency while looking at the development of the Global South.

In addressing the target of halving the global proportion of people who suffer from hunger between 1990 and 2015, there has been much progress made in Eastern and Western Asia, as well as in Latin America. 'Eastern Asia showed the greatest improvement and is surpassing the MDG target, largely due to nutritional advances in China' (United Nations, 2007b; 8). However, due to the immense lag in progress in Sub-Saharan Africa and South Asia, the latter part of the first MDG will most likely not be met by 2015. Using the indicator of the proportion of children under age five who are underweight, Sub-Saharan Africa went from 33 per cent in 1990 to 29 per cent in 2005 and the South Asian percentage decreased from 53 to 46 between 1990 to 2005 (United Nations, 2007b; 8).

Goal 2 - Reduce Child Mortality:

Although the global and infant mortality rates have declined, disproportion exists between the improvements made in different regions around the world. Once again, Sub-Saharan Africa is advancing the slowest, followed by South Asia. In 1990 the under-five mortality rate (per 1,000 live births) was 185 for Sub-Saharan Africa and 126 for Southern Asia. In 2005, the rate decreased to 166 for Sub-Saharan Africa and 82 for South Asia (United Nations, 2007b; 14). This lack of progress is intrinsically linked with the quality of, and access to, health systems, as well as the AIDS epidemic and the spread of Malaria. It is also essential for international organizations to focus on the economic divide in the developing world.

'In most countries that have made substantial reductions in child mortality in recent years, the largest changes were observed among children living in the richest 40 per cent of households, or in urban

areas, or whose mothers have some education' (United Nations, 2007b; 14).

It is no longer sufficient to observe progress through the generalization of the poor. Governments must dissect the data received through monitoring systems to confirm exactly which part of the population needs to be helped by poverty reduction and create health policies that target the poor.

Goal 3 - Improve Maternal Health:

The goal of reducing by three quarters between 1990 and 2015 the maternal mortality ratio is severely off track.

'Over half a million women still die each year from treatable and preventable complications of pregnancy and childbirth. The odds that a woman will die from these causes in Sub-Saharan Africa are 1 in 16 over the course of her lifetime, compared to 1 in 3,800 in the developed world' (United Nations, 2007b; 4).

The majority of maternal deaths that occur could be prevented by existing technologies that are under utilized due to inefficient health systems and inadequate funding for facilities, technology and skilled employees. South Asia, followed closely by Sub-Saharan Africa, takes the lead in having the smallest percentage of the proportion of deliveries attended by skilled health care personnel between 1990 and 2005 (United Nations, 2007b; 16)

However, there is not just a disparity in maternal health in a global context, but in a domestic context as well.

'According to surveys conducted between 1996 and 2005 in 57 developing countries, 81 percent of urban women deliver with the help of a skilled attendant, versus only 49 per cent of their rural counterparts' (United Nations, 2007b; 17).

There is also inequality related to the amount of educated women versus uneducated women who receive skilled personnel present during birth, proving that the poverty-health-education linkage is very strong and cannot continue to be ignored.

Progress has been made in the areas of antenatal care, where all regions have seen a significant improvement. It is also necessary for governments to incorporate all health policies made addressing maternal health into the national ownership aspect of the PRSP process. Each region has specific maternal health issues indigenous to that area and it is crucial for governments to first evaluate what these issues are, then subsequently design strategies specifically for the most poor and vulnerable in their country that address the relevant ailments pregnant women face (United Nations, 2007b; 17).

Goal 4 - Combat HIV/AIDS, Malaria & other diseases:

Although HIV prevalence is beginning to level off, there are still millions of people living in the developing world dying from the AIDS virus. 'The number of people dying from AIDS world wide increased to 2.9 million in 2006, and prevention measures are failing to keep pace with the growth of the epidemic' (United Nations, 2007b; 4). The methods of transmission that are shown to be the most popular include drug use and unprotected sex, especially now among men to men in the Asian countries. In addition, due to gender inequalities, half of those suffering from HIV are women. For example, in Sub-Saharan Africa, the share of adults (15+) living with HIV who are women went from 54 per cent in 1990 to 59 per cent in 2006 (United Nations 2007b; 18). This increase in infection of women is due to the patriarchal systems inherent in many developing countries, as well as women's inability to provide for themselves, financially and physically, without the assistance of men. These statistics show the need not only for prevention and education measures to be scaled up, but also for the advocacy of gender empowerment and the protection of women's bodies and human rights.

The fight against other contagious diseases, such as Malaria and Tuberculosis (TB) are showing results, but scaled up efforts are needed to achieve the goal of halting and reversing the incidence of these diseases by 2015. Malarial campaigns have helped the most effected areas, like Sub-Saharan Africa, put in place systems to prevent the spread of the disease. For example, countries such as Zambia and Malawi have had up to a 20 per cent increase in the proportion of children who are sleeping under insecticide-treated bed nets (ITN) from 1999 to 2006. However, only a few countries came close to the 60 percent coverage goal desired in the African region (United Nations, 2007b; 20). There is a great difference between those who are being covered with ITN in the urban and rural areas as well as who is accessing appropriate medical treatment within the society.

The incidence of Tuberculosis is also beginning to subside in the majority of the world. However, the number of new cases is still increasing, especially due to population growth. In Sub-Saharan Africa, the number of tuberculosis cases per 100,000 population rose from 331 in 1990 to 490 in 2005. In the Commonwealth of Independent States there was also a rise in the incidence rate from 83 in 1990 to 137 in 2005 (United Nations, 2007b; 21). However these regions have begun to see stagnation in the incidence rate, and globally the prevalence of TB is beginning to level off. However, the goal of halving the prevalence and death rate from TB by 2015 will most likely not be reached due to lags in the regions mentioned above (United Nations, 2007b; 21).

The advancement of the developing world in achieving the MDGs and decreasing the rate of poverty within their countries has been strictly monitored by the United Nations as well as several other international organizations. The following sections will provide a broader understanding of the progress made in the areas of poverty reduction and health improvement by presenting the view points of the various IGO and NGOs related to these fields.

How Does the PRSP Address Health?

The World Health Organization (WHO) Perspective on Progress Made to Date

The World Health Organization (WHO) has voiced its concerns on health and poverty in *The Report of Working Group I of the Commission on Macroeconomics and Health*, recognizing: "...ill health disproportionately afflicts poor people... Ill health therefore imposes a higher level of risk on the poor" (WHO, 2002:9).

As such, the WHO has stressed that action towards improving health must focus on pro-poor outcomes, where: "Beyond health facilities themselves, governments have a role in deciding which non-sector policies also influence the accessibility of services, with transportation being the obvious target. But, in the final analysis, given the clear effect of income on the differences in health determinants between the poor and non-poor, it will be government financing and redistributive policies that are likely to have the greatest impact" (WHO, 2002:52).

The WHO considers that PRSPs can be appropriate for addressing health. However, in its critical assessment of PRSPs, certain biases and common errors in policy design and implementation have been identified.

In the preliminary report of the *WHO monitoring project of PRSPs* as well as in the 2004 update, *Poverty Reduction Strategy Papers: Their Significance for Health: second synthesis report*, findings on the reviews of PRSPs from ten countries have been gathered and analyzed. These reveal that: "an important distinction needs to be made in discussion of the health component of the PRSP, between a 'health strategy for poverty reduction', and a 'health strategy to meet the needs of the poor(est)' – these two objectives are overlapping, but different" (Dood and Hinshelwood, 2002:1).

The WHO review finds that PRSPs have concentrated on the first

component, by mainly focusing on investment in health to reduce poverty, but that insufficient efforts toward the second component have been made. The main shortcomings in the PRSPs which hamper pro-poor outcomes are:

- failure to create a definition of poverty which distinguishes between different groups of the impoverished and lack of attention towards regional disparities and inequality;
- lack of attention to the role of the private sector as a health provider;
- limited discussion of financial barriers to care;
- many strategies lack a focus on people with disabilities;
- not addressing non-communicable diseases such as smoking;
- absence of monitoring indicators for impact evaluation on the poor and for participation in the monitoring process (WHO, 2004).

Further, sufficient consideration to intersectoral action is also critical. Though sectors such as agriculture, education and the environment fall outside the scope of health policies, these directly affect the poor. As such,

“an appropriate restructuring of the development processes at the national level is required to enable sectors to formulate policies and act in relation to multisectoral goals, so that horizontal linkages become clearly identified at all levels, and development strategies are not confined within sectoral boundaries” (WHO, 1986:17).

In the 2004 review, the WHO found that a majority of PRSPs now describe a relationship between poverty and health, but few have a multi-dimensional aspect (WHO, 2004: 3.3). The best practices in defining the poverty-health linkage were found in those PRSPs that explored the effects of improved health on poverty reduction and presented a breakdown of the varied health needs of the poor. In terms of health-related sectors, most PRSPs reviewed, addressed water and sanitation independently from health, despite the impact that poor

sanitation has on the health of citizens. Although most PRSPs have a thorough plan of action for improvement of water programs and sanitation, this is usually included under rural sectors. Also, few PRSPs link nutrition and rural development together and there is an inadequate poor-specific analysis of nutrition in terms of the causes of malnourishment (WHO, 2004: 4.4).

Also in the 2004 review, the WHO discovered further problems with the PRSP approach to health services, communicable and non-communicable diseases as well as towards maternal and child health. The review showed:

- There has been a scaled up inclusion of communicable diseases in the drafting of PRSPs but policies addressing the reduction of non-communicable diseases, such as smoking are still lacking. Also, there is still a need for pro-poor targeting techniques (WHO, 2004: 4.2).
- Although the majority of PRSPs now discuss maternal and child health in relation to poverty reduction, there is a need for greater pro-poor targeting strategies that address the barriers the poorest women face in terms of health care (WHO, 2004: 4.3).
- In reviewing the PRSP analysis of health systems, many countries now include proposals for reducing the financial barriers to improved health services. However, few dissect the problem of corruption or inefficient management. Also, there needs to be more discussion of the role of the private sector and non-state actors in the delivery of health services. (WHO, 2004: 4.1)

In regards to the improvement of social indicators, the WHO found mixed results in terms of inclusion of poverty targeting and indicators in reviewing PRSPs from several developing countries. The two approaches to poverty targeting that were most common were:

- ‘Universal Coverage which by definition would include poor as well as non-poor (used for programmes such as vaccination, coverage of

health clinics).’

- ‘To target specific poor regions or groups with a specific health programme.’ (WHO, 2004)

Out of these two strategies, Universal Coverage was advocated much more in the PRSPs studied than specific targeting strategies. This is due to the fact that the latter requires much more data and information on health issues that are specific to the poor, and therefore is much more costly. This is one of the biggest faults with current indicators of health in PRSP strategies because without specific poor data, a country’s capacity for health targeting is very limited (WHO, 2004).

In conclusion, the main message from the WHO is that a special emphasis on health policies targeting the poor is essential. Elements of correct policy design should consider identifying the diseases afflicting the poor and how to provide access to medicines, especially with regard to AIDS and other infectious diseases.

The WHO has proposed a *framework for action* (WHO, 2001) for the poor, envisaging participation of two main actors, namely the international community and the governments of least-developed countries (LDCs). These two need to undertake a number of joint and parallel actions in order to improve health. The core actions considered by the framework are:

- Mobilize additional resources
- Channel and manage funds efficiently and effectively
- Identify, prioritize, produce and distribute global public goods for health
- Develop effective health systems
- Measure progress
- Advocate and foster social mobilization and awareness
- Seek policy coherence across the different sectors

Optimizing Policy Design and Policy Implementation in the Health Sector

Several actors have expressed their views on how to deal with health and poverty in an optimal form. After critically assessing the shortcomings of PRSPs, among the many contributions the following stand out:

The World Bank Perspective

The PRSP is an instrument for poverty reduction with a multidisciplinary approach. It is meant to tackle all the elements that contribute to raising poverty, including health. As such, from a health perspective, the PRSP process should *diagnose and analyze* the health situation, identify the causes of bad health, the health system components and what government actions and policies may be necessary to break the poverty and ill-health vicious cycle.

The diagnosis and analysis stage of the PRSP should also pay particular attention to *intersectoral linkages*⁹ that have an impact on health. “Such an analysis should aim to show how action in sectors other than health services might help improve the health of the poor and reduce the impoverishing effects of ill health” (World Bank, 2002k: 224).

Furthermore, because the PRSP is supposed to be the end result of a participatory process in a poor country, it should ideally reflect the most urgent needs brought forward by the relevant sectors involved. In the case of health, the PRSP envisages actions and partnership among three main sectors: households and communities, the health system and the government. When *prioritizing actions and policy design*, these three

⁹ There is a longstanding recognition of the incidence of agriculture, nutrition, access to drinking water and environment, among other factors, on health. Policies and government actions in such sectors are therefore crucial to health. For an exhaustive approach on an intersectoral approach to health, please see WHO, 1986.

sectors need to consider:

- “assessing what changes at the household and community level would be necessary and sufficient to provide the needed contribution from the health sector;
- assessing what groups of actions the government can take in each of the three areas – macroeconomic, systems, interventions – that would be necessary and sufficient to achieve the desired changes at the household and community levels for the poor;
- assessing what specific inputs and costs would be associated with these actions; and
- assessing what indicators should be used to evaluate progress and how these would be collected and used to adjust the Programme” (World Bank, 2002k: 224-226).

In this context, actions will be constrained by budgets. Consolidating and ranking priorities, defining concrete actions and identifying targets and indicators of health outcomes for monitoring and evaluation of the strategy are necessary.

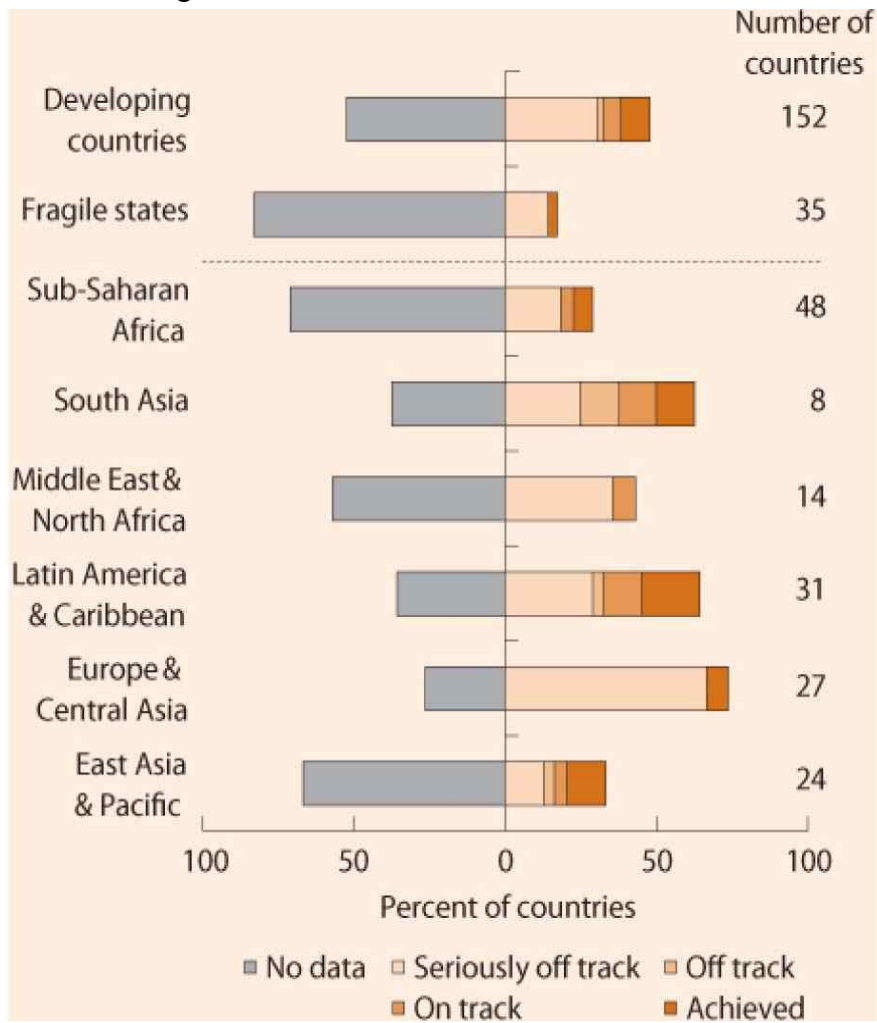
A World Bank Perspective on Progress Made to Date

There has been much progress made towards achievement of the Millennium Development Goals (MDGs), however the World Bank has noted that developing countries still have a long road to travel in terms of improvement in the health sector in relation to poverty reduction.

Many obstacles have been overcome in the process of achieving Goal one of the MDGs. The number of people living in extreme poverty (less than US\$1 a day) went from 29% in 1990 to 18% in 2004. Global poverty is also expected to fall to 12% by 2015 (World Bank, 2008a). Although regions such as East Asia and the Pacific are experiencing great development, Sub-Saharan Africa still poses a large threat to the achievement of the MDGs. Below is a graph from the 2007 Global

Monitoring Report published by the World Bank, displaying the projected progress towards the poverty reduction goal of 2015.

Figure 2. Proportion of Countries on Track to Achieve the Poverty Reduction Target



Source: World Bank; <http://go.worldbank.org/CTLGXZD9C0>.

As mentioned above, Sub-Saharan Africa is seriously off track

from reaching the poverty reduction target. One reason behind the lack of progress is due to the abundance of “fragile states” in the region. A fragile state is defined as a country that lacks strong governance, institutions and capacity. These fragile states make up over one-fourth of the extreme poor today, and lack the data needed to estimate their progress made towards the MDG targets (IMF, 2007: 2). For this reason, the World Bank included the problem of “fragile states” as one of the main obstacles to progress in global poverty reduction.

The achievement of the second half of goal 1, to halve the amount of people suffering from hunger from 1990 to 2015 has achieved less progress than the first half.

‘More than half of countries in Sub-Saharan Africa are off track to reach the 2015 target of cutting malnutrition rates by half. Half of the countries in South Asia are on track to reach the target, but they also have the highest rates of malnutrition in the world and will continue to have the largest share of malnourished children, even if the target is achieved’ (World Bank, 2008a).

The second MDG, the goal of reducing by two-thirds between 1990 and 2015 the under-five mortality rate, has a much grimmer outlook. While a majority of countries have made some progress in reducing their child mortality rate since 1990, very few, if any, have made enough advancement to achieve the MDG by 2015.

‘Based on estimates through 2005, only 33 countries are on track to achieve a two-thirds reduction in the mortality rate. Every country in Sub-Saharan Africa is off track, and in some countries mortality rates have increased since 1990’ (World Bank, 2008b).

One cause for the delay in infant-mortality reduction in Sub-Saharan Africa is due to the ill effects of HIV/AIDS as well as internal conflicts within the region. There is also evident inefficiency as well as lack of access to proper health care systems for infants and children due

to the fact that the tools needed to fight malnourishment exist and are prevalent in many developed countries. ‘Oral rehydration therapy, insecticide-treated bednets, breastfeeding, and common antibiotics for respiratory diseases could prevent an estimated 63% of child deaths’ (IMF, 2007: 5). However, despite the abundance of tools and medicine available, many opportunities have been lost for achieving this goal by 2015.

Target six of the third MDG, to reduce by three-quarters between 1990 and 2015 the maternal mortality ratio, remains very hard to measure and is therefore difficult to assess the progress made to date. This is due to the fact that there is not enough data or monitoring techniques to track progress. Out of the households that are surveyed, the progress that is being documented in improving maternal-mortality is mostly among richer households, showing that most countries have not developed pro-poor targeting techniques for this area of health. The World Bank recommends that to fill in the missing data, countries should use “skilled attendance at delivery” as a measurement for improvement in maternal health care (IMF, 2007: 5).

Work towards the sixth Millennium Development Goal, to combat HIV/AIDS, malaria, and other diseases, has produced positive results but there is still much to be done in terms of prevention and control of diseases in developing countries. ‘By end-2006 an estimated 39.5 million people globally were living with HIV, up 2.4 million since 2004, and an estimated three million people had died from AIDS’ (World Bank, 2008c). The development work done both by donor agencies and national governments has proven that it is possible to implement effective treatment for HIV/AIDS and halt the spread of the virus. However, much more needs to be done in the areas of prevention.

One success is shown through the increased awareness and advocacy for both Malaria and Tuberculosis (TB). The World Bank has sponsored several malaria initiative programs in response to the disease and the only area where the incidence of TB has not declined is in Africa (IMF, 2007: 6). Although support for the program Directly Observed

Treatment, Short-course (DOTS)¹⁰ is showing successes, there are still many challenges. ‘In 2006 a new strain of TB – extensively drug-resistant TB – was discovered in South Africa’ (IMF, 2007: 6). This discovery has posed a serious obstacle to the alleviation of TB, specifically in Africa where the poverty-health cycle has made it even more difficult to assure the effective implementation of treatment.

For future improvement in the health sector, the World Bank recommends an emphasis on quality as well as quantity of health care. To guarantee improvements in the health sector, governments must improve their monitoring systems and create more accurate databases. Also, many countries have been shown to have large gaps between what health care providers know is right and the actions they take in implementing health services. One remedy the World Bank recommends for this issue is the “performance contracting” of health professionals to confirm quality care (IMF, 2007: 8). Also, the World Bank places a great emphasis on the need for enhanced harmonization with donor groups, Intergovernmental Organizations and national governments. This will help to organize aid initiatives and finances for the health sector.

The Donors’ Perspectives

Along the same line, other active voices in favor of better health for the poor are NGOs and various international organizations. Several of these organizations have contributed with research on health policy design in poverty alleviation. Germany and the United States are two of the countries that provide the most amount of overseas development assistance (ODA) to developing countries. Their respective development organizations, USAID and BMZ have produced extensive documents on the health-poverty linkage and have tied health as a social factor into development assistance programs. Other development agencies that are

¹⁰ For more information regarding DOTS please visit the Tuberculosis page of the World Health Organizations’ website: <http://www.who.int/tb/strategy/en/>.

evaluating the current progress on the MDGs and the subsequent poverty-health linkage include Canadian International Development Agency (CIDA), Swiss Agency for Development and Cooperation (SDC), and the Danish Agency for Development Assistance. In particular, the UK Department for International Development (DFID) stands out in the research it has done regarding poverty reduction strategies and health, as well as the data and surveillance they have produced while monitoring the progress of the MDG health indicators. Their viewpoints regarding poverty reduction and health as well as the progress of the MDG indicators will be explained in detail throughout this section.

DFID outlines four key responses in order to improve health for the poorer sectors of society. These are:

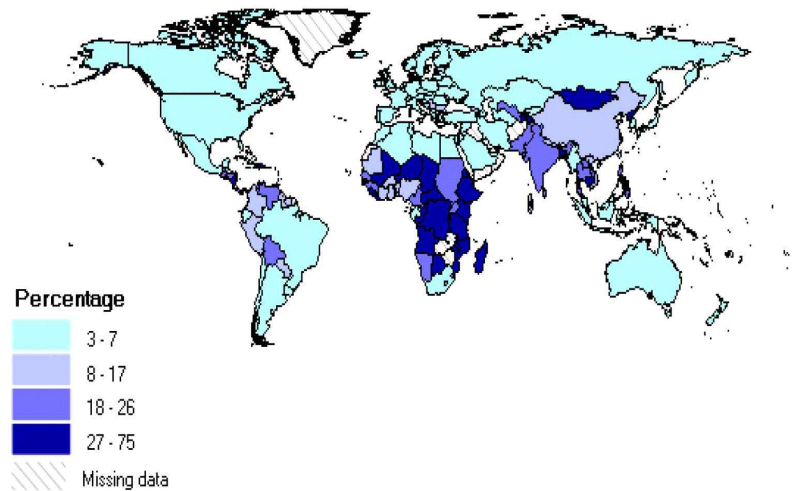
- *Response one:* addressing the priority health problems of the poor people; strengthening access to care, services and products.
- *Response two:* Investment in strong, efficient and effective health systems (public, private and informal).
- *Response three:* A more effective global response to HIV/AIDS.
- *Response four:* Supporting the necessary social, political and physical environments that enable poor people to maximize access to better health. (DFID, 2000:32).

These responses can only be successful if there is a building of partnership at the local, national and international community level. In this regard, a binding commitment to the achievement of international development targets is stressed in the following DFID statement: “We will pursue these goals through partnerships at country, regional and global levels, through our engagement in international summits and for drawing on DFID’s field experience and network of health professionals” (DFID, 2000:36).

The DFID estimates that much progress has been made since 1990 in moving towards the Millennium Development Goals (MDGs).

However, certain regions of the world have progressed much further in reducing poverty and improving their health sectors than others. In Eastern and South Eastern Asia, countries have made great strides in reducing the amount of people malnourished and living in poverty. However, the amount of poor in sub-Saharan Africa is still on the rise and DFID predicts that by 2015, over 90% of the poor will be located either in South Asia or Africa (DFID, 2007f). The percentage of those living in hunger has been seriously reduced in East and South East Asia, as well as in Latin America and the Caribbean. If the momentum continues, these regions may be able to meet the target for the first MDG by 2015. However, once again in Saharan Africa, South and West Asia the percentage of malnourished people has increased (DFID, 2007c). Below is a map displaying the global percentage of malnourishment as of 2004 taken from the DFID website:

Figure 3. Global Percentage of Malnourishment as of 2004



Prevalence of under nourishment (2004)

Source: UN "Millennium Development Goals Indicators Database" (2007).

‘Poverty is the primary cause of hunger and poverty reduction is the

principle means of tackling it' (DFID, 2007c: 2). To reduce hunger, it is not only necessary to reduce poverty but to improve other sectors of the government as well, such as agriculture, trade, and rural development. People need to have the *means* to obtain food as well. In reviewing past PRSPs, DFID believes countries have focused too much energy on treating the symptoms of hunger rather than the causes. Governments should also include in PRSPs, information regarding 'accessibility and affordability' of food as well as the production of food (DFID, 2007c: 3).

To increase and improve maternal and child health care, it is necessary for government programs to focus on the lifecycle, monitoring health 'from pregnancy through childbirth into childhood' (DFID, 2007a: 2). To do this, it is necessary to strengthen health systems with maternal, newborn and child health (MNCH) programs at the center (DFID, 2007a: 2). To reduce child mortality, governments need to take advantage of the existing knowledge and techniques designed to help prevent diseases commonly linked to infant mortality. Most of the diseases that effect children are preventable through improved health systems. An example of an effective policy would be to scale up HIV prevention during child birth. Although the services are available, in 2005 only 9% of HIV infected women were offered services to protect their newborns from the virus (DFID, 2007a: 3). Monitoring systems also need to be scaled up in order to better track the effects of policies on child mortality.

With the implementation of MNCH programs, more attention needs to be paid to reducing the maternal mortality rate. Most maternal deaths are preventable; however, the poor have less access to those health services than the rich (DFID, 2007e: 2). To improve maternal health, it is necessary to advocate for greater skilled health providers, improved water and sanitation, better facilities, and other infrastructural improvements. It is also necessary to advocate for greater gender equality, to make sure the sexual and reproductive rights of women are protected and that their voices are heard. The biggest challenge facing the achievement of the fifth MDG is that there is very little data available for countries to track the

progress of maternal health. A majority of developing countries lack the necessary systems available for implanting tractable indicators (DFID, 2007e: 3).

The campaign to fight the HIV/AIDS virus has received an increasing amount of publicity over the past decade. The incidence rate has begun to level off in developing countries and there has been a large increase in the amount of people treated for the disease. “By the end of 2006, over 2 million people were receiving antiretroviral therapy in low and middle income countries, which is a 54% increase on the previous year.” (DFID, 2007b: 2). However, there is a dire need to scale up prevention measures of the disease to halt the increasing infection rate. It is also important to create specific policies that target the most vulnerable and poor, who are particularly susceptible to the virus. The AIDS initiative has received large amounts of funding in recent years, however there has been serious mismanagement of resources, as well as a void in implementation (i.e. enforcing gender inequality and reducing stigma and discrimination) (DFID, 2007b: 3).

Malaria and Tuberculosis (TB) are also serious health threats in a majority of developing countries and therefore pose a threat to the poverty reduction strategies being implemented globally. The five main challenges the DFID defines as key barriers to the fight against malaria are:

- Lack of funding
- Resistance; Malaria has now become resistant to first-line drugs in many developing countries. New medicines have been developed around Artemisinin (ATCS)¹¹ but many countries lack access to these medications
- Need for development of new products (i.e. drugs, a vaccine...etc)

¹¹ The creation of many anti-malarial drugs is based on the ingredient of the ancient Chinese herb *Artemisia annua* and has spurred the race to discover new anti-malarial drugs through investigating essential medicines.

- Natural disasters and conflict; displacement increases the risk of exposure to the disease
- HIV; There is increasing evidence showing HIV increases the risk for contracting Malaria (DFID, 2007d: 3)

Along with Malaria, movement towards the reduction of TB also needs to be scaled up, specifically in Sub-Saharan Africa where the incidence of TB has increased since 2005 (DFID, 2007g: 1). An example of a relief plan that has been taken to scale up aid is The Global Plan to Stop TB (2006-2015). This was launched in January of 2006 during the Davos conference to create a clear plan of action and set aside resources to achieve the MDG of halving the incidence and mortality rate of TB by 2015 (DFID, 2007g: 2). Also, the DOTS program has shown promising results but needs to be scaled up to detect and treat more cases. Problems developing countries now face in the fight against tuberculosis include the emergence of the extensively drug-resistant (XDR) TB. This poses a huge threat because there is no available cure for this strain of the disease (DFID, 2007g: 3). It is therefore imperative to improve health systems and obtain greater guarantees of completion of the TB treatment through creating ‘fully-functioning laboratories, reliable drug supplies and skilled health workers’ (DFID, 2007g: 3).

In conclusion, the DFID acknowledges that achievements have been made in many regions in the areas of health and poverty reduction. However, there is still a great need for increased funding, improved monitoring and health systems, and an increase in the amount of poor-specific targeting strategies to halt the poverty-health cycle.

The ILO Perspective

The ILO has a mandate to work on health-related issues as indicated explicitly in the Philadelphia Declaration, reflected through a large number of ILO Conventions on social security, and as reconfirmed by the 2001 International Labour Conference. However, the ILO does

not aim to work on all health aspects. Only health issues closely related to the world of work have a place within its decent work mandate. Its action in this field is mainly focused on the demand side that is on the health needs of workers, employers and their families. The work that it does thus complements that of other UN agencies working in this sector, notably WHO, UNICEF and UNFPA (these agencies are more focused on the supply side). This complementarity of mandates has given rise to inter-agency agreements and various concrete collaborations, for example:

- ILO/Pan American Health Organization initiative on the extension of social protection in health in Latin America and the Caribbean;
- Coalition between ILO-STEP, UNFPA, UNICEF and WHO in the framework of a global Programme on the improvement of access to quality health care for poor and excluded populations;
- Joint ILO-STEP / WHO initiative on contracting between health care providers and health service users in Africa;
- ILO-STEP participation within the Commission on Macroeconomics and Health (CMH) of the WHO, in collaboration with the World Bank, on community health care financing schemes;
- Partnership with WHO and the World Bank in a joint research project on community health care financing schemes.” (Walter and Holden, 2003: 25-26)

The ILO addressed the health factor in its Decent Work Agenda (DWA), where it identifies nine core areas of action, namely: (ILO, 2003g: 7-11).

- Skills development for sustainable livelihoods
- Investing in jobs and the community
- Promoting entrepreneurship
- Making money work for poverty reduction
- Building local development through cooperatives

- Overcoming discrimination
- Working to end child labour
- Ensuring incomes and basic social security
- Working safely out of poverty

The DWA recognizes the importance of health in poverty reduction through two of these core actions: *working safely out of poverty and ensuring incomes and basic social security*.

The ILO has stressed that: “The importance of universal access to basic health care and primary and secondary education is well recognized by many developing countries. For a poor family, securing basic income, basic health care and school places for the children is a foundation for participating productively in society and the economy” (ILO, 2003g: 12).

Ensuring incomes and basic social security improves access to proper food and to sanitary and medical services, which in turn prevents sickness, enhances family planning and sanitary habits and conditions, thereby contributing to better health and less poverty.

In relation to work safety, the ILO has noted: “The poorest workers are the least protected... prevention of occupational accidents and diseases is missing... Hazardous work takes its toll on the health of workers and on productivity” (ILO, 2003g: 12). *Work security* translates into occupational health and safety, where accidents, illness and strains on the worker are addressed.

Although decent work for all is not listed as a Millennium Development Goal (MDG), it is included in several indicators used to achieve the MDGs. In 2005, the ILO published a joint-analysis of the role of employment in promotion of the MDGs along with the United Nations Development Programme. In this analysis, the ILO discussed three crucial MDGs related to health and their links to the need for improved employment conditions. Surrounding their employment strategies was the broader category of gender equality. Both the ILO and UNDP believe that to reduce poverty and obtain improved health

conditions, it is necessary to have gender equality and female empowerment. The paper addressed the issues of maternal health, child mortality and the control of infectious diseases such as the HIV/AIDS epidemic (ILO, 2005b).

Decent employment greatly impacts the societal status of women as well as their capability to maintain adequate health care for themselves and their children. A 2003 study showed that ‘women’s status within the household vis-à-vis men was found to have a significantly positive effect on their nutritional status and their general ability to take care of themselves’ (ILO, 2005b: 10). Women’s employment and income are also crucial in shaping child health care. The three main determinants of child health according to the ILO are food, hygiene, and care. By improving a mother’s status (i.e. through elevated income and employment) she is more equipped to prevent underweight births by providing better food and health care for herself during pregnancy, as well as to provide for her children once outside of the womb (ILO, 2005b: 14).

To aid in improving the fight against HIV/AIDS and other diseases, the ILO suggests that all strategies be gender sensitive. The combination of poverty and women’s low status in patriarchal societies gives women less control over their own sexuality and places them in the vulnerable group for contracting HIV. Also, due to insecurity from poverty, women are forced to sell themselves for sex in order to earn an income (ILO, 2005b: 15). Therefore, gender-sensitive employment strategies help by improving a woman’s ability to provide for herself. Improving employment for women gives them more access to basic essentials and offers them a safer environment to live in. The other vulnerable group poverty strategies should target is the migrant male worker. These men frequent prostitutes while working for long periods away from home, often returning and spreading diseases they have contracted to their unsuspecting partners.

In this respect, the ILO’s contribution to better health policies in the PRSPs is “...to provide support to PRSP processes both at the design

stage and, increasingly, at the stage of implementation (ILO, 2003g: 101). As such, the identified priority issues relating to health which the PRSP should address are:

- “The impact of poor health, particularly HIV/AIDS, on employment and incomes and the policy priorities
- Financing of health care and the potential for extending insurance schemes to people living in or vulnerable to poverty
- Income support systems for families with school-age children, the elderly and people with disabilities
- Reform of existing social insurance schemes with a view to a medium-term strategy for extension of coverage and synergies with small-scale voluntary schemes
- Improvement of mechanisms for establishing and enforcing minimum wages
- Occupational health and safety policies, with particular focus on hazardous occupations such as agriculture, construction, mining and small-scale manufacturing, where many lower income workers are employed
- Community maternity support” (ILO, 2003g: 104).

In conclusion, the ILO envisages the importance of health care, prevention and safety as crucial elements of labour policies and practices for working out of poverty.

Discussion and Conclusions

Obstacles to Progress

Over the last decade, the link between health and poverty has become increasingly recognized by the global community. Gradually, more international organizations are acknowledging that the traditional methods of establishing growth and development in the Global South have to be altered to include determinants outside of the sphere of macro and microeconomic issues. Increasing funding for health issues, as well

as enhanced advocacy for health agendas that are not directly linked with poverty reduction is appearing on the scene within the global health sector. However, there is still a huge gap between words and actions. Although PRSPs claim greater inclusion of social determinants in their poverty reduction strategies, the health sector is still on the very bottom of most government's agendas and is forced to scrounge for funding to strengthen social programs.

Policies aimed at improving the health sector are also tragically flawed, due to the tendency of international organizations, national governments, and donor agencies to lean towards more "vertical programs" for health. Vertical health programs are initiatives that are 'disease-specific projects' whereas horizontal health programs are aimed 'towards more broad-based improvements in population health, such as preventive measures, primary care services, and health workforce development' (De Maeseneer 2008, 1). Studies have proven vertical health programs alone are not enough to improve the overall health of a society. The large amounts of funding invested in such vertical programs as AIDS, Tuberculosis and Malaria prevention are thus creating inefficiency and waste, due to the neglect of other cross-cutting issues that are pertinent to those campaigns. Due to the lack of communication between the different health care initiatives, many programs overlap and result in chaos and squandering of funds on the ground level. In an article published by the Royal College of General Practitioners, regarding the need for strengthening of primary health care systems, the authors argued that:

'The stronger a country's primary healthcare system, the higher the system's quality and cost-effectiveness and the greater its impact on health. Where income disparities are widest (most developing countries), the positive impact of primary care in redressing health disparities is greatest' (De Maeseneer 2008, 1).

With a greater incorporation of horizontal health programs and the

strengthening of health systems, it may be possible to speed up the progress of many of the health MDGs, such as reducing the maternal mortality rate and infant mortality rate, both of which are strongly linked with the strength of health systems and accessibility of health services within a country.

Related to the lack of horizontal programming in PRSPs is the need for greater multisectoral linkages during the design and implementation of poverty reduction strategies. Many indirect indicators of poverty, such as proper sanitation and water facilities, universal primary education, and decent work and income level are all intrinsically linked with the improvement of health and health systems, and indirectly involved in reducing the debilitating poverty-health cycle that plagues many developing countries. It is essential that all influential actors in the PRSP process realize the importance of inclusion of this multisectoral approach in looking at poverty and formulate policies accordingly.

One main obstacle to the achievement of greater incorporation of horizontal programming and social determinants of health into policy making and funding allocation is due to the structuring and ethos behind those international organizations with a firm hand in the development process of the poorest countries. One example of this would be the World Health Organization (WHO), the world's leader in health policy creation and proposals. Due to the largely bureaucratic nature of the organization, the WHO has many departments and clusters devoted to different health issues, but work towards greater health and the incorporation of social determinants of health gets lost in the mass of complex clusters and committees. Many of the obstacles the WHO faces in implementing social health policies are due to the constraints placed on them by their donors and member states. The WHO has now become heavily dependent on voluntary contributions from donors and this has added to its bureaucratic nature. It has been suggested by many academics and health professionals, that the conditions set by donors regarding the allocation of funding has prevented a more horizontal approach to health provision. An example of restrictions would be funding for HIV/AIDS

programs.

Although many health professionals have argued that funding for greater prevention and education programs would help decrease the incidence of HIV/AIDS, especially in Sub-Saharan Africa, it is difficult to allocate funding for such programs due to the abundance of conditions attached to HIV/AIDS funding. Also, many argue that social determinants of health are neglected due to the difficulty to produce quick results in these areas. Donors need to be able to show hard evidence that their money is being utilized efficiently and therefore do not have the time to wait for improvement in the social sector. This is also the case with national governments who do not have the time to implement social programs to improve healthcare during the PRSP creation stage, when the reception of debt relief depends on them presenting quick results to different donors and IFIs.

In 1978, WHO and UNICEF advocated for the Alma-Ata declaration on primary health care. This declaration acknowledged the need for greater equality in access to primary health as well as the impact of health on economic and social development. It proposed universal health care for all by 2000 (WHO, 1978). However, this goal was far from accomplished after the millennium. In fact, many contribute the disappearance of the advocacy for primary health care and inclusion of social determinants in health policy to the failed outcomes of the declaration. In an article published by the British Medical Journal, one professor at Yale University described the situation by saying,

“It became an unfashionable, if not ‘dirty word’ in the 1990s ... Health for All was tied up with a political battle for equity and inclusion. In the ‘90s, health policy came to reflect the prevailing ideology. An ideology which emphasised health systems reform — a market oriented approach informed by economic tools and neoliberal values” (Yamey, 2002).

Since this period, it has been hard for advocates of social

determinants to have their concerns recognized, due to the rejection of horizontal programming for development and the acceptance of vertical programs and economic policies as the accepted way of passage. This also poses a serious question for health policy during the post-Millennium Development Goals period. If the health MDGs are not achieved by 2015, as some most likely will not be, what will happen to the momentum for greater inclusion of social factors in poverty reduction strategies and health reform? Will the western organizations return to an emphasis on economics and trade or will the approach towards poverty reduction adapt and turn a new corner, leaving cross-cutting issues like education, rural development and gender equality in the dust?

The Impact of Trade Liberalization on the improvement of Health Systems

As the 2015 deadline for the Millennium Development Goals approaches, dialogue and ideas have been churning as to how to address the failure of health systems in developing countries and the subsequent lag in progress towards many of the health MDGs. One such topic is the question of trade liberalization and its possible impact on health systems in developing countries. The role of health systems in improving the performance of the health sector has been repeatedly emphasized throughout this paper, as well as by several academics and professionals in the field.

‘Health Systems require the availability of basic physical and human infrastructure throughout a country if they are to be effective and equitable. Countries need to invest in the development of this infrastructure, but many have no resources to do so’ (Global Health Watch, 2006, Chpt. B1: 59).

There have been several recent initiatives campaigning for the incorporation of trade into development policies. Examples of these

programs include the Enhanced Integrated Framework, finalized by the WTO in 2006, as well as the Doha Declaration on the TRIPS Agreement and Public Health, adopted in 2001. Both of these outlines provide ideas for the integration of freer trade policies in national development agendas.¹² However, whether or not trade liberalization of the health sector will have a positive or negative impact on health care, especially in the Global South, is still subject to heated debate.

There are four general modes of trade according to the General Agreement on Trade in Services (GATS):

‘Mode 1 occurs when a service is provided “from the territory of one member to the territory of another member;” Mode 2 occurs when the service is provided “in the territory of one member to the consumer services of another member;” Mode 3 takes place when a service is provided “by a provider from a member through the commercial presence in the territory of another Member,” and Mode 4 applies when a service is provided “by a provider from a Member through the presence of individuals from a Member in the territory of another Member”’ (Wasserman 1999, 124).

These modes become complicated when applied to the health sector because the involvement of trade in a social sector can threaten equity within the developing countries. However, many economists and policy makers argue that several health systems in the developing world are struggling to survive and can barely provide adequate health services for the poor as it is. They suggest creating an adequate security net to protect the most vulnerable from the ill effects that come with the opening of markets and free trade. In a 2005 conference held at the Woodrow Wilson International Center for Scholars, a panel of economists discussed the

¹² Visit the WTO website for further information regarding the Enhanced Integrated Framework as well as the TRIPS Agreement and Public Health: www.wto.org.

possible outcomes of increased trade liberalization on health systems in developing countries. There was a general agreement that ‘trade liberalization had a generally positive effect in stimulating economic growth and that growth often had the effect of reducing overall poverty’ (Wilson Center 2005). However, the panel acknowledged the necessity for governments to prevent the inequality gap from widening by implementing important safety net policies addressing issues of ‘income support, access to health care and education’ before trade liberalization took place (Wilson Center 2005).

An example of where trade liberalization has been tested is in the Latin American Region. There has been both a North-to-South exportation of health services (computer databases, diagnostic services and telemedicine, services related to pharmaceuticals, etc.) as well as a South-to-North exportation (non traditional approaches to health which appeal to the older and richer populations of the north) (Wasserman 1999, 125-126). An example of improved health systems through freer trade is seen in Colombia’s health sector. In 1993, Colombia reformed its health system by taking measures to increase the access of the poor. Private insurers took over management of the health care financing from the Social Security Fund and Health Ministry, but the government still regulated payments by the citizens. This plan was a success and ‘total coverage...grew from 6 million in 1993 to 22 million in 1996’, with the state paying in full for around seven million of its poor citizens (Wasserman 1999, 134).

Although there have been examples of growth benefits from trade liberalization, questions remain regarding measurements of the negative impacts open health markets may leave in the Global South, especially among the most poor and vulnerable. First, addressing Mode four of the GATS, many have argued this could aggravate the increasing problem of the “brain drain”, where skilled workers from developing countries are leaving to provide medical services in the developed countries, where there is an increased demand. Policy makers argue that with trade liberalization, this problem may worsen. However, the counter argument

by the World Bank is that

‘Mode 4 trade mainly refers to temporary stays of service suppliers abroad. The brain drain could therefore in principle rather take the character of “brain circulation”, as services suppliers return to their home country with increased professional experience’ (World Bank 2006, 28).

Also, many argue that while abroad, these skilled workers provide a large portion of revenue for their home country through remittances (money sent home by workers abroad). Therefore, although the brain drain could escalate in the beginning, there may be systems put in place that could prevent ill consequences for the developing world. A second problem that has been posed is the idea that if trade liberalization occurs and governments are no longer held accountable to their citizens but to private organizations, the results may lead to what is called “cherry picking”, where those labeled as a risky investment are left without insurance coverage or adequate healthcare. The World Bank responds again by saying that governments should institute appropriate safety nets such as requiring ‘all private hospitals to reserve a minimum percentage of beds for free treatment for the needy, to offer some basic medical services in remote rural areas, or to train beyond the number required for the purpose of these institutions...’ (World Bank 2006, 29).

The impact of such neoliberal ideas as free trade and investment on the health sector is still unclear and more research is needed in this area. However, with the MDG deadline fast approaching, health policy and poverty reduction strategies will once again be in the spotlight and the direction that the world will take next is still unknown.

Final Thoughts

For Poverty Reduction Strategy Papers to be successful, governments need to be reminded of the purpose of these documents.

PRSPs need to be less detached from national needs and goals and should be transformed from paper into action. It is necessary to have less of a focus on immediate results and more on the long-term picture for poverty reduction. Social determinants, although they may take longer and involve more short-term funding, are cross-cutting issues that if cured will prevent further economic and social destruction in the Global South.

Further development of PRSPs requires a greater emphasis on multisectoral connections between education, health, trade, rural development and governance. It is also necessary for greater inclusion of gender equality in poverty reduction strategies. Increases in gender equality and gender empowerment will improve the status and livelihood of women in developing countries allowing them to provide better healthcare for not only themselves, but their children as well. In addressing the health-education linkage, when women are given the power to provide for their children, they will also have more influence in provision of health care and championing of education. This is particularly important for the daughters of poor families, who are usually forced to stay at home at a young age, giving up education to the needs of the family. Due to the poverty-health cycle, when a household has a sick relative suffering from a disease such as HIV/AIDS, the family cannot afford to pay for health care for him/her and it is usually the young girls of the family who are forced to stay at home and provide care. Therefore, greater advocacy for gender equality in the PRSP process will not only provide better health outcomes, but also will improve the education and employment sectors of any given society.

Along with female empowerment, governments should increase funding towards better institutional capacities to improve monitoring systems and data bases within developing countries. Without the ability to track progress made in the MDG health indicators, it will be hard for governments to analyze what areas of the health system need greater aid and what parts of the population are suffering the most. Increasing institutional capacity will also decrease national governments dependence on western donor agencies and IFIs for data and tracking systems,

increasing national ownership during the PRSP process.

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Appendix

Appendix 1. Top and Bottom ten countries of the Least Developed Countries (LDCs) Data taken from the United Nations Statistics Division.

Indicators on water supply and sanitation

Last update: Dec 2007

Country or area	Improved Drinking Water Coverage (%)			Improved Sanitation Coverage (%)		
	2004			2004		
	Total	Urban	Rural	Total	Urban	Rural
Top ten of the LDCs						
Afghanistan	39	63	31	34	49	29
Angola	53	75	40	31	56	16
Bangladesh	74	82	72	39	51	35
Benin	67	78	57	33	59	11
Bhutan	62	86	60	70	65	70
Burkina Faso	61	94	54	13	42	6
Burundi	79	92	77	36	47	35
Cambodia	41	64	35	17	53	8
Cape Verde	80	86	73	43	61	19
Central African Republic	75	93	61	27	47	12
Bottom ten of the LDCs						
Somalia	29	32	27	26	48	14
Sudan	70	78	64	34	50	24
Tanzania	62	85	49	47	53	43
Timor Leste	58	77	56	36	66	33
Togo	52	80	36	35	71	15
Tuvalu	100	94	92	90	93	84
Uganda	60	87	56	43	54	41
Vanuatu	60	86	52	50	78	42
Yemen	67	...	65	43	86	28
Zambia	58	90	40	55	59	52

Source: 2007. *Social Indicators*. Geneva: United Nations.

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Appendix 2. Top and Bottom ten countries of the Least Developed Countries (LDCs) Data taken from the United Nations Statistics Division.

Indicators on income and economic activity

Last update: Dec 2007

Country or area	Year	Per Capita GDP (US\$)	Adult (15+) economic activity rate		
			Total	Men	Women
Top ten of the LDCs					
Afghanistan	2006	319	65	88	40
Angola	2006	2,855	82	92	74
Bangladesh	2006	437	70	86	52
Benin	2006	536	70	86	54
Bhutan	2006	1,422	66	81	49
Burkina Faso	2006	416	83	89	78
Burundi	2006	114	93	93	92
Cambodia	2006	453	77	80	75
Cape Verde	2006	2,153	54	76	34
Central African Republic	2006	333	80	89	71
Bottom ten of the LDCs					
Somalia	2006	283	77	95	59
Sudan	2006	934	47	71	24
Timor-Leste	2006	319	70	83	56
Togo	2006	356	70	90	50
Tuvalu	2006	2,441
Uganda	2006	346	83	86	80
United Republic of Tanzania: Mainland	2006	335	88	90	86
Vanuatu	2006	1,635	84	88	80
Yemen	2006	853	53	75	30
Zambia	2006	938	78	91	66

Source: 2007. Social Indicators. Geneva: United Nations.
<<http://unstats.un.org/unsd/demographic/products/socind/inc-eco.htm>>.

Appendix 3. Countries from the top and the bottom of the list of Least Developed Countries (LDCs).

Indicators on education

Last update: Dec 2007

School life expectancy (in years). Primary to tertiary education

Country or area	Year	Total	Men	Women
Afghanistan	2004	7 ^a	9 ^a	4 ^a
Bangladesh	2004	9	9	9
Benin	2001	7 ^a	9 ^a	6 ^a
Burkina Faso	2005	5 ^a	5 ^a	4
Burundi	2005	6 ^a	7 ^a	6 ^a
Cambodia	2004	10 ^a	11 ^a	9 ^a
Cape Verde	2005	11 ^a	11 ^a	11
Sudan	2000	5 ^a ^a
Timor-Leste	2002	11 ^a
Togo	2000	9 ^a	11 ^a	7 ^a
Tuvalu	2001	11 ^b	11 ^b	11
Uganda	2004	10 ^a	11 ^a	10
Vanuatu	2004	11 ^a	11 ^a	10 ^a
Yemen	2005	9 ^a	... ^a	7 ^a
Zambia	2000	7 ^a	7 ^a	6 ^a

Data taken from the United Nations Statistics Division.

Source: 2007. *Social Indicators*. Geneva: United Nations.

<<http://unstats.un.org/unsd/demographic/products/socind/education.htm>>.