1. **Introduction**

This report presents an analysis of Poverty Reduction Strategy Papers, or PRSPs, from a health perspective. It asks two distinct but related questions – to what extent is improved health seen to play a role in poverty reduction, and, to what extent does the health component of a PRSP identify, and propose strategies to meet, the specific health needs of poor people.

This review takes forward a report produced by WHO in late 2001.¹ The level of interest generated by that review prompted WHO to carry out a more detailed and systematic analysis which also includes new PRSPs not analysed in the initial review. A new framework for analysis was developed (see Annex 2), which was then applied to 10 full and three interim PRSPs. (See Annex 1 for list of countries reviewed.)

**Why look at health in PRSPs?**

PRSPs are important instruments of development policy for low-income countries (see box 1). As PRSPs are linked to accessing concessional loans, they have the potential to significantly increase funding for health programmes in poor countries. In addition, it is now generally accepted that health is central to economic growth and poverty reduction objectives, and therefore it is reasonable to expect PRSPs to include a significant focus on health.

This review also aims to facilitate an assessment of whether PRSPs include a significant focus on health and whether health is perceived to have an impact on poverty reduction. Furthermore, it gives a snapshot into the poverty focus of existing national health policies, as most PRSPs reflect or summarize these to some extent.

**What is the added value of this review?**

This review builds on the work of other development partners who have looked at the place of health in PRSPs, including the World Bank, the UK’s Department for International Development, and Wemos. This review attempts to go further in three ways:

- It seeks to examine the poverty context from a health perspective, and the health strategy from a poverty perspective. In order to do this, it traces the poverty-health links from contextual information provided in PRSPs through to the proposed strategy. In doing so it facilitates an assessment of how far the health strategy presented in the PRSP responds to the overall poverty-health analysis, and to what extent the impact and progress indicators are appropriate to the strategy presented.

- It seeks to determine how far the health components of PRSPs aim to improve the health of the poorest groups and the poorest regions. We believe this is important because, although many of the health strategies outlined in PRSPs are implicitly pro-poor, it is possible that targets will be achieved without reaching the very poorest.

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¹ Health in PRSPs, WHO Submission to World Bank/IMF Review of PRSPs, Department of Health and Development (HDE), December 2001.
It is based on a series of case studies of individual PRSPs, which should prove to be a useful resource for others interested in this topic. Each case study extracts from the PRSP all information relevant to health (not only from the health chapter but also from other sections) and presents this in an accessible form which other researchers can use to make their own analyses. Case studies will be available on line by end 2002.

**Box 1 – What are PRSPs?**

Poverty Reduction Strategy Papers, or PRSPs, are national planning frameworks for low-income countries. All countries wishing to access concessional loans from the World Bank (WB) or IMF, or wishing to benefit from debt relief under the Highly-Indebted Poor Countries (HIPC) initiative are required to produce a PRSP. As of September 2002, 18 countries have produced “full” PRSPs and around 35 more have produced interim papers and are in the process of preparing a full document.

The World Bank emphasizes that PRSPs should be written and produced by countries themselves, and go beyond macroeconomic stabilization and liberalization to address issues of poverty and equitable growth.

According to the World Bank, 26 countries have reached “decision point” under the HIPC initiative, and are now receiving debt relief which will amount to $41 billion over time (this represents 70% of total debt relief projected to be delivered under HIPC). Countries reach “decision point” once they have completed an interim PRSP which has been accepted by WB and IMF. Countries reach the “completion point” once they have implemented a full PRSP for one year.

**Anticipated increased in health spending**

World Bank figures suggest that social expenditure in decision point countries will increase from an average of 6% of GDP in 1999 to 9% in 2002, equivalent to an average increase of $830 million per year. The Bank adds: “increases in education and health spending are expected to absorb about two-thirds of the total [debt] relief, with about 40% directed towards education and 25% to health care”.² It is still too early to tell whether those projections will be realized.

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2. Methodology and report outline

A desk review of 10 full PRSPs and three interim PRSPs was carried out using a framework (Annex 2) developed by a team from WHO and an external consultant. The framework addressed the following seven main areas in order to analyse the poverty-health links. This report is structured around these areas.

**Poverty-health context**
1. Defining poverty
2. Examining the pattern of poverty
3. Examining the links between health and poverty

**Health-specific analysis**
4. Health services
5. Communicable and noncommunicable diseases (including HIV/AIDS)
6. Maternal and child health
7. Health-related sectors (e.g. water and sanitation, nutrition).

The main constraint of carrying out a desk review is that it is impossible to know how far the strategies presented in PRSPs reflect reality. A “good” PRSP may be a reflection of an excellent health strategy, or it may reflect the good writing skills of the author. Nevertheless, we believe that this review provides a valuable input to further discussion on the future direction of health policy in poor countries.