3. Poverty-health context[1]

The review looked at the way in which PRSPs define and examine poverty. This included looking at the level of information given about who is poor, and the depth of analysis of the links between poverty and health. This was seen to be vital as the poverty analysis provides the basis on which the overall poverty reduction strategy, and the health component, rests.

3.1 Defining poverty

- All PRSPs acknowledge that poverty is a complex and multi-dimensional phenomenon and make the point that a person's well-being does not rest entirely on their level of income. Non-income characteristics of poverty cited in PRSPs include: limited access to basic services such as education and health, insufficient levels of consumption, and vulnerability to disaster. This analysis implies that, as poverty is a multi-faceted phenomenon, a poverty reduction strategy will need to address an equivalent range of components.

- PRSPs use various methods to calculate poverty, including the poverty line, consumption levels, Unsatisfied Basic Needs indicator, Poverty Head Count Index and the Human Development Index. The detail given in the calculation of poverty varies across the range of PRSPs.

- Seven out of 10 PRSPs make reference to a qualitative or participatory poverty assessment (QPA - which seeks to analyse poverty means the perspective of poor people themselves), and six provide limited details of these assessments. References to QPAs are sporadic rather than systematic; only Niger used the findings to rigorously inform their health strategy. This suggests that PRSPs are not systematically based on locally-specific manifestations and perceptions of poverty.

3.2 Examining the pattern of poverty

The review assessed the extent to which the PRSPs identify the poorest regions or groups within the country. The purpose was to determine whether PRSPs establish a basis from which to apply methods of targeting the poor and vulnerable, and define indicators for monitoring the impact of the programmes on poor people. In other words, are the strategies and monitoring programmes outlined in PRSPs consistent with their analysis of poverty?

- Eight out of 10 full PRSPs identify the poorest geographical regions and provide comprehensive data in the form of statistics or poverty mapping, usually based on one or two methods of poverty analysis e.g. poverty line and consumption. All PRSPs state that poverty is more prevalent in the rural areas; and six say that urban poverty is widespread and/or on the increase.

- Most PRSPs make some analysis of regional disparities in poverty, but this was limited in some cases to one or two sentences, for example equating poverty with the distance from the capital city; with the incidence of armed conflict; or with the

[1] In this preliminary draft, analysis is confined to the review of full PRSPs. It is also important to note that the study team has not yet had the opportunity to check the frameworks for consistency – i.e. to make sure that those reviewed first are scored and analysed in the same way as those reviewed last.

topography or environment. Inequality is flagged up as a specific problem in only three PRSPs, reflecting a lack of attention to the issue.

- PRSPs are less clear in their identification of poor groups of people, and often do not distinguish between poverty, vulnerability and social exclusion. Broad categories of vulnerable groups are identified, such as food crop farmers, female or child-headed households, specific ethnic groups and older people. Six out of 10 PRSPs specifically link gender to poverty. **In several cases, health is a factor in determining vulnerable groups**, for example the physically and mentally disabled, and families caring for someone living with HIV/IADS. Five out of 10 PRSPs identify disabled people as poor or vulnerable.

3.3 Examining the links between health and poverty

The review sought to determine the extent to which the causal links between ill health and poverty and between good health and poverty reduction are examined. It went on to assess whether proposed health strategies are grounded in such an examination.

- Eight out of 10 PRSPs identify aspects of health in their definition of poverty (for example, high incidence of disease, lack of appropriate medical services). However, as mentioned above, any multi-dimensional analysis of poverty is limited.

- Six out of 10 PRSPs recognize **poverty as a cause of ill-health** but the analysis is usually limited to one or two sentences (e.g. “The poor are at greater risk of becoming ill”; “poverty affects access to health services”; “chronic and/or incurable diseases undermine the living conditions of those affected”) rather than a rigorous analysis which would provide the basis for a poverty-focused health strategy.

- Five out of 10 PRSPs recognize **ill-health as a cause of poverty** but again the analysis is sketchy. For example: “limited access to health services causes poverty”; “poor health…exacerbates the poor’s ability to climb out of poverty” “poor health has adverse affects on productivity, which contributes to poverty”.

- Poverty-health links are explored in detail in just four PRSPs. This is taken to mean that the PRSP points to specific health issues relevant to poor people. This issue is taken up in more detail in Section 4.

- While causal links between poverty and ill-health are insufficiently made in the majority of the reports, nine out of 10 PRSPs state that **improving health contributes to economic growth** and all PRSPs find a prominent place for health in their overall strategies. It is notable that only one PRSP states that improving health will improve well-being, and none mention health as a human right.

Summary points

1. All PRSPs recognize poverty as multi-dimensional, and in most cases state that ill-health is one characteristic of poverty. However, the analysis of the links between poverty and ill-health is sketchy in all but a few reports.

2. In PRSPs that do provide a more detailed examination of the links, clear justification is made for health to form a key part of the PRSP strategy. However, in others this prominent place may not be justified given the level of analysis provided in the PRSP.

3. The level of detail on the geographical distribution of poverty is fairly comprehensive, although this rarely extends to a geographically-disaggregated examination of the health dimension of poverty. Rural areas are unanimously identified as poorer, although several reports maintain that urban poverty is on the increase. Broad categories of poor and vulnerable people are identified, but less statistical detail is provided.

4. Best practice in this section was demonstrated by:

◊ a clear indication of the complex nature of poverty;
◊ an examination of how poverty affects ill health and how ill health affects poverty;
◊ an exploration of how improved health contributes to poverty reduction;
◊ a breakdown of varied health needs of poor people.