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BECOMING POVERTY-FOCUSED: IMPLICATIONS FOR HEALTH ACTORS

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Becoming poverty-focused: implications for health (2000, issues paper)

This paper explores approaches to understanding the links between poverty, vulnerability, exclusion and demand for health care, and outlines strategies to encourage an inter-sectoral and inclusive approach to health improvement and poverty reduction strategies. Developed with the Centre for Development Studies, Swansea University, and presented on behalf of DFID at the Partnership in Health and Poverty conference (International Poverty and Health Network), June 2000.

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ABBREVIATIONS

CDF	Comprehensive Development Framework
CESCR	Convention on the Elimination of Racial Discrimination
DFID	UK Department for International Development
HDI	Human Development Index
HIPC	Highly Indebted Poor Countries
ICCPR	International Covenant on Civil and Political Rights
PRSP	Poverty Reduction Strategy Papers
SL	Sustainable Livelihoods
SLA	Sustainable Livelihoods Approach
SWAps	Sector Wide Approaches
TOR	Terms of Reference
UNDP	United Nations Development Programme

EXECUTIVE SUMMARY

1. This paper explores the relationship between health sector interventions and poverty analysis. It is written by poverty specialists with a broad understanding of the potential role the health sector may play in the reduction of poverty. It seeks to answer the following question:
 - If health actors say that their work has poverty reduction at its core, what implications does this have for health sector interventions?
2. Emphasis is placed on a processual approach to poverty and health policy analysis. Long-standing health sector concerns, for instance in relation to equity, provide a valuable foundation on which relatively new frameworks for understanding poverty can be based. In this respect, these poverty frameworks may offer a new approach to tackling problems of illness and poverty, while building on long-established health sector knowledge and expertise.
3. To discuss how health actors can assist the poor to maintain health, a clear view must be held of what is meant by poverty and how to analyse it. The way poverty is conceptualised affects how it is measured, the type of interventions advocated, and the monitoring and evaluation of change. It is important to:
 - distinguish who the poor are;
 - encompass inequality and social exclusion;
 - capture the nature of vulnerability.
4. It is argued that health specialists and others need to recognize the complex strategic decisions made by the poor with respect to a range of material and non-material assets. Attention is focused on how the causes and impacts of ill-health can be tackled through a more comprehensive understanding of the dynamic relationship between health outcomes and the livelihood strategies poor individuals and groups adopt.
5. Insight into the decision-making and strategies of poor people is based on a conceptualization of poverty as a process, in which people's situation is dynamic and subject to change. This understanding of poverty recognizes that it has many different manifestations. These manifestations encompass the many features that render people vulnerable, from lack of access to a wide range of assets, goods and services, to poor health, lack of participation in decision-making processes and social exclusion.
6. This understanding of poverty is based on vulnerability models that share a concern with the ability of individuals, households and communities to manage change that affects their lives. A critical premise is that the poor are *not passive* and that they have *strengths* (as opposed to *needs*) that can be mobilised in development planning. We suggest this approach provides a powerful analytical entry point into considering how an agenda on health and poverty reduction might roll out as good practice in policy. We emphasise that a dynamic approach will provide operational momentum towards interventions that recognise and synthesise with complex strategies adopted by poor individuals, households and communities. We argue that the joined-up nature of the asset approach leads the health specialist towards an inter-sectoral approach and provides that extra stimulation to engage with often unwilling sector partners and with governments who are slow to own poverty reduction and health policies.
7. Adopting a broad view of poverty implies that analysis has to be based on a combination of methods and types of data. Both qualitative and quantitative data are necessary to address the wide range of issues that enter into a comprehensive poverty analysis. Thus, the

challenge is to achieve a trade-off between measurability - which requires standardisation - and local complexity. An issue for the health sector will be to find a means to integrate new methods for analysing poverty with existing methodologies.

8. The implications of a poverty-focused approach for health sector interventions are multiple. As a starting point there is a need to facilitate change from a managerial, top-down approach to health sector interventions, in which external actors determine necessary health actions, towards an inclusive approach that encompasses poor people's own health-promoting understandings and actions. In part this is a plea for the need to strengthen participation. Beyond this, however, a proper appreciation of the causes and nature of poverty would assist the health sector to identify key priorities, and to design of health interventions that can effectively target the poor.
9. Participation lies at the heart of a poverty-focused approach, both as a means to understand the nature of demand and problems of access, but more significantly to empower women and men to actively engage in the process of delivering health care and reducing poverty.
10. It is recognised that policy makers and practitioners in the health sector have been exposed to a long history of participation, with often negative results. However, in many cases, this has been the outcome of institutional fora or structures 'imposed' in the name of participation, as a consequence they are not locally owned and therefore not sustainable. If health sector interventions are to have a positive and sustained impact on the lives of poor people, the importance of building 'ownership' over an intervention and not rushing the process, cannot be emphasised enough. People must want to 'buy into' a new programme or project, which can only happen if they perceive it to have positive results for them, e.g. in terms of access or better health outcomes. If participation is to be successful and to become more meaningful within the health sector, the single most important message we can give is that this has to be based on a genuine commitment by key actors at a senior level.
11. A poverty analysis underlines the fact that a 'pro-poor approach' to health sector interventions is concerned with ensuring accessibility, quality, relevance and accountability for the poor. Means to this end include:
 - moving beyond a narrow sectoral focus on health issues;
 - reducing vulnerability by supporting the livelihood strategies poor people adopt in order to manage risk and generate positive livelihood outcomes;
 - increasing accessibility through an understanding of demand;
 - extreme poverty may require special measures to protect people from serious harm; policy directed towards this category is concerned with protection against adversity and deprivation, in preference to support for strategies or assets
 - ensuring consumer rights through realigning relationships with service providers.

1. INTRODUCTION

- 1.1 The objective of this paper is to explore the relationship between health sector interventions and poverty analysis. It is written by poverty specialists with a broad understanding of the potential role the health sector may play in the reduction of poverty.
- 1.2 Emphasis is placed on a processual approach to poverty and to health policy analysis. Long-standing health sector concerns, for instance in relation to equity, provide a valuable foundation on which relatively new frameworks for poverty analysis can be based. In this respect, these frameworks may offer a new approach to tackling problems of illness and poverty, while building on long-established health sector knowledge and expertise.
- 1.3 The paper seeks to answer the following question:
 - If health actors say that their work has poverty reduction at its core, what implications does this have for health sector interventions?
- 1.4 It is argued that in order to understand fully the significance of health in the lives of poor people and to design interventions that link improving health status more consciously to poverty reduction, health specialists and others need to recognize the complex strategic decisions made by the poor with respect to a range of material and non-material assets. Attention is focused on how the causes and impacts of ill-health can be tackled through a more comprehensive understanding of the dynamic relationship between health outcomes and the livelihood strategies poor individuals and groups adopt.
- 1.5 Insight into the decision-making and strategies of poor people is based on a conceptualization of poverty as a process, in which people's situation is dynamic and subject to change. This understanding of poverty recognizes that it has many different manifestations. These manifestations encompass the many features that render people vulnerable, from lack of access to a wide range of assets, goods and services, to poor health, lack of participation in decision-making processes and social exclusion.
- 1.6 The implications of a poverty-focused approach for health sector interventions are multiple. As a starting point there is a need to facilitate change from a managerial, top-down approach to health sector interventions, in which external actors determine necessary health actions, towards an inclusive approach that encompasses poor people's own health-promoting understandings and actions. In part this is a plea for the need to strengthen participation. Beyond this, however, a proper appreciation of the causes and nature of poverty would assist the health sector to identify key priorities, and to design health interventions that can effectively target the poor.
- 1.7 It is recognised that health professionals may have had direct experience of unsuccessful participatory initiatives, nonetheless it has to be stressed that participation is at the centre of a poverty-focused approach. For health interventions to have a sustained and positive impact on the health of the poor, it is essential that they are 'internalised' and 'owned' by the people concerned – this can only occur through people's full involvement in the intervention process. It should be emphasised that the many past examples of badly designed 'participation' imposed by external actors must not be confused with best practice. If participation is to be successful and to become meaningful within the health sector, the single most important message we can give is that this has to be based on a genuine commitment by key actors at a senior level.

- 1.8 To consider how poverty reduction can be at the core of international approaches to health, members of the Poverty and Health Contact Group have developed a 3-level framework on Health in Development (Appendix 1). This framework depicts the relationships between:
- determinants of health of the poor;
 - the protection and improvement of health outcomes; and
 - determinants of development.
- 1.9 The framework highlights the challenges we are confronted with in leading health sector policy towards poverty reduction outcomes. It facilitates an understanding of the way health interventions can contribute positively to social development. This paper uses the framework as a 'springboard' to focus on how the causes and impacts of ill-health can be tackled through a more comprehensive understanding of the dynamic relationship between health outcomes and the livelihood strategies poor people adopt through their access to a range of assets and resources.
- 1.10 Hence from a poverty perspective, an important addition to the framework is a box inserted between 'determinants of health of the poor' and the 'protection and improvement of health outcomes assets'. (See Appendix 1).¹ This box indicates people's access to assets and their livelihood strategies, and creates the analytical space to consider how poor people interact with policies and institutions to generate protection and improvement of health outcomes/assets.
- 1.11 The paper is divided into two main sections. Section 2 considers the analytical link between health and poverty. Section 3 explores the implications for health actors of becoming more poverty focused.
- 1.12 Appendix 2 is a glossary of definitions used in this report, indicating the conceptual frameworks from which these terms derive. Some of the terminology may need simple clarification. However, it is also the case that health and poverty specialists share a common language but impute different meanings to important terms.

2. FROM DESCRIBING POVERTY OUTCOMES TO ANALYSING POVERTY DYNAMICS

- 2.1 To discuss how health actors can assist the poor to maintain health, a clear view must be held of what is meant by poverty and how to analyse it. The way poverty is conceptualised affects how it is measured, the type of interventions advocated, and the monitoring and evaluation of change. It is important to:
- distinguish who the poor are;
 - encompass inequality and social exclusion;
 - capture the nature of vulnerability.
- 2.2 Conventional measurements of poverty identify a 'poverty line'. This defines poverty in terms of basic needs - deprivation resulting from inadequate command over commodities.² It provides an indication of overall incidence of income poverty and trends over time and may be useful to raise awareness, generate political momentum and monitor the impact of policy. However, sole reliance on poverty line measurements causes a number of problems:

¹ Compare also with the diagram of the Sustainable Livelihoods Framework (DFID) in Appendix 4.

² The poverty line remains the basis for poverty monitoring using large-scale sample surveys. It uses quantitative measurements that conceive deprivation in terms of a series of indicators based on income or consumption.

- it does not provide a sufficient basis for understanding causes and processes (e.g. relationships between employment, health, lack of access to health care, the socio-economic and political context, and the policy environment);
- it is defined by outsiders and neglects people's own definitions of poverty (e.g. lack of access to health services, ill-health and degrees of vulnerability);
- it implies that the poor are passive beneficiaries of external interventions, ignoring strategies for coping and securing well-being;
- it carries only limited capacity to illuminate the nature of poverty in particular communities, households or social groups, or to explain its continuation, reduction or deepening.

2.3 The UNDP has developed the Human Development Index (HDI) as an alternative to income / consumption measures of poverty. This index seeks to measure outcomes of deprivation based on indicators (national averages), such as:

- life expectancy
- infant mortality rates
- maternal mortality ratios
- access to education
- access to welfare resources

Although the Human Development Index provides a broader picture of human development outcomes the problems associated with poverty line approach and identified above still largely hold for broader welfare indices such as the HDI.

2.4 If the health sector wishes to place poverty reduction at its core, then a more sophisticated conceptualisation and analysis of poverty is needed. Current thinking on poverty views it as a *process* of change.³ It is both dynamic and multi-dimensional. This is in keeping with the definition of poverty adopted at the Copenhagen Social Development Summit in 1995.⁴

2.5 Vulnerability models of poverty, as described in Appendix 4,⁵ encompass poverty as a phenomenon with many different dimensions that can only be captured through context-specific understandings of people's lives and the environments in which they live. They share a concern with the ability of individuals, households and communities to manage change that affects their lives. A critical premise is that the poor are *not passive* and that they have *strengths* (as opposed to *needs*) that can be mobilised in development planning.

2.6 By providing a means to systematically analyse linkages between the causes, nature and consequences of poverty; vulnerability models are a tool that can help health actors improve effectiveness in targeting the health-disease-poverty nexus.

2.7 Health is a central component of human capital; it is a 'building block' needed for people to have the capacity to transform different assets into income, food and other

³ Lipton & Maxwell, 1992.

⁴ "Poverty has many manifestations, including the lack of income and productive resources sufficient to ensure sustainable livelihoods; hunger and malnutrition; ill-health; limited or lack of access to education and other basic services; increased morbidity and mortality from illness; homelessness and inadequate housing; unsafe environments and social discrimination and exclusion. It is also characterised by a lack of participation in decision-making and in civil society and cultural life...Absolute poverty is a condition characterised by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to services" (Para. 19, Chapter 2, Programme for Action, Social Development Summit, Copenhagen, 1995).

⁵ These models are the Asset Vulnerability Framework (e.g. Moser, 1998; Swift, 1989), the Sustainable Livelihoods Framework (e.g. DFID, 1999; UNDP, 1999), and the Risk Management Approach (e.g. World Bank, 2000).

necessities. Participatory studies have revealed that many people regard ill health as a core dimension of poverty, and thus over-coming it may be an objective in itself.⁶ Likewise, poor families may prioritize spending on health services over and above other expenditure in order to ensure that all household members are either working or studying.⁷

- 2.8 Poor people's capacity to gain access to assets that maintain health and access to health service providers will relate to who they are in a given social context. Therefore, it is critical to examine the social composition of a particular group and to reveal social divisions and sub-categories that exist within this group. Major social divisions may include: gender, age, ethnicity, kinship, caste, religion, and class. These social divisions will be associated with the power relations that shape differential access to assets, education and services.
- 2.9 Once social divisions are identified, analysis can turn to the institutional structures and social/political processes that contribute to poor health. (See Box 1). Over-coming institutionalized discrimination in relation to health services and provision is critical if human rights are to be respected, and if people's entitlement to the highest attainable standard of health is to be recognized in practice.⁸ (See Appendix 3 for details of international laws pertinent to health as a human right).

Box 1: Analysis of the Social Dynamics of Discrimination⁹

Social and political institutions and processes that contribute to poor health may include:

- urbanization and changes in kinship and social support structures (e.g. changes in extended family structures, rise in female headed households);
- employment structures and processes (e.g. lack of secure employment opportunities & exclusion from employment-based health insurance or pension schemes);
- poor participation (e.g. lack of voice that reaches key health actors);
- factors contributing to exclusion from access to health information and education;
- factors contributing to exclusion from access to productive assets and capital (e.g. gender relations, inheritance rights);
- processes by which groups are excluded from accessing services (e.g. by age, marital status, ethnicity, gender, disability);
- geographical location (e.g. rural area without access to services, urban periphery with long travel time to reach services).

- 2.10 Processes that have a positive or negative role on people's capacity to remain healthy and to cope with illness are played out in daily life (e.g. through people's diet, work, relationships, living conditions, sexual activity, etc.) and through exclusion from or inclusion within institutions and decision-making that affects their lives (e.g. informal organizations, health services, government departments, access to community leaders, etc.). In given contexts, different categories of poor people experience social discrimination and exclusion from health institutions in ways that have negative consequences for health maintaining behavior, for capacity to control fertility, and for support in times of illness.
- 2.11 Assessment of health care amongst minority groups or of people with different political and social identities can reveal the extent to which rights are unequally distributed in a given society. Repressive regimes may actively use the delivery or denial of health care and health-promoting initiatives as part of their political leverage. However, processes of

⁶ Chambers, 1989; Brock, 1999; World Bank, 2000.

⁷ Moser, 1998.

⁸ Right to health is enshrined in the Universal Declaration on Human Rights, it was central to the Alma Ata Declaration of 1978, and reinforced at subsequent international fora.

⁹ Source: Hawkins & Price, forthcoming: 2/4.

exclusion may also be institutionalised in apparently liberal contexts. Analysis of institutions and processes will reveal negative forces acting against poor people, but it may help to identify how people can be better linked to health care systems, both state and private.¹⁰

2.12 Once understanding has been gained of the institutional structures and processes that discriminate against certain categories of people, attention can shift to focus on individual, household and community vulnerability.¹¹ (See Box 2).

- The concept of vulnerability is concerned with the *capacity of individuals, households and communities to maintain well-being in the face of a changing environment*.¹²
- Attention is focused on the social, economic, political and environmental contexts in which people are placed at risk to ill health and disease.
- A key question relates to capability: in these circumstances, given this knowledge and these constraints, what scope does a particular group of people have for maintaining health/avoiding infection, or for diagnosing/acknowledging/treating infection once it occurs.¹³

Box 2: Understanding vulnerability

Vulnerability has 'internal' and 'external' factors. For example:

- life cycle change (e.g. physiological vulnerability in childhood, pregnancy and old age);
- inter-generational (e.g. a pregnant woman with inadequate nutrition may give birth to a low birth weight baby who subsequently experiences development problems, etc.);
- gender-based relations of power and control (e.g. unequal access for women to assets, information, etc.);
- local health knowledge and belief systems / health seeking behaviour;
- vulnerability due to exclusion based on caste, ethnicity, class, etc.;
- poor physical environment (e.g. poor drainage, sewage systems, impure water etc.).

2.13 People's capacity to remain healthy in a given context, and their resilience to negative change is shaped by their *strategies*. Namely, sets of decisions and choices people undertake to make a living and to achieve a sense of well being. These strategies will depend on the *opportunities* that are available and the *access* individuals; households and communities have to different *assets* in order to exploit these opportunities.

2.14 Vulnerability models of poverty distinguish between:

- *tangible assets*: material assets such as income, land, labour.
- *intangible assets*: such as social capital, good household relations and knowledge.

Poor people require both tangible and intangible assets to maintain health and to make a living (i.e. money is very important but it is not enough, and people may have assets even when they do not have money). (See Box 3).

Box 3: Assets¹⁴

The poor are managers of complex and changing 'asset portfolios'.¹⁵ These assets include:

¹⁰ de Haan, 1997.

¹¹ Health-related risk tends to be concentrated at the micro (idiosyncratic) level of the individual or household, with the exception of epidemics, which will affect groups of households, a community or region (see Appendix 4, section on risk management). Therefore this discussion on vulnerability is focused at the micro-level; however, it could be broadened to consider macro-level factors such as war, drought, financial crisis, global warming, etc.

¹² Moser & Holland, 1997.

¹³ Wallman, 1996: 232.

¹⁴ Source: Moser, 1998.

- Labour: ability to mobilise labour is critical as a means to generate income, to carry out productive and reproductive functions, and to respond to change at household level.
- Human capital: development of human capital is closely linked to economic and social infrastructure provision. Social services ensure people gain skills and knowledge, economic infrastructure together with health care ensure that they use their skills and knowledge productively.
- Housing: housing is commonly identified as a basic need, but it is also an important productive asset that cushions households against severe poverty.
- Household relations: play an important part in a household's ability to adjust to external change, with household composition and structure, and the cohesion of family members determining its ability to mobilise additional labour.
- Social capital: the extent to which a community itself can be considered an asset that reduces vulnerability or increases opportunities, depends on its stock of social capital, identified as the reciprocity networks, norms and trust that facilitate co-ordination and co-operation for mutual benefit.¹⁶

2.15 Emphasis is placed on the need to examine and understand the way people manage their assets in totality (see Appendix 4 for further details). An obvious, but nonetheless important point is that use of assets generally means depreciating them.¹⁷ Careful asset management means that people have to invest in assets rather than simply use them. Individuals, households and social groups cope effectively with change when they avoid irreversible damage to their net asset position. This is an important issue for health sector policy concerning payments for health care, as shall be discussed in Section 3.

2.16 Poverty outcomes, as measured by welfare indicators, are determined by the dynamic between changes that make people vulnerable, their access to assets, and the strategies they adopt. Although implicit, knowledge is a critical part of this process. Knowledge includes formal education and ability to use what is learnt, but it is also concerned with the 'everyday' understandings that, for example, shape people's health maintaining practices (e.g. women's knowledge of cooking, child rearing, house cleaning, etc.).

2.17 From this perspective, health and well-being are generated by people having:

- Ability to access assets, services, and education (formal & informal); and to integrate these features into daily lives;
- capacity to manage assets and transform them into income, food, shelter, etc.;
- ability to adopt strategies that reduce, mitigate and cope with potential health threats in a changing environment.

Each of these features is concerned with what the poor *do for themselves* to maintain health and attempt to alleviate poverty.

2.18 In this discussion, a distinction has been made between (i) the institutional structures and processes that generate social exclusion, and (ii) the vulnerability context in which threats to health arise. In practice the two are closely linked because the extent to which poor people are vulnerable, and the way change impacts on their lives, will be mediated

¹⁵ See Appendix 4 and compare the different categorisation of assets in the Asset - Vulnerability and the Livelihoods Frameworks.

¹⁶ Putnam, 1993 cited in Moser, 1998.

¹⁷ With the exception of social capital, which tends to increase with use and erode when *not* used e.g. a relationship is maintained with one's neighbour when interaction and mutual support occurs on a regular basis. In this case social capital is being used but at the same time regenerated (World Bank, 1997).

by institutions that shape access to health maintaining assets and services. Institutions also play a role in the achievement of inclusion and human rights.¹⁸

- 2.19 A broad view of poverty that encompasses an understanding of what makes poor people more or less vulnerable, can help to:
- address the complex causal processes that perpetuate poverty and ill-health, rather than focusing attention on managing the [health] consequences of poverty;¹⁹
 - enable health actors to develop context-specific understandings of poverty and key health drivers, and to situate these understandings within a broader frame of reference;
 - identify the interfaces between macro-level processes and institutions and individual, household or community assets or strategies (i.e. this is essential to understand the potential impact of health/development policies on people's lives);
 - understand rationales behind the ways poor people act in different circumstances (e.g. why and when different types of health care are sought);
 - justify policies that target people identified as deprived and socially excluded (e.g. targeting particular social groups, or providing a regional focus);
 - facilitate the formulation of health policies tailored to support poor people's livelihood strategies without contributing to further poverty (e.g. through prioritising support to certain categories of people such as the disabled);
 - help specific categories of people to access health education (e.g. women) and to design appropriate health education messages.

Methodologies for Poverty Analysis

- 2.20 Adopting a broad view of poverty implies that analysis has to be based on a combination of methods (contextual and non-contextual)²⁰ and types of data (qualitative and quantitative). The distinction between methods and data is an important one for poverty analysis. Literature often labels both the methods employed and the type of data collected as "quantitative" or "qualitative". However this creates a problem when analysing what the comparative advantages of different methods and data types are in understanding poverty and vulnerability. Therefore, "those data collection methods are labelled contextual which attempt to understand poverty dimensions within the social, cultural, economic and political environment of a locality".
- 2.21 A further common confusion is that participatory methods and qualitative data are one and the same. This is not the case; while participatory methods are contextual and yield qualitative data, it does not follow that all qualitative data is generated through participation. This is an important distinction, a decision to use or reject particular participatory methods has to be made separately from decisions concerning the type of data (qualitative/quantitative) on which poverty analyses, monitoring or evaluation are to be based.
- 2.22 The method-data framework below (see Box 4) presents an overview of the potential scope of combination of method (contextual or non-contextual) and data type (qualitative or quantitative) as a way of fulfilling different information requirements.

¹⁸ Appendix 4 contains a diagram of the Sustainable Livelihoods Framework (DFID) this illustrates the connections between institutions & processes and vulnerability context.

¹⁹ Sköld, 1990.

²⁰ Henschel, 1998: 8. See also Booth et al. 1998.

Box 4: The Method-Data Framework²¹

METHODS	
<p>* Participatory Analysis * Ethnographic investigations * Rapid assessments</p>	<p><i>more contextual</i></p> <p>* Longitudinal village surveys</p>
<p>DATA <i>more qualitative</i></p> <p>* Qualitative module of questionnaire survey</p>	<p><i>more quantitative</i></p> <p>* Household and health surveys * Epidemiological surveys</p> <p><i>less contextual</i></p>

2.23 Different, but complementary, types of data facilitate an understanding of the complex social realities that affect the utilisation of health facilities and health care decision making by poor people.²²

2.24 Both qualitative and quantitative data are necessary to address the wide range of issues that enter into a comprehensive poverty analysis. (See Box 5).

- The challenge is to achieve a trade-off between measurability - which requires standardisation - and local complexity. This challenge may be greatest at the level required for sector-wide planning.²³

Box 5: Issues for Poverty Analysis²⁴

To establish a poverty profile of a given population a range of issues need to be addressed. For example:

- Current estimates of poverty levels have to be ascertained (e.g. poverty ratio).
- National data have to be examined to see how poverty is defined (e.g. by per capita income, income distribution, distribution of welfare, access to resources).
- Variations in levels of poverty have to be considered (regional, urban-rural, gender disparities, disparities between ethnic groups, seasonality).
- The most disadvantaged groups/groups with highest incidence of poverty have to be identified (e.g. ethnic groups, rural women, agricultural labourers).
- An important issue is whether the poverty profile is reflected in key health indicators (e.g. national and regional infant mortality rate, maternal mortality ratios, HIV sero-prevalence data – i.e. are certain groups absent from the health picture? Or, is there a 'lack of fit' that needs to be examined?).
- Gaps in existing poverty assessments have to be identified (e.g. are perspectives of the poor represented?).

2.25 A further common confusion is that participatory methods and qualitative data are one and the same. This is not the case; while participatory methods are contextual and yield qualitative data, it does not follow that all qualitative data are generated through participation. This is an important distinction, a decision to use or reject particular

²¹ Source: Henschel, 1998, 10.

²² Henschel, 1998.

²³ Maxwell, 1999.

²⁴ Based on Hawkins & Price, forthcoming: 2/3.

participatory methods has to be made separately from decisions concerning the type of data (qualitative/quantitative) on which poverty analyses, monitoring or evaluation are to be based.

2.26 The views of the poor are crucial to understanding the multi-dimensional nature of poverty and its relationship to health. Participatory studies clearly demonstrate that different kinds of poor people experience their lives in very different ways.²⁵ Examples of local difference:

- Geographical difference: in rural areas emphasis may be placed on food security, as well as lack of work, money and assets. In urban areas, emphasis may be placed on the living environment, crowded, insanitary housing, lack of access to water, dangerous streets, violence within and outside the household.
- Vulnerability of particular groups within a community: the old, women, children, the disabled, and those living alone, isolated from social networks.

Successful pro-poor health strategies must involve poor people in identifying the causes and effects of ill health and poverty. Participation is also a crucial step in empowerment of the poorest and a pre-requisite for ensuring that health outcomes contribute to the building of human capital as part of long term poverty reduction strategies.²⁶

2.27 A conceptualisation of poverty as a multi-dimensional phenomenon implies that analysis is based on a combination of methods (contextual/non-contextual) and data types (qualitative/quantitative). Participation will also be an important component of methodologies for generating qualitative data. A challenge for the health sector will be to find means to integrate this with health methodologies.

3. REVISITING POLICY ANALYSIS FOR HEALTH CARE

3.1 The implications of a poverty-focused approach for policy analysis are explored in this final section. It is first helpful to remember the question this paper set out to address, as stated in the TOR. Namely, if health actors say that their work has poverty reduction at its core, what implications does this have for health sector interventions?

3.2 A poverty analysis underlines the fact that a 'pro-poor approach' to health sector interventions is concerned with ensuring accessibility, quality, relevance and accountability for the poor. In order to meet these concerns, a number of key policy issues will have to be tackled. These include:

- How to target interventions most effectively to reach the poor.
- How to prioritise services and interventions that will have a positive impact on the health status of poor and vulnerable people.
- Where to locate health facilities so they can be fully accessed by the poor.
- What is the best use of the resources that are actually available for health sector policy to generate positive outcomes for the poor?
- How can bridges be made between the public and private sectors (where the poor spend most of their money on health care)?

3.3 Resolving these issues must be achieved through an emphasis on the process aspect of a poverty focus. This means consulting key stakeholders including the poor themselves, raising the voice of the poor in challenging existing service provision, and, where appropriate, including the poor in the institutional design and delivery of health care.

²⁵ Brock, 1999.

²⁶ EU, 1999c: 1.

Moving Beyond a Narrow Sectoral Focus on Health Issues

- 3.4 Sector-based planning implies that social life and social needs can be catered for through division into discrete sector-based activities. Crucially, the poverty analysis frameworks reviewed in this paper share a common conceptual concern with the holistic decision making of poor people, and with cumulative characteristics that keep poor people deprived. When a mother decides to buy life-saving drugs for her child, she denies the possibility of more strategic investment in human capital for herself or other family members. Long periods waiting in queues for hospital treatment represent a major opportunity cost for women. A decision to change health-seeking behaviour with respect to HIV risk reduction threatens at the same time to undermine the social status of a woman as part of important intangible social capital networks. Applying this understanding to policy analysis therefore creates an imperative to situate health interventions within a more comprehensive and dynamic policy framework.
- 3.5 The recent World Bank policy innovation of the Comprehensive Development Framework (see Box 6) provides an encouraging momentum towards a cross-sectoral perspective that places social development at the centre of public action. Action on the Comprehensive Development Framework is, however, in its infancy. Thus, for the present, emphasis has to be placed on generating synergies between health and other sectors.

Box 6: The Comprehensive Development Framework (CDF)²⁷

The Comprehensive Development Framework takes a holistic approach to development. It seeks a better balance in policy making by highlighting the interdependence of all elements of development - social, structural, human, governance, environmental, economic, and financial. It seeks to move beyond discrete indicators of economic performance and human capacity to address "the fundamental long-term issues of the structure, scope, and substance of social development".

- Ownership by the country, which determines the goals and the phasing, timing, and sequencing of its own development programs.
- Partnership between governments, civil society, donor agencies and the private sector in defining development needs and implementing programs.
- Long-term vision of needs and solutions built on national consultations, which can engender sustained national support.
- Equal and contemporary treatment of structural and social concerns with macro-economic and financial concerns.

- 3.6 Agencies working in the health sector recognise that a broad approach is needed to make health central to economic and human development; although by the same token they do not wish to reproduce the shortcomings of 'integrated' development projects.²⁸ Furthermore, it is recognised that in-country planning takes place on a largely sectoral basis, and that this has to be encompassed by future health policy. For example, recognition that education, livelihood, food security and social integration activities need to complement health sector policies and programmes at country and global level, has led DFID to be involved in programmes which generate links between health and other sectors.²⁹

²⁷ World Bank, 2000a/b.

²⁸ DFID, 1999a; EU, 1999b; WHO, 1999a; World Bank, 2000b.

²⁹ DFID, 1999a: 21.

- 3.7 In this regard, a vulnerability model, such as the Sustainable Livelihoods (SL) Framework (see Appendix 4), can assist in drawing out and sequencing key priorities and entry points for intervention.³⁰ Furthermore, application of the SL Framework – and the participatory approach it implies – may help prevent interventions from being appropriated by the non-poor, although it is recognised that this is a difficult issue.
- 3.8 The Sustainable Livelihoods framework also points to the need for health programmes to give due emphasis to the development of local institutional structures and processes. Strong structures and processes may help generate an enabling environment in which the broader determinants of health, such as education, sanitation and water provision, can be addressed.³¹ Conversely, pro-poor health programmes that neglect the development of local institutions are unlikely to be sustainable.

Participation

- 3.9 Participation lies at the heart of a poverty-focused approach, both as a means to understand the nature of demand and problems of access, but more significantly to empower women and men to assert their rights in the face of highly corrupt and non-transparent service providers, and to break down the passive client-provider relationship in actively engaging in the process of delivering health care and reducing poverty.
- 3.10 It is recognised that policy makers and practitioners in the health sector have been exposed to a long history of participation, with often negative results.³² For instance non-representative or non-functioning village health committees, or inappropriate village demands such as for hospitals. However, in many cases, these negative results have been the outcome of institutional fora or structures ‘imposed’ in the name of badly designed participation; as a consequence they are not locally owned and therefore not sustainable. The importance of building ‘ownership’ over an intervention, and not rushing the process, cannot be emphasised enough. People must want to ‘buy into’ a new programme or project, which can only happen if they perceive it to have positive results for them, e.g. in terms of access or better health outcomes. This does not only refer to the level of the community, but also to those employed within the health service.
- 3.11 The design of community-level, poverty-focused initiatives requires direct consultation with the poor to learn about what they consider to be health care priorities in their communities. Moreover, a poverty-focused approach must recognise that interventions will be more likely to succeed if they are internalised, owned and implemented by the poor.³³
- 3.12 At policy level, health and related specialists in donor and other agencies can take a number of steps to ensure successful application of participatory principles. The approach based on Poverty Reduction Strategy Papers (PRSP) presently being piloted by the World Bank with HIPC-eligible countries represents a potentially significant step towards the institutionalisation of participatory approaches in dialogue and policy analysis with national governments and civil society.³⁴ The PRSP offers civil society a role in shaping and implementing national anti-poverty reduction strategies. In principle

³⁰ Carney, 1998.

³¹ WHO, 1999a.

³² Participation is not new in the health sector, the idea of community involvement was enshrined in the Alma-Ata Declaration on primary health care in 1978 (Rifkin, 1990).

³³ World Bank, 2000b; McGee & Norton, 2000; IDS 2000b.

³⁴ See for example World Bank, 1999a.

it offers an unprecedented opportunity for development efforts to re-focus on poverty reduction and for civil society organisations to influence anti-poverty policy.

3.13 Important steps for participation include:

- *Building the case for participation.* The most important precondition for a successful participatory approach is political will on the part of central government and commitment by key actors. Governments need to be as interested as the donor, and ideally more so, in participatory approaches if their efforts are to be sustainable. Health and related specialists can show borrowers the value of adopting policies and procedures conducive to stakeholder involvement in development efforts. Such awareness raising can be achieved through policy dialogue, country and sector studies and sharing practical, positive examples from inside the country and elsewhere.
- *Building stakeholder inclusion early into policy discussions.* This will involve early identification and analysis of primary and secondary stakeholders (typically through social assessment), and the employment of appropriate techniques for facilitating dialogue among stakeholders, such as focus groups, workshops, conferences and video technology.
- *Supporting participatory initiatives:* policies, programmes and institutional reforms which assist governments to interact better with a broader range of stakeholders, especially the poor.
- *Supporting policy analysis that involves local agencies and participatory processes:* by building capacity and subsequent supporting in-country agencies to conduct (and local governments to support) participatory studies relevant to donor concerns, such as monitoring SWApS.

3.14 Participation can be employed at all levels of intervention - macro, sectoral, programme and project - and at each stage of planned interventions from identification to evaluation (see Table 1).

Table 1: Participatory Possibilities for Primary Stakeholders³⁵

	Identification	Design	Implementation	Monitoring & Evaluation
Objective	Identifying and prioritising the concerns of the poor	Facilitating analysis and action by the poor to fully realise the potential benefits of interventions and partnerships	Harnessing the poor as actors in development, not passive recipients	Incorporating poor peoples' viewpoints into evaluation feedback
Policy/Macro	Which features of the policy environment are seen as harmful or irrelevant by the poor; what are their key macro-related concerns (e.g. inflation, credit or employment)?	Representative structures which allow for the concerns of the poor to be heard.	Representative structures which allow for the concerns of the poor to be heard.	Do poor people's perceptions correspond with the "real data"? What can participation say about barriers to benefiting from growth?
Sector	What are the sectoral priorities	How can services be designed (and how	Participatory structures at the	Canvassing the views of the

³⁵ Holland & White, forthcoming.

	of the poor (e.g. which level of health service, which types of road?)?	might institutional structures and processes be changed) so as to maximise accessibility/use by the poor (including exemption mechanisms? What do participatory approaches suggest about willingness to pay?	local level	poor on sectoral issues and institutional performance
Project	Which potential project activities are identified by the poor and how prioritised?	If there are a range of design alternatives, which are preferred by the poor?	Representation in project management activities	Participatory evaluation e.g. Calcutta Slum Improvement Project

- For participation to be meaningfully integrated into policy and programme design, the timing and phasing of some health interventions may need to be re-visited, with a longer pre-intervention lead in period.
- Participatory approaches need to include political and sectoral decision-makers to generate political commitment and ownership of a donor funded programme. (See Box 7).³⁶

Box 7: An Example of Participation by Health Sector Staff

The Ghana Health Sector Strategy³⁷

In the preparation of the Ghana health sector strategy there was wide participation through regional, district and local level regular consultations involving stakeholders from all levels of the central Ministry and the district level, as well as with key representatives from the central government agencies. The considerable effort devoted to two-way communication with staff at all levels has been sustained, and is a major strength of the programme. The May 1999 Annual Review involved a wide cross-section of staff, and field visits confirmed strong understanding and commitment down to district level and below. Indeed local participation was so intense that some donors felt marginalised. In order to keep the process manageable, large six monthly meetings with strong involvement by local stakeholders had to be supplemented with smaller 'business meetings' at which concerns of Government and donor partners could be raised openly, and addressed in greater detail.

- A recent review of Participatory Poverty Assessment findings, along with related participatory studies on demand responses demonstrated the expertise and willingness of the poor to engage in dialogue and identify problems and solutions in public service delivery.³⁸ An example of consultation in service delivery is included in Box 8.

³⁶ World Bank, 1996.

³⁷ Source: Foster et al., 2000: 38 citing the 1999 Health SIP Review.

³⁸ Brocklesby & Holland, 1998.

Box 8: Consultation on Service Delivery

The Benue Health Fund's Drug Revolving Fund, Nigeria³⁹

The BHF Drug Revolving Fund (DRF) is a PHC programme aimed at bringing affordable and high quality drugs to rural communities on a sustainable basis. The client group that is permanently or temporarily unable to pay for health care at the PHC facility is of prime concern to the BHF. The DRF aims to increase access for this group whilst at the same time sustaining itself through self-financing and community management.

Local analysis of poverty and coping strategies revealed that treatment of illness was a common cause of borrowing among the rural poor. In some instances, community associations may provide interest-free loans for health care purposes. In other cases, an informal clinic-based deferrals system may be an important source of credit for health care. However, even where a clinic-based deferrals system is apparently functioning well, the poorest are unlikely to make use of such a system if they have no confidence in their ability to repay. While it was generally acknowledged that in such cases there is a social obligation for the kindred or the community to provide support, this does not always translate into action quickly enough to be of benefit. Death triggers a timely response in terms of social assistance while sickness is commonly ignored until it is too late.

This underlines the importance of readily-accessible financial assistance for the poorest in cases of urgent need.

The consistently recurring first choice for treatment was said to be a hospital or clinic, more so now that new, effective and cheap drugs are available. Yet many people, mainly in poor and vulnerable categories, are unable or unwilling to use PHC. The lack of credit availability exacerbates this pattern. Furthermore, awareness of the scheme, generally quite high, was lowest among the most vulnerable groups. All these findings threaten the success of a poverty-targeted Deferrals and Exemptions scheme. Nevertheless, the community consensus was to start such a scheme, funded by collective effort (with various modalities put forward) and under trustworthy management.

Alternative management options included elders and clan representatives either at community level or at clan level. In some cases lack of confidence in the management skills of community members prompted some to recommend control by the BHF! Some argued that those closest by blood ties to the beneficiary should carry more of the burden. Fears of decapitalisation pervaded, however, as reflected in the opinion of many that eligibility for deferrals should be based on credit-worthiness. Emergency cases were also mentioned in connection with deferrals. Exemptions were approved of only if they did not encourage "inappropriate" behaviour, such as passivity, ingratitude and indiscipline. Study participants identified qualification criteria, including the lack of any close relations, disability and poverty and vulnerability more generally. Responsibility for targeting the D&E system was argued by some to be best handled by the VDC or by existing groups of elders. In some instances, community members argued for a new, separate committee for targeting and monitoring.

This operational research programme suggests a number of important areas for the design of the pilot D&E scheme. Notably, exemption is in principle more acceptable than deferral, while at the same time the analysis of seasonal stresses on access underlined the potential importance of a deferral system. Study participants seemed clear on generic groups eligible for exemptions but challenges remain in moving beyond tokenism and in identifying self-reliance alongside welfarism. The site for location and administration of the D&E scheme will be a major issue, with clear distinctions emerging between community level and clan schemes, the latter offering greater certainty of physical and social proximity. Finally, sustainable options for generating income might include in the long term the relatively marketable area of livestock farming, although shorter-term options such as rolling contributions and levies might need to be considered.

³⁹ Anyebe et al, 1999.

- 3.15 The importance of creating an enabling environment to address the health needs of poor people, raises the necessity of ensuring that there are no sources of systemic institutional bias that prevent health policy from being responsive to the needs and realities of poor and socially excluded groups.⁴⁰ This is an issue for national down to local levels.

Increasing Accessibility through an Understanding of Demand

- 3.16 It has been acknowledged that achieving a meeting between an effective and efficient 'supply side' with a pro-active 'demand side' is an emerging challenge for health policy.⁴¹ A poverty-focused approach compels policy makers to recognise the constraints and costs to access that impinge upon the poor as they make decisions about health and related consumption.
- 3.17 A broad conceptualisation of demand will encompass an understanding of both poor people's priorities and problems, and the social contexts within which health, illness, and poverty are experienced (See Box 10).⁴² A recent 23 country consultation process was carried out within poor countries as a background study for the World Development Report 2000.⁴³ This consultation process demonstrates how open-ended and largely qualitative methods provide valuable information on prioritising funding allocation and policy content within sectors based on local perceived priorities and on existing access, quality and relevance as perceived by both local service users and local service providers.⁴⁴

Box 9: Understanding demand

Messages from the poor

A recent review of Participatory Poverty Assessment findings⁴⁵, along with related participatory studies on demand responses⁴⁶ demonstrated the expertise and willingness of the poor to engage in dialogue and identify problems and solutions in public service delivery.⁴⁷ The following key dimensions of service provision emerged:

Financial barriers to access. High and often increasing, costs of public services imposed a severe constraint on access for the poor, particularly in a policy context of increasing cost recovery through user charge introduction. Financial access was affected further by the coincidence of costs with seasonal 'stress points' of disease and livelihood vulnerabilities. Cost recovery without effective safety nets threatened to compromise the potential equity and efficiency benefits of reform. The rural poor were constrained by a low level of liquid assets. Intra-household prioritisation of consumption was mediated by gender roles and opportunity costs. A more flexible approach to user charges was called for, backed by special targeted help.

⁴⁰ Norton & Bird, 1998.

⁴¹ DFID, 1999a; WHO 1999a.

⁴² Hawkins & Price, forthcoming: 1/4 -1/5.

⁴³ World Bank, forthcoming; Narayan, 2000.

⁴⁴ Brocklesby & Holland, 1998.

⁴⁵ Ibid.

⁴⁶ See, for example, Booth D et al, 1994. "Coping with Cost Recovery: A Study of the Social Impact of and Responses to Cost recovery in Basic Services (Health and Education) in Poor Communities in Zambia", Report to SIDA, commissioned through the Development Studies Unit, Department of Social Anthropology, Stockholm University

⁴⁷ Brocklesby & Holland, 1998.

Physical barriers to access. Rural users linked physical isolation to limited mobility (particularly in climatic zones with high seasonal rainfall), inadequate geographical coverage of services and low levels of community outreach. Rural participants in seasonal rainfall zones called for all-weather roads and access to transport systems. Urban users emphasised the relationship between public safety (strongly linked to gender roles and relations) and access to services.

Social, cultural and political barriers to access. Socio-cultural constraints on girls' access to key services emerged in many contexts and women's ability to juggle their time commitments often restricted their access. Access to information was often a critical constraint to both individual and community access to public services. Provider attitudes (of rudeness or indifference) to users was an important constraint, compounded by complicated procedures and processes for accessing services. Political exclusion was articulated in terms of perceptions of corruption and clientelism among providers and powerful users.

Quality of provision. Concerns across services related to levels of supplies, staffing levels (and related waiting times) and performance, adequacy of space and cleanliness. Participants called for greater accountability of government departments.

Relevance of provision. In different sectors and in different contexts, the supply of services did not always match the expressed needs of the poor. Participants expressed a demand for greater involvement in the design of public services.

- 3.18 From a community perspective, demand, access and quality may be hard to separate. Access determines whether an interested individual is able to make contact with a service. Once contact has been made, quality of care affects a potential client's decision whether to use a service or product.⁴⁸ Quality of care can therefore significantly affect demand as well as on access.
- 3.19 Approaches to increasing marginalised and vulnerable groups access to health care and services need to be based on an understanding of health-seeking behaviour and the needs of primary stakeholders. Ways of increasing access may include:
- support to self-help groups and community-based care and support networks (e.g. for people living with HIV/AIDS);
 - support to micro-credit schemes to reduce economic vulnerability and insecurity among poor and marginalised groups;
 - strengthening women's rights and health networks;
 - strengthening men's informal and formal networks to address issues of gender equity and sexual and reproductive health;
 - strengthening existing mechanisms for community participation;
 - strengthening the capacity of community-based groups to undertake advocacy work.⁴⁹

Reducing Vulnerability by Supporting Informal Institutions and Strategies for Managing Risk

- 3.20 To protect the health of the poor and to ensure access to health without generating greater poverty, a social welfare approach that considers what can be done *for* the poor is not enough. The sustainable livelihoods approach urges policy analysts to support what the poor *do for themselves* to maintain health, to generate health creating environments, and to cope with illness. This means building into health and poverty

⁴⁸ Bertrand et al. 1995: 65.

⁴⁹ Source: Hawkins & Price, forthcoming: 2/16.

reduction programmes a greater understanding and recognition of the reality of poor people's lives.⁵⁰

- 3.21 Three areas where assistance can be given to poor people's own health-maintaining actions are: actions that maintain people's asset base; support for people's strategies; and capacity to manage assets in a sustainable fashion; and, creating enabling environments for behaviour change, as elaborated below.

Asset Management

- 3.22 People's capacity to manage their assets must be reinforced, not undermined. This is true both for those living in poverty and for those 'non-poor' who are vulnerable to poverty. It is critical to design policies that reduce the risk to individuals, households, and communities of losing assets at times of economic downturn or events with negative impact. (See Box 10).

Box 10: Support for People's Asset Base

Three important means for the health sector to support people's capacity to manage their assets through appropriate policies are by:

- preventing families from suffering catastrophic payments for health care (i.e. poverty enhancing/producing); and,
- preventing poor people from wasting money on ineffective or over-priced health care;
- enabling individuals/families to control their fertility in terms of size and spacing.

Strategies

- 3.23 Health sector policy needs to be guided by and sensitive to existing informal strategies and coping mechanisms to manage potentially negative change and to promote well being. Policies that recognise and synthesise with people's strategies to cope, mitigate or prevent health problems are particularly important (see Table 2, especially shaded area). Bennett et al. (1998) argue persuasively for facilitating community contribution to health risk mitigation, thus allowing limited external resources to be directed at improving the quality and accessibility of health service provision.

Table 2: Mechanisms for managing health-related risks⁵¹

	Informal mechanisms		Formal mechanisms	
	Individual & household	Group-based	Market-based	Publicly provided
Risk reduction	-preventative health practices -migration	-collective action -common property resource management (e.g. of water supply)		-Pro-poor public health policy -Infrastructure to improve environment (drainage, sewage, water, garbage disposal)
Risk mitigation - portfolio diversification	-investment in human capital -diversification of income sources	-rotation savings and credit associations -occupation/church	-savings accounts in financial institutions -micro-finance	

⁵⁰ WHO, 1999a.

⁵¹ Adapted from World Bank forthcoming: 5.14 [Holzmann & Jorgensen, 1999].

- insurance	-marriage & extended family	associations -investment in social capital (e.g. networks, associations)	-old age annuities -accident & disability insurance	-health and disability insurance -pension systems
Risk coping	-diversion of income to pay for medicine -support for child at expense of mother's health -sale of assets	-transfers from mutual support networks	-sale of financial assets -loans from financial institutions	-social assistance

- Referring specifically to strategies people employed to try to *prevent* or *reduce* health risks. Preventative health measures have a set of accepted methodologies, encompassing, for example, fertility, education, water, and communicable diseases. However, these measures should not be confused with people's own prevention strategies, which health policies also need to support.
- Understanding the interplay between an individual or family's asset management and the strategies adopted to generate positive livelihood outcomes, can assist interventions that seek to enable people to have control over their fertility.

3.24 Linkages between literacy, health care and improved access to other resources can help in the generation of better resilience, creating effective safety nets, and well-being can help encompass change to people's poverty status.⁵²

Enabling Environments for Behaviour Change

3.25 Vulnerability models place an emphasis on the need for context specific understandings of poverty. Social behaviour is embedded within specific social relations and political and cultural contexts, which determine and constrain behaviour change. Creating enabling environments for behaviour change is a critical part of any programme design.

3.26 For example, one study found that in an area of urban Kampala the risk for a woman of losing a boyfriend by asking him to use a condom was considered far worse in terms of threat to livelihood, identity, and social status, than the risk of catching one more infection in an already infectious environment.⁵³ An understanding of this context played a key role in the design of a gender-sensitive information campaign, and in the instigation of initiatives aimed at developing female support networks.

Box 11: Creating enabling environments for behaviour change⁵⁴

The generation of enabling environments may encompass a range of elements in programme design, including:

- Peer support networks: the most effective communication approaches are those in which behaviour change is reinforced from within peer group networks and in which information is received and exchanged based on trust.
- Enhancing existing sources of social capital and community-based structures/organisations: capacity building of existing informal and formal community-based support networks and organisations is essential for enhancing social capital and for bringing about sustained behaviour change. Examples include micro-credit

⁵² World Bank, 2000b.

⁵³ Wallman, 1996.

⁵⁴ Source: Hawkins & Price, 2000.

schemes, strengthening the capacity of community-based groups to undertake advocacy work, and strengthening mechanisms for community participation.

Social Protection

- 3.27 Extreme poverty may require special measures to protect people from serious harm (e.g. safety nets). Amongst the poor, the disabled, the elderly and the chronically sick are commonly identified as people who cannot lift themselves out of poverty, and who place a burden on others, contributing to extreme household poverty. Policy directed towards this category is concerned with protection against adversity and deprivation, in preference to support for strategies or assets.⁵⁵

Box 12: Support for Social Protection

The Swedish Disabled International Aid Association promotes the importance of social protection for people with disabilities. This is defined as housing, health care, rehabilitation services and access devices (e.g. artificial limbs, wheelchairs, hearing aids, Braille machines). It does this through development and strengthening of organisations of disabled people in developing countries. It prioritises programmes that enable people with disabilities to speak for themselves and which, in turn strengthen human rights.⁵⁶

- 3.28 Governments must secure health care financing for the very poor who cannot make significant financial contributions for health services. This is particularly for use of hospital care, either through direct payment from tax revenues or cross-subsidies in insurance-based systems.⁵⁷

Ensuring Consumer Rights through Realigning Relationships with Service Providers

- 3.29 A concern with poverty is increasingly inseparable from a concern with realising human rights. When considering a poverty-focused approach to health interventions, this translates into a concern for empowering the poor to use their voice and have the confidence and capacity to exercise and demand those rights. The objective of the emerging DFID Human Rights Strategy, for instance, is "to enable all people to be active citizens with rights, expectations and responsibilities".⁵⁸ For poverty-focused health interventions, then, this means creating the institutional conditions in which poor users of health and other services can project voice and demand accountability and transparency from service providers.
- 3.30 Accountability networks in public and private health services in many countries are extremely dense and often very limited in their external accountability. Particularly in contexts of monopoly provision of services (i.e. where no competing provider exists) consumers are unable to use exit strategies as a response to poor service.⁵⁹
- 3.31 Policy mechanisms for increasing accountability and ensuring the rights of the consumer, particularly women health users, under these circumstances include demand-side initiatives to raise awareness and legal literacy among poor consumers and encourage advocacy and public monitoring. The also include supply-side initiatives to

⁵⁵ Mullen, 2000.

⁵⁶ DFID, 2000a.

⁵⁷ Bennett, 2000.

⁵⁸ DFID, 2000b.

⁵⁹ Gopakumar, n.d.

shift service providers away from a closed shop mentality to a situation of group/peer accountability with incentives. Perhaps most importantly they should also include institutional initiatives that bring service providers and users together in a fora that allows for a “win-win” exploration of solutions to accountability and service access issues (see Box 15).

Box 13: Public Sector Accountability in Uganda⁶⁰

In Uganda a range of measures have been taken to address illegal charges for health care. A tracking study of Government funds revealed significant diversion to unintended uses. Government reacted by imposing conditions on the use of block grants to districts, and increasing transparency to ensure they are used as intended: advertisements in press and displayed a facility level show sums disbursed to districts, schools, clinics, and enable population to challenge how they are used. Follow up found 90% compliance with the requirement to display school budgets and staff lists. Issues of corruption and financial probity have received further attention: 1998 integrity study looked at incidence of staff seeking bribes by sector, participatory poverty assessment district reports have raised local corruption issues.

⁶⁰ Foster & Fozzard, 2000.

4. CONCLUSION

- 4.1 The Copenhagen Summit for Social Development has provided an important stimulation for specialists within the health field to connect with the poverty agenda. This paper has argued for the adoption of a multidimensional conceptualisation of poverty that recognises the complex strategic decisions made by the poor with respect to a range of material and non-material assets, a juggling act played out in a changing economic, natural and social environment and within the political parameters created by a web of institutional structures and processes.
- 4.2 We have suggested that vulnerability models, such as the Sustainable Livelihoods Framework, provide a powerful analytical entry point into considering how this agenda might roll out as good practice in policy. We have emphasised that a dynamic approach will provide operational momentum towards interventions that recognise and synthesise with complex strategies adopted by poor individuals, households and communities. We have argued that the joined up nature of the asset approach leads the health specialist towards an inter-sectoral approach and provides that extra stimulation to engage with often unwilling sector partners and with governments who are slow to own poverty reduction and health policies.⁶¹
- 4.3 We have stressed that participation lies at the heart of a poverty-focused approach, both as a means to understand the nature of demand and problems of access, but more significantly to empower women and men to assert their rights in the face of highly corrupt and non-transparent service providers and to break down the passive client-provider relationship in actively engaging in the process of delivering health care and reducing poverty.
- 4.4 This report has addressed the implications a poverty-focused approach has for the health sector. This is obviously a first step, for it is not only an issue for the health sector, but health also has to be comprehensively integrated within poverty reduction frameworks.⁶² By necessity, this raises the need to encompass a wide range of actors working outside the health sector with influence over policy for poverty reduction and health. Furthermore, this is an issue that has to be addressed through a multi-level approach, from the international arena down to local institutional change.

⁶¹ WHO, 1999b.

⁶² WHO, 1999a.

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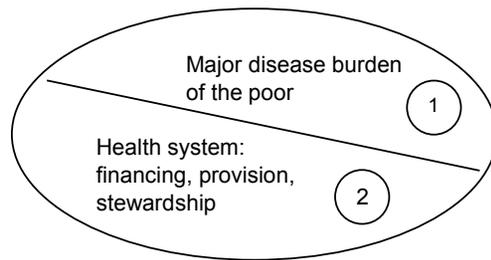
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APPENDIX 1: HEALTH IN HUMAN DEVELOPMENT

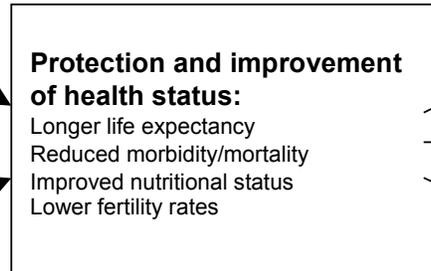
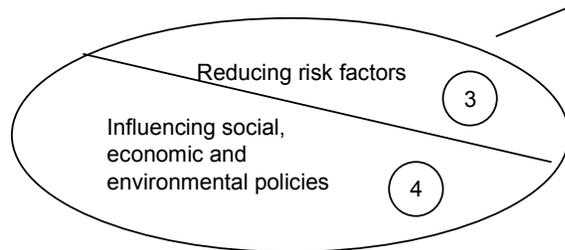
Determinants of health of the poor

Determinants of development

Health sector



Dimensions of health in development



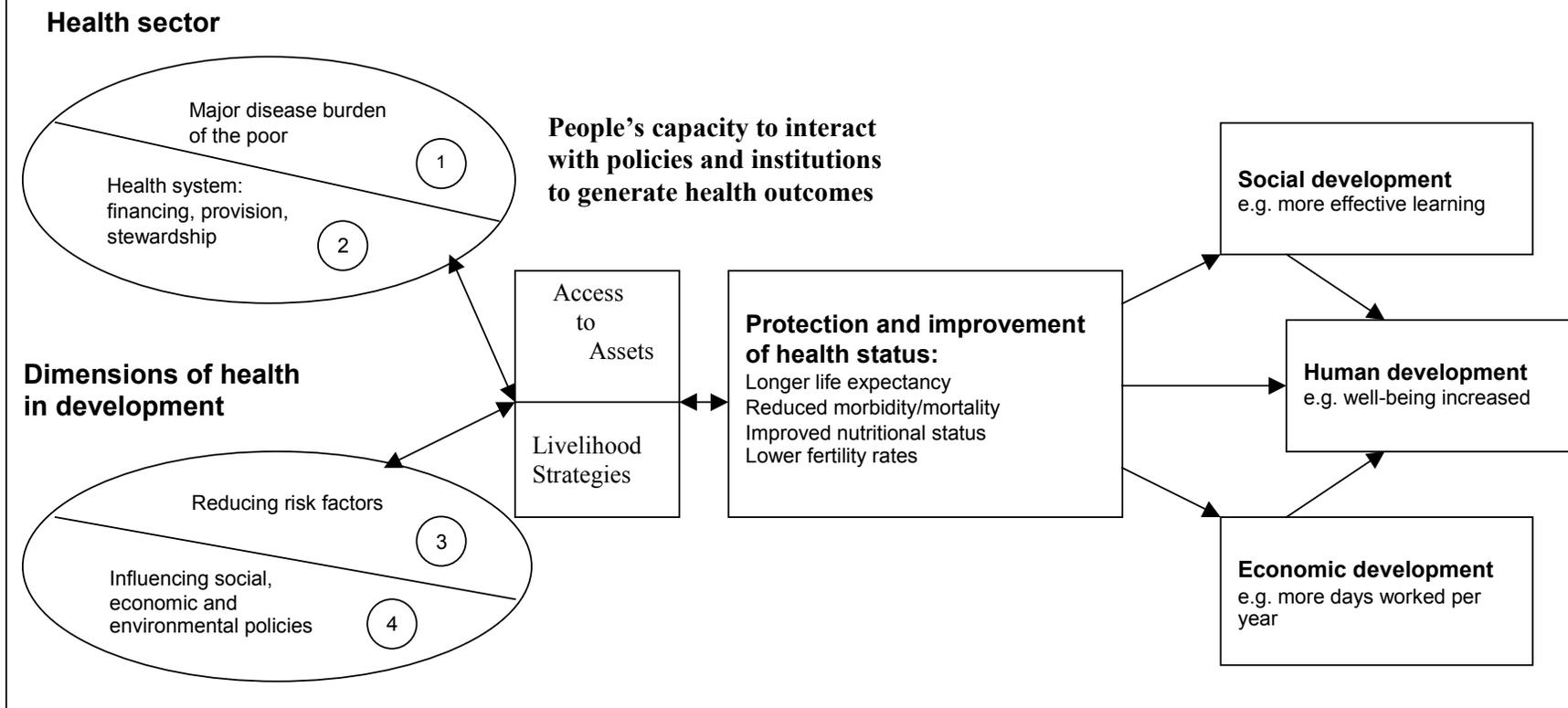
Source: WHO/HSD

- 1 Reducing the burden of excess mortality and disability, especially in poor and marginalized populations.
- 2 Developing health systems that equitably improve health outcomes; respond to peoples' legitimate demands, and are financially fair.
- 3 Reducing risk factors to human health that arise from environmental, economic, social and behavioural causes.
- 4 Developing an enabling policy, an institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

APPENDIX 1: Health in Human Development (suggested amendments)

Determinants of health of the poor

Determinants of development



Source: WHO/HSD

1 Reducing the burden of excess mortality and disability, especially in poor and marginalized populations.

2 Developing health systems that equitably improve health outcomes; respond to peoples' legitimate demands, and are financially fair.

3 Reducing risk factors to human health that arise from environmental, economic, social and behavioural causes.

4 Developing an enabling policy, an institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

APPENDIX 2: GLOSSARY

Assets or capital endowment	People's strengths that can be converted into positive livelihood outcomes. Although the term 'capital' is used, not all the assets are capital stocks in the strict economic sense of the term (in which capital is the product of investment which yields a flow of benefits over time).
Contextual	Those data collection methods are labelled contextual which attempt to understand poverty dimensions within the social, cultural, economic and political environment of a locality.
Livelihood	To make a living; way of making a living.
Livelihood strategy	The range and combination of activities and choices that people make/undertake in order to achieve their livelihood goals (including productive activities, investment strategies, reproductive choices, etc).
Livelihood outcome	The achievement of livelihood strategies. These outcomes include income and material goods, but people also value non-material things such as increased wellbeing.
Risk	Uncertain events which can damage well-being (e.g. the risk to become ill).
Risk exposure	Measures the probability that a certain risk will occur.
Shock	An event that threatens wellbeing or increases vulnerability.
Vulnerability	The resilience against a shock, i.e. the likelihood that a decline in well-being will take place as a result of a shock. Vulnerability is primarily a function of the household's asset endowment and insurance mechanisms.
Environment	The political, social, economic and physical environment in which people live.

APPENDIX 3: HEALTH AS A HUMAN RIGHT ENSHRINED IN INTERNATIONAL LAW

- 1.1 Human rights are defined and protected in a number of instruments which are legally binding on states party to the instruments. These include the Covenant on Civil and Political Rights (ICCPR), the Convention on Economic, Social and Cultural Rights (CESCR), The Convention on the Elimination of Racial Discrimination (CERD), the Convention on the Rights of the Child (CRC), amongst others. Additionally, states are increasingly bound to uphold individual rights through the mechanism of customary law, whereby those standards articulated and widely practised by virtue of their prevalence and acceptance become the norm to which all states must adhere.⁶³
- 1.2 The right to health is specifically protected in a number of different human rights, the most important of which include:
- **The right to freedom of expression** encompasses the right to express and receive opinions and ideas as well as the right to receive and impart information. Thus information necessary for individual health, for public debate on health issues and for health education are all protected
 - **The right to equality and non-discrimination** is among the most fundamental principles of international human rights law. As stated in the UN Charter, one of the four overarching purposes of the UN is 'to achieve international co-operation in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language or religion.'⁶⁴ Article 12 (1) of the Women's Convention requires states parties to 'eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, included those related to family planning.' The UN Committee on Economic, Social and Cultural Rights (which monitors compliance with the CESCR) has underlined 'the fact that even in times of severe resource constraints...the vulnerable members of society can and indeed must be protected by adoption of relatively low-cost targeted programmes.'⁶⁵
 - **The right to life** contained in all major treaties that protect civil rights under the 'inherent right to life' declaration. The UN Human Rights Committee (which monitors compliance with the ICCPR) in 1989 expanded the interpretation of this phrase by stating that, 'inherent right to life cannot be properly understood in a restrictive manner, and the protection of this right requires that states adopt positive measures.'⁶⁶ The Committee made special mention that states parties should take, 'all possible measures to reduce infant mortality and increase life expectancy'.
 - **The right to health** is clearly stated in the CESCR; Article 12 reads: The states parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- 1.3 The steps to be taken...to achieve the full realisation of this right shall include those necessary for:

⁶³ For example, the fact that the Convention on the Rights of the Child has been almost universally ratified implies that the principles and standards elaborated have legal force even in those countries which have not ratified the Convention.

⁶⁴ UN Charter, Art.1.

⁶⁵ Committee on Economic, Social and Cultural Rights, General Comment 3, (5th Session, 1990).

⁶⁶ Human Rights Committee, General Comment 6 on Art.6 (16th Session 1982).

- a. The provision for the reduction of the still-birth rate and of infant mortality and the healthy development of the child;
 - b. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.
- 1.4 The right to health is also stated in the Universal Declaration of Human Rights, the Children's Convention, the Women's Convention and several regional treaties including the African Charter.⁶⁷
- 1.5 This summary of international human rights law provisions for the right to health, although still in its infancy in terms of articulating the obligations these rights impose on governments, certainly provides a human rights perspective; namely that any view of health looks seriously at its connections to social conditions such as poverty and discrimination. The effect of the various laws and treaties has been to underline that the biological events by which health status is routinely measured are produced and conditioned by complex webs of social and economic relations which exist at, and between, all levels.
- 1.6 Far too often poor health is linked to social systems in which those relationships are marked by deep and pervasive inequality based on gender, race and class. Work with mothers to improve child health, for example, requires attention to a range of issues including, gender discrimination, basic education, water and sanitation. Similarly, work with street children must include attention to issues such as the failure of the education system, family poverty and physical and sexual abuse. Child labour needs to be understood as a social problem arising from extreme poverty and the lack of educational opportunities which could encourage employment and increase family income.

⁶⁷ For a detailed discussion on health and international law, see *The Right to Know. Human rights and access to reproductive health information*. ARTICLE 19 and the University of Pennsylvania Press. 1995.

APPENDIX 4: VULNERABILITY MODELS

- This appendix describes three vulnerability models that share the same conceptual roots but are each slightly different. The Asset-Vulnerability Framework focuses on people's coping strategies. This can be very helpful, but the emphasis is on after-the-event strategies; it cannot assist in the design of appropriate health policy responses to enable the poor to manage risk by *preventing* and *mitigating* risk and lessening the impact of shocks. The emphasis on prevention and mitigation is a strength of the risk management approach. The Sustainable Livelihoods Framework locates ideas about vulnerability, assets and strategies in a central position, but it adds to this by enabling us to link what is happening at the micro-level to policies, institutions and processes.

The Asset Vulnerability Approach

- 1.1 The asset vulnerability framework is based on the idea that vulnerability is linked to asset ownership: the more assets people have, the less vulnerable they are; the greater erosion of assets, the greater the level of insecurity.⁶⁸ Taking the starting point that poor people have assets and are managers of a complex asset portfolio, the obstacles and opportunities that affect their capacity to accumulate assets can be identified. The framework can be used to illustrate how asset management affects household vulnerability.
 - 1.2 In respect to health, the framework provides a basis for contextual analysis of the threats that render poor people vulnerable to health problems. This can be linked to individual, household, and community capacity for resilience and responsiveness to health threats. Thus, the emphasis is on poor people's coping strategies when confronted by crisis and in the face of uncertainty.
 - 1.3 The framework enables us to demonstrate how improved health would have a positive impact on poverty. By identifying different types of asset (tangible and intangible; see Section 2 on assets in the main report) in a given context, the poverty impacts of support for these assets can be explored. For instance support for adequate accessible health care may reduce illness and bolster human capital as an asset, helping people to gain a sense of wellbeing, enhancing their life chances and increasing their productive capacity.
- In terms of policy intervention, the framework can contribute to the development of appropriate analytical tools to remove obstacles to good health, and to promote people's coping strategies.
- 1.4 Strength of the asset vulnerability framework is that responses to health threats can be located within the context of people's broader coping strategies, enabling the development of policy interventions to bolster these strategies. However, this focus is also a limitation for one is dealing with situations that follow a shock or crisis; the emphasis is not on prevention. In considering interventions to prevent health crisis from occurring, a valuable contribution can be made by frameworks for analysing risk management.

Household Coping Strategies

⁶⁸ Moser, 1998.

1.5 An episode of poor health or illness may be characterised by poor people as an event forming part of a chain of events resulting in impoverishment, or resulting from impoverishment. An example is provided in Table 3.

- Key question: what risks do poorer households take in order to withstand a crisis, and what is the damage to their net asset position?

Table 3: Events leading to impoverishment

Indicator of vulnerability	Shock	Treatment seeking behaviour	Household coping strategy	Impact on net assets	Entry points to support coping strategies
<ul style="list-style-type: none"> - Overcrowded housing conditions - open sewers - chaotic garbage disposal - lack of access to clean water - mother working long hours outside home - childcare by elder daughter 	<ul style="list-style-type: none"> - Illness of child (diarrhoea, dehydration and fever) 	<ul style="list-style-type: none"> i. home treatment then after a period of time ii. treatment seeking outside home (i + ii involving female/mother decision-making) 	<ul style="list-style-type: none"> - money diverted from other expenditure to pay for medicine - female/mother individual health jettisoned 	<ul style="list-style-type: none"> - Decline of wellbeing (female/mother) - Decline in social capital (inter-household reciprocity is stretched) - Decline in human capital (money diverted from schooling of 5 other children) - Negative impact on 5 children left at home / inadequate care 	<ul style="list-style-type: none"> - more specific health education to encourage mothers to seek help from health units before symptoms become too severe - alternative health providers (shopkeepers / traditional healers) targeted for training - need to improve quality of care in government units / communication between providers & carers.

Source: Adapted from Moser, 1998 and Wallman, 1996.

The Sustainable Livelihoods Approach

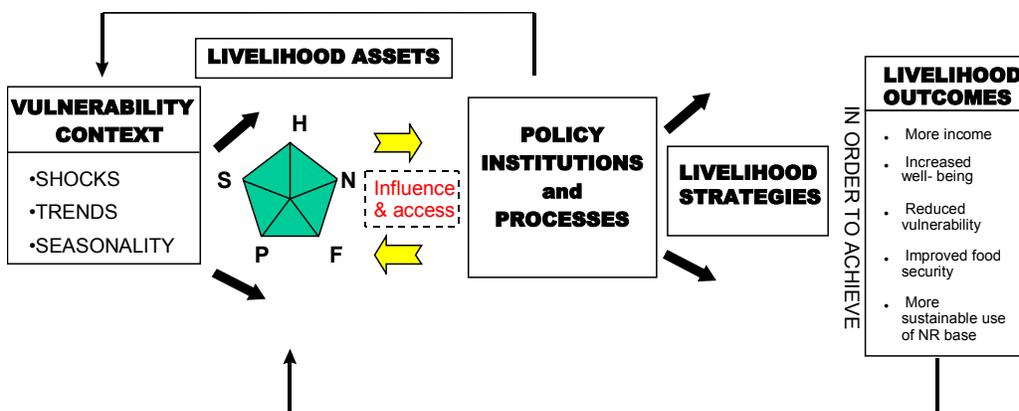
1.6 The Sustainable Livelihoods Approach (SLA) is a way of thinking about objectives, scope and priorities for development. It is a dynamic and process oriented approach to understanding the nature of poverty, and to implementing and assessing poverty reduction interventions. The SLA brings provides a framework for policy analysis and implementation which draws on thinking and practice on poverty reduction strategies, sustainable development, participation and empowerment processes. The approach takes a holistic view and starts from the premise that development interventions need to build on people's strengths, not their needs.

- 1.7 In relation to health interventions, the SLA can:
- Analyse the multiple linkages between poor people's quality of health, their sense of well-being or ill-being, and other aspects of their livelihoods.
 - Connect health to poverty issues using poverty indicators that people themselves define.
 - Link the asset of good health to the macro structures and processes that affect individual livelihoods.
 - Identify appropriate 'entry points' for health-related interventions.
 - Assess the effectiveness of existing health care interventions in contributing towards poverty reduction.

The Sustainable Livelihoods Approach at a Policy Level

1.8 DFID is amongst several organisations that have adopted the sustainable livelihoods approach at a policy level (e.g. UNDP, CARE, Oxfam). DFID represent the SLA through a diagrammatic framework for analysis.⁶⁹ (See Figure 2). The Sustainable Livelihoods Framework (SLF) separates an understanding of sustainable livelihoods into three basic components: the vulnerability context, people's capital assets, and transforming structures and processes.

Figure 1: The DFID Sustainable Livelihoods Framework



The vulnerability context

1.9 The framework views people as operating in a context of vulnerability. Vulnerability includes 'shocks': for example, severe flooding in Mozambique was accompanied by increased risk of diseases such as cholera and malaria, and also malnutrition. Or it may be a 'trend': for example, a decline state capacity to provide clean water and sanitation in Zambia was linked to an increased risk of disease. Alternatively, vulnerability may be seasonal. For example in urban Madagascar the rainy season is associated with a rise in the risk of disease such as diarrhoea, malaria, infectious respiratory diseases, and scabies (CARE, 1998). The fragility of poor people's livelihoods and limited assets makes them unable to cope with stresses brought about through external factors.

Capital Assets

⁶⁹ DFID, 1999; Carney & Ashley, 1999.

- 1.10 Within the vulnerability context, people have access to certain capital assets or poverty reducing factors. These factors gain their meaning and value through the prevailing social, institutional and organisational environment. Analysis of people's access to capital assets is based on the idea that they require a range of assets to achieve positive livelihood outcomes. No single category of asset – e.g. income – is sufficient on its own. Thus, asset status is broken into five different types of 'capital': human, physical, financial, social and natural. This asset status is dynamic and constantly changing.
- Health as an asset is situated within 'human capital' which "represents the skills, knowledge, ability to labour and good health that together enable people to pursue different livelihood strategies and achieve their livelihood objectives".⁷⁰
- 1.11 Human capital is seen as a 'building block' necessary to make use of other types of capital asset, in order to achieve livelihood outcomes. Thus, critical linkages can be made between people's health status and other dimensions of their livelihoods. Moreover, many people regard ill health as a core dimension of poverty and thus overcoming it may be one of their primary livelihood objectives.

What type of information is required to analyse human capital?

- 1.12 There are many well-developed indicators of human health. In many cases these provide exact measures. However it may be equally appropriate to investigate variations. For example: is child mortality lower or higher among a particular group? Are the children of one group more poorly nourished than other children? Does the quality of health care available to different groups differ markedly?

Transforming Structures and Processes

- 1.13 Transforming structures and processes that have a profound influence on access to assets. These are the institutions, organisations, policies and legislation that shape livelihoods. They effectively determine: (i) access (to various types of capital, to livelihood strategies and to decision-making bodies and sources of influence); (ii) the terms of exchange between different types of capital; (iii) returns (economic or otherwise) to any given livelihood strategy. In addition, they have a direct impact upon whether people are able to achieve a feeling of inclusion and well-being.
- 1.14 Structures and processes feed into the vulnerability context: policies (processes), established and implemented through organisations (structures), affect trends both directly (e.g.?) and indirectly (e.g. health policy / population trends). They can also help cushion the impact of external shocks (e.g. policy on the density of relief providing agencies).
- 1.15 Institutions can restrict people's choice of livelihood strategy. More common are policies and regulations that affect the attractiveness of particular livelihood choices through their impact upon expected returns.
- 1.16 There may also be a direct impact on livelihood outcomes. Responsive political structures that implement pro-poor policies, including extending health services into areas in which the poor live, can significantly increase people's sense of well-being.
- 1.17 One of the main problems faced by the poor is that the processes that frame their livelihoods systematically restrict them and their opportunities for advancement. This is

⁷⁰ DFID, 1999.

a characteristic of social exclusion and it is one reason why it is so important that governments adopt pro-poor policies. The fact that processes can transform livelihoods makes them a key focus for donor activity. One comprehensive means of addressing problems in this area is through sector programmes. Amongst other things, sector programmes are concerned with defining the appropriate role of the state and helping it to execute this role better.

Livelihood Strategies

- 1.18 The combination of activities and choices that people make/undertake in order to achieve their livelihood goals. People's access to different levels and combinations of assets is probably the major influence on their choice of livelihood strategy. For example, good health is an essential component of human capital which required to undertake different livelihood activities.

Livelihood Outcomes

- 1.19 Livelihood outcomes are what are achieved by livelihood strategies. Part of these outcomes includes income and material goods, but people also value non-material things such as increased wellbeing. This is affected by many factors, for example, their health status, self-esteem, and access to services.

Risk Management

- 1.20 Work on risk management emerged in studies on famine and food security, but it has gained wider currency in thinking on poverty reduction. Frameworks for analysing risk can contribute to pro-poor health interventions because they enable us to identify policy entry points to assist poor people to manage health risks. Of particular value is the emphasis risk management places on preventative health measures.
- 1.21 Contributions of risk analysis to understanding the health-poverty nexus:
- Identification of linkages between risk exposure, illness and poverty.
 - Design of appropriate health policy responses to enable the poor to manage risk (by preventing and mitigating risk and lessening the impact of shocks).

The Nature of Risk and Health Vulnerabilities

- 1.22 The concept of risk is used to refer to situations of uncertainty, in which events may arise that can damage well-being. The uncertainty can pertain to the timing and/or the magnitude of the event. Risk is closely linked to vulnerability; people become insecure through exposure to risk, the subsequent possibility of a decline in well being would mean that people are vulnerable to this risk. The term 'shock' is used to refer to the event that triggers a decline in well being. A shock may be unpredictable (for instance harvest failure), or predictable (for instance seasonal food shortage); lack of predictability may also refer to severity or frequency. In both cases, risk management strategies are needed to prevent shocks or buffer their impact.
- 1.23 Health-related shocks (e.g. illness, death of family member) are but one dimension of the multiple risks that confront poor households. Other dimensions include natural shocks (harvest failure, flooding), shocks related to crime or violence, and macro-level shocks (war, taxation, structural adjustment policies). To target policy interventions to enable the poor to manage health-related risks, it is necessary to (i) contextualise health

risks in relation to other risks; and (ii) contextualise health risks in relation to the multi-dimensional nature of vulnerability at the household level.

- 1.24 A typology of risks and shocks can help us to understand health-related risk and vulnerability better, leading to the design of appropriate policy responses. Figure 3 classifies shocks by level (micro, meso, macro) and by the nature of the event (natural, economic, etc.).

Table 4: Health Risks in Relation to Other Sources of Risk⁷¹

Type of risk	Micro (idiosyncratic) Individual or household	Meso Groups of households, community	Macro (covariant) National, international
Natural		Rainfall	Floods, droughts
Health	Illness, injury, disability, old age, death	Epidemic	
Social	Crime, domestic violence	Terrorism	Civil strife, war, social upheaval
Economic	Unemployment, harvest failure	Involuntary resettlement	Balance of payments, financial or currency crisis, trade-induced terms of trade shocks
Political		Riots	Political default on social programmes, coup d'état
Environmental		Pollution	Global warming

- 1.25 Distinction of the level of risk is critical in determining the policy responses, although in practice micro, meso and macro level shocks may be entwined. For example, a national emergency (macro) such as an earthquake is likely to be followed by risk of epidemics (meso), and this in turn will have a differential affect on households and individuals (micro). However, the way poor households are impacted by different shocks will be affected by the extent to which safety nets and other institutions include the poor (World Bank, 2000). It is therefore critical to identify the institutions that mediate shocks and shape differential impacts at household level.

- 1.26 Health risks are concentrated at the micro, idiosyncratic level. Although some conditions affect rich and poor, many have a greater impact on the poor. In this respect poverty and poor health feed into one another, with illness becoming one event in a chain of events that result both in and from impoverishment. Poor health can contribute to decline in labour productivity, worsening people's poverty. Environments which expose people to health risk (water contamination, cramped living conditions, etc.), limited access to health care, poor nutrition, unsafe labour conditions, can each generate shocks which, even when apparently 'minor', can feed into people's existing vulnerabilities. The extent of the impact a shock can generate will also be affected by when someone is ill (seasonal), how long the illness lasts, and whether an individual or family are in a regular state of ill health.

- 1.27 The World Development Report (2000) argues that health risks are strongly connected to food availability, which is affected by many other risks confronting the poor.⁷² In

⁷¹ Source: Adapted from World Bank, 2000: 5.4 [Holzmann & Jorgensen, 1999; Sinha & Lipton, 1999]. The table can be refined by distinguishing shocks by severity and frequency, and by distinguishing which household assets are affected by a particular shock.

⁷² World Bank, 2000: 5.5.

addition, these risks are higher in rural areas, where the majority of the world's poor is concentrated, and where access to health care is typically worse than in urban areas.⁷³

- 1.28 Above the level of micro shocks, epidemics can affect a region and communities within it. At this level, when individual, household and community coping strategies break down, government intervention is needed to provide emergency health care and other support.

Household and community responses to risk

- 1.29 People respond to risk through different strategies. Understanding these strategies is important for the formulation and implementation of appropriate policy responses Risk management strategies are divided into two types, informal mechanisms and formal mechanisms.
- 1.30 Risk management strategies are further categorised in terms of (i) risk reduction, (ii) risk mitigation, and (iii) risk coping strategies. In each case we have to think of which household members are central to decision making on household resource allocation and ways of reducing, mitigating or coping with shocks.

Risk reduction

- 1.31 Risk reduction refers to actions that can be taken to reduce the probability of a shock. For poor individuals and households, capacity to act in order to reduce health-related risk are extremely limited. In this area, policy interventions at the meso and macro level to support institutions that reduce risk at individual and household level are critical.
- 1.32 Public health campaigns (e.g. vaccination, adequate nutrition, condom use) are premised on the idea that health risk prevention is up to the individual. While this may appear to be the case, an understanding of the vulnerability context may raise awareness of how limited an individual's power to act may be in a given situation. Placing emphasis on an individual's capacity to 'strategise', carries the danger that people are held responsible for not acting on the risks health experts have identified. We have to consider individual capability, and the appropriate questions may be: in these circumstances, given this knowledge, these constraints, what scope do women (for example) have for avoiding infection, or for diagnosing, acknowledging, treating infection once it occurs?
- 1.33 Discussion of individual capacity for preventative action leads to a further issue. Namely, the need to understand how different categories of risk are perceived and acted on by the individual. 'Irrational' or 'irresponsible' behaviour in relation to one type of risk may be understood as a responsible judgement in relation to another. In this respect, the social meaning of a given risk, disease, or form of behaviour is extremely important, because it helps us to understand what aspects of life are touched upon (Wallman, 1996). Taking a broader view, prevention and treatment may be about family life, local organisation, morality, cosmology, opportunity, economics, mobility, and self esteem - each aspects of livelihood.

1.1 ⁷³ Ibid. citing Sinha & Lipton, 1999.

Risk mitigation

- 1.34 Risk mitigation refers to actions taken to limit the impact of a shock, for instance through insurance or broadening a household's asset portfolio.
- 1.35 Diversification of a household's asset portfolio may provide a family with options which minimise a health-related shock. For instance, if a child falls sick and money is available to pay for health care, the child may be taken to clinic at a far earlier point in the illness than could otherwise be expected. Likewise, availability of finances and of neighbourly support for the family may mean that negative impacts on other children are reduced for instance, they do not have to stay away from school.
- 1.36 Risk mitigation through insurance can take three forms: self-insurance, informal insurance, and formal insurance. Market based formal insurance plays a minor role in risk mitigation for the poor.

Risk coping

- 1.37 Risk coping strategies aim to relieve the impact of a shock after it occurs (as discussed in Section on Asset Vulnerability Framework).

Policies for improving risk management

- 1.38 The policy response to health-related risk should concentrate on three strategies:
- Preventing risk
 - Mitigating risk
 - Coping with shocks (alleviating their impact)
- Each strategy can include formal and informal mechanisms, provided by public and private sectors.
- 1.39 In principle, risk prevention is the most appropriate option, but in reality, this can be prohibitively expensive. In turn, support for coping strategies is an after-the-event action, which may perpetuate a cycle of poverty, as described in reference to the Asset Vulnerability Framework. The balance needs to be on policies for reducing and mitigating health-risks. However there are areas where support for coping strategies needs to be addressed, for instance safety nets for people to cope with global trends over which state-level policies have little influence.