



At Merrill health dispensary next to the livestock market in Marsabit Country, Kenya. Photo: Chip Bury/USAID.

HEALTH, RESILIENCE, AND SUSTAINABLE POVERTY ESCAPES

Synthesis

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EXECUTIVE SUMMARY

Health intersects with resilience and sustained poverty escapes in at least three ways. Health problems can be a shock that reduces wellbeing temporarily or with longer term impoverishing effects. Health is also an important form of human capital that can act as a resilience capacity to protect individuals, households, and communities in the face of adversity. Finally, health outcomes are in and of themselves development outcomes that need to be sustained in the face of shocks and stresses. The objective of this brief is to present evidence on the first two of these three channels.

The brief presents findings around health shocks and health as a resilience capacity, from a series of 11 country studies on drivers of poverty dynamics in both Africa (Tanzania, Rwanda, Niger, Malawi, Ethiopia, Uganda, rural Kenya) and Asia (Philippines, Nepal, rural Cambodia, rural Bangladesh). It also offers health-related policy and programming implications for building resilience capacities to contribute to sustained poverty reduction. The brief draws on results of mixed methods research involving: (i) analysis of panel surveys tracking the same households over time, from the late 1990s to present; (ii) key informant interviews and focus group discussions between 2016 and 2018; and (iii) life history interviews also between 2016 and 2018 to investigate pathways of sustained poverty escapes.

The results across countries point to the impoverishing effects of ill-health. Regression results in the Philippines, Nepal, Uganda, and Cambodia indicate that an increase in health expenditures, a proxy for health shocks, is associated with an increased risk of impoverishment relative to sustaining a poverty escape. In Uganda, Nepal, and rural Bangladesh, an increase in health spending is associated with a higher risk of an escape from poverty being transitory rather than sustained. The qualitative evidence also highlights health shocks as a key constraint in households' ability to sustain poverty escapes. Specifically, the qualitative results indicate the following:

Multiplier effects and sequences aggravate health shocks. When an income-earner in the household falls ill, the ratio of active members to dependents falls. The effects may be compounded by lost earnings and taking care of the ill family member, or funeral costs upon death. Sequencing of shocks also affects impoverishment. A small health shock may be managed, but a series of health and non-health shocks can impoverish. Finally, the type of health shock matters. Disability on its own often impoverishes in most countries. Severe disability is associated with chronic poverty in rural Bangladesh. There are also other health-related illnesses, which can impoverish including chronic health issues, mental health problems, and alcoholism.

Limitations in the healthcare system may contribute to impoverishment. Findings from the fieldwork indicated that most countries had low health insurance coverage, even where policies intended to reach a larger share of the population. Even having health insurance did not guarantee access to or even demand for health care. Problems of health service quality are widespread, as are problems around access related to high user costs. As a result, many households opt for healthcare only in response to emergencies rather than as a preventative measure.

Households without health insurance engaged in various coping strategies for health shocks, such as relying on savings, selling assets, receiving support from family members, or taking out loans from informal moneylenders. These all have potentially negative impacts on future household wellbeing.

In this context, the following policy implications are drawn out and recommendations suggested:

- **Universal health insurance** is a key policy to help prevent impoverishment due to health shocks. This may require developing new health insurance mechanisms or expanding and strengthening

existing systems to more effectively provide safety nets for the poor and vulnerable near-poor social groups alongside sustainable financing mechanisms.

- **Achieving universal health coverage is possible in different policy contexts.** Rwanda has opted successfully for compulsion alongside improved quality of healthcare and subsidies for the poor, while others (Kenya, Tanzania, Nepal) have relied on devolved governance structures.
- For universal health insurance to succeed in preventing impoverishment and sustaining poverty escapes, and where there is no health insurance or intention of providing it, **public health systems including health referral systems could benefit from increased coverage in remote areas and better quality** (in terms of facilities, number of doctors, and technical support) to be effective.
- **There is a wide range of health-related conditions that would benefit from expansion or upgrading of existing health services**, including better coverage of reproductive health, and improved responses to chronic medical issues, mental health problems, and alcoholism.
- **Critical links need to be developed**, with health improvements tied to investments in other areas including in pro-poor education, improved access to financial services and cash transfers.

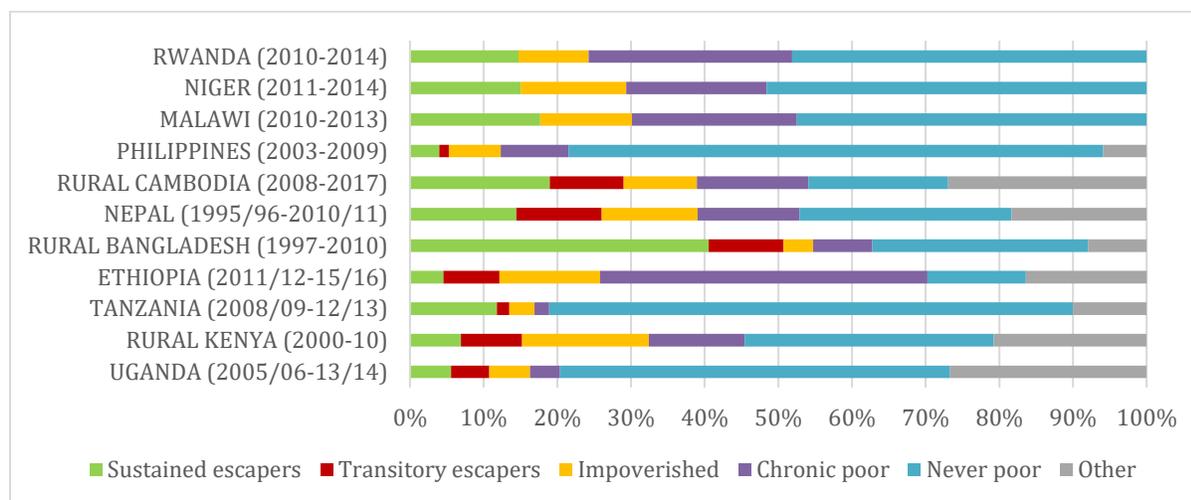
INTRODUCTION

Health intersects with resilience and sustained poverty escapes in at least three ways. Health problems can be a shock that reduces wellbeing temporarily or with longer term impoverishing effects. Health is also an important form of human capital that can act as a resilience capacity to protect individuals, households, and communities in the face of adversity. Finally, health outcomes are in and of themselves development outcomes that need to be protected in the face of shocks and stresses. The objective of this brief is to present evidence on the first two of these three channels. The brief presents findings around health shocks and resilience capacities from a series of country studies on drivers of poverty dynamics in Africa and Asia, and offers health-related policy and programming implications for building resilience capacities to contribute to sustained poverty reduction.

This synthesis draws on mixed-methods research by CPAN supported by USAID, which analyzed the interrelationship between resilience, health, and sustainable poverty escapes in Africa (Tanzania, Rwanda, Niger, Malawi, Ethiopia, Uganda, rural Kenya) and Asia (Philippines, Nepal, rural Cambodia, rural Bangladesh), and offered policy and programming implications. The reports explored the sources of resilience that enable people to sustainably escape poverty given the complex risk environments in which they live. In particular, it investigated the resources (land, livestock, and assets), attributes (household composition and education level), and activities (including jobs and engagement in non-farm activities) of households that enable them to escape poverty sustainably and minimize the likelihood of returning to living in poverty again often in the face of shocks (ranging from household health shocks to subnational conflict and disasters). Box 1 outlines definitions of resilience and poverty dynamics used in this study.

As illustrated in Figure 1, there was a significant share (although varied) of sustained escapes across countries. However, findings across the countries also indicate a considerable number of both transitory poverty escapes and impoverishment, often due to the adverse effects of ill health and health shocks (see definitions in Box 1). Indeed, the country studies found that health shocks emerged as a near-universal source of impoverishment or transitory poverty escapes rather than sustained. At the same time, good health can be a form of resilience capacity to protect households in the face of adversity.

Figure 1: Poverty dynamics using national poverty lines



Note: Niger, Malawi, and Rwanda have only two waves, and so examines a one-time escape from poverty instead of a longer, sustained escape from poverty.

Sustained escapes are typically achieved with a combination of the following resources and strategic opportunities: (1) diversification within farming (where land resources not too diminished by inheritance and sales); (2) employment or self-employment in the rural nonfarm economy (which is frequently supported by access to gradually increasing levels of financial services); (3) migration (either as an alternative to diversification, or as a means of later diversifying); (4) urban investment; and (5) development of labor intensive manufacturing (which provides relatively poor men and women an opportunity to get employment, helping the whole household out of poverty). Diwakar and Shepherd (2018) discuss these strategies in more detail.

Underlying facilitating factors include education (usually more than completion of primary school education), with skills training being important in many stories of escaping and staying out of poverty – making migration or nonfarm work more productive. Collaborative social relationships – marriages where spouses support each other economically, and broader extended family collaboration provides the social capital to invest in businesses, education and to weather ill health and other shocks, and avoid asset depletion. Using up family social capital in this way constrains investment and family ‘take off’ (Diwakar and Shepherd, 2018).

Box 1: Definitions of poverty trajectories used in the study

Impoverishment in this study refers to the process whereby a person or household that is non-poor slips into poverty. **Chronic poverty** is long-term poverty that persists over many years or even a lifetime, and is often transmitted intergenerationally. **Transitory poverty escapes** refer to individuals or households that used to live in poverty, succeeded in escaping poverty, and then subsequently fell back into poverty. USAID defines resilience as “the ability of people, households, communities, countries and systems to mitigate, adapt to and recover from shocks and stresses in a manner that reduces chronic vulnerability and facilitates inclusive growth” (USAID, 2015). In this work, resilience is viewed as a set of capacities enabling households to escape poverty and remain out of poverty over the long term (a **sustained poverty escape**), even in the face of shocks and stresses. In other words, in the context of this study, the capacity to be resilient means an individual or household is ultimately able to avoid becoming impoverished or a poverty escape that is transitory.

This policy brief draws on results of the mixed methods research, to offer policy and programming implications for the health sector to better enable sustained poverty escapes. The data sources on which the country studies was based are presented in Annex A and include: (i) analysis of panel surveys; (ii) key informant interviews from 2016 to 2018 with a range of policy makers, researchers, development partners and program implementers in the capital city and communities of fieldwork in each country; and (iii) a range of 20-75 qualitative life history interviews per country with men and women between 2016 and 2018 to investigate the pathways of sustained poverty escapes.

KEY FINDINGS ON HEALTH

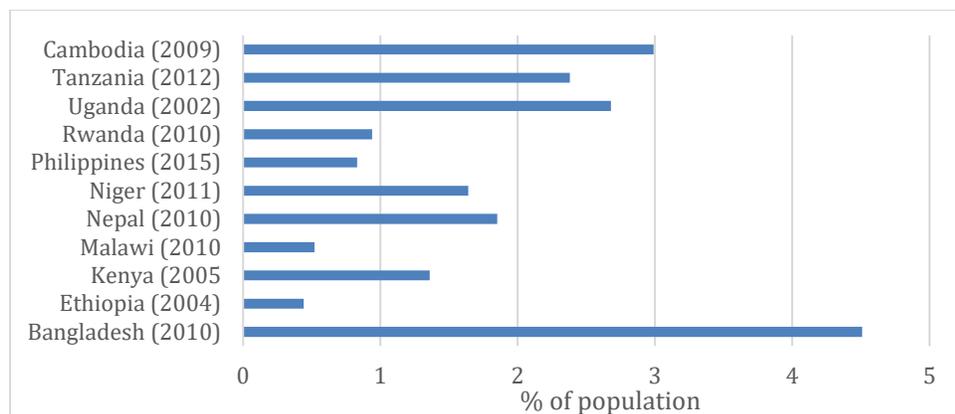
This section relies on the results of mixed-methods country studies in 11 countries across Africa and Asia to investigate the extent to which factors associated with chronic ill health and health shocks constrain the ability of households to escape poverty sustainably, and how health can also be a positive source of human capital to build resilience capacities and promote sustained poverty escapes.

The regression results across several countries (Philippines, Nepal, Uganda, Cambodia) indicate that an increase in health expenditures, a proxy for health shocks, is associated with an increased risk of impoverishment relative to sustaining a poverty escape. In Uganda, Nepal, and rural Bangladesh, an increase in health spending is also associated with a higher risk of an escape from poverty being only

transitory rather than sustained, all results being statistically significant at conventional levels. Of the countries studied, Bangladesh, Cambodia, and Uganda also have the highest rates of impoverishment due to health spending as calculated by the WHO (Figure 2).

Although the quantitative findings provide us with an indication of the relationship between health shocks and poverty escapes, there are limitations to what survey data and these corresponding figures can illuminate. The limitations may be due to the one-off nature of shocks compared to longer-term impacts not captured in surveys, and a lack of depth on the links between shocks, coping strategies, and poverty, and incomplete response categories (Heltberg et al., 2015; Baulch and Davis, 2008).

Figure 2: Population pushed below the \$1.90 a day poverty line by household health expenditures (%)



Note: this chart is not based on panel data. The indicator is computed based on household surveys, as “the difference in the incidence of poverty based on household’s total consumption expenditure... net of health expenditures.” Source: WHO, 2018.

The qualitative evidence points almost universally to the impoverishing effect of health shocks and its role as a key constraint in households’ ability to sustain poverty escapes. This operates through multiple channels, where the severity of impoverishment depends on: 1) *who* is affected and *how* in terms of the type of illness (e.g., chronic, mental health problems, alcohol abuse), but also includes the *sequence* of illness, 2) what *contextual constraints* they face, and 3) their *coping strategies* for these shocks. We treat each in turn below based on the qualitative evidence provided, unless explicitly indicated otherwise.

MULTIPLIER EFFECTS AND SEQUENCES AGGRAVATE HEALTH SHOCKS

Key Messages:

- **When an income-earner in the household falls ill, the ratio of active members to dependents falls. Effects may be compounded by lost earnings and taking care of ill members of the household. Death can impose additional burdens to meet funeral costs.**
- **The sequencing of shocks also affects the degree of impoverishment. A small health shock may be managed, but a series of health shocks can impoverish. Similarly, health and non-health shocks in close succession can co-occur to push households into poverty.**
- **The type of health shock matters. Disability, for example in the form of a physical impairment such as paralysis, is largely a shock that on its own impoverishes. There are also other types of health-related illnesses, which can impoverish including chronic health issues, mental health problems, and alcoholism.**

The degree of impoverishment is determined by who is affected, how, and when. When an income-earner

in the household falls ill, the ratio of active members to dependents falls. When the income earner is a breadwinner or equivalent, or a major earner has to stop work to take on the role of caretaker, these financial effects may be doubled through lost earnings alongside additional costs of treatment (Box 2). Beyond pure monetary costs, there may also be adverse psychological effects of ill-health, adopting the role of caretaker, or dealing with death that could also prevent bouncing back.

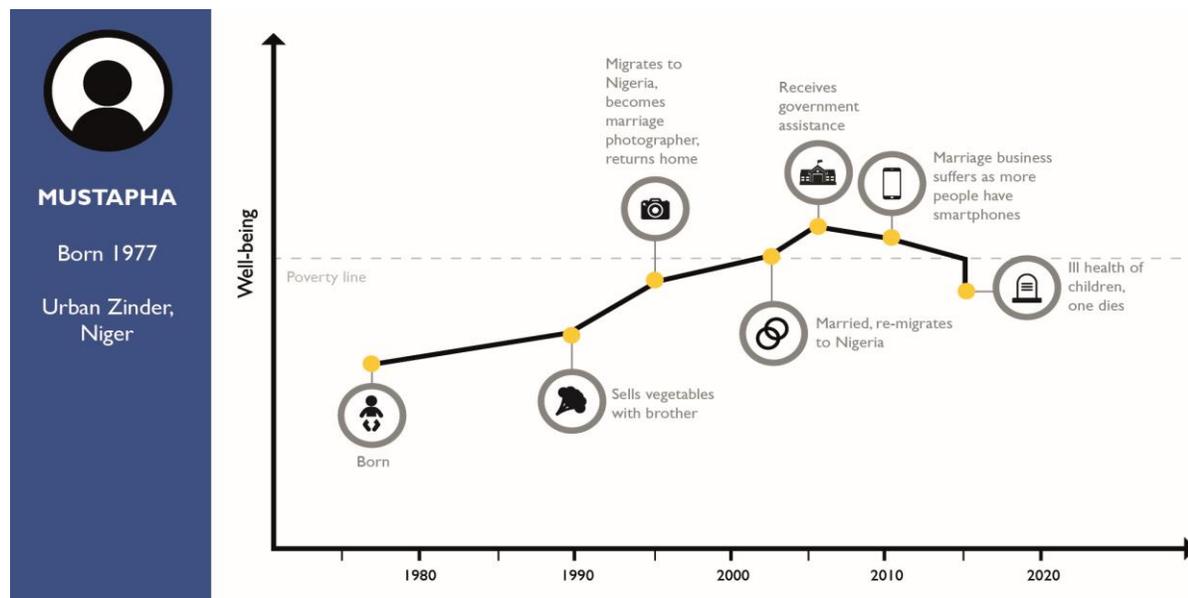
Box 2: Role of care and health costs prevent escape from being sustained

Chanyu was a successful farmer who benefited from cooperative union involvement, agricultural inputs and a loan from “Promotion of Rural Initiative and Development Enterprises” (PRIDE) to increase his farm production as crops were in sharp demand. He was thus able to move into agribusiness, by selling potatoes and other crops in bulk to businessmen coming from Iringa and Dar es Salaam. However, the chronic illness of his wife depleted his finances and made him a caretaker for four years until his wife died in 2014. He was unable to rejuvenate his livelihoods thereafter. Now he has only two acres of land and cannot afford to buy inputs, so harvests are low.

Source: LHI with Chanyu (M, 61 years old, transitory escaper) in rural Tanzania

The death of a household member can add additional burdens. In Cambodia, meeting funeral costs was noted to have negative consequences for the household as a whole. Death sometimes was enough to push households into poverty, as seen in Niger (Figure 3). In Kenya, death was also sometimes associated with the loss of land due to insecure land tenure and inheritance problems, with female-headed households having to fight off ‘land grabbing’ by relatives and even neighbors in the event of their partner’s death.

Figure 3: Ill health and death create a double financial burden enough to impoverish



The type of health shock matters. Being disabled is a shock that on its own can impoverish (Shepherd, 2017). Disability due to old age was seen to impoverish in many study sites (Box 3). Relatedly, chronically poor women with disabilities face a ‘triple discrimination,’ experiencing lower receipt of social transfers and vulnerable employment, and consequently often engaging in a distress sale of assets, making it particularly difficult to escape poverty in rural Bangladesh (Diwakar, 2017). This also has effects on multidimensional wellbeing in areas of life beyond income, aggravated through social exclusion, discrimination, stigma, and impeded access to social services (Davis, 2016).

Box 3: Disability due to old age as an impoverishing force

Fatem is a widow who is now around 100 years old, who experiences reduced sight and other health problems. She does not receive government support, lives in chronic poverty, and relies on her children. She states: “my house is just a hut. I have no bed; I have no cattle and no food. I have nothing in my house. I just wait for my children to invite me for a meal.”

Source: LHI with Fatem (F, approximately 100 years old, chronic poor) in rural Ethiopia

There are also other types of impoverishing health-related illnesses. Chronic health issues that require longer treatments such as diabetes, cancer, and tuberculosis were particularly expensive for life history respondents in the Philippines and drained the resources of families and extended family networks through the cost of treatment and care as well as lost earnings. Alcoholism is another chronic health problem, with domestic violence typically accompanied by accounts of drunkenness for example in rural Kenya and also associated with loss of wages. Mental health issues are also widespread though the type of mental illness is less often specified in the qualitative interviews, sometimes with impoverishing effects for the wider household as illustrated in Box 4.

Box 4: Impoverishment through chronic mental health issues

In 2010, my third born son who used to stay in Nairobi started to have a mental illness and began to disappear and come home. We took him to Mbale hospital where he was admitted for three days. We parted with Ksh. 49,000. The following year the problem persisted and took him to Kakamega where we spent Ksh. 39,000. In 2013, again the family used Ksh.42, 000 for his medication. In 2014, I was advised by the doctor to stop injecting him as he will continue to be violent and will require strong men to be holding him. Instead, he should be taking medication on daily basis. I used to have a well-stocked kiosk, but the business collapsed since 2013. My sons are not financially stable enough to help me. I depend on his aunt who works in Nairobi and assists in buying medication.

Source: LHI with Florence (F, 68 years old, impoverished) in rural Kenya

The sequencing of shocks also affects the degree of impoverishment. A small health shock may be managed, but a series of health shocks can impoverish (Box 5). Similarly, health and non-health shocks in close succession can combine to push households into poverty (Box 6 and Figure 4).

Box 5: A series of health shocks prevents poverty escape from being sustained

In the past, Ranya had to sell land to provide Tk 13,000 for her elder daughter’s uterus infection. She then had to sell even more land and trees in the same year when her son also fell ill and required clinical care for three months. For this illness, Ranya expended Tk 3 lakh 50 thousand. In the last three years, Ranya has also been sick. For her diabetes and pain, she spends Tk 500 each month. Fortunately, her eldest son sends her Tk 3,000 a month, and she receives irregular payments from her daughter so that she can afford the costs of medicines. However, to cope with their family’s medical expenses, Ranya has reduced her amount of food consumption.

Source: LHI with Ranya (F, 43 years old, transitory escape) in rural Bangladesh

Box 6: Transitory escapes through a combination of failure of a cash crop and a serious health shock

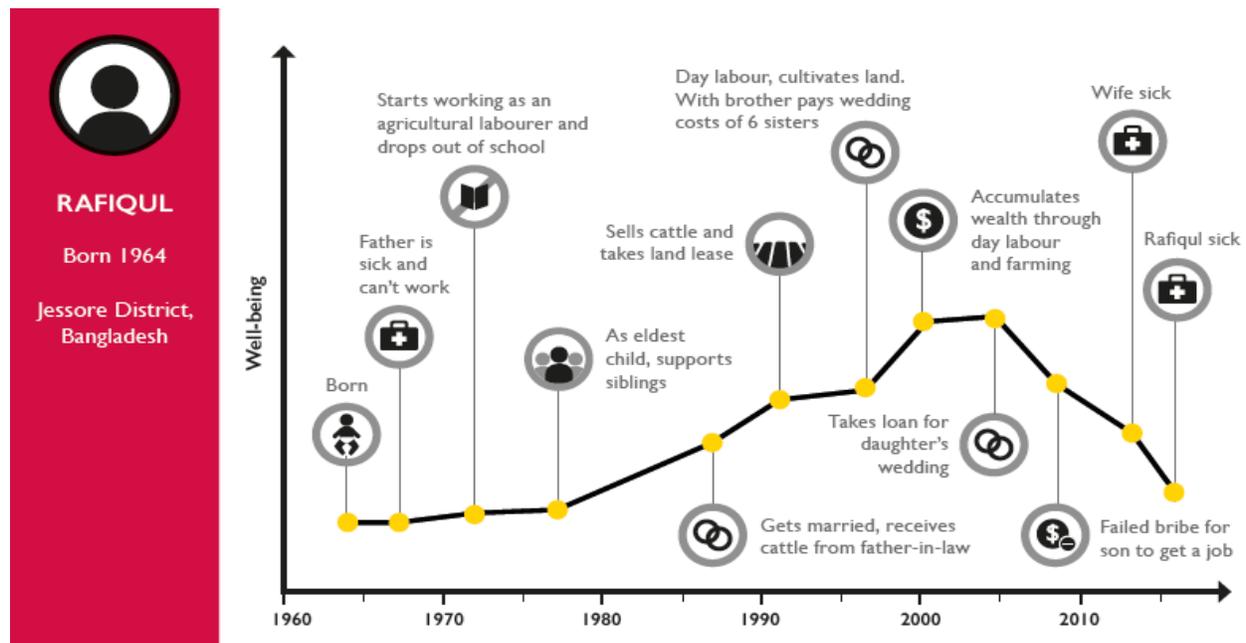
Ssenyonjo’s father was a fisherman and his mother was a subsistence farmer. He was the first-born of eight children. He went to school but dropped out in Senior 3 in 1989 because of his father’s death in a boat accident. There and then he became a breadwinner to his siblings, and so stopped schooling and

went into fish mongering at the age of 14. He learnt the trade from his father while he was still alive. He realized he had to stand up 'as a man.'

In 1992 he bought his first piece of land, which was three-quarters of an acre. Ssenyonjo later learnt that he could sell some fish and get into the coffee business, which proved to be more lucrative. At the peak of it, in 2005, he used to sell two truckloads a week during harvest. But in 2006 there was a heavy outbreak of coffee wilt disease, which completely destroyed his crops. He had workers to pay amidst other pending obligations and soon fell into debt. In 2014 he got infected by a complicated disease and needed an expensive operation. That further depleted his resources; he drew down his savings and sold some small livestock.

Source: LHI with Ssenyonjo (M, 45 years old, transitory escape) in rural Uganda

Figure 4: Multiple health shocks and non-health shocks exert downward pressures



BARRIERS TO HEALTHCARE REINFORCE IMPOVERISHMENT

Key Messages:

- The fieldwork indicated that most countries researched had low health insurance coverage in the fieldwork, even where policies were intended to reach a larger share of the population. Even having health insurance coverage, however, did not guarantee access to health care or that individuals would seek such health care.
- Problems of health service quality are widespread, and problems around access related to high user costs, such as for transportation to get to the healthcare center or the cost of medicines. As a result, many households opt for healthcare only in response to emergencies rather than as a preventative measure, while others forego treatment altogether due to high costs. This allows problems to go untreated and to build up over time, with the potential to increase impoverishment or a transitory poverty escape.

Most countries researched had low health insurance coverage in the fieldwork, even where policies intended to reach a larger share of the population. For example, many of the chronic poor in the Philippines were not PhilHealth members. Anton (rural Philippines) noted “My family and I don’t have

PhilHealth because we don't have the financial means to be a part of it." As a result, they did not have enough money to continue his father's treatment, who then eventually passed away. In Kenya, though the National Hospital Insurance Fund exists, only a small share of the population is covered and take-up remains low. For example, of the 60 life histories collected in our research in rural Kenya, only one person had enrolled in the government's health insurance scheme (Shepherd et al., 2018). Life history respondents cited barriers such as a lack of 'interest' and understanding of the product, as well as the cost of the premiums in opting out of the NHIF. In Cambodia, only six of the 60 life history respondents had an IDPoor card, and only 38 per cent of chronically poor households reported free or subsidized access to health care in the 2017 panel survey.

Even having health insurance coverage, however, did not guarantee access to health care or that individuals would seek such health care. In urban areas, these issues are sometimes particularly severe due to the inaccessibility of public health services, with supply often not increasing to meet demand in congested areas, and private facilities being more expensive for the majority of the poor. Partly as a result, the degree of impoverishment may be particularly high. For example, 16% of impoverished household heads in urban areas of Niger had a health problem that prevented the head of household from carrying out normal activities for more than two weeks, compared to just 2% amongst households that escaped poverty in urban areas, according to analysis of panel data in Niger between 2011 and 2014 (see Annex). These dynamics differ from rural areas, where just 3% of impoverished household heads in the panel dataset had a health problem preventing their normal activities (McCullough and Diwakar, 2018).

Quality concerns remain across areas of residence. In Cambodia, life histories indicate the quality of treatment varies between cities and villages. Meng, a sustained escaper, did not trust the village or provincial health center because of the lack of material and skillful staff. He and other sustained escapers instead prefer to attend hospitals in Vietnam. Similarly, key informant interviews in Malawi note that there is not enough medication in clinics and hospitals, with patients often asked to buy medications in private pharmacies. Women focus group discussants in the country also added that they were forced to travel long distances to receive health support, requiring high transportation and treatment costs. In Tanzania, in some cases the commute could be a ten-hour drive to a hospital necessary to treat more complicated conditions, sometimes associated with lodging fees in a less familiar city, leading qualitative respondents to measure cost by 'how many hours away' the hospital was.

Problems of access can also relate to high user costs, such as for transportation to get to the healthcare center or the cost of medicines. In Malawi, high user costs of government healthcare was particularly cited by female household heads. As a result of inaccessibility and low quality of health services, there may be preference for private medical care for convenience (Box 7), or traditional forms of treatment (Box 8).

Box 7: High user costs render private care an attractive substitute

Stella mentioned that a key benefit of being married was that her husband paid for private medical care which was closer to her house. This was especially important in the rainy season: 'During the rainy seasons the roads became impassable and so if her child was sick instead of going to free hospital (2-3km) she was able to have the money to go to the private clinic which was closer to her house - walkable distance.'

Source: LHI with Stella (F, 40 years old, transitory escaper) in rural Malawi

Box 8: Traditional treatments in place of formal healthcare

"The destitute and poor just stay home using traditional treatment in the village. They only go to hospital when they have a serious illness. Even though they have an ID Poor Card they do not use it as they do

not have a motorbike to travel 10km to reach the hospital. Also, nurses and doctors will not take care of them and give them treatment because they are not able to pay for it.”

Source: FGD respondent (F, chronic poor) in rural Cambodia

As a result, many households such as in Niger and Nepal only opt for healthcare only in response to an emergency rather than as a preventative measure, while others forego treatment altogether due to high costs. For example, Asenga’s husband underwent a series of operations, but on his last operation he refused, stating “I am not seeing any other future for me... save that money, you can use it in my funeral.” High opportunity costs also can prevent health access. Nena’s (urban Philippines, chronically poor) husband did not receive medical consultation for a cyst due to the possibility of her husband having to stop work. “We cannot afford for my husband to stop working. Our family relies on him,” she noted.

COPING STRATEGIES FOR HEALTH SHOCKS

Key Messages:

- **For households that were under health insurance coverage, with access to good quality health care, downward mobility due to ill health was rare, freeing up time and resources to contribute to sustained poverty escapes.**
- **Households without health insurance had alternative coping mechanisms, such as relying on savings, selling assets such as livestock, receiving support from family members and wider social networks, or taking out loans from informal moneylenders. These all have potentially negative impacts on future household wellbeing.**

For households that were under health insurance coverage, downward mobility due to ill health was rare, freeing up households with time and resources through which to sustain escapes from poverty. Rwandan life histories are prime examples in this regard (see Box 11 below). In other countries, coverage by health insurance, although rare, was also seen to benefit families and prevent downward mobility. For example, Lewis (rural Kenya, sustained escaper) was registered with the National Hospital Insurance Fund, so the hospital bills when his wife gave birth by caesarean were catered for.

Households without health insurance had alternative coping mechanisms to health shocks, such as relying on savings, selling assets such as livestock, receiving support from family members and wider social networks, or taking out loans from informal moneylenders. These are explored below.

Some households, particularly sustained escapers, were able to cope more easily with health shocks due to accumulated savings. This was especially true for single medical conditions. In Tanzania, poor health was often less of an issue for households that had sustained poverty escapes. For example, Juhudi (sustained escaper) recalls that when his wife underwent caesarean operations during childbirth his life “did not shake” due to savings. Meas (sustained escaper, rural Cambodia) had to have surgery for a tumor on her spine in 2018, costing USD 5-6,000. She drew down on savings, borrowed from family as well as USD2,000 from AMK microfinance, and USD1,000 from her husband’s employer. Some life history respondents that had sustained poverty escapes also viewed larger assets, such as their investments in property, as forms of insurance against ill health. For example, Time (sustained escaper, rural Malawi) mentioned that he invests in houses as a health insurance modality that would enable him to take care of the health needs of his family.

Amongst transitory escapers, medical conditions had the possibility of treatment and their cost managed instead primarily by the sale of assets, typically livestock. For example, Redo (rural Ethiopia) had to spend what he had on medical care with a lasting impact. “When the doctor referred my mentally-ill daughter to a big hospital in Addis Ababa, I had to spend Birr 11,000. Then my son got sick and I had to spend Birr

7,000 for medication. I had to sell my only ox to cover these expenses.”

Health costs are also managed through taking loans. The requirement of a quick infusion of cash often prevented households experiencing health shocks from applying for a formal or NGO loan. As a result, many families in Nepal for example often borrowed the required funds from relatives or informal money lenders, with the latter at high interest rates. Yet even in these contexts, households already in debt face limited options. “The debt to the villager money lender is still there. We can’t ask for anymore loans, as we can’t pay back the previous debts,” notes Chetan (urban Nepal). More generally, persons with disabilities can sometimes face constraints in loan acquisition (Box 9).

Box 9: Disability preventing an escape from poverty from being sustained

After I passed my class 10 exams I went to India to work, and so things improved a little and we were able to afford decent clothes and proper food. But then I fell down and broke my hip. I have been completely bed ridden for 5-6 months when I was in a paralyzed state. I had no money so couldn’t get any medical support. It was just a dislocated hip and if had received treatment back then I would have been perfectly fine by now. We didn’t have any money, so they couldn’t take me to a hospital for check-up. My brothers too weren’t of any help. Now, I could do better if I am able to grow my business but for that I need some money, which I currently don’t have. I can’t get loans from anyone because they believe that because I am disabled I will not be able to pay back the loans.

Source: LHI with Gaurav (M, 38 years old, transitory escaper) in rural Nepal

Social networks play a key role where health insurance coverage and other coping strategies remain inadequate (Box 10). In Cambodia, meeting funeral costs has also been addressed by burial societies or group insurance schemes. However, social capital typically remains weak for the chronic poor.

Box 10: Family networks in times of distress

In August 2017, Dindo began to suffer from severe stomach pains. As the main income-earner in his family, he continued to drive his tricycle albeit with great difficulty. However, by November, he became immobilized from the pain and was hospitalized for treatment of stomach cancer. Dindo has been staying at home this year because of his weakened condition and has stopped driving his tricycle. His wife, mother and two sisters now take care of him. His mother, who used to work in the rice fields, has recently stopped her work as well because of a worsening case of rheumatism. Nobody in his immediate family is working, which has put a strain on finances and reduced his family’s wellbeing.

Dindo’s family meet everyday subsistence needs through provisions by his brother, and his two sisters’ husbands who work in Legaspi city on minimum wage salaries. He now relies on siblings for his medical expenses. His wife on several occasions also asked her siblings and close relatives in Tabaco City to lend her money so that she can bring her husband for hospital check-ups and buy him his medicines. However, the family is unable to raise money for his treatments and has foregone a number of scheduled appointments and medications due to lack of funds.

Source: LHI with Dindo (M, 35 years old, transitory escaper) in rural Philippines

POLICY IMPLICATIONS

Key Messages:

- **Universal health insurance is a key policy that can help prevent impoverishment due to health-related shocks and help contribute to sustained poverty escapes. This may require developing a new health insurance system or expanding existing systems to more**

effectively provide safety nets for the poor. This also requires developing sustainable financing mechanisms.

- **Achieving universal health coverage is possible in different policy contexts. Rwanda has opted successfully for compulsion alongside improved quality of healthcare and subsidies for the poor, while others (Kenya, Tanzania, Nepal) have relied on devolved governance structures.**
- **For universal health insurance to succeed in preventing impoverishment and sustaining poverty escapes, public health systems including referral systems need to be up to the task. Increasing their effectiveness requires improving the coverage of health services and its quality (e.g. in terms of facilities, number of doctors, and technical support).**
- **Research results indicate a wide range of ailments and ill health that require an expansion or upgrading of existing health services. This includes better coverage of reproductive health, and improved responses to chronic medical issues and mental ill-health, and alcoholism, such that these do not contribute to impoverishment.**

Health policy has an important role to play in preventing impoverishment or transitory poverty escapes due to ill-health, and simultaneously building human capital that can nurture resilience capacities and sustained poverty escapes. However, different contexts can enable or constrain the success of these policies. For example, Rwanda is an outlier insofar as there was a relative absence of impoverishment evident in both the quantitative survey data (Simons, 2018) and the life histories (da Corta, 2018) as a result of ill health or health shocks. This is achieved partly through a context where compulsion is normalized within a highly centralized governance structure, alongside improved quality of health systems and subsidized premiums for the poor (Box 11).

Box 11: The impact of Rwanda's health insurance alongside improved coverage and subsidies for the poorest

Key to Rwanda's success in preventing health-related impoverishment is due to the requirement of health insurance premiums for all but the two poorest income segments, improving the quality of public health services including its referral systems, and public works which cushion shocks for the very poor. These measures resulted in over 80% of Rwanda's population being enrolled in the scheme.

The near absence of the impact of ill health on impoverishment was striking. For instance, Emmanuel (LH 18) survived a bad motorcycle crash which could have left him permanently disabled. The medical costs could have also impoverished his family. Instead, his fractures were healed in a hospital and though he complains of minor medical costs the family prospered after he was healed. We did see instances of those who sold land who didn't have health insurance (before health insurance legislation) such as for giving birth – and those who didn't have insurance but the frequency of impoverishing periods of ill health was fewer. This is confirmed in the national household panel data results, with having health insurance significantly associated with escaping poverty.

Even so, supply-side challenges remain in Rwanda, such as the sustainability of the cost of subsidizing premiums for the poorest and continued targeting errors in subsidizing the poor, according to KIIs. In terms of demand, there are tradeoffs that poor people sometimes have to make between paying premiums, education their children, and investing in businesses, for example.

Source: da Corta et al, 2018; Simons, 2018

There are also dangers in compulsion, particularly if fees must be paid for too many issue areas or are too steep. In Rwanda, there were small fees that added up and created barriers to involvement in government programs and market inclusion, such as fees to set up stalls for petty traders, to access SACCO credit, continue secondary school (including lunch costs, and teacher motivation costs, for example), and have photo ID cards for health insurance. This can also impoverish households or force households to make choices between for example educating children or developing homes and businesses (da Corta et al.,

2018). At the same time, it can be difficult for governments to subsidize enough poor people. These are concerns that the Rwandan government will have to grapple with in seeking to ensure the sustainability of its health financing for the poor.

Other countries like Tanzania and Kenya have also managed to make some headway in health outcomes for the poor through devolution, as illustrated in Box 12 for Kenya. The Kenya and Rwanda examples suggest that health policies can make a difference to resilience capacities and the quality and duration of poverty escapes, even in situations where households experience severe health shocks. Accordingly, the following sections highlight how specific policies, primarily universal health insurance, can be designed to prevent impoverishment and sustain poverty escapes. It also explores what is needed to ensure that health systems are up to the task of delivering quality healthcare for poor and near-poor households, and how health systems can better respond to the needs of vulnerable populations such as poor women and people facing mental illness.

Box 12: Devolution and health outcomes in Kenya

The 2010 constitution in Kenya, for example, led to the implementation of a serious devolution of power from central to local levels of government. Some county governors have managed to achieve more effective implementation as a result of increased local governance. There are counties where governors have been very active in promoting health services (Makueni, Kakamega, and Kisumu), which has included the initiation of conditional cash transfers for poor expectant mothers and improved maternal health services in some counties like Kakamega. There will also be four pilot Universal Health Coverage counties announced soon, where all households will have NHIF membership and government will subsidize those who can't afford the premium with a targeting system based on that used for the social protection schemes and developed with the World Bank. Several counties have also upgraded health facilities and so today are able to deal with a wider selection of ailments that earlier was only possible in a few national hospitals (KIHBS, 2018).

However, the emphasis almost exclusively on local governance structures has also resulted in wide variations in health outcomes sub-nationally, and quality of public services more generally remains a key issue. Health services have been devolved to counties, but the health budget based on capitation fees goes to the county treasury, apparently unearmarked, and may not reach the hospitals. The capitation system means that, if these moneys get transferred, over time there should be an improvement in quality. There is almost certainly a need to increase public expenditure on health – Rwanda with over 80% health insurance coverage of its population spends 7-9%, compared to Kenya's 5-6% of GDP on health (WDI, 2018).

Source: KII, unless indicated otherwise

UNIVERSAL HEALTH INSURANCE

Developing a new health insurance program

Developing a new health insurance program that can work towards universal health coverage requires research and evaluation into existing efforts to prevent duplication and build on lessons learned. In Niger, the previous *mutuelles assurance santé* need to be re-assessed to learn from past experiences. A new program could develop out of piloting in urban and rural areas, which is then scaled up to a national scheme, once public revenues are available to support it financially (Niger's public revenues are currently largely absorbed in tackling conflict). This is required in contexts like Niger where health insurance schemes do not exist or are of poor quality. Rural pilots could be linked to agricultural micro-credit programs where these reach poor households, undertaken with direct provision of health services or

partnering with the government to upgrade services (Shepherd, 2018). Doing so could help reduce health shocks and build human capital such that households' strengthened resilience capacities can contribute to sustained poverty escapes.

Experiences for Niger to learn from include Rwanda (Box 11 above), and the 'mutuelles' (community-based health insurance schemes) closer to home in Senegal and Mali (Shepherd, 2018). However, a recent evaluation of their insurance schemes found challenges in terms of a lack of proper establishment of the scheme at the village level, inadequate development of scheme managers supported by volunteers, insufficient coverage of prevalent illnesses and medical conditions, poor development of pilots, and an inability to properly manage the subsidy of premiums (Ouattara and Ndiaye, 2017).

Expand health insurance to more effectively provide safety nets

Where health insurance does exist, health care that is free at the point of delivery can offer an important protective function for households, and free up resources that can then contribute to sustained poverty escapes. Particularly in contexts of limited resources and health financing, it becomes important to prioritize health financing for direct and indirect 'user' costs borne by high-risk groups and vulnerable populations. This partly requires improving targeting mechanisms. In Cambodia, for example, there were known exclusion errors in assessments for ID Poor Cards through which poor populations could receive free healthcare, with some interviewees perceiving that the system was unable to track changes in wellbeing between assessment periods which occurred every three years (Bird et al., 2018). In this context, more frequent revision of the ID Poor lists would be appropriate (Shepherd, 2018).

Informal workers are a vulnerable group often with low health insurance coverage. In Kenya, since 2013 the government has made attempts to expand coverage to informal workers (Box 13), but enrollment is voluntary and take-up is low. The absence of employer contributions to social protection coverage for informal workers often means that these workers have little protection. This is particularly problematic where the informal work was in professions hazardous to health, like tricycle driving in the Philippines or rickshaw driving in Bangladesh (Diwakar, 2018; Begum and Sen, 2004). In these contexts, "enforcement of road safety, improved public provisioning of emergency health care, and better coverage of urban primary health care systems" is needed (WHO, 2017). Occupational hazards should also be addressed as public health concerns that are preventative rather than curative. This can help bring together government line agencies, organizations working towards improving road safety, and civil society more generally (WHO, 2017).

Box 13: Constraints and ongoing discussions around Kenya's health insurance fund

Kenya's National Hospital Fund (NHIF) now has 8 million members (in addition to their spouses and children under 18). Of these most are formal sector workers, where membership is compulsory and premiums are graduated (KES 150 to 1700), and 1.7 million are voluntary members in the informal sector, paying a flat premium of KES 500. Retention of members is a challenge: many join for a specific purpose (e.g., birth of a child) and then don't continue paying premiums. Poverty is the main constraint on expansion of membership. Various efforts are underway to tackle this issue: (i) around 300,000 social protection beneficiaries have been given membership cards; (ii) older people over 70, have been registered and will receive cards once government has transferred the budget; people with severe disabilities and Orphans and Vulnerable Children in receipt of cash transfers also get free membership; (iii) the World Bank's Health Insurance Subsidy Programme, which subsidized 500 households in each county; (iv) development of an 'agency' model, in collaboration with Equity Bank, making use of existing savings and loans groups to persuade people to keep up payments.

There is a discussion about the premium level for informal sector members, as KES 500 is much higher

than the lower end of the formal sector premiums (KES 150). KES 300 has been suggested but this would create financial sustainability issues, as the poorest people are those who use the most services. Cross subsidy among members, and further allocation of government budgets will be necessary to expand the membership to the bottom of the income distribution.

Source: KII

Another approach taken in Kenya is to combine social protection instruments, for example by automatically enrolling social assistance beneficiaries onto the health insurance scheme and for the government to pay premiums. Here, the issue is how to ensure sustainability of financing and ensure that health services can deliver for the increased numbers of patients that may result (Shepherd, 2018).

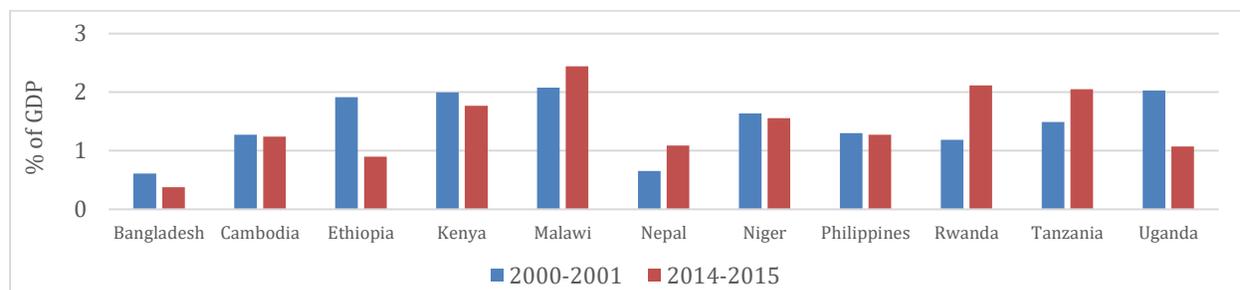
It is vital to include the near-poor in health insurance as much as can be done, since they will be able (and possibly willing) to pay the premiums on which the financial sustainability of the whole enterprise depends. Households across countries that experienced only transitory rather than sustained escapes from poverty were often not poor at the moment when a health shock or non-health shocks struck. Even here, the Rwanda evidence suggests that the near poor may have difficulty paying premiums, especially if they are required to pay several other fees at the same time. This was also an objection to community health insurance in Tanzania (da Corta et al., 2018). These combined fees may limit their ability to invest in productive assets that can build resilience capacities and contribute to sustained poverty escapes.

In conjunction with supply-side expansion, it is important to ensure uptake. Across countries, common reasons for not having health insurance cited by focus groups and life history respondents was a lack of money and perceptions of high cost of insurance. Improving awareness and education of the benefits of health insurance can overcome inaccurate perceptions. However, ‘no country has attained universal population coverage by relying mainly on voluntary contributions to insurance schemes, whether they are run by nongovernmental organizations, commercial companies, “communities”, or governments. Compulsion, with subsidization for the poor, is a necessary condition for universality.’ (Kutzin, 2012). The art of creating a successful social health insurance scheme involves combining risk pools (contributors and non-contributors) and revenue sources (premiums and government revenues) (Kutzin, 2012).

Financing health insurance for the poor

Public spending on health varies greatly, from 0.39% of GDP in Bangladesh to 2.67% of GDP in Malawi in 2015 (WDI, 2018). The share of health spending increased in only four countries since 2000, and even decreased considerably in some countries like Uganda and Ethiopia (Figure 5). The largest increase in government general health spending is in Rwanda, which close to doubled its spending on health since 2000, when measured as a share of its GDP.

Figure 5: Domestic general government health expenditure (% of GDP)



Source: WDI, 2018

Especially in low income countries with limited government budgets, there is a need to find ways to finance the costs of health insurance for the poor. Innovative financing schemes and efforts at cross-subsidization exist and are worth emulating: congressional approval of a law on restructuring excise taxes on alcohol and tobacco in the Philippines created \$1 billion which was mainly allocated to the needs of the poorest in the health sector (Padilla, 2016; Wild et al., 2015). Another example is provided in Box 14.

Box 14: Risk transfers to facilitate health insurance for the poor in the Philippines

Action Against Hunger works in communities displaced by conflict or affected by disasters and implements programs to improve resilience of vulnerable communities throughout the Philippines. It has recently extended the concept of risk transfer mechanisms to the health sector, by using community savings group as a platform for introducing health micro-insurance. With a co-payment scheme of 60-40, the members of the NGO's community savings group who elect to be part of the health micro-insurance bear 60% of the premium for annual health insurance coverage, while Action Against Hunger shoulders the remaining 40%. Members of the health micro-insurance scheme, after opting into this risk transfer mechanism, would then be able to avail of PHP10,000 to PHP20,000 worth of medical benefits in case of illnesses requiring hospitalization. Currently, 31 of the 60 groups that have been organized by the AAH have been enrolled in this scheme. The NGO simultaneously continues to engage community members on the importance of risk transfer mechanisms through its financial literacy program.

Source: KII with Action Against Hunger, Philippines

Other options to consider as complements could include the development of public-private partnerships, given that many nongovernmental organizations already work closely with poor populations, or community-based responses. However, there is a vast literature arguing that public-private partnerships have not shown to work well for the poor in resource-constrained environments (World Bank, 2016). Similarly, community financing mechanisms have had mixed responses particularly in contexts of local governance (Box 15). So neither option would be a substitute for financing, but rather could help defray some of the costs of targeting.

Box 15: Community Health Funds in Tanzania

Tanzania's Community Health Funds was designed partly to increase local revenue for health and improve the quality of health services through empowering local communities. Its income stems from member contributions matched by central government grants. However, lack of clear guidelines for its implementation has created variations in CHF schemes. Even though former President Mkapa urged districts to cover CHF premiums for the poor, local responses varied. In some areas, the local authorities relied on private companies or NGOs for one-time support, which was largely unsustainable. "Anecdotal evidence suggests that 1 in 10 districts allocate their own resources to pay for CHF premiums for the poor." In this context, Tanzania's new Health Financing Strategy is expected to improve health sector outcomes and help advance health coverage for the poor. Its core reform is in creating a mandatory Single National Health Insurance for all citizens, financed through cross-subsidization between the rich and poor. Its explicit objective is to establish a pro-poor financing mechanism. For this to be successful, it needs to be complemented by quality services available for the poor.

Source: Wang and Rosemberg, 2018, unless stated otherwise

IMPROVING HEALTH SYSTEMS TO MEET LOCAL NEEDS

Improve quality of healthcare

For health insurance to help prevent impoverishment or escapes from poverty that are only transitory rather than sustained, health systems need to be strengthened. In particular, health services delivery should

“assure dignity, confidentiality, autonomy, quality, and timeliness of services for poor and marginalized people” (USAID, 2015). This includes making use of alternate supply chain systems where standard ones are not functioning (USAID, 2018). Health referral systems are also critical. Many poor patients bypass primary public healthcare facilities due to low quality facilities, few doctors, weak technical support, non-availability of drugs, with resulting high costs and overcrowding. Box 16 highlights ways in which quality has been improved in the HEF in Cambodia.

Box 16: Increased uptake of health services due to quality and fee payments in Cambodia

‘Three configurations of HEF were examined for their ability to attract beneficiaries to initiate care at public health facilities and their degree of financial risk protection: HEF covering only hospital services (HoHEF), HEF covering health centre and hospital services (CHEF), and Integrated Social Health Protection Scheme (iSHPS) that allowed non-HEFB community members to enroll in HEF. The iSHPS also used vouchers for selected health services, pay-for-performance for quantity and quality of care, and interventions aimed at increasing health providers’ degree of accountability. A cross sectional survey collected information from 1636 matched HEFB households in two health districts with iSHPS and two other health districts without iSHPS.’

The additional interventions under iSPHS appear to be better than stand-alone HEF in attracting sick beneficiaries to public health facilities and lowering their direct costs.

56% of beneficiaries in districts with iSHPS initiated care at public health facilities, higher than the 40% observed at Comprehensive HEF and much higher than the 13% for Hospital Only HEF. Costs were also lowest in iSPHS districts. Lower costs resulted from the high use of primary health care facilities, lower user fees at public health facilities as well as at private facilities, and less use of other providers. Awareness about entitlements was also important for beneficiaries to access available services.

Source: Jacobs et al., 2018, in Shepherd, 2018

Expand coverage of health services

Improving the quality of public health facilities is only part of the solution in developing resilience capacities, preventing impoverishment, and sustaining poverty escapes. Across contexts, accreditation of health facilities by health insurance providers should expand to remote areas where many of the poorest households reside and where need is greatest. For example, qualitative evidence from Tanzania and Nepal suggests that individuals may travel long distances to reach specialist hospitals (da Corta, 2018; Diwakar, 2018). In this setting, there is a need for policies on location of specialist facilities, which make it possible to attend for as many people as possible.

Nepal is making some headway in offering commitments that if implemented can improve accessibility. In its National Annual Review, the Ministry of Health in Nepal put forth a set of commitments underpinned by a desire for social inclusion. This included special focus on the health of farmers, laborers, Dalits, women, children, differently-abled people and senior citizens. One of its 26 commitments was career development incentives for health workers to stay in remote areas of the country, while connecting facilities in these areas with specialist hospitals to improve referral mechanisms (MoH, 2017).

EXPANDING SUPPORT FOR WHAT CONSTITUTES ILL HEALTH

The furthest behind not only often face intersecting deprivations, but may also experience different forms of ill health typically not covered in primary or even secondary healthcare facilities. There is a need to take into consideration various forms of ill health, such as chronic illnesses, alcoholism, mental-health problems, and reproductive health, which are prevalent in many contexts and may prevent households from sustaining escapes from poverty. Efforts in these areas have varying levels of success.

Sexual and reproductive health

In some countries, early marriage and teenage pregnancies were the norm in rural areas. In Niger in urban and rural settings, this situation was particularly pronounced, with maternal health being the biggest associated health issue even amongst sustained escapers. In contrast, health concerns were less of an issue in Malawi, and virtually absent in the Rwandan life histories. Box 17 explores reasons for these discrepancies and offers suggestions on how to improve maternal health outcomes.

Maternal and child services are also important in these contexts, particularly around sexual and gender based violence which can have lasting physical and psychological effects on its victims and may also contribute to mental health problems (explored below).

Box 17: Differences in maternal outcomes in Rwanda, Malawi, Niger, and Uganda

Malawi, Niger, Rwanda, and Uganda are comparable in terms of experiencing resource scarcity and until recently a heavy reliance on external sources of financing for their public healthcare. Yet, Rwanda and Malawi has seen a dramatic fall in maternal mortality ratios since 2000, while Uganda experienced just a small decrease and the improvement in Niger was almost negligible.

An effective public education campaign in Rwanda on the importance of family planning and antenatal care was important in leading to an increase in the uptake of maternal health services. There has also been fines for women who do not attend this care and deliver in health care centers. Evidence suggests that Malawi has also progressed in some of these areas.

Timely transfers to higher-level facilities have been important for progress. In Rwanda, community health insurance and voluntary community health workers have helped reduce bottlenecks, and there has been more ‘waiting wards’ for expectant mothers.

In Niger, however, patients have to pay for fuel and other expenses even though ambulances are available, sometimes limiting the ability of poor people to use these services. Subsidies should account for high user fees if the goal is to improve health outcomes amongst poor and near poor populations.

Another key aspect in promoting uptake has been the improved service of healthcare in local facilities in Rwanda. In contrast, in Uganda, health centers continue to experience overcrowding, low numbers of staff, and opening hours that are “rarely respected”. In Malawi and Niger, additionally, staff attitudes have been found to be less respectful towards patients.

Source: Chambers and Booth, 2012.

Mental health problems

Factors associated with poverty are also often linked to mental health. Chronic poverty can be associated with exclusion or adverse inclusion, which contributes to insecurity in ways that could affect people’s mental wellbeing. This may be particularly prevalent for marginalized persons with disabilities, indigenous people, displaced people or those exposed to disaster and conflict, and people who experience other forms of chronic illness (Bird and Pratt, 2004). Individuals in these vulnerable groups may be more at risk for developing symptoms of depression, anxiety, post-traumatic stress, alcohol abuse, etc.

As people’s mental wellbeing is reduced, their ability to build the livelihoods and assets conducive to sustained poverty escapes is also affected. The WHO’s Mental Health and Poverty Project in South Africa and Uganda offer some recommendations in breaking this vicious cycle (Box 18). ‘The negative economic consequences of mental illness greatly exceed the costs of treatment. Thus it is important to treat mental illness’ (Insel, 2008, in Yeramilli and Bipeta, 2012).

Box 18: Interventions to break the cycle of poverty and mental ill health in Uganda and South Africa

The Mental Health and Poverty Project was a research consortium that sought to provide evidence on what policies are needed to break the cycle of poverty and mental health problems, and work towards improved access to mental health care for the poorest communities. Its studies on South Africa and Uganda offered the following recommendations:

- Coordinated interventions across mental health and poverty policy and programming
- Evidence for cost-effective interventions should be brought to the attention of policy makers
- Integration of mental health into primary health care to ensure equity and access to affordable mental health care
- New mental health policy should link with existing poverty reduction programs
- Mental health impacts of poverty reduction programs should be assessed
- Recovery and inclusion of people with mental disabilities should be promoted
- Users of mental health care should be targeted for inclusion in employment generation programs
- Access to social grants and state support is needed for mental health care users who are unable or constrained in their participation in income generating activities due to their psychosocial difficulties

Source: WHO, 2008; Kigozi and Ssebunnya, 2009.

However, it is not clear that western models of mental health treatment can be effective in the often very different, varied and diverse cultures of developing countries (Bass et al., 2007). The alternative is to ‘establish a model based on [people’s] needs with small baselines in-country surveys that focus on values, beliefs, resiliency, health promotion and recovery (Kopinach, 2015). There is now a plethora of innovative projects generating new and context relevant models of treatment. These include initiatives, which integrate traditional healers, community health workers, social networks and develop referral systems to specialist clinics.¹

A focus on gender-specific interventions is also needed. Depression or anxiety is more common amongst women linked sometimes to sexual and gender-based violence, while other mental health issues like alcohol dependence is common especially amongst men. These relate to underlying risk factors including gender-based roles and socioeconomic disadvantage. Yet the cause of these differences are under-researched and so therapeutic approaches and health provisions are often in their infancy (Riecher-Rossler, 2016). Programs focusing on cognitive behavior therapy, for example in relation to substance abuse and mental health issues, would be welcome in these settings, building on extensive research conducted in non-western contexts to examine the common elements of evidence-based mental health interventions (Murray et al., 2014).

CRITICAL LINKS

Resilience will be achieved most rapidly and comprehensively if there are policies and programming covering the major risks faced by poor and near-poor people. This requires a holistic approach which

¹ Examples include: Canada’s Global Challenges programme: https://www.eurekalert.org/pub_releases/2016-01/tca-pia012116.php

assesses the major impoverishing hazards of different kinds and provides a policy or programming response to each one. Health programming needs to take account of non-health risks; and non-health risk policy makers and programmers need to think about health-related risks. Otherwise the gains to be made from reducing impoverishment in one field can be negated if risks from another field are not covered.

Given the number of important risks to be covered, and the diversity of government agencies involved in covering them, the co-ordination of a risk informed poverty eradication approach should probably be with a prime minister's or president's office. In a programming context, mechanisms for breaking down sectoral silos will be needed to achieve risk informed programming.

The analysis here suggests that the degree of impoverishment due to ill health depends on how the shock manifests, the succession of events surrounding the health shock, barriers to treatment and services and contextual factors more generally related to health insurance coverage and user costs. Health insurance can help mitigate these adverse effects and help build resilience capacities of households, but this needs to be tied to investments in other areas. Pro-poor education could directly ensure that populations understand the importance for example of taking preventative healthcare measures, but also indirectly benefit poor job-seekers and build knowledge on nutrition that can ward off certain forms of ill health (Ensor and Cooper, 2004). Improved access to financial services for the poor could also help households respond to health shocks even in the absence of insurance coverage. A study of the slums of Pokhara, Nepal found that households with savings accounts increased their education expenditures by 20%, and their income was less affected by health shocks (Prina, 2013). Cash transfers combined with other forms of support can also help households graduate from social assistance and improve liquidity in times of crises.

In Ethiopia, there are benefits from bundling community-based health insurance together with the Productive Safety Nets Programme. 'Individuals covered by both programs, as opposed to neither, are 5 percentage points more likely to use outpatient care, ... 21 percentage points more likely to participate in off-farm work, ... and participation in both programs is associated with a 5 percent increase in livestock, the main household asset, and a 27 percent decline in debt' (Shigute et al, 2017). There are similar findings from a Unicef/IFPRI evaluation of the overlap (Box 19).

Box 19. Linking Community Based Health Insurance with the Productive Safety Net Program

A study using rich household survey data from the areas covered by the PSNP found that though PSNP has had a positive impact on improving household food security and preventing asset depletion, many PSNP households remain vulnerable to sudden illnesses. Several PSNP households reported unexpected illnesses leading to cuts in their consumption, losses of their assets, or both. This is particularly worrying, considering PSNP's core objective of improving food security. Health insurance would help, but less than 25 percent of all PSNP beneficiary households were enrolled in CBHI. Moreover, less than half of the enrollees had their CBHI insurance premiums waived. Considering that PSNP participants include the poorest and most food insecure households that would potentially greatly benefit from health insurance, this relatively low proportion of CBHI clients receiving premium waivers is of concern (Hirvonen, et al, 2017).

Health insurance has been explored in this brief as a major line of action against the impoverishing effects of ill health while also indirectly helping build resilience capacities to promote sustained escapes from poverty. To work, it requires accompanying improvements to health services, including referral systems, as well social marketing if not compulsion to join and pay premiums, and subsidies for the poor who cannot afford paying premiums. If Rwanda can do it as a LIC, LMICs are likely to be able to manage a significant effort. Other LICs with weaker governance and political systems than Rwanda may need considerable support from development partners over a substantial period of time, particularly in resource constrained environments.

At the same time, health may be less of a priority for people (and politicians) than education or hard infrastructure like roads. In this context, government expenditure and other effort may be less than for other policy areas. Nevertheless, it is certainly possible to combat ill health as a source of impoverishment. Rwanda illustrates this, though remains an outlier by comparison to the other countries studied. Strategies to increase demand for health services are needed here, which can lay the foundation for increased expenditures. Such strategies include financial services such as conditional cash transfers or community-based health insurance, enhancing patient transfers through emergency transport funds and intermediate forms of transportation, and nurturing community involvement through community-based interventions and women's and other groups practicing participatory action (Elmusharaf et al., 2015).

Finally, it is worth highlighting that health insurance is only part of the story to helping build resilience and promote sustained poverty escapes. The analysis of drivers and processes of escaping poverty also highlight the many risks households experience that can threaten their ability to sustain these escapes over time (Diwakar and Shepherd, 2018). What is needed is risk-informed poverty eradication programming. Households experience various risks requiring forms of insurance, including around asset loss, sometimes due to theft. Preventing these other shocks that can aggravate health shocks when they do occur will be a necessary component in a holistic approach to risk-informed programming. There is a lot of attention to this in climate change and disaster risk management circles, but few examples of comprehensive or holistic risk approaches. Building on this holistic framing and relating it to the need to sustain health outcomes in the face of shocks and stresses is an area ripe for future research.

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ANNEX

TABLE A1: CPAN COUNTRY STUDIES OF POVERTY DYNAMICS

Country	Country report	Panel data (years/ households)		Qualitative data (sample/date)			
		Rural/urban ²	Source ³	Dataset and years	N	LHI	FGD
Bangladesh (R)	Scott and Diwakar, 2016		Chronic Poverty and Long Term Impact Study: 1997/2000, 2006, 2010	1193	60 (2016) 24 (2016)	0 6	0 18
Cambodia (R)	Bird et al., forthcoming		Agriculture, Rural Development and Poverty Reduction Survey: 2001, 2004, 2008, 2011, 2014, 2017	852	60 (2018)	36	24
Ethiopia (R)	Mariotti and Diwakar, 2016 Woldehanna et al., 2018		Ethiopian Rural Household Survey: 1994, 1995, 1997, 1999, 2004, 2007, 2009 Living Standards Measurement Survey: 2011, 2013, 2015	1056 3388	23 (2016) 75 (2017)	2 8	3 10
Kenya (R)	Scott et al., 2018		Tegemeo Agricultural Panel Survey: 2004, 2007, 2010	1243	60 (2017)	4	15
Malawi (R & U)	Da Corta et al., 2018		Malawi Integrated Household Panel Survey 2010, 2013	1720	40 (2018)	8	23
Nepal (R & U)	Diwakar, 2018a		Nepal Living Standards Survey: 1995, 2003, 2010	434	40 (2017)	8	18
Niger (R & U)	McCullough and Diwakar, 2018		Living Standards Measurements Survey - National Survey on Household Living Conditions and Agriculture: 2011, 2014	3436	40 (2018)	8	14
Philippines (R & U)	Diwakar, 2018b		Family Income and Expenditure Survey: 2003, 2006, 2009	6519	40 (2018)	8	19
Rwanda (R & U)	Da Corta et al., 2018		Enquête Intégrale sur les Conditions de Vie des ménages: 2010, 2014	1920	79 (2018)	12	25
Tanzania (R & U)	Da Corta et al., 2018		Living Standards Measurement Survey – National Panel Survey: 2008, 2010, 2012	3079	20 (2017) 60 (2017)	8 24	15 29
Uganda (R & U)	Scott et al., 2016		Living Standards Measurement Survey – National Panel Survey: 2005, 2009, 2010, 2011, 2013	1398	24 (2016)	6	21

² Some datasets are not nationally representative, which affects the generalizability of results. For example, the Bangladesh survey was purposively collected purely in certain rural areas of the country. Nevertheless, these surveys still broadly characterize the variability of livelihoods and ago-ecological zones in rural areas.

³ Please refer to Chronic Poverty Advisory Network country reports for country-specific qualitative analysis as well as tables of regression results, summary statistics and other quantitative analysis into the drivers of sustained and transitory poverty escapes. Note: Regression results for rural Bangladesh and Uganda are slightly different to those in the 2016 reports as a result of modifications to the earlier data approach.

⁴ This includes the overall number of interviews at national and local levels, as well as individual or group interviews with knowledgeable community members. In Rwanda, this refers to local level/ district interviews.