



# MARKETLINKS AGRILINKS

## HEALTH, RESILIENCE AND SUSTAINABLE POVERTY ESCAPES

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QUESTION AND ANSWER TRANSCRIPT

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## PRESENTERS

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Vidaya Diwakar, Chronic Poverty Advisory Network

Tiffany Griffin, USAID Bureau for Food Security

## OPENING REMARKS

Julie MacCartee, USAID Bureau for Food Security

Julie MacCartee: Welcome, everyone. On behalf of the US Agency for International Development and the Feed the Future Initiative, I would like to welcome you to today's seminar on Health Resilience and Sustainable Poverty Escapes. This seminar is a joint production of Agrilinks, Microlinks and the US AID Center for Resilience so we've got a lot of players coming together to hold this discussion on a cross-cutting issue of health and how it relates to the other sectors. My name is Julie MacCartee and I'm a knowledge management specialist with the US AID Bureau for Food Security and I am your Agrilinks facilitator so if you've been to an Agrilinks event before, you've probably seen me up here. And if you have any feedback about Agrilinks events, Marketlinks events or any of the knowledge sharing experiences at the US AID Bureau for Food Security, I'm happy to answer those questions. Before we get started, I wanted to go over just a few housekeeping issues. First, for those of us who are joining in person, please silence your cell phones so that we don't interrupt the speakers. If you're joining us online, you are welcome to not silence your cell phones if you wish. On that note, we do have a sizable online audience expected today. We actually had about 600 people register for the webinar, which I think is a record number for an Agrilinks or Marketlinks webinar so that's exciting. We'll have more people joining us online than we have here in the room. We will be holding questions and answers until after the presentations and we'll come pass around a mic to those of you in the room and we'll alternate questions with the online and in-person audiences. We are also recording this webinar and if you signed up to attend or signed in on the sheet out there, you will get an email with the recording, the transcript and some additional recommended resources. All right, I think that's all I've got for introductory pieces so I'm going to introduce our speakers and then pass it off to them. So we will have Tiffany Griffin giving an introduction and framing the work that you'll be hearing about today. And she's with the US AID Bureau for Food Security and is the resilience measurement monitoring evaluation and analysis or does that work for the work for the US AID Center for Resilience. We also have Vidaya Diwakar, who is a mixed methods researcher at the Chronic Poverty Action Network specializing in gender, disaggregated analysis of poverty dynamics, conflict and education. She'll be next. And then next up will be Andrew Shepherd with the Chronic Poverty Action Network and Andrew has been with CPAN since its inception in 2011 and with ODI where CPAN is now hosted since 2002 and he has three decades of work on poverty under his belt. And, lastly, we will welcome Lynn Michalopoulos, who is a consultant with the Center for Resilience at US 4 AID and is providing expertise and technical support related to resilience measurement and analysis, especially as it relates to psycho-social factors. And she is also currently an associate professor at Columbia School of Social work. But first – oops, go back to Lynn there. I'll head back here. First up we'll have Christine Gottshalk, who is the acting director with the US AID Center for Resilience. And she brings over 15 years of experience

in international humanitarian and development assistance and she'll be giving a welcome on behalf of the Center for Resilience so first up, Christine.

Christine Gottshalk: Hi. Good morning, everyone. Thank you so much for joining. But first I just want to thank Julie and the whole Agrilinks team for hosting this event. It's great that we're setting a record and have over 600 people who are registered for this webinar. It really, truly is great to see so much interest in resilience and also in this topic in particular really looking at health, resilience and the links with sustainable poverty escapes. US AID is committed to helping to build the resilience of vulnerable communities and to increasing their ability to manage through crises and without compromising their future well-being. Evidence like this work by ODI has been and continues to be really critical in advancing our understanding of resilience, why it matters and how it is different and in shaping the vision for the agency. Some of you may be aware the proposed US AID redesign recognizes that resilience is needed to break the cycle of chronic vulnerability, poverty and hunger. It's needed to reduce the need for recurrent humanitarian assistance and to accelerate progress on the journey to self-reliance. And as a result, it really is being elevated as we look at the future work of the agency. This work that we're going to learn about today by ODI furthers our understanding of health shocks on the household and approaches that we can take to help build resilience. So without further ado, I invite Tiffany to start us off so we can get into the meat of the discussion. And thanks all and many thanks to our speakers today.

Tiffany Griffin: Hi. Good morning, everyone. I'm just going to keep talking until someone tells me that my audio isn't working. My name is Tiffany Griffin and I am the lead for resilience measurement and analysis for the Center for Resilience. Thank you to everyone who is attending today's webinar. I'm really excited to convene this group to talk about today's work. Just as a little bit of background, this works off of three pilots on resilience and sustainable poverty escapes that we did a couple years ago in Uganda, 5 Bangladesh and Ethiopia. And in those pilots a few themes emerged and bubbled up to the top. So the first is that development progress isn't linear so there are dynamics. For all of the gains that we have with respect to strengthening our development outcomes, those gains can easily be lost at macro levels and at a household level. So the short version of that is there are dynamics in and around the development outcomes that we care about. Sizable proportions of communities escape poverty and that's good. But these analyses showed that they also fall back into poverty at alarming rates. Another big theme that emerged from that initial set of pilot case studies is that shock, particularly those occurring sequentially so back-to-back

shocks and including idiosyncratic shocks or those shocks that cumulatively affect individual households really matter for sustaining development gains. And then third, many of the sources of resilience that began to emerge, these resilience capacities that help households and communities manage risk in the face of recurrent shocks and covariant shocks also seem to help households escape poverty and stay out of poverty over time. So they have these dual advantages, these sources of resilience. So these findings have been extremely powerful to date. They've helped countries that do not necessarily face those recurrent crises like recurrent drought or recurrent flooding. They've helped those types of context and countries and populations apply resilience thinking and approaches to their context. Because of the initial power – because of the power of these initial pilots, we partnered with ODI to conduct another set of case studies in a second set of countries and they'll be talking about those results today. But in designing this convening to bring our resilience community together to discuss the collection of case studies at large, we decided to focus in on rather than looking at poverty dynamics at large, we decided to focus in on a theme that kept emerging across these case studies and that theme is the theme of health. So theoretically health should intersect with resilience and poverty dynamics in at least three ways, right. First, ill health at the individual, household and/or community level can present a shock that threaten sustainable poverty escapes over time. Second, positive health statuses so including healthy nutrition, strong health systems, widespread access to affordable health insurance – these act as important sources of resilience or important resilience capacities in the face of shocks and stresses that protect households' poverty escape over time, help them sustain their poverty escape over time. And then, 6 third, health outcomes are in and of themselves development outcomes that need to be protected in the face of shocks and stresses. So today's presentation that Vidaya and Andrew and Lynn will guide us through puts some analytics and some analysis to that conceptual and theoretical frame. In today's presentation you'll hear our colleagues focus in on those first two ways that health, resilience and poverty intersect, namely the importance of health shock and the importance of health as a resilience capacity with respect to protecting poverty alleviation over time. And it's my hope that in addition to yielding important findings in and of themselves that this work also prompts some of the folks in the audience today to take on analysis of that third bucket as well: analyzing health outcome dynamics in the face of shocks and stresses. So with that, thank you again to our ODI colleagues for leading these analyses. Welcome, again, to all of you who are attending today's webinar and a big thanks to our K-Dad Center for Resilience and BSF colleagues for organizing this event. Vidaya, over to you.

Vidaya Diwakar: Thank you so much, Corrine. Thank you for that. So hi, everyone. My name is Vidaya and I work in the Chronic Poverty Advisory Network. In this presentation I will first find the slide. I will first begin by providing a big of context, outlining some methods and providing some background motivation for this set of work that we've been undertaking over the last two to three years as Tiffany mentioned. And this will then be followed by some synthesized findings across country studies to then contextualize what Andrew Shepherd, director of CPAN, will be speaking about which will be specifically synthesized findings around and policy implications stemming from the health theme of today's presentation. So, as Tiffany mentioned, our health and resilience conceptual framework itself, the main focus of today's event, is around health, resilience and sustainable poverty escapes so specifically viewing health as a shock but also as a resilience capacity that can then – should be nurtured over time in order to sustain poverty escapes. So really quickly before delving into the synthesis findings across studies, a bit of working backwards to provide some of the key takeaways from this work. And this work has taken place across 11 countries in subSaharan Africa, in South and Southeast Asia. And some key takeaways which we'll speak in the coming slides are, for example, around the fact that, as Tiffany noted as well, that sustained escapes and transitory escapes really vary in their prevalence across countries as well that agriculture remains critical in sustaining escapes even amidst decreasing land sizes and incomes although it should be noted as well that small holder farmers rarely get the level of support that they typically need, which we'll come 7 back to again. As well as that adverse gender and other social norms can prolong chronic poverty and even prevent households initially escaping poverty let alone sustaining escapes over time. And then there's really conflict climate nexus as well that we've seen across these country studies on a sub-national level, which provides a hotbed for impoverishment. And the regarding health, what we see is that health shocks typically in sequence or in combination as well with other shocks can really contribute to high levels of impoverishment. And in this context coping strategies to these health shocks really vary for households in the absence of health insurance. And then but in spite of these coping strategies, there's also clear policy areas which are identified as quite critical in the study with regards to sustaining poverty escapes. And these include universal health insurance, improvements around the quality and coverage of health services and critical links as well really pointing to the need for a portfolio response. So that's just a bit of background but now to set the scene of it. So as I noted, I work in the Chronic Poverty Advisory Network, which is a network of researchers, policymakers and practitioners. We're hosted by the Overseas Development Institute in London. And in CPAN we believe that to get to zero extreme poverty this requires three types of action. So action area No. 1 is tackling chronic poverty. That is typically poverty that is long and persistent, often transmitted intergenerationally from parents to children and so on. But this

is not the only action area. Instead, it should be combined with efforts to prevent impoverishment or households falling into poverty. And then as well once households do escape poverty, ensuring that these escapes are in fact sustained over time. And this was a key message of our last chronic poverty report on getting to zero poverty so you can take a look at that if interested. Now, our recent set of studies on sustained poverty escapes that we've undertaken along with US AID here has revealed a relatively consistent set of processes whereby individuals typically begin with a set of endowments and resources and they use these endowments and livelihood strategies to over time invest in assets. And together these livelihoods and assets can contribute to sustained escapes from poverty but typically in the presence of critical conversion factors so factors that convert these assets and livelihood income sources into sustained escapes. And this is really in a capabilities framing, capabilities approach. So critical conversion factors then, one key one which Andrew will be speaking about is around the health systems and health shocks and so on that can inhibit some of these efforts to sustain escapes. 8 So in undertaking this mixed methods analysis we've relied both on quantitative and qualitative data sources so CSPAN's hallmark Q-squared approach typically involves merging quantitative analysis of panel data, panel data being datasets, household surveys which repeatedly survey that same households over time, and this allows poverty trajectories of these households to be constructed. And what we do is undertake econometric analysis of this panel data to really understand the correlates of these various poverty trajectories. And then we complement this panel data analysis with qualitative fieldwork in a subset of geographies within a country. And within the qualitative fieldwork this comprises key informant interviews with policymakers, researchers, NGOs and so on, a range of stakeholders at the national and community levels. And we complement this as well with focus group discussions with poor men and women. And then really the brunt of the qualitative approach comes through an intensive life history interview process, which interviews men and women on our different poverty trajectories of interest to really understand the processes and pathways through which households are able to escape poverty and subsequently remain out. So together what this Q-squared approach does is it really allows you to assess both correlates, drivers, magnitudes of these correlates, of these drivers associated with poverty trajectories but through the life history work and so forth really understand the processes and pathways as well across different levels of analysis, which is then really informative of policy gaps, policy options as well as evaluations where these are structured into survey data. So on this process of getting to zero poverty, what this graph shows is that there are various poverty dynamics in play. So, for example, this is using panel data across the countries we've explored so Niger, Malawi, Tanzania, Rwanda, rural Kenya, Uganda, Tanzania, Ethiopia, Bangladesh, Cambodia, Philippines and Nepal. And what we really see across countries is that

chronic poverty remains significant, especially so in Ethiopia. This is the yellow bar and this is where risks remain high even in spite of the PSNP. Chronic is less so prevalent according to this diagram in Tanzania, but this is largely an artifact of an effectively low poverty, national poverty line. And also what we see from this series of poverty dynamics is that transitory escapes are also significant so in other words escapes not being converted into sustained escapes. Transitory escapes here is where a household begins poor, then escapes poverty but subsequently falls back into poverty, and this is especially prevalent in Africa. 9 In contrast, sustained escapes are more so prevalent in Bangladesh and Cambodia, both countries where a relatively significant degree of laborintensive manufacturing has been taking place and economic transformation accompanying this. So today, as noted, I'll be presenting some key findings across country context and then Andrew will really hone in on the health findings across country studies and the policy implications from that. So, as noted earlier, sorry, as noted earlier, our research explored the endowments, resources, assets and conversion factors which can contribute to or prevent sustained escape, so I'll very quickly be focusing on some key findings in each area. So with regards to sustained escapes, for example, a key finding around endowments and resources is that, as noted earlier from the key takeaway slide, is that agriculture continues to be important in sustaining escapes. And this is even so where land holdings have become smaller and focused on food farming. So we see this on the graph on the left, for example, in rural Kenya in terms of land holdings which are even lower amongst the chronic poor and also relatively in a different country context in Cambodia where the share of income from crops and livestock as well remain significant. However, in the policy scene what you see is that these farmers typically get very little external support even though there are critical interventions that can make a big difference. So here there's really a need for state support to small holder agriculture as well as consideration for agricultural workers and irrigation, integration of livestock, value chain developments and so on. But more typically what we've seen across studies is that for agriculture to contribute to sustained escapes, this typically involves some level of diversification within agriculture so within crops and livestock, upgrading livestock from small ruminants to bigger cattle and so on but then also diversification from agriculture. But both, of course, have risks so, for example, around diversification from agriculture into non-farm activities. There's risks around capital – around acquiring sufficient capital for businesses around credit and so on. But then also alongside this rural non-farm economy there's also a rising importance of cross-studies of migration. This is typically combined with skill acquisition including around business developments. And this skill acquisition and migration strategy skills can often be applied upon one's migrant's return to the home countries. This is seen in Kenya, Niger, Cambodia to name a few. But then, of course, even when migration can begin as a distress strategy,

what's quite promising is that over time in some cases it can also convert 10 into a strategic choice by many households. And here remittances have also been quite critical across countries both in as a key input but at the same time it can be a survival level as well so there's always these tradeoffs. There's always – there's no necessarily one magic bullet for sustaining an escape. And, ultimately, then yes this – these livelihood strategies can contribute to sustain escapes but there's also some typically a level of beneficial social inclusion that can really aid this through an enabling context. Yet, what you see across countries is varying levels of adverse social norms, discrimination of marginalized groups that can oftentimes prolong chronic poverty. So with regards to social exclusion, for example, typical groups, social exclusion, for example, is often higher for women but also minority ethnic groups, those in remote regions as we see in Nepal here in our graph where chronic poverty was much higher amongst disadvantaged groups in the far west. And as Ketten, one of our life history interviewees noted, this was also linked to one's chronic poverty status but also low economic condition, poor economic conditions. So this is partly a minority group, minority ethnic group story but it's also one highly related to gender-based norms and so on. So relatedly there's across countries we see a repeated denial of women's access to property, which can impoverish. Women head of households also most commonly facing theft, oftentimes even of their farm and business assets even from relatives. But instead, on the policy side you see that statutory laws as well do not provide really adequate protection for widowed, divorced and separated women which, of course, then is quite a politically contested issue, especially in patriarchal societies. So on the flipside, though, this is quite a negative picture that I'm painting. But it should be noted on the flipside across studies in spite of these constraining environments we see women repeatedly exerting agency and really the importance of collaborative social relationships often spousal relationships between but also more broadly across family-based networks, which can then contribute to sustained escapes. But ultimately even with social inclusion, even with this degree of pro-poorest growth from below what we see as disasters and shocks can really reverse the gains around poverty reduction and sustained escapes. And typically these – we've see across studies, for example, a large direct impact of disasters on preventing sustained escapes but then also in direct impacts such as drought and its effect on armed conflict as manifest through worsening pastoral farmer conflicts in the Sahel in Niger but also in Kenya and in Tanzania here in our life history diagram where Tabuku, who is already chronically poor, then lost her farm. She lost her crops and 11 she lost her home following conflicts to the extent that she ultimately had to return home to living with her birth family assetless. And also to be noted that environmental shocks interacts yes as noted just now with conflict in very complex ways, which if you consider this graph, what this graph shows is households which became impoverished or reimpoverished over time, and it compares this

with the share of households which sustained poverty escape, so it's a ratio of these two figures. And what we see here is that those with highly negative ratios, highly, high rates of impoverishment and transitory escapes are also seen in places with a strong disaster-conflict nexus and inadequate pro-poorest growth initiatives. So finally that's some of the research findings at large and, of course, then these indicate important policy directions. So some big picture takeaways if you remember from the original slide is that one sustained escape, yes, they vary in prevalence. But they're typically produced by combinations of factors so you see diversification within farming where land resources are not too small and also to rural non-farming economic activities. This is also supported by financial services, by education, specifically secondary education and as well the gender aspects where female heads of household still manage to sustain escapes oftentimes supported by strong women's financial inclusion and related microbusiness support in the short term but with needed long-term interventions as well around inheritance and land tenure reform. So this combination of factors then really points to the need to avoid this siloization, especially with regards to building resilience and in the road towards zero poverty through these sustainable poverty escapes. So relatedly then this is with regards to sustaining escapes, but at the same time policies need to address major reasons for transitory escapes from poverty. And here is really where health insurance is one critical area in combating a major source of impoverishment, which Andrew will go to speak about. And then beyond this as well there's a need to really add in negative – neglected policy areas which really require renewed focus with, of course, context specificities. So, for example, agriculture especially irrigation remains quite neglected as a policy area in Africa. Same for livestock, which is really important in sustaining escapes, but it's also neglected and risks are relatively less adequately managed. And there's also a need to support the rural non-farm sector more generally as well as the informal sector within that. So then with regards to this enabling environment with regards to these critical conversion factors that can promote sustained escapes, what we see across these studies that it's part economic development trajectory, sure. It's part growth from below. But then it's also part progressive social policy change, part progressive social change as seen through beneficial social inclusion and it's also part policies to promote sustained escapes. So on this note while we've seen so far that converting transitory escapes into sustained escapes and preventing impoverishment is key to building resilience, as mentioned, there are many sources of this downward mobility and impoverishment of which ill health is a major one. Andrew Shepherd will now address this issue.

Andrew Shepherd: Well, thank you very much, Vidaya, for giving us an insight into the general findings of this research. And as Vidaya said, I'm going to focus now a

little bit on health. If I don't turn the slides over in the right time, just give me a shout, would you, because sometimes I forget. So, as you can gather, we're poverty analysts. We're not health professionals, but we've been looking at health from a poverty angle and we hope that what we have to say has some use for a health professional. So those of you who are health professionals in the room, we're not trying to substitute for you in any way. [Laughs] Some of the health-specific findings from the research, firstly, there are multiple and sequenced drivers of downwards mobility and impoverishment, as Vidaya has mentioned. And here's a case of Mustafa in urban Zinder, Niger. And his issues, his shocks, if you like, that he experienced were business decline. There was reduced demand for the service that he was providing, which was as a wedding photographer. And then this was combined with illnesses that his children experienced. Yeah? Is that better? Yeah, illnesses that his children experienced and I think the death of one of those children. And from the panel data in Indonesia we know that 16 percent of impoverished household heads in urban areas had a health problem that prevented the head of household from carrying out normal activities for more than a couple of weeks. So urban health issues seem to be quite prevalent, more prevalent in fact in our data than rural issues. This is Rafigal's story in Jessore, Bangladesh, and this illustrates how ill health can combine with old age to make prospering very difficult. And this is a frequent connection that we've found in the research, the combination of old age and ill health perhaps not surprisingly. And this was for Rafigal this was after a lifetime of struggling through agricultural wage laboring, leasing land, making a go of it including providing dowry for, I think, it was six of his sisters to marry. For me, this illustrates very clearly the need for an old age pension or some other kind of support for older people. Barriers to healthcare: low health insurance coverage is prevalent across our countries and Rwanda is an exception to that, which I'll discuss in a moment. Quality of health services is very variable meaning that people, including poor people, often seek private healthcare where they often get better treated too. I don't mean treated in a technical sense but better treated as human beings. I think there's quite a lot of research on that and I think we're now programmed to try to improve the way that public health services treat their patients. This was illustrated by the case of Stella, who during the rainy season when access to the public health facility – sorry, I'm just talking about the third point, third bullet point now – the high opportunity costs or high user costs is another barrier to accessing health and this is what Stella is illustrating. So during the rainy season the roads became impassable. She couldn't get to the public health facility so she used a nearer by private health facility. She was very lucky that her husband could manage to pay for that. So in the absence of health insurance or in the absence of an accessible free quality health service, coping strategies vary. We have Mierce in Cambodia, who draws down on savings, borrows from family and takes a couple of loans. One of the

findings on the financial inclusion side in this research, which is quite disturbing, is that across many different contexts people are taking loans to repay a loan and you can see how this happens in this case. Then we had Redu in Ethiopia who sells his ox in order to pay for a treatment for his mentally ill daughter. And we have Dindo in the Philippines who has stomach cancer and gets support including care from his social network, care from his immediate nuclear family. But the care that he can get and the financial support that he can get is failing. His mother has had to stop work due to rheumatism. She was one of his carers and supporters. And his migrant siblings are not always able to pay for his treatments so he's had to stop going to his treatments on occasion because they haven't been able to support him financially. And there's another factor here: Reliance on kin, I mean, we might think of this is a very positive aspect of social capital. But it means that those relatives who are called on are not – are themselves hampered in saving or investing or paying for other things like education so they're a knock-on effect. Our analysis – we've tried to draw out some policy implications from the analysis that we've made and, firstly, there are different – I think it's 14 important to stress that there are different pathways to reducing the impoverishment which ill health can cause. There's no magic bullet here although we might want to discuss that later. [Laughs] Sorry, yes, we've got here low-income Rwanda where we've also studied poverty dynamics through mixed methods research. It has woken the world up to what can be accomplished by high rates of health insurance coverage and have over 80 percent of the population covered in their national health insurance scheme. They've made health insurance compulsory and they use their pretty exceptional machinery of government to follow this up and make sure that people do actually enroll in health insurance. The Rwandan government has mechanisms to make people do things, persuade people to do things. We can discuss that as well. But it also subsidizes the premiums for the poorest people. We can discuss that as well, how well it works. And it had greatly improved the health service, including the referral system which is absolutely critical if you want people to subscribe to a health insurance system. It makes it worth signing up. And in our data it's the only country other than Malawi where ill health does not feature as a major source of downward mobility in our collections of life stories. So for me this was one of the most remarkable findings in the research. And Tanzania and Kenya are aware of what Rwanda has been doing and they are busy now working out what they can do. Meanwhile, Kenya has devolved health to its 47 counties or a large part of health service provision to its 47 counties as part of the creation of one of the most devolved systems of government in developing countries. Some counties have made significant investment. One example is the development of conditional cash transfer for poor expectant mothers and greatly improved maternal health services in Kakamega, again, partly based on borrowing from Rwandan experience but in response to very high levels of maternal mortality in that district in that country. However,

because it's a devolved system, the experience has not been uniform across the counties. It's very much depended on the enthusiasms and the abilities and capacities of individual county governors among other factors. Tanzania is trying to develop a unified health insurance system with crosssubsidization to make sure it's inclusive, having failed to develop adequately it's earlier community-based version. Kenya is taking another approach, gradually including different groups in its National Hospital Insurance Fund with the NHIF waiting to get a budget at the moment, waiting to get a budget from the government to include the elderly as a first step. The elderly have all been registered. The government as of late 15 October when I was there, early November, haven't yet handed over the money to the fund. So countries are moving in this direction. If health systems are really to be upgraded, this involves committing high levels of public expenditure. Malawi, the other country where we didn't find life stories indicating that ill health was a major source of impoverishment, has the highest level of per capital expenditure among our countries. And this, coupled with its well-trained health carders, much poached sadly by the UK, not least may explain why ill health was not found to be a leading cause of impoverishment there, both in the quantitative evidence that we have and in the qualitative evidence. There have been – and I've been trying to dig further into this. I don't know Malawi personally so if anybody knows Malawi, maybe you have some answers that you can contribute. There seem to have been massive investments in mosquito control, and malaria accounts for or accounted for a couple of years ago 40 percent of all hospitalization. Malaria treatment, I think, has also been a big focus as well as HIV/AIDS. However, you know there are downsides. Stunting incidence is very high and I think US AID has been focusing on this formally in its programs. There's a very good health sector strategic plan for the current period, which also reviewed the previous health sector strategic plan and indicated that certain fundamentals like inadequate and volatile supply of medicines and healthcare financing being very volatile and sometimes inadequate were, you know, remain very strong problems. So it's not all sunshine as far as I can see in the health sector in Malawi by any means. But I think we do have a remarkable result there, which I'd like to try and find the explanation. We also found some pretty good evidence in Cambodia. The health equity funds there are another approach where government allows free access to healthcare for those with an ID poor card. So the government has a system of identifying the poorest people. they get a card. They can get access to free treatment whereas others have to pay. In some work supported by US AID, which is up on the screen, different approaches to this – to the health equity funds have been tried. And what was found was that the broader set of intervention – the broader the set of interventions and inclusion so if you could include more people other than those in the system of health equity funds perhaps on payment of a small premium, other than those who were identified by the ID poor card and if you could provide more and better quality services,

this meant that there was greater usage of the public health services. Also greater usage by those with the ID poor card so that they poor actually made better use when these wider services and better quality services were provided. 16 So another implication of this work is that perhaps the – we need to have a broader focus. It's not just about curative medicine here and I think for many years donors have been very much trying to encourage developing country governments to focus on primary healthcare and preventive health. So just there's a few issues here: chronic illnesses, alcoholism, reproductive health and mental health programs which are perhaps in at least some circumstances focused on less than they might be given their importance in determining poverty outcomes. So our analyses in Bangladesh and Rwanda, particularly, have revealed that acquiring a disability, especially a severe one, can be enough to impoverish a household. It's the one cause that we've found which is enough by itself to general impoverishment. In general other causes require a combination or a sequence to actually generate impoverishment for any length of time. But disability, a severe disability, is the one which doesn't need to be accompanied by another shock. But chronic illnesses in our extensive qualitative work on disability in Bangladesh have the same effect, perhaps reflecting low levels of treatment success in that area. We know from research done over several countries that alcoholism can also have extremely damaging effects with few interventions to address it. Reproductive health is extremely important as increasing dependency ratios is often associated with impoverishment or temporary escapes. And results vary widely across the country in terms of maternal mortality and use of family planning services. Again, lots of scope for further work in those areas. How am I doing for time? Two more minutes. Okay, in that case I will cut to the last of these issues which is mental health which also deserves quite a substantial additional focus but is highly problematic. Mental health is a high proportion – often over 10 percent, often more than that – of the burden of disease in many countries. And the Uganda story illustrates the rather dismal state of policy responses. There was a mental health and poverty project in 2008 and '10 run from a South African university but working very closely with the government and its mental health services. And this produced a policy, a draft policy based on consultation. It was a good process. However, legislation was then delayed. Finally, in 2017 the ministry developed child and adolescent mental health guidelines but the service remains grossly under resourced. If we look generally across certainly low-income countries and also lower middle income countries, we find that progress in mental health has been made through context-specific pilot projects, some of which get scaled up. There's Canada's Global Challenges Program, which if you do a Google search, comes up frequently. There's another program with the Welcome Plus but there's very little out there as far as I can see at least. 17 It's an area for a lot of innovation and much-needed political commitment it seems to me. A recent paper from ODI argued that mental health is an

economic issue with 56 million years of work lost annually to the anxiety and depression across the 36 largest countries in the world. It's possible to have clear measurable targets. For example, in WHO's current mental health strategy to increase service. One of the targets there is to increase service coverage for severe mental disorders by 20 percent, which can be measured by the number and proportionate persons with a severe mental disorder who received mental healthcare in the last year. There are increasing numbers of inexpensive solutions going under the heading of task-sharing. This is where lay health workers, that is health workers with no formal mental health accreditation, are trained to provide basic mental health support. Development programs are demonstrating that this is working to at least partially fill the treatment gap, though ideally this needs to happen alongside an increase in the number of trained mental health professionals. And, finally, mental health programming can be tacked onto other programs. For example, in some countries there's a strong incidence of suicide among farmers. Agricultural programs could attempt to tackle that issue. Post-natal depression could be tackled in programs focused on newborn and child health. On that note – and this is my last point – we have argued across this research that – Vidaya's already mentioned this – that a portfolio response wherever into the extent possible is needed. There are no magic bullet solutions to poverty applicable everywhere. In relation to enhancing health capacities as a way of achieving resilience, critical links across policy and programming include the example here: combining health insurance with other forms of social protection as in the example from Ethiopia where outcomes were much better for people who had access to both rather than one or the other. Poverty-focused programming, which often has an economic core, can also acknowledge the major risks underlying impoverishment and temporary escapes and find ways of directly or indirectly addressing these, in a sense adding these to the economic programs to avoid undermining the results which economic programming can achieve. So on the one hand, the programs are focused on achieving the positive but without taking into account the risks that people face in developing those positive outcomes.

18 And in closing I would just like to say that going forward, we were encouraged by US AID to do this work on health. We'd like – we think it's produced some interesting results and we've been able to draw out some interesting policy implications. We would like to do further sectoral or topical analysis on issues like education, on agriculture, on gender and so on, migration, urbanization. So if anybody's interested in talking about those afterwards, please do come and talk to me. And the other thing looking to the future of this work, we'd like to expand our work in more fragile and conflict-affected environments. Thank you very much.

[Applause]

I'm going to pass over for some immediate comments to Lynn. Lynn

Michalopoulos:

Good morning, everyone. Is this okay? Okay so thank you Vidaya and Andrew for the great presentation. Being a part of this process, it was really great to hear your perspectives and the synthesis of this massive project. I really like how Vidaya gave the overall context in terms of the general findings and Andrew gave the more specific health-related findings. I just wanted to point out a couple of key takeaways, some reflections that I had related to this work. I wanted to first start out by talking about how resilience programs really started out as an – in response to climate shocks. And I think that through in the past years that there's really been more and more of a recognition that there needs to – we need to have a wider lens to really look at different types of shocks that may affect individuals, households and communities. With this, we need to understand the impacts of those different types of shocks and how do we then really strengthen the resilience capacities to be able to improve wellbeing and coping strategies related to these different types of shocks. So if you came in and did the poll, we asked you to answer a poll of in your work what's the most prevalent shock that you're working with. And overall, of course, this is not representative but most people chose climate shocks. But there was a large number of you that worked with health shocks, conflict and lesser so but still people chose also price shocks as well as gender disposition. So I think that that's really important and really shows that the wide variety of shocks that we're working with and that people are exposed to. And also I want to point out that they're cooccurring and also can have the multiplier effect, which I think Andrew alluded to. The second point that I wanted to make was that I really like how in this report and through the findings that we highlighted that different types of health-related shocks matter. So it's not just focused on chronic or acute health-related shocks or non-communicable disease but this emphasis on 19 mental health and alcoholism. There's going to be different resiliencerelated programs related to different types of shocks. There are going to be different barriers related to these different types of shocks. We know that mental health is a huge burden on many communities. Andrew really pointed that out nicely. There's also stigma related to mental health problems, a lack of services. In many of these contexts there is a lack of health professionals trained to be able to provide services. There are evidence-based treatments that are out there that can be integrated into resilience programs, but without them actually being adapted and for people being able to deliver them, then it's not really worth it. In addition I also wanted to mention as someone that's really focused in on shocks and the outcomes in terms of psychosocial functioning that we're talking about shocks and how they impact individuals, households, communities, we also need to account for not only depression and anxiety but post-trauma symptoms as well and actually what does that look like in these contexts because we can't base it on just Western conceptualizations of mental health and how people

experience shocks. So that kind of brings me to the third point that context really matters. And I think one strength of this massive project that Andrew and Vidaya kind of overtook was that using these mixed methods really allowed us to see differences across context, and the qualitative piece allowed us to really get an in-depth look that could inform the quantitative findings. So I think that that was really important and then this can inform programs and policies that are adapted to different contexts. At the same time, we can look to see what's working in certain contexts so you talked about Rwanda and how this wasn't the issue and see what's working there and what can we take to apply in different contexts? Fourth, I think that it's important to look at this in terms of taking a holistic approach so policies and programs really need to be across sectors and across levels so not just at the systems level but really down starting from the individual level working itself up and seeing how all of this is interrelated. And then finally the key takeaway that I have in terms of hearing all this and kind of putting it all together is how do we actually account for healthrelated shocks and integrate them in into our current resilience programming? I think that there are a lot of challenges, but I think that it can be done and I think that we should start moving in this direction because the shocks – it's clear that these health-related shocks really impact households and the system as a whole. So with that, I will end and we can take questions from here. Thank you.

[Applause]

[End of Audio]