Banking on Reproductive Health

The World Bank's Support for Population, the Cairo Agenda and the Millennium Development Goals

Global Health Council

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FOREWORD

Women of childbearing age constitute a billion of the world's poorest people, and adolescents just entering adulthood are a billion on their own. For both these groups, reproductive health issues predominate among the burdens of current and future ill health and productivity loss. Clearly, without the full and healthy participation of nearly one-third of humankind in economic life, broad-based poverty reduction will remain a distant aspiration.

The Millennium Development Goals (MDGs) do not include a goal specific to reproductive health. Yet the contribution of these issues to health and productivity is well documented. Impacts at the macro level are also clear: without adequate access to these services, fertility rates among the poor in the great majority of countries engaged in the Heavily Indebted Poor Countries (HIPC) Initiative have not begun to decline. Extremely rapid population growth challenges attainment of even modest improvements in the percentages enrolled in school, raises the ratio of patients to health providers, and makes new job creation an endless treadmill. And of course, in a world of AIDS, a comprehensive approach to sexual and reproductive health is necessary to turn the tide on this pandemic.

This report focuses attention on the World Bank, which has made a public and corporate commitment to the MDGs. As a development bank committed to the expansion of knowledge and application of empiricism to health and development strategies, the Bank's leadership is critical. As outlined in the ICPD Programme of Action a full decade ago, universal access to reproductive health is essential, but the reality of progress has seriously lagged behind the commitments made.

This report examines the Bank's attention to the Cairo agenda through the lens of its commitment to the MDGs. Key challenges and constraints remain, not the least of which is a realistic assessment of current investments and the appropriate place of reproductive health in the broader development agenda. As this report makes clear, it is unlikely that these goals can be met absent significantly increased support and expansion of proven interventions, measurement of progress, commitment of resources and technical expertise, and collaboration between donors and recipient countries.

Clearly, the Bank can play a more central role of leadership in promoting universal access to reproductive health as a necessary, efficient and just means of achieving the MDGs. Through this emphasis, the Bank can further its mission of a world free of poverty. It is our hope that this report can contribute to this ongoing dialogue.

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EXECUTIVE SUMMARY

The Road after Cairo

The 10th anniversary of the groundbreaking International Conference on Population and Development (ICPD) at Cairo provides an impetus to reaffirm the commitments made during that landmark event. Commonly referred to as the "Cairo Consensus," the hard-won Programme of Action agreed to by representatives of 179 nations has provided a robust vision to donors, governments, development agencies and non-governmental organizations (NGOs). This notably ambitious, 20-year roadmap has not only raised awareness of the multiplicity of factors influencing reproductive health, but also inspired innovative and improved services in many parts of the world. Yet many question whether the Programme can be fully implemented by its 2015 target date. At present, the poorest countries continue to have very high levels of population growth, maternal and infant deaths, unintended pregnancies and unsafe abortions. And in the time since Cairo, new priorities, such as HIV/AIDS, have emerged to compete with these issues for a limited pool of global resources

The devastation of HIV/AIDS, not fully appreciated 10 years ago, has affected every sector of society, decimating an entire generation in the most affected countries. The re-emergence of other communicable diseases such as tuberculosis, combined with the new global vertical funding initiatives established to address them, have made the competition for resources more onerous. Donor support mechanisms emphasizing sector-wide budgetary and program support rather than support of specific projects, run the risk that reproductive health will not be included among development activities. Health reforms and poverty reduction strategies designed to promote equity, efficiency, access and ownership may detract attention from reproductive health. A focus on "new" demographic issues, including aging and below-replacement fertility, has also diverted attention from the fact that rapid population growth and a large unmet need for reproductive health services, remain significant challenges to development in many of the poorer countries. Health systems with inadequate capacity to address the broad Cairo agenda, coupled with limited political commitment and a worsening political economy in many countries, threaten the likelihood of achieving the goals set forth in the ICPD Programme of Action within 10 years.

As the world's largest lender for health, the World Bank has committed to assist countries in their efforts to achieve the Millennium Development Goals (MDGs) by the year 2015. These goals build on previous international agreements, including those reached in Cairo. Both the MDGs and Cairo Consensus offer compelling synergies that not only contribute to meeting the targets set forth in both pacts, but also expedite the process of reaching these goals. Achieving these objectives means having a major impact on the quality of life for millions of the world's poorest citizens.

Banking on Reproductive Health

The report *Banking on Reproductive Health* reviews the World Bank's investment in population and reproductive health in light of new health priorities facing the millennium. It encourages the Bank to mobilize internal commitment and resources to support sustainable population growth and improved reproductive health as cornerstones of economic development and the achievement of the MDGs. The report also seeks to enhance communication among civil society organizations (CSOs), policy-makers and the World Bank in order to expand opportunities for engagement in the development and implementation of poverty reduction strategies to address population and reproductive health issues.

Banking on Reproductive Health draws from interviews with current and former staff of the World Bank, NGOs, and bilateral and multilateral donors. It reviews documents from the World Bank and other sources, and examines Bank investments and actions in light of new donor funding mechanisms and priorities such as health reform.

The Current Situation

Under World Bank President James Wolfensohn's leadership, the Bank has strengthened its strategic focus, improved internal and investment operations, and implemented many worthwhile strategies to reduce poverty and improve health. The accountability required of its commitment to the MDGs will drive the Bank to do more and do it better. At the same time, the growing

impact of HIV/AIDS has made the realization of the Bank's poverty reduction agenda increasingly difficult. In some countries, rapid population growth continues to make even modest increases in education, jobs and health status more difficult to achieve. Poor governance, limited absorptive capacity and a shortage of resources make the Bank's intended work more challenging.

While the outlook may appear bleak, greater efficiency and effectiveness is achievable. The World Bank's increased recognition of the importance of human development to economic and social advancement and its analytical work on health equity has informed its efforts to reach the poor. The Bank has invested significantly to educate girls and integrate attention to gender issues throughout its work.

However, aside from its work to address HIV/AIDS, the Bank is currently devoting less attention and resources to population and reproductive health issues than it has in the past. As a result, it has missed important opportunities for synergy between the Cairo Consensus and its own objective to reduce poverty. While the World Bank was one of the largest financiers of population assistance in 1994, the Bank's contribution to this issue has declined from 25 percent to 10 percent of total global resources by 2002. At a time when 31 of heavily indebted poor countries (HIPCs) engaged in the Poverty Reduction Strategy Paper (PRSP) process have total fertility rates (TFRs) of five or more births per woman and many others are struggling to meet the demands of rapid growth from past high fertility, many PRSPs fail to include strategies to address rapid population growth as a development issue. Fewer Bank investments are being made through International Development Association (IDA) credits to poor countries for population and reproductive health than at any time since 1997. In actual dollars, fewer resources are being directed to the basic population research and demographic analysis that is needed to inform investments in the poorest countries. The Bank also has fewer staff with the expertise to address these issues either analytically or in the policy arena.

The Bank has not given sufficient attention to recent economic analyses demonstrating that high fertility retards economic growth while declining fertility contributes to reducing both poverty and inequality.[2] Few Bank documents in the last decade pay heed to stabilizing population growth, whether in relation to environment, urbanization, expansion of social sector infrastructure and services or poverty reduction. While the Bank's health equity analyses have documented that the poor have unequal access to and use of reproductive health services, there has not been a corresponding commitment to expand services to the poor. The Bank does not take the opportunity through Joint Staff Assessments (JSAs) and other reviews to better inform the policy discussions about influential macro-economic issues related to poverty, including rapid population growth. Country assistance strategies (CAS) may fail to note the assistance the Bank could offer in terms of analysis and capacity building to strengthen attention to these issues.

Recommendations

The following recommendations aim to increase the prominence of population and reproductive health issues within the Bank's portfolio in support of its mission to reduce poverty and achieve the MDGs.

1. Lead efforts to clarify the relationships between population growth, reproductive health and poverty.

The Bank's economic and financial expertise should be brought to bear in mobilizing global attention to population as a core development issue and improved reproductive health as a critical strategy to reduce poverty and achieve the MDGs. The Bank's leadership in assessing and further building the evidence for these issues is critical both for country development and to share leadership and responsibility with its international partners, particularly the United Nations Population Fund (UNFPA), which provides global leadership to increase access to reproductive health services and information.

As a financial institution and the world's largest lender for health, the Bank's comparative advantage is in establishing the "business case" for how population growth and change affect a country's economic and social development. The Bank can best demonsrate how reducing reproductive morbidities, mortality and unintended pregnancies improves health equity, and, by extension, the lives of the poor. The fastest growing portion of the population, those who live in poverty, are disproportionately disadvantaged according to every reproductive health indicator and have the least

access to services. By improving the reproductive health of the poor, the cycle of poverty can be interrupted and slower population growth can benefit all sectors of the economy. Therefore, these issues are of paramount importance not just for the health sector, but also for the finance, education, labor, environment, transportation, and water and sanitation sectors. The business case helps build nonpartisan support for reproductive health as offering broad societal benefits.

The Bank's focus on poverty is an opportunity to draw greater attention to the relationship between population growth, age structure, momentum and the prospects for economic development, savings and health. The Bank should address the diverse demographic and economic conditions, with special attention to the poorest countries with the worst economic and social indicators in sub-Saharan Africa, South Asia and the Middle East/North Africa (MENA) regions. The Bank should build on and support research that examines the critical pathways between reproductive health and poverty and the economic and social benefits of investing in youth reproductive health. The Bank's empirical work should continue to elucidate understanding of these issues as well as the cost of not investing in reproductive health at the country level. These analyses should be better incorporated in national policies, PRSPs and CASs.

2. Assure that the Bank's work is evaluated, documented and widely disseminated.
Because the MDGs focus on achievements within a specific timeframe, greater investment in monitoring and evaluation systems will allow the Bank to better monitor its progress toward realizing these goals. Moreover, donor countries that are being asked to increase their contributions to the MDGs will expect documentation that their investments are paying off.

Internal and external reviews of its performance have indicated that the Bank needs to improve its monitoring and evaluation systems, and strengthen clients' capacity to collect the data necessary to track and report on outcomes. Poverty reduction strategies do not often specify how they contribute to meeting the MDGs. These and other Bank lending mechanisms must identify appropriate indicators, routinely and systematically collect high quality and reliable data, evaluate findings and base decisions on the evidence.

The Bank's senior managers should strive for an organizational culture that values evaluation, uses it to make decisions and rewards attention to it by staff and recipient countries. This calls for a feedback mechanism where empirical evidence on past investments guides decisions on future expenditures. Bank specialists must have a fundamental understanding of the principles of evaluation and make use of technical partners to extend their skills as necessary. The Bank should assess the impact and sustainability of its recent investments in population and reproductive health through greater collaboration with the Bank's research and evaluation specialists.

Building the evidence base of what works through a focused research agenda and getting this information to the audiences most in need of it are two key requirements for being a "knowledge Bank." The Bank must better assure that its reports, analyses, briefing sheets and web materials reach those who need them, particularly at the country level, and in the format most appropriate for the audience. The Bank should therefore work methodically to understand and serve its "information customers," particularly at the country level. For developing countries, access to information is limited if it is only available on the web or insufficiently disseminated in print.

Information on Bank investments by sub-sector and target audience is important to the knowledge base. Although the Bank has invested in new financial tracking systems, it remains difficult for external partners to obtain accurate, reliable and comprehensible information on Bank investments. The Bank could improve transparency and help its development partners understand its investment priorities by making its financial tracking systems less obtuse and more accessible to the public.

3. Update guidance on population and reproductive health issues to reflect new research, new donor support mechanisms and the MDGs.
The MDGs and new donor support mechanisms require that guidance on population and reproductive health issues be updated to substantiate the importance of these issues to the achievement of poverty reduction and other

goals. The population strategy note of 1999 and the existing reproductive health strategy predate the MDGs. They are not grounded in poverty reduction strategies and sector-wide approaches (SWAps). The existing reproductive health strategy does not deal with efforts to infuse reproductive health into the MDGs for maternal health and child mortality.

Whether or not this update is done in the context of a formal strategy, new guidance is needed to bring forth the recent empirical evidence, highlight the synergies with other sectors and assure that attention to these issues is not neglected in poverty reduction strategies and donor support mechanisms. Updated guidance should address how failure to attend to population growth and reproductive health can derail progress toward the MDGs, while attention to these issues can speed their achievement. Measures should be proposed to improve the reproductive health and population literacy of all Bank staff who provide technical recommendations to address these issues in policy dialogues, joint staff assessments and funding decisions.

The reproductive health guidance should incorporate and build upon new and growing evidence of a causal link between poor reproductive health and poverty, and identify the analytical work necessary to solidify and extend the evidence that reproductive health is essential to poverty reduction. The Bank's health equity work is important as it demonstrates the risk of "failing while succeeding" – possibly improving average levels of reproductive health with no effect on the poor, and hence, on poverty reduction. Basic requirements of a demand-enhancing, client-centered, Cairo-friendly program that specifically addresses the needs of the poorest 40 percent of the population, whose access to and demand for services is most limited and whose needs are greatest, should be outlined.

The guidance should give particular attention to synergies between reproductive health inputs and achievement of other goals, and propose strengthened intersectoral coordination within the Bank and at the country level to facilitate multisectoral attention to population/reproductive health (Pop/RH) issues. Although the Bank has invested significantly in mainstreaming gender, the Bank lags behind UNAIDS, UNFPA, International Planned Parenthood Federation (IPPF) and the United States Agency for International Development (USAID) in the attention given to promoting the constructive involvement of men in a woman-centered health agenda. Guidance is needed to combat gender discrimination and violations of human rights, for example in access to HIV/AIDS treatment for women and girls. Greater coordination with the gender sector and the Bank's Multi-Country AIDS Program (MAP) and other HIV/AIDS programs should be recommended, including that a gender advisor sit on the Health, Nutrition and Population (HNP) Board to facilitate this coordination. Strengthened linkage and referral mechanisms to facilitate the scale up of HIV/AIDS programs while strengthening attention to meeting reproductive health needs should be proposed and best practices identified as feasible.

4. Use health equity research, demand-creation, improved quality and health reform to strengthen reproductive health systems for the poor.

The Bank's investments in poverty reduction and the MDGs should be informed by its work on health equity. Goals to improve reproductive health must be set in terms of improvements among the poor. The Bank should invest in creating demand for reproductive health services among the poor through improving quality and reducing barriers.

Bank investments in reproductive health have focused heavily on strengthening the supply side, including expensive investments in health infrastructure. Greater attention is needed to identifying and removing barriers that prevent clients, especially youth and the poor, from using reproductive health services. The Bank should engage in the necessary policy dialogue with countries to encourage a shift of investment resources from the supply side to generating demand. Investment decisions to strengthen demand should be informed by formative research. Moreover, interventions should address the significant social and cultural factors, including gender inequity, that affect demand and limit access.

The Cairo Agenda provides relevant guidance on the important and neglected dimension of quality, recognizing that quality, rather than mere availability, often underlies the decision on whether to use services.

Special outreach programs to poor women and other efforts to overcome the barriers imposed by culture, religion, poverty and gender inequity are also needed. While the approaches best suited to particular cultural contexts should be examined through research, experimentation for improving service delivery to the poor needs to begin immediately. The overwhelming barriers that prevent unmarried youth from accessing services must be overcome if HIV/AIDS and unintended pregnancies are to be reduced. Providers must be trained to welcome youth while demand for services among youth is generated. Increased demand can often not be accomplished in the absence of community mobilization and awareness raising. This may be better undertaken by providing social action funds to community-based organizations engaged in advocacy for the poor, women's health, gender equity and youth than by relying on the Ministry of Health.

It is also counterproductive to the Bank's poverty and equity agenda to support cost-recovery schemes that impose fees on the poor, particularly for youth who rarely have access to income. The Bank must assure that its investments in health sector reform include stakeholder participation of women, youth and the poor to give voice to their needs and concerns. Reforms should build capacity in priority settings, give balanced attention to preventive and curative reproductive health services, and address human resource issues – a key barrier to scaling up.

5. Build capacity of Bank staff and country partners to make the "business case" for population and reproductive health and evaluate progress toward the MDGs.
Key Bank population and reproductive health specialists have emphasized that slowing population growth through expanding and improving reproductive health services would help to achieve the MDGs and reduce poverty. At present, broad technical competence in population and reproductive health concepts is limited within the Bank, as evidenced by relevant input into policy and review documents. Expertise in these issues is even more limited at the country level, particularly in those countries most severely affected by rapid growth and very young age structures. As a result, appropriate interventions, indicators and evaluation mechanisms to address these issues are frequently not specified in the PRSP or policy and implementation frameworks. Analytical work that would substantiate the importance of population/reproductive health to poverty reduction and guide appropriate interventions is not often recommended. Bank staff serving in an advisory role should have the capability to make a credible business and financial argument for the best investments in health and development. There is a clear need for improved capacity of technical staff to evaluate and coordinate population/reproductive health issues in PRSPs and CASs, and to ensure that MDG targets are addressed and measured. Countries in crisis require in-depth population analyses to inform the policy dialogue, ideally before strategies are developed, but certainly before they are approved. A demographer is needed in regions with poor reproductive health indicators to analyze the effects of population growth and age structures, and advise on the full range of reproductive health and demographic issues that have a bearing on investment decisions and the MDGs. Staff are also needed to identify and commission relevant sector analyses that could be undertaken internally or through partners (UNFPA, World Health Organization (WHO), USAID and other bilaterals, as well as CSOs). Staff should seek to inform and improve future lending decisions through shared learning on PRSP development and outcomes. Bank staff should further know where to find the expertise and in-depth analyses to inform their work. The capacity of existing staff can be built through World Bank Institute courses, seminars and self-directed learning. However, the Bank's commitment to the health MDGs will be difficult to meet with existing staff allocations, and Trust Fund resources for staff are inadequate to meet the needs of all who compete for them.

At the country level, an understanding of demographic issues is important to investment decisions. Strengthening reproductive health services through improved quality and demand generation, and investments in youth, including youth reproductive health, are paramount strategies to influence macro-demographic change. In-country experts must evaluate the relative importance of these investments among the competing priorities that poor countries face. Policy-makers need the technical knowledge and expertise to enable them to build the "business case" for why such entities as the Ministry of Finance should care about these issues from a financial standpoint. A mix of skills is needed and should include ability to inform and influence the policy dialogue with compelling and empirically based information.

Consistent with the Bank's commitment to the MDGs, it must be willing to invest as necessary to build capacity in the poorest countries to help achieve these goals. The Bank should consider longer term training to build the necessary cadre of population and evaluation specialists in the poorest countries that confront the most serious population and reproductive health challenges. In the poorest countries, the number of personnel with evaluation and demographic analysis skills is small and inadequate to meet this challenge. Demographers who were trained through UN regional training centers in Africa have moved into other lines of work or retired. The possibility of identifying and retraining such personnel can be investigated. The Bank should actively investigate establishing a new Trust Fund that specifically focuses on expanding such capacity. Donors should be sought to endow this Fund with sufficient resources to enable a significant impact on capacity in demographic analysis, economic analysis, public expenditure, management and evaluation.

6. Optimize linkages of reproductive health and HIV/AIDS services and systems to scale up HIV prevention and treatment efforts and better meet reproductive health needs.

Through its HIV/AIDS initiatives in the Human Development Network (HDN) and MAP, the Bank must strengthen the linkages between population and reproductive health programs and services, and HIV/AIDS prevention, care and treatment for the betterment of both efforts. Existing mechanisms can be built upon to prevent primary HIV infection, prevent unintended pregnancies among women infected with HIV, provide voluntary counseling and testing (VCT), diagnose and treat STIs, and prevent transmission of HIV from mother to child. The Bank's leadership is needed to scale up its own investments and influence the work of its development partners to maximize the use of existing reproductive health infrastructure, personnel and logistic systems. The Bank should address any barriers, internal or external, to collaboration and cooperation between the HIV/AIDS and reproductive health communities. The reproductive health community has invested significantly in research to identify what is needed to make sexual and reproductive health services attractive and accessible to youth and has built upon the empirical evidence to expand youth-friendly services. This research, experience and infrastructure should be used to maximize expansion of HIV prevention services to youth.

7. Assure the security and equitable distribution of reproductive health commodities including contraceptives, condoms and antiretroviral drugs.

The Bank should do its part to assure the security and equitable distribution of reproductive health commodities including contraceptives, condoms, sexually transmitted infection (STI) treatments and antiretroviral (ARV) drugs. Through its role as policy advisor, the Bank can help ensure that countries include contraceptives and condoms as part of essential drug packages. The Bank's expertise, particularly through its convening power and support for infrastructure and logistics systems, is needed to avoid anticipated shortfalls that could undermine reproductive health and HIV objectives. The contraceptive logistics system can be adapted to assure a consistent and equitably disseminated supply of antiretroviral drugs. The Bank should seek the appropriate and necessary partners to fulfill this mission, including civil society and advocacy organizations that can raise the profile of the issue at the national and local levels. The Bank can further explore whether engaging with the private sector will help to ensure affordable and consistent contraceptive and drug supply.

8. Broaden and strengthen strategic and collaborative partnerships with development partners and civil society organizations.

The Bank can make better use of its partners to improve health and reduce poverty. Greater partnership is needed with organizations with expertise in defining and expanding high quality reproductive health services, identifying and addressing barriers and generating demand for services among vulnerable groups.

More commitment is needed within regions to advance the Bank's collaboration with UNFPA. Where UNFPA has an in-country presence or is able to more consistently participate in policy dialogues at the country level, it is well positioned to make the case for country investments in reproductive health and population policy. This partnership can lead to country requests for Bank investments in population/reproductive health interventions.

While headway is now being made in sub-Saharan Africa, attention to the role of rapid population growth in unemployment and social unrest in the MENA region is reportedly not on the development agenda. UNFPA and other partners can help frame the debate and make the analytical case for synergy between these issues and country development goals.

CSOs are the locus of much technical and advocacy expertise in gender, youth and reproductive health. Through partnership with CSOs the Bank can build capacity and long term sustainability of its own programs while simultaneously strengthening the capacity and development effectiveness of CSOs. In poor countries with a history of poor governance, CSOs may be the most effective and reliable partners for Bank investments. Where governance is stronger and SWAps are being implemented, the Bank should encourage participation of CSOs in design, implementation and participatory evaluation.

The potential for advocacy organizations to help sustain positive health reforms following a change in regimes or government priorities suggests that the Bank should nurture and support relationships with CSOs engaged in advocacy for women's health and other issues central to the population/reproductive health agenda, including gender equity and girls' education. For example, using grant mechanisms to support the work of CSOs focusing on gender, the Bank could enhance its attention to gender issues in high fertility settings or where gender inequity is most implicated in HIV transmission. Overall, more funding for CSO collaboration should be identified. Youth-serving and youth-run CSOs should participate in decision-making and have assistance in applying for funds, for example, through the MAP.

9. Urge shareholders to live up to commitments made to achieve the MDGs.

To expand its own work, the Bank must place greater emphasis on holding its shareholders accountable for commitments made in international agreements to support the MDGs. The Bank's sizable corporate commitment to the health MDGs is not consistent with the limited level of staff and resources currently programmed for health. Resources for reproductive health and population have not grown as a proportion of the HNP budget, nor has HNP grown as a proportion of the HDN budget. These budgets reflect a failure of development assistance to make available the level of resources essential to achieving the health MDGs.

The Bank must apply leadership and better evidence of needs and effectiveness to increase development funds for poverty reduction, reproductive health and the MDGs. The business case for reproductive health as a sound and necessary intervention to slow population growth and reduce poverty must be made both within the Bank and among it major donors if these allocations are to be more realistic. The Bank should help recipient countries determine the resources that would be necessary to achieve the MDGs. Shortages of human resources are clearly becoming a bottleneck to meeting the health MDGs. Many countries are beyond their absorptive capacity given staff levels. The forecast of resources needed should address what is required to improve retention of doctors, nurses and other health professionals. Debt forgiveness would enable poor countries to finance more ambitious country strategies to achieve the MDGs.

The gap between available and needed resources, and the improvements in health that can be expected with more resources can encourage greater investments in health by donors as well as by countries themselves. Only if the goals are adequate funded can the true feasibility of international commitment to the MDGs be known.

The MDGs for poverty reduction, health and the environment will require a doubling in aid. The United States remains the only major contributor to provide less than 0.2 percent of its Gross National Income (GNI) to development assistance. The Bank must join with other donors, governments and advocacy organizations to draw attention to the failure of wealthy nations, most notably the United States, to do their part. The Bank is exploring with other partners a number of new mechanisms to raise

additional revenue. It is to be expected that donors such as the U.S. will demand more evidence that aid is effective if they are to increase their allocations. This will reinforce the need for the Bank and other development partners, including stakeholder countries, to become more results-oriented.

Conclusion: Cairo at 10

The World Bank has made achievement of the MDGs a corporate priority. Reinvigorated support of the Cairo Programme of Action will provide the synergies necessary to achieve these interrelated goals. Through leadership in building the evidence base and raising international attention to the interrelationship between poor reproductive health, rapid population growth and poverty, the Bank and its development partners can ensure that the vision of Cairo is fully implemented in the context of achieving poverty reduction and attaining the MDGs.

The Bank's clear, empirically based endorsement of a fully funded "MDGs plus Cairo" agenda is critically needed. The agenda should include population analysis and reproductive health, and plans to raise awareness of these issues at the highest levels. By doing more of those things that the Bank does well and strengthening the areas in which the Bank's own staff have identified need for improvement, the Bank can spur achievement of these critical goals. Such actions are urgently needed to benefit the world's most needy citizens and achieve the Bank's mission of a world free of poverty.

PART I. CHANGING REALITIES: CAIRO AT 10 AND THE MDGS

Developing the Reproductive Health Agenda

During the 1990s, a series of United Nations (UN)-sponsored conferences devoted to women, human rights and reproductive health contributed to a new agenda for international development.[i] The Programme of Action,[ii] adopted in 1994 at the International Conference on Population and Development (ICPD) in Cairo, gave high priority to reproductive health and rights in both the global and the national spheres. This ambitious, 20-year action plan aims, by 2015, to generate, meet the demand for, and make universally available high quality, client-centered reproductive health services.

The ICPD Programme of Action addresses individuals' and couples' reproductive health and related unmet needs throughout their lives. It recommends a package of services that include family planning, safe pregnancy and delivery, as well as the prevention and treatment of sexually transmitted infections (STIs), including HIV/AIDS. Recognizing the important linkages with other development issues, the Programme also calls for universal primary education for girls and a significant reduction in infant mortality by 2015.

Empowering women and meeting their needs for education and health, especially reproductive health, was seen as a necessity for both the advancement of the individual and to achieve broader development goals. The demographic objectives adopted at previous international population and development conferences[iii] were expected to be met through a focus on educating and meeting the needs of the consumer through client-centered, reproductive health services. However, the importance of population dynamics to development is reflected in the Programme of Action.

> **"Efforts to slow population growth, reduce poverty, achieve economic progress, improve environmental protection and reduce unsustainable consumption and production patterns are mutually reinforcing…The objective is to facilitate the demographic transition as soon as possible. Governments are urged to give greater attention to the importance of population trends for development. In attempting to address concerns with population growth, countries should recognize the interrelationships between fertility and mortality levels and aim to reduce high levels of infant, child and maternal mortality."**
>
> ICPD Programme of Action, Chapters III and VI

The Programme of Action also calls upon governments and donors to address the impact of rapid population growth on the environment and foster the sustainable use of resources. In 1999, the ICPD Plus Five meeting, a five-year follow up to Cairo, adopted by consensus "key actions for the further implementation of the Programme of Action," placing greater emphasis on the needs of the billion youth entering their reproductive years.

> **"Governments…should, by 2005, ensure that at least 90 percent and by 2010, at least 95 percent, of young men and women aged 15 to 24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods such as female and male condoms, voluntary testing, counseling and follow up. Governments should use, as a benchmark indicator, HIV rates in persons 15 to 24 years of age, with the goal of ensuring that by 2005, prevalence in this age group is reduced globally, and by 25 percent in the most affected countries, and that by 2010, prevalence in this age group is reduced globally by 25 percent."**
>
> Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development (Paragraph 70): Resolution Adopted by the General Assembly, A/RES/S-21/2: November 1999

Sadly, it is clear that many of the goals established in the Programme of Action will not be reached by the first target date in 2005.

Millennium Development Goals and Reproductive Health

In 2000, a new global contract was drawn up between the world's rich and poor countries, pledging, for the first time with quantified goals and a realistic timetable, to greatly reduce extreme poverty and many of the factors associated with it by 2015. The Millennium Development Goals (MDGs) include eight key development objectives and 18 targets that will be used to measure progress made toward meeting them. While the MDGs do not explicitly include an overarching reproductive health goal, many of the development goals cannot be achieved without directing attention to reproductive health.

[i] Conferences include the World Conference on Human Rights in Vienna (1993), International Conference on Population and Development (ICPD) in Cairo (1994), World Summit for Social Development in Copenhagen (1995) and the Fourth World Conference on Women in Beijing (1995). In 1999, the ICPD Plus Five meeting reaffirmed the Programme of Action adopted in Cairo.
[ii] See Table 1 for list of key goals and the Annex for excerpts from the ICPD Programme of Action.
[iii] Previous population and development conferences were held in Bucharest (1974) and Mexico City (1984).

The Unfinished Agenda of Cairo

The 10th anniversary of the Cairo Conference provides an impetus to reaffirm the commitment to the agenda agreed to by representatives of 179 nations in 1994. The hard-won Cairo Programme of Action has provided a robust vision to donors, governments, development agencies and non-governmental organizations (NGOs). While notably ambitious, the Programme has raised awareness of the multiplicity of factors influencing reproductive health and has inspired innovative and improved services in many parts of the world. However, as global attention moves to realization of the MDGs, the unfinished agenda highlighted in Cairo a decade ago is evident:

- Rapid population growth, urbanization and environmental degradation challenge development throughout many parts of the world. Nineteen countries, including 17 in Africa, have total fertility rates (TFR)[iv] of six or more births per woman and have yet to begin the transition to lower fertility. An additional 19 African countries have TFRs of five or more.[1]
- 99 percent of all population increase is occurring in poor countries. Developing country populations will expand by 55 percent by 2040.[1]
- 350 million women, primarily in poor countries, lack access to safe, effective and affordable contraception. As a result, nearly half of all pregnancies are unplanned and 25 percent are unwanted.[2]
- The 120 million unwanted pregnancies each year result in 46 million abortions, 20 million of which are unsafe.[3]
- 78,000 deaths due to unsafe abortion constitute 13 percent of all maternal deaths.[3]
- 40 million people are living with HIV/AIDS and half of all new HIV infections occur in youth ages 15-24.[4]
- The largest youth cohort in history – more than a billion – are entering their reproductive years with insufficient access to reproductive health information and services.
- 340 million new cases of treatable STIs occur each year, largely among youth. These STIs lead to nearly 16 million disability-adjusted life years (DALYs) lost.[5]
- Gender inequity and gender-based violence disempower women to refuse sex, increase their risk of contracting HIV and other STIs, and decrease the likelihood that they will have equal access to treatment.[6]

Changing Global Priorities and Processes

In the face of these existing health and development challenges, a significant shift in global priorities reduces the likelihood of fulfilling the Cairo agenda within the next decade. The devastation of HIV/AIDS, not fully appreciated 10 years ago, has affected every sector of society. The reemergence of other communicable diseases such as tuberculosis (TB), and the creation of new vertical funding initiatives adopted to address them, compete for resources with "older" health challenges, including the unmet need for family planning. Health reform and poverty reduction strategies designed to promote equity, efficiency, access and ownership may detract attention from reproductive health. New donor support mechanisms emphasizing sector-wide budgetary and program support rather than support of projects risk that reproductive health will fail to be included among development activities. Health systems with inadequate capacity to address the broad Cairo action plan, coupled with weak political commitment and a worsening economy in many countries, pose serious challenges. New demographic issues, including rapidly aging populations, migration, refugees and below-replacement fertility obscure attention from the factors underlying why the poorest countries have yet to embark upon the demographic transition from high to low fertility.

Objectives of the Report

Against this backdrop and the 10th anniversary of the Cairo Programme of Action, it is timely to review the actions of the World Bank as a key actor in the Cairo agenda and the world's largest lender for health. The Bank has committed to assist countries in achieving the MDGs by the year 2015. These important goals build on previous international agreements, including those reached at Cairo.

Banking on Reproductive Health addresses the World Bank's investment in the Cairo Programme of Action since the 1997 publication of an earlier review of the Bank's assistance to population and reproductive health[7] and the Bank's response to that critique.[8] It aims to assist the Bank in raising awareness and mobilizing internal and external commitment to addressing the population and reproductive health challenges experienced by many low-income countries. This report also provides a vehicle for communicating information to the Bank's partner organizations, especially civil society organizations (CSOs), on opportunities for engaging in

[iv] Defined as the number of children that would be born to each woman if she were to live to the end of her childbearing years and bear children at each age in accordance with prevailing age-specific fertility rates.

the development and implementation of poverty reduction strategies (PRS) that address population and reproductive health issues. Finally, it recommends ways that the Bank can work more effectively and efficiently to strengthen population and reproductive health objectives and achieve poverty reduction within its programs.

Banking on Reproductive Health is based on interviews with colleagues working in the population/reproductive health field, primarily current and former staff of the World Bank, as well as discussions with staff from NGOs and other donor organizations. Numerous reports, largely available to the public from the World Bank, the United Nations Population Fund (UNFPA), the World Health Organization (WHO) and the United Nations Population Division, were also reviewed.

"The MDGs serve as a visionary challenge to help galvanize new energies and resources for the development agenda, with a focus on outcomes. At the same time, the adoption of the MDGs entails risks and challenges for the World Bank. Since it is clear that, given current trends of progress, many countries and regions will be unable to achieve the MDGs by 2015, the risk of disappointment and cynicism must be mitigated." [9]

Synergies between Cairo and the MDGs

Like the Cairo agenda, the eight Millennium Development Goals call for improved child health, reduced maternal mortality, gender balance in education, universal access to primary education and reversal in the spread of HIV/AIDS. For political expediency, universal access to reproductive health services, including family planning – the highest priority of the Cairo Programme of Action – was not included among the MDGs. Though many felt that the contribution of reproductive health to meeting the other goals would be so obvious as to not require an explicit goal, this has proven not to be the case. Many documents outlining the MDGs or plans to address them fail to note even the more essential linkages.

"If [communicable diseases] were controlled in conjunction with enhanced programmes of family planning, impoverished families could not only enjoy lives that are longer, healthier and more productive, but they would also choose to have fewer children, secure in the knowledge that their children would survive, and could thereby invest more in the education and health of each child."

WHO Commission on Macroeconomics and Health, 2001

The correspondence between the MDGs and Cairo Programme of Action is highlighted in Table 1. It can be seen that Goals 2, 3, 4, 5 and 6 are very similar or identical to a number of Cairo targets (see shaded area of Table 1). MDG 7, focusing on the environment, does not specifically note the links between rapid population growth in rural areas, and environmental degradation, growth of urban slums, hunger and susceptibility to disease in densely settled areas. Nor does it note that these macro-demographic changes are influenced by the availability of family planning services and reproductive health services. The MDG framework also gives less attention than does Cairo to human rights, most notably reproductive rights. Despite the absence of these important elements, the MDG framework is more explicit in many instances in identifying targets, timeframes and indicators, which are necessary to promote progress and measure accountability toward these commitments.

The MDG framework thus presents an important new opportunity to raise the profile of population and reproductive health.[10] The compelling synergies offered by the Cairo focus on reproductive health and population will contribute to meeting all of the MDGs and meeting them more rapidly. These synergies have been recognized in recommendations of the UN Millennium Project to include universal access to reproductive health through primary health services as a key strategy to reach the MDGs.[11] [12] Achieving the mutual objectives of Cairo and the MDGs would have a major impact on the quality of life for millions of the world's poorest citizens.

Table 1 Millennium Development Goals and ICPD Programme of Action

Millennium Development Goals	ICPD Programme of Action
Goal 1: Eradicate Extreme Poverty and Hunger • Halve between 1990 and 2015, the proportion of people whose income is less than US$ 1 a day • Halve between 1990 and 2015, the proportion of people who suffer from hunger	**Economic and Social Development** • Invest in the education and skill development of women and girls • Reduce reproductive health morbidity to enable increased economic productivity and improve childcare and survival
Goal 2: Achieve Universal Primary Education • Ensure that by 2015, all children will be able to complete a full course of primary schooling	**Education and Literacy** • Achieve universal access to primary education by 2015
Goal 3: Promote Gender Equality and Empower Women • Eliminate gender disparity in primary and secondary education by 2005 and in all levels of education by 2015 • Improve the ratio of literate females to males among 15- to 24-year-olds • Increase the share of women in wage employment in the non-agricultural sector • Increase the seats held by women in national parliament	**Gender Equality and Equity** • Eliminate the gender gap in primary and secondary education by 2005 • Eliminate all practices that discriminate against women and help women establish and realize their rights, including those that relate to reproductive health
Goal 4: Reduce Child Mortality • Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate • Reduce infant mortality rates • Increase proportion of one-year-old children immunized against measles	**Reduce Infant and Child Mortality** • Reduce infant and under-five mortality rates by one-third or to 50 and 70 per 1,000 live births, respectively, whichever is less, by 2000 • Achieve an infant mortality rate below 50 deaths per 1,000 live births and an under-five mortality rate below 60 deaths per 1,000 live births by 2005 • By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-five mortality rate below 45 per 1000
Goal 5: Improve Maternal Health • Reduce by three-quarters between 1990 and 2015, the maternal mortality ratio • Increase the proportion of births attended by skilled health personnel	**Reduce Maternal Mortality and Increase Access to Reproductive Health Services Including Family Planning** • Reduce maternal mortality by one-half of the 1990 levels by 2000 and a further one-half by 2015 • Increase the availability of reproductive health services to all individuals through the primary health care system by 2015 • Decrease the gap between contraceptive use and the proportion of indi viduals wanting to space or limit their families by at least 50 percent by 2005, 75 percent by 2010, and 100 percent by 2050
Goal 6: Combat HIV/AIDS, Tuberculosis, Malaria and other Diseases • Halt by 2015, and begin to reverse, the spread of HIV/AIDS and the incidence of TB and malaria	• Ensure that 90 percent of 15- to 24-year-olds by 2005, and 95 percent by 2010, have access to information, education and communication (IEC), and reproductive health services that will reduce vulnerability to HIV* • Reduce HIV prevalence among 15- to 24-year-olds by 25 percent by 2010 *
Goal 7: Ensure Environmental Sustainability • Integrate the principles of sustainable development into country policies and programs, and reverse the loss of environmental resources • Halve by 2015, the proportion of people without access to safe drinking water and basic sanitation • Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers	**Population and Environment** • Ensure population and environmental integration • Integrate environmental factors into planning and decision-making • Modify unsustainable consumption and production patterns to foster sustainable resource use and prevent environmental degradation • Implement policies to address the ecological implication of demographic dynamics
Goal 8: Develop a Global Partnership for Development • Develop further an open, rule-based, predictable, non-discriminatory trading and financial system (includes good governance, development and poverty reduction—nationally and internationally) • Address the special needs of the least developed countries, land locked countries and small island developing states • Take measures to help countries with debt with sustainable efforts • In cooperation with developing countries, pharmaceutical companies, and private sector, develop and implement strategies for decent and productive work for youth, provide access to affordable, essential drugs, and make available the benefits of new technologies	**Broad-based Partnerships for ICPD Implementation** • Promote broad and effective partnerships among governments, non-governmental organizations, the private sector and the international community in all aspects of program development, implementation and evaluation • Such partnerships will depend on appropriate systems that enable each organization to contribute according to its distinctive role, responsibility, autonomy and capacity

Adapted from United Nations, 2003;

* ICPD Plus Five, Key Actions Document, 1999

Major Demographic Challenges

The major challenges to meeting the MDGs and reducing poverty include the constraints imposed by demographic change – population growth, population momentum and the effects of age structure and spatial distribution.

The Cairo agenda envisioned that by educating and empowering women, increasing the survival of infants and children, and supporting the "basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, to have the information and means to do so, and to have the right to attain the highest standard of sexual and reproductive health,"[v] couples would chose to have fewer children and population growth would decline to a sustainable rate. Accessible and high quality reproductive health services are a primary means to achieve population stabilization. These objectives have not been met in the poorest countries.

Rapid Population Growth is not a Dead Issue

The majority of the world's population is not yet confronting the "new" demographic issues, such as below-replacement fertility, that grab media attention. Rapid population growth continues to exert unmanageable pressures in many of the world's poorest countries where improvements in child survival, girls' education and access to reproductive health services have been very limited.

Population growth and TFR averages as shown in Table 2 disguise great unevenness in these measures within regions, notably in sub-Saharan Africa, the Middle East and North Africa (MENA). In 17 sub-Saharan African countries, including three of the largest four, no discernable transition from high to low fertility has begun, as evidenced by a TFR that remains at six or more births per woman. An additional 19 countries have a TFR between five and six. The countries comprising the Arab States region have an average population growth rate of 2.7 percent, nearly double the rate for less developed countries as a whole (1.5 percent). These countries have extremely young populations; 44 percent of the population of sub-Saharan Africa is under the age of 15.[13] The very young age structure of the poorest countries assures a strong "population momentum" that will sustain rapid population growth far into the future.

Table 2 Regional Population Growth and Total Fertility Rates

	Average Annual Population Growth Rate (Percent)		Total Fertility Rate (Average Number of Births per Woman)	
	1980-2001[13]	2004[14]	1980[13]	2004[14]
East Asia	1.4	0.6	3.1	1.6
Europe	0.5	-0.2	2.5	1.4
Latin America/Caribbean	1.8	1.6	4.1	2.6
Middle East/Western Asia	2.6	2.0	6.2	3.7
North Africa	2.2	2.0	5.8	3.4
South-Central Asia	2.0	1.8	5.3	3.3
South-East Asia	1.9	1.5	4.6	2.7
Sub-Saharan Africa	2.7	2.5	6.6	5.5
United States	1.1	1.0	1.8	2.0

Population Momentum

The term "population momentum" refers to the tendency of population growth to continue beyond the time that replacement-level fertility has been achieved. This momentum is created when mortality decline precedes fertility decline. This is typical during the early stages of a "demographic transition" from high to low fertility. Because child survival rates are higher, a larger number of youth survive to reproductive ages. As they begin to bear children, the sheer size of the youth cohort propels population growth. As fertility has declined in developing countries by as much as half, the numbers of those in the reproductive ages (15-45) has more than doubled. For example, in China, as fertility fell quickly from seven births per woman in 1963 to 2.2 in 1980,[14] the enormous cohort of youth born when birth rates were high and death rates were low eventually began to have children. The population continued to grow not as the result of women having more babies but because many more women were having (fewer) babies. Recognizing the implications, the government took the drastic step of implementing a "one-child policy" in the late 1970s. This did not halt population momentum, but shortened

Continued on next page

[v]See Annex for more information.

the length of time that the population will continue to grow, thus reducing the size of the population that will ultimately be reached. The often extremely long time lag between achievement of replacement-level fertility and population stabilization caused by population momentum is rarely part of development discussions yet has implications for every sector of society.

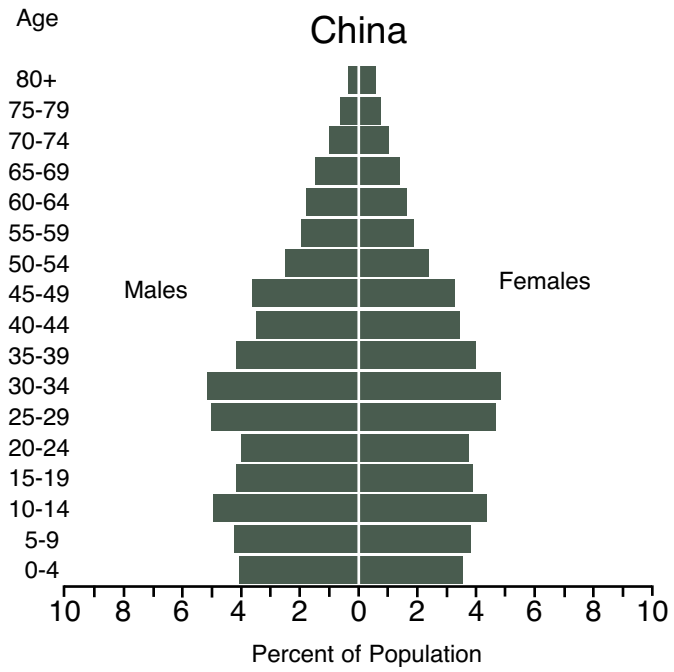
Population momentum has been likened to a "pig in a python." The bulge created by the enormous cohort of reproductive-aged youth must work its way through the age structure and graduate from the reproductive years, before population size finally stabilizes.

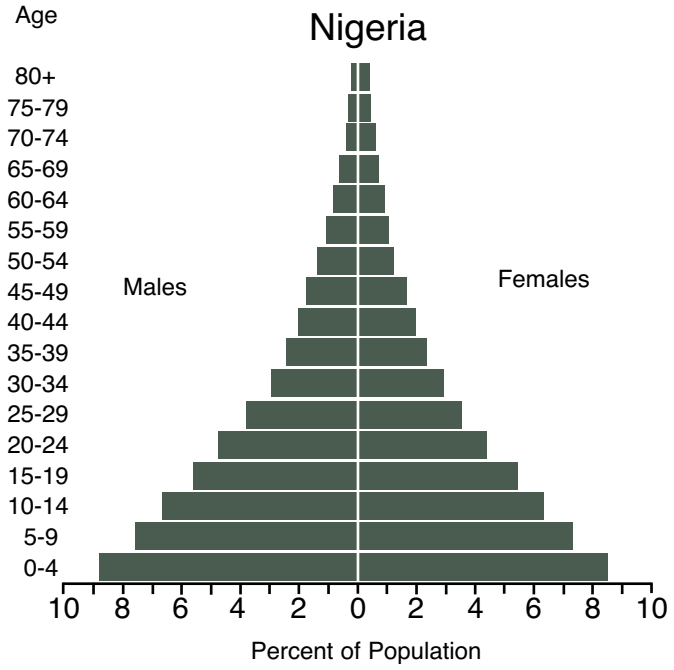
Globally, more people are entering the reproductive years than are leaving it, and this will continue to be true for at least the next 25 years. In countries where fertility was very high in the recent past, population momentum will fuel population growth for up to a century. Such large absolute increases in numbers of people greatly exacerbate the difficulties faced by poor countries for food security, environmental integrity, health and social services, housing and jobs.

Age Structure: The Shape of Things to Come

The age structure of a population is, perhaps, its single, most defining concept. The greatest impact of a large birth cohort occurs not in the year of birth, but 15 to 18 years later when its members enter the labor force or begin producing children. A country with a broad-based pyramidal age structure, typical of most developing countries, is one in which the size of each new birth cohort exceeds that of the previous year's.[vi] The age structures of most countries in the sub-Saharan African and MENA regions, as well as those in many other parts of the developing world, are heavily weighted toward those in the younger ages. Societies with fertility at or below-replacement (TFR of approximately 2.1) struggle with finding the resources to meet the social security and health needs of their growing population of retired elderly. Those with youthful age structures face unending demands for more schools, more health care and more jobs. The size of the cohort thus affects the opportunities available to its members, and in turn, the economic and social behavior of age cohorts is shaped by opportunity – for example, whether a young person has access to schooling or is able to prevent an unwanted pregnancy.

Figure 1 Illustrative Population Age Structures, 2000





United Nations, 2002

[vi] Generally, five-year intervals disaggregated by sex.

Demographic Bonus – or Not

Under the right circumstances, a large and well-prepared young labor force can contribute to a one-time demographic "bonus" or "dividend." When fertility has declined and the combined "dependent" population of children and elderly is still small – many are working and have fewer dependents to support – economies can expand and savings can grow. Research on the relationship between economic growth and rapid fertility decline during the 1970s and 1980s in East Asia revealed the positive contribution of a more favorable "dependency ratio" on saving, income and development. However, a demographic bonus can only be realized if, as was true in East Asia, human capital investments have been made in the health and education of those entering the labor-force, and jobs have been created to meet the demand. Only then can youth realize their potential as healthy and productive members of society and boost their countries' economic and development status. Investment in youth must be made early enough to create the conditions for this bonus to occur. Otherwise, a large, uneducated, unhealthy, unskilled and under-employed workforce creates a burden to society and threatens its stability.[15]

Economic Dividends through Reproductive Health

As the largest cohort of young people in history enters its productive and reproductive years, the investments that have or have not been made to prepare youth for the future will begin to influence economies in potentially dramatic ways. For countries now beginning a transition to lower fertility, the opportunity to benefit from a demographic bonus in the future is relevant. Providing reproductive health services and creating jobs to meet the needs of this giant generation are of paramount concern.

Impact of Population Growth on Economic Growth and the MDGs

Recent economic analyses are better able to demonstrate that rapid population growth exerts a negative impact on economic growth, and that rapid fertility decline contributes to reducing the severity and incidence of poverty. This is especially relevant to the poorest countries, as the lower the initial level of development, the greater the net positive impact of fertility decline on per capita income.[16] One estimate based on data from 45 countries indicates that a decline of five births per 1,000 in the 1980s would have reduced the percentage of persons living in poverty a decade later by one-third.[17] Meeting the needs of a rapidly growing population for health, education, housing and jobs prevents governments from making alternative investments that may raise economic productivity, increase savings and alleviate poverty. With population growth rates as high as 3 percent per year (corresponding to a doubling time of 23 years), economies growing at 4 percent per year are barely making headway. For the most disadvantaged countries, maintaining even current low percentages of school enrollment for an ever-growing number of youth is a significant challenge. The Millennium Development Goals to halve the population of those living on less than US$ 1 per day or those who are hungry, to reduce maternal and child mortality, to create meaningful employment opportunities for youth, and to ensure environmental sustainability, are also largely unfeasible in the face of population growth rates of this magnitude.

Intersections of Health and Population Growth Contribute to Crisis in Education

The second MDG aims to achieve universal primary education by 2015. Meeting this goal would require thousands of new schools and teachers. In most HIPCs (Table 3), due to rapid population growth and population momentum, the increase in schools and teachers is barely able to keep pace with increased number of students. Furthermore, in 2002 alone, nearly 1 million African children lost a teacher to HIV/AIDS.[18] This fact strikingly illustrates the intersections between population growth, health and education, and highlights the need to create positive rather than negative synergies between them if the MDGs are to be met.

Spatial Distribution: Growing Density and People on the Move

Rapid urbanization is occurring in many countries, as poor rural residents seeking economic opportunity move to slums outside of or within major metropolitan areas. Compared to their urban neighbors, these new migrants have poorer health indicators in all dimensions.[19] Migration across borders, whether forced or voluntary, legal or illegal, contributes to the challenge of controlling communicable diseases, including TB, SARS and HIV/AIDS. The redistribution to either urban areas or other countries is driven largely by competition for scare

resources in the place of origin. Rapid population growth fuels these processes as increasing population density forces overuse of environmental resources, leading to deforestation, over-fishing, soil depletion and water insufficiency. As land parcels become too small or depleted to support families, migration inevitably increases.

Population Growth, Reproductive Health and the MDG for Environmental Sustainability

The Cairo Programme of Action gave a high profile to the ecological implications of population dynamics. The recommendations to integrate population and environmental planning and decision-making are no less valid for helping to achieve MDG 7. Goal 7 calls for halving the proportion of people without access to safe water and sanitation, and improving the lives of at least 100 million slum dwellers. The relationship between rapid population growth and the sustainability of the environment – water, soil, forests, biodiversity, fisheries and climate – should motivate attention to reproductive health and population policy.[20] Unwanted fertility contributes twice as much to future population growth as does desired fertility. Thus helping women meet their reproductive intentions would be the most effective and humane path to slow rapid population growth. Globally, slowing population growth sooner rather than later will result in 2 to 3 billion fewer people (or nearly half of the present global population) when the global population is expected to stabilize by the end of next century. These are goals worth striving for.

"At the societal level, rapid rural population growth in particular puts enormous stress on the physical environment (e.g., deforestation, as forests are cut for firewood and new farm land) and on food productivity as land-labour ratios in agriculture decline. Desperately poor peasants are then likely to crowd cities, leading to very high rates of urbanization, with additional adverse consequences in congestion and in declining capital per person (e.g., policing services, water and sanitation, etc.)"

World Health Organization, Commission on Macroeconomics and Health, 2001

Reproductive Health, Poverty Reduction and the MDGs

There is also growing evidence of the interrelatedness of reproductive health and the macro-economy and that poor reproductive health contributes to poverty.[21] The economic toll of HIV/AIDS, estimated to cost Africa 1 percent of per capita growth per year,[18] is the most obvious example. Millennium Development Goal 1, calling for halving the numbers who live in extreme poverty by 2015, will be difficult to achieve when 99 percent of population growth is occurring in poor countries. The economic consequences of poor reproductive health occur through a variety of pathways[22] including childbearing that occurs too early, is unwanted or is too closely spaced. Poor reproductive health can initiate, perpetuate or deepen poverty. High fertility is associated with reduced investment in individual children, including less schooling. A mother's low educational attainment is associated with early childbearing, lower wages, lower participation in the paid labor force, diminished health and survival of her children, as well as with lower educational levels achieved by her own children, perpetuating the intergenerational transmission of poverty.[23] Reproductive morbidities, including HIV/AIDS, reduce productivity and investments in children, as well as income.[22] Addressing the unfinished agenda of Cairo will remove a roadblock to poverty reduction by assuring that the poor receive the same access to reproductive health services that others enjoy.

Reproductive Health, Maternal Mortality and Morbidity

The difference in maternal mortality between rich and poor countries is one of the greatest disparities of all human development indicators. Complications of pregnancy and childbirth are among the leading cause of death and disability for women of reproductive age in developing countries. Of the more than 500,000 maternal deaths each year, nearly all occur in developing countries, and most among poor women. Women in sub-Saharan Africa have a one in 13 chance of dying in childbirth, and for each pregnancy-related death, 30 women suffer short or long-term disabilities, infections and injuries.[24] Poor reproductive health is responsible for more than a third of all DALYs lost by women in the reproductive ages.[25] Malnutrition, young maternal age, closely spaced births, and a high number of previous pregnancies increase the risk for both mother and infant.

Reaching the MDGs for Reducing Maternal and Infant Mortality

A focus on emergency obstetric care will not be sufficient to meet MDG 5 to reduce the maternal mortality ratio (MMR) by three-fourths by 2015. Meeting MDG 4 to reduce infant and child mortality within the timeframe also implicitly demands preventing unwanted, too early and too closely spaced births. The synergies that could be realized in support of the MDGs through reproductive health interventions are clear in the use of family planning to achieve an optimal birth interval. Birth spacing has a strong influence on infant and child survival. An estimated 25 percent of maternal deaths could be avoided through adequate birth spacing and fewer total births[26 27] and an even greater impact can be made on infant mortality. For India alone, a birth interval of 36 months is estimated to reduce infant mortality by 29 percent, under-five mortality by 35 percent, and to prevent the deaths of nearly 1.5 million children annually.[26] Such major reductions in both maternal and infant mortality that are achievable through reproductive health interventions should make them an obvious priority for investment.

Unsafe Abortion

Of the nearly 700,000 women who died between 1995 and 2001 because of an inability to prevent an unintended pregnancy, approximately 440,000 deaths (68 percent) resulted from unsafe abortions.[28] Reducing the toll of unsafe abortion through increasing access to contraception is, therefore, essential to reducing maternal mortality.

Abortion is nearly always a response to unwanted or ill-timed pregnancy. The rate of abortion is, therefore, likely to increase as the gap between availability of supplies/services and the desire for smaller families widens.[29 30] The risk of death is highest in sub-Saharan Africa where poor access to contraception leads to use of unsafe abortion as a fertility control measure of last resort and where one in 150 women who undergo unsafe abortion dies.[31] The true extent of unsafe abortion in Africa is largely unknown but is estimated on the basis of a gap between the total fertility rate and the level of contraceptive prevalence that would be expected to achieve that rate.[3] In Nigeria, 30 to 40 percent of all maternal deaths are estimated to be due to complications of unsafe abortion.[vii] While safe abortion carries a very low risk to health, it is often not available even where it is legal[24] and stigma promotes the clandestine use of unsafe methods even where safe abortion is available. In addition to the human toll, abortion exerts tremendous demand on health resources. In some settings, the treatment of complications from unsafe abortion consumes a major share of hospital budgets for obstetrics and gynecology.[32]

Lack of Access, Lack of Quality and Unmet Need for Contraception

Lack of access to quality reproductive health services, including contraception, remains a problem for the poor throughout the world, but especially in countries with high rates of population-growth and poverty. Contraceptive prevalence of modern methods remains below 10 percent[33] in at least six HIPCs (see Table 3). Although desired family size is high and demand for contraception is said to be weak in many of these countries, there is also significant "unmet need" among women of reproductive age who would like to stop or space their next birth but are not using effective contraception. The range of those with unmet need is as high as 35 percent among women in Uganda and Senegal.[34] At least 200 million women worldwide have such an unmet need.[35] This number is expected to increase due to projected population growth, rising demand for smaller families, and inconsistent supplies of contraceptives.

"Weak demand" for family planning may reflect sociocultural factors that are difficult to address programmatically, including gender inequity and women's lack of power to control fertility decisions within patriarchal societies. Demand may also be hindered by the low quality of available services. Poor women, in particular, are subject to disrespectful treatment by providers. These women attribute their failure to use contraceptives – despite a desire to control fertility – to the poor quality of services rather than to the unavailability of services.[36]

HIV/AIDS, STIs, Gender Inequity and the MDGs

As a driving force behind the HIVpandemic.[37] gender inequity stands in the way of achieving MDG 6, to reverse the spread of HIV/AIDS. Efforts toward achieving MDGs 1, 2 and 3 for poverty reduction, universal education and women's empowerment respectively, will ultimately empower young women to avoid the sexual and economic exploitation that fuel a far greater vulnerability to HIV among young women than among men of the same age.[4] More immediate gains in prevention can be achieved through a focus on reproductive health and maximizing linkages between HIV and reproductive health services.

[vii] www. ipa.org/religion/nigeriaEG.htm

The escalation of the HIV/AIDS pandemic reflects the inadequacy of reproductive health services to meet the needs of women, men and youth for information, education, counseling and services, including STI testing, treatment and referral. Reducing the spread of HIV/AIDS requires preventing primary infections, unwanted pregnancies among women infected with HIV, and transmission of HIV from mother to child. All of these preventive actions benefit from high quality and confidential reproductive health services. The growing demands of the pandemic have led to a shift of resources away from providing universal access to family planning and other reproductive health services.[38] Many countries with poor logistics systems also lack sufficient supplies of condoms and basic medicines to treat STIs. Untreated STIs increase the risk of acquiring HIV by six to 10 times[39] and are the underlying cause of half of the 60 to 80 million cases of infertility.[40] The challenges for inadequate systems to prevent new HIV infections as well as to provide care, support and, ultimately, treatment for an ever-growing target population, are formidable. Better linkages between HIV and reproductive health services would significantly contribute to meeting these challenges.[41]

Youth Reproductive Health

Improving access to youth-friendly and confidential reproductive health information and services is essential if the devastation of HIV among youth is to be stopped. The prevalence of HIV/AIDS among 15- to 19-year-old girls in some parts of Africa is as high as 30 percent.[42] Girls must be enabled to control the circumstances under which sex takes place and to negotiate safer sex. These skills are strongly tied to level of education and economic independence, yet 90 million girls age six to 11 are not in school.[43] The Cairo agenda provides guidance to the improvements needed in youth reproductive health that can contribute to meeting all eight of the MDGs. Most critically, the objectives to achieve gender equity, provide livelihood opportunities for girls, and promote the responsible behavior of boys and men, will spur the achievement of MDG 6, to halt and reverse the spread of HIV/AIDS.[43] Addressing the multi-dimensional aspects of youth reproductive health, including schooling, livelihoods and gender equity, is also essential to facilitate a demographic bonus.

Why Focus on the World Bank?

As the world's largest lender for health and an influential organization in international development assistance, the World Bank is well positioned to address population and reproductive health issues within the broader development agenda. Since its founding in 1945, the Bank has channeled more than US$ 500 billion to more than 100 countries through its various lending and grant programs.[18] The Bank provides financial assistance to governments and loans to the private sector (through the International Finance Corporation (IFC)). The Bank has a legacy of investment in population and reproductive health over the past three decades and its expertise and leadership to address these issues is still needed. Although it is a lending rather than an implementing institution, the Bank has provided analytical and technical support to many countries in formulating their population and reproductive health policies, and has facilitated and funded programs that have led to beneficial reproductive health outcomes in many countries that are now rising out of poverty.

Corporate Commitment to the MDGs

In congruence with its vision of a "world free of poverty," the Bank has made a corporate commitment to achieve the Millennium Development Goals. However, the agreement by 189 member states of the UN to the goals in 2000 provides a strong endorsement and incentive for the Bank to use these commitments to speed implementation of its own poverty reduction agenda. Although they extend beyond the Bank's ongoing poverty reduction agenda, there are close parallels between the MDGs and the Bank's corporate strategy. Only Goal 8, to develop a global partnership for development (see Table 1), has not previously served as a goal for the Bank.[9]

Presently, many developing countries are not on track to achieve MDG targets, particularly for maternal and child health and HIV.[44] These goals require strong reproductive health inputs. The MDGs and the Bank's strengthened focus on poverty reduction also provide a compelling rationale to rekindle attention to population dynamics and reproductive health. Slowing the growth of population will contribute to achieving the MDGs for environmental sustainability, meaningful employment opportunities for youth, and universal primary education. Linking these objectives through intersectoral work will promote synergies that will speed progress across all of the goals.

PART II. THE WORLD BANK'S INVESTMENT IN POPULATION AND REPRODUCTIVE HEALTH

> **"Our goal is a world free of poverty"**
>
> World Bank Mission Statement

The Role of the World Bank in Population and Development

The World Bank acts as an advisor, broker, donor, knowledge resource and partner to its 184 member countries. As a specialized agency within the UN, the Bank offers financial and technical assistance aimed at reducing poverty, increasing economic growth, and improving quality of life in low-income countries. At the core of the Bank's strategy is the recognition that greater attention must be paid in developing countries to governance, institutional capacity and organizing services to better reach the poor.

In the 1970s population projects were the Bank's first foray into the health sector. However, since the 1990s, other health issues have taken priority. In recent years, the Bank has focused increasingly on poverty alleviation in the poorer countries by providing grants or loans at concessional rates. Bank support[viii] has moved strongly into the area of human development with health, education and social services among the top sectors supported by the Bank after the law, justice and public administration sectors.[18] The Bank also has thematic areas dealing with issues of urbanization and environment (see Box below).

Since the Bank's reorganization in 1997, Bank support to the health sector has evolved significantly, with the emerging global health agenda, including HIV/AIDS, having important implications for population and reproductive health. A focus on population issues (primarily demographic analysis) declined to the point where, by the mid-1990s, population and reproductive health activities were subsumed under the Bank's Health, Nutrition and Population (HNP) Sector. Bank investments have increasingly supported country priorities and these have, in recent years, put less emphasis on population growth as a key constraint to development.

The Bank's Response to Cairo

The Cairo Programme of Action has been influential in shaping the Bank's approach to population and reproductive health issues. The emphasis on the long-term impact of investments in girls' education, and health systems which offer a broad package of reproductive and child health programs, is consistent with the Bank's human development agenda that emerged since 1997. For the non-health sector components of the reproductive health agenda, the Bank significantly increased post-Cairo lending and spending for girls' education and gave greater attention to gender issues.

[viii] World Bank loans represent multi-year commitments disbursed over several years, but are recorded in the year approved.

Key World Bank Project/Program Sectors

- Agriculture, fishing and forestry
- Education
- Energy and mining
- Finance
- Housing finance and real estate markets
- Health and other social services
- Industry and trade
- Information and communications
- Law and justice and public administration
- Transportation
- Water, sanitation and flood protection

World Bank Thematic Areas

- Agriculture and Rural Development
- AIDS
- Anti-Corruption
- HIPC Debt Relief
- Education and Training
- Energy
- Environment
- Evaluation Monitoring
- Financial Sector
- Gender
- Globalization
- Global Monitoring
- Governance and Public Sector Reform
- Health, Nutrition and Population
- Information and Communication Tech.
- Infrastructure
- Knowledge Sharing
- Law and Justice
- Macroeconomics and Growth
- Mining
- Participation
- Policies
- Poverty
- Private Sector Development
- Social Development
- Social Protection and Labor
- Sustainable Development
- Trade
- Transport
- Urban Development
- Water Resources Management
- Water Supply and Sanitation

Girls' Education

Both Cairo and the MDGs aim to achieve universal primary education by 2015 and eliminate gender imbalance in primary and secondary education by 2005. The education of girls and women is known to be a top-ranked social investment, associated with, among other positive outcomes, lower fertility, higher child survival and increased earnings.[45] Following the ICPD conference, the Bank considerably bolstered its advocacy and lending for girls' education. By 1999, the Bank supported three times as many active projects with girls' education components as it had in 1991. Bank lending for girls' education peaked in 1998 and was approximately US$ 800 million in 2004. Recent projects tend to include a wider range of interventions that address the broader range of barriers to girls' education including those related to economics, culture and infrastructure.[46] The Bank's education projects are placing emphasis on improving education quality and relevance for girls, including efforts to increase the proportion of well-trained female teachers, gender sensitization for teachers, textbook revision to eliminate gender biases, development of gender-sensitive curricula, and awareness campaigns to increase parental and community knowledge of the importance of girls' education. The Bank has identified 31 Girls' Education Target Countries that have particularly large gender disparities in basic education. Target country profiles have been created to provide a clear picture of the status of girls' education and progress from the mid-1980s to date.[5]

Gender

The World Bank's work on gender equity began in the 1970s, but its efforts to improve the status of women and girls were notably increased subsequent to the Cairo and Beijing agreements. Following the 1997 reorganization, the Bank established a Gender Sector Board to strengthen the Bank's attention to gender in all sectors. The official strategy for mainstreaming gender was approved by the Bank's board in 2001. The strategy is "intended to establish an enabling environment that will foster country-led, country specific strategies for changing the gender patterns that are costly to growth, poverty reduction and human well-being."[98] A key component of the strategy is the preparation of country gender assessments to identify critical areas for gender-responsive actions in a particular country context.[98]

Progress in mainstreaming gender is significant in countries and sectors where a relevant gender analysis has already been completed, reinforcing the key role of gender assessments in addressing critical development issues and priorities.[18] There is substantial gender activity in each of the regions. Each region has a gender advisor and its own web site that contains key resources (including data resources and publications), information on projects, programs and training materials and links to partners and other resources.[ix] The Bank also published *Gender Equality and the Millennium Development Goals*[43] in 2003, showing that working for women's empowerment and gender equality is essential to a number of goals and offers a "win-win" approach for policy-makers aiming to attain the MDGs.[43]

The Norwegian/Dutch Fund for gender mainstreaming (GENFUND) was established in 2001 by the government of Norway. The Dutch government has recently joined in support to this fund. GENFUND encourages innovative gender mainstreaming in Bank activities in order to develop good practice examples and reinforce an institutional culture of greater attention to gender issues. The fund is also intended to build capacity in client governments and foster closer links to external partners. GENFUND has provided more than US$ 2 million to World Bank staff for incorporating gender-responsive action and analysis into their work. Numbers of projects have dealt with reproductive health issues including HIV/AIDS, violence and female genital mutilation.[x]

Shifting Priorities within the Bank

It is interesting to contrast the investments in girls' education and gender with lending for population and reproductive health, which has been relatively flat over the past decade at around US$ 300 million per year (not including HIV/AIDS spending).[xi] The decline in Bank support for population issues and flat funding for family planning and reproductive health in relation to other global health concerns reflects a failure of overall development dollars for reproductive health to keep pace with the increased demand for reproductive health services, now including HIV/AIDS. It also reflects a failure to maximize synergies between investments in reproductive health and HIV/AIDS.

[ix] For a list of recent publications, see:
http://wbln0018.worldbank.org/external/lac/lac.nsf/6d4b30e53303849d852567d6006c117d/9e19dbb70ee52ca4852568190057d952?OpenDocument.
The Africa Region has a well-established country gender database that provides gender indicators and data for each country.

[x] For further details, see http://www.worldbank.org/gender/partnerships/genfund.htm.

[xi] HNP lending data as of August 2004.

Two World Bank reports in the 1990s signaled its growing interest in helping countries to enhance the performance of health care systems and mobilize health care financing. The Bank's 1993 World Development Report, *Investing in Health*, provided a framework for health reforms in developing countries to improve system efficiency and long-term financial sustainability.[47] This report formed the basis for the Bank's HNP Sector Strategy prepared in 1997.[47] The HNP Strategy touched on fertility reduction as part of "promoting good health, nutrition and reproductive policies to allow countries to break out of the vicious circle of poverty, high fertility, poor health and low economic growth, replacing this with a 'virtuous circle' of greater productivity, low fertility, better health and rising incomes."[48] However, the main legacy of the strategy has been the help provided to countries to focus on enhancing the performance of health care systems and to mobilize sustainable health care financing.

Criticism from the Outside

In 1997, Population Action International (PAI) produced a report critical of the Bank's work in population. The report, *Falling Short*, noted the potential for the Bank's health reform agenda to detract countries from supporting reproductive health programs.[7] The PAI report did not dwell on the broader aspects of the Cairo agenda: investments in girls' education, women's empowerment and employment and gender equality. While acknowledging the Bank's important support to these non-health issues, it emphasized the immediate need for greater support for population and reproductive health programs.

The PAI report faulted the Bank for failing to take a stronger position on the contribution of population stabilization and reproductive health to development and concluded that "the Bank's economic establishment remains unconvinced that population factors have a negative impact on economic growth."[7] As a result, the Bank was neglecting the role of population growth in its economic analyses and was not conducting research on the linkages between population growth and poverty alleviation. Specific recommendations of the report include the formation of an interdisciplinary unit to integrate population analyses into all Bank strategies, particularly where high population growth rates are likely to affect development, to ensure that this issue is adequately addressed in assistance strategies.

Insufficient and declining lending for reproductive health programs, despite growing needs, and concerns about contraceptive security, were also noted in the PAI report. There was increasing unease, even in 1997, that while the development community had initially increased population assistance after Cairo, donors were losing interest in population and reproductive health issues. Increased concessional lending was suggested to encourage more government attention to reproductive health services.

The report also took note of the decline in numbers of Bank HNP staff with strong technical skills in reproductive health and population, use of highly qualified staff to manage more general health projects, and reliance on economists with limited experience to manage reproductive health projects. It recommended expanding central and regional expertise in reproductive health, adding regional advisors in population and reproductive health, maximizing use of those with reproductive health expertise, and developing new systems for building long-term capacity through collaboration with a broad range of bilateral, multilateral and NGO specialists.

The release of the PAI report gained the attention of the Bank's executive directors. The influential Committee on Development Effectiveness took up the issue of the Bank's inadequate commitment to population and development when it considered how the principles and recommendations of the 1997 HNP Sector Strategy would be applied to the Bank's work on population and reproductive health.

A Post-Cairo Road Map for the Bank

The concerns raised in the PAI report and the subsequent attention it received from the Bank's board were welcomed by staff working on population and reproductive health. The management directive to prepare a response was an opportunity to clarify the Bank's role in helping countries implement the Cairo Programme of Action. The resulting Bank report, *Population and the World Bank – Adapting to Change*, was published in 1999 and revised in 2000.[8]

By the mid-1990s, there were signs that fertility rates were falling in most developing countries, and a global demographic transition from high to low rates of fertility and mortality appeared to be irreversible. However, the yet-to-begin transition in some countries was less newsworthy than below-replacement fertility in Europe, with its implications for aging populations and inadequate social security systems. The authors of *Adapting to Change*, while conceding that the Bank did not always take the opportunity in policy dialogues to discuss population issues, offered a new framework, recognizing the diversity of need among the Bank's borrower countries. A typology based on a key set of indicators and reference levels was developed to assist Bank staff in considering the key population and reproductive health issues and strategic interventions in "pre-transitional" countries or delayed transition countries. For those in the pre-transition phase (primarily sub-Saharan African countries), policy responses include assessing the effects of population growth and distribution and the demographics of HIV/AIDS. Programmatically, it was necessary to build capacity to provide family planning and reproductive health information and services and to include them in basic service packages.

In "incipient or delayed transition" countries (including Pakistan, Haiti, Jordan and Venezuela),[8] policy issues included assessing the supply and demand factors underlying fertility and contraceptive use, and, for programs, costing and resource mobilization for family planning and reproductive health services. *Adapting to Change* also covered a range of population and reproductive health issues for countries at advanced and post-transition stages.

Adapting to Change reaffirmed the importance of support for a multisectoral approach as highlighted in the Cairo Programme of Action. This approach included investments in girls' education and women's empowerment through labor and micro-credit programs as essential contributions to positive reproductive health outcomes.

The report also identified a number of Bank mechanisms that needed to be strengthened if engagement with countries on population and reproductive health were to improve. These included empowering staff through professional development, sharpening the Bank's strategic focus, strengthening effective partnerships and improving knowledge management – a crosscutting issue that informs all of the other areas.

To hone the Bank's strategic focus, the report proposed to systematically monitor population and reproductive health policies through a population policy watch list. Regional operations staff would track a set of key population and reproductive health indicators for specified countries where actions were most needed and then include references to these indicators in key documents such as the Country Assistance Strategies (CAS). Similarly, a portfolio watch list (see Key Indicators for Population and Portfolio Watch Lists box) was proposed to better monitor the effectiveness of Bank operations in reproductive health. However, new resources to prepare and track the watch lists were not identified.

Key Indicators for Population and Portfolio Watch Lists

- **Total fertility**
- **Maternal mortality**
- **Prevalence of HIV/AIDS**
- **Adolescent fertility**
- **Contraceptive prevalence**
- **Population momentum**
- **Urban population growth**
- **Young working-age population growth**
- **Enrollment of girls in secondary school**
- **Population aging**
- **Prevalence of female genital cutting**

During the preparation of the *Adapting to Change* report, the Bank undertook a major initiative to increase its capacity to identify and share development "knowledge." New resources were allocated to create "communities of practices" on sub-thematic topic areas. More than 100 such groups were created throughout the Bank, including nine within the HNP Sector. The Population/Reproductive Health (Pop/RH) Thematic Group provided an opportunity for all Bank staff working on population and reproductive health issues to disseminate news and information as well as promote knowledge sharing on the latest research in the field and best practices from operations – as envisioned in *Adapting to Change.*

Aftermath of the *Adapting to Change* Report

The Bank's track record in implementing the ICPD Programme of Action has been somewhat uneven. While the Bank has launched major efforts to advance the economic and social status of women, educate girls and prevent HIV/AIDS, the links between these efforts and population/reproductive health care have often not been explicit and are rarely maximized.

The broader health sector provides the main organizing principle for the Bank's work in HNP. As a sub-theme within the HNP sector, population and reproductive health issues are no longer seen to receive the attention they merit, particularly in poor countries with high growth rates and inadequate reproductive health systems. This view is reinforced by the declining number of population/reproductive health specialists and demographers working on population and reproductive health issues within the Bank, a reduction that has occurred mainly through attrition.

The bolstered resources needed to create a critical mass of interest and expertise to carry forward the *Adapting to Change* report's recommendations did not materialize. This was especially significant for staff's ability to implement the watch lists. Without such resources, existing staff could not sustain attention to countries where population growth continued unabated.

Renewed Commitment to Poverty Reduction

In 1999, World Bank President James D. Wolfensohn launched the Comprehensive Development Framework (CDF) aimed at providing a more holistic approach to development through integrating social, structural, governance, environmental, economic and financial aspects of development. Later that year, the World Bank and the International Monetary Fund (IMF) initiated the Poverty Reduction Strategy Papers (PRSPs) – poverty alleviation strategies based on a participatory process corresponding to the key principles of the CDF. PRSPs became the basis for concessional lending for International Development Association (IDA) countries[xii] and debt relief for heavily indebted poor countries (HIPCs). Preparation of a PRSP is now a requirement for each country applying for concessional lending or debt relief under the HIPC initiative.

The guiding principles for preparing a PRSP are that it:

- Be country-driven
- Focus on results benefiting the poor
- Be holistic in addressing the multiple determinants and outcomes of poverty
- Incorporate collaboration/agreements with development partners
- Demonstrate a long-term perspective for poverty reduction

The PRSP approach requires health sector specialists to provide advisory services to governments on priority areas for improving health outcomes of the poor. This strategic advice is influential and ultimately should be reflected in the design of projects.[49] Poverty Reduction Strategies are reviewed and approved jointly by staff from the IMF and the World Bank (Joint Staff Assessments (JSAs)). Both organizations are required to incorporate the approved strategies into their business plans – the CAS for the Bank and the Poverty Reduction and Growth Facility (PRGF) Program for the Fund. As a result, a PRSP is central for future lending and investment. Given the comprehensive scope of the PRSP, many issues cannot be considered in depth, but the mention of specific themes or concerns can lead to further sectoral analysis and lending programs.

Poverty Reduction and the Health Sector

The Poverty Reduction Strategy process has the potential to greatly advance attention to population and reproductive health if participants in the country-driven process are sufficiently cognizant of the critical links between economic development and population/reproductive health. These links include the relationship between rapid population growth and slow or stalled economic growth at the macro level, or between reproductive health and productivity at the household level. For example, the Bank's ability to successfully elevate the understanding of the interrelations between health and poverty has been demonstrated in the recognition of the HIV/AIDS pandemic as a development crisis requiring simultaneous attacks on multisectoral fronts.

To facilitate this understanding, the HNP contribution to the World Bank's Poverty Reduction Strategy Source

[xii] Eighty-one countries – 39 in Africa, 13 in East Asia and the Pacific, 10 in Europe and Central Asia, nine in Latin America and the Caribbean, eight in South Asia, and two in the Middle East and North Africa – are eligible for IDA loans based on a GNI of less than US$ 865 per capita (2002) and financial inability to borrow from the International Bank for Reconstruction and Development (IBRD). Of these, 42 countries – 34 in Africa, four in Latin America, three in Asia and one in the Middle East – are eligible for the HIPC initiative due to their extreme poverty and unsustainable debt burden. See http://web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/IDA/0,,pagePK:118644~theSitePK:73154,00.html and http://www.worldbank.org/hipc/index.html.

Book, *Poverty Reduction and the Health Sector*, includes a new conceptual framework for linking household behaviors with health systems and government policies leading to improved health outcomes.[49] The Source Book acknowledges the important role of demand factors that constrain the use of health services by the poor.

> **"The priority accorded to health in national budgets, in costing PRSPs, mid-term expenditure frameworks and CASs is not commensurate with the role of health in general and reproductive health more specifically for poverty reduction."**
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> World Bank, Africa HNP Family, 2003

Attention to Population and Reproductive Health Issues in PRSPs

Recent reviews of available PRSPs have found that they often do not explicitly make the critical links between population and reproductive health and economic development. Separate reviews conducted by Bank HNP staff[50] and the Global Health Council[51] reveal that population, reproductive and adolescent health, and development issues are insufficiently covered. In some cases, the issues were recognized but no strategies were proposed to address them. In others, strategies were proposed but no appropriate indicators to measure progress were included. Furthermore, policies were proposed without specifying institutions, budget or timeline for implementation, decreasing the likelihood that they would be implemented.

The review by HNP staff found that the relationship between population growth and poverty was not well recognized and noted a "worrisome" lack of attention to adolescent health in the PRSPs.[50] HNP recommended that the Bank take an active role in PRSP development and review, encourage the involvement and active participation of CSOs focused on reproductive health and youth, commit financial and technical resources to build the capacity of NGOs working to reduce poverty and improve health and standardize the use of Demographic and Health Surveys (DHS) indicators to track progress.

The Influence of the MDGs on Bank Operations in the HNP Sector

The Millennium Development Goals are increasingly framing the Bank's strategy for work in the HNP sector. The Bank staff report that MDG discussions with other donors have helped to clarify and define a list of key indicators for monitoring and evaluating progress, and the Bank is currently preparing a report for staff as well as country and donor counterparts to guide efforts to achieve the MDGs. The draft report[52] situates reproductive health within the context of the MDG for improving maternal health.

Given the Bank's new focus on the MDGs and what would be required of the HNP Family to achieve them, it is not surprising that a recent internal review[53]of the HNP Sector Board noted that the 1997 sector strategy was outdated. It is clear that the health MDGs must be addressed through a multisectoral approach and HNP is working more closely on the health dimensions of operations such as water supply and transport. The review acknowledged the challenges of these cross-sectoral endeavors and proposed incentives to encourage staff to work collaboratively across sectors. It recommended that the Bank put more effort into building capacity at the country level for monitoring and evaluating systems to track progress on the MDGs. As yet the Bank has not developed a strategy to track the standardized set of intermediate indicators that are proposed to measure progress toward achieving the MDGs.[54]

Opportunities and Challenges to Implement Population and Reproductive Health Strategies

For most of the 1990s, despite the number of countries with very poor health indicators and no discernable decline in fertility (see Table 3), a sense of urgency about rapid population growth was not a central feature of the Bank's economic advice to countries. Recently, the "new" demographic issues, notably the effect of age structure and dependency ratios on economic variables, has received more attention in comparison to aggregate population growth. For example, the ratio of dependents (those under 15 and over 60 years of age) to workers and the "demographic bonus" that contributed to rapid economic advancement in East Asia has been discussed in Bank publications. The 2003 World Development

Report, *Sustainable Development in a Dynamic World*, emphasizes the opportunity for savings and growth that was created by a lower dependency ratio following fertility decline.[55] The HIV/AIDS crisis and the Bank's commitment to poverty alleviation and the MDGs highlight the need as well as the opportunity for the Bank to more coherently address population and reproductive health issues

New Donor Support Mechanisms

While the opportunity presented by the MDGs to bring population and reproductive health back into prominence is welcomed, success is far from assured. According to Bank staff, increasing trends toward support to budgets rather than to projects, while favorable overall, do not provide sufficient opportunity for Bank staff to focus on implementation issues. For example, sector-wide approaches (SWAps) are an innovation in lending strategy[56] that enable multiple donors to pool their resources in funding joint donor-government programs which are under government management. SWAps support nationally defined policies rather than donor-specific projects. Their advantages include the streamlining of monitoring and reporting procedures and simplification of the often unduly complex and conflicting requirements that different donors may impose. Governments have greater autonomy and responsibility, while donor influence and involvement is more limited. Under SWAps, the focus of the Bank and other donors shifts from project planning and management to the framework guiding policy, institutions and finances for health.[56] Population and reproductive health issues must be addressed in this framework if they are to be appropriately included in implementation strategies.

Table 3 Selected Heavily Indebted Poor Countries (HIPCs) with Key Population/Reproductive Health Indicators

	Total Population, Millions (2001)	Average Annual Population Growth, Percent (1980-2001)	Average Annual Population Growth, Percent (2001-2015)	Total Fertility Rate, Ave. No. Births Per Woman (1980)	Total Fertility Rate, Ave. No. Births Per Woman (2001)	Contraceptive Prevalence Rate, Percent of Women Ages 15-49 (1990-2001)	Adolescent Fertility Rate, Births Per 1,000 Women Ages 15-19 (2002)	Births Attended By Skilled Health Staff, Percent (2003)	Maternal Mortality Ratio, Maternal Deaths Per 100,000 Live Births (2000)	Youth HIV Prevalence Rate, Percent of Ages 15-25 (2001)	
Benin	6.4	3.0	2.4	7.0	5.4	16	103	60	850	1.17	3.71
Burkina Faso	11.6	2.4	2.1	7.5	6.4	12	133	27	1000	3.97	9.73
Cameroon	15.2	2.6	1.7	6.4	4.7	19	127	56	730	5.44	12.67
Chad	7.9	2.7	2.9	6.9	6.3	4	182	16	1500	2.38	4.28
Cote d'Ivoire	16.4	3.3	1.6	7.4	4.7	15	118	47	690	2.91	8.31
Ethiopia	65.8	2.7	2.1	6.6	5.6	8	143	10	850	4.39	7.82
Gambia, The	1.3	3.5	2.0	6.5	4.9	..	139	51	540	0.52	1.35
Ghana	19.7	2.9	1.6	6.5	4.1	22	79	44	540	1.36	2.97
Guinea	7.6	2.5	1.9	6.1	5.1	6	153	35	740	0.57	1.43
Guinea-Bissau	1.2	2.3	2.2	6.0	5.7	..	182	35	1100	1.06	2.98
Madagascar	16	2.8	2.5	6.6	5.3	19	157	46	550	..	..
Malawi	10.5	2.5	1.8	7.6	6.2	31	137	56	1800	6.35	14.89
Mali	11.1	2.5	2.1	7.1	6.2	7	167	24	1200	1.37	2.08
Mauritania	2.7	2.7	2.3	6.4	4.5	8	135	57	1000	0.38	0.59
Mozambique	18.1	1.9	1.6	6.5	5.1	6	153	44	1000	6.13	14.67
Niger	11.2	3.3	2.8	8.0	7.2	8	205	16	1600	0.95	1.5
Rwanda	8.7.	2.5	1.6	8.3	5.8	13	52	31	1400	4.91	11.2
Senegal	9.8	2.7	2.0	6.8	5.0	11	89	51	690	0.19	0.54
Tanzania	34.4	2.9	1.7	6.7	5.2	25	115	35	1500	3.55	8.06
Uganda	22.8	2.7	2.4	7.2	6.1	15	179	38	880	1.99	4.63
Zambia	10.3	2.8	1.2	7.0	5.2	26	129	47	750	8.06	20.98

World Bank, World Indicators Report, 2003. HIPC countries listed at www.worldbank.org/hipc

A Sector-Wide Approach (SWAp) in Ghana

Ghana is among a handful of poor countries that have outperformed expectations. In comparison with much of sub-Saharan Africa, Ghana's development indicators are among the best (see Table 3). Declines in the rate of population growth contributed to moderate economic growth, which enabled Ghana to reduce the percentage of persons living in extreme poverty (income of less than US$ 1 per day) from 52 percent in 1992 to 40 percent in 1999. Ghana adopted the ICPD definition of reproductive health and formulated an adolescent reproductive health policy in 2000. Its National AIDS Control Program dates to 1986 and Ghana has made strides in linking reproductive health and HIV/AIDS programs. Youth-friendly services are promoted in public facilities, and adolescent reproductive health and HIV prevention programs are under way in 20 districts.[57]

Ghana was one of the first countries to successfully complete an initial sector-wide program in health. With the support of development partners including the World Bank, UK Department for International Development (DFID), Danish International Development Agency (DANIDA), the Netherlands, European Union (EU) and Nordic Development Fund, health policies are explicitly and comprehensively linked to resource allocation and disbursements to performance. As agreed with donors, Ghana has now increased its own per capita spending on health.

The success of SWAps in Ghana was made feasible by a stable government and strong coordination between government and donors.[99] Despite these favorable characteristics, several years were required to reach agreement and get the SWAp under way. Donors and the Ghanaian Ministry of Health had to agree upon common methods for financial management, auditing, logistics, monitoring and reporting. After some time, partners agreed upon 25 sector-wide performance indicators. A baseline survey established the starting points for these indicators and, beginning in 1998, annual performance reviews demonstrated progress in such areas as immunization coverage, reproductive health and service utilization. Financial incentives for good performance are built into the Ghana SWAp. Of the total IDA credit of US$ 35 million, US$ 30 million or 86 percent is unallocated. Annual disbursements can move up or down according to how well the program is being implemented, whether it has demonstrated that more funds can be successfully absorbed and other relevant criteria.[92]

A second Bank-supported Ghana Health Sector Program Support Project (2003-2006) builds on the previous SWAp and includes population and reproductive health among its five themes.

The Bank is currently examining the coverage of the MDGs in the Poverty Reduction Support Credits (PRSCs), a new lending instrument designed to support implementation of the PRSPs. These credits, created to complement traditional adjustment loans, also give greater voice to country priorities. Because Bank investments respond to government priorities, the Bank has been most active in addressing population and reproductive health issues where countries have been concerned with these issues. Bank staff note that project managers must address competing demands and concerns, e.g., HIV/AIDS, communicable diseases or tobacco. Budgets for project development and supervision are decided by country directors who focus on macroeconomic issues rather than on decisions at the household level.

The MDGs are seen by some staff to create an opportunity to highlight population and reproductive health issues. In addition, the emphasis of the MDGs on measuring progress and achieving outcomes is welcomed as it keeps pressure on the Ministries of Finance and Planning to mobilize the resources necessary to meet the goals. The MDGs reinforce that human development is essential for economic development, and that cross-sectoral approaches are needed. This requirement in turn supports Bank efforts to encourage intersectoral investments that reach the poor. HNP is currently developing a policy framework for achieving the MDGs. An important message will be the need to develop in-country knowledge and capacity, and focus more attention on the human resource gap and programming capacity.

Partnerships

Since the Bank adopted the MDGs, there has been a strong effort to work with partners in developing a strategic framework for donors and countries.[52] Several high-level consultations aimed at supporting effective partnerships to improve implementation of reproductive health programs have been held. The Bank has established a formal collaboration plan with UNFPA that identifies specific technical areas and countries for improved collaboration and coordination. The Bank has also been an active supporter of the Safe Motherhood Initiative and works toward the establishment of the new Partnership for Safe Motherhood and Newborn Health. These partnerships have become crucial, as the global health agenda has moved significantly into new priority areas such as control of particular diseases that now compete with reproductive health for limited resources. The Bank has

long supported WHO to conduct research on new contraceptive methods and better mechanisms to deliver existing methods. In 2002, the World Bank convened a meeting on effective partnerships for accelerating the implementation of reproductive health programs. The Bank has also participated or catalyzed the formation of new collaborations, such as the International Partnership on Microbicides.

At the same time, the Bank's work with multilateral and bilateral partners to support SWAps, as in the Ghana example cited earlier, can require years of negotiation to reach a common agreement on issues ranging from financial management to identification of appropriate indicators. Some feel that the Bank is too independent and not as collaborative with partners as it could or should be. Rather than assisting governments in mobilizing international partners with expertise in reproductive health, the Bank can serve as a technical gatekeeper. This is somewhat dependent on the Bank technicians who are responsible for brokering these relationships. Some are viewed as more collaborative than others.

Partnerships with Civil Society

The extent of the Bank's partnership with CSOs at the country level has also been influenced by individual relationships. However, as the number and capacity of CSOs has grown, the Bank has taken major steps in the last several years to expand opportunities for CSO engagement.[xiii] This includes the establishment of a CSO liaison office that provides institutional coordination and interacts regularly with Washington-based CSOs. In 2002, a network of 120 "civil society engagement specialists" was launched. These specialists work at the country, regional and departmental level to encourage CSO participation in Bank projects and programs. Bank staff, including its president, engage directly with representatives of country CSOs during the annual meetings. Nearly 70 percent of Bank-financed projects now involve CSOs in some capacity.[58]

The Bank invests principally in government programs that may then in turn fund CSOs. In the HNP sector, the Bank also partners directly with large international NGOs through a small grants program called the Population Capacity Building Program. Through this endeavor, partner NGOs can apply for funds totaling US$ 2 million per year, enabling them to award and manage grants to smaller local NGOs. This program has supported a number of women's groups to work on reproductive health issues that were not included in their country's national program, including efforts to promote abandonment of female genital cutting (FGC) and to work with youth. Though the fund is small, the program has successfully leveraged over US$ 14 million from other donors to support and continue the reproductive health activities of grantees.[xiv]

The Bank's Pro-Poor Health Equity Analyses and Reproductive Health

The Bank's Poverty and Health Group has pioneered analytical work to highlight the importance of targeting interventions to reach the poor and promote greater equity in health. This work has had considerable influence both within and outside of the Bank. The Group developed a wealth asset index from DHS information and undertook disaggregation analyses of DHS data for 44 countries. These analyses examining access to health services and health status by income quintile[xv] have convincingly demonstrated the consistent and generally monotonic relationship between poverty and poor health status – the poorer the individual, the more unfavorable the health indicator.[59] This work now frames the Bank's work to improve access to services for the poor. Access to and use of reproductive health services is noteworthy for the great disparity between the wealthiest and poorest quintiles.

As Table 4 shows, the use of reproductive health services varies tremendously according to wealth. In these countries, as in most of the 50 or so others with available data, the wealthiest 20 percent of women are far more likely (as much as 12 times as likely as shown by the ratio in Column 4) to give birth with a qualified medical attendant as are the poorest 20 percent of women. In Pakistan, less than 5 percent of poor women are attended by health personnel during delivery. For contraceptive use, poor women are more disadvantaged in Tanzania than in Peru or India, where family planning is more accessible.

Not surprisingly, the poorest are also the most likely to have the highest levels of fertility and infant mortality. This health equity research has also demonstrated that

[xiii] More information is available on the Bank's Civil Society website, http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/CSO/0,,pagePK:220469~theSitePK:228717,00.html

[xiv] Information on the Population Capacity Building Program is available on the Bank's website: http://wbln0018.worldbank.org/dgf/dgf.nsf/1ceba8f5effa2874852566a9007ceeee/d298076894acbef885256d9b005d57b3?OpenDocument

[xv] A second set of analyses for 54 countries is under way.

Table 4 Coverage of Reproductive Health Services According to Wealth in Six Illustrative Developing Countries[60]

	Col. 2	Col. 3	Col. 4
Region/Country	**Coverage Rate in Lowest 20 Percent**	**Coverage Rate in Highest 20 Percent**	**High/Low Rate Ratio (Col.3/Col.2)**
Use of Modern Contraception			
Africa: **Tanzania**	5.6 %	32.1 %	5.7 : 1
Latin America: **Peru**	36.8 %	58.0 %	1.6 : 1
S. Asia: **India**	23.8 %	55.2 %	2.3 : 1
Skilled Attendance at Birth			
Africa: **Kenya**	23.2 %	79.6 %	3.4 : 1
Latin America: **Paraguay**	41.2 %	98.1 %	2.4 : 1
S. Asia: **Pakistan**	4.6 %	55.2 %	12.0 : 1

programs that aim to reach the general population tend to benefit those who are better off, sometimes increasing inequity. Only by explicit strategies to reach the poor can these inequities be narrowed. To this end, the World Bank's Pop/RH Cluster in HNP prepared a series of country profiles that highlight key reproductive, child and nutritional status indicators and interventions by income quintile for a number of HIPCs. The health and poverty profiles provide useful background for PRSPs and can influence health projects to target health interventions to the poor.[xvi]

Significance of Youth to Economic Development

The World Bank's relatively new focus on youth as significant to economic growth and development can be attributed to a combination of factors. Demographically, the largest generation of youth in history (1.7 billion) is preparing to enter adulthood – almost half of all people in the world are under the age of 25.[61] Eighty-six percent of these young people live in developing countries. Just over 40 percent of those young people live on less than US$ 2 a day.[61] The heavy toll of HIV/AIDS on youth has raised global concern and action. The Bank has increasingly recognized that investing in youth is an investment in human capital and the future. The Bank has also been requested by client countries, UN agencies specializing in youth, and youth leaders to demonstrate and scale up its commitment to youth development.[61] In addition, while all of the MDGs would indirectly benefit from investment in youth, at least half include specific targets and indicators that relate directly to youth. The Bank created a new position of child and youth advisor to prepare a strategy for the Bank's approach to youth.[62] The Bank is making an effort to address the gaps in research, data and operational work on youth

MDGs Related to Youth

- **Goal 2: Achieve universal primary education (Indicator: Literacy rates among 15- to 24-year-olds)**
- **Goal 3: Promote gender equality and empower women (Indicator: Ratio of literate females to males among 15- to 24-year-olds)**
- **Goal 6: Combat HIV/AIDS, malaria and other diseases (Indicator: HIV prevalence among 15- to 24-year-old pregnant women)**
- **Goal 8: Develop a global partnership for development. Target: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth (Indicator: Unemployment rate of 15- to 24-year-olds)**

[xvi] The profiles are available from: http://www1.worldbank.org/hnp/PopRH/prhindex.asp

development. A paper commissioned by the Bank calls for further research on the effects of investments in youth as an area meriting the highest priority.[45]

Capacity Building: The World Bank Institute

The World Bank Institute (WBI), the Bank's Human Development training arm, has created and sustained interest in population and reproductive health issues, and emphasized their links to the MDGs. Beginning in 1997, WBI mobilized significant resources to develop a training program for country officials entitled *Adapting to Change Learning Program on Population, Reproductive Health and Health Reform.* In addition to WBI funds, several foundations with a strong commitment to population and reproductive health have provided assistance to develop the body of materials that has been utilized for a two-week course and a range of regional and national activities. These courses are offered regularly within regions to policy-makers, program managers, civil society representatives, Bank staff and other interested parties. Regional learning networks have been established in Latin America and Africa to build capacity of senior policy-makers and program managers. At the request of UNFPA, WBI has conducted several learning activities for UNFPA staff and their country counterparts. WBI has also organized a number of training events specifically for the Africa region, including a distance-learning course to help design health and population elements for PRSPs.

Cairo Estimates and Bank Lending for Population and Reproductive Health

At the time of the Cairo Conference, the level of resources needed to expand basic reproductive health services and achieve the goal of universal access to reproductive health at the country level was estimated to be US$ 17 billion in 2000, growing to US$ 21.7 billion in 2015. Two-thirds of the funds were to be provided by the countries themselves and one-third by external sources.[63] The most recent report on resource flows from UNFPA shows that neither external population assistance nor domestic spending for population have kept pace with these financial goals.[64] International donors, including the Bank, fell US$ 5.7 billion short of meeting their goals in 2001. International assistance for population was only 44 percent of the amount identified at Cairo. Country commitments to the Cairo Agenda were similarly inadequate.

In 2002, the Bank provided US$ 327 million for population and reproductive health, the lowest level since 1997. Of the total, 71 percent were IDA credits made at highly concessional rates to poor countries and 29 percent were the International Bank for Reconstruction and Development (IDRB) loans made at close to market rates.[64] IDA funds were more than US$ 100 million lower than in 2000 and 2001. Although the 2002 figure represents a decline in Bank lending from US$ 538 million in 2000, current resource tracking does not allow disaggregation of spending on population and reproductive health activities that may be embedded in other basic social service projects. Thus, these numbers may be an underestimate. Bank loans accounted for about 10 percent of total funds for global population assistance in 2002, compared to about 25 percent in 1996. It should be noted that the Bank is a financier of last resort when bilateral and other funding is available.

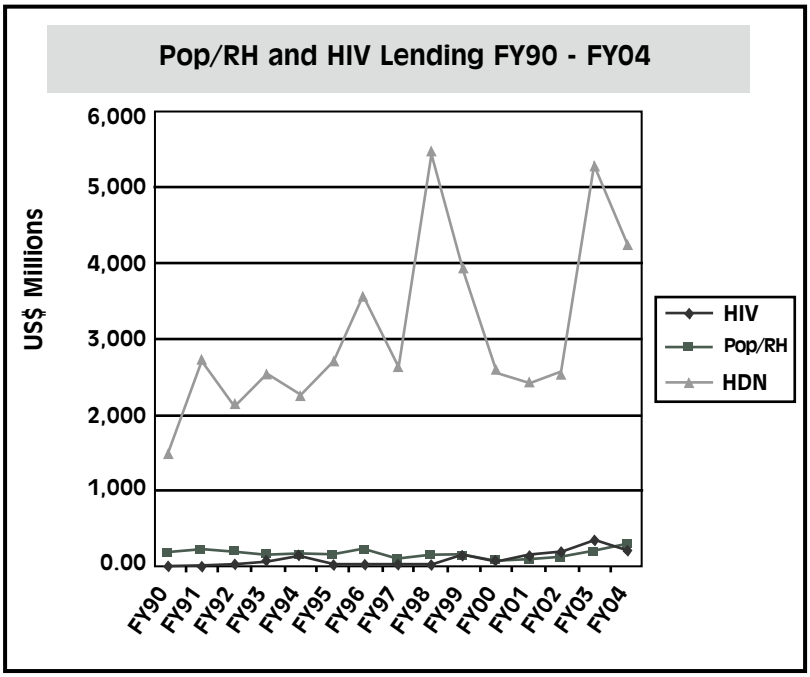
The unrelenting demands of HIV/AIDS have consumed an increasing proportion of international support for population and reproductive health, even as overall funding in constant dollars was nearly a third larger in 2002 than in 1996. Forty-three percent of total population assistance supported HIV/AIDS and STI activities in 2002 as compared to 9 percent in 1995. Funding for population and development policy analysis, data and basic research declined by about US$ 45 million between 1995 and 2002. The largest reallocations occurred in sub-Saharan Africa, where the share of support going to family planning services and population policy analysis declined from 43 percent to 26 percent in 2001, while funding for HIV/AIDS increased from 39 percent to 62 percent over the same time period.[64] These reallocations reflect the inadequacy of contributions to both meet the growing demand of HIV/AIDS and enable expanded access to reproductive health services. Unfortunately, reallocations have been greatest in countries where population growth rates are highest and unmet need for reproductive health services is most acute.

According to the new system put in place to better track support for the Millennium Development Goals, Bank support for population and reproductive health activities has been fairly flat over the past decade as overall lending for HNP has fluctuated widely from year to year. Over the past 15 years, Pop/RH lending has represented about 5 percent of total lending for the Human Development Network (see Figure 2).

Difficulties in Tracking Bank Support to Population and Reproductive Health

As the Bank moves to broader health sector projects that support system reform and strengthening, it is difficult to isolate the portion of a project that supports a specific area such as population and reproductive health. This is true of SWAps and PRSCs that provide multisector budget support aimed at improving public resource allocation for the poor based on a country's PRSP. The new tracking system currently includes HIV/AIDS under communicable diseases but work is under way to have a separate accounting for HIV/AIDS. There is also an intention to track lending in other areas, such as water and sanitation, and transportation, which are linked to health.

Figure 2 World Bank Support for Population/Reproductive Health Activities



World Bank, HNP Calculation, 2004

Analyzing Bank Effectiveness

A 2000 review of the Bank's HNP Portfolio analyzed the extent to which a set of services known to be "best buys" in terms of their investment value as health interventions was included in HNP projects. The review examined 152 projects with loans approved in fiscal years (FY) 1993 through 1999. More than half included broadly-defined safe motherhood components.[65] Of these, 25 percent included all components of safe motherhood: family planning, prenatal and delivery care, clean/safe delivery by trained attendants, and post partum and essential obstetric care. Slightly less than half of the projects included family planning.

Due to limited project documentation, the "best buy" review was not able to establish the extent to which these projects included attention to quality issues such as counseling and offering a wide range of contraceptive methods. Task managers interviewed for the review said that program implementation was made more challenging by major institutional constraints such as the separation of population/family planning and other reproductive health services. The review concluded that while the Bank is the largest source of external assistance in reproductive and child health services, information about the services in which the Bank invests is insufficient. Furthermore, interventions were found to be often not of the quality and comprehensiveness necessary to achieve their full potential effect on health outcomes. The report recommended that in order to have a bigger impact on maternal mortality, Bank projects should provide the complete package of "best buy" services in the area of safe motherhood. These includes a continuum of reproductive health care, from family planning and antenatal care at the community level to essential and emergency obstetric care at the facility level.

While the above review found information on effectiveness insufficient, the success of safe motherhood projects in Honduras, Bolivia, Indonesia, Brazil, the Philippines and Chad was documented in the Bank's 1999 publication, *Safe Motherhood and the World Bank*.[66] The report recommended that the Bank scale up such efforts in countries where maternal mortality remained high. Although there have been fewer stand-alone safe motherhood projects since that time, the Bank's advice has been influential. Several countries identified in the 1999 report as having high mortality rates now have or are preparing a PRSC that emphasizes improving maternal health services for the poor.[xvii]

A review of development effectiveness in HNP was conducted by the Bank's Operations Evaluation Department in 1999.[67] It found that the Bank was more successful at expanding health delivery systems than in improving

[xvii] For example, the Poverty Reduction Support Operation Project in Burkina Faso aims to provide incentives to address health labor supply shortages in the rural areas and decrease user fees for attended deliveries in hospitals. World Bank website. www.worldbank.org, Accessed Dec 29, 2003 p. 62, Burkina Faso, Poverty Reduction Support Operation project.

service quality and efficiency or promoting institutional change. The report recommended that the Bank shift its attention from inputs to monitoring progress on outcomes. Most importantly, the report found the Bank to be overly ambitious and needing to set more realistic goals in terms of what can be accomplished in a given time frame. The report noted that the growth in size and ambition of the HNP portfolio had not corresponded with an increase in staff and there had been stagnation in resources for supervision as well as a decline in funding for analytical work. Given the degree to which staff were over-programmed to address complex issues, the report called for greater selectivity of countries and sector activities, and more support for analytical work. In line with the Bank's goal of reducing poverty, it suggested more effort toward targeting the poor in HNP projects, more attention to health determinants outside the health system (e.g., water and sanitation), and that the HNP Sector Board should strengthen its focus on the quality of its portfolio.

A recent HNP portfolio review by the Bank examined traditional investment projects with a major focus on maternal and child health implemented between 1990 and 2003. A key weakness identified in Bank project design was the inadequate assessment of the institutional and human resource capacity needed to implement projects, which were typically overly complex at the outset. The report also found limited evidence of an impact on maternal and child health outcomes in over half of the projects. Among the main recommendations, the review advised that project objectives should be defined more clearly and that more attention be paid to capacity issues.[68]

The Bank's history of investing in complexly designed projects has led staff to identify a need in a number of high fertility countries for targeted interventions to address high priority reproductive and family planning health requirements of specific sub-populations, including the poor.

Internal Critique of the Broad Cairo Agenda

The ICPD Programme of Action advanced the notion that a broadly defined package of reproductive health services was necessary for both individual advancement and national development. While there is a consensus that the reproductive health approach is the right and most strategic approach for long-term sustainable change, some demographers, economists and others working in the population field hold that the approach, by its very broadness, has deflected attention from population growth and demographic issues where they remain critical impediments to development. Several Bank staff interviewed for this review indicated that the broad multisectoral reproductive health agenda, including girls' education and reduced child and maternal mortality, was difficult to implement at the country level, especially in poor countries where population growth remains high. Rather than supporting population decline through meeting the reproductive intentions of individuals, the multifaceted Cairo agenda was thought by some to dilute attention to provision of basic family planning services where they were most needed.

It is possible that the broad Cairo Programme encouraged overly complex project designs, which have been a common characteristic of many Bank investments that were judged to be less-than-successful. However, project completion reports and evaluations suggest that factors other than design were sometimes responsible when projects failed to meet their objectives. Where political will to expand access to quality reproductive health services was lacking and implementation efforts were weak, one could question whether the reproductive health approach to promote population stabilization and other Cairo goals had been fairly tested. A Cairo approach implemented through a multi-donor project in the Philippines provides an example. (see box on next page)

Was the Cairo Agenda Fairly Tested in the Philippines?

The 7,000 islands that make up the Philippines are at the lower end of lower middle-income countries.[xviii] Prior to the ICPD, investments in women's health were primarily through maternal and child health programs and focused almost entirely on the child. After decades of vacillating political support for women's reproductive health and in the face of faster population growth than most countries at a similar stage of economic growth (TFR=3.3 as compared to 2.4 in Indonesia and 1.4 in Thailand),[69] the government committed to reducing high maternal mortality (about 200 deaths per 100,000 live births) and eliminating the unmet need for family planning, affecting about one-third of all married women aged 15 to 45. Eighty percent of the population is Catholic, adding complexity to the government's ability to address reproductive health and population issues in the Philippines. The government has yet to outline a population policy, and more than 80,000 women are hospitalized with complications of unsafe abortion each year.[70]

The Bank was a partner in the multi-donor project implemented between 1995 to 2002 designed to address Cairo goals for improving the quality and range of maternal and reproductive health services and information, including STI and cervical cancer screening. The project also aimed to explore ways to reduce violence against women, empower women and improve program effectiveness through enhanced participation of communities and NGOs. The Bank contributed US$ 13.7 million to the US$ 84 million project, far less than envisioned in the original design. Long delays in implementation and procurement resulted in an unsatisfactory review by the Bank in 1998, after which the project was scaled back.

At project's end, the multiple project objectives were judged by a Bank Implementation Completion Report (ICR) to have been clear and appropriate, even as the project was "stretching the bounds of the women's health program."[71] Success with the earlier safe motherhood project indicated that the complexities could be managed.[66] However, the government's performance was judged in this case to be unsatisfactory. Management weaknesses were aggravated by the recent decentralization of health services from central government to 1,600 local government units. According to an analysis by Lakshiminarayanan,[72] decision-making on services to be offered had also devolved to the local level, allowing religious leaders in some locales to limit access to contraception. The central government had no mechanism in place to ensure continued universal access.[72]

Although the project design was judged to be sound[71] and capacity to implement the project was available, the success of the project was hindered by a number of other common and uncommon occurrences: delays caused by multiple donor procurement and disbursement procedures, a succession of seven different secretaries in the Department of Health over the life of the project and a backlog of local providers who were untrained to provide family planning. The project had proposed to integrate the drug and contraceptive logistic systems, but the United States Agency for International Development (USAID) objected, claiming that integration would threaten its own distribution system.[xix] These elements, rather than the pro-Cairo design, appear to be key factors in the failure of the project to have achieved many of its objectives.

[xviii] Those with incomes between US$ 761 and US$ 3,030 per capita.

[xix] USAID has announced it is ending contraceptive procurement for the Philippines, triggering women's health advocates to demand the development of a national population policy that would ensure continued access to condoms and oral contraceptives. (Christine Herrer and Rio Araja in the Manila Standard, Aug. 4, 2004)

Building In-Country Data Collection, Analysis and Utilization Capacity

An ability to demonstrate effectiveness of its investments through sound monitoring and evaluation has not been a core strength of Bank projects.[67] In turn, systematic monitoring and evaluation of outcomes is also not a core component of country programs. Only about 40 percent of CASs are considered satisfactory in terms of monitoring, and nearly 50 percent have no core targets.[9] Those that include targets do not always relate them to a strategy to help the country to achieve them. The Bank is working to address this issue in a number of ways, including through 29 country-level projects funded through the Trust Fund for Statistical Capacity Building. In 2002, the Bank launched an initiative to help countries adopt results-based strategies and increase the Bank's own results orientation.[9]

The Bank's Response to the HIV/AIDS Crisis

The Bank's consideration of HIV/AIDS as a critical development issue, especially in Africa, has helped mobilize additional Bank financing. The Bank is an important cosponsor of UNAIDS and has supported multisectoral plans of action in every heavily affected country. The Bank supports the concept of the "Three Ones" – one national HIV/AIDS framework, one broad-based multisectoral HIV/AIDS coordinating body and one system for country-level monitoring and evaluation – to support efficiencies and donor coordination to maximize effective strategies.

The Bank currently addresses HIV/AIDS through three mechanisms: 1) freestanding projects that typically focus only on HIV/AIDS; 2) component projects that are added to an existing project in either health or another sector;[100] and 3) the Multi-Country AIDS Program (MAP) for sub-Saharan Africa and the Caribbean. The Bank has made more than US$ 2 billion available in AIDS lending in 80 freestanding AIDS projects or projects with AIDS components.[xx] Established to streamline and speed implementation of HIV/AIDS programs in worst-affected countries, MAP has provided nearly US$ 1 billion dollars since it began in 2001. Originally concessionary loans, all funding is now in the form of grants. All countries eligible for MAP funds in Africa have now applied for grants, which have ranged from US$ 9 million to nearly US$ 100 million.

A hallmark of the MAP program is that up to half of the funds can flow to CSOs through small grants programs.[73] This has the potential to significantly expand civil society influence and availability of expertise in Bank programs. The MAP project design ensures greater awareness and involvement of government leaders and emphasizes the importance of prevention programs, especially those focused on youth. While the Bank's strategy emphasizes the cost-effectiveness of preventing HIV/AIDS, MAP projects now support antiretroviral (ARV) treatment delivered within the public sector and through CSOs.

Gender and HIV

In terms of attention to gender issues in the design of HIV/AIDS projects, an assessment found that the quality of the design of the reviewed projects was high. However, it was less clear that implementation was gender-responsive, and monitoring and evaluation data according to gender-sensitive indicators and sex-disaggregated data were weak. Strategies to transform the power imbalance between men and women, which contribute to women's risk of and vulnerability to HIV, were notably absent. The assessment called for greater attention to activities that empower women, increased government mechanisms for mainstreaming gender at all levels, and stronger monitoring and evaluation.[74]

The Bank's documents reflect relatively little attention overall to men's roles in reproductive health and rarely acknowledge that power imbalances between men and women are difficult to alter without influencing the behavior of men. There is also very little mention of efforts to influence, through the educational system and other sectors, the ways in which boys are socialized to assume power and authority, as well as to take risks with their own health and that of women.

Integration of HIV/Reproductive Health Programs

Eight countries heavily affected by HIV/AIDS participated in a recent videoconference that highlighted the importance of linking HIV/AIDS programs to family planning, adolescent health, safe motherhood and STI activities.[xxi] The Bank's vice president for the Africa region noted that unmet need for contraception in Africa has continued to grow, outstripping resources. He spoke in support of the Cairo agenda and stressed that integration of HIV/AIDS and reproductive health services results in savings of lives and money, greater efficiency

[xx] Information available from World Bank/AIDS website

[xxi] For more information on this event please see the World Bank website: http://www1.worldbank.org/hnp/trng_prh62503agenda.asp

and better coverage.[75] A recent Bank guide, *Preventing HIV Infections in Infants and Young Children*, also emphasizes the importance of reproductive health programs.[76] Such strategic advice aims to raise Bank staff awareness of these issues as well as to prepare them for discussion with their country counterparts.

A major World Bank Operations Evaluation Department (OED) study is under way to review the effectiveness of the Bank's country-level HIV/AIDS assistance and distill lessons for future HIV/AIDS activities. Effectiveness will be assessed with respect to intermediate outcomes and, to the extent possible, behavioral and epidemiological outcomes. The evaluation will also link the results to the global context and activities of other partners.[xxii]

Reproductive Health Commodity Security

Falling donor support, increased demand and growth in the numbers of people of reproductive age all contribute to a potential crisis in the secure supply and distribution of reproductive health commodities, including contraceptives and condoms. The Bank collaborated in an analysis which examined overall contraceptive needs as well as anticipated condom needs for dual protection against STIs and HIV/AIDS. Condom demand was expected to more than triple by 2020.[77] An internal review of commodities for reproductive health in Bank projects found that, overall, purchase of contraceptives through Bank projects is declining even as demand is growing. Although all Bank HIV/AIDS projects include condom promotion and the option to prioritize these purchases, very few project funds have supported the purchase of condoms. To date, few MAP projects have used funds to purchase either condoms or contraceptives. Less than 2 percent of World Bank HIV/AIDS funds have supported condom purchases.[78]

Where countries have not taken necessary actions, stock-outs of critical supplies have occurred. Although many countries were noted to lack capacity to forecast, procure and distribute commodities, the review further found that Bank loans did not usually include funds for the development of a distribution system, logistical infrastructure and information management systems. Furthermore, where the Bank did support the purchase of commodities, the procurement process was unduly long, ranging from two to six years for the first purchase. Such delays dissuade countries in need from including commodities in their loans. The review noted that the Bank is well positioned to play a strategic role in assisting countries to develop the capacity to forecast, finance, procure and distribute reproductive health commodities. Further, it can strongly encourage long range procurement planning and help to expand the role of the private sector to address the unmet needs.

Bank staff members interviewed for this report differed in their concern over the commodities issue. Some felt that countries have too long relied on donors to supply contraceptives while managing to purchase all other essential drugs on their own. They felt that it is time to cut country dependence on donors to meet contraceptive demand. Others felt that without donor attention, stock-outs and shortages of essential commodities will endanger lives and cannot be left to chance. An analysis commissioned by UNFPA for Ethiopia is illustrative of the challenge (see box below).

Ethiopia, a country with a rapidly growing population, low contraceptive prevalence and an emerging HIV epidemic, provides a startling example that the costs of providing contraceptive security are substantial and spiraling. The projected annual cost of commodities, if purchased on the international market, would increase 10 fold between 2000 and 2020 (from US$ 2.47 million to US$ 25.78 million for the "ambitious" variant in which contraceptive prevalence rises to 46 percent by 2020).[79] This dramatic cost increase is attributable in part to Ethiopia's very young age structure and rapid growth of those entering reproductive age. Nevertheless, the situation is likely to be similar in most HIPCs with nascent fertility declines. In addition, the cost of logistics systems to deliver supplies is estimated at 20 to 25 percent of commodity costs and often not fully factored into projections.

More recently, the Bank is working with other partners to establish a Reproductive Health Commodity Security Coalition to address the myriad supply chain issues of contraceptives and reproductive health supplies.

[xxii] Further information on this review is forthcoming at http://www.worldbank.org/oed/aids/index.html

Regional Variations in Support of Reproductive Health Issues

There is considerable variation in regional capacity to use Bank services, including lending and technical assistance, to implement poverty reduction strategies and improve reproductive health. Predictably, discussions with Bank staff and reviews of project documents show that higher income regions with greater existing capacity are more successful in implementing basic health projects.

Latin America's Challenge

In Latin America, most health projects include integrated reproductive health services in government-sponsored programs. Judging by the improvement in reproductive health indicators in the region, this approach has had a measurable impact at least at the national level. Challenges remain in poorer and rural areas, and these are being noted and addressed in the PRSPs and health systems projects in affected countries. The PRSPs for Bolivia, Honduras and Nicaragua, for example, all place emphasis on addressing basic health issues among the poor through targeted interventions. In Mexico, a government commitment to address reproductive health needs of the poor is being implemented through the Expansion of Basic Health Services Program, backed by a US$ 660 million loan from the World Bank. Family planning is part of the basic health care package being extended to 8.2 million people, mostly in small communities that previously lacked access to basic health care.

Support in MENA

Compared to other regions aside from East Asia, a smaller proportion of Bank loans in the MENA region include lending from the Human Development sector, which encompasses health, nutrition and population. The economy of the region is growing at 3.1 percent while population growth is above 2 percent. Whereas the Bank has recently supported a Pop/RH program in rapidly growing Yemen, unemployment, rather than population growth and reproductive health, is seen as the major problem in the region. The Bank's goal has been to create a favorable investment climate by improving public sector efficiency and governance, education, water management and gender equity.[18] Bank staff report a lack of interest in much of the region in population as a development issue or in strengthening reproductive health programs.

The Cairo Approach in South Asia

The Bank has had a long engagement on population and reproductive health issues in the region, notably in Bangladesh and India. The Bank made major technical, policy and financial investments in Bangladesh that have facilitated a consensus to adopt an enlightened Cairo-based reproductive health agenda in the context of health reform. The Bank has contributed substantially to the success of this program through its encouragement of strong leadership of the family planning program, and support for sustained outreach and improved access to reproductive health services. A multi-year consultative process brought community, NGO, donor and government stakeholders into agreement.[80] Client-centered and integrated health and family planning services were designed to enable women to more easily access health services for themselves and their children. Over the course of two decades, contraceptive prevalence increased from 3 to 54 percent, and the total fertility rate fell from seven to 3.4 births per woman. This was far beyond what would have been expected based on investments that had been made to improve economic and social conditions. The Bangladesh family planning story is one of 17 case studies cited in a forthcoming book describing health interventions that were successfully scaled up in poor settings.[81] Although many actors were involved in Bangladesh, the Bank's technical and advisory staff played a critical role. Backsliding on these agreements by the new government, however, also illustrates the fragility of such agreements in the face of regime change.[80]

The Bank also played an important role in assisting the government of India to launch a US$ 250 million reproductive and child health program in 1997. The program aimed to remove method-specific contraceptive targets as the basis of the national family welfare program, and, in principle, to establish client satisfaction as the program's primary goal. The Bank's support to the program emphasized enhanced performance monitoring through independent district-level reproductive and child health surveys. The program supported a decentralized planning process based on reproductive health needs at the village level. To date, the program has expanded coverage of services at the district level with appropriate outreach and service delivery activities to reach disadvantaged areas. Recent survey data show improved reproductive health indicators. The national TFR has continued on a downward trend from 3.2 in 1995 to 3.0 in 2001[xxiii] with continuing sharp regional differences.

A follow-on program, designed to facilitate donor collaboration and intersectoral linkages, is under preparation. It aims to build capacity, improve quality of care, address gender issues at the household level, strengthen referral linkages to ensure skilled attendance at birth, broaden informed choice of family planning methods, meet the reproductive needs of adolescents, and improve collaboration with the national HIV/AIDS program.

Rapid Population Growth and Poor Reproductive Health Services Impede Development in Niger

Niger's per capita gross national income (GNI) of US$ 180 is among the lowest in the world and 63 percent of its population lives in poverty. A population growth rate of 3.1 percent per year, with no indication of a decline in fertility, propels Niger toward a doubling of population in only 23 years. The current TFR, now estimated to be between 7.5 and 8.0, is the highest in the world. By 2050, Niger's population could be five times its current size. Before that happens, drought, deforestation and desertification, intensified by explosive population growth, will lead to food insecurity and deepening poverty.

Niger's population is also exceedingly young, with nearly 50 percent under 15 years of age. Half of all girls are married by age 15 and the adolescent fertility rate is the highest among HIPCs. Niger's maternal mortality ratio is 1,600 per 100,000 live births, with up to a third of maternal deaths due to complications of unsafe induced abortion. The ever-expanding population faces enormous constraints to obtaining reproductive health services, including poor access (more than half the population lives more than 5 km from a health facility), gender inequity and cultural and religious traditions favoring high fertility. Great inequities by income exist in virtually all dimensions of health. A woman in the wealthiest income quintile is 8 times as likely as one in the poorest quintile to have skilled attendance at birth.[86] Even in the absence of high HIV/AIDS-related mortality, life expectancy at birth is only 46 years.[85]

Despite an emerging desire for smaller families, use of modern contraception is just over 4 percent.[29] A recent Bank Implementation Completion Report (ICR) of a Niger health sector development program implemented between 1997 and 2002 aimed at improving coverage and quality of health services in 14 districts found that utilization of family planning services actually declined over the life of the project. Clients reported that the primary barrier to use was poor service quality. Contraceptives were also not free to the poor. No explicit quality indicators were identified or tracked. Instead, the program emphasized construction of health centers and hospitals that were found by the ICR mission to often be closed due to lack of drugs or staff. The ICR rated both the Bank and the borrower performance as unsatisfactory. It recommended that health sector reform should be results-driven and focus on removing systemic bottlenecks. The key to results was seen to be improving the quality of services, particularly through attracting and maintaining a qualified and committed health staff who would be perceived as trustworthy and competent by clients.[87]

In Niger's 2001 PRSP, it was noted that the poor themselves identify high population growth as the most important determinant of vulnerability to poverty. Yet the PRSP noted no clear strategies for addressing population growth, and no reproductive health objective was specified. The PRS aimed to more than double (to 84 percent) the percentage of children enrolled in primary school by 2015. However, with the number of children aged six to 12 years expected to double by 2020, the likelihood of meeting this target is slim.

The JSA, while noting that the success of poverty reduction strategies depend crucially on appropriate policies to address population growth and high fertility, found the PRSP to not have adequately considered the link between rapid population growth and desertification, deforestation, lack of access to safe water and sanitation and difficulties of expanding per capita coverage of health facilities, schools and other infrastructure. Nevertheless, the JSA deemed the framework to be adequate and approved it for funding.

Recognition in the CAS that population growth and gender issues were not sufficiently considered in the PRSP and ensuing discussions by the Bank's executive board, triggered a review of the fertility and population growth issues by a national consultant working with a Bank staff demographer. The resulting report discussed the impact of population growth on the agriculture, health and education sectors and consequences for poverty reduction.[84] This report formed the backdrop for a national forum aimed at strengthening the population and reproductive health components of the next Bank-financed health project in Niger.

[xxiii] World Development Indicators Report, various years

The demographically diverse South Asia region is also the focus of a major Bank study of women's health issues, specifically focusing on the critical reproductive health issues facing Bangladesh, India, Nepal, Pakistan and Sri Lanka. While Sri Lanka has the fastest aging population in the region,[82] 42 percent of Pakistan's population is under 15 years of age, and its population will nearly double to 300 million by 2045.[69] This study, expected by late-2004, will identify program gaps and make recommendations on areas for further Bank support.[83]

The Bank's Investment in Africa

In reviewing the range of actions, partnerships, research studies and multisectoral development strategies of the Bank, it is clear that it has invested significantly in Africa. While there has been progress, unfavorable demographics have slowed the poverty reduction process. In reproductive health, results have been poor in many instances. Although the Bank is the largest donor for health on the continent, it is far from the only donor and the reasons for the lack of progress are complex. A primary challenge is that "the political will to invest in population and reproductive health activities, including family planning, is acutely missing"[84] in many African countries. Some political leaders are said to consider that population growth will be rendered irrelevant by HIV/AIDS mortality. Governments are also said to be more interested in tangible improvements in infrastructure and less in investment in health interventions that are persistently viewed as consumption.[13]

The urgency for more attention to population/reproductive health issues is especially evident among the poorest countries, as shown in Table 3. The indicators in many countries eligible for debt relief through the HIPC Initiative show little improvement over the past decade.[13]

As the case of Niger illustrates, much more needs to be done to address population and reproductive health in the face of many competing priorities in Africa (see box on previous page).

Staffing Issues

The MDG and poverty reduction strategies have placed additional responsibilities on technical staff, particularly in the HNP sector, as they have taken on the task of integrating population and reproductive health into the MDGs for maternal health, child health and HIV/AIDS. The HNP staffing situation has declined rather than improved since the *Falling Short* report recommended an increase.[xxiv] In addition to their responsibilities to develop and supervise health projects, HNP staff are expected to assess the health and poverty linkages in PRSPs and other documents. These responsibilities necessarily compete for staff attention with the desire to improve monitoring and evaluation.

Even prior to the new lending mechanisms and initiatives, staff reported time and budgetary constraints to providing countries with needed technical assistance. As the Bank moves toward program support or sector-wide lending, staff commented that often the total allocation for a country's health budget is agreed upon with very limited opportunities to engage in technical capacity building. Bank staff could rely more on partners in technical agencies, but time is also needed to identify the appropriate partners. In this regard, a recent analysis of the Bank's relationship with CSOs concludes that the Bank does not provide adequate guidance to staff on how to engage with CSOs, and with whom they can or should engage.[58]

The Bank is especially thin in terms of staff with strong demographic skills capable of analyzing and forecasting population trends. Few Bank staff can credibly bring critical demographic issues to the attention of senior management or raise these issues in negotiations at the country level.

There is a sense among some Bank staff that the rhetoric on the importance of the health sector in meeting the Bank's commitment to the MDGs is not matched by internal resources needed to help countries implement poverty reduction strategies and to meet their MDG targets. Some of the additional staff and resources needed to meet the demands of the ever-expanding health agenda are being met through other resources accessible within the Bank's budgeting system, primarily from Trust Fund Accounts. Over the years, major donors, including the Netherlands, Japan, Canada and Denmark have established a number of Trust Funds at the Bank that can be used to fund short-term or emerging needs. The relative share of Trust Funds used by HNP more than doubled between FY00 and FY02.[53] Although staff are frustrated by the time-consuming process involved in acquiring these additional resources, they note a bigger frustration in not seeing a major shift in the allocation of Bank budget commensurate with the health sector's increased responsibilities relative to the MDGs.

[xxiv] In FY00, 265 staff members were included in the sector and by FY02, only 187 were recorded. This includes external recruitment of only five new staff in FY02 as compared to 23 in FY00. (Quality Assurance Group, 2003. Health, Nutrition and Population Sector Board Assessment. December 19, 2003. Final Report. Washington DC: World Bank.)

PART III. RENEWING LEADERSHIP IN POPULATION/REPRODUCTIVE HEALTH

Under Bank President James Wolfensohn's leadership, the World Bank has strengthened its strategic focus, improved operations and implemented many worthwhile strategies to reduce poverty and improve health, including reproductive health. The commitment it has made to help countries achieve the Millennium Development Goals will drive the Bank to be more strategic, effective and accountable. Greater attention to population and reproductive health in the Bank's portfolio can speed progress on multiple fronts. For example, none of the sub-Saharan African countries are on track to meet MDG 4, to reduce child mortality. Yet little attention has been devoted within the Bank and elsewhere to the linkages between improved reproductive health and reduced child mortality.

The Bank has made significant investments in educating girls and mainstreaming attention to gender – both of which are important pillars of Cairo. However, aside from its work to address reproductive health in the context of HIV/AIDS, the Bank is currently devoting less attention and resources to population and reproductive health issues than it has in the past. In 1994, the World Bank was one of the largest financiers of population assistance. By 2002, the Bank's contribution had declined from 25 percent to 10 percent of the total global resources for population and reproductive health. At present, 19 poor countries have not yet begun the fertility transition and many others continue to struggle with high fertility and inadequate reproductive health services. Nonetheless, fewer Bank investments are being made through IDA credits for population and reproductive health than at any other time since 1997. In addition, fewer resources are being directed to basic population research and demographic analysis than are needed to inform investments in the poorest countries.[64]

The Bank also has fewer staff with the expertise to address these issues analytically or in the policy arena.

The technical staff that do have extensive population and reproductive health training and experience have done a commendable job of making the case for population and reproductive health within the MDGs, particularly for maternal health.

Recent evidence on the macroeconomic effects of population growth provides the impetus, if not the necessity, to address rapid population growth as a development issue. However, the evidence has not dispelled skepticism within the Bank that rapid population growth impedes economic progress, or that the Cairo reproductive health agenda is a means to both influence macro-demographic change and reduce poverty at the household level. Few Bank documents from the past decade pay heed to stabilizing population growth – whether in relation to environment, urbanization, expansion of social sector infrastructure and services or poverty reduction. Many PRSPs fail to include strategies to address the constraints that rapid population growth imposes on investment decisions. Though the Bank's health equity analyses have documented that the poor have unequal access to and use of reproductive health services, there has not been a corresponding commitment to expand these services to the poor. The Bank has not maximized the opportunity through JSAs and other reviews to better inform policy discussions about influential macro-economic issues related to poverty, including rapid population growth. CASs may fail to note the analysis and capacity building needed to strengthen attention to these issues.

The Bank has recently taken greater initiative to address the needs of youth. Major reproductive health issues affecting youth and a detailed analysis of the Bank's work in the emerging arena of youth reproductive health in relation to the MDGs was published in a companion report by the Global Health Council.[62] The key recommendations of the report are shown on next page.

Recommendations to Further the Bank's Work on Behalf of Youth Reproductive Health to Meet the MDGs[62]

- **Increase lending and grants to achieve the MDGs, based on established financial needs and objectives for improved youth reproductive health**
- **Improve financial tracking and reporting by target beneficiaries, including youth**
- **Identify new funds for innovation and mainstreaming of youth reproductive health**
- **Expand engagement with and support of civil society with expertise in youth reproductive health**
- **Expand and apply the evidence base to promote synergies between improved youth reproductive health, poverty reduction and economic growth**
- **Improve evaluation of development effectiveness to enable sound decision-making about youth interventions**
- **Increase and improve knowledge-sharing efforts to reach youth and youth-serving groups**
- **Leverage the PRS process in support of attention to youth reproductive health to achieve the MDGs**
- **Use health sector reform mechanisms to serve the reproductive health needs of youth**
- **Include rights conventions in policy dialogue to support health rights of youth**
- **Support meaningful youth involvement in Bank programs and processes**

Promising indications that population concerns are on the Bank's poverty agenda include President Wolfensohn's speech to delegates attending the 2003 World Bank-IMF annual meeting. Wolfensohn focused on the growing imbalance between rich and poor countries and emphasized that higher population growth in poorer countries will perpetuate this imbalance.[88] His concerns need to be translated into actions including pro-poor reproductive health interventions that contribute to health equity and sustainable development. The message needs to be embraced by Bank management and sustained in the Bank's documents and advice to countries.

Recommendations

The following recommendations aim to increase the prominence of population and reproductive health within the Bank's portfolio in support of its mission to reduce poverty and achieve the MDGs.

1. Lead efforts to clarify the relationship between population growth, reproductive health and poverty.

The Bank's economic and financial expertise should be brought to bear in mobilizing global attention to population as a development issue and improved reproductive health as a critical strategy to reduce poverty and achieve the MDGs. The Bank's leadership in assessing and further building the evidence for these issues is critical not only for country development but also for assisting its international partners, such as UNFPA, in working to increase access to reproductive health services and information.

As the world's largest lender for health, the Bank has a comparative advantage in establishing the "business case" for how population growth and change affect a country's economic and social development. Demonstrating how reducing reproductive morbidities, mortality and unintended pregnancies improves health equity and the lives of the poor helps build nonpartisan support for reproductive health as a human right with broad societal benefits. Those living in poverty have the least access to services and are the most rapidly growing portion of the population. By meeting the needs of the poor for improved reproductive health services, the cycle of poverty can be interrupted and the advantages of slower population growth can benefit all sectors of the economy.

The Bank's focus on poverty is an opportunity to draw parallels between population growth, age structure, momentum and the prospects for economic development, savings and health. The Bank should build on existing and support new research that examines the critical pathways between reproductive health and poverty, thus illustrating the economic and social benefits of investing in reproductive health. In addition, at the country level, support for empirical work should elucidate the cost of not investing in reproductive health programs. These analyses should be better incorporated in national policies, PRSPs and CASs.

The Bank should address the diverse demographic and economic conditions, with special attention to the poorest countries with the worst economic and social indicators in sub-Saharan Africa, South Asia and the MENA region. Each high-fertility HIPC deserves an in-depth analysis of the macro-economic effects of population growth and poor reproductive health. Working with country partners, the Bank can help foster synergies that contribute to meeting the MDGs more quickly. When men, women and youth attain a standard of reproductive health that allows them to avoid disease, have healthy children and be fully productive members of society, progress is made on multiple fronts. The Bank should encourage cross-sectoral dialogue (e.g., between Bank and country advisors in population, reproductive health, gender and youth with those in education, environment, etc.). These discussions should translate into intersectoral work plans that create the synergies needed to meet the MDGs. Institutional roadblocks that discourage intersectoral work must be removed.

Through its convening power, partnerships, strategic guidance, lending programs, analytical work and support to global programs, the Bank can place these issues high on the development agenda and gain commitment to feasible, well-reasoned strategies that are necessary for development.

The second High Level Forum (HLF) to be sponsored by the Bank and WHO will focus on concrete actions to accelerate progress toward the MDGs. For this meeting, a paper addressing aid effectiveness, "poor performers," and countries in crisis is to be prepared.[101] This paper is an opportunity for the Bank to examine the population and reproductive health profiles of a sample of countries in crisis as well as the impact of projected population growth on economic growth, environment, requirements for schools, health, water and sanitation facilities, and HIV/AIDS services and treatment. The cost and impact of differing population growth-rate scenarios can also be explored. Links between growth in the number of women of reproductive age, demand for and use of contraception, maternal deaths, child mortality and savings per birth averted should also be clearly forecasted. Such information can raise the profile of reproductive health at the international level.

2. Assure that the Bank's work is evaluated, documented and widely disseminated.

> **"What must the Bank do? Focus on implementation of our promises to work toward the MDGs. We must measure our results more rigorously and, with others, we must be held accountable in the context of broader country goals and the MDGs."**
>
> James D. Wolfensohn, speech to the annual meetings, 2002[9]

Long before the MDGs necessitated a more sophisticated capacity to measure progress, the need for the Bank to improve its monitoring and evaluation systems and strengthen client capacity to collect the data necessary to track and report on outcomes has been cited in both internal and external reviews of the Bank's performance. The MDGs require a significant new orientation toward achieving results within a specific timeframe. Progress can only be gauged through measurement. The Bank's senior managers should strive for an organizational culture that values evaluation, utilizes it to make decisions, and rewards attention to it by staff and recipient countries. Poverty reduction strategies and other Bank lending mechanisms must identify appropriate indicators, routinely and systematically collect high quality and reliable data, evaluate findings and base decisions on the evidence. Documentation on returns to investment will also be expected by donor countries being asked to increase their contributions toward achieving the MDGs.

Bank specialists need the requisite knowledge to assure that appropriate population/reproductive health indicators are specified in CASs and the ability to provide technical assistance to facilitate routine and accurate measurement. Few PRSPs specify reproductive health indicators beyond contraceptive prevalence or total fertility rates. The 2003 *Annual Review of Development Effectiveness*, which aimed to assess how well the Bank's country, sector and global programs were helping their clients to meet the MDGs and other targets, cites the need for qualitative, intermediate indicators to complement quantitative indicators. For example, "client satisfaction with health services is as important, if not more important, than the number of hospitals built – even if it is not as

easily measured."[9] Indicators that are both *measurable* and systematically *measured* are essential to determine whether progress is in fact being made. Much more needs to be done to incorporate gender and equity indicators into health information systems in order to know whether gains are actually benefiting women or the poor[89] and enabling appropriate adjustments to be made as needed.

The Bank should monitor its investments more closely in the first half of project life. Close monitoring and the provision of appropriate technical inputs allows more rapid scale up of good interventions and allows the Bank to reward good governance and curtail wasted or unproductive investment. More opportunities should be offered to advance the evaluation skills of Bank specialists. Numerous on-line courses in monitoring and evaluation are available that can provide evaluation basics and enable staff to make better use of technical evaluation partners. Overextended staff within the Bank will likely need incentives and dedicated time to enable them to participate in courses or self-directed learning.

> **"Lessons can be learned in failure as well as success."**
>
> Carvalho, 2003

Building a knowledge base through a focused research agenda and getting this information to the audiences most in need of it are two key requirements for being a "knowledge Bank."

The Bank produces a wealth of information, much of which remains internal or available only to those with Internet access. The Bank can better assure that its reports, analyses, briefing sheets and web materials reach those who need them, particularly at the country level, and in the most appropriate format(s). In developing countries, access to information is limited if the information is only available through the web and insufficiently disseminated in print. Print copies of Bank publications are cost-prohibitive to those in resource-poor settings.

Although the Bank has invested in new financial tracking systems, obtaining accurate, reliable and comprehensible information on Bank investments is an arduous process for external partners and the general public. By making its financial tracking systems less onerous and more accessible to the public, the Bank would become more transparent and, as a result, help its development partners understand and evaluate its investment priorities. Ideally, aggregate lending by sector and country should be available on its web site. Explanations of the various fluctuations and provision of five-year averages would help to facilitate understanding of whether investments in reproductive health, for example, have decreased or remained stable. It should also be easier to search for investments by sector, region and country on the Bank's website.

The Bank should establish a mechanism of continual feedback to ensure that the best available empirical evidence guides future investment decisions. The Bank should assess the impact and sustainability of its recent investments in population and reproductive health. This requires greater collaboration with the Bank's research and evaluation specialists. Bank specialists, in addition to having a fundamental understanding of the principles of evaluation, should make use of technical partners to extend their skills as necessary.

3. Update guidance on population and reproductive health issues to reflect new research, donor support mechanisms and the Millennium Development Goals.

The MDGs and new donor support mechanisms require that guidance on population and reproductive health issues be updated to substantiate the importance of these issues to the achievement of poverty reduction and other goals. The population strategy note of 1999 and the existing reproductive health strategy predate the MDGs. Moreover, they are not grounded in poverty reduction strategies and SWAps, nor do they discuss the efforts to infuse reproductive health into the MDGs for maternal health and child mortality. Guidance is needed to reflect the new priorities for the Bank in light of these new developments. Whether or not this update is done in the context of a formal strategy, new guidance is needed to bring forth the recent empirical evidence, highlight the synergies with other sectors and assure that attention to these issues is not neglected in PRSPs and SWAps.

It should address how failure to attend to population growth and reproductive health can derail progress toward the MDGs, while attention to these issues can speed their achievement.

The reproductive health guidance should identify the analytical work necessary to solidify and extend the evidence that improved reproductive health is essential to poverty reduction. The Bank's health equity work is important to demonstrate the possibility of "failing while succeeding" to improve average levels of reproductive health with no effect on the poor, and hence, on poverty reduction.

Attention to countries in crisis should reinforce the advantages that slower population growth offers for poverty reduction, environmental sustainability and economic progress. The recent Niger analysis[84] is a useful model. The guidance should propose measures to improve the competency of all Bank staff providing technical input at the country level to address population issues in policy dialogues, joint staff assessments and funding decisions. The opportunity to demonstrate the feasibility and time required to meet particular MDGs with and without attention to population growth and improved reproductive health should not be lost. Measures should be proposed to integrate population concerns fully into all aspects of development planning at all levels.

Basic requirements of a demand-enhancing, client-centered, Cairo-friendly program that specifically addresses the needs of the poorest 40 percent of the population, should be outlined. A common criticism of Bank projects has been that project designs are overly-complex. Some Bank staff interviewed for this report believe that in countries where basic access to reproductive health services has not been achieved and where rapid population growth and lack of resources prevent expansion of more complex, integrated services, a need remains for basic vertical family planning programs. There is a middle road between narrowly defined vertical programs and those that specifically address the needs of a narrowly defined group, such as the poor, whose access to and demand for reproductive health services is most limited and needs are greatest.

The guidance should propose strengthened intersectoral coordination within the Bank and at the country level to facilitate multisectoral attention to Pop/RH issues. For example, by identifying and addressing the barriers affecting use of reproductive health services, whether it be a lack of transportation, poor physical energy due to malnutrition, anemia or malaria, lack of autonomy due to inequitable gender norms, or lack of education, the new guidance can suggest how the Bank can advance progress toward the MDGs on multiple fronts.

The necessity of working cross-sectorally is becoming clearer in the areas of HIV/AIDS and gender. Vulnerability to HIV is driven by unequal gender power relations between men and women. Although the Bank has invested significantly in mainstreaming gender, reproductive health is not a focus of the Bank's gender sector nor is there a gender advisor within HNP. This works to the disadvantage of reproductive health in both sectors. For example, Bank documents reviewed for this report pay little attention to the male role in reproductive decision-making, or to the fact that women are rarely able to operate independently in reproductive actions or decisions. The Bank lags behind UNAIDS, UNFPA, the International Planned Parenthood Federation (IPPF) and USAID in the attention given to promoting the constructive involvement of men in a woman-centered health agenda. Program models to engage men as part of the solution to reproductive problems have been successful in some of the most rigidly patriarchal settings in Africa, Latin America and South Asia.[102] These programs have also recognized that male roles become solidified early in life and the potential to encourage more equitable gender norms is greatest in childhood and adolescence through working with parents, communities, the education system and boys themselves. Guidance is needed to combat gender discrimination and violations of human rights, for example, unequal access to AIDS treatment for women and girls.[6]

To achieve these objectives, greater coordination is needed between the Bank's gender sector, HNP, and MAP and other HIV/AIDS programs. A representative of HNP sits on the Gender Sector Board; a gender advisor should similarly sit on the HNP board to facilitate coordination. Gender advisors should have greater opportunity to review and influence the gender content of MAP

propopals and projects. Strengthened linkages and referral mechanisms to facilitate scale up of HIV/AIDS programs while strengthening attention to meeting reproductive health needs should be proposed and best practices identified as feasible.

4. Use health equity research, demand creation, improved quality and health reform to strengthen reproductive health systems for the poor.

The Bank's groundbreaking health equity work demonstrates that, in the absence of special efforts to reach the poor, interventions that are geared toward the general population would disproportionately benefit those who are better off.[90] These analyses demonstrate that health indicators are universally less favorable for the poor, especially for reproductive and maternal health. The poorest people have more children, more unintended pregnancies and higher levels of infant and child mortality. Without specifically targeting the poor, average levels of health can improve with no improvement among the poorest members of the population. To prevent this, reproductive health goals must be set in terms of improvements among the poorest women within a society, not simply within the society as a whole. New approaches can then be designed to ensure that services reach this particular population.

The Bank should invest in creating demand for reproductive health services through improving quality and reducing barriers. The Bank's investments in reproductive health have focused heavily on strengthening the supply side, including expensive investments in infrastructure. Greater attention is needed to identify and remove barriers that prevent clients, especially youth and the poor, from using reproductive health services. The Bank should engage in the necessary policy dialogue with countries to encourage a shift of investment resources from the supply side to the demand side. Investment decisions to strengthen demand should be informed by formative research. Interventions should address the significant social and cultural factors, including gender inequity, that affect demand and limit access.

The Cairo Agenda provides relevant guidance on the important and neglected dimension of quality, recognizing that quality, rather than mere availability, often underlies the decision of whether to use services. "Weak demand" for fertility control, as was thought to characterize sub-Saharan Africa, may increasingly reflect client dissatisfaction with the quality of services from a variety of standpoints. Lack of privacy and confidentiality or disrespectful treatment on the part of staff can lead clients to stay away from or drop out of services, even those that they need or want.[36] Conversely, the client's perception that services are of high quality is associated with significantly higher contraceptive use.[91]

Special outreach programs to ensure that poor women are aware of the availability and advantages of such care are also important. While the approaches best suited to particular cultural contexts should be examined through research, exploring ways of improving service delivery to the poor needs to begin immediately. One mechanism to reach the poor, which appears to have worked well in Indonesia and China and is under consideration for Bangladesh, is to identify poor women and provide them with vouchers that can be used in place of cash to cover the cost of antenatal, delivery and postpartum care. The Mexican experience with "conditional cash transfers" – negative user fees or cash payments – to families in poor villages who come for services also provides a model. [xxv]

The constraints that gender inequity may place on women's mobility and decision-making must also be addressed in PRSPs and CASs. In high fertility countries, male partners who control decisions on family size and cultural norms that create strong disincentives for couples to use family planning are likely to be more significant barriers than either physical distance or inadequate facilities. Illiteracy creates an important information barrier. Moreover, stigma and discrimination, whether based on ethnicity, poverty, gender or disease status, may create insurmountable barriers to access without specific interventions to address them. At a time when far too many youth are becoming infected with HIV and dying of AIDS, age is a deadly barrier when it prevents unmarried youth from accessing services. "Cairo Plus Five" called on governments to meet the needs of adolescents for user-friendly and accessible reproductive and sexual health services. Providers must be trained to welcome youth and eliminate any implication that services are limited to adults or married women.

[xxv] See http://econ.worldbank.org/wdr/wdr2004/library/doc?id=27999 for information on Mexico incentives.

It is also counterproductive to the Bank's poverty and equity agenda to support cost-recovery schemes that impose fees on youth who rarely have access to income.

The Bank must ensure that its investments in health sector reform include stakeholder participation of women, youth and the poor aimed at expanding access to reproductive health services. Reforms should build capacity in priority settings and give balanced attention to preventive and curative reproductive health services. While health reforms are intended to expand access to services and reduce inequity, devolution of control over decision-making can lead to a contraction of reproductive health services. The Bank should aim to ensure that reproductive health is included in health reforms supported by PRSCs and other mechanisms. Bank-supported health reform should address human resource issues that impair expansion of reproductive and other health services. The intense brain drain of health professionals in many poor countries has made it unfeasible to increase the per capita ratio of doctors and nurses as the output of medical and nursing schools in some countries barely makes up for the number of staff lost through attrition and migration. Given existing constraints, including low wages, inadequate health budgets and competition from the international labor market, the exodus of skilled personnel is unlikely to end.[92] New attention must be devoted to this issue if reproductive health services are to be strengthened and scaled up.

5. Build capacity of Bank staff and country partners to make the "business case" for population and reproductive health and to evaluate progress toward the MDGs.

Bank population and reproductive health specialists have emphasized that slowing population growth through expanding and improving reproductive health services would help to achieve the Millennium Development Goals and reduce poverty more rapidly. At present, broad technical competence in population and reproductive health concepts is limited within the Bank, as evidenced by relevant input into policy and review documents. Expertise in these issues is even more limited at the country level, particularly in those most severely affected by rapid growth and very young age structures. As a result, appropriate interventions, indicators and evaluation mechanisms to address these issues are frequently not specified in PRSPs or policy and implementation frameworks. Analytical work that would substantiate the importance of Pop/RH to poverty reduction and guide appropriate interventions is not often recommended.

All Bank staff serving in an advisory role should have the capability to build the business and finance case for the best investments in health and development. The PRSP process is the key entry point for linking Pop/RH issues to poverty reduction and MDGs. There is a clear need for staff capacity to evaluate and coordinate Pop/RH issues in PRSPs and CASs and ensure that MDG targets and measurement of progress are not neglected. The synergies to be achieved through intersectoral work to address population and reproductive health issues could be better explored and exploited. Bank staff should assess whether the effect of rapid population growth on the expansion of education, health facilities, infrastructure, unemployment and long-term security is fully recognized. If not, what policy dialogue or further analytical work is needed to build the case? Are the links between a healthy and well-educated mother and the survival, health and productivity of her children sufficiently clear? Has contraceptive security been assured? Do maternal health projects include a focus on preventing unwanted births and unsafe abortion through improved access to family planning services and commodities? Is HIV/AIDS recognized as an issue aggravated by gender inequity, poverty and lack of access to reproductive health services and commodities for both disease and pregnancy prevention? Do gender strategies address men as well as women? Are efficiencies and sustainability being achieved through integration of STI/RH/HIV services? Checklists and algorithms can help Bank staff determine the appropriate questions. International partners and civil society experts should be engaged in answering the questions and advocating for inclusion of the needed actions among development priorities.

While reservations about the Bank's role in influencing the country-driven PRSP process are justified, non-prescriptive steps that are within the Bank's legitimate sphere of influence include support of analytical work on the effects of RH on poverty at the household level, application of research to the policy dialogue, strategic advice toward establishment of appropriate standards for monitoring and evaluation, and partnering with CSOs

and technical agencies better positioned to advocate for attention to these issues. JSAs should not routinely approve PRSPs that fail to address obvious bottlenecks to development. Bank dialogue and analyses should aim for broad participation and well-informed partners that can reach consensus on how investments can best address these issues.

Countries in crisis require in-depth population analyses to inform the policy dialogue; ideally before strategies are developed but certainly before they are approved. A demographer is needed to analyze the effects of population growth in regions with poor reproductive health indicators and young age structures to advise on the full range of reproductive health and demographic issues that have a bearing on investment decisions and the MDGs. Staff are also needed to identify and commission relevant sector analyses that could be undertaken internally or through partners (UNFPA, WHO, USAID and other bilaterals as well as CSOs). Staff should seek to inform and improve future lending decisions through shared learning on PRSP development and outcomes. Bank staff should further know where to find the expertise and in-depth analyses to inform their work. To guide programming for MAP, staff specialists are needed to strengthen reproductive health/HIV integration and provide reproductive health inputs to programs such as those reaching youth. Staff specialists could spearhead efforts to integrate HIV/AIDS voluntary counseling and testing (VCT) into family planning/reproductive health services, coordinate links between HIV/AIDS projects and health programs (e.g., linking contraceptive commodity security and logistics with access to ARV treatment) and help strengthen monitoring and evaluation of appropriate indicators.

The capacity of existing staff can be built through WBI courses, seminars and self-directed learning. However, the Bank's commitment to the health MDGs will be difficult to meet with existing staff allocations, and Trust Fund resources for staff are inadequate to meet the needs of all competing for them.

At the country level, an understanding of demographic issues including population growth rate, momentum and the potential for a demographic "bonus" is important to investment decisions. Strengthening reproductive health services through improved quality and demand generation, and increasing investments in youth, including youth reproductive health, are paramount strategies to influence macro-demographic change. In-country experts must evaluate the relative importance of these investments among the competing priorities that poor countries face. Policy-makers at the country level also need the technical knowledge and expertise to enable them to build the "business case" that would convince entities such as the Ministry of Finance that these are issues worthy of investment. The business case can examine the alternative investments that could be made if new infrastructure to meet growing populations were not continually required. It can also address, from a less controversial financial standpoint, issues affecting women's reproductive rights. For example, what toll does unsafe abortion take on health care resources and how might these resources be more productively used for prevention? Given the high maternal and resource costs of unsafe abortion, increased availability of high quality family planning services can be expected to result in fewer abortions and a net savings to the health system. Such analyses may offer compelling arguments in favor of investing in reproductive health and can also be used in policy dialogue around the PRSPs, MDGs and with CSOs.

The number of personnel in poorest countries with monitoring, evaluation and demographic analysis skills is inadequate. The first High Level Forum noted that a "much greater international effort is needed to address monitoring and evaluation challenges posed by the MDGs and poverty reduction strategies."[89] At the same time, Bank staff report that countries are unwilling to invest resources in evaluation, and project funds specified for evaluation have gone unspent.

Consistent with the Bank's claim of a high level of commitment to the MDGs, it must be willing to build capacity in the poorest countries to help achieve these goals. The Bank's intention to strengthen statistical and evaluation capacity in a number of countries[xxvi] is only a first step in the direction of what is needed. There are opportunities to strengthen the capacity of NGOs involved in implementation to engage in participatory monitoring and evaluation, building their own skills for understanding what does and does not work. The Bank has some experience in this realm to build upon.[93]

[xxvi] For more information on the World Bank's Statistical Capacity Building Program see the following website: http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/SCBEXTERNAL/0,,contentMDK:20100816~menuPK:244195~pagePK:229544~piPK:229605~theSitePK:239427,00.html

The Bank has attempted to fill some of these needs through WBI courses, which are presently oversubscribed. More resources should be devoted to expand access to regional courses addressing population, reproductive health and evaluation. Short courses should be offered in countries with the greatest need in order to build a critical mass of decision-makers with a working knowledge of population/reproductive health issues. However, to build in-depth expertise of country partners goes beyond what WBI courses can accomplish in a short timeframe and will require substantially more funding. It is advisable for the Bank to establish a new Trust Fund that specifically focuses on expanding capacity in the poorest countries that are confronting the most serious population and reproductive health challenges. Donors should be sought to endow this fund with sufficient resources to enable a significant impact on capacity in demographic analysis, evaluation and ability to develop a sound business case for reproductive health.

6. Optimize linkages of reproductive health and HIV/AIDS services and systems to scale up HIV prevention and treatment efforts and better meet reproductive health needs.

Through its HIV/AIDS initiatives in the Human Development Network (HDN) and MAP program, the Bank must strengthen the linkages between population and reproductive health programs and services and HIV/AIDS prevention, care and treatment for the betterment of both efforts. HIV/AIDS is a reproductive health crisis, transmitted primarily by sexual intercourse. HIV is also transmitted to a million infants each year by their HIV positive mothers, many of whom did not want or intend to become pregnant.[41] The reproductive health system in many countries is uniquely positioned to offer sexual health information and counseling in addition to addressing prevention of unintended pregnancy, yet the existing reproductive health infrastructure is underutilized to address HIV. For example, the Bank's Global AIDS Advisor recently lamented that VCT is only available to one in nine people in developing countries and that less than one in 20 pregnant women can access services to prevent mother to child transmission.[xxvii] These services could be expanded through the existing reproductive health infrastructure in many countries. The audiences for family planning and other reproductive health services are much the same as the audiences most vulnerable to HIV – youth and individuals in their reproductive years. The messages for prevention and protection are much the same and requirements in terms of personnel and equipment are similar.

The reproductive health community has invested significantly in research to identify what is needed to make sexual and reproductive health services attractive and accessible to youth and has built upon the empirical evidence to expand youth-friendly services. This research, experience and infrastructure should be used to maximize expansion of HIV prevention services for youth. Existing mechanisms can be built upon to prevent primary HIV infection, avert unintended pregnancies among women infected with HIV, provide volutary counseling and testing, diagnose and treat STIs, and prevent transmission of HIV from mother to child. The Bank's leadership is needed to scale up its own investments and to influence the work of its development partners to maximize the use of existing RH infrastructure, personnel and logistic systems. The Bank should address any barriers, internal or external, to collaboration and cooperation between the HIV/AIDS and reproductive health communities.

7. Assure the security and equitable distribution of reproductive health commodities including contraceptives, condoms and antiretroviral drugs.

The Bank should do its part to assure the security and equitable distribution of reproductive health commodities including contraceptives, condoms, STI treatments and ARVs. Through its role as policy advisor, the Bank can help ensure that countries include contraceptives and condoms as part of essential drug packages. The Bank's expertise, particularly through its convening power and support for infrastructure and logistics systems, is needed to avoid anticipated shortfalls that could undermine reproductive health and HIV objectives. The Bank is arguably the only donor capable of supporting the development of infrastructure and systems required to maintain and reliably deliver reproductive health commodities.[78]

In most countries, a contraceptive logistics system is in place to anticipate supply needs and to deliver contraceptives to even remote health posts. These systems can be adapted to assure a consistent and equitably distributed supply of ARVs. The Bank should seek the appropriate and necessary partners to fulfill this mission

[xxvii] Comments made during a presentation to students at George Washington University by Debrework Zwedie in October 2003.

and explore whether engaging with the private sector will help to ensure affordable and consistent contraceptive and drug supply. Wherever reproductive health commodity supply links are not secure, PRSPs should include a complete analysis of reproductive health commodity and logistic system issues and indicate how any shortcomings will be addressed.

8. Broaden and strengthen strategic and collaborative partnerships with development partners and civil society organizations.

The Bank can make better and more appropriate use of its partners to improve health and reduce poverty. Greater partnership is needed with organizations that possess expertise in defining and expanding high quality reproductive health services and generating demand among vulnerable groups.

A greater level of commitment is needed to advance the Bank's collaboration with UNFPA. Where UNFPA has an in-country presence or is able to more consistently participate in policy dialogues at the country level, it is well positioned to make the case for country investments in reproductive health and population policy. This partnership can lead to requests from countries for Bank investments in population/reproductive health interventions. While some sub-Saharan African countries are making progress in addressing rapid population growth as a macroeconomic barrier to poverty reduction, there remains little attention to the issue in high fertility countries in the MENA region. The contribution of rapid population growth to high rates of unemployment and social unrest is reportedly not on the development agenda. UNFPA and other partners can help frame the debate and make the analytical case for synergy between these issues and country development goals in the MENA and other regions.

CSOs are the locus of much technical and advocacy expertise in gender, youth and reproductive health. Through partnership with CSOs, the Bank can build capacity and long-term sustainability of its own programs while simultaneously strengthening the capacity and development effectiveness of CSOs. In impoverished countries with poor governance, CSOs may be the most effective and reliable partners for the Bank.[94] Where governance is stronger and SWAps are being implemented, the Bank should encourage participation of CSOs in implementation and participatory evaluation. Support to CSOs would facilitate involvement of women, youth and other stakeholders in the PRSP process. Support could also enable their contribution to participatory research on reproductive health at the household level to strengthen attention to these issues in PRSPs.

The potential for advocacy organizations to help sustain health reforms following a change in regimes or government priorities[80] suggests that the Bank should nurture and support relationships with CSOs engaged in advocacy for women's health, gender equity, girls' education and other issues central to the Pop/RH agenda. More funding for CSO collaboration, presently only US$ 2.5 million for the health sector, should be identified. With financial support and capacity building, these partners can play a more influential role, particularly in African countries faced with weak capacity and fragile government commitment to population and reproductive health.

Several, if not all of the MDGs, require significant attention to gender, for example, to counter the vulnerability of poor women to transactional sex, a primary mechanism for contracting HIV/AIDS. Linking identified gender priorities with specific follow-up actions has been found to be a weakness of the Bank's CASs.[9] This may reflect a lack of appropriate models and expertise. Using grant mechanisms to support the work of CSOs focusing on gender, the Bank could enhance its attention to gender issues in high fertility settings or where gender inequity is most implicated in HIV transmission. Responses to this gender priority would focus on increasing the access of women and girls to viable livelihoods as well as on strengthening the legal frameworks that protect women against exploitation and violence.

Support for the greater involvement of well-functioning NGOs to provide reproductive health services, outreach, social marketing and behavior change communication is needed to bolster public sector activities. Youth-serving and youth-run CSOs should participate in decision-making and be given assistance in applying for funds, for

example, through MAP. Funds available to CSOs through MAP are reportedly not being programmed to the extent permissible. The Bank must monitor and address this issue, particularly as programming capacity is weak in many MAP countries and the collaboration and expertise of CSOs should be maximized.

9. Urge shareholders to live up to commitments made to achieve the MDGs.

The Bank's commitment to the MDGs cannot be met by simply doing the best it can with existing resources. What is needed to fully implement the goals must be forecast, raised, programmed, tracked and evaluated. The gap between available and needed resources and the improvements in health that can be expected with more resources can encourage greater investments in health by donors as well as by countries themselves. Only if the goals are adequately funded can the true feasibility of such an international commitment be known.

To expand its own work, the Bank must hold its shareholders accountable for commitments made in international agreements to support the MDGs. The Bank's corporate commitment to the health MDGs is not consistent with the level of staff and resources currently programmed for health. Resources for reproductive health and population have not grown as a proportion of the Bank's HNP budget, nor has HNP grown as a proportion of the HDN budget. These budgets reflect a failure of development assistance to make available the resources necessary to achieve the health MDGs.

The Bank must apply leadership and better evidence of needs and effectiveness to increase development funds for poverty reduction, reproductive health and the MDGs. The business case for reproductive health as a sound and necessary intervention to slow population growth and reduce poverty must be made both within the Bank and among its major donors if these allocations are to be more appropriate. The Bank should help recipient countries determine the resources that would be necessary to achieve the MDGs. The forecast of resources needed should address what is required to improve retention of doctors, nurses and other health professionals. Shortages of human resources are clearly becoming a bottleneck to meeting the health MDGs. Many countries are beyond their absorptive capacity, given the current staffing levels.[44] Debt forgiveness is a rational strategy that would enable poor countries to better finance country strategies to achieve the MDGs instead of servicing debt. Enabling this would further demonstrate the strength of global commitment to poverty reduction and improving the lives of the poor. The World Bank has a key role to play in each of these endeavors.

A Bank report suggests that meeting the MDGs for poverty reduction, health and the environment will require a doubling in aid.[9] Some estimate that $35 to $75 billion more aid is needed per year.[95] The United States remains the only major contributor to provide less than 0.2 percent of GNI to development assistance. Moreover, the majority of U.S. international aid supports political stabilization or countries in conflict rather than health.[94] One strategy for raising resources is to focus on countries that are furthest from providing the recommended 0.7 percent of gross national product (GNP) per year for development assistance.[96] If this contribution is to be approached, the Bank and other donors, governments and advocacy organizations must be willing to draw attention to the failure of wealthy nations, most notably the United States, to do their part.[103]

The Bank is already exploring with other partners a number of new mechanisms to raise additional revenue. "Frontloading" would make aid funds that have been pledged for future years available sooner through a borrowing mechanism on the premise that the economic and social benefits of achieving the MDGs will far exceed the cost of borrowing.[97] This would require the Bank and its partners to empirically substantiate the wisdom of applying greater resources sooner. It is logical that donors will expect more evidence that aid is effective if they are to increase their allocations. This will reinforce the need for the Bank and other development partners, including stakeholder countries, to become more results-oriented.[94]

Conclusion: Cairo at 10

In a time of improving its overall strategic focus and attention to the poor, the World Bank has given less attention to population and reproductive health in the last decade and has missed important opportunities for synergy between the Cairo Agenda and its own objective to reduce poverty. Some Bank staff have embraced the MDG framework as an important new opportunity to again raise the profile of these critical issues. However, this view will remain credible only in the presence of strong efforts to maximize the opportunity. Reproductive health advocates both within and outside of the Bank must continue to elucidate the contribution that achieving the Cairo agenda can make to poverty reduction. Universal access to high quality family planning, universal girls' education, gender equity, human rights, child survival and population stabilization all contribute to these goals. These contributions can be demonstrated to be achievable and cost-effective poverty reduction strategies. The Bank's clear, empirically-based endorsement of a fully funded "MDG plus Cairo" agenda and its advocacy for this plan at the highest levels will further international understanding that this is not only a sound investment with enormous payoffs in human, financial and social terms, but it is a plan that can succeed in meeting the MDGs.

As was true for the goals of Alma Ata and Cairo, the Millennium Development Goals are viewed by some as an idealistic vision of what *should* be rather than a blueprint for what *will* be, given appropriate interventions and adequate resources. The Bank's commitment to the goals as a corporate priority will require intensive and sustained effort to reduce poverty, devastating illness and gross inequity. These efforts will bring about change more rapidly and synergistically if the Bank takes leadership in bringing population issues back into the forefront of international attention and in fortifying existing reproductive health systems to meet growing demands, especially those driven by HIV/AIDS. By doing more of the many things that the Bank does well and strengthening the areas in which the Bank's own staff and others have identified as in need of improvement, the Bank, in coordination with its stakeholders-countries and development partners, can reinforce and support speedy progress toward the achievement of these critical goals, for the benefit of the world's most needy citizens. These actions will contribute toward achieving a world free of poverty.

ANNEX

ICPD Language

The ICPD Programme of Action definition of reproductive rights health and rights:

- Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.
- Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children, to have the information and means to do so, and to have the right to attain the highest standard of sexual and reproductive health.

The Programme promoted a broad range of reproductive health services to be integrated with other health services. Aspects of reproductive health care are defined as follows:

- Family planning services, counseling, information and education
- Prenatal care, safe delivery, postnatal care and the management of complications of pregnancy and delivery
- Prevention, diagnosis and treatment of infertility
- Prevention of abortion and treatment of the consequences of unsafe abortion
- Diagnosis and treatment of reproductive tract infections (RTIs) and STIs, including HIV/AIDS
- Information, education and counseling on human sexuality, reproductive health and responsible parenthood
- Diagnosis and treatment of breast cancer and cancers of the reproductive system
- Active discouragement of harmful practices such as female genital cutting (FGC) and gender-based violence

Specific Language Regarding Family Planning

Chapter VII, Reproductive Rights and Reproductive Health

Family planning. Actions are recommended to help couples and individuals meet their reproductive goals; to prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality; to make quality services affordable, acceptable and accessible to all who need and want them; to improve the quality of advice, information, education, communication, counseling and services; to increase the participation and sharing of responsibility of men in the actual practice of family planning; and to promote breast-feeding to enhance birth spacing. The text emphasizes that governments and the international community should use the full means at their disposal to support the principle of voluntary choice in family planning. As part of the effort to meet unmet needs, all countries are asked to identify and remove all major remaining barriers to the use of family planning services. Governments are urged to provide a climate that is favorable to good-quality public and private family planning and reproductive health information and services through all possible channels. The international community is urged to move, on an immediate basis, to establish an efficient coordination system and global, regional and sub-regional facilities for the procurement of contraceptives and other commodities essential to reproductive health programmes of developing countries and countries with economies in transition.

Specific Language Regarding Population Stabilization

Chapter III, Interrelationships between Population, Sustained Economic Growth and Sustainable Development

A. *Integrating population and development strategies.* There is general agreement that persistent widespread poverty and serious social and gender inequities have significant influences on, and are, in turn, influenced by demographic factors such as population growth, structure and distribution. There is also general agreement that unsustainable consumption and production patterns are

contributing to the unsustainable use of natural resources and to environmental degradation. Section A seeks to integrate population concerns fully into development strategies and into all aspects of development planning at all levels. The sustained economic growth that results will help meet the needs and improve the quality of life of present and future generations. It will also promote social justice and help eradicate poverty.

Governments should seek to strengthen political commitment to such integration in three ways: (a) by undertaking public education and information programs; (b) by increasing resource allocations, in cooperation with NGOs and the private sector; and (c) by improving the knowledge base through research and national and local capacity-building. They should also reduce and eliminate unsustainable patterns of consumption and production and promote appropriate demographic policies.

B. *Population, sustained economic growth and poverty.* Efforts to slow population growth, reduce poverty, achieve economic progress, improve environmental protection and reduce unsustainable consumption and production patterns are mutually reinforcing.

Sustained economic growth within the context of sustainable development is essential to eradicate poverty. Eradicating poverty will contribute to slowing population growth and to achieving early population stabilization. Women are generally the poorest of the poor. They are also key actors in the development process. Eliminating all forms of discrimination against women is thus a prerequisite for eradicating poverty, promoting sustained economic growth, ensuring quality family planning and reproductive health services, and achieving balance between population and available resources.

Chapter VI, Population Growth and Structure

A. *Fertility, mortality and population growth rates.* The objective is to facilitate the demographic transition as soon as possible in countries where there is an imbalance between demographic rates and social, economic and environmental goals. This process will contribute to the stabilization of the world population. Governments are urged to give greater attention to the importance of population trends for development. In attempting to address concerns with population growth, countries should recognize the interrelationships between fertility and mortality levels and aim to reduce high levels of infant, child and maternal mortality.

ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
LAC	Latin America and the Caribbean
STD	Sexually Transmitted Disease
ARV	Antiretroviral
Bank (the)	The World Bank
Cairo Agenda, Cairo Consensus	International Conference on Population and Development (ICPD) Programme of Action
CAS	Country Assistance Strategy
CDF	Comprehensive Development Framework
CSO	Civil Society Organization
DALY	Disability-Adjusted Life Year
DANIDA	Danish International Development Agency
DfID	Department for International Development (United Kingdom)
DHS	Demographic and Health Surveys
FGC	Female Genital Cutting
FY	Fiscal Year
GENFUND	Norwegian/Dutch Trust Fund for Gender Mainstreaming
GNI	Gross National Income
GNP	Gross National Product
HDN	Human Development Network
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Virus
HLF	High Level Forum (WHO/World Bank meeting)
HNP	Health, Nutrition and Population
IBRD	International Bank for Reconstruction and Development
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
ICR	Implementation Completion Report
IDA	International Development Association
IFC	International Finance Corporation
IPPF	International Planned Parenthood Federation
JSA	Joint Staff Assessment
MAP	Multi-Country AIDS Program
MDG	Millennium Development Goal
MENA	Middle East and North Africa
MMR	Maternal Mortality Ratio
NGO	Non-Governmental Organization
OED	Operations Evaluation Department
PAI	Population Action International
POP	Population
POP/RH	Population and Reproductive Health
PRGF	Poverty Reduction and Growth Facility
PRS	Poverty Reduction Strategy
PRSC	Poverty Reduction Support Credit
PRSP	Poverty Reduction Strategy Paper
RH	Reproductive Health
RTI	Reproductive Tract Infection
STATCAP	Statistical Capacity Building Program
STI	Sexually Transmitted Infection
SWAps	Sector-Wide Approaches
TB	Tuberculosis
TFR	Total Fertility Rate
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNESCO	United Nations Education, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
US$	United States Dollar
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WBI	World Bank Institute
WHO	World Health Organization

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