

**THE WORLD BANK'S REPRODUCTIVE HEALTH ACTION PLAN
2010-2015**

APRIL 2010



The World Bank

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Acronyms

AAA	Analytic and Advisory Services
AFR	Africa
CAS	Country Assistance Strategy
CCT	Conditional Cash Transfers
CSO	Civil Society Organization
DALY	Disability Adjusted Life Years
DEC	Development Economics
DHS	Demographic and Health Survey
DPT 3	Diphtheria Polio Tetanus 3
EAP	East Asia and Pacific
ECA	Europe and Central Asia
FIGO	International Federation of Gynecology and Obstetrics
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GNI	Gross National Income
HDN	Human Development Network
HDNHE	Human Development Network Health
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HLTF	High Level Task Force on Innovative Financing
HNP	Health, Nutrition, and Population
HSO	Health Systems for Outcomes
HSS	Health Systems Strengthening
ICM	International Council of Midwives
ICPD	International Conference on Population and Development
ICR	Implementation Completion Report
IDA	International Development Association
IEG	Independent Evaluation Group
IHME	Institute for Health Metrics and Evaluation
IHP	International Health Partnership
IHP+	International Health Partnership and related initiatives
IUD	Intra-uterine Device
LCR	Latin America and Caribbean
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MNA	Middle East and North Africa
MNH	Maternal and Neonatal Health
MTCT	Mother to Child Transmission
MTR	Mid Term Review
NGO	Non-governmental organization
ODA	Official Development Assistance
PMNCH	Partnership for Maternal, Newborn and Child Health

PMTCT	Prevention of Mother to Child Transmission
PREMGE	Poverty Reduction and Economic Management Network, Gender
QER	Quality Enhancement Review
RBF	Results Based Financing
RH	Reproductive Health
RHAP	Reproductive Health Action Plan
RHSC	Reproductive Health Supplies Coalition
SAR	South Asia Region
SBA	Skilled Birth Attendant
SGA	Small for Gestational Age
SRH	Sexual and reproductive health
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WBI	World Bank Institute
WDI	World Development Indicators
WHO	World Health Organization

THE WORLD BANK'S REPRODUCTIVE HEALTH ACTION PLAN: 2010-2015

I. Introduction

1. Reproductive health (RH) is a key facet of human development. Improved RH outcomes – lower fertility rates, improved pregnancy outcomes, and lower sexually-transmitted infections (STIs) – have broader individual, family, and societal benefits, including a healthier and more productive work force; greater financial and other resources for each child in smaller families; and as a means for enabling young women to delay childbearing until they have achieved educational and other goals.¹ Many studies have demonstrated that poor RH outcomes – early pregnancies, unintended pregnancies, excess fertility, poorly managed obstetric complications – adversely affect the opportunities for poor women and their families to escape poverty.² Women's full and equal participation in the development process is contingent on accessing essential RH services, including the ability to make voluntary and informed decisions about fertility. Men, too, play an important role in supporting a couple's reproductive health needs, especially since effective use of contraceptive methods as well as seeking maternal health care services are often influenced by men.³ One consequence of high fertility is high population growth which can constrain countries at low levels of socio-economic development. Reductions in fertility lead to low youth dependency and a high ratio of working people to total population, creating a demographic window of opportunity during which output per capita rises and countries enjoy a demographic dividend.

2. Improvements in RH have generally lagged improvements in other health outcomes in many low-income countries. The Millennium Development Goal (MDG) for maternal health is one where the least amount of progress of all the MDGs has been made to date globally.⁴ Many low-income countries continue to have high fertility, and rates of unmet need for contraceptive services, and very high maternal mortality. Twenty-eight countries – mostly in sub-Saharan African – have fertility rates in excess of five births per woman.⁵ Even within countries with relatively good RH outcomes, access to family planning, antenatal care, and delivery assistance among the poor and other vulnerable groups tend to be far worse than the national average.⁶

3. RH issues only recently have begun to be prioritized in the development agenda, and even though levels of official development assistance (ODA) for RH have increased, the

¹ Singh, S, JE Darroch, M Vlassoff, and J Nadeau (2004), *Adding it up: the Benefits of Investing in Sexual and Reproductive Health Care*, New York: UNFPA /Alan Guttmacher Institute

² Greene, ME and TW Merrick (2005), *Poverty Reduction: Does Reproductive Health Matter?* HNP Discussion Paper Series, Washington, DC: World Bank.

³ Family Health International (1998), *Men and Reproductive Health*, Network Quarterly Bulletin, Vol. 18 (3), Spring 1998, Durham NC: FHI

⁴ The maternal mortality MDG calls for a three-fourths reduction in the maternal mortality ratio over the period 1990-2015. For recent update on status of MDGs, see World Bank (2009), *Global Monitoring Report: A Global Emergency*, Washington, DC: World Bank.

⁵ This is based on 2005 data from the World Development Indicators database. 2005 is the latest year for which data on both total fertility rates and maternal mortality rates are available.

⁶ Gwatkin, DR, S Rutstein, K Johnson, E Suliman, A Wagstaff, and A Amouzou (2007), *Socio-Economic Differences in Health, Nutrition, and Population within Developing Countries*, Washington, DC: World Bank.

share of health ODA going to RH has declined in the past decade. A similar trend is evident at the World Bank, where the share of RH in the health portfolio has declined from 18 percent in 1995 to 10 percent in 2007, even though some of the decline has been offset by increases in commitments for health systems strengthening. The reduced focus on RH within the Bank is not limited to financing: a recent IEG evaluation, for example, found that substantive analyses of RH issues rarely figured in the Bank's poverty assessments, even in high-fertility countries.⁷

4. However, a renewed global consensus on the need to make progress on MDG5, together with greater attention to gender issues within and outside the Bank is refocusing attention on RH and offering an unprecedented opportunity to redress the neglect of the previous decade. Notable among these developments is that in 2007 the UN fully incorporated RH within the MDG framework. There is now a new Partnership for Maternal, Newborn, and Child Health (PMNCH) aimed at raising awareness and advocacy related to RH and child health issues. A range of new initiatives has been launched, including the Global Campaign for the Health MDGs, which focus specifically on maternal and child health. The High Level Task Force on Innovative Financing, co-chaired by the Bank, has recently helped raise awareness and suggested options for helping bridge national financing gaps for attaining MDGs 4 & 5. The Bank, together with UNFPA, UNICEF, and WHO, has signed the UN Joint Statement on Maternal and Neonatal Health (UN-MNH/H4) through which the four organizations are working with country governments to ensure that core interventions for addressing maternal and neonatal health are addressed within the national health plans, including IHP+ compacts, and that this is translated into action on the ground.⁸ In addition, the Bank has renewed its commitment to increase investments in gender, for example, through addressing adolescent motherhood as a priority area for the sixteenth replenishment of IDA resources.

5. This document presents a detailed operationalization of the RH component of the Bank's 2007 Health, Nutrition, and Population (HNP) Strategy.⁹ In tandem with the global re-emphasis of RH and in recognition of the importance of RH for human development, this Action Plan aims at reinvigorating the Bank's commitment to helping client countries improve their RH outcomes, particularly for the poor and the vulnerable and in the context of the Bank's overall strategy for poverty alleviation. It underscores the Bank's strong commitment to RH in line with the Program of Action of the 1994 International Conference on Population and Development (ICPD) and presents a series of specific activities – both at the global as well as national levels – aimed at improving RH outcomes in target countries.¹⁰ The Action Plan outlines activities that the Bank will undertake in order to better serve client countries in their efforts to

⁷ World Bank (2009), *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population*, Washington, DC: World Bank.

⁸ World Bank (2009), *Implementation of the World Bank's Strategy for Health, Nutrition and Population (HNP) results: Achievements, Challenges and the Way Forward*, Washington DC: World Bank

⁹ World Bank (2007), *Health Development: The World Bank Strategy for Health, Nutrition, and Population*, Washington, DC: World Bank.

¹⁰ The ICPD Program of Action called for achieving broader development goals through empowering women and meeting their needs for education and health, especially safe motherhood and sexual and reproductive health. It recommended that health systems provide a package of services, including family planning, prevention of unwanted pregnancy, and prevention of unsafe abortion and dealing with its health impact, safe pregnancy and delivery, postnatal care, as well as the prevention and treatment of reproductive-tract infections and sexually transmitted diseases, including HIV/AIDS.

improve RH outcomes. Within the broader framework of health systems strengthening (HSS), the RH Action Plan proposes helping countries to address high fertility, including unmet demand for contraception, improve pregnancy outcomes, and reduce STIs.¹¹

6. The remainder of this document is organized as follows. Section II describes the context in which this Action Plan is being proposed. Section III discusses some of the challenges that may constrain the ability of countries and development partners to find solutions to address reproductive health issues. Details of the Action Plan are presented in Section IV. A Results Framework is placed in Section V, which also concludes. The development of the Action Plan has been guided by an extensive internal and external consultative process, full details of which can be found in Annex A.

II. The Context

7. Millennium Development Goal 5 calls for a reduction in the maternal mortality ratio (MMR) by three-quarters between 1990 and 2015, equivalent to an annual decrease of about 5.5 percent; and access to universal reproductive health care by 2015. Against this target, the current global average rate of reduction is under 1 percent – only 0.1 percent in sub-Saharan Africa, where levels of mortality are the highest – and at the present rate of progress, the world will fall well short of achieving this MDG.

8. The maternal mortality ratio in developing countries is 450 maternal deaths per 100,000 live births on average versus 9 in developed countries. Fourteen countries – thirteen of which are in sub-Saharan Africa – have maternal mortality ratios¹² of at least 1,000 per 100,000 live births: Afghanistan, Angola, Burundi, Cameroon, Chad, Democratic Republic of the Congo, Guinea-Bissau, Liberia, Malawi, Niger, Nigeria, Rwanda, Sierra Leone and Somalia.¹³ Globally, more than half a million women die each year because of complications related to pregnancy and childbirth (Box 1). Of the estimated 536,000 maternal deaths worldwide in 2009, developing countries, where 85 percent of the population lives, accounted for about 99 percent. About half of the maternal deaths (265,000) occurred in sub-Saharan Africa alone and one third took place in South Asia (187,000).¹⁴

¹¹ The development of the Action Plan has been guided by an extensive internal and external consultative process, full details of which can be found in Annex A.

¹² The maternal mortality ratio (MMR) is the annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified year (expressed per 100,000 live births). The maternal mortality ratio should not be confused with the maternal mortality rate (whose denominator is the number of women of reproductive age), which measures the likelihood of both becoming pregnant and dying during pregnancy or six weeks after delivery.

¹³ World Health Organization (2007), *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and the World Bank*. Geneva: WHO

¹⁴ United Nations Children's Fund (2008); *Progress for Children: Report Card on Maternal Mortality*, No. 7; UNICEF: New York

Box 1. How Many Maternal Deaths Are There In The World?

The data on the number of maternal deaths and the maternal mortality ratio (MMR) used in this Action Plan are those estimated for 2005 by an interagency group consisting of WHO, UNICEF, UNFPA, and the World Bank. Recently, estimates for 2008 have been issued by the Institute for Health Metrics and Evaluation (IHME), based on a new modeling approach and an expanded dataset. The findings of this study show that the MMR has been declining from 526 thousand in 1990 to 343 thousand in 2008.

If confirmed, such a decline would be welcome news. But this and similar studies highlight the poor quality of health data, which are frequently incomplete or absent and make evidence-based decision-making difficult. Given the uncertain quality of the data, it will be important to validate the numbers against those being updated by the interagency group, which will be published in mid-2010.

Source: Margaret C. Hogan et al. "Maternal mortality for 181 countries, 1980-2009: a systematic analysis of progress towards Millennium Development Goal 5". www.thelancet.com, published online April 12, 2010

9. Women die from a wide range of complications in pregnancy, childbirth or the postpartum period, many of which develop because of their pregnant status and some because pregnancy aggravates an existing disease.¹⁵ The four major killers are severe bleeding (pre and/or post delivery), infections or sepsis, hypertensive disorders in pregnancy including eclampsia and obstructed labor. Complications of unsafe abortion cause 13 percent of these deaths. Globally, about 80 percent of maternal deaths are due to these causes, and 99 percent of these deaths are a result of poor access to quality obstetric care, and are preventable.¹⁶ Among the indirect causes (20 percent) of maternal death are diseases that complicate pregnancy or are aggravated by pregnancy, such as malaria, anemia and HIV. Women also die because of poor health and nutrition at conception and a lack of adequate care needed for the healthy outcome of the pregnancy for themselves and their babies. Women in developing countries have more pregnancies on average compared to women in high-income countries, and thus have a higher lifetime risk of maternal death.¹⁷

10. Overall, RH-related mortality and morbidity account for almost one-third of the global burden of disease among women of reproductive age and one-fifth of the burden of disease among the world's population overall.¹⁸ Globally, an estimated 10 to 20 million women develop physical or mental disabilities every year as a result of poor access to quality obstetric care for complicated pregnancies and deliveries. For example, it is estimated that each

¹⁵ World Health Organization (2005), World Health Report 2005: *Make Every Mother and Child Count*, Geneva: WHO

¹⁶ World Health Organization (2005), World Health Report 2005: *Make Every Mother and Child Count*, Geneva: WHO

¹⁷ Lifetime risk of maternal death varies on average from 1 in 7,300 in developed countries to as high as 1 in 75 in developing countries. These averages understate the range, which varies from 1 in 7 in Niger to 1 in 48,000 in Ireland.

¹⁸ Singh, S, JE Darroch, M Vlassoff, J Nadeau (2004), *Adding it Up: The Benefits of Investing in Sexual and Reproductive Health Care*, New York: UNFPA/Alan Guttmacher Institute.

year at least 75,000 women develop obstetric fistula and approximately 2 million women are currently living with an untreated obstetric fistula.¹⁹ The UN expects the burden to increase by 40 percent by the year 2050, as record numbers of young people enter their prime reproductive years.²⁰

11. Every year more than 133 million babies are born, of which 3 million are stillborn, almost a quarter dying during childbirth.²¹ The causes of these deaths are similar to the causes of maternal deaths: obstructed or very long labor, eclampsia and infections. Poor maternal health and nutrition and diseases that have not been adequately treated before or during pregnancy contribute not only to intrapartum death, but also to babies being born preterm and with low birth weight. Among the babies born alive each year, 2.8 million die in the first week of life and slightly less than 1 million in the following three weeks. The patterns of babies' deaths are similar to the patterns of maternal deaths: large numbers in Africa and Asia and very low numbers in high-income countries. The rates vary from 7 per 1,000 births in high-income countries to 74 per 1,000 births in central Africa. Maternal and perinatal deaths (stillbirths and first-week deaths) together add up to 6.3 million lives lost every year.²²

12. Data show that less than 60 percent of women in developing countries receive assistance from a skilled health worker when giving birth. This means that 50 million home deliveries each year are not assisted by skilled health personnel.²³ In high-income countries, virtually all women have at least four antenatal care visits, are attended by a midwife and/or a doctor for childbirth and receive postnatal care. In low- and middle-income countries, just above two thirds of women get one or more antenatal visits, but in some countries less than one third of the women get just one antenatal care visit. Even fewer women have the birth attended by a skilled health worker. The 63 percent average for low- and middle-income countries covers large differences: from 34 percent in Eastern Africa to 89 percent in Latin America and the Caribbean.²⁴

13. Many countries have achieved remarkable reductions in fertility rates during the last three decades. Overall, the average total fertility rate (TFR) in developing countries has declined from about 6 in 1960 to 2.6 in 2006.²⁵ Bangladesh brought down its TFR from 6.8 in 1960 to 2.8 in 2007, while Kenya brought its TFR down from 8 in 1960 to almost 5 in 2007.²⁶ Fertility rates are lowest in the Europe and Central Asia (ECA) region, which had a population-

¹⁹ United Nations Children's Fund (2008); Progress for Children: Report Card on Maternal Mortality, No. 7; UNICEF: New York

²⁰ Speidel, J, E Maguire, M Neuse, D Gillespie, and S Sinding (2009), *Making the Case for US International Family Planning Assistance*, Baltimore: Johns Hopkins University/Gates Institute.

²¹ World Health Organization (2005), World Health Report 2005: *Make Every Mother and Child Count*, Geneva: WHO

²² Ibid

²³ United Nations Children's Fund (2008); Progress for Children: Report Card on Maternal Mortality, No. 7; UNICEF: New York

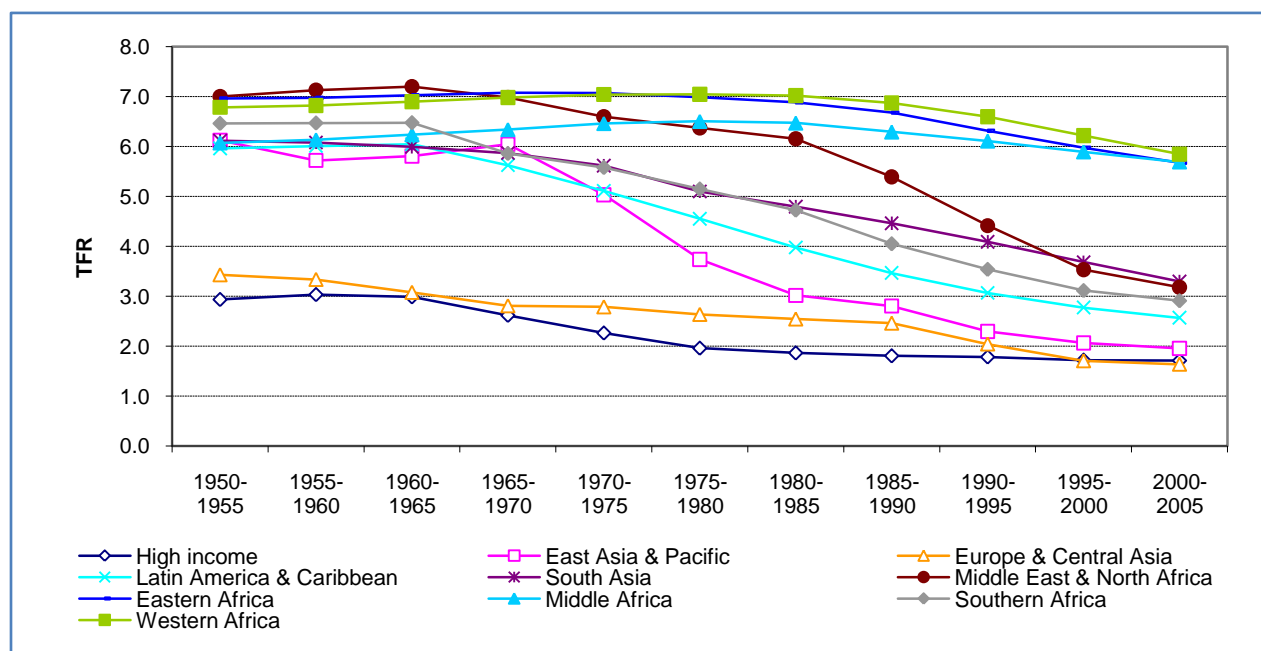
²⁴ World Development Indicators; www.worldbank.org; Accessed February 2010

²⁵ United Nations Children's Fund (2008); Progress for Children: Report Card on Maternal Mortality, No. 7; UNICEF: New York

²⁶ World Development Indicators online: World Bank; accessed February 2010.

weighted average TFR of only 1.7 in 2007, and highest in the sub-Saharan Africa (SSA) region which had a population-weighted TFR of 5.1 in 2007 (Figure 1).²⁷

Figure 1. Trends in Fertility by Region, 1950-2000



Source: WDI

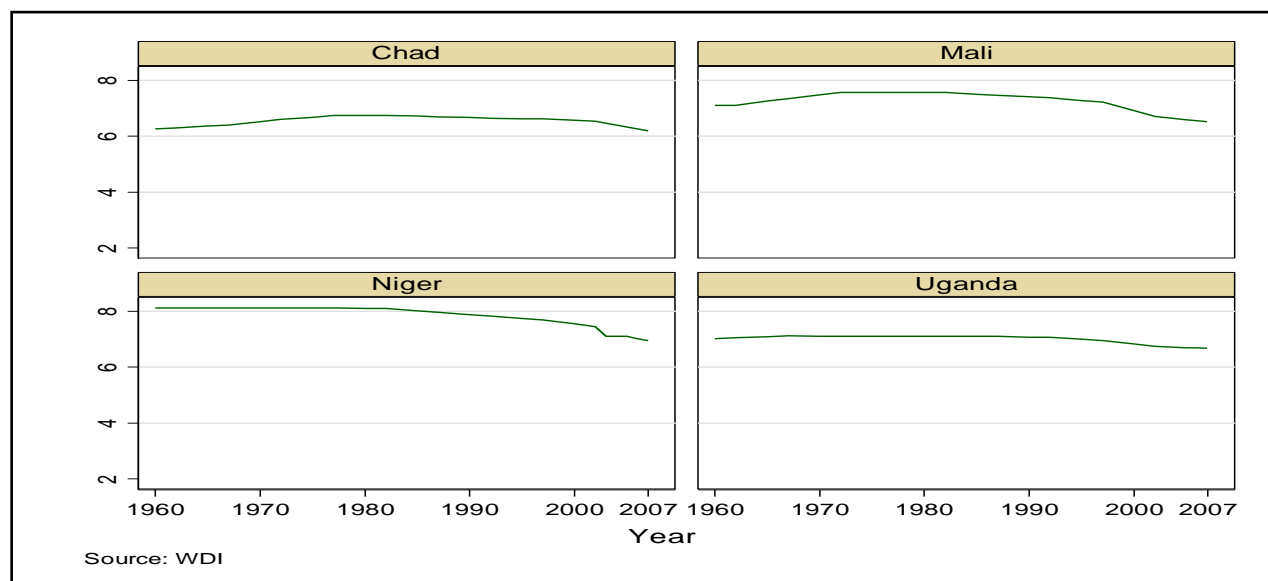
14. Fertility reduction is accompanied by a downward trend in maternal mortality, largely because the decline in fertility reduces the exposure to the risk of pregnancy and pregnancy-related mortality. Family planning programs have contributed to this downward trend, and can make further contributions in countries with high fertility – in two ways. First, pregnancies that carry a particularly high risk (those that are closely spaced, or occur at very young or older ages) can be averted through contraception. Second, an overall fertility reduction leads to a reduction in the exposure to the risk of maternal mortality. Fertility decline has resulted in a significant decrease in the maternal mortality rate, as well as the life-time risk of dying from maternal causes.

15. However, fertility rates have declined at a very slow pace in twenty eight of the least-developed countries – mostly in sub-Saharan Africa – which have fertility rates in excess of five. In countries such as Chad, Mali, Niger, and Uganda, fertility rates are in excess of six, with little or no decline over the past five decades (Figure 2). Social and economic indicators are generally poor in these countries, which also have low levels of educational attainment, high gender inequalities, high mortality, and high levels of poverty. Several of the high-fertility countries have experienced or are experiencing conflict, which has made it difficult to deliver basic health and education services. Low contraceptive use in many of the high-fertility countries

²⁷ United Nations (2004), World Population Prospects. United Nations Department of Economic and Social Affairs Population Division; New York: UN (United Nations)

also stems from a desire to have more children rather than from the lack of awareness about fertility control or lack of access to contraception.

Figure 2. Trends in Fertility Rates, Chad, Mali, Niger and Uganda, 1960-2007



16. In addition to the differences between countries, there are also large disparities within countries between people with high and low income and between rural and urban populations. In Columbia, for example, Demographic and Health Survey (DHS) data reveal big differences in fertility rates by economic status: fertility rate in the highest wealth quintile is 1.4 versus 4.1 in the lowest wealth quintile, suggesting significantly higher unmet needs and/or higher desired fertility among the latter population sub-group. Table 1 provides additional examples of countries with relatively large fertility differentials by wealth status.

Table 1. Fertility rates by wealth quintiles (selected countries)

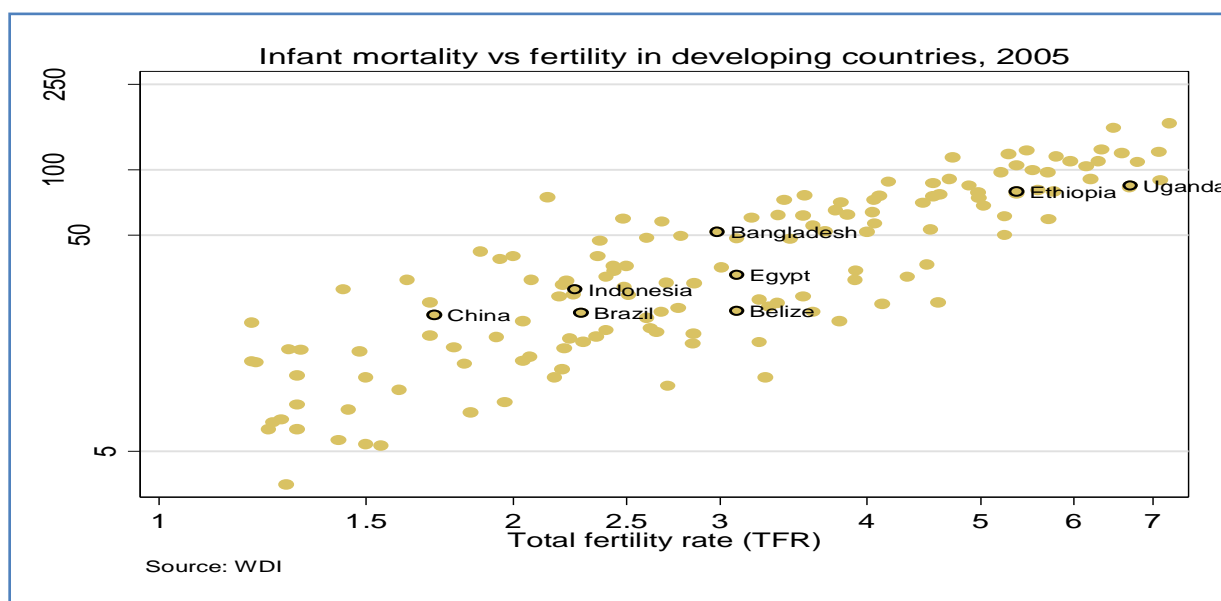
Country	Wealth Quintiles					Total
	Lowest	Second	Middle	Fourth	Highest	
Bangladesh 2007	3.2	3.1	2.7	2.5	2.2	2.7
Colombia 2005	4.1	2.8	2.4	1.8	1.4	2.4
India 2006	3.9	3.2	2.6	2.2	1.8	2.7
Namibia 2007	5.1	4.3	4.1	2.8	2.4	3.6
Philippines 2003	5.9	4.6	3.5	2.8	2.0	3.5

Source: DHS surveys (various years)

17. There has been a huge increase in the prevalence of contraceptive use among women, from less than 10 percent in 1960 to nearly 60 percent in 2005, but unmet need is

still high in countries with high fertility rates. Unmet need for contraception for spacing and limiting births is typically higher for women living in the poorest households, though in some countries unmet need is uniformly low or high for the poor and rich alike. Much higher unmet need for the poorest households is often found in countries in which the transition to lower fertility has been under way for some time (such as Zimbabwe, Namibia and Kenya), whereas lower unmet need for the poor is associated with the earlier stages of decline, in which more educated, urban women want to space or limit births but are unable to obtain a suitable contraceptive method (such as Benin, Nigeria and Central African Republic). In some other countries, unmet need is either high or low for all wealth quintiles (such as Mali and Mozambique). Contraceptive use, in contrast, is consistently higher for women living in wealthier households. Women in wealthier households are more likely to use family planning irrespective of the overall level of contraceptive prevalence in the country. The steepness of this curve – the rate of increase of contraceptive use when comparing women in poor versus wealthier households – varies considerably, indicating greater inequities in access to appropriate contraception in some countries.

Figure 3. Infant Mortality versus Total Fertility Rate in Developing Countries, 2005



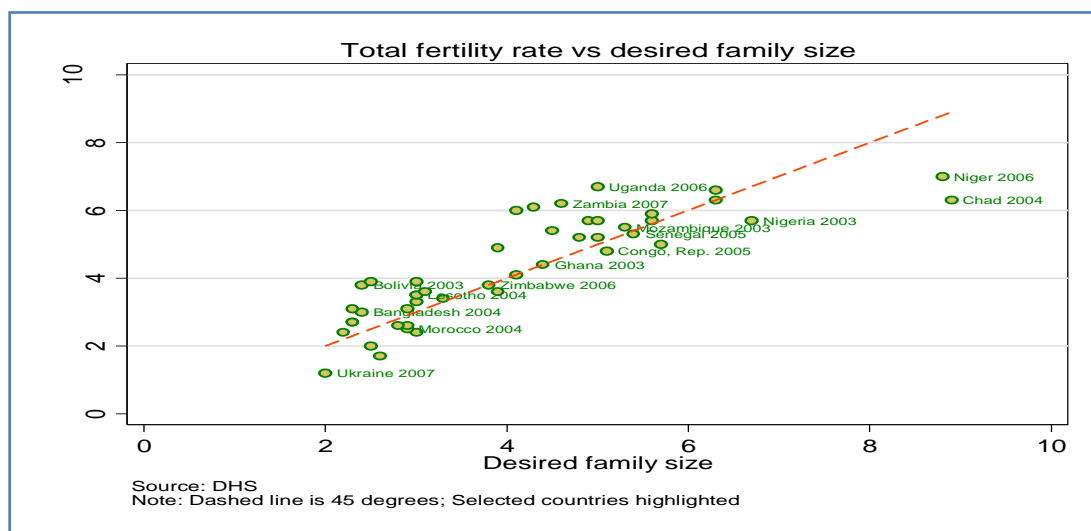
18. High fertility rates are closely linked with high infant mortality rates (Figure 3). This is, in large part, a result of weak health systems as well as poor socio-economic conditions which influence mortality and fertility-related outcomes. In countries with high infant mortality, high fertility is a natural response to achieving a given desired family size. However, the association goes the other way too: high-parity women are more likely to have births with shorter inter-pregnancy intervals and, therefore, would be prone to the adverse effects of such frequent births.²⁸ For instance, short inter-pregnancy intervals (in particular, those less than 6 months) are

²⁸ The inter-pregnancy interval is the interval between a woman's last delivery and the next conception.

known to be a risk factor for low birth weight, pre-term births, and small for gestational age²⁹. This increases the likelihood of fetal death, neonatal death, maternal death, and anemia in pregnancies. These effects have been attributed to maternal protein-calorie and micronutrient depletion as a result of closely spaced pregnancies.³⁰

19. High fertility rates are also linked with gender inequality, particularly parents preference for sons. Evidence from several countries suggests that parents respond to the absence of sons with continued child bearing.³¹ There could be several reasons for this preference including the differences in the costs of raising boys and girls. For one, parents' expected benefits from investing in sons could be larger than the benefits of investing in daughters if men earn higher wages in the labor market or if female labor force participation is low. Parents might also expect higher benefits from investing in boys because sons are the providers of old age support. In some cultures, the practices of dowry and exogamous marriage effectively reduce girls' expected contribution to their natal homes. Finally, parents may also value sons more not just for their economic contribution but also for the role they play in customs and in maintaining the family line. Son preference and its effect on fertility is particularly high in Central Asia and South Asia.

Figure 4. Desired versus Actual Total Fertility Rate in Selected Countries



²⁹ Small for gestational age (SGA) babies are those whose birth weight, length, or head circumference lies below the 10th percentile for that gestational age. Small for gestational age babies have usually been the subject of intrauterine growth restriction.

³⁰ Smits, LJ, and GG Essed (2001), "Short Interpregnancy Intervals and Unfavorable Pregnancy Outcomes: Role of Folate Depletion," *Lancet*, 358: 2074-2077; King, JC (2003), "The Risk of Maternal Nutritional Depletion and Poor Outcomes Increases in Early or Closely Spaced Pregnancies," *Journal of Nutrition*, 133:1732S-1736S; Zhu, BP (2005), "Effect of Interpregnancy Interval on Birth Outcomes: Findings from Three Recent US studies," *International Journal of Gynecological Obstetrics*, 89 (Suppl 1): S25-33.

³¹ Filmer D, JA Friedman, and N Schady (2009), "Development, Modernization, and Son Preference in Fertility Decisions", World Bank Policy Research Working Paper No. 4716. Washington DC: The World Bank

20. In many situations, fertility rates are high not because of unmet need for contraception but because desired fertility itself is high, sometimes as a result of cultural and religious factors, or as a poverty coping mechanism, or even because infant mortality rates are high. Figure 4 shows the high correlation between desired and actual fertility rates in selected countries. Niger has a relatively low unmet need for family planning of 15.8 percent in contrast to Uganda at 40.6 percent, even though the two countries have similar TFR of 7 and 6.8 births per woman, respectively. Niger has a high desired family size of 8.8 as opposed to a desired family size of 5 for Uganda. Similarly, Chad has a high desired family size relative to the prevailing TFR in the country. In such settings, improving access to RH services may not be enough and the focus would also need to be on multi-sectoral interventions designed to influence desired fertility levels.

21. HIV is the leading cause of death and disease among women of reproductive age (15-49 years) worldwide. Sexual transmission remains the main mode of transmission fueling the HIV epidemic across the world. In 2008, 71 percent of all new infections occurred in Sub Saharan Africa. Each year, approximately 1.4 million HIV infected women become pregnant. HIV among child bearing women is the main cause of HIV infection among children, as more than 90 percent of infant and young child infections occur through mother-to-child transmission, either during pregnancy, labor and delivery, or breastfeeding.

22. Adolescent reproductive health presents yet another challenge. In many developing countries, adolescent fertility remains important despite an overall decline in fertility. Moreover, in many of the countries with high fertility and/or high maternal mortality, births to 15-24 year olds account for between 30 to 50 percent of all births. An early transition to motherhood can potentially negatively impact young women's life chances/opportunities by reducing young women's schooling, future employment opportunities and earnings.³² A mother's education and income, in turn, affects her children's school enrollment and attainment and their health and nutrition outcomes. Thus, addressing adolescent pregnancy will also contribute to prevent intergenerational transmission of poverty - a powerful reason to target adolescent fertility.

23. More than half the young in many countries are sexually active, and the proportion who become sexually active before the age of 15 is increasing.³³ Unprotected sexual activity can lead to acquiring sexually transmitted infections (STIs) and their consequences. Studies show that less than half of sexually active young people use condoms, even though, in addition to pregnancies, unprotected sex is the greatest risk factor for HIV transmission in most areas of the world. In Mozambique, a country with moderately high HIV prevalence, sexual activity among youth is common, but condom use is low. The share of sexually active boys using condoms ranges from 20 percent in Mali to about 50 percent in Zambia. Condom use is higher among unmarried sexually active girls than among married girls, but less than half married

³² Greene, ME and T Merrick (2005), "Poverty Reduction: Does Reproductive Health Matter?" Health, Nutrition and Population Discussion Paper. Washington DC: The World Bank; Singh, K(1998), "Part-time employment in high-school and its effects on academic achievement", *The Journal of Educational Research* 91(3): 131-139; Lloyd, CB (2005) , *Growing up Global: The Changing Transition to Adulthood in Developing Countries*. Washington DC: National Academies Press.

³³ Singh, S and JE Darroch (2000), "Adolescent Pregnancy and Childbearing: Levels and Trends in Developed Countries", *Family Planning Perspectives* 32(1):14-23.

young girls use condoms. Unprotected sex increases the risk that married young girls will become infected, especially since many younger women are married to older men,³⁴ who have a higher chance of being infected through risky sex with partners outside marriage.³⁵ Risky sexual behavior is more likely to occur among poor youth, who are in a weaker position to negotiate safe sex, and are more likely to experience sex for exchange.³⁶

24. People under the age of 25 also account for over 100 million STIs annually, other than HIV.³⁷ Even though most STIs are easily treated, many go unnoticed, and many of the young, especially women and girls do not seek services, especially in countries where premarital sex is frowned upon or if they believe that the facility staff is hostile or judgmental or because of high cost.³⁸ In Ghana, for instance, services were denied to young or unmarried clients, and to married women who could not demonstrate the consent of their spouses. In South Africa, many reproductive health services are not easily accessible by youth, and young people feel that facility staff is judgmental and hostile. In Nigeria, adolescents who contracted an STI would rather go to a traditional healer than use formal reproductive health services because of the high cost and low quality.³⁹

25. Adolescent pregnancies carry a higher risk of obstetric complications, such as obstructed labor, eclampsia and fistula, and yet they are less likely to receive adequate antenatal or obstetric care, making them twice as likely to die during childbirth as women over the age of 20. The risks faced by a young woman living in a low resource country are further compounded when the pregnancy is unintended or unwanted and she seeks an abortion.⁴⁰

26. Each year a large number of young women undergo unsafe and illegal abortions, essentially because pregnancies bring immense social costs for unmarried women in societies where family networks do not support out-of-wedlock births. In Sub-Saharan Africa, about 60 percent of women who have unsafe abortions are 15–24 years old.⁴¹ In Latin America and the Caribbean, young women make up about 40 percent of those who undergo

³⁴ Clark S (2004), “Early Marriage and HIV Risks in Sub-Saharan Africa.” *Studies in Family Planning* 35 (3): 149–60.

³⁵ One study in rural Uganda found that the HIV infection rate among married women under 20 was nearly three times that of unmarried women under 20. Konde-Lule, J. K., N. Sewankambo, and M. Morris. 1997. “Adolescent Sexual Networking and HIV Transmission in Rural Uganda.” *Health Transition Review* 7(Suppl):89–100.

³⁶ National Research Council and Institute of Medicine (2005), *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*. Panel on Transitions to Adulthood in Developing Countries. Cynthia B. Lloyd, ed. Committee on Population and Board on Children, Youth, and Families. Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

³⁷ World Health Organization (2005a), *Effectiveness of Drug Dependence Treatment in Preventing HIV among Injecting Drug Users*. Geneva: WHO.

³⁸ Stanback J and KA Twum-Baah (2001), “Why Do Family Planning Providers Restrict Access to Services? An Examination in Ghana”, *International Family Planning Perspectives* 27(1):37–41.

³⁹ Okonofua FE, P Coplan, S Collins, F Oronsaye, D Ogunsakin, JT Ogonor, JA Kaufman, and K Heggenhougen (2003), “Impact of an Intervention to Improve Treatment-seeking Behavior and Prevent Sexually Transmitted Diseases among Nigerian Youths”, *International Journal of Infectious Diseases* 7(1):61–73.

⁴⁰ Lule E, S Singh, SA Chowdhury,(2007), “Fertility regulation behavior and Their Costs: Contraception and unintended Pregnancies in Africa, Eastern Europe and Central Asia”, Health, Nutrition and Population (HNP) Discussion Paper, Washington DC: The World Bank

⁴¹ World Bank 2007. *Population Issues in the 21st Century: The Role of the World Bank*. Washington DC.

unsafe abortions.⁴² In Kenya, Nigeria, and Tanzania, adolescent girls make up more than half of the women admitted to the hospital for complications following illicit abortions, adding to the costs of an already under-resourced health system.⁴³

27. Information presented in this section shows that many low-income countries continue to have very high maternal morbidity and mortality, high fertility, and high rates of unmet need for contraceptive services. Complications of pregnancy and childbirth are the leading cause of death and disability among women of reproductive age and improving women's health and nutrition could save millions of women in developing countries from needless suffering or premature death in developing countries. Women's health is influenced by complex biological, social, and cultural factors that are highly interrelated. Significant progress can be achieved by strengthening and expanding an essential package of health services for women, improving the policy environment, and promoting more positive attitudes and behavior towards women's health. The Millennium Development Goal for maternal health is one where the least amount of progress of all MDGs has been made to date, and strong concerted actions would need to be taken to achieve significant progress as we enter the last five years of the MDG countdown phase.

III. Challenges and Solutions

28. Despite the fact that technical solutions to most of the problems associated with mortality and morbidity in pregnancy and childbirth are well-known, over half a million women still die due to complications developed during pregnancy and childbirth every year. The Global Safe Motherhood Initiative was launched by the World Bank, WHO and UNFPA in 1987, but since then more than 11 million women have died and another 10 to 20 million women suffer serious illness or disability each year. There is widespread consensus that a majority of these deaths could have been prevented and most of the morbidity could have been managed if women had access to quality maternal healthcare before, during and after childbirth. So, why have maternal deaths not fallen over the last two decades?

29. Most of the maternal morbidity and mortality of the last two decades could have been prevented with a coordinated set of actions, sufficient resources, strong leadership and political will. For a variety of reasons, maternal health has not emerged as a political priority, and even though there is growing shared understanding on the solution set, it has not been framed in a way that has been able to generate political commitment and subsequent action.⁴⁴ In fact, a variety of reasons explain the waning global attention accorded to maternal health issues.⁴⁵ Successful reductions in fertility rates in many countries, the rise of competing priorities, and the unintended loss of focus on family planning services within the broader ICPD

⁴² Shah I and E Ahman (2004a), "Age Patterns of Unsafe Abortion in Developing Country Regions." *Reproductive Health Matters*, 12(24 (Abortion law, policy and practice supplement)):9–17.

⁴³ World Health Organization (1998), *The Second Decade: Improving Adolescent Health and Development*. Geneva: WHO. Available online at <http://www.who.int/reproductive-health/docs/adolescenthealth.html>.

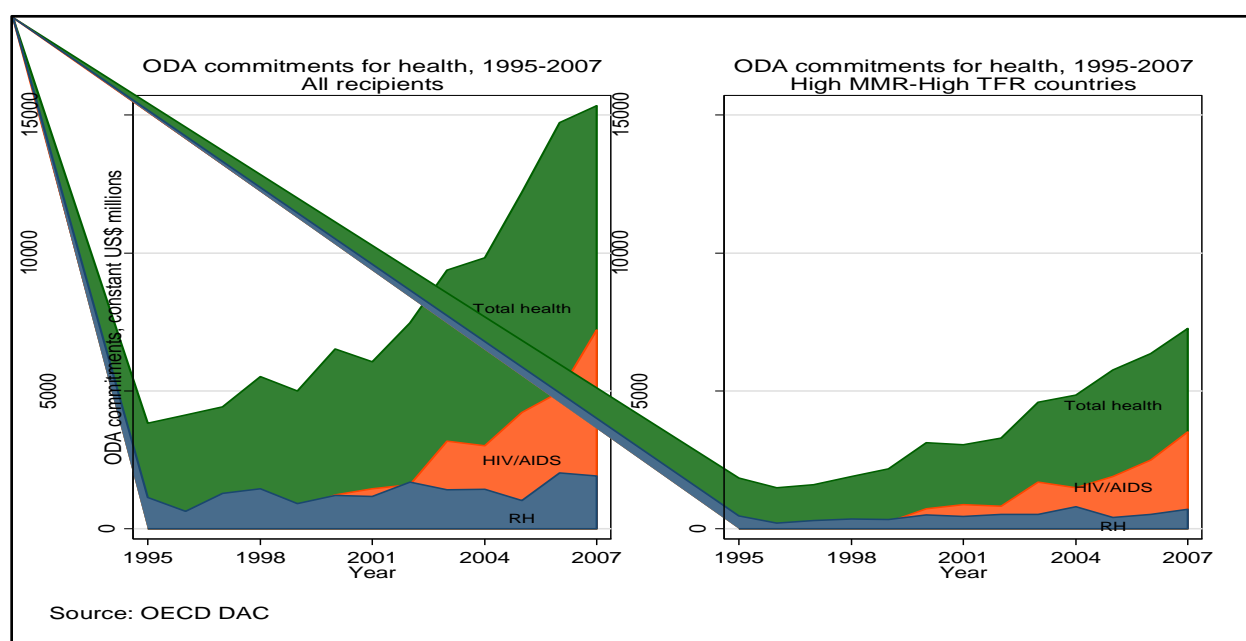
⁴⁴ Shiffman J and S Smith (2007), "Generation of Political Priority for Global Health Initiatives: A Framework and Case Study of Maternal Mortality", *The Lancet*, 370 (9595):1370-1379

⁴⁵ United Nations Population Fund (2006), *Meeting the Need: Strengthening Family Planning Programs*, New York: UNFPA/PATH.

agenda have all contributed to declining attention and funding.⁴⁶ At the same time, HIV/AIDS, TB, and malaria – the major causes of the disease burden in developing countries – have attracted a major share of available resources for health. A UNFPA study in 2003 identified that half of the resources being provided for population was now going for HIV/AIDS-related activities.⁴⁷

30. All this manifested in a declining share in recent years of development assistance for RH activities. While total ODA for health rose fivefold from US\$3,823 million in 1995 to US\$15,264 million in 2007, commitments for reproductive health increased only about 61 percent, from US\$1,143 million in 1995 to US\$1,835 million in 2007.⁴⁸ Furthermore, only a third of ODA for RH has targeted countries with high MMR and high TFR (Figure 5). Some of the biggest recipients of ODA for RH in 2007 – India and Bangladesh, for example – now have relatively low fertility rates (TFR<3).

Figure 5 Official Development Assistance for Health and its Composition, 1995-2007



31. Within the World Bank Group as well, the share of RH commitments in overall health fell from about 18 percent in 1995 to less than 10 percent by 2007. Although the Bank has continued to finance a broader range of projects that address different aspects of the RH

⁴⁶ Speidel J, E Maguire, M Neuse, D Gillespie, and S Sinding (2009), *Making the Case for US International Family Planning Assistance*, Baltimore: Johns Hopkins University/Gates Institute.

⁴⁷ UNFPA (2003), *State of the World Population: Making 1 billion count: Investing in Adolescents' Health and Rights*; New York: United Nations Population Fund

⁴⁸ Dennis, S (2009), "Making Aid Effectiveness Work for Family Planning and Reproductive Health", PAI Working Paper, New York: Population Action International.

agenda, there has been less of a focus on the delivery of family planning services.⁴⁹ Lending to reduce high fertility or improve access to family planning accounted for only 4 percent of the Bank's health portfolio during the last decade, dropping by two-thirds between the first and second half of the decade at a time when the need for such support was high. Population support was directed to only about a quarter of the countries the Bank identified as having the highest fertility (i.e., with TFR>5). Though 75 percent of the CASs in high fertility countries discussed population issues in their analytical frameworks, only half of the health programs in these countries actually addressed high fertility as a strategic focus for Bank lending. Where the Bank identified high fertility and population growth as a strategic focus for the CAS, only 61 percent of such CASs included a population indicator (e.g., TFR, population growth, contraceptive prevalence rate, etc) in the results matrix. The majority of CASs did not provide specific recommendations and guidance about the type of lending that would be most effective in addressing high fertility and rapid population growth.⁵⁰

32. The announcement of a set of MDGs in 2000 stimulated renewed activity, with maternal health getting its own MDG directed at reducing the global maternal mortality ratio by 75 percent over 1990 levels by 2015. Maternal health started figuring more actively within the global development community, including among AIDS activists, proponents of human rights, and those who focused on public health policy on behalf of women or newborns. The surge to combat maternal and child mortality spawned over 80 new national and international partnerships, including the Partnership for Maternal, Newborn and Child Health, which brought together three existing partners. Realizing the need for renewed and consistent push in achieving the health-related MDGs, an informal group of heads of eight health-related organizations (WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI, Bill & Melinda Gates Foundation, and the World Bank – the so-called 'H8') was formed and meets regularly. The White Ribbon Alliance, in which Sarah Brown, wife of the British Prime Minister, is the Chief Patron, launched its *Mothers Day Every Day* campaign in partnership with CARE. Funding also started increasing, with renewed support for comprehensive reproductive health services and overall health infrastructure in the developing world from a number of donor countries.

33. The significant increase in attention to RH issues in terms of greater awareness, better internal cohesion, and high-level political engagement underscores the need to ensure that investments are directed toward solutions that are technically seen as essential to reducing maternal mortality and morbidity. At the minimum, this solution set would include improved access to quality family planning and other reproductive health services, skilled birth attendance, emergency obstetric care, and postnatal care for mothers and newborns.

34. The first step for avoiding maternal deaths is to ensure that women have access to modern contraceptives and the ability to plan their families. In 2008, of the 1.4 billion women in the developing world of reproductive age (15-49 years), over 800 million women wanted to avoid pregnancy and thus had a need for contraception. Of this, 600 million were using modern contraceptives, which prevented 188 million unintended pregnancies, 1.2 million

⁴⁹ While some of this decline has been offset by increases in commitments for HSS, RH issues are not fully addressed within the current emphasis on health systems strengthening.

⁵⁰ A recent IEG evaluation found that substantive analysis of population issues rarely figured in the Bank's poverty assessments.

newborn deaths and 230,000 maternal deaths. Contraceptive use has increased in all developing regions, but remains low in sub-Saharan Africa, where contraceptive prevalence was still only 22 percent in 2008 (though almost double of the 12 percent in 1990). In many countries, the proportion of demand for birth spacing or limiting that is being met by use of modern contraception is closely linked to household wealth and location. Among the wealthiest quintiles, this proportion of demand satisfied is rarely under 80 percent. However, in the poorest quintiles, levels are at par with aggregate contraceptive prevalence. In sub-Saharan Africa, unmet need for family planning exceeds 24 percent. Overall, less than half of demand for spacing and limiting – less than a quarter among the poorest quintile – is being met.

35. By further increasing contraception coverage and reducing unmet need for family planning, the reduction of closely-spaced births, unwanted pregnancies and unsafe abortions will lead to better health outcomes for women and children. Estimates suggest that if all inter-birth intervals of less than 24 months were increased to at least that length, the lives of 0.9 million children under the age of five could be saved. Increasing the interval to 33 months would save an additional 0.9 million lives, reaching a total of 1.8 million.

36. The women who continue pregnancies need care during this critical period for their health and for the health of the babies they are bearing. Since the 1990s, the proportion of pregnant women in the developing regions who had at least one antenatal care visit increased from around 64 percent to 79 percent. However, less than 50 percent of pregnant women in the period 2003-2008 were attended to at least four times during their pregnancy by skilled health personnel, as recommended by WHO and UNICEF. In 2007, only 61 percent of women in developing countries delivered with the help of skilled birth attendants. Since the 1990s, the presence of skilled birth attendants at delivery has increased in all developing regions, though the percentage of births attended by skilled health personnel in sub-Saharan Africa was only 44 percent and 42 percent in Southern Asia (Table 2).

Table 2. Proportion of births attended by skilled health personnel.⁵¹

	Around 1990	Around 2007
World	58	64
Developing Regions	53	61
Northern Africa	45	79
Sub-Saharan Africa	42	44
Latin America and the Caribbean	70	87
Eastern Asia	94	98
Southern Asia	29	42
Southern Asia excluding India	15	30
South-Eastern Asia	46	68
Western Asia	62	77
Commonwealth of Independent States (CIS)	98	99
Developed Regions	99	99
Transition countries of South-Eastern Europe	99	98

⁵¹ WHO; Proportion of birth attended by a skilled health worker; 2008 Updates, WHO, Geneva

37. Most maternal deaths are avoidable, and the health care solutions to prevent or manage the complications are well known. Severe bleeding after birth, which can rapidly become fatal, can be effectively controlled by drugs such as oxytocin. Sepsis, which is second most frequent cause of maternal death, can be eliminated if treated early. Eclampsia can be detected during pregnancy, and drugs such as magnesium sulfate can be used to lower the risk of developing fatal convulsions. Obstructed labor can be recognized by practitioners skilled in following the progress of labor and the maternal and fetal condition, and ensure that Caesarean section is performed on time to save the mother and the baby. However, since complications are not predictable, all women need care from skilled health professionals during pregnancy, childbirth and in weeks after delivery.⁵²

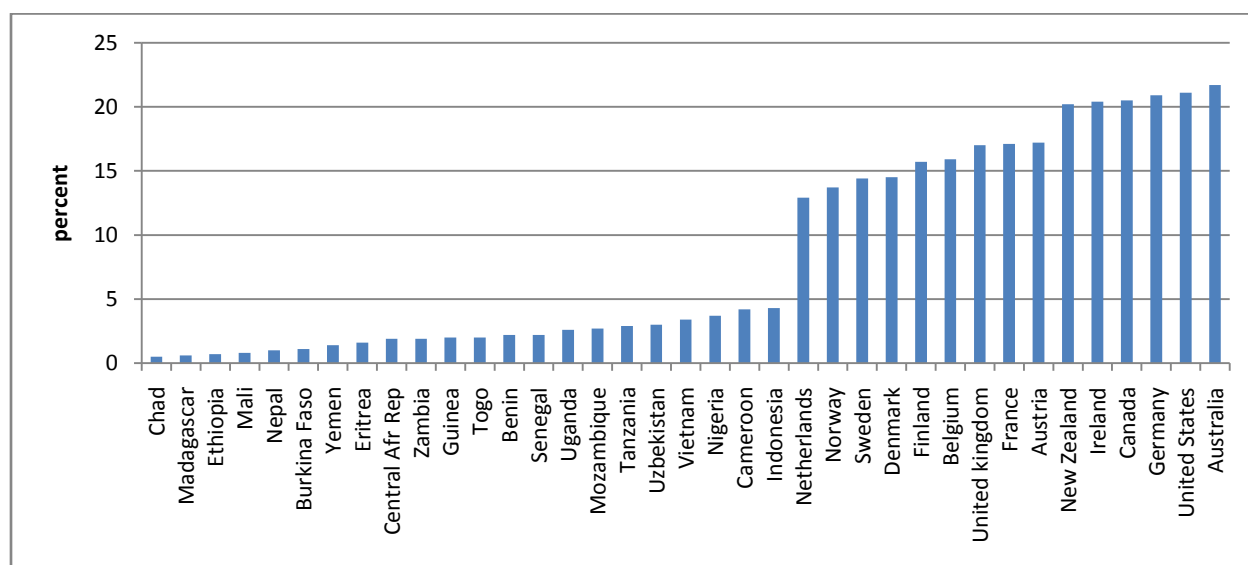
38. Since complications can occur without warning at any time during pregnancy and childbirth, prompt access to quality obstetric services equipped to provide lifesaving drugs, antibiotics and transfusions and to perform Caesarean sections and other surgical interventions is critical.⁵³ An indicator of whether such emergency obstetric services are available in a country is the rate of Caesarean section (or C-section) deliveries. Estimates from UNICEF, WHO and UNFPA suggest that a minimum of 5 percent of deliveries will likely to require a C-section in order to preserve the life and health of mother or infant, which implies that countries reporting less than 5 percent of births by C-section typically have many life-threatening complications that are not receiving the necessary care.⁵⁴ Figure 6 presents the percentage of deliveries by C-Section in selected low- and high-income countries and shows that a large number of countries have C-Section rates lower than 5 percent. These are also countries with the highest MMR rates.

⁵² The foundations for maternal risk are often laid in girlhood. Women whose growth has been stunted by chronic malnutrition are vulnerable to obstructed labor. Anemia predisposes to hemorrhage and sepsis during delivery and has been implicated in at least 20 percent of post-partum maternal deaths in Africa and Asia. The risk of childbirth is even greater for women who have undergone female genital mutilation, an estimated 2 million girls every year.

⁵³ The factors that cause maternal morbidity and death also affect the survival chances of the fetus and newborn, leading to an estimated 8 million infant deaths a year (over half of them fetal deaths) occurring just before or during delivery or in the first week of life.

⁵⁴ Rates higher than 15 percent, on the other hand, are suggestive of inappropriate use of C-Sections.

Figure 6. Percent of Deliveries by C-Section



Source: DHS (Various Years)

39. The continuum of care from pre-pregnancy to two years postpartum for women and their children provides many points for intervention, but gaps in the capacity and quality of health systems and barriers to accessing health services need to be identified and tackled. Different countries have approached this challenge with varying degrees of success, but in all cases the emphasis has been on strategies to rapidly reach populations in need of family planning, and strategies that aim to speed up access to appropriate skilled care, including emergency obstetric care, by women during pregnancy and delivery. Strategies to rapidly reach populations in need of family planning include relying on first-level health providers to provide contraceptives. One such example has been the provision of injectable contraceptives, which has resulted within the last 10 years to a doubling (to 35 million worldwide) of the number of women worldwide who use injectable contraceptives to prevent pregnancies. Countries around the world are experimenting with innovative ways to speed up access to appropriate skilled care by women during pregnancy and delivery. In a supply-side intervention, for example, Mozambique’s “Road Map to Accelerate the Reduction of Maternal, Newborn and Child Deaths” provides a temporary home to pregnant women with good nutrition. In India, the National Rural Health Mission has used demand-side financing to ensure the public system delivers high-quality maternity services as part of the *Janani Suraksha Yojana* or Maternity Safety Plan. The result has been an increase in the number of women using the services – from 700,000 in 2005-06 to more than seven million in 2007-08.

40. The decline in maternal mortality in North Africa, East Asia, South East Asia and Latin America and the Caribbean shares many common features: increased use of contraception to delay and limit childbearing and better access to high quality obstetric care services. Experiences from countries such as Iran, Malaysia, Sri Lanka, and China, and from projects in countries like Tanzania and India, show that outcomes in reproductive, maternal, newborn, and child health can be improved through integrated packages that are gradually introduced within the health system. Such packages include community-based interventions along with social protection and actions in other social sectors. Appropriate and supported

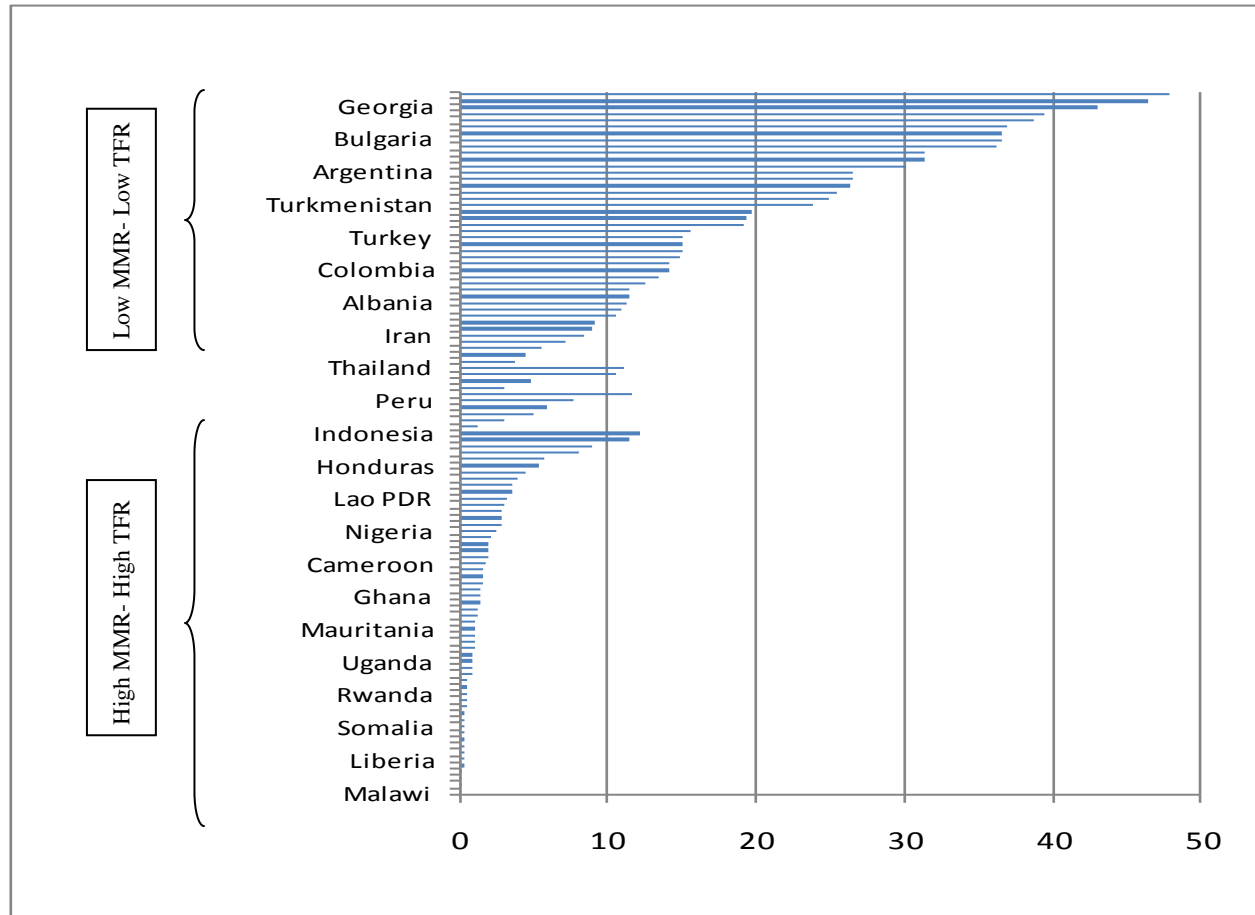
decentralization of roles and finances aids localized planning and implementation. Many of these elements can be discerned in the reductions in child mortality and improvements in health outcomes for women in Rwanda.

41. Effective reproductive health services delivery – including access to quality family planning and reproductive health services, skilled birth attendance, emergency obstetric care, and postnatal care for mothers and newborns – depend on the strength of the overall health system. On the ground, in practical terms, it means putting together the right chain of events (financing, regulatory framework for private-public collaboration, governance, insurance, logistics, provider payment and incentive mechanisms, information, well-trained personnel, basic infrastructure, and supplies) to ensure equitable access to effective interventions and a continuum of care to save and improve lives. Achieving strong and sustainable RH results requires a well-organized and sustainable country health system, capable of responding to the needs of women, children and families. Inputs necessary for health care delivery include financial resources, competent health care staff, adequate physical facilities and equipment, essential medicines and supplies, current clinical guidelines, and operational policies.

42. Well-resourced health systems include appropriate numbers of skilled health workers and managers that are spatially distributed according to need. However, many countries, especially in Africa, have critical shortages estimated at 2.4 million doctors, nurses and midwives. The shortage is especially acute in countries characterized with high MMR and high TFR, which typically have fewer health personnel per 10,000 population relative to other groups of countries (Figure 7).⁵⁵ The percentage of births attended by qualified health personnel is also low in these countries relative to other groups of countries, which underscores the importance of adequate supply and availability of skilled health professionals and is another indicator of weaknesses in the health system (Figure 8).

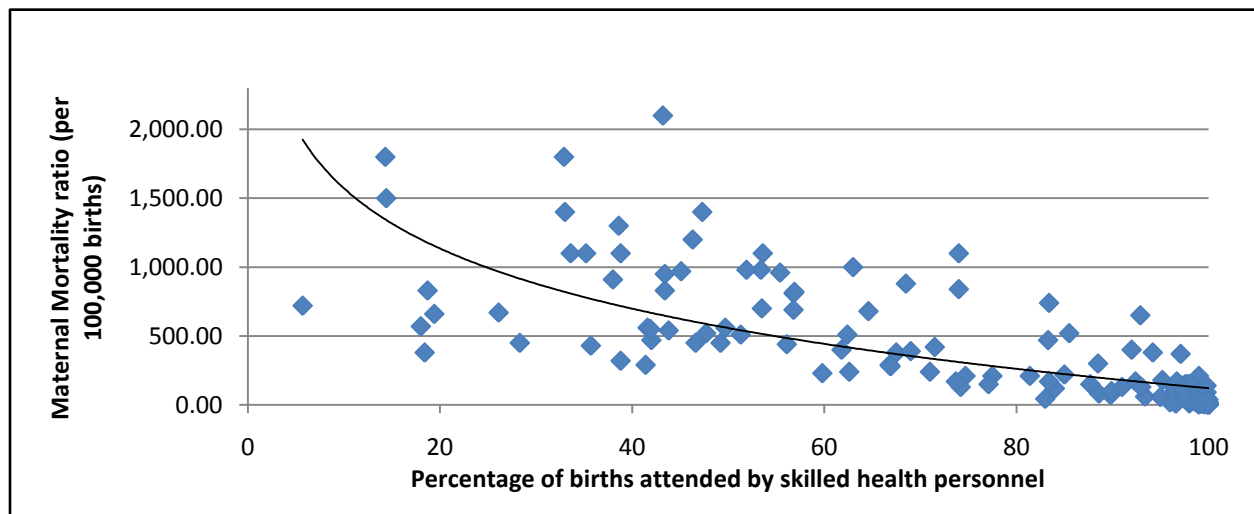
⁵⁵ Ratios of physicians, nurses, and/or midwives per 10,000 population are important indicators, but by themselves do not sufficiently measure health care coverage. Adequate numbers of all cadres of health care professionals as well as their appropriate distribution throughout the country are needed to ensure coverage. This indicator is useful for cross-country comparisons, for monitoring targets, and for measuring against international standards.

Figure 7. Physicians per 10,000 of Population



Source: World Development Indicators

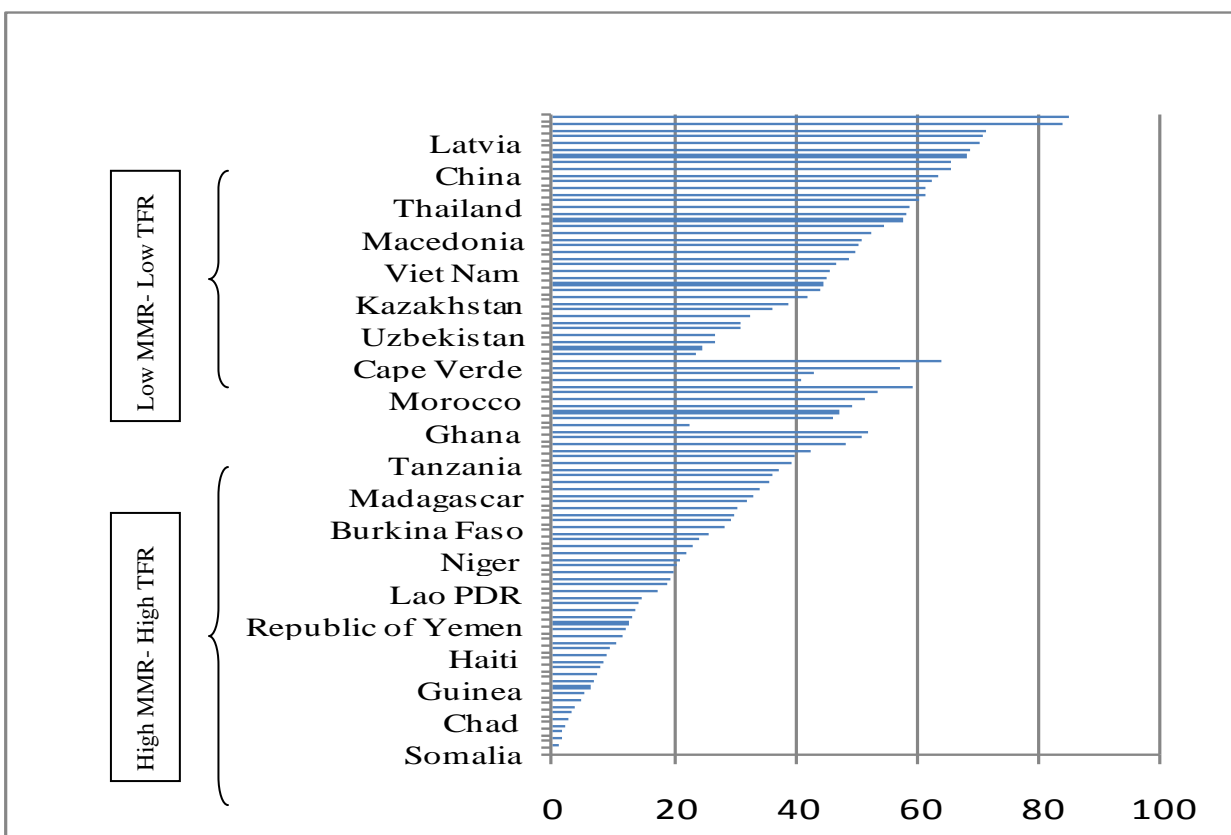
Figure 8. Percent Births Attended by Skilled Personnel and MMR (per 100,000 births)



Source: World Development Indicators

43. Another aspect of strong health systems is the quality of overall governance, which directly affects the environment in which health systems operate and the ability of government health officials to exercise their responsibilities. Governance can be broadly defined as the set of traditions and institutions by which authority is exercised, which includes the capacity of the government to effectively formulate and implement sound policies; and the respect of citizens, private organizations, and the state for the institutions that govern their economic and social interactions. In the area of government effectiveness (which measures the quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government's commitment to such policies), countries in the High MMR-High TFR group rank consistently lower than other groups of countries (Figure 9).⁵⁶ Where countries have made strides in addressing TFR and MMR, governments' interest and ownership has been critical for these successes and for ensuring that these are sustained.

Figure 9. Government Effectiveness (percentile rank)



⁵⁶ Data on governance presented here are drawn from the World Bank's Worldwide Governance Indicators database since specific data related to governance in the health sector are not available. The percentile rank indicates the percentage of countries worldwide that rate below the selected country. While these indicators are for overall governance in a country, they are relevant to the health sector.

44. The 2009 Global Consensus on Maternal and Neonatal Health (MNH), signed by 41 bilateral and multilateral development agencies, including the Bank, provides a checklist of policies and prioritized interventions to ensure improved MNH outcomes.⁵⁷ The Global Consensus recognizes that MDGs 4 & 5 will not be reached without country leadership and the prioritization of reproductive, maternal, and newborn health at country level. The Global Consensus proposes a five point plan that includes: (i) political, operational, and community leadership and engagement; (ii) a package of evidence-based interventions through effective health systems along a continuum of good quality care, with a priority on quality care at birth; (iii) services for women and children free at the point of use if countries choose to provide them; (iv) skilled and motivated health workers in the right place at the right time, with supporting infrastructure, drugs, and equipment; and (v) accountability for results with robust monitoring and evaluation. Sustained political commitment and leadership, especially at the national and local levels, is vital to scale up care, ensure translation of commitments into overcoming of implementation bottlenecks, effective service delivery, and financial protection for all mothers and children, as well as a multi-sectoral commitments to tackling the root causes of poor MNH, including inequity, poverty, gender inequality, the low education status of women, and lack of respect for women's human rights.

45. In broader terms, the implementation of the interventions mentioned above would require addressing implementation constraints at various levels.⁵⁸ These include: (i) community and household level (e.g., increasing the demand for services and removing financial and geographic barriers to maternal health services); (ii) health services delivery level (e.g., effective human resource management to ensure health personnel attend to deliveries; upgrading and equipping health facilities; strengthening health management information systems for monitoring and evaluation); (iii) health sector policy and strategic management level (e.g., strategic public-private partnerships to ensure universal access to health services); (iv) public policies cutting across sectors (e.g., promoting education of girls, expand road networks and making available affordable transport); (v) fragmentation of donor efforts and financing (e.g., harmonizing and coordinating the efforts of donors at country level to support countries to improve maternal health). The World Bank is in a unique position to address these constraints simultaneously. The Bank's Action Plan brings together these dimensions through targeting high burden countries, emphasizing reproductive health within health systems strengthening, focusing on the poor and the adolescents, as well as leveraging its partnerships, including those with civil society.

⁵⁷ Government of Norway (2009), *Leading by Example- Protecting the most Vulnerable during the Economic Crisis – The Global Campaign for the Health Millennium Goals, 2009*, Second Year Report, Published by the Office of the Prime Minister of Norway, Oslo, June 2009.

⁵⁸ International Health Partnership (2009), *Constraints to Scaling Up and Costs*. Technical Report of the Working Group 1 for the High Level Task Force on Innovative International Financing for Health Systems, June 5, 2009. Available at: <http://www.internationalhealthpartnership.net/taskforce.html>. Accessed September 24 2009.

IV. The Bank's Action Plan

46. The economic, poverty reduction, and equity rationales for the Bank's focus on RH are compelling. Improved RH outcomes – lower fertility rates, improved pregnancy outcomes, and lower sexually-transmitted infections (STIs) – have broader individual, family, and societal benefits including a healthier and more productive work force; greater financial and other resources for each child in smaller families; and as a means for enabling young women to delay childbearing until they have achieved educational and other goals.⁵⁹ Women endure a disproportionate burden of poor RH outcomes, but investments in reproductive health have multiple payoffs for families, communities, and the national economy. Poor RH outcomes – early pregnancies, unintended pregnancies, excess fertility, poorly managed obstetric complications – adversely affect the opportunities for poor women and their families to escape poverty.⁶⁰ In particular, reproductive health has a significant effect on the health and productivity of the next generation, in addition to the benefits for the current generation. Women can fully and equally participate in the development process if they have access to quality RH services, including the ability to make voluntary and informed decisions about fertility. Overall, investing in reproductive health confers widespread benefits to the society as a whole and contributes to sustainable development through improving equity, quality of life, and economic potential.

Country Focus

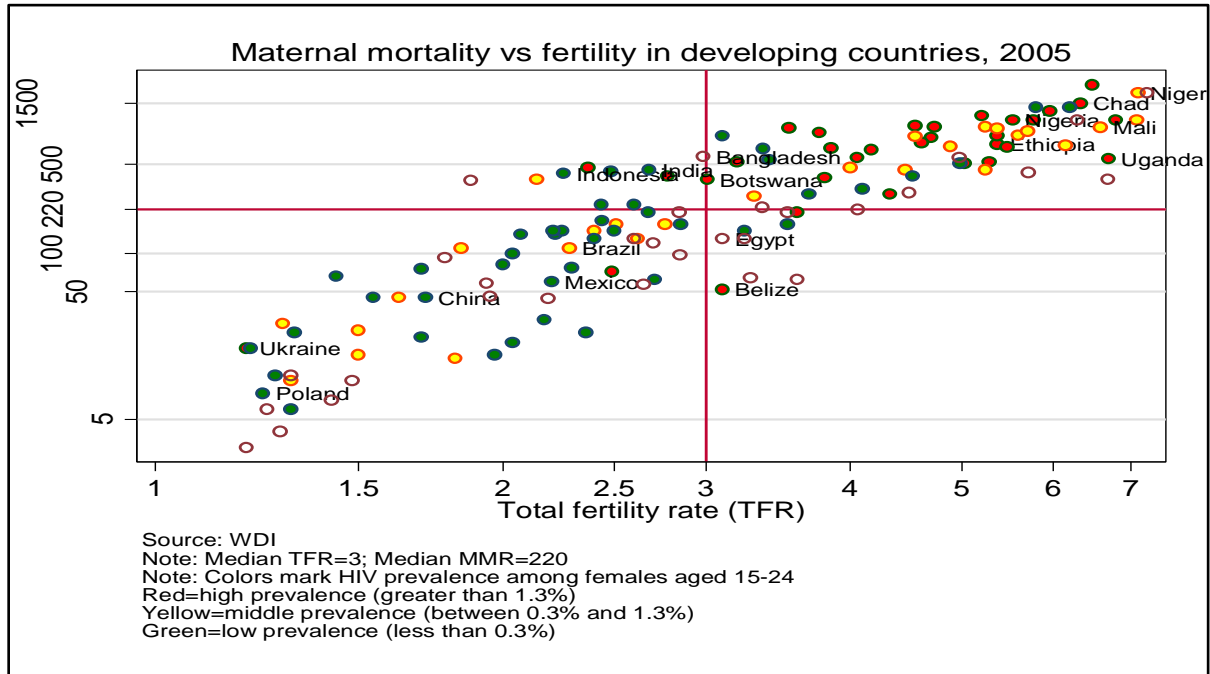
47. In general, MMR, TFR, STI and other RH outcomes tend to be highly correlated across countries: high MMR countries also tend to have high TFR and relatively high levels of HIV prevalence among young women, and vice-versa. Exceptions include countries such as Indonesia and Bangladesh, which have relatively lower TFR and HIV, but relatively high MMR, and Egypt and Belize, which have relatively low MMR but high TFR. Figure 10 highlights the different quadrants in which countries fall based on MMR (greater than or equal to the median MMR 220 being high) and TFR values (greater than or equal to the median TFR of 3 being high).⁶¹ Box 2 lists the countries in these quadrants.

⁵⁹ Singh, S, JE Darroch, M Vlassoff, and J Nadeau (2004), *Adding it up: the Benefits of Investing in Sexual and Reproductive Health Care*, New York: UNFPA /Alan Guttmacher Institute

⁶⁰ Greene, ME and TW Merrick (2005), *Poverty Reduction: Does Reproductive Health Matter?* HNP Discussion Paper Series, Washington, DC: World Bank.

⁶¹ There is considerable heterogeneity within these indicative quadrants. In the high MMR-high TFR quadrant, for example, in some countries MMR and TFR are declining while in others these indicators are relatively stagnant.

Figure 10. Maternal Mortality versus Total Fertility Rates in Developing Countries, 2005



48. Countries with high MMR, high TFR, and high STIs also have weak health systems and low implementation capacities. Table 3 shows that almost all high MMR-high TFR-high STI countries fall in the bottom two groups for two or more of the following three health systems indicators: DPT3 vaccination coverage, skilled birth attendance, and physicians per capita.⁶² Countries that have high MMRs and high TFR are also those that are predominantly low-income with generally poorer socio-economic indicators and implementation capacities. By way of contrast, low MMR and low TFR countries are generally upper middle-income with relatively high levels of female literacy, physicians per capita, DPT3 vaccination coverage rates, and skilled birth attendance rates, and very few of them have weak health systems.⁶³

⁶² The MMR is often in of itself considered to be a proxy of the state of the health system in a country. However, measurement challenges make it difficult to be used as a tracer indicator.

⁶³ See Ranson, MK, K Hanson, V Oliveira-Cruz, and A Mills (2003), "Constraints to Expanding Access to Health Interventions," *Journal of International Development*, 15: 15-39

Table 3. Country characteristics based on MMR and TFR classifications

Classification	GNI per capita (US\$)	Health expenditure per capita (US\$)	Female literacy rates (%)	Physicians per 1000 population	DPT3 vaccinations (%)	Skilled birth attendance (%)	Proportion with “weak” health systems (%)
High MMR- High TFR	\$862	\$47	52	0.18	72	48	98
High MMR- Low TFR	\$1,783	\$91	65	0.71	85	64	70
Low MMR- High TFR	\$2,927	\$152	81	1.32	90	83	44
Low MMR- Low TFR	\$4,120	\$279	92	2.16	93	96	9

49. In terms of geographic prioritization, therefore, the Bank will focus on the 58 countries with high MMR and high TFR, and within this group, on countries where MMR and TFR rates have remained high over extended periods of time. Interventions would necessarily vary, depending on whether MMR and TFR are declining, stagnant or rising. In high-TFR countries which are already experiencing the beginnings of fertility decline, it would be necessary to accelerate the pace of fertility decline via, for instance, targeted awareness-generation/media campaign to provide information on the benefits of having smaller families and on improving access to a variety of quality family planning services.⁶⁴ On the other hand, in countries such as Uganda, where unmet need for family planning is high and the TFR is higher than the desired family size, the approach will be to improve access to quality family planning services. Similarly, MMR is declining in many countries (such as Botswana, Tanzania and Peru), and the focus in these countries will be on sustaining the progress that has been made to date. In other countries, where MMR rates have been high and stagnant, interventions would need to be focused on addressing the health systems issues such as human resources, availability of quality emergency obstetric care services and a political commitment to bring about a change.

50. The next group of focus countries have high MMR but low TFR. In these 10 countries, strategies for addressing high MMR will be the same as for countries in the high MMR-high TFR quadrant. However, family planning approaches will be targeted on population sub-groups and sub-national areas that have relatively higher TFR.

51. In the group of countries with low MMR high TFR as well as those with low MMR low TFR, it will be important not to lose sight of population subgroups that may still have outcomes similar to those in the high burden countries. Accordingly, the focus on the 9 countries with low MMR and high TFR will be to address the unmet need for contraceptives

⁶⁴ Das Gupta, M (2009), “The Arguments against Donor Involvement in Family Planning: How Valid Are They?” DECRG Presentation, World Bank, Washington, DC.

with the same kind of approaches as for countries with high MMR and high TFR. Strategies for addressing maternal morbidity and mortality, as well as high fertility, will be targeted on population sub-groups and sub-national areas that have relatively higher MMR or high TFR. In the group of countries with low MMR and low TFR, the emphasis will also be on learning from their experiences and generating lessons on how these countries have successfully maintained improvements in reproductive health.

Box 2. Countries Classified according to MMR and TFR

This list is restricted to countries that had maternal mortality ratio estimates in 2005. It excludes countries with populations less than 250,000 and a few others for which estimates were not available. The countries that are High MMR-High TFR and High MMR-Low TFR are also the same countries that have been identified for tracking progress on maternal, neonatal, and child health indicators for the Countdown to 2015 and H4 joint work program.

High MMR-High TFR (TFR 3 or more; MMR 220 or more): Afghanistan, Angola, Burundi, Benin, Burkina Faso, Bolivia, Botswana, Central African Republic, Cote d'Ivoire, Cameroon, Congo, Rep., Comoros, Djibouti, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Gambia, The, Guinea-Bissau, Equatorial Guinea, Guatemala, Honduras, Haiti, Iraq, Kenya, Cambodia, Lao PDR, Liberia, Lesotho, Madagascar, Mali, Mozambique, Mauritania, Malawi, Niger, Nigeria, Nepal, Pakistan, Philippines, Papua New Guinea, Rwanda, Sudan, Senegal, Solomon Islands, Sierra Leone, Somalia, Swaziland, Chad, Togo, Timor-Leste, Tanzania, Uganda, Yemen, Rep., Congo, Dem. Rep., Zambia, Zimbabwe

High MMR-Low TFR (TFR less than 3; MMR 220 or more): Bangladesh, Bhutan, Guyana, Indonesia, India, Morocco, Myanmar, Peru, Korea, Dem. Rep., South Africa

Low MMR-High TFR (TFR 3 or more; MMR less than 220): Belize, Cape Verde, Egypt, Arab Rep., Jordan, Namibia, Oman, Paraguay, Syrian Arab Republic, Tajikistan

Low MMR-Low TFR (TFR less than 3; MMR less than 220): Albania, Argentina, Armenia, Azerbaijan, Bulgaria, Bosnia and Herzegovina, Belarus, Brazil, Barbados, Chile, China, Colombia, Costa Rica, Cuba, Czech Republic, Dominican Republic, Algeria, Ecuador, Estonia, Fiji, Georgia, Croatia, Hungary, Iran, Islamic Rep., Jamaica, Kazakhstan, Kyrgyz Republic, Lebanon, Libya, Sri Lanka, Lithuania, Latvia, Moldova, Maldives, Mexico, Macedonia, FYR, Mongolia, Mauritius, Malaysia, Nicaragua, Panama, Poland, Romania, Russian Federation, El Salvador, Suriname, Slovak Republic, Thailand, Turkmenistan, Trinidad and Tobago, Tunisia, Turkey, Ukraine, Uruguay, Uzbekistan, Venezuela, RB, Vietnam

Focus on Health Systems Strengthening

52. In line with its HNP strategy, the Bank will work closely with countries and development partners to strengthen health systems to ensure improved access to quality family planning and other reproductive health services, skilled birth attendance, emergency obstetric care, and postnatal care for mothers and newborns. As discussed earlier, a well-organized and sustainable health system, capable of responding to the needs of

women, children and families, is necessary to ensure production and delivery of RH services. In practical terms, this means identifying and putting in place a set of actions that ensure that appropriate health goods and services are produced, financed, delivered and utilized in order to address all the challenges of high fertility and high maternal morbidity and mortality. The World Health Organization provides a useful framework which identifies the central elements of health systems strengthening in terms of a discrete number of six “building blocks” that make up the system: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance.⁶⁵ The World Bank Institute’s Flagship Program on Health Sector Reform and Sustainable Financing highlights five health system “control knobs” that, in appropriate combination, can address deficiencies in performance that relate both to the lack of essential inputs as well as the behavioral drivers of effectiveness and efficiency. These areas of policy design and implementation are financing, payment, organization, regulation, and persuasion. Financing refers to the ways in which funding is generated, pooled, and managed for health systems. Payment relates to the use of financial incentives for both providers and consumers. Organization is concerned primarily with the arrangements for health service delivery and the production of essential inputs to service provision such as pharmaceuticals, human resources, and physical infrastructure. Regulation encompasses the efforts, mainly by governments, to use laws and administrative rules to improve health systems and protect the public. Persuasion includes other approaches to behavior change for both providers and consumers, such as communications, social marketing, and the like. Together, these health system control knobs provide a menu of policy and action strategies that will be used by the Bank staff to design, plan, implement, and evaluate health systems performance for improving reproductive health outcomes.

53. The Bank's support for health system strengthening for reproductive health outcomes will seek an appropriate and client-focused balance of essential inputs and innovations for results. In developing strategies for health system strengthening, it is important to distinguish between the investments needed to ensure an adequate supply of essential inputs such as human resources, pharmaceuticals and supplies, and buildings and vehicles and the financing of strategies to improve the productivity, quality, and equity in the use of inputs. These latter strategies can include management improvements and a wide range of innovative approaches to improve performance through incentives and accountability mechanisms. The Bank supports both types of investments. Certainly many low income countries lack adequate levels of essential inputs and these must be increased to improve outcomes. Increasing inputs does not necessarily mean using traditional investment lending, especially since other types of lending instruments may be more appropriate and effective in many cases. The Bank will support innovative approaches to improve performance engaging with both the state and non-state sectors. These include strategies such as results-based financing, demand-generation strategies and demand-side financing, and strengthening community-based services and accountability.

54. It is widely recognized that skilled care at childbirth is most important for the survival of women and their babies, and availability of qualified and trained health personnel to assist deliveries is key to ensuring optimal pregnancy outcomes; yet one-third of all deliveries take place without a skilled attendant. While doctors are necessary for the management of most complications, health professionals “educated and trained to proficiency in

⁶⁵ WHO (2007): “Strengthening Health Systems to Improve Health Outcomes.”

the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns”.⁶⁶ are required to monitor pregnancies, detect complications, provide preventive measures, monitor the progress of labor during delivery, manage complications such as breech deliveries, provide post-natal care, counseling on postnatal contraception, and prevent mother-to-child transmission of HIV.⁶⁷

55. A key health system strengthening intervention, therefore, is to train new health workers and strengthen the skills of the existing health workers with midwifery skills and effectively deploy them. Training programs for traditional birth attendants have not yielded the expected results and have generally been unsuccessful in reducing maternal mortality. Working closely with all high-MMR countries, the Bank will focus on identifying the gaps in the availability of health workers skilled in midwifery as well as doctors with obstetric skills, task shifting and setting in place training programs aimed at meeting the shortage.

56. Bridging the health worker gap may require changes in the incentive systems governing the recruitment and deployment of health workers with midwifery skills and doctors with obstetric training. Policies and interventions that change the incentive structures typically involve using the “payment control knob” to change relative payment levels and realign incentives. One way of achieving this realignment of incentives is through results-based financing, which combines the use of incentives for health-related behaviors with a strong focus on results, and can support efforts to achieve the MDGs. Early evidence suggests that when health workers and facilities are paid according to achievement of targets, those targets tend to be met. In Haiti, a government scheme supported by USAID paid NGO health providers that agreed to reach certain targets such as proportion of children fully immunized and pregnant women receiving prenatal care. In the seven years that the program has been operating, huge improvements in key health indicators have been achieved (including a remarkable 13 percentage point increase in full immunization coverage). In Rwanda, the national government selected features from three donor-supported RBF pilots to construct a national, unified approach for paying public and NGO service providers based on services provided. Between 2001 and 2004, RBF provinces saw an increase in curative care visits per person from 22 to 55 percent and institutional deliveries nearly doubled (from 12 to 23 percent). Effectively, results-based financing moves funding away from inputs – salaries, construction, training, equipment – to results, and creates a whole new set of incentives for providers. This strategy would also be used for contraceptive services. In addition, the Bank recognizes that incentives to providers for family planning services also need to be studied. The Bank will commence work on developing programmatic guidelines to avoid negative consequences of incentives, based on past experience and knowledge. Using the recently established Norway and UK-funded Results-Based Financing Trust Fund, the Bank will support the aggressive use of results-based financing to modify incentives for skilled birth attendants and doctors so as to meet the 100 percent target for skilled attendance at birth. This strategy may also be extended to delivery of contraceptive services. This would need to be carefully implemented, to ensure that any negative consequence of incentives

⁶⁶ See “Making pregnancy safer: the critical role of the skilled attendant,” joint statement by WHO, ICM and FIGO, Geneva, World Health Organization, 2004.

⁶⁷ See “Making pregnancy safer: the critical role of the skilled attendant,” joint statement by WHO, ICM and FIGO, Geneva, World Health Organization, 2004.

for contraceptive services are avoided. Recognizing this, the Bank will commence work on developing programmatic guidelines based on past experience and knowledge.

57. Pregnancies that result in complications which cannot be addressed by skilled birth attendants need attention and treatment at well-staffed and equipped health facilities, settings in which many newborns who might otherwise die can also be saved. About 1 in 7 pregnancies results in a complication that would need this higher level of care, a statistic whose significance is further enhanced by the random and unpredictable nature of complications. Timing is critical in preventing maternal death and disability during these complications. Post-partum hemorrhage can kill a woman in under two hours, while for most other complications, a woman has between 6 and 12 hours or more to get life-saving emergency care. Similarly, most perinatal deaths occur during labor and delivery, or within the first 48 hours thereafter. The aspirational goal would thus be that all births should take place in well-equipped health facilities; in the short-run and until this is possible, it would be necessary to ensure that all women with complications have rapid access to emergency obstetric care if meaningful reductions in maternal mortality and morbidity are to be achieved. In areas where rapid access to such a facility is not possible, some countries have set up waiting homes near these facilities where women can spend several days before delivery so that obstetric care is available when needed. In Cambodia and Malawi, for example, high-risk mothers from remote rural areas are encouraged to stay in a safe and clean waiting home before delivering in the provincial hospital with all facilities. Joint guidelines and recommendations from WHO, UNICEF, and UNFPA have been issued for the number and type of emergency obstetric centers and well-equipped health facilities, and the Bank will support countries in the high-MMR, high TFR groups seeking resources to meet these guidelines. Existing facilities can often, with just a few changes, be upgraded to provide emergency obstetric and newborn care, and the Bank will support countries in identifying and refurbishing these facilities.

58. At the same time as supply-side issues are addressed by training new health workers and redeploying existing health workers, it is also important to promote awareness of pregnancy-related health risks and enhance the care-seeking behavior of pregnant women. Results-based financing has also been shown to help to increase patient demand for health services. Evaluations of large-scale conditional cash transfer programs in Latin America and the Caribbean show increases in the use of clinic services for children (Honduras, Nicaragua, Colombia) and prenatal care (Mexico, Honduras) and decreases in childhood stunting (Mexico, Nicaragua, and Colombia). In 1997, Mexico introduced *Oportunidades*, a large-scale conditional cash transfer (CCT) program, aimed in part at improving birth outcomes by providing cash transfers to beneficiary households conditioned on pregnant women's completing at least four antenatal care visits, two post-partum care visits, and attending health and nutrition lectures. A key objective of both the educational sessions and the meetings with the elected beneficiary representatives was to inform beneficiary women of their right to social services and to empower women on how to make the best out of their interaction with health care providers. The payment mechanism is cash at program-specific payment points, and program compliance is via certification at public clinics and schools. The program's average cost per family beneficiary of \$4.67 was affordable given that the total program budget of US\$2.8 billion (by 2005 for a total of five million household beneficiaries) represented less than 1 percent of Mexico's GDP. Numerous evaluations of Mexico's *Oportunidades* program have shown that this program

increased utilization of health services and improved maternal health outcomes. The Bank will support countries in high MMR and high TFR groups planning to introduce CCTs to influence patient behavior and increase utilization of maternal health services.

59. A reliable and adequate supply of good-quality contraceptives, including intrauterine devices (IUDs), oral contraceptives, condoms, emergency contraceptives, and injectables, is essential for reproductive health services. Increasing demand for contraceptives, shortage of funds and weaknesses in the supply chain are all contributing to the inability of many developing countries to maintain a secure supply of contraceptives. The Bank will work closely with country governments, agencies and partners such as USAID, UNFPA, UNICEF and the Reproductive Health Supplies Coalition (RHSC) to establish robust logistics, regulatory, and quality assurance systems – all of which are key elements of a strong health system – to minimize stock-outs, shipment delays, and under- or over-supply of certain contraceptives.

60. Integrating HIV prevention into RH services provides an essential entry point to improve health and behavior outcomes, reduce sexual transmission and maternal mortality, as well as mother to child HIV infection. Without intervention, 1 in 3 children born to an HIV infected mother will be infected. In 2008, 430,000 babies were born with HIV in Africa. Evidence shows that timely administration of antiretroviral prophylaxis to HIV-positive pregnant women significantly reduces the risk of HIV transmission to their babies. Currently, only 45 percentage of HIV-positive pregnant women are receiving antiretroviral therapy prophylaxis in low- and middle-income countries. Integrated HIV prevention and SRH services can provide dual protection for women attending antenatal care clinics: HIV prevention and birth control. In India's high HIV prevalence Southern and Western states, Bank supported targeted interventions among sex workers and their clients have helped to reduce HIV prevalence among young women attending antenatal clinics by approximately 50 percent. Prevalence has gone down from about 2 percent in 2000 to less than 1 percent in 2007.

Focus on Reaching the Poor

61. There is widespread evidence that poor people suffer from far higher levels of morbidity, mortality, and malnutrition than do the better-off; and their inadequate health is one of the factors keeping them poor or for their being poor in the first place. An analysis of DHS datasets shows that there is a strong correlation between maternal health and poverty, and that services related to reproductive health were more inequitable than any other cluster of services, suggesting that the public health sectors were failing to protect poor women in many parts of the developing world. The analysis shows that the poorest women have almost double the number of children as the wealthiest (the poorest adolescents are 2.4 times as likely to give birth as the wealthiest) and the wealthiest women are two-and-half time more likely to have trained delivery attendance as the poorest.⁶⁸

62. Poor reproductive health outcomes contribute to poverty in a number of different ways, but mainly through their negative impact on overall health. In addition, large family

⁶⁸ Greene, ME and TW Merrick (2005), *Poverty Reduction: Does Reproductive Health Matter?* HNP Discussion Paper Series, Washington, DC: World Bank

size promotes poverty by slowing economic growth and distorts the distribution of income to the detriment of the poor. Early childbearing disrupts schooling and affects future employment opportunities for female adolescents. Adolescent mothers also tend to have poorer health during pregnancy, through less use of healthcare services and biological constraints associated with their age. Table 4 shows the inequalities in utilization of modern family planning methods in four countries. The poor also use considerably less of the basic maternal and health services – such as antenatal care, oral rehydration therapy, immunization, attended delivery, treatment of fever, etc. – than the rich.

Table 4. Percent of currently married women (15–49) using a modern family planning method

Wealth Quintiles	Malawi (2000)	Zambia (2002)	Kenya (2003)	Guatemala (1999)
Poorest	19.8	10.8	11.8	5.4
Second	24.2	13.2	24.2	11.9
Third	24.9	19.7	33.4	24.5
Fourth	25.3	31.3	41.0	45.0
Richest	36.2	52.5	44.5	59.7

63. Proactively pursuing strategies that ensure access to family planning and maternal services among the poor can succeed in reducing inequality and improving health status of women in the lower wealth quintiles. Bolivia has aggressively implemented social insurance schemes which have ensured access to reproductive health services for all women of reproductive age, including the poor. This has been supported by a strong supply-chain system that ensures the arrival of products to remote service delivery points. As a result, births in health facilities have increased in the last decade and there have been marked decreases in inequality in use of family planning and antenatal care services. On the other hand, countries such as Guatemala, which have not been as aggressive in pursuing strategies to ensure access to reproductive health services for the poor, continue to have huge inequalities in access and use. Recent legislation in 2004 mandating that 15 percent of the tax on alcoholic beverages be used for reproductive health, family planning, and alcoholism programs has started improving access, but the momentum would need to be sustained for a longer time period for a significant change in utilization levels among the poor.

64. The link between reproductive health and poverty reduction has important implications for policies and program responses in developing countries. Yazbeck (2009) outlines a menu of pro-poor policies that provides a useful framework for thinking about potential interventions in areas of financing, provider payments, organization, regulation and persuasion, and highlights the scope of the impact of these interventions at the macro level, health system level and the micro community and facility level (Table 5). Box 3 provides a number of success stories of interventions implemented in a number of low-income countries, which can also be tailored to specifically meet the reproductive health of women in lower wealth

quintiles.⁶⁹ The Bank will provide technical assistance and support to countries in their effort to reach women in the lower two wealth quintiles and ensure that they have access to the full range of maternal and family planning services.

Table 5. Menu of pro-poor policies

	<i>Finance</i>	<i>Provider Payment</i>	<i>Organization</i>	<i>Regulation</i>	<i>Persuasion</i>
Macro level (overall policy and finance)	Expand insurance coverage for the poor Geographic targeting (allocation) Needs-based targeting (allocation) Targeted conditional cash transfers (the cash part)		Integrated approaches (health, safety nets, education roads, and so on)	Monitoring tools (Public Expenditure Reviews/Benefit Incidence Analysis) Poverty map creation and update	Charter of rights for the poor Targeted conditional cash transfers (the conditional part)
Health system level	Level of care targeting (allocation-input balance) Voucher systems for the poor	Contracting incentives to serve the poor Equity-related performance-based allocation Hardship payments for locating providers	Pro-poor benefits package Balanced human resources allocation	Standards for facilities serving the poor Input market regulation (drugs, equipment and the like)	Social marketing Health education focus Strengthening outreach Prioritizing demand generation
Micro level (community)	Exemption policies for	Provider payment	Local or community	Local or community	Community mobilization

⁶⁹ Yazbeck, Abdo S. (2009): Attacking Inequality in the Health Sector – A Synthesis of Evidence and Tools; The World Bank, Washington DC.

and facility)	the poor	linked to use by poor	management of services	oversight	Health education campaigns
	Facility equity funds	Community-based mechanisms for identifying the poor	Participatory planning Campaign mode delivery Mobile delivery Approaches	Supervision of facilities serving the poor Active identification of the poor	

Source: Yazbeck, Abdo S. (2009)

Box 3. Reaching the Poor -- Lessons from Success Stories

Finance Reforms—Both Resource Mobilization and Allocation

1. *Delink payment by the poor from use.* In a number of evaluated reforms, policy actions decreased inequality if they minimized or eliminated the financial disincentives for poor households to seek care. Examples include expansion of health insurance coverage to the poor (Colombia, Mexico, Rwanda) and fee exemption mechanisms for cost recovery (Cambodia health equity funds, Indonesia health card program).

2. *Make the money follow the poor.* Some of the successful reforms reviewed included policy actions that reoriented resource allocation mechanisms to serve the poor. Examples include geographic targeting (Brazil), targeted conditional cash transfers (Chile, Mexico), vouchers, and targeting facility levels that serve the poor (the Kyrgyz Republic).

Provider Payment Reforms

3. *Link provider payment to use by the poor.* The growing literature on the impact of reforms shows that creating explicit links between provider compensation and service use by the poor decreases inequality. Examples include incentives to municipalities to increase use by the poor (Brazil), incentives to contracted nongovernmental organizations (NGOs) that reach the poor and payment to hospitals serving the poor (Cambodia).

Organizational Reforms

4. *Close the distance between the poor and services.* The case studies confirmed that reforms that brought services geographically closer to the poor had a positive impact on inequality. A number of programs defined a benefits package to serve the needs of the poor (Brazil, Cambodia contracting, Colombia, Mexico, Nepal, Rwanda). Social distance between providers and the poor is also an important factor. Effective methods to close the social distance in health services include use of familiar and trusted community members to provide health services (India Self-Employed Women's Association), engagement of the community in service management (Rwanda), and collaboration with the community in program design.

Regulatory Reforms

5. *Amplify the voice of the poor.* A number of the evaluated policies successfully reduced inequality by engaging the poor in the design and implementation of health sector reforms. Examples include participatory planning (Nepal), community oversight (Rwanda), community identification of the poor (Cambodia health equity fund), research on the needs and preferences of the poor (Tanzania), household-level planning (Chile), and community mobilization (Kenya).

Persuasion Reforms—Behavior Change

6. *Close the gap between need and demand by the poor.* Closing the need-to-demand gap may require information, persuasion, and incentives. Examples include conditional cash transfers (Chile and Mexico), social marketing (Tanzania), and outreach health education (Brazil, Cambodia, Chile, and Kenya).

Source: Yazbeck, Abdo S. (2009): Attacking Inequality in the Health Sector – A Synthesis of Evidence and Tools; The World Bank, Washington DC.

Focus on Adolescents

65. More than half the youth in many countries are sexually active.⁷⁰ Among sexually active young men and young women, the use of condoms is low, increasing their risk of acquiring STIs. Demographic and Health Survey data show that the share of sexually active boys using condoms ranges from a high of 50 percent in Zambia to about 20 percent in Mali. Among girls, condom use is higher among unmarried sexually active girls than among married girls.⁷¹ As mentioned earlier, people under the age of 25 account for over 100 million STIs annually. Most STIs are easily treated, but many go unnoticed, and when the effects become apparent, many of the young people may not even seek the services, fearing prohibitive costs, refusal, and judgmental facility staff.⁷² The Bank will support countries to improve access to reproductive health services for the youth, especially for the treatment of sexually transmitted infections.

66. Service providers often ignore reproductive issues not because they discount their importance, but because they may not know how to talk about reproductive and sexual health concerns in sensitive and engaging ways, especially with the youth. It is critical that young people get knowledge on ways to prevent unwanted pregnancy and information on contraceptive methods and reproductive health services. Information and services could be delivered through youth friendly health services programs and school programs for both in- and out-of-school adolescents. The Bank will work closely with countries and development partners in providing training to doctors and nurses to deal with the special reproductive health needs of young clients.

⁷⁰ Singh, Susheela, and Jacqueline E. Darroch. 2000. "Adolescent Pregnancy and Childbearing: Levels and Trends in Developed Countries." *Family Planning Perspectives* 32(1):14–23.

⁷¹ World Development Report (2007): Development and the Next Generation, The World Bank, 2007

⁷² Stanback, John, and K. A. Twum-Baah. 2001. "Why Do Family Planning Providers Restrict Access to Services? An Examination in Ghana." *International Family Planning Perspectives*, 27(1):37–41.

67. Of the estimated 200 million pregnancies that occur every year, some 20 million end in unsafe abortions which put women at substantial risk of lasting injury or death. In low-income countries where abortion is restricted or illegal, deaths from unsafe abortion practices can be substantial, accounting for 13 percent of maternal mortality globally, and in some countries as much as 25 percent of maternal deaths are due to unsafe abortion.⁷³ At least one-fourth of the estimated 20 million unsafe abortions per year are performed on women aged 15 to 19.⁷⁴ Consequently the Bank considers that unsafe abortion is a serious public health issue for women and supports family planning services, including emergency contraception, which helps to prevent or reduce unsafe abortion as part of a country's basic health program. In addition, access to safe abortion services and post-abortion care will greatly reduce the health risks to women of unplanned pregnancies. Where countries permit abortion and request help, the Bank will support their national efforts to provide safe abortion and post-abortion services to women. In addition to expanding information/knowledge about family planning and avoiding HIV/AIDS and sexually transmitted infections, the Bank will help countries to motivate young women to stay in school and pursue their studies and acquire life skills before starting their families.⁷⁵

Working with partners and civil society

68. Guided by the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, the Bank will work closely with partners to support country-led health system strengthening strategies to produce, finance and deliver and increase utilization of reproductive health services. With just five years left until 2015, many countries are still struggling to achieve the vastly better health results and development potential signified in the MDG targets. Progress has been especially slow in achieving MDG 5, and it is important that reproductive health strategies and actions are strongly aligned with national systems in their design and implementation so as to maximize the synergies and potential outcomes.

69. Besides national ownership and alignment with national systems, the implementation of the RH Action Plan at the country level will be guided by the IHP+ focus on results, harmonization among development partners at the country level and country systems, and mutual accountability among all stakeholders in the existing national planning and monitoring processes. Better and coordinated use of existing and new funds will improve results on the ground, while better and improved coordination among development partners will reduce fragmentation and avoid duplication. The RH Action Plan will benefit from ongoing efforts by the GAVI Alliance, Global Fund, World Bank and World Health Organization to develop a Health Systems Funding Platform, which aims at supporting country progress towards national health goals and the MDGs. Mobilizing and streamlining the flow of existing and new international resources to support health systems components of national health

⁷³ World Health Organization, 2004. *Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2000*. Geneva: World Health Organization.

⁷⁴ Lule, Elizabeth, Singh, Susheela; Chowdhury, Sadia Afroze, 2007. Fertility regulation behavior and Their Costs: Contraception and unintended Pregnancies in Africa, Eastern Europe and Central Asia; World Bank, 2007.

⁷⁵ This section draws heavily on World Development Report (2007): Development and the Next Generation, The World Bank, 2007, which makes a compelling case for investing in the youth, including in health and education.

plans will strengthen country capacity to deliver RH programs to all, especially the poor and vulnerable sections of the society.

70. Together with UNFPA, UNICEF, and WHO, the Bank as a part of the H4, is committed to work with country governments and civil societies to strengthen national capacity to achieve MDG 5. Building on its core competency and areas of comparative advantage, the Bank will use its unique leveraging position to maximize individual and collective efforts to tackle the root causes of maternal morbidity and mortality.

V. Results Framework

71. This Action Plan will contribute to reducing high fertility, improving pregnancy outcomes, and reducing STIs particularly in the countries with high MMR or TFR. This will be achieved chiefly through efforts directed at helping countries develop strong and robust health systems by focusing on the five areas noted earlier. Several inputs, processes, and output indicators will be used in the lead up to the desired outcomes. Table 6 presents the results framework for this RH Action Plan, which is closely aligned with the country outcomes, intermediate indicators, and processes included in the HNP Sector Strategy.

72. The Results Framework shown in Table 6 has three tiers. The first tier includes country-level development outcomes, which are final outcomes (such as declines in mortality and fertility) that are determined by action in many sectors, the overall macroeconomic environment, and technological change. The second tier covers indicators measuring Bank outputs and outcomes that, together with the activities of countries and development partners, lead to improving coverage with interventions known to contribute to country outcomes. Indicators in the second tier will be disaggregated by age, poverty quintile, and urban-rural, when data are available to do so. The third tier lists Bank activities and concrete actions to improve its efficiency, quality and effectiveness that will enable intermediate coverage indicators to be achieved.

73. In order to assist the countries in the renewed push toward meeting MDG 5, the Bank will take steps to strengthen its capacity and expertise across a number of core competencies. Specifically, the Bank will seek to increase its expertise base by training existing HNP specialists in reproductive health issues, identifying RH focal points in all Bank regions, and hiring new HNP specialists with expertise in reproductive health. The Bank's Africa region has already initiated the development of a population and reproductive health strategy for the region (see Annex B). Further, the Bank will increase the emphasis on analytical work in order to provide the basis for assisting countries, inform policy dialogue, and for raising awareness on RH issues. Examples of analytical work include analysis of country-specific constraints for RH; tracking of resource flows for RH and identification of financing gaps; and documentation of success stories and "good practices" in an effort to learn from the positive experiences. Additionally, the 2012 World Development Report which will focus on *Development and Gender Equity* will also ensure the inclusion of reproductive health issues. The Bank will target to increase the level and effectiveness of lending and support for health systems strengthening and multi-sectoral interventions to address reproductive health in priority countries.

74. In addition, the Bank will focus on improving data collection and monitoring of trends in fertility and maternal mortality. The use of new information and communication technologies holds promise for improving timely referrals, health records, and computerized decision support. This will require investing in efforts to improve civil registration systems in countries, which are currently too incomplete to provide useable information on vital statistics in the majority of countries. Strengthening such systems is a challenge that will take time to address, but it is widely recognized that such efforts are key to improving countries' overall statistical development in many areas.⁷⁶ To address the data gaps in the meantime, several other data collection tools will be incorporated into the Bank's lending, including household surveys, facility surveys, and public expenditure tracking surveys.

⁷⁶ P Mahapatra SD, Kenji Shibuya MD, AD Lopez, F Coullare, FC Notzon, C Rao, S Szreter (2007) "Civil registration systems and vital statistics: successes and missed opportunities", The *Lancet*, Volume 370, Issue 9599, Pages 1653 - 1663, 10 November 2007

Table 6. Results Framework for Reproductive Health Action Plan

1. COUNTRY DEVELOPMENT OUTCOMES	
PRIORITY AREA	INDICATORS and TARGETS^a
Reducing high fertility	Total fertility rate reduced (<i>HNP Sector Strategy indicator</i>)
Improving pregnancy outcomes	Maternal mortality ratio reduced (<i>HNP Sector Strategy indicator</i>)
Reducing STIs	Reduced morbidity and mortality from HIV/AIDS and other priority STIs (<i>HNP Sector Strategy indicator</i>)
2. HOW THE BANK CONTRIBUTES: INTERMEDIATE OUTCOME INDICATORS	
PRIORITY AREA	INDICATORS and TARGETS^a
Reducing high fertility	Adolescent fertility rate in target countries reduced ^b (<i>HNP Sector Strategy indicator</i>)
	Contraceptive prevalence rate increased to allow women to reach desired family size (<i>HNP Sector Strategy indicator</i>)
	Number of target countries with reproductive health strategic plans incorporated in national health strategies
	Number of target countries with no stock outs of contraceptives in the preceding year
Improving pregnancy outcomes	Births attended by skilled health personnel in target countries increased (<i>HNP Sector Strategy indicator</i>)
	Newborns protected against tetanus in target countries increased (<i>HNP Sector Strategy indicator</i>)
	Pregnant women receiving prenatal care in target countries increased (<i>HNP Sector Strategy indicator</i>)
Reducing STIs	Pregnant women living with HIV who received antiretroviral to reduce the risk of MTCT increased
	Number of target countries promoting contraceptive availability for HIV positive women increased.
	Number of target countries with programs on STI prevention, treatment, and counseling for adolescents (both male and female) increase

3. AGENCY EFFECTIVENESS: WORLD BANK ACTIVITIES' THAT CONTRIBUTES TO COUNTRY AND INTERMEDIATE OUTCOMES			
	ACTIVITIES	INDICATORS & TARGETS	RESPONSIBILITY
Analytical and Advisory Activities to facilitate policy dialogue	Conduct analytical work to identify country specific RH constraints to feed into Country Assistance Strategies (CASs) and lending operations.	Percentage of CAS's scheduled for 2010-2015 that have been informed by country-specific gender analysis including reproductive health in target countries (Target: 100%) ^b	PRMGE, HDNHE, HNP Regions
		Percentage of health projects scheduled for 2010-2015 in countries with high MMR or high TFR that address high fertility or maternal mortality (no target but track annually)	HDNHE, HNP Regions
	Track resource flow for RH and identify financing gaps for RH using NHA framework	Number of RH National Health sub-accounts developed for selected countries (track annually)	HDNHE, HNP Regions, Development Partners
	Conduct and disseminate Regional Flagship AAAs in Africa, Europe and Central Asia region, South Asia., Middle East and North Africa, and East Asia and Pacific regions , addressing RH Issues	Disseminate the South Asia report <i>Sparing Lives</i> (by Dec 2010).	SASHD
		Africa Region Flagship report completed and disseminated (by Dec 2012)	AFTHE
		Europe and Central Asia region Flagship report completed and disseminated (by Dec 2012)	ECSHD
		East Asia and Pacific region Flagship report completed and disseminated (by Dec 2011)	EASHH
		Middle East and North Africa region Flagship report completed and disseminated (by June 2013)	MNAHD

	Ensure reproductive health issues are included in the 2012 World Development Report <i>Development and Gender Equity</i>	RH issues incorporated in 2012 World Development Report <i>Development and Gender Equity</i>	DEC, PREM, HDNHE , HNP Regions
	Develop case studies to document success stories and best practices	Number of case studies reports disseminated (ongoing)	HDNHE, HNP Regions
Develop Bank capacity and expertise in RH			
	Establish RH expert team including representation from other sectors	Expert team on RH Issues , including representatives from PREM, DEC, education, and other relevant sectors established (by June 2010)	HNP Sector Board
	Strengthen skills of existing staff in RH and recruit new staff as necessary	RH focal points in all Bank regions identified.	HNP Sector Board
		Recruit new HNP specialists with strong skills in RH for Africa, South-Asia and HDNHE as required by operational needs	HNP Sector Board
	Develop and disseminate FAQs/guidance notes for addressing RH constraints	FAQs/guidance notes developed, disseminated and available on HNP website (ongoing)	HDNHE, HNP Regions
	Review and strengthen the existing Flagship Course on RH	Number of TTLs in countries with high MMR or high TFR who have completed flagship courses (track annually)	HDNHE, WBI, HNP Regions
	Develop learning session for HDN learning week	Short Course on Reproductive Health delivered during the Nov 2010 learning week	HDNHE, HNP Regions
	Development marketplace for RH	Conduct Development Market place in RH in Africa and South Asia regions	SAR, AFTHE, HDNHE

Improving portfolio Monitoring			
	Prepare Monthly updates of the list of pipeline projects and CASs to identify countries for AAAs and RH technical support	Matrix of list of pipeline projects and CASs shared with regional RH focal points monthly	HDNHE, HNP Regions
	Prepare Monthly updates of the list of ongoing projects to identify projects due for MTRs and ICRs	Matrix of list of projects with upcoming MTRs and ICRs shared with regional RH focal points monthly	HDNHE, HNP Regions
	Develop a list of countries with high MMR or high TFR that do not have current or pipeline projects for AAAs or policy dialogue with countries	Matrix of list of countries without current or pipeline projects shared with regional RH focal points monthly	HDNHE, HNP Regions
	Track key RH indicators (as identified earlier) by poverty quintiles in countries with high MMR or high TFR	List of RH indicators for monitoring country RH outcomes developed and annually updated	HDNHE, HNP Regions
	Participation in Quality Enhancement Review (QER) Panel of projects under preparation with PopRH theme in countries with high MMR or high TFR	Number of panels with RH expertise participating in QERs (ongoing)	HNP Quality team, HDNHE, HNP Regions
	Participation in Midterm reviews or ICRs of health projects with PopRH theme in countries with high MMR or high TFR	Number of midterm reviews with RH expertise participating in each MTR or ICR (ongoing)	HNP Quality team, HDNHE, HNP Regions

^aThe country level reproductive health outcomes do not have targets as countries and other development partners will also contribute to these outcomes.

^bIn the Results Framework for GENDER in IDA16 (Operational Policy OP4.20 stipulates gender assessments in all CASs

ANNEX A

Consultations on the Reproductive Health Action Plan

MAIN OUTCOMES OF EXTERNAL CONSULTATIONS

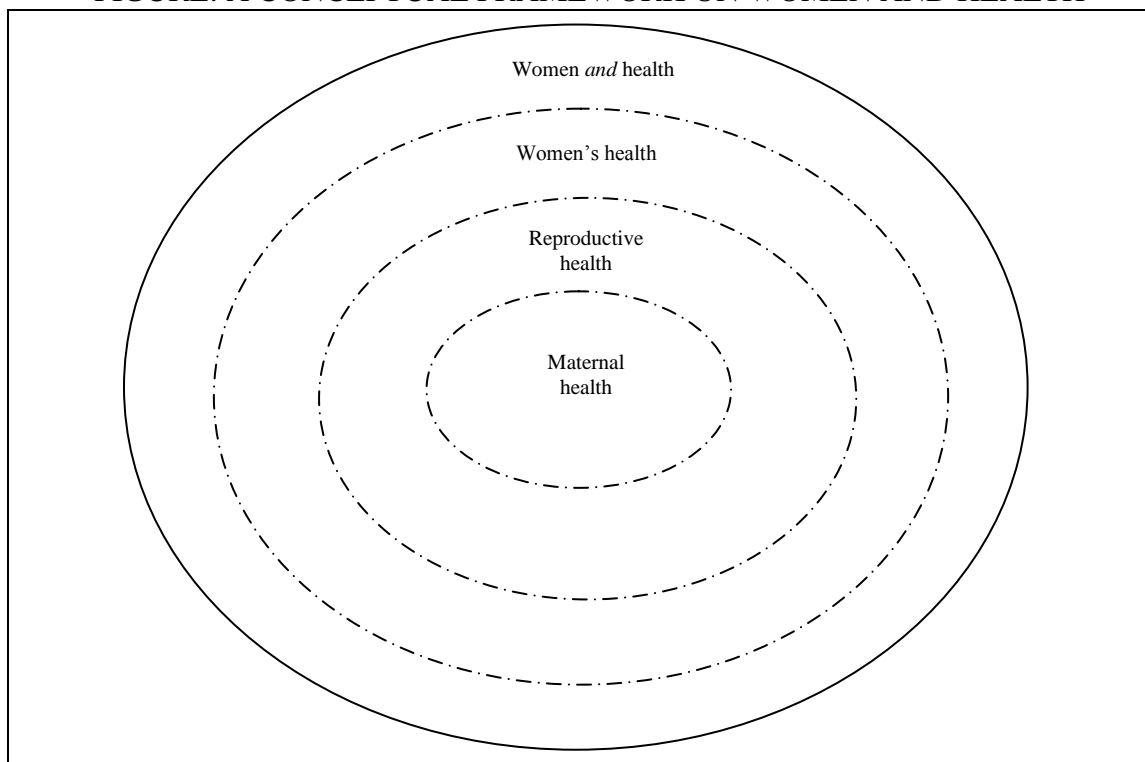
The Reproductive Health Action Plan has been developed through a consultative process. Four consultations were held with donor organizations, UN agencies, academia, think tanks and civil society organizations. The main outcomes of these consultations include:

1. Conceptual and definitional issues

- The World Bank's definition of sexual and reproductive health includes pregnancy and pre-pregnancy related care, neonatal care, contraception, delivery, post-partum, STIs, and building linkages with HIV/AIDS and with gender and youth.
- RH should not be framed purely as a health issue. It is important to recognize and leverage cross-sectoral linkages (transport, communications, gender esp. women's empowerment, girls' education, and human rights, and poverty) in addressing reproductive health. This is an area where the World Bank has a comparative advantage.
- The 1994 ICPD was a unique event and central to establishing definitions and concepts of reproductive health. One major innovation was incorporating human rights into health. The field has moved forward since then in different ways – towards sexual health, women and health, human rights, and health systems.
- The discussion on ICPD 1994 refers to a shift in focus from reproductive health because of the broader human rights frameworks posed by ICPD 1994. While this can be misinterpreted as a criticism of ICPD 1994 POA, it in fact highlights a reality.
- ICPD was a compromise that brought together a variety of stakeholders. Within the ICPD, three different frameworks resonate with stakeholders and how they translate into policy: women's rights, public health, and population growth/demography.
- Cairo's concepts were broad – Cairo is not a convention or treaty, but a normative statement that was debated by governments. This breadth is a strength for bringing together different political constituencies, but it has also generated a series of issues and challenges. These range from confusion over program components, particularly in the relative emphasis to place on family planning, to measurement problems over inputs and results. In the World Bank's Action Plan, there is a need to be specific without being reductionist.
- A critical challenge coming out of ICPD's broad approach is in how to set priorities in country programs. Reproductive health programs have long struggled with developing effective measurement tools to assist with priority setting. The unfinished agenda of the MDGs provides a focus for current efforts, but in the longer term, ICPD encompasses emerging agendas such as linking reproductive health to non-communicable disease.

- Language and word choices matter in the signals they give to partners, emphasizing the need for conceptual clarity. Reproductive health encompasses some profound ideological differences, and the use of certain language can be perceived to legitimize activities seen as controversial. Scientifically derived evidence can be a good arbiter in these ideological discussions.
- One way to think about how to bridge the multiple concepts that Cairo brought together in an actionable way is to envision a series of concentric circles (figure below). This framework could emphasize the message that the World Bank has responded to the ICPD's broad consensus because it considers women and women's rights at the outer circle but then focuses in to maternal health and attempts to drive specific changes in concrete measurable outcomes.

FIGURE: A CONCEPTUAL FRAMEWORK ON WOMEN AND HEALTH



- At the same time, role of men as decision makers at the household level, and as partners in choices about family planning needs to be incorporated into the framework.
- Resources for reproductive health and family planning have stayed flat in recent years and not met Cairo goals. The challenges of tracking resources for reproductive health have been made more difficult by a lack of definitional clarity over reproductive health and its sub-components.

- The World Bank remains committed to ICPD, a commitment re-affirmed in its 2007 HNP strategy. The Bank's approach is to start from ICPD, but within that, the Bank's comparative advantage is through a public health and health systems approach. From there, the World Bank can build links to related sectors supporting women's empowerment and gender equality that support ICPD. The final decision about the types of interventions on RH rests with the countries and would consider social and cultural issues. In that respect, engaging in dialogue based on scientific research can yield more convincing results.

2. Using the health systems strengthening platform

- Health systems strengthening (HSS) has developed out of the tensions between vertical/disease-specific programs and horizontal/system-wide programs. Many global health initiatives have hesitated to use system-wide approaches out of a concern that the health system is a black box, a black hole, and/or a laundry list. Vertical programs, meanwhile, can create parallel structures that are disruptive to the creation of an effective country health system.
- Health systems strengthening needs to happen, but should be biased towards sexual and reproductive health – the outcomes will be dramatic. A diagonal approach seeks to focus on using investments on specific interventions such as reproductive health interventions to strengthen health systems. This approach maintains the focus of the global health community on achieving results for definable outcomes while investing in the development of necessary systems.
- HSS and the diagonal approach are appropriate strategies in which the Bank can fulfill its reproductive health commitments while building on its comparative advantages. One recommendation in implementing the diagonal approach would be to have HSS interventions as the main framework, with the diagonal approach coming in to look at reproductive health outcomes that guide these interventions.
- The development of a package of service and entitlements is a core tool for the diagonal approach. Every good package should have “a clinical overview” with capabilities at least for diagnosis, palliation and referral. Rather than an aggregation of interventions, in the diagonal approach the package is a resource allocation tool that considers workforce, information and other inputs and processes needed to implement the package.
- Using the language of entitlements in designing a package of services is a concrete step to take in implementing a human rights approach. This makes the rights approach operational because these entitlements can be acted upon.
- There is a need to quantify and address the potential spillover effects of HSS for reproductive health. The family planning community has done a good job of articulating the multiple benefits of family planning. To be able to demonstrate the broader impact of work done in a narrow spectrum would provide compelling evidence to ministries of health and finance.
- Strengthening health information systems is a necessary part of HSS. For the case of maternal mortality, this could mean starting with better case-finding and estimates. At the

beginning, this could lead to higher estimates of maternal mortality but the end result of more accurate estimates is a stronger health information system. This is a clear example of the spillover effects. Capacity development in countries in HMIS/data collection, analysis and use-training for countries in this should be in the plan.

- Governance and accountability of health systems are also key issues. The Action Plan needs to detail how exactly the Bank will work with countries on governance issues. Some suggestions on this include focus on process of decentralization of services delivery; system of peer review.
- There are several pitfalls to be aware of in adopting HSS as a core framework. It is possible to lose some focus on the immediate needs and requirements of strong reproductive health interventions in the push towards systems strengthening. And as HSS becomes more mainstreamed, there is a danger of duplication or verticalization of HSS as its own separate program, rather than a key theme linking a range of global health agendas.
- Effective coverage was proposed as a possible measurement approach to adopt in assessing progress on HSS for reproductive health. Rather than focus on an ultimate outcome, i.e. maternal mortality, which is difficult to monitor on a day-to-day basis, effective coverage focuses on those interventions that have been proven to be highly correlated with positive outcomes. By measuring this process, it is possible to get an approximate measure of the outcome.
- Building these metrics will require further research on the effectiveness of core reproductive health interventions, such as skilled birth attendance. Filling this knowledge gap will be a global public good. The perfect, however, should not be the enemy of the good, and implementation of the World Bank's Action Plan should not wait on the development of ideal metrics.
- Other donors are also grappling with these challenges. USAID, for example, has the idea of a dual-track approach that focuses on identifying quick wins along with longer term investments. Coordination across agencies and donors implementing HSS is needed to avoid confusion as to what country can apply for resources and from whom and how the assistance platform is designed.
- There are many successful examples of functioning vertical RH programs that should also not be ignored or dismantled. Instead focus should be on how these can be successfully integrated into health systems.
- In countries like Nepal, with hard to reach remote areas, about 80 percent of births are home deliveries. Reaching health facilities and SBAs is hard. Expecting them to have access to facility based service delivery is unrealistic. There needs to be a clear strategy on how to best reach women in these remote pockets successfully. Low-cost high output community-based approaches may be most efficient for reducing TFR. For example, in Nepal there are a large number of female community health volunteers. Training them to provide injectable

contraceptives at the community level would be a fast and efficient way to increase contraceptive use/reduce unmet need.

- Health policy in many developing countries restricts reproductive health services doctors only, including very simple ones such as counseling women on the best form of family planning. However, nurses and mid-level providers, given the right training, are perfectly capable of providing family planning counseling, inserting and removing IUD, and indeed all the essential components of emergency obstetric care. Task-shifting downwards and changing health policy so that mid-level providers can access training and legitimately provide reproductive health services would remove an enormous bottleneck.
- While ensuring contraceptive supplies and logistics including supply chain management is area of comparative advantage for Bank, Support should also be provided for procurement of contraceptives. Advised to avoid the long lead time necessary for Bank procurement; use of UN partners such as UNFPA/UNICEF etc for this.
- Many of the drivers of poor reproductive health are the same as the drivers as HIV infections and the responses often overlap, particularly with family planning programming and HIV prevention programs. Combining these services has benefits in terms of efficiency as well as reaching women living with HIV, and PMTCT. These linkages should be made stronger in the Bank's strategy.
- A major bottleneck is that public health services have given very low priority to reproductive health in the past, and as such a lot of reproductive health provision exists in the non-state sector. There are many NGOs and private healthcare providers providing reproductive health services. Supporting governments to regulate these non-state providers, incorporating them into the public sector has potential for creating greater synergies in reaching the target populations.
- Action Plan has to also recognize and leverage the private sector's involvement in reproductive health, especially since in most of the focus countries the private sector is the primary source of services. There is also a need to recognize that the private sector is not monolithic, so approaching this through market segmentation is necessary.

3. Stewardship

- Maternal mortality has not received the attention it deserves. This is due to several reasons that need to be addressed. There is a lack of political will because of a lack of will to talk about anything related to sex. The perception problem exists within the United States as well (e.g. Members of Congress questioning need to include maternity care in the US health bill); Secretary of State, Hillary Clinton, really gets this issue and is one of the main reasons why the US is including maternal health in new policies. Her leadership should be leveraged to help further this cause.

- Role of men in RH as decision makers in political legislature was also brought up. There is a need for their capacity development and technical engagement to really try and educate the political leadership on the needs to address some of these issues.
- Buy-in has to come from members of parliament as well as NGOs and civil society organizations in order to have the ownership in setting priorities, especially for reproductive health and sexual and reproductive health. This requires at a minimum access to decision making procedures if not a place at the decision making table. In this regard beginning with a matrix of options that gives structure and priority would be a useful tool.
- There is a need for legal frameworks surrounding RH for several reasons. Legal frameworks should ensure (a) reproductive health as a right in all the nations through long-term commitment of state governments to ensuring safe-motherhood and other reproductive health rights; (b) training for non medical staff for provision of reproductive health services in vital in countries like Nepal. These legal frameworks should be flexible enough to be able to review and meet new challenges for meeting the demand for services. The Bank has a role to play here - inclusion of RH within the social protection programs for example may be useful.
- The problem also exists with the current priority-setting tools employed that measure the burden of disease and maternal mortality doesn't rank high when compared to malaria, TB, etc. There is a need to develop/employ better tools that accurately assess the impact of maternal mortality and morbidity on countries' development. Employment of DALYs as a measure of lost productivity due to RH related mortality and morbidity is one option.
- Health systems have several functions, and the function of service provision is part of the larger system. The weakest health system function in many countries is the stewardship function. Lack of strong stewardship creates situations where health workers at the end of the line receive uncoordinated approaches and donors completely bypass local structures.
- Using the diagonal approach requires planning and priority setting skills, important features of the stewardship function. In the World Bank's 28 priority countries, the ability to build a plan at the national level and set priorities may be particularly lacking.
- The H4, which includes the World Bank, has a window of opportunity to deliver as one on maternal and child health; and to provide the leadership needed to achieve the MDG-5 targets. The Bank has a very central role within this work.

4. Strengthening the role of Ministries of Health

- One of the key strategies in the diagonal approach is to strengthen the Ministry of Health to improve stewardship. The World Bank has played this role previously with Ministries of Finance and has a comparative advantage in stewardship and governance.
- Strengthening Ministries of Health can contribute to operationalizing health systems strengthening at the local level by improving coordination and communication about priorities.

5. World Bank's role in Advocacy and Resource Tracking

- The World Bank has a convening role to play in stimulating global dialogue on reproductive health. This could reenergize discussions of the theoretical understandings of linkages between reproductive health and development as well as considerations of how to operationalize reproductive health at the country level.
- The need for funding was brought up in all consultations (e.g. by civil society in Guatemala, especially in reference to reaching indigenous populations). The Bank has a role in advocating with partners for reallocation of resources within the existing health system for RH. This includes ensuring that RH interventions are included in the basic package that is being financed particularly under IHP and within HHA countries.
- There are great partnerships to be utilized and agreements on the ground that are getting no traction (Maputo plan example, agreed to by heads of state in 50 African countries, about to be renewed in January). Under the Maputo plan, African Union Health Ministers have already drafted a Comprehensive Plan for Sexual Reproductive Health and Rights, which was ratified by the Executive Council of the African Union and it's now incumbent among member states to implement. However, there are no resources to implement it. Resources to support the Maputo Plan of Action could ensure that the Bank's Reproductive Health Action Plan does get national ownership within Africa.
- The World Bank is uniquely positioned at the country level to take on advocacy for reproductive health, particularly in reaching Ministers of Finance. This will require utilizing the World Bank's economic analysis and technical resources to marshal arguments for investment in reproductive health. Bank's country directors have key role to play in process of making RH a country priority through their policy dialogue with governments.
- On the issue of cultural barriers, it was pointed out that the reproductive health bill in Nigeria has been presented to the Parliament four or five times, and has always been rejected because it is equated with abortion, and that always raises a lot of moral and religious questions.
- The Action Plan should build on existing indicators while doing the necessary work to improve measurement, another comparative advantage of the World Bank. Reproductive health and HSS bring together several complementary challenges in measuring effective interventions, effective processes, and effective delivery mechanisms.
- The World Bank has tended to work more on the upstream side of health systems. Its strength has not been in devising technical content, but in governance and financing. From this position, the World Bank can review health system indicators from a reproductive health perspective as well as identify success stories in where health systems and reproductive health intersect at the country level. These actions will contribute to the global public good of a better knowledge base.

- The World Bank can make an important difference in capacity building. One outcome indicator could be to see where in the poverty reduction strategy papers or the country strategy papers reproductive health or health in general is put forward as a focal area.
- The World Bank has a critical role to play in tracking resources, in coordination with agencies such as the WHO, UNFPA, and OECD involved in similar exercises. Systematic data teasing out health expenditures by governments, nongovernmental organizations, and households are needed to assist in tracking resources flowing to reproductive health.
- National health accounts with reproductive health sub-accounts are an important tool in tracking resources, but different approaches are used to make estimates, requiring better harmonization. Bank should support countries with necessary expertise as well as capacity building for countries that lack the expertise. Support for budget estimations based on actual needs calculation needs to be emphasized. There should be a budget line in the Health Budget on RH.
- Tracking resources through NHA has also allowed to identify potential problems. For example, the recent National Health of Accounts shows that health expenditure in Niger has increased from \$10 dollar per capita to about \$44 dollars per capita, but that the resources are focused mainly on tertiary services, when what we need more of is primary health care and referral services, which would have highest impacts. Being able to gauge these sorts of issues quickly is important in ensuring that remedial actions can be taken.
- Time is another dimension that should be factored into country programs and funding. We should ensure that we don't write off countries that are immediately successful – we have seen a complete reversal or backsliding on RH in certain countries when funding was removed once indicators showed some progress.

6. Fiscal and other Economic Incentives

- Innovations in financing should be incorporated into the Action Plan. The World Bank has a comparative advantage in this area because of expertise and connections with Ministries of Finance.
- Not only system inputs but system processes need to be considered in health systems strengthening. We need understand the dynamic aspects of how inputs are translated into services and outcomes. These include incentives and different delivery platforms.
- At the same time, consumer mobilization is important. Generating demand for health services such as ante-natal and post-natal care, institution-based deliveries, etc. The role of the civil society actors in mobilizing the communities in empowering the community with information, and also, in monitoring and evaluation and social audits, should be highlighted in a strategy such as this. It also makes sense from the point of governance.

- Another issue is that women's health is often neglected even when they have access to health care facilities. For example, the women will bring their children for checkups and immunization, but not enough attention is given to postnatal care for the mother.
- Demand-side financing, such as conditional cash transfers, has been shown to be effective with positive reproductive and child health outcomes. This knowledge base was developed because the intervention was rigorously evaluated with a solid research design that allowed for inferences about attribution. The Bank is in a position to ensure that whatever policy is implemented is based on evidence and is not ideology driven.
- Track access for demand utilization of services. For example in Niger having the indicators incorporated in the national framework that tracks results, has allowed for annual monitoring and evaluation instead of waiting for the next DHS or other survey to be conducted to find out how much progress has been made on RH.
- A comment was made on the effectiveness of incentives in generating demand. There have been a lot of experiences in the field, (e.g. in Nepal) with subsidizing and giving incentives for reducing financial barriers to accessing obstetric care. This discussion needs to be brought out.

7. Keeping Engaged/Next Steps

- It was proposed that there should be regular meetings between the Global Health Council (GHC) membership and the World Bank.
- Moving forward emphasis should be on three things: (a) quality of care including improving the quality of existing facilities; (b) reducing barriers to access whether financial, physical or cultural; and (c) improving monitoring systems for maternal and newborn health.
- The Action Plan should look at the big picture. RH has a gender dimension to it as well. In addition, there are three main issues: i) political stability is important for improving RH outcomes; ii) MMR and TFR are correlated to quality of state health systems and poverty; and iii) child survival is related to TFR. The World Bank should look at RH from not only the health perspective but also along the dimensions of poverty, education and gender.
- There should be a flexible approach that takes country context into account. Each country has its own values and different issues are interlinked differently. A broader strategy is easier to translate into the social and cultural contexts at the country level.
- Implementation research should be built into the design of interventions.
- The Action Plan should build on existing platforms, such as the Global Fund and GAVI's collaborative actions with the World Bank on HSS. The Action Plan should also link to the recent High Level Taskforce on Innovations in Financing, particularly to work in the priority countries identified by the Taskforce.

- The Action Plan should be rooted within Aid Effectiveness Agenda and it should be stated up front. It would be easier to find solutions to issues such as financing payment or human resources within this context as opposed to in isolation.
- The Action Plan should work to build on the same indicators as those created for the MDGs and for the Countdown to 2015 process. Because they are compiled regularly and published in the Lancet, these indicators could act as a baseline for the Bank's action plan to measure progress.
- A World Development Report on reproductive health or women's health in 2012 would be welcomed by technical specialists and civil society as a signal of the World Bank's commitments and as a technical contribution to the field.
- Malnutrition is a major issue in Nepal. Nutrition should be a key component of the ENC package to improve the pregnancy outcome. This includes linking neonatal health with RH. Other areas include HIV/AIDS, gender based violence (GBV), and adolescent sexual and reproductive health (ASRH).
- Reproductive morbidity is another issue that should be addressed, including issues such as cancer of cervix and fistula, which are rarely addressed for example within the Nepal context. The World Bank could bring in lessons learned from other countries how this has been incorporated into national health systems.
- In terms of family planning, it may also be useful to have a profile of the target populations. For example, in Nepal, migrant couples have higher CPR compared to the general reproductive age group. This type of knowledge is important in determining the target groups and how to reach them.
- Preferences for family planning methods may also be an area for further work – why is it that some methods are more easily adopted or more popular in certain settings.
- Marginalized or vulnerable populations also need special focus. There is a need for better understanding of the requirements and preferences of indigenous populations – analysis to understand what is culturally relevant to bring indigenous women into the fold of RH service delivery. In this regard, education is particularly relevant, especially to reduce teenage pregnancies and the incidence of HIV/AIDS. With reference to World Bank projects, the Bank's comparative advantage is in having safeguards in its multi-sectoral projects that foster the development and protection of women and the women's development. Participants stressed the importance of child and youth education and incorporating SRH into the Bank's education projects (in the Guatemalan context).
- Gender issues such as poor female mobility, financial and cultural barriers, may be preventing women from accessing secured institutional deliveries. These need to be included in the RH action plan.

- Learning from best practices was emphasized. This includes successes in RH, as well as successes in other sub-sectors in health e.g. for TB to improve access to the actual commodities in terms of availability of drugs or for here we would be possibly looking at contraceptives and others. Similarly, how has visibility of programs specifically getting country commitments, political ownership and to actually drive programs, what can we learn from the HIV programs that we can then bring into the reproductive health per se and try to focus on that.
- Another area could be integration of voices of CSOs at the national level. CSOs have been integrated successfully into policy dialogue at the international level, but at the national level they are not as much. Since these grassroots organizations have access to ground level outcomes and activities, they can serve a function in measuring success.
- The action plan has identified key priority areas for focus. The next step should be to have country-specific action plans, which are more participatory in nature to determine the exact interventions in each country. To further the national action plans, the World Bank's role would be to facilitate knowledge sharing on innovations and best practices.

CONSULTATION LOGISTICS: Locations, Dates, and Participants

Global Health Council (GHC)

Washington DC

November 4, 2009

Participants: Jeff Sturchio (GHC), Bev Johnson (USAID), Crystal Landers (CEDPA), Susan Ehlers (PAI), Deborah Gordis (CARE), Janet Fleischman (CSIS), Claudia Morrissey, Jeff Meer (PPFA), Alex Garita, Susan Cohen (AGI), Jennifer Redner, Jill Sheffield (Family Care International), Craig Lasher (PAI), Smita Brauha (GHC), Chris Bennett (GHC), Julian Schweitzer (World Bank), Mukesh Chawla (World Bank), Sadia A Chowdhury (World Bank), Ajay Tandon (World Bank), Ed Bos (World Bank), Tom Merrick (World Bank), Carolyn Reynolds (World Bank), Sam Mills (World Bank), Seemeen Saadat (World Bank).

Harvard Global Equity Initiative (HGEI)

Boston, MA

November 6, 2009

Participants: Julio Frenk (Harvard University), Lincoln Chen (China Medical Board), Felicia Knaul (HGEI), Flavia Bustreo (PMNCH), Werner Haug (UNFPA), John Bongaarts (Population Council), John Townsend (Population Council), Gilda Sedgh (AGI), Amy Tsui (JHSPH), Eli Adashi (Brown University), Kenneth Hill (Harvard University), Ana Langer (EngenderHealth), Marina Njelekela (Muhimbili University), Rachel Nugent (CGD), Ann Starrs (Family Care International), Mindy J Roseman (Harvard University), Joanne Manrique (GHC), Gustavo Nigenda (NIPH, Mexico), Ramiro Guerrero (HGEI), Afsan Bhadelia (HGEI), Julian Schweitzer (World Bank), Mukesh Chawla (World Bank), Sadia A Chowdhury (World Bank), Ajay Tandon (World Bank), Carolyn Reynolds (World Bank), Sam Mills (World Bank), Seemeen Saadat (World Bank).

International Family Planning Conference

Kampala, Uganda
November 17, 2009

Participants: Eliya Msiyaphazi Zulu (African Institute for Development Policy), Kebede Kassa (African Union, Ethiopia), Ulrike Neubert (DSW, Germany), Barbara Seligman (Abt Assoc., USA), Nancy P Harris (JSI, Madagascar), Alex Todd-Lippak (USAID), Cynthia Eldridge (Marie Stopes Int'l, Kenya), Karen M Jacquin (PSI, USA), Anna Bakilana (World Bank), Eduard Bos (World Bank), Sadia A Chowdhury (World Bank).

Video-Conference with Countries

Washington DC, Nigeria, Kenya, Nepal, Guatemala, Geneva, London, Brussels, Paris
December 7, 2009

Participants by Location:

Abuja (NIGERIA): Anne Okigbo (Chair), Chinwe Ogbonna (UNFPA), Esther Obinya (UNICEF); Brussels (BELGIUM): Sandor Sipos (Chair), Guggi Laryea (World Bank), Dr Philip Davies (European Cervical Cancer Association), Isabel Litwin (European Cervical Cancer Association), Marieke Boot (EU), Maaïke van Min (EU), An Huybrechts (IPPF Europe), Eef Wuyts (IPPF Europe), Dr. Michel Lavollay, Alix Masson (World Scout Bureau), Rachel Hammonds (Helene de Beir Foundation), Senator Marleen Temmerman, Arthur de Kermel (World Scout Bureau); Catherine Olier (Red Cross); Natasha Sirrieh (German Foundation for World Population – DSW), Johanna Stratmann (German Foundation for World Population – DSW), Catherine Giboin (Medecins du Monde France), Nadine Krysostan (European Parliamentary Forum on Population and Development);

Guatemala City (GUATEMALA): Anabela Garcia-Abreu (Chair), Carlos Perez-Brito (World Bank), Myrna Montengro (Reproductive Health Women Observatory), Veronica Buch (Indigenous Women Alianza for Reproductive Health), Silvia Ximico (Indigenous Women Alianza for Reproductive Health), Nadine Gasman (UNFPA), Isabel Stout (USAID), Jaqueline Lavidali (Reproductive Health Unit, Ministry of Health), Virginia Moscoso (Maternal-Infant Health and Nutrition Project);

Kathmandu (NEPAL): Albertus Voetberg (Chair); Nastu Sharma (World Bank); Dr. Laximi Raj Pathak (Chief PPICD, MOHP), Dr. Naresh Pratap K.C (Director, Family Health Division, DOHS); Dr BR Marasini (MOHP), Shanta Lall Mulmi (Center for Primary Health Care, Nepal), Dr. Arju Deuba Rana (Safe Motherhood NGO Network), Pedan Pradhan (UNFPA), Sutaram Depkota (USAID), Susan Clapham (DFID), Navine Toppa (Family Planning Association);

London (UNITED KINGDOM): Leo Bryant (Chair; Marie Stopes International); Riva Eskinazy (IPPF); Helena Lindberg (DFID); Fionnuala Murphy (Interact Worldwide), Rebecka Rosenquist (Action for Global Health), Christina Pagel (UCL Institute for Child Health); Susan Crane (International Health Research Programme), John Nduba (AMREF), Regina Keith (World Vision), Frank Smith (Child Health Now Global Campaign), Nouria Brikci (Save the Children), Anna Marriot (Oxfam GB), Riva Eskinazy (IPPF), Toby Akroyd (Population Sustainability Network); Nairobi (KENYA): Chris Lovelace (Chair); Patricia Odero (GTZ), Muthoni Ndung'u (PPFA), Dr. Sarah Onyango (PPFA), Dr. Kigen Barmasai (MoH), Dr. Mutungi (University of Nairobi);

Paris (FRANCE) – observers only: Barbara Genevaz (World Bank); Rachel Winter Jones (World Bank).

Geneva (SWITZERLAND): Dr Monir Islam (WHO);

Washington DC (USA): Mukesh Chawla (World Bank), Sadia A Chowdhury (World Bank), Ajay Tandon (World Bank), Carolyn Reynolds (World Bank), Eduard Bos (World Bank) Marcelo Bortman (World Bank), Dinesh Nair (World Bank), Ramesh Govindaraj (World Bank), Seemeen Saadat (World Bank);

ANNEX B

AFRICA REGION

OUTLINE OF A STRATEGIC PLAN

FOR POPULATION AND REPRODUCTIVE HEALTH

The outline of this sub-Saharan Africa-specific Strategic Plan for Population and Reproductive Health has been prepared by the Africa Region at the World Bank. The purpose of this Plan is to complement the Action Plan on Reproductive Health that is being prepared by the HNP Anchor. This Africa-specific Strategic Plan was discussed by the Africa Region during a presentation chaired by the Sector Manager for Health, Nutrition, and Population, with the Africa Region Chief Economist as the Discussant. This meeting was attended by 60 staff from the various sectors, representing both the Africa Region and the Anchor.

Background

Sub-Saharan Africa faces huge challenges to integrate into the world economy, increase its rate of economic growth, and lift its men and women out of poverty. To achieve these goals, Africa must inter alia improve its governance, build its human capital, improve the health of its citizens, trigger an education revolution, manage the rapid pace of urbanization, increase its agricultural productivity, protect its environment, and adapt to global climate change. The rapid growth of the sub-Saharan population is exacerbating all these challenges, making more difficult the achievement of the Millennium Development Goals (MDGs).

Sub-Saharan Africa (SSA) hosts 25 of the 28 high fertility countries of the world, defined by a total fertility rate (TFR) higher than 5 children per woman. The fertility transition of the 49 least developed countries (LDCs) is lagging 30 to 50 years behind the fertility declines that occurred in Latin America, the Caribbean, and Asia. Within the LDCs, the SSA's fertility transition is lagging even further behind. However, Southern Africa (only 7 percent of the SSA population) is most advanced in its fertility transition while Eastern, Western and Central Africa are less advanced (they are ranked by the decreasing degree of completion of their fertility transition). This reflects the importance of the various cultural and gender settings within SSA.

The high levels of population growth in SSA are fueled by rapidly declining levels of mortality despite the HIV/AIDS epidemic, and by high levels of fertility that are decreasing only slowly and irregularly. Since the 1960s, sub-Saharan Africa's population has grown at the rate of 2.5 percent per year, implying a doubling time of the population of 28 years. Demographic growth has been even faster for younger age groups. In the last 50 years, the number of children 0-4 has increased 3.5 times and the number of children hoping to go to school (age 5-14) has increased almost 4 times.

Current use of contraception is low in SSA and the rate of increase of contraceptive use is very slow. Less than one woman in five uses a modern contraceptive in SSA. Moreover, the

rate of increase of the contraceptive prevalence rate (CPR) is estimated at only 0.5 percentage point per year. However, a few countries have been able to increase their contraceptive prevalence rates at a faster pace, namely the Southern Africa countries and, more recently, Madagascar, Malawi, Rwanda and Ethiopia. Their success could be used as a benchmark for other SSA countries.

Poor access to family planning services results in high numbers of unwanted pregnancies and induced abortions in sub-Saharan Africa. The low levels of contraceptive use bring two direct consequences. First, half of all pregnancies are at risk because they are too early, too many and too close. Second, African women are often compelled to seek unsafe abortion to regulate their fertility. A recent IPAS study shows that of the 20 million unsafe abortions that occur worldwide every year, 5 million take place in sub-Saharan Africa. About 44 percent of pregnancy-related deaths in Africa are due to unsafe abortion. A Bank ESW carried out recently in three African countries (Eritrea, Malawi and Niger) identified abortion as the leading obstetric complication treated at health facilities. Both pregnancies at risk and unsafe abortions are detrimental to the health and the very survival of African women.

The highest level of maternal mortality in the world occurs in sub-Saharan Africa. The average maternal mortality ratio for SSA (824 per 100,000) far exceeds the levels observed in other regions of the world (Asia: 329; Latin America: 132). About half of all maternal deaths in the world occur in Sub-Saharan Africa, i.e., 247,000 out of 529,000 every year. Women in SSA face a 1 in 16 chance of dying due to causes related to pregnancy and childbirth. Some of the highest maternal mortality ratios are observed in countries such as Sierra Leone, Malawi, Angola, Niger, Tanzania, Rwanda and Mali, and the rate of decline has stalled.

Sub-Saharan African women want to have access to family planning services as demonstrated by the high levels of unmet needs for family planning. Such unmet needs are estimated at 25 percent of women on average. This illustrates the double denial of the rights of the African women, namely the right to have information on family planning (and express their views on the issue) and also the right to have access to family planning services. Although SSA women have on average more than 5 children, fertility levels for men have sometimes been estimated at 13 children or more.

Since the mid-1990s, African governments and their development partners have not been fully committed to population and reproductive health issues. Many misconceptions prevail, such as old-fashioned fears of population control, the complacency about allegedly low population densities and the misconstrued belief that large markets by themselves will foster economic growth. Moreover, international and Africa region's attention has shifted to other urgent issues, such as the HIV/AIDS epidemic, humanitarian crises, good governance and, more recently, climate change, the food crisis and the financial crisis. As a result, funding of population and reproductive health programs has been neglected.

This lack of attention to population and reproductive health issues is most unfortunate because the rapid pace of population growth in SSA impacts on four major dimensions that are all related to human and socio-economic development. First, as explained, rapid population growth and high levels of fertility are detrimental to the health of women, especially

maternal mortality and the survival outcomes of their children. Second, rapid population growth jeopardizes the formation of human capital (education and health), which creates tensions in the fiscal space. Third, rapid population growth perpetuates high levels of poverty, especially among the poorest households. And fourth, additional population pressure stresses even further the fragile ecosystems (e.g., access to land, deforestation, water supply, etc.).

Although socio-economic development is by far the best contraceptive, contraceptives are also necessary for socio-economic development, in particular when demographic growth is too fast. To be sure, the relationship between declining fertility and economic growth goes both ways. However, should we let economic growth alone bring high fertility levels down in SSA? Or should we also provide public interventions to address “market failures” such as the lack of correct information on contraceptives? Questions of this nature still divide the community of development practitioners. They would need to be addressed squarely in order to justify public investments in the area of population and reproductive health.

Recent Developments

There is a new discourse on population and reproductive health issues in sub-Saharan Africa. First, a “new demography” has emerged from the body of research on the East Asia experience. It stresses the importance of age structure, dependency ratios, the “demographic dividend” and the linkages between demographic trends and socio-economic outcomes. Second, the human rights agenda, that includes access to RH and family planning services, has also gained prominence in recent years. The importance of the demographic factor was established for sub-Saharan Africa as well, most recently in the seminal study by Benno Ndulu and colleagues, *Challenges of African Growth* (World Bank 2007). See also the ESW on Ethiopia, *Capturing the Demographic Bonus* by Christiaensen, May et al. (World Bank 2005).

The World Bank Africa Region is increasing its efforts to work with countries to address Pop/RH issues. The Africa Region has completed three ESWs on Population (Niger, Ethiopia and Mali) and one ESW on maternal health (covering Eritrea, Malawi and Niger); has prepared several background chapters or papers on demography to feed into CASes (Madagascar, Burkina Faso), CEMs (Uganda, Burkina Faso, Burundi), and country programs (Rwanda); has mainstreamed Pop/RH issues in some PRSPs (e.g., Ethiopia); has prepared or is preparing free-standing projects on population and reproductive health (Niger, Burkina Faso); and is providing specific technical assistance in population issues (Burkina Faso, Mali).

A family planning supply-driven approach has worked effectively in several countries. Madagascar, Malawi, Ethiopia and Rwanda are among the family planning success stories of SSA (and these are best practices for other SSA countries). Success hinges around three main factors: high level of commitment of the leadership, raised awareness of the population about the benefits of family planning and a secure supply of family planning services. Madagascar exemplifies this perfectly. The President pushed a family planning breakthrough, as indicated by the new emphasis in the name of the Ministry of Health and Family Planning. This was followed by year-long information, education, and communication (IEC) and behavioral communication for change (BCC) campaigns. Finally, these efforts were backed up by a secure supply-chain for

contraceptives. Ethiopia deployed thousands of community health workers, delivered injectables at the community level and changed its legal texts with respect to reproductive health. It also addressed the logistical supply of contraceptives and long-term methods.

The SSA Health Systems for Outcomes (HSO) initiative has helped countries to achieve faster rates of contraceptive coverage. The case in point is Rwanda, where the strengthening of the health system has made possible impressive gains in the supply of family planning services. The results-based financing (RBF), the expansion of health insurance and the decentralization of the health system have all contributed to the improvements both in health coverage and health services delivery. All types of health personnel have been trained in delivering all family planning services, including long-term methods. Thanks to better management and strong support from the development partners, contraceptive commodities stock-outs are now very rare in Rwanda (the Government has started to use its own resources to buy contraceptives). Finally, more women have been encouraged to deliver in health centers and more than 50 percent do so.

The Way Forward

Update the respective positions of economists and population specialists regarding the importance of the demographic factor for socio-economic development. Recent analytical work on the East Asia situation has demonstrated that demographic changes, in particular rapid declines in fertility, have brought about a “demographic dividend” caused by more favorable dependency ratios and a relatively larger share of the labor force. Measurement of this, however, will require additional work. In particular, a production function will need to be identified for the declining fertility, in order to be able to run models such as the DEC MAMs (Maquette for MDG Simulation) to simulate the effects of fertility changes on development outcomes, as is already done for education and health.

A specific and systematic focus on Pop/RH issues in the SSA 25 high fertility countries. A mechanism will be established to monitor key strategic documents and lending activities. In particular, it will follow up on all CASEs in the pipeline, so that Pop/RH issues are brought within all development and poverty reduction strategies. Furthermore, no CEM and no PRSP for SSA high fertility countries can ignore Pop/RH dimensions. Poverty papers should also factor in demographic issues. Key sector operations, such as education, gender, social protection, etc., need to be informed with correct and realistic demographic data and analyses. In addition, it is proposed to prepare briefs on Pop/RH issues, to share them with CDs and CTs.

Sharpened HSO approaches, to be geared at better delivery of reproductive health and family planning services. First, the pace of increase of the contraceptive prevalence rate (CPR) will need to triple to grab the “low hanging fruits” and cover unmet needs over the next 15 years (reliable costing estimates will be needed). Second, MDG-5 has galvanized a renewed focus on the search for solutions for preventing maternal mortality and sub-Saharan Africa will be the key battleground. The reduction in the number of maternal deaths will be achieved in part by increasing the percentage of women delivered by skilled attendants. Today, 61 percent of African women are still delivered by unskilled practitioners and financial and cultural barriers are still major determinants of low utilization of safe delivery. However, in several SSA

countries, maternal mortality remains high in spite of high levels of maternal health care utilization. This will require a closer examination of the failures in the health service delivery system that may explain maternal deaths among women who do reach health facilities. These factors are the shortage of personnel, the lack of drugs, equipment and blood supplies, administrative delays, problems in referral provision and clinical mismanagement of patients.

Differentiation between family planning services and services to reduce maternal mortality.

Good evidence does exist for family planning service delivery, but better evidence is needed for maternal mortality reduction interventions (this should be done in parallel to current models to assist in planning other aspects of health and education). Such evidence will help guide client governments about investments to bring a reduction in high levels of fertility and maternal mortality. Last but not least, the synergy between various sector interventions as well the potential of the private sector should both be tapped in order to enhance and/or complement public sector's efforts.

A stronger evidence base to bring Pop/RH issues to the core of the socio-economic development agenda, to be used in policy dialogue and communication tools. Such tools will help convince leaders, policy makers, civil society representatives and religious leaders as well as the development community about the importance of Pop/RH issues. Bank's partners have already developed such tools, e.g., the SPECTRUM family of models funded under USAID that includes the RAPID model (currently being updated). The Population Reference Bureau (PRB) has developed a new ENGAGE model as well as simple brochures on Pop/RH. The Bank is currently developing similar tools in Mali and Burkina Faso. All this will entail renewed efforts to enhance data quality and measurement. In particular, a more coherent data collection strategy (censuses, surveys and civil registration data) will need to be put forward.

A renewed policy dialogue to guide investments in Pop/RH issues in SSA. A Concept Note for a new regional AAA study on SSA Pop/RH issues will be developed in March/April 2010 for funding in July 2010. The Bank last paper of this nature, *Population Growth and Policies in Sub-Saharan Africa*, was prepared in 1986 (World Bank 1986). The new paper will build on the "new demography" that came from the East Asia experience. It will help rationalize and solidify the new discourse on SSA Pop/RH issues and the new approaches that have been piloted so far. The new paper will also offer a detailed Action Plan on how to tackle SSA Pop/RH issues effectively.

Other partners' efforts in Pop/RH are rekindled. The Africa Region will leverage its efforts' with other partners' endeavors, in particular those of USAID, UNFPA and the other major bilateral partners. The time to do so is particularly propitious as the new US Administration is fully reengaged on Pop/RH issues under its Global Health Initiative. Other prominent NGOs and foundations have either rejoined the field of Pop/RH or are at least giving it serious thoughts.

Addressing urgently the Pop/RH expertise crisis in the World Bank Africa Region and strengthening the ability to respond to clients needs. The Africa Region will soon lose its only demographer. Moreover, it does not have much expertise left in reproductive health. There is an urgent need to re-establish a solid Pop/RH work program in the Africa Region, which means more Pop/RH professionally qualified staff. Such staff could be attracted from other

regions in the Bank. Funding will need to come from Bank Budget as well as Trust Funds. A stop-gap interim measure would be to ask a development partner (e.g., USAID) to provide a Pop/RH expert to be seconded to the Africa Region.

Expected Results and Outcomes

Pop/RH issues in high fertility countries will be brought back to the socio-economic development agenda and become central to poverty reduction strategies and operations. As a result, Pop/RH issues will no longer be confined to the HNP Technical Family but will become a concern of the Education and Social Protection streams within Human Development. PREM will also be reengaged on macro-demographic issues, as those are closely linked to the issues of labor force, human capital investments and poverty reduction. These efforts will be supported through additional non-lending programs of technical assistance (TAs) in Pop/RH issues (ten countries will be covered in 5 years).

Renewed and sustained Bank efforts in SSA reproductive health and family planning programs will help position at least half of the high fertility as the incipient stage of fertility transition in the next 10 to 15 years (defined by CPR for modern methods of 25 to 30 percent). This will be achieved by addressing HSO issues and creating the conditions for faster uptakes of family planning services. An expected result will be the improvement of key indicators. The contraceptive prevalence rate will improve (using the benchmark of 1.5 percentage point increase per year) as well as the other indicators for Target 5a and 5b of MDG-5, especially those pertaining to maternal mortality. Last but not least, this will help fulfill the reproductive health rights of the women in sub-Saharan Africa.

ANNEX C

Global Consensus on Maternal, Newborn and Child Health

Consensus for Maternal, Newborn and Child Health

Our Aim: "Every pregnancy wanted, every birth safe, every newborn and child healthy"
Saving the lives of over 10 million women and children by 2015

Our Timeline: 2009 – 2015



Bold, focused and co-ordinated action on reproductive, maternal, newborn and child health is urgently needed. Such action at global, national and sub-national levels will accelerate progress toward Millennium Development Goals 4 (reduce child mortality) and 5 (improve maternal health), as well as MDG 6 (combat HIV/AIDS, malaria and other diseases). Maternal and newborn health must be emphasized – while addressing major gaps in child survival – because women and infants are at greatest risk of death in the first few hours and days around birth. The Consensus recognizes the need to align current momentum in politics, advocacy and finance behind a commonly agreed set of policies and priority interventions aimed at accelerating progress on the ground.

How we can make it happen:

1. **Political leadership and community engagement** and mobilization
2. **Effective health systems** that deliver a package of high quality interventions in key areas along the continuum of care:
 - Comprehensive family planning – advice, services and supplies
 - Skilled care for women and newborns during and after pregnancy and childbirth, including antenatal care, quality delivery care in a health facility, emergency care for complications, postnatal care, and essential newborn care
 - Safe abortion services (when abortion is legal)
 - Improved child nutrition and prevention and treatment of major childhood diseases
3. **Removing barriers to access**, with services for women and children being free at the point of use where countries choose
4. **Skilled and motivated health workers** in the right place at the right time, with the necessary infrastructure, drugs, equipment and regulations
5. **Accountability** at all levels for credible results



What will it take?

- In 2015, an additional 50 million couples using modern methods of family planning
- An additional 234 million births taking place in facilities that provide quality care for both normal and complicated births
- 276 million additional women receiving quality antenatal care
- 234 million additional women and newborn babies receiving quality postnatal care
- More than 164 million additional episodes of child pneumonia taken for appropriate treatment
- 2.5 million additional health care professionals and 1 million additional community health workers, towards the WHO target of at least 2.3 health workers per 1,000 of population

What will it achieve?

- Preventing the deaths of up to 1 million women from pregnancy and childbirth complications
- Saving the lives of at least 4.5 million newborn babies
- Saving the lives of at least 6.5 million children (1 month to 5 years)
- Preventing 1.5 million stillbirths
- A significant decrease in the global number of unwanted pregnancies and of half the number of unsafe abortions
- An effective end to the current unmet need for family planning services
- Reducing by over one-third the rate of chronic malnutrition in children age 12 to 23 months

What will it cost?

The total additional programme cost of achieving these targets is \$30 billion for the period 2009-2015, with annual costs ranging from \$2.5 billion in 2009 to \$5.5 billion in 2015.

¹ Figures are totals for 49 aid-dependent countries (total population in 2009 is 1.4 billion; excludes India and China) for the 2009-2015 period, based on calculations done for the High Level Task Force on Innovative International Financing for Health Systems (HLTF), Mar 2009. See http://www.internationalhealthpartnership.net/CMS_files/documents/working_group_1_report_EN.pdf

² The HLTF estimates that the total programme and health system cost for maternal and newborn health; child health; family planning; HIV/AIDS/TB; malaria; and basic health services for 2009-2015 is \$25.1 billion, of which \$18.6 billion is health system costs that are needed for progress in all the specific health programme areas.

This consensus was launched at "Healthy Women, Healthy Children: Investing in Our Common Future" an event held at the United Nations on 23 September 2009, organized by the High-Level Task Force on Innovative International Financing for Health Systems and PMNCH. For more information, contact: The Partnership for Maternal, Newborn & Child Health • Tel: + 41 22 791 2595 • www.pmnch.org

ANNEX D

Joint World Bank, WHO, UNICEF and UNFPA Statement on MNCH



JOINT STATEMENT ON MATERNAL AND NEWBORN HEALTH

Accelerating Efforts to Save the Lives of Women and Newborns

Today, **25 September 2008**, as world leaders gather for the High-Level Event on the Millennium Development Goals (MDGs), we jointly pledge to intensify our support to countries to achieve Millennium Development Goal 5 *To Improve Maternal Health* — the MDG showing the least progress.

During the next five years, we will enhance support to the countries with the highest maternal mortality. We will support countries in strengthening their health systems to achieve the two MDG 5 targets of reducing the maternal mortality ratio by 75 per cent and achieving universal access to reproductive health by 2015. Our joint efforts will also contribute to achieving MDG 4 *To Reduce Child Mortality*.

Every minute a woman dies in pregnancy or childbirth, over 500,000 every year. And every year over one million newborns die within their first 24 hours of life for lack of quality care. Maternal mortality is the largest health inequity in the world; 99 per cent of maternal deaths occur in developing countries — half of them in Africa. A woman in Niger faces a 1 in 7 chance during her lifetime of dying of pregnancy-related causes, while a woman in Sweden has 1 chance in 17,400.

Fortunately, the vast majority of maternal and newborn deaths can be prevented with proven interventions to ensure that every pregnancy is wanted and every birth is safe.

We will work with governments and civil society to strengthen national capacity to:

- Conduct needs assessments and ensure that health plans are MDG-driven and performance-based;
- Cost national plans and rapidly mobilize required resources;
- Scale-up quality health services to ensure universal access to reproductive health, especially for family planning, skilled attendance at delivery and emergency obstetric and newborn care, ensuring linkages with HIV prevention and treatment;
- Address the urgent need for skilled health workers, particularly midwives;
- Address financial barriers to access, especially for the poorest;
- Tackle the root causes of maternal mortality and morbidity, including gender inequality, low access to education — especially for girls — child marriage and adolescent pregnancy;
- Strengthen monitoring and evaluation systems.

In the countdown to 2015, we call on Member States to accelerate efforts for achieving reproductive, maternal and newborn health. Together we can achieve Millennium Development Goals 4 and 5.

Margaret Chan
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