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Better Health for Women and Families:

The World Bank's Reproductive Health Action Plan 2010–2015

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Foreword

Vastly better health for women and families lies at the heart of the transformational promise of the Millennium Development Goals (MDGs) for 2015. The landmark 1994 Cairo International Conference for Population and Development had earlier recognized the vital importance of women's health to development progress in calling for a comprehensive approach to reproductive health. In the years immediately following the conference, reproductive health gained much-needed prominence. But by the turn of the century, family planning and other reproductive health programs vital to poor women had fallen off the development radar of many countries, donors, and aid agencies. This inattention was despite the reproductive health ordeal lived out by women in many low-income countries worldwide.

Globally, more than 350,000 women die each year because of pregnancy and childbirth complications, 99 percent of them in developing countries. Thirty-five poor countries, mainly in Sub-Saharan Africa, have the world's highest birth rates (more than five children per mother). They are also home to some of the world's poorest social and economic results, with low levels of education, high death rates, and extreme poverty.

Many poor women turn to abortion as a last-resort means of birth control. Some 68,000 women die each year from unsafe abortions, while another 5.3 million suffer temporary or permanent disability. In the 35 highest-fertility countries in Africa, Asia, and the Middle East, aid for women's family planning and reproductive programs started at US$150 million in 1995 and increased to US$432 million in 2007, while overall aid for health in these countries went from US$915 million to US$4.9 billion.

Over the last 18 months, however, the development community has put reproductive health back in the vanguard of development priorities, spurred on by the realization that as the 2015 deadline for the Millennium Development Goals gets closer, MDG 5—reducing maternal mortality and achieving universal access to reproductive health—has shown the least progress of all the MDGs.

For its part, the World Bank has released a new five-year Action Plan to help 57 countries with high maternal death and fertility rates improve their reproductive health services and prevent the widespread deaths of mothers and children. Given the weak state of health systems in many countries, the Bank is working closely with governments, aid donors and agencies, and other partners to strengthen these systems so that women gain significantly better access to quality family planning and other reproductive health services, skilled midwives at their births, emergency obstetric care, and postnatal care for mothers and newborns.

Under its new Action Plan, which benefited greatly from extensive consultations with global and national partners as well as civil society organizations, the Bank will help im-

prove reproductive health systems in the following ways:

More contraception—The first step to avoid maternal deaths is to ensure that women have access to modern contraceptives and the ability to plan their families. At the country level, a sound logistics system can distribute contraceptives and other reproductive health supplies efficiently so that each clinic or pharmacy has enough stock on hand to meet clients' needs.

Skilled attendance at birth—Women who continue pregnancies need care during this critical period for their and their babies' health. 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 stands at only 44 percent in Sub-Saharan Africa and 42 percent in Southern Asia.

Spread preventive knowledge—Most maternal deaths are avoidable, and the health care solutions to prevent or manage the complications are well known. It is widely recognized that skilled care at childbirth is most important for the survival of women and their babies, and that the availability of qualified and trained health personnel to assist deliveries can ensure better pregnancy outcomes. Yet a third of all deliveries occur without a skilled attendant.

Train new health workers—An important way to strengthen health systems is to train new health workers, strengthen the skills of the existing health workers with midwifery skills, and deploy them effectively. Falling maternal death rates in North Africa, East Asia, Southeast Asia, and Latin America and the Caribbean share many common features: greater use of contraception to delay and limit childbearing and better access to high-quality obstetric care services.

Expand girls' education—High birth rates are closely allied with fragile health, little or no education, and entrenched poverty. Analysis of demographic and health surveys in all regions shows that women with secondary or higher education have fewer children than women with primary or no education. Time and again we see how girls' education provides life-saving knowledge, builds job skills that allow women to join the workforce and marry later in life, and gives them the power to say how many children they want and when. These are enduring qualities that women will hand down to their daughters as well.

Work closely with lead health agencies—The new Bank Action Plan strongly welcomes the re-emergence of maternal and child health as a priority among countries, donors, and other partners, which has jumpstarted more than 80 new national and international partnerships, including the Partnership for Maternal, Newborn and Child Health. In addition, an informal group of heads of four health-related organizations (WHO, UNICEF, UNFPA, and the World Bank—called the "H-4") meets regularly on measures to strengthen country efforts to improve maternal and child health and avoid fragmentation of donor efforts and financing (such as harmonizing and coordinating the efforts of donors at country level to support countries to improve maternal health).

Investing in family planning is also important for HIV prevention, especially by preventing mother-to-child transmission. Women's economic empowerment is a big part of the fight against poverty, and better reproductive health affords women and their families a better chance to achieve that. Healthier mothers can take better care of themselves and their children, invest in their well-being, and help them become more productive members of society as adults.

With 2010 marking the start of the five-year countdown to the MDGs, this new Reproductive Health Action Plan reaffirms the World Bank's commitment to helping countries mobilize the financing and the technical expertise they will need to achieve the two targets of MDG 5: to reduce maternal mortality and achieve universal access to reproductive health by 2015.

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Acronyms and Abbreviations

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
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

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Introduction

Reproductive health is a key facet of human development. Improved reproductive health outcomes—lower fertility rates, better pregnancy outcomes, and fewer sexually transmitted infections—have broader individual, family, and societal benefits. The benefits include a healthier and more productive work force, greater financial and other resources for each child in smaller families, and enabling young women to delay childbearing until they have achieved educational and other goals.[1] Many studies have demonstrated that poor reproductive health outcomes—early pregnancies, unintended pregnancies, excess fertility, and 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 reproductive health services, including the ability to make voluntary and informed decisions about fertility. Men also play an important role in supporting a couple's reproductive health needs, especially since they often influence the effective use of contraceptive methods and seeking maternal health care services.[3] Reductions in fertility lead to low youth dependency and a high ratio of working people to total population, creating a demographic window of opportunity for output per capita to rise and countries to enjoy a demographic dividend.

Improvements in reproductive health have generally lagged improvements in other health outcomes in many low-income countries. The Millennium Development Goal (MDG) for maternal health has seen the least progress of all the MDGs.[4] Many low-income countries continue to have high fertility, high rates of unmet need for contraceptive services, and very high maternal mortality. Twenty-eight countries—mostly in Sub-Saharan African—have total fertility rates (TFR) in excess of five births per woman.[5] Even in countries with relatively good reproductive health outcomes, access to family planning, antenatal care, and delivery assistance among the poor and other vulnerable groups tends to be far worse than the national average.[6]

Reproductive health issues have only recently begun to be a priority in the development agenda. Even though official development assistance (ODA) for reproductive health has increased, the share of health ODA going to reproductive health declined in the past decade. A similar trend is evident at the World Bank, where the share of reproductive health in the health portfolio 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 system strengthening. The reduced focus on reproductive health at the Bank is not limited to financing: a recent IEG evaluation found that substantive analyses of reproductive

health issues rarely figured in the Bank's poverty assessments, even in high TFR countries.[7]

A renewed global consensus on the need to make progress on MDG 5, together with greater attention to gender issues within and outside the Bank, is refocusing attention on reproductive health and offering an unprecedented opportunity to redress the neglect of the previous decade. Notable among these developments is that the UN fully incorporated reproductive health in the MDG framework in 2007. There is now a new Partnership for Maternal, Newborn, and Child Health aimed at raising awareness and advocacy related to reproductive and child health. New initiatives, including the Global Campaign for the Health MDGs, 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 and 5. The Bank, together with UNFPA, UNICEF, and WHO, has signed the UN Joint Statement on Maternal and Neonatal Health, for the four organizations to work with country governments to ensure that core interventions for addressing maternal and neonatal health are addressed in 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 through addressing adolescent motherhood as a priority area for the sixteenth replenishment of IDA resources.

This document presents a detailed operationalization of the reproductive health component of the Bank's 2007 Health, Nutrition, and Population (HNP) Strategy.[9] In tandem with the global re-emphasis of reproductive health and in recognition of its importance for human development, this Action Plan aims to reinvigorate the Bank's commitment to helping client countries improve their reproductive health 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 reproductive health in line with the Program of Action of the 1994 International Conference on Population and Development and presents specific activities—global and national—to improve reproductive health outcomes in target countries.[10] The Action Plan outlines activities that the Bank will undertake to serve client countries in their efforts to improve reproductive health outcomes. Within the broader framework of health system strengthening, the Plan proposes helping countries to address high fertility, improve pregnancy outcomes, and reduce sexually transmitted infections.[11]

The remainder of this document is organized as follows. Section 2 describes the context for this Action Plan. Section 3 discusses some of the challenges that may constrain countries and development partners in finding solutions to reproductive health issues. Details of the Action Plan are presented in section 4. A Results Framework is in section 5. The development of the Action Plan has been guided by an extensive internal and external consultative process; full details are in annex A.

Context

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 for universal access to 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 mortality is the highest. And at the present rate of progress, the world will fall well short of achieving this MDG.

The average MMR in developing countries is 450 deaths per 100,000 live births, compared with 9 in developed countries. Fourteen countries—13 are in Sub-Saharan Africa—have MMR[12] 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, with 85 percent of the population, accounted for 99 percent. About half the maternal deaths (265,000) were in Sub-Saharan Africa and a third took place in South Asia (187,000).[14]

Women die from a wide range of complications in pregnancy, childbirth, or the postpartum period, many because of their pregnant status and some because pregnancy aggravates an existing disease.[15] The four major killers are severe bleeding (pre and post delivery), infections or sepsis, hy-

Box 1 | How Many Maternal Deaths in the World?

The data on the number of maternal deaths and the maternal mortality ratio used in this Action Plan are those estimated for 2005 by an interagency group of WHO, UNICEF, UNFPA, and the World Bank. Recently, estimates for 2008 have been issued by the Institute for Health Metrics and Evaluation, based on a new modeling approach and an expanded dataset. The findings show a decline from 526,000 deaths in 1990 to 343,000 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: Hogan MC, and others, 2010. "Maternal mortality for 181 countries, 1980–2009: A Systematic Analyis of Progress towards Millennium Development Goal 5." www.thelancet.com, published online 12April.

pertensive disorders including eclampsia, and obstructed labor. Complications of unsafe abortion cause 13 percent of deaths. Globally, about 80 percent of maternal deaths are due to these causes, and 99 percent 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 than women in high-income countries, and thus have a higher lifetime risk of maternal death.[17]

Overall, reproductive health-related mortality and morbidity account for almost a third of the global burden of disease among women of reproductive age and a 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 year at least 75,000 women develop obstetric fistula and about 2 million women live with an untreated obstetric fistula.[19] The UN expects the burden to increase by 40 percent by 2050, as record numbers of young people enter their prime reproductive years.[20]

Every year more than 133 million babies are born, 3 million of them stillborn, almost a quarter dying in 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 fewer than 1 million in the following three weeks. Very many die in Africa and Asia, very few 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]

Data show that fewer 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 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 fewer than a third 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]

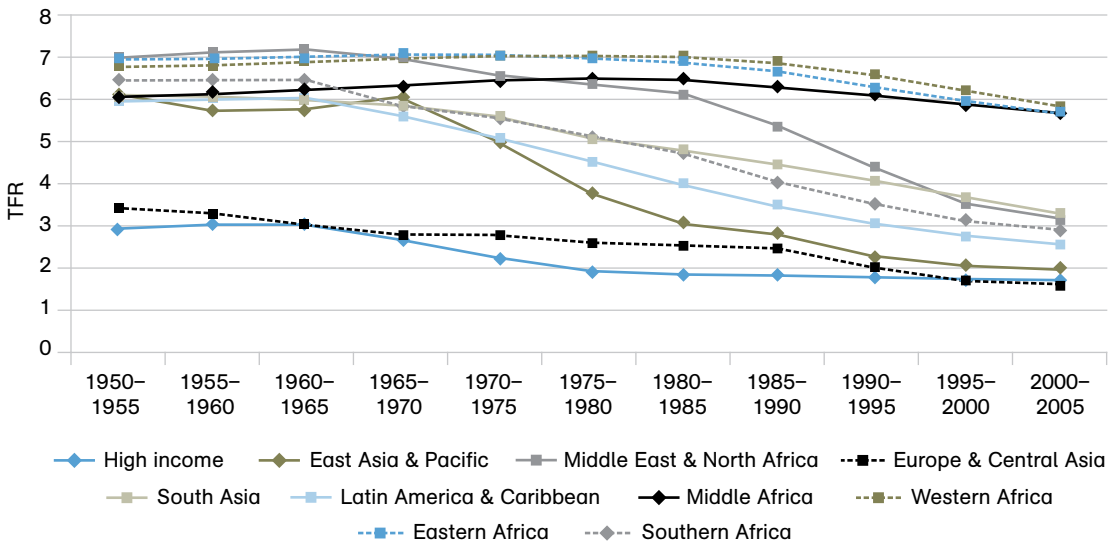
Many countries have achieved remarkable reductions in TFR in the last three decades. Overall, the average TFR in developing countries has declined from about 6 in 1960 to 2.6 in 2006.[25] Bangladesh brought down its rate from 6.8 in 1960 to 2.8 in 2007,

Kenya from 8 to almost 5.[26] TFR are lowest in the Europe and Central Asia region, which had a population-weighted average TFR of only 1.7 in 2007, and highest in the Sub-Saharan Africa region which had a population-weighted TFR of 5.1 in 2007 (figure 1).[27]

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. The fertility decline has resulted in a significant decrease in the MMR, as well as the lifetime risk of dying from maternal causes.

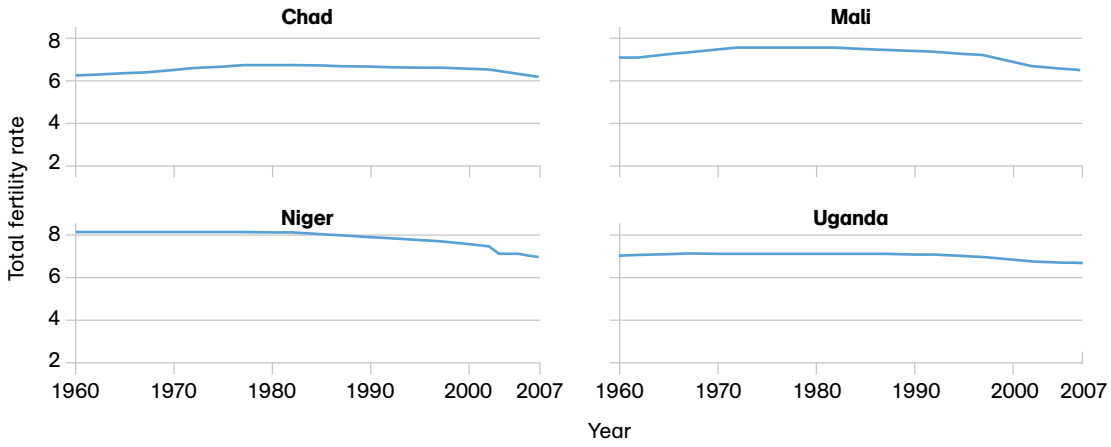
But TFR have declined at a very slow pace in 28 of the least developed countries—mostly in Sub-Saharan Africa—which have TFR above 5. In Chad, Mali, Niger, and Uganda, TFR are in excess of 6, with little or no decline over the past five decades (figure 2). Social and economic indicators are generally poor in these countries, which also have low educational attainment, high gender inequalities, high mortality, and high levels of poverty. Several of the high TFR countries have experienced or are experiencing conflict, making it difficult to deliver basic health and education services. Low contraceptive use in many of the high TFR countries stems more from a desire to have more children rather than from a lack of awareness about fertility control or a lack of access to contraception.

Figure 1 | Trends in Fertility by Region, 1950–2000



Source: World Development Indicators.

Figure 2 | Trends in Total Fertility Rates in Chad, Mali, Niger, and Uganda, 1960–2007



Source: World Development Indicators.

In addition to the differences between countries, there are large disparities within countries between people with high and low income and between rural and urban populations. In Columbia, Demographic and Health Survey data reveal big differences in TFR by economic status: the rate is 1.4 in the highest wealth quintile and 4.1 in the lowest, suggesting significantly higher unmet needs or higher desired fertility among the latter population subgroup (table 1).

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 unit is uniformly low or high for poor and rich. The unmet need for the poorest households is often

Table 1 | Total Fertility Rates by Wealth Quintiles (selected countries)

	Wealth quintiles					
Country	Lowest	Second	Middle	Fourth	Highest	Total
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

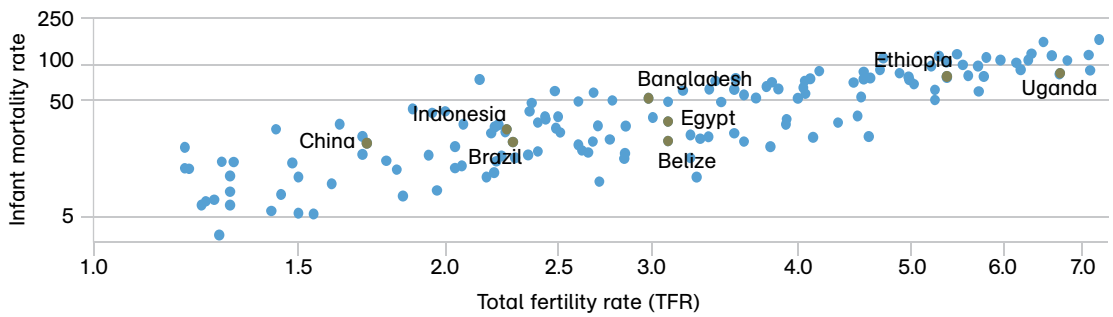
Source: DHS surveys (various years).

much higher in countries where the transition to lower fertility has been under way for some time (such as Zimbabwe, Namibia, and Kenya). The 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, by contrast, is consistently higher for women in wealthier households, who are more likely to use family planning irrespective of the overall contraceptive prevalence in the country. The steepness of this curve—the rate of increase of contraceptive use when comparing women in poorer and wealthier households—varies considerably, indicating greater inequities in access to appropriate contraception in some countries.

High fertility rates are closely linked with high infant mortality rates (figure 3). This is, in large part, a result of weak health systems and poor socio-economic conditions, which influence mortality and fertility-related outcomes. In countries with high infant mortality, high TFR is a natural response to achieving a given desired family size. But the association goes the other way, too: high-parity women are more likely to have births with shorter interpregnancy intervals and, therefore, would be prone to the adverse effects of such frequent births. For instance, short interpregnancy intervals (in particular, those less than six months) are known to be a risk factor for low birth weight, pre-term births, and small for gestational age.[29] 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 from closely spaced pregnancies.[30]

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

Figure 3 | Infant Mortality and Total Fertility Rates in Developing Countries, 2005



Source: World Development Indicators.

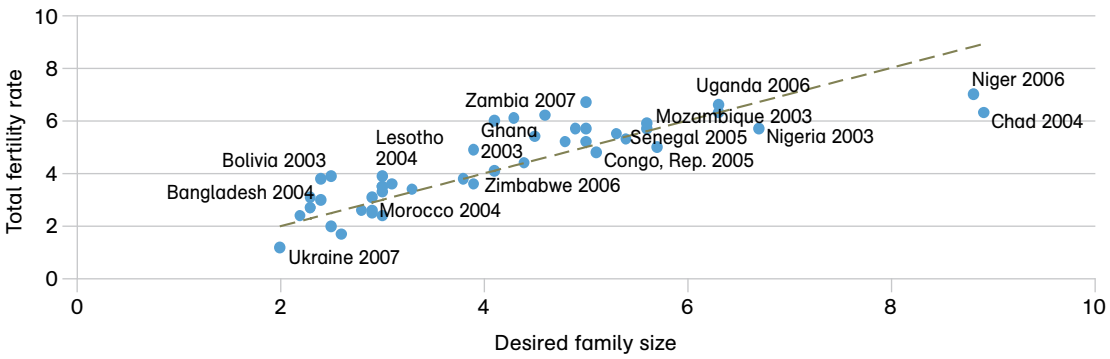
in daughters if men earn higher wages in the labor market or if female labor force participation is low. Parents might also expect higher benefits from investing in boys because sons are the providers of support in old age. In some cultures, the practices of dowry and exogamous marriage effectively reduce girls' expected contribution to their natal homes. Finally, parents may also value sons more not just for their economic contribution but also for their role in customs and in maintaining the family line. Son preference and its effect on fertility is particularly high in Central Asia and South Asia.

In many situations, fertility rates are high not because of unmet need for contraception but because desired fertility is itself high, sometimes as a result of cultural and religious factors, or as a poverty coping mechanism, or even because infant mortality rates are high. 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 (figure 4). 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 reproductive health services may not be enough, and the focus would also need to be on multisectoral interventions to influence desired fertility.

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 childbearing women is the main cause of HIV infection among children, with more than 90 percent of infant and young child infections through mother-to-child transmission, either during pregnancy, labor and delivery, or breastfeeding.

Adolescent reproductive health presents yet another challenge. In many devel-

Figure 4 | Desired and Actual Total Fertility Rate in Selected Countries



Source: DHS
Note: Dashed line is 45 degrees; Selected countries highlighted.

oping countries, adolescent fertility remains important despite an overall decline in fertility. Moreover, in many of the countries with high TFR or high MMR, births to 15–24 year olds account for between 30 to 50 percent of all births. An early transition to motherhood can potentially reduce young women's life chances and opportunities by reducing their 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. So, addressing adolescent pregnancy will also contribute to prevent intergenerational transmission of poverty—a powerful reason to target adolescent fertility.

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 sexually transmitted infections 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 fewer than half of married 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 among poor youth, who are in a weaker position to negotiate safe sex and more likely to experience sex for exchange.[36]

People under the age of 25 also account for more than 100 million sexually transmitted infections, other than HIV each year.[37] Even though most sexually transmitted infections are easily treated, many go unnoticed, and many of the young, especially women and girls, do not seek services, especially 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 a sexually transmitted infection would rather go to a traditional healer than use formal reproductive health services because of the high cost and low quality.[39]

Adolescent pregnancies carry a higher risk of obstetric complications, such as obstructed labor, eclampsia, and fistula, and yet girls are less likely to receive adequate antenatal or obstetric care, making them twice as likely to die during childbirth as women more than 20 years old. 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]

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

So, 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 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 toward women's health. The Millennium Development Goal for maternal health is one where the least progress has been made to date, and strong concerted actions need to be taken to achieve significant progress as we enter the last five years of the MDG countdown phase.

Challenges and Solutions

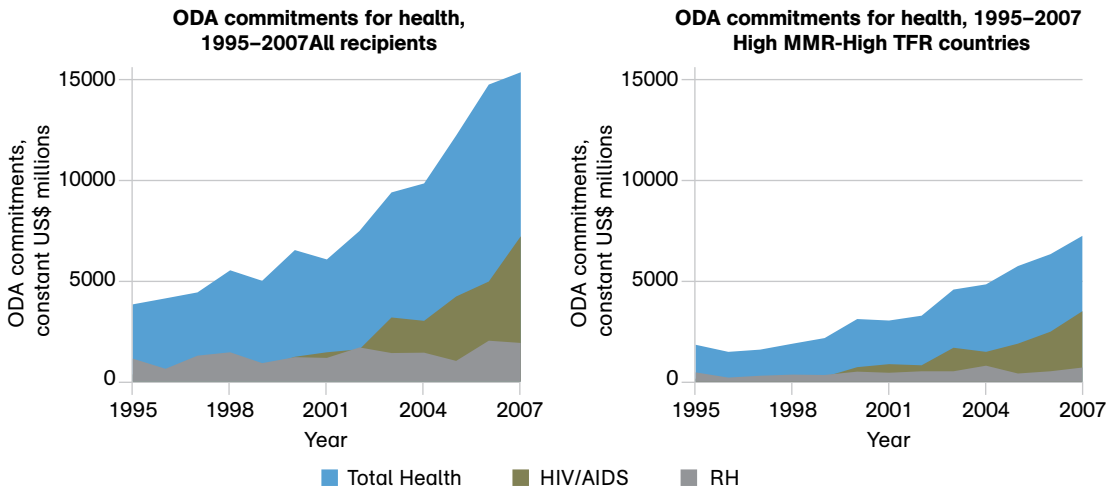
Despite the fact that technical solutions to most of the problems associated with mortality and morbidity in pregnancy and childbirth are well known, more than half a million women still die due to complications developed during pregnancy and childbirth every year. The Global Safe Motherhood Initiative 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 a 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?

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

All this reduced the share of development assistance for reproductive health 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 to US$1,835 million.[48] And only a third of ODA for reproductive health has targeted countries with high MMR and high TFR (figure 5). Some of the biggest recipients of ODA for reproductive health in 2007—India and Bangladesh, for example—now have fairly low TFR (less than 3).

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

Figure 5 | **Official Development Assistance for Health and its Composition, 1995–2007**



Source: OECD DAC.

4 percent of the Bank's health portfolio in the last decade, dropping by two-thirds between the first and second half of the decade, 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 TFR (with rates above 5). Though 75 percent of the country assistance strategies (CASs) in high fertility countries discussed population issues in their analytical frameworks, only half 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 (such as the TFR, population growth, or contraceptive prevalence rate) 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]

The announcement of the 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 more than 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 'H8') was formed and meets regularly. The White Ribbon Alliance—with Sarah Brown, wife of the former British Prime Minister, as 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.

The significant increase in attention to reproductive health issues through greater awareness, better internal cohesion, and high-level political engagement underscores the need to ensure that investments are directed toward solutions that are seen technically 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.

The first step in 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), more than 800 million women wanted to avoid pregnancy and thus had a need for contraception. Of this number, 600 million were using modern contraceptives, which prevented 188 million unintended pregnancies, 1.2 million 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 twice the 12 percent in 1990). In many countries, the proportion of demand for birth spacing or limiting 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 less than 80 percent. But in the poorest quintiles, levels are at par with aggregate contraceptive prevalence. In Sub-Saharan Africa, the unmet need for family planning exceeds 24 percent. Overall, less than half the demand for spacing and limiting—and less than a quarter among the poorest quintile—is being met.

By further increasing contraception coverage and reducing the unmet need for family planning, the reduction of closely spaced births, unwanted pregnancies, and unsafe abortions will improve health outcomes for women and children. Estimates suggest that if all interbirth intervals of less than 24 months were increased to at least that length, the lives of 0.9 million children under the age of 5 could be saved. Increasing the interval to 33 months would save an additional 0.9 million lives, for a total of 1.8 million.

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 about 64 percent to 79 percent. But fewer than 50 percent of pregnant women in the period 2003–08 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 was only 44 percent in Sub-Saharan Africa and 42 percent in Southern Asia (table 2).

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 controlled by drugs such as oxytocin. Sepsis, the 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 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 sections are performed on time to save the mother and the baby. But since complications are not predictable, all women need care from skilled health professionals during pregnancy, childbirth, and the weeks after delivery.[51]

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.[52] 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 to preserve the life and health of mother or infant, which implies that countries reporting fewer than 5 percent of births by C-section typically have many life-threatening complications that are not receiving the necessary care.[53] A large number of countries, many with the highest MMR, have C-Section rates lower than 5 percent (figure 6).

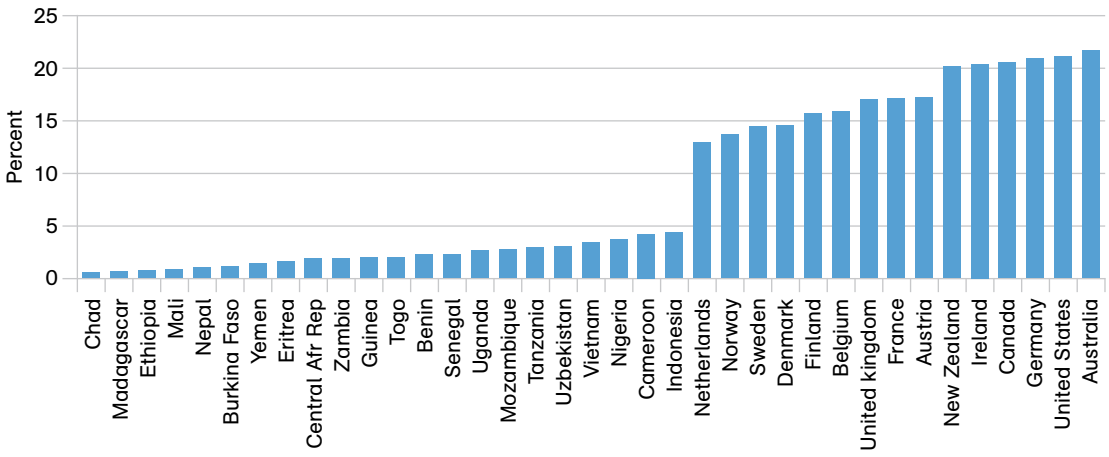
Table 2 | Proportion of Births Attended by Skilled Health Personnel

	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

Source: WHO, 2008, *Proportion of birth attended by a skilled health worker.* 2008 updates, Geneva.

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 success, but in all cases the emphasis has been on rapidly reaching populations in need of family planning and speeding access to appropriate skilled care, including emergency obstetric care, for women during pregnancy and delivery.

Figure 6 | Deliveries by C-Section



Source: DHS (various years).

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 doubled in the last 10 years (to 35 million worldwide) the number of women worldwide who use injectable contraceptives to prevent pregnancies.

Countries around the world are experimenting with innovative ways to speed access to appropriate skilled care by women during pregnancy and delivery. In a supply-side intervention, 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 that 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 7 million in 2007–08.

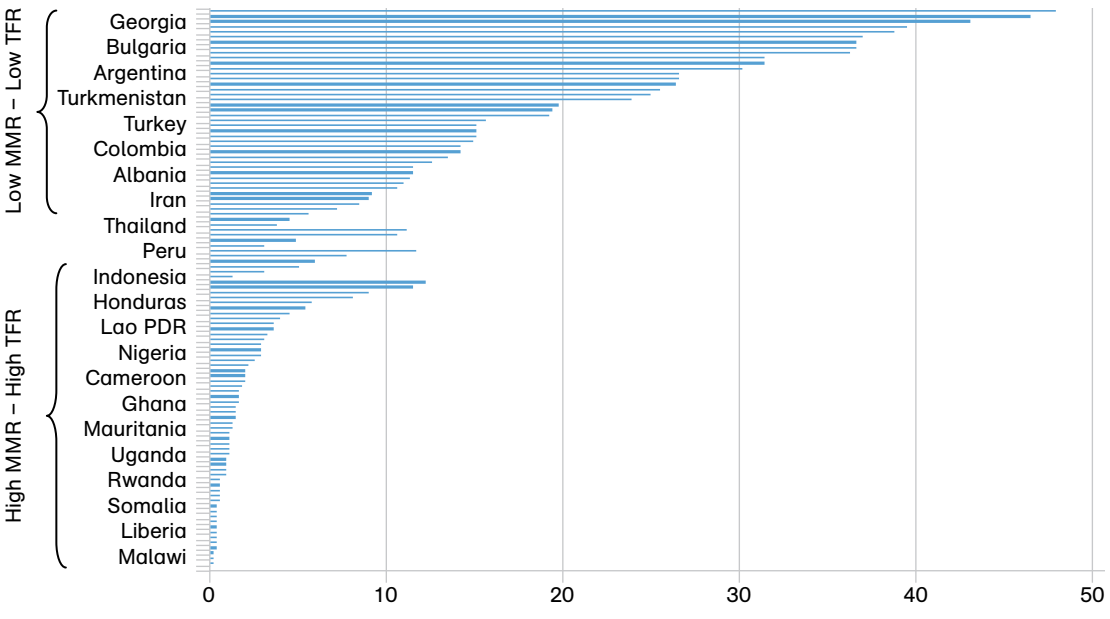
The decline in maternal mortality in North Africa, East Asia, South East Asia, and Latin America and the Caribbean shares many common features: increased use of contraception to delay and limit childbearing and better access to high quality obstetric care services. Experiences from China, Iran, Malaysia, and Sri Lanka, and from projects in India and Tanzania, 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.

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, this 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 reproductive health results requires a well-organized and sustainable country health system, capable of responding to the needs of women, children, and families. Inputs 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.

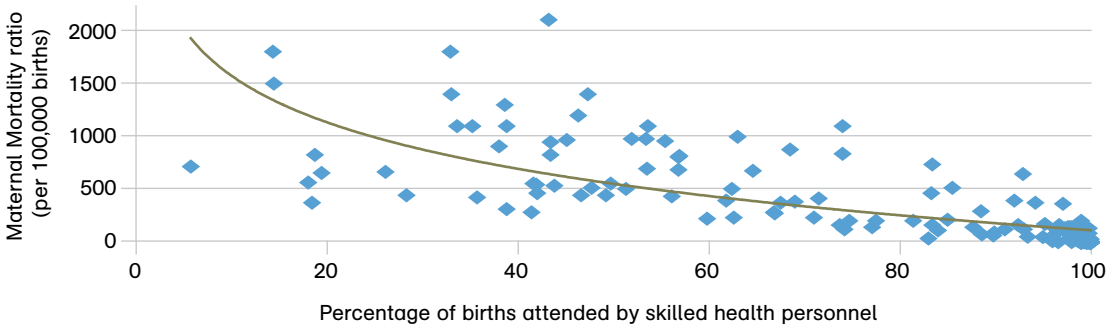
Well-resourced health systems include appropriate numbers of skilled health workers and managers who are spatially distributed according to need. But many countries, especially in Africa, have shortages estimated at 2.4 million doctors, nurses and midwives. The shortage is especially acute in countries with high MMR and high TFR, which typically have fewer health personnel per 10,000 population relative to other groups of countries (figure 7).[54] 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).

Figure 7 | Physicians per 10,000 Population



Source: World Development Indicators.

Figure 8 | **Percentage of Births Attended by Skilled Personnel and the Maternal Mortality Ratio (per 100,000 births)**



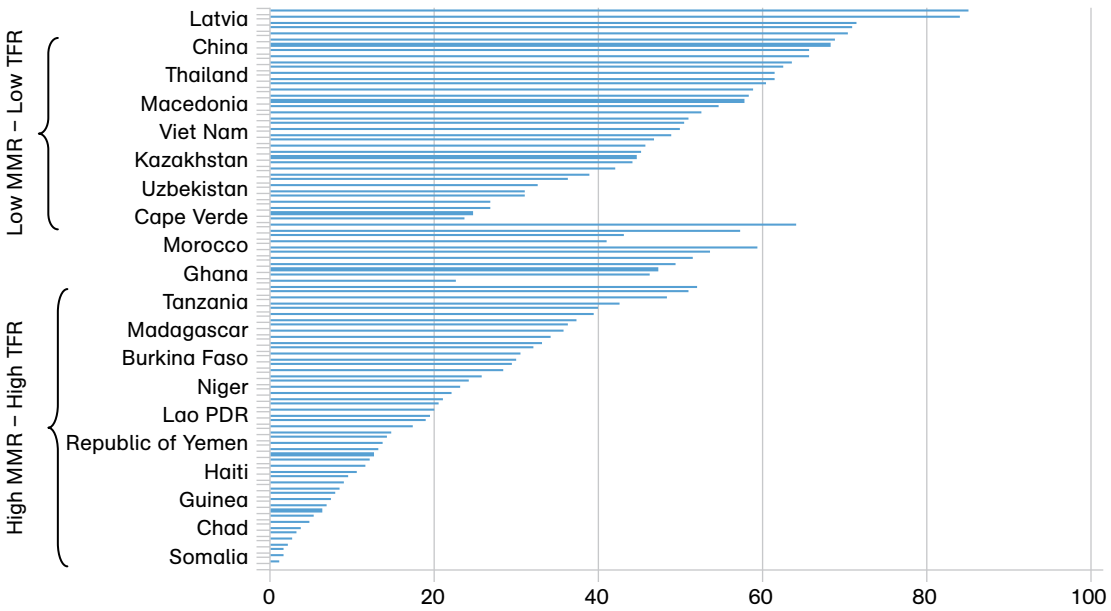
Source: World Development Indicators.

Another aspect of strong health systems is the quality of overall governance, which directly affects the environment for health systems to 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. It 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).[55] Where countries have made strides in addressing TFR and MMR, government interest and ownership have been critical for these successes and for ensuring that these are sustained.

The 2009 Global Consensus on Maternal and Neonatal Health, signed by 41 bilateral and multilateral development agencies, including the Bank, provides a checklist of policies and priority interventions to ensure improved outcomes.[56] The Global Consensus recognizes that MDGs 4 and 5 will not be reached without country leadership and setting reproductive, maternal, and newborn health as priorities at country level. The Global Consensus proposes a five-point plan that includes:

- Political, operational, and community leadership and engagement.
- 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.
- Services for women and children free at the point of use if countries choose to provide them.
- Skilled and motivated health workers in the right place at the right time, with supporting infrastructure, drugs, and equipment.

Figure 9 | Government Effectiveness (percentile rank)



Source: World Bank's Worldwide Governance Indicators database

→ Accountability for results with robust monitoring and evaluation.

Sustained political commitment and leadership, especially at the national and local levels, are 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. So are multisectoral commitments to tackle the root causes of poor maternal and neonatal health, including inequity, poverty, gender inequality, the low education status of women, and lack of respect for women's human rights.

In broader terms, implementing the foregoing interventions would require addressing implementation constraints at various levels.[57] For communities and households, this would include increasing the demand for services and removing financial and geographic barriers to maternal health services. For health service delivery, it would require effective human resource management to ensure health personnel attend to deliveries, upgrading and equipping health facilities, and strengthening health management information systems for monitoring and evaluation. For health sector policy and strategic management level, strategic public-private partnerships to ensure universal access to health services. For public policies cutting across sectors, promoting education of girls, expanding road networks, and making available affordable transport. For remedying fragmentation of donor efforts and financing, 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. Its Action Plan brings together these dimensions through targeting high burden countries, emphasizing reproductive health within health system strengthening, focusing on the poor and the adolescents, and leveraging partnerships, including those with civil society.

The Bank's Action Plan

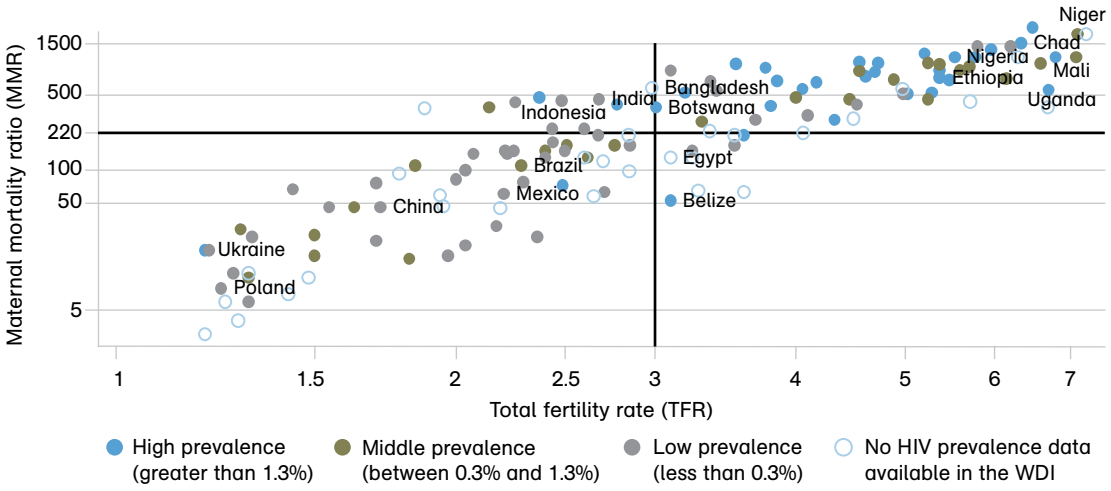
The economic, poverty reduction, and equity rationales for the Bank's focus on reproductive health are compelling. Improved outcomes—lower fertility rates, improved pregnancy outcomes, and lower sexually-transmitted infections—have broader individual, family, and societal benefits. The benefits include a healthier and more productive work force, greater financial and other resources for each child in smaller families, and enabling young women to delay childbearing until they have achieved educational and other goals.[58] Women endure a disproportionate burden of poor reproductive health outcomes, but investments in reproductive health have multiple payoffs for families, communities, and the national economy. Poor reproductive health outcomes—early pregnancies, unintended pregnancies, excess fertility, and poorly managed obstetric complications—adversely affect the opportunities for poor women and their families to escape poverty.[59] 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 reproductive health services, including the ability to make voluntary and informed decisions about fertility. Overall, investing in reproductive health confers widespread benefits to society and contributes to sustainable development through improving equity, economic potential, and the quality of life.

Country focus

In general, MMR, TFR, STI, and other reproductive health outcomes tend to be highly correlated across countries: high MMR countries also tend to have high TFR and relatively high HIV prevalence among young women, and vice-versa. Exceptions include Bangladesh and Indonesia, which have lower total fertility and HIV but high MMR, and Egypt and Belize, which have lower MMR but high TFR. Figure 10 highlights the different quadrants countries fall in 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).[60] Box 2 and figure 11 depict the countries in these quadrants.

Countries with high MMR, high TFR, and high STIS also have weak health systems and low implementation capacities. Almost all high MMR-high TFR-high STI countries fall in the bottom two groups for two or more of the following three health system indicators: DPT3 vaccination coverage, skilled birth attendance, and physicians per capita (table 3)[61]. Countries that have high MMRs and high TFRs are also predominantly low-income, with generally poorer socio-economic indicators and implementation capacities. By 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.[62]

Figure 10 | Maternal Mortality Ratios Versus Total Fertility Rates in Developing Countries, 2005



Source: WDI
Note: Median TFR=3; Median MMR=220
Colors mark HIV prevalence among females aged 15–24

In terms of geographic prioritization, the Bank will focus on the 57 countries with high MMR and high TFR and, within this group, on countries where MMR and TFR have remained high over extended periods. Interventions would necessarily vary, depending on whether rates are declining, stagnant, or rising. In high TFR countries already experiencing the beginnings of fertility decline, it would be necessary to accelerate the pace of fertility decline through, say, targeted awareness-generation and media campaigns to provide information on the benefits of having smaller families and on improving access to a

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

variety of quality family planning services.[63] But in countries such as Uganda, where unmet need for family planning is high and the total fertility is higher than the desired family size, the approach will be to improve access to quality family planning services. Similarly, the MMR is declining in many countries (Botswana, Tanzania, and Peru), and the focus in these countries will be on sustaining the progress to date. In other countries, where MMR have been high and stagnant, interventions would focus on addressing the health system issues such as human resources, availability of quality emergency obstetric care services, and a political commitment to bring about a change.

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. But family planning approaches will be targeted on population subgroups and subnational areas that have higher TFR.

In the group of countries with low MMR and high TFR as well as those with low MMR and 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 nine countries with low MMR and high TFR will be to address the unmet need for contraceptives with the same kind of approaches as for countries with high MMR and high TFR. Strategies for ad-

Box 2 | Countries Classified According to MMR and TFR

This list is restricted to countries that had MMR 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.

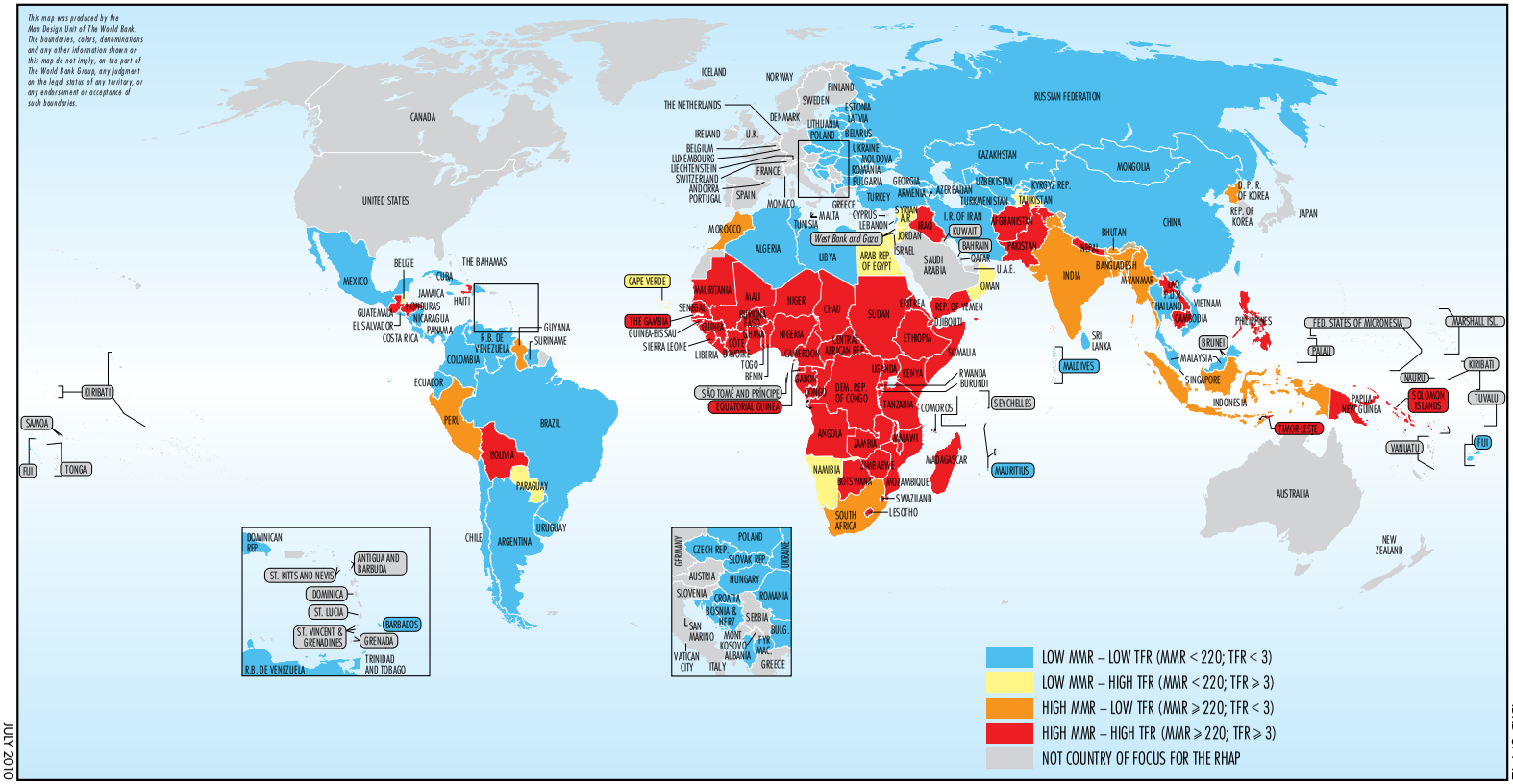
High MMR-High TFR (TFR 3 or more; MMR 220 or more): Afghanistan, Angola, Burundi, Benin, Burkina Faso, Bolivia, Botswana, Central African Republic, Côte d'Ivoire, Cameroon, Congo, Rep., Comoros, Djibouti, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Gambia, The, Guinea-Bissau, Equatorial Guinea, Guatemala, 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.

Figure 11 | Countries Classified According to MMR and TFR



dressing maternal morbidity and mortality, as well as high fertility, will be targeted on population subgroups and subnational areas that have 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.

Health System Strengthening

In line with its HNP strategy, the Bank will work closely with countries and development partners to strengthen health systems to improve 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 reproductive health 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 that identifies the central elements of health system strengthening as six "building blocks" that make up the system: service delivery; health workforce; information; medical products, vaccines, and technologies; financing; and leadership and governance.[64]

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 system performance for improving reproductive health outcomes.

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 nonstate sectors. These include results-based financing, demand-generation strategies, demand-side financing, and strengthening community-based services and accountability.

Skilled care at childbirth is most important for the survival of women and their babies. And the availability of qualified and trained health personnel to assist deliveries is key to ensuring optimal pregnancy outcomes. Yet a 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 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"[65] 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.[66]

A key health system strengthening intervention is thus 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 maternity mortality 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.

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 pro-

viders that agreed to reach certain targets such as proportion of children fully immunized and pregnant women receiving prenatal care. In the seven years 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 pilots to construct a national, unified approach for paying public and NGO service providers based on services provided. Between 2001 and 2004, curative care visits per person increased from 22 percent to 55 percent and institutional deliveries nearly doubled (from 12 percent to 23 percent). Such results-based financing moves funding away from inputs—salaries, construction, training, and equipment—to results, and creates a whole new set of incentives for providers.

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

Pregnancies that result in complications that cannot be addressed by skilled birth attendants need attention and treatment at well-staffed and equipped health facilities, where many newborns who might otherwise die can be saved. About one in seven pregnancies results in a complication that would need this higher level of care, a statistic enhanced by random and unpredictable complications. Timing is critical in preventing maternal death and disability during complications. Post-partum hemorrhage can kill a woman in less than 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. 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, 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 emer-

gency 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.

Also important is promoting awareness of pregnancy-related health risks and enhancing the care-seeking behavior of pregnant women. Results-based financing has been shown to increase patient demand for health services. Evaluations of large-scale conditional cash transfer programs in Latin America and the Caribbean show greater use of clinic services for children (Honduras, Nicaragua, and Colombia) and prenatal care (Mexico, Honduras) and less childhood stunting (Mexico, Nicaragua, and Colombia).

In 1997 Mexico introduced *Oportunidades,* a large-scale conditional cash transfer 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 5 million household beneficiaries) represented less that 1 percent of Mexico's GDP. Numerous evaluations of Mexico's *Oportunidades* program have shown that it increased the use of health services and improved maternal health outcomes. The Bank will support countries in high MMR and high TFR groups planning to introduce conditional cash transfers to influence patient behavior and increase the use of maternal health services.

A reliable and adequate supply of good-quality contraceptives—including intrauterine devices, oral contraceptives, condoms, emergency contraceptives, and injectables—is essential for reproductive health services. Increases in demand for contraceptives, shortages 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 to establish robust logistical, regulatory, and quality assurance systems—all of which are key elements of a strong health system—to minimize stockouts, shipment delays, and the undersupply or oversupply of certain contraceptives.

Integrating HIV prevention into reproductive health 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, one in three 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 anti-

retroviral 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 sexual and reproductive health 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 half. Prevalence came down from about 2 percent in 2000 to less than 1 percent in 2007.

Reaching the Poor

There is widespread evidence that poor people suffer from far higher morbidity, mortality, and malnutrition than do the better-off; and their inadequate health is one of the factors for their being poor. An analysis of DHS datasets shows a strong correlation between maternal health and poverty. 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 poorest women have almost twice 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.[67]

Poor reproductive health outcomes contribute to poverty in different ways, mainly through the negative impact on overall health. In addition, large family 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 the biological constraints associated with their age. Table 4 shows the inequalities in use 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, and treatment of fever.

Ensuring access to family planning and maternal services among the poor can reduce inequality and improve the health

Table 4 | Percentage of Currently Married Women (15–49) Using a Modern Family Planning Method

Wealth quintile	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

status of women in the lower wealth quintiles. Bolivia has aggressively implemented social insurance schemes that 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 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 reductions in inequality in using family planning and antenatal care services. By contrast, 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 will need to be sustained for a longer period for a significant change in use among the poor.

The link between reproductive health and poverty reduction has important implications for policies and program responses in developing countries. A menu of pro-poor policies 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). And successful interventions in low-income countries can also be tailored to specifically meet the reproductive health of women in lower wealth quintiles (box 3). 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.

Reaching Adolescents

More than half the youth in many countries are sexually active.[68] Among sexually active young men and young women, the use of condoms is low, increasing their risk of acquiring sexually transmitted infections. Demographic and Health Survey data show that the share of sexually active boys using condoms ranges from about 20 percent in Mali to a high of 50 percent in Zambia. Among girls, condom use is higher among unmarried sexually active girls than among married girls.[69] As mentioned earlier, people under the age of 25 account for more than 100 million sexually transmitted infections annually. Most 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.[70] The Bank will support countries to improve access to reproductive health services for the youth, especially for the treatment of sexually transmitted infections.

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 ser-

Table 5 | Menu of Pro-poor Policies

	Finance	Provider payment	Organization	Regulation	Persuasion
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 resource allocation	Standards for facilities serving the poor Input market regulation (drugs, equipment, and the like)	Social marketing Health education focus Strengthening outreach Generating demand
Micro level (community and facility)	Exemption policies for the poor Facility equity funds	Provider payment linked to use by poor Community-based mechanisms for identifying the poor	Local or community management of services Participatory planning Campaign mode delivery Mobile delivery approaches	Local or community oversight Supervision of facilities serving the poor Active identification of the poor	Community mobilization Health education campaigns

Source: Yazbeck, AS, 2009. Attacking Inequality in the Health Sector—A Synthesis of Evidence and Tools. Washington, DC: World Bank.

Of the estimated 200 million pregnancies 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 many as 25 percent of maternal deaths.[71] At least a fourth of the estimated 20 million unsafe abortions each year are for women aged 15 to 19.[72] 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

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, and 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 and 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, and 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, Mexico), social marketing (Tanzania), and outreach health education (Brazil, Cambodia, Chile, Kenya).

Source: Yazbeck, AS, 2009. *Attacking Jnequality in the Health Sector – A Synthesis of Evidence and Tools.* Washington, DC: World Bank.

vices 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.

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 and 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.[73]

Working with Partners and Civil Society

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, deliver, and increase the use of reproductive health services. With just five years 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 be strongly aligned with national systems in their design and implementation to maximize the synergies and potential outcomes.

Besides national ownership and alignment with national systems, implementation of the reproductive health 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 reproductive health 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 toward national health goals and the MDGs. Mobilizing and streamlining the flow of existing and new international resources to support health system components of national health plans will strengthen country capacity to deliver reproductive health programs to all, especially to the poor and vulnerable.

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 competencies 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.

Results Framework

This Action Plan will contribute to reducing high fertility, improving pregnancy outcomes, and reducing sexually transmitted infections, 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 just noted. 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 reproductive health Action Plan, which is closely aligned with the country outcomes, intermediate indicators, and processes included in the HNP Sector Strategy.

The Results Framework in table 6 has three tiers. The first includes country-level development outcomes, which are final outcomes (such as declines in mortality and fertility) 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 better coverage with interventions known to contribute to country outcomes. Indicators in this 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 to enable achieving the intermediate coverage indicators.

To assist the countries in the renewed push toward meeting MDG 5, the Bank will strengthen its capacity and expertise across several core competencies. The Bank will seek to increase its expertise by training existing HNP specialists in reproductive health issues, identifying reproductive health 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 to provide the basis for assisting countries, informing policy dialogues, and raising awareness on reproductive health issues. Examples of analytical work include analyzing of country-specific constraints for reproductive health; tracking resource flows for reproductive health and identifying financing gaps, and documenting success stories and "good practices" to learn from positive experiences. In addition, the 2012 World Development Report, *Development and Gender Equity*, will include reproductive health issues. The Bank will increase the level and effectiveness of lending and support for health system strengthening and multisectoral interventions to address reproductive health in priority countries.

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 civil registration systems that are too incomplete to provide usable information on vital statistics. 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.[74] 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.

Table 6 | Results Framework for the Reproductive Health Action Plan

1. Country Development Outcomes	
Priority Area	**Indicators and Targets[a]**
Reducing high fertility	Total fertility rate reduced (*HNP Sector Strategy indicator*)
Improving pregnancy outcomes	Maternal mortality ratio reduced (*HNP Sector Strategy indicator*)
Reducing sexually transmitted infections	Reduced morbidity and mortality from HIV/AIDS and other priority STIs (*HNP Sector Strategy indicator*)

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] (*HNP Sector Strategy indicator*)
	Contraceptive prevalence rate increased to allow women to reach desired family size (*HNP Sector Strategy indicator*)
	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 (*HNP Sector Strategy indicator*)
	Newborns protected against tetanus in target countries increased (*HNP Sector Strategy indicator*)
	Pregnant women receiving prenatal care in target countries increased (*HNP Sector Strategy indicator*)
Reducing sexually transmitted infections	Pregnant women living with HIV who received antiretrovirals to reduce the risk of mother-to-child transmission 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 Contribute to Country and Intermediate Outcomes			
	Activities	**Indicators and 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 CASs 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

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Table 6 | Results Framework for the Reproductive Health Action Plan (*continued*)

		Percentage of health projects scheduled for 2010–15 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 National Health reproductive health subaccounts 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 reproductive health issues	Disseminate the South Asia report *Sparing Lives* (by December 2010). Africa Region flagship report completed and disseminated (by December 2012) Europe and Central Asia region flagship report completed and disseminated (by December 2012) East Asia and Pacific region flagship report completed and disseminated (by December 2011) Middle East and North Africa region flagship report completed and disseminated (by June 2013)	SASHD AFTHE ECSHD EASHH MNAHD
	Ensure reproductive health issues are included in the 2012 World Development Report *Development and Gender Equity*	Reproductive health issues incorporated in 2012 World Development Report *Development and Gender Equity*	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 reproductive health	Establish reproductive health expert team including representation from other sectors	Expert team on reproductive health issues, including representatives from PREM, DEC, education, and other relevant sectors established (by June 2010)	HNP Sector Board
	Strengthen skills of existing staff in reproductive health and recruit new staff as necessary	Reproductive health focal points in all Bank regions identified Recruit new HNP specialists with strong skills in reproductive health for Africa, South-Asia and HDNHE as required by operational needs	HNP Sector Board HNP Sector Board
	Develop and disseminate FAQs and guidance notes for addressing reproductive health constraints	FAQs and guidance notes developed, disseminated, and available on HNP website (ongoing)	HDNHE, HNP Regions

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Table 6 | Results Framework for the Reproductive Health Action Plan (*continued*)

	Review and strengthen the existing flagship course on reproductive health	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 reproductive health	Conduct Development Marketplace in reproductive health 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 reproductive health technical support	Matrix of list of pipeline projects and CASs shared with regional reproductive health focal points monthly	HDNHE, HNP Regions
	Prepare monthly updates of the list of ongoing projects to identify projects due for mid-term reviews and implementation completion reports	Matrix of list of projects with upcoming mid-term reviews and implementation completion reports shared with regional reproductive health 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 reproductive health focal points monthly	HDNHE, HNP Regions
	Track key reproductive health indicators (as identified earlier) by poverty quintiles in countries with high MMR or high TFR	List of reproductive health indicators for monitoring country reproductive health outcomes developed and annually updated	HDNHE, HNP Regions
	Participation in Quality Enhancement Review Panel of projects under preparation with Pop/RH theme in countries with high MMR or high TFR	Number of panels with reproductive health expertise participating in quality enhancement review (ongoing)	HNP Quality team, HDNHE, HNP Regions
	Participation in mid-term reviews or implementation completion reports of health projects with Pop/RH theme in countries with high MMR or high TFR	Number of midterm reviews with reproductive health expertise participating in each mid-term review or implementation completion reports (ongoing)	HNP Quality team, HDNHE, HNP Regions

[a] The country level reproductive health outcomes do not have targets because countries and other development partners will also contribute to these outcomes.
[b] In 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 include the following.

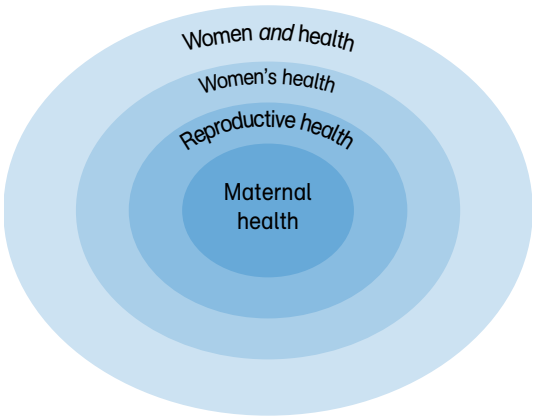
1. Conceptual and definitional issues

- The World Bank's definition of sexual and reproductive health includes pregnancy and pre-pregnancy related care, neonatal care, contraception, delivery, post-partum, sexually transmitted infections, and building linkages with HIV/AIDS and with gender and youth.
- Reproductive health should not be framed purely as a health issue. It is important to recognize and leverage cross-sectoral links in addressing reproductive health (transport, communications, women's empowerment, girls' education, human rights, and poverty). This is an area where the World Bank has a comparative advantage.
- The 1994 International Conference on Population and Development (ICPD), a unique event, was 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—toward 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 and demography.
- Cairo's concepts were broad—Cairo is not a convention or treaty, but a normative statement debated by governments. This breadth is a strength for bringing together different political constituencies, but it has also generated issues and challenges. These range from confusion over program components, particularly in the relative emphasis 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 noncommunicable 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.
- At the same time, the role of men as decisionmakers in households, 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 subcomponents.
- The World Bank remains committed to ICPD, a commitment reaffirmed 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 system 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 reproductive health rests with the countries and would consider social and cultural issues. In this respect, engaging in dialogue based on scientific research can yield more convincing results.

A Conceptual Framework for Women and Health



2. Using the health system strengthening platform

- Health system strengthening has developed out of the tensions between vertical disease-specific programs and horizontal systemwide programs. Many global health initiatives have hesitated to use system-

wide approaches because of concern that the health system is a black box, a black hole, or a laundry list. Vertical programs, meanwhile, can create parallel structures that are disruptive to an effective country health system.

- Health system strengthening needs to happen, biased toward sexual and reproductive health—and 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.
- Health system strengthening 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 health system strengthening 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, the package in the diagonal approach is a resource allocation tool that considers workforce, information, and other inputs and processes needed to implement it.
- Using the language of entitlements in designing a package of services is a concrete step 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 health system strengthening 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 health system strengthening. For MMR, this could mean starting with better case-finding and estimates. At the beginning, this could lead to higher estimates of MMR, but the result of more accurate estimates is a stronger health information system. This is a clear example of the spillover effects. Capacity development data collection, analysis, and use 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 include the process of decentralizing service delivery and a system of peer review.
- There are several pitfalls to be aware of in adopting health system strengthening 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 to-

ward system strengthening. And as health system strengthening becomes more mainstreamed, there is a danger of duplication or verticalization of health system strengthening as its own separate program, rather than as 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 health system strengthening for reproductive health. Rather than focus on an ultimate outcome—MMR, which is difficult to monitor day-to-day—effective coverage focuses on those interventions 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 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 reproductive health programs that should not be ignored or dismantled. Instead, the focus should be on how to integrate them 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 skilled birth attendants 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. Low-cost high-output community-based approaches may be most efficient for reducing the total fertility rate. 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 and 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 intraurine devices, and indeed performing all the essential components of emergency obstetric care. Task-shifting downward 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 the procurement of contraceptives. To avoid the long lead time for Bank procurement, UN partners, such as UNFPA/UNICEF, can do 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 efficiency and in reaching women living with HIV and preventing mother-to-child transmission. These links 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. Many NGOs and private healthcare providers offer reproductive health services. Supporting governments to regulate these nonstate providers and incorporate them in the public sector has potential for creating greater synergies in reaching the target populations.
- The Action Plan also has to recognize and leverage the private sector's involvement in reproductive health, especially since the private sector is the primary source of services in most of the focus countries. There is also a need to recognize that the private sector is not monolithic.

3. Stewardship

- Maternal health has not received the attention it deserves—for several reasons. There is a lack of political will because of an unwillingness to talk about anything related to sex. The perception problem exists within the United States as well (members of Congress question need to include maternity care in the U.S. health bill). But Secretary of State Hillary Clinton really gets this issue and is one of the main reasons why the U.S. is including maternal health in new policies. Her leadership should be leveraged to help further this cause.
- The role of men in reproductive health as decision makers in political legislature was also brought up. There is a need for their capacity development and technical engagement to try to educate political leaders 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 for 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. Beginning with a matrix of options that gives structure and priority would be a useful tool.
- There is a need for legal frameworks surrounding reproductive health for several reasons. Legal frameworks should ensure 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. And training for non-medical staff for provision of reproductive health services is vital in countries like Nepal. These legal frameworks should be flexible enough to review and meet new challenges for meeting the demand for services. The Bank has a role to play

here—as in including reproductive health in social protection programs.

- The problem also exists with the current priority-setting tools that measure the burden of disease. Maternal health doesn't rank high when compared with malaria and TB. There is a need to develop and use better tools to accurately assess the impact of maternal mortality and morbidity on countries' development. Employment of DALYs as a measure of lost productivity due to reproductive health-related mortality and morbidity is one option.
- Health systems have several functions, with service provision is part of the larger system. The weakest health system function in many countries is stewardship: 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 stewardship. 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 in 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 system strengthening at the local level by improving coordination and communication about priorities.

5. Advocacy and resource tracking

- The World Bank has a convening role in stimulating global dialogue on reproductive health. This could reenergize discussions of the theoretical understanding of links between reproductive health and development as well as considerations of how to operationalize reproductive health in countries.
- The need for funding was brought up in all consultations (by civil society in Guatemala, especially in reference to reaching indigenous populations). The Bank can advocate with partners for a reallocation of resources within the existing health system for reproductive health. This includes ensuring that reproductive health interventions are included in the basic packages financed, particularly those under International Health Partnership and within HHA countries.
- Some agreements on the ground are getting no traction (such as the Maputo Plan, 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. It is now incumbent on member states to implement the Plan.

But there are no resources to implement it. Providing resources to support the Maputo Plan could ensure that the Bank's Reproductive Health Action Plan gets national ownership within Africa.

- The World Bank is uniquely positioned at the country level to advocate for reproductive health, particularly in reaching Ministers of Finance. This will require using the World Bank's economic analysis and technical resources to marshal arguments for investing in reproductive health. Bank's country directors have key role in making reproductive health a country priority through their policy dialogue with governments.
- On cultural barriers, it was pointed out that the reproductive health bill in Nigeria, presented to the Parliament four or five times, has always been rejected because it is equated with abortion, raising 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 health system strengthening 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 been not 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 and identify success stories for health systems and reproductive health to 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 reproductive health or health in general is put forward as a focal area in the poverty reduction strategy papers or the country strategy papers.
- The World Bank has a critical role in tracking resources, in coordination with such agencies 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 subaccounts are an important tool for tracking resources, but different approaches are used to make estimates, requiring greater harmonization. The Bank should support countries with necessary expertise and build capacity in countries that lack it. Support for budget estimations based on actual needs has to be emphasized. There should be a budget line for reproductive health in the health budget.
- Tracking resources through national health accounts have also allowed to identify potential problems. For example, the recent national health of accounts show that health expenditure in Niger has increased from $10 per capita to about $44 per capita. But the resources are focused mainly on tertiary services, when more primary health care

and referral services would have greater impacts. Being able to gauge these sorts of issues quickly is important in ensuring remedial actions.

- Time is another dimension to factor 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 reproductive health in certain countries when funding was removed.

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.
- Both system inputs and system processes need to be considered in health system strengthening. We need to understand the dynamic aspects of how inputs are translated into services and outcomes. These include incentives and different delivery platforms.
- Consumer mobilization is important, generating demand for health services such as antenatal and postnatal care, and institution-based deliveries. Civil society actors can mobilize the communities through information, social audits, and monitoring and evaluation, such strategy also makes sense from the point of governance.
- Women's health is often neglected even when they have access to health care facilities. For example, women will bring their children for checkups and immunization, but receive little postnatal care.
- 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 driven by ideology.
- It is important to track demand for services. In Niger, indicators incorporated in the national framework that tracks results have allowed for annual monitoring and evaluation to find out the progress on reproductive health, rather than waiting for the next DHS or other survey.
- Incentives can generate demand. There have been a lot of experiences in the field (as in Nepal) with subsidizing and giving incentives for reducing financial barriers to obstetric care. This discussion needs to continue.

7. Keeping engaged – next steps

- There should be regular meetings between Global Health Council members, and the World Bank.
- Emphasis should be on improving the quality of care, including that of existing facilities, reducing barriers to access whether financial, physical, or cultural, and improving monitoring systems for maternal and newborn health.
- The Action Plan should look at the big picture. Reproductive health has a gender dimension as well. Political stability is important for improving reproductive health outcomes. MMR and TFR are correlated

with the quality of state health systems and poverty, and child survival is related to the total fertility rate. The World Bank should look at reproductive health not only from 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 health system strengthening. 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 in the Aid Effectiveness Agenda and that should be stated up front. It would be easier to find solutions to financing payments or human resources within this context rather than isolation.
- The Action Plan should build on the same indicators as those created for the MDGs and the Countdown to 2015 process. Because they are compiled regularly and published in *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 package to improve the pregnancy outcome. This includes linking neonatal health with reproductive health. Other areas include HIV/AIDS, gender based violence, and adolescent sexual and reproductive health.
- Reproductive morbidity should be addressed, including cancer of the cervix and fistula, rarely addressed in Nepal. The World Bank could bring lessons from other countries on how this has been incorporated into national health systems.
- For family planning, it may be useful to have a profile of the target populations. For example, in Nepal, migrant couples have higher contraceptive prevalence rates than the general reproductive age group. This type of knowledge is important in determining target groups and how to reach them.
- Preferences for family planning methods may also be an area for further work: Why are some methods more easily adopted or more popular in certain settings?
- Marginalized or vulnerable populations also need a special focus. There is a need for better understanding of the requirements and preferences of indigenous populations—and of what is culturally relevant to bring indigenous women into the fold of reproductive health service delivery. Education is particularly rel-

evant, especially to reduce teenage pregnancies and the incidence of HIV/AIDS. The Bank's comparative advantage is in having safeguards in its multisectoral projects that foster the protection and development of women. Participants stressed the importance of child and youth education and incorporating sexual and reproductive health into the Bank's education projects (as in Guatemala).

- Gender issues—such as poor female mobility and financial and cultural barriers—may be preventing women from institutional deliveries and need to be included in the reproductive health Action Plan.
- Learning from best practices was emphasized, including successes in reproductive health, and in other health subsectors. What can we learn from HIV programs that we can then bring into reproductive health?
- Another area could be integration of the voices of civil society organizations at the national level. They have been integrated successfully into policy dialogue at the international level, but not as much at the national level. Since these grassroots organizations have access to ground level outcomes and activities, they can help in measuring success.
- The Action Plan has identified key priority areas. The next step should be to have participatory country-specific action plans to determine the interventions in each country. To further the national action plans, the World Bank's would facilitate knowledge sharing on innovations and best practices.

Consultation Logistics: Locations, Dates, and Participants

Global Health Council

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

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

Guerrera (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), Maaike 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. Outline of African Region Population and Reproductive Health Strategic Plan

The outline of this Sub-Saharan Africa Strategic Plan for Population and Reproductive Health has been prepared by the Africa Region at the World Bank. The purpose is to complement the Reproductive Health Action Plan 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 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 hosts 25 of the 28 high fertility countries, defined by a total fertility rate higher than five children per woman. The fertility transition of the 49 least developed countries (LDCs) is lagging 30 to 50 years behind the fertility declines in Latin America, the Caribbean, and Asia—and among the LDCs, Sub-Saharan Africa's fertility transition is lagging even further behind. Southern Africa (7 percent of the Sub-Saharan 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 Sub-Saharan Africa.

The high levels of population growth in Sub-Saharan Africa 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 2.5 percent a year, implying a doubling time 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, and the rate of increase of contraceptive use is very slow. Less than one woman in five uses a modern contraceptive. Moreover, the rate of increase of the contraceptive prevalence rate is estimated at only 0.5 percentage point a year. However, a few countries have increased their contraceptive prevalence rates at a faster pace: the Southern African countries and, more recently, Madagascar, Malawi, Rwanda, and Ethiopia. Their success could be a benchmark for other Sub-Saharan countries.

Poor access to family planning services results in high numbers of unwanted pregnancies and induced abortions. The low levels of contraceptive use bring two direct consequences. First, half of all pregnancies are at risk because they are too early, too numerous, and too close. Second, African women are often compelled to seek unsafe abortions to regulate their fertility. A recent study shows that, of the 20 million unsafe abortions worldwide every year, 5 million are in Sub-Saharan Africa. About 44 percent of pregnancy-related deaths in Africa are due to unsafe abortion. Bank work in 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 survival of African women.

Maternal mortality ratios are highest in Sub-Saharan Africa. Its average maternal mortality ratio (824 per 100,000) far exceeds that in other regions (Asia 329; Latin America 132). About half of all maternal deaths are occur in Sub-Saharan Africa, 247.000 of 529,000 every year. Women there face a 1 in 16 chance of dying due to causes related to pregnancy and childbirth. Some of the highest maternal mortality ratios are in Angola, Malawi, Mali, Niger, Rwanda, Sierra Leone, Tanzania, and the rate of decline has stalled.

Sub-Saharan 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: the right to have information on family planning (and express their views on the issue) and the right to have access to family planning services. Although Sub-Saharan women have on average more than 5 children, fertility levels for some men have been 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, complacency about allegedly low population densities, and the misconstrued belief that large markets by themselves will foster economic growth. Moreover, international and African 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, the 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 affects four major dimensions related to human and socioeconomic 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 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 (such as access to land, deforestation, and water supply).

Although socioeconomic development is by far the best contraceptive, contraceptives are also necessary for socioeconomic development, particularly when demographic growth is too fast. To be sure, the relationship between declining fertility and economic growth goes both ways. But should we let economic growth alone bring down high fertility levels in Sub-Saharan Africa? Or should we also provide public interventions to address "market failures," such as the lack of correct information on contraceptives? Such questions still divide development practitioners. But they need to be addressed squarely to justify public investments in population and reproductive health.

Recent Developments

There is a new discourse on population and reproductive health in Sub-Saharan Africa. A "new demography" has emerged from the body of research on the East Asian experience. It stresses the importance of age structure, dependency ratios, the demographic dividend, and the links between demographic trends and socioeconomic outcomes. And the human rights agenda, which includes access to reproductive health and family planning services, has 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 work with countries to address population and reproductive health. The Region has completed three ESWs on Population (Niger, Ethiopia, and Mali) and one on maternal health (covering Eritrea, Malawi, and Niger). It has prepared several background chapters or papers on demography to feed into CASs (Madagascar and Burkina Faso), CEMs (Uganda, Burkina Faso, and Burundi), and country programs (Rwanda). It has mainstreamed population and reproductive health issues in some PRSPs (such as Ethiopia). It has prepared or is preparing free-standing projects on population and reproductive health (Niger and Burkina Faso). And it is providing technical assistance in population issues (Burkina Faso and Mali).

A supply-driven family planning approach has worked in several countries. Madagascar, Malawi, Ethiopia, and Rwanda are among the family planning success stories (and are best practices for other Sub-Saharan countries). Success hinges around a 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. 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 and behavioral communication for change cam-

paigns. These efforts were backed up by a secure supply-chain for contraceptives. So does Ethiopia, which deployed thousands of community health workers, delivered injectables at the community level, and changed its legal texts on reproductive health. It also addressed the logistical supply of contraceptives and long-term methods.

The Health Systems for Outcomes (HSO) initiative has helped countries achieve faster rates of contraceptive coverage. In Rwanda, the strengthening of the health system has made possible impressive gains in the supply of family planning services. The results-based financing, the expansion of health insurance, and the decentralization of the health system 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 developments partners, contraceptive commodities stock-outs are now very rare (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 on the demographic factor for socioeconomic development. Recent analytical work on East Asia has demonstrated that demographic changes, particularly rapid declines in fertility, have brought about a demographic dividend caused by more favorable dependency ratios and a larger share of the labor force. But measuring this will require additional work. In particular, a production function will need to be identified for the declining fertility, 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.

Focus on population and reproductive health issues in the 25 high TFR Sub-Saharan countries. A mechanism will be established to monitor key strategic documents and lending activities. In particular, it will follow up on all CASs in the pipeline, so that population and reproductive health issues are brought into all development and poverty reduction strategies. Furthermore, no CEM and no PRSP for Sub-Saharan high TFR countries can ignore population and reproductive health dimensions. Poverty papers should also factor in demographic issues. Key sector operations, such as education, gender, and social protection, need to be informed with correct and realistic demographic data and analyses. In addition, it is proposed to prepare briefs on population and reproductive health issues, to share with country directors and country terms.

Sharpen health system for outcome approaches, to gear them better delivery of reproductive health and family planning services. First, the pace of increase of the contraceptive prevalence rate 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 to 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. But in several Sub-Saharan countries, maternal mortality remains high despite high maternal health care use. 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: the shortage of personnel, the lack of drugs, equipment, and blood supplies, the administrative delays, the problems in referral provision, and the clinical mismanagement of patients.

Differentiate 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 with current models to assist in planning other aspects of health and education). Such evidence will help guide client governments about investments to reduce high fertility and maternal mortality. The synergy between various sector interventions and potential of the private sector should both be tapped to enhance and complement the public sector's efforts.

Strengthen the evidence base to bring population and reproductive health issues to the core of the socioeconomic development agenda, for use in policy dialogues and communication tools. Such tools will help convince political leaders, policy makers, civil society representatives, and religious leaders as well as the development community about the importance of population and reproductive health issues. Bank partners have already developed such tools, such as the SPECTRUM family of models funded under USAID, including the RAPID model (now being updated). The Population Reference Bureau has developed a new ENGAGE model as well as simple brochures on population and reproductive health. The Bank is 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 will need to be put forward (censuses, surveys, and civil registration data).

Renew the policy dialogue to guide investments in population and reproductive health issues. A Concept Note for a new regional AAA study on Sub-Saharan population and reproductive health issues was developed in March/April 2010 for funding in July 2010. The Bank's last paper of this nature, *Population Growth and Policies in Sub-Saharan Africa*, was prepared in 1986. The new paper will build on the "new demography" from the East Asian experience. It will help rationalize and solidify the new discourse on population and reproductive health issues and the new approaches piloted so far. And it will also offer a detailed Action Plan on how to tackle population and reproductive health issues effectively.

Rekindle other partners' efforts in population and reproductive health. 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 U.S. Administration is fully reengaged on population and reproductive health issues under its Global Health Initiative. Other prominent NGOs and foundations have either rejoined the field or giving it serious thoughts.

Address urgently the population and reproductive health expertise crisis in the World Bank Africa Region and strengthen the ability to respond to clients needs. The Africa Region will soon lose its only demographer. Nor does it have much expertise left in reproductive health. There is an urgent need to re-establish a solid population and reproductive health work program in the Africa Region, which means more professionally qualified staff, some attracted from other regions in the Bank. Funding will need to come from the Bank Budget as well as Trust Funds. A stop-gap measure would be to ask a development partner (such as USAID) to second a population and reproductive health expert to the Africa Region.

Expected Results and Outcomes

Population and reproductive health 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, they 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 re-engaged on macro-demographic issues, closely linked to the issues of labor force, human capital investments, and poverty reduction. These efforts will be supported through additional nonlending programs of technical assistance (10 countries will be covered in five years).

Renewed and sustained Bank efforts in Sub-Saharan 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 as a contraceptive prevalence rates for modern methods of 25 to 30 percent). This will be achieved by addressing health system for outcome 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 a 1.5 percentage point increase per year) as will the other indicators for Targets 5a and 5b of MDG-5, especially those pertaining to maternal mortality. All 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

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

The Partnership for Maternal, Newborn & Child Health

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), May 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 $251 billion, of which $186 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 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

November 2009

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.

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Thoraya Ahmed Obaid
Executive Director, UNFPA

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Annex E. Acknowledgments – Longer Version

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[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 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). It 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.

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

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

[51] 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.

[52] 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 (more than half of them fetal deaths) occurring just before or during delivery or in the first week of life.

[53] Rates higher than 15 percent suggest inappropriate use of C-Sections.

[54] Ratios of physicians, nurses, 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.

[55] 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.

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[60] 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.

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