Overview

The global demographic situation has changed dramatically since the World Bank started population work three decades ago. In the 1960s, accelerating population growth created by declining mortality and high fertility was a concern in most developing countries. Today, the demographic challenges facing countries are much more diverse.

Many countries in sub-Saharan Africa, Asia, and the Middle East still face rapid population growth, and policies are needed to deal with the impact of large population increases on the environment and on the demand for services such as water, sanitation, and public transportation. In other countries, fertility rates have fallen for older, married women, but there is an epidemic of unwanted pregnancy and unsafe sexual practice among youth. The growing young adult population needs appropriate reproductive health care, education, and economic opportunities to enable them to become productive members of society.

An estimated 120 million women who currently wish to space or limit further childbearing are not using contraception. Tragically large numbers of preventable deaths continue to occur among women during childbirth, and reproductive tract infections are widespread.

Countries with aging populations and pay-as-you-go financing of social services for their elderly face an increasingly unfavorable balance between the working-age and older-age populations. Growing numbers of older women are without family or societal support systems and are at greater risk of falling into poverty.

In several African and Asian countries HIV/AIDS is decimating the young-adult populations and reversing earlier gains in life expectancy. This global epidemic is posing critical health, social, and economic challenges and is undermining productivity and public-sector management capacity.

In addition to these challenges, an overarching task is how to address the changing meanings and approaches to population that have evolved over the past quarter century and that have been summed up by the Programme of Action of the 1994 International Conference on Population and Development (ICPD). ICPD addresses population issues through people-centered policies and programs rather than top-down targets. It seeks to improve reproductive health through information and services that will help people avoid unwanted fertility, unsafe sexual behaviors, sexually transmitted infections (STIs) and HIV/AIDS, and ensure safe pregnancies and deliveries. ICPD also recognizes the crucial importance of contextual factors, particularly those related to gender equity and human rights, to the achievement of these goals.

The World Bank is helping countries pursue these goals and objectives by

- **Linking population to poverty reduction and human development.** Countries that need to slow population growth require sustained, synergistic support for family planning, child survival, and maternal health, and for girls' education and women's empowerment and autonomy.
- **Adapting to diversity and change.** Population policies and reproductive health programs need to be adapted to diverse and changing demographic, economic, and geographic conditions, with special attention to the poorest countries.
- **Being sensitive to country contexts.** Implementing a reproductive health approach poses special challenges. Reproductive health outcomes are

affected by social conditions as well as by services and information. Attitudinal changes among communities, families, and policymakers are required, as well as behavioral changes among couples (not merely individuals) and service providers.

- **Building on analysis and dialogue; providing sustained support.** The World Bank can facilitate analysis and dialogue to help borrowers understand how demographic shifts affect the agendas for human development and poverty reduction, and provide sustained support over the longer time frame required to deal with reproductive health issues.
- **Strengthening skills and partnerships.** The World Bank needs to maintain an appropriate mix of core skills suited to the diverse and changing conditions of borrower countries and to deal with the cross-cutting dimensions of population and reproductive health issues. Staff development needs to be complemented by efforts to collaborate with the best expertise available outside the Bank.

Changing Context

Population growth

In the three decades since the World Bank first started population work, the global demographic situation has changed quite dramatically. In the 1960s, most developing countries were either at the initial stages of their demographic transitions from high to low fertility rates, or had not started at all. There have since been rapid declines in fertility in many developing regions, and the current demographic situation in borrower countries is much more diverse (see Figure 2, p. 10).

In the 1960s, preferences for large families kept fertility high in many countries. Since then, desired family size has declined in many countries, while unwanted fertility and population momentum today play much larger roles in population growth.* Growth rates are still high in sub-Saharan Africa, and in some countries of South Asia and the Middle East where fertility transitions have not yet started or are in their initial stages (the countries in red and yellow on the map on p. 10). These countries will account for most of the 2 billion to 3 billion growth projected before global population stabilizes sometime late in the next century.

Even in countries where transitions are more advanced (the countries in blue on the map), fertility decline does not mean an immediate end to population growth. In some South Asian countries, such as India and Bangladesh, population momentum has become increasingly important. Increasing the use of family planning to reduce unwanted fertility and addressing factors such as early marriage and early childbearing can help offset the effects of population momentum.

Age composition

Rapid fertility decline is also changing the age composition of the population in many countries. For example, in Brazil and Thailand, the proportion of the population under 15 years of age has dropped significantly. In both countries, the number children under age relative to the population in the

* Unwanted fertility refers to births from pregnancies that were poorly timed or unintended. Population momentum is an effect of high fertility rates in the recent past, leading to growth in the size of reproductive-age population that is large enough to offset the effect of lower fertility. Momentum can cause substantial population increase even after fertility has reached the replacement level. Declines in adult mortality also contribute to continued population increase.

working ages (15-59) is declining rapidly, while the elderly (age 60+) dependent population is growing.

As child dependency ratios decline, the size of the youth age group (15-24) increases. The number of youth in developing countries is expected to reach 1.1 billion by 2025, an increase of 28 percent over 1995. If this growing group of young people can be educated and find productive employment, there is potential for economic gain; if not, they could generate unemployment and political unrest. The rapid increase in the number of young people also contributes to population momentum.

The decline of child dependency ratios and the increase in old-age dependency are accompanied by a shift from infectious diseases and high mortality among infants and children to chronic diseases of mature and elderly adults. Better management of chronic health conditions increases life expectancy at older ages, thus increasing the resources required for old-age support and health care.

Spatial distribution

Much of the projected population growth will be concentrated in cities and areas of current population settlement, particularly environmentally stressed sea coasts and river valleys. Rural to urban migration, high fertility in urban areas, and population momentum all contribute to rapid urban growth. This growth is projected to occur in many poor countries, including those that have been predominantly rural up to now.

Urban areas are expected to absorb much of the population increase generated by population momentum in Asia. A similar pattern is emerging, though at a slower pace, in Africa. In Latin America, conversely, urban growth is likely to be much slower than it was over the last two decades. That region is already highly urbanized, and population growth rates are much lower today than during the peak rural-to-urban migrations of the 1960s and 1970s.

HIV/AIDS

The emergence of HIV/AIDS has serious demographic as well as socioeconomic implications. Around the world, HIV/AIDS now rivals the greatest epidemics in history, and in certain areas of Africa, one in four adults is infected with HIV. At the same time, evidence shows that early interventions are cost-effective and prevention efforts are working.* Nonetheless, the growing

Box 1: Impact of HIV/AIDS on Development in Africa

In many African countries, HIV/AIDS is reversing hard-won improvements in health, survival, education, and quality of life. Over the last decade, life expectancy has significantly declined, and mortality rates of young adults, infants, and children are increasing.

HIV/AIDS is putting increased burdens on already fragile health systems. In many urban hospitals in Africa, about half of the hospital beds are occupied by patients with HIV. In rural households, women provide most of the care for AIDS patients—including those who return from the cities when they fall ill—and bear the costs of food, medical care, and funerals.

Highly trained and skilled workers, such as doctors, teachers, and soldiers, are being decimated by AIDS. Even agriculture is being severely affected as cultivation of labor-intensive crops is abandoned, and agricultural knowledge and management skills are lost. As the income earners in families die of AIDS, poverty increases, especially in female-headed households.

* See World Bank, *Confronting AIDS: public priorities in a global epidemic,* Oxford University Press, 1997.

number of individuals—especially young adults—becoming sick and dying of AIDS or AIDS-related infections is having devastating economic and social impacts on families as well as communities.

In regions where AIDS prevalence is high and growing rapidly, such as sub-Saharan Africa, (see Box 1, p. 4), population growth rates are slowing, though actual population decline is not projected. Average life expectancy has fallen by 10 years or more in some African countries. In other regions, where early prevention has slowed the spread of the disease, the impact is likely to be less.

Population, Poverty Reduction, and Human Development

Despite the pressures of rapid population increase, developing countries have made substantial progress in improving living standards. Average incomes per person in the developing world have doubled in 25 years, an achievement that took nearly 40 years in the United States and more than 60 years in the United Kingdom.

Although population growth in and of itself does not lead to poverty, evidence suggests that high fertility is both a symptom and a cause of poverty. Analyses of cross-national data found little evidence of negative effects of population growth on per capita income the 1960s and 1970s. In the 1980s, the negative effects of population growth outweighed the positive in the poorest countries (for example, in sub-Saharan Africa), while the reverse occurred in the more advanced developing countries, particularly in East Asia.*

Households and families are the most important between changing demographic conditions and poverty reduction. Research on the demographic transition shows that changes in attitudes and behaviors at the household level affect both fertility and mortality. Families move from having large numbers of children—with low investments in their human development (education, health, and nutrition)—to having fewer children, with a higher proportion surviving and with greater investment per child.

Female education

The crucial links, both direct and indirect, between the education of girls and women and population have long been known. By giving women greater access to knowledge and information, exposing them to new ideas, and increasing their job opportunities and social status, education enables women to become more economically and socially autonomous. Women are then more likely to enter the labor market, be aware of reproductive values outside their community, possess greater knowledge about contraceptive options, be more effective contraceptive users, and have a closer and more egalitarian relationship with their spouses.

In most parts of the developing world, fewer girls than boys enroll, stay, and learn in school. The enrollment of girls ages 6-11 years is only three-fourths that of boys, and declines with each succeeding educational level. However, there is considerable regional variation. For example, although sub-Saharan Africa has made progress in eliminating the gender gap in enrolling girls in school, overall

* A.C. Kelley and R.M. Schmidt, "Savings, dependency and development," *Journal of Population Economics* (1996) 9: 365-86; D.A. Ahlburg, "Population growth and poverty," in R. Cassen, et al., *Population and development: old debates, new conclusions* (Transaction Publishers, 1994).

enrollment rates remain very low and, in some countries, are even decreasing. In South Asia, girls lag far behind, with only 53 girls enrolled for every 100 boys in some countries.

Cultural and institutional factors can limit girls' chances for education. In some situations, girls are less well fed than boys, less likely to get health care, and are more often required to drop out of school to care for younger siblings. With limited education, they are more likely to begin childbearing at a younger age, to have limited earnings opportunity, and to have little control over household decisions once they marry—thus creating an intergenerational cycle of disadvantage for women.

Public-sector management

To avoid the adverse effects of rapid population growth and realize the benefits of slower growth, governments must manage the economy and natural resources well. More people consuming more goods that require higher inputs of energy and natural resources to produce pose serious challenges to environmental management.

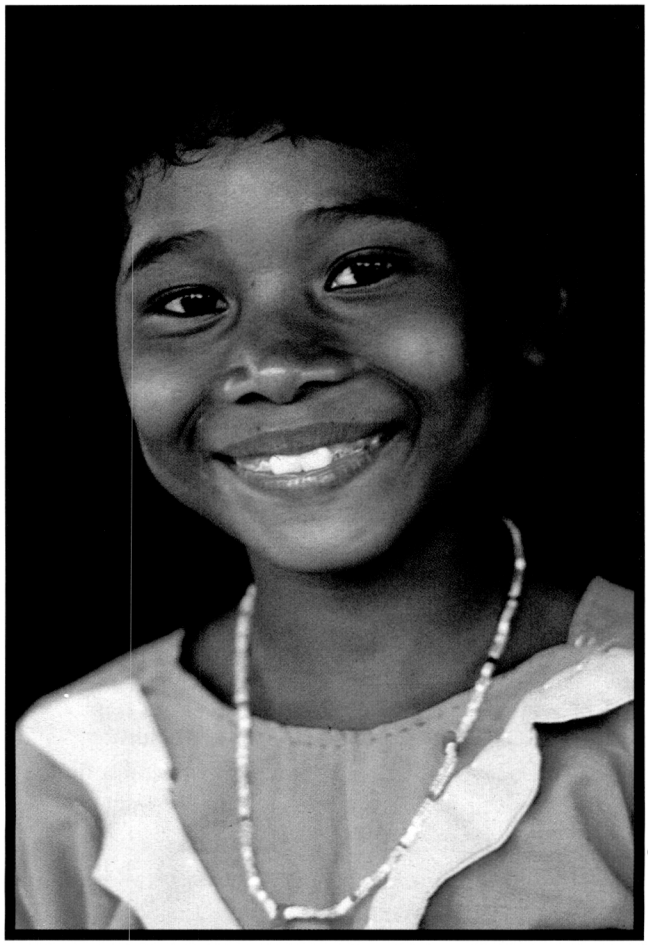
In the Middle East and North Africa, and in many of the rapidly expanding urban centers of the developing world, large increases in population challenge the effective management of water resources, including urban sanitation. Because competition for water resources is often international in scope, effective management is difficult at best.

Good public economics promote broadly based growth that benefits all, particularly the poor. Growth that raises the incomes of the poor will help to lower fertility. How governments address other aspects of population depends on local conditions and needs. In settings such as sub-Saharan Africa and South Asia, where population growth is a major problem, there is still a strong case for governments to seek a faster transition to lower fertility and slower population growth.

Even where population growth is not an issue, rapidly changing age structure, urbanization, and changing health conditions will have an impact on entitlement programs, such as social security and health care for the elderly and on social services, such as education, public transportation, water, and sanitation. In these and other areas, population change is not likely to be the cause of problems, but failure to take account of the underlying demographics can impede or defeat efforts to deal with them.

Unfinished Agendas

Despite important gains, there are unfinished agendas. Women in the



UNICEF Photo 88-012, Nicaragua/Aarbus

developing world have less opportunity for education than men. The gender gap in education is greatest in low-income countries with low levels of educational attainment. The poor in all regions continue to experience unacceptably poor reproductive health, including much unwanted fertility, malnutrition, and high child and maternal mortality rates. An estimated 120 million women who wish to space or limit further childbearing are not using contraception. Almost 10 percent of the total disease burden in the developing world is due to maternal and perinatal conditions. Among women ages 15-44 years, the leading cause of disease and death is pregnancy-related illness.

Gender differences in health and education reflect broader societal forces that undermine efforts to improve women's lives. While poverty affects all men, women, and children, many of the burdens of poverty, including malnutrition and lack of economic opportunity, weigh more heavily on girls and women, and their children. Some of these issues can be addressed by ensuring that programs in health and education are gender sensitive, or through gender-focused microenterprise and employment programs. Others, such as domestic violence and legal structures that deprive women of property and full economic participation, require parallel efforts to change attitudes and legal/regulatory barriers. Multisectoral approaches are needed to address these broader contextual factors.

Box 2: Implementing the Reproductive Health Approach in India

The India Reproductive and Child Health project supports the government's reorientation of its family planning program away from demographically driven goals toward addressing the reproductive health and family planning needs of clients. The project includes a nationwide policy reform package covering monitoring and evaluation, institutional strengthening, and service delivery. A local-capacity enhancement component funds district and city-level subprojects aimed at meeting specific local needs.

Challenges and Lessons

Twenty-five years of experience have shown that population issues are best addressed through broad policies and programs that seek to improve the lives of the poor through improved nutrition, health, and education; through greater economic autonomy for women; and through family planning information and services. This has been the overarching message of a series of international conferences with which the World Bank has been closely associated, including the ICPD in Cairo.

The ICPD Programme of Action articulates revised approaches to population issues and endorses a reproductive health approach to individuals' reproductive health rights and needs throughout their lives. It recommends that health systems provide a package of services, including family planning, safe pregnancy, and delivery, and the prevention and treatment of reproductive tract infections. It also recognizes the broader dimensions of reproductive health and the important linkages between reproductive health and rights and other development issues, particularly those related to gender inequality. The World Bank is working with its client countries and other donors to implement these new approaches (see Box 2).

Many of the issues of reproductive health and rights agreed upon at ICPD were endorsed and amplified a year later at the Fourth World Conference on Women in Beijing. The Beijing Conference focused on a range of economic and social issues affecting women's participation in civil society, as well as the close linkages between women's status and population and reproductive health outcomes. During the Beijing Conference, the World Bank pledged itself to reduce the gender gap in education and to ensure that women have equitable access to and control over economic resources.

The World Bank has also worked during the last decade to reduce the burden of disease related to pregnancy and childbearing through the Safe Motherhood Initiative. It is clear that no pregnancy is risk-free: women everywhere suffer life-threatening complications of pregnancy, delivery, and unsafe abortion. To minimize these risks, good quality, affordable obstetric services and skilled attendants during childbirth are essential. If complications do occur, it is critical that they be promptly identified and attended to. Services for pregnant women will vary depending on geographic access, available health personnel, and affordability. But women need to be empowered to utilize such services, and communities and families need to be mobilized to assist women when help is needed.

Regional and cultural diversity

The range of unmet reproductive health needs—including effective contraception and safe sexual behavior, healthy pregnancy, and safe childbearing—as well as the size of the gap, varies substantially among the regions of the world.

As Table 1 shows, women in developing countries are much more likely to die of pregnancy-related complications than women in developed countries. The risks vary considerably between regions and countries. For example, despite similar per capita incomes, maternal mortality in Yemen is 10 times higher than in Vietnam, and almost 30 times higher in Cote d'Ivoire than in Sri Lanka.

The capacity to address reproductive health issues also varies between regions and within countries. Attitudes and cultural barriers are complex and particular to each country, which necessitates interventions that are context-specific and culturally and socially sensitive. Attention to contextual factors is particularly important because healthy sexual behavior and reproductive health can require changes in sensitive, highly personal areas of human behavior. Differing attitudes and opinions about some reproductive issues, notably HIV/AIDS and abortion, create added constraints. While much of the focus in reproductive health is on women, the critical role of male partners also needs to be recognized. To facilitate change, policymakers need to consider the perspectives and motivations of both genders.

Table 1: Women's Lifetime Risk of Dying from Pregnancy-Related Complications

Region	Risk of Dying
Africa	1 in 16
Asia	1 in 65
LAC	1 in 130
Europe	1 in 1,400
North America	1 in 3,700
All developing countries	**1 in 48**
All developed countries	**1 in 1,800**

Source: WHO Safe Motherhood Factsheet, 1998.

UNICEF Photo 92-578, China/Lemoyne

Weak institutional capacity, limited experience

In many settings, weak institutional capacity is a major constraint to population and reproductive health. A recent internal review of the Bank's Health, Nutrition, and Population (HNP) lending found that while 60 percent of projects achieved physical objectives, only one in five made substantial contributions to institutional development and policy change.* Inadequate training and management of outreach workers; weak information, education and communication (IEC) programs; and poor monitoring and logistics systems all undermine effectiveness. While the Bank's skill mix and internal procedures are well suited to assist borrowers to ensure good quality civil works and equipment procurement, they are less appropriate to assist with these "software" aspects of HNP projects.

Improvements in capacity and consensus building are needed if the broad scope of reproductive health is to be addressed successfully. For example, reducing the number of maternal deaths requires timely and appropriate recognition, referral, and management of life-threatening complications of pregnancy and childbirth. Without adequate linkages between primary and secondary levels of health care, progress is likely to be slow. Therefore, institutional capacity-building, including financial, organizational, and human resource development, become even more important, and will be needed at all levels of the health care system—from outreach and primary care to referral hospitals.

As countries seek to strengthen their capacities for present and future reproductive health work, they can build on nearly four decades of experience in family planning programs. Making use of the strong outreach and logistics/supply systems of family planning programs is often the first step in provision of a broader range of reproductive health services.

* World Bank Operations Evaluation Department, *Lessons from experience in HNP*, June 1998.

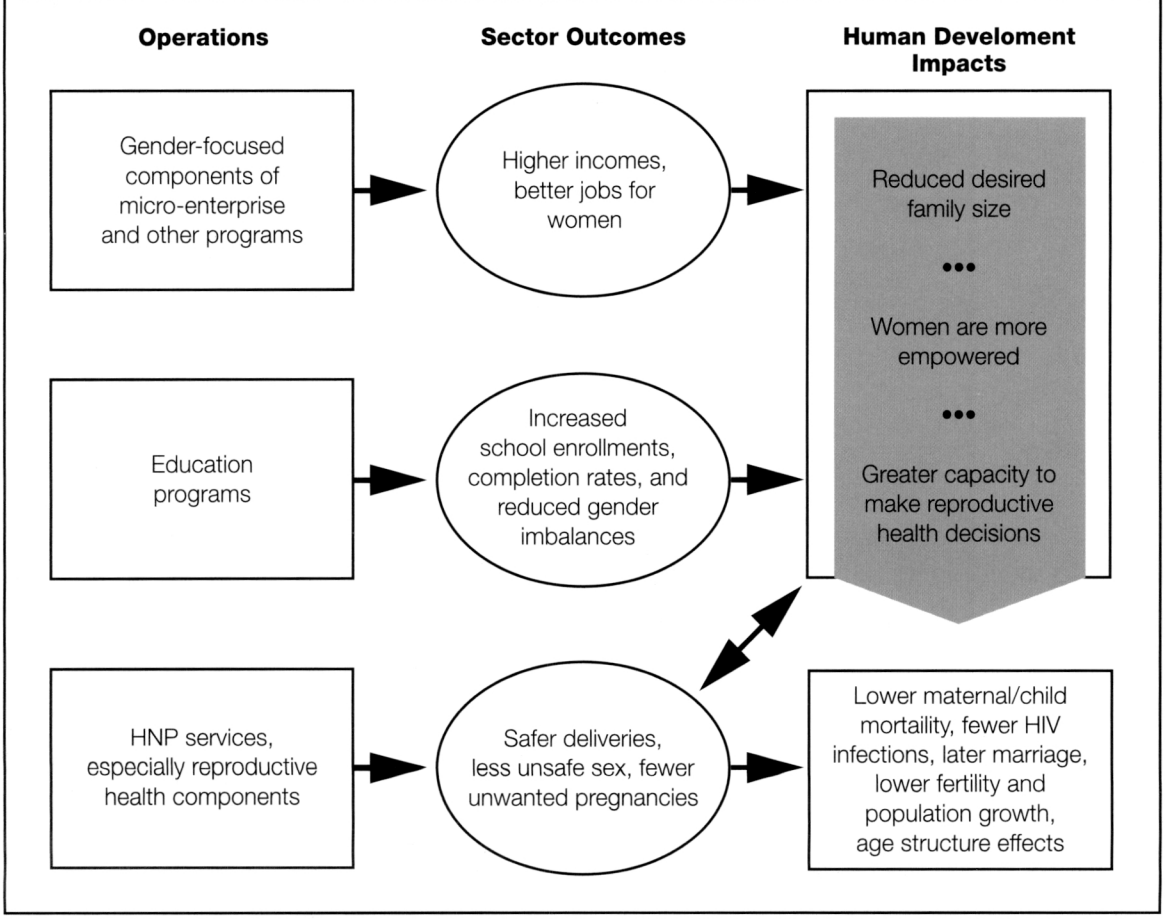
Family planning has also shown that where the public sector is weak, the private sector and NGOs can do a better job in expanding access (for example, through social marketing of contraceptives) and improving quality.

For many reproductive health issues, including STIs, monitoring safe motherhood, and linking health services to credit programs, there is limited knowledge and experience on effective approaches. Much more needs to be understood about incentives and interventions to change household and personal behavior in different contexts. Carefully crafted pilot projects can provide much sorely needed information. Lessons learned from family planning and primary education indicate that improving consumer choice and quality of services will be key to changing behaviors.

Higher resource needs, competing priorities

It is generally recognized that the expanded scope of reproductive health will require additional resources. However, there is little reliable information on how much the additional services cost, and few health systems have financial information systems that can readily provide such information. Special efforts are needed to focus research and evaluation on such issues

Figure 1: Population and Reproductive Health-Related Development Impacts of Bank Operations



and to provide rapid feedback for policy and strategy formulation.

The move to a reproductive health approach comes at a time when competition for resources is increasing. For example, the challenge of HIV/AIDS is placing heavy burdens on already fragile financial resources and institutional capacity. The international donor community is also turning its attention to other health issues, such as tobacco and malaria. Without a careful analysis of the costs and benefits, reproductive health programs may not receive necessary investments.

The Response

The World Bank is the largest single source of external funding in developing countries for human development—which includes HNP; education; and social protection. These sectors are also the fastest-growing areas of Bank lending, accounting for 20 percent of lending for the last three fiscal years, as compared with 3 percent a decade ago.

The Bank is involved in two types of activity in borrower countries: policy dialogue (based on analytical work) and lending operations. Although Bank lending for population and reproductive health touches on many sectors, those areas that are generally acknowledged to have the most direct impact include HNP, education, and gender-focused programs. These programs contribute directly to outcomes that are important in their own right (the middle column of Figure 1, p. 9). They also contribute indirectly through changes in the environment, for example, by influencing desired family size or by increasing women's capacity to make decisions that affect their reproductive health (as shown in the right-hand column of Figure 1). At the policy level, recognizing these broader development links and ensuring that social programs contribute positively to them is much of what ICPD meant when it called for population issues to be addressed in a broader developmental context.

Current estimates indicate that reproductive health activities constitute a significant portion—just under one-third—of all lending for population, health, and nutrition (see the shaded area of Table 2).

Over the past three decades the Bank has lent over US$4 billion to support population and reproductive health through 212 projects in over 80 countries. The overall trend has been steadily upward. In recent years, Bank lending has integrated reproductive health projects with its population programs, financing over $1.1 billion in projects

Table 2: Trends in World Bank Lending for Education and Health, Nutrition, and Population

	Lending for education (US$mil)	Number of projects	Lending for HNP (US$mil)	Number of projects	Population/ reproductive health components of HNP (US$mil)	Number of projects with population/ reproductive health
Before 1981	3,909	228	523	27	401	22
1982-1991	9,450	197	4,146	98	1,063	66
1992-1998	13,455	185	9,414	132	2,697	124
Total	**26,814**	**610**	**14,083**	**257**	**4,161**	**212**

involving population and reproductive health activities over the past three fiscal years (1996-1998, see Annex 1, p. 19).

Other Bank-funded projects also make significant contributions to population and reproductive health. Over the past three fiscal years the Bank has committed nearly 1 billion dollars in new lending to increase education for girls. In addition, rural development projects provide microcredit, which contributes to the empowerment of women and enables them to exercise greater choice in reproductive decisions. Gender-focused initiatives in a number of sectors have similar effects.

Reproductive health

In the 1970s, Bank-funded projects supported development of facilities and skills to implement large-scale public sector family planning programs. During the 1980s, the focus expanded to cover primary health care, particularly addressing the health care needs of children and, more recently, of women. In the 1990s, operations have increasingly addressed health sector reform and emerging health problems, including HIV/AIDS. Reproductive health and family planning are more often being addressed as components of broader health programs. This broader approach is expected to be more cost-effective and yield greater consumer satisfaction, which in turn is likely to lead to more effective use of information and services.

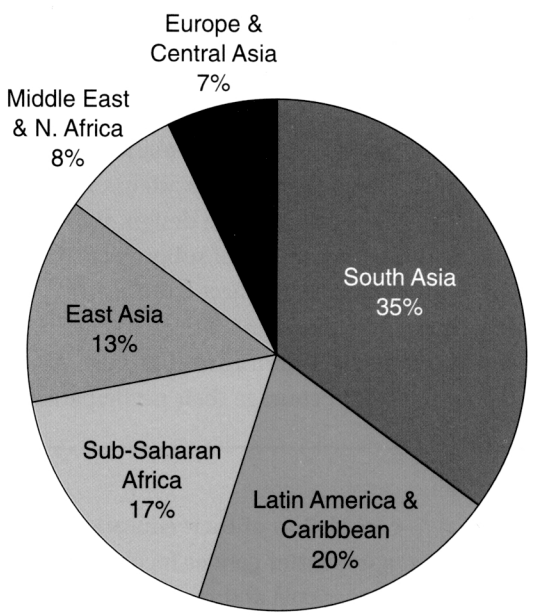
All of the Bank's six regional units made major commitments to reproductive health and family planning during the period from FY 1992 to FY 1998. South Asia accounts for the largest share of the $2.7 billion in loans and credits during that period (see Figure 3).

Although lending volume is well distributed between regions, internal analyses indicate that only 57 percent of total HNP investments were in countries of lower-middle and low social settings, where the need would be expected to be highest. Stronger mechanisms are required to ensure that adequate attention is given to countries of greatest need.

Education

Most Bank-supported projects in primary education emphasize improvements in classroom instruction, and many have components that specifically benefit girls. The proportion of these has grown from 3 percent in the 1970s to 16 percent in the 1990s. In addition, a small number of Bank-assisted projects have focused on girls' and women's education outside of formal school systems. Because research suggests that helping a mother become literate is likely to improve the chances that she will send her daughter to

FIGURE 3: WORLD BANK LENDING FOR POPULATION AND REPRODUCTIVE HEALTH, FY 1992-98 BY REGION



school, providing adult literacy can also be viewed as a strategy for improving girls' access to schooling.

The Bank has identified 42 countries that are at risk of not achieving universal primary education for girls. In 34 of these countries, the Bank is already supporting a range of innovative activities to reduce gender disparities in education. These include offering specialized scholarship programs, addressing specific obstacles to girls' completion of their education, encouraging better gender focus in the design of curricula and facilities, and lowering monetary and opportunity costs by making schedules more flexible.

Box 3: Multisector Projects Incorporating Gender in Malawi

The Malawi Social Action Fund Project (MASAF) is helping women gain better access to health care, education, and employment by funding upgrading and construction of schools, health facilities, community water points, rural/urban markets, and granaries. The project focuses attention on women's involvement in the design, implementation, and management of subprojects. One-third of Community Project Committee members are women, and MASAF staff and facilitators receive training to maximize benefits to women and encourage their participation.

Opportunities for economic improvement

Women's autonomy and economic participation are being encouraged in Bank-supported projects through the introduction of microenterprise development and other income-generating programs, training and employment programs, and by increasing access to credit and financial services. Several projects also provide alternative childcare services to permit young mothers to work outside the home. A review of 43 enterprise development and financial assistance projects in South and East Asia from 1983 to 1992 noted that one-sixth specifically addressed women. Efforts to reach women have focused on the agricultural sector, and current programs are training women to handle routine maintenance and repairs of water supply facilities.

In Africa, social action programs and social funds have proved to be valuable, multisectoral initiatives to reduce poverty and improve reproductive health and population (see Box 3).* Targeted on the poor rather than on specific sectoral inputs, they have mobilized community support and funding for family planning and reproductive health services as well as credit and job creation for rural women.

The Bank's comparative advantage

The World Bank's partners in the population and reproductive health fields provide borrowers with most of the technical expertise as well as significant financial assistance for their programs. These partners look to the Bank for support in policy dialogue and resource mobilization. Because of the Bank's access to finance and planning ministries, as well as to functional ministries such as health, education, and women's affairs, it is well positioned to facilitate synergistic policies that link investments in different sectors to achieve optimum impact. Further, it has the financial capacity to support strengthening of obstetrical referral systems and first referral hospital

* A. Marc, et. al., *Social action programs and social funds: a review of design and implementation in sub-Saharan Africa,* World Bank Discussion paper no. 274, 1995.

facilities that are essential for safe motherhood.

Sustained support is another important role for the Bank. It is generally accepted that a horizon of at least 15 years may be needed to achieve results in human development interventions. For population/reproductive health, horizons might need to be even longer. For example: female education and women's empowerment are powerful determinants of reproductive behavior. While some benefits of increased female education are immediate, others will become apparent only when better-educated girls enter reproductive ages.

Adapting to Change

The World Bank has introduced sweeping changes aimed at making itself more responsive to the needs of its clients. Sectoral networks, including the Human Development Network, are central to this renewal process. Most technical staff are now organized in large sectoral management units for each region which provide technical support to projects at the request of country management teams. The regional sectoral units are linked by a Bankwide functional network structure.

Improving quality and effectiveness

New approaches bring opportunities for addressing particular reproductive health issues. For example, sector reform can address many of the underlying constraints that make health systems unresponsive to the reproductive health needs of the poor. These constraints include financial mechanisms, institutional incentives, and civil service structures and procedures that undermine efforts to strengthen institutional capacity. Another constraint is the inability of national health budgets to finance the annual expenditures required for salaries and consumables, including essential drugs and contraceptives. Health reforms can address these issues.

One important way to address resource constraints is to make more effective use of existing resources. During the past few years, the World Bank has focused intensely on improving its effectiveness in the social sectors. Many of the reform initiatives described in the Bank's HNP Strategy Paper are aimed at improving effectiveness through better definition of public and private sectors in the financing and delivery of services, through better organization and management of health systems, and through greater community involvement in the design and oversight of services.

As countries implement reforms in areas such as financing, reorganization, and decentralization, they need to ensure that the quality and accessibility of reproductive health services is maintained. These services (including family planning) are an ideal core around which to strengthen primary and secondary health care. Managers in central technical units, who previously controlled vertical programs, need to learn new roles. These include training and human resource management, setting standards, assessing needs, guiding new players in decentralized systems on how to plan and allocate resources, and monitoring the impact of reforms on key reproductive health indicators.

Health reform involves many new—but untested—financing and service delivery approaches that have great potential for improving the effectiveness and impact of reproductive health services. The HNP Network is developing mechanisms to enable HNP staff to systematically support regional managers and front-line staff in applying lessons from the reproductive health field to improve

effectiveness and to monitor and signal operations that might require more intensive support.

Empowering staff

The Bank needs to ensure that it has a critical mass of core staff with the requisite skills and experience in both population and reproductive health. The new approaches to population and reproductive health are creating additional demands on staff capacity. Region-specific analyses are needed to identify where additional training or positions are needed. There is also need for regional "lead persons" to coordinate region-specific population and reproductive health initiatives and to make critical judgments about when and how to draw on the specialized skills of partner agencies.

Strategic focus

Population may not be a major component in most country programs, yet population growth and other demographic changes can affect whether or not they achieve their poverty reduction and human development objectives. Earlier reviews have noted that the Bank has not always taken advantage of opportunities to bring a demographic perspective into the policy dialogue. New methods are being implemented to ensure that a population perspective is included in such key documents as the Country Assistance Strategy (CAS). A database of key population and reproductive health indicators, such as total fertility rate, maternal mortality, and secondary school enrollment of girls, will be maintained to identify issues for possible discussion in CASs and other key documents.

Strengthening partnerships

Many Bank-funded population and reproductive health projects involve collaboration between governments, international agencies, other donors, and NGOs. By strengthening its partnerships with these specialized agencies, the Bank can improve its effectiveness in population and reproductive health.

- **United Nations Population Fund (UNFPA):** UNFPA is the lead international agency in the population field, with a strong network of field offices that are knowledgeable about local conditions and issues. The Bank already uses UNFPA's contraceptive procurement facility and is working to increase collaboration in such areas as training, procurement, strategy development, and country program management.
- **World Health Organization (WHO):** WHO is the lead international agency in health, with strong links to the scientific community for maternal, reproductive, and child health. The Bank supports WHO's program for training and research in reproductive health, and WHO provides the Bank with policy guidance and technical support.
- **Joint United Nations Programme on AIDS (UNAIDS):** UNAIDS is a global partnership cosponsored by the World Bank and five other international agencies. Its goal is to provide policy and technical leadership to countries in their efforts to turn back the epidemic.
- **United Nations Children's Fund (UNICEF):** UNICEF is a partner in a number of Bank-supported reproductive health operations and has recently begun to expand its focus on adolescent reproductive health. UNICEF's specialized skills in advocacy and health communication are particularly important for reproductive health initiatives.

- **Bilateral Donors:** Bilateral donors cofinance population and reproductive health activities in a number of borrower countries and provide a broad range of technical support.
- **Nongovernmental organizations (NGOs):** NGOs have played critical roles in the population and reproductive health fields, particularly in developing and testing novel approaches to problems in settings where the government and for-profit private sectors are particularly weak.

Addressing the multisectoral dimensions of population and reproductive health also requires working with partners outside the HNP sector. Within the Bank, links to Education and Social Protection, as well as Gender, Poverty Reduction and Environment, need to be strengthened. Outside the Bank, ties need to be nurtured with general development groups as well as with those focusing on gender, the environment, and human rights.

One of the most effective mechanisms for working with these partners is through grants given under the Bank's new Development Grant Facility (DGF, formerly the Special Grants Program). In addition to WHO programs, these grants have enabled the Bank to support grass-roots groups in borrower countries that work on issues (such as female genital mutilation) that cannot be addressed through the lending program. Another DGF-supported initiative, the South-South Partnership in Population and Reproductive Health, is already helping a range of development partners to collaborate in training and interagency coordination.

Actions

The Bank is putting into action these recommendations to be implemented by the ***Population and Reproductive Health Thematic Group*** (TG) through a series of initiatives, including:

- A review of ***knowledge management*** (KM) content areas by the TG to ensure the quality and relevance of material in the system.
- The oversight and coordination by the TG of ***professional development*** through the learning program being developed by the Economic Development Institute (EDI). This program brings together state-of-the-art evidence and experience in dealing with the multisectoral dimensions of population, as well as for designing and implementing cost-effective packages of reproductive and child health services.
- ***Strategic focus*** for which the TG will promote reduction in maternal

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mortality as an HNP area of priority emphasis. The TG is developing and will disseminate a Safe Motherhood Action Plan. Individual members will take responsibility for ensuring that population and reproductive health issues in their regional units are addressed in the CASs and other sectoral analyses.

- The ***improvement of quality and effectiveness,*** for which the TG will identify issues for focus in review processes and work closely with the HNP Quality Group to address problems in population and reproductive health. It will also work with other TGs inside and outside of HNP on crosscutting issues, including procurement of contraceptives and other reproductive health medicines (coordinated with the Pharmaceuticals TG), and ensuring adequate attention to population and reproductive health under sectorwide reforms (coordinated with the Health Systems TG).
- The ***strengthening of partnerships,*** for which the TG will identify issues and develop a plan for more effective collaboration with key internal and external partners and oversee inputs to the KM system to assist in this process.

Annex: World Bank Lending for Population and Reproductive Health, FY 1996-1998

Region/ Country	Fiscal Year	Project	IBRD/IDA* lending (millions)	P/RH** lending (millions)
Africa				
Cote d'Ivoire	1996	Integrated Health Services Department	40.0	13.5
Sierra Leone	1996	Integrated Health Sector Investment	20.0	1.3
Mozambique	1996	Health Sector Recovery Program	98.7	35.9
Niger	1997	Health Sector Development Program	40.0	1.7
Eritrea	1998	National Health Development Program	18.3	9.9
Gambia	1998	Participatory Health, Population & Nutrition	18.0	5.8
Guinea-Bissau	1998	National Health Development Program	11.7	9.3
Madagascar	1998	Community Nutrition II Project	27.6	5.0
Mauritania	1998	Health Sector Investment Project	24.0	8.0
Senegal	1998	Integrated Health Sector Development Program	50.0	20.0
Ghana	1998	Health Sector Support Program	35.0	7.0
Subtotal			**383.3**	**117.4**
Middle East and North Africa				
Egypt	1996	Population	17.2	17.2
Morocco	1996	Social Priorities Program: Basic Health	68.0	20.3
Egypt	1998	Health Sector Reform Project	90.0	33.0
Tunisia	1998	Health Sector Loan	50.0	5.0
Subtotal			**225.2**	**75.5**
East Asia and Pacific				
China	1996	Disease Prevention	100.0	89.9
Indonesia	1996	HIV/AIDS and Sexually Transmitted Diseases (STD) Prevention and Management	24.8	24.8
Vietnam	1996	National Health Support	101.2	39.6
Vietnam	1996	Population and Family Health	50.0	50.0
Cambodia	1997	Disease Control and Health Development	30.4	6.1
Indonesia	1997	Intensified Iodine Deficiency Control	28.5	1.9
China	1998	Basic Health Services	85.0	6.1
Indonesia	1998	Safe Motherhood Project	42.5	42.5
Philippines	1998	Early Childhood Development Project	19.0	2.0
Subtotal			**481.4**	**262.9**

* International Bank for Reconstruction and Development/International Development Association
**Population/Reproductive Health

Region/ Country	Fiscal Year	Project	IBRD/IDA lending (millions)	P/RH lending (millions)
South Asia				
India	1996	Second State Health Systems Development	350.0	56.0
Pakistan	1996	Northern Health Program	26.7	26.7
India	1997	Reproductive and Child Health	248.3	124.1
Sri Lanka	1997	Health Services	18.8	7.6
Bangladesh	1998	Health & Population Program Project	250.0	84.0
India	1998	Orissa Health Systems Development Project	76.4	7.0
India	1998	Woman and Child Development	300.0	80.0
Subtotal			**1,270.2**	**385.4**
Europe and Central Asia				
Bulgaria	1996	Health Sector Restructuring	26.0	9.5
Georgia	1996	Health Project	14.0	8.1
Kyrgyz Republic	1996	Health Sector Reform	18.5	4.2
Russian Federation	1996	Medical Equipment	270.0	90.0
Bosnia-Herzegovina	1997	Essential Hospital Services	15.0	2.0
Russia	1997	Health Reform Pilot	66.0	19.7
Turkey	1997	Primary Health Care Services	14.5	4.4
Armenia	1998	Health Financing and Primary Health Care Development Project	10.0	2.7
Subtotal			**434.0**	**140.6**
Latin America and the Caribbean				
Mexico	1996	Second Basic Health Care	310.0	111.8
Argentina	1997	Maternal and Child Health and Nutrition II	100.0	33.3
Paraguay	1997	Maternal Health and Child Development	21.8	16.2
Argentina	1997	AIDS and Sexually Transmitted Diseases Control	15.0	15.0
Dominican Republic	1998	Provincial Health Services Project	30.0	14.4
Ecuador	1998	Health Services Modernization Project	45.0	7.8
Nicaragua	1998	Health Sector Modernization Project	24.0	6.0
Mexico	1998	Health System Reform	700.0	70.0
Subtotal			**1,245.8**	**274.5**
Grand Total FY 1996-1998			**4,039.9**	**1,166.4**