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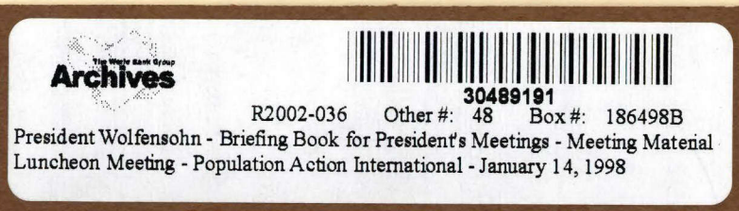

(Pop-In) Luncheon Meeting: Population Action International

Wednesday, January 14, 1998
1:45 - 2:00 p.m.
MC Dining Room "D", MC C1 Level

Archive Management for the President's Office

Document Log

Reference # : Archive-01973

IRD

Edit Print

A. CLASSIFICATION

- [x] Meeting Material
- [ ] Trips
- [ ] Speeches
- [ ] Annual Meetings
- [ ] Corporate Management
- [ ] Communications with Staff
- [ ] Phone Logs
- [ ] Calendar
- [ ] Press Clippings/Photos
- [ ] JDW Transcripts
- [ ] Social Events
- [ ] Other

B. SUBJECT: (POP-IN) LUNCHEON MEETING: POPULATION ACTION INTERNATIONAL (B) (N) <Actual time of luncheon meeting: 12:45 to 2:30 p.m.> // TIME: 1:45 - 2:00 P.M. // VENUE: MC DINING ROOM 'D', MC C1 LEVEL // CONTACT: JOAN SANTINI @ 38729 // NOTE: JDW TO POP-IN AFTER HIS EDI MTG // TO ACCOMPANY: MARISELA MONTOLIU // (B) BY DE FERRANTI // DUE THURSDAY, JAN. 8 // EXC: MM // LFG (12/01)
Brief includes:
--- Information Folder: Population Action International (PAI)
--- Population Action International: Annual Report 1996
--- Population Action International Publication: Falling Short: The World Bank's Role in Population and Reproductive Health, 1997
--- List of Participants
--- Bios
--- Brief: Background Info.:Population Action International, by T. Merrick, Jan 12.
--- Population Action International Requests to World Bank President
--- Population Action International Talking Points for PAI's January 14 Meeting with World Bank Leadership

DATE: 01/14/98

C. VPU

Corporate

- [ ] CTR
- [ ] EXT
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Regional

- [ ] AFR
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- [ ] LAC
- [ ] MNA
- [ ] SAS

Central

- [ ] CFS
- [ ] DEC
- [ ] ESD
- [ ] FPD
- [ ] FPR
- [ ] HRO

Affilliates

- [ ] GEF
- [ ] ICSID
- [ ] IFC
- [ ] Inspection Panel
- [ ] Kennedy Center
- [ ] MIGA

D. EXTERNAL PARTNER

- [ ] IMF
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- [ ] Private Sector

- [ ] Part I
- [ ] Part II
- [ ] Other

Contraceptive Choice

WORLDWIDE ACCESS TO FAMILY PLANNING

Developed Country Contraceptive Choice Index

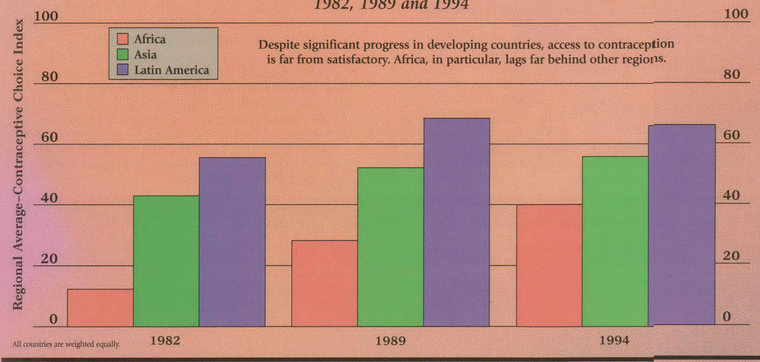
Access to modern contraceptive methods

Country	1996 Access Score: Condoms	Oral Contraceptives	IUDs	Injectable Contraceptives	Female Sterilization	Vasectomy	Contraceptive Choice Index	
Germany	20.0	20.0	20.0	20.0	20.0	20.0	**100.0**	EXCELLENT
New Zealand	20.0	20.0	20.0	20.0	20.0	20.0	**100.0**	
Spain	20.0	20.0	20.0	20.0	20.0	20.0	**100.0**	
Sweden	20.0	20.0	20.0	20.0	20.0	20.0	**100.0**	
Switzerland	20.0	20.0	20.0	20.0	20.0	20.0	**100.0**	
United States	20.0	20.0	15.0	20.0	20.0	20.0	**95.8**	
Norway	20.0	20.0	20.0	15.0	17.5	20.0	**93.8**	
Canada	20.0	20.0	20.0	10.0	20.0	20.0	**91.7**	
Ireland	20.0	20.0	20.0	20.0	15.0	15.0	**91.7**	
Netherlands	20.0	20.0	17.5	17.5	17.5	17.5	**91.7**	
United Kingdom	17.5	20.0	17.5	20.0	17.5	17.5	**91.7**	
Australia	20.0	15.0	15.0	15.0	20.0	20.0	**87.5**	VERY GOOD
Belgium	20.0	20.0	20.0	15.0	15.0	15.0	**87.5**	
Denmark	20.0	20.0	20.0	5.0	20.0	20.0	**87.5**	
Austria	20.0	20.0	20.0	10.0	15.0	15.0	**83.3**	
Greece	20.0	20.0	20.0	0.0	20.0	20.0	**83.3**	
Czech Republic	20.0	20.0	20.0	20.0	5.0	5.0	**75.0**	
Finland	20.0	20.0	20.0	20.0	5.0	5.0	**75.0**	
Hungary	20.0	20.0	20.0	0.0	15.0	15.0	**75.0**	
Italy	20.0	20.0	20.0	20.0	5.0	5.0	**75.0**	
Estonia	20.0	20.0	20.0	20.0	5.0	0.0	**70.8**	
France	20.0	20.0	20.0	20.0	5.0	0.0	**70.8**	
Slovakia	20.0	20.0	20.0	15.0	5.0	2.5	**68.8**	GOOD
Russian Federation	20.0	16.3	17.5	11.3	8.8	6.3	**66.7**	
Latvia	20.0	15.0	20.0	10.0	5.0	5.0	**62.5**	
Portugal	15.0	20.0	15.0	5.0	10.0	10.0	**62.5**	
Bulgaria	20.0	20.0	20.0	10.0	0.0	0.0	**58.3**	
Kyrgyzstan	15.0	15.0	15.0	15.0	10.0	0.0	**58.3**	
Turkmenistan	15.0	15.0	15.0	15.0	10.0	0.0	**58.3**	
Uzbekistan	15.0	15.0	20.0	15.0	0.0	0.0	**54.2**	
Lithuania	17.5	15.0	15.0	10.0	5.0	0.0	**52.1**	
Georgia	20.0	20.0	5.0	5.0	5.0	5.0	**50.0**	
Kazakstan	10.0	10.0	20.0	10.0	5.0	0.0	**45.8**	FAIR
Moldova	20.0	15.0	15.0	0.0	5.0	0.0	**45.8**	
Japan	20.0	0.0	10.0	0.0	10.0	10.0	**41.7**	
Romania	20.0	10.0	10.0	5.0	5.0	0.0	**41.7**	
Tajikistan	10.0	10.0	10.0	10.0	10.0	0.0	**41.7**	
Ukraine	15.0	10.0	10.0	10.0	5.0	0.0	**41.7**	
Armenia	15.0	10.0	15.0	0.0	0.0	0.0	**33.3**	

UNDERSTANDING THE DATA FOR DEVELOPED COUNTRIES: The access scores for each contraceptive method are estimates of the extent to which couples in a given country have access to that method. The scores fall within a range of 0 to 20. A score of 0 means that a method is essentially unavailable; a score of 20 means that the method is generally available. The ***Developed Country Contraceptive Choice Index*** is the sum of the access scores for each method, converted to a 100-point scale. Countries are ranked by their total scores on the *Index* and grouped in four categories: **EXCELLENT** (90 points or more); **VERY GOOD** (70-89 points); **GOOD** (50-69 points); and **FAIR** (less than 50 points). The first category is labeled Excellent rather than Very Good because a maximum score reflects essentially universal access to contraception, while for developing countries it means only that *at least* 80 percent of couples have access to modern contraceptive methods. No developed country scored low enough to justify a rating of Poor or Very Poor. Figures may not add due to rounding.

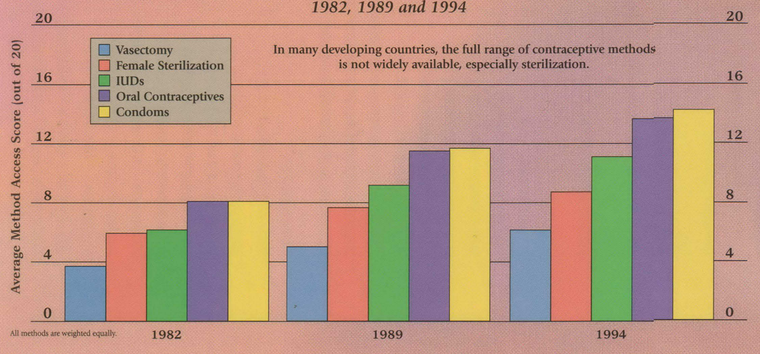
Access by Region–Trends in the Developing World

1982, 1989 and 1994



Access by Method–Trends in the Developing World

1982, 1989 and 1994



Around the world, people increasingly want smaller families. Easy and affordable access to a wide range of contraceptive methods is essential for each couple to find the method that best meets their needs in planning their families. Since no one method can satisfy all couples, a greater choice of methods also helps to increase overall contraceptive use. This in turn contributes to healthier patterns of childbearing, slower population growth, and overall development.

Contraceptive Choice: Worldwide Access to Family Planning highlights the progress countries have made in expanding access to contraception in recent years, as well as the enormous remaining gaps in the availability of some contraceptive methods. It underscores the distance many developing and some developed countries still need to go to make the full range of contraceptive options widely available.

This study, the seventh in a Population Action International (PAI) series titled *Progress Towards World Population Stabilization*, includes 127 countries with a population size of over one million, representing 98 percent of the world's population. It ranks each country on a 100-point *Contraceptive Choice Index* reflecting the availability and accessibility of different contraceptive methods. The emphasis is on ease of access to methods rather than actual patterns of contraceptive use. The analysis gives equal weight to each contraceptive method and also weights countries equally, rather than on the basis of population size.

Contraceptive Choice includes separate assessments for developing and developed countries:

- The ***developing country assessment*** ranks 88 countries on access to five contraceptive methods—condoms, birth control pills, intrauterine devices (IUDs), female voluntary sterilization, and vasectomy. The data come from a 1994 survey of family planning program effort undertaken by demographers W. Parker Mauldin and John A. Ross, together with identical studies in 1982 and 1989.
- The ***developed country assessment*** scores 39 industrialized countries and former Soviet republics on access to six contraceptive methods—the five methods studied for developing countries, plus injectable contraceptives. The data reflect information gathered directly by PAI in 1996.

Overall Trends in Access

- ***All the developing regions have made substantial progress in improving access to contraception.*** Between 1982 and 1994, the average developing country access score on the *Contraceptive Choice Index* increased from 35 to 54 out of a maximum score of 100. This increase reflects the expansion of organized family planning programs. However, the pace of improvement slackened in the early 1990s compared to the 1980s, possibly reflecting the greater difficulty in expanding access once the most easily served groups have been reached.
- ***Despite this progress, many couples in developing countries still lack access to the full range of contraceptive methods.*** The average 1994 access score for developing countries corresponds to wide availability of only 2.7 of the methods studied—an improvement over the 1.7 methods available in 1982, but far from satisfactory.
- ***Access to contraception is strikingly better in developed countries than in the developing world.*** The average developed country score of 72 on the *Contraceptive Choice Index* corresponds to wide availability of 4.3 of the six methods studied. Of 39 developed countries studied, 32 have an access score of 50 or more out of 100; in the developing world, only 48 of 88 countries have an access score of 50 or more.
- ***Although higher income levels make it easier to obtain contraception, especially from private sources, government policies make a difference.*** In general, wealthier countries do better on the developing country *Index*, but some relatively poor countries strongly committed to family planning have very high scores.

Access by Region

- ***Latin America—including the Caribbean—has the highest average access score in the developing world, followed by Asia and then Africa.*** East Asia, however, has the highest average of any sub-region. Moreover, if the regional averages were adjusted for the number of women of childbearing age in each country, Asia would have the highest average access score. This reflects the influence of China and India, which have above average scores and account for half the population in the developing world.
- ***Africa lags far behind the other regions.*** Availability of contraception has increased fastest in Africa, but the region began from a very low base and its 1994 average country score remains below the 1982 scores for the other regions. Africa's low score reflects not merely limited method choices, but poor access to *all* health and family planning services in most countries in the region. Major exceptions are Southern Africa, which has the third highest access score of any sub-region, and North Africa, which is almost equal to the developing world average.
- ***Gaps in access exist even in the developed world.*** In most of Western Europe and North America, couples have good access to the full range of contraceptive methods. Choices are more limited in Southern and Eastern Europe and the Baltic states. Japan, Romania, and several former Soviet republics have very limited contraceptive choices compared to other developed—and many developing—nations.

Access by Method

- ***Condoms—easily obtained in most countries from pharmacies and other retail outlets—are the most accessible method worldwide.*** Birth control pills rank a close second in accessibility in developing countries, followed by IUDs. Access scores for all three methods, however, are still low in a large number of developing countries. In contrast, in developed countries, condoms, pills and IUDs are almost universally available; injectable contraceptives are slightly less accessible.
- ***Male and female voluntary sterilization are the least accessible methods, reflecting both a lack of services and restrictive policies.*** Sterilization services are limited or nonexistent not only in many developing countries, but also in parts of Europe. Cultural prejudices, legal prohibitions, and restrictions such as minimum age and family size requirements constrain access to sterilization in many countries.
- ***Access to vasectomy lags far behind female sterilization, although vasectomy involves fewer health risks and is less costly.*** In many countries, limited knowledge of and demand for the method, together with biases on the part of health officials, reinforce the low availability of vasectomy services.

Strategies for Expanding Contraceptive Choices

In order to ensure access to a broad range of contraceptive methods, policymakers need to:

- *Remove policy and medical barriers to access and choice.*
- *Expand health and family planning networks.*
- *Use a variety of public and private channels to provide reasonably equal access to a range of methods.*
- *Ensure that all methods are affordable.*
- *Educate people about available family planning choices.*
- *Invest in contraceptive research and development.*

Editor: Shanti R. Conly
Researched and prepared by: Nada Chaya
Assisted by: Karen Helsing

Population Action International

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http://www.populationaction.org
1997

Developing Country Contraceptive Choice Index

Access to modern contraceptive methods

Country	1994 Access Score: Condoms	Oral Contraceptives	IUDs	Female Sterilization	Vasectomy	Contraceptive Choice Index: 1994	1982	Improvement 1982-1994	
Hong Kong	20.0	20.0	20.0	20.0	20.0	**100.0**	97.5	2.5	VERY GOOD
Singapore	20.0	20.0	20.0	20.0	20.0	**100.0**	97.5	2.5	
South Korea	20.0	20.0	20.0	20.0	20.0	**100.0**	100.0	0.0	
Taiwan	20.0	20.0	20.0	20.0	20.0	**100.0**	100.0	0.0	
Tunisia	20.0	20.0	20.0	20.0	20.0	**100.0**	71.0	29.0	
Mexico	20.0	20.0	20.0	20.0	18.9	**98.9**	82.0	16.9	
Venezuela	20.0	20.0	20.0	20.0	18.6	**98.6**	34.5	64.1	
Botswana	19.3	19.1	19.3	19.3	19.3	**96.2**	34.0	62.2	
Sri Lanka	20.0	20.0	18.8	18.6	18.6	**95.9**	82.0	13.9	
Thailand	20.0	20.0	15.7	19.3	20.0	**95.0**	88.0	7.0	
China	17.8	18.0	20.0	20.0	17.8	**93.6**	95.0	-1.5	
Trinidad & Tobago	20.0	20.0	20.0	16.5	16.5	**93.0**	65.0	28.0	
El Salvador	20.0	19.1	15.0	17.7	16.7	**88.4**	80.0	8.4	
Ecuador	20.0	20.0	16.1	17.1	12.2	**85.4**	55.0	30.4	
Costa Rica	20.0	20.0	19.2	15.2	9.8	**84.1**	64.5	19.6	
Malaysia	20.0	20.0	18.8	12.5	12.5	**83.8**	70.5	13.3	
Colombia	17.5	20.0	15.5	20.0	10.5	**83.5**	91.0	-7.6	
Mauritius	20.0	20.0	20.0	10.8	10.5	**81.3**	59.5	21.8	
Bangladesh	19.0	20.0	13.4	13.9	14.1	**80.3**	76.5	3.8	
India	18.2	13.3	13.0	19.6	15.9	**79.8**	62.0	17.8	GOOD
Jamaica	20.0	20.0	20.0	16.3	2.5	**78.8**	69.5	9.3	
South Africa	18.4	20.0	14.0	13.6	10.8	**76.8**	–	–	
Iran	17.3	10.0	13.4	17.2	17.4	**75.1**	11.0	64.1	
Guatemala	17.7	13.6	8.5	20.0	15.0	**74.8**	55.0	19.8	
Peru	18.0	18.4	17.5	15.0	5.5	**74.4**	26.5	47.9	
Turkey	20.0	20.0	19.4	11.6	2.9	**73.8**	15.0	58.8	
Namibia	20.0	20.0	9.7	19.9	2.5	**72.0**	–	–	
Dominican Republic	20.0	20.0	20.0	11.3	0.3	**71.5**	67.5	4.0	
Nicaragua	20.0	16.3	13.8	13.8	7.5	**71.3**	33.0	38.3	
Kenya	17.6	17.9	15.7	10.6	8.3	**70.0**	17.5	52.5	
Jordan	17.3	18.2	16.3	12.5	5.0	**69.2**	37.0	32.2	
Indonesia	15.1	16.2	16.6	9.5	9.6	**66.9**	63.0	3.9	
Chile	20.0	20.0	18.8	2.5	4.9	**66.1**	50.5	15.6	
Cuba	9.5	4.4	20.0	20.0	10.0	**63.9**	80.0	-16.1	
Uruguay	20.0	20.0	18.0	3.4	2.3	**63.7**	–	–	
Morocco	20.0	20.0	16.5	6.8	0.0	**63.3**	37.5	25.8	
Kuwait	19.7	20.0	20.0	2.5	0.0	**62.2**	0.0	62.2	
Zimbabwe	19.1	20.0	9.8	7.9	4.9	**61.6**	26.0	35.6	
Lebanon	19.8	20.0	20.0	0.0	0.0	**59.8**	43.0	16.8	FAIR
Brazil	13.4	20.0	6.4	15.0	4.3	**59.0**	49.0	10.0	
Cameroon	19.3	16.9	13.6	6.3	0.3	**56.3**	8.0	48.3	
Paraguay	9.8	9.4	5.0	20.0	10.0	**54.2**	20.0	34.2	
Vietnam	15.9	11.3	19.6	5.0	2.5	**54.2**	50.0	4.2	
Oman	11.0	17.0	9.3	8.2	8.2	**53.6**	2.5	51.1	
United Arab Emirates	17.5	17.5	17.5	0.0	0.0	**52.5**	2.5	50.0	
Bolivia	12.8	8.0	11.0	20.0	0.0	**51.8**	0.0	51.8	
Pakistan	18.4	13.7	12.3	5.3	1.1	**50.7**	44.5	6.2	
Honduras	12.3	9.0	9.6	12.9	6.7	**50.4**	49.5	0.9	
Tanzania	17.8	19.1	5.2	5.1	2.5	**49.6**	9.0	40.6	
Mongolia	16.8	7.0	9.8	11.7	3.6	**48.9**	0.0	48.9	
Sierra Leone	17.6	15.9	13.9	0.7	0.7	**48.8**	17.5	31.3	
Algeria	15.0	20.0	12.5	0.0	0.0	**47.5**	4.0	43.5	
Philippines	15.0	13.7	11.0	3.7	3.7	**47.0**	75.0	-28.1	
Ghana	17.7	13.6	8.5	3.5	1.8	**45.1**	6.0	39.1	
North Korea	11.3	11.9	10.5	1.3	7.5	**42.4**	55.0	-12.6	
Nepal	17.0	8.4	5.9	5.0	5.0	**41.3**	32.0	9.3	
Panama	9.1	9.0	3.0	11.3	9.0	**41.3**	95.5	-54.2	
Syria	10.2	16.3	13.5	0.0	0.0	**39.9**	7.5	32.4	POOR
Zambia	8.8	9.0	6.7	9.1	5.9	**39.4**	5.0	34.4	
Uganda	12.8	13.5	6.2	3.9	2.9	**39.2**	4.0	35.2	
Senegal	15.0	12.5	11.0	0.5	0.0	**39.0**	12.5	26.5	
Lesotho	8.5	8.6	4.9	9.3	6.4	**37.7**	4.5	33.2	
Egypt	5.7	20.0	11.3	0.0	0.0	**36.9**	38.5	-1.6	
Mozambique	14.3	11.8	8.2	2.3	0.0	**36.5**	15.5	21.0	
Guinea-Bissau	8.7	7.8	6.5	7.7	2.5	**33.1**	8.5	24.6	
Nigeria	13.8	7.9	6.6	3.9	0.8	**33.0**	9.5	23.5	
Benin	17.5	12.0	1.0	0.0	0.0	**30.5**	9.0	21.5	
Haiti	15.0	10.0	2.5	1.5	0.5	**29.5**	39.5	-10.0	
Myanmar	6.9	11.8	5.0	2.6	1.5	**27.7**	18.0	9.7	
Niger	10.8	9.2	3.0	2.5	1.0	**26.4**	4.5	21.9	
Yemen	7.5	7.5	7.5	2.5	1.3	**26.3**	0.6	25.7	
Malawi	8.5	9.0	2.6	3.7	2.2	**25.9**	5.0	20.9	
Guinea	10.0	10.0	3.9	< 0.1	0.0	**23.9**	3.0	20.9	
Papua New Guinea	10.0	4.6	3.5	2.5	2.5	**23.1**	27.5	-4.4	
Côte d'Ivoire	12.5	7.5	0.5	0.0	0.0	**20.5**	6.0	14.5	
Central African Rep.	16.3	2.5	1.0	0.5	0.0	**20.3**	3.0	17.3	
Sudan	5.7	7.8	3.8	1.9	0.0	**19.1**	1.5	17.6	VERY POOR
Ethiopia	8.8	4.3	3.4	1.6	0.2	**18.1**	4.0	14.1	
Angola	6.3	5.7	3.8	1.5	0.0	**17.2**	–	–	
Saudi Arabia	1.0	12.5	2.5	0.0	0.0	**16.0**	1.0	15.0	
Madagascar	1.7	9.1	1.6	0.0	2.5	**14.9**	12.5	2.4	
Argentina	3.4	6.0	4.9	0.0	0.0	**14.3**	–	–	
Cambodia	4.3	3.8	2.7	1.9	0.3	**13.0**	0.0	13.0	
Mali	4.5	5.5	1.9	0.5	0.0	**12.3**	7.5	4.8	
Mauritania	3.0	4.0	2.0	0.5	0.0	**9.5**	6.5	3.0	
Laos	0.2	0.4	1.1	0.6	0.0	**2.2**	0.0	2.2	
Chad	0.0	1.0	0.0	0.0	0.0	**1.0**	2.0	-1.0	
Congo	0.0	< 0.1	0.0	< 0.1	0.0	**0.1**	5.5	-5.4	

UNDERSTANDING THE DATA FOR DEVELOPING COUNTRIES: The access scores for each contraceptive method are estimates of the extent to which couples in a given country have "ready and easy access" to that method, defined as *requiring no more than two hours or one percent of a month's wages to obtain contraceptive supplies and services for one month*. The scores fall within a range of 0 to 20. A score of 0 means that a method is essentially inaccessible; a score of 20 does not necessarily reflect universal access, but means *that at least 80 percent of couples have ready and easy access to that method* through the public and private sectors. The ***Developing Country Contraceptive Choice Index*** is the sum of the access scores for each method and ranges from 0 to 100 points. Countries are ranked by their total scores on the *Index* and rated in five categories: **VERY GOOD** (80 points or more); **GOOD** (60-79 points); **FAIR** (40-59 points); **POOR** (20-39 points); and **VERY POOR** (0-19 points). Figures may not add due to rounding.

1997 REPORT ON PROGRESS TOWARDS WORLD POPULATION STABILIZATION

Population Action International

Contraceptive Choice: Worldwide Access To Family Planning

CONTRACEPTIVE CHOICE: DATA SOURCES AND METHODOLOGY

Both *Contraceptive Choice* and earlier PAI studies analyzing the accessibility and affordability of birth control methods are based on two data sets, one for developing countries, the other for developed countries. The developing country data come from a 1994 study of family planning program effort sponsored by The Futures Group International and carried out by demographers W. Parker Mauldin and John A. Ross, together with identical earlier studies. In both the present and previous studies, PAI directly gathered the data for developed countries.

Developing Country Data and Methodology

The series of studies on family planning program effort, undertaken in 1982, 1989 and 1994, examines 30 indicators grouped into four categories: (1) policy and stage-setting activities; (2) service and service-related activities; (3) record keeping and evaluation; and (4) availability and accessibility of fertility control methods.

Contraceptive Choice focuses only on this last category of program effort indicators, specifically on five indicators of access to condoms, oral contraceptives, IUDs, female sterilization and vasectomy. Data on accessibility of injectable contraceptives, implants and barrier methods other than condoms were not readily available and could not be included. Because the present study focuses only on contraception, it excludes data in the original program effort study on access to abortion services.

The methodology for all three program effort studies was identical. The researchers sent detailed questionnaires to experts in all developing countries with a population of one million or more. The questionnaire asked for information relating to all 30 indicators studied, including the availability and accessibility of contraceptive methods.

According to the questionnaire, "Accessible contraception means that the recipient spends no more than an average of two hours per month to obtain contraceptive supplies and services. Affordable contraception also implies that the cost of contraceptive supplies is not burdensome, i.e., a one-month supply of contraceptives should cost less than 1% of a month's wages to meet this criterion."

The researchers coded all responses with a conversion formula developed to produce scores from the information provided by the respondents. Responses relating to the accessibility of contraceptive methods were converted to a scale of 0 to 4. A score of 0 means the method is essentially unavailable. A score of 1 means that 20 percent of the population has easy and affordable access to the method. Each additional point means access for a further 20 percent of the population, with the maximum possible score of 4 representing easy and affordable access for at least 80 percent of the population.

In coding the responses, the researchers took a number of steps to protect against biased responses. Nevertheless, although the questionnaire was intended to reflect accessibility of methods from all sources, the responses appear to incorporate some bias towards publicly funded services. The coding system may also understate the availability of methods which are primarily provided through community-based distribution and social marketing programs.

The 1982, 1989 and 1994 studies include data for 96, 98 and 94 developing countries respectively. No data were available in 1994 for: Afghanistan, Burkina Faso, Burundi, Eritrea, Iraq, Gabon, The Gambia, Liberia, Libya, Rwanda, Somalia, Togo, and Zaire. Many of these countries, especially those experiencing war or civil conflict, appear likely to fare very poorly with respect to contraceptive choice and women's health care more generally. The 1994 program effort study also included three central Asian republics. However, PAI chose to collect data directly for these countries and to include them with the other former Soviet republics in the separate developed country assessment.

For *Contraceptive Choice*, PAI converted the access scores for each method in the program effort surveys to a 20-point scale. The scores for the five methods were then simply added to create a 100-point ***Developing Country Contraceptive Choice Index***.

Developed Country Data and Methodology

For the developed countries, including Eastern Europe and the newly independent states of the former Soviet Union, PAI developed a questionnaire on access to contraception which it sent in 1996 to experts in 43 countries. Respondents from 39 countries completed the questionnaires.

The questionnaire asked the experts to rate current access in their respective countries to seven methods of contraception—condoms, oral contraceptives, IUDs, injectables, contraceptive implants, and female and male voluntary sterilization. The questionnaire asked the experts to rate access to methods and services on a 5-point scale reflecting a range from virtually no availability to essentially universal accessibility. The data gathered on contraceptive implants, however, were not used in the study owing to inconsistencies in the responses.

For scoring purposes and approximate comparability with the developing country assessment, PAI converted the 5-point score for each of the six methods included in the developed country assessment to a 20-point scale. These scores were then added and the totals converted again to a 100-point scale to create the ***Developed Country Contraceptive Choice Index***.

PAI acknowledges with gratitude the generous support of the John D. & Catherine T. MacArthur Foundation for this project.

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Population Action International

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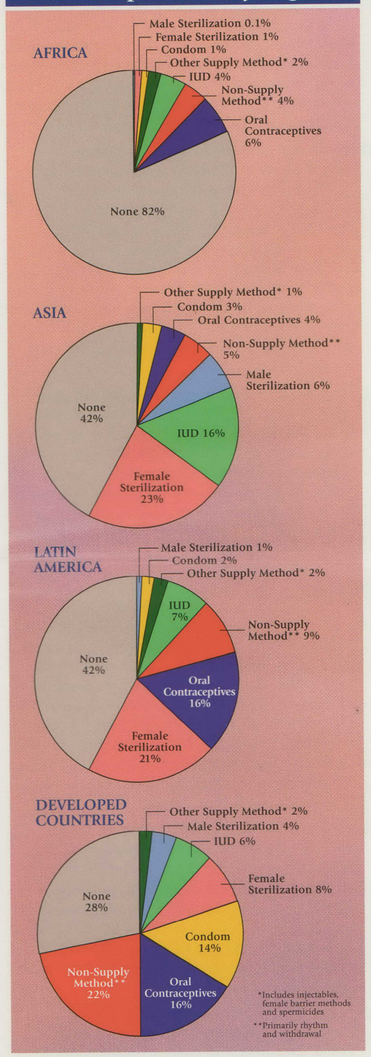
Contraceptive Choice

Throughout the developing world, a revolution in reproductive behavior is underway. Today, over half of all couples in developing countries use a contraceptive method, compared to one in ten couples in the 1960s. On average, couples are having between three and four children, compared to six children 30 years ago. As government family planning programs and the commercial sector expand availability of contraception, couples everywhere are increasingly having children by choice, not by chance.

The Importance of Contraceptive Method Choice

The number of different contraceptive methods offered on a consistent basis is important because access is enhanced when couples can choose from alternatives. No one method is adequate to meet the needs of every couple. Some couples want a temporary method to space the birth of their next child, while others do not want any more children and want a long-term method. Individuals vary in their personal preferences and in their assessment of the risks and benefits of each contraceptive method. The experience in many countries suggests that each additional method offered attracts a new group of contraceptive users.

Contraceptive Use by Region



Data Source: United Nations

A choice of methods is also important from a health perspective. Many women find birth control pills satisfactory, while others experience unacceptable side effects. Some hormonal methods are inappropriate for breast-feeding mothers and their babies. IUDs pose potential health problems for women at risk of sexually transmitted infections, while condoms provide protection from both pregnancy and disease.

The availability of a range of methods provides alternatives for individuals dissatisfied with their current choice of contraceptive. The ability to change methods is important since a third of all couples discontinue a method within a year of initiating use and about half discontinue use within two years.

Access to a choice of contraceptive methods is thus a key element of quality health care. By helping each couple find a method that fits their needs, the availability of multiple methods contributes to improved child spacing and enhances the health of mothers and children. Moreover, a greater choice of methods increases contraceptive continuation and effectiveness, as well as overall use of family planning. Thus, expanded method choice also contributes to efforts to slow population growth and advance social and economic development.

Key Elements of Access and Choice

Government policies have a powerful impact on the availability and accessibility of methods. Policymakers decide which contraceptive methods will be available, yet these decisions are often based on outdated laws, misperceptions about health risks, or biases about specific methods. In some countries, cumbersome procedures for new drug approval limit access to methods that are widely used elsewhere. Program restrictions, such as minimum age and family size requirements, often lack a medical rationale and stifle access.

The distance and time required to obtain contraceptive services and supplies are among the most important elements of access. The geographic coverage of health and family planning services varies greatly both among and within countries; rural areas especially tend to be underserved. The proximity of sources is particularly important for methods such as birth control pills, which require resupply on a regular basis.

Even where services are available, however, cultural factors such as the ability of women to travel freely to clinics may limit access and use. Similarly, poor quality of care can deter use of existing services.

The availability of methods through multiple channels enhances choice. A combination of complementary approaches is usually needed to make a full range of contraceptive services widely available, since public health services rarely reach the entire population. Different delivery systems are appropriate for different contraceptive methods and can help to reach different groups within a society. For example, the middle class may prefer private services over the public health system, often perceived as less convenient and lower quality.

The affordability of supplies and services—and of travel to obtain them—is also a key element of access and choice. In virtually all countries, some people are unable to pay the full cost of services. In many developing countries, including much of Africa, the majority of the population cannot afford the full commercial price of contraceptives and require at least partially subsidized services.

Awareness of a range of methods, and of their risks and benefits, is essential to informed choice. While knowledge of family planning has increased in many countries, in others it is still limited. Moreover, many women discontinue using family planning because of inadequate information and unfounded fears about side effects.

Developing Countries: Patterns of Contraceptive Choice

Contraceptive Choice examines access in **88** developing countries to the five most widely used modern contraceptive methods: condoms, oral contraceptives, intrauterine devices (IUDs), female voluntary sterilization, and vasectomy. These five methods represent 98 percent of all modern method use in developing countries.

The study scores the availability of each method in a country on a 20-point scale. A score of 20 for a method does not necessarily reflect truly universal access; rather, it indicates that *at least 80 percent of couples have easy access to that method* through the public and private sectors. For purposes of the study, easy access is defined as *requiring no more than two hours or one percent of a month's wages to obtain contraceptive supplies and services for one month*.

The scores for each method were added to create the ***Developing Country Contraceptive Choice Index,*** with a maximum score of 100. The study ranks countries on the *Index*, rating them **Very Good, Good, Fair, Poor** and **Very Poor.**

- **VERY GOOD:** Most of the **19** countries in this category have very high scores for all five methods of contraception, although a few lag in access to voluntary sterilization. Hong Kong, Singapore, South Korea, Taiwan, and Tunisia all earn the maximum possible score. Many countries in this category are wealthier nations in East and Southeast Asia and Latin America, along with Botswana and Mauritius in sub-Saharan Africa. However, they also include Bangladesh, China and Sri Lanka, low income countries with strong government commitment to family planning. In Bangladesh, international donor assistance has also played a key role in expanding contraceptive access and choice.
- **GOOD:** This category includes **19** countries from all regions, including **8** in Latin America and **5** in Africa. Some countries in this group, including India, provide good access to sterilization and condoms, but fare less well on availability of effective reversible methods such as birth control pills and IUDs. Other countries have very good access to reversible methods, but limited availability of sterilization, especially vasectomy. These include several Muslim nations, including Indonesia, where religious concerns have limited access to sterilization. In Iran, however, sterilization is widely available.
- **FAIR:** This category includes **19** countries in all the major developing regions. Most of these countries have good or moderate access scores for condoms and pills, but low scores for clinical methods, especially sterilization. In Lebanon, for example, all reversible methods are widely available through the public health system, but costly private clinics are the only source of sterilization services. Bolivia and Paraguay run counter to this pattern with high scores for female sterilization, reflecting recent policy changes aimed at expanding access to most family planning methods.
- **POOR:** Of **19** countries in this category, **13** are in sub-Saharan Africa. Almost all have very low access scores for IUDs and sterilization, reflecting the poor availability of clinical health services of any kind in many African countries. However, most African countries in this category have moderate access to condoms, an important achievement given the problem with AIDS in the region. Egypt falls in the **Poor** category, largely because its relatively successful national family planning program does not provide voluntary sterilization services.
- **VERY POOR:** This category includes **12** countries, including **8** low income African countries. In this category, access scores for *all* methods—even condoms—are low; clinical methods are essentially unavailable. Of special interest are Argentina and Saudi Arabia, two wealthy developing countries where restrictive policies constrain access to all family planning methods. Also in this category are Cambodia and Laos, two Southeast Asian countries where war and civil upheaval have impeded social development, including access to health care and contraception.

Developed Countries: Patterns of Contraceptive Choice

The study analyzes access in **39** developed countries to six major modern contraceptive methods: condoms, oral contraceptives, IUDs, injectable contraceptives, female voluntary sterilization, and vasectomy. The study scores the availability of each method in a given country on a 20-point scale, with the maximum score reflecting essentially universal availability. The study then converts the total score for each country to a 100-point ***Developed Country Contraceptive Choice Index,*** rating each country **Excellent, Very Good, Good** or **Fair.**

- **EXCELLENT:** The **11** countries in this category have broad-based access to all six methods studied. **Five** countries have the maximum possible score: Germany, New Zealand, Spain, Sweden, and Switzerland. The United States ranks sixth, with the maximum score for five methods and a slightly lower score for IUDs.
- **VERY GOOD:** The **11** countries in this category represent all the regions of Europe plus Australia. In these countries, most reversible methods are universally available, with the exception of injectable contraceptives in Denmark, Greece and Hungary. Several countries in this category, however, have very limited access to sterilization, including the Czech Republic, Estonia, Finland, France and Italy. Hungary is among the few countries in Eastern Europe where sterilization is relatively easily available.
- **GOOD:** The **10** countries in this category include **7** former Soviet republics. These countries score surprisingly well on access to most reversible methods, reflecting rapid recent improvements in availability of pills and condoms through private pharmacies. The IUD, the most widely used method during the Soviet era, also still enjoys broad availability. However, sterilization services are poor to nonexistent, reflecting both negative attitudes toward the method and the neglect of modern contraceptive technologies during the Soviet period.

Contraception Reduces Reliance on Abortion

About 50 million abortions take place annually, many of them in developing countries under unsafe conditions, leading to the deaths of between 50,000 and 100,000 women each year. Evidence from around the world is mounting that improved access to contraception—and to more effective contraceptive methods—helps to reduce reliance on abortion.

In Chile, Colombia, Hungary and South Korea, substantial increases in contraceptive use over several decades have been accompanied by dramatic declines in abortion rates (the annual number of abortions for every 1,000 women of reproductive age). As in Korea in the 1970s, the expansion of contraceptive services may initially lag behind the growing desire for smaller families, resulting in a short-term increase in *both* contraceptive use *and* abortion. Over the long-term, however, abortion rates almost always fall substantially as access to contraception and effectiveness of use improve.

More recently, in Russia, Kazakstan and Ukraine, both abortion rates and the annual number of abortions have declined very rapidly following the expansion of contraceptive services. However, abortion remains a major method of fertility control in many former Soviet republics, reflecting the uneven availability and high cost of contraceptive services.

Reliance on less effective contraceptive methods appears linked to greater use of abortion. In Turkey, roughly half the women who reported having an abortion were using withdrawal, a method which has a high failure rate. Conversely, a study of 12 industrialized countries found abortion rates to be lower where a higher proportion of women rely on more effective methods such as sterilization, pills and IUDs.

- **FAIR:** The **7** countries in this category include Japan, Romania and **5** former Soviet republics. These countries have very limited contraceptive choices compared to the rest of the developed world. In Japan, the government has not approved the birth control pill, other hormonal methods or the newest copper-bearing IUDs; the vast majority of Japanese couples rely on condoms, backed up by abortion. In Romania and the former Soviet republics in this category, availability of birth control pills and injectables is improving, but access remains constrained by high costs and irregular supply, especially in rural areas.

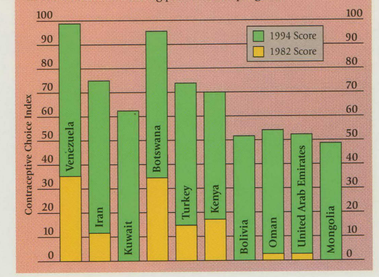
Strategies for Expanding Contraceptive Choices

The study reveals that couples in many countries still do not have broad-based access to the full array of safe and effective contraceptive technologies:

Ten Countries Making the Most Progress in Access to Contraception, 1982 to 1994

A number of countries dramatically increased their scores on the *Contraceptive Choice Index* between 1982 and 1994. Strong political commitment appears a crucial factor underlying their advances. Bolivia, Iran, Mongolia and Oman have all made major policy changes endorsing family planning and initiating national programs where none previously existed. Botswana and Kenya were among the first African countries to initiate family planning programs and have been unwavering in their commitment. In contrast, countries such as the Philippines, which have lacked consistent political commitment to family planning, have shown little improvement.

Improvements in access in Kuwait and the United Arab Emirates, however, reflect the increased availability of contraception from private as well as public sources, in response to the growing demand for contraception among their relatively wealthy and educated populations. In Venezuela, too, the expanded availability of private services appears to explain advances in access in the absence of a strong public sector program.



- Of **88** developing countries covered by this study, **9** countries have virtually no access to condoms, as reflected by a country score for the method of less than 5 out of 20; another **9** have virtually no access to birth control pills; **22** to IUDs; **38** to female sterilization; and **51** to vasectomy.
- In contrast, condoms, birth control pills and IUDs are widely available in the **39** developed countries studied; in only one country, Japan, is the pill virtually unavailable. However, **3** developed countries have virtually no access to female sterilization, **5** to injectable contraceptives, and **13** to vasectomy.

Governments can take a number of steps to expand access to a broader range of contraceptive methods:

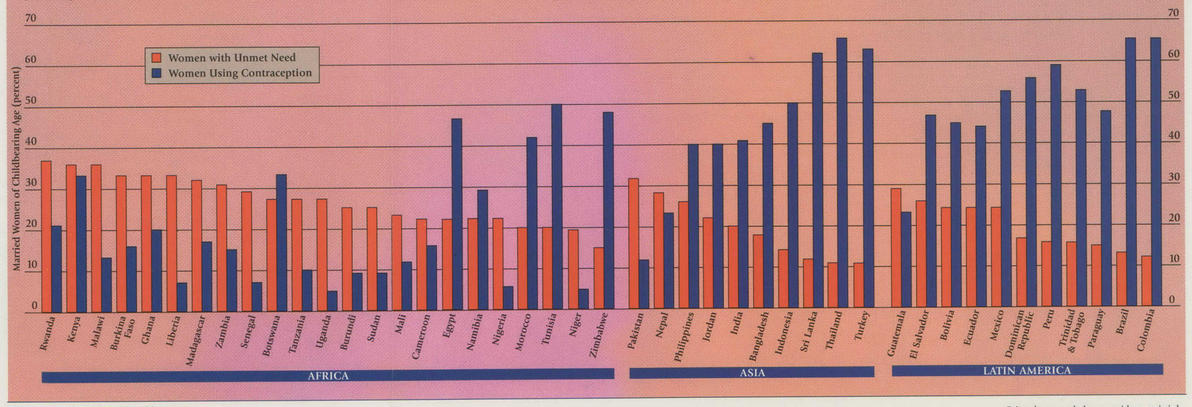
- ***Remove policy and medical barriers to access and choice.*** Governments should review their laws and policies with the aim of promoting the availability of all safe and effective contraceptive methods. Restrictions should be limited to those essential to protect clients from health risks or involuntary procedures.
- ***Expand health and family planning networks.*** Where the geographic coverage of family planning services remains limited, increasing method choices must go hand in hand with broadening the reach of services. Many African countries, for example, need to expand health facilities and personnel in rural areas.
- ***Use a variety of public and private channels to provide reasonably equal access to a range of methods.*** Clinics and trained health staff are needed to provide IUDs, contraceptive implants and sterilization. However, various community networks can help ensure the widest possible availability of pills, condoms and other non-clinical methods. Involving private groups such as commercial distributors, voluntary agencies, doctors, midwives and pharmacists can expand access while reducing the financial burden on the public sector.
- ***Ensure that all methods are affordable.*** Governments have a key role to play in ensuring that services are provided free or at a modest charge to those who could not otherwise afford them, either through the public health system or through subsidies to the private sector. Sensible cost recovery measures need not, however, prove a major impediment to use by low income populations.
- ***Educate people about available family planning choices.*** Television, radio and other media campaigns can help counter misinformation about the health risks of contraceptive methods and educate the public about methods that are not widely used. To complement these efforts, health workers need to provide good counseling to women and men seeking contraceptive services.
- ***Invest in contraceptive research and development.*** Even where a broad range of methods is available, some couples have difficulty finding an appropriate method. Industrialized countries need to increase public funding for research on new contraceptive methods, an area which private companies have largely abandoned. The many individual and social benefits of increased contraceptive choice provide a strong rationale for investing in an expansion of such choices for the future.

The Unmet Need for Family Planning

Over 100 million married women of childbearing age in the developing world are considered to have an "unmet need" for family planning, because they say they want to postpone or stop having children but are not using a contraceptive method. Although this definition of unmet need does not directly reflect a desire to use contraception, this gap between reproductive intentions and behavior signals some level of potential demand. This definition of unmet need is, however, very narrow; it does not include unmarried adolescents or women using less effective traditional family planning methods.

The reasons these women do not use contraception include lack of access to and poor quality of family planning services; fear of side effects of specific methods, often reflecting a lack of information; and opposition from husbands and other family members. Yet another reason is *a lack of access to the methods these women prefer*. In South Korea and India, studies found that unmet need often reflects dissatisfaction with the limited choice of methods available. Analysis of unmet need in 44 countries confirms that the fewer the contraceptive methods available, the higher the level of unmet need.

In developing countries (excluding China), roughly 20 percent of married women in their childbearing years have an unmet need for family planning. India has the largest number—about 30 million. But the proportion is highest in Africa, where in many countries up to a third of women have an unmet need for family planning, a proportion often greater than those using a contraceptive method.



Data Source: Demographic and Health Surveys

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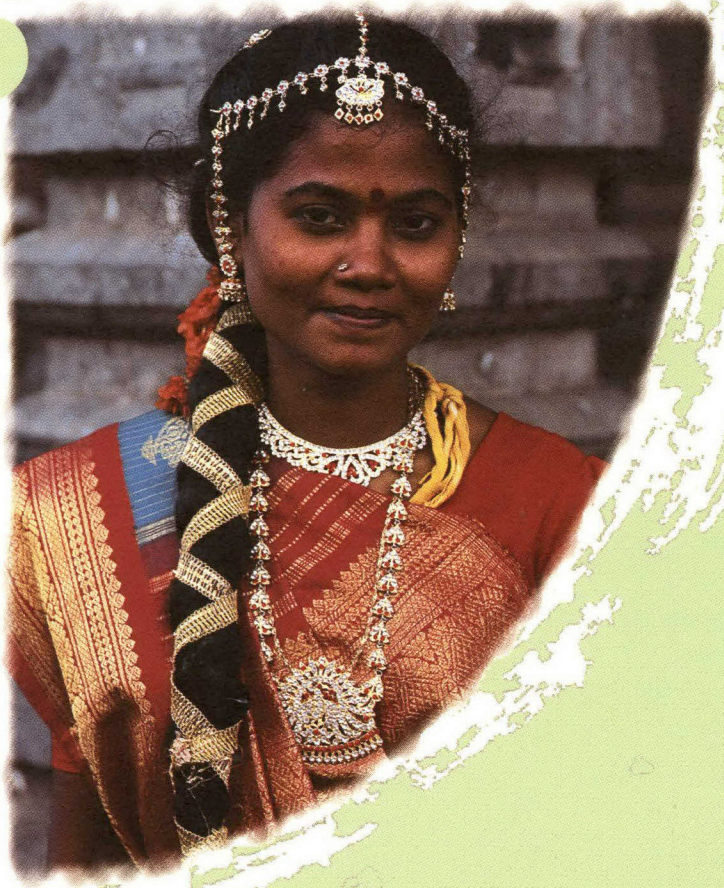
Population Action International



Population Action International

Population Action International (PAI) is dedicated to advancing policies and programs that slow population growth in order to enhance the quality of life for all people.

PAI advocates the expansion of voluntary family planning, other reproductive health services, and educational and economic opportunities for girls and women. These strategies promise to improve the lives of individual women and their families while slowing the world's population growth.

To these ends, PAI seeks to increase global political and financial support for effective population policies and programs grounded in individual rights.

PAI fosters the development of U.S. and international policy on urgent population issues through an integrated program of policy research, public education and political advocacy. PAI reaches out to government leaders and opinion makers through the dissemination of strategic, action-oriented publications, broader efforts to inform public opinion, and coalitions with other development, reproductive health and environmental organizations.

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A Message from PAI's National Chairperson—Robin Chandler Duke

The two biggest challenges facing this generation and the next are how to help the poorest half of humanity become part of the global economy, and how to help that economy grow without further degrading our planet and exhausting its resources. The global marketplace may be tough, but being left out will be even tougher.

Women's participation is essential to both efforts. Whether working in or out of the home, women have a tremendous impact on the productive capacity of local and national economies and on their surrounding environment. And their ability to make a difference depends, in turn, on their ability to make choices: to plan their families, to get an education, and to put their skills to work. The whole package is tied together. The kind of world our grandchildren will inherit depends on what we do about this today.

PAI thinks of its mission as broadly humanitarian—dedicated to the promotion of good health, girls' education and family well-being, as well as population stabilization, sustainable development, and the preservation of the environment. Without global progress in reproductive health care and family planning, it will be difficult to realize these goals, to strengthen emerging democracies, to protect the environment from further degradation, or to develop new opportunities for trade and investment.

When policymakers choose to deny, reduce or delay funds for health programs, including maternity and family planning services, they are in fact downgrading the fate of women and children around the world.

Robin Chandler Duke and Hillary Rodham Clinton
S. Raskin

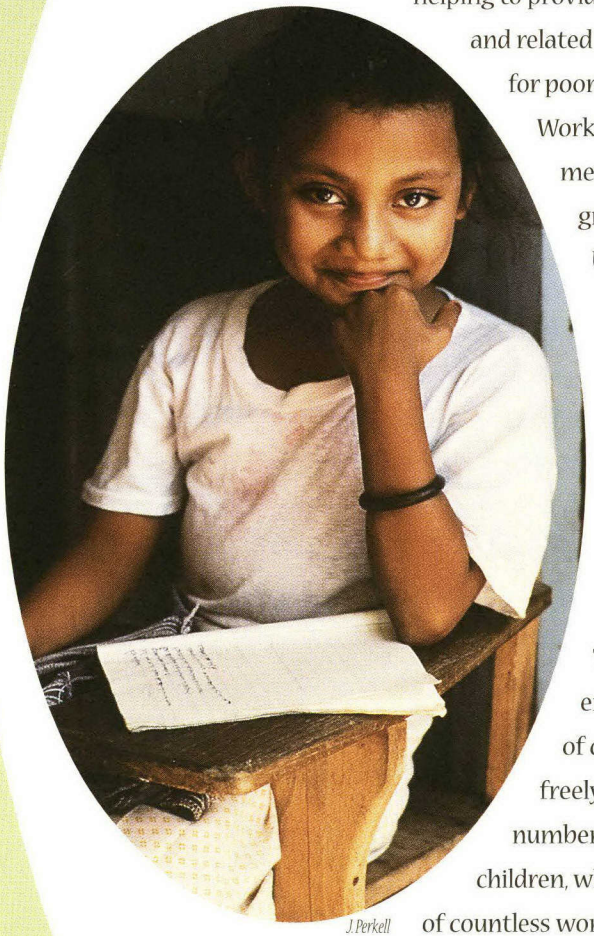
PAI's job is to help the world's governments and major financial institutions see how important these connections are. Mutual funds have invested $135 billion in emerging nations—up from $14 billion in 1990. Developing countries now buy 25 percent of the exports of industrialized countries. If we expect these promising economic trends to continue, couples worldwide will need the same health services and life choices long taken for granted here. When policymakers choose to deny, reduce or delay funds for health programs, including maternity and family planning services, they are in fact downgrading the fate of women and children around the world, and foreclosing the development possibilities of poor countries.

Today, governments and consumers in developing countries pay about 75 percent of their own costs for family planning services, recognizing that family planning safeguards the health of women, children, and families while also improving the economic and educational outlook for everyone. However, the number of women in their childbearing years is growing by about 24 million a year, and family planning services will need to expand rapidly to serve the largest number of women of childbearing age in history. Will the United States increase its support at this critical time?

Fifty years ago, Secretary of State George Marshall proposed a bold and visionary postwar plan to rebuild a peaceful, prosperous, democratic Europe. Despite isolationist opposition in Congress, his plan succeeded brilliantly. That vision of international cooperation is needed just as urgently now as it was

a half-century ago. Most of Europe is safely out of harm's way, but our trading partners in the developing world are not.

Between 1965 and 1995, the United States led the world in helping to provide family planning and related health services for poor couples abroad. Working with governments and private groups alike, the United States developed over a 30 year period an expertise and technical capability that cannot be easily replaced overnight by others. The program has enabled tens of millions of couples to determine freely and responsibly the number and spacing of their children, which has saved the lives of countless women and children everywhere. Yet for the last two years, Congress has attacked our overseas family planning program, reducing international population assistance by one-third and imposing administrative restrictions on how and when the money can be spent. After thirty years of bipartisan congressional support, we appear to be abdicating U.S. leadership in this vital field. Why?



J. Perkell

We look to the day when every child is loved and well cared for and when all women can survive their childbearing years in good health.

Three out of four Americans say they want to sustain or increase U.S. spending on family planning to poor countries, and the need for such support has never been greater. Yet a vocal minority in Congress has raised the red flag of abortion and turned every vote on family planning into a political Armageddon—despite the fact that our foreign aid statutes clearly prohibit the use of U.S. funds for abortion, and our history of compliance with such statutes is unblemished.

Despite this stiff opposition, a slim majority in Congress recently voted to release long delayed 1997 international family planning funds. PAI is working to help more legislators understand that improving access to voluntary family planning is the best way to reduce the incidence of abortion and among the most effective measures to reduce maternal mortality and protect the lives of children. In accepting this view, Congress has shown that there can be common ground between abortion rights advocates and opponents—safe, voluntary family planning.

We at Population Action International intend to build on this important victory, to shift the debate to what is truly important—the well-being of mothers and their children. We look to the day when every child is loved and well cared for and when all women can survive their childbearing years in good health. We thank you for your support in this worthy humanitarian endeavor and hope that we can count on you again in 1997.

Sincerely,

Robin Chandler Duke

Robin Chandler Duke
National Chairperson

A Message from the PAI's President—Hugo Hoogenboom

Last November, the United Nations Population Division reported that in the year 2050, the world would likely have one half billion fewer people than had previously been projected. For those of us concerned with the impact of rapid population growth on the health and well-being of women, families, and the planet, this is remarkably good news. It tells us that the modest efforts of the world's nations to address the problem of population growth are in fact paying off, and that the agreement forged in 1994 at the International Conference on Population and Development (ICPD) in Cairo set the right course.

It is far too early to talk about success, however, as we are still growing at a rate of about 81 million people each year. And the babies that were born during the years of greatest growth are themselves now entering adulthood, so that more people than ever are moving into their childbearing years. Indeed, the number of women of childbearing age is increasing by 24 million a year.

Despite this evidence of enormous need, the Congress has cut the U.S. population program by an average of one-third over the last two years and hamstrung it with restrictions. And although Denmark, the European Union, Germany, the Netherlands and the United Kingdom have substantially increased their funding, the international community cannot achieve the goals set at the Cairo conference unless the United States is a full partner. Nor can these few nations compensate for several other important donors of development assistance—especially France, Italy and Spain—that allocate only minor amounts for family planning and other reproductive health programs.

To reach the year 2000 targets laid out in 1994 at the International Conference on Population and Development would require that the donor countries increase funding, on average, by more than 20 percent each year.

To reach the year 2000 targets laid out at the ICPD in 1994 would require that the donor countries increase funding, on average, by more than 20 percent each year. Moreover, the poor example now being set by the world's strongest economy—the United States—does little to encourage either donor or developing nations to meet their respective commitments to population programs and their promise of a better life.

That simple phrase—a better life—is perhaps the key to understanding the importance of population programs. More than 30 years ago, Population Action International had its origin in the conviction that the economic and social development efforts already underway could not succeed if they did not also address the problem of rapid population growth. Since then, we have reached a better and more detailed understanding of population growth and its impact on human welfare, including an understanding of the dynamic relationship between population and development programs—that each needs the other to work well.

Developed and developing nations alike have a direct interest in supporting these programs. Now is not the time to falter. If we do, women, families, and nations will suffer the consequences. The United Nations Population Fund recently estimated that projected shortfalls in population assistance between 1995 and the year 2000 could result in at

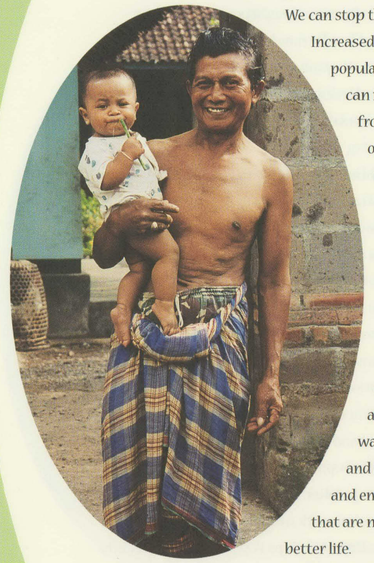
Nafis Sadik, Executive Director of the United Nations Population Fund (UNFPA), and Hugo Hoogenboom

Dunn Photographics

least 120 million additional unintended pregnancies, 49 million abortions, 5 million deaths among infants and young children, and 65,000 additional pregnancy-related deaths among women.

We can stop this carnage. Increased investments in population programs can free women from the burden of unintended pregnancy and avert the needless deaths of mothers and children. These investments are also essential if each of us is to have adequate food, water and clean air, and access to the educational and employment opportunities that are necessary to realize a better life.

Why are we hesitating?



V. Sant

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Hugo Hoogenboom
President

1999

January

Washington Population Update

February

Legislative and Policy Update

April

Pakistan's Population Program: The Challenge Ahead

Carol Bellamy, Executive Director of UNICEF, addresses PAI board.

Dunn Photographics

May

Legislative and Policy Update

Expert meeting: Population-Environment field projects

June

Why Population Matters fact sheet

July

Policy seminar: "Pakistan's Population Program: Current Trends and Prospects for Donor Support"

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Profiles of UN Organizations Working in Population

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Directions in Japanese Population Assistance

November

Why Population Matters

December

Legislative and Policy Update

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2000

January

"Save Family Planning" newspaper ad in 15 cities across the United States

Policy seminar: "UNFPA—Meeting the Challenges of the 21st Century"

February

Why the United States Should Support Family Planning Overseas

March

Contraceptive Choice: Worldwide Access to Family Planning

Legislative and Policy Update

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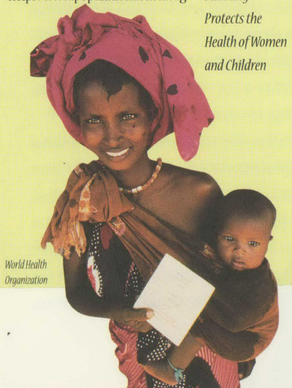
April

Launch of PAI web site—http://www.populationaction.org



World Health Organization

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How Family Planning Protects the Health of Women and Children

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Why the United States Should Support UNFPA

Lost Opportunities: Population Growth and Economic Change

International edition of *Why Population Matters*

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Plan & Conserve: Population-Environment Projects in the Field

Contraceptive Choice in Developed Countries

"Save Family Planning" radio public service announcements begin

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Population Programs in Sub-Saharan Africa: Progress and Prospects

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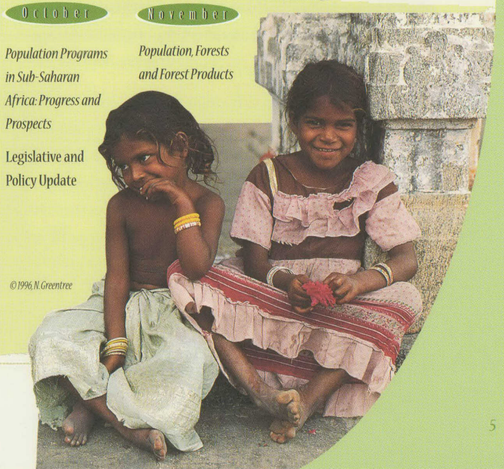
Population, Forests and Forest Products



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Major Milestones of the Last Year

This year, there will be about $223 million more available for family planning programs in developing countries than there might have been without the efforts of PAI and like-minded colleague organizations. We collectively managed to head-off further delays in the release of U.S. population assistance, and to encourage a dramatic increase in Dutch funding for international family planning.

J. Rosen

Thanks to the commitment of its donors, PAI was able to expand its annual budget by 37 percent this year, to increase its staff, to expand its media outreach, and to diversify the content and format of its publications to reach more audiences.

PAI has continued to track donor compliance with the global funding commitments endorsed at the International Conference on Population and Development (ICPD) in Cairo. Two such PAI reports were issued in 1997: on trends in donor assistance generally since 1994 and on Japan's implementation of its post-Cairo funding commitments. Numerous citations and calls from colleagues indicate that such PAI reports have become a vital source of information on donor assistance.

PAI is creating new databases to monitor demographic, reproductive health, family planning, educational and economic indicators in order to measure progress toward the goals agreed upon at the ICPD.

V. Sant

PAI provided timely legislative updates, policy insights and analyses to an expanding network of editorial writers, print journalists, and radio program hosts in the United States and worldwide—helping to keep the public informed about the latest developments in the U.S. funding battle. Paid newspaper display advertising in 15 cities prompted phone calls to members of Congress from their constituencies and helped secure congressional approval for the long overdue release of U.S. family planning aid for 1997. Had the outcome been otherwise, $123 million less in U.S. aid would be paid out for family planning services in developing countries this year.

Whether working in or out of the home, women have a tremendous impact on the productive capacity of local and national economies and on their surrounding environment.

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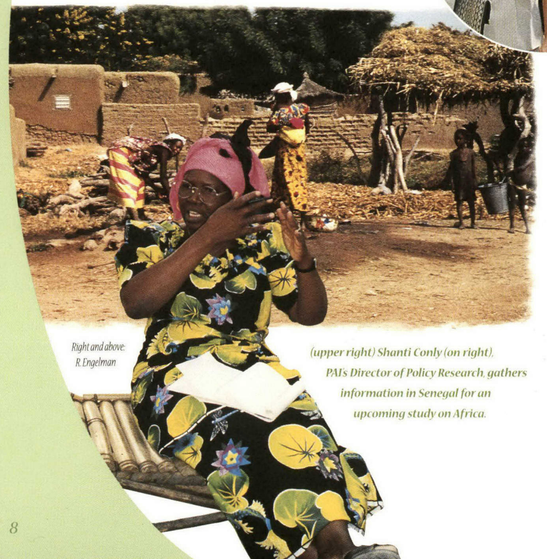
Representative Tom Sawyer (D-OH) and PAI Vice President Victoria Markell



Right and above: R. Engelman

(upper right) Shanti Conly (on right), PAI's Director of Policy Research, gathers information in Senegal for an upcoming study on Africa.

Calendar of Events and Publication Dates

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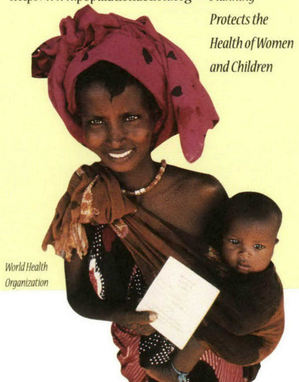

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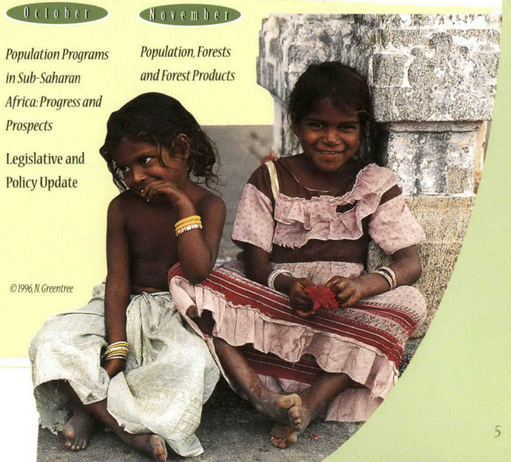

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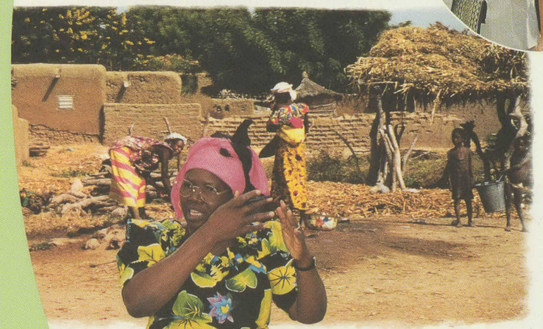

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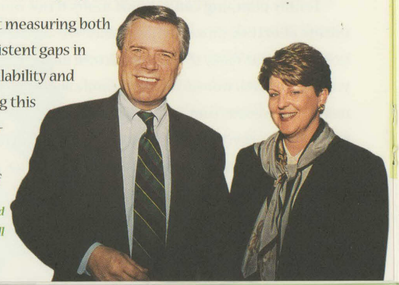


Representative Tom Sawyer (D-OH) and PAI Vice President Victoria Markell

(upper right) Shanti Conly (on right), PAI's Director of Policy Research, gathers information in Senegal for an upcoming study on Africa.

V. Sant

providing the poor around the world with opportunities to exercise individual responsibility and self-determination. Internationally, we are using this report to remind policymakers that access to family planning and to a choice of contraceptive methods is crucial to achieving better reproductive health and other ICPD goals.

PAI has developed and disseminated a plan for strengthened leadership, interagency coordination, and funding for the Cairo action plan among United Nations agencies and is developing a similar set of recommendations to promote increased World Bank support for ICPD objectives.

Family planning could bring more benefits to more people at less cost than any other single technology now available to the human race.

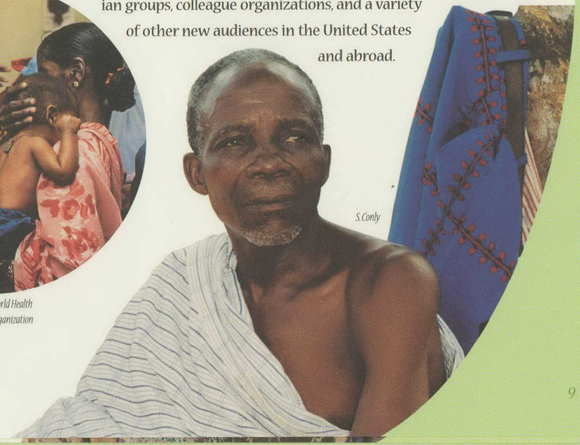
UNICEF

PAI has continued its work to inform, support and coordinate the efforts of expanding networks and coalitions of like-minded humanitarian organizations in both the United States and Europe, all working to promote implementation of the policy and funding goals endorsed in Cairo by 180 nations. PAI has established a small satellite office in Europe to help support the work of its advocacy partners and, in recognition of their success in building support for ICPD goals and funding, has doubled its annual financial assistance to these partners. In 1996, PAI provided grants and shared its experience and advice with advocacy groups in France, Germany, the Netherlands, Spain, Britain, Brazil, and the Philippines. Among the 1996 activities financed in part by PAI were:

- The development of a common e-mail network for 20 European population and family planning groups to facilitate information exchange and collaborative initiatives.
- The creation of a 70 member population parliamentary group in the French National Assembly, which is encouraging allocation of a greater share of France's sizable foreign aid budget for family planning programs in developing countries.
- The successful efforts of the World Population Foundation in the Netherlands to encourage the Dutch Parliament to allocate four percent of its foreign aid budget to ICPD related activities—an annual funding increase for family planning of about $100 million.
- Implementation of a broad-scale public awareness campaign in the London underground.

World Health Organization

PAI has continued to project and articulate the many consequences of population growth for human and planetary welfare—for the press, the lay public, grassroots membership groups, policymakers, environmentalists, scientists and academics, humanitarian groups, colleague organizations, and a variety of other new audiences in the United States and abroad.



S. Conly

Dunn Photographics

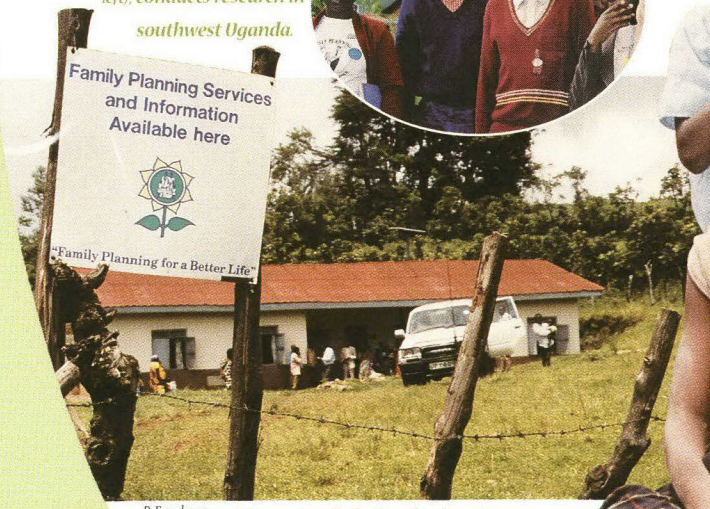
Two of PAI's resource studies—*Conserving Land* and *Sustaining Water*—were part of the official U.S. presentation to the November 1996 World Food Summit in Rome.

PAI's report on how population growth contributes to global warming helped launch the concept of "tradable emissions permits" three years ago. Now the United States is proposing that such permits be among the amendments to the global emissions treaty taken up at an international conference in Kyoto this coming December.

PAI's report that by 2025 some 48 nations and 3 billion people will suffer water shortages has been incorporated in booklets on population and sustainable development distributed to UN missions worldwide by the UN Development Programme and the UN Population Fund.

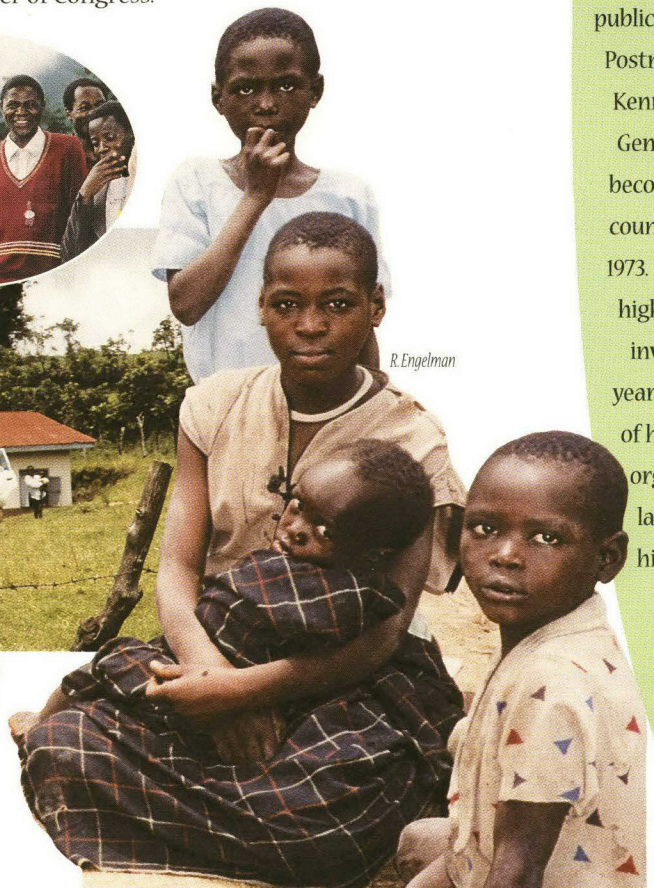
The book *Biodiversity and Human Health*, to which PAI contributed a chapter, is now being distributed to every member of Congress.

PAI Director of the Population and Environment Program, Robert Engelman (second from left), conducts research in southwest Uganda.



R. Engelman

The project links family planning services and natural resource conservation.



R. Engelman

In Memoriam

James Edward Day, one of PAI's most dedicated, able and long-serving Board members, died on October 29, 1996. After a distinguished career in law and public service, including serving as Postmaster General in President Kennedy's cabinet, Ed accepted General Draper's call in 1965 to become our organization's legal counsel and joined the Board in 1973. His readily volunteered and highly expert legal advice was invaluable in our formative years, and he gave unstintingly of his time and talents to our organization and the population cause right up until his death. His enthusiasm, wisdom, humor and friendship are greatly missed.

Robert A. Fearey Retires

At its spring 1997 meeting, the Board of Directors of Population Action International bid a reluctant but fond farewell to Robert A. Fearey, expressing admiration for his many contributions to the board, the organization, and the cause of population stabilization.

Bob joined the Population Crisis Committee as Administrator and Assistant Treasurer in 1979. He came from nearly 40 years in the U.S. Foreign Service, where he had last served as deputy to Ambassador Marshall Green in the newly established Office of the Population Coordinator. It was there that he acquired the understanding of population issues and the dedication to population stabilization that were to mark his work at Population Action International.

Bob served with cheerfulness, attention to detail, judgment, and initiative. PAI will miss him more than is possible to put in words, but his spirit and the results of his work will remain with us, as will our recollections of his charming wife and helpmate, Shirley.

Financial Report

The figures below summarize the financial status of Population Action International for fiscal years 1995 and 1996. Copies of our audited 1996 financial statements and the unqualified opinion of Stegman & Company, Certified Public Accountants, are available upon request. For presentation purposes, the figures below have been rounded to the nearest thousand.

Financial Overview

Throughout its history, PAI has received the majority of its individual contributions in the last two weeks of the year, which typically made efforts to synchronize program expenses with income levels somewhat difficult. To address this problem, PAI has changed its reporting period from a calendar year basis to a fiscal year ending November 30th. Beginning with FY 1997, the December contributions arrive in the beginning of the fiscal year rather than the end—thus facilitating a more accurate matching of program expenses with income levels.

To carry out this change, FY 1996 was shortened to eleven months. Because December 1996 will be part of FY 1997, there is no high income (annual appeal) month falling in FY 1996. Nevertheless, PAI's 11-month income for 1996 exceeded its 12-month income for 1995. However, 1996 program expenses no longer include the full complement of the staff costs and grant expenses previously associated with PAI's Special Projects Fund—much of which have been absorbed by The Wallace Global Fund.

Total Income and Expenses

	1996 Unrestricted	1996 Temporarily Restricted	1996 Total	1995 Total
Contributions and Other Income	$3,116,000	$1,286,000	$4,402,000	$3,760,000
Program Expenses and Allocations	($3,576,000)		($3,576,000)	($4,383,000)
Revenue Minus Expenses	($460,000)	$1,286,000	$825,000	($623,000)

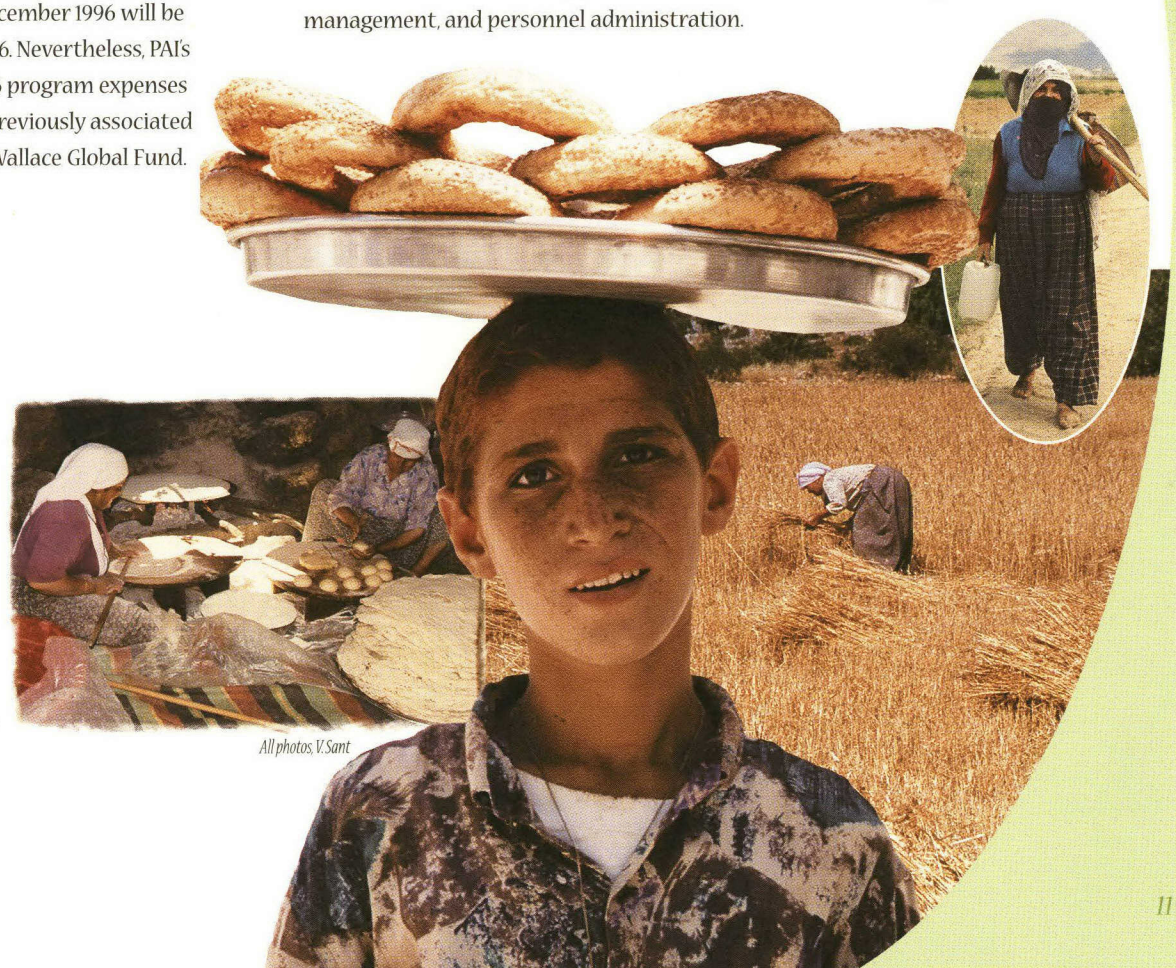
The increase in total revenue over expenses reflects not only a substantial increase in multi-year pledges but also the very strong performance of PAI's investments in 1996, thanks in part to the engagement of a professional portfolio manager and to the reinvestment of money market proceeds in equity holdings (which now comprise about half of PAI's diversified portfolio). The majority of the $1.29 million balance of temporarily restricted funds is comprised of grants and firm pledges for future years.

Summary

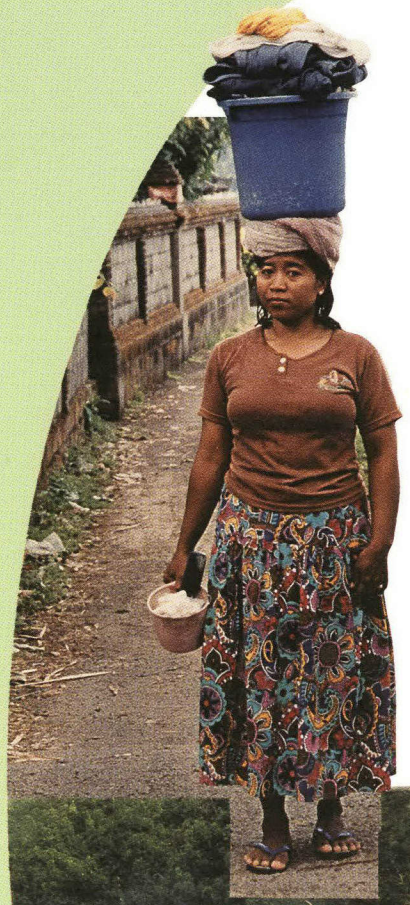
The balance sheet as of November 30, 1996, shows total assets at $7.8 million, of which $6 million was invested in diversified portfolios yielding over $513,000 in net interest, dividends, and market appreciation and the remainder was in the form of property and equipment ($.22 million), cash and equivalents ($.12 million), contributions receivable ($1.36 million), and other assets ($.10 million).

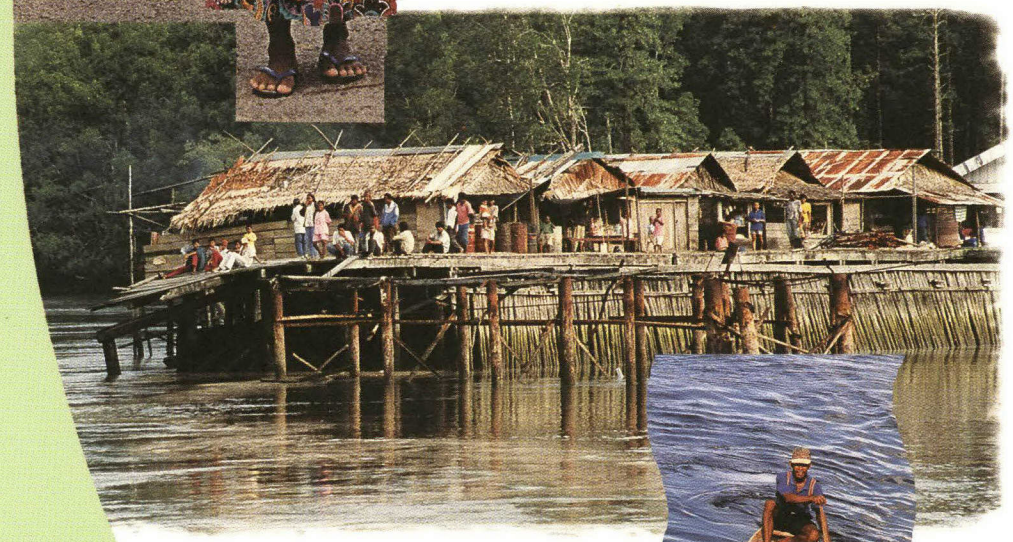
Program Expenses

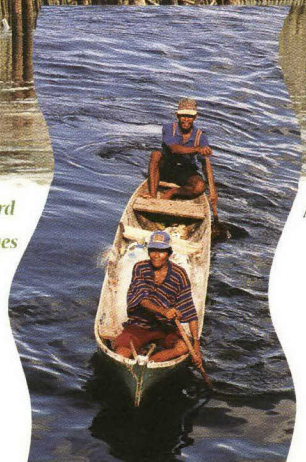
Program expenses in 1996 totaled $3.58 million. **More than 82 percent of all disbursements went to project activities. Only 4.1 percent of income was allocated to fundraising activities.** About 10.4 percent of income was allocated to support services that include accounting, audits, management, and personnel administration.



All photos, V. Sant







Family planning has helped families safeguard their health even in the most remote villages of the world.

All photos, V.Sant

PAI's 1996 project expenses were allocated as follows: U.S. and International Population Policy activities including a Pakistan Family Planning Program Critique, a World Bank Study, two donor reports, and a study on the Role of UN Agencies in Global Population Assistance—$1,214,035; grants and technical assistance to population projects and advocacy partners abroad—$987,816; and Media, Public Education and Environment Programs, including public education and press outreach on reports noted above, as well as *Why Population Matters* and a number of forthcoming reports on population, economic growth and other development issues—$733,051.

Restricted Funds

Interest and investment income from PAI's Endowment Funds are assets that can be used in accordance with specific endowment guidelines to help advance PAI's mission by sustaining key elements of its program. These restricted funds are as follows:

Draper Leadership Fund

The Draper Leadership Fund was established in 1981, with a gift of $347,000 to support leadership activities in the population field similar to those undertaken by PAI's principal founder, General William H. Draper, Jr. In 1996, net income and appreciation totaled $127,000, up from $88,000 in 1995.

General Endowment Fund

The General Endowment Fund was established in 1988 to enable donors to contribute to an endowment for general support. Investment income during 1996 totaled $44,600, up from $24,000 in 1995.

Special Projects Funds

PAI has had two earmarked funds for the support of highly leveraged overseas projects. The first Special Projects Fund (SPF) was established in 1975 as an operating fund that accepted donor contributions and disbursed grants to projects overseas. An SPF Endowment Fund was subsequently established in 1990 to generate investment income to support Special Projects activities and grants.

In 1995, PAI's National Co-Chair Robert B. Wallace established a new foundation, The Wallace Global Fund, which absorbed a number of grantmaking and project management activities, as well as a number of the professional staff formerly associated with PAI's Special Projects Fund. Thus, the income and expenses of this activity were phased down at PAI in this fiscal year. In 1996, the Special Projects Operating Fund generated $7,500 in income and appreciation, but disbursed $289,000 to projects abroad. The remaining fund balance is $25,000, which is earmarked to fulfill an ongoing grant. These events do not reflect a material change in the financial strength of PAI's other ongoing programs.

In October 1996, at the direction of PAI's Board of Directors, **the Special Projects Endowment Fund was re-named The Robert and Gordon Wallace Fund for Population Initiatives, in honor of its principal benefactors.** As of November 30, 1996, assets of this new Wallace Fund totaled $2,464,000. The purpose of this fund is to support ground-breaking program and policy initiatives with the potential for regional or global impact in support of PAI's mission. Fund income for 1996 totaled $202,000.

Six Reasons to Contribute to Population Action International in 1997

To reach a combined audience of about 500 million people worldwide with a steady stream of press and radio messages on the importance of efforts to stabilize human numbers, to conserve dwindling natural resources, and to educate women to participate fully in the economic, political, and intellectual life of their communities for the sake of our collective future.

To effect a significant change in the collective will of world leaders to give priority to population and family planning programs all around the world—especially in the United States where congressional support for international family planning has seriously faltered for the last two years.

To persuade the world's donor governments and multilateral institutions, including the World Bank and the United Nations, to provide the money and technical assistance needed to make universal access to contraception and improved reproductive health care a reality within the next 15 years.

To strengthen the family planning programs of the world's most populous countries and to promote the most effective use of the resources made available for family planning and reproductive health care services.

To help sustain and strengthen a broad network of scientists, environmentalists, development experts, health care professionals, human rights advocates, and family planning organizations that use PAI materials to help advance public understanding and our common humanitarian goals.

To promote implementation of the Programme of Action endorsed in Cairo by 180 nations in 1994, and to ensure revalidation of explicit Cairo Conference priorities—population stabilization, reproductive health care, female education, and sustainable development—in the documents and agreements generated by subsequent international conferences.

Population Action International is a nonprofit 501 (c)(3) organization supported entirely by tax-deductible contributions from individuals and foundations. PAI welcomes contributions and bequests to its program in any form, including securities or insurance proceeds. Planned giving arrangements can be tailored to fit the needs of individual donors. Brochures and professional consultations on estate planning and planned giving are available upon request.

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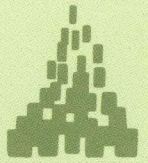

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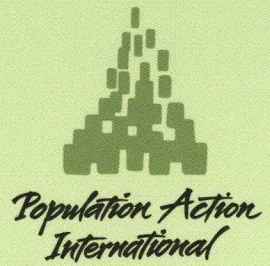

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Falling Short

THE WORLD BANK'S ROLE IN POPULATION AND REPRODUCTIVE HEALTH

By Shanti R. Conly and Joanne E. Epp

Population Action International

Falling Short: The World Bank's Role in Population and Reproductive Health

Population Action International (PAI) is dedicated to advancing policies and programs that slow population growth in order to enhance the quality of life for all people.

PAI advocates the expansion of voluntary family planning, other reproductive health services, and educational and economic opportunities for girls and women. These strategies promise to improve the lives of individual women and their families while slowing the world's population growth.

To these ends, PAI seeks to increase global political and financial support for effective population policies and programs grounded in individual rights.

PAI fosters the development of U.S. and international policy on urgent population issues through an integrated program of policy research, public education and political advocacy. PAI reaches out to government leaders and opinion makers through the dissemination of strategic, action-oriented publications, broader efforts to inform public opinion, and coalitions with other development, reproductive health and environmental organizations.

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Falling Short

The World Bank's Role in Population and Reproductive Health

Shanti R. Conly and Joanne E. Epp

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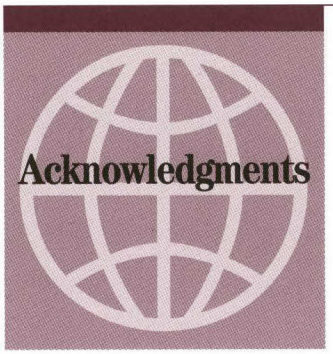
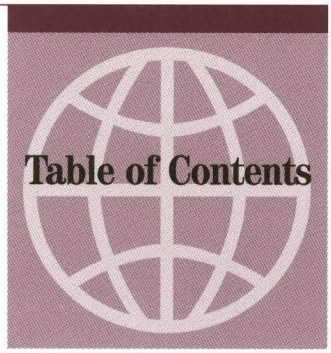


Acknowledgments

In early 1997, Population Action International (PAI) staff met with World Bank colleagues in the health, nutrition and population sector to discuss the Bank's activities in population and reproductive health. This exchange sparked PAI's decision to prepare its own assessment of the Bank's contribution to addressing the needs in this area identified by the 1994 Cairo conference on population and development.

PAI was aided in the effort by the encouragement of the World Bank's leadership in human development and health. Many Bank staff graciously took the time to meet with us, share documents with us, and respond to our never-ending requests for additional information. This report owes its strengths to their efforts to educate us about the intricacies of the Bank, an extremely complex and highly decentralized organization, and one that is currently experiencing major change. The report's faults, of course, are our own.

We owe a special debt of gratitude to Tom Merrick, the Bank's population advisor, who patiently bore the brunt of our information requests. However, we are very grateful to *all* our colleagues at the Bank, both for their assistance and for the openness with which they responded to us. We also thank colleagues inside and outside the World Bank who took the time and trouble to give us valuable comments and perspective on an earlier draft of this report.



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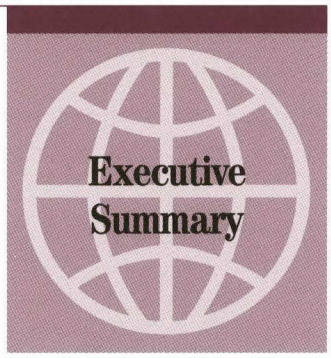


Implementing ICPD: The Role of the World Bank

The number of women—and men—in need of reproductive health services will almost double over the next two decades. Action taken now by the world community to expand reproductive choices for these individuals will have a significant impact on their health and well-being, on the eventual size of the world's population and on the quality of life for future generations. Recognizing these needs, 180 nations endorsed a comprehensive strategy for improving reproductive health at the 1994 International Conference on Population and Development (ICPD).

The World Bank has enormous potential to help developing countries implement the ICPD strategy.

The World Bank has enormous potential to help developing countries implement this strategy. The Bank has great influence on national development policies and can help advise governments on appropriate investments in population programs. In addition, the Bank's substantial loan resources can help finance the large new investments in reproductive health services and women's educational and economic opportunities called for by the ICPD. The Bank's financial resources are especially important since the gap between reproductive health and family planning needs and funds available for these programs is growing, while donor country contributions to population programs lag far behind commitments made at the ICPD.

The Bank's current leadership is introducing sweeping changes aimed at making the institution more responsive to the needs of developing countries. Some of these changes—for example, efforts to redirect loan resources from infrastructure to health and education projects and to pay greater attention to women's issues—hold promise to advance the goals of the ICPD. However, recent changes do little to address the limited attention the Bank has given to the problem of rapid population growth in the last few years. Moreover, in the health sector, the Bank is increasingly emphasizing broad policy reform and financing issues, a trend which could detract from support to improvement of actual health services, including reproductive health and family planning.

Attention to Population-Development Linkages at the Policy Level

Bank reports analyzing the economic situation and development prospects of a country form the basis for policy discussions with the government and for the Bank's lending program to that country. In a positive shift, the Bank is moving to incorporate more analysis of social issues in these country strategy documents. However, if population concerns are to be reflected in the policy dialogue with borrower countries, it is important that the Bank's analytical reports more consistently and fully address problems associated with rapid population growth.

One reason for the frequent neglect of population concerns in economic analyses is that the Bank's economic establishment remains unconvinced that population factors have a negative impact on economic growth. While in the past the Bank has sponsored important research on the linkages between population growth and various development outcomes, it currently supports very limited work in this area. Recent initiatives to disseminate new research on economic and other benefits of slower population growth are, however, encouraging.

Overall, the Bank has not taken a strong position in support of population stabilization, and has favored investments in health and education over family

planning as a strategy for encouraging a shift to smaller families. Although such investments are an essential part of a comprehensive population strategy, the Bank also needs to recognize the central role improved access to contraceptive services has played in rapid fertility decline.

In practice, however, the Bank has had difficulty adopting a multisectoral approach. Responsibility for population activities falls narrowly under the health sector, limiting the potential to incorporate population concerns into the Bank's overall approach to development. No organizational unit has responsibility for integrating population issues in a cross-cutting way into broader development analyses. The recent reorganization and the low profile the Bank's leadership has maintained on the subject of population have reinforced the neglect of these issues.

Responsibility for population activities falls under the health sector, limiting the potential to incorporate population concerns into the Bank's overall approach to development.

Recommendations for Strengthening Attention to Population in Policy Work:

If the Bank is to make population a central and cross-cutting policy concern and strengthen attention to population issues in analytical work, it needs to:

- establish a unit for multisectoral population analysis outside the health sector;
- prepare a formal corporate statement on the role of population in development and a strategy for addressing population concerns;
- support more research on the economic, environmental and health consequences of both rapid population growth and fertility decline;
- hold staff responsible for addressing the implications of rapid population growth in strategic documents for countries experiencing such growth; and
- ensure that Bank officials at all levels consistently incorporate population concerns into policy discussions with countries with rapidly growing populations.

Bank Lending for Reproductive Health and Family Planning

While the ICPD endorsed a broad strategy for slowing population growth, the Programme of Action adopted by the conference calls specifically for increased investments in a core package of reproductive health services. Key elements of this package include family planning, care in pregnancy and childbirth, and prevention and management of sexually transmitted diseases (STDs), including HIV/AIDS.

Overall Trends in Bank Lending for Reproductive Health: The Bank's contribution in the area of reproductive health, together with its overall lending for health, nutrition and population (HNP) projects, has evolved significantly over time. Initially, in the 1970s, Bank lending in health focused on population and family planning. Subsequently, it expanded support for other health and nutrition activities. Beginning in the late 1980s, the Bank has also substantially stepped up support for programs to control HIV/AIDS and other sexually transmitted diseases (STDs), and for safe motherhood activities.

Overall lending for health and education projects has risen dramatically in recent years. Combined lending for population and reproductive health activities has also increased, reaching a high of over $500 million in fiscal year (FY) 1996. However, increases in lending for population and reproductive health lag behind the overall growth of health sector lending, and have lost ground in

terms of their share of total HNP lending. Moreover, in FY 1995 and FY 1996, new loan commitments for family planning activities alone declined to a little over $100 million a year, roughly half the average annual lending level in the early 1990s. As the Bank has shifted away from specialized or stand-alone population projects, reproductive health and family planning activities are also increasingly becoming small and often marginalized components of larger, comprehensive health projects.

Uneven Regional Responses: The Bank's involvement in reproductive health has varied greatly across regions and countries. Several different factors account for this unevenness, including the variable eligibility of countries for concessional financing, the extent of their commitment to population programs and reproductive health, and the Bank's larger priorities vis-a-vis the overall lending program.

Although overall lending for health projects has risen dramatically, increases for population and reproductive health have not kept up.

South and East Asia have benefited most from Bank support to population and reproductive health programs. The Bank has made important contributions to family planning efforts in a number of Asian countries, most notably Bangladesh and India. In the late 1980s and early 1990s, the Bank initiated population activities in a large number of sub-Saharan African countries, mostly as small components of larger health projects. The gap between Bank assistance and current needs, however, remains greatest in Africa.

In the Middle East and North Africa, the Bank's assistance has been limited but has nevertheless supported family planning programs in several countries. The Bank has also recently initiated reproductive health projects in a number of countries in Latin America and the Caribbean, after years of maintaining a low lending profile with respect to family planning in the region. It has, however, largely neglected reproductive health needs in Europe and Central Asia.

Overall, the Bank has made and continues to make a major contribution in the family planning field in a few countries, especially in Asia, and is to be commended for increasing attention and financial support to AIDS and safe motherhood activities. But there are many more countries, especially in sub-Saharan Africa, where reproductive health needs remain great and there are opportunities for the Bank to do much more. Current plans for future sector-level analytical work and for new projects indicate relatively few activities in the pipeline focusing on reproductive health, especially in the area of family planning.

Effectiveness of Bank Activities: The Bank's contribution should be judged not only by the magnitude of its funding commitments, but also by the effectiveness and impact of its projects. Over the past five years, the Bank's leadership has made an effort to bring about a shift within the Bank from a culture which rewards processing and approval of new loans to one that emphasizes effective implementation and the impact of projects. Systematic information on the effectiveness of Bank reproductive health projects is lacking; still, there appears to be considerable scope for strengthening the impact of Bank assistance in this area.

First, the shift towards development of broader projects supporting health sector-wide management and financing reforms threatens to overshadow the urgent need in many countries to strengthen reproductive health services. The sector-wide approach is important to address systemic constraints on the delivery of health services. However, especially where basic services are weak, there is also a need for more focused efforts to improve reproductive health. In countries with more developed health systems, input from reproductive health experts could help structure health reform projects to give higher priority to reproductive health.

Current plans for future analytical work and for new projects indicate few activities with a focus on reproductive health.

The quality of project design has also been an issue, especially since the Bank has cut back resources for the analytical work required for good project preparation. While Bank projects across all sectors suffer from deficiencies in design, the complexity of HNP projects make them more vulnerable to design-related implementation problems.

Monitoring and supervision of reproductive health activities is another weak point for the Bank. Especially where such activities represent only a small component of larger integrated health projects, they receive minimal attention during supervision visits. The squeeze on operating expense budgets over the last couple of years has reduced travel funds for projects in the human development sectors, undermining recent efforts by the Bank's leadership to strengthen project supervision and implementation. The Bank has done better in project implementation in Bangladesh and India, where it has funded large, focused population projects and deploys technical staff in country.

The effectiveness of Bank-financed projects also depends on the extent to which the Bank's assistance complements assistance from other donors. In general, the Bank has done better in coordinating with other donors during project development and where it has technical staff in its resident missions. The Bank has also done well at mobilizing additional donor resources for population and reproductive health programs, both through grant financing to complement Bank projects and in a few countries, through leadership of joint donor initiatives. Still, the effectiveness of Bank projects would be enhanced by more complementary programming with those donors having greater technical capacity and more staff in the field.

The Bank is often criticized for inadequate involvement in its projects of non-governmental organizations (NGOs), which can provide a vital link to local communities. However, Bank support to NGOs has been greater in reproductive health and family planning than in many other areas of Bank activity. A small central grants program has supported a range of special reproductive health initiatives; numerous country-level health and family planning projects also incorporate funding for NGO activities. Nevertheless, there is a need for more effective mechanisms for Bank support to NGO activities at the country level.

The Bank has done less well in supporting for-profit and social marketing initiatives in reproductive health and family planning. This reflects both reluctance on the part of borrower governments to channel funds to commercial sector activities, and the limited staff in the Bank with expertise in this area.

Recommendations for Strengthening Bank Support to Reproductive Health and Family Planning Programs:

The Bank needs to increase its financial support to reproductive health and family planning programs as well as to improve the effectiveness of projects in this area. To enhance its contribution in reproductive health and family planning, the Bank should:

- expand financing on concessional terms for social sector projects;
- support reproductive health and family planning projects alongside health sector reform projects, or structure sector-wide projects to give special attention to reproductive health;
- increase the profile of reproductive health and family planning activities within integrated health projects as well as through stand-alone reproductive health projects;

- review ongoing programs to identify priority countries for additional reproductive health and family planning investments;
- monitor the adequacy of financial resources and staff allocated to all key elements of reproductive health;
- maintain a strong program of sector-level analytical work in reproductive health as a basis for providing sound advice to countries;
- institute more rigorous quality control and technical review systems during project design;
- provide sufficient funds for technical oversight during project supervision;
- work in a more complementary way with donors having greater technical expertise and field staff in reproductive health; and
- expand support for both NGOs and for-profit reproductive health and family planning activities, while also developing more effective mechanisms for support to programs in these areas.

The Bank's Technical Capacity in Reproductive Health and Family Planning

The recent initiative to strengthen regional and country-level staff is a positive development, but reproductive health staffing remains uneven across regions.

In recent years, the Bank has experienced an erosion of technical expertise across all sectors, including within the human development and health sectors. In the HNP sector, there is a small core of highly qualified health experts, including a smaller group of reproductive health and family planning specialists. Yet economists represent the largest single group of HNP staff, and many HNP staff lack specialized health expertise. Moreover, those staff with specialized skills in reproductive health often work on other aspects of health, while others working on reproductive health projects lack specialized expertise in this area.

Despite the demonstrated importance of field staff to sound project design and implementation, the Bank has relatively few technical staff in its resident missions. The recent initiative by certain country departments in the Bank to decentralize staff and strengthen resident missions is a very positive development. Still, given the high cost of maintaining staff in the field, most field offices are unlikely to include staff with specialized reproductive health expertise. Thus, there is likely to be a continuing role for headquarters in policy guidance and technical oversight.

As in the case of lending, staffing is uneven across the Bank's regional departments. Overall, no regional department has adequate reproductive health expertise. The South and East Asia departments are somewhat better staffed in this area than other departments. Both the Middle East/North Africa and Latin America/Caribbean departments have only a few staff with reproductive health expertise. In Europe and Central Asia, there are essentially no staff with real expertise in this area. The Africa department has a small group of AIDS and family planning experts, but their numbers are inadequate to the needs, especially given weak managerial and technical capacity within the region. Despite the dearth of expert staff—and unlike some other donors—the Bank has no mechanisms to draw on external technical expertise in a systematic way to support country level projects.

The recent reorganization has created a new system of "networks" linking technical staff across the Bank. The human development network council and the HNP sector board, comprising representatives from all the regional departments, have primary responsibility for strengthening the Bank's technical expertise in the health sector, including the reproductive health area. The reorganiza-

tion has grouped technical staff together at the regional level, helping to establish a critical mass of expertise and a structure more responsive to program needs. However, the recent restructuring has eroded the central core of expertise in the human development department, a move which could weaken Bank-wide leadership in reproductive health as well as other technical areas.

The Bank has considerable influence over the priorities of developing country governments, but is falling short of its potential to advance population policies and reproductive health programs.

Recommendations for Strengthening the Bank's Technical Capacity in Reproductive Health and Family Planning:

In order to support an expanded and more effective engagement in this area, the Bank needs to:

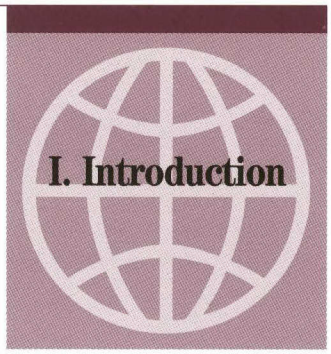
- appoint senior reproductive health and family planning experts to provide leadership both at the central level and in each regional department;
- closely monitor the impact of the reorganization on technical capacity, and reestablish a core of experts in the central human development department, if needed;
- recruit additional specialists to fill gaps in staffing in the regional departments, especially the Africa department;
- use existing reproductive health and family planning expertise more effectively;
- initiate a training program for non-specialist staff who work on reproductive health projects;
- increase technical staff in resident missions; and
- develop new mechanisms to systematically tap external institutional expertise in the reproductive health field.

Priorities for Bank Management

Overall, despite some important contributions, the Bank appears to be falling short of its significant potential to advance population policies and reproductive health programs, and to help the international community meet the financial goals agreed to at the ICPD. Bank staff often attribute low levels of population lending to weak demand on the part of borrower countries. Yet the Bank itself has considerable influence over the priorities of developing country governments. Inadequate demand in part reflects a lack of initiative by the Bank to promote the benefits of slower population growth to policymakers, and to assist countries in developing multisectoral strategies that can accelerate both fertility decline and economic and social development.

If top management is seriously committed to a greater leadership role for the Bank with respect to population policies and programs, the following are priority areas for action:

- Ensure that policy discussions with borrower governments consistently address the implications of rapid population growth across all areas of development, and the most appropriate strategies to help slow such growth.
- Monitor new loan commitments in all key areas of reproductive health, as well as plans for future analytical work and development of new projects in these areas.
- Put in place the staff and contractual mechanisms necessary to mobilize the very best quality expertise to support the effective implementation of Bank-financed reproductive health activities.



The Importance of the World Bank to Population and Development

The World Bank—by far the most influential organization in international development assistance—has an important role to play in helping developing countries implement the new and comprehensive approach to slowing population growth agreed on at the International Conference on Population and Development (ICPD) held in Cairo in 1994.

The ICPD *Programme of Action* recognizes the right of women to make their own decisions about childbearing as well as the negative effect of rapid population growth on prospects for long-term, environmentally sustainable development. Acknowledging the links between the status of women, broader social policy and fertility, it recommends a comprehensive strategy to promote both improved reproductive health and population stabilization. This strategy includes expanded access to better quality contraceptive services, to a broader range of reproductive and child health services, and to educational and economic opportunities for women.

Despite the ICPD's call for increased investments to help achieve these goals, total development assistance has been decreasing. Donor funding for population programs increased in 1994 and 1995, but now appears to be leveling off or declining while still far from the goals agreed to in Cairo. To a large extent, therefore, the achievement of conference objectives depends on the developing countries themselves. *The World Bank is uniquely positioned to assist these countries in financing the investments in reproductive health and family planning, girls' education and women's empowerment that are important in their own right and that also help to lower fertility.*

The Bank's importance in international development assistance stems first from the magnitude of financial resources at its disposal—it commits over $20 billion a year in new loans across all sectors. Although the Bank's assistance is in the form of loans and concessional credits, its investments often serve a catalytic role in mobilizing grant funds from other donors as well as additional resources from developing country governments.

By virtue of its financial clout and its analytical expertise, the Bank also has great influence on the policies and budgets adopted by developing countries. The Bank's engagement in virtually every aspect of development is a further advantage in promoting the multi-faceted strategies needed to improve reproductive health and also stimulate declines in high fertility. More than any other donor, then, the Bank has the ability to convey to governments the importance of slowing rapid population growth for long-term development.

The Changing Bank Environment

In Cairo in 1994, the late Bank president Lewis Preston acknowledged the consequences of population growth for all aspects of development: "Putting it bluntly: if we do not deal with rapid population growth, we will not reduce poverty—and development will not be sustainable."

Inspired by a similar rationale, beginning in 1970, the Bank began providing financial support for the development of family planning programs in a number of countries, primarily in Asia. Historically, it has also helped to stimulate the adoption of population policies in a larger number of countries.

Yet the Bank has not consistently made population issues a priority. Attention to population—and lending

"Putting it bluntly: if we do not deal with rapid population growth, we will not reduce poverty—and development will not be sustainable."
Lewis Preston, former World Bank President

In the 1990s, the Bank's leadership has correctly assigned increased importance to social investments such as health and education, to poverty reduction and to women's issues.

for family planning projects—declined dramatically following a 1987 reorganization which shifted responsibility for population lending from a central department to individual country departments. Interest and lending rose between 1989 and 1991, after the Bank's leadership responded to external criticism by promising to increase lending for population projects. In recent years, however, attention to population concerns appears to be on the downswing again.

In the 1990s, the Bank's leadership has correctly assigned increased importance to social investments such as health and education, to poverty reduction and to women's issues. The trend towards expanded lending for health and education projects has the potential to increase resources for population programs, broadly defined, and to reinforce more direct efforts to reduce fertility. However, the focus of health lending is increasingly shifting to broad health sector reform and financing, a trend which could potentially detract from efforts to strengthen specific health services, including reproductive health and family planning.

The Bank has also been undergoing perhaps the most sweeping institutional transformation in its history. Recent changes include a restructuring of technical support functions in the social sectors, and have the potential to affect the Bank's population work in both positive and negative ways. Thus, at present there is great fluidity and change within the Bank. This evolving environment offers a unique opportunity to influence the Bank's work in population and reproductive health, but also presents the challenge of a moving target.

PAI's Review of the Bank's Engagement in Population and Reproductive Health

Population Action International (PAI), an organization that seeks to stimulate action toward early world population stabilization, has undertaken a series of analyses of the effectiveness of international institutions and donor agencies that are key to the success of population programs around the world. These reports include a 1989 analysis of the World Bank's population activities. Changes since that time, both in the Bank and the international context within which it operates, warrant a fresh look at the Bank's contribution in this area.

The present review examines three key questions:

- In policy discussions with borrower countries, to what extent is the Bank encouraging attention to the relationships between population dynamics and development and ensuring that population concerns are adequately addressed?
- To what extent is the Bank providing financial support to reproductive health programs, including family planning? How can the Bank expand lending for these programs, improve the effectiveness of Bank-financed projects and stimulate additional donor and national funding?
- What capacity does the Bank have for providing expert advice with respect to the sound planning and effective implementation of reproductive health and family planning projects? How are current organizational changes affecting the Bank's work in both population and reproductive health?

To address these questions, PAI interviewed a broad spectrum of World Bank population and health sector staff, reviewed numerous Bank documents, and undertook an independent analysis of recent Bank loan commitments for health and population. Our report is constrained by the limited information available in the public domain on the effectiveness and impact of Bank projects. It is, moreover, difficult to generalize about the Bank, a decentralized institution working to address the varied needs of borrower countries in many different ways. Within these constraints, we have tried to provide a frank but balanced assessment of the Bank's recent policy work on population and its lending for reproductive health and family planning.

A word on terminology: within the Bank—and outside it—there is a tendency to confuse population (i.e., demographic dynamics) with family planning (the provision of contraceptive services). The Bank has contributed to this confusion by classifying lending for family planning activities as population (or more recently as part of population and reproductive health). At the risk of perpetuating this confusion, for purposes of consistency we have used the Bank's own terminology in discussing annual trends in lending.

A final caveat relates to the scope of this report. Clearly, a broad spectrum of Bank investments influence fertility. The Bank deserves special credit for increasing lending for girls' education—especially at the primary level—and for new initiatives in the area of micro-enterprise credit for women. However, this report focuses more narrowly on the extent to which the Bank has made broader linkages between population and development explicit in its policy work, and on its record in financial support for the reproductive health and family planning activities which represent the core of the Cairo agenda. A broader look at the Bank's efforts to improve the status of women is beyond both the scope of the current report and PAI's expertise; fortunately, other organizations have taken on this challenge.*

The focus on broad health sector reform could potentially detract from efforts to strengthen reproductive health and family planning services.

*Mayra Buvinic et al., *Investing in Women: Progress and Prospects for the World Bank* (Washington DC: Overseas Development Council, 1996); also, the U.S. chapter of the Women's Eyes on the World Bank Campaign plans to release its report, *Gender Equity and the World Bank Group: A Post-Beijing Assessment*, in November 1997.

II. Making the Case: Increasing Attention to Population Concerns at the Policy Level

Macro-economic policy analysis and advice are the cornerstones of the Bank's involvement in developing countries. The Bank's assessment of the economic conditions in a country largely determines its lending program to that country. Consequently, borrower countries look to the Bank for advice and closely follow its recommendations on development policy. Economists in the Bank's country departments usually take the lead in these discussions with governments.

Inadequate Attention to Population in Policy Discussions

In general, population concerns do not feature prominently or consistently in the strategic documents that form the basis for policy discussions with borrower governments. As part of these discussions, the Bank prepares a country assistance strategy analyzing the country's situation in order to identify priority areas for further analytical work, and ultimately, for its lending program to that country. Ideally, in countries where population growth represents a problem, the country assistance strategy should identify the most important investments to help accelerate the pace of fertility decline.

The country strategy process is central to including population issues on the agenda of both the Bank and borrower. Attention to population-development relationships in this process can help promote a better understanding among governments of the benefits of investments in slowing population growth, as well as more explicit consideration of population impacts in the design of other development programs. Bank population staff note that raising population concerns early in the process of formulating country strategies is key to the subsequent development of population-related projects.

The Bank has a long history of neglecting population issues in its economic analyses. For example, a 1991 evaluation criticizes the Bank for uneven attention to population issues in policy work and for failing to consider demographic impacts in developing projects in other sectors. Over the past decade, other external and internal reviews of the Bank's population activities have also highlighted a lack of systematic attention to population in analytical work.

Because access to country strategy documents is generally limited to Bank staff and respective borrower governments, it is difficult to assess the extent to which these documents currently address population issues. According to several Bank staff, progress remains limited. In many instances, staff who work on population issues—or for that matter other staff with expertise specific to a particular technical area—are not at the table during formulation of country strategies. While strategy documents may mention population factors, they seldom address them with any depth of analysis. Moreover, they tend to raise these issues solely in the context of the health and family planning sectors, rather than their implications for achieving broader development goals.

On the positive side, the Bank is increasingly incorporating more social analysis—especially of gender-related issues—in country strategies, a trend which could potentially reinforce the Cairo conference goals. In addition, there are a number of recent instances where the Bank has drawn attention to population concerns in policy discussions with borrower countries. In Yemen, for example, the Bank has invested in a major study of the implications of population growth and is now working with the government to develop investment strategies. In Senegal, too, the Bank has used its access to high-level policymakers

The Bank has a long history of neglecting population issues in its economic analyses.

The Bank is incorporating more social analysis in country strategy reports, a trend which could reinforce ICPD goals.

to draw attention to the need to slow population growth. Bank staff cite Paraguay and Malawi as other examples of countries where recent country strategy reports include substantial discussion of population issues.

Nevertheless, the Bank needs to more consistently address population issues in analytical work on countries with high population growth rates. Treatment of population issues is reportedly inadequate in country assistance strategies prepared in 1997 for Côte d'Ivoire, Ethiopia and Ghana, among other countries. Yet population growth merits special attention in these countries because of its cross-cutting impact on virtually every sphere of human activity, on the environment, and ultimately, on prospects for long-term sustainable development.

Reasons for Inadequate Attention to Population in Policy Work

There are many reasons why population concerns do not receive adequate attention in economic and analytical work. First and foremost, many Bank economists remain unconvinced of the importance of population factors to development. Their ambivalence underlies the lack of clear guidance on population issues in the Bank's official policy statements and the limited current support for research on population-development linkages. In addition, the Bank's organizational structure, the current reorganization and top management have all marginalized population concerns.

Ambivalence of Economists on Importance of Population: *Many Bank economists do not believe that slowing population growth consistently contributes to development.* They are profoundly influenced by the research on the macro-economic impact of rapid population growth, research which until very recently has been sparse and inconclusive.

An influential literature review, carried out by the National Research Council in the mid-1980s, failed to find a consistent relationship between population growth and economic growth—in part because of the complexity of factors involved. A subsequent analysis sponsored by the Bank shows that population growth had a negative impact on economic growth across countries during the 1980s, with the most significant negative effects in the poorest countries.This analysis further suggests that this relationship has persisted in poor countries since the 1960s.

A more recent literature increasingly supports the notion that, at least in East Asia, fertility decline played an important role in economic growth in countries with strong institutions and good economic policies. There is also growing evidence that smaller family size improves well-being at the household level.*

*Research referred to in the section above includes: *Population Growth and Economic Development: Policy Questions* (Washington, DC: National Academy Press, 1986); Allen C. Kelley and Robert M. Schmidt, "Population and Income Change: Recent Evidence," World Bank Discussion Paper, no. 249 (Washington, DC: World Bank, 1994); World Bank, *The East Asian Miracle: Economic Growth and Public Policy* (Oxford: Oxford University Press, 1993); Asian Development Bank, *Emerging Asia: Changes and Challenges* (Manila: Asian Development Bank, 1997); Kenneth H. Kang, "Why Did Koreans Save So 'Little' and Why Do They Now Save So 'Much'?" and Ronald Lee, Andrew Mason, and Timothy Miller, "Savings, Wealth and the Demographic Transition in East Asia, " in *Proceedings of the Conference on Population and the East Asian Miracle*, 7-10 January 1997 (Honolulu: East-West Center Program on Population, 1997); Cynthia B. Lloyd, "Investing in the Next Generation: The Implications of High Fertility at the Level of the Family," Population Council Working Paper, no. 63 (New York: The Population Council, 1994).

In light of the econometric evidence, the majority of Bank economists acknowledge that high population growth rates have a profound negative impact on long-term prospects for economic and social development in very poor countries. However, many economists—often unfamiliar with the emerging evidence relating to East Asia—consider the links between population growth and development to be less evident in middle-income countries. They perceive other demographic trends, such as the aging of populations, to have more important economic consequences in more developed settings.

Within the Bank's central economics establishment, the policy research group has been profoundly skeptical of the interaction between population and development. This group has focused very narrowly on statistical relationships between population growth rates and macro-economic indicators across countries. Moreover, a few senior economists within this group view the *demand* for smaller families as key to fertility decline and question the need for *government* intervention, arguing that increased demand should stimulate the expansion of contraceptive services by the private sector. These views, expressed in international journals as well as in internal Bank memoranda commenting on specific country proposals, reinforce the reluctance of rank-and-file economists in the country departments to call for investments to influence fertility through the expansion of family planning services.*

Population growth is implicitly reflected in the Bank's main yardstick of country economic performance—per capita gross domestic product (GDP)—since growth in per capita GDP is effectively deflated by the rate of population growth. Yet many Bank economists focus on overall rates of GDP growth; as a result, the Bank's poverty analyses often fail to identify population growth as a contributing factor to persisting low levels of per capita GDP. Bank economists also see population as a long-term issue. Although birthrates in a number of countries have fallen steeply in as little as 10 to 15 years, fertility reduction does not lend itself to the 3 to 5 year time horizon within which the Bank expects countries to develop economic plans and deliver results.

The situation is complex because rapid population growth is no longer as significant a problem across all developing regions. The Bank's borrower countries have become increasingly diverse in their level of development and in their health and fertility status. High population growth rates and poor access to reproductive health and contraceptive services remain a problem throughout Africa, South Asia, most Middle Eastern countries, and some countries in South and Central America. Yet fertility has fallen dramatically in most of East Asia and in a number of countries in Latin America. Given this diversity, the need is for country-specific rather than more generalized strategies.

Still, there is a strong argument for the World Bank to pay special attention to countries where population growth rates remain high. The most recent research supports the existence of a relationship between fertility and economic growth, while suggesting this relationship is complex and varies depending on the point in time, the country and region, and the level of development. Quite apart from any macro-economic impacts, common sense dictates that rapid population growth makes it more difficult for

The Bank's central economics establishment has been profoundly skeptical of the interaction between population and development.

*Lant Pritchett, "Desired Fertility and the Impact of Population Policies," *Population and Development Review* 20, no. 1 (March 1994): 1-55

The most recent research supports the existence of a relationship between fertility and economic growth, while suggesting this relationship is a complex one.

governments to keep up with the demand for basic services. Finally, econometric analyses do not capture the long-term effects of population growth on the environment and future quality of life. By demanding a higher statistical standard of proof, the Bank risks losing valuable time and seeing the benefits of a range of development programs eroded by population growth.

Recent research has also increasingly highlighted the importance of organized family planning programs in fertility decline, especially as fertility preferences change and family planning programs gain in strength. The need for public investment in this area is moreover borne out by evidence that the free market often fails when it comes to providing family planning information and services.*

Finally, regardless of the economic effects of population growth, there are important reasons for public investment in reproductive health and family planning. The Bank should support these services because they are a major point of contact with health systems for women and thus an important vehicle for improving women's health. In addition, improving access to reproductive health and family planning services is key to the broader social transformation required to address gender inequality and promote the empowerment of women.

Lack of Clear Guidance in Official Policy Statements: *In part because of the lack of internal consensus, the Bank has not taken a strong corporate position in support of population stabilization.* In official documents, the Bank recognizes that population stabilization necessitates a range of potential interventions. Among these interventions, official Bank policy statements emphasize indirect investments in economic and social development as a strategy for fertility reduction, down-playing the importance of more direct investments in contraceptive information and services.

- For example, a 1994 communiqué issued by the World Bank Development Committee states that an integrated population policy must recognize the links between economic growth, population, poverty reduction, health, investment in human resources and environmental degradation. According to the communiqué, "Family planning is only one of the available instruments and needs to be seen in the broader context of changing social patterns and the increased awareness of women's roles."
- Similarly, the World Bank's 1996 Annual Report plays down the urgency of more focused interventions for fertility reduction and sees improved economic growth through human capital investments in areas such as girls' education as a key strategy for slowing population growth.

While investments in health and education should be part of a comprehensive population strategy, the Bank's official policy statements understate the significant contribution investments in contraceptive services have made to rapid fertility decline. Indeed, the expansion of voluntary family planning services needs to be a central element of any strategy to encourage smaller families, although these services alone may not be adequate to bring about the magnitude of fertility decline desired by many governments.

*John Bongaarts and Susan Cotts Watkins, "Social Interactions and Contemporary Fertility Transitions," *Population and Development Review* 22, no. 4 (December 1996): 639-682; National Research Council, *Resource Allocation for Family Planning in Developing Countries: Report of a Meeting* (Washington, DC: National Academy Press, 1995), 4-6.

In addition, a long-term strategy to address gender equality will not meet existing unmet need for family planning among the estimated 100 million or more women who want to avoid another pregnancy *now*. The Bank's bias towards long-term, indirect strategies is especially troublesome in the African context, where unmet need is high and timely action is urgently needed to avoid a doubling of population in the next two decades.

In the final analysis, investments in family planning and broader social development reinforce each other—both are needed. Recent research suggests that the appropriate mix of strategies for slowing population growth is likely to differ depending on each country's situation. While improving access to contraception is crucial where unwanted fertility and unmet need are high, education and other social programs can also play an important role by shaping the desire for smaller families and encouraging later childbearing.*

Moreover, there is an internal contradiction between the Bank's rhetoric, which emphasizes a comprehensive approach to population policy, and its internal treatment of population issues. The Bank has placed population within the health sector, reflecting the important role the sector plays in the delivery of family planning services. However, the association of population with health undermines attention to other population-development linkages and has made it almost impossible for the Bank to adopt a broad, multisectoral approach.

Significantly, the Bank's new *Sector Strategy Paper for Health, Nutrition and Population* lacks any focus on population. The paper makes clear at the outset that its scope is confined to the health sector and to a limited extent to reproductive health. It makes passing references to the Cairo conference, to problems associated with high fertility and to reproductive health services. But it is essentially a health sector strategy focusing on broad health issues; in the introduction, it explicitly relegates the interaction of demographic factors with various aspects of development to other existing and forthcoming strategy papers. This leaves the Bank without a comprehensive blueprint for its population work.

Limited New Research on Population-Development Linkages: *Although there is still a need to explore the role of population interventions, the Bank is currently sponsoring little new research on interactions between population and key aspects of development, including poverty, economic growth and the environment.* In the recent past, the Bank has sponsored important but little publicized research on population-development linkages. For example, the 1993 publication, *The East Asian Miracle*, discusses the positive effects of fertility decline on the economies of East Asian countries during the 1980s. The study links fertility decline in these countries to lower dependency rates, increased spending per pupil, increased savings rates, reduced trade deficits and improved wages and economic growth. However, owing to skepticism among Bank economists regarding the economic impacts of demographic change, the Bank has not sponsored similar research for other regions.

Overall, the Bank's role in research is shrinking across all development sectors. Currently, the policy research group within the Bank's central development economics department has no staff working on the

Investments in family planning and broader social development reinforce each other—both are needed.

*John Bongaarts, "Population Policy Options in the Developing World," *Science* 263 (11 February 1994): 771-776.

Currently, the Bank's central development economics department is doing no research on the links between slower population growth and poverty alleviation.

links between slower population growth and poverty alleviation. The group's research agenda is spread thin across the array of poverty and human resource issues. Since completion of a major research project on the economic and policy determinants of fertility in sub-Saharan Africa, the group has given precedence to research on AIDS and other health sector issues. The number of major Bank research publications on population-related topics has declined substantially since 1995.

Nevertheless, in some quarters of the Bank, positive initiatives are underway. The Economic Development Institute (EDI)—a research and training group also within the core development economics department—is attempting to revive attention to population-development linkages. In July 1997, EDI organized an educational forum for Bank staff which highlighted the most recent evidence of the impacts of demographic change at both the macro-economic and family levels. EDI is also planning a new training program to disseminate this information to borrower government officials. While these are promising initiatives, the extent to which they can stimulate sustained attention to population concerns within the Bank remains to be seen.

A further encouraging development is the 1996 publication, *Toward Environmentally Sustainable Development in Sub-Saharan Africa: A World Bank Agenda*, prepared by the environment department. This report highlights the negative impacts of population growth on the environment in Africa and recommends a dual strategy of investing in human capital through education while also facilitating fertility reduction. Although the dialogue within the Bank during preparation of such a publication is important, the impact of the report will ultimately depend on the extent to which its recommendations are reflected in policy discussions with African governments. Moreover, similar analytical work is needed to highlight the environmental impacts of population growth in other regions.

Lack of a Focal Unit for Population Work Within the Bank: *A long-standing problem is that population—as a cross-cutting development issue distinct from reproductive health and family planning—has lacked an appropriate institutional home within the Bank.* External assessments going back to the 1970s point out that the Bank has lacked a central unit to coordinate broader analyses and activities relating to the determinants and impacts of demographic change. The Bank has always placed population policy concerns within the social sectors—as part of human resources or human development activities, depending on the nomenclature of the day.

Formerly, the central Population, Health and Nutrition (PHN) Department was the Bank's focal point for population issues. In the early 1990s, the Bank established the Population Advisory Service, comprising a core group of population and family planning experts, within this department. Although this group provided important leadership in the area of population and reproductive health, its association with the social sectors limited its influence on macro-economic thinking and policy work.

Moreover, following the publication of the *World Development Report* focusing on health in 1993, the PHN department increasingly focused on health sector reform and financing issues to the detriment of attention to population concerns. In 1996, the Population, Health and Nutrition sector was renamed the Health, Nutrition and Population sector, a move indicative of this change in priorities. The critical mass of staff assigned to

the Population Advisory Service has gradually eroded. A single staffer is assigned to respond to requests from Bank operations staff for analyses relating to such demographic trends as labor force size and school entrants, with no mandate for broader analysis of the determinants and consequences of demographic change.

Impact of the Reorganization on Population: *The current reorganization threatens to further marginalize population concerns.* The reorganization has created a new system of networks linking technical staff across the Bank. Within the Bank, there are four networks:

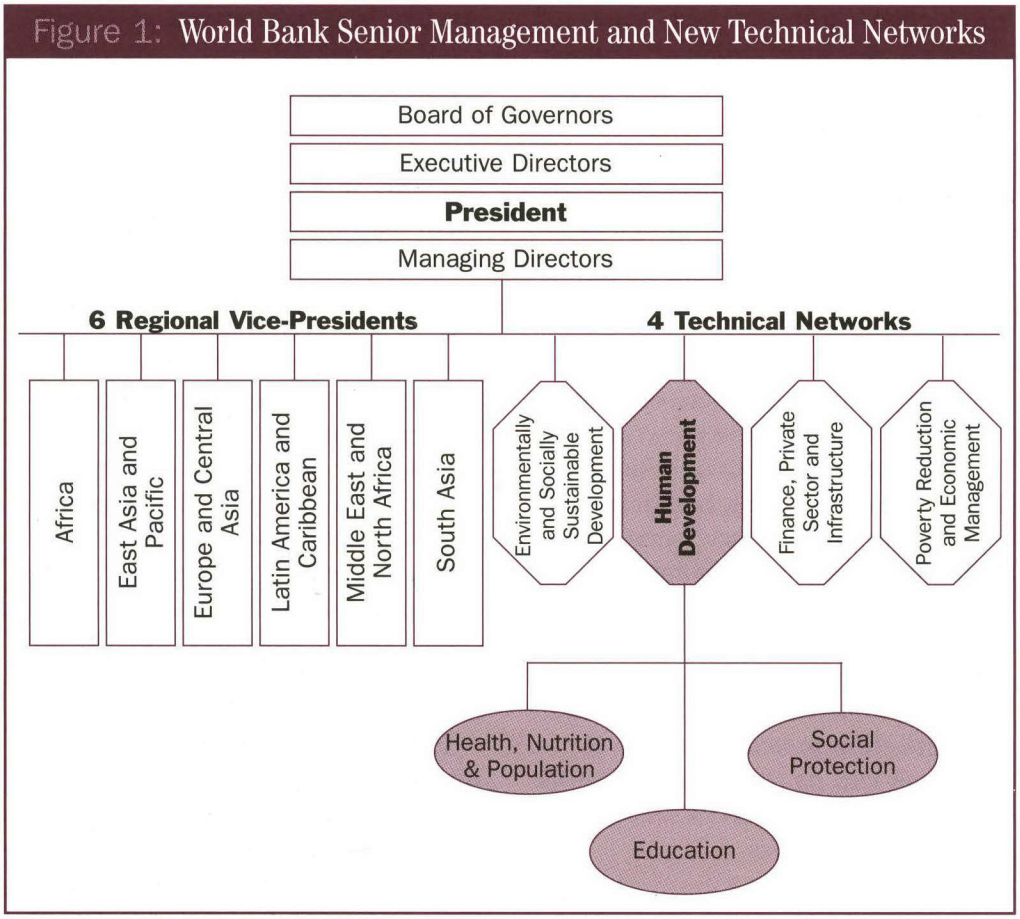
- Human Development;
- Poverty Reduction and Economic Management;
- Environmentally and Socially Sustainable Development; and
- Finance, Private Sector and Infrastructure.

The Human Development (HD) network encompasses three sectors—Health, Nutrition and Population (HNP); Education; and Social Protection, which includes a range of other social sector activities. Each network is managed by a council comprising senior staff from each regional department; similarly, there is a sector board for each technical area, including Health, Nutrition and Population.

At the central level, the former PHN department has been merged with education and social protection and renamed the Human Development Department (HDD). Under the reorganization, the central department will be much smaller and have much reduced functions.

External assessments going back to the 1970s point out that the Bank has lacked a central unit to coordinate broader analyses and activities relating to the determinants and impacts of demographic change.

Figure 1: World Bank Senior Management and New Technical Networks



Source: World Bank

The leadership factor should not be underestimated. The messages the Bank's president and vice-presidents send externally to borrower governments are important.

Currently, only two population positions are planned for the central department. The Population Advisory Service has been essentially disbanded. Moreover, there is no voice for population issues on the HD network council and HNP sector board. The Health Advisor represents the central HNP group on the network council and chairs the sector board; the Population Advisor is not a member of either body. As chair of the HNP sector board, the Health Advisor oversees the Population Advisor and population activities.

At the regional level, the reorganization groups technical staff in large units under single leadership, in contrast to the previous structure of fragmented sector-specific operations units. This new structure brings social sector staff together under the umbrella of the human development network, a move which could potentially encourage a broader approach to promoting fertility reduction. However, while the network system is relatively new, it does not appear to have stimulated a more coordinated approach to population policy—either by the regional departments or the Bank-wide network council and sector board.

In part, this reflects the reality that population remains a relatively low priority. Education and health dominate social sector lending and drive the agenda of the HD network. The majority of staff on the network council come from a health or education background. Similarly, health has emerged as the primary focus of the HNP sector board—dominated by health specialists—while population and nutrition receive less attention. *Thus, the reorganization has further reinforced the subordinate position of population to health within the Bank, as well as the inadequate linkages between population and other development sectors.*

Lack of Attention to Population by the Bank's Leadership: *Since the early 1990s, top management has not signaled either the Bank's borrowers or its staff that it assigns any particular importance to population concerns.* The leadership factor is intangible but should not be underestimated. The messages the Bank's president and vice-presidents send externally to borrower governments are important. In the late 1980s, for example, former president Barber Conable's willingness to raise the issue of rapid population growth with several African heads of state contributed to breakthroughs in population policy in a number of countries.

The Bank is an extremely hierarchical organization, and the messages top leadership sends internally to staff also have great influence. Frequent public statements about the importance of slowing population growth to development by former president Robert McNamara in the 1970s and by Mr. Conable in the late 1980s had a significant impact within the Bank. Similarly, former vice-presidents Ernest Stern in the 1980s and Edward Jaycox in the early 1990s were not only forceful advocates for population programs with developing country leaders, but also took steps to ensure that Bank staff gave adequate attention to population in analytical work and in the lending program.

The importance of commitment at the top is evident in the Bank's increased attention to gender concerns. In the face of criticism from women's groups, the current president, James Wolfensohn, has been the driving force in raising the profile of these important issues within the Bank.

In contrast, top Bank officials rarely draw attention to population concerns. Although Mr. Wolfensohn is known to be concerned about population issues, he has not highlighted these concerns in public statements

or internal meetings. A public presentation in early 1997 by one of the Bank's vice-presidents for Africa, "Rural Development Prospects in Africa: the World Bank's Perspective," barely mentioned the problems of high fertility and population growth rates, or the need for appropriate policy and program responses.

Ultimately, the Bank's leadership is accountable to the Board of Executive Directors who represent the Bank's member countries. The limited interest the Board has shown in population-development linkages in recent years is a further reason for the neglect of these issues by top management, and for management's failure to hold staff accountable for addressing population concerns in policy documents and discussions with borrowers.

Recommendations for Strengthening Attention to Population in Policy Work

The Bank needs to make population concerns a key policy issue in its development work across all sectors, elevating these concerns above those relating to the delivery of reproductive health and family planning services. Full implementation of this recommendation requires the commitment of Bank management and, in all likelihood, additional staff and financial resources. The following are specific steps the Bank needs to take if population is to become an integral element in multisectoral planning.

- **The Bank should establish an interdisciplinary unit for population policy, staffed by a mix of demographers, economists, environmental and population policy experts.** The role of this unit should be to integrate analysis of population factors with *all* the Bank's core objectives for poverty reduction, environmentally sustainable development and human development. An appropriate home for this unit may be the Environmentally and Socially Sustainable Development Department, where the current leadership has a profound appreciation of the linkages between population, environmental and gender issues. However, this unit should also maintain close links to the human development network and the health, nutrition and population sector, as well as the poverty reduction and economic management network.
- **The population policy unit should prepare a formal corporate statement on the role of population factors in sustainable development and produce a strategy paper for addressing population concerns.** The Bank should promote a coordinated, multisectoral approach, involving a mix of social investments appropriate to the specific country situation. However, the Bank's strategy for addressing rapid population growth must also ensure adequate priority to the expansion of reproductive health and family planning information and services.
- **The population policy unit should sponsor more research on the links between demographics and development.** Recent research on the complex relationship between fertility dynamics and macro-economics highlights the need for additional work on these issues. The Bank needs to expand the knowledge base from which to advise countries about alternative population strategies and the consequences of demographic change. It should expand support for such research by external experts, while shifting the emphasis from cross-national macro-economic studies to coun-

The limited interest the World Bank Board has shown in population-development linkages in recent years is a further reason for the neglect of these issues by top management.

Country strategies and other economic analyses should more consistently discuss the implications of population dynamics for long-term development.

try-specific analyses of a broader range of development impacts. The Bank should appoint a task force including outside experts to advise on a relevant research agenda relating to the consequences of high population growth and of fertility reduction.

- **Where high population growth rates are likely to have an adverse effect on development, the Bank must ensure that population concerns are adequately reflected in its country assistance strategies.** Better integration of a population perspective in the Bank's own analytical work is a key first step to further Bank action. Country strategies and other economic analyses should more consistently discuss the implications of population dynamics for long-term development; managers reviewing these documents need to ensure these issues are adequately addressed. The Bank may need to provide special training on population-development linkages to country economists and senior managers, together with guidance on how to incorporate population analyses into key strategic documents.
- **Bank officials at all levels need to consistently incorporate population issues into policy discussions with countries experiencing rapid population growth.** These issues should be on the agenda when Mr. Wolfensohn, the managing directors and vice-presidents meet with borrower country officials. The country departments should reinforce the need to support population programs at annual donor consultative group meetings. While Bank officials will need to address population-development interactions in a country-specific way, policy discussions should emphasize the potential benefits of fertility reduction at the macro-economic, environmental and family levels, as well as the synergy with gender concerns.

III. Reproductive Health and Family Planning Programs: The Bank's Contribution

The ICPD Programme of Action projects a need for a significant increase in funding to meet the growing demand for reproductive health services and to improve the quality of existing services.

A. Overall Trends in Population and Health Lending

While the Cairo conference endorses a comprehensive strategy for slowing population growth, the heart of the conference recommendations is a call for increased investment in a package of basic reproductive health services. The core elements of this package identified by the ICPD include: family planning; care in pregnancy and childbirth; and prevention of HIV/AIDS and management of other sexually transmitted diseases (STDs).

The *Programme of Action* projects a need for a significant increase in funding to meet the growing demand for reproductive health services (especially given the increasing number of women in their childbearing years) and to improve the quality of existing services and broaden their scope. It estimates that meeting these needs will cost about $17 billion annually in 1993 constant dollars by the year 2000, a goal the international community is still far from achieving. According to the United Nations Population Fund (UNFPA), developing countries spent about $7.5 billion on reproductive health in 1995. Total donor assistance—including lending by multilateral development banks—amounted to another $2 billion in the same year, but indications are that donor funding has since declined.

As borrower governments have become more aware of reproductive health needs following the ICPD, the Bank has significantly expanded lending for reproductive health activities in recent years. This shift is part of a longer-term—and continuing—evolution of the Bank's overall lending for health, nutrition and population over the past three decades.

The Bank began lending for population projects in 1970—for the most part supporting family planning programs. Population lending initially reflected concern that Bank investments in other development sectors would be undermined without concurrent efforts to slow population growth. In 1976 the Bank initiated lending for nutrition activities; it was only in 1981 that it began lending for a broad range of other health projects.

Especially in the 1970s and early 1980s, Bank population lending was limited to a handful of countries, primarily in Asia. Today, the Bank finances population and reproductive health activities in many more countries; between 1992 and 1996 alone, the Bank expanded population and family planning activities to about 30 new countries, the majority in Africa. Over the years, the Bank has provided very significant resources for population and family planning projects. Cumulatively, through the end of fiscal year (FY) 1996, the Bank had committed $3.9 billion for population activities through 175 projects in 82 countries.

Since the late 1980s, the Bank has also expanded support for projects to prevent the spread of HIV/AIDS and other STDs. The Bank has supported over 60 projects that include HIV/AIDS activities; of these, 10 have been stand-alone or specialized AIDS/STD control projects. AIDS activities appear to be receiving an increasing share of resources for reproductive health; over the next three years, the Bank plans to support 18 additional projects with HIV/AIDS components.

Even before the ICPD, the Bank recognized improved maternal health as a goal independent of its linkages to child health and fertility. Following the 1987 Safe Motherhood conference in Nairobi, the Bank joined with other international organizations to launch the worldwide Safe Motherhood Initiative. In keeping with the recommendations of the

The Bank has expanded support for maternal health, both through integrated primary health projects and more recently through specialized maternal health projects.

1993 World Development Report, the Bank has encouraged maternal health activities to be provided as part of an essential package of health services, which in principle should also include family planning. In most instances, support for maternal health has been integrated within primary health projects; the number of projects which include safe motherhood activities has grown from 9 in 1987 to 70 in 1993. More recently, the Bank has also initiated specialized or stand-alone maternal health projects, for example in Argentina, India, Indonesia and Paraguay.

Combined lending for family planning and other reproductive health activities has risen steadily from $318 million in FY 1992, the first year for which such data are available, to $504 million in FY 1996. (The Bank reports a figure of $599 million in population and reproductive health lending for FY 1996, but PAI's analysis suggests this figure includes funds for child immunization and other activities not directly related to reproductive health. See Annex Table 1.)

This increase in lending for population and reproductive health has occurred in a larger context of massive increases in lending for the human development sectors overall. Annual lending for these sectors increased from about $1 billion in FY 1986 to nearly $5 billion in FY 1996. Human development lending has also received an increasing *share* of total Bank lending. In FY 1986, 8 percent of $16 billion in new loans went to human development projects; in FY 1996, projects in these sectors received 24 percent of $21.3 billion in new lending.

In FY 1996, health, nutrition and population projects accounted for nearly half of new human development lending, or approximately $2.4 billion. Education accounted for 35 per cent and social protection for 16 per cent.

In FY 1997, commitments for new projects declined very significantly for the human development sectors overall. HNP lending also declined sharply to $940 million. There appears to be a number of reasons for this decrease, including the decline in demand for loans the Bank is experiencing across most sectors, the disruptive effect of the reorganization on the development of new projects, and a shift in emphasis by management towards implementation of ongoing projects.

Despite the overall upward trend in HNP lending through FY 1996, recent shifts in the composition of lending in the sector have troubling implications for the Bank's commitment to helping countries strengthen reproductive health and family planning services and for the future of Bank assistance in this area.

Declining Share of HNP Lending for Population and Reproductive Health: *Although lending for population and reproductive health (PRH) has increased, PRH activities are losing ground in terms of their* ***share*** *of overall HNP lending.* The composition of HNP lending has changed over the last few years, reflecting a shift in HNP priorities. Lending for population and reproductive health has fallen from roughly one-third of all HNP lending between FY 1986 to 1991 to a little less than one-quarter between FY 1991 to 1995. The shift is even more dramatic since lending classified as PRH during the period FY 1986 to 1991 was almost exclusively for family planning, while PRH lending from FY 1991 to 1995 supported an expanded range of reproductive health activities.

While the share of total HNP resources flowing to population and reproductive health has declined, the share of resources allocated to most other components of HNP lending has remained roughly constant, with the

Table 1: Shift in Composition of Health, Nutrition and Population (HNP) Lending Over Time

	Relative Share of Total HNP Lending Portfolio (Percent)	
	1986-91	**1991-95**
Population and Reproductive Health	**32.7**	**23.4**
Basic Health Services	20.0	20.4
Sector Wide Reforms	3.6	16.4
Disease Control	13.1	13.1
Nutrition	7.5	9.7
Capacity Building	16.5	8.8
Supply Inputs	6.7	7.7
Reconstruction	0.0	0.5

Source: World Bank

PAI's analysis suggests that new loan commitments for family planning activities declined significantly in FY 1995 and 1996.

exception of funding for sector-wide reform activities, which has increased substantially. The priorities articulated in the new strategy paper for Health, Nutrition and Population suggest this trend towards health reform and financing and away from reproductive health and family planning is likely to continue. This trend also reflects the priorities of the leadership in human development and health.

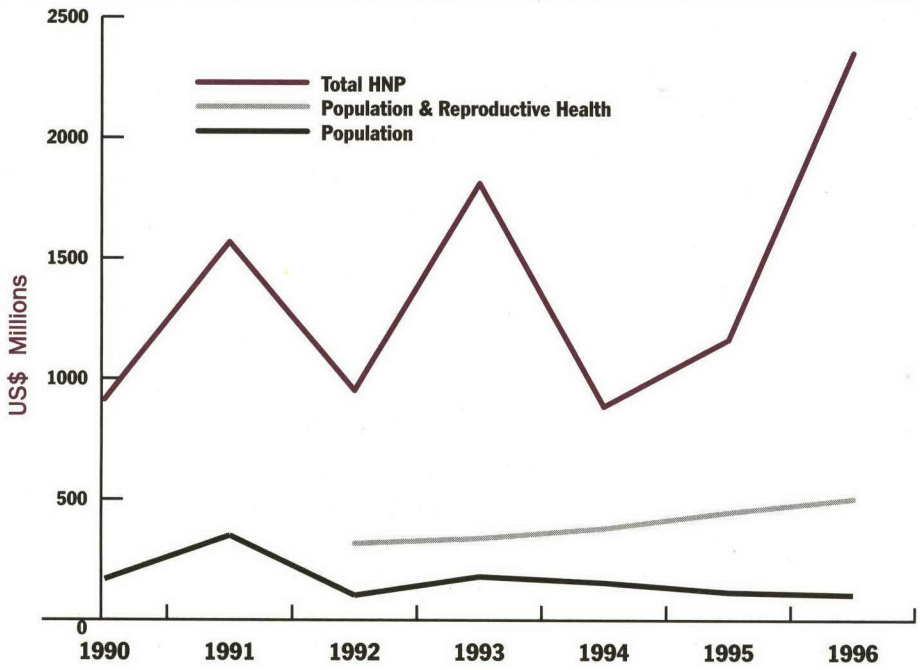
Decline in Lending for Population/Family Planning: *While lending for overall reproductive health has increased, lending for family planning alone declined significantly in FY 1995 and 1996, suggesting that the Bank is neglecting this key element of the ICPD Programme of Action.* Expanded access to high quality contraceptive services is a central element of the reproductive health package promoted by the ICPD and also key to reducing fertility. However, the Bank's current reporting system lacks transparency regarding lending for family planning activities. Prior to FY 1994, the Bank reported separately on population lending. However, beginning in FY 1995, it began reporting only a combined total for population and reproductive health lending. This has made it difficult to track the Bank's financial support for the various elements of reproductive health, including family planning.

Annual assessments of population lending levels have never been an exact science, especially since they rely on subjective judgments regarding the share of integrated health projects allocated to family planning. The Bank itself has been inconsistent in its definition of population lending over time; in the early years especially, "population" projects often included substantial support for maternal and child health activities. Nevertheless, in recent years Bank estimates of population funding levels have been based on standardized definitions and have provided an important although approximate reference point for evaluating the Bank's support for population and family planning.

In order to assess recent trends in population lending, PAI carried out an analysis of HNP projects approved in FY 1995 and 1996 to identify the level of support for family planning activities in these years. This analysis suggests that new loan commitments for family planning activities declined significantly in these years. Lending for population—using essentially the same definition used by the Bank in prior years—totaled about $117 mil-

In each of the last three years, the Bank has initiated only one or two projects with a specialized focus on family planning.

Figure 2: New Loan Commitments in the Health, Nutrition and Population (HNP) Sector and for Population and Reproductive Health Activities, 1990-1996



(US$ Millions)	1990	1991	1992	1993	1994	1995	1996
Total HNP	933.4	1567.6	961.7	1811.6	885.7	1162.3	2353.4
POP & RH	N/A	N/A	318.3	340.0	381.5	448.1	504.0
POP	169.3	351.0	103.2	181.1	156.3	116.8	106.5

Sources: 1995 and 1996 Population and 1996 Population & Reproductive Health amounts are PAI estimates. All other numbers are World Bank data. HNP sector only: excludes 1994 funds for Population & Reproductive Health activities funded through social sector projects. No data for Reproductive Health prior to 1992.

lion in FY 1995 and $106 million in FY 1996. *This is roughly half the average of about $200 million a year in new loan commitments for population activities in the early 1990s, and well below the FY 1991 peak of $351 million.*

However, lending for family planning appears likely to increase substantially in FY 1997 over the low levels of the two previous years. This increase reflects the approval of a major new $248 million reproductive and child health project in India, which includes significant support for family planning. With the exception of this single large activity, new lending for family planning appears negligible in FY 1997. However, reproductive health lending for this year also includes two stand-alone maternal and child health projects and an AIDS/STD control project, all in Latin America.

Marginalization of Family Planning Activities: *One reason for the apparent downward trend in population lending is that the Bank is increasingly supporting fewer stand-alone population projects.* In the early years, most Bank projects in the health sector devoted a substantial proportion of their budgets to population and family planning activities. As the Bank has expanded lending for other health activities, this sit-

uation has changed. In each of the last three years, the Bank has initiated only one to two projects with a specialized focus on family planning. *Looking to the future, the relative paucity in the pipeline of new projects with a significant focus on reproductive health and family planning is a cause for major concern.*

The shift away from stand-alone projects has coincided with a decline in the share of reproductive health resources allocated to family planning. Between 1994 and 1996, the population/family planning share of PRH lending declined from 37 to 18 percent. This reflects the positive recent trend towards increasing lending for safe motherhood and AIDS/STD control activities. However, it also reflects a negative trend—especially in Africa and Latin America—for family planning to be reduced to insignificant components of larger health projects. The Bank's shift to sector-wide health projects runs the risk of further marginalizing not only family planning, but also other reproductive health activities.

B. Adequacy of Regional Responses

The Bank-wide trends described above conceal a great unevenness in the Bank's contribution in population and reproductive health across regions and countries. This unevenness reflects the interaction of various factors, including differences in health needs and in the Bank's health priorities in each region. The willingness of a country to borrow for population and reproductive health projects also depends to some extent on the terms of Bank financing available and on the strength of its own internal political commitment. Finally, the Bank responds to a larger set of priorities which drive the overall lending program.

Terms of Financing: *The type of Bank financing for which countries are eligible affects their willingness to borrow for population projects.* The World Bank provides two main types of loans: International Bank for Reconstruction and Development (IBRD) loans available to middle-income countries at close to commercial interest rates; and International Development Assistance (IDA) credits, available only to poorer countries (the majority in Africa and Asia), essentially interest free with repayment over a period of up to 40 years.

Countries differ greatly in their willingness to use IBRD funds for social sector projects—including health and population projects—that do not provide direct financial returns with which to repay the loans. Governments are generally more willing to use IBRD funds for hardware such as construction and equipment, than for the software such as training, communications campaigns and contraceptive supplies commonly needed in population projects. Owing to the greater readiness to use IDA funds for social sector projects, IDA credits have historically accounted for over 70 percent of population lending. However, many countries remain ineligible for such credits.

Political Commitment to Population: *The Bank's borrowers vary greatly in their commitment to slowing population growth.* Countries in South and East Asia have absorbed nearly 70 percent of the Bank's total support for population over time. Three countries—Bangladesh, India and Indonesia—account for more than half of all Bank lending for population. Projects in these countries have typically been large stand-alone activities compared to smaller, integrated projects in other regions. The large share of Bank population lending to South and East Asia reflects both the high level of commit-

Three countries—Bangladesh, India and Indonesia—account for more than half of all Bank population lending.

Despite the increase in social sector lending, the Bank still devotes considerably more resources to industry, transportation, agriculture and power projects.

ment and the eligibility of countries in these regions for IDA funds. In contrast, political commitment is lower in many countries in Africa, Latin America and the Middle East.

Overall Bank Priorities: *Population and reproductive health, which together represent a little over two percent of Bank lending, are relatively low priorities within the overall lending program.* IBRD loans, which mainly focus on infrastructure development, account for roughly two-thirds of total Bank lending. Despite the increase in social sector lending, the Bank still devotes considerably more resources to industry, transportation, agriculture and power projects. Moreover, the bulk of infrastructure financing is directed more towards larger middle-income countries. In FY 1996 nearly half of all IBRD lending went to three countries: China, Russia and Argentina.

As a result, issues of importance to larger middle income countries tend to take precedence over concerns of smaller, poorer countries. Even within the HNP sector, issues related to health financing and sector reform in larger middle income countries in Latin America, Central and Eastern Europe and East Asia receive more attention than issues of importance to the poorer regions.

Population and Reproductive Health Lending by Region

Reflecting the interplay of these various factors, the lending program in population and reproductive health has evolved very differently in each of the Bank's regional departments. In summary, the Bank is making a major contribution in reproductive health and family planning in a few countries, including several large Asian countries. In a number of additional countries, it is making a more limited but still important contribution. But there are many more countries, especially in Africa, where the needs remain great and there is scope for the Bank to do much more. Within the Bank itself, shifting health sector priorities and a shortage of staff remain major constraints to expanding population and reproductive health lending.

South Asia: *The Bank's most substantial involvement in population programs has been in South Asia.* This region has received a very significant share of overall World Bank funding for HNP activities. The Bank has been, and continues to be, a major financier of family planning infrastructure and programs in Bangladesh and India, and has undoubtedly contributed to the dramatic fertility declines experienced in both countries. The Bank also supports family planning programs in Nepal, Pakistan and Sri Lanka.

In India, the Bank has supported nine IDA-funded projects. Over the last two years, it has invested enormous staff resources in policy analyses and discussions aimed at laying the groundwork for a major new reproductive and child health project. The project seeks to support the Indian government's efforts to reorient its family welfare program from a target-driven approach emphasizing sterilization to a client-oriented program addressing a broader range of health needs.

In Bangladesh, the Bank has had a similarly long-standing involvement through four population projects. The Bank has played an important role in mobilizing funds from other donors and coordinating their participation. It is currently developing a fifth project to help the government address issues of sustainability and to broaden current family planning efforts into a more comprehensive approach to fertility reduction.

Table 2: World Bank Lending for Population and Reproductive Health, by Region, 1990-1996

New Loan Commitments for Population, by Region (US$ millions)

Fiscal Year	Africa	Middle East and North Africa	East Asia and Pacific	South Asia	Europe and Central Asia	Latin America and the Caribbean	Total
1990	45.7	11.9	0.0	96.7	0.0	15.0	169.3
1991	135.3	26.0	104.0	75.0	0.0	10.7	351.0
1992	18.7	0.0	0.0	63.3	20.9	0.3	103.2
1993	2.0	72.2	33.8	52.0	0.0	21.1	181.1
1994	31.5	0.0	9.4	133.1	0.0	24.5	198.5
1995	31.3	0.3	5.1	65.1	0.0	15.0	116.8
1996	20.5	27.2	35.9	2.7	0.2	20.0	106.5
Total	285.0	137.6	188.2	487.9	21.1	106.6	1,226.4

Sources: 1995 and 1996 are PAI estimates for population; all other numbers are World Bank data. Includes social sector projects.

New Loan Commitments for Population and Reproductive Health, by Region (US$ millions)

Fiscal Year	Africa	Middle East and North Africa	East Asia and Pacific	South Asia	Europe and Central Asia	Latin America and the Caribbean	Total
1992	25.2	0.0	0.5	243.7	46.6	2.3	318.3
1993	67.1	79.4	79.3	78.6	0.0	35.6	340.0
1994	96.7	0.0	9.4	133.1	0.0	184.5	423.7
1995	145.8	46.4	93.5	106.7	1.8	54.0	448.2
1996	54.4	37.5	111.7	82.7	105.9	111.8	504.0
Total	389.2	163.3	294.4	644.8	154.3	388.2	2,034.2

Sources: 1996 reflects PAI estimate for population and reproductive health; all other numbers are World Bank data. Includes social sector projects.

The Bank has about 40 ongoing projects in Africa with population and family planning components, most of them small activities within larger health projects.

In response to the strong demand from governments, the Bank appears likely to maintain a high-level of involvement in the region. *The Bank's continued support is needed to sustain and consolidate the impressive gains that have been made with its assistance.*

East Asia and Pacific: *The Bank has also made a major contribution to fertility decline in East and Southeast Asia.* Significant Bank funds have supported several stand-alone family planning projects in Indonesia.

Given the success of the Indonesian family planning program, the Bank is now broadening the scope of its assistance to increase support for AIDS prevention and safe motherhood activities. Throughout the region, a shift to broader health projects is underway and the Bank appears unlikely to return to large-scale population projects. However, in FY 1996 it approved a new Population and Family Health project in Vietnam.

With rising income levels and declining fertility, health and family planning needs are changing in a number of East and Southeast Asian countries. Moreover, many countries that are no longer eligible for IDA funding are reluctant to borrow IBRD funds for health projects. *There is still a need, however, to strengthen family planning as well as other reproductive health services in a number of countries in the region, including Cambodia, Laos, Myanmar, Papua New Guinea, the Philippines and Vietnam.* There is a need too in China, one of the Bank's largest borrowers, for dialogue at the policy level on alternatives to China's compulsory family planning program.

Africa: *From a regional perspective, the largest gap in the Bank's population and reproductive health lending is in sub-Saharan Africa.* The region faces great challenges in addressing very high levels of fertility, maternal mortality, and AIDS and STD prevalence. In much of the region, there is still a continuing desire for large families. Access to reproductive health care of all kinds remains limited, yet political commitment in this area is new and fragile and local infrastructure and capacity are weak. In French-speaking countries, until very recently, the policy environment for family planning was especially unfavorable. Civil upheavals have been an impediment to development efforts more generally in a number of countries.

In the 1970s and 1980s, the Bank supported stand-alone family planning projects in a few countries, including four projects in Kenya. In 1989 to 1990, the Bank's Africa department intensified its focus on population and its policy dialogue with governments. This in turn led to the development of a number of new integrated health projects with sizable family planning and AIDS components.

However, in the early 1990s the Africa department shifted attention and resources to the AIDS epidemic, developing large stand-alone AIDS and STD control projects in Kenya and Uganda. Meanwhile, ongoing integrated health and family planning projects encountered major implementation problems and built up large pipelines of undisbursed funds. Throughout the 1990s, the Bank's work across all sectors in Africa also suffered from repeated reorganizations of the Africa department.

Currently, the Bank has about 40 ongoing projects with population and family planning components in the Africa region; most of these activities are relatively small elements of larger primary health projects. *Because of this marginalization of family planning, there is hardly a country in Africa where the Bank is making a significant contribution to the*

INDIA

CASE HISTORY

Bank Assistance has Shifted from Local, Vertical Projects to Policy Work and Comprehensive National Projects

India is the Bank's largest recipient of population and reproductive health funds

The World Bank has assisted India's family welfare program since the early 1970s through nine population/family planning projects, and more recently, through projects addressing child survival and safe motherhood, AIDS control, and reproductive and child health. The Bank had committed almost $1.2 billion through FY 1997 for population and reproductive health activities in India—more than any other country.

The Indian program, the oldest official family planning program in the world, has been characterized by too great a focus on demographic targets, an excessive emphasis on sterilization, inadequate attention to the quality of services, and overly centralized planning and management. Nevertheless, between 1970 and 1990, fertility in India declined from six to four births per woman, reflecting the rising demand for smaller families and the greater effectiveness of the family planning program in some regions. The national average masks a variation in fertility rates from close to two children in several southern states to five or higher in poorer states in the north.

Bank assistance from the 1970s through the mid-1980s was limited in impact

The Bank's earliest projects essentially helped the government to expand the service delivery network in selected districts. Subsequent projects included support for monitoring systems, communications activities and training, as well as the expansion of urban family planning services.

Prior to 1987, the Bank had limited impact on program directions. It did not involve itself with policy issues, or play a leadership or coordination role with other donors. Moreover, in the 1980s, the Bank's financial assistance, while significant, represented no more than four percent of Indian government expenditures on the family welfare program.

Early Bank projects focused on construction of facilities and did not address fundamental problems of staff training, motivation and supervision. While the Bank sought to encourage localized strategies, this goal was never fully realized. The Bank-funded projects suffered from inadequate community involvement and essentially implemented the centralized Indian family welfare program model with all its weaknesses.

Bank-financed projects also experienced a number of implementation problems, including slow disbursement of funds due to cumbersome bureaucratic procedures and poor coordination between the central government and the states. Bank supervision was weak; relatively few staff were assigned to monitor these projects, and from the late 1970s through 1987 there were no staff in Delhi working on population activities.

INDIA

CASE HISTORY

Subsequent projects were more successful

In the late 1980s, Bank population projects were larger and operated at the state rather than the district level. They paid more attention to management and training than to expansion of facilities, and included funds for NGOs, social marketing and operations research. Still, these projects did not seek to address key program weaknesses identified in Bank analyses and continued to allocate significant funds for construction. The fifth Bank project, however, was successful in improving services and outreach in urban slums, and in shifting the emphasis from sterilization to serving the broad health needs of women and children.

The Child Survival and Safe Motherhood Project, approved in 1992, represented an important shift in approach by seeking to stimulate changes in the program at the field level. The project contributed to a 20 percent increase in the number of children fully immunized and the rising proportion of women who receive post-natal care and deliver their babies in hospitals. Close collaboration between the Indian government, the World Bank and UNICEF was key to the project's success.

More recent Bank assistance has been grounded in intensified policy dialogue

Since the late 1980s, the Bank has supported several analyses of big picture policy and program issues, taking advantage of the government's greater willingness to rethink its program strategy. In the mid-1990s, the Bank supported an analysis of women's health needs, as well as a major review of the family welfare program which made recommendations for shifting the emphasis from meeting demographic targets to a more client-centered approach.

The Bank's assistance has gradually shifted toward more integrated and comprehensive projects. Building on its analytical work, in 1997 the Bank approved a $248 million reproductive and child health project that is national in scope. The project seeks to expand the range of reproductive health services available, by strengthening prenatal and delivery services, treatment of reproductive tract infections and provision of spacing methods of family planning, as well as child health services. The project aims to maximize the impact of past Bank and government investments by improving the coverage, quality and effectiveness of the family welfare program. In recognition of past problems, it encourages decentralization and local ownership. More Bank staff are now in place to monitor and support these efforts, both at headquarters and in Delhi.

The project calls for ambitious changes in program philosophy, management styles and work patterns at the field level. This is an enormous challenge, given the historical difficulty in bringing about change in India's family welfare program. It is too early to judge the impact of these recent efforts, but these new directions are promising.

national family planning effort. Even in Kenya, where the Bank previously provided substantial assistance, it has not been a major player in the family planning program in the decade of the 1990s.

Meanwhile, a wholesale shift in the approach to HNP lending is underway. In most countries, new projects under development are focusing on broader reform of health sector financing and management. There are just a few countries—for example, Ethiopia, Guinea and Zimbabwe—where new projects are expected to emphasize reproductive health and family planning.

In the Africa department of the Bank, most country strategy documents mention the problems population growth rates—averaging three percent a year—pose for sustainable development. Yet despite the weakness of reproductive health and family planning services, country department and health sector managers assign higher priority to health sector reform. Under previous management, the department is reported to have responded negatively to interest in family planning on the part of some African governments; for example, Bank staff are said to have discouraged support for a community-based family planning activity for which the government of Niger requested assistance.

The department faces the challenge of serving 49 countries in a region with many urgent health problems. The limited level of Bank financing available to many small countries constrains lending opportunities in HNP. Moreover, project development in the Africa region is very staff intensive; managers accordingly see a focus on sector-wide reform and financing as the most strategic investment in health systems. Finally, the current regional vice-presidents, unlike their predecessor, have shown little interest in population or family planning.

Latin America and the Caribbean: *In this region, the Bank has maintained a low profile on reproductive health and family planning and has very little strength in the lending program.* In the 1970s and 1980s, opportunities for population lending were limited by political sensitivity on the part of governments, high reliance on the private sector for contraceptive services, and the fact that most countries in the region are not eligible for IDA funds.

Increasingly, however, governments in the region recognize the need to strengthen basic health services, creating opportunities for the Bank to initiate maternal and child health projects. In a number of instances—for example, in Argentina, Mexico, Paraguay and Peru—these projects include small family planning components. Since the mid-1990s, the Bank has also approved stand-alone AIDS/STD projects in Brazil and Argentina.

Fertility and maternal mortality have declined in many countries in the region but remain high in others such as Bolivia, Ecuador, Peru and in Central America. In some of these countries with high fertility and unmet need for family planning, substantial grant aid from other donors has been available. *Nevertheless, there are still untapped opportunities to expand lending for safe motherhood activities and AIDS/STD programs and to strengthen the focus on family planning within larger integrated health projects.* Moreover, to effectively support reproductive health activities in the region, the Bank needs to find ways to work with the private sector and nongovernmental organizations (NGOs) as well as with government health systems.

Middle East and North Africa: *Bank support for population and reproductive health activities has also been limited in this region.* As

To effectively support reproductive health activities in Latin America, the Bank needs to find ways to work with the private sector and NGOs as well as with government health systems.

Unfortunately, a lack of systematic information makes it difficult to assess the effectiveness of Bank projects in reproductive health, as well as other sectors.

in the case of Latin America, family planning has been a culturally sensitive topic and many countries are ineligible for IDA funding. Nevertheless, the Bank has supported stand-alone population projects in Egypt, Iran and Tunisia. Morocco is financing contraceptives through an IBRD-funded primary health project. Intensive discussions on new initiatives are underway in Yemen.

This region still has very high fertility and rates of population growth. The regional human development director predicts some expansion of Bank reproductive health lending in the region, including limited funding for family planning. *Lack of political commitment remains a constraint to the expansion of Bank financing for family planning activities in the region, highlighting a need for intensified policy discussions on the consequences of population growth, along the lines of the initiatives now underway in Yemen.*

Europe and Central Asia: *There is minimal activity in reproductive health in this region.* Population size in most Eastern European countries is essentially stable or shrinking. Regional staff do not assign priority to reproductive health and family planning needs based on analyses of the burden of disease. Nevertheless, there is a need for expanded access to better quality contraceptive services to reduce unintended pregnancy and reliance on abortion. The Bank has supported small maternal health components within some larger health projects, with very limited attention to family planning. In Russia and Romania, it is financing contraceptive supplies.

C. Effectiveness of the Bank's Population and Reproductive Health Activities

Ideally, the Bank's success should be measured by the effectiveness and impact of its projects rather than by the mere volume of loan commitments. Much of the preceding analysis of population and health lending is based on staff appraisal reports describing the Bank's new loan commitments and the activities they are expected to support. Yet these reports represent plans and budget estimates. Over several years of implementation, projects may diverge significantly from the original plan in the disbursement of funds and activities undertaken. Project components may need to be modified over time; some may never be implemented.

Unfortunately, a lack of systematic information makes it difficult to assess the effectiveness of Bank projects in reproductive health as well as other sectors. The Bank tracks expenditures by such categories as civil works and goods and services, rather than by the type of activity supported. Internal project completion reviews and audits are not available to the public. Data on project impact are limited.

An eight country study prepared by the Bank's Operations Evaluation Department in 1991 is one of the few systematic assessments of the effectiveness of Bank-financed population projects. This largely historical evaluation examined projects implemented during the 1970s and 1980s, in countries where the Bank had major stand-alone population projects as well as others where it provided negligible assistance. The report found that the Bank had become progressively more effective in the population field, but still lacked a comparative advantage over other donors in supporting

national population programs. It made a number of recommendations as to how the Bank could play a more effective role.

Among these recommendations, the report highlighted the importance of field staff and good donor coordination to effective project implementation. It revealed the neglect in several countries of small family planning components where these were incorporated into larger health projects. It also criticized the Bank for overemphasizing physical inputs such as construction at the expense of building local institutional capacity. Finally, it suggested that the Bank work with a broader range of institutions in implementing population programs, rather than only with ministries of health.

More recently, the Bank's leadership has made the impact of Bank-financed projects in all sectors a priority issue. The 1992 "Wapenhans report" marked a watershed in recognizing the poor performance of many Bank projects. The report identifies an excessive emphasis throughout the Bank on approving new loans at the expense of effective project supervision. It attributes many implementation problems to the growing tendency to design more complex projects with multiple objectives and components. In response, the Bank has developed an action plan aimed at strengthening project design, monitoring and evaluation. The current Bank president, Mr. Wolfensohn, has strongly promoted the need to improve the Bank's "development effectiveness."

Yet in many instances operational staff still lack the resources to effectively support project design and implementation. Since 1990, the administrative budget has twice been subjected to across-the-board 6 percent cuts. The recent reorganization led to further reductions in the FY 1997 budget for frontline operations, in order to accommodate initiatives such as the networks and staff retraining within the total existing budget. All HNP staff interviewed for this report mentioned the squeeze on operational budgets and the negative impact on project work. One staffer estimated that budgets in the Latin America department have been cut by 30 to 40 percent since 1994.

Despite these problems, Bank staff have unprecedented access to extra-budgetary funds for operating expenses in the form of special grants or "trust funds" from certain donor countries, some but not all tied to the use of national consultants for technical services. Japan has earmarked such trust funds especially for the design of projects in the human development sectors. Given the stringency of their operational budgets, human development staff have relied more heavily on donor grant funds than staff in other sectors.

The "Wapenhans report" attributes many implementation problems to the growing tendency to design more complex projects.

Constraints to the Effectiveness of Reproductive Health Activities

Overall, the Bank still faces a number of constraints to enhancing its effectiveness in the reproductive health field. While design and implementation problems plague Bank projects in all sectors, these problems tend to be more acute in HNP projects, which often support complex components such as training and institutional capacity-building. The fact that reproductive health activities tend to be small elements of larger projects makes them especially vulnerable to implementation problems.

Despite the Bank's limited technical capacity in reproductive health and family planning, it has not done enough to develop partnerships which draw on the expertise of other donors. It has also provided very limited support for the activities of the private sector and NGOs.

Most health and family planning experts at the Bank agree that a sector-wide approach has the potential to create a policy environment more conducive to the equitable, efficient and effective delivery of health services.

Moreover, as noted earlier, the shift towards health sector reform has the potential to undermine support for reproductive health and family planning services.

The Push for Health Sector Reform

Recently, the Bank has increasingly favored projects that deal with the overarching management and financing issues facing the health sector in a country. The Bank's movement towards health sector reform is part of a larger shift within the health field and the donor community—a shift which represents an effort to move away from small-scale, narrowly-focused projects and increase the impact of health sector assistance. It also reflects the Bank's view of its comparative advantage at the policy level, and the importance Bank economists assign to appropriate financing strategies in health as well as other sectors. Health sector reform is a relatively new area for the Bank and one that is evolving rapidly.

Most health and family planning experts at the Bank agree that a sector-wide approach has the potential to create a policy environment more conducive to the equitable, efficient and effective delivery of health services. They see more traditional service-delivery projects as having limited impact in the absence of efforts to address systemic constraints on health delivery systems. The sector reform approach, for example, might seek a shift in health budgets towards neglected rural and primary care services, or an overhaul of inefficient systems for the procurement and management of essential drugs and supplies.

The Bank's Social Action Program (SAP) in Pakistan illustrates the power of the sector-wide approach. By involving four different technical ministries as well as the Ministry of Finance, the SAP has given the social sectors a higher profile. It has helped to draw the attention of the political leadership to inadequate budget allocations and to increase the resources available to these sectors.

However, Bank technical staff are concerned that where projects support sector-wide management reform and financing, this larger agenda could overtake a focus on reproductive health. While these staff agree that the Bank can and should influence the policy environment, they see a concurrent and urgent need for financial and technical assistance to strengthen the delivery of key services. They worry that a shift to the sector approach could undermine progress in countries such as Bangladesh, which have made significant strides in provision of services.

One solution, especially where basic health services are weak, is for the Bank to pursue a two-track approach, giving equal importance to the strengthening of specific services on the one hand, and to larger policy issues on the other. This approach is also consistent with the Bank's new Sector Strategy Paper for Health, Nutrition and Population, which promotes three major areas of activity—improving HNP outcomes for the poor, enhancing performance of services through effective policies and reforms, and improving health financing.

The Bank has already adopted this parallel approach in a few countries. In Pakistan, for example, it has financed more focused sector-level projects, including a major family planning activity, alongside the multi-sector Social Action Program. In Côte d'Ivoire, the ongoing Population, Health and Nutrition project has separate components dealing with longer-term sector-wide issues and short-term strengthening of reproductive health services. In Guinea, a planned future reproductive health

and family planning activity aims to complement an ongoing health sector project.

In addition, health reform projects, if appropriately structured, could give a real push to reproductive health and family planning activities. In Ghana, for example, a Health Sector Support Program Credit now under development explicitly states that family planning, obstetric and STD services are "part of the priority health services interventions" covered under the proposed program of work. This strategy is especially relevant to countries with more developed health systems where these services currently receive inadequate priority.

To be successful, this approach will require the involvement of technical experts in reproductive health and family planning (and other priority areas) in the structuring of health sector reform programs. While most Bank staff who have taken the lead in these efforts have strong financing and management skills, they lack expertise in specific technical areas, including reproductive health and family planning. As a result, these projects have focused on issues such as decentralization and financial accountability, without sufficient attention to the quality of services and technical capacity.

At the same time, it is important to recognize that, especially in the case of family planning, integration with health may not always make sense. Promoting family planning as part of a larger effort to improve women's health has created new opportunities to expand services in Africa and Latin America. However, in some settings, especially in Asia, more focused interventions have proved successful in getting family planning established despite otherwise weak health systems.

Moreover, reproductive health and family planning differ in many respects from other health needs, and thus require somewhat different strategies. While some elements of family planning programs overlap with health, others more appropriately belong outside the health delivery system. Some public education activities, for example, may be more effectively implemented through standalone population projects or multisectoral approaches involving other relevant institutions such as mass media networks.

Moreover, health sector reform efforts focusing on the public sector may not be the best vehicle to support the private sector, which has played an important role in the delivery of reproductive health and family planning services. In many countries, NGOs are major service providers; social marketing, or the subsidized promotion and sale of contraceptives through commercial channels, has been a successful strategy for improving access to contraceptive supplies outside publicly-run health facilities. In Ghana, some NGOs which received support under a previous World Bank health and population project have been concerned about their ability to secure funds under the new health sector support program.

In the final analysis, the sector approach is new and untested. The Bank's Operations Evaluation Department is currently undertaking a major review of the effectiveness of the Bank's approach to health projects, but the results are not yet available. Until more evidence of impact is available, the Bank needs to maintain an open mind and flexibility in its efforts to promote health reform.

If sector-wide projects are to successfully promote reproductive health, technical experts need to be involved in the structuring of health sector reform programs.

Inadequate Attention to Project Design

Only 1 of 21 HNP sector reports for FY 1997 has a specific focus on population and reproductive health.

Sound design is important to the effectiveness of any development project. Many implementation problems can be avoided when early and adequate attention is paid to all aspects of the project, from program delivery mechanisms to procurement and contracting arrangements, to financial sustainability.

Traditionally, the Bank has initiated the design process with sector work or the preparation of detailed reports analyzing sector-specific problems and issues. These analyses provide a basis for project preparation—the Bank and the borrower identifying activities to be implemented under the new project. Finally, the Bank prepares an appraisal report which includes a detailed description of and budget for the specific activities to be supported by the project.

Decline in Sector Work: *Managers and staff in the human development sectors acknowledge the importance of high quality analytical work to the policy and technical dialogue with borrowers and to negotiations over new projects.* Sector reports provide the information and analysis for soundly designed projects and represent an advocacy tool to convince a country to adopt a particular approach in a project; on the downside, they add to time required for project preparation.

Table 3: Health, Nutrition and Population Sector, FY 1997 Sector Reports

Region/Country	Subject of Report
Africa	
Africa Region	Gender Action Plan
Djibouti	Poverty Assessment
Ghana	Gender Strategy
Mauritius	Health Sector Review
East Asia and Pacific	
Indonesia	Pharmaceuticals
Indonesia	Health Patterns
Indonesia	Health Financing
Philippines	Environmental Health Assessment
South Asia	
Asia Region	Health Reform in Asia
Bangladesh	Population and Health Sector Strategy*
India	State Health Reform
Pakistan	Health Strategy
Europe and Central Asia	
Azerbaijan	Poverty Assessment
Azerbaijan	Azerbaijan Health Note
Kazakstan	Health Sector Note
Russian Federation	Health Sector Note
Russian Federation	Social Challenges
Tajikistan	Health Sector Note
Latin America and the Caribbean	
Argentina	Health Financing
Costa Rica	Poverty Assessment
El Salvador	Rural Health Care

* Report Focusing on Population/Reproductive Health

Source: World Bank

Recent budget cuts have significantly reduced resources for HNP sector work over the last two to three years. Diminished availability of resources has led to a dramatic decline in the production of sector reports in HNP. In the 1980s, HNP staff produced one sector report for every staff appraisal report; between 1992 and 1996, this ratio declined to one sector report for every two appraisal reports. Moreover, while expenditure on sector work has declined, lending levels have increased. Many Bank staff are concerned that the decline in sector work is affecting the quality of design and could cause a further increase in implementation problems down the road.

The decline in sector work has been a particular problem in population and reproductive health; in the last few years, there have been only a handful of sector reports in this area. Only 1 of 21 HNP sector reports for FY 1997 —a report on Bangladesh—has a specific focus on population and reproductive health. The decline in sector work represents missed opportunities for policy dialogue on reproductive health. Such analyses have the potential to help countries identify appropriate follow-up to the ICPD and set priorities, and could have significant influence on reproductive health policies and programs.

Gaps in Project Design: *A variety of design problems have limited the effectiveness of Bank reproductive health projects.* Reproductive health and family planning activities are no exceptions to the pressures for loan approval and the inadequate availability of staff that shortchange project preparation and result in poorly designed projects across all sectors. Only limited and fragmentary information is available about the impact of such problems in reproductive health projects:

- A recent internal review of the performance of 40 HNP projects with population components reveals major gaps in the design of these projects, including inadequate analyses of recurrent cost issues and insufficient consideration of alternative approaches involving the private sector.
- A Bank evaluation of a family health project in Zimbabwe in the late 1980s found inadequate design adversely affected the effectiveness of an urban family planning component. The municipalities responsible for the city clinics were not involved in project development. Start-up of the activity was delayed partly because of confusion as to the agency responsible for implementation.
- *Contraceptive procurement is another area that Bank staff have neglected during the design process.* In the 1990s, a growing number of countries, especially in Africa and South Asia, are turning to the Bank to help finance their contraceptive requirements. Procurement is a generic problem in Bank health projects financing drugs for the public health sector. However, projects involving contraceptive procurement have special design needs, including projections of future demand and contraceptive requirements, as well as careful consideration of procurement and logistics management issues.

In several cases, the failure to spell out institutional arrangements and other details relating to contraceptive procurement in advance has led to serious implementation problems. These include the Fourth Population project in Kenya, which earmarked substantial funds for contraceptives. The government of Kenya proved unable to procure these commodities in accordance with Bank regulations; after seven years the Bank

A recent internal review of the performance of 40 HNP projects with population components reveals major gaps in the design of these projects.

Small population and reproductive health activities often do not receive adequate attention during implementation.

had disbursed only $8 million of an original credit of $35 million. To avoid a supply shortfall, other donors have provided contraceptives on an emergency basis.

In the case of contraceptive procurement, HNP sector staff have prepared materials to orient operations staff to these issues and provide information on available technical resources in this area. In other areas too, there is a similar need to identify common design problems and disseminate information to prevent their recurrence in new projects.

A positive recent development is that the Bank is moving to encourage the use of pilot activities to test different approaches prior to initiating full-scale projects. The Bank has used pilot projects very effectively in some countries. While a pilot approach may reduce loan volume in the short-term, it could help tailor projects to specific country needs and contribute to more effective large-scale projects in the long-term. Moreover, pilot projects can often be prepared fast and cheap.

Ineffective Oversight of Project Implementation

Frequent and effective monitoring remains critical to the successful implementation of social sector activities, including complex HNP projects. Yet supervision of population activities has been another major stumbling block for the Bank.

For years, the Bank has overseen project implementation by sending supervision missions or teams of experts to a country to visit the project every few months. This approach worked tolerably well with the construction activities which dominated population lending early on. However, as Bank population and health projects increasingly deal with complex policy and service delivery issues, this mode of oversight is no longer effective in ensuring that all elements of a project receive sufficient attention. *Both the Bank and other donors have been more successful in implementation where they have invested heavily in field supervisory staff, as the Bank itself has done in Bangladesh.*

Neglect of Population Components During Supervision: *The increasing marginalization of population and reproductive health activities within large, multi-component HNP projects presents a special challenge for effective supervision.* The small amounts of money allocated to these components frequently mask a complex range of activities. Given time constraints, Bank staff on supervision missions tend to concern themselves with the larger project components. A further problem is that these missions often focus on disbursement problems rather than technical issues. As a result, small population and reproductive health activities often do not receive adequate attention during implementation.

The Tanzania Health and Nutrition project is a classic example. The project, under implementation for nine years, includes multiple, unrelated project components. The $60 million project, approved in 1990, includes a $2 million activity with the Ministry of Plan for population policy development. An internal review in 1997 found that Bank staff had never looked at the activity during supervision missions. There had been no progress in implementation since the project's inception almost a decade ago.

The same review noted similar problems in two out of three other countries visited, where large health projects included small population components. A small family planning component in a recently completed primary health project in Yemen and a number of small safe motherhood components in other projects have also experienced similar neglect.

These experiences suggest that the Bank needs to revisit the current approach of including population and reproductive health as small components within larger health projects. But they also suggest a need for the Bank to adopt a more systematic approach to monitoring the progress of all project components, and to expand the use of in-country staff and consultants.

Insufficient Funds for Supervision: *Despite the new emphasis on project implementation and effectiveness, financial support for project supervision remains inadequate.* While this problem affects all sectors of Bank activity, the impact on the human development sectors appears especially severe. A recent internal analysis suggests that per project expenditure for staff time and travel for supervision in the human development sector is well below the overall Bank average. The review asserts that "resources have been cut beyond the point of greatest efficiency and into the muscle and bone of operations."

The situation is a complex one. The Bank's top management has reportedly increased the average project allocation for supervision. However, the country departments which control budgets following the reorganization do not appear to be passing these increases on to field operations. In many instances, budget reductions appear to have cut deeply into travel, despite its importance to effective project supervision.

As a result of the budget crunch, in at least one of the South Asia human resources divisions there were virtually no funds in FY 1997 for travel essential to achievement of the division's work objectives. Responsibility for supervision has been shifted to national staff in the Bank's country mission, a positive step in many respects but reportedly without sufficient headquarters oversight. Meanwhile, HNP staff covering Latin America report they are limited to one visit per project per year.

Thus, adminstrative budget cuts are undermining efforts to strengthen project implementation and perpetuating the Bank's front-loaded attention to loan approval. Mr. Wolfensohn has acknowledged these problems and indicated his intent to shift more resources to frontline operations and project implementation. Decentralization of staff to field offices—a very positive development with significant potential to strengthen implementation—has begun. A central quality assurance group has been established to improve the project monitoring process and identify implementation problems early on.

Budget reductions have cut deeply into travel, despite its importance to effective project supervision.

Mixed Record on Collaboration with other Donors

The potential for effective Bank-financed projects appears greatest when the Bank's efforts complement those of other donors. Countries stand to benefit when the Bank and other donors coordinate their assistance to play to their respective strengths and weaknesses. As part of the ongoing reinvention process, the Bank's leadership has said it is committed to closer collaboration with other international partners. In the reproductive health and family planning field, closer collaboration with other donors could potentially help compensate for the Bank's limited technical expertise in this area; currently such collaboration takes place at several different levels.

Global and Regional Collaboration: *At the global level, the Bank has worked closely with other multilateral and bilateral donors in several areas.* For example, it is engaged in an effort, led by the United Nations Population Fund

Overall, coordination tends to be better in the few countries—Bangladesh, India—where the Bank maintains in-country technical personnel.

(UNFPA) and involving other bilateral donors, to coordinate contraceptive commodity assistance worldwide. The Bank has participated in the Safe Motherhood Initiative with several UN and other agencies. It has also worked closely with other donors to coordinate data collection efforts and to sponsor and organize high level policy meetings. At the regional level too, the Bank has undertaken joint initiatives with other donors, for example, co-financing a number of regional projects and technical meetings with UNFPA.

For the most part, staff in the Bank's central Human Development Department have been the focal point for organizing the Bank's participation in these initiatives. The reduction of central staff under the current reorganization could potentially weaken ongoing efforts to collaborate with other donors at the global and regional levels.

Country-Level Collaboration: At the country level, donor coordination, in principle, should be the responsibility of governments of aid-recipient countries. In reality, however, donors often need to take more direct responsibility for coordinating their activities, especially where national governments are weak.

At the country level, the Bank's record in coordinating and collaborating with other donors in the reproductive health field has been mixed. First, the Bank's engagement in reproductive health and family planning, the magnitude of its financing and its field presence vary greatly from one country to another; opportunities for effective collaboration with other donors vary accordingly. Overall, coordination tends to be better in the few countries (e.g., Bangladesh, India) where the Bank maintains in-country technical personnel. A frequent complaint of other donors is that coordination suffers in those countries where the Bank lacks field-level technical leadership.

This unevenness is reflected in the Bank's efforts in a number of countries to use UNFPA's expertise in contraceptive procurement and supply management. In its efforts to serve as a procurement agency for the Bank, UNFPA has found that Bank staff working on different country programs have very different interpretations of Bank policy concerning contraceptive procurements. Moreover, many project managers in the highly decentralized Bank are not even aware of the availability of UNFPA technical assistance.

In general, coordination efforts are strongest during project development. On an ongoing basis, the Bank and other donors exchange information, share the results of major programming exercises and ensure complementarity of inputs in the formulation of new programs and projects. During the design phase of a project, the Bank is more likely to engage in discussions with other donors aimed at ensuring adequate funding for key elements of a country's program, avoiding duplication and identifying which activities are best supported through loan or grant funds. In Ghana and Senegal, the Bank and the government have initiated a series of coordination meetings with other donors in developing new health sector projects, an approach that is typical in other countries as well.

However, especially where the Bank lacks technical field staff, coordination during implementation is often poor. Staff on supervision missions for Bank population and health projects generally visit other donors active in the sector during their visits to a country. But because they operate from headquarters in Washington, they are rarely able to assure close day-to-day coordination of project activities.

Design and Implementation Problems Undermine the Impact of Four Population Projects

The World Bank has provided significant support to Kenya's family planning program, committing $82.2 million in concessional loans through four projects approved in 1974, 1982, 1988 and 1990, respectively. A number of problems, however, have limited the overall impact of the Bank's contribution.

The first two projects helped expand the health care system but did little to influence fertility

In the 1970s, most Kenyans still wanted large families, and political support for family planning was new and fragile. The first two Bank projects aimed to support the integration of family planning into maternal and child health services. At the time, the availability of health services was very limited; at the government's request, these projects were largely devoted to creating a basic network of rural health centers and training schools. The projects achieved their construction and training objectives, but provided little or no direct support to family planning services and had little short-run impact on population growth. Nevertheless, they laid the groundwork for a strong primary health care system and for the future expansion of contraceptive services through this system.

Up until the mid-1980s, there was little change in contraceptive use and fertility. An evaluation suggested early Bank projects could have done more to encourage a desire for smaller families by supporting family planning information programs, investing in education and coordinating more closely with other donors in this area.

The third population project failed to consider the need for contraceptive supplies

By 1988, political support for family planning was stronger, and there were signs of growing demand for contraception. The Bank's third population project sought to develop urban family planning services and establish a national program for surgical contraception. The project included funds to construct a new headquarters and district offices for the National Council for Population and Development (NCPD) as well as 14 voluntary sterilization clinics. Although the project paid little attention to future contraceptive needs, soon after the new project was approved, the demand for contraceptives appeared likely to outstrip available supplies. In 1990, the Bank quickly designed a fourth project to finance $35 million in contraceptives, essentially as an add-on to the third project.

The fourth project did not adequately consider the government's weak procurement capacity

Unfortunately, the fourth project failed to take into account long-standing problems in procurement of drugs and supplies by the Ministry of Health. Other donors in the population field had used their own centralized procurement

systems to provide contraceptive supplies and had not sought to strengthen local procurement capacity. After initial procurement efforts were derailed, the Bank and the Kenyan government agreed to select a professional agent to handle all future purchases of drugs and contraceptives under Bank health projects. Following further delays, the Bank approved a contract award to such an agent in late 1996. As of March 1997, the Bank had disbursed only $8 million of the original commitment of $35 million.

Meanwhile, a mid-term review of the third project had recommended against construction of the NCPD offices. Only one of the voluntary sterilization clinics had been completed by 1996, owing to a lack of counterpart funds from the government, cost increases and slow action by the Ministry of Health. Delays in funds caused many construction sites to be abandoned; in early 1997, the government agreed to complete the clinics with funds from the Bank's fourth project.

The Bank's future involvement in Kenya will focus on building local capacity

Demand for family planning services in Kenya is now strong. The government is moving to address family planning and other reproductive health needs through an integrated approach under a broad health sector reform initiative. Meanwhile, a new National Policy on Population and Development recognizes the need to link population to other development efforts, especially those relating to the status of women.

The government, however, faces some major problems in implementing its reproductive health strategy. It is uncertain where future contraceptive and drug supplies will come from once the Bank's fourth population project ends. The Ministry of Health's capacity for procurement and financial management remains weak, and budgetary constraints severely limit the availability of local funds.

In 1995, the Bank broadened the scope of its reproductive health assistance to include a $40 million project to control the spread of sexually transmitted diseases. More recently, the Bank has begun developing a health sector reform project, but has made clear that future support to the sector depends on the government's commitment to address problems experienced in earlier projects. The Bank currently has no plans for any further projects directly supporting the family planning program.

In Senegal, for example, at the government's request the different donors to the national family planning program, including the Bank, cover different geographic regions. Under a recently completed health and population project, the Bank provided funds for family planning training of health workers in the region to which it provides support. According to other donors, Bank staff made little effort to standardize training efforts with those in other regions, nor did they adequately monitor the quality and technical content of the training.

Bangladesh represents a more positive example of the division of labor between the Bank and other donors. In Bangladesh, the Bank has played a leadership role in creating a consortium of about a dozen donors in maternal child health and family planning. Through the consortium, the Bank has mobilized financing and supported construction, while the U.S. Agency for International Development (USAID) and its contractors and UNFPA have provided intensive technical support to service delivery and institutional development. The Bank has taken a lead role in coordinating the inputs of donors in the consortium, while working closely with USAID and UNFPA, the major donors outside the consortium, as well.

Given the technical constraints of the Bank, it is essential that it draw on other sources of population expertise. Yet in most countries, the Bank has made little effort to achieve real joint programming with other donors having greater technical expertise. Several USAID-funded technical assistance agencies, for example, report that their collaboration with the Bank at the country level has been ad hoc and relatively negligible. Moreover, both USAID and its technical agencies view the Bank as an unreliable partner because it often fails to deliver on its commitments. This is true in Kenya, where the Bank has taken years to procure contraceptive supplies, and in Burkina Faso and Pakistan, where Bank funds for technical assistance activities were subject to long delays.

In the real world, moreover, opportunities for effective partnerships in reproductive health and family planning are often limited. The regional teams of experts that provide technical advisory services to UNFPA-funded projects, for example, represent a potential source of assistance in the design and implementation of Bank projects. However, according to Bank staff, the experience with these technical advisory teams has been a mixed one, owing to the variable caliber of their expertise. Bank staff also report problems in their efforts to collaborate with the European Union, largely owing to the inadequacy of its population and reproductive health expertise.

The donor landscape is shifting. As USAID withdraws from many countries, governments are turning to the Bank as the donor of last resort. In this context, the Bank needs to strengthen its coordination with other donors but also develop its own capacity for on-the-ground technical support.

Mobilization of Funding through Project Co-Financing: *The Bank has done much better at mobilizing additional financial resources for population and reproductive health activities.* In many instances, the Bank has taken a leadership role in seeking out grant assistance from other donors to supplement its own loan commitments for specific projects, as well as in leveraging increased budget allocations by national governments. As such, the Bank has played an important role in increasing funds available for population and health programs: In FY 1993 the total value of government and

Given the technical constraints of the Bank, it needs to work more closely with other donors that have greater expertise.

In Bangladesh, the Bank has mobilized and coordinated donor financing, a model for other countries.

Table 4: Bangladesh—Mobilization of Financial Resources by The World Bank

World Bank Population and Family Health Project Budgets by Financing Source, 1975-1997 (in US$ millions)

	World Bank/ IDA Credits **US$ Millions**	Cofinanced Grants from Other Donors **US$ Millions**	Bangladesh Government Counterpart Funds **US$ Millions**	Total **US$ Millions**
Population Project I	15	25	5	45
Population Project II	32	67	11	110
Population Project III	78	99	36	213
Population Project IV	180	255	165	600
Total	305	446	217	969

Source: World Bank. Totals may not add due to rounding.

donor contributions to Bank-financed population projects was double the value of the Bank's loan commitments.

Co-financing provides the Bank with greater flexibility to include project activities that governments are often reluctant to support with loan funds. For example, in some countries, the Japanese government has provided grant funds earmarked for training to World Bank projects. Given the Bank's limited in-country presence, co-financing also enables Bank staff to rely on other donors to support activities requiring more sustained staff input than the Bank can provide. In general, more innovative, leading-edge reproductive health activities are not the comparative advantage of the Bank.

There is no better example than Bangladesh to illustrate the Bank's role as a catalyst for mobilizing funds from other sources. The consortium has provided smaller donor countries with an opportunity to participate in a coordinated international effort without a major administrative burden. *In the past two decades, the Bank has mobilized nearly a billion dollars through the consortium.* However, the Bank has adopted this innovative approach in only a few countries and has not utilized it to full advantage.

Limited Support for Private Sector and NGO Activities

In recent years, especially under Mr. Wolfensohn's leadership, the Bank has sought to build partnerships with a broader range of institutions, especially with NGOs. The Bank faces some constraints in working outside the public sector, since it makes loans to governments that they must eventually repay. Nevertheless, to an unprecedented extent, the Bank is consulting NGOs and encouraging their participation in the development of new projects. Many if not most resident missions now have NGO liaison officers. An NGO advisory committee, appointed by the Bank, is working to identify strategies for expanding NGO participation in Bank projects. To a great extent, these developments are a response to NGO critics, who still see these initiatives as too limited and too late.

The Bank has also supported NGO activities through numerous country-level projects, especially social fund-type projects which often include small grants programs to support social services at the local community level. Beyond project funding, the Bank administers a central special grants program which is a potential

source of funding for NGOs. Currently, the program primarily funds regional and global activities—mostly research—that are of importance within a larger development context. The Bank's management is considering expanding this program and developing a direct funding mechanism for support to NGOs.

Reliance on NGOs in the HNP Sector: *HNP projects have always financed NGO activities to a greater extent than other sectors within the Bank.* NGOs have played a very important role in service delivery in the reproductive health field, especially in family planning. They provide a link to local communities, and have experience in service delivery and implementation that the Bank itself often lacks. Community service organizations can more easily reach disadvantaged and marginalized groups—such as the urban poor or adolescents—with reproductive health and other social services.

For a number of years, the Bank's central special grants program has provided funds for safe motherhood activities and for population NGOs. In 1996, it added a special grants program to support activities relating to female genital mutilation and adolescent health. A relatively modest amount of funding is available under these initiatives, which disbursed a total of just over $2 million in FY 1996.

The Bank has included substantial support to NGOs in its population projects. Many if not most of the health and population projects approved in the Africa region in the late 1980s and early 1990s—for example, the Côte d'Ivoire Integrated Health Services Development Project—include some support for national family planning associations affiliated with the International Planned Parenthood Federation (IPPF).

The recently developed Reproductive and Child Health Project in India also includes substantial funding for NGO initiatives. Both the ongoing Social Action Program and population loan activity in Pakistan similarly incorporate funds for NGO family planning activities. Other countries where the Bank is working with NGOs include Vietnam and the Philippines for family planning service delivery, and Indonesia where NGOs are testing strategies for STD/AIDS prevention.

In actual implementation, however, the Bank has faced some difficulties with NGO components. Many small NGOs have greater difficulty accessing Bank funds than those of other donors. The Bank lacks the staff and mechanisms to work with governments to help local NGOs develop proposals for Bank funding and to provide technical support during project implementation. Almost none of the NGO liaison officers in the resident missions, for example, have more than a passing acquaintance with reproductive health issues.

While international NGOs could play a retailing role by channeling Bank resources to smaller, local NGOs, governments are often reluctant to use loan funds for the overhead and foreign exchange costs entailed in working through international organizations. Thus, while the Bank has made a substantial effort to support NGO activities through its projects, it still lacks modalities for promoting effective NGO-government partnerships at the country level.

The Private Sector: *In contrast, few Bank projects have supported private sector and social marketing initiatives in reproductive health and family planning.* Of the HNP projects approved in FY 1995 and 1996, only the Chad Population and AIDS Control Project includes support for social marketing.

While the Bank has made a substantial effort to support NGO activities through its projects, it still lacks ways to promote effective NGO-government partnerships at the country level.

The Bank needs to recognize the importance of the private sector in improving access and cost recovery, and to move more strongly to support initiatives in these areas.

There are several reasons why the Bank lags in support for private sector initiatives in reproductive health, while strongly promoting private commercial sector involvement in many other areas. Some governments remain reluctant to channel Bank resources outside the public health system. In India, for example, the government did not use very significant funds earmarked by the Bank for social marketing under an earlier population project. The new India Reproductive and Child Health project does not include support for social marketing activities, although an important goal of the project is to expand access to spacing methods of family planning. But a further important reason for the neglect of private sector strategies is that very few Bank staff have expertise in this area.

Nevertheless, worldwide, the majority of couples using spacing methods of family planning get their supplies from commercial sources. The Bank needs to recognize the importance of the private sector in improving access and cost recovery, and to move more strongly to support initiatives in these areas.

Recommendations for Strengthening Bank Support to Reproductive Health and Family Planning Programs

The financing the Bank provides is of crucial importance, but the effective utilization of funds is also key. Unless the Bank takes the steps necessary to strengthen the impact of its financial assistance, it may have greater potential for influence through its analytical and policy work than through support for reproductive health and family planning projects.

- **The Bank should provide more concessional financing for social sector projects, including reproductive health and family planning activities, to encourage governments to increase their investments in such projects.** The Bank's leadership has indicated that the development of new products will be part of the current process of institutional transformation. The development of new borrower-friendly loan packages for social sector projects and broader, more inclusive eligibility criteria for such financing would go a long way to increasing the willingness to borrow for health and family planning projects.
- **The Bank should look for synergies between health sector reform and reproductive health and family planning.** In countries with weak health systems, the Bank should support more focused projects addressing reproductive health and family planning needs, alongside projects dealing with larger sector-wide policy issues. At the same time, in countries with more advanced health systems, the Bank should look for ways to strengthen reproductive health services through its health care reform efforts and include reproductive health specialists at the table in structuring these programs.
- **The Bank should feature reproductive health and family planning activities much more prominently within HNP projects.** While HNP projects need to be tailored to the specific country context, in general they should incorporate simpler designs with fewer components. This does not imply a full-scale shift to stand-alone projects, whether in family planning or other areas of reproductive health. However, reproductive health and family planning should represent more significant elements within larger, integrated primary health projects. The Bank

should also continue to support new stand-alone reproductive health or family planning projects in countries where these activities deserve high priority and a more focused approach makes sense.

- **The Bank needs to review its current effort in reproductive health and family planning and identify priority countries for additional Bank investments.** The HNP network in each region should prepare country-by-country assessments of the adequacy of Bank activities in reproductive health relative to the needs. The Human Development network council and HNP sector board should review these analyses and actively monitor the pipeline of new projects to ensure all major elements of reproductive health receive attention in priority countries.
- **Strengthening the Bank's focus on reproductive health and family planning requires the support of senior management.** In the culture of the Bank, it is essential for the president, managing directors and vice-presidents to indicate support for reproductive health as a priority area of activity and to monitor staff and financial resources allocated to this area. The Bank's leadership should require the regions to compile and monitor disaggregated information on loan commitments in all key areas of reproductive health.
- **The Bank's leadership should ensure sufficient budgetary support for analytical work in the human development sectors generally, as well as in the HNP sector more specifically.** If the Bank is to play a substantial advisory role in countries and help governments make tough choices, it must maintain a strong program of analytical work. Through sector work, the Bank can also analyze the financial needs of reproductive health and family planning programs and incorporate these issues into its broader policy dialogue on health financing.
- **The Bank needs to improve the design of reproductive health and family planning activities.** The HNP network should establish a solid quality control system to ensure thorough analysis of all aspects of new projects. In addition, it should support case studies aimed at identifying the most common problems in the design of Bank-financed reproductive health activities and disseminate this information to HNP staff in all regions. Until adequate resources are available from the regular budget, other donors should continue to provide grant funds for design work and consider relaxing restrictions on the use of these funds.
- **The Bank's leadership needs to ensure adequate budgetary support for supervision of HNP projects, including reproductive health and family planning activities.** Many new initiatives under discussion, including decentralization of Bank staff to the country level, could transform the Bank's current style of managing projects. However, budget constraints are likely to preclude deployment of reproductive health and family planning specialists in every Bank resident mission. Accordingly, the Bank's leadership must ensure that adequate funds are budgeted for the time of headquarters specialists and for their travel to oversee the technical aspects of projects.
- **The HNP network in each region needs to develop specific strategies for strengthening partnerships in reproductive health with other donor agen-**

It is essential for the president, managing directors and vice-presidents to indicate support for reproductive health as a priority area of activity and to monitor staff and financial resources allocated to this area.

The Bank must budget adequate travel funds for specialists from headquarters to oversee the technical aspects of projects.

cies. At the country-level, HNP staff should seek closer collaboration with UNFPA, USAID and such bilateral donors as Germany and the United Kingdom, all of which have a field presence and some capacity for technical support. At the international level, the Bank should expand efforts to mobilize additional grant funds from donor countries that do not have significant bilateral programs, through both the co-financing and donor consortium models. Donor consultative group meetings represent a potential forum to explore these possibilities on a country-specific basis.

- **The Bank should greatly strengthen support through its projects for private sector reproductive health and family planning activities—both NGOs and for-profit and social marketing activities.** The HNP network and leadership in each region need to review the design of reproductive health and family planning activities for adequate attention to private sector approaches. This will require at least a few staff with experience in this area, along with access to external expertise. The Bank also needs to work with international and national NGOs to find more effective ways to support NGOs at the community level.

IV. The Bank's Technical Capacity in Reproductive Health and Family Planning

Staffing is key to an expanded and more effective Bank involvement in reproductive health and family planning. Adequate staffing can help to ensure that implementation bottlenecks are recognized and addressed as they arise, especially in countries where technical and absorptive capacity are limited. While a critical mass of staff is important, the quality and relevance of expertise is also essential to good project design and implementation, and to exercising leadership with country-level counterparts.

The Bank's current leadership has recognized the need to strengthen substantive expertise within the Bank across all development sectors. External observers perceive the Bank to have experienced a decline in technical expertise in many areas over the past decade. In general, the management structure has not encouraged technical experts in a given area to play a lead role in shaping the lending program. These concerns apply to the HNP sector as well.

It is not easy to analyze the staff situation with respect to reproductive health. Consistent data on trends in staffing in this area are not readily available. Official job titles do not always reflect whether a particular individual has reproductive health and family planning expertise. As in other sectors, most reproductive health specialists work on other aspects of health as well, while many staff lacking specialized expertise work on reproductive health projects.

Key Issues Relating to HNP Staffing

Inadequacy of Technical Expertise: Human development staff—including those working in health, nutrition and population—have reportedly grown by roughly 80 percent since 1986. Some observers believe this rapid expansion has contributed to a decline in the quality of staff.

The number of HNP staff with real technical skills appears very limited, and the number with expertise in population and reproductive health is even smaller. In 1993, of a total of 360 staff in the human development sectors, 41 (13 percent) were health and nutrition specialists and 20 (6 percent) were population specialists. At the present time, there appear to be a small number of staff with specialized health and family planning expertise; a number of staff lacking expert credentials but having substantial experience in the sector; and a greater number with very limited knowledge relating to the delivery and content of health services. In general, few staff have first-hand field experience in the actual implementation of programs.

As a result, relatively large numbers of staff lacking specialized expertise in reproductive health—especially economists, but also some staff with more general project management or public health background—work on projects which include population and reproductive health activities. The dearth of specialized expertise, both at headquarters and in the field, makes it difficult for the Bank to advise governments on how to strengthen their reproductive health and family planning programs.

Inappropriate Use of Reproductive Health and Other Specialists: In most but not all instances, the managers of the few stand-alone reproductive health projects are experts in this field. However, these experts also work increasingly on other health and social sector projects. *In some cases, family planning specialists are so busy managing health projects that they cannot provide technical advice on family planning to projects which they do not directly manage.* This is especially the case since the work-

The number of HNP staff with real technical skills appears very limited, and the number with expertise in population and reproductive health is even smaller.

Many HNP staff in influential and highly sought-after task manager positions are economists or other staff with limited health expertise.

load has increased faster than the number of staff; on average, each staff person is responsible for a greater loan volume and more projects than before.

Excessive Reliance on Economists as Project Managers: *The human development sectors, including HNP, have relied very heavily on economists.* In 1993, economists represented the largest single group of human development staff, at 30 percent. The proportion of economists appears to have increased since that time, a trend health experts in the Bank believe is driving the current push for health financing reform.

Within the health sector, there is an underlying tension between the need for staff with expertise in health service delivery on the one hand, and with savvy about Bank operations and ability to manage the loan process on the other. The Bank has often come down in favor of the latter, especially in selecting the task managers who oversee the design and implementation of projects. Many HNP staff in these influential and highly sought-after positions are economists or other staff with limited health expertise.

Many Bank staff perceive the individual expertise and interests of task managers to play too great a role in the identification of new projects. To a large extent, the content of a project depends on the exchange between the task manager and the borrower. Technical staff are often not involved in project identification. As a result, individual agendas too often drive the lending program.

Inadequate Field Staff: *Inadequate technical staff at the field level and the centralization of design and supervision processes at headquarters have been major constraints to the effectiveness of Bank social sector projects.* A few country departments at the Bank have now cut back Washington staff in favor of field-based managers, a trend with great potential to improve project monitoring and effectiveness. Only when Bank staff are sitting with their counterparts in a country, working together to solve implementation problems—such as contraceptive procurement and distribution or procedures for channeling funds to NGOs—will Bank lending in the sector begin to approach the effectiveness of assistance provided by donors such as UNICEF and USAID. Bangladesh is an outstanding example of the benefits of having Bank staff on the ground.

Yet, as the Bank shifts project management responsibilities to some resident missions, new issues are emerging. Given the high cost of maintaining staff in the field, most staff assigned to resident missions are unlikely to have specialized reproductive health skills. Headquarters staff also note that where resident missions rely on national staff, these staff may find it difficult to take a strong stand on important policy issues with their own governments. Thus, as the Bank expands its country presence and shifts responsibility to the field, headquarters staff are likely to play a continued role in policy guidance and technical oversight.

Adequacy of Reproductive Health Staff by Region

In the early 1990s, specialists in the central Population Advisory Service helped to support regional staff working on reproductive health and family planning activities. Since this unit has been virtually dismantled, the HNP network in each regional department is essentially the sole source of technical support to reproductive health and family planning activities. As in the case of the lending program, the adequacy of staffing relative to needs varies greatly across regions.

Overall, there is no regional department that has sufficient staff capacity in reproductive health and family planning. In most regions, the Bank lacks the critical mass of reproductive health expertise needed to have a significant influence on country programs. Moreover, the concerns of experts in these areas are often overshadowed by other more powerful constituencies within the Bank.

South Asia: *With support from regional leadership, the South Asia department has historically dedicated significant staff resources to population activities, especially for projects in Bangladesh and India.* In addition to several reproductive health specialists at headquarters, the department has drawn extensively on central human development staff, and deployed reproductive health and family planning experts in its field offices to assist in project implementation.

The high level of involvement of Bank staff in these two countries contrasts with most other regions and has contributed to project effectiveness. In India, for example, intensive staff inputs in policy discussions over the past two years have been crucial to help accelerate a major shift in direction in the family welfare program.

Nevertheless, the staffing situation in the department at present raises some concerns. Over the last couple of years, several population specialists have left the department, resulting in diminished staff support for important programs in Bangladesh and Pakistan. Several senior experts will be eligible to retire in the next couple of years. Meanwhile, the magnitude of Bank reproductive health assistance in the region suggests a need to sustain or even increase staff inputs.

East Asia and Pacific: *This region has had a strong complement of roughly a half dozen highly qualified family planning and reproductive health specialists, but this expertise is also being eroded.* It is not clear how the region will utilize its existing expertise as the lending program shifts towards other health issues. However, the Bank will need higher staff inputs relative to loan volume to work effectively in poorer countries in Southeast Asia having less managerial capacity than the traditional borrowers in the region.

Middle East and North Africa: *This department has recently strengthened its reproductive health and family planning staff.* Previously, such expertise was virtually non-existent. Still, the number of specialists remains limited to only a couple of real reproductive health and family planning experts.

Africa: *As in the case of the lending portfolio, the biggest gap in staffing is in the Africa region.* The number of staff in Africa HNP operations has not kept pace with the growth in project activity in the region, and current staff resources are stretched very thin. Moreover, in addition to its project-related work, the department provides secretariat support for several regional initiatives.

At headquarters, Africa department health staff are dominated by public health specialists with limited interest in family planning. There is a core of roughly a half dozen highly qualified family planning experts. These are too few to meet the needs of the 49 countries in the region, and they spend substantial time working on other health issues. The department has several staff with AIDS expertise, but virtually no specialists in the area of safe motherhood.

Recently, however, new management of the Africa HNP network is seeking to rebuild population and reproductive health expertise, and has recruited two new senior advisers in these areas. The HNP manager also plans to expand health expertise in

Even as resident mission staff increase, headquarters staff are likely to continue playing a role in policy guidance and technical oversight.

Bank reproductive health projects have rarely drawn on the growing international network of technical assistance agencies.

the Bank's resident missions—a half dozen missions already have health staff including a few with reproductive health expertise.

Latin America and the Caribbean: *Population and reproductive health staff are also inadequate in the Latin America and Caribbean region.* HNP operations staff have not increased commensurate to the number of ongoing projects and the planned increase in future health projects in the pipeline. The Bank could be doing much more in reproductive health in Latin America, but current staff are insufficient to handle even the present work load. Currently, the region has two staff with expertise in maternal and child health and family planning, both of whom spend substantial time on other health activities.

Europe and Central Asia: *This region is similarly understaffed.* Overall lending in the HNP sector has not been matched by staffing levels. The division is dominated by economists and needs more staff with health service delivery expertise. Despite the significant reproductive health needs in the region, regional staff include only one physician with minimal reproductive health expertise.

Limited Reliance on External Technical Expertise

In contrast to USAID and other major donors, Bank projects have not used external institutional expertise in a systematic way for technical support and capacity building.

A large and growing international network of private organizations has played an important role in technical support to family planning programs in developing countries. This network, initially consisting of U.S. organizations funded by USAID, has contributed to the success of U.S. population assistance efforts and helped build local capacity in many developing countries. More recently, this network has evolved to include organizations from other donor and developing countries, a broader range of reproductive health expertise, and collaboration with a greater diversity of bilateral and multilateral donors.

Bank population and reproductive health projects have rarely drawn on these resources. When they have done so, it has generally been for short-term technical assistance, rather than for long-term capacity-building and support. More typically, when Bank staff identify a need for specific technical skills in project development or supervision, they use donor trust funds to bring in short-term individual consultants.

To a large extent, the Bank lacks mechanisms to tap into this wealth of international population expertise. Given pressure on budgets, Bank staff have been unable to afford the costs of external institutional expertise—including overhead—from the Bank's administrative budget. Borrowers are generally reluctant to use loan funds for technical services and often have to overcome obstacles within their own bureaucracies to implement such arrangements.

Nevertheless, a handful of population and reproductive health projects have included funds for technical support. In Bangladesh, the Bank has had a long-standing and successful experience using grant funds from other donors to finance a special project implementation unit. In Pakistan, the Bank had a more mixed experience when it included funds in the project budget for advisory services to replace USAID technical support; procurement problems on the Pakistan government's side delayed the contract award for several years.

Effects of the Reorganization on Technical Capacity

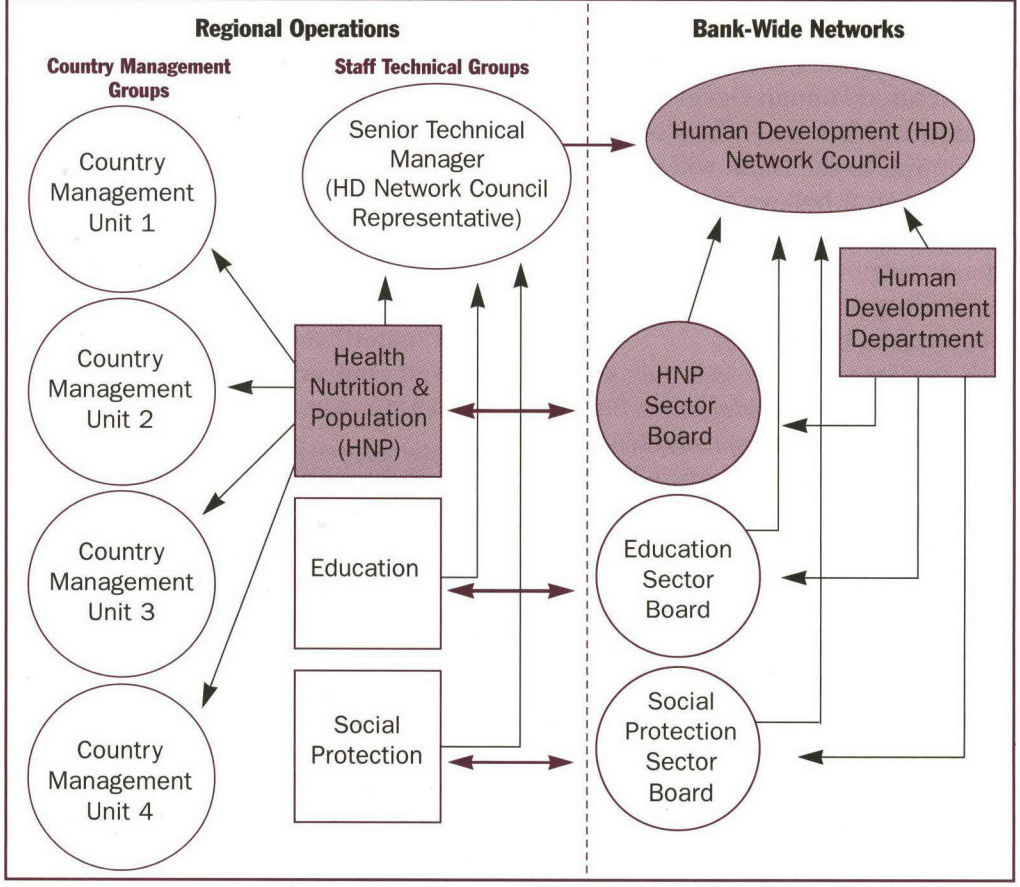
The current reorganization is an ambitious effort to transform the Bank and the way it does business. Mr. Wolfensohn has recognized that excessive reliance on generalists has been a source of problems with project design and implementation. For example, he is reported to have expressed concern that Bank staff without education expertise design education projects. Accordingly, the new plan contemplates significant changes in the management and staffing structure aimed at strengthening the level of technical expertise.

The sector networks are central to the strategy to strengthen the Bank's technical capacity. The reorganization groups most technical staff in the regional departments together in large sector management units, which provide technical support to projects at the request of country management units. This network structure is intended to encourage sharing of experience across sectors and countries, and promote teamwork and more coordinated strategies.

Many technical staff view this restructuring favorably. By grouping all HNP staff in the same unit, the reorganization has established a critical mass of technical expertise at the regional level, unlike the previous arrangement which isolated technical staff in fragmented country operations units. Each staff person can work across several countries, potentially promoting a more consistent Bank response as well as a sharing of experience within each region.

By grouping all HNP staff in the same unit, the reorganization has established a critical mass of technical expertise at the regional level.

Figure 3: Human Development Sectors Following Reorganization



Following reorganization, there will no longer be a central core of expertise within the Bank in areas such as women's health.

Regional staff also see the new network structure as an improvement over the previous relationship between the center and the regional departments. In the past, the central Human Development Department had responsibility for policy and research while the regions were responsible for managing the lending program. Regional staff frequently perceived central policy guidance to be irrelevant to operational needs.

Still, the central department has played an important leadership role in areas such as safe motherhood. HDD publications such as *Making Motherhood Safe (1993)* and *Women's Health and Nutrition: Making a Difference* (1994) make the case for investments in these areas as well as providing guidance on appropriate program directions to Bank staff and the larger international health community.

Under the new system, senior technical staff from the regional departments serve on the Bank-wide network council and sector boards and drive policy and decision making. The restructured Human Development Department has essentially become a secretariat to the Bank-wide network. Regional staff believe the new system will reorient the research and policy agenda towards needs identified in the lending program and better serve the needs of borrowers.

Nevertheless, there is a risk that the networks will undermine Bank-wide leadership in reproductive health and family planning. While the central PHN department had a staff of about 19 in 1994 to 1995, the restructured HDD will have only about 6 health, nutrition and population positions. While these positions include a population/reproductive health advisor, this advisor will have limited operational influence and virtually no staff support. Indeed, the position may not be attractive to a high caliber professional, and it may also prove difficult to find an individual with expertise in both population and reproductive health.

As a result of these changes, there will no longer be a central core of specialized expertise in areas such as women's health, safe motherhood and AIDS. The current reorganization could thus result in the same erosion of technical capacity that occurred with the decentralization of population and health staff in 1987. Moreover, the priority given to reproductive health is likely to vary greatly across the regional departments.

The network council and sector boards are responsible for managing professional staff resources. They will determine where the Bank has adequate expertise and where additional staff are needed through training or recruitment. Their responsibilities include the development of professional standards for staff recruitment and promotion, including standards for reproductive health specialists of various kinds.

Finally, the HNP network has not yet clarified future plans relating to the use of external technical services. Despite the emphasis on strengthening technical capacity, there has been little discussion and no specific proposals to date regarding the potential use of external contract expertise or regarding the funding and contracting mechanisms needed to procure such services.

Recommendations for Strengthening the Bank's Technical Capacity in Reproductive Health and Family Planning

The Bank's ability to have an impact on country programs depends on the caliber and expertise of the staff who develop and manage its projects. As the Bank moves forward with its institutional restructuring, it needs to

enhance its technical leadership in reproductive health and family planning and to make major changes in how it manages its investments.

- **It is essential for the Human Development Department to include a high caliber reproductive health and family planning expert to provide Bank-wide leadership in this area.** This reproductive health expert should be a member of the HNP sector board. This position should be additional to a senior population advisor who heads up the population policy unit proposed above.
- **Bank and network managers need to closely monitor the impact of recent organizational changes on capacity in reproductive health and other technical areas.** Leadership in reproductive health or any area requires a strong dedicated senior staff person backed up by a high-level unit. If expertise at the center appears to have been reduced to the point of undermining technical leadership within the Bank, management should consider reestablishing a small central core of technical experts in reproductive health, and possibly in other technical areas as well.
- **The HNP network in each region should consider establishing a position for a senior regional reproductive health and family planning advisor**. The incumbent in this position—similar in concept to the two positions recently created in the Africa region—would provide technical leadership and coordinate and monitor activities in the region. Again, such leadership positions in the regions may be appropriate in other technical areas as well. This approach would be consistent with the emphasis of the current reorganization on both decentralization and strengthening of technical capacity.
- **Several regional departments, especially the Africa department, need to recruit additional staff with expertise in reproductive health and family planning.** Each region should carry out a systematic review of current staff relative to needs in this area and establish a critical mass of specialized expertise. In establishing technical standards for these staff, network managers need to recognize the need for skills in several specialized areas of reproductive health, notably family planning, safe motherhood and AIDS/STD control.
- **The network council, sector board and regional HNP sector managers also need to review the current approach to staff deployment to ensure that reproductive health and other experts are utilized for maximum impact.** Reproductive health and other specialist staff should spend the bulk of their time working on the technical aspects of projects, rather than on routine tasks relating to project administration. At the same time, these experts should be included in the design and implementation of broader health projects, including health sector reform efforts, in order to ensure that these projects give adequate attention to reproductive health.
- **The HNP network should take steps to enhance knowledge of reproductive health and family planning among nonspecialists who work on these issues.** The networks should develop special training programs for a broad range of nonspecialist staff involved in reproductive health and family planning projects, including country managers, economists, public health generalists and NGO liaison officers in resident missions.

The Bank needs to enhance its technical leadership in reproductive health and family planning and make major changes in how it manages projects.

Reproductive health staff should spend their time working on the technical aspects of projects rather than on routine administrative tasks.

- **The Bank needs more staff in its resident missions with the ability to monitor and support the implementation of reproductive health and family planning projects.** This is especially important in Africa, with its large number of countries, logistical difficulties and weaknesses in local capacity. There should be a staff person with broad knowledge of the HNP sector in every resident mission in Africa to support implementation. For more specialized reproductive health expertise, the Bank could rely on a combination of local-hire experts, visits by headquarters technical staff and external contract expertise. The Bank should also consider assigning specialist staff to selected resident missions from where they can provide support to Bank-financed programs in neighboring countries as well.
- **The Bank needs to develop new mechanisms for the use of external contract expertise in reproductive health and family planning.** Especially in Africa, it should shift from use of individual consultants on an ad hoc basis to more systematic use of institutional expertise for long-term capacity building. Given the frequent difficulties in convincing countries to use loan funds for technical services, the Bank should provide funds for such services in its own administrative budget and develop appropriate contractual mechanisms. Such a move would help shift budget resources to front-line operations and strengthen the effectiveness of its work in the social sectors. However, specialized external expertise is not a substitute for strengthening the Bank's own technical capacity. The Bank will still need a core of technical staff to organize and manage such specialized contractual expertise.

  Given the large community of U.S. organizations with expertise in reproductive health, a U.S. trust fund, similar to those established by other donors, could facilitate the Bank's use of this expertise. USAID and the Bank could also explore ways to provide technical support to World Bank activities through USAID's existing centralized contractual arrangements. The need, however, is for more comprehensive mechanisms which can draw on a broad range of specialized expertise—including existing bilateral and multilateral technical support networks, for-profit and nonprofit private organizations, and emerging South-to-South partnerships.

V. Conclusion: Priorities for Bank Management

The preceding analysis suggests that the Bank overall is not exercising real leadership in population policy development or in financial support to reproductive health and family planning programs. This is not to diminish the significant contributions the Bank has made and continues to make, especially in a number of Asian countries. However, it is generally these *countries* that have taken the lead, and it is their unshakable commitment to population stabilization that has generated a strong demand for projects and Bank loans to support them.

Beyond these few countries, it is difficult to find many instances where the Bank has played a central role. The Bank's organization and staffing arrangements are an important part of the problem. Both money and technical advice are important for effective engagement in population and reproductive health; the Bank's ability to provide both has been constrained by its inadequate technical staff in this area.

For years, Bank staff have found it too easy to attribute poor performance in lending for population and family planning to a lack of demand on the part of its clients. This is, however, too modest a view of the Bank's influence. In reality, the Bank's lending program in population or any other sector is the outcome of the complex interaction of several factors. These include the priority both the Bank and its borrowers assign to the sector as well as the Bank's capacity to support policy work and projects in the sector.

In reality then, there is a push-pull dynamic between the Bank and its borrowers in which the Bank has considerable influence. If the Bank does not take the initiative to raise an issue, it is less likely to come up in initial policy discussions and countries are less likely to ask for projects. Subsequent Bank missions are then less likely to include the right kind of staff to help develop a request and design a project.

In poor countries where population growth impedes economic and social development, the Bank should be working much more actively to convince finance ministers and heads of state of the importance of slowing such growth. It should be much more deeply engaged in helping countries develop comprehensive multisectoral population strategies. These efforts would help advance both the goals promoted at the ICPD and broader economic and social development. They are vitally important in Africa, where rapid population growth remains a critical obstacle to development.

Moreover, at a time when grant aid to population programs appears to be stagnating, the Bank should be providing substantially increased funding for reproductive health and family planning. *If the international community is to meet the financial and programmatic goals for the year 2000 agreed on at Cairo, including $17 billion in reproductive health and family planning expenditures, the Bank needs to provide new loan commitments of at least $1 billion a year. At present, the level of Bank financial assistance in this area is inadequate relative to both current needs and its own potential to support these programs.*

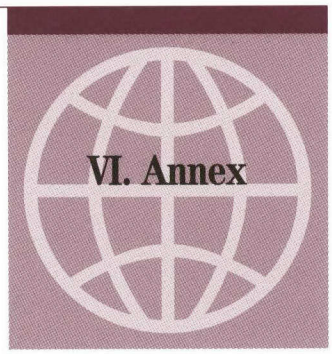
This report recommends a comprehensive set of actions to strengthen the Bank's contribution in population and reproductive health. While there are no simple solutions to ensuring appropriate attention to these issues, we suggest three priority areas for action:

- The Bank's top leadership should insist that population issues are consistently addressed in country assistance strategies.

At a time when grant aid to population programs appears to be stagnating, the Bank should be providing substantially increased funding for reproductive health and family planning.

- Management needs to monitor loan commitments and plans for future sector work and new project development in all key areas of reproductive health.
- The Bank needs to put in place both a critical mass of technical staff in each region and mechanisms to draw on external institutional expertise in order to better support reproductive health and family planning activities.

These are challenges that the Bank's leadership could easily address, given sufficient will and commitment.



■ **Annex Table 1: World Bank Lending for Population and Reproductive Health: Fiscal Years 1990-1996** 55-61

FY 1990 World Bank Lending for Population 55
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■ **Annex Table 2: World Bank Lending for Health, Nutrition and Population Sector, FY 1997** 62

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

ANNEX TABLE 1

90 FY 1990 World Bank Lending for Population

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population Programs (US$ Millions)	Population Programs as % of Total Loan
Africa				
Kenya—Fourth Population	IDA	35.0	35.0	100%
Lesotho—Second Population, Health and Nutrition	IDA	12.1	1.2	10%
Tanzania—Health and Nutrition	IDA	47.6	9.5	20%
Europe, Middle East and North Africa				
Morocco—Health Sector Investment	IBRD	104.0	10.4	10%
Yemen—Second Health	IDA	15.0	1.5	10%
South Asia				
India—Seventh Population	IBRD/IDA	96.7	96.7	100%
Latin America and the Caribbean				
Brazil—Second Northeast Basic Health Services	IBRD	267.0	13.4	5%
Haiti—First Health	IDA	28.2	1.6	6%
TOTAL			169.3	

Source: World Bank

ANNEX TABLE 1

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

91 FY 1991 World Bank Lending for Population

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population Programs (US$ Millions)	Population Programs as % of Total Loan
Africa				
Senegal—Human Resources Development—Population and Health	IDA	35.0	14.8	42%
Rwanda—First Population	IDA	19.6	19.6	100%
Nigeria—National Population	IDA	78.5	78.5	100%
Togo—Population and Health Sector Adjustment	IDA	14.2	4.3	30%
Madagascar—Health Sector Improvement	IDA	31.0	4.4	14%
Malawi—Population, Health and Nutrition Sector Credit	IDA	55.5	5.8	10%
Mali—Health, Population and Rural Water Supply	IDA	26.6	3.0	11%
Ghana—Second Health and Population	IDA	27.0	4.9	18%
Europe, Middle East and North Africa				
Tunisia—Population and Family Health	IBRD	26.0	26.0	100%
East Asia and Pacific				
Indonesia—Fifth Population	IBRD	104.0	104.0	100%
South Asia				
Pakistan—Family Health	IDA	45.0	13.5	30%
Bangladesh—Fourth Population and Health	IDA	180.0	61.5	34%
Latin America and the Caribbean				
Venezuela—Social Development	IBRD	100.0	5.0	5%
Haiti—Economic and Social Fund	IDA	11.3	0.5	4%
Honduras—Social Investment Fund	IDA	20.0	0.2	1%
El Salvador—Social Sector Rehabilitation	IBRD	26.0	1.5	6%
Mexico—Basic Health Care	IBRD	180.0	3.5	2%
TOTAL			351.0	

Source: World Bank

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

92 FY 1992 World Bank Lending for Population

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population Programs (US$ Millions)	Population Programs as % of Total Loan
Africa				
Niger—Population	IDA	17.6	11.6	66%
Mauritania—Health and Population	IDA	15.7	6.9	44%
Equatorial Guinea—Health Improvement	IDA	5.5	0.2	4%
South Asia				
India—Family Welfare	IDA	79.0	63.2	80%
India—Child Survival and Safe Motherhood	IDA	214.5	0.1	<0.1%
Europe and Central Asia				
Poland—Health	IBRD	130.0	6.5	5%
Romania—Health Services Rehabilitation	IBRD	150.0	14.4	10%
Latin America and the Caribbean				
Honduras—Second Social Investment Fund	IDA	10.2	0.1	<1%
Guyana—Health, Nutrition, Water and Sanitation	IDA	10.3	0.2	2%
TOTAL			103.2	

Source: World Bank

ANNEX TABLE 1

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

93 FY 1993 World Bank Lending for Population

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population Programs (US$ Millions)	Population Programs as % of Total Loan
Africa				
Burundi—Social Action	IDA	10.4	0.5	5%
Guinea Bissau—Social Sector	IDA	8.8	0.9	10%
Angola—Health	IDA	19.9	0.6	3%
Middle East and North Africa				
Iran—Primary Health Care and Family Planning	IBRD	141.4	59.5	42%
Jordan—Health Management	IBRD	20.0	2.0	10%
Yemen—Family Health	IDA	26.6	10.7	40%
East Asia and the Pacific				
Papua New Guinea—Population and Family Planning	IBRD	6.9	6.9	100%
Philippines—Urban Health and Nutrition	IDA	70.0	17.5	25%
Indonesia—Third Community Health and Nutrition	IBRD	93.5	9.4	10%
South Asia				
India—Social Safety Net Sector Adjustment Program	IDA	500.0	40.0	8%
Pakistan—Second Family Health	IDA	48.0	12.0	25%
Latin America and the Caribbean				
Honduras—Nutrition and Health	IDA	25.0	0.1	<1%
Ecuador—Second Social Development: Health and Nutrition	IBRD	70.0	15.4	22%
Columbia—Municipal Health Services	IBRD	50.0	5.0	10%
Guatemala—Social Investment Fund	IBRD	20.0	0.6	3%
TOTAL			181.1	

Source: World Bank

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

94 FY 1994 World Bank Lending for Population and Reproductive Health

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population and Reproductive Health Bank Estimates (US$ Millions)	Population Bank Estimates (US$ Millions)
Africa				
Burkina Faso—Health and Nutrition	IDA	29.2	7.5	7.5
Burkina Faso—Population and AIDS Control	IDA	26.3	26.3	14.1
Chad—Health and Safe Motherhood	IDA	18.5	6.1	4.6
Comoros—Population and Human Resources	IDA	13.0	4.3	2.8
Guinea—Health and Nutrition Sector	IDA	24.6	2.5	2.5
Uganda—Sexually Transmitted Infections (STI)	IDA	50.0	50.0	0.0
East Asia and Pacific				
China—Rural Health Workers Development	IDA	110.0	8.9	8.9
Malaysia—Health Development	IBRD	50.0	0.5	0.5
South Asia				
India—Family Welfare (Assam, Rajasthan, Karnataka)	IDA	88.6	70.9	70.9
Nepal—Population and Family Health	IDA	26.7	21.4	21.4
Social Sector—Pakistan—Social Action Program	IDA	200.0	40.8	40.8
Latin America and the Caribbean				
Argentina—Maternal and Child Health and Nutrition	IBRD	100.0	12.0	12.0
Brazil—AIDS and Sexually Transmitted Diseases (STD)	IBRD	160.0	160.0	0.0
Nicaragua—Health Sector Reform	IDA	15.0	0.6	0.6
Peru—Basic Health and Nutrition	IBRD	34.0	10.5	10.5
Social Sector—Peru—Social Development and Compensation Fund	IBRD	100.0	1.4	1.4
TOTAL			423.7	198.5
Total without Social Sector Projects			381.5	156.3

Source: World Bank

ANNEX TABLE 1

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

95 FY 1995 World Bank Lending for Population and Reproductive Health

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population and Reproductive Health Bank Estimates (US$ Millions)	Population PAI Estimates (US$ Millions)
Africa				
Benin—Health and Population	IDA	27.8	13.9	2.8
Burundi—Second Health and Population	IDA	21.3	8.0	4.0
Cameroon—Health, Fertility and Nutrition	IDA	43.0	21.5	10.0
Chad—Population and AIDS Control	IDA	20.4	20.4	12.5
Kenya—Sexually Transmitted Infections (STI)	IDA	40.0	40.0	0.0
Senegal—Community Nutrition	IDA	18.2	1.8	0.0
Uganda—District Health Services Pilot and Demonstration	IDA	45.0	11.3	2.0
Zambia—Health Sector Support	IDA	56.0	28.0	0.0
Zambia—Second Social Recovery	IDA	30.0	0.9	0.0
Middle East and North Africa				
Lebanon—Health Sector Rehabilitation	IBRD	35.7	8.9	0.3
Turkey—Second Health Project: Essential Services and Management Development in Eastern and Southeastern Anatolia	IBRD	150.0	37.5	0.0
East Asia and Pacific				
China—Comprehensive Maternal and Child Health	IDA	90.0	45.0	0.0
China—Iodine Deficiency Disorders Control	IBRD/IDA	27.0	2.7	0.0
Indonesia—Fourth Health Project: Improving Equity and Quality of Care	IBRD	88.0	22.0	0.0
Lao, P.D.R.—Health System Reform and Malaria Control	IDA	19.2	4.8	1.7
Philippines—Women's Health and Safe Motherhood	IBRD	18.0	18.0	3.4
Cambodia—Social Fund	IDA	20.0	1.0	0.0
South Asia				
India—Andhra Pradesh First Referral Health System	IDA	133.0	26.6	0.0
Pakistan—Population Welfare Program	IDA	65.1	65.1	65.1
Bangladesh—Integrated Nutrition	IDA	59.8	14.9	0.0
Europe and Central Asia				
Croatia—Health	IBRD	40.0	1.6	0.0
Estonia—Health	IBRD	18.0	0.2	0.0
Latin America and the Caribbean				
Panama—Rural Health	IBRD	25.0	4.0	0.0
Mexico—Program of Essential Social Services	IBRD	500.0	50.0	15.0
TOTAL			448.1	116.8

Source: World Bank

ANNEX TABLE 1

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

96 FY 1996 World Bank Lending for Population and Reproductive Health

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population and Reproductive Health Bank Estimates (US$ Millions)	Population and Reproductive Health PAI Estimates (US$ Millions)	Population PAI Estimates (US$ Millions)
Africa					
Côte d' Ivoire—Integrated Health Services Department	IDA	40.0	13.5	13.5	12.0
Sierra Leone—Integrated Health Sector Investment	IDA	20.0	1.3	5.0	2.5
Mozambique—Health Sector Recovery Program	IDA	98.7	35.9	35.9	6.0
Middle East and North Africa					
Egypt—Population	IDA	17.2	17.2	17.2	17.2
Morocco—Social Priorities Program: Basic Health	IBRD	68.0	20.3	20.3	10.0
East Asia and Pacific					
China—Disease Prevention	IDA	100.0	89.9	4.2	0.0
Indonesia—HIV/AIDS and Sexually Transmitted Diseases (STD) Prevention and Management	IBRD	24.8	24.8	24.8	0.0
Vietnam—National Health Support	IDA	101.2	39.6	32.7	10.9
Vietnam—Population and Family Health	IDA	50.0	50.0	50.0	25.0
South Asia					
India—Second State Health Systems Development	IDA	350.0	56.0	56.0	0.0
Pakistan—Northern Health Program	IDA	26.7	26.7	26.7	2.7
Europe and Central Asia					
Bulgaria—Health Sector Restructuring	IBRD	26.0	9.5	4.5	0.0
Georgia—Health Project	IDA	14.0	8.1	7.2	0.2
Kyrgyz Republic—Health Sector Reform	IDA	18.5	4.2	4.2	0.0
Russian Federation—Medical Equipment	IBRD	270.0	90.0	90.0	0.0
Latin America and the Caribbean					
Mexico—Second Basic Health Care	IBRD	310.0	111.8	111.8	20.0
TOTAL			598.8	504.0	106.5

Source: World Bank

ANNEX TABLE 2

World Bank Lending for Health, Nutrition and Population Sector, FY 1997

Region/Project	IBRD/IDA	Total Loan (US$ Millions)
Africa		
Niger—Health Sector Development Program	IDA	40.0
Senegal—Endemic Disease Control	IDA	14.9
East Asia and Pacific		
Indonesia—Intensified Iodine Deficiency Control	IBRD	28.5
Cambodia—Disease Control and Health Development	IDA	30.4
South Asia		
India—Malaria Control	IDA	164.8
India—Reproductive and Child Health*	IDA	248.3
India—Rural Women's Development and Empowerment	IDA	19.5
India—Tuberculosis Control	IDA	142.4
Sri Lanka—Health Services	IDA	18.8
Europe and Central Asia		
Turkey—Primary Health Care Services	IBRD	14.5
Bosnia-Herzegovina—Essential Hospital Services	IDA	15.0
Russia—Health Reform Pilot	IBRD	66.0
Latin America and the Caribbean		
Argentina—Maternal and Child Health and Nutrition II*	IBRD	100.0
Paraguay—Maternal Health and Child Development*	IBRD	21.8
Argentina—AIDS and Sexually Transmitted Diseases Control*	IBRD	15.0
TOTAL		939.9

* Projects focusing on Reproductive Health

Source: World Bank

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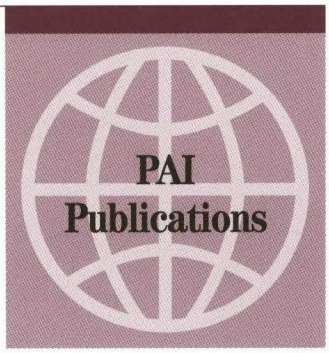

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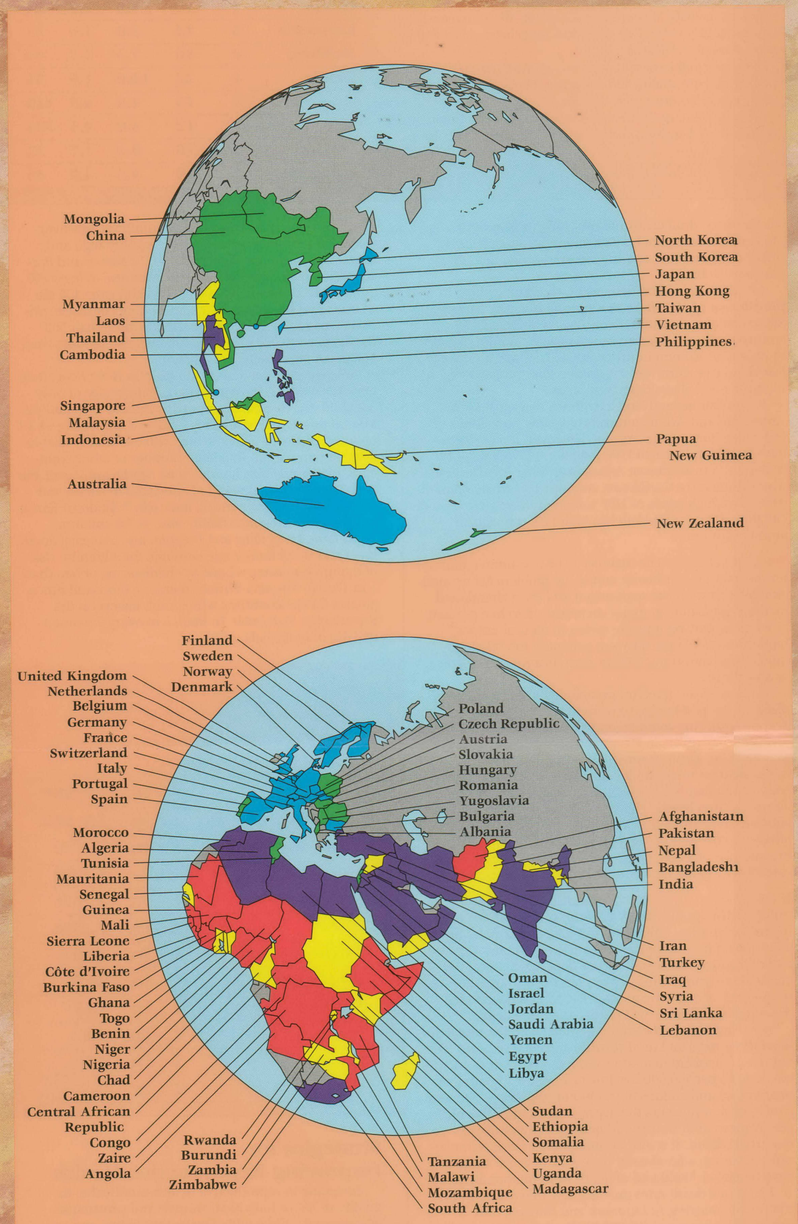
Reproductive Risk

A Worldwide Assessment of Women's Sexual and Maternal Health



Reproductive Risk: A Worldwide Assessment of Women's Sexual and Maternal Health is the sixth in an annual series of report cards on *World Progress Towards Population Stabilization* prepared by Population Action International. This 1995 report card ranks the reproductive health status of women in 118 countries, representing about 94 percent of the world's population, on a 100 point *Reproductive Risk Index*. The study highlights the need for sound policies to address not only the unmet need for family planning but other critical women's health needs: prenatal and maternity care, access to safe abortion, and protection from HIV/AIDS and other sexually transmitted diseases (STDs).

Risks relating to sexual activity and childbearing — and the associated health status of women — vary enormously from country to country. These variations reflect differences in public investment in women's health, income levels, and social and cultural practices affecting access to health care for women. The study ranks countries using 10 indicators representing issues of central importance to women's health, including fertility and fertility regulation; access to health care and survival in pregnancy and childbirth; and HIV/AIDS prevalence among women.

The study reveals that women in the rich industrialized countries face a very low level of reproductive risk compared to women in many poor countries. In **Italy, Denmark, Norway** and **Sweden,** which fare best on the *Reproductive Risk Index*:

- Over 75 percent of women use family planning (in most, but not all cases, relying on safe, effective modern contraception).
- Safe abortion is available at a woman's request.
- Teen birthrates are very low, and women have an average of two children or fewer.
- Access to maternal health services is virtually universal.
- A woman has a lower than 1 in 15,000 lifetime risk of dying in pregnancy or childbirth, as a result of both low fertility and good maternal health care.
- AIDS is a relatively minor problem among women. However, in some countries infertility is slightly above normal, indicating moderately high levels of other STDs.

In sharp contrast, women in sub-Saharan African countries bear the greatest burden of poor sexual and reproductive health. With only a few exceptions, these countries have the highest risk levels on the overall index and, indeed, have the worst profile on virtually every indicator. In **Zaire, Angola,** and **Somalia,** which ranked last:

- Fewer than 10 percent of women use any method of family planning, and abortion is illegal or permitted only to save a woman's life.
- More than one-fifth of 15 to 19 year olds give birth each year, and women have, on average, six to seven children.
- Most women lack access to basic health care in pregnancy and childbirth.
- A woman has a greater than 1 in 20 lifetime risk of death from maternal causes, owing to this profile of high-risk childbearing and poor health coverage.
- At least 10 percent of women are infertile, reflecting high prevalence of STDs.
- HIV prevalence is high in **Zaire,** moderate in **Angola,** and low in **Somalia,** the latter being an exception among most African countries.

The Reproductive Risk Index: Key to Rankings

The 10 indicators used in the study were scored on a 100 point scale, and the scores averaged to yield a total score on the *Reproductive Risk Index*. Based on their overall scores, countries are classified according to their risk levels.

Very Low Risk (Less than 15 points)

The **23** countries in this category are relatively wealthy and characterized by very low fertility; high contraceptive use and liberal abortion policies; good maternal health coverage and low maternal mortality; and low HIV prevalence. In some countries, infertility is slightly above natural levels.

Low Risk (15 to 29 points)

The *Index* rates **20** countries as having low levels of reproductive risk, including several Eastern European and developing countries. These countries have a generally similar profile to the preceding category, but tend to have somewhat higher maternal mortality.

Moderate Risk (30 to 44 points)

The **29** countries in this category represent all the developing regions. Their scores reflect moderate levels of contraceptive use, mixed maternal health coverage and high maternal mortality. In most cases, abortion is illegal or available only on limited health grounds. Four countries have moderate levels of HIV prevalence among women.

High Risk (45 to 59 points)

All the developing regions are represented by the **25** countries in this category, which include 13 countries in Africa. The profile of these countries is one of high teen birthrates and overall fertility, poor maternal health coverage, and high maternal mortality. Roughly half also have significant levels of infertility and HIV prevalence among women.

Very High Risk (60 points or more)

Of the **21** countries in this category, the vast majority are in Africa. All have negligible contraceptive use, very high fertility, staggeringly high levels of maternal mortality, high STD-related infertility, restrictive abortion policies, and, with a few exceptions, moderate to high levels of HIV infection in women.

Country rankings on the *Reproductive Risk Index* are strongly related to income levels. **Italy** and **Denmark** have the lowest risk levels, with scores of 6.6 and 6.7 respectively. Women in other industrialized countries, as well as several Eastern European countries and newly industrializing countries such as **Singapore** and **Taiwan,** are also at very low risk. Some poor countries which have invested heavily in health also fare quite well, including **China, Cuba,** and **Tunisia.**

A number of developing countries, including **Brazil** and **Indonesia,** have moderate to high levels of reproductive risk despite significant gains in increasing contraceptive use and lowering fertility. These higher risk levels reflect slower progress in reducing maternal mortality, as well as restrictive abortion policies. Sub-Saharan African countries, however, predominate among countries with the highest risk levels. Of the 21 countries where women are at highest risk, all but **Afghanistan** and **Haiti** are in Africa. **Zaire** has the highest level of risk, with a score of 76.5 on the *Index*.

Comprehensive reproductive health services, especially prenatal and delivery care and STD services, are crucial to prevent unnecessary deaths and improve women's health. A significant reduction in maternal death rates is also unlikely to occur without improved access to emergency care during childbirth, or without access to safe abortion services. Public education aimed at the prevention of AIDS and other STDs is another high priority.

The study also underscores the many benefits of family planning to reproductive health. Sexuality education and contraceptive services for young people can help prevent high risk pregnancies in teenage girls. Access to safe, effective and affordable contraception enables women to exercise choice over childbearing and have the smaller families many of them desire. At the same time, use of family planning diminishes risks associated with too frequent childbearing, and helps reduce reliance on unsafe abortion by preventing unwanted pregnancies. Finally, family planning programs can help prevent AIDS, as well as other STDs and related infertility, by promoting condom use and safer sex. Access to family planning is thus essential to women's health.

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POPULATION ACTION INTERNATIONAL
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The Reproductive Risk Index

Country	Annual Births per 100 Women Aged 15-19	Women Using Contraception (%)	Abortion Policies*	Pregnant Women with Anemia (%)	Women Receiving Prenatal Care (%)	Births Attended by Trained Personnel (%)	Level of HIV/AIDS in Women	Infertility in Women (%)	Average Births per Woman (TFR)	Maternal Deaths per 100,000 Births	Reproductive Risk Index	
Italy	1	78	A	10	100	100	Low	6	1.2	4	**6.6**	VERY LOW RISK
Denmark	1	78	A	8	100	99	Low	6	1.8	3	**6.7**	
Norway	2	76	A	*17*	95	100	Low	5	1.8	3	**8.1**	
Sweden	1	78	A	*17*	100	100	Low	5	2.0	5	**8.4**	
Belgium	1	79	A	*17*	90	100	Low	7	1.6	3	**8.7**	
Netherlands	1	76	A	18	95	100	Low	5	1.6	10	**10.0**	
France	1	81	A	18	99	94	Low	6	1.7	9	**10.1**	
Australia	2	76	B	*20*	100	99	Low	5	1.9	5	**10.3**	
Singapore	1	74	A	18	95	100	Low	5	1.8	10	**10.4**	
Canada	3	73	A	20	100	100	Low	7	1.8	5	**10.6**	
Finland	1	80	B	*17*	100	100	Low	5	1.8	11	**10.6**	
Austria	2	71	A	*17*	96	96	Low	5	1.5	8	**10.7**	
United Kingdom	3	81	B	19	98	98	Low	6	1.8	8	**11.8**	
Czech Republic	5	69	A	23	100	100	Low	4	1.7	10	**11.8**	
Japan	0	64	B	*20*	99	100	Low	6	1.5	11	**12.4**	
Taiwan	2	75	B	*37*	99	100	Low	5	1.7	9	**12.9**	
Hong Kong	1	86	C	*37*	99	99	Low	5	1.2	4	**13.0**	
United States	6	71	A	17	95	99	Low	6	2.1	7	**13.0**	
Spain	1	59	C	9	96	96	Low	4	1.2	5	**13.7**	
Germany	1	75	C	12	99	100	Low	5	1.3	11	**14.1**	
Switzerland	1	71	C	*17*	—	99	Low	5	1.5	4	**14.3**	
Slovakia	4	67	A	*40*	100	100	Low	5	1.9	10	**14.4**	
Bulgaria	6	76	A	*40*	100	100	Low	6	1.5	12	**14.5**	
Hungary	4	73	B	*40*	100	99	Low	5	1.7	13	**15.1**	LOW RISK
Poland	3	75	C	16	99	99	Low	3	2.1	11	**15.1**	
Portugal	3	66	C	*17*	96	98	Low	5	1.5	10	**16.5**	
China	2	83	A	*37*	98	94	Low	5	2.0	95	**16.8**	
North Korea	1	*67*	A	*37*	100	100	Low	2	2.4	130	**17.0**	
Israel	2	*65*	C	25	90	99	Low	6	2.9	3	**17.1**	
New Zealand	4	70	C	22	95	100	Low	5	2.1	13	**18.2**	
Yugoslavia	4	55	A	*40*	100	86	Low	5	2.0	18	**18.2**	
Cuba	9	70	A	34	99	100	Low	6	1.8	36	**18.5**	
South Korea	1	79	C	*37*	89	89	Low	2	1.6	32	**19.1**	
Romania	4	57	A	*40*	100	99	Low	6	1.4	149	**20.8**	
Costa Rica	9	75	C	28	91	97	Low	2	3.2	18	**21.3**	
Albania	1	10	A	40	100	99	Low	5	3.0	30	**22.2**	
Mongolia	4	*38*	A	26	100	99	Low	5	4.5	140	**22.9**	
Uruguay	6	*72*	C	*37*	80	96	Low	3	2.4	36	**23.7**	
Vietnam	2	53	A	*63*	73	90	Low	2	3.7	120	**25.7**	
Argentina	6	*66*	C	*37*	90	92	Low	3	2.9	140	**26.9**	
Malaysia	3	48	C	34	75	92	Low	4	3.6	59	**27.8**	
Chile	6	*43*	E	21	91	98	Low	3	2.5	67	**27.9**	
Tunisia	2	50	A	38	58	68	Low	7	3.3	127	**29.8**	
Sri Lanka	3	62	E	62	86	94	Low	4	2.5	80	**31.0**	MODERATE RISK
Jordan	5	40	C	50	76	87	Low	3	5.6	40	**31.0**	
Turkey	4	63	A	74	43	76	Low	2	3.5	146	**31.5**	
Jamaica	9	67	C	62	95	90	Low	7	2.9	115	**31.6**	
Colombia	7	66	E	24	80	71	Low	2	2.7	200	**32.2**	
Brazil	8	66	D	34	74	73	Low	2	3.0	200	**33.1**	
Thailand	5	66	C	52	77	66	Medium	2	2.2	37	**33.2**	
Saudi Arabia	12	*14*	C	31	86	90	Low	3	5.5	41	**33.4**	
Venezuela	10	49	E	29	74	97	Low	2	3.6	200	**34.2**	
Panama	9	58	C	*42*	72	84	Medium	3	2.9	60	**35.3**	
South Africa	7	50	C	37	84	86	Medium	5	3.8	84	**35.7**	
Lebanon	3	*55*	E	*50*	85	45	Low	3	2.9	128	**36.2**	
Philippines	3	40	E	48	77	55	Low	2	4.1	74	**36.2**	
Peru	6	59	C	53	64	60	Low	3	3.5	300	**36.9**	
Mexico	8	53	D	41	60	69	Low	3	3.2	200	**37.5**	
Ecuador	8	53	C	46	52	84	Low	5	3.8	300	**37.6**	
Oman	12	9	E	*50*	79	75	Low	3	6.9	7	**37.8**	
Iraq	5	14	C	*50*	65	74	Low	3	5.7	117	**38.3**	
India	6	41	B	88	49	70	Low	3	3.4	420	**39.5**	
Algeria	3	47	C	42	58	15	Low	3	4.2	129	**39.6**	
Nicaragua	15	49	E	*42*	92	73	Low	3	4.6	300	**40.0**	
Paraguay	9	48	E	63	84	66	Low	3	4.4	300	**41.2**	
El Salvador	13	53	C	*42*	34	66	Low	2	3.9	300	**41.4**	
Libya	11	*14*	E	*53*	76	76	Low	3	6.4	80	**42.1**	
Egypt	7	47	C	47	53	34	Low	4	3.9	266	**42.2**	
Bolivia	8	30	C	25	45	55	Low	3	4.8	600	**42.4**	
Dominican Republic	9	56	E	*52*	97	72	Medium	5	3.3	300	**42.8**	
Iran	9	*38*	E	*50*	47	70	Low	3	6.0	120	**42.9**	
Morocco	4	42	C	46	34	31	Low	3	4.0	327	**43.4**	
Indonesia	6	55	E	74	76	40	Low	7	2.9	400	**45.6**	HIGH RISK
Syria	11	20	E	52	60	61	Low	3	6.2	143	**45.7**	
Zimbabwe	10	43	C	*47*	92	69	High	*10*	5.0	77	**46.3**	
Myanmar	3	*46*	E	58	75	57	Medium	*5*	3.8	460	**46.9**	
Sudan	9	9	D	36	70	69	Low	9	6.1	550	**47.2**	
Honduras	13	47	E	*42*	45	81	Medium	*3*	5.2	221	**47.7**	
Papua New Guinea	2	*5*	C	75	68	43	Low	5	5.4	700	**48.0**	
Guatemala	12	23	E	*42*	34	51	Low	3	5.4	300	**49.7**	
Benin	15	9	E	55	64	45	Low	3	7.1	161	**50.5**	
Bangladesh	13	40	B	51	12	7	Low	4	4.4	650	**50.6**	
Pakistan	6	12	C	57	27	35	Low	4	6.1	600	**51.4**	
Cambodia	13	*44*	E	*63*	100	47	Medium	*5*	5.3	800	**51.8**	
Madagascar	16	17	E	*47*	78	58	Low	*10*	6.1	570	**52.1**	
Ghana	13	13	C	64	82	59	Medium	3	6.0	1000	**52.1**	
Laos	5	*18*	E	62	—	20	Low	5	6.3	300	**52.4**	
Zambia	14	15	B	*47*	92	51	High	14	6.5	151	**52.6**	
Cameroon	14	16	C	*54*	79	64	Medium	12	5.8	430	**53.9**	
Yemen	10	10	E	*50*	26	16	Low	2	7.6	330	**55.7**	
Rwanda	6	21	C	*47*	80	22	High	*10*	6.2	300	**56.0**	
Togo	13	12	E	47	81	42	Medium	*10*	6.6	420	**57.2**	
Malawi	17	13	C	49	78	50	High	*10*	6.7	167	**57.9**	
Burundi	6	9	C	68	80	19	High	3	6.7	800	**58.3**	
Senegal	16	7	E	55	21	40	Low	4	6.0	933	**59.3**	
Kenya	14	33	E	57	77	45	High	7	5.4	500	**59.4**	
Nepal	10	23	C	*75*	9	6	Low	6	5.5	850	**59.9**	
Guinea	24	*5*	C	*56*	36	25	Low	6	6.0	800	**60.7**	VERY HIGH RISK
Mauritania	13	3	E	*56*	26	20	Low	6	6.5	800	**61.3**	
Liberia	23	6	C	78	50	58	Medium	4	6.8	600	**61.4**	
Nigeria	15	6	E	43	57	37	Medium	8	6.5	800	**61.5**	
Haiti	5	10	E	64	52	40	High	7	5.8	600	**62.3**	
Tanzania	13	10	E	80	90	53	High	10	6.3	342	**62.5**	
Uganda	22	5	C	*47*	86	38	High	*10*	7.4	550	**63.4**	
Burkina Faso	17	8	C	*56*	49	41	High	6	6.9	810	**63.8**	
Sierra Leone	21	*12*	C	45	30	25	Medium	*10*	6.5	450	**64.4**	
Mozambique	13	*12*	E	58	50	25	Medium	14	6.5	300	**64.6**	
Afghanistan	15	*2*	E	*75*	8	8	Low	*5*	6.9	640	**66.3**	
Central African Rep.	16	*16*	E	67	69	66	High	17	5.7	600	**66.9**	
Ethiopia	17	4	C	*47*	20	10	Medium	*10*	6.9	900	**67.7**	
Chad	19	*20*	E	*54*	30	15	Medium	11	5.9	710	**68.9**	
Côte d'Ivoire	23	3	E	*56*	66	40	High	10	7.4	680	**70.0**	
Niger	22	4	E	47	30	15	Medium	9	7.4	700	**70.3**	
Mali	20	5	E	65	31	27	Medium	8	7.1	1750	**71.1**	
Congo	15	*15*	C	*54*	35	—	High	21	5.5	900	**72.1**	
Somalia	21	*5*	E	73	2	2	Low	*10*	7.0	1100	**72.8**	
Angola	24	*2*	E	*54*	25	15	Medium	12	6.6	650	**73.5**	
Zaire	23	8	E	76	90	—	High	21	6.7	800	**76.5**	

■ This 1995 report on *World Progress Towards Population Stabilization* includes countries with a population of two million or more. The following countries were dropped because data were only available for eight or fewer indicators: Bosnia and Herzegovina, Croatia, Eritrea, Greece, Ireland and Macedonia.

■ Numbers in italics indicate estimates.

*Key to Abortion Policies:
A = available on request
B = permitted on broad social and health grounds
C = permitted on limited health grounds
D = permitted only for special cases (rape, incest, to save a woman's life)
E = illegal or permitted only to save a woman's life

1995 REPORT ON PROGRESS TOWARDS WORLD POPULATION STABILIZATION

Population Action International

Reproductive Risk: A Worldwide Assessment of Women's Sexual and Maternal Health

REPRODUCTIVE RISK INDEX: DATA SOURCES AND METHODOLOGY

GEOGRAPHIC COVERAGE: The study ranks 118 countries with a population size of two million or more, including 4 countries which have data for only 9 of 10 indicators. The former Soviet Republics could not be ranked for lack of comparable data, but the study includes a table showing key reproductive health indicators, including abortion rates, for these countries.

SOURCES: The primary sources for the study include a series of data bases compiled by the Maternal Health and Safe Motherhood Programme of the World Health Organization (WHO) and the United Nations Population Division. Other key sources include the U.S. Bureau of the Census; WHO's Global Programme on AIDS; the World Bank's *World Development Report*, 1993; UNDP's *Human Development Report*, 1994; and UNICEF's *State of the World's Children Report*, 1995.

DATA QUALITY: The study encountered a number of data related problems. National statistics on women's health are often of poor quality or lacking, especially where vital registration systems are not well developed. For example, maternal mortality and AIDS incidence are systemmatically underreported for a variety of reasons, including the social stigma associated with these problems. Underreporting is also common for abortion and adolescent pregnancy, owing to the controversies surrounding these issues. Moreover, data are often inadequately differentiated by gender and age group, and statistics on the coverage of health services do not reflect the quality of available care.

Wherever feasible, data gaps were filled by outreach to international experts and in-country sources. In other cases, the study used regional estimates or averages to fill gaps. For example, for a few developing countries with no data, contraceptive prevalence was estimated from total fertility rates, using regression analysis. Gaps in data on anemia were filled using regional averages developed by nutrition experts. Similarly, regional estimates were used to fill gaps in data on infertility, given that infertility tends to follow regional patterns of sexual behavior and STD prevalence.

SCORING SYSTEM: Each indicator was scored on a 100 point scale, and the scores were averaged to yield a total score on the *Reproductive Risk Index*. Scoring for each indicator is described below.

- For *contraceptive prevalence, percentage of women receiving prenatal care* and *percentage of births attended by trained personnel,* the data for each country were subtracted from 100, so that high observations representing a lower risk situation would yield a low score and vice versa.
- The data for *percentage of pregnant women with anemia* for each country were used directly as the scores for this indicator.
- For *annual births per 100 women aged 15-19* and *percentage of women infertile,* the data were converted to a 100 point scale and used directly as the scores for each country.
- To avoid assigning scores which reflect judgments about family size, while still recognizing its influence on women's health status, the study calculates the *lifetime risk of death in pregnancy and childbirth* for each country from *total fertility rates (TFR)* and *maternal mortality ratios (MMR).* A logarithmic function was used to reduce the range of observations and to help differentiate between countries with low lifetime risk. The outcome was then converted to a 100-point scale for scoring purposes. This score was weighted twice in the overall score, since its reflects two separate and important indicators.
- National *abortion policies* were classified according to the circumstances under which abortion is permitted. Each category was assigned a score:

◆ Available on request	0 points
◆ Permitted on broad social and health grounds	10 points
◆ Permitted on limited health grounds	50 points
◆ Permitted only for special cases (rape, incest, to save a woman's life)	70 points
◆ Illegal or permitted only to save a woman's life	80 points

- Using data from studies of HIV infection rates in low risk groups such as pregnant women, countries were classified as having low, medium or high *HIV prevalence in women* and assigned a score on the following basis:

◆ Low HIV infection rates (less than 1 percent)	0 points
◆ Medium HIV infection rates (1 to 5 percent)	50 points
◆ High HIV infection rates (over 5 percent)	90 points

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Trends in Women's Health

Around the world, women's health overall is improving. Increasingly, women have access to an education, marry later, and are more likely to use contraception and to have smaller families, all of which contribute to better reproductive health. Yet about 1.3 million women still die each year of reproductive health related and largely preventable causes. Moreover, in developing countries, reproductive health related problems represent one third of the total disease burden among women of childbearing age.

Many biological, social and cultural factors influence women's health. The low status of women in many societies helps perpetuate patterns of early and frequent child-bearing and is often an obstacle to women's ability to use available health services. Also harmful to reproductive health are cultural traditions such as female genital mutilation in Africa, child marriage in parts of Asia and Africa, and food taboos in many countries which contribute to poor nutrition in pregnancy. Thus, depending on local circumstances, the health risks associated with sexual activity and childbearing vary greatly by country.

STDs and Women's Health

Each year, some 250 million men and women contract a sexually transmitted disease (STD) other than HIV/AIDS. Less severe infections account for about half these cases, but STDs with serious consequences are also widespread.

STDs are more common in poor countries than in rich countries and infection rates are highest in Africa, reflecting poor access to health care and social and cultural practices. STD prevalence is usually highest among sex workers and others with many sexual partners. Data for the general population are scarce, but studies show that often 10 to 20 percent of pregnant women are infected.

In both men and women, hepatitis and untreated syphilis can cause serious or fatal illness. Other STDs have more severe consequences for women than men. Gonorrhea and chlamydia can cause infections resulting in chronic pain, tubal pregnancy and infertility. Cervical cancer, the most common cancer in developing countries, is linked to a sexually-transmitted virus. Infection with another STD, moreover, substantially raises the risk of HIV infection. Infants born to infected women also have a higher risk of serious health problems or death.

Especially in poor countries, STDs account for a significant share of death and disease. The World Bank estimates that STDs account for 9 percent of all disease among women of childbearing age, compared to 1.5 percent for men the same age. The economic impact of STDs is substantial — both the direct costs of medical care and the indirect costs of lost productivity owing to ill health.

Women's Sexual and Maternal Health: Reproductive Risk Indicators

The study ranks countries on 10 indicators of women's reproductive health for which comparable national data are available. The indicators reflect both *access* to services and *outcomes* relating to fertility and fertility regulation, health and survival in pregnancy and childbirth, and the prevalence of HIV/AIDS in women. Two other important aspects of reproductive health — sexually transmitted diseases (STDs), other than HIV, and reproductive cancers — could not be directly included in the *Index* for lack of data. However, the study addresses the problem of STDs indirectly by using infertility as an indicator, since high levels of infertility are generally linked to STDs.

■ EARLY CHILDBEARING: In both rich and poor countries, girls in their early teenage years — whether married or unmarried — have a much higher risk of medical complications or death in pregnancy and childbirth than women in their twenties, partly owing to their physical immaturity. Adolescent childbearing also jeopardizes the future of young girls, limiting their educational and employment opportunities.

The study scores each country on the ***annual number of births per 100 women aged 15 to 19.*** *Japan* has the lowest teenage birthrates, with less than 1 birth for every 100 women in this age group each year. Other industrialized and East Asian countries also have very low rates. The *United States*, however, with its high birthrates among unmarried teenage girls, fares worse than other developed countries with 6 percent of this age group giving birth each year. This teen birthrate is higher than in *Haiti* and *Iraq*, and on a par with *India* and *Pakistan*, where girls still marry and bear their first child at a very early age. Teen birthrates are highest, however, in *Angola* and *Guinea*, where 24 percent of 15 to 19 year olds give birth each year.

■ USE OF FAMILY PLANNING: The availability of contraception helps women to delay, space or limit births, avoiding patterns of childbearing that increase maternal risk — for example, pregnancies in very young or older women. The *Index* scores countries on the ***contraceptive prevalence rate*** — the percentage of women aged 15 to 49 who are married or in union who use a modern or a traditional method of contraception.

Hong Kong has the highest level of contraceptive use at 86 percent, followed closely by *China* with its controversial compulsory family planning policy. Most other East Asian and industrialized countries also have high contraceptive use, with couples in these countries primarily relying on effective modern contraception. In some countries, however, use of traditional methods is high. In *Italy*, which ranked highest overall in the study, 78 percent of couples use family planning, with 46 percent using traditional methods — mostly withdrawal — backed up by safe abortion.

Many Asian and Latin American countries have made significant strides in expanding access to family planning; over 25 developing countries studied have levels of contraceptive use exceeding 50 percent. In some 24 countries, however — the vast majority in Africa — fewer than 10 percent of women use family planning. At 2 to 3 percent, *Afghanistan, Angola, Mauritania* and *Côte d'Ivoire* have the lowest levels of contraceptive use.

■ ABORTION POLICIES: Induced abortion is practiced in all cultures, to varying degrees, by women facing an unwanted pregnancy. Abortion is a very safe procedure when properly performed by trained health personnel. Yet in many countries, abortion remains legally restricted, leading women to resort to unsafe abortion, a major cause of maternal deaths, injuries and illness worldwide. An estimated 20 million unsafe abortions take place each year, accounting for between 50,000 and 100,000 deaths annually.

Since good data on unsafe abortion are unavailable, the study rates countries on their ***official abortion policies,*** which are grouped into five categories. Such policies do not always accurately reflect *access* to safe abortion *services*, but are an important factor influencing the availability and cost of such services.

In 24 countries, abortion is available at a woman's request, and in 9 more, on broad health and social grounds. Most industrialized countries fall in these categories, but some developing countries including *China, India, Turkey* and *Vietnam* also have liberal abortion laws. Some 43 countries permit abortion for a narrower range of health and social reasons. Most of these countries are in the developing world, but they also include *Germany* and a few other wealthy countries. In 39 additional developing countries, abortion is nominally legal only to save a woman's life; in 3 more, it is also permitted in cases of rape or incest.

■ NUTRITIONAL ANEMIA IN PREGNANCY: Especially where malnutrition is widespread, a woman can become acutely anemic when a pregnancy depletes already low reserves of vital nutrients. Anemia in pregnancy is a serious problem which contributes to maternal deaths from causes such as hemorrhage but which can be easily treated with oral iron supplements.

The *Index* scores countries on the ***prevalence of anemia in pregnant women,*** an indicator reflecting nutritional status, dietary practices and access to prenatal care. *Denmark*, where only 8 percent of pregnant women are anemic, does best on this indicator. Most other rich countries, however, have rates of 15 to 20 percent. A few developing countries, including *Chile* and *Singapore*, have low rates of anemia, but in most poor countries, over half of all pregnant women suffer from anemia. *India* has the highest rate, with 88 percent of women suffering from anemia in pregnancy.

■ ACCESS TO HEALTH CARE IN PREGNANCY AND CHILDBIRTH: Pregnancy and childbirth are a risky business. Regular and effective prenatal care can address problems before they become life-threatening emergencies, but even with effective screening, some women will develop complications in delivery. A trained attendant present during labor can provide skilled help if problems arise and can recognize when more sophisticated medical care is needed.

The *Reproductive Risk Index* scores countries separately on the ***percentage of women receiving prenatal care*** and the ***percentage of births attended by trained personnel.*** (The term "trained personnel" includes doctors, nurse/midwives and trained traditional midwives, encompassing a great variation in skills. Similarly, the frequency and quality of prenatal care vary greatly.) These indicators reflect the availability of health services, cultural practices, and social and economic status.

In most industrialized countries, virtually all pregnant women receive prenatal care and give birth in health facilities attended by skilled medical personnel. East Asian and Eastern European countries also have high levels of coverage for both prenatal care and delivery. The *United States*, however, ranks lower than other wealthy countries on prenatal coverage, and also scores lower than *Cuba, Mongolia* and *Hong Kong*.

Within each developing region, great differences exist in coverage of prenatal care. Globally, moreover, only slightly more than half of all births are attended by trained personnel. Worst off are women in *Somalia*, only two percent of whom receive prenatal care and have a trained attendant at delivery, followed by *Afghanistan, Nepal*, and *Bangladesh*. In these countries, tradition often dictates that only female relatives may attend a birth.

■ HIV/AIDS AMONG WOMEN: HIV/AIDS is a major new threat to women's health, especially in sub-Saharan Africa. In most other regions, HIV infection is not yet widespread among women in the general population and is primarily a problem among homosexual men, sex workers, drug users and other high-risk groups. However, women are biologically more susceptible to infection than men, and may be at risk owing to their partners' behavior.

Countries are classified as low, medium or high in ***prevalence of HIV infection among low-risk women.*** Since national data on HIV/AIDS are not available, country ratings are based on small-scale studies, usually of pregnant women in urban areas. HIV prevalence of less than 1 percent was considered low; 1-5 percent, medium; and above 5 percent, high.

All of Europe and North America and most Latin American and Asian countries have low prevalence of HIV infection among women. However, 19 countries have medium levels of HIV infection in women — 13 in Africa, 3 in Southeast Asia and another 3 in Central America and the Caribbean. Another 13 African countries have high levels of HIV infection in women. Outside Africa, only *Haiti* has high HIV prevalence among women.

■ INFERTILITY: The inability to bear wanted children represents a major health and social problem for women; childless women are stigmatized and even abandoned by their husbands in many societies. Up to five percent of women may be infertile owing to natural causes; higher levels of infertility are generally the result of infections caused by STDs or complications in delivery or abortion.

Countries are rated on ***prevalence of primary infertility*** — the percentage of women who remain childless despite exposure to pregnancy. East Asia has the lowest levels of infertility; in much of North Africa and the Middle East, Latin America and Asia, infertility is also consistent with natural levels. Many industrialized countries, including the *United States*, have infertility slightly above natural levels. The worst problem, however, is in sub-Saharan Africa. In 19 African countries, infertility affects 10 percent of women or more, reflecting high prevalence of STDs. *Congo* and *Zaire* have the highest infertility among the countries studied, at 21 percent.

■ RISK OF DEATH IN CHILDBEARING: A half million women die each year from complications relating to pregnancy, childbirth and unsafe abortion, almost all of them in developing countries. A woman's lifetime risk of dying of maternal causes depends both on the chance of dying during a given pregnancy, and the frequency of exposure to that risk; thus, a decline in the number of births will reduce maternal deaths.

For this reason, the study includes both the ***maternal mortality ratio*** and ***total fertility rate*** as indicators. The *maternal mortality ratio* represents the number of maternal deaths per 100,000 live births for causes relating to pregnancy and childbirth (including abortion). The *total fertility rate* represents the average number of live births per woman, and thus the frequency of exposure to maternal death. It is also an independent risk factor because women who already have four or more children have a higher likelihood of death from maternal causes.

Maternal death rates are very low in wealthy industrialized countries; in *Denmark* and *Norway*, only 3 women die for every 100,000 births. A number of relatively poor countries such as *China, Sri Lanka, Zimbabwe* and *Jordan*, have also succeeded in reducing maternal death rates. In many developing countries, however, maternal mortality remains unacceptably high and, moreover, is often underestimated. In *Mexico* and *Brazil*, and indeed, in much of Latin America, at least 200 women die for every 100,000 live births; over 400 die in *India* and *Indonesia*. In 30 developing countries, primarily in Africa, women experience more than 500 deaths per 100,000 births; death rates rise to more than 1,000 in *Ghana, Somalia* and *Mali*.

Women have the fewest children in *Hong Kong, Italy* and *Spain*, which have an average family size of only 1.2 children. In total, 32 countries studied — including several developing countries — have a family size of 2.1 children or fewer, a level which will eventually lead to a stable population. In a large number of other countries, too, family size has declined significantly over the past 30 years. Yet in much of sub-Saharan Africa and the Middle East, women still have 6 to 7 children. *Yemen* has the largest average family size, at 7.6 children.

In *Italy, Hong Kong* and *Belgium*, low maternal death rates and small family size combine for a lifetime risk of dying for reasons related to childbearing of less than 1 in 17,000. The risk is more than one thousand times greater for the countries which rank lowest on the *Reproductive Risk Index*. In *Mali*, 1 in every 7 women will die of maternal causes.

Reproductive Health in the Former Soviet Republics

The newly independent states (NIS) of the former Soviet Union are not ranked in the study for lack of comparability on key indicators; new data suggest that the health status of women is mixed.

Throughout the NIS, HIV prevalence is low; abortion is available on request; and virtually all women have access to health care during pregnancy and delivery. Maternal mortality is, however, higher than in the rest of Europe; both family size and maternal mortality are also generally higher in the Central Asian republics than in the European NIS. Use of modern contraceptive methods is lower than in many developing countries, owing to limited availability of supplies. As a result, abortion rates are high, especially in the European NIS, and abortion is a major cause of maternal deaths.

Economic problems following the political changes have undermined the quality and coverage of health services. For example, the prevalence of anemia in pregnant women is estimated to be higher than in the former Soviet Union, reflecting malnutrition resulting from food shortages and economic difficulties.

Country	Annual Births per 100 Women Aged 15-19	Women Using Modern Contraception (%)	Abortions per 100 Women Aged 15-44	Average Births per Woman (TFR)	Maternal Deaths per 100,000 Births
Armenia	6	10	3.0	2.6	40
Azerbaijan	2	7	1.4	2.7	9
Belarus	3	13	10.4	1.7	22
Georgia	5	8	4.6	2.2	21
Kazakhstan	3	22	8.5	2.5	67
Kyrgyzstan	4	25	7.6	3.6	120
Latvia	4	19	7.0	1.7	24
Lithuania	3	12	3.0	1.9	23
Moldova	4	16	7.5	2.1	44
Russia	4	22	12.0	1.6	51
Tajikistan	3	15	4.4	4.5	120
Turkmenistan	2	12	4.0	4.1	134
Ukraine	4	16	8.3	1.7	33
Uzbekistan	3	19	4.5	4.0	43

Sources: • World Health Organization. "Family Planning and Reproductive Health in CCEE/NIS." Draft. November 1994. • Andrej A. Popov. *Family Planning and Induced Abortion in the Post Soviet Russia of the Early 1990s*. 1994.

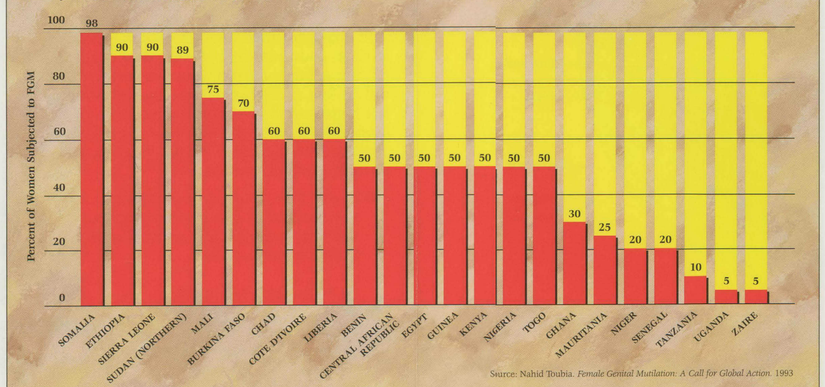
Chance of a Woman Dying from Complications of Pregnancy, Childbirth or Unsafe Abortion During Her Lifetime

Italy	1	in	17,361
Norway	1	in	15,432
Australia	1	in	8,772
United States	1	in	5,669
Poland	1	in	3,608
Cuba	1	in	1,286
China	1	in	439
Zimbabwe	1	in	217
Mexico	1	in	131
India	1	in	59
Kenya	1	in	31
Mali	1	in	7

Female Genital Mutilation: A Harmful Tradition in Africa

Female genital mutilation or FGM (also called female circumcision) involves the removal of the external female genitalia in varying degrees of severity. A tradition predating Islam and Christianity, FGM is practiced primarily in Africa and affects over 100 million women and girls. Among the reasons societies practice FGM are the beliefs that it preserves virginity and enhances beauty. It also often celebrates the passage to womanhood.

Health consequences at the time of the procedure include severe bleeding, infection and shock, sometimes leading to death. Long-term effects include scarring, which can cause life threatening complications in childbirth, and chronic infection and infertility. Women subjected to FGM often experience psychological trauma, painful intercourse and menstruation, and lack of sexual pleasure.



Source: Nahid Toubia. *Female Genital Mutilation: A Call for Global Action.* 1993

Strategies for Improving Reproductive Health

Investing in reproductive health is critical to the quality of life of individual women and contributes to improved child health, family well-being, and economic productivity. Based on the preceding analysis, a comprehensive approach to improving women's reproductive health should include:

- efforts to delay early childbearing through good sexuality education for all young people, linked to contraceptive counseling and services;
- universal access to high quality family planning services and a choice of contraceptive methods;
- at a minimum, emergency care for complications of unsafe abortion; ideally, access to *safe* abortion services;
- regular, effective prenatal care and safe management of routine deliveries;
- access to emergency medical care to deal with complications in childbirth;
- public education, counseling, and increased promotion of condoms to prevent the spread of AIDS and other STDs;
- diagnosis and treatment of STDs and reproductive cancers, where resources and circumstances permit; and
- efforts to educate local communities about harmful cultural practices and to encourage women to seek health services when needed.

In many poor countries, limited financial resources, health facilities and trained personnel will make it difficult to provide all these services at the present time. Long-term investments will be needed, for example, to build up clinical health networks. Where resources are limited, countries should identify and support a minimum package of services, based on priority needs and potential health impact.

1993 REPORT ON PROGRESS TOWARDS WORLD POPULATION STABILIZATION

Population Action International

CLOSING THE GENDER GAP: EDUCATING GIRLS

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Closing the Gender Gap: Educating Girls

Female Education Index: Country Rankings

Closing the Gender Gap: Educating Girls ranks countries on a 100 point scale on a *Female Education Index*, rating them Very Good, Good, Fair, Poor and Very Poor. The indicators used include three absolute measures of the educational status of girls, and two gender gap measures reflecting differences in enrollment for girls compared to boys. (See "Understanding the Data and Methodology," below.)

Some 22 countries fall in the Very Good category, including most of the wealthy industrialized countries. **France** ranks highest with a *Female Education Index* score of 99.7. A few less wealthy countries — including **Mongolia** and **Cuba** — also fall in the Very Good category.

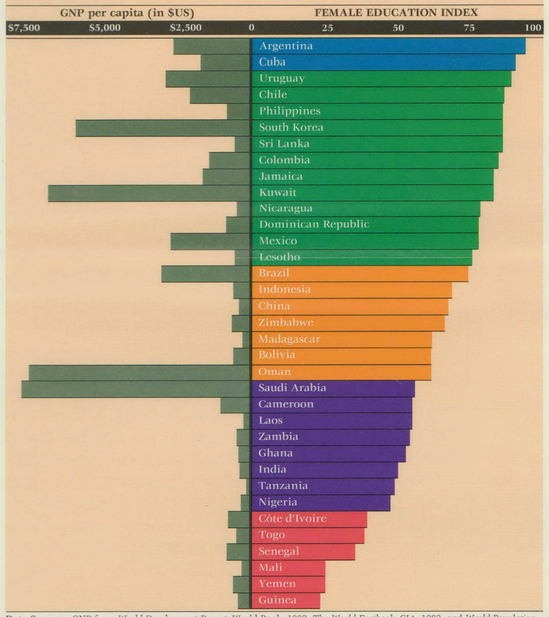
The 34 countries in the Good category represent a broad range of income levels and include several countries in Eastern and Southern Europe, as well as in Latin America and the Caribbean. A few Asian, African and Middle Eastern countries — for example, the **Philippines, Botswana** and **Kuwait** — also receive a rating of Good.

The Fair category includes 20 countries representing all the developing regions of the world. **China**, with 20 percent of the world's population, falls into the Fair category.

Some 18 countries rank in the Poor category, and 18 in the Very Poor range. **Chad** ranks lowest in the study, with a score of 21. Some 25 of the 36 countries in the Poor and Very Poor categories are in sub-Saharan Africa, but these categories also include most of South Asia and several Middle Eastern countries.

The study suggests a strong relationship between per capita income levels and access to education for girls. Political and cultural factors also appear important. **Sri Lanka** and **Nicaragua** — both relatively poor countries — are rated Good on the *Female Education Index* because of their long-standing efforts to improve the educational status of women. In contrast, **Saudi Arabia**, where per capita income is high but the status of women is low, receives a Poor rating.

Income Levels and Female Education Index, Selected Countries



Data Sources: GNP from *World Development Report*, World Bank, 1992; *The World Factbook*, CIA, 1992; and *World Population Data Sheet*, Population Reference Bureau, 1992.

Gender Differentials in School Enrollment

Closing the Gender Gap: Educating Girls also identifies countries which have a gender gap in education based on significant differences between female and male enrollment in primary and secondary school. In countries identified as having a gap, the study found about 76 million fewer girls than boys enrolled, compared to total enrollment of about 486 million students. About 42 million fewer girls were enrolled in primary school, and about 34 million fewer in secondary school.

The difference between the *total* number of boys and girls in school worldwide is higher because in many countries where no gender gap in education exists, the number of male students exceeds that of females since there are more boys than girls in the total population. Worldwide, roughly 485 million boys and 400 million girls are in school, a difference of about 85 million. In addition, some countries were excluded from the study due to inadequate data.

The study found no gender gap in education for the more developed countries, or in most Latin American countries. But in most of South Asia, the Middle East and Africa, differences in enrollment for boys and girls are marked. These regions also account for the majority of countries where male literacy rates exceed female literacy by 20 percentage points or more. Not surprisingly, they also have the highest levels of fertility and child mortality.

Gender differences in enrollment rates are greater at the secondary school level than at the primary level, and are the greatest at the secondary school level in South Asia. **India** alone represents over 40 percent of the global education gender gap identified in the study, with almost 33 million fewer girls than boys enrolled in school in 1990. Overall enrollment rates, however, are lowest in Africa, where secondary level enrollment represents only 20 percent of school-age boys and 14 percent of school-age girls. Closing the education gender gap would therefore still leave female enrollment in some countries at very low levels. In many countries, closing the gender gap will only be the first step to expanding educational opportunities for girls. Similarly, in several countries with no gender gap in enrollment, education levels for both girls and boys still need to be improved.

Cost of Closing the Education Gender Gap

Closing the Gender Gap: Educating Girls provides policymakers in each country that had an education gender gap in 1990 with a price tag for eliminating gender differentials in schooling. The study estimates that, together, these countries would have had to enroll an additional 42 million girls in primary school and 34 million girls in secondary school in 1990, at a cost of more than $6.5 billion, to increase girls' enrollment to that of boys. This sum is additional to the approximately $41 billion these countries spent in 1990 to finance the recurrent costs of primary and secondary education.

A more realistic goal is to equalize female and male enrollments at all grade levels by 2005, the time required for girls entering school in 1994 to complete grades 1 through 12. When population growth is taken into consideration, closing the gender gap would require the enrollment of 123 million additional girls at the primary level and 56 million girls at the secondary level, over 1990 female enrollment levels. Educating these 179 million girls in the year 2005, assuming constant expenditures per pupil, would cost more than $18 billion (in constant dollars) over 1990 expenditures. This is somewhat more than the amount required to make family planning services universally available. Expenditures in both areas are critical to bringing about early world population stabilization. Both also contribute to improved child survival and women's empowerment.

Why Do Gender Differentials Persist?

Unfortunately, in many low-income countries with high rates of population growth, investments in education have not kept up with the rapidly increasing school-age population. Many developing countries, moreover, faced with declining terms of trade and economic recession, cut social spending during the 1980s, shifting more responsibility to families for financing schooling.

Direct costs such as school fees, transportation, uniforms and books make it more difficult for poor families to educate all their children. Where school capacity or parental resources are limited, parents in many countries give priority to sons.

Parents may see limited economic benefits to educating daughters. Girls are viewed as less likely than boys to get good jobs when they leave school and more likely to marry and move away from home. In many countries, girls are also more likely than their brothers to be kept home to perform household chores, including caring for younger siblings. For these and other reasons, including early marriage and pregnancy, dropout rates for girls also tend to be higher than those for boys.

In cultures which place a high value on the chastity of girls, parents are reluctant to allow their daughters to travel long distances to school, to be taught by male teachers, to enroll in schools without separate facilities for girls, or to attend boarding schools in distant towns.

Strategies for Increasing School Enrollment for Girls

Efforts to increase female enrollment levels must recognize the complex factors limiting educational opportunities for girls, as well as their continued enrollment once within the school system. Building more schools — and building them closer to rural communities — is often important to expand educational opportunities for girls. But especially in poor countries which spend large sums on relatively few students, more efficient use of existing resources for education could make possible the enrollment of more students, particularly girls.

Hiring more female teachers and providing separate facilities for girls can help to address cultural barriers. In some countries, financial incentives such as scholarships for girls and provision of free or low-priced school supplies and uniforms have also proved successful in encouraging parents to keep their daughters in school. Flexible school schedules can help to accommodate competing demands on girls at home and school.

Educating Girls: The Impact on Fertility and Mortality Declines

Expanding access to good quality family planning services remains the quickest and most effective way to reduce unwanted pregnancies and to lower population growth rates in developing countries. Similarly, direct measures like childhood immunization are the quickest way to reduce deaths to young children. But family planning programs also contribute to improved child health, just as child survival programs may help to change desired family size and contribute to lower fertility.

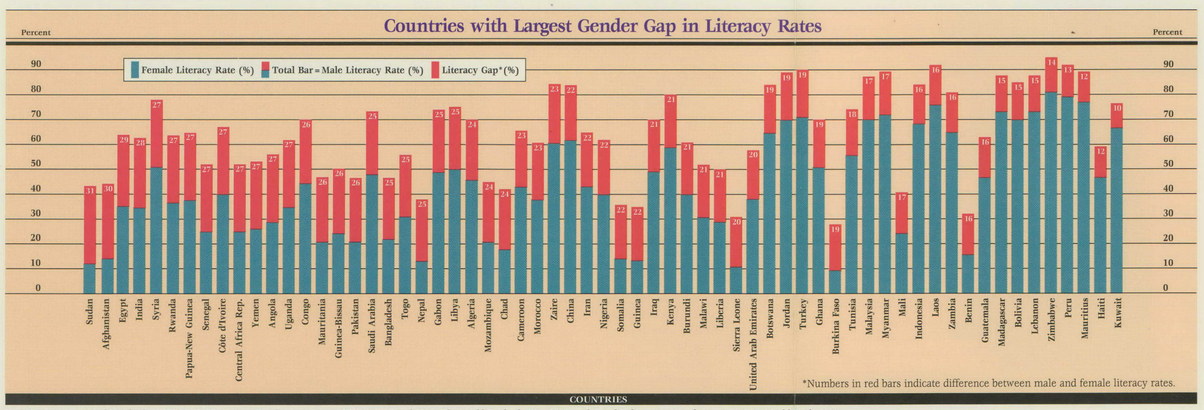
Average family size and child death rates are *lowest*, however, in countries such as **South Korea** and **Sri Lanka**, which combine strong family planning and health programs with high levels of education for women. Conversely, family size and child death rates are *highest* in those countries which combine low female educational levels with weak family planning and child health programs — as is the case in **Ethiopia**, **Malawi** and many other African countries. These findings reaffirm the synergy between schooling for girls and good health and family planning programs as a strategy for dealing with high fertility and mortality.

Average Family Size and Infant Mortality in Selected Countries, by Years of Schooling for Women and Strength of Family Planning Program

Average Years of Schooling for Women	Family Planning Program Effort Score: Strong (67+)	TFR	IMR	Moderate (46-66)	TFR	IMR	Weak (21-45)	TFR	IMR	Very Weak (0-20)	TFR	IMR
At least 6 years	South Korea	1.8	17	Chile	2.5	17	Uruguay	2.3	21			
	Sri Lanka	2.4	19	Colombia	2.7	37	Argentina	2.8	29			
				Panama	2.9	21						
4-5 years	Mexico	3.3	39	Jamaica	2.8	16	Paraguay	4.6	32	Kuwait	3.4	14
	El Salvador	4.2	53	Costa Rica	3.1	16	Lesotho	5.6	93	United Arab	4.6	23
				Malaysia	3.8	16	Jordan	6.3	51	Emirates		
2-3 years	Mauritius	1.9	20	Honduras	5.2	64	Brazil	3.2	57	Myanmar	3.8	64
	Thailand	2.5	27	Guatemala	5.4	62	Turkey	3.5	60	Iraq	6.2	65
	China	2.5	29	Iran	6.2	88	Bolivia	4.8	92	Laos	6.7	103
	Indonesia	3.1	61	Ghana	6.2	85	Syria	6.5	43			
Less than 2 years	Tunisia	3.6	44	Egypt	4.0	66	Cen. Afr. Rep.	5.8	101	Liberia	6.3	136
	India	4.0	92	Morocco	4.5	67	Cameroon	5.8	88	Côte d'Ivoire	6.7	95
	Bangladesh	4.6	105	Nepal	5.7	121	Nigeria	6.0	98	Somalia	6.8	126
				Pakistan	5.8	103	Zaire	6.2	94	Malawi	7.6	149
				Kenya	6.5	67	Mozambique	6.4	137			
				Zambia	6.7	82	Tanzania	6.6	115			
							Ethiopia	7.5	132			

Data Sources: Family Planning Effort Score from J. Ross and P. Mauldin, et al., *Family Planning and Child Survival Programs*, Population Council, 1992. TFR and IMR from *World Development Report*, The World Bank, 1992. Average Years of Schooling from *Human Development Report*, UNDP, 1993.

Countries with Largest Gender Gap in Literacy Rates



Data Source: *Statistical Yearbook*, UNESCO, 1992; *Human Development Report*, UNDP, 1992 and 1993; *The World Factbook*, CIA, 1992; and *Social Indicators in Development 1991-92*, World Bank, 1992.

UNDERSTANDING THE DATA AND METHODOLOGY

Female Education Index

The study covers 116 countries, excluding those with a population of less than one million. Four of these countries could not be ranked because only partial data were available, and 12 more were excluded because the data were inadequate. Both education and cost data are for 1990 or the most recent year available. They were drawn primarily from the UNESCO *Statistical Yearbook*, 1992, and from UNDP's *Human Development Report*, 1992 and 1993. Gaps in the data were filled from various World Bank, UN and CIA publications.

The countries in the study were scored on five indicators, each worth 100 points. The five scores were averaged to yield a total score on the *Female Education Index* from 0 to 100. The five indicators are:

- *Educational attainment for women.* The average number of years of schooling for adult women was converted to a 100 point scale for scoring purposes.
- *Primary female-male enrollment ratio.* This indicator measures the number of girls enrolled for every 100 boys in primary school, a true gender gap indicator.
- *Secondary female-male enrollment ratio.* This indicator measures the number of girls enrolled per 100 boys at the secondary school level.
- *Gross primary enrollment rate for girls.* This indicator measures the number of girls enrolled in primary school as a percent of the primary school-age female population.
- *Gross secondary enrollment rate for girls.* This measures secondary school enrollment of girls as a percent of the secondary school-age female population.

In ranking the countries on the *Index*, the female-male enrollment ratios and the gross enrollment rates at both the primary and secondary level were cut off at 105, so as not to artificially inflate scores for countries which had disproportionately high enrollment rates for girls compared to boys and those with very high levels of out-of-age-group girls enrolled.

Cost Estimates

Total public recurrent expenditures on primary and secondary education for all countries for which data were available were converted into U.S. dollars. These expenditure figures were divided by the number of students enrolled in primary and secondary school to estimate the average cost per student at the primary and secondary levels, respectively. The study then identified those countries which in 1990 had a significant gender gap, based on the ratio of female to male students, and estimated how many additional girls would have had to be enrolled to equalize male and female enrollment at both the primary and secondary levels. The average cost per student was then multiplied by this number to arrive at the total additional expenditures theoretically required to equalize enrollment in 1990 in those countries.

The study then estimated the costs of equalizing male and female enrollments in 2005, assuming that 12 years are required for girls entering school in 1994 to complete grades 1 through 12. Assuming growth in the school-age population in line with the United Nations medium variant population projections, and holding constant the enrollment rate for boys, the study estimated the additional number of girls who would have to be enrolled to close the gender gap at both the primary and secondary level in 2005. The number of additional girls was multiplied by the average cost per student to arrive at the annual cost of closing the education gender gap in 2005. This estimate excludes both those countries lacking cost data and the cost of educating the additional boys required to keep enrollment rates constant.

The cost estimates included in this study represent only recurrent expenditures by governments on public schooling. They do not include capital expenditures, expenditures on private schooling, or private expenditures on public schooling, since these data are unavailable or incomplete for most countries. The cost estimates in the study also do not allow for much-needed improvements in the quality of education in many countries.

Closing the Gender Gap: Educating Girls

Female Education Index, Child Survival and Average Family Size

Country	Infant Mortality Rate	FEMALE EDUCATION INDEX	Total Fertility Rate
France	7	99.7	1.8
Canada	7	99.4	1.7
Finland	6	98.3	1.8
Norway	8	98.2	1.8
Belgium	8	97.8	1.6
United States	9	97.7	1.9
Netherlands	7	97.4	1.6
Sweden	6	97.1	1.9
Denmark	8	96.2	1.7
United Kingdom	8	96.1	1.8
Australia	8	95.8	1.9
Germany	7	95.7	1.5
Japan	5	95.7	1.6
New Zealand	10	95.5	2.0
Ireland	7	95.3	2.2
Austria	8	93.7	1.5
Argentina	29	93.0	2.8
Spain	8	91.8	1.5
Mongolia	62	91.5	4.7
Israel	10	91.4	2.8
Cuba	11	90.8	1.9
Former USSR	23	90.0	2.3
Uruguay	21	89.9	2.3
Former Czechoslovakia	12	89.8	2.0
Hungary	15	89.0	1.8
Poland	16	88.2	2.1
Romania	27	87.8	2.2
Greece	11	87.2	1.5
Chile	17	86.8	2.5
Philippines	41	86.3	3.7
South Korea	17	86.2	1.8
Sri Lanka	19	86.2	2.4
Colombia	37	85.2	2.7
Italy	9	85.2	1.3
Panama	21	84.5	2.9
Bulgaria	14	83.1	1.9
Jamaica	16	82.9	2.8
United Arab Emirates	23	82.9	4.6
Kuwait	14	82.6	3.4
Hong Kong	7	82.6	1.5
Former Yugoslavia	24	81.2	1.9
Ecuador	55	80.8	3.7
Jordan	51	79.3	6.3
Portugal	12	79.1	1.6
Singapore	7	78.4	1.9
Venezuela	34	78.3	3.6
Nicaragua	55	78.3	5.3
Malaysia	16	77.9	3.8
Dominican Republic	56	77.9	3.2
Mexico	39	77.9	3.3
Albania	28	77.5	3.1
Costa Rica	16	77.1	3.1
Botswana	38	76.4	4.7
Lesotho	93	75.9	5.6
Mauritius	20	75.7	1.9
Honduras	64	75.0	5.2
Brazil	57	74.7	3.2
Paraguay	32	73.7	4.6
Namibia	100	72.2	5.9
Congo	116	71.4	6.6
Indonesia	61	68.8	3.1
El Salvador	53	67.6	4.2
China	29	67.0	2.5
Iran	88	67.0	6.2
Egypt	66	66.9	4.0
Thailand	27	66.5	2.5
Zimbabwe	49	66.2	4.9
Syria	43	65.8	6.5
Myanmar	64	64.3	3.8
Tunisia	44	63.2	3.6
Turkey	60	63.0	3.5
Madagascar	116	62.2	6.3
Bolivia	92	61.8	4.8
Oman	33	61.7	7.0
Algeria	67	61.1	5.1
Haiti	95	60.0	4.8
Iraq	65	59.3	6.2
Kenya	67	57.0	6.5
Saudi Arabia	65	56.3	7.0
Cameroon	88	54.7	5.8
Laos	103	54.5	6.7
Zambia	82	53.8	6.7
Ghana	85	52.3	6.2
India	92	50.4	4.0
Rwanda	120	50.2	6
Tanzania	115	50.0	6.6
Nigeria	98	47.0	6.0
Morocco	67	46.1	4.5
Papua-New Guinea	57	44.2	5.1
Bangladesh	105	42.7	4.6
Burundi	107	42.3	6.8
Uganda	117	42.0	7.3
Zaire	94	41.9	6.2
Malawi	149	41.8	7.6
Côte d'Ivoire	95	39.3	6.7
Togo	88	38.1	6.6
Mozambique	137	38.0	6.4
Senegal	81	37.1	6.5
Sierra Leone	147	36.5	6.5
Ethiopia	132	35.8	7.5
Nepal	121	33.3	5.7
Mauritania	121	33.0	6.8
Central African Republic	101	32.8	5.8
Burkina Faso	134	29.6	6.5
Benin	113	28.9	6.3
Pakistan	103	27.6	5.8
Niger	128	25.0	7.2
Mali	166	24.2	7.1
Afghanistan	172	24.1	6.9
Yemen	124	24.1	7.7
Guinea	138	21.9	6.5
Chad	125	21.0	6.0

1993

INFANT MORTALITY = *Infant deaths per 1,000 live births* TOTAL FERTILITY RATE = *Average number of children per woman*

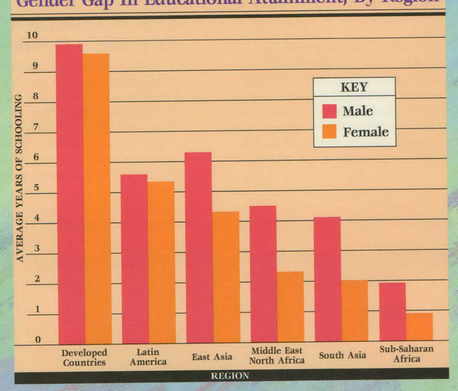
Closing the Gender Gap: Educating Girls ranks the educational status of girls in 112 countries with a combined population of about 5.2 billion, or 95 percent of the world's population. The study serves as the *1993 Report on World Progress Towards Population Stabilization*, the fourth in a series of reports by Population Action International (formerly the Population Crisis Committee). The 1993 Report Card's focus on female education reflects the growing consensus that birth rates and child death rates both decline fastest when countries expand access to good quality health and family planning services *and* educational opportunities for girls.

The *Female Education Index* ranks countries on a 100 point scale, rating them Very Good, Good, Fair, Poor and Very Poor. The rankings are based on indicators measuring the enrollment of girls in primary and secondary school, differences in enrollment between girls and boys, and the average level of schooling attained by women.

Major findings include the following:

- In many countries, girls are at a disadvantage in their access to education. The study estimates the gender gap in education was about 76 million girls, in the countries studied, in 1990. Gender differences in school enrollment are greatest in South Asia, the Middle East and Africa.
- Country rankings on the *Female Education Index* are strongly related to average per capita income, but government commitment can make a difference. Some poor countries committed to educating girls score high on the *Index*, while a few wealthier countries, especially in the Middle East, have relatively low scores.
- The costs of expanding educational opportunities for girls will be substantial. The study estimates that equalizing female and male school enrollment in 1990 in those countries with a gender gap would have required more than $6.5 billion in additional expenditures on primary and secondary education in that year. Taking population growth into consideration, the cost of closing the gender gap would rise to more than $18 billion in constant dollars by 2005.
- Closing the education gender gap would still leave female enrollment in some countries at very low levels, especially in sub-Saharan Africa. Further investments will be needed in these countries for meaningful expansion of educational opportunities for both girls and boys.
- Average family size and child death rates are lowest in those developing countries which have *both* strong family planning and maternal-child health programs *and* high levels of female education. Investments in both areas appear mutually reinforcing and have the potential to accelerate world population stabilization in addition to their many other individual and societal benefits.

Gender Gap In Educational Attainment, By Region



Benefits of Schooling for Girls

The benefits of educating girls are enormous — to individual girls both when they are young and later as adult women, to their future families, and to society as a whole. By empowering women within their families and communities, education enables women to achieve greater self-fulfillment and to contribute more fully to the social and economic development of their societies. A girl's education is also an investment in future generations; the more educated a mother is, the more likely her children — particularly her daughters — are to enroll in and stay in school.

Female Education and Health:

The level of education attained by women is strongly associated with lower child mortality. Each additional year of schooling for women is associated with a decline in child deaths of between 5 and 10 percent, especially in poor countries where access to good health care is limited. Experts believe that more educated mothers practice better hygiene and nutrition, use health services more frequently, and manage family resources better, resulting in improved child health and survival. Women with more schooling tend to be healthier themselves, perhaps reflecting their enhanced ability to avoid frequent childbearing and to take advantage of available health services during pregnancy and childbirth.

Female Education and Fertility:

The educational level achieved by women, next to their access to family planning services, has the most powerful influence on family size. The impact of education on family size is strongest and most consistent for women who have completed some secondary schooling. Educating girls is three times more likely to lower family size than educating boys. Education appears to affect family size in many ways. More educated women not only want fewer children than their less educated counterparts, they are also more likely to use effective contraception successfully and to limit their families to the number of children they want. Women with more schooling tend to marry and have children later, also contributing to smaller family size.

Population Action International

Population Action International's annual reports, *World Progress Towards Population Stabilization*, include all countries with a population of one million or more. The following countries with over one million population do not appear in the tables above because information was inadequate: Cambodia, Lebanon, Liberia, Libya, North Korea, Peru, Somalia, South Africa, Sudan, Taiwan, Trinidad and Tobago, Vietnam.

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Female Education Index and Cost Estimates for Equalizing Enrollment of Girls and Boys

Country	Average Years of Schooling/ Females	Number of Female Students per 100 Males (Primary)	Number of Female Students per 100 Males (Secondary)	Female Gross Enrollment Rate (Primary)	Female Gross Enrollment Rate (Secondary)	FEMALE EDUCATION INDEX	1990 Cost of Closing Education Gender Gap (Additional to Actual Expenditures, in $US)	2005 Cost of Closing Education Gender Gap (Additional to 1990 Expenditures in Constant $US)	
France	11.7	94	102	110	100	99.7	No Gap	No Gap	VERY GOOD
Canada	11.9	93	96	104	107	99.4	No Gap	No Gap	
Finland	10.5	95	114	99	124	98.3	No Gap	No Gap	
Norway	11.5	95	99	99	102	98.2	No Gap	No Gap	
Belgium	10.7	97	96	103	104	97.8	No Gap	No Gap	
United States	12.4	95	95	104	91	97.7	No Gap	No Gap	
Netherlands	10.8	98	93	118	101	97.4	No Gap	No Gap	
Sweden	11.1	95	100	107	93	97.1	No Gap	No Gap	
Denmark	10.3	96	96	98	110	96.2	No Gap	No Gap	
United Kingdom	11.6	96	98	107	85	96.1	No Gap	No Gap	
Australia	11.4	95	99	105	85	95.8	No Gap	No Gap	
Germany	10.6	95	92	105	98	95.7	No Gap	No Gap	
Japan	10.6	95	97	101	97	95.7	No Gap	No Gap	
New Zealand	10.6	94	99	105	91	95.5	No Gap	No Gap	
Ireland	8.8	96	104	101	102	95.3	No Gap	No Gap	
Austria	10.5	95	99	102	85	93.7	No Gap	No Gap	
Argentina	8.9	103	105	114	78	93.0	No Gap	No Gap	
Spain	6.5	93	102	108	112	91.8	No Gap	No Gap	
Mongolia	6.8	100	107	100	96	91.5	No Gap	No Gap	
Israel	9.0	97	104	95	86	91.4	No Gap	No Gap	
Cuba	7.7	91	108	100	94	90.8	No Gap	No Gap	
Former USSR	7.2	97	107	88	100	90.0	No Gap	No Gap	
Uruguay	8.2	95	113	106	76	89.9	No Gap	No Gap	GOOD
Former Czechoslovakia	8.4	97	102	93	87	89.8	No Gap	No Gap	
Hungary	9.7	95	96	94	79	89.0	No Gap	No Gap	
Poland	7.7	95	100	98	84	88.2	No Gap	No Gap	
Romania	6.6	106	93	96	90	87.8	No Gap	No Gap	
Greece	6.5	94	90	101	97	87.2	No Gap	No Gap	
Chile	7.2	95	106	97	77	86.8	No Gap	No Gap	
Philippines	7.0	94	99	110	75	86.3	No Gap	No Gap	
South Korea	6.7	94	91	110	85	86.2	No Gap	No Gap	
Sri Lanka	6.1	93	105	105	77	86.2	No Gap	No Gap	
Colombia	7.3	98	116	111	57	85.2	No Gap	No Gap	
Italy	7.3	95	96	96	78	85.2	No Gap	No Gap	
Panama	6.9	93	105	105	62	84.5	No Gap	No Gap	
Bulgaria	6.4	93	99	95	75	83.1	No Gap	No Gap	
Jamaica	5.2	98	107	105	63	82.9	No Gap	No Gap	
United Arab Emirates	5.2	93	101	114	72	82.9	No Gap	No Gap	
Kuwait	4.7	96	92	99	87	82.6	No Gap	No Gap	
Hong Kong	5.4	92	97	104	75	82.6	No Gap	No Gap	
Former Yugoslavia	5.4	94	93	95	79	81.2	No Gap	No Gap	
Ecuador	5.3	96	102	117	57	80.8	No Gap	No Gap	
Jordan	4.0	94	92	99	78	79.3	No Gap	No Gap	
Portugal	5.2	91	97	117	59	79.1	No Gap	No Gap	
Singapore	3.1	90	100	109	71	78.4	No Gap	No Gap	
Venezuela	6.2	100	132	94	41	78.3	No Gap	No Gap	
Nicaragua	4.5	104	137	101	44	78.3	No Gap	No Gap	
Malaysia	5.0	95	102	93	58	77.9	No Gap	No Gap	
Dominican Republic	4.0	98	122	96	57	77.9	No Gap	No Gap	
Mexico	4.6	94	99	110	53	77.9	No Gap	No Gap	
Albania	5.0	93	81	98	74	77.5	No Data	No Data	
Costa Rica	5.6	94	101	101	43	77.1	No Gap	No Gap	
Botswana	2.4	107	109	112	47	76.4	No Gap	No Gap	
Lesotho	4.0	121	147	115	31	75.9	No Gap	No Gap	
Mauritius	3.3	97	97	104	53	75.7	No Gap	No Gap	
Honduras	3.7	98	116	109	36	75.0	No Gap	No Gap	
Brazil	3.8	95	116	97	45	74.7	No Gap	No Gap	FAIR
Paraguay	4.6	93	101	106	31	73.7	No Gap	No Gap	
Namibia	1.7	108	125	99	38	72.2	No Gap	No Gap	
Congo	1.1	87	79	164	77	71.4	5,433,000	40,174,000	
Indonesia	2.9	93	81	114	41	68.8	33,364,000	44,659,000	
El Salvador	4.1	98	102	78	26	67.6	No Gap	No Gap	
China	3.6	86	73	129	41	67.0	652,638,000	1,843,982,000	
Iran	3.1	86	71	106	47	67.0	1,680,578,000	5,802,241,000	
Egypt	1.6	81	79	90	71	66.9	266,440,000	839,201,000	
Thailand	3.3	95	93	85	32	66.5	No Gap	No Gap	
Zimbabwe	1.7	99	67	116	46	66.2	31,442,000	78,161,000	
Syria	3.1	87	71	102	43	65.8	53,799,000	226,342,000	
Myanmar	2.1	92	89	100	23	64.3	1,770,000	6,024,000	
Tunisia	1.2	85	76	109	40	63.2	49,405,000	52,807,000	
Turkey	2.3	89	60	105	42	63.0	121,661,000	350,976,000	
Madagascar	1.7	95	94	90	18	62.2	No Gap	No Gap	
Bolivia	3.0	90	85	78	31	61.8	1,145,000	9,007,000	
Oman	0.3	89	70	99	48	61.7	29,349,000	176,946,000	
Algeria	0.8	81	77	88	53	61.1	237,519,000	514,965,000	
Haiti	1.3	93	96	81	19	60.0	No Gap	No Gap	
Iraq	3.9	79	61	87	37	59.3	247,351,000	696,434,000	POOR
Kenya	1.3	94	69	92	19	57.0	17,807,000	88,514,000	
Saudi Arabia	1.5	84	72	72	41	56.3	562,906,000	2,726,653,000	
Cameroon	0.8	85	68	93	21	54.7	21,450,000	86,796,000	
Laos	2.1	77	66	91	21	54.5	No Data	No Data	
Zambia	1.7	91	59	91	14	53.8	7,777,000	30,076,000	
Ghana	2.2	81	64	67	31	52.3	17,220,000	53,094,000	
India	1.2	71	55	83	33	50.4	1,433,539,000	2,257,350,000	
Rwanda	0.5	99	74	68	6	50.2	1,826,000	8,904,000	
Tanzania	1.3	98	74	63	4	50.0	4,427,000	18,581,000	
Nigeria	0.5	76	75	63	17	47.0	32,502,000	112,747,000	
Morocco	1.5	65	68	55	30	46.1	206,799,000	411,846,000	
Papua-New Guinea	0.6	80	61	65	10	44.2	No Data	No Data	
Bangladesh	0.9	81	46	68	11	42.7	70,058,000	110,034,000	
Burundi	0.2	80	62	64	4	42.3	4,410,000	14,109,000	
Uganda	0.6	82	52	63	8	42.0	32,067,000	94,081,000	
Zaire	0.8	73	47	67	16	41.9	9,583,000	34,408,000	
Malawi	1.1	81	52	64	3	41.8	3,065,000	12,568,000	
Côte d'Ivoire	0.9	71	44	62	12	39.3	95,772,000	355,989,000	VERY POOR
Togo	0.8	63	31	80	10	38.1	14,609,000	32,057,000	
Mozambique	1.2	70	57	48	5	38.0	No Data	No Data	
Senegal	0.4	72	50	49	11	37.1	24,568,000	54,534,000	
Sierra Leone	0.4	70	58	39	12	36.5	1,149,000	2,211,000	
Ethiopia	0.7	64	67	30	12	35.8	36,646,000	116,220,000	
Nepal	1.0	47	37	57	17	33.3	18,008,000	41,184,000	
Mauritania	0.1	69	43	42	10	33.0	8,406,000	20,598,000	
Central African Republic	0.5	63	40	51	6	32.8	5,642,000	12,243,000	
Burkina Faso	0.1	62	52	28	5	29.6	10,908,000	24,850,000	
Benin	0.3	51	41	44	6	28.9	No Data	No Data	
Pakistan	0.7	52	41	26	13	27.6	250,916,000	361,907,000	
Niger	0.1	57	42	21	4	25.0	12,835,000	28,819,000	
Mali	0.1	58	41	17	4	24.2	11,112,000	30,177,000	
Afghanistan	0.2	49	49	16	5	24.1	30,342,000	82,487,000	
Yemen	0.2	37	19	52	11	24.1	126,428,000	229,379,000	
Guinea	0.3	46	32	24	5	21.9	6,525,000	12,709,000	
Chad	0.1	44	22	35	3	21.0	No Data	No Data	
Angola	1.0	92	No Data	No Data	No Data	-	No Data	No Data	NOT RATED
Gabon	1.3	98	77	No Data	No Data	-	No Data	No Data	
Guatemala	3.8	82	No Data	No Data	17	-	No Data	No Data	
Switzerland	10.7	96	105	No Data	No Data	-	No Gap	No Gap	
Cost to Close Enrollment Gap (in 1990 constant $US)							6,491,198,000	18,147,044,000	

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WHY Population MATTERS

Population growth around the world affects Americans through its impact on the economy, the environment, and the world our children will inherit. This flier briefly explains some of the key reasons population growth is important and why the U.S. government provides assistance (roughly $500 million dollars annually, or $2 per American) for population programs in developing countries. These programs help couples have children when they want to, thereby reducing birthrates, protecting the health of women, and strengthening families.

1 Slowing population growth helps poorer countries develop economically and participate in world trade. When each new generation is similar in size to the preceding one, governments find it easier to provide roads, clean water, health care and education. The investment and economic growth supported by these services boost trade, which benefits the increasingly export dependent U.S. economy.

2 Competition for scarce jobs eases when population grows more slowly. Only extremely energetic economic growth can provide well-paid jobs to labor forces that are growing rapidly. Having a stable population—while no guarantee of full employment—tends to allow a better balance of job seekers and decent paying jobs. In today's global economy, slower population growth around the world can help support better paying jobs in the United States.

3 Migration pressures are aggravated by rapid population growth. The search for work is the leading reason people leave the communities of their childhood. When job seekers exceed an economy's capacity to generate employment, migration—to a large city or across an international border—is a logical response. Environmental degradation, often related to population growth, spurs the movement of people as well.

4 Worsening water scarcity stems in large part from increases in human demand. The availability of renewable fresh water is finite and increasingly constrained. By one recent estimate, more than half of all the world's accessible renewable fresh water is already being used, indicating the problems the world may face if population doubles. Within a single generation, the number of nations facing chronic water shortage is projected to rise to 50, mostly in the Middle East and Africa.

A Growing Risk to U.S. Interests and to Human Well-being

5 Worldwide, 800 million people are malnourished, and the number could grow significantly. The food of the future will be produced mostly on today's farmland, and much of that land is deteriorating. Water scarcity and environmental problems limit the spread of irrigation. Slower population growth would ease the strain on limited farmland.

6 The world's oceans are essentially fully fished. Despite the growth of aquaculture (fish farming), the global production and catch of fish have fallen behind population growth in recent years. With less fish available worldwide per person, the price of fish is rising. The world's poor face the loss of one of their few sources of high quality protein.

7 Humanity is rapidly changing the earth's atmosphere and thus its climate. High energy consumption in industrialized countries is the biggest contributor to the buildup of greenhouse gases in the atmosphere. Developing countries are catching up, however, and population growth in both wealthy and less wealthy countries amplifies the role of rising consumption levels in human induced global temperature increase.

8 Wild habitats that shelter endangered plants and animals are giving way to human activities and needs. By the estimates of conservation biologists, tens of thousands of species may be disappearing each year—a rate thousands of times higher than is natural. The extinction of these species threatens the life system that humans depend on as well.

9 Disease knows no borders, and population growth is a factor in the recent upsurge of infectious disease. By living and interacting in densely populated settlements, human beings make it easier for disease-causing microorganisms to move from one host to the next. Crowding, travel and the increase of livestock—all associated with population growth—increase the opportunities for the spread of infection.

10 Civil conflict often emerges in societies where rapid population growth combines with environmental scarcity to undermine governments. By contributing to environmental degradation and natural resource scarcity, population growth can play a role in tensions between groups. Governments often fail to resolve these tensions peacefully.

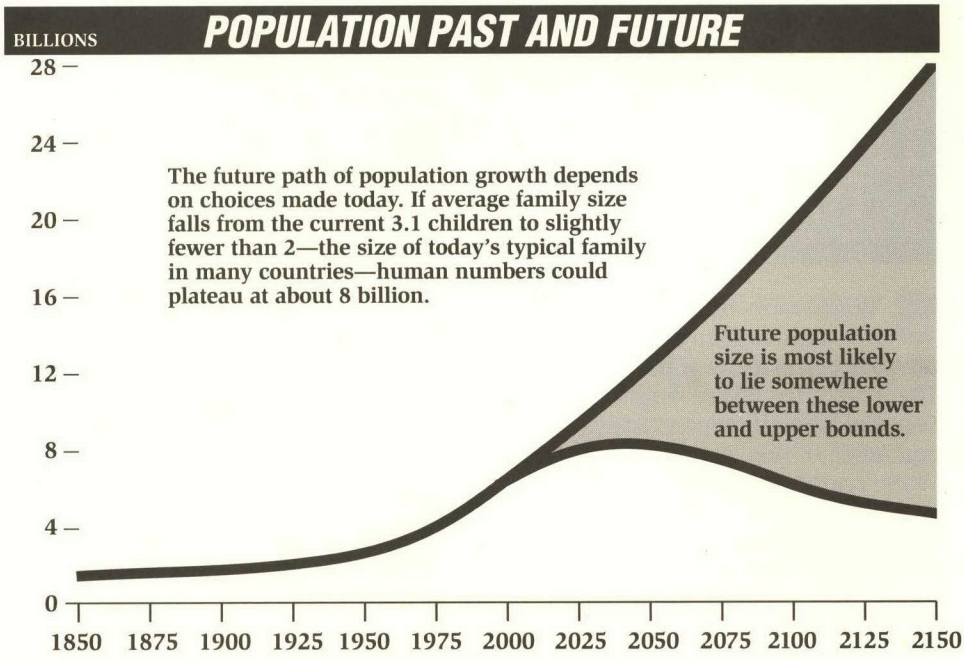
Today's Choices, Tomorrow's Population

The rate of world population growth is already declining, but the number of people could still double or even triple from the current level before stabilizing a century or more from now. Yet there is reason for optimism. The combination of education for girls, economic opportunity for women, and access to family planning and reproductive health care services could lower birthrates enough to stabilize world population well before today's 5.8 billion people becomes 11.6 billion.

At a 1994 international conference in Cairo, the world's nations reached a historic consensus on both the need and the means to slow population growth and eventually stabilize human numbers. The strategy is grounded in the recognition that couples have the right to make their own decisions on childbearing. Among the most important needs is universal access to the information and means to plan families. The use of contraception prevents maternal deaths by helping women avoid high-risk pregnancies. Lengthening the time between births also improves the chances children will survive their early years. Finally, contraception helps reduce the number of abortions, to which many women without access to effective contraception turn in desperation.

The number of children that couples want to have is falling worldwide, while the number of women in their childbearing years grows by 24 million each year. Both trends mean the need for voluntary family planning and related health services is growing rapidly. If affordable voluntary family planning services were within reach of those women who report they do not want to become pregnant now or in the future, birthrates would likely fall about halfway to the point that would lead to stabilized populations. Widely available education for girls would result in even lower birthrates, as women with some secondary schooling tend to marry later—which also contributes to slowing population growth—and to have fewer children. Economic opportunities for women also lead to later marriage and smaller families.

These are "win-win" strategies. Access to voluntary family planning services helps women survive pregnancy and childbirth and helps children survive their first few years of life. Family planning and greater educational and economic opportunities for women improve the quality of life generally—while slowing population growth. Self-interest as well as generosity leads Americans to support international population assistance. Because, in today's world, no place is really far from home.



Some Population Facts

- *World population currently numbers about 5.8 billion people and is growing by about 85 to 90 million people each year.*
- *It took all of history up to the year 1800 for world population to reach 1 billion people, and until 1960 to reach 3 billion. Today, the world gains 1 billion people every 11 years.*
- *The annual rate of world population growth has declined from about 2.1 percent in 1970 to less than 1.6 percent today. If the rate is not reduced further, population will double by 2040.*
- *Although population in most industrialized countries continues to grow (and the U.S. population growth rate is greater than one percent per year), more than 90 percent of the world's population growth is occurring in developing countries.*
- *Since 1960, a revolution in childbearing has occurred. The average woman gave birth to more than five children 36 years ago. Today the average woman gives birth to just over three children—less than ever in human history. In order to stabilize world population while maintaining low death rates, average births will need to total only about two children per woman.*

Population Action International

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NUMBER TWO

fact sheet

HOW FAMILY PLANNING PROTECTS THE HEALTH OF WOMEN AND CHILDREN

Family planning dramatically improves the health and chances of survival of both mothers and their children. At the same time, when parents are assured of their childrens' survival, they may be more likely to plan their families. U.S. foreign assistance should support both child health and family planning programs because they are complementary. Together, these programs contribute to improved maternal and child health, to family well-being, and to stronger families, communities and nations.

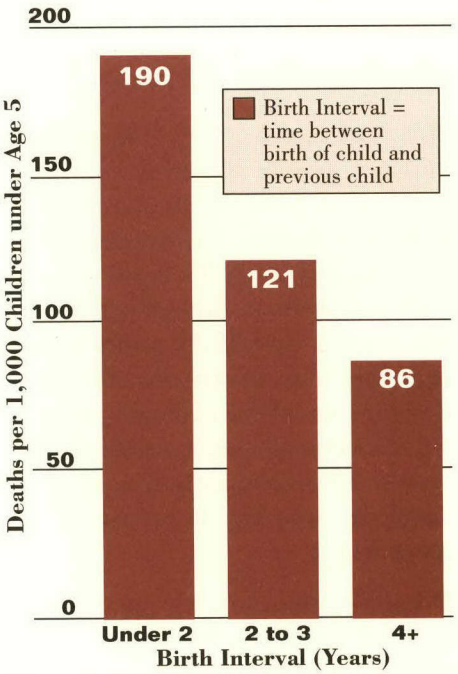
TOO MANY DEATHS

■ **Maternal and child deaths in developing countries are unacceptably high.** Every minute of every day, a woman dies in pregnancy or childbirth and more than 20 children die of largely preventable causes. More than 12 million children under age five die each year. In addition, an estimated 585,000 women die in pregnancy or childbirth every year, accounting for one-quarter to one-half of deaths to women of childbearing age. In some places, pregnancy is the leading killer of women this age.

HEALTHY MOTHERS = HEALTHY CHILDREN

■ **A mother's health affects the health of her children.** To survive the vulnerable first few days and years, children need a good start in life. Women who are in poor health or poorly nourished are more likely to give birth to unhealthy babies and often cannot provide adequate care, diminishing the chances their children will survive and thrive. Breaking the cycle of weak mothers bearing weak babies gives both mothers and children a better chance.

Deaths To Children Under Age 5 By Birth Interval



*Average for 20 developing countries based on surveys conducted 1990-94.

Source: Demographic and Health Surveys

■ **The death of a mother is devastating for her family.** Studies in Bangladesh show that when a mother dies after giving birth her newborn baby has only a small chance of surviving until its first birthday. Her other young children under age 10, especially girls, are also more likely to die. Children who survive a mother's death are less likely to receive adequate nourishment and health care. Older girls often drop out of school to care for younger siblings and do household chores.

BIRTH SPACING IMPROVES CHILD SURVIVAL

■ **The timing of births has a powerful impact on a child's chances of survival.** Over the past two decades, survey after survey has shown that children born less than two years after the previous birth are twice as likely to die by age one than children born two to four years apart. These children also have a roughly 50 percent greater risk of dying by age five. When births are spaced less than 18 months apart, the risk of death before age five doubles.

■ **Close spacing of births harms the health of mother and baby during pregnancy and forces children to compete for nourishment and maternal care.** When a pregnant woman has not had time to fully recover from the previous birth, the new baby often develops too slowly and is born underweight or premature, increasing its chances of dying in

infancy. Nursing a previous child during a pregnancy may harm the health of both children; the older child may also suffer if the new pregnancy precipitates early weaning. Children born close together have higher rates of malnutrition, develop more slowly, and are at increased risk of contracting and dying from childhood infectious diseases.

TEEN PREGNANCIES ALSO AT RISK

■ **Pregnancies to very young mothers also carry increased risks for both mother and baby.** Children born to mothers under age 18 have a 50 percent greater chance of dying before age five, compared with births to mothers aged 20 to 34. Babies born to very young mothers are again more likely to be premature or underweight. Teenage girls who are not physically mature are at greater risk of obstructed labor and complications during delivery. They are less likely to get prenatal care and to have the means to safeguard the health of their infants.

■ **Adolescent girls are also more likely to undergo unsafe abortions.** Even where abortion is legal, access may be difficult for unmarried girls. Worldwide, at least two million teenage girls have unsafe abortions each year; in many countries the number of abortions to adolescents is growing and unsafe abortion is a leading cause of death among teenage girls.

SAVING CHILDREN'S LIVES

■ **Healthier patterns of childbearing could save the lives of several million children each year.** By preventing closely-spaced births or those to very young mothers, family planning could reduce infant and child mortality by up to 25 percent, or about three million deaths a year. Simply spacing all births at least two years apart could reduce infant and child deaths on average by 15 to 20 percent. Moreover, improving patterns of childbearing requires access to effective contraception; while breastfeeding helps to space births, it does not provide reliable protection against pregnancy beyond four to six months.

■ **The potential to save children's lives is greater where a high proportion of births are closely spaced.** Improved spacing of births could reduce child deaths by a third in Egypt and Brazil. In sub-Saharan Africa, a smaller proportion of births are at risk because lengthy breastfeeding and sexual abstinence after birth help to space births further apart. But family planning is needed to protect child health as these traditional practices are abandoned.

SAVING MOTHERS' LIVES

■ **By preventing high risk pregnancies, family planning could prevent at least one-quarter of maternal deaths.** Girls under age 18, women over age 35, those who have four or more children and those who already have health problems are at greatest risk. In one area of Bangladesh, increased use of family planning significantly reduced maternal deaths among women of childbearing age simply by reducing the number of pregnancies.

■ **Family planning can prevent many if not most deaths from unsafe abortion.** Unwanted pregnancies result in about 50 million abortions every year, many of them performed under unsafe conditions. Each year, about 75,000 women die from unsafe abortions; tens of thousands more suffer serious complications leading to chronic infection, pain and infertility. Studies in several countries show that increased contraceptive use has contributed to dramatic declines in abortion rates, thereby reducing abortion-related deaths as well.

■ **Family planning programs help prevent the growing epidemic of HIV/AIDS and other sexually transmitted diseases (STDs) among women.** Every year, over one million women contract HIV/AIDS; over 125 million contract other STDs that contribute to stillbirths and infant deaths. Family planning services can help educate women about safer sexual practices and encourage the use of condoms, the primary means of preventing these diseases.

A BETTER FUTURE

■ **A planned family is the best environment for a child's overall development.** Studies show that unwanted children may suffer conscious or unconscious neglect. Parents with fewer children are able to devote more time and money to giving each child adequate food, health care, and education. Thus, family planning not only helps children survive, but makes it possible for them to develop their full potential and grow into healthy, productive adults.

MORE FUNDS NEEDED

■ **Family planning is highly cost effective.** According to the World Bank, family planning is one of the best ways for a country to improve maternal and child health, at a cost of only $1 to $2 per person a year. Yet family planning receives only a tiny fraction of health budgets and only two percent of all international development assistance. Recognizing that family planning saves lives, strengthens families, curbs population growth and promotes sustainable development, UNICEF has declared that "Family planning could bring more benefits to more people at less cost than any other single 'technology' now available to the human race."

Population Action International

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NUMBER ONE

fact sheet

WHY THE UNITED STATES SHOULD SUPPORT FAMILY PLANNING OVERSEAS

The U.S. foreign aid program has expanded access to contraception for millions of couples in developing nations, enabling them to plan their families. The program has also helped to slow population growth rates, making an important contribution to the future quality of life on our planet. Yet the job is far from done. For global family planning efforts to fully succeed, Americans and their leaders must continue to support U.S. population assistance.

PEOPLE WANT FAMILY PLANNING

■ **Couples in developing nations want smaller families.** U.S. family planning assistance responds to the growing desire of couples worldwide to make their own decisions about how many children to have and when to have them. Today, family size averages fewer than four children, down from six children 30 years ago—in large part reflecting the improved availability of family planning. Yet in many countries, women still have more children than they would like.

■ **Contraceptive use is growing rapidly.** From Bangladesh to Botswana to Brazil, increasing numbers of women are using modern contraception, contributing to declining birth rates around the world. Roughly half of all married women in developing countries now use family planning, compared to 10 percent in the 1960s. In many countries, however, contraceptive services are still difficult to obtain, unaffordable, or of poor quality.

■ **Most developing country governments now support family planning, recognizing its many benefits.** Family planning saves the lives of mothers and children by helping women to avoid high risk pregnancies and increase the time between births. Smaller family size also improves the economic situation of families. Moreover, slower population growth makes it easier for countries to provide education, health care and jobs, and to protect natural resources from further degradation.

NEEDS ARE GROWING

■ **There is still a great unmet need for family planning.** Surveys show that the majority of women in developing countries want to delay or avoid having another child. *Yet over 100 million married women of childbearing age who do not want another child right away are not using contraception.* Many women say their last birth was poorly timed or unwanted. Each year, millions of women resort to abortion; between 50,000 and 100,000 women die from unsafe abortion.

■ **The *number* of couples in need of family planning is increasing.** Although world population growth is slowing, over 80 million people were added in 1996 for a total of 5.8 billion people. It took until the early nineteenth century to reach the first billion people; it will take only 12 years to add the sixth billion. Moreover, because of past population growth, the number of women in their childbearing years in developing countries is growing by about *24 million* a year, faster than ever before. *Family planning services have to expand rapidly to keep up with both population growth and rising demand.*

U.S. LEADERSHIP IS IMPORTANT

■ **The United States has been one of the strongest supporters of international population programs.** In 1965, the United States became one of the first countries to provide family planning assistance to poor countries, as part of efforts to slow rapid world population growth. U.S. leadership has encouraged other nations—both rich and poor—to strengthen their support for family planning programs.

■ **U.S. organizations lead the world in expertise on international family planning.** A strong partnership between the U.S.

government foreign aid program and private groups has helped develop a wealth of knowledge relating to the effective management of family planning programs. U.S. voluntary agencies, universities and private companies share valued advice and know-how with colleagues throughout the world on how to deliver high quality services cost-effectively. Other donor countries are just beginning to develop such expertise.

A FOREIGN AID SUCCESS STORY

■ **U.S. population assistance is highly effective.** U.S.-funded programs have had a practical focus on expanding and improving family planning services. U.S. foreign aid has supported contraceptive services provided by both governments and the private sector; supplied contraceptives; helped train health workers and managers; and introduced creative new approaches to educating people about family planning and reaching them with services. Tens of millions of couples use family planning as a direct result of U.S. assistance. Many millions more have benefited indirectly from improvements in services resulting from American advice and innovations.

■ **Countries receiving U.S. assistance have experienced remarkable increases in contraceptive use and declines in birth rates.** In the 28 most populous countries receiving U.S. funds, the average number of children per family has dropped from 6.1 in the 1960s to 4.2 today. In Colombia, Indonesia and Mexico—all countries which have received extensive U.S. assistance—average family size is now close to three children. Taiwan and Thailand, which were early recipients of U.S. assistance, now have an average family size of two children and no longer require U.S. assistance.

■ **U.S.-assisted programs are voluntary and do not support abortion.** U.S. assistance is based on the free and informed choice and consent of individuals. U.S.-funded programs seek to empower couples to make their own decisions, for example, by working to expand the number of contraceptive methods available and training staff in proper counseling techniques. By law, U.S. funds cannot support programs that use coercion or incentives to encourage use of family planning and cannot be used to perform abortions. Improving access to contraception is also the best way to reduce reliance on abortion.

U.S. FUNDS CRUCIAL, COST PER CITIZEN SMALL

■ **The cost of U.S. population assistance to each American is negligible.** In 1995, prior to recent budget cuts, U.S. family planning aid amounted to $583 million or just *a little over $2 for each American.* Americans contribute less per person than the Danes, Dutch, Germans, and Norwegians. (Danes and Norwegians contribute the most, about $10 each.)

■ **U.S. funds are vital to global family planning efforts.** As the industrialized nation with the largest population and economy, the United States remains the biggest donor in the field. The U.S. contribution currently represents about one-third of all grant aid for family planning, but with U.S. encouragement, other donors are taking up more of the financial burden. Moreover, governments and consumers in developing countries pay most of the costs—about 75 percent of global expenditures on family planning. *Total funding from all sources, however, is currently only about one-third of total estimated need.*

A DEFINING MOMENT

■ **The decisions we make now will make a difference to the future of our planet and to our children and grandchildren.** In an interconnected world, Americans stand to benefit directly from efforts to slow population growth with its negative impacts on the global economy and environment. The prospects for peace and economic development in the twenty-first century will depend, among other things, on slowing population growth and meeting human needs. Without continued commitment, there is no guarantee that population trends will continue to move rapidly in their current positive direction.

■ **The U.S. must not falter now in its efforts to expand worldwide access to family planning.** For many years, the United States and its Congress set an example to other governments. However, U.S. leadership has been undermined by recent funding cuts and restrictions on family planning assistance, which can only lead to more unwanted pregnancies and abortions. Congress must restore funds and avoid new restrictions on family planning aid, if the United States is to live up to the responsibility that comes with its wealth and role as a world leader.

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POPULATION ACTION INTERNATIONAL

Recommendations from *Falling Short: The World Bank's Role in Population and Reproductive Health*

Strengthening Attention to Population in Policy Work:

If the Bank is to make population a central and cross-cutting policy concern and strengthen attention to population issues in analytical work, it needs to:

- establish a unit for multisectoral population analysis outside the health sector;
- prepare a formal corporate statement on the role of population in development and a strategy for addressing population concerns;
- support more research on the economic, environmental and health consequences of both rapid population growth and fertility decline;
- hold staff responsible for addressing the implications of rapid population growth in strategic documents for countries experiencing such growth; and
- ensure that Bank officials at all levels consistently incorporate population concerns into policy discussions with countries with rapidly growing populations.

Strengthening Bank Support to Reproductive Health and Family Planning Programs:

The Bank needs to increase its financial support to reproductive health and family planning programs as well as to improve the effectiveness of projects in this area. To enhance its contribution in reproductive health and family planning, the Bank should:

- expand financing on concessional terms for social sector projects;
- support reproductive health and family planning projects alongside health sector reform projects, or structure sector-wide projects to give special attention to reproductive health;
- increase the profile of reproductive health and family planning activities within integrated health projects as well as through stand-alone reproductive health projects;
- review ongoing programs to identify priority countries for additional reproductive health and family planning investments;
- monitor the adequacy of financial resources and staff allocated to all key elements of reproductive health;
- maintain a strong program of sector-level analytical work in reproductive health as a basis for providing sound advice to countries;
- institute more rigorous quality control and technical review systems during project design;
- provide sufficient funds for technical oversight during project supervision;
- work in a more complementary way with donors having greater technical expertise and field staff in reproductive health; and
- expand support for both NGOs and for-profit reproductive health and family planning activities, while also developing more effective mechanisms for support to programs in these areas.

Strengthening the Bank's Technical Capacity in Reproductive Health and Family Planning:

In order to support an expanded and more effective engagement in this area, the Bank needs to:

- appoint senior reproductive health and family planning experts to provide leadership both at the central level and in each regional department;
- closely monitor the impact of the reorganization on technical capacity, and reestablish a core of experts in the central human development department, if needed;
- recruit additional specialists to fill gaps in staffing in the regional departments, especially the Africa department;
- use existing reproductive health and family planning expertise more effectively;
- initiate a training program for non-specialist staff who work on reproductive health projects;
- increase technical staff in resident missions; and
- develop new mechanisms to systematically tap external institutional expertise in the reproductive health field.

Synopsis of Key Population Action International Recommendations

See Executive Summary of *Falling Short* for Full Listing of Recommendations

1. Attention to Population in Policy Work

- Major address on population and regular public statements by president
- Small population policy unit outside the health sector
- Corporate statement supporting population
- Expanded support for research on population and development
- Coverage of population concerns in key Bank documents
- Inclusion of population issues in policy discussions with borrowers

2. Program Support to Reproductive Health

- Concessional financing for social sector projects
- More support for reproductive health activities in projects
- Identification of priority countries for reproductive health activities
- Monitoring lending levels for reproductive health and family planning
- More analytical work in reproductive health at country level
- More expert reproductive health input in design and supervision of relevant health projects
- Closer collaboration with other donors having reproductive health expertise in the field
- Expanded funding for NGOs and for-profit sector in reproductive health

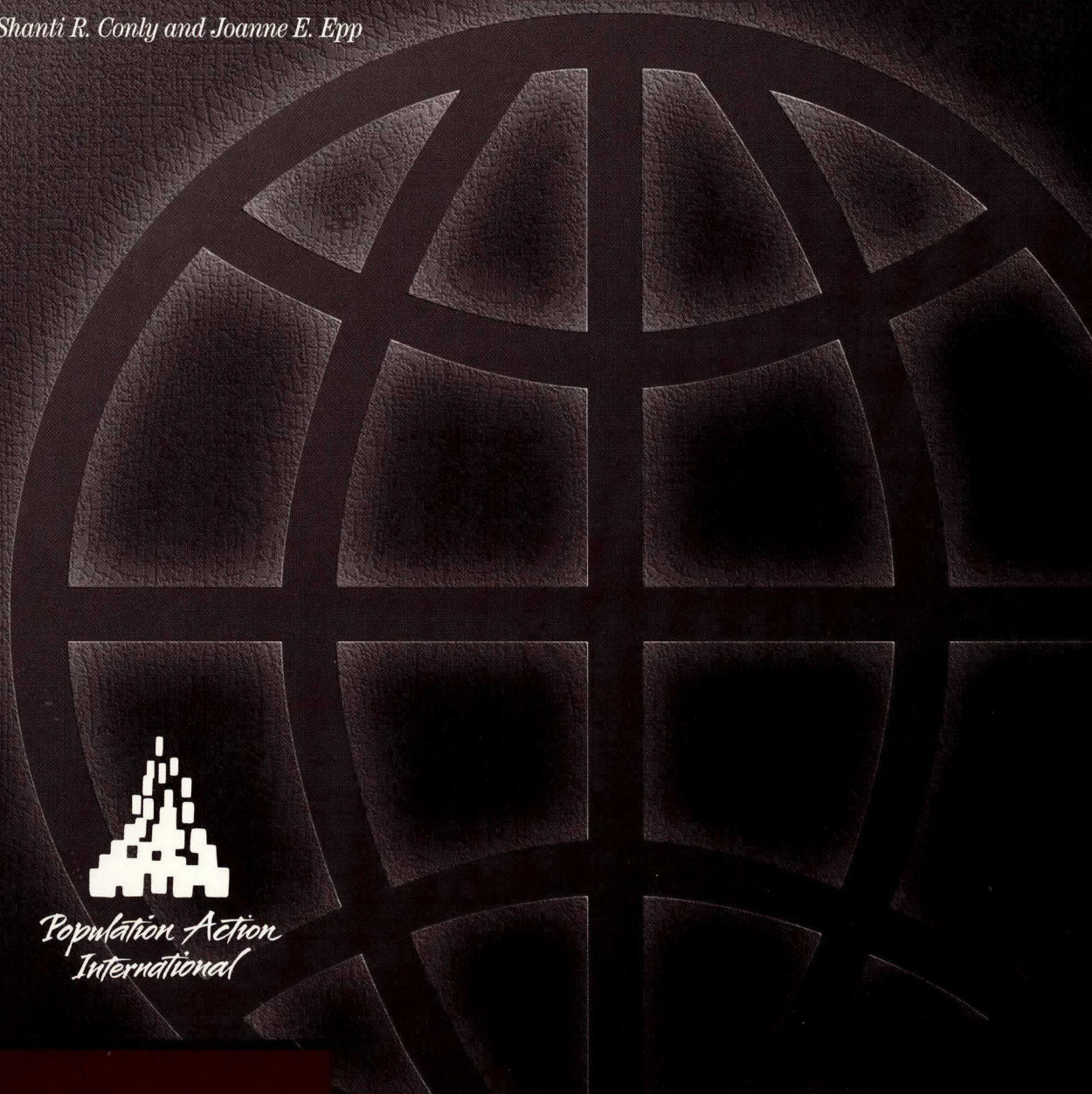
3. Strengthening Technical Capacity

- Senior leadership in reproductive health at both central and regional levels
- Sufficient core of reproductive health and family planning experts in each region, utilized for their specialized technical input
- Training in reproductive health for non-specialist staff working in this area
- More technical health staff, including reproductive health experts, in key resident missions
- Increased use of outside reproductive health expertise—including specialized institutions

Falling Short

THE WORLD BANK'S ROLE IN POPULATION AND REPRODUCTIVE HEALTH

By Shanti R. Conly and Joanne E. Epp



Population Action International

Falling Short: The World Bank's Role in Population and Reproductive Health

Population Action International (PAI) is dedicated to advancing policies and programs that slow population growth in order to enhance the quality of life for all people.

PAI advocates the expansion of voluntary family planning, other reproductive health services, and educational and economic opportunities for girls and women. These strategies promise to improve the lives of individual women and their families while slowing the world's population growth.

To these ends, PAI seeks to increase global political and financial support for effective population policies and programs grounded in individual rights.

PAI fosters the development of U.S. and international policy on urgent population issues through an integrated program of policy research, public education and political advocacy. PAI reaches out to government leaders and opinion makers through the dissemination of strategic, action-oriented publications, broader efforts to inform public opinion, and coalitions with other development, reproductive health and environmental organizations.

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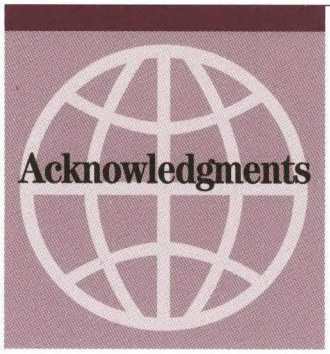
Falling Short

The World Bank's Role in Population and Reproductive Health

Shanti R. Conly and Joanne E. Epp

Population Action International

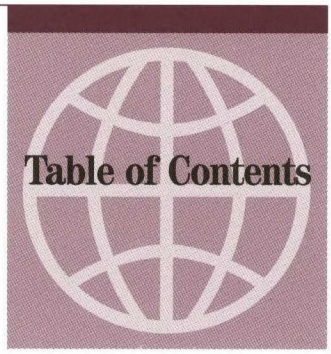


Acknowledgments

In early 1997, Population Action International (PAI) staff met with World Bank colleagues in the health, nutrition and population sector to discuss the Bank's activities in population and reproductive health. This exchange sparked PAI's decision to prepare its own assessment of the Bank's contribution to addressing the needs in this area identified by the 1994 Cairo conference on population and development.

PAI was aided in the effort by the encouragement of the World Bank's leadership in human development and health. Many Bank staff graciously took the time to meet with us, share documents with us, and respond to our never-ending requests for additional information. This report owes its strengths to their efforts to educate us about the intricacies of the Bank, an extremely complex and highly decentralized organization, and one that is currently experiencing major change. The report's faults, of course, are our own.

We owe a special debt of gratitude to Tom Merrick, the Bank's population advisor, who patiently bore the brunt of our information requests. However, we are very grateful to *all* our colleagues at the Bank, both for their assistance and for the openness with which they responded to us. We also thank colleagues inside and outside the World Bank who took the time and trouble to give us valuable comments and perspective on an earlier draft of this report.



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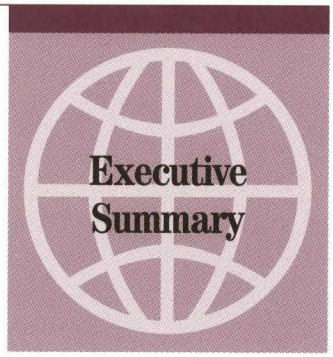


Implementing ICPD: The Role of the World Bank

The number of women—and men—in need of reproductive health services will almost double over the next two decades. Action taken now by the world community to expand reproductive choices for these individuals will have a significant impact on their health and well-being, on the eventual size of the world's population and on the quality of life for future generations. Recognizing these needs, 180 nations endorsed a comprehensive strategy for improving reproductive health at the 1994 International Conference on Population and Development (ICPD).

The World Bank has enormous potential to help developing countries implement this strategy. The Bank has great influence on national development policies and can help advise governments on appropriate investments in population programs. In addition, the Bank's substantial loan resources can help finance the large new investments in reproductive health services and women's educational and economic opportunities called for by the ICPD. The Bank's financial resources are especially important since the gap between reproductive health and family planning needs and funds available for these programs is growing, while donor country contributions to population programs lag far behind commitments made at the ICPD.

The World Bank has enormous potential to help developing countries implement the ICPD strategy.

The Bank's current leadership is introducing sweeping changes aimed at making the institution more responsive to the needs of developing countries. Some of these changes—for example, efforts to redirect loan resources from infrastructure to health and education projects and to pay greater attention to women's issues—hold promise to advance the goals of the ICPD. However, recent changes do little to address the limited attention the Bank has given to the problem of rapid population growth in the last few years. Moreover, in the health sector, the Bank is increasingly emphasizing broad policy reform and financing issues, a trend which could detract from support to improvement of actual health services, including reproductive health and family planning.

Attention to Population-Development Linkages at the Policy Level

Bank reports analyzing the economic situation and development prospects of a country form the basis for policy discussions with the government and for the Bank's lending program to that country. In a positive shift, the Bank is moving to incorporate more analysis of social issues in these country strategy documents. However, if population concerns are to be reflected in the policy dialogue with borrower countries, it is important that the Bank's analytical reports more consistently and fully address problems associated with rapid population growth.

One reason for the frequent neglect of population concerns in economic analyses is that the Bank's economic establishment remains unconvinced that population factors have a negative impact on economic growth. While in the past the Bank has sponsored important research on the linkages between population growth and various development outcomes, it currently supports very limited work in this area. Recent initiatives to disseminate new research on economic and other benefits of slower population growth are, however, encouraging.

Overall, the Bank has not taken a strong position in support of population stabilization, and has favored investments in health and education over family

planning as a strategy for encouraging a shift to smaller families. Although such investments are an essential part of a comprehensive population strategy, the Bank also needs to recognize the central role improved access to contraceptive services has played in rapid fertility decline.

In practice, however, the Bank has had difficulty adopting a multisectoral approach. Responsibility for population activities falls narrowly under the health sector, limiting the potential to incorporate population concerns into the Bank's overall approach to development. No organizational unit has responsibility for integrating population issues in a cross-cutting way into broader development analyses. The recent reorganization and the low profile the Bank's leadership has maintained on the subject of population have reinforced the neglect of these issues.

Responsibility for population activities falls under the health sector, limiting the potential to incorporate population concerns into the Bank's overall approach to development.

Recommendations for Strengthening Attention to Population in Policy Work:

If the Bank is to make population a central and cross-cutting policy concern and strengthen attention to population issues in analytical work, it needs to:

- establish a unit for multisectoral population analysis outside the health sector;
- prepare a formal corporate statement on the role of population in development and a strategy for addressing population concerns;
- support more research on the economic, environmental and health consequences of both rapid population growth and fertility decline;
- hold staff responsible for addressing the implications of rapid population growth in strategic documents for countries experiencing such growth; and
- ensure that Bank officials at all levels consistently incorporate population concerns into policy discussions with countries with rapidly growing populations.

Bank Lending for Reproductive Health and Family Planning

While the ICPD endorsed a broad strategy for slowing population growth, the Programme of Action adopted by the conference calls specifically for increased investments in a core package of reproductive health services. Key elements of this package include family planning, care in pregnancy and childbirth, and prevention and management of sexually transmitted diseases (STDs), including HIV/AIDS.

Overall Trends in Bank Lending for Reproductive Health: The Bank's contribution in the area of reproductive health, together with its overall lending for health, nutrition and population (HNP) projects, has evolved significantly over time. Initially, in the 1970s, Bank lending in health focused on population and family planning. Subsequently, it expanded support for other health and nutrition activities. Beginning in the late 1980s, the Bank has also substantially stepped up support for programs to control HIV/AIDS and other sexually transmitted diseases (STDs), and for safe motherhood activities.

Overall lending for health and education projects has risen dramatically in recent years. Combined lending for population and reproductive health activities has also increased, reaching a high of over $500 million in fiscal year (FY) 1996. However, increases in lending for population and reproductive health lag behind the overall growth of health sector lending, and have lost ground in

terms of their share of total HNP lending. Moreover, in FY 1995 and FY 1996, new loan commitments for family planning activities alone declined to a little over $100 million a year, roughly half the average annual lending level in the early 1990s. As the Bank has shifted away from specialized or stand-alone population projects, reproductive health and family planning activities are also increasingly becoming small and often marginalized components of larger, comprehensive health projects.

Uneven Regional Responses: The Bank's involvement in reproductive health has varied greatly across regions and countries. Several different factors account for this unevenness, including the variable eligibility of countries for concessional financing, the extent of their commitment to population programs and reproductive health, and the Bank's larger priorities vis-a-vis the overall lending program.

Although overall lending for health projects has risen dramatically, increases for population and reproductive health have not kept up.

South and East Asia have benefited most from Bank support to population and reproductive health programs. The Bank has made important contributions to family planning efforts in a number of Asian countries, most notably Bangladesh and India. In the late 1980s and early 1990s, the Bank initiated population activities in a large number of sub-Saharan African countries, mostly as small components of larger health projects. The gap between Bank assistance and current needs, however, remains greatest in Africa.

In the Middle East and North Africa, the Bank's assistance has been limited but has nevertheless supported family planning programs in several countries. The Bank has also recently initiated reproductive health projects in a number of countries in Latin America and the Caribbean, after years of maintaining a low lending profile with respect to family planning in the region. It has, however, largely neglected reproductive health needs in Europe and Central Asia.

Overall, the Bank has made and continues to make a major contribution in the family planning field in a few countries, especially in Asia, and is to be commended for increasing attention and financial support to AIDS and safe motherhood activities. But there are many more countries, especially in sub-Saharan Africa, where reproductive health needs remain great and there are opportunities for the Bank to do much more. Current plans for future sector-level analytical work and for new projects indicate relatively few activities in the pipeline focusing on reproductive health, especially in the area of family planning.

Effectiveness of Bank Activities: The Bank's contribution should be judged not only by the magnitude of its funding commitments, but also by the effectiveness and impact of its projects. Over the past five years, the Bank's leadership has made an effort to bring about a shift within the Bank from a culture which rewards processing and approval of new loans to one that emphasizes effective implementation and the impact of projects. Systematic information on the effectiveness of Bank reproductive health projects is lacking; still, there appears to be considerable scope for strengthening the impact of Bank assistance in this area.

First, the shift towards development of broader projects supporting health sector-wide management and financing reforms threatens to overshadow the urgent need in many countries to strengthen reproductive health services. The sector-wide approach is important to address systemic constraints on the delivery of health services. However, especially where basic services are weak, there is also a need for more focused efforts to improve reproductive health. In countries with more developed health systems, input from reproductive health experts could help structure health reform projects to give higher priority to reproductive health.

The quality of project design has also been an issue, especially since the Bank has cut back resources for the analytical work required for good project preparation. While Bank projects across all sectors suffer from deficiencies in design, the complexity of HNP projects make them more vulnerable to design-related implementation problems.

Monitoring and supervision of reproductive health activities is another weak point for the Bank. Especially where such activities represent only a small component of larger integrated health projects, they receive minimal attention during supervision visits. The squeeze on operating expense budgets over the last couple of years has reduced travel funds for projects in the human development sectors, undermining recent efforts by the Bank's leadership to strengthen project supervision and implementation. The Bank has done better in project implementation in Bangladesh and India, where it has funded large, focused population projects and deploys technical staff in country.

Current plans for future analytical work and for new projects indicate few activities with a focus on reproductive health.

The effectiveness of Bank-financed projects also depends on the extent to which the Bank's assistance complements assistance from other donors. In general, the Bank has done better in coordinating with other donors during project development and where it has technical staff in its resident missions. The Bank has also done well at mobilizing additional donor resources for population and reproductive health programs, both through grant financing to complement Bank projects and in a few countries, through leadership of joint donor initiatives. Still, the effectiveness of Bank projects would be enhanced by more complementary programming with those donors having greater technical capacity and more staff in the field.

The Bank is often criticized for inadequate involvement in its projects of non-governmental organizations (NGOs), which can provide a vital link to local communities. However, Bank support to NGOs has been greater in reproductive health and family planning than in many other areas of Bank activity. A small central grants program has supported a range of special reproductive health initiatives; numerous country-level health and family planning projects also incorporate funding for NGO activities. Nevertheless, there is a need for more effective mechanisms for Bank support to NGO activities at the country level.

The Bank has done less well in supporting for-profit and social marketing initiatives in reproductive health and family planning. This reflects both reluctance on the part of borrower governments to channel funds to commercial sector activities, and the limited staff in the Bank with expertise in this area.

Recommendations for Strengthening Bank Support to Reproductive Health and Family Planning Programs:

The Bank needs to increase its financial support to reproductive health and family planning programs as well as to improve the effectiveness of projects in this area. To enhance its contribution in reproductive health and family planning, the Bank should:

- expand financing on concessional terms for social sector projects;
- support reproductive health and family planning projects alongside health sector reform projects, or structure sector-wide projects to give special attention to reproductive health;
- increase the profile of reproductive health and family planning activities within integrated health projects as well as through stand-alone reproductive health projects;

- review ongoing programs to identify priority countries for additional reproductive health and family planning investments;
- monitor the adequacy of financial resources and staff allocated to all key elements of reproductive health;
- maintain a strong program of sector-level analytical work in reproductive health as a basis for providing sound advice to countries;
- institute more rigorous quality control and technical review systems during project design;
- provide sufficient funds for technical oversight during project supervision;
- work in a more complementary way with donors having greater technical expertise and field staff in reproductive health; and
- expand support for both NGOs and for-profit reproductive health and family planning activities, while also developing more effective mechanisms for support to programs in these areas.

The Bank's Technical Capacity in Reproductive Health and Family Planning

The recent initiative to strengthen regional and country-level staff is a positive development, but reproductive health staffing remains uneven across regions.

In recent years, the Bank has experienced an erosion of technical expertise across all sectors, including within the human development and health sectors. In the HNP sector, there is a small core of highly qualified health experts, including a smaller group of reproductive health and family planning specialists. Yet economists represent the largest single group of HNP staff, and many HNP staff lack specialized health expertise. Moreover, those staff with specialized skills in reproductive health often work on other aspects of health, while others working on reproductive health projects lack specialized expertise in this area.

Despite the demonstrated importance of field staff to sound project design and implementation, the Bank has relatively few technical staff in its resident missions. The recent initiative by certain country departments in the Bank to decentralize staff and strengthen resident missions is a very positive development. Still, given the high cost of maintaining staff in the field, most field offices are unlikely to include staff with specialized reproductive health expertise. Thus, there is likely to be a continuing role for headquarters in policy guidance and technical oversight.

As in the case of lending, staffing is uneven across the Bank's regional departments. Overall, no regional department has adequate reproductive health expertise. The South and East Asia departments are somewhat better staffed in this area than other departments. Both the Middle East/North Africa and Latin America/Caribbean departments have only a few staff with reproductive health expertise. In Europe and Central Asia, there are essentially no staff with real expertise in this area. The Africa department has a small group of AIDS and family planning experts, but their numbers are inadequate to the needs, especially given weak managerial and technical capacity within the region. Despite the dearth of expert staff—and unlike some other donors—the Bank has no mechanisms to draw on external technical expertise in a systematic way to support country level projects.

The recent reorganization has created a new system of "networks" linking technical staff across the Bank. The human development network council and the HNP sector board, comprising representatives from all the regional departments, have primary responsibility for strengthening the Bank's technical expertise in the health sector, including the reproductive health area. The reorganiza-

tion has grouped technical staff together at the regional level, helping to establish a critical mass of expertise and a structure more responsive to program needs. However, the recent restructuring has eroded the central core of expertise in the human development department, a move which could weaken Bank-wide leadership in reproductive health as well as other technical areas.

The Bank has considerable influence over the priorities of developing country governments, but is falling short of its potential to advance population policies and reproductive health programs.

Recommendations for Strengthening the Bank's Technical Capacity in Reproductive Health and Family Planning:

In order to support an expanded and more effective engagement in this area, the Bank needs to:

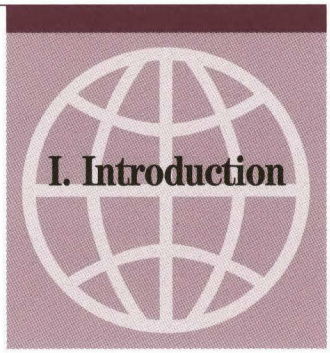
- appoint senior reproductive health and family planning experts to provide leadership both at the central level and in each regional department;
- closely monitor the impact of the reorganization on technical capacity, and reestablish a core of experts in the central human development department, if needed;
- recruit additional specialists to fill gaps in staffing in the regional departments, especially the Africa department;
- use existing reproductive health and family planning expertise more effectively;
- initiate a training program for non-specialist staff who work on reproductive health projects;
- increase technical staff in resident missions; and
- develop new mechanisms to systematically tap external institutional expertise in the reproductive health field.

Priorities for Bank Management

Overall, despite some important contributions, the Bank appears to be falling short of its significant potential to advance population policies and reproductive health programs, and to help the international community meet the financial goals agreed to at the ICPD. Bank staff often attribute low levels of population lending to weak demand on the part of borrower countries. Yet the Bank itself has considerable influence over the priorities of developing country governments. Inadequate demand in part reflects a lack of initiative by the Bank to promote the benefits of slower population growth to policymakers, and to assist countries in developing multisectoral strategies that can accelerate both fertility decline and economic and social development.

If top management is seriously committed to a greater leadership role for the Bank with respect to population policies and programs, the following are priority areas for action:

- Ensure that policy discussions with borrower governments consistently address the implications of rapid population growth across all areas of development, and the most appropriate strategies to help slow such growth.
- Monitor new loan commitments in all key areas of reproductive health, as well as plans for future analytical work and development of new projects in these areas.
- Put in place the staff and contractual mechanisms necessary to mobilize the very best quality expertise to support the effective implementation of Bank-financed reproductive health activities.



The Importance of the World Bank to Population and Development

The World Bank—by far the most influential organization in international development assistance—has an important role to play in helping developing countries implement the new and comprehensive approach to slowing population growth agreed on at the International Conference on Population and Development (ICPD) held in Cairo in 1994.

The ICPD *Programme of Action* recognizes the right of women to make their own decisions about childbearing as well as the negative effect of rapid population growth on prospects for long-term, environmentally sustainable development. Acknowledging the links between the status of women, broader social policy and fertility, it recommends a comprehensive strategy to promote both improved reproductive health and population stabilization. This strategy includes expanded access to better quality contraceptive services, to a broader range of reproductive and child health services, and to educational and economic opportunities for women.

Despite the ICPD's call for increased investments to help achieve these goals, total development assistance has been decreasing. Donor funding for population programs increased in 1994 and 1995, but now appears to be leveling off or declining while still far from the goals agreed to in Cairo. To a large extent, therefore, the achievement of conference objectives depends on the developing countries themselves. *The World Bank is uniquely positioned to assist these countries in financing the investments in reproductive health and family planning, girls' education and women's empowerment that are important in their own right and that also help to lower fertility.*

The Bank's importance in international development assistance stems first from the magnitude of financial resources at its disposal—it commits over $20 billion a year in new loans across all sectors. Although the Bank's assistance is in the form of loans and concessional credits, its investments often serve a catalytic role in mobilizing grant funds from other donors as well as additional resources from developing country governments.

By virtue of its financial clout and its analytical expertise, the Bank also has great influence on the policies and budgets adopted by developing countries. The Bank's engagement in virtually every aspect of development is a further advantage in promoting the multi-faceted strategies needed to improve reproductive health and also stimulate declines in high fertility. More than any other donor, then, the Bank has the ability to convey to governments the importance of slowing rapid population growth for long-term development.

The Changing Bank Environment

In Cairo in 1994, the late Bank president Lewis Preston acknowledged the consequences of population growth for all aspects of development: "Putting it bluntly: if we do not deal with rapid population growth, we will not reduce poverty—and development will not be sustainable."

Inspired by a similar rationale, beginning in 1970, the Bank began providing financial support for the development of family planning programs in a number of countries, primarily in Asia. Historically, it has also helped to stimulate the adoption of population policies in a larger number of countries.

Yet the Bank has not consistently made population issues a priority. Attention to population—and lending

"Putting it bluntly: if we do not deal with rapid population growth, we will not reduce poverty—and development will not be sustainable."
Lewis Preston, former World Bank President

In the 1990s, the Bank's leadership has correctly assigned increased importance to social investments such as health and education, to poverty reduction and to women's issues.

for family planning projects—declined dramatically following a 1987 reorganization which shifted responsibility for population lending from a central department to individual country departments. Interest and lending rose between 1989 and 1991, after the Bank's leadership responded to external criticism by promising to increase lending for population projects. In recent years, however, attention to population concerns appears to be on the downswing again.

In the 1990s, the Bank's leadership has correctly assigned increased importance to social investments such as health and education, to poverty reduction and to women's issues. The trend towards expanded lending for health and education projects has the potential to increase resources for population programs, broadly defined, and to reinforce more direct efforts to reduce fertility. However, the focus of health lending is increasingly shifting to broad health sector reform and financing, a trend which could potentially detract from efforts to strengthen specific health services, including reproductive health and family planning.

The Bank has also been undergoing perhaps the most sweeping institutional transformation in its history. Recent changes include a restructuring of technical support functions in the social sectors, and have the potential to affect the Bank's population work in both positive and negative ways. Thus, at present there is great fluidity and change within the Bank. This evolving environment offers a unique opportunity to influence the Bank's work in population and reproductive health, but also presents the challenge of a moving target.

PAI's Review of the Bank's Engagement in Population and Reproductive Health

Population Action International (PAI), an organization that seeks to stimulate action toward early world population stabilization, has undertaken a series of analyses of the effectiveness of international institutions and donor agencies that are key to the success of population programs around the world. These reports include a 1989 analysis of the World Bank's population activities. Changes since that time, both in the Bank and the international context within which it operates, warrant a fresh look at the Bank's contribution in this area.

The present review examines three key questions:

- In policy discussions with borrower countries, to what extent is the Bank encouraging attention to the relationships between population dynamics and development and ensuring that population concerns are adequately addressed?
- To what extent is the Bank providing financial support to reproductive health programs, including family planning? How can the Bank expand lending for these programs, improve the effectiveness of Bank-financed projects and stimulate additional donor and national funding?
- What capacity does the Bank have for providing expert advice with respect to the sound planning and effective implementation of reproductive health and family planning projects? How are current organizational changes affecting the Bank's work in both population and reproductive health?

To address these questions, PAI interviewed a broad spectrum of World Bank population and health sector staff, reviewed numerous Bank documents, and undertook an independent analysis of recent Bank loan commitments for health and population. Our report is constrained by the limited information available in the public domain on the effectiveness and impact of Bank projects. It is, moreover, difficult to generalize about the Bank, a decentralized institution working to address the varied needs of borrower countries in many different ways. Within these constraints, we have tried to provide a frank but balanced assessment of the Bank's recent policy work on population and its lending for reproductive health and family planning.

A word on terminology: within the Bank—and outside it—there is a tendency to confuse population (i.e., demographic dynamics) with family planning (the provision of contraceptive services). The Bank has contributed to this confusion by classifying lending for family planning activities as population (or more recently as part of population and reproductive health). At the risk of perpetuating this confusion, for purposes of consistency we have used the Bank's own terminology in discussing annual trends in lending.

A final caveat relates to the scope of this report. Clearly, a broad spectrum of Bank investments influence fertility. The Bank deserves special credit for increasing lending for girls' education—especially at the primary level—and for new initiatives in the area of micro-enterprise credit for women. However, this report focuses more narrowly on the extent to which the Bank has made broader linkages between population and development explicit in its policy work, and on its record in financial support for the reproductive health and family planning activities which represent the core of the Cairo agenda. A broader look at the Bank's efforts to improve the status of women is beyond both the scope of the current report and PAI's expertise; fortunately, other organizations have taken on this challenge.*

The focus on broad health sector reform could potentially detract from efforts to strengthen reproductive health and family planning services.

*Mayra Buvinic et al., *Investing in Women: Progress and Prospects for the World Bank* (Washington DC: Overseas Development Council, 1996); also, the U.S. chapter of the Women's Eyes on the World Bank Campaign plans to release its report, *Gender Equity and the World Bank Group: A Post-Beijing Assessment*, in November 1997.

II. Making the Case: Increasing Attention to Population Concerns at the Policy Level

Macro-economic policy analysis and advice are the cornerstones of the Bank's involvement in developing countries. The Bank's assessment of the economic conditions in a country largely determines its lending program to that country. Consequently, borrower countries look to the Bank for advice and closely follow its recommendations on development policy. Economists in the Bank's country departments usually take the lead in these discussions with governments.

Inadequate Attention to Population in Policy Discussions

In general, population concerns do not feature prominently or consistently in the strategic documents that form the basis for policy discussions with borrower governments. As part of these discussions, the Bank prepares a country assistance strategy analyzing the country's situation in order to identify priority areas for further analytical work, and ultimately, for its lending program to that country. Ideally, in countries where population growth represents a problem, the country assistance strategy should identify the most important investments to help accelerate the pace of fertility decline.

The country strategy process is central to including population issues on the agenda of both the Bank and borrower. Attention to population-development relationships in this process can help promote a better understanding among governments of the benefits of investments in slowing population growth, as well as more explicit consideration of population impacts in the design of other development programs. Bank population staff note that raising population concerns early in the process of formulating country strategies is key to the subsequent development of population-related projects.

The Bank has a long history of neglecting population issues in its economic analyses. For example, a 1991 evaluation criticizes the Bank for uneven attention to population issues in policy work and for failing to consider demographic impacts in developing projects in other sectors. Over the past decade, other external and internal reviews of the Bank's population activities have also highlighted a lack of systematic attention to population in analytical work.

Because access to country strategy documents is generally limited to Bank staff and respective borrower governments, it is difficult to assess the extent to which these documents currently address population issues. According to several Bank staff, progress remains limited. In many instances, staff who work on population issues—or for that matter other staff with expertise specific to a particular technical area—are not at the table during formulation of country strategies. While strategy documents may mention population factors, they seldom address them with any depth of analysis. Moreover, they tend to raise these issues solely in the context of the health and family planning sectors, rather than their implications for achieving broader development goals.

On the positive side, the Bank is increasingly incorporating more social analysis—especially of gender-related issues—in country strategies, a trend which could potentially reinforce the Cairo conference goals. In addition, there are a number of recent instances where the Bank has drawn attention to population concerns in policy discussions with borrower countries. In Yemen, for example, the Bank has invested in a major study of the implications of population growth and is now working with the government to develop investment strategies. In Senegal, too, the Bank has used its access to high-level policymakers

The Bank has a long history of neglecting population issues in its economic analyses.

The Bank is incorporating more social analysis in country strategy reports, a trend which could reinforce ICPD goals.

to draw attention to the need to slow population growth. Bank staff cite Paraguay and Malawi as other examples of countries where recent country strategy reports include substantial discussion of population issues.

Nevertheless, the Bank needs to more consistently address population issues in analytical work on countries with high population growth rates. Treatment of population issues is reportedly inadequate in country assistance strategies prepared in 1997 for Côte d'Ivoire, Ethiopia and Ghana, among other countries. Yet population growth merits special attention in these countries because of its cross-cutting impact on virtually every sphere of human activity, on the environment, and ultimately, on prospects for long-term sustainable development.

Reasons for Inadequate Attention to Population in Policy Work

There are many reasons why population concerns do not receive adequate attention in economic and analytical work. First and foremost, many Bank economists remain unconvinced of the importance of population factors to development. Their ambivalence underlies the lack of clear guidance on population issues in the Bank's official policy statements and the limited current support for research on population-development linkages. In addition, the Bank's organizational structure, the current reorganization and top management have all marginalized population concerns.

Ambivalence of Economists on Importance of Population: *Many Bank economists do not believe that slowing population growth consistently contributes to development.* They are profoundly influenced by the research on the macro-economic impact of rapid population growth, research which until very recently has been sparse and inconclusive.

An influential literature review, carried out by the National Research Council in the mid-1980s, failed to find a consistent relationship between population growth and economic growth—in part because of the complexity of factors involved. A subsequent analysis sponsored by the Bank shows that population growth had a negative impact on economic growth across countries during the 1980s, with the most significant negative effects in the poorest countries.This analysis further suggests that this relationship has persisted in poor countries since the 1960s.

A more recent literature increasingly supports the notion that, at least in East Asia, fertility decline played an important role in economic growth in countries with strong institutions and good economic policies. There is also growing evidence that smaller family size improves well-being at the household level.*

*Research referred to in the section above includes: *Population Growth and Economic Development: Policy Questions* (Washington, DC: National Academy Press, 1986); Allen C. Kelley and Robert M. Schmidt, "Population and Income Change: Recent Evidence," World Bank Discussion Paper, no. 249 (Washington, DC: World Bank, 1994); World Bank, *The East Asian Miracle: Economic Growth and Public Policy* (Oxford: Oxford University Press, 1993); Asian Development Bank, *Emerging Asia: Changes and Challenges* (Manila: Asian Development Bank, 1997); Kenneth H. Kang, "Why Did Koreans Save So 'Little' and Why Do They Now Save So 'Much'?" and Ronald Lee, Andrew Mason, and Timothy Miller, "Savings, Wealth and the Demographic Transition in East Asia, " in *Proceedings of the Conference on Population and the East Asian Miracle*, 7-10 January 1997 (Honolulu: East-West Center Program on Population, 1997); Cynthia B. Lloyd, "Investing in the Next Generation: The Implications of High Fertility at the Level of the Family," Population Council Working Paper, no. 63 (New York: The Population Council, 1994).

In light of the econometric evidence, the majority of Bank economists acknowledge that high population growth rates have a profound negative impact on long-term prospects for economic and social development in very poor countries. However, many economists—often unfamiliar with the emerging evidence relating to East Asia—consider the links between population growth and development to be less evident in middle-income countries. They perceive other demographic trends, such as the aging of populations, to have more important economic consequences in more developed settings.

Within the Bank's central economics establishment, the policy research group has been profoundly skeptical of the interaction between population and development. This group has focused very narrowly on statistical relationships between population growth rates and macro-economic indicators across countries. Moreover, a few senior economists within this group view the *demand* for smaller families as key to fertility decline and question the need for *government* intervention, arguing that increased demand should stimulate the expansion of contraceptive services by the private sector. These views, expressed in international journals as well as in internal Bank memoranda commenting on specific country proposals, reinforce the reluctance of rank-and-file economists in the country departments to call for investments to influence fertility through the expansion of family planning services.*

Population growth is implicitly reflected in the Bank's main yardstick of country economic performance—per capita gross domestic product (GDP)—since growth in per capita GDP is effectively deflated by the rate of population growth. Yet many Bank economists focus on overall rates of GDP growth; as a result, the Bank's poverty analyses often fail to identify population growth as a contributing factor to persisting low levels of per capita GDP. Bank economists also see population as a long-term issue. Although birthrates in a number of countries have fallen steeply in as little as 10 to 15 years, fertility reduction does not lend itself to the 3 to 5 year time horizon within which the Bank expects countries to develop economic plans and deliver results.

The situation is complex because rapid population growth is no longer as significant a problem across all developing regions. The Bank's borrower countries have become increasingly diverse in their level of development and in their health and fertility status. High population growth rates and poor access to reproductive health and contraceptive services remain a problem throughout Africa, South Asia, most Middle Eastern countries, and some countries in South and Central America. Yet fertility has fallen dramatically in most of East Asia and in a number of countries in Latin America. Given this diversity, the need is for country-specific rather than more generalized strategies.

Still, there is a strong argument for the World Bank to pay special attention to countries where population growth rates remain high. The most recent research supports the existence of a relationship between fertility and economic growth, while suggesting this relationship is complex and varies depending on the point in time, the country and region, and the level of development. Quite apart from any macro-economic impacts, common sense dictates that rapid population growth makes it more difficult for

The Bank's central economics establishment has been profoundly skeptical of the interaction between population and development.

*Lant Pritchett, "Desired Fertility and the Impact of Population Policies," *Population and Development Review* 20, no. 1 (March 1994): 1-55

The most recent research supports the existence of a relationship between fertility and economic growth, while suggesting this relationship is a complex one.

governments to keep up with the demand for basic services. Finally, econometric analyses do not capture the long-term effects of population growth on the environment and future quality of life. By demanding a higher statistical standard of proof, the Bank risks losing valuable time and seeing the benefits of a range of development programs eroded by population growth.

Recent research has also increasingly highlighted the importance of organized family planning programs in fertility decline, especially as fertility preferences change and family planning programs gain in strength. The need for public investment in this area is moreover borne out by evidence that the free market often fails when it comes to providing family planning information and services.*

Finally, regardless of the economic effects of population growth, there are important reasons for public investment in reproductive health and family planning. The Bank should support these services because they are a major point of contact with health systems for women and thus an important vehicle for improving women's health. In addition, improving access to reproductive health and family planning services is key to the broader social transformation required to address gender inequality and promote the empowerment of women.

Lack of Clear Guidance in Official Policy Statements: *In part because of the lack of internal consensus, the Bank has not taken a strong corporate position in support of population stabilization.* In official documents, the Bank recognizes that population stabilization necessitates a range of potential interventions. Among these interventions, official Bank policy statements emphasize indirect investments in economic and social development as a strategy for fertility reduction, down-playing the importance of more direct investments in contraceptive information and services.

- For example, a 1994 communiqué issued by the World Bank Development Committee states that an integrated population policy must recognize the links between economic growth, population, poverty reduction, health, investment in human resources and environmental degradation. According to the communiqué, "Family planning is only one of the available instruments and needs to be seen in the broader context of changing social patterns and the increased awareness of women's roles."
- Similarly, the World Bank's 1996 Annual Report plays down the urgency of more focused interventions for fertility reduction and sees improved economic growth through human capital investments in areas such as girls' education as a key strategy for slowing population growth.

While investments in health and education should be part of a comprehensive population strategy, the Bank's official policy statements understate the significant contribution investments in contraceptive services have made to rapid fertility decline. Indeed, the expansion of voluntary family planning services needs to be a central element of any strategy to encourage smaller families, although these services alone may not be adequate to bring about the magnitude of fertility decline desired by many governments.

*John Bongaarts and Susan Cotts Watkins, "Social Interactions and Contemporary Fertility Transitions," *Population and Development Review* 22, no. 4 (December 1996): 639-682; National Research Council, *Resource Allocation for Family Planning in Developing Countries: Report of a Meeting* (Washington, DC: National Academy Press, 1995), 4-6.

In addition, a long-term strategy to address gender equality will not meet existing unmet need for family planning among the estimated 100 million or more women who want to avoid another pregnancy *now*. The Bank's bias towards long-term, indirect strategies is especially troublesome in the African context, where unmet need is high and timely action is urgently needed to avoid a doubling of population in the next two decades.

In the final analysis, investments in family planning and broader social development reinforce each other—both are needed. Recent research suggests that the appropriate mix of strategies for slowing population growth is likely to differ depending on each country's situation. While improving access to contraception is crucial where unwanted fertility and unmet need are high, education and other social programs can also play an important role by shaping the desire for smaller families and encouraging later childbearing.*

Moreover, there is an internal contradiction between the Bank's rhetoric, which emphasizes a comprehensive approach to population policy, and its internal treatment of population issues. The Bank has placed population within the health sector, reflecting the important role the sector plays in the delivery of family planning services. However, the association of population with health undermines attention to other population-development linkages and has made it almost impossible for the Bank to adopt a broad, multisectoral approach.

Significantly, the Bank's new *Sector Strategy Paper for Health, Nutrition and Population* lacks any focus on population. The paper makes clear at the outset that its scope is confined to the health sector and to a limited extent to reproductive health. It makes passing references to the Cairo conference, to problems associated with high fertility and to reproductive health services. But it is essentially a health sector strategy focusing on broad health issues; in the introduction, it explicitly relegates the interaction of demographic factors with various aspects of development to other existing and forthcoming strategy papers. This leaves the Bank without a comprehensive blueprint for its population work.

Limited New Research on Population-Development Linkages: *Although there is still a need to explore the role of population interventions, the Bank is currently sponsoring little new research on interactions between population and key aspects of development, including poverty, economic growth and the environment.* In the recent past, the Bank has sponsored important but little publicized research on population-development linkages. For example, the 1993 publication, *The East Asian Miracle*, discusses the positive effects of fertility decline on the economies of East Asian countries during the 1980s. The study links fertility decline in these countries to lower dependency rates, increased spending per pupil, increased savings rates, reduced trade deficits and improved wages and economic growth. However, owing to skepticism among Bank economists regarding the economic impacts of demographic change, the Bank has not sponsored similar research for other regions.

Overall, the Bank's role in research is shrinking across all development sectors. Currently, the policy research group within the Bank's central development economics department has no staff working on the

Investments in family planning and broader social development reinforce each other—both are needed.

*John Bongaarts, "Population Policy Options in the Developing World," *Science* 263 (11 February 1994): 771-776.

Currently, the Bank's central development economics department is doing no research on the links between slower population growth and poverty alleviation.

links between slower population growth and poverty alleviation. The group's research agenda is spread thin across the array of poverty and human resource issues. Since completion of a major research project on the economic and policy determinants of fertility in sub-Saharan Africa, the group has given precedence to research on AIDS and other health sector issues. The number of major Bank research publications on population-related topics has declined substantially since 1995.

Nevertheless, in some quarters of the Bank, positive initiatives are underway. The Economic Development Institute (EDI)—a research and training group also within the core development economics department—is attempting to revive attention to population-development linkages. In July 1997, EDI organized an educational forum for Bank staff which highlighted the most recent evidence of the impacts of demographic change at both the macro-economic and family levels. EDI is also planning a new training program to disseminate this information to borrower government officials. While these are promising initiatives, the extent to which they can stimulate sustained attention to population concerns within the Bank remains to be seen.

A further encouraging development is the 1996 publication, *Toward Environmentally Sustainable Development in Sub-Saharan Africa: A World Bank Agenda*, prepared by the environment department. This report highlights the negative impacts of population growth on the environment in Africa and recommends a dual strategy of investing in human capital through education while also facilitating fertility reduction. Although the dialogue within the Bank during preparation of such a publication is important, the impact of the report will ultimately depend on the extent to which its recommendations are reflected in policy discussions with African governments. Moreover, similar analytical work is needed to highlight the environmental impacts of population growth in other regions.

Lack of a Focal Unit for Population Work Within the Bank: *A long-standing problem is that population—as a cross-cutting development issue distinct from reproductive health and family planning—has lacked an appropriate institutional home within the Bank.* External assessments going back to the 1970s point out that the Bank has lacked a central unit to coordinate broader analyses and activities relating to the determinants and impacts of demographic change. The Bank has always placed population policy concerns within the social sectors—as part of human resources or human development activities, depending on the nomenclature of the day.

Formerly, the central Population, Health and Nutrition (PHN) Department was the Bank's focal point for population issues. In the early 1990s, the Bank established the Population Advisory Service, comprising a core group of population and family planning experts, within this department. Although this group provided important leadership in the area of population and reproductive health, its association with the social sectors limited its influence on macro-economic thinking and policy work.

Moreover, following the publication of the *World Development Report* focusing on health in 1993, the PHN department increasingly focused on health sector reform and financing issues to the detriment of attention to population concerns. In 1996, the Population, Health and Nutrition sector was renamed the Health, Nutrition and Population sector, a move indicative of this change in priorities. The critical mass of staff assigned to

the Population Advisory Service has gradually eroded. A single staffer is assigned to respond to requests from Bank operations staff for analyses relating to such demographic trends as labor force size and school entrants, with no mandate for broader analysis of the determinants and consequences of demographic change.

Impact of the Reorganization on Population: *The current reorganization threatens to further marginalize population concerns.* The reorganization has created a new system of networks linking technical staff across the Bank. Within the Bank, there are four networks:

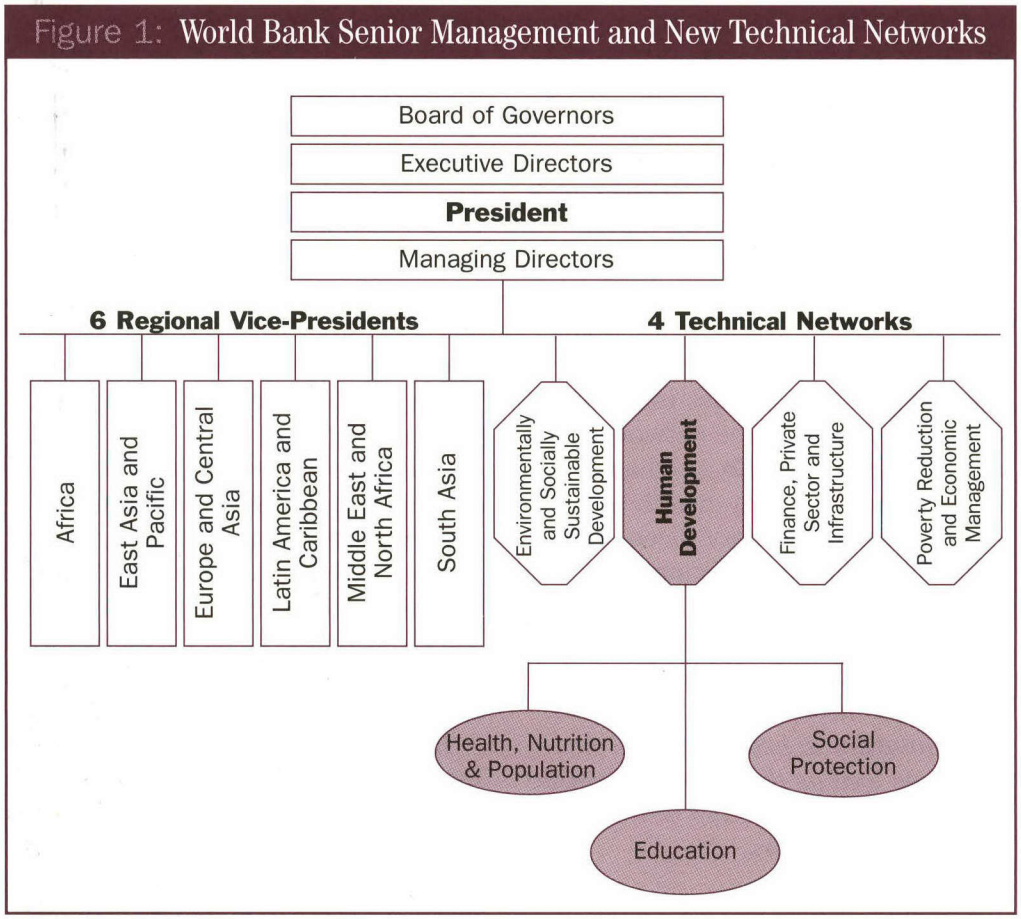
- Human Development;
- Poverty Reduction and Economic Management;
- Environmentally and Socially Sustainable Development; and
- Finance, Private Sector and Infrastructure.

The Human Development (HD) network encompasses three sectors—Health, Nutrition and Population (HNP); Education; and Social Protection, which includes a range of other social sector activities. Each network is managed by a council comprising senior staff from each regional department; similarly, there is a sector board for each technical area, including Health, Nutrition and Population.

At the central level, the former PHN department has been merged with education and social protection and renamed the Human Development Department (HDD). Under the reorganization, the central department will be much smaller and have much reduced functions.

External assessments going back to the 1970s point out that the Bank has lacked a central unit to coordinate broader analyses and activities relating to the determinants and impacts of demographic change.

Figure 1: World Bank Senior Management and New Technical Networks



Source: World Bank

The leadership factor should not be underestimated. The messages the Bank's president and vice-presidents send externally to borrower governments are important.

Currently, only two population positions are planned for the central department. The Population Advisory Service has been essentially disbanded. Moreover, there is no voice for population issues on the HD network council and HNP sector board. The Health Advisor represents the central HNP group on the network council and chairs the sector board; the Population Advisor is not a member of either body. As chair of the HNP sector board, the Health Advisor oversees the Population Advisor and population activities.

At the regional level, the reorganization groups technical staff in large units under single leadership, in contrast to the previous structure of fragmented sector-specific operations units. This new structure brings social sector staff together under the umbrella of the human development network, a move which could potentially encourage a broader approach to promoting fertility reduction. However, while the network system is relatively new, it does not appear to have stimulated a more coordinated approach to population policy—either by the regional departments or the Bank-wide network council and sector board.

In part, this reflects the reality that population remains a relatively low priority. Education and health dominate social sector lending and drive the agenda of the HD network. The majority of staff on the network council come from a health or education background. Similarly, health has emerged as the primary focus of the HNP sector board—dominated by health specialists—while population and nutrition receive less attention. *Thus, the reorganization has further reinforced the subordinate position of population to health within the Bank, as well as the inadequate linkages between population and other development sectors.*

Lack of Attention to Population by the Bank's Leadership: *Since the early 1990s, top management has not signaled either the Bank's borrowers or its staff that it assigns any particular importance to population concerns.* The leadership factor is intangible but should not be underestimated. The messages the Bank's president and vice-presidents send externally to borrower governments are important. In the late 1980s, for example, former president Barber Conable's willingness to raise the issue of rapid population growth with several African heads of state contributed to breakthroughs in population policy in a number of countries.

The Bank is an extremely hierarchical organization, and the messages top leadership sends internally to staff also have great influence. Frequent public statements about the importance of slowing population growth to development by former president Robert McNamara in the 1970s and by Mr. Conable in the late 1980s had a significant impact within the Bank. Similarly, former vice-presidents Ernest Stern in the 1980s and Edward Jaycox in the early 1990s were not only forceful advocates for population programs with developing country leaders, but also took steps to ensure that Bank staff gave adequate attention to population in analytical work and in the lending program.

The importance of commitment at the top is evident in the Bank's increased attention to gender concerns. In the face of criticism from women's groups, the current president, James Wolfensohn, has been the driving force in raising the profile of these important issues within the Bank.

In contrast, top Bank officials rarely draw attention to population concerns. Although Mr. Wolfensohn is known to be concerned about population issues, he has not highlighted these concerns in public statements

or internal meetings. A public presentation in early 1997 by one of the Bank's vice-presidents for Africa, "Rural Development Prospects in Africa: the World Bank's Perspective," barely mentioned the problems of high fertility and population growth rates, or the need for appropriate policy and program responses.

Ultimately, the Bank's leadership is accountable to the Board of Executive Directors who represent the Bank's member countries. The limited interest the Board has shown in population-development linkages in recent years is a further reason for the neglect of these issues by top management, and for management's failure to hold staff accountable for addressing population concerns in policy documents and discussions with borrowers.

Recommendations for Strengthening Attention to Population in Policy Work

The Bank needs to make population concerns a key policy issue in its development work across all sectors, elevating these concerns above those relating to the delivery of reproductive health and family planning services. Full implementation of this recommendation requires the commitment of Bank management and, in all likelihood, additional staff and financial resources. The following are specific steps the Bank needs to take if population is to become an integral element in multisectoral planning.

- **The Bank should establish an interdisciplinary unit for population policy, staffed by a mix of demographers, economists, environmental and population policy experts.** The role of this unit should be to integrate analysis of population factors with *all* the Bank's core objectives for poverty reduction, environmentally sustainable development and human development. An appropriate home for this unit may be the Environmentally and Socially Sustainable Development Department, where the current leadership has a profound appreciation of the linkages between population, environmental and gender issues. However, this unit should also maintain close links to the human development network and the health, nutrition and population sector, as well as the poverty reduction and economic management network.
- **The population policy unit should prepare a formal corporate statement on the role of population factors in sustainable development and produce a strategy paper for addressing population concerns.** The Bank should promote a coordinated, multisectoral approach, involving a mix of social investments appropriate to the specific country situation. However, the Bank's strategy for addressing rapid population growth must also ensure adequate priority to the expansion of reproductive health and family planning information and services.
- **The population policy unit should sponsor more research on the links between demographics and development.** Recent research on the complex relationship between fertility dynamics and macro-economics highlights the need for additional work on these issues. The Bank needs to expand the knowledge base from which to advise countries about alternative population strategies and the consequences of demographic change. It should expand support for such research by external experts, while shifting the emphasis from cross-national macro-economic studies to coun-

The limited interest the World Bank Board has shown in population-development linkages in recent years is a further reason for the neglect of these issues by top management.

Country strategies and other economic analyses should more consistently discuss the implications of population dynamics for long-term development.

try-specific analyses of a broader range of development impacts. The Bank should appoint a task force including outside experts to advise on a relevant research agenda relating to the consequences of high population growth and of fertility reduction.

- **Where high population growth rates are likely to have an adverse effect on development, the Bank must ensure that population concerns are adequately reflected in its country assistance strategies.** Better integration of a population perspective in the Bank's own analytical work is a key first step to further Bank action. Country strategies and other economic analyses should more consistently discuss the implications of population dynamics for long-term development; managers reviewing these documents need to ensure these issues are adequately addressed. The Bank may need to provide special training on population-development linkages to country economists and senior managers, together with guidance on how to incorporate population analyses into key strategic documents.
- **Bank officials at all levels need to consistently incorporate population issues into policy discussions with countries experiencing rapid population growth.** These issues should be on the agenda when Mr. Wolfensohn, the managing directors and vice-presidents meet with borrower country officials. The country departments should reinforce the need to support population programs at annual donor consultative group meetings. While Bank officials will need to address population-development interactions in a country-specific way, policy discussions should emphasize the potential benefits of fertility reduction at the macro-economic, environmental and family levels, as well as the synergy with gender concerns.

III. Reproductive Health and Family Planning Programs: The Bank's Contribution

The ICPD Programme of Action projects a need for a significant increase in funding to meet the growing demand for reproductive health services and to improve the quality of existing services.

A. Overall Trends in Population and Health Lending

While the Cairo conference endorses a comprehensive strategy for slowing population growth, the heart of the conference recommendations is a call for increased investment in a package of basic reproductive health services. The core elements of this package identified by the ICPD include: family planning; care in pregnancy and childbirth; and prevention of HIV/AIDS and management of other sexually transmitted diseases (STDs).

The *Programme of Action* projects a need for a significant increase in funding to meet the growing demand for reproductive health services (especially given the increasing number of women in their childbearing years) and to improve the quality of existing services and broaden their scope. It estimates that meeting these needs will cost about $17 billion annually in 1993 constant dollars by the year 2000, a goal the international community is still far from achieving. According to the United Nations Population Fund (UNFPA), developing countries spent about $7.5 billion on reproductive health in 1995. Total donor assistance—including lending by multilateral development banks—amounted to another $2 billion in the same year, but indications are that donor funding has since declined.

As borrower governments have become more aware of reproductive health needs following the ICPD, the Bank has significantly expanded lending for reproductive health activities in recent years. This shift is part of a longer-term—and continuing—evolution of the Bank's overall lending for health, nutrition and population over the past three decades.

The Bank began lending for population projects in 1970—for the most part supporting family planning programs. Population lending initially reflected concern that Bank investments in other development sectors would be undermined without concurrent efforts to slow population growth. In 1976 the Bank initiated lending for nutrition activities; it was only in 1981 that it began lending for a broad range of other health projects.

Especially in the 1970s and early 1980s, Bank population lending was limited to a handful of countries, primarily in Asia. Today, the Bank finances population and reproductive health activities in many more countries; between 1992 and 1996 alone, the Bank expanded population and family planning activities to about 30 new countries, the majority in Africa. Over the years, the Bank has provided very significant resources for population and family planning projects. Cumulatively, through the end of fiscal year (FY) 1996, the Bank had committed $3.9 billion for population activities through 175 projects in 82 countries.

Since the late 1980s, the Bank has also expanded support for projects to prevent the spread of HIV/AIDS and other STDs. The Bank has supported over 60 projects that include HIV/AIDS activities; of these, 10 have been stand-alone or specialized AIDS/STD control projects. AIDS activities appear to be receiving an increasing share of resources for reproductive health; over the next three years, the Bank plans to support 18 additional projects with HIV/AIDS components.

Even before the ICPD, the Bank recognized improved maternal health as a goal independent of its linkages to child health and fertility. Following the 1987 Safe Motherhood conference in Nairobi, the Bank joined with other international organizations to launch the worldwide Safe Motherhood Initiative. In keeping with the recommendations of the

The Bank has expanded support for maternal health, both through integrated primary health projects and more recently through specialized maternal health projects.

1993 World Development Report, the Bank has encouraged maternal health activities to be provided as part of an essential package of health services, which in principle should also include family planning. In most instances, support for maternal health has been integrated within primary health projects; the number of projects which include safe motherhood activities has grown from 9 in 1987 to 70 in 1993. More recently, the Bank has also initiated specialized or stand-alone maternal health projects, for example in Argentina, India, Indonesia and Paraguay.

Combined lending for family planning and other reproductive health activities has risen steadily from $318 million in FY 1992, the first year for which such data are available, to $504 million in FY 1996. (The Bank reports a figure of $599 million in population and reproductive health lending for FY 1996, but PAI's analysis suggests this figure includes funds for child immunization and other activities not directly related to reproductive health. See Annex Table 1.)

This increase in lending for population and reproductive health has occurred in a larger context of massive increases in lending for the human development sectors overall. Annual lending for these sectors increased from about $1 billion in FY 1986 to nearly $5 billion in FY 1996. Human development lending has also received an increasing *share* of total Bank lending. In FY 1986, 8 percent of $16 billion in new loans went to human development projects; in FY 1996, projects in these sectors received 24 percent of $21.3 billion in new lending.

In FY 1996, health, nutrition and population projects accounted for nearly half of new human development lending, or approximately $2.4 billion. Education accounted for 35 per cent and social protection for 16 per cent.

In FY 1997, commitments for new projects declined very significantly for the human development sectors overall. HNP lending also declined sharply to $940 million. There appears to be a number of reasons for this decrease, including the decline in demand for loans the Bank is experiencing across most sectors, the disruptive effect of the reorganization on the development of new projects, and a shift in emphasis by management towards implementation of ongoing projects.

Despite the overall upward trend in HNP lending through FY 1996, recent shifts in the composition of lending in the sector have troubling implications for the Bank's commitment to helping countries strengthen reproductive health and family planning services and for the future of Bank assistance in this area.

Declining Share of HNP Lending for Population and Reproductive Health: *Although lending for population and reproductive health (PRH) has increased, PRH activities are losing ground in terms of their* ***share*** *of overall HNP lending.* The composition of HNP lending has changed over the last few years, reflecting a shift in HNP priorities. Lending for population and reproductive health has fallen from roughly one-third of all HNP lending between FY 1986 to 1991 to a little less than one-quarter between FY 1991 to 1995. The shift is even more dramatic since lending classified as PRH during the period FY 1986 to 1991 was almost exclusively for family planning, while PRH lending from FY 1991 to 1995 supported an expanded range of reproductive health activities.

While the share of total HNP resources flowing to population and reproductive health has declined, the share of resources allocated to most other components of HNP lending has remained roughly constant, with the

Table 1: Shift in Composition of Health, Nutrition and Population (HNP) Lending Over Time

	Relative Share of Total HNP Lending Portfolio (Percent)	
	1986-91	**1991-95**
Population and Reproductive Health	**32.7**	**23.4**
Basic Health Services	20.0	20.4
Sector Wide Reforms	3.6	16.4
Disease Control	13.1	13.1
Nutrition	7.5	9.7
Capacity Building	16.5	8.8
Supply Inputs	6.7	7.7
Reconstruction	0.0	0.5

Source: World Bank

PAI's analysis suggests that new loan commitments for family planning activities declined significantly in FY 1995 and 1996.

exception of funding for sector-wide reform activities, which has increased substantially. The priorities articulated in the new strategy paper for Health, Nutrition and Population suggest this trend towards health reform and financing and away from reproductive health and family planning is likely to continue. This trend also reflects the priorities of the leadership in human development and health.

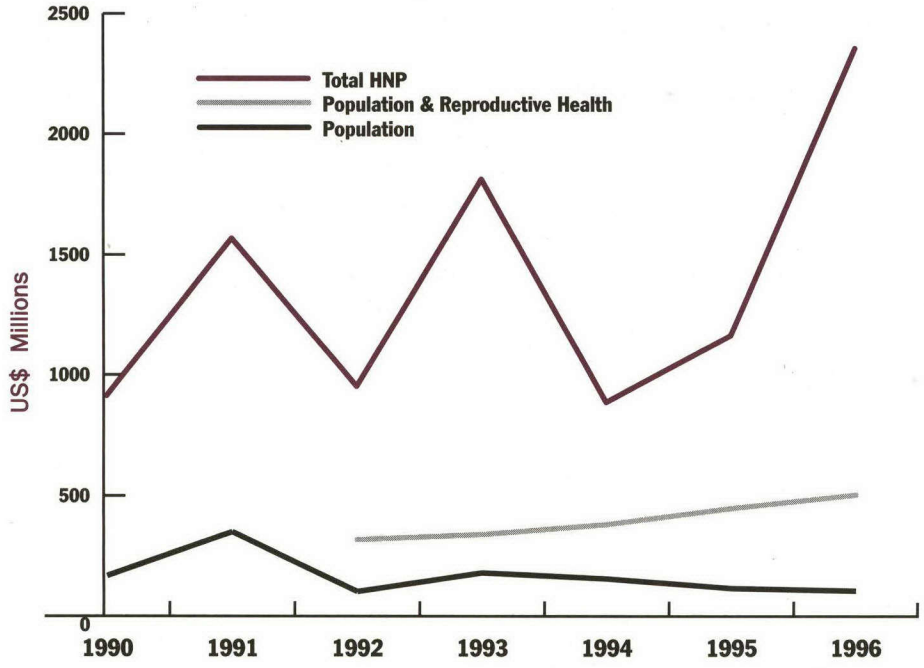
Decline in Lending for Population/Family Planning: *While lending for overall reproductive health has increased, lending for family planning alone declined significantly in FY 1995 and 1996, suggesting that the Bank is neglecting this key element of the ICPD Programme of Action.* Expanded access to high quality contraceptive services is a central element of the reproductive health package promoted by the ICPD and also key to reducing fertility. However, the Bank's current reporting system lacks transparency regarding lending for family planning activities. Prior to FY 1994, the Bank reported separately on population lending. However, beginning in FY 1995, it began reporting only a combined total for population and reproductive health lending. This has made it difficult to track the Bank's financial support for the various elements of reproductive health, including family planning.

Annual assessments of population lending levels have never been an exact science, especially since they rely on subjective judgments regarding the share of integrated health projects allocated to family planning. The Bank itself has been inconsistent in its definition of population lending over time; in the early years especially, "population" projects often included substantial support for maternal and child health activities. Nevertheless, in recent years Bank estimates of population funding levels have been based on standardized definitions and have provided an important although approximate reference point for evaluating the Bank's support for population and family planning.

In order to assess recent trends in population lending, PAI carried out an analysis of HNP projects approved in FY 1995 and 1996 to identify the level of support for family planning activities in these years. This analysis suggests that new loan commitments for family planning activities declined significantly in these years. Lending for population—using essentially the same definition used by the Bank in prior years—totaled about $117 mil-

In each of the last three years, the Bank has initiated only one or two projects with a specialized focus on family planning.

Figure 2: New Loan Commitments in the Health, Nutrition and Population (HNP) Sector and for Population and Reproductive Health Activities, 1990-1996



(US$ Millions)	1990	1991	1992	1993	1994	1995	1996
Total HNP	933.4	1567.6	961.7	1811.6	885.7	1162.3	2353.4
POP & RH	N/A	N/A	318.3	340.0	381.5	448.1	504.0
POP	169.3	351.0	103.2	181.1	156.3	116.8	106.5

Sources: 1995 and 1996 Population and 1996 Population & Reproductive Health amounts are PAI estimates. All other numbers are World Bank data. HNP sector only: excludes 1994 funds for Population & Reproductive Health activities funded through social sector projects. No data for Reproductive Health prior to 1992.

lion in FY 1995 and $106 million in FY 1996. *This is roughly half the average of about $200 million a year in new loan commitments for population activities in the early 1990s, and well below the FY 1991 peak of $351 million.*

However, lending for family planning appears likely to increase substantially in FY 1997 over the low levels of the two previous years. This increase reflects the approval of a major new $248 million reproductive and child health project in India, which includes significant support for family planning. With the exception of this single large activity, new lending for family planning appears negligible in FY 1997. However, reproductive health lending for this year also includes two stand-alone maternal and child health projects and an AIDS/STD control project, all in Latin America.

Marginalization of Family Planning Activities: *One reason for the apparent downward trend in population lending is that the Bank is increasingly supporting fewer stand-alone population projects.* In the early years, most Bank projects in the health sector devoted a substantial proportion of their budgets to population and family planning activities. As the Bank has expanded lending for other health activities, this sit-

uation has changed. In each of the last three years, the Bank has initiated only one to two projects with a specialized focus on family planning. *Looking to the future, the relative paucity in the pipeline of new projects with a significant focus on reproductive health and family planning is a cause for major concern.*

The shift away from stand-alone projects has coincided with a decline in the share of reproductive health resources allocated to family planning. Between 1994 and 1996, the population/family planning share of PRH lending declined from 37 to 18 percent. This reflects the positive recent trend towards increasing lending for safe motherhood and AIDS/STD control activities. However, it also reflects a negative trend—especially in Africa and Latin America—for family planning to be reduced to insignificant components of larger health projects. The Bank's shift to sector-wide health projects runs the risk of further marginalizing not only family planning, but also other reproductive health activities.

B. Adequacy of Regional Responses

The Bank-wide trends described above conceal a great unevenness in the Bank's contribution in population and reproductive health across regions and countries. This unevenness reflects the interaction of various factors, including differences in health needs and in the Bank's health priorities in each region. The willingness of a country to borrow for population and reproductive health projects also depends to some extent on the terms of Bank financing available and on the strength of its own internal political commitment. Finally, the Bank responds to a larger set of priorities which drive the overall lending program.

Terms of Financing: *The type of Bank financing for which countries are eligible affects their willingness to borrow for population projects.* The World Bank provides two main types of loans: International Bank for Reconstruction and Development (IBRD) loans available to middle-income countries at close to commercial interest rates; and International Development Assistance (IDA) credits, available only to poorer countries (the majority in Africa and Asia), essentially interest free with repayment over a period of up to 40 years.

Countries differ greatly in their willingness to use IBRD funds for social sector projects—including health and population projects—that do not provide direct financial returns with which to repay the loans. Governments are generally more willing to use IBRD funds for hardware such as construction and equipment, than for the software such as training, communications campaigns and contraceptive supplies commonly needed in population projects. Owing to the greater readiness to use IDA funds for social sector projects, IDA credits have historically accounted for over 70 percent of population lending. However, many countries remain ineligible for such credits.

Political Commitment to Population: *The Bank's borrowers vary greatly in their commitment to slowing population growth.* Countries in South and East Asia have absorbed nearly 70 percent of the Bank's total support for population over time. Three countries—Bangladesh, India and Indonesia—account for more than half of all Bank lending for population. Projects in these countries have typically been large stand-alone activities compared to smaller, integrated projects in other regions. The large share of Bank population lending to South and East Asia reflects both the high level of commit-

Three countries—Bangladesh, India and Indonesia—account for more than half of all Bank population lending.

Despite the increase in social sector lending, the Bank still devotes considerably more resources to industry, transportation, agriculture and power projects.

ment and the eligibility of countries in these regions for IDA funds. In contrast, political commitment is lower in many countries in Africa, Latin America and the Middle East.

Overall Bank Priorities: *Population and reproductive health, which together represent a little over two percent of Bank lending, are relatively low priorities within the overall lending program.* IBRD loans, which mainly focus on infrastructure development, account for roughly two-thirds of total Bank lending. Despite the increase in social sector lending, the Bank still devotes considerably more resources to industry, transportation, agriculture and power projects. Moreover, the bulk of infrastructure financing is directed more towards larger middle-income countries. In FY 1996 nearly half of all IBRD lending went to three countries: China, Russia and Argentina.

As a result, issues of importance to larger middle income countries tend to take precedence over concerns of smaller, poorer countries. Even within the HNP sector, issues related to health financing and sector reform in larger middle income countries in Latin America, Central and Eastern Europe and East Asia receive more attention than issues of importance to the poorer regions.

Population and Reproductive Health Lending by Region

Reflecting the interplay of these various factors, the lending program in population and reproductive health has evolved very differently in each of the Bank's regional departments. In summary, the Bank is making a major contribution in reproductive health and family planning in a few countries, including several large Asian countries. In a number of additional countries, it is making a more limited but still important contribution. But there are many more countries, especially in Africa, where the needs remain great and there is scope for the Bank to do much more. Within the Bank itself, shifting health sector priorities and a shortage of staff remain major constraints to expanding population and reproductive health lending.

South Asia: *The Bank's most substantial involvement in population programs has been in South Asia.* This region has received a very significant share of overall World Bank funding for HNP activities. The Bank has been, and continues to be, a major financier of family planning infrastructure and programs in Bangladesh and India, and has undoubtedly contributed to the dramatic fertility declines experienced in both countries. The Bank also supports family planning programs in Nepal, Pakistan and Sri Lanka.

In India, the Bank has supported nine IDA-funded projects. Over the last two years, it has invested enormous staff resources in policy analyses and discussions aimed at laying the groundwork for a major new reproductive and child health project. The project seeks to support the Indian government's efforts to reorient its family welfare program from a target-driven approach emphasizing sterilization to a client-oriented program addressing a broader range of health needs.

In Bangladesh, the Bank has had a similarly long-standing involvement through four population projects. The Bank has played an important role in mobilizing funds from other donors and coordinating their participation. It is currently developing a fifth project to help the government address issues of sustainability and to broaden current family planning efforts into a more comprehensive approach to fertility reduction.

Table 2: World Bank Lending for Population and Reproductive Health, by Region, 1990-1996

New Loan Commitments for Population, by Region (US$ millions)

Fiscal Year	Africa	Middle East and North Africa	East Asia and Pacific	South Asia	Europe and Central Asia	Latin America and the Caribbean	Total
1990	45.7	11.9	0.0	96.7	0.0	15.0	169.3
1991	135.3	26.0	104.0	75.0	0.0	10.7	351.0
1992	18.7	0.0	0.0	63.3	20.9	0.3	103.2
1993	2.0	72.2	33.8	52.0	0.0	21.1	181.1
1994	31.5	0.0	9.4	133.1	0.0	24.5	198.5
1995	31.3	0.3	5.1	65.1	0.0	15.0	116.8
1996	20.5	27.2	35.9	2.7	0.2	20.0	106.5
Total	285.0	137.6	188.2	487.9	21.1	106.6	1,226.4

Sources: 1995 and 1996 are PAI estimates for population; all other numbers are World Bank data. Includes social sector projects.

New Loan Commitments for Population and Reproductive Health, by Region (US$ millions)

Fiscal Year	Africa	Middle East and North Africa	East Asia and Pacific	South Asia	Europe and Central Asia	Latin America and the Caribbean	Total
1992	25.2	0.0	0.5	243.7	46.6	2.3	318.3
1993	67.1	79.4	79.3	78.6	0.0	35.6	340.0
1994	96.7	0.0	9.4	133.1	0.0	184.5	423.7
1995	145.8	46.4	93.5	106.7	1.8	54.0	448.2
1996	54.4	37.5	111.7	82.7	105.9	111.8	504.0
Total	389.2	163.3	294.4	644.8	154.3	388.2	2,034.2

Sources: 1996 reflects PAI estimate for population and reproductive health; all other numbers are World Bank data. Includes social sector projects.

The Bank has about 40 ongoing projects in Africa with population and family planning components, most of them small activities within larger health projects.

In response to the strong demand from governments, the Bank appears likely to maintain a high-level of involvement in the region. *The Bank's continued support is needed to sustain and consolidate the impressive gains that have been made with its assistance.*

East Asia and Pacific: *The Bank has also made a major contribution to fertility decline in East and Southeast Asia.* Significant Bank funds have supported several stand-alone family planning projects in Indonesia.

Given the success of the Indonesian family planning program, the Bank is now broadening the scope of its assistance to increase support for AIDS prevention and safe motherhood activities. Throughout the region, a shift to broader health projects is underway and the Bank appears unlikely to return to large-scale population projects. However, in FY 1996 it approved a new Population and Family Health project in Vietnam.

With rising income levels and declining fertility, health and family planning needs are changing in a number of East and Southeast Asian countries. Moreover, many countries that are no longer eligible for IDA funding are reluctant to borrow IBRD funds for health projects. *There is still a need, however, to strengthen family planning as well as other reproductive health services in a number of countries in the region, including Cambodia, Laos, Myanmar, Papua New Guinea, the Philippines and Vietnam.* There is a need too in China, one of the Bank's largest borrowers, for dialogue at the policy level on alternatives to China's compulsory family planning program.

Africa: *From a regional perspective, the largest gap in the Bank's population and reproductive health lending is in sub-Saharan Africa.* The region faces great challenges in addressing very high levels of fertility, maternal mortality, and AIDS and STD prevalence. In much of the region, there is still a continuing desire for large families. Access to reproductive health care of all kinds remains limited, yet political commitment in this area is new and fragile and local infrastructure and capacity are weak. In French-speaking countries, until very recently, the policy environment for family planning was especially unfavorable. Civil upheavals have been an impediment to development efforts more generally in a number of countries.

In the 1970s and 1980s, the Bank supported stand-alone family planning projects in a few countries, including four projects in Kenya. In 1989 to 1990, the Bank's Africa department intensified its focus on population and its policy dialogue with governments. This in turn led to the development of a number of new integrated health projects with sizable family planning and AIDS components.

However, in the early 1990s the Africa department shifted attention and resources to the AIDS epidemic, developing large stand-alone AIDS and STD control projects in Kenya and Uganda. Meanwhile, ongoing integrated health and family planning projects encountered major implementation problems and built up large pipelines of undisbursed funds. Throughout the 1990s, the Bank's work across all sectors in Africa also suffered from repeated reorganizations of the Africa department.

Currently, the Bank has about 40 ongoing projects with population and family planning components in the Africa region; most of these activities are relatively small elements of larger primary health projects. *Because of this marginalization of family planning, there is hardly a country in Africa where the Bank is making a significant contribution to the*

INDIA

CASE HISTORY

Bank Assistance has Shifted from Local, Vertical Projects to Policy Work and Comprehensive National Projects

India is the Bank's largest recipient of population and reproductive health funds

The World Bank has assisted India's family welfare program since the early 1970s through nine population/family planning projects, and more recently, through projects addressing child survival and safe motherhood, AIDS control, and reproductive and child health. The Bank had committed almost $1.2 billion through FY 1997 for population and reproductive health activities in India—more than any other country.

The Indian program, the oldest official family planning program in the world, has been characterized by too great a focus on demographic targets, an excessive emphasis on sterilization, inadequate attention to the quality of services, and overly centralized planning and management. Nevertheless, between 1970 and 1990, fertility in India declined from six to four births per woman, reflecting the rising demand for smaller families and the greater effectiveness of the family planning program in some regions. The national average masks a variation in fertility rates from close to two children in several southern states to five or higher in poorer states in the north.

Bank assistance from the 1970s through the mid-1980s was limited in impact

The Bank's earliest projects essentially helped the government to expand the service delivery network in selected districts. Subsequent projects included support for monitoring systems, communications activities and training, as well as the expansion of urban family planning services.

Prior to 1987, the Bank had limited impact on program directions. It did not involve itself with policy issues, or play a leadership or coordination role with other donors. Moreover, in the 1980s, the Bank's financial assistance, while significant, represented no more than four percent of Indian government expenditures on the family welfare program.

Early Bank projects focused on construction of facilities and did not address fundamental problems of staff training, motivation and supervision. While the Bank sought to encourage localized strategies, this goal was never fully realized. The Bank-funded projects suffered from inadequate community involvement and essentially implemented the centralized Indian family welfare program model with all its weaknesses.

Bank-financed projects also experienced a number of implementation problems, including slow disbursement of funds due to cumbersome bureaucratic procedures and poor coordination between the central government and the states. Bank supervision was weak; relatively few staff were assigned to monitor these projects, and from the late 1970s through 1987 there were no staff in Delhi working on population activities.

INDIA

CASE HISTORY

Subsequent projects were more successful

In the late 1980s, Bank population projects were larger and operated at the state rather than the district level. They paid more attention to management and training than to expansion of facilities, and included funds for NGOs, social marketing and operations research. Still, these projects did not seek to address key program weaknesses identified in Bank analyses and continued to allocate significant funds for construction. The fifth Bank project, however, was successful in improving services and outreach in urban slums, and in shifting the emphasis from sterilization to serving the broad health needs of women and children.

The Child Survival and Safe Motherhood Project, approved in 1992, represented an important shift in approach by seeking to stimulate changes in the program at the field level. The project contributed to a 20 percent increase in the number of children fully immunized and the rising proportion of women who receive post-natal care and deliver their babies in hospitals. Close collaboration between the Indian government, the World Bank and UNICEF was key to the project's success.

More recent Bank assistance has been grounded in intensified policy dialogue

Since the late 1980s, the Bank has supported several analyses of big picture policy and program issues, taking advantage of the government's greater willingness to rethink its program strategy. In the mid-1990s, the Bank supported an analysis of women's health needs, as well as a major review of the family welfare program which made recommendations for shifting the emphasis from meeting demographic targets to a more client-centered approach.

The Bank's assistance has gradually shifted toward more integrated and comprehensive projects. Building on its analytical work, in 1997 the Bank approved a $248 million reproductive and child health project that is national in scope. The project seeks to expand the range of reproductive health services available, by strengthening prenatal and delivery services, treatment of reproductive tract infections and provision of spacing methods of family planning, as well as child health services. The project aims to maximize the impact of past Bank and government investments by improving the coverage, quality and effectiveness of the family welfare program. In recognition of past problems, it encourages decentralization and local ownership. More Bank staff are now in place to monitor and support these efforts, both at headquarters and in Delhi.

The project calls for ambitious changes in program philosophy, management styles and work patterns at the field level. This is an enormous challenge, given the historical difficulty in bringing about change in India's family welfare program. It is too early to judge the impact of these recent efforts, but these new directions are promising.

national family planning effort. Even in Kenya, where the Bank previously provided substantial assistance, it has not been a major player in the family planning program in the decade of the 1990s.

Meanwhile, a wholesale shift in the approach to HNP lending is underway. In most countries, new projects under development are focusing on broader reform of health sector financing and management. There are just a few countries—for example, Ethiopia, Guinea and Zimbabwe—where new projects are expected to emphasize reproductive health and family planning.

In the Africa department of the Bank, most country strategy documents mention the problems population growth rates—averaging three percent a year—pose for sustainable development. Yet despite the weakness of reproductive health and family planning services, country department and health sector managers assign higher priority to health sector reform. Under previous management, the department is reported to have responded negatively to interest in family planning on the part of some African governments; for example, Bank staff are said to have discouraged support for a community-based family planning activity for which the government of Niger requested assistance.

The department faces the challenge of serving 49 countries in a region with many urgent health problems. The limited level of Bank financing available to many small countries constrains lending opportunities in HNP. Moreover, project development in the Africa region is very staff intensive; managers accordingly see a focus on sector-wide reform and financing as the most strategic investment in health systems. Finally, the current regional vice-presidents, unlike their predecessor, have shown little interest in population or family planning.

Latin America and the Caribbean: *In this region, the Bank has maintained a low profile on reproductive health and family planning and has very little strength in the lending program.* In the 1970s and 1980s, opportunities for population lending were limited by political sensitivity on the part of governments, high reliance on the private sector for contraceptive services, and the fact that most countries in the region are not eligible for IDA funds.

Increasingly, however, governments in the region recognize the need to strengthen basic health services, creating opportunities for the Bank to initiate maternal and child health projects. In a number of instances—for example, in Argentina, Mexico, Paraguay and Peru—these projects include small family planning components. Since the mid-1990s, the Bank has also approved stand-alone AIDS/STD projects in Brazil and Argentina.

Fertility and maternal mortality have declined in many countries in the region but remain high in others such as Bolivia, Ecuador, Peru and in Central America. In some of these countries with high fertility and unmet need for family planning, substantial grant aid from other donors has been available. *Nevertheless, there are still untapped opportunities to expand lending for safe motherhood activities and AIDS/STD programs and to strengthen the focus on family planning within larger integrated health projects.* Moreover, to effectively support reproductive health activities in the region, the Bank needs to find ways to work with the private sector and nongovernmental organizations (NGOs) as well as with government health systems.

Middle East and North Africa: *Bank support for population and reproductive health activities has also been limited in this region.* As

To effectively support reproductive health activities in Latin America, the Bank needs to find ways to work with the private sector and NGOs as well as with government health systems.

Unfortunately, a lack of systematic information makes it difficult to assess the effectiveness of Bank projects in reproductive health, as well as other sectors.

in the case of Latin America, family planning has been a culturally sensitive topic and many countries are ineligible for IDA funding. Nevertheless, the Bank has supported stand-alone population projects in Egypt, Iran and Tunisia. Morocco is financing contraceptives through an IBRD-funded primary health project. Intensive discussions on new initiatives are underway in Yemen.

This region still has very high fertility and rates of population growth. The regional human development director predicts some expansion of Bank reproductive health lending in the region, including limited funding for family planning. *Lack of political commitment remains a constraint to the expansion of Bank financing for family planning activities in the region, highlighting a need for intensified policy discussions on the consequences of population growth, along the lines of the initiatives now underway in Yemen.*

Europe and Central Asia: *There is minimal activity in reproductive health in this region.* Population size in most Eastern European countries is essentially stable or shrinking. Regional staff do not assign priority to reproductive health and family planning needs based on analyses of the burden of disease. Nevertheless, there is a need for expanded access to better quality contraceptive services to reduce unintended pregnancy and reliance on abortion. The Bank has supported small maternal health components within some larger health projects, with very limited attention to family planning. In Russia and Romania, it is financing contraceptive supplies.

C. Effectiveness of the Bank's Population and Reproductive Health Activities

Ideally, the Bank's success should be measured by the effectiveness and impact of its projects rather than by the mere volume of loan commitments. Much of the preceding analysis of population and health lending is based on staff appraisal reports describing the Bank's new loan commitments and the activities they are expected to support. Yet these reports represent plans and budget estimates. Over several years of implementation, projects may diverge significantly from the original plan in the disbursement of funds and activities undertaken. Project components may need to be modified over time; some may never be implemented.

Unfortunately, a lack of systematic information makes it difficult to assess the effectiveness of Bank projects in reproductive health as well as other sectors. The Bank tracks expenditures by such categories as civil works and goods and services, rather than by the type of activity supported. Internal project completion reviews and audits are not available to the public. Data on project impact are limited.

An eight country study prepared by the Bank's Operations Evaluation Department in 1991 is one of the few systematic assessments of the effectiveness of Bank-financed population projects. This largely historical evaluation examined projects implemented during the 1970s and 1980s, in countries where the Bank had major stand-alone population projects as well as others where it provided negligible assistance. The report found that the Bank had become progressively more effective in the population field, but still lacked a comparative advantage over other donors in supporting

national population programs. It made a number of recommendations as to how the Bank could play a more effective role.

Among these recommendations, the report highlighted the importance of field staff and good donor coordination to effective project implementation. It revealed the neglect in several countries of small family planning components where these were incorporated into larger health projects. It also criticized the Bank for overemphasizing physical inputs such as construction at the expense of building local institutional capacity. Finally, it suggested that the Bank work with a broader range of institutions in implementing population programs, rather than only with ministries of health.

More recently, the Bank's leadership has made the impact of Bank-financed projects in all sectors a priority issue. The 1992 "Wapenhans report" marked a watershed in recognizing the poor performance of many Bank projects. The report identifies an excessive emphasis throughout the Bank on approving new loans at the expense of effective project supervision. It attributes many implementation problems to the growing tendency to design more complex projects with multiple objectives and components. In response, the Bank has developed an action plan aimed at strengthening project design, monitoring and evaluation. The current Bank president, Mr. Wolfensohn, has strongly promoted the need to improve the Bank's "development effectiveness."

Yet in many instances operational staff still lack the resources to effectively support project design and implementation. Since 1990, the administrative budget has twice been subjected to across-the-board 6 percent cuts. The recent reorganization led to further reductions in the FY 1997 budget for frontline operations, in order to accommodate initiatives such as the networks and staff retraining within the total existing budget. All HNP staff interviewed for this report mentioned the squeeze on operational budgets and the negative impact on project work. One staffer estimated that budgets in the Latin America department have been cut by 30 to 40 percent since 1994.

Despite these problems, Bank staff have unprecedented access to extra-budgetary funds for operating expenses in the form of special grants or "trust funds" from certain donor countries, some but not all tied to the use of national consultants for technical services. Japan has earmarked such trust funds especially for the design of projects in the human development sectors. Given the stringency of their operational budgets, human development staff have relied more heavily on donor grant funds than staff in other sectors.

The "Wapenhans report" attributes many implementation problems to the growing tendency to design more complex projects.

Constraints to the Effectiveness of Reproductive Health Activities

Overall, the Bank still faces a number of constraints to enhancing its effectiveness in the reproductive health field. While design and implementation problems plague Bank projects in all sectors, these problems tend to be more acute in HNP projects, which often support complex components such as training and institutional capacity-building. The fact that reproductive health activities tend to be small elements of larger projects makes them especially vulnerable to implementation problems.

Despite the Bank's limited technical capacity in reproductive health and family planning, it has not done enough to develop partnerships which draw on the expertise of other donors. It has also provided very limited support for the activities of the private sector and NGOs.

Most health and family planning experts at the Bank agree that a sector-wide approach has the potential to create a policy environment more conducive to the equitable, efficient and effective delivery of health services.

Moreover, as noted earlier, the shift towards health sector reform has the potential to undermine support for reproductive health and family planning services.

The Push for Health Sector Reform

Recently, the Bank has increasingly favored projects that deal with the overarching management and financing issues facing the health sector in a country. The Bank's movement towards health sector reform is part of a larger shift within the health field and the donor community—a shift which represents an effort to move away from small-scale, narrowly-focused projects and increase the impact of health sector assistance. It also reflects the Bank's view of its comparative advantage at the policy level, and the importance Bank economists assign to appropriate financing strategies in health as well as other sectors. Health sector reform is a relatively new area for the Bank and one that is evolving rapidly.

Most health and family planning experts at the Bank agree that a sector-wide approach has the potential to create a policy environment more conducive to the equitable, efficient and effective delivery of health services. They see more traditional service-delivery projects as having limited impact in the absence of efforts to address systemic constraints on health delivery systems. The sector reform approach, for example, might seek a shift in health budgets towards neglected rural and primary care services, or an overhaul of inefficient systems for the procurement and management of essential drugs and supplies.

The Bank's Social Action Program (SAP) in Pakistan illustrates the power of the sector-wide approach. By involving four different technical ministries as well as the Ministry of Finance, the SAP has given the social sectors a higher profile. It has helped to draw the attention of the political leadership to inadequate budget allocations and to increase the resources available to these sectors.

However, Bank technical staff are concerned that where projects support sector-wide management reform and financing, this larger agenda could overtake a focus on reproductive health. While these staff agree that the Bank can and should influence the policy environment, they see a concurrent and urgent need for financial and technical assistance to strengthen the delivery of key services. They worry that a shift to the sector approach could undermine progress in countries such as Bangladesh, which have made significant strides in provision of services.

One solution, especially where basic health services are weak, is for the Bank to pursue a two-track approach, giving equal importance to the strengthening of specific services on the one hand, and to larger policy issues on the other. This approach is also consistent with the Bank's new Sector Strategy Paper for Health, Nutrition and Population, which promotes three major areas of activity—improving HNP outcomes for the poor, enhancing performance of services through effective policies and reforms, and improving health financing.

The Bank has already adopted this parallel approach in a few countries. In Pakistan, for example, it has financed more focused sector-level projects, including a major family planning activity, alongside the multi-sector Social Action Program. In Côte d'Ivoire, the ongoing Population, Health and Nutrition project has separate components dealing with longer-term sector-wide issues and short-term strengthening of reproductive health services. In Guinea, a planned future reproductive health

and family planning activity aims to complement an ongoing health sector project.

In addition, health reform projects, if appropriately structured, could give a real push to reproductive health and family planning activities. In Ghana, for example, a Health Sector Support Program Credit now under development explicitly states that family planning, obstetric and STD services are "part of the priority health services interventions" covered under the proposed program of work. This strategy is especially relevant to countries with more developed health systems where these services currently receive inadequate priority.

To be successful, this approach will require the involvement of technical experts in reproductive health and family planning (and other priority areas) in the structuring of health sector reform programs. While most Bank staff who have taken the lead in these efforts have strong financing and management skills, they lack expertise in specific technical areas, including reproductive health and family planning. As a result, these projects have focused on issues such as decentralization and financial accountability, without sufficient attention to the quality of services and technical capacity.

At the same time, it is important to recognize that, especially in the case of family planning, integration with health may not always make sense. Promoting family planning as part of a larger effort to improve women's health has created new opportunities to expand services in Africa and Latin America. However, in some settings, especially in Asia, more focused interventions have proved successful in getting family planning established despite otherwise weak health systems.

Moreover, reproductive health and family planning differ in many respects from other health needs, and thus require somewhat different strategies. While some elements of family planning programs overlap with health, others more appropriately belong outside the health delivery system. Some public education activities, for example, may be more effectively implemented through standalone population projects or multisectoral approaches involving other relevant institutions such as mass media networks.

Moreover, health sector reform efforts focusing on the public sector may not be the best vehicle to support the private sector, which has played an important role in the delivery of reproductive health and family planning services. In many countries, NGOs are major service providers; social marketing, or the subsidized promotion and sale of contraceptives through commercial channels, has been a successful strategy for improving access to contraceptive supplies outside publicly-run health facilities. In Ghana, some NGOs which received support under a previous World Bank health and population project have been concerned about their ability to secure funds under the new health sector support program.

In the final analysis, the sector approach is new and untested. The Bank's Operations Evaluation Department is currently undertaking a major review of the effectiveness of the Bank's approach to health projects, but the results are not yet available. Until more evidence of impact is available, the Bank needs to maintain an open mind and flexibility in its efforts to promote health reform.

If sector-wide projects are to successfully promote reproductive health, technical experts need to be involved in the structuring of health sector reform programs.

Inadequate Attention to Project Design

Only 1 of 21 HNP sector reports for FY 1997 has a specific focus on population and reproductive health.

Sound design is important to the effectiveness of any development project. Many implementation problems can be avoided when early and adequate attention is paid to all aspects of the project, from program delivery mechanisms to procurement and contracting arrangements, to financial sustainability.

Traditionally, the Bank has initiated the design process with sector work or the preparation of detailed reports analyzing sector-specific problems and issues. These analyses provide a basis for project preparation—the Bank and the borrower identifying activities to be implemented under the new project. Finally, the Bank prepares an appraisal report which includes a detailed description of and budget for the specific activities to be supported by the project.

Decline in Sector Work: *Managers and staff in the human development sectors acknowledge the importance of high quality analytical work to the policy and technical dialogue with borrowers and to negotiations over new projects.* Sector reports provide the information and analysis for soundly designed projects and represent an advocacy tool to convince a country to adopt a particular approach in a project; on the downside, they add to time required for project preparation.

Table 3: Health, Nutrition and Population Sector, FY 1997 Sector Reports

Region/Country	Subject of Report
Africa	
Africa Region	Gender Action Plan
Djibouti	Poverty Assessment
Ghana	Gender Strategy
Mauritius	Health Sector Review
East Asia and Pacific	
Indonesia	Pharmaceuticals
Indonesia	Health Patterns
Indonesia	Health Financing
Philippines	Environmental Health Assessment
South Asia	
Asia Region	Health Reform in Asia
Bangladesh	Population and Health Sector Strategy*
India	State Health Reform
Pakistan	Health Strategy
Europe and Central Asia	
Azerbaijan	Poverty Assessment
Azerbaijan	Azerbaijan Health Note
Kazakstan	Health Sector Note
Russian Federation	Health Sector Note
Russian Federation	Social Challenges
Tajikistan	Health Sector Note
Latin America and the Caribbean	
Argentina	Health Financing
Costa Rica	Poverty Assessment
El Salvador	Rural Health Care

* Report Focusing on Population/Reproductive Health

Source: World Bank

Recent budget cuts have significantly reduced resources for HNP sector work over the last two to three years. Diminished availability of resources has led to a dramatic decline in the production of sector reports in HNP. In the 1980s, HNP staff produced one sector report for every staff appraisal report; between 1992 and 1996, this ratio declined to one sector report for every two appraisal reports. Moreover, while expenditure on sector work has declined, lending levels have increased. Many Bank staff are concerned that the decline in sector work is affecting the quality of design and could cause a further increase in implementation problems down the road.

The decline in sector work has been a particular problem in population and reproductive health; in the last few years, there have been only a handful of sector reports in this area. Only 1 of 21 HNP sector reports for FY 1997 —a report on Bangladesh—has a specific focus on population and reproductive health. The decline in sector work represents missed opportunities for policy dialogue on reproductive health. Such analyses have the potential to help countries identify appropriate follow-up to the ICPD and set priorities, and could have significant influence on reproductive health policies and programs.

Gaps in Project Design: *A variety of design problems have limited the effectiveness of Bank reproductive health projects.* Reproductive health and family planning activities are no exceptions to the pressures for loan approval and the inadequate availability of staff that shortchange project preparation and result in poorly designed projects across all sectors. Only limited and fragmentary information is available about the impact of such problems in reproductive health projects:

- A recent internal review of the performance of 40 HNP projects with population components reveals major gaps in the design of these projects, including inadequate analyses of recurrent cost issues and insufficient consideration of alternative approaches involving the private sector.
- A Bank evaluation of a family health project in Zimbabwe in the late 1980s found inadequate design adversely affected the effectiveness of an urban family planning component. The municipalities responsible for the city clinics were not involved in project development. Start-up of the activity was delayed partly because of confusion as to the agency responsible for implementation.
- *Contraceptive procurement is another area that Bank staff have neglected during the design process.* In the 1990s, a growing number of countries, especially in Africa and South Asia, are turning to the Bank to help finance their contraceptive requirements. Procurement is a generic problem in Bank health projects financing drugs for the public health sector. However, projects involving contraceptive procurement have special design needs, including projections of future demand and contraceptive requirements, as well as careful consideration of procurement and logistics management issues.

In several cases, the failure to spell out institutional arrangements and other details relating to contraceptive procurement in advance has led to serious implementation problems. These include the Fourth Population project in Kenya, which earmarked substantial funds for contraceptives. The government of Kenya proved unable to procure these commodities in accordance with Bank regulations; after seven years the Bank

A recent internal review of the performance of 40 HNP projects with population components reveals major gaps in the design of these projects.

Small population and reproductive health activities often do not receive adequate attention during implementation.

had disbursed only $8 million of an original credit of $35 million. To avoid a supply shortfall, other donors have provided contraceptives on an emergency basis.

In the case of contraceptive procurement, HNP sector staff have prepared materials to orient operations staff to these issues and provide information on available technical resources in this area. In other areas too, there is a similar need to identify common design problems and disseminate information to prevent their recurrence in new projects.

A positive recent development is that the Bank is moving to encourage the use of pilot activities to test different approaches prior to initiating full-scale projects. The Bank has used pilot projects very effectively in some countries. While a pilot approach may reduce loan volume in the short-term, it could help tailor projects to specific country needs and contribute to more effective large-scale projects in the long-term. Moreover, pilot projects can often be prepared fast and cheap.

Ineffective Oversight of Project Implementation

Frequent and effective monitoring remains critical to the successful implementation of social sector activities, including complex HNP projects. Yet supervision of population activities has been another major stumbling block for the Bank.

For years, the Bank has overseen project implementation by sending supervision missions or teams of experts to a country to visit the project every few months. This approach worked tolerably well with the construction activities which dominated population lending early on. However, as Bank population and health projects increasingly deal with complex policy and service delivery issues, this mode of oversight is no longer effective in ensuring that all elements of a project receive sufficient attention. *Both the Bank and other donors have been more successful in implementation where they have invested heavily in field supervisory staff, as the Bank itself has done in Bangladesh.*

Neglect of Population Components During Supervision: *The increasing marginalization of population and reproductive health activities within large, multi-component HNP projects presents a special challenge for effective supervision.* The small amounts of money allocated to these components frequently mask a complex range of activities. Given time constraints, Bank staff on supervision missions tend to concern themselves with the larger project components. A further problem is that these missions often focus on disbursement problems rather than technical issues. As a result, small population and reproductive health activities often do not receive adequate attention during implementation.

The Tanzania Health and Nutrition project is a classic example. The project, under implementation for nine years, includes multiple, unrelated project components. The $60 million project, approved in 1990, includes a $2 million activity with the Ministry of Plan for population policy development. An internal review in 1997 found that Bank staff had never looked at the activity during supervision missions. There had been no progress in implementation since the project's inception almost a decade ago.

The same review noted similar problems in two out of three other countries visited, where large health projects included small population components. A small family planning component in a recently completed primary health project in Yemen and a number of small safe motherhood components in other projects have also experienced similar neglect.

These experiences suggest that the Bank needs to revisit the current approach of including population and reproductive health as small components within larger health projects. But they also suggest a need for the Bank to adopt a more systematic approach to monitoring the progress of all project components, and to expand the use of in-country staff and consultants.

Insufficient Funds for Supervision: *Despite the new emphasis on project implementation and effectiveness, financial support for project supervision remains inadequate.* While this problem affects all sectors of Bank activity, the impact on the human development sectors appears especially severe. A recent internal analysis suggests that per project expenditure for staff time and travel for supervision in the human development sector is well below the overall Bank average. The review asserts that "resources have been cut beyond the point of greatest efficiency and into the muscle and bone of operations."

The situation is a complex one. The Bank's top management has reportedly increased the average project allocation for supervision. However, the country departments which control budgets following the reorganization do not appear to be passing these increases on to field operations. In many instances, budget reductions appear to have cut deeply into travel, despite its importance to effective project supervision.

As a result of the budget crunch, in at least one of the South Asia human resources divisions there were virtually no funds in FY 1997 for travel essential to achievement of the division's work objectives. Responsibility for supervision has been shifted to national staff in the Bank's country mission, a positive step in many respects but reportedly without sufficient headquarters oversight. Meanwhile, HNP staff covering Latin America report they are limited to one visit per project per year.

Thus, adminstrative budget cuts are undermining efforts to strengthen project implementation and perpetuating the Bank's front-loaded attention to loan approval. Mr. Wolfensohn has acknowledged these problems and indicated his intent to shift more resources to frontline operations and project implementation. Decentralization of staff to field offices—a very positive development with significant potential to strengthen implementation—has begun. A central quality assurance group has been established to improve the project monitoring process and identify implementation problems early on.

Budget reductions have cut deeply into travel, despite its importance to effective project supervision.

Mixed Record on Collaboration with other Donors

The potential for effective Bank-financed projects appears greatest when the Bank's efforts complement those of other donors. Countries stand to benefit when the Bank and other donors coordinate their assistance to play to their respective strengths and weaknesses. As part of the ongoing reinvention process, the Bank's leadership has said it is committed to closer collaboration with other international partners. In the reproductive health and family planning field, closer collaboration with other donors could potentially help compensate for the Bank's limited technical expertise in this area; currently such collaboration takes place at several different levels.

Global and Regional Collaboration: *At the global level, the Bank has worked closely with other multilateral and bilateral donors in several areas.* For example, it is engaged in an effort, led by the United Nations Population Fund

Overall, coordination tends to be better in the few countries—Bangladesh, India—where the Bank maintains in-country technical personnel.

(UNFPA) and involving other bilateral donors, to coordinate contraceptive commodity assistance worldwide. The Bank has participated in the Safe Motherhood Initiative with several UN and other agencies. It has also worked closely with other donors to coordinate data collection efforts and to sponsor and organize high level policy meetings. At the regional level too, the Bank has undertaken joint initiatives with other donors, for example, co-financing a number of regional projects and technical meetings with UNFPA.

For the most part, staff in the Bank's central Human Development Department have been the focal point for organizing the Bank's participation in these initiatives. The reduction of central staff under the current reorganization could potentially weaken ongoing efforts to collaborate with other donors at the global and regional levels.

Country-Level Collaboration: At the country level, donor coordination, in principle, should be the responsibility of governments of aid-recipient countries. In reality, however, donors often need to take more direct responsibility for coordinating their activities, especially where national governments are weak.

At the country level, the Bank's record in coordinating and collaborating with other donors in the reproductive health field has been mixed. First, the Bank's engagement in reproductive health and family planning, the magnitude of its financing and its field presence vary greatly from one country to another; opportunities for effective collaboration with other donors vary accordingly. Overall, coordination tends to be better in the few countries (e.g., Bangladesh, India) where the Bank maintains in-country technical personnel. A frequent complaint of other donors is that coordination suffers in those countries where the Bank lacks field-level technical leadership.

This unevenness is reflected in the Bank's efforts in a number of countries to use UNFPA's expertise in contraceptive procurement and supply management. In its efforts to serve as a procurement agency for the Bank, UNFPA has found that Bank staff working on different country programs have very different interpretations of Bank policy concerning contraceptive procurements. Moreover, many project managers in the highly decentralized Bank are not even aware of the availability of UNFPA technical assistance.

In general, coordination efforts are strongest during project development. On an ongoing basis, the Bank and other donors exchange information, share the results of major programming exercises and ensure complementarity of inputs in the formulation of new programs and projects. During the design phase of a project, the Bank is more likely to engage in discussions with other donors aimed at ensuring adequate funding for key elements of a country's program, avoiding duplication and identifying which activities are best supported through loan or grant funds. In Ghana and Senegal, the Bank and the government have initiated a series of coordination meetings with other donors in developing new health sector projects, an approach that is typical in other countries as well.

However, especially where the Bank lacks technical field staff, coordination during implementation is often poor. Staff on supervision missions for Bank population and health projects generally visit other donors active in the sector during their visits to a country. But because they operate from headquarters in Washington, they are rarely able to assure close day-to-day coordination of project activities.

KENYA

CASE HISTORY

Design and Implementation Problems Undermine the Impact of Four Population Projects

The World Bank has provided significant support to Kenya's family planning program, committing $82.2 million in concessional loans through four projects approved in 1974, 1982, 1988 and 1990, respectively. A number of problems, however, have limited the overall impact of the Bank's contribution.

The first two projects helped expand the health care system but did little to influence fertility

In the 1970s, most Kenyans still wanted large families, and political support for family planning was new and fragile. The first two Bank projects aimed to support the integration of family planning into maternal and child health services. At the time, the availability of health services was very limited; at the government's request, these projects were largely devoted to creating a basic network of rural health centers and training schools. The projects achieved their construction and training objectives, but provided little or no direct support to family planning services and had little short-run impact on population growth. Nevertheless, they laid the groundwork for a strong primary health care system and for the future expansion of contraceptive services through this system.

Up until the mid-1980s, there was little change in contraceptive use and fertility. An evaluation suggested early Bank projects could have done more to encourage a desire for smaller families by supporting family planning information programs, investing in education and coordinating more closely with other donors in this area.

The third population project failed to consider the need for contraceptive supplies

By 1988, political support for family planning was stronger, and there were signs of growing demand for contraception. The Bank's third population project sought to develop urban family planning services and establish a national program for surgical contraception. The project included funds to construct a new headquarters and district offices for the National Council for Population and Development (NCPD) as well as 14 voluntary sterilization clinics. Although the project paid little attention to future contraceptive needs, soon after the new project was approved, the demand for contraceptives appeared likely to outstrip available supplies. In 1990, the Bank quickly designed a fourth project to finance $35 million in contraceptives, essentially as an add-on to the third project.

The fourth project did not adequately consider the government's weak procurement capacity

Unfortunately, the fourth project failed to take into account long-standing problems in procurement of drugs and supplies by the Ministry of Health. Other donors in the population field had used their own centralized procurement

systems to provide contraceptive supplies and had not sought to strengthen local procurement capacity. After initial procurement efforts were derailed, the Bank and the Kenyan government agreed to select a professional agent to handle all future purchases of drugs and contraceptives under Bank health projects. Following further delays, the Bank approved a contract award to such an agent in late 1996. As of March 1997, the Bank had disbursed only $8 million of the original commitment of $35 million.

Meanwhile, a mid-term review of the third project had recommended against construction of the NCPD offices. Only one of the voluntary sterilization clinics had been completed by 1996, owing to a lack of counterpart funds from the government, cost increases and slow action by the Ministry of Health. Delays in funds caused many construction sites to be abandoned; in early 1997, the government agreed to complete the clinics with funds from the Bank's fourth project.

The Bank's future involvement in Kenya will focus on building local capacity

Demand for family planning services in Kenya is now strong. The government is moving to address family planning and other reproductive health needs through an integrated approach under a broad health sector reform initiative. Meanwhile, a new National Policy on Population and Development recognizes the need to link population to other development efforts, especially those relating to the status of women.

The government, however, faces some major problems in implementing its reproductive health strategy. It is uncertain where future contraceptive and drug supplies will come from once the Bank's fourth population project ends. The Ministry of Health's capacity for procurement and financial management remains weak, and budgetary constraints severely limit the availability of local funds.

In 1995, the Bank broadened the scope of its reproductive health assistance to include a $40 million project to control the spread of sexually transmitted diseases. More recently, the Bank has begun developing a health sector reform project, but has made clear that future support to the sector depends on the government's commitment to address problems experienced in earlier projects. The Bank currently has no plans for any further projects directly supporting the family planning program.

In Senegal, for example, at the government's request the different donors to the national family planning program, including the Bank, cover different geographic regions. Under a recently completed health and population project, the Bank provided funds for family planning training of health workers in the region to which it provides support. According to other donors, Bank staff made little effort to standardize training efforts with those in other regions, nor did they adequately monitor the quality and technical content of the training.

Bangladesh represents a more positive example of the division of labor between the Bank and other donors. In Bangladesh, the Bank has played a leadership role in creating a consortium of about a dozen donors in maternal child health and family planning. Through the consortium, the Bank has mobilized financing and supported construction, while the U.S. Agency for International Development (USAID) and its contractors and UNFPA have provided intensive technical support to service delivery and institutional development. The Bank has taken a lead role in coordinating the inputs of donors in the consortium, while working closely with USAID and UNFPA, the major donors outside the consortium, as well.

Given the technical constraints of the Bank, it is essential that it draw on other sources of population expertise. Yet in most countries, the Bank has made little effort to achieve real joint programming with other donors having greater technical expertise. Several USAID-funded technical assistance agencies, for example, report that their collaboration with the Bank at the country level has been ad hoc and relatively negligible. Moreover, both USAID and its technical agencies view the Bank as an unreliable partner because it often fails to deliver on its commitments. This is true in Kenya, where the Bank has taken years to procure contraceptive supplies, and in Burkina Faso and Pakistan, where Bank funds for technical assistance activities were subject to long delays.

In the real world, moreover, opportunities for effective partnerships in reproductive health and family planning are often limited. The regional teams of experts that provide technical advisory services to UNFPA-funded projects, for example, represent a potential source of assistance in the design and implementation of Bank projects. However, according to Bank staff, the experience with these technical advisory teams has been a mixed one, owing to the variable caliber of their expertise. Bank staff also report problems in their efforts to collaborate with the European Union, largely owing to the inadequacy of its population and reproductive health expertise.

The donor landscape is shifting. As USAID withdraws from many countries, governments are turning to the Bank as the donor of last resort. In this context, the Bank needs to strengthen its coordination with other donors but also develop its own capacity for on-the-ground technical support.

Mobilization of Funding through Project Co-Financing: *The Bank has done much better at mobilizing additional financial resources for population and reproductive health activities.* In many instances, the Bank has taken a leadership role in seeking out grant assistance from other donors to supplement its own loan commitments for specific projects, as well as in leveraging increased budget allocations by national governments. As such, the Bank has played an important role in increasing funds available for population and health programs: In FY 1993 the total value of government and

Given the technical constraints of the Bank, it needs to work more closely with other donors that have greater expertise.

In Bangladesh, the Bank has mobilized and coordinated donor financing, a model for other countries.

Table 4: Bangladesh—Mobilization of Financial Resources by The World Bank

World Bank Population and Family Health Project Budgets by Financing Source, 1975-1997 (in US$ millions)

	World Bank/ IDA Credits **US$ Millions**	Cofinanced Grants from Other Donors **US$ Millions**	Bangladesh Government Counterpart Funds **US$ Millions**	Total **US$ Millions**
Population Project I	15	25	5	45
Population Project II	32	67	11	110
Population Project III	78	99	36	213
Population Project IV	180	255	165	600
Total	305	446	217	969

Source: World Bank. Totals may not add due to rounding.

donor contributions to Bank-financed population projects was double the value of the Bank's loan commitments.

Co-financing provides the Bank with greater flexibility to include project activities that governments are often reluctant to support with loan funds. For example, in some countries, the Japanese government has provided grant funds earmarked for training to World Bank projects. Given the Bank's limited in-country presence, co-financing also enables Bank staff to rely on other donors to support activities requiring more sustained staff input than the Bank can provide. In general, more innovative, leading-edge reproductive health activities are not the comparative advantage of the Bank.

There is no better example than Bangladesh to illustrate the Bank's role as a catalyst for mobilizing funds from other sources. The consortium has provided smaller donor countries with an opportunity to participate in a coordinated international effort without a major administrative burden. *In the past two decades, the Bank has mobilized nearly a billion dollars through the consortium.* However, the Bank has adopted this innovative approach in only a few countries and has not utilized it to full advantage.

Limited Support for Private Sector and NGO Activities

In recent years, especially under Mr. Wolfensohn's leadership, the Bank has sought to build partnerships with a broader range of institutions, especially with NGOs. The Bank faces some constraints in working outside the public sector, since it makes loans to governments that they must eventually repay. Nevertheless, to an unprecedented extent, the Bank is consulting NGOs and encouraging their participation in the development of new projects. Many if not most resident missions now have NGO liaison officers. An NGO advisory committee, appointed by the Bank, is working to identify strategies for expanding NGO participation in Bank projects. To a great extent, these developments are a response to NGO critics, who still see these initiatives as too limited and too late.

The Bank has also supported NGO activities through numerous country-level projects, especially social fund-type projects which often include small grants programs to support social services at the local community level. Beyond project funding, the Bank administers a central special grants program which is a potential

source of funding for NGOs. Currently, the program primarily funds regional and global activities—mostly research—that are of importance within a larger development context. The Bank's management is considering expanding this program and developing a direct funding mechanism for support to NGOs.

Reliance on NGOs in the HNP Sector: *HNP projects have always financed NGO activities to a greater extent than other sectors within the Bank.* NGOs have played a very important role in service delivery in the reproductive health field, especially in family planning. They provide a link to local communities, and have experience in service delivery and implementation that the Bank itself often lacks. Community service organizations can more easily reach disadvantaged and marginalized groups—such as the urban poor or adolescents—with reproductive health and other social services.

For a number of years, the Bank's central special grants program has provided funds for safe motherhood activities and for population NGOs. In 1996, it added a special grants program to support activities relating to female genital mutilation and adolescent health. A relatively modest amount of funding is available under these initiatives, which disbursed a total of just over $2 million in FY 1996.

The Bank has included substantial support to NGOs in its population projects. Many if not most of the health and population projects approved in the Africa region in the late 1980s and early 1990s—for example, the Côte d'Ivoire Integrated Health Services Development Project—include some support for national family planning associations affiliated with the International Planned Parenthood Federation (IPPF).

The recently developed Reproductive and Child Health Project in India also includes substantial funding for NGO initiatives. Both the ongoing Social Action Program and population loan activity in Pakistan similarly incorporate funds for NGO family planning activities. Other countries where the Bank is working with NGOs include Vietnam and the Philippines for family planning service delivery, and Indonesia where NGOs are testing strategies for STD/AIDS prevention.

In actual implementation, however, the Bank has faced some difficulties with NGO components. Many small NGOs have greater difficulty accessing Bank funds than those of other donors. The Bank lacks the staff and mechanisms to work with governments to help local NGOs develop proposals for Bank funding and to provide technical support during project implementation. Almost none of the NGO liaison officers in the resident missions, for example, have more than a passing acquaintance with reproductive health issues.

While international NGOs could play a retailing role by channeling Bank resources to smaller, local NGOs, governments are often reluctant to use loan funds for the overhead and foreign exchange costs entailed in working through international organizations. Thus, while the Bank has made a substantial effort to support NGO activities through its projects, it still lacks modalities for promoting effective NGO-government partnerships at the country level.

The Private Sector: *In contrast, few Bank projects have supported private sector and social marketing initiatives in reproductive health and family planning.* Of the HNP projects approved in FY 1995 and 1996, only the Chad Population and AIDS Control Project includes support for social marketing.

While the Bank has made a substantial effort to support NGO activities through its projects, it still lacks ways to promote effective NGO-government partnerships at the country level.

The Bank needs to recognize the importance of the private sector in improving access and cost recovery, and to move more strongly to support initiatives in these areas.

There are several reasons why the Bank lags in support for private sector initiatives in reproductive health, while strongly promoting private commercial sector involvement in many other areas. Some governments remain reluctant to channel Bank resources outside the public health system. In India, for example, the government did not use very significant funds earmarked by the Bank for social marketing under an earlier population project. The new India Reproductive and Child Health project does not include support for social marketing activities, although an important goal of the project is to expand access to spacing methods of family planning. But a further important reason for the neglect of private sector strategies is that very few Bank staff have expertise in this area.

Nevertheless, worldwide, the majority of couples using spacing methods of family planning get their supplies from commercial sources. The Bank needs to recognize the importance of the private sector in improving access and cost recovery, and to move more strongly to support initiatives in these areas.

Recommendations for Strengthening Bank Support to Reproductive Health and Family Planning Programs

The financing the Bank provides is of crucial importance, but the effective utilization of funds is also key. Unless the Bank takes the steps necessary to strengthen the impact of its financial assistance, it may have greater potential for influence through its analytical and policy work than through support for reproductive health and family planning projects.

- **The Bank should provide more concessional financing for social sector projects, including reproductive health and family planning activities, to encourage governments to increase their investments in such projects.** The Bank's leadership has indicated that the development of new products will be part of the current process of institutional transformation. The development of new borrower-friendly loan packages for social sector projects and broader, more inclusive eligibility criteria for such financing would go a long way to increasing the willingness to borrow for health and family planning projects.
- **The Bank should look for synergies between health sector reform and reproductive health and family planning**. In countries with weak health systems, the Bank should support more focused projects addressing reproductive health and family planning needs, alongside projects dealing with larger sector-wide policy issues. At the same time, in countries with more advanced health systems, the Bank should look for ways to strengthen reproductive health services through its health care reform efforts and include reproductive health specialists at the table in structuring these programs.
- **The Bank should feature reproductive health and family planning activities much more prominently within HNP projects.** While HNP projects need to be tailored to the specific country context, in general they should incorporate simpler designs with fewer components. This does not imply a full-scale shift to stand-alone projects, whether in family planning or other areas of reproductive health. However, reproductive health and family planning should represent more significant elements within larger, integrated primary health projects. The Bank

should also continue to support new stand-alone reproductive health or family planning projects in countries where these activities deserve high priority and a more focused approach makes sense.

- **The Bank needs to review its current effort in reproductive health and family planning and identify priority countries for additional Bank investments.** The HNP network in each region should prepare country-by-country assessments of the adequacy of Bank activities in reproductive health relative to the needs. The Human Development network council and HNP sector board should review these analyses and actively monitor the pipeline of new projects to ensure all major elements of reproductive health receive attention in priority countries.
- **Strengthening the Bank's focus on reproductive health and family planning requires the support of senior management.** In the culture of the Bank, it is essential for the president, managing directors and vice-presidents to indicate support for reproductive health as a priority area of activity and to monitor staff and financial resources allocated to this area. The Bank's leadership should require the regions to compile and monitor disaggregated information on loan commitments in all key areas of reproductive health.
- **The Bank's leadership should ensure sufficient budgetary support for analytical work in the human development sectors generally, as well as in the HNP sector more specifically.** If the Bank is to play a substantial advisory role in countries and help governments make tough choices, it must maintain a strong program of analytical work. Through sector work, the Bank can also analyze the financial needs of reproductive health and family planning programs and incorporate these issues into its broader policy dialogue on health financing.
- **The Bank needs to improve the design of reproductive health and family planning activities.** The HNP network should establish a solid quality control system to ensure thorough analysis of all aspects of new projects. In addition, it should support case studies aimed at identifying the most common problems in the design of Bank-financed reproductive health activities and disseminate this information to HNP staff in all regions. Until adequate resources are available from the regular budget, other donors should continue to provide grant funds for design work and consider relaxing restrictions on the use of these funds.
- **The Bank's leadership needs to ensure adequate budgetary support for supervision of HNP projects, including reproductive health and family planning activities.** Many new initiatives under discussion, including decentralization of Bank staff to the country level, could transform the Bank's current style of managing projects. However, budget constraints are likely to preclude deployment of reproductive health and family planning specialists in every Bank resident mission. Accordingly, the Bank's leadership must ensure that adequate funds are budgeted for the time of headquarters specialists and for their travel to oversee the technical aspects of projects.
- **The HNP network in each region needs to develop specific strategies for strengthening partnerships in reproductive health with other donor agen-**

It is essential for the president, managing directors and vice-presidents to indicate support for reproductive health as a priority area of activity and to monitor staff and financial resources allocated to this area.

The Bank must budget adequate travel funds for specialists from headquarters to oversee the technical aspects of projects.

cies. At the country-level, HNP staff should seek closer collaboration with UNFPA, USAID and such bilateral donors as Germany and the United Kingdom, all of which have a field presence and some capacity for technical support. At the international level, the Bank should expand efforts to mobilize additional grant funds from donor countries that do not have significant bilateral programs, through both the co-financing and donor consortium models. Donor consultative group meetings represent a potential forum to explore these possibilities on a country-specific basis.

- **The Bank should greatly strengthen support through its projects for private sector reproductive health and family planning activities—both NGOs and for-profit and social marketing activities.** The HNP network and leadership in each region need to review the design of reproductive health and family planning activities for adequate attention to private sector approaches. This will require at least a few staff with experience in this area, along with access to external expertise. The Bank also needs to work with international and national NGOs to find more effective ways to support NGOs at the community level.

IV. The Bank's Technical Capacity in Reproductive Health and Family Planning

Staffing is key to an expanded and more effective Bank involvement in reproductive health and family planning. Adequate staffing can help to ensure that implementation bottlenecks are recognized and addressed as they arise, especially in countries where technical and absorptive capacity are limited. While a critical mass of staff is important, the quality and relevance of expertise is also essential to good project design and implementation, and to exercising leadership with country-level counterparts.

The Bank's current leadership has recognized the need to strengthen substantive expertise within the Bank across all development sectors. External observers perceive the Bank to have experienced a decline in technical expertise in many areas over the past decade. In general, the management structure has not encouraged technical experts in a given area to play a lead role in shaping the lending program. These concerns apply to the HNP sector as well.

It is not easy to analyze the staff situation with respect to reproductive health. Consistent data on trends in staffing in this area are not readily available. Official job titles do not always reflect whether a particular individual has reproductive health and family planning expertise. As in other sectors, most reproductive health specialists work on other aspects of health as well, while many staff lacking specialized expertise work on reproductive health projects.

Key Issues Relating to HNP Staffing

Inadequacy of Technical Expertise: Human development staff—including those working in health, nutrition and population—have reportedly grown by roughly 80 percent since 1986. Some observers believe this rapid expansion has contributed to a decline in the quality of staff.

The number of HNP staff with real technical skills appears very limited, and the number with expertise in population and reproductive health is even smaller. In 1993, of a total of 360 staff in the human development sectors, 41 (13 percent) were health and nutrition specialists and 20 (6 percent) were population specialists. At the present time, there appear to be a small number of staff with specialized health and family planning expertise; a number of staff lacking expert credentials but having substantial experience in the sector; and a greater number with very limited knowledge relating to the delivery and content of health services. In general, few staff have first-hand field experience in the actual implementation of programs.

As a result, relatively large numbers of staff lacking specialized expertise in reproductive health—especially economists, but also some staff with more general project management or public health background—work on projects which include population and reproductive health activities. The dearth of specialized expertise, both at headquarters and in the field, makes it difficult for the Bank to advise governments on how to strengthen their reproductive health and family planning programs.

Inappropriate Use of Reproductive Health and Other Specialists: In most but not all instances, the managers of the few stand-alone reproductive health projects are experts in this field. However, these experts also work increasingly on other health and social sector projects. *In some cases, family planning specialists are so busy managing health projects that they cannot provide technical advice on family planning to projects which they do not directly manage.* This is especially the case since the work-

The number of HNP staff with real technical skills appears very limited, and the number with expertise in population and reproductive health is even smaller.

Many HNP staff in influential and highly sought-after task manager positions are economists or other staff with limited health expertise.

load has increased faster than the number of staff; on average, each staff person is responsible for a greater loan volume and more projects than before.

Excessive Reliance on Economists as Project Managers: *The human development sectors, including HNP, have relied very heavily on economists.* In 1993, economists represented the largest single group of human development staff, at 30 percent. The proportion of economists appears to have increased since that time, a trend health experts in the Bank believe is driving the current push for health financing reform.

Within the health sector, there is an underlying tension between the need for staff with expertise in health service delivery on the one hand, and with savvy about Bank operations and ability to manage the loan process on the other. The Bank has often come down in favor of the latter, especially in selecting the task managers who oversee the design and implementation of projects. Many HNP staff in these influential and highly sought-after positions are economists or other staff with limited health expertise.

Many Bank staff perceive the individual expertise and interests of task managers to play too great a role in the identification of new projects. To a large extent, the content of a project depends on the exchange between the task manager and the borrower. Technical staff are often not involved in project identification. As a result, individual agendas too often drive the lending program.

Inadequate Field Staff: *Inadequate technical staff at the field level and the centralization of design and supervision processes at headquarters have been major constraints to the effectiveness of Bank social sector projects.* A few country departments at the Bank have now cut back Washington staff in favor of field-based managers, a trend with great potential to improve project monitoring and effectiveness. Only when Bank staff are sitting with their counterparts in a country, working together to solve implementation problems—such as contraceptive procurement and distribution or procedures for channeling funds to NGOs—will Bank lending in the sector begin to approach the effectiveness of assistance provided by donors such as UNICEF and USAID. Bangladesh is an outstanding example of the benefits of having Bank staff on the ground.

Yet, as the Bank shifts project management responsibilities to some resident missions, new issues are emerging. Given the high cost of maintaining staff in the field, most staff assigned to resident missions are unlikely to have specialized reproductive health skills. Headquarters staff also note that where resident missions rely on national staff, these staff may find it difficult to take a strong stand on important policy issues with their own governments. Thus, as the Bank expands its country presence and shifts responsibility to the field, headquarters staff are likely to play a continued role in policy guidance and technical oversight.

Adequacy of Reproductive Health Staff by Region

In the early 1990s, specialists in the central Population Advisory Service helped to support regional staff working on reproductive health and family planning activities. Since this unit has been virtually dismantled, the HNP network in each regional department is essentially the sole source of technical support to reproductive health and family planning activities. As in the case of the lending program, the adequacy of staffing relative to needs varies greatly across regions.

Overall, there is no regional department that has sufficient staff capacity in reproductive health and family planning. In most regions, the Bank lacks the critical mass of reproductive health expertise needed to have a significant influence on country programs. Moreover, the concerns of experts in these areas are often overshadowed by other more powerful constituencies within the Bank.

South Asia: *With support from regional leadership, the South Asia department has historically dedicated significant staff resources to population activities, especially for projects in Bangladesh and India.* In addition to several reproductive health specialists at headquarters, the department has drawn extensively on central human development staff, and deployed reproductive health and family planning experts in its field offices to assist in project implementation.

The high level of involvement of Bank staff in these two countries contrasts with most other regions and has contributed to project effectiveness. In India, for example, intensive staff inputs in policy discussions over the past two years have been crucial to help accelerate a major shift in direction in the family welfare program.

Nevertheless, the staffing situation in the department at present raises some concerns. Over the last couple of years, several population specialists have left the department, resulting in diminished staff support for important programs in Bangladesh and Pakistan. Several senior experts will be eligible to retire in the next couple of years. Meanwhile, the magnitude of Bank reproductive health assistance in the region suggests a need to sustain or even increase staff inputs.

East Asia and Pacific: *This region has had a strong complement of roughly a half dozen highly qualified family planning and reproductive health specialists, but this expertise is also being eroded.* It is not clear how the region will utilize its existing expertise as the lending program shifts towards other health issues. However, the Bank will need higher staff inputs relative to loan volume to work effectively in poorer countries in Southeast Asia having less managerial capacity than the traditional borrowers in the region.

Middle East and North Africa: *This department has recently strengthened its reproductive health and family planning staff.* Previously, such expertise was virtually non-existent. Still, the number of specialists remains limited to only a couple of real reproductive health and family planning experts.

Africa: *As in the case of the lending portfolio, the biggest gap in staffing is in the Africa region.* The number of staff in Africa HNP operations has not kept pace with the growth in project activity in the region, and current staff resources are stretched very thin. Moreover, in addition to its project-related work, the department provides secretariat support for several regional initiatives.

At headquarters, Africa department health staff are dominated by public health specialists with limited interest in family planning. There is a core of roughly a half dozen highly qualified family planning experts. These are too few to meet the needs of the 49 countries in the region, and they spend substantial time working on other health issues. The department has several staff with AIDS expertise, but virtually no specialists in the area of safe motherhood.

Recently, however, new management of the Africa HNP network is seeking to rebuild population and reproductive health expertise, and has recruited two new senior advisers in these areas. The HNP manager also plans to expand health expertise in

Even as resident mission staff increase, headquarters staff are likely to continue playing a role in policy guidance and technical oversight.

Bank reproductive health projects have rarely drawn on the growing international network of technical assistance agencies.

the Bank's resident missions—a half dozen missions already have health staff including a few with reproductive health expertise.

Latin America and the Caribbean: *Population and reproductive health staff are also inadequate in the Latin America and Caribbean region.* HNP operations staff have not increased commensurate to the number of ongoing projects and the planned increase in future health projects in the pipeline. The Bank could be doing much more in reproductive health in Latin America, but current staff are insufficient to handle even the present work load. Currently, the region has two staff with expertise in maternal and child health and family planning, both of whom spend substantial time on other health activities.

Europe and Central Asia: *This region is similarly understaffed.* Overall lending in the HNP sector has not been matched by staffing levels. The division is dominated by economists and needs more staff with health service delivery expertise. Despite the significant reproductive health needs in the region, regional staff include only one physician with minimal reproductive health expertise.

Limited Reliance on External Technical Expertise

In contrast to USAID and other major donors, Bank projects have not used external institutional expertise in a systematic way for technical support and capacity building.

A large and growing international network of private organizations has played an important role in technical support to family planning programs in developing countries. This network, initially consisting of U.S. organizations funded by USAID, has contributed to the success of U.S. population assistance efforts and helped build local capacity in many developing countries. More recently, this network has evolved to include organizations from other donor and developing countries, a broader range of reproductive health expertise, and collaboration with a greater diversity of bilateral and multilateral donors.

Bank population and reproductive health projects have rarely drawn on these resources. When they have done so, it has generally been for short-term technical assistance, rather than for long-term capacity-building and support. More typically, when Bank staff identify a need for specific technical skills in project development or supervision, they use donor trust funds to bring in short-term individual consultants.

To a large extent, the Bank lacks mechanisms to tap into this wealth of international population expertise. Given pressure on budgets, Bank staff have been unable to afford the costs of external institutional expertise—including overhead—from the Bank's administrative budget. Borrowers are generally reluctant to use loan funds for technical services and often have to overcome obstacles within their own bureaucracies to implement such arrangements.

Nevertheless, a handful of population and reproductive health projects have included funds for technical support. In Bangladesh, the Bank has had a long-standing and successful experience using grant funds from other donors to finance a special project implementation unit. In Pakistan, the Bank had a more mixed experience when it included funds in the project budget for advisory services to replace USAID technical support; procurement problems on the Pakistan government's side delayed the contract award for several years.

Effects of the Reorganization on Technical Capacity

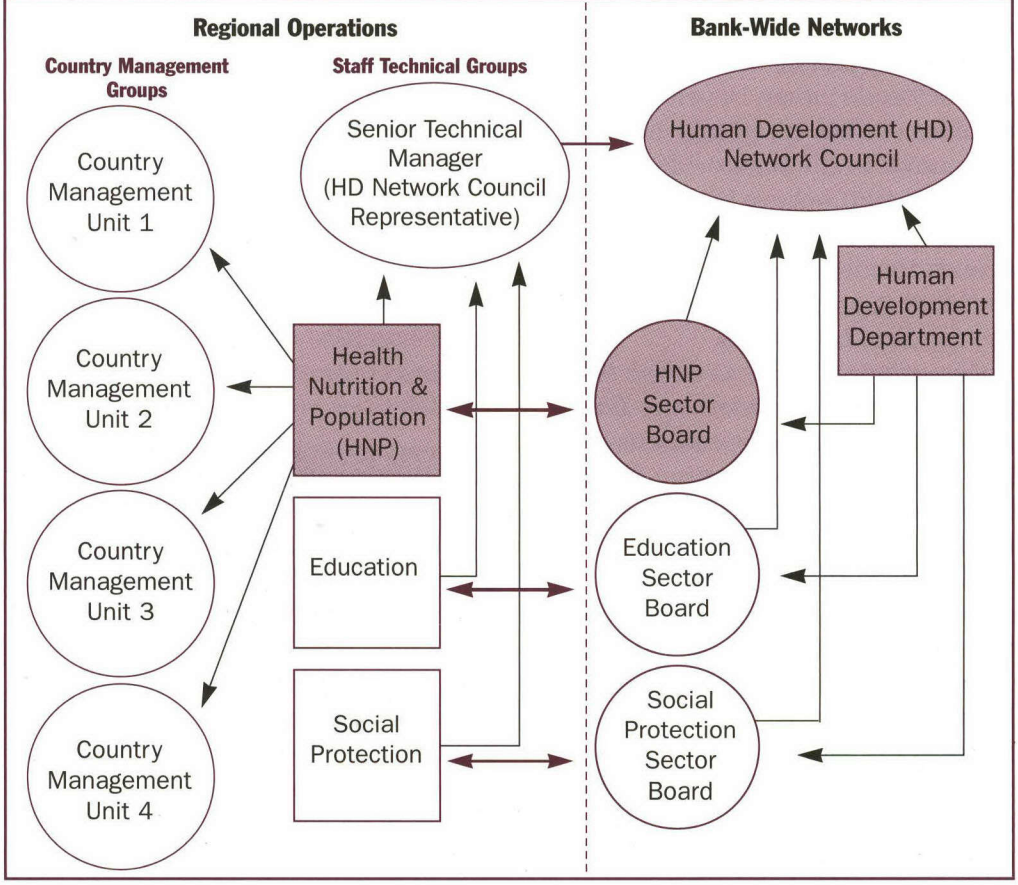
The current reorganization is an ambitious effort to transform the Bank and the way it does business. Mr. Wolfensohn has recognized that excessive reliance on generalists has been a source of problems with project design and implementation. For example, he is reported to have expressed concern that Bank staff without education expertise design education projects. Accordingly, the new plan contemplates significant changes in the management and staffing structure aimed at strengthening the level of technical expertise.

The sector networks are central to the strategy to strengthen the Bank's technical capacity. The reorganization groups most technical staff in the regional departments together in large sector management units, which provide technical support to projects at the request of country management units. This network structure is intended to encourage sharing of experience across sectors and countries, and promote teamwork and more coordinated strategies.

Many technical staff view this restructuring favorably. By grouping all HNP staff in the same unit, the reorganization has established a critical mass of technical expertise at the regional level, unlike the previous arrangement which isolated technical staff in fragmented country operations units. Each staff person can work across several countries, potentially promoting a more consistent Bank response as well as a sharing of experience within each region.

By grouping all HNP staff in the same unit, the reorganization has established a critical mass of technical expertise at the regional level.

Figure 3: Human Development Sectors Following Reorganization



Following reorganization, there will no longer be a central core of expertise within the Bank in areas such as women's health.

Regional staff also see the new network structure as an improvement over the previous relationship between the center and the regional departments. In the past, the central Human Development Department had responsibility for policy and research while the regions were responsible for managing the lending program. Regional staff frequently perceived central policy guidance to be irrelevant to operational needs.

Still, the central department has played an important leadership role in areas such as safe motherhood. HDD publications such as *Making Motherhood Safe (1993)* and *Women's Health and Nutrition: Making a Difference* (1994) make the case for investments in these areas as well as providing guidance on appropriate program directions to Bank staff and the larger international health community.

Under the new system, senior technical staff from the regional departments serve on the Bank-wide network council and sector boards and drive policy and decision making. The restructured Human Development Department has essentially become a secretariat to the Bank-wide network. Regional staff believe the new system will reorient the research and policy agenda towards needs identified in the lending program and better serve the needs of borrowers.

Nevertheless, there is a risk that the networks will undermine Bank-wide leadership in reproductive health and family planning. While the central PHN department had a staff of about 19 in 1994 to 1995, the restructured HDD will have only about 6 health, nutrition and population positions. While these positions include a population/reproductive health advisor, this advisor will have limited operational influence and virtually no staff support. Indeed, the position may not be attractive to a high caliber professional, and it may also prove difficult to find an individual with expertise in both population and reproductive health.

As a result of these changes, there will no longer be a central core of specialized expertise in areas such as women's health, safe motherhood and AIDS. The current reorganization could thus result in the same erosion of technical capacity that occurred with the decentralization of population and health staff in 1987. Moreover, the priority given to reproductive health is likely to vary greatly across the regional departments.

The network council and sector boards are responsible for managing professional staff resources. They will determine where the Bank has adequate expertise and where additional staff are needed through training or recruitment. Their responsibilities include the development of professional standards for staff recruitment and promotion, including standards for reproductive health specialists of various kinds.

Finally, the HNP network has not yet clarified future plans relating to the use of external technical services. Despite the emphasis on strengthening technical capacity, there has been little discussion and no specific proposals to date regarding the potential use of external contract expertise or regarding the funding and contracting mechanisms needed to procure such services.

Recommendations for Strengthening the Bank's Technical Capacity in Reproductive Health and Family Planning

The Bank's ability to have an impact on country programs depends on the caliber and expertise of the staff who develop and manage its projects. As the Bank moves forward with its institutional restructuring, it needs to

enhance its technical leadership in reproductive health and family planning and to make major changes in how it manages its investments.

- **It is essential for the Human Development Department to include a high caliber reproductive health and family planning expert to provide Bank-wide leadership in this area.** This reproductive health expert should be a member of the HNP sector board. This position should be additional to a senior population advisor who heads up the population policy unit proposed above.
- **Bank and network managers need to closely monitor the impact of recent organizational changes on capacity in reproductive health and other technical areas.** Leadership in reproductive health or any area requires a strong dedicated senior staff person backed up by a high-level unit. If expertise at the center appears to have been reduced to the point of undermining technical leadership within the Bank, management should consider reestablishing a small central core of technical experts in reproductive health, and possibly in other technical areas as well.
- **The HNP network in each region should consider establishing a position for a senior regional reproductive health and family planning advisor**. The incumbent in this position—similar in concept to the two positions recently created in the Africa region—would provide technical leadership and coordinate and monitor activities in the region. Again, such leadership positions in the regions may be appropriate in other technical areas as well. This approach would be consistent with the emphasis of the current reorganization on both decentralization and strengthening of technical capacity.
- **Several regional departments, especially the Africa department, need to recruit additional staff with expertise in reproductive health and family planning.** Each region should carry out a systematic review of current staff relative to needs in this area and establish a critical mass of specialized expertise. In establishing technical standards for these staff, network managers need to recognize the need for skills in several specialized areas of reproductive health, notably family planning, safe motherhood and AIDS/STD control.
- **The network council, sector board and regional HNP sector managers also need to review the current approach to staff deployment to ensure that reproductive health and other experts are utilized for maximum impact.** Reproductive health and other specialist staff should spend the bulk of their time working on the technical aspects of projects, rather than on routine tasks relating to project administration. At the same time, these experts should be included in the design and implementation of broader health projects, including health sector reform efforts, in order to ensure that these projects give adequate attention to reproductive health.
- **The HNP network should take steps to enhance knowledge of reproductive health and family planning among nonspecialists who work on these issues.** The networks should develop special training programs for a broad range of nonspecialist staff involved in reproductive health and family planning projects, including country managers, economists, public health generalists and NGO liaison officers in resident missions.

The Bank needs to enhance its technical leadership in reproductive health and family planning and make major changes in how it manages projects.

Reproductive health staff should spend their time working on the technical aspects of projects rather than on routine administrative tasks.

- **The Bank needs more staff in its resident missions with the ability to monitor and support the implementation of reproductive health and family planning projects.** This is especially important in Africa, with its large number of countries, logistical difficulties and weaknesses in local capacity. There should be a staff person with broad knowledge of the HNP sector in every resident mission in Africa to support implementation. For more specialized reproductive health expertise, the Bank could rely on a combination of local-hire experts, visits by headquarters technical staff and external contract expertise. The Bank should also consider assigning specialist staff to selected resident missions from where they can provide support to Bank-financed programs in neighboring countries as well.
- **The Bank needs to develop new mechanisms for the use of external contract expertise in reproductive health and family planning.** Especially in Africa, it should shift from use of individual consultants on an ad hoc basis to more systematic use of institutional expertise for long-term capacity building. Given the frequent difficulties in convincing countries to use loan funds for technical services, the Bank should provide funds for such services in its own administrative budget and develop appropriate contractual mechanisms. Such a move would help shift budget resources to front-line operations and strengthen the effectiveness of its work in the social sectors. However, specialized external expertise is not a substitute for strengthening the Bank's own technical capacity. The Bank will still need a core of technical staff to organize and manage such specialized contractual expertise.

  Given the large community of U.S. organizations with expertise in reproductive health, a U.S. trust fund, similar to those established by other donors, could facilitate the Bank's use of this expertise. USAID and the Bank could also explore ways to provide technical support to World Bank activities through USAID's existing centralized contractual arrangements. The need, however, is for more comprehensive mechanisms which can draw on a broad range of specialized expertise—including existing bilateral and multilateral technical support networks, for-profit and nonprofit private organizations, and emerging South-to-South partnerships.

V. Conclusion: Priorities for Bank Management

The preceding analysis suggests that the Bank overall is not exercising real leadership in population policy development or in financial support to reproductive health and family planning programs. This is not to diminish the significant contributions the Bank has made and continues to make, especially in a number of Asian countries. However, it is generally these *countries* that have taken the lead, and it is their unshakable commitment to population stabilization that has generated a strong demand for projects and Bank loans to support them.

Beyond these few countries, it is difficult to find many instances where the Bank has played a central role. The Bank's organization and staffing arrangements are an important part of the problem. Both money and technical advice are important for effective engagement in population and reproductive health; the Bank's ability to provide both has been constrained by its inadequate technical staff in this area.

For years, Bank staff have found it too easy to attribute poor performance in lending for population and family planning to a lack of demand on the part of its clients. This is, however, too modest a view of the Bank's influence. In reality, the Bank's lending program in population or any other sector is the outcome of the complex interaction of several factors. These include the priority both the Bank and its borrowers assign to the sector as well as the Bank's capacity to support policy work and projects in the sector.

In reality then, there is a push-pull dynamic between the Bank and its borrowers in which the Bank has considerable influence. If the Bank does not take the initiative to raise an issue, it is less likely to come up in initial policy discussions and countries are less likely to ask for projects. Subsequent Bank missions are then less likely to include the right kind of staff to help develop a request and design a project.

In poor countries where population growth impedes economic and social development, the Bank should be working much more actively to convince finance ministers and heads of state of the importance of slowing such growth. It should be much more deeply engaged in helping countries develop comprehensive multisectoral population strategies. These efforts would help advance both the goals promoted at the ICPD and broader economic and social development. They are vitally important in Africa, where rapid population growth remains a critical obstacle to development.

Moreover, at a time when grant aid to population programs appears to be stagnating, the Bank should be providing substantially increased funding for reproductive health and family planning. *If the international community is to meet the financial and programmatic goals for the year 2000 agreed on at Cairo, including $17 billion in reproductive health and family planning expenditures, the Bank needs to provide new loan commitments of at least $1 billion a year. At present, the level of Bank financial assistance in this area is inadequate relative to both current needs and its own potential to support these programs.*

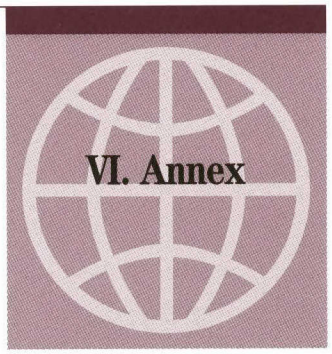
This report recommends a comprehensive set of actions to strengthen the Bank's contribution in population and reproductive health. While there are no simple solutions to ensuring appropriate attention to these issues, we suggest three priority areas for action:

- The Bank's top leadership should insist that population issues are consistently addressed in country assistance strategies.

At a time when grant aid to population programs appears to be stagnating, the Bank should be providing substantially increased funding for reproductive health and family planning.

- Management needs to monitor loan commitments and plans for future sector work and new project development in all key areas of reproductive health.
- The Bank needs to put in place both a critical mass of technical staff in each region and mechanisms to draw on external institutional expertise in order to better support reproductive health and family planning activities.

These are challenges that the Bank's leadership could easily address, given sufficient will and commitment.



■ **Annex Table 1: World Bank Lending for Population and Reproductive Health: Fiscal Years 1990-1996** 55-61

FY 1990 World Bank Lending for Population 55
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■ **Annex Table 2: World Bank Lending for Health, Nutrition and Population Sector, FY 1997** 62

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

ANNEX TABLE 1

90 FY 1990 World Bank Lending for Population

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population Programs (US$ Millions)	Population Programs as % of Total Loan
Africa				
Kenya—Fourth Population	IDA	35.0	35.0	100%
Lesotho—Second Population, Health and Nutrition	IDA	12.1	1.2	10%
Tanzania—Health and Nutrition	IDA	47.6	9.5	20%
Europe, Middle East and North Africa				
Morocco—Health Sector Investment	IBRD	104.0	10.4	10%
Yemen—Second Health	IDA	15.0	1.5	10%
South Asia				
India—Seventh Population	IBRD/IDA	96.7	96.7	100%
Latin America and the Caribbean				
Brazil—Second Northeast Basic Health Services	IBRD	267.0	13.4	5%
Haiti—First Health	IDA	28.2	1.6	6%
TOTAL			169.3	

Source: World Bank

ANNEX TABLE 1

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

91 FY 1991 World Bank Lending for Population

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population Programs (US$ Millions)	Population Programs as % of Total Loan
Africa				
Senegal—Human Resources Development—Population and Health	IDA	35.0	14.8	42%
Rwanda—First Population	IDA	19.6	19.6	100%
Nigeria—National Population	IDA	78.5	78.5	100%
Togo—Population and Health Sector Adjustment	IDA	14.2	4.3	30%
Madagascar—Health Sector Improvement	IDA	31.0	4.4	14%
Malawi—Population, Health and Nutrition Sector Credit	IDA	55.5	5.8	10%
Mali—Health, Population and Rural Water Supply	IDA	26.6	3.0	11%
Ghana—Second Health and Population	IDA	27.0	4.9	18%
Europe, Middle East and North Africa				
Tunisia—Population and Family Health	IBRD	26.0	26.0	100%
East Asia and Pacific				
Indonesia—Fifth Population	IBRD	104.0	104.0	100%
South Asia				
Pakistan—Family Health	IDA	45.0	13.5	30%
Bangladesh—Fourth Population and Health	IDA	180.0	61.5	34%
Latin America and the Caribbean				
Venezuela—Social Development	IBRD	100.0	5.0	5%
Haiti—Economic and Social Fund	IDA	11.3	0.5	4%
Honduras—Social Investment Fund	IDA	20.0	0.2	1%
El Salvador—Social Sector Rehabilitation	IBRD	26.0	1.5	6%
Mexico—Basic Health Care	IBRD	180.0	3.5	2%
TOTAL			351.0	

Source: World Bank

ANNEX TABLE 1

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

92 FY 1992 World Bank Lending for Population

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population Programs (US$ Millions)	Population Programs as % of Total Loan
Africa				
Niger—Population	IDA	17.6	11.6	66%
Mauritania—Health and Population	IDA	15.7	6.9	44%
Equatorial Guinea—Health Improvement	IDA	5.5	0.2	4%
South Asia				
India—Family Welfare	IDA	79.0	63.2	80%
India—Child Survival and Safe Motherhood	IDA	214.5	0.1	<0.1%
Europe and Central Asia				
Poland—Health	IBRD	130.0	6.5	5%
Romania—Health Services Rehabilitation	IBRD	150.0	14.4	10%
Latin America and the Caribbean				
Honduras—Second Social Investment Fund	IDA	10.2	0.1	<1%
Guyana—Health, Nutrition, Water and Sanitation	IDA	10.3	0.2	2%
TOTAL			103.2	

Source: World Bank

ANNEX TABLE 1

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

93 FY 1993 World Bank Lending for Population

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population Programs (US$ Millions)	Population Programs as % of Total Loan
Africa				
Burundi—Social Action	IDA	10.4	0.5	5%
Guinea Bissau—Social Sector	IDA	8.8	0.9	10%
Angola—Health	IDA	19.9	0.6	3%
Middle East and North Africa				
Iran—Primary Health Care and Family Planning	IBRD	141.4	59.5	42%
Jordan—Health Management	IBRD	20.0	2.0	10%
Yemen—Family Health	IDA	26.6	10.7	40%
East Asia and the Pacific				
Papua New Guinea—Population and Family Planning	IBRD	6.9	6.9	100%
Philippines—Urban Health and Nutrition	IDA	70.0	17.5	25%
Indonesia—Third Community Health and Nutrition	IBRD	93.5	9.4	10%
South Asia				
India—Social Safety Net Sector Adjustment Program	IDA	500.0	40.0	8%
Pakistan—Second Family Health	IDA	48.0	12.0	25%
Latin America and the Caribbean				
Honduras—Nutrition and Health	IDA	25.0	0.1	<1%
Ecuador—Second Social Development: Health and Nutrition	IBRD	70.0	15.4	22%
Columbia—Municipal Health Services	IBRD	50.0	5.0	10%
Guatemala—Social Investment Fund	IBRD	20.0	0.6	3%
TOTAL			181.1	

Source: World Bank

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

ANNEX TABLE 1

94 FY 1994 World Bank Lending for Population and Reproductive Health

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population and Reproductive Health Bank Estimates (US$ Millions)	Population Bank Estimates (US$ Millions)
Africa				
Burkina Faso—Health and Nutrition	IDA	29.2	7.5	7.5
Burkina Faso—Population and AIDS Control	IDA	26.3	26.3	14.1
Chad—Health and Safe Motherhood	IDA	18.5	6.1	4.6
Comoros—Population and Human Resources	IDA	13.0	4.3	2.8
Guinea—Health and Nutrition Sector	IDA	24.6	2.5	2.5
Uganda—Sexually Transmitted Infections (STI)	IDA	50.0	50.0	0.0
East Asia and Pacific				
China—Rural Health Workers Development	IDA	110.0	8.9	8.9
Malaysia—Health Development	IBRD	50.0	0.5	0.5
South Asia				
India—Family Welfare (Assam, Rajasthan, Karnataka)	IDA	88.6	70.9	70.9
Nepal—Population and Family Health	IDA	26.7	21.4	21.4
Social Sector—Pakistan—Social Action Program	IDA	200.0	40.8	40.8
Latin America and the Caribbean				
Argentina—Maternal and Child Health and Nutrition	IBRD	100.0	12.0	12.0
Brazil—AIDS and Sexually Transmitted Diseases (STD)	IBRD	160.0	160.0	0.0
Nicaragua—Health Sector Reform	IDA	15.0	0.6	0.6
Peru—Basic Health and Nutrition	IBRD	34.0	10.5	10.5
Social Sector—Peru—Social Development and Compensation Fund	IBRD	100.0	1.4	1.4
TOTAL			423.7	198.5
Total without Social Sector Projects			381.5	156.3

Source: World Bank

ANNEX TABLE 1

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

95 FY 1995 World Bank Lending for Population and Reproductive Health

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population and Reproductive Health Bank Estimates (US$ Millions)	Population PAI Estimates (US$ Millions)
Africa				
Benin—Health and Population	IDA	27.8	13.9	2.8
Burundi—Second Health and Population	IDA	21.3	8.0	4.0
Cameroon—Health, Fertility and Nutrition	IDA	43.0	21.5	10.0
Chad—Population and AIDS Control	IDA	20.4	20.4	12.5
Kenya—Sexually Transmitted Infections (STI)	IDA	40.0	40.0	0.0
Senegal—Community Nutrition	IDA	18.2	1.8	0.0
Uganda—District Health Services Pilot and Demonstration	IDA	45.0	11.3	2.0
Zambia—Health Sector Support	IDA	56.0	28.0	0.0
Zambia—Second Social Recovery	IDA	30.0	0.9	0.0
Middle East and North Africa				
Lebanon—Health Sector Rehabilitation	IBRD	35.7	8.9	0.3
Turkey—Second Health Project: Essential Services and Management Development in Eastern and Southeastern Anatolia	IBRD	150.0	37.5	0.0
East Asia and Pacific				
China—Comprehensive Maternal and Child Health	IDA	90.0	45.0	0.0
China—Iodine Deficiency Disorders Control	IBRD/IDA	27.0	2.7	0.0
Indonesia—Fourth Health Project: Improving Equity and Quality of Care	IBRD	88.0	22.0	0.0
Lao, P.D.R.—Health System Reform and Malaria Control	IDA	19.2	4.8	1.7
Philippines—Women's Health and Safe Motherhood	IBRD	18.0	18.0	3.4
Cambodia—Social Fund	IDA	20.0	1.0	0.0
South Asia				
India—Andhra Pradesh First Referral Health System	IDA	133.0	26.6	0.0
Pakistan—Population Welfare Program	IDA	65.1	65.1	65.1
Bangladesh—Integrated Nutrition	IDA	59.8	14.9	0.0
Europe and Central Asia				
Croatia—Health	IBRD	40.0	1.6	0.0
Estonia—Health	IBRD	18.0	0.2	0.0
Latin America and the Caribbean				
Panama—Rural Health	IBRD	25.0	4.0	0.0
Mexico—Program of Essential Social Services	IBRD	500.0	50.0	15.0
TOTAL			448.1	116.8

Source: World Bank

ANNEX TABLE 1

World Bank Lending for Population and Reproductive Health: Fiscal Years (FY) 1990-1996

96 FY 1996 World Bank Lending for Population and Reproductive Health

Region/Project	IBRD/IDA	Total Loan (US$ Millions)	Population and Reproductive Health Bank Estimates (US$ Millions)	Population and Reproductive Health PAI Estimates (US$ Millions)	Population PAI Estimates (US$ Millions)
Africa					
Côte d' Ivoire—Integrated Health Services Department	IDA	40.0	13.5	13.5	12.0
Sierra Leone—Integrated Health Sector Investment	IDA	20.0	1.3	5.0	2.5
Mozambique—Health Sector Recovery Program	IDA	98.7	35.9	35.9	6.0
Middle East and North Africa					
Egypt—Population	IDA	17.2	17.2	17.2	17.2
Morocco—Social Priorities Program: Basic Health	IBRD	68.0	20.3	20.3	10.0
East Asia and Pacific					
China—Disease Prevention	IDA	100.0	89.9	4.2	0.0
Indonesia—HIV/AIDS and Sexually Transmitted Diseases (STD) Prevention and Management	IBRD	24.8	24.8	24.8	0.0
Vietnam—National Health Support	IDA	101.2	39.6	32.7	10.9
Vietnam—Population and Family Health	IDA	50.0	50.0	50.0	25.0
South Asia					
India—Second State Health Systems Development	IDA	350.0	56.0	56.0	0.0
Pakistan—Northern Health Program	IDA	26.7	26.7	26.7	2.7
Europe and Central Asia					
Bulgaria—Health Sector Restructuring	IBRD	26.0	9.5	4.5	0.0
Georgia—Health Project	IDA	14.0	8.1	7.2	0.2
Kyrgyz Republic—Health Sector Reform	IDA	18.5	4.2	4.2	0.0
Russian Federation—Medical Equipment	IBRD	270.0	90.0	90.0	0.0
Latin America and the Caribbean					
Mexico—Second Basic Health Care	IBRD	310.0	111.8	111.8	20.0
TOTAL			598.8	504.0	106.5

Source: World Bank

ANNEX TABLE 2

World Bank Lending for Health, Nutrition and Population Sector, FY 1997

Region/Project	IBRD/IDA	Total Loan (US$ Millions)
Africa		
Niger—Health Sector Development Program	IDA	40.0
Senegal—Endemic Disease Control	IDA	14.9
East Asia and Pacific		
Indonesia—Intensified Iodine Deficiency Control	IBRD	28.5
Cambodia—Disease Control and Health Development	IDA	30.4
South Asia		
India—Malaria Control	IDA	164.8
India—Reproductive and Child Health*	IDA	248.3
India—Rural Women's Development and Empowerment	IDA	19.5
India—Tuberculosis Control	IDA	142.4
Sri Lanka—Health Services	IDA	18.8
Europe and Central Asia		
Turkey—Primary Health Care Services	IBRD	14.5
Bosnia-Herzegovina—Essential Hospital Services	IDA	15.0
Russia—Health Reform Pilot	IBRD	66.0
Latin America and the Caribbean		
Argentina—Maternal and Child Health and Nutrition II*	IBRD	100.0
Paraguay—Maternal Health and Child Development*	IBRD	21.8
Argentina—AIDS and Sexually Transmitted Diseases Control*	IBRD	15.0
TOTAL		939.9

* Projects focusing on Reproductive Health

Source: World Bank

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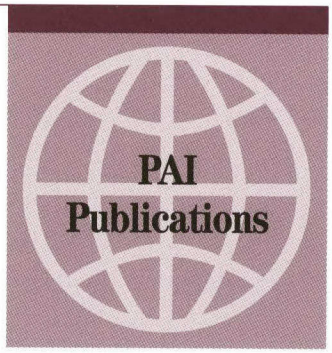

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Meeting between
the World Bank and
Population Action International (PAI)

January 14, 1998

*MC Dining Room "G" ***

** The lunch will take place from 12:30 to 2:00 pm. Mr. Wolfensohn has agreed to drop by around 1:45 pm. He will be accompanied by Ms. Marisela Montoliu.

Representing the World Bank:

David de Ferranti
Richard Feachem
Tom Merrick
Maureen Law
Ok Pannenborg
Debrework Zewdie
Indra Pathmanathan
Anne Tinker

Representing Population Action International:

Constance Spahn, new National Chair
Robin Duke, former National Chair
Joe Wheeler, PAI Board
Shanti Conly, PAI staff and report author

Please find attached:

-- bios of PAI participants
-- briefing materials prepared for the January 14 lunch
-- general information about PAI

Briefing materials prepared by Tom Merrick, January 12, 1998.

Biographic Sketches of
Population Action International (PAI) Representatives
January 14th Meeting with World Bank Staff

Constance Spahn is PAI's new **National Chair**, effective January 1998. A resident of New York City she is Chairman of Global Information, Inc. She is also Chairman of the Board of Down East Enterprise, which originated and confers annually the State of Maine Environmental Award. She co-founded and chairs the John Catt Publishing Company, the leading publisher of educational directories in the UK, was a member of the 1987 U.S.-U.S.S.R. Trade Delegation, founded Global Finance Magazine, with offices in Tokyo, London, New York and Frankfurt, and was co-founder and Vice-Chairman from 1972 to 1990 of the International School of London. A past member of the Young Presidents' Organization, Gotham Chapter, she is a Trustee of the American Museum of Natural History and a Director and member of the Executive Committee of the Volunteer Development Council for U.N. Delegations.

Robin Chandler Duke, currently PAI **Co-Chair**, served as **National Chair** from 1991 to 1997 and previously as charter Chair of the Draper Fund, National Co-Chair and a Director of PAI. In addition to a distinguished career spanning the fields of journalism, diplomacy, politics and finance, Mrs. Duke is a leading spokesperson for international family planning and women's reproductive rights. She is a former President of the National Abortion Rights Action League, a Director of the Alan Guttmacher Institute, and a past Director of the Planned Parenthood Federation of America. Mrs. Duke served as head of the U.S. Delegation to the UNESCO meetings in Belgrade in 1980, with the rank of Ambassador. She is a recipient of the Margaret Sanger Award, and is a member of four major corporate boards. Mrs. Duke volunteers substantial time to PAI's public policy program and to its fundraising efforts. She oversees PAI's New York office, which maintains liaison with New York-based population organizations, foundations and UN agencies.

Joseph C. Wheeler, a **member** of PAI's **Board of Directors**, is currently a consultant on international development problems, after over 40 years experience in that field in government and international organizations. His last position, from early 1991 to mid-1992, was as Director of Programme Integration in the Secretariat of the United Nations Rio Summit Conference on Environment and Development, a senior position in the planning for and conduct of the Conference. Before that he served from 1985 to 1991 as Chairman of the OECD's Development Assistance Committee in Paris. Earlier positions included Director of the USAID Mission in Pakistan, 1969-1977, Assistant Administrator of AID's Near East Bureau, 1977-1980, Deputy Administrator of AID 1980-1982, and Deputy Executive Director of the U.N. Environment Program at its world headquarters in Nairobi, Kenya, 1982-1985. A 1948 graduate of Bowdoin College, Mr. Wheeler earned a degree in Public Administration at Harvard.

Shanti Conly, PAI's **director of policy research**, is responsible for PAI publications on population and reproductive health issues. Ms. Conly is the author of in-depth PAI reports on family planning programs in India, China and Pakistan and on assistance provided by the major donor countries and institutions in the population field. She is the editor of recent PAI wallcharts and policy information kits on a range of reproductive health issues. Ms. Conly also serves as PAI spokesperson for these studies with the electronic and print media. Prior to joining Population Action International in 1987, Ms. Conly worked for ten years with development and population programs in Niger, Egypt and Pakistan, and in Bangladesh, where she worked with USAID to expand the role of grassroots NGOs in the national family planning program. She has also undertaken many international consulting assignments in the family planning field. Ms. Conly was born in Sri Lanka. She is a Phi Beta Kappa, summa cum laude graduate of the University of Pennsylvania, and has a Master's degree from the Woodrow Wilson School of Public Affairs at Princeton University.

Talking Points for PAI's January 14 Meeting with World Bank Leadership

PAI thanks the World Bank for the opportunity to meet with senior officials and is pleased the Bank is taking our report and its suggestions seriously. We understand the Bank is working on a new population sector strategy paper which we hope will address many of the issues raised in our report. We applaud the Bank for refocusing on population and reproductive health, and wish to underscore the following points.

1. The Bank Must Demonstrate Stronger Leadership on Reproductive Health.

If the Bank is to strengthen its commitment to reproductive health including family planning, it must first overcome the perception among staff that this area is too politically sensitive. While these issues are controversial with conservatives in the U.S. Congress, the Clinton administration is strongly supportive and several donor countries as well as the European Union have substantially increased their financial support to population programs. There is also a growing consensus in support of population programs among developing countries. The South-to-South "Partners in Population and Development" initiative which grew out of the Cairo conference now has 12 member nations.

The Bank's defense that it "only responds to what countries want" neglects the reality that countries often ask for what the Bank likes to finance. Furthermore, they focus on what the banker says is important, whether it is fiscal policy, roads, education—or reproductive health and family planning. With the Bank's resources and influence comes the responsibility to exercise leadership, especially in more difficult areas with potential for major development impact. The upcoming meeting with African heads of state in Kampala represents an opportunity for Mr. Wolfensohn to make a high-profile speech reaffirming the Bank's commitment. This would be especially appropriate since Africa is the region where poor reproductive health and rapid population growth pose the greatest constraints to long-term sustainable development.

2. The Bank Needs to Support *Both* Girls Education *and* Family Planning.

The Bank appears to see its work in girls' education as its major contribution to slowing population growth. PAI also supports girls' education, because it is good for women, for development and for fertility decline, encouraging not only smaller families but also later marriage, and slowing population momentum. But education is a long-term strategy that won't help those couples who want smaller families *now*. The Bank *also* needs to provide more direct support for reproductive health services, especially family planning. Improved access to these services is central to women's health, autonomy and well-being, while also helping to slow population growth.

Education and family planning support each other in many ways—not only do educated women have smaller families, but when women use family planning their daughters are less likely to stay home from school to care for younger siblings. Teenage girls with access to good sexual health education and services are less likely to get pregnant and drop out of school. Together, education and family planning are more than the sum of their parts.

There are many ways to approach the population issue—the implications of increasing human numbers for development, the right and ability of women to enjoy educational and economic opportunities, the contribution of family planning to child health and to reducing pregnancy and childbirth-related illness and deaths. The rationale may be less important—the reality is that so many people want to control the timing and number of births that simply providing them with high quality services at the community level will go a long way to address-

ing the numbers problem. However, *how soon* we expand services will determine *how many* people there will be a generation from now. With the size of the childbearing population increasing very fast, the number of people in need of services is growing rapidly too. This population momentum, moreover, will account for a major share of future population growth.

Bangladesh illustrates why we should not wait for progress in education to support family planning. A Herculean effort by the government and donors (including the Bank) has brought contraceptive services to people's doorsteps. As a result, fully half of couples now practice family planning, and average family size has fallen from over seven to a little over three—a remarkable feat in a very poor society where 75 percent of women are illiterate.

3. The Bank Should Make Reproductive Health a Special Thrust Area.

The Bank has the capacity to provide far greater resources for reproductive health overall, and to make a difference in meeting the current shortfall in resources required for population programs. The Bank's own World Development Report 1993 highlights family planning as highly cost-effective, and the Bank needs to restore declining support to family planning activities. Currently, very few reproductive health projects are reportedly in the pipeline. If the Bank made reproductive health including safe motherhood and family planning a high priority, it could make an enormous difference within a decade or so to improving the health of poor women and children. The funds needed are small compared to total investments in development. The donor community provides less than $2 billion annually in total population assistance, or only about two percent of official development aid. There is plenty of scope to give priority to reproductive health, education, as well as other health issues

The Bank should also keep in mind that health sector-wide projects may not always be the most appropriate vehicles to provide assistance in population dynamics or reproductive health, including family planning. Sector-wide projects provide a comprehensive vehicle for restructuring within the health sector, but may not represent the best vehicle for a multisectoral effort to address cross-cutting population concerns. Moreover, where reproductive health and family planning services are new or neglected, more focused projects may help strengthen services.

4. Reproductive Health and Family Planning Require Expert Staff.

The Bank would not do water, transportation or power projects without having some experts in the Bank and access to a great many more from the outside. Similarly, it needs specialized staff in reproductive health including family planning. It also needs a strategy for accessing additional outside professional expertise in these disciplines.

In any development agency, having sufficient, competent staff makes all the difference to project identification, design and implementation. The Africa region has established a good model by appointing one senior staff person to provide leadership on population issues at the *policy* level and one to provide leadership on strengthening reproductive health *services*. The recent appointment of the regional population policy advisor is reportedly contributing to fuller treatment of population concerns in country assistance strategies for the region. Other regions within the Bank could benefit from similar staffing arrangements.

PAI Requests to World Bank President

1. **Make a major address on population and reproductive health, talk about these issues on high level visits and insist that other senior staff do likewise.**

2. **Issue a corporate statement supporting population and reproductive health.**

3. **Insist that key planning documents address population (including country strategies, human resource sector strategies, and health projects and strategies).**

4. **Declare reproductive health—including safe motherhood and family planning—a priority area within the health sector.**

5. **Review the pipeline of future projects with population, reproductive health and family planning components.**

6. **Provide more grant resources for technical assistance in reproductive health.**

7. **Review staffing strategies with attention to needs in population and reproductive health.**

Population Action International (formerly the Population Crisis Committee) has just released a report entitled "Falling Short: The World Bank's Role in Population and Reproductive Health." They have distributed it to Bank management and have requested a meeting to discuss it. The January 14 lunch is in response to that request. PAI may also hold a briefing on the report for the press and other interested parties, but no date has yet been set for that briefing.

About PAI

PAI has been a leading advocate for U.S. international family planning assistance. It has strong ties to the U.S. Agency for International Development (USAID) and the U.S. family planning establishment, including many Members of Congress. PAI has issued similar critiques of other agencies, including United Nations Population Fund (UNFPA) and USAID.

- Robin Chandler Duke was chair of the PAI Board when the report was prepared. Constance Spahn has now assumed that position. Both will attend the lunch. Three former Bank presidents (McNamara, Conable and Claussen) also serve.
- PAI has been very effective in lobbying Congress to fund USAID's family planning program; recently their influence has waned, particularly in the House of Representatives.
- PAI has traditionally been a strong advocate for family planning as a means of population control. Other important groups in the field, including UNFPA, the Population Council, the International Planned Parenthood Federation and the International Women's Health Coalition, put greater emphasis on individual health and welfare, as well as demographic gains that result from this approach.

The Report's Main Messages

- PAI calls for Bank management to speak out more on population issues, particularly in the policy dialogue and in Country Assistance Strategies. The report criticizes the Bank for having "buried" population in health.
- It also criticizes the Bank for not lending enough for family planning and calls for more free-standing projects to support family planning.
- PAI wants the Bank to increase its staff capacity for population and family planning work.

Our Views on the Report

- The Bank appreciates PAI's thoughtful critique, particularly their efforts to consult with Bank staff in preparing it.
- We could do a better job in bringing population into the policy dialogue; the HD Network is addressing this through efforts in knowledge management, training (including an EDI core course on population) and staff development.

- The Bank is fully committed to the broader approach to population called for at the International Conferences in Cairo and Beijing; it is addressing population through girls' education, credit for poor women, and other social programs as well as by efforts to ensure that all women have access to high-quality family planning and other reproductive health services. Lending to support these efforts has expanded rapidly during the 1990s.

Our Views on Core Population Issues

Rapid population growth is still a problem in many developing countries. But fertility (births per woman) has fallen faster than expected 20 years ago. Global and country populations will still get much larger in the next hundred years, despite fertility declines. Both the eventual *levels* reached and *rates of change* remain important concerns.

- The *levels* appear more sustainable now than was thought previously, thanks in part to improved food production prospects; but the environmental implications are still serious.
- The *rates of change* are still a major concern in the poorest countries, given the huge challenges and costs of providing services (education, health, etc.) and infrastructure for their rapidly expanding populations.

Past efforts focusing on population "control" have serious deficiencies. Their message of control -- by officials vis a vis common people and also by rich countries vis a vis poor countries -- will not succeed over the long run. Newer approaches have found success by emphasizing together:

- *empowerment and choice* -- i.e., giving people the means (family planning information, education, supplies, access) to enable them to make their own choices about family size. This helps reduce unwanted births -- and ultimately total births too, as people over time come to understand more about their options and prefer smaller numbers of children.
- *health considerations* -- i.e., promoting better reproductive health ("safe motherhood"), including helping women avoid the risks of too many births, too closely spaced, or initiated when the mother is too young or too old. Improvements in reproductive health have multiple benefits: lower fertility, lower maternal mortality, healthier children, and better-off families.
- *linkages with broader development policies* -- i.e., focusing not just on family planning but more broadly on the full range of actions needed, including in particular, girls' education, women's status, poverty reduction, etc.

These messages will form the core of the population strategy that the HD Network is preparing during this fiscal year. Both the global and regional issues raised by the PAI report will be addressed in the strategy document.

E. COMMENTS:

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