Review of World Bank Assistance to Population: Focus on Support to Family Planning Activities in 35 High-Fertility Countries 1994–2008

Portfolio Review

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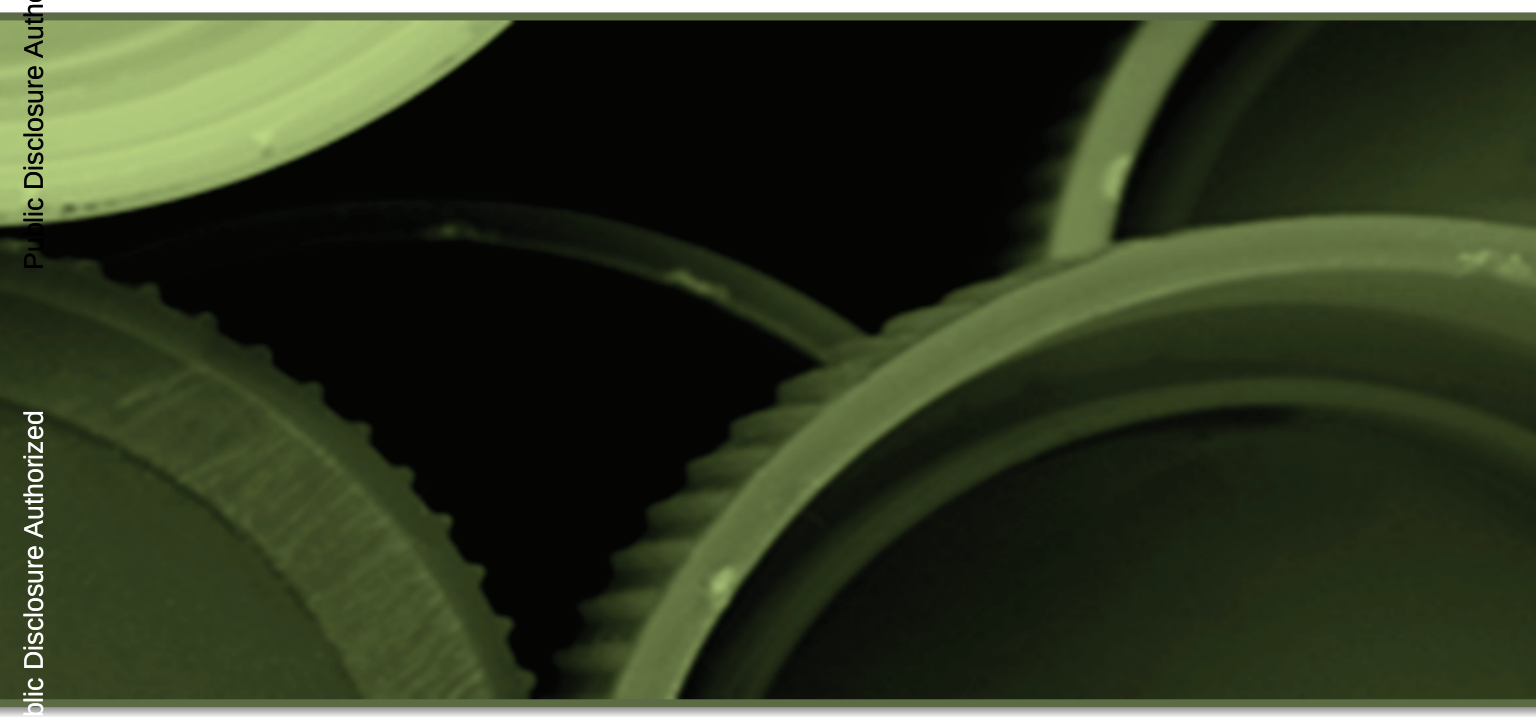

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Preface

In 2007 the Health, Nutrition, and Population Unit of the World Bank drafted a discussion paper, "Population Issues in the 21st Century: The Role of the World Bank,"[1] as background for the World Bank's new sector strategy for health, nutrition, and population. Covering recent changes in population trends as well as the relationship among high fertility, poor reproductive health, and poverty, this paper made a strong case for increasing Bank assistance to reproductive health and family planning programs, along with identifying entry points into high-fertility countries. The paper identified high fertility and rapid population growth as obstacles to the achievement of two core Bank objectives: economic growth and poverty reduction in the developing world. It recommended increasing financial support to family planning and other reproductive health programs, with the objective of improving access to health services for the poor and other vulnerable groups, including adolescents. Identifying 35 countries with total fertility rates greater than or equal to 5 children per woman,[2] the paper called for further analysis to determine the causes of sustained high fertility, examining—among others—unfavorable socioeconomic factors influencing household behaviors, the desire for more children, and reproductive health services that do not adequately address needs.

In response to this report, the Health, Nutrition and Population Unit of the Human Development Network, embarked on Economic and Sector Work in June 2008 to (1) conduct a literature review of both implications and determinants of sustained high levels of fertility; (2) identify and develop case studies on countries that were able to address high fertility to analyze and understand what works and what does not work across countries in regard to addressing high fertility; and (3) review World Bank policies and strategies since 1994 related to population issues, including global and country-specific Analytical and Advisory Activities (AAA) products, and World Bank lending from 1994 to 2008 to population and reproductive health programs with a focus on family planning services in these 35 high-fertility countries to better understand the direction and focus of the Bank's support to address high fertility.

The purpose of this analysis is to (1) stimulate debate within the Bank on the Bank's role and actions necessary for improving access to family planning and reproductive health services in countries with continuing high rates of fertility, and (2) better understand how to accelerate the Bank's support in these countries. The primary audience for this report is the Bank management and task team leaders in charge of programs in the 35 high-fertility countries and their country partners and colleagues.

This report, the third part of this analytical work, reviews World Bank strategies

and policies, Country Assistance Strategies (CASs), and AAA work in the 35 high-fertility countries, as well as World Bank lending for population and reproductive health, with a focus on family planning between 1994 and 2008.

Acknowledgments

This report was prepared by Sadia Chowdhury of the Health, Nutrition, and Population unit of the Human Development Network at the World Bank (HDNHE), Lauren Mueenuddin (HDNHE), Adrien Arnoux Dozol (HDNHE), Geir Solve Sande Lei (HDNHE) and Brian Chin (University of Pennsylvania Population Studies Center).

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Correspondence Details:

- Sadia Chowdhury (HDNHE), World Bank, Mail Stop G7–701, 1818 H Street N.W., Washington, DC 20433, USA, Tel: 202-458-1984, email: schowdhury3@worldbank.org
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List of Acronyms

AAA	Analytical and Advisory Activities
AFTHE	Health, Nutrition, and Population unit of the Africa region
AFTQK	Africa Operational Quality and Knowledge Services
CAS	Country Assistance Strategy
HDNHE	Human Development Network, Health,Nutrition, and Population unit
HDNVP	Office of the Senior Vice President and Head of Human Development Network
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HNP	Health, Nutrition, and Population
ICPD	International Conference on Population and Development
IEC	Information, Education, And Communication
IEGWB	Independent Evaluation Group, World Bank
MDG	Millennium Development Goals
ODA	Official Development Assistance
PRSP	Poverty Reduction Strategy Paper
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
WBIHS	World Bank Institute Health Systems

Executive Summary

In recent decades many countries worldwide have made important progress in lowering fertility rates, with far-reaching consequences in improved health, education, employment, and social protection. In many countries, fertility rates have declined more rapidly than the predictions of even the most optimistic demographers. For example, Bangladesh has witnessed a phenomenal decline in its fertility rate, from more than 7 children per woman in 1970 to an estimated 2.7 children per woman in 2009. Similar declines have taken place in parts of East Asia, Latin America, the Middle East, and North Africa.[3]

Despite these significant successes, the decline in fertility rates has been noticeably uneven across the globe. Thirty-five countries,[4] mainly in Sub-Saharan Africa, as of 2007, have total fertility rates of 5 and greater live births per woman (annex 1), with a very slow pace of fertility decline. In these countries, national averages mask substantial differences in fertility levels between the highest and lowest economic quintiles, highlighting the critical issue of equity and poverty.

Improved sexual and reproductive health and access to family planning services have broad individual, family, and societal benefits, including a healthier and more productive work force, greater financial investment on each child in smaller families, reduced public expenditures on education and health care services, and—very importantly—a means for enabling young women to delay childbearing until they have achieved education and training goals that contribute to their greater community and political participation.[5] Studies have also shown that poor reproductive health outcomes—early pregnancy, unintended pregnancy, high fertility, and poorly managed obstetric complications—adversely affect the chances of poor women, their children, and their families to escape poverty.[6] Family planning also contributes to improved maternal health by reducing unintended and high-risk pregnancies (closely spaced, at very young or old ages).

Although many projects have addressed the need to expand reproductive health care generally and family planning services in particular, an estimated 215 million women worldwide still have an unmet need for contraception. And sexual and reproductive ill health accounts for one-third of the global burden of disease among women of reproductive age and one-fifth of the burden of disease in the world's population.[7] The United Nations expects this number to increase by 40 percent by the year 2050, as record numbers of young people enter their prime reproductive years.[8]

In addition to bogging down countries in their efforts to achieve economic and social development, the unmet need for contraception worldwide has contributed to the estimated 205 million unwanted pregnancies each year—one in five of which end in abortion. Half of these 41 million abortions

are unsafe,[9] making it one of the major direct causes of maternal death. Not only is this a devastating and tragic reality for many families, it also remains an affront to women's right to health and life worldwide.

Despite the acknowledged role of family planning services as a powerful investment for improved health of individuals and families and a potent tool for poverty reduction,[10] family planning activities have had declining prominence in international programming and financing during the past decade.

Multilateral assistance for family planning services through the United Nations system has declined while private assistance has increased considerably since 1994.[11] Overall budget allocations to family planning information and services have stagnated, still at the same level in 2009 as in 1974, taking into account current rates of inflation.[12] The Bank's share of global funding for population assistance declined from 25 percent in 1994 to 10 percent in 2004, and population issues have not been included in the Poverty Reduction Strategy Papers of the high-fertility countries.[13]

Objectives of the Portfolio Review

A 2007 World Bank discussion paper, "Population Issues in the 21st Century: The Role of the World Bank,"[14] advised the Bank to undertake intensive analytical work to better understand the determinants and implications of sustained high fertility. In response, the Bank's Health, Nutrition, and Population unit reviewed the Bank's support for population and reproductive health in 35 high-fertility countries as a part of its larger economic sector work on population and fertility. (High-fertility countries were defined as countries with a total fertility rate equal to or greater than 5 during the study period.) This report summarizes the review of Bank policies and strategies, Analytical and Advisory Activities (AAA) related to population and reproductive health, and lending in the 35 high-fertility countries.

Findings of the Portfolio Review

The World Bank had a consistent yet evolving policy on population issues from 1994 to 2008. Over the study period focus shifted from the *demographic* rationale of fertility control to the *health* rationale of family planning, emphasizing the cost effectiveness of the intervention and its dramatic effect on improved health status for women and children, particularly the poor. Although the Bank has articulated well the importance of fertility and population issues in many of its key documents, its lending for population and reproductive health and family planning services has not been consistent or commensurate with the importance placed on population issues in these policy documents.

A majority of Country Assistance Strategies (CASs) in high-fertility countries (75 percent) discuss population issues in their analytical frameworks, but less than half of the countries (45 percent) that cited high fertility issues actually made them a strategic focus for lending. In many cases in which the CASs did make population growth a strategic focus, the results frameworks did not propose specific monitoring indicators to track population and reproductive health inputs and outputs. The majority of CASs did not provide specific recommendations and guidance on lending to address high fertility and rapid population growth. And countries with multiple CASs for the study period have not consistently maintained a focus on population issues over time.

The World Bank has undertaken several global AAA on population and reproductive health from 1994 to 2008. Although none of these AAA products specifically focused on the issue of rapid population growth, several touched upon the role of family planning services in improving maternal health. A number of AAA products for the 35 high-fertility countries mentioned the role of rapid population growth in their health sector analyses, but only three AAA products specifically addressed the issue of high fertility and the need for family planning programs or made specific recommendations for lending in population and reproductive health.

Official Development Assistance (ODA) for all countries, including the 35 high-fertility countries, increased for health and HIV/AIDS from 1994 to 2007, but lagged behind for population and reproductive health in both absolute dollars and rate of increase. Similarly, the total World Bank population and reproductive health commitments in the 35 high-fertility countries was a fraction of overall Health, Nutrition, and Population commitments to these same countries over the study period. Most ODA and World Bank support has gone to countries with lower fertility rates (fewer than five children per woman). The Bank has provided support to other important sectors—such as education and gender—in high-fertility countries, but further analysis is required to assess the effects of multisectoral lending on changes in fertility.

Some population and reproductive health projects supported by the World Bank have been successful in targeting essential health services to the poor, creating synergies between preventing HIV/AIDS and reducing the number of unwanted pregnancies, addressing fundamental health systems issues (such as health care worker training, logistics, and management), and ensuring improved financial access to services for vulnerable groups. All of these are critical for delivering quality reproductive and family planning services. When reproductive health and family planning services are bundled into other health service packages or larger sector-wide objectives, details about specific family planning components, descriptions of the means for operationalizing family planning services in the field, and the supervision and monitoring of inputs and outputs are less clear—leaving the review unable to determine which service delivery model was most effective at improving services.

The review took an in-depth look at the World Bank's sector-wide approach (SWAp) for health to determine if this approach contributed to improved population and reproductive health outcomes, reviewing internal assessments of the SWAp conducted by the Independent Evaluation Group at the World Bank and the Implementation Completion Reports of individual SWAps in the 35 high-fertility countries. The review was unable to attribute improved population and reproductive health outcomes to the SWAp. Individual countries are realizing certain anticipated benefits of the SWAp, such as strengthened country health sector capacity for planning, budgeting, and management or greater country leadership in setting the direction of the sector. But weaknesses in the monitoring and evaluation of SWAps persist. In some cases the SWAp led to implementation delays. Most important, little evidence supports the hypothesis that the SWAp has benefitted

either health outcomes or the effectiveness of the overall sectoral program and policies.

Closer country-by-country analysis would help identify the factors contributing to successful family planning programs in high-fertility countries and better inform the design of future programs. Country-specific analysis would enable reviewers to overcome the obstacles created by diverse project outcomes, monitoring and reporting issues, diverse service delivery mechanisms, health systems bottlenecks and governance issues at the country level, and variety in the level of other donor and in-country support to population growth issues.

Recommendations

The policy documents of high-fertility countries should better articulate the links among high fertility, overall health, nutrition, and population outcomes, and the poverty reduction goals. Many more of the Bank's CASs in high-fertility countries need to (1) discuss the role of fertility reduction policies, especially in improving maternal health; (2) make fertility reduction a strategic focus; (3) sustain the focus on this critical area over time; and (4) have clear recommendations for subsequent lending to affect the determinants of fertility.

The Bank needs to reassess its level of support for population and reproductive health, aligning it with the Bank's strong recognition of the link between high fertility and poverty reduction and of the role of family planning in improved maternal and child health outcomes. The Bank should develop methods to better monitor support to family planning activities within larger reproductive and primary health projects, quantifying the inputs to reproductive health and family planning programs needed to produce tangible changes in fertility rates and assessing the effect of multisectoral lending on fertility rates. Finally, the Bank needs to ensure continuity in funding for family planning, especially for high-fertility countries over the long term.

More analytical work should be commissioned within the Bank to study the effects and burdens of rapid population growth on high-fertility countries and create the evidence base for policy dialogue with the country governments. Health sector analyses for high-fertility countries should address the issue of high fertility and make specific recommendations for program interventions to address high fertility to be addressed through subsequent Bank support.

The Bank projects with components on fertility should use appropriate indicators specific to fertility (such as contraceptive prevalence rate or adolescent fertility), and collect baseline and endline data to ensure better monitoring of results and greater accountability. Standard indicators for baseline and endline results should be reported in a systematic way, indicating when or why data are not available.

A more systematic approach to mainstreaming population issues within the core agendas of the Human Development and Poverty Reduction and Economic Management networks would greatly enhance the adoption of a multisectoral approach.

It is important for the Bank to leverage its comparative advantage through its collaboration with a wide array of development partners such as the UNFPA, UNICEF, WHO, bilateral, multilaterals, civil society organizations, the private sector, and local communities.

1. World Bank Health, Nutrition, and Population Sector Strategies and Policies on Population

The World Bank had a consistent yet evolving policy on the issue of rapid population growth from 1994 to 2008, moving from an early focus on rapid population growth as an impediment to economic growth to one that sees family planning as a key investment for improving health status, reducing poverty, and improving equity. Over the study period focus shifted from the *demographic* rationale of fertility control to the *health* rationale of family planning, emphasizing the cost effectiveness of the intervention and its dramatic effect on improved health status for women and children, particularly the poor. After 1994, the Bank embraced the recommendations of the 1994 International Conference on Population and Development in Cairo, which stressed the need to integrate family planning into a holistic approach to reproductive health and rights and called for multisectoral support in other social sectors such as gender and education, as well as support to policy development and analytical work. (See annex 2 for details of these policies.)

Policies before the 1994 International Conference on Population and Development

Throughout the 1950s and 1960s the World Bank expressed concern about the negative consequences of population growth on economic development. Although the Bank's main focus was on promoting economic growth through investments in infrastructure and public utilities, an increasing consensus emerged from economic and demographic literature of the 1960s that rapid population growth was a major hindrance to economic development.

By the late 1960s the World Bank had committed to supporting projects with a clear objective of slowing population growth through direct support to family planning service delivery, with the first loan approved for Jamaica in 1970. In 1979 it created the Population, Health and Nutrition Department, and soon thereafter, the Bank committed itself to direct lending in the health sector. The policy paper recognized the importance of providing services to the poorest groups in society and

drew a tighter link among health sector activities, poverty alleviation, and family planning.[15]

With publication of the 1984 World Development Report, *Population and Development*, the Bank explicitly acknowledged the benefits of population programs for the overall health sector. The report stated that population programs contributed to improved overall health, particularly for women and infants, and ensured that women could benefit from a greater range of economic and educational opportunities by delaying and spacing their births. This report also highlighted the important fact that family planning programs offered the greatest potential benefits for the poor, who tend to have higher fertility and mortality rates.

The 1993 World Development Report, *Investing in Health,* reaffirmed that family planning services were not only critical for helping couples achieve their fertility goals but also an effective means for reducing maternal and child mortality and morbidity. Family planning services were among the more cost effective interventions in health, according to an analysis of cost per disability-adjusted life years.[16] The report recommended that family planning be included in every country's essential health care package.

The 1994 International Conference on Population and Development and the World Bank

The 1994 International Conference on Population and Development (ICPD) in Cairo broadened the population policy agenda from a sole focus on meeting fertility reduction targets to a more holistic vision of sexual and reproductive health and rights, including social and economic policies to empower women. The program addressed population issues through people-centered approaches, taking particular account of gender equity and human rights.

The World Bank policy paper, *Population and Development: Implications for the World Bank,* prepared for the 1994 ICPD conference supported "an emerging consensus that population policy should be integrated with broad social development goals, and that population program strategies should build on linkages between demographic behavior and social and economic progress."[17] Core recommendations on population issues included:

- Work with countries experiencing very high rates of population growth to address unmet need for services, with special attention to the protection of human rights.
- Integrate population policy and objectives within broader social goals and policies, such as family welfare, education—especially of girls—and overall improvement in the status of women.
- Develop country-specific strategies, taking into account that country's particular needs, cultural values, and financial and institutional constraints.
- Focus population programs on providing access to services for the poor, with interventions responsive to individuals' particular fertility-regulation and broader reproductive health needs.
- Integrate reproductive health services—family planning, maternal care, and treatment for sexually transmitted infections—as a component of a comprehensive primary health care package.

Post-ICPD World Bank Policies on Population Issues

The World Bank's 1997 Health, Nutrition, and Population (HNP) Sector Strategy called high fertility a major development challenge and included it in the strategy's first strategic direction, "to assist client countries to improve the health, nutrition, and population outcomes of the poor, and to protect the population from the impoverishing effects of illness, malnutrition, and high fertility."[18] The rationale for addressing high fertility was twofold: 1) rapid population growth places a heavy burden on health systems and social services, and 2) lack of access to family planning and maternal health services is causally linked to high maternal mortality. Additional measures included:

- Linking reproductive health policies to girls' education, the status of women, and overall poverty reduction.
- Preventing unwanted pregnancies through information and contraceptive choice and by training female workers at the community level to provide family planning services.
- Facilitating safe pregnancy, deliveries, and motherhood by preventing and managing pregnancy complications and eliminating unsafe abortion.
- Promoting positive health practices such as safe sex, early treatment of STIs, birth spacing, and education.
- Preventing harmful social practices such as early marriage, gender discrimination, domestic violence, and genital mutilation.

The Bank's 2000 note, *Population and the World Bank,* reiterated many of the same points made in earlier strategies.[19] Policies should build on the link between population and human development. And a multisectoral response is needed to provide a sustained, synergetic support for family planning, child survival, maternal health, girls' education, and women's empowerment and autonomy.

The 2005 World Bank paper, *Improving Health, Nutrition and Population Outcomes in Sub-Saharan Africa: The Role of the World Bank,* explicitly stated that high fertility is an impediment to economic growth in Sub-Saharan Africa because of the unbalanced demographic structure and high dependency ratios resulting from rapid population growth.[20] The paper further stated that high fertility, along with illness, malnutrition, and premature deaths, is becoming an increasingly important determinant of poverty. It advocated multisectoral action— a comparative advantage of the World Bank's development capacity—to improve health, nutrition, and population outcomes.

The World Bank's 2007 *Healthy Development: The World Bank Strategy for Health, Nutrition and Population Results* is also aligned with the commitment embedded in the 1994 Program of Action for the International Conference on Population and Development. Recommendations do not focus solely on population or fertility; rather, the strategy recommends that health systems should provide a comprehensive package of services that includes family planning, prevention of unsafe abortion, safe pregnancy and delivery, postnatal care, and the prevention and treatment of STIs, including HIV/AIDS. The 2007 strategy further stated that the HNP sector would be accountable to report on two intermediate indicators measuring access to family planning services: contraceptive prevalence rate among women of reproductive age and unmet need for contraception.

2. World Bank Country Assistance Strategies in the 35 High-Fertility Countries

A majority (75 percent) of the Country Assistance Strategies (CASs)[21] for high-fertility countries[22] since 1994 reviewed for this report discussed population issues in their analytical frameworks, but only 45 percent of the countries that cited high fertility issues actually made them a strategic focus for lending (see annex 3). In some cases where the CASs did cite population growth as a strategic focus, the results frameworks did not propose specific monitoring indicators to track population and reproductive health inputs and outputs. Most CASs did not provide specific recommendations and guidance on lending to address high fertility and rapid population growth. And countries that have multiple CASs for the study period have not consistently maintained a focus on population issues.

Findings

Of the 78 CASs reviewed for this report, 75 percent discussed high fertility or population issues in the analytical framework, demonstrating that country governments, the World Bank, and other stakeholders did acknowledge the critical importance of population issues in the country's overall development framework.

The implications of high fertility or rapid population growth most often discussed in the CASs included in the review were the impact on economic growth and on the health sector. Thirty-eight CASs (48 percent) acknowledged that high fertility and population growth are an economic development challenge, 31 identifying them as a challenge for the health sector because they worsened health outcomes (such as maternal mortality) and challenged service delivery. Other implications identified in the CASs included: environmental issues surrounding deforestation or desertification, education, inequity, gender, and agriculture. Thirty-seven CASs mentioned that the link between high fertility and population growth and poverty is manifested in decreases in overall national gross domestic product (GDP).[23]

Of the CASs that cited high fertility or population growth issues, less than half actually made them a strategic focus in their subsequent recommendations for lending. Even when high fertility or population growth was identified as a development challenge, it did not necessarily become a focus for subsequent Bank lending.

Of the 22 countries with two or more CASs during 1994–2008, four (18 percent) sustained the focus on population issues over time, while 18 (82 percent) did not sustain a focus on high-fertility issues.

After the introduction of the Millennium Development Goals (MDGs) in 2000, indicators such as girls' education, maternal mortality ratio, use of skilled birth attendants, and antenatal care coverage became more prominent in the results matrices of the CASs (table 1). The Bank's use of contraceptive prevalence and total fertility rates as indicators declined after 2000—perhaps because the target for universal access to reproductive health (MDG 5b), with unmet need for family planning and contraceptive prevalence rates as indicators, was only introduced in 2007.

Of the CASs (28) that identified high fertility as a strategic focus, only 67 percent (19) proposed indicators on population and fertility (total fertility rate, population growth, and contraceptive prevalence rate) in the results matrix.

CAS recommendations for subsequent lending do not seem to give clear advice on high fertility. Only two CASs (Ethiopia 1997 and Guinea 1997) explicitly indicated that high fertility would be addressed by a multisectoral project or concomitant operations in different sectors (such as education, women's empowerment) to influence fertility outcomes during the CAS period.

CAS coverage of population issues[24]

The 2003 CAS for Niger not only acknowledged that high fertility and rapid population growth were major problems but also used fertility as one of the CAS performance benchmarks. Moreover, a 2004 population Economic Sector Work strengthened Niger's in-country policy dialogue on population issues, resulting in a stand-alone Bank population operation, the first population-specific operation in the Africa Region in many years. The preparation of a national population and reproductive health strategy was a CAS benchmark as well as a lending trigger, and reproductive health was included in one of the CAS pillars. Other Bank partners, such as the European Union and the United Nations Population Fund, have joined the effort. And population issues are also a high priority in the World Bank's Rural and Social Policy Reform Credit Development Policy Lending Project for Niger.

The 2006 and 2009 CASs for Yemen designated high fertility as one of five key CAS areas. The list of indicators includes population growth rate, linked to economic growth and water supply. High fertility rates are documented, as is the significant youth population.

Table 1 | Population and Reproductive Health as Country Assistance Strategy Monitoring Indicators

Country Assistance Strategy monitoring indicators	Fiscal 1995–2000 (percent, N=34)	Fiscal 2001–08 (percent, N=34)
Total fertility rate	21	15
Contraceptive prevalence rate	29	35
Girls' education, secondary school enrollment	53	73
Maternal mortality ratio, skilled birth attendance, antenatal care	29	79
STI, HIV/AIDS	47	85

Note: The result matrix could be found for 68 of the 79 Country Assistance Strategies.
Source: World Bank Country Assistance Strategies (CAS) for the 35 high fertility countries.

A national population strategy to address these issues is in place. The Bank also commissioned AAA work on Yemen's population policy in 2003 and in 2005 and is preparing a Health and Population Project, which is scheduled for approval in December 2010.

Burundi's 1995 CAS links population growth with food production and the environment. The government agenda includes the generation of a national population policy to reduce demographic growth. A proposal for a "Health and Population" lending project is currently under preparation.

Timor-Leste's 2005 CAS links the population growth rate with per capita income, poverty, food security, and land use, and mentions the growing youth population in connection with the need for job creation. A population AAA proposed in the CAS has been completed, and family planning is included in the CAS's service delivery pillar.

The CASs (as of July 2006) for Djibouti, Madagascar, Mali, Mozambique, and Sierra Leone did not mention fertility issues. The CASs for the remaining high-fertility countries mention fertility issues at least contextually.

Even though in many cases the CASs do identify high fertility and population growth as major developmental issues, these CASs do not necessarily make population and fertility a strategic focus, propose specific indicators to monitor progress, or offer clear advice on lending to address fertility issues. And mention of population issues in earlier CASs for high-fertility countries does not ensure that the focus will be sustained over time. The CASs for high-fertility countries need to forge tighter links among the developmental challenge of high fertility, its inclusion as an area of strategic focus, and subsequent advice and lending for population and reproductive health.

Fertility issues in recent Poverty Reduction Strategy Papers for high-fertility countries

A 2007 World Bank review[25] of the most recent Poverty Reduction Strategy Papers (PRSPs) of the high-fertility countries (27 countries had most recent PRSPs available) indicated that about half recognized population growth as an issue for poverty reduction and had objectives or strategies to address the issue and at least one indicator. Five PRSPs had at least one policy; five more had both a policy and an indicator. Thirteen had neither a policy nor an indicator related to population and family planning. Most had an indicator on condom use as a prevention measure for STI/HIV/AIDS, but not for family planning.

3. Analytical and Advisory Activities on Population Issues and within the 35 High-Fertility Countries

The World Bank has commissioned Analytical and Advisory Activities (AAA) work in population and reproductive health issues both as an overall issue and also with a specific focus on the 35 high-fertility countries—but without a clear focus on the impact of high fertility and rapid population growth on the health of women and children or on the burden of excessive fertility in other key development sectors such as education. High-fertility countries would benefit from focused analyses of the costs of high fertility for development objectives—such as poverty reduction—and from convincing and thoughtful advice on how to scale up crucial family planning services to address these issues within countries.

Findings

Eighteen of the 72 analytical products analyzed for this review (25 percent) had population and reproductive health as a primary or secondary theme.[26] Only 8 of the 35 high-fertility countries (23 percent) had any analytical work focused on population or reproductive health as a primary or secondary theme: Burkina Faso, Ethiopia, Kenya, Mali, Niger, Uganda, Yemen, and Zambia.

Three studies, funded by World Bank, published during 1994–2008 addressed women's reproductive health and maternal health as their major theme: *Investing in Maternal Health: Learning from Malaysia and Sri Lanka* (2003), *Sparing Lives: Better Reproductive Health for Poor Women in South Asia* (2009) and *Obstetric Care in Poor Settings in Ghana, India and Kenya (2007)*. None of these reports reviewed focused on high fertility or rapid population growth as key development issues, although several mentioned the importance of family planning as a key intervention for improving maternal health.

The 2003 World Bank report *Investing in Maternal Health: Learning from Malaysia and Sri Lanka* comprehensively analyzes the factors behind declining maternal mortality in these countries during the past 50–60 years and explores the magnitude of health systems expenditure on maternal health.[27] The report concludes that fertility reduction is associated with declining maternal mortality ratios at certain stages of health systems development, and that political will, adequate investment, and district-based planning are critical components of successful programs.

Sparing Lives: Better Reproductive Health for Poor Women in South Asia comprehensively reviews women's reproductive health in five South Asian countries, demonstrating the links among poverty, inequality, and women's health. The report describes the use and quality of reproductive health services (including the barriers to use and supply of family planning services), identifies the household and individual characteristics that affect reproductive health status and use of services, and presents a simple, effective method for regional decentralized action planning to improve reproductive health services and outcomes.

The 2007 World Bank–BNPP report, *Obstetric Care in Poor Settings in Ghana, India and Kenya*, studies maternal morbidity and mortality in the developing world in order to influence policies on appropriate services.[28] The study investigates recent maternal deaths to understand the level and causes of maternal mortality; analyzes the utilization of obstetric services (routine antenatal and delivery as well as emergency obstetric care), including the delays and barriers to utilization of emergency obstetric care and the socioeconomic and access factors determining the use of professional delivery care; and assesses the adequacy of emergency obstetric care provided by selected health facilities. The recommendations for all three countries include a very strong plea for comprehensive family planning services.

Only 8 of the 35 high-fertility countries had country specific analytical work with population and reproductive health as a primary or secondary theme.[29] Although most of the analytical work addressed general aspects of population and reproductive health, a few examples did discuss rapid population growth and high fertility and their impact on other important development sectors such as health, education, and food supply. These also emphasized the importance of a strong family planning component within health projects to help reduce the burden of high maternal mortality due to excessive fertility, reduce the number of unwanted pregnancies, and address high unmet need for contraception. Specific examples include AAA work in Mali, the Democratic Republic of Congo, Niger, and Yemen.

4. Official Development Assistance and World Bank Lending for Population and Reproductive Health in the 35 High-Fertility Countries

Both World Bank and official development assistance (ODA) commitments to population and reproductive health did not increase much from 1994 to 2008. And population and reproductive health was only a fraction of total World Bank and ODA spending for health for all countries as well as the 35 high-fertility countries.

Official Development Assistance for Population and Reproductive Health

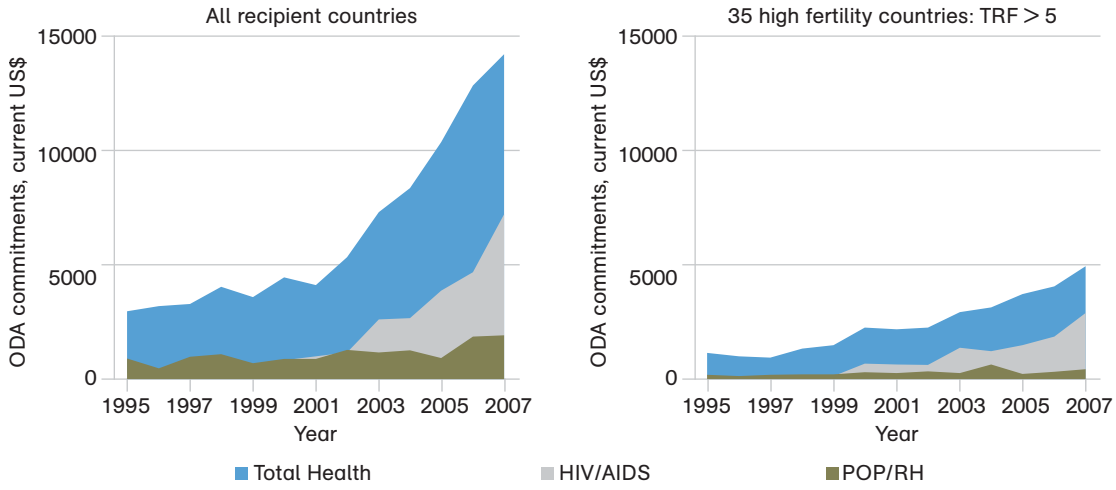
While total ODA for health rose fivefold from US$3,823 million in 1995 to US$15,264 million in 2007, commitments for reproductive health increased only about 61 percent, from US$1,143 million in 1995 to US$1,835 million in 2007. The overall ODA for health increased mostly because the ODA for STIs including HIV/AIDS increased (figure 1). And the highest ODA commitments (both per capita and overall) for population and reproductive health did not necessarily follow fertility rates: much of the ODA for population and reproductive health went to countries with a total fertility rate of fewer than 5 children per woman (figure 1).

Total ODA commitments for the 35 high-fertility countries show a similar trend: a fast-paced increase in overall commitments for health and HIV/AIDS and a slower pace for population and reproductive health. Commitments to population and reproductive health for these 35 countries increased from $150 million in 1995 to $432 million in 2007, a 188 percentage increase, while overall ODA for health increased from $915 million to $4,928 million—an increase by 438 percentage points (figure 1).

World Bank Commitments for Population and Reproductive Health

The World Bank's commitments for population and reproductive health—both for all countries and for the 35 high-fertility countries—also did not increase as rapidly as its commitments for health and for HIV/AIDS. Total World Bank Health, Nutrition, and Population commitments to health in 35 high-fertility countries from 1994 to 2008 was $4,495 million, while commitments to population and reproductive health was $590 million (13 percent;[30] figure 2). The Bank's

Figure 1 | ODA Commitments for Health, 1995–2007

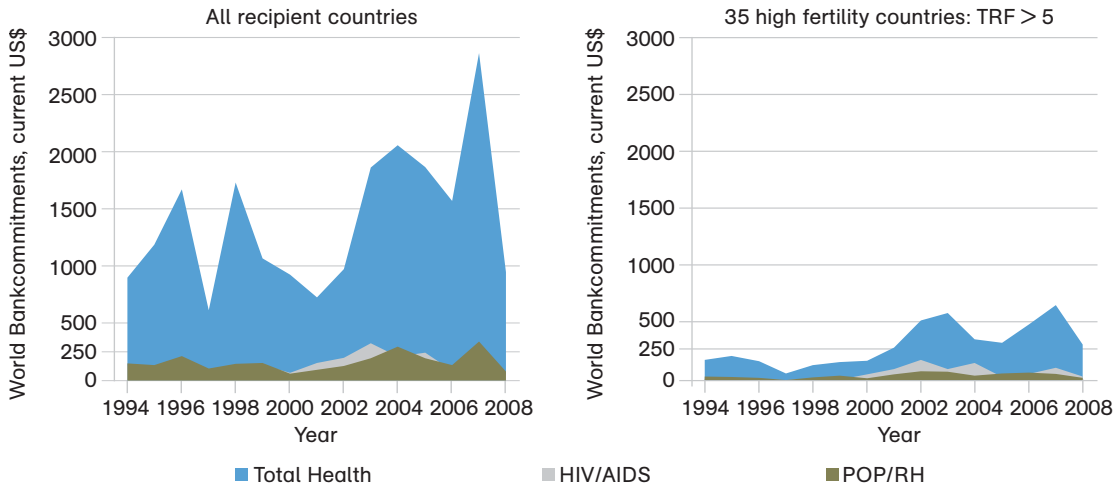


Source: Online World Development Indicators.

continuing portfolio plus new commitments to population and reproductive health increased steadily from about $175 million in 1994 to about $300 million in fiscal year 2004, but the share of those population and reproductive health commitments in total health lending has fallen during the study period, from about 18 percent to less than 10 percent (figure 3).

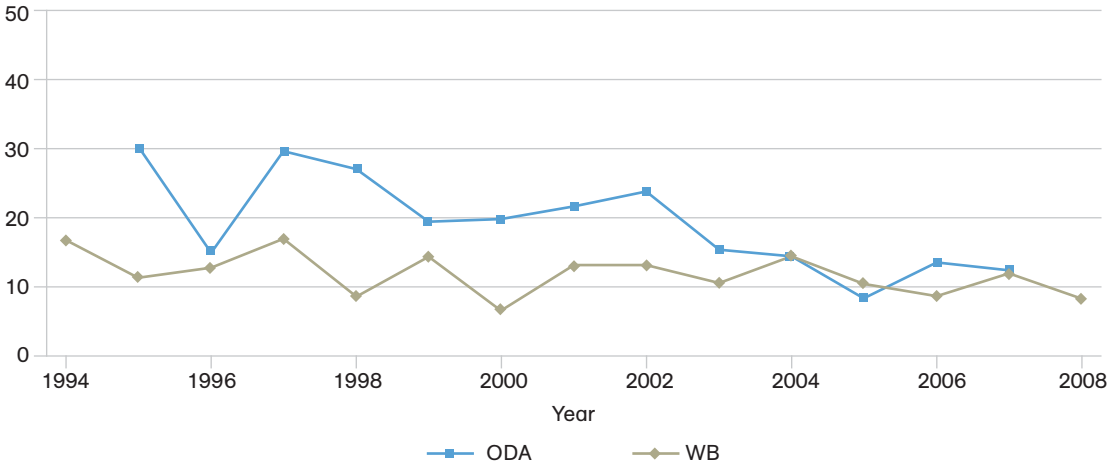
Both World Bank and ODA commitments to population and reproductive health remained fairly flat from 1994 to 2008. And

Figure 2 | World Bank Commitments for Health, 1994–2008



Source: Online World Development Indicators.

Figure 3 | **Share of Population and Reproductive Health in Total World Bank and ODA Commitments to Health (percent)**



Source: Online World Development Indicators.

they continued to be a fraction of overall spending for health in all countries as well as in the 35 high-fertility countries (figures 2 and 3). Please refer to annex 4 for a list of high-fertility countries ranked by level of World Bank Health, Nutrition, and Population commitments.

5. World Bank Support for Population and Reproductive Health Projects with a Focus on Family Planning in the 35 High-Fertility Countries

This study reviewed World Bank-supported population and reproductive health projects in the 35 high-fertility countries (total fertility rate equal to and greater than 5) between 1994 and 2008 to assess the level and type of World Bank support for activities specifically related to fertility reduction and the expansion of family planning services (see annex 5 for details on project selection and methodology).

Five of the 35 high-fertility countries (Angola, Djibouti, Equatorial Guinea, Tanzania, and Togo) did not receive World Bank support specifically for population and reproductive health from 1994 to 2008.

In the remaining 30 high-fertility countries, the Bank approved 75 projects focused on population and reproductive health between July 1, 1994, and June 30, 2008. Of those projects, 36 had health interventions affecting fertility or family planning, including the following activities:

- Provision of family planning services through public health facilities, community health workers, and private sector facilities, including social marketing.
- Information, education, and communication activities on family planning, from one-to-one personal interactions to national campaigns.
- Procurement of modern contraceptives.
- Training of medical health personnel in all aspects of family planning service delivery, including community-based health family planning.
- Policy development, including support for the development of a population policy, surveys and data collection to assess fertility levels, secondary analysis of data for related analysis, and workshops or meetings to discuss the evidence.

Findings

Of the 36 World Bank projects that had health interventions affecting fertility or family planning, 13 projects are still active, and 23 are closed (Annex 6). The lending instruments used for these projects included investment and development policy lending operations. Investment operations included 4 Emergency Recovery Loans, 27 Sector Investment Loans, one Adaptable Program Loan, one Learning and Innovation Loan, and one Sector Invest-

ment and Maintenance Loans. Development policy lending operations included two Poverty Reduction Support Credits.

The World Bank gave considerable support to other sectors—education, gender, HIV/AIDS—in the 35 high-fertility countries from 1994 to 2008. But without further study it is difficult to assess the impact of this lending in other sectors on fertility reduction.

Types of delivery models

The Bank delivered population-related activities not only through projects with "population" in their titles, but also through projects supporting other health sector programs (maternal, child, and reproductive health), and through sector-wide development projects and Poverty Reduction Support Credits. Population activities in the projects used five types of delivery models selected in response to country-specific conditions, including institutional and implementation capacity, sector priorities, and working partnerships in the country:

- Stand-alone population interventions (9 projects).
- Sector-wide health approaches (11 SWAps or projects to support a follow-up to a SWAp).
- Basic health service packages including family planning components (10 projects).
- Combined population and HIV/AIDS prevention programs (4 projects).
- Poverty Reduction Support Credits (2 credits).

Most of the 36 projects reviewed used World Bank support for family planning service delivery (93 percent of projects), followed by training for service providers (79 percent) and information, education, and communication for men and women (72 percent). Forty-three percent had a policy development focus, and 69 percent included a component on improving access to and delivery of contraceptive supplies.

Stand-alone population projects focused on implementing activities that will help countries to address rapid population growth by developing a national population policy, expanding delivery of reproductive and family planning health services, ensuring contraceptive supplies, training staff in reproductive health and family planning, and engaging national and local education and information campaigns to increase demand for services. Indicators for tracking inputs and outputs related to reproductive health and family planning components—contraceptive prevalence rates, knowledge on family planning methods, unmet need—are more prominent and better articulated in such stand-alone projects. Examples include the Benin Health and Population Project (1995–2003) and the Malawi Population and Family Planning Project (1999–2003).

A **sector-wide approach** looks at the health sector as a whole and attempts to address systemic bottlenecks affecting the overall functioning of the sector. Reproductive health and family planning service delivery become subcomponents of larger, more dominant themes and objectives, such as improving the management and financial viability of national public health systems, expanding basic health coverage for the poor, and ensuring that basic health services are more accessible and more affordable. Specific project components related to family planning services are embedded in larger health packages—and often not elaborated upon in project documents. Inputs and

results related to family planning are also difficult to tease out of these overall health packages. Addressing sector-wide issues is clearly expected to positively affect the delivery of quality health services, but project documents do not comment extensively on how and why. Examples include the Mauritania Health Sector Investment Project (1998–2004) and the Ethiopia Health Sector Development Project (1999–2006). (See chapter 6 for an in-depth review of sector-wide approaches.)

In projects focused on providing and expanding **basic health service packages** for countries, family planning has been one intervention among many in larger reproductive health and maternal and child health packages. These projects often focused on expanding basic health service packages for the poor, targeting women and children in particular through a wide range of interventions, including basic primary care, immunization, infectious disease control, improved reproductive health, and nutrition. The family planning components often are not clearly described in detail, with little said about actual, on-the-ground implementation mechanisms. Examples include the Madagascar Second Health Sector Support Project (2000–07) and Supplemental Financing (2005) and the Afghanistan Health Sector Emergency Reconstruction and Development Project and Additional Financing I and II (2003, 2006, and 2008).

Projects that integrate overall reproductive health and family planning objectives into **programs addressing HIV/AIDS** seek to build on natural synergies found in combining prevention, education, and service delivery components for HIV/AIDS with expanding family planning services. Information and education campaigns and service delivery components combine efforts to increase awareness of preventing HIV/AIDS and reducing unwanted pregnancies. Condom distribution efforts to stem the rise of new HIV/AIDS infections also seek to increase condom use for preventing pregnancy. In a number of cases, however, the magnitude of the HIV/AIDS epidemic has overshadowed the focus on family planning. Examples of combined family planning and HIV/AIDS programs include the first Chad Population and AIDS Control Project (1995–2001) and the Eritrea—HIV/AIDS/STI, TB, Malaria and Reproductive Health Project II (2005).

Finally, **Poverty Reduction Support Credits** are very large country-wide loans focused on improved sector management in a number of sectors, such as health, education, and water. The prominence of the reproductive health and family planning components becomes diminished in wider, more general goals of reducing poverty and improving basic service delivery in many sectors. Teasing out the inputs and results of specific family planning components in project descriptions, results matrices, and completion reports is very difficult. Examples include the Benin Poverty Reduction Support Credit 1 (2004) and the Uganda Fourth Poverty Reduction Support Operation (2005).

Monitoring and evaluation

The monitoring and evaluation frameworks and reporting on results in many of these projects' documents differ in quality. In many cases, Project Appraisal Documents propose to monitor project progress on family planning components through specific family planning indicators, such as contraceptive prevalence rates, unmet need for contraception, numbers of new users of modern methods, and in-

creased knowledge of family planning health benefits. But the same indicators are not reported on in a systematic way in those projects' Implementation Completion Reports. In some cases, Project Development Objectives that include population and family planning objectives do not propose any specific indicators to monitor results. In projects using sector-wide, basic health service package, or poverty reduction approaches, the family planning indicators are crowded out by the need to report on many other key indicators. Of the 36 projects reviewed for this study, 28 had indicators to track family planning inputs and outputs, but 8 projects did not have any family planning indicators. And in many cases, baseline and end data are not available.

Several projects—such as those in Burundi, Côte D'Ivoire, Mali, Niger, and Senegal—involved population and reproductive health specialists in either design or supervision of the project. But in most cases projects were designed and monitored by general health specialists and economists.

Stand-alone population and reproductive health projects that are clearly focused on fertility reduction—Benin, Burundi, Guinea, Malawi, and Rwanda—have shown some success in meeting specific family planning targets. For example, in Malawi the end-of-project survey showed that 95 percent of the adult population in control districts held a positive view of family planning, and the contraceptive prevalence rate rose from about 20 percent to 36 percent. But there has been little systematic monitoring of key family planning targets across all programs.

Sector-wide approaches are important for strengthening the overall health sector and addressing bottlenecks in the system's functioning that ultimately will improve the delivery of basic health services, including family planning. For example, while improving the overall delivery of primary care services, the Mauritania Health Sector Investment Project was also able to increase contraceptive use and reduce the total fertility rate by the close of the project. In other cases—as in Nigeria—the broader objectives of the sector-wide approach diminished the focus on the family planning component. Although there is general agreement that addressing bottlenecks in the health system through sector-wide approaches is important, this review was unable to measure the effect of a sector-wide approach on the quality of family planning service delivery. (See chapter 6 for an in-depth analysis of sector-wide projects.)

A number of projects that combined population and reproductive health services with **HIV/AIDS prevention and treatment** found some clear synergistic benefits. In a number of other cases (Eritrea, for example), the family planning component became marginalized in the larger overall package focused primarily on the mitigation of HIV/AIDS. A few examples of targeted **basic health packages** with embedded family planning, such as in Afghanistan and Madagascar, have produced some results. But in most health service packages monitoring of the family planning component is often limited, even through intermediate targets such as contraceptive prevalence rate.

The **Poverty Reduction Support Credits** reviewed for this study have not focused on fertility reduction as a key intervention, evidenced by the absence of a specific outline of family planning components and indicators to monitor. But their policy documents drew a clear link between rapid population growth and poverty.

6. Findings on Sector-Wide Projects

In addition to the extensive review of World Bank projects in 35 high-fertility countries between 1994 and 2007, this study took a closer look at sector-wide approaches to determine if this approach has resulted in improved population and reproductive health outcomes.

The sector-wide approach (SWAp)[31] first emerged in the mid-1990s as an alternative to stand-alone project interventions. A fundamental change in the focus, relationship, and behavior of development partners and governments, SWAps were meant to enhance the effectiveness of development assistance by promoting coordination among the major players—bilateral and multilateral—and to ensure their sustainability by empowering local authorities.

After reviewing internal assessments of the sector-wide approach (conducted by the World Bank's Independent Evaluation Group) and the Implementation Completion Reports of individual SWAps in the 35 high-fertility countries, this study is unable to attribute improved population and reproductive health outcomes to the SWAp. Certain anticipated benefits of the SWAp are being realized in individual countries, such as improvements in some sector outcomes, alignment and coordination of donors, greater country leadership in setting the direction of the sector, and strengthened country health sector capacity for planning, budgeting, and management. But weaknesses persist in monitoring and evaluation of the approach, and in some cases the SWAp led to implementation delays. Most important, there is little evidence to support the hypothesis that the SWAp has had a positive impact on the effectiveness of the overall sectoral program and policies and on health outcomes.

Quality of Documentation on the Sector-Wide Approach

Much of the World Bank internal analytical work on SWAps has been descriptive in nature, providing definitions and how-to advice for World Bank staff considering a SWAp in their countries. This work has focused more on the challenges and opportunities in implementing the approach than on a systematic evaluation of its outcomes. The SWAp Learning Workshop conducted in 2009 examined the Bank's experience in countries such as Bangladesh, Brazil, Nepal, and Ghana but it did not look closely at any of the 35 high-fertility countries nor focus on the issues of health outcomes. And the Implementation Completion Reports of completed SWAps did not yield much data on health outcomes and results, largely because of monitoring, evaluation, and reporting difficulties.

Independent Evaluation Group Findings on Health Outcomes under Sector-Wide Approaches

Two Independent Evaluation Group reports, *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population* (2009) and "Do Health Sector-Wide Approaches Achieve Results?" (2009), have examined the effectiveness of SWAps in achieving improved health outcomes.

In *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population* (2009), the Independent Evaluation Group noted that under SWAps country capacity was strengthened in the areas of budgeting, sector planning, and the management of fiduciary systems.[32] SWAp resources were used to finance an explicit program of work linked to the national health strategy. SWAps enabled governments to exercise greater leadership in directing the use of resources and conducting and coordinating dialogue on health issues.

The Independent Evaluation Group found fundamental weaknesses, however, in the design and use of monitoring and evaluation systems.[33] For the most part, the project documents did not fully articulate the results chains of the strategies and programs. In a number of cases baseline data was outdated or missing and information and systems were scattered—making it difficult to assemble a coherent picture of the evolution of outputs and how they relate to outcomes.

Improving Effectiveness and Outcomes for the Poor found it difficult to determine whether the improved coordination, ownership, and other reforms introduced by the SWAps have had any long-run impact on the equality or efficiency of health programs. Any SWAp effect remains a hypothesis.

In "Do Health Sector-Wide Approaches Achieve Results?" (2009), the Independent Evaluation Group found that the SWAp partially achieved capacity and efficiency benefits in six countries: Bangladesh, Ghana, Kyrgyz Republic, Malawi, Nepal, and Tanzania.[34] Health SWAps were largely successful in putting in place critical tools and processes for improved sector coordination and oversight and made some progress in improving the harmonization and alignment of development assistance. But they have been only moderately successful in achieving improved sector stewardship.

Portfolio Review Findings on Sector-Wide Approaches

This portfolio review found mixed improvement of health outcomes under SWAps. The SWAp took a comprehensive view of the health sector and attempted to address systemic bottlenecks affecting its overall functioning. Objectives such as improving management and financial viability of national public health systems, harmonizing donor collaboration, and developing joint assessment and monitoring tools became predominant. But the delivery of specific health service packages, such as reproductive health and family planning, became subsidiary. Specific project components related to family planning services were embedded in larger health packages, often not elaborated upon in project documents. And inputs and results related to family planning were difficult to tease out of overall health packages.

Addressing sector-wide issues is clearly expected to positively affect the delivery of quality health services, but SWAp project documents do not comment extensively on how and why.

Findings from Review of the Implementation Completion Reports of Sector-Wide Approaches in the 35 High-fertility Countries

The introduction of the SWAp has helped improve health sector performance in a number of high-fertility countries. Many of the explicit benefits of the approach—institutional strengthening, better donor collaboration, improved budget planning practices, better management practices, and more professionalism through staff training—are clearly evident in project Implementation Completion Reports. For example, the Implementation Completion Reports of the Ethiopia Health Sector Development Project (1999–2006), the Mauritania Health Sector Investment Project (1998–2004), and the Mozambique Health Sector Recovery Program (1996–2003) showed improvements in the performance of the sector as a whole as well as in some health outcomes: expansion of health facilities providing treatment, increases in personnel and their capacity, and creation of a formal coordination framework for aligning donors to the sector policy and ensuring better donor coordination. The Implementation Completion Reports also show that SWAps often increased the efficiency and speed of government implementation by harmonizing procurement, supervision, and reporting procedures.

For a number of other projects, the benefits of the SWAp are less clear. The Implementation Completion Report for the Mali Health Sector Development Program (1999–2006) states that, although institutional capacity has been strengthened and some procedures have been streamlined, implementation arrangements within the Ministry of Health remain problematic and in some respects have become more complicated as decentralization—a key goal of the SWAp process—has expanded. The Implementation Completion Report for the Zambia Health Sector Support Project (1994–2002) states that it is difficult to ascribe to the project any significant improvements in the functioning of the health system—its main objective. The project did help to sustain district-level heath care through purchases of equipment, drugs, and medicines, but it did not adequately address capacity weaknesses in the health sector. And there is no evidence to suggest that the project had any measureable impact on the health status of the Zambian population.

7. Key Findings of the Portfolio Review

The portfolio review of World Bank support of fertility and family planning activities in 35 high-fertility countries offers the following key findings about Bank policies, Country Assistance Strategies, Analytical and Advisory Activities, lending for population and reproductive health, projects with family planning components, and sector-wide approaches.

Policies

The World Bank had a consistent yet evolving policy on population issues from 1994 to 2008, moving from an early focus on rapid population growth as an impediment to economic growth to one that sees family planning as a key investment for improving health status, reducing poverty, and improving equity. After 1994, the Bank embraced International Conference on Population and Development recommendations stressing the need to integrate family planning into a holistic approach to reproductive health and rights. The Bank's comparative advantage in the area of reproductive health is in multisectoral lending, policy development, and analytical work. Although the Bank has articulated well the importance of fertility and population issues, its lending for population and reproductive health and family planning services has been insufficient and inconsistent over time.

Country Assistance Strategies

Of the 78 Country Assistance Strategies reviewed for this report, 75 percent discussed population issues in their analytical frameworks; 25 percent did not. Only half of the countries that cited high fertility issues actually made them a strategic focus for lending. When the Bank did identify high fertility and population growth as a strategic focus, only 61 percent of these Country Assistance Strategies included indicators on population and fertility (total fertility rate, population growth, and contraceptive prevalence rate) in the results matrix. The majority of Country Assistance Strategies did not provide specific recommendations and guidance about the type of lending that would most effectively address high fertility and rapid population growth.

Analytical and Advisory Activities Work

The World Bank has commissioned some analytical work in population and reproductive health issues—both generally and specifically in the 35 high-fertility countries—but without a clear focus on the effects of high fertility and rapid population growth on the health of women and children nor on the effects of excessive fertility on other key development sectors, such as education. High-fertility countries would benefit from focused analyses of the costs of high fertility

on development objectives, such as poverty reduction, as well as from convincing and thoughtful advice on how to scale up crucial family planning services to address high fertility within countries.

Lending for Population and Reproductive Health

The Bank extended $590 million in support of population and reproductive health interventions to high-fertility countries during 1994–2008. Whether this was sufficient to effectively address the host of issues related to population and reproductive health, including family planning, fell beyond the scope of this review. The total fertility rates of the 35 high-fertility countries have declined very little—an average 5.7 percent—over the 15 years of the study. (And according to available data, Timor-Leste actually increased its total fertility rates over the period.) This decline represents about a quarter of a child reduction over the study period. Of course, many other factors than World Bank lending for population and reproductive health may explain the reasons why the total fertility rate in these countries has not declined significantly during this period, such as post-conflict fragile statehood, lack of government commitments to fertility reduction, governance issues, and health systems problems.

The health and HIV/AIDS portfolio of Official Development Assistance for all countries and for the 35 high-fertility countries increased from 1994 to 2007, but population and reproductive health increases lagged behind in both absolute dollar amounts and rates of increase. These statistics indicate that decreasing attention to family planning has been a global phenomenon, not just a World Bank trend. The World Bank's total commitments for population and reproductive health in the 35 high-fertility countries were 13 percent of its overall Health, Nutrition, and Population commitments to these countries over the study period. World Bank lending for other sectors, such as education, grew dramatically over the period while population and reproductive health spending remained constant. But the effects of lending in other sectors on reducing the total fertility rates still need to be assessed.

Population and Reproductive Health Projects with Family Planning Components

World Bank-supported projects in high-fertility countries with a family planning component show a wide range of outcomes. Although a number of projects had clearly defined objectives related to reducing fertility and expanding family planning services, in most cases the project documents did not adequately describe specific project components, the means for operationalizing components in the field, and the supervision and monitoring of inputs and outputs. A closer country-by-country review would help identify which service delivery models, partnerships, and institutional arrangements are most conducive for producing successful and replicable outcomes and for addressing context-specific implementation bottlenecks, relevant to the country context.

Sector-Wide Approaches

Reviews of the sector-wide approach (SWAp) by the Independent Evaluation Group at the World Bank and of the Implementation Completion Reports of individual SWAps in the 35

high-fertility countries by this portfolio review were unable to attribute improved population and reproductive health outcomes to the SWAp. Individual countries are realizing certain anticipated benefits of the sector-wide approach, such as strengthened country health sector capacity for planning, budgeting, and management or greater country leadership in setting the direction of the sector. But weaknesses in the monitoring and evaluation of the SWAp persist. In some cases the SWAp even led to implementation delays. Most important, little evidence supports the hypothesis that the SWAp approach has benefitted either health outcomes or the effectiveness of the overall sectoral program and policies.

8. Recommendations

The portfolio review suggests the following recommendations for future World Bank activities in fertility and family planning.

Policies and Strategies

The Bank's policy documents for high-fertility countries need to better articulate the links among high fertility, overall Health, Nutrition, and Population outcomes, and the poverty reduction goals of the World Bank. Many more of the Bank's Country Assistance Strategies in high-fertility countries need to discuss the role of fertility reduction policies (especially in improving maternal health), make fertility reduction a strategic focus, sustain the focus on this critical area over time (82 percent now do not), and make clear recommendations for subsequent lending (79 percent now do not).

Lending and Analytical Work

The World Bank needs to bring its expenditures on population and reproductive health in line with the importance it places on the link between high fertility and poverty reduction and on the role of family planning in improved maternal and child health outcomes. The Bank should develop methods to better monitor support for family planning activities within larger reproductive and primary health care packages to track inputs, outputs, and results more closely. It should also develop methods to quantify inputs to reproductive health and family planning needed to produce tangible changes in fertility rates. The Bank should move to engage in multisectoral lending to assess the effects of its support on population and reproductive health in general and fertility rates in particular. Finally, the Bank needs to ensure continuity in funding for family planning, especially for high-fertility countries over the long term. More analytical work should be commissioned within the Bank to study the effects and burdens of rapid population growth on high-fertility countries. Health sector analyses for high-fertility countries should address the issue of high fertility and make specific recommendations for program interventions to address high fertility to be included in subsequent projects proposals.

Monitoring and Measurement

The Bank needs to emphasize the use of appropriate indicators specific to fertility (such as contraceptive prevalence rate or total fertility rate) to ensure better monitoring of results and greater accountability. Monitoring and measurement plans should be clear about what results can be attributed to the project (rather than to other, non-project influences) and should specify the types of data needed to demonstrate program results (such as data derived from routine program operations or data that must be collected through periodic surveys).

Indicators and targets for baseline and endline results should be reported in a systematic way, indicating when or why data are not available. Without better indicators of success,

conclusions about the relative benefits of different approaches to delivering family planning services will be difficult to reach. The Bank needs to develop better indicators to help identify what does and does not create synergies among the various related programs in the health sector. And the Bank needs to continue strengthening sector-level analytical work on fertility as a basis for sound advice to client countries.

Multisectoral Approach

Fertility is influenced by trends in many sectors. In particular, female education, gender empowerment, female labor participation, and income growth can all greatly affect demand for family planning and reduced fertility. Population and reproductive health issues have traditionally been harbored within the Bank's Health, Nutrition, and Population sector, even though these issues are affected—positively or negatively—by many other sectors, such as education, gender, social protection, and poverty reduction and economic management. A more systematic approach to mainstream population issues within the core agenda of both the Human Development and Poverty Reduction and Economic Management networks would greatly enhance the Bank's adoption of a truly multisectoral approach.[35] A health systems approach and broad support for improvements in health sector strategies to help build country capacity—including strengthening logistics and financial management, providing a continuum of care from community to facility level, strengthening human resource management, and monitoring for results—are critical for successful family planning programs. The Bank is well positioned to systematically include population and reproductive health issues in key strategic documents—such as the Country Assistance Strategy, the Country Economic Memorandum, and the Public Expenditure Review—providing fiscal and economic analysis to ensure that the overall development financing agenda of the country includes funding of population issues.

Working with Partners

To get results in the high-fertility countries, the World Bank needs to work on reproductive health issues with the close support and collaboration of the client country and partners within and outside the country. The Bank's 2007 Health, Nutrition, and Population Sector Strategy recognized the United Nations Population Fund (UNFPA) and the World Health Organization (WHO) as the main agencies working on the technical aspects of reproductive health. Because population issues are linked to reproductive health, HIV/AIDS, and child survival, the United Nations Children's Fund (UNICEF), UNAIDS, and private foundations are natural partners to the Bank's work helping to build collective strength and synergy.

Together with UNFPA, UNICEF, and WHO, the Bank as a part of the "H4" is committed to working with governments and civil societies in the high-fertility and high-maternal-mortality countries to strengthen national capacity to achieve Millennium Development Goal 5 (improve maternal health). Building on its core competency and areas of comparative advantage, the Bank will use its unique leveraging position to maximize individual and collective efforts to tackle the root causes of maternal morbidity and mortality, including high fertility.

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Annex 1. High-Fertility Countries Selected for the Review

(total fertility rate greater than or equal to 5 births per woman)

Country	Total fertility rate 2000–2005	Total population (millions) 2000–2005
Afghanistan	7.5	–
Angola	6.8	15,490,049
Benin	5.9	8,177,208
Burkina Faso	6.7	12,821,686
Burundi	6.8	7,281,837
Central African Republic	5.0	3,985,971
Chad	6.7	9,447,944
Congo, Dem. Rep.	6.7	55,852,888
Congo, Rep.	6.3	3,882,947
Côte d'Ivoire	5.1	17,871,896
Djibouti	5.1	779,102
Equatorial Guinea	5.9	492,233
Eritrea	5.5	4,231,538
Ethiopia	5.9	69,960,840
Guinea	5.9	9,201,759
Guinea-Bissau	7.1	1,539,712
Kenya	5.0	33,467,328
Liberia	6.8	3,240,578
Madagascar	5.4	18,112,724
Malawi	6.1	12,608,271
Mali	6.9	13,124,015
Mauritania	5.8	2,980,357
Mozambique	5.5	19,423,920
Niger	7.9	13,498,802
Nigeria	5.8	128,708,944
Rwanda	5.7	8,882,365
Senegal	5.0	11,385,913
Sierra Leone	6.5	5,336,449

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Country	Total fertility rate 2000–2005	Total population (millions) 2000–2005
Somalia	6.4	7,964,414
Tanzania	5.0	37,626,916
Timor-Leste	7.8	924,642
Togo	5.4	5,988,380
Uganda	7.1	27,820,556
Yemen, Rep.	6.2	20,329,354
Zambia	5.7	11,478,886

Source: United Nations 2004; World Bank data from 2000–05.
– No data available.

Annex 2. High Fertility and Population Growth in World Bank Strategies, 1994–2008

Name of strategy	Population and Development: Implications for the World Bank
Year	1994
Global or regional	Global
Definition of high fertility	The country needs are not only assessed by fertility level but also by a framework that looks at the level of integration of reproductive health/family programs and broader social policy. Countries with a total fertility rate above 6 are considered to be emergent in their fertility transitions. Other indicators are used along with total fertility rate to define emergent demographic settings (contraceptive prevalence rate, under-5 mortality, maternal mortality ratio, and antenatal care).
Fertility recognized as a development challenge	The nature and severity of the effects of high rates of population growth vary across and in countries, with no generalization possible. However, public action is needed in poor countries where rapid population growth adversely affects investments in human capital, poverty reduction, and the environment.
Regional focus	No priority countries are cited but a country typology is given based on demographic characteristics: stage in the demographic transition and social development.
Role of the World Bank in the field of population	• Mobilize resources with countries, other donors, public and private sector. • Country assistance, emphasizing infrastructure, institutional capacity, and effective management. • Support effort to supply to core package of essential health services (as called for in *World Development Report 1993*). • Strengthen skill mix. • Undertake analytical work to inform population policy.
Policy recommendations to address high fertility	• Population policy should be integrated with social policies, and population objectives integrated within broader social goals (family welfare, education, especially of girls, and overall improvement of women's status). • In countries with rapid population growth, government should implement actions to reduce fertility, with a special attention to human rights. • Strategies must be country specific to take into account country needs, cultural values, and financial and institutional constraints. • Public sector should be involved in family planning and reproductive health to overcome market failure. Appropriate role of government depends on country context: not always financer and provider but responsible for ensuring access to information and services. • Countries starting demographic transition should invest in expanding reproductive health and family planning services, education, and other key social services due to future needs linked to population momentum.

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Programmatic recommendations to address high fertility	• Population programs should focus on providing access to services for the poor, and interventions should be responsive to individuals' fertility regulation and other reproductive health needs. • Design and delivery of services responsive to clients' needs, for both women and men. • Integration of reproductive health services (family planning, maternal care, STI care), as a component of a comprehensive primary health care package. • Public sector programs linked with delivery and promotion of contraceptives by the private sector, including nonprofit organizations. • Program should include promotional activities. • Emergent demographic settings should invest in infrastructure and institutional capacity to deliver basic package of reproductive health services, pilot alternative service delivery methods, and develop capacity for promotion activities.
Recommendations for monitoring and evaluation	No recommendation on indicators for monitoring and evaluation of population projects.
Name of strategy	**Health, Nutrition, and Population Sector Strategy**
Year	1997
Global or regional	Global
Definition of high fertility	No definition
Fertility recognized as a development challenge	High fertility is explicitly mentioned as a major development challenge and included in the first strategic direction to assist client countries to improve the health, nutrition, and population outcomes of the poor, and to protect the population from the impoverishing effects of illness, malnutrition, and high fertility. Another strategic direction is improving the performance of health systems and the financial sustainability of the sector (World Bank 1997). Although middle-income countries and some low-income countries have already completed their demographic transitions, the poorest countries are lagging behind. The rational for addressing high fertility was twofold: the burden that rapid population growth places on health systems and social services, and the link between lack of access to family planning and maternal health services and high maternal mortality.
Regional focus	No regional focus
Role of the World Bank in the field of population	The strategy lays out three strategic directions for the Bank in the Health, Nutrition, and Population (HNP) sector: improve HNP outcomes for the poor and protect them from the impoverishing effect of illness, malnutrition, and high fertility; enhance the performance of the health care systems; and improve health care financing.
Policy recommendations to address high fertility	The Bank will support effective population policies as well as nutrition policies. The strategy links the responses to high fertility to food security, as they both require a broad range of social policies, particularly in low-income countries. Policies should seek to improve women's status, enable women's labor participation by providing adequate child care and child health services, and promote the design of interventions sensitive to traditional values and attitudes. To improve the performance of health care systems, sector-wide reforms are often needed. In low-income countries, where the private sector activities often dominate, the strategy recommends that the government focus on providing essential services for the poor, regulating the private sector more effectively, strengthening the public managerial capacity, supporting medical education and research and development, and securing sustainable financing, quality assurance, and client satisfaction. Population services are included in the list of essential services.

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Programmatic recommendations to address high fertility	Additional policies on reproductive health have evolved out of the recommendation of the International Conference on Population and Development. The strategy lists the following mix of policy options and interventions: • Linking reproductive health policies to girls' education, the status of women, and overall poverty reduction. • Preventing unwanted pregnancies through information and contraceptive choice, and by training female workers at the community level to provide family planning. • Facilitating safe pregnancy, delivery, and motherhood by preventing and managing pregnancy complications and by eliminating unsafe abortion. • Promoting positive health practices such as safe sex, early treatment of STIs, delayed marriages, birth spacing, and education. • Preventing harmful practices such as genital mutilation, discrimination, and domestic violence.
Recommendations for monitoring and evaluation	• No recommendation on indicators for monitoring and evaluation of population projects. • Fertility and maternal mortality are progress indicators in the HNP Sector Strategy Matrix.
Name of strategy	**Health, Nutrition, and Population Sector Strategy**
Year	1999
Global or regional	Global
Definition of high fertility	High fertility countries are defined as those with a total fertility rate over five. However, the paper defines a typology of countries using a broader set of indicators. Pre-transitional countries are defined by a set of epidemiological indicators and policy and programs responses: high total fertility rate, rapid population growth (over 2 percent), and poor reproductive health (maternal mortality ratio over 200 and selected reproductive health issues including high prevalence of AIDS or other STIs and unsafe abortion).
Fertility recognized as a development challenge	High fertility is as much a consequence of poverty as a cause. Effects of population growth on per capita income growth are both negative and positive. However, the negative effects outweighed the positive in the poorest countries (for example in Sub-Saharan Africa) in the 1980s. Projects that poor countries with rapid population growth will be challenged to feed and employ large increases in population, with risks of environmental degradation and difficulty in managing resources on a sustainable basis. The note recognizes the diversity of situations and that some low- and middle-income countries have already experienced a rapid fertility decline (East Asia, Latin America).
Regional focus	Population growth is a serious problem for Sub-Saharan Africa, and for several countries in Asia and the Middle East.

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Role of the World Bank in the field of population	Within the framework of the HNP strategy, the note identified the Bank's key comparative advantage in enhancing synergies between sectors, such as health and education or micro-enterprise programs, which can have an indirect impact on population and reproductive health outcomes. The World Bank can improve the effectiveness of programs by supporting health sector reforms that can address constraints making health systems unresponsive to the reproductive health needs of the poor. Such constraints can be financial, institutional incentives, and civil service structure. While promoting greater effectiveness through financing, reorganization, and decentralization, the Bank will ensure that health systems maintain the quality and accessibility of reproductive health services. The note also identifies the mechanisms through which the network can effectively address population issues: empowering Bank staff though professional development; sharpening the Bank's strategic focus, with a population watch list of countries to ensure the inclusion of population perspectives in key documents such as Country Assistance Strategies; and enhancing the quality of the portfolio by providing technical support to lending operations in countries.
Policy recommendations to address high fertility	Policies should build on the link between population and human development. A multisectoral response is needed with a sustained, synergetic support for family planning, child survival and maternal health, and for girl's education and women's empowerment and autonomy. Adapt population policies and reproductive health programs to socioeconomic and geographical characteristics, with a focus on the poorest countries. Population policies and programs should be sensitive to country contexts. Policies should address population issues with a people-centered approached, not with targets.
Programmatic recommendations to address high fertility	Population programs must be broader than family planning programs, within the agenda of population, reproductive health and rights, and development set by the program of action of the International Conference on Population and Development. People-centered approaches are more effective. Programs should be responsive to individual reproductive health needs.
Recommendations for monitoring and evaluation	The following are recommended indicators for countries with rapid population growth, Sub-Saharan Africa, and several countries in Asia and the Middle East: total fertility rate, contraceptive prevalence rate, desired fertility rate, and female secondary enrollment rate.

a. This note builds on the 1997 Health, Nutrition, and Population sector strategy, further discussing the application of its the principles and recommendations to the Bank's work on population and reproductive health.

Name of strategy	Improving Health, Nutrition, and Population outcomes in Sub-Saharan Africa: the role of the World Bank
Year	2004
Global or regional	Regional—Sub-Saharan Africa
Definition of high fertility	No definition
Fertility recognized as a development challenge	The strategy states that high fertility is an impediment to economic growth because of the demographic structure resulting from high fertility. High dependency ratios have a negative impact on economic growth. High fertility, along with illness, malnutrition, and premature death, is becoming increasingly important as a central determinant of poverty. High fertility pushes up the absolute level of poverty.
Regional focus	Sub-Saharan Africa
Role of the World Bank in the field of population	The report does not discuss the role of the World Bank in population issues in Sub-Saharan Africa nor focus on any specific health priorities. It discusses opportunities to achieve sustainable improvement for the sector in lending operations—in particular, the benefits and challenges of the sector-wide approach now becoming the norm. However, the report acknowledges the role of non-lending activities in fertility reduction. The Bank can step up advocacy and macro-economic dialogue to engage the country clients' commitment to addressing population challenges. Producing empirical evidence on the effects of high fertility on poverty reduction can contribute to this work.
Policy recommendations to address high fertility	The health sector should work more closely with the central ministries on decentralization, civil service reform, taxation, and financial management. Stronger linkages should be drawn between the social sector and central ministries (finance, economics, planning, local government, treasury) to advocate for the beneficial effects of better health and nutrition and lower fertility on poverty reduction. Advocacy is needed to increase the share of public spending allocated to health, nutrition, and population and to improve the way the poverty reduction strategies address health, nutrition, and population.
Programmatic recommendations to address high fertility	Family planning is the most effective way to prevent unwanted pregnancies and limit the number of births. Contraceptive use is directly related to the intensity and duration of efforts to increase access to family planning services. The report emphasizes that multisectoral action—a comparative advantage of the World Bank—is needed to improve health, nutrition, and population outcomes. In particular, education and school health are important inputs to reduced fertility and better health and nutrition. Education alone can be a determinant of better health outcomes, school a channel to convey health promotion messages. Another intervention in the education sector that will impact fertility outcome is the inclusion of health education in the school curriculum from an early age. The report suggest that educating children on how they can prevent unwanted pregnancies, as well as AIDS and sexually transmitted diseases, will have the greatest impact on subsequent generations.
Recommendations for monitoring and evaluation	The strategy emphasizes that a strong monitoring and evaluation framework and baseline data are crucial—a prerequisite to successful project implementation—but does not make specific recommendations about population indicators. It does state that the Country Assistance Strategy and lending operations will be assessed for their potential impact on achieving the Millennium Development Goals.

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Name of strategy	Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results
Year	2007
Global or regional	Global
Definition of high fertility	The strategy groups countries into three categories with broadly similar population issues. One category is countries with high fertility rates (total fertility rate over 5.0), often showing little change in fertility over time.
Fertility recognized as a development challenge	Rapid population growth places constraints on countries at low levels of socioeconomic development and makes providing basic services more difficult. High population growth poses significant challenges to country efforts to alleviate poverty. The HNP–development dynamic is complex and operates in both directions. Higher income may inspire governments to invest more in safe water, sanitation, and health care while it also changes health-related decisions at the household level, in particular related to fertility, as birth spacing generally increases with increased income. This virtuous circle means that ensuring economic growth is also crucial to achieve HNP results.
Regional focus	Countries with high unmet needs in sexual and reproductive health are a priority. Total fertility rates are very high in Sub-Saharan Africa (East, West, and Middle sub-regions) and many countries in the Middle East and North Africa.
Role of the World Bank in the field of population	The strategy identifies areas of work for the Bank based on its comparative advantages and on country requests for assistance: • Assessing multisectoral constraints to reducing fertility, determining impacts of population changes on health systems and other sectors, and assisting countries in strengthening population policies. • Providing financial support and policy advice for comprehensive sexual and reproductive health services, including family planning and maternal and newborn health. • Generating demand for reproductive health information and services, including reducing gender disparities and improving girls' education and women's economic opportunities. • Raising the economic and poverty dimensions of high fertility in strategic documents that inform policy dialogue (such as Country Assistance Strategies, Country Economic Memorandums, and country-led Poverty Reduction Strategy Papers).
Policy recommendations to address high fertility	The strategy is aligned with the commitment embedded in the Program of Action of the International Conference on Population and Development. Therefore the recommendations are not focused on population or fertility alone. The strategy reiterates the point that broader development goals should be achieved through empowering women and meeting their needs for education and health, especially safe motherhood and sexual and reproductive health. Family planning is part of the basket of services, as well as the prevention of unwanted pregnancy, prevention of unsafe abortion, safe pregnancy and delivery, postnatal care, and the prevention and treatment of STIs, including HIV/AIDS.
Recommendations for monitoring and evaluation	The HNP strategy result framework is intended to guide the regions and country teams to set targets in the context of result-based Country Assistance Strategies and for HNP programs and projects. The framework is not prescriptive and should be adapted to the country context. The result framework identifies four indicators to measure results related to the achievement of improved maternal, reproductive, and sexual health (Millennium Development Goal 5, target 6): three related to population—total fertility rate, adolescent fertility rate, and increased birth spacing—plus The maternal mortality ratio. The HNP sector will also be accountable to report on two population intermediate indicators: "contraceptive prevalence rate among women of reproductive age" and "unmet need for contraception."

Annex 3. Total Fertility Rates and Mention of Population Issues in Country Assistance Strategies and Interim Strategy Notes for High Fertility Countries, 1994–2008

Country	Total fertility rate	Year of CAS	Mention of population issues
Afghanistan	7.5		
Angola	6.8	No CAS	
Benin	5.9	2003	yes
Benin		2001	yes
Burkina Faso	6.7	2005	no
Burkina Faso		2000	yes
Burkina Faso		1996	yes
Burkina Faso		1994	no
Burundi	6.8	1995	yes
Central African Rep.	5.0	No CAS	
Chad	6.7	2003	no
Chad		2001	yes
Chad		1996	yes
Congo, Dem. Rep.	6.7	2007	no
Congo, Rep.	6.3	1996	no
Côte d'Ivoire		2002	yes
Côte d'Ivoire	5.1	1997	yes
Côte d'Ivoire		1994	no
Djibouti	5.1	2005	yes
Djibouti		2001	yes
Equatorial Guinea	5.9	No CAS	
Eritrea		2000	no
Eritrea	5.5	1996	yes
Ethiopia	5.9	2003	yes

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Country	Total fertility rate	Year of CAS	Mention of population issues
Ethiopia		2000	no
Ethiopia		1997	yes
Ethiopia		1995	no
Guinea	5.9	2003	yes
Guinea		1997	yes
Guinea-Bissau	7.1	1997	no
Kenya	5.0	2004	yes
Kenya		1998	yes
Kenya		1996	yes
Liberia	6.8	No CAS	
Madagascar		2007	yes
Madagascar	5.4	2003	yes
Madagascar		2002	no
Madagascar		1997	yes
Madagascar		1994	no
Malawi		2007	yes
Malawi		1998	yes
Malawi		1996	yes
Mali		2007	yes
Mali	6.9	2003	no
Mali		1998	yes
Mali		1994	no
Mauritania		2007	yes
Mauritania	5.8	2002	no
Mauritania		1997	yes
Mozambique		2007	no
Mozambique	5.5	2003	no
Mozambique		2000	no
Mozambique		1997	yes
Mozambique		1995	no
Niger	7.9	2003	yes
Niger		1997	yes
Niger		1994	no
Nigeria		2005	yes
Nigeria		2002	yes
Nigeria		2001	yes
Nigeria	5.8	2000	no

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Country	Total fertility rate	Year of CAS	Mention of population issues
Rwanda	5.7	2002	yes
Rwanda		1998	yes
Senegal		2007	no
Senegal	5.0	2003	yes
Senegal		1997	yes
Senegal		1995	no
Sierra Leone	6.5	2005	no
Somalia	6.4		
Tanzania		2007	yes
Tanzania	5.0	2000	no
Tanzania		1997	yes
Timor-Leste	7.8	2005	yes
Togo	5.4	1995	yes
Uganda		2005	yes
Uganda	7.1	2000	no
Uganda		1995	no
Yemen, Rep.	6.2	2006	yes
Yemen, Rep.		2002	yes
Yemen, Rep.		1999	yes
Yemen, Rep.		1996	yes
Zambia	5.7	2004	no
Zambia		1999	no
Zambia		1996	no

Source: Data for this table taken from a Review of the CAS documents as part of this study.

Annex 4. High-fertility Countries Ranked by Level of World Bank Health, Nutrition, and Population Thematic Commitments

High-fertility countries	World Bank Health, Nutrition, and Population thematic commitments, 1994–2008 ($ millions)	World Bank Population and Reproductive Health thematic commitments, 1994–2008 ($ millions)
Nigeria	543.90	76.49
Congo, Democratic Republic	471.80	39.90
Ethiopia	454.07	31.04
Uganda	267.92	53.50
Tanzania	236.28	0.00
Burkina Faso	200.33	28.90
Kenya	196.71	23.50
Mozambique	185.92	15.95
Madagascar	176.32	23.56
Rwanda	139.89	11.16
Chad	130.33	31.84
Côte d'Ivoire	125.45	19.40
Zambia	115.22	10.50
Afghanistan	114.89	28.50
Niger	114.79	20.30
Benin	113.65	22.50
Senegal	111.16	25.61
Mali	104.79	22.38
Eritrea	99.96	15.76
Guinea	94.93	22.03
Malawi	90.93	6.90
Burundi	75.18	14.83
Mauritania	57.11	10.76
Congo, Republic of	56.00	8.00

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High-fertility countries	World Bank Health, Nutrition, and Population thematic commitments, 1994–2008 ($ millions)	World Bank Population and Reproductive Health thematic commitments, 1994–2008 ($ millions)
Sierra Leone	54.23	4.60
Yemen, Republic of	40.51	9.31
Angola	30.04	0
Timor-Leste	24.04	3.61
Djibouti	23.48	4.35
Guinea-Bissau	18.04	1.19
Central African Republic	13.08	2.38
Liberia	10.13	0
Togo	3.95	0
Somalia	0.03	0
Total	4,495.04	590.42

Annex 5. Methodology of the Review

A.1.1 The first part of the review focused on the evolution of Bank strategies and policies on population issues from the early 1970s through the present. This policy review looked at the development of the Bank's thinking about the role of rapid population growth and high fertility in overall development and its link to a key goal of the Health, Nutrition, and Population Unit—improved health outcomes—and to a key World Bank goal—poverty reduction.

A.1.2 The second part was a desk review of the World Bank Country Assistance Strategies (CAS) and Interim Strategy Notes for the 35 countries with a total fertility greater-than-or-equal-to 5 children per woman for 1994 through 2008. Focusing on the priority given to rapid population growth and high fertility in relation to development, this review determined whether each CAS selected population growth and high fertility as a strategic focus and identified what kinds of recommendations it made for subsequent lending operations to address the issue of high fertility.[36] If a CAS did not address these issues, it was classified as not having addressed fertility issues and excluded from the dataset. Seventy-nine CASs were reviewed. Of the 35 high-fertility countries in the review, six countries (Afghanistan, Angola, Central African Republic, Equatorial Guinea, and Somalia) did not have a CAS available for review,[37] seven countries had only one CAS during the period of analysis, and while 22 countries had two or more CASs.

A.1.3 The third part looked at global and country-specific Analytical and Advisory Activities (AAA) that addressed population and reproductive health issues during the study period. A search of all AAA products in health was conducted, yielding a list of 72 individual AAA products, of which 28 were available for review. A second search was conducted for AAA work with a theme code of 69 (for population and reproductive health), yielding a list of 18 AAA products, all of which were available. These documents were reviewed to determine their contribution to a better understanding of population issues, and to determine the kind of technical advice and recommendations they provided on population and reproductive health issues.

A.1.4 The fourth part of the review looked at World Bank lending to population and reproductive health worldwide and in the 35 high-fertility countries between 1994 and 2008. Levels of World Bank commitment were determined through a review of the Bank support identified by the thematic code 69, "Popula-

tion and Reproductive Health."[38] This code includes activities related to demographic analysis, the development of national population policies and multi-sectoral linkages, support for improving access to family planning services, and provision of contraceptives and condoms. This theme code also includes the range of activities related to improved maternal health (basic and comprehensive emergency obstetric care), training of midwives, pre- and postnatal care, and the prevention of sexually transmitted diseases.

A.1.5 The financial data used for the figures on OECD commitments were taken from the OECD DAC database. Financial commitments for Health, Pop/RH and HIV/AIDS in all recipient countries and for the 35 high fertility countries for were compared for the study period 1994–2008.

A.1.6 The fifth part examined in greater detail World Bank support to family planning activities within stand-alone population and reproductive health projects, larger and more comprehensive health projects, sector-wide approaches, and Poverty Reduction strategies for the 35 high-fertility countries. An initial search identified 75 projects approved between July 1, 1994 and June 30, 2008, in the 35 high-fertility countries that had a focus on population and reproductive Health. To select population and reproductive health projects with a family planning component, the study reviewed the Project Appraisal Document—including the Project Development Objectives, key performance indicators, and detailed project description—to identify whether the project included fertility or family planning activities, such as the following:

- Provision of family planning services, through public health facilities, community health workers, and private sector facilities including social marketing.
- Information, education, and communication, from one-to-one personal interactions to national campaigns, on family planning.
- Procurement of modern methods of contraceptives.
- Training of medical health personnel in all aspects of family planning service delivery, including community-based health family planning.
- Policy development, including support for the development of a population policy, surveys and data collection to assess fertility levels, secondary analysis of data for related analysis, and workshops or meetings to discuss the evidence.

A.1.7 In cases where a Project Appraisal Document was not available, the Memorandum and Recommendation of the President, Staff Appraisal Report, Program Document (for Poverty Reduction Support Credits), Project Paper (for Supplemental Financing Operations), or the Grant Agreements were used for the review.

A.1.8 The review of project components, objectives, and indicators made it possible to differentiate population projects

with a clear family planning component from broader reproductive health projects that focused on HIV/AIDS, STI prevention, or maternal and child health, or from other health-related interventions (for malaria, nutrition, and prevention of harmful practices on vulnerable groups). This distinction was particularly important when reviewing the primary focus of activities such as information, education, and communication, procurement of modern methods of contraceptives, and training of health personnel, which can be undertaken in projects for other reproductive health goals as well as projects with a family planning component. Only when these activities supported specific family planning objectives was the project considered a population project.

A.1.9 Of the initial 75 projects, 36 projects in 24 of the 35 high-fertility countries[39] were identified as having a family planning component. For these 36 projects,[40] all available documents—including Mid-term Reviews and Implementation Completion Reports of closed projects—were reviewed for the following issues:

- Project development objectives and project components.
- Project approaches and lending instruments.
- Service delivery models.
- Monitoring and evaluation framework, including the indicators for monitoring progress on family planning components.
- Skill mix and technical capacity in the design and supervision of the project.

A.1.10 The project review attempted to draw conclusions and make recommendations about ways for the World Bank to accelerate support for family planning. Although the review of individual projects did not attempt to assess which project delivery model was most effective in delivering population and reproductive health outcomes, the review did try to delve deeper into the question of whether the sector-wide approach—increasingly used by the Bank in its lending operations—has affected population and reproductive health outcomes. Sources of information on the sector-wide approach included two reports drafted by the Independent Evaluation Group: "Do Health Sector-Wide Approaches Achieve Results?"[41] and *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population*.[42] The review also examined project outcomes and results in the Implementation Completion Reports of closed sector-wide approaches for health in the 35 high-fertility countries.

Annex 6. Review of World Bank Population and Reproductive Health Projects by Service Delivery Approach

Stand-alone Population Projects

Country and project name	Year approved	Amount for population and reproductive health/Project status
Benin Health and Population Project	1995	$6.95 million/Closed
Burundi Second Health and Population Project and Supplemental Grant for the Health and Population II Project	1995 2003	$5.33 million/Closed $9.50 million/Closed
Guinea Population and Reproductive Health Project	1999	$4.52 million/Closed
Chad Supplemental Health and Safe Motherhood Project	1999	$2.73 million/Closed
Malawi Population and Family Planning Project	1999	$2 million/Closed
Rwanda Health and Population Project (Supplemental Credit)	2001	$2.31 million/Closed
Niger Multi-sector Demographic Project	2007	$2.90 million/Open
Liberia Pilot Project to Strengthen SRH And Rights for War Affected Youth	2008	$0.23 million/Open

Rapid Overview of Closed Stand-alone Population and Reproductive Health Projects

Benin Health and Population Project: (1995–2002)

The Project Development Objectives articulated clear family planning components and population issues. The project supported the development of a population policy, expansion of family planning services into a basic package of health services, and staff training. The Implementation Completion Report shows that the project exceeded the target of 5.5 percent contraceptive prevalence rate by 1.5 percent in 2001 but could not meet its overall target of increasing the contraceptive prevalence rate by 11 percent.

Burundi Second Health and Population Project (1995–2006)

The original objectives of this project were to: strengthen Ministry of Public Health's capacity to design and implement key sector reforms, improve the availability and quality of health care delivery in rural areas, contribute to reducing population growth and maternal and child mortality rates, and promote

beneficial health and family planning behaviors. The family planning component is part of a larger program for improving the health sector functionality. Because of civil conflict in 1996, sanctions were imposed on Burundi until 1999, resulting in a suspension of donor funding after withdrawal of government participation in the project. The project started out with a strong focus on population and family planning issues, but it was restructured in 2002 to focus more on basic health services for displaced populations in the supplemental grant financing.

Guinea Population and Reproductive Health Project (1999–2003)

The project sought to support the government's efforts to improve the well-being of the population by preventing the risks related to poor reproductive health, preventing and reducing the occurrence of illnesses among vulnerable groups, and ultimately reducing infant, child, and maternal mortality rates. The program development objectives were to reduce the three major mortality rates—infant, child and maternal—through slower population growth, safer behavior and adequate health practices, and improved reproductive and child health services. The project was the first phase of a multiyear sector program in support of the government's efforts on population issues, reproductive and child health, and management coordination of population and reproductive health programs. But the project was closed at the end of the first phase because World Bank management decided to discontinue the project in favor of nontargeted budget support through a Poverty Reduction Support Credit.

Malawi Population and Family Planning Project (1999–2003)

The objective of this project was to test a community-based distribution approach to provision of population and family planning service in three pilot districts. The goal was to increase the contraceptive prevalence rate through improved knowledge about family planning and increased access to services for men, women, and adolescents living in rural and underserved areas. The overall achievement of project objectives was deemed satisfactory. The end-project survey showed that 95 percent of the adult population in control districts held a positive view of family planning. Contraceptive use also doubled in all villages covered in the pilot districts, while the contraceptive prevalence rate rose from about 20 percent to 36 percent.

Rwanda Health and Population Project Supplemental Credit (approved in 2000)

The project was originally designed to support the implementation of the national population policy: reducing fertility levels, improving maternal and child health, and integrating demographic dimensions in cross-sectoral activities. The project was restructured in 1996 into a health and population project to support implementation of the national health policy, strengthen the government's capacity to formulate and implement a comprehensive and sustainable strategy of AIDS control on a national scale, and strengthen the government's capacity to formulate and carry out a population policy. Although final evaluations thought that the project performed very well in developing a national population policy and raising

awareness on population issues, family planning services have experienced a downturn due to the pronatalist tendencies of the population after the genocide losses. In November 2000, a $7 million supplemental credit was provided to continue support for AIDS control activities, supply of pharmaceuticals, health district activities, and population activities.

Rapid Overview of Open Stand-alone Population and Reproductive Health Projects

Niger Multi-sector Demographic Project (approved in 2007)

The objective of this project is to build a national response to rapid population growth and to link this response to poverty alleviation and human welfare objectives by strengthening the government's capacity to implement a large, multisector demographic program—including the supply-side interventions—and by helping put in place the necessary conditions for the onset of the fertility transition, especially demand-creation interventions. This is to be accomplished by improving maternal, infant, and child survival; expanding family planning services; enhancing women's education and autonomy; and integrating population activities with development of basic infrastructure. The project is working in a multisectoral fashion on an information, education, and communication (IEC) campaign, advocacy, women's gender issues (including improving school enrollment and supporting women's economic opportunities), legal reforms and harmonization, coordination of multisectoral interventions, and capacity-building for monitoring and evaluation. This project is in too early a phase of implementation to assess effectiveness. No midterm evaluation has yet to be conducted.

Liberia Pilot Project to Strengthen Sexual and Reproductive Health and Rights for War Affected Youth Vulnerable Youth (approved in 2008)

This project is a small grant of $.49 million dollars to improve access to and utilization of reproductive health services through IEC and behavior change communication (BCC) campaigns and improving access to services to reduce STIs, including HIV/AIDS. The project does not have indicators related to family planning, although project documents do mention its attempt to reduce unwanted pregnancies among teens. As the project was only approved in July 2008, information on implementation is not yet available.

Rapid Overview of Closed SWAps

Sierra Leone Integrated Health Sector Investment Project (1996–2003)

This SWAp project supports family planning activities—including IEC and procurement of contraceptives—as part of its efforts to improve maternal health, a key priority in the health sector. The overall objective of the project is to improve the health status of the population by increasing access to and improving the quality of a basic package of health services. The May 1997 coup d'état and ousting of the elected government rendered the implementation of any project activities impossible for over a year. Donors' pledged contributions could no longer materialize, as most donors had left the country. After the reinstatement of the government, the country suffered another

Sector-Wide Approach (SWAp) Projects

Country and project name	Year approved	Amount for population and reproductive health/ Project status
Sierra Leone Integrated Health Sector Investment Program	1996	$3.40 million/Closed
Mauritania Health Sector Investment	1998	$6 million/Closed
Ethiopia Health Sector Development Project	1999	$14 million/Closed
Mali Health Sector Development Program	1999	$16 million/ Closed
Senegal Integrated Health Sector Development Project	1998	$16.5 million/Closed
Nigeria Health Systems Development Project II	2002	$27.9 million/Open
Guinea Health Sector Support Project	2005	$8.25 million/Open
Niger Institutional Strengthening and Health Sector Support project	2006	$10.15 million/Open
Madagascar Sustainable Health System Development Project	2007	$2.20 million/Open
Timor-Leste Health Sector Strategic Plan Support Project	2008	$0.16 million/Open
Republic of Congo Health Sector Services Development Project	2008	$8 million/Open

rebel invasion in January 1999, further obstructing implementation of the project in the district areas and thus rendering initial project objectives and design obsolete. Because of civil unrest, the project was restructured to focus on emergency relief for displaced populations.

Mauritania Health Sector Investment Project (1998–2004)

This sector-wide project focused on improving the delivery of key health services, including reproductive health and family planning. The overall objective of the project was to improve the health status of the population in general (and of underserved groups in particular) through the provision of more accessible and affordable quality health services. The program's specific objectives were to improve health services quality and coverage, improve health sector financing and performance, mitigate the effects of major public health problems, promote social action, and create an environment conducive to health. The specific indicator to evaluate the family planning outcomes was to reduce the total fertility rate to 5.5 in 2002. The Implementation Completion Report shows that the fertility rate actually declined to somewhere between 4.1 and 4.6, greater than originally expected in the Project Appraisal Document and an important achievement.

Ethiopia Health Sector Development Project (1999–2006)

The main objective of the Health Sector Development Project was to develop a health system that provides comprehensive and integrated primary care services, primarily based at community health level facilities where reproductive health activities—including traditional maternal health as well as family planning services—are part of the health service delivery. The project sought to increase the contraceptive prevalence rate from 8 percent in 1997 to 15–20 percent in 2002 and 40 percent in 2017. The Implementation Completion Report shows that the contraceptive prevalence

rate increased from the baseline of 8 percent to 14.7 percent, close to the lower end of the project's 2002 target of 15–20 percent).

Mali Health Sector Development Project (1999–2006)

The objective of this project was to improve the health outcome of the population, focusing on meeting the needs of the underserved and accelerating the country's demographic transition toward slower population growth. The project proposed a program of sector-wide activities aimed at expanding access to quality health care (including reproductive health and nutrition services), strengthening health system management, and developing sustainable financing schemes for health sector development, with safety nets for the poor. There was a clear emphasis on prevention and on primary and first-level referral care, with a particular focus on obstetric care and the management of high risk pregnancies, provision of family planning information and services, child survival and integrated management of childhood illness (including the alleviation of malnutrition among under-5 children and their mothers and), and the fight against AIDS and other communicable diseases. According to the Implementation Completion Report, the design of the monitoring and evaluation system was weak, evidenced by the large number of poorly defined indicators, most of which were not reported on systematically during program implementation. In the end the project's success in meeting Project Development Objectives was rated as negligible.

Senegal Integrated Health Sector Development Program (1998–2005)

The purpose of the program was to provide support for the implementation of the government's Integrated Health Sector Development Program. Its objectives were to improve the management and financial viability of the public health system, improve access to quality health care for the majority of the underserved and vulnerable groups in urban and rural settings, and contribute to fertility decline and reduce the high population growth rate by improving the management and delivery of reproductive health services. According to the Implementation Completion Report, the family planning component achieved few results: the number of women using contraceptives remains very low, and fertility decreased little over the project period. On the basis of development objectives stated in the project description, the key project indicators, and results from studies, surveys, and the national information system, the project outcome was rated as moderately unsatisfactory.

Rapid Overview of Open SWAps

Nigeria Health Systems Development Project II (approved in 2002)

The goal of this project is to assist the Nigerian health authorities to redress the deterioration in the delivery of basic health care services following decades of neglect and to build institutional capacities, paving the way for a more sustained development of the Nigerian health care system. The project proposes to strengthen capacities for system management, support improvements in the delivery of primary health care services with a particular focus on maternal and child health and reproductive health services, and help the federal government strengthen its policy formulation and further develop a system to monitor the health sector performance. The

project supports improvements in reproductive health services, including improved access to family planning initiatives, as part of the delivery of primary health services. However, the Project Appraisal Document does not specifically mention IEC, contraception, or policy development activities in the project description. The project does not contain any family planning indicators, and the details of the reproductive health and family planning component are very vaguely described. No midterm or final report is available.

Guinea Health Sector Support Project (approved in 2005)

The two key objectives of the project are to reduce maternal and infant mortality rates by improving access and quality of health care services, including family planning and reproductive health services. The project also provides funding for equipment for a new reproductive health training and research center. The project does not detail the family planning component and does not monitor family planning indicators. The project is still in implementation, with no final or midterm results yet available.

Niger Institutional Strengthening and Health Sector Support Project (approved in 2006)

The objectives of this sector-wide program are to establish a health project contributing to the reduction of maternal and child mortality, and to improve the sector capacity, effectiveness, and efficiency through the provision of a minimum package of essential health services. The project aims to increase the effectiveness of essential reproductive health services through the introduction of family planning services in a minimum health package targeted at the poor, women, and children. Specific objectives of the project are to increase access and utilization by the population to this minimum package of health essential services, strengthen reproductive health services and malaria control programs, and improve overall sector management and organizational capacity. Monitoring indicators were proposed to measure progress toward meeting a minimum package of basic services including contraceptive use. The project is still in early implementation; no final or midterm results are yet available.

Madagascar Sustainable Health System Development Project (approved in 2007)

This sector-wide project focuses on strengthening service delivery and development and management of human resources, introducing innovations in health financing management, and improving demand and utilization of health services. Family planning services will be integrated into an overall maternal and child health package. A key objective of this SWAp program is to scale up the production and delivery of health programs with an emphasis on endemic infectious diseases, reproductive health (family planning, STIs, HIV/AIDS), and nutrition. Despite the varied population activities supported by the project, the only population-related indicator is "proportion of women using contraceptives," and the rollout of the family planning component is very vaguely discussed in the Project Appraisal Document. It is unclear how well the family planning component has been integrated into the basic maternal and child health service package. No midterm or final evaluation is available.

Timor-Leste Health Sector Strategic Plan Support Project (approved in 2008)

The overall objective of the project is to improve the quality and coverage of preventive and curative health services, particularly for women and children, in order to accelerate progress toward the health Millennium Development Goals. Specific objectives include improving accessibility, demand for, and quality of health services; strengthening support services, human resource development, and management; and strengthening coordination, planning, and monitoring. Progress toward achievement of these objectives will be monitored using a combination of sector-wide health service indicators, such as vaccination coverage, contraceptive prevalence, and trained birth attendance. This project did not become effective until June of 2008, so no reports on implementation status are available.

Republic of Congo Health Sector Services Development Project (approved in 2008)

The project, although not a SWAp, intends to pave the way for a future SWAp in the sector. The sector-wide reforms proposed include building sector leadership, instituting an efficient human resource management system, rehabilitating primary health facilities, and defining and streamlining priority curative, preventive, and promotional interventions. The project supports the improved delivery of a package of essential health services covering child and maternal health (including population and reproductive health and family planning services), communicable diseases (especially malaria), and non-communicable diseases. Under the essential services package, accessibility, availability, and use of family planning services will be strengthened by integrating services in all health centers and maternity clinics and wards in the country. In addition, community-based distribution of contraceptives will be introduced and performance family planning indicators incorporated into health information systems. As the project was approved in 2008, it is too early to assess effectiveness in meeting goals and no mid-term evaluation is available.

Rapid Overview of Closed Reproductive Health and HIV/AIDS Projects

Chad Population and AIDS Control Project (1995–2001)

This project supported Chad's longterm strategy in the areas of population and family planning and HIV/AIDS control. Components included implementation of a population policy, implementation of a program to address HIV/AIDS/STIs, social marketing of condoms, and a social fund to involve nongovernmental organizations. The project was viewed as very successful even though it did not meet the end-of-project target of raising the contraceptive prevalence rate to 10 percent (which was overly ambitious) nor fully implement the population policy. The project did succeed in decentralizing HIV/AIDS and STI services, expanding a social marketing program of condoms for both HIV/AIDS prevention and prevention of pregnancies, and involving nongovernmental organizations in population, family planning, and HIV/AIDS prevention activities.

Reproductive Health and HIV/AIDS Projects

Country and project name	Year approved	Amount for population and reproductive health/ Project status
Chad Population and AIDS Project Control and Second Population and AIDS Project	1995 2002	$6.73 million (1995) $6.14 million (2002) /Closed
Kenya Decentralized Reproductive Health and HIV/AIDS Project	2001	$12.50 million/Closed
Eritrea – HIV/AIDS/STI, TB, Malaria and Reproductive Health Project (HAMSET II)	2005	$5.76 million/Open

Chad Second Population and AIDS Project (2002–08)

This project built further on synergies between HIV/AIDS and population programs, including IEC and BCC activities for both reproductive health and HIV/AIDS prevention, promotion and distribution of condoms for both HIV/AIDS prevention and fertility reduction, and activities focused on the needs of adolescents. According to the Implementation Completion Report, the project did not succeed in raising the modern contraceptive prevalence rate to 10 percent, the end-of-project target. By the project's end, the contraceptive prevalence rate was estimated at 2 percent. Available data indicate that the total fertility rate in Chad has remained constant over the life of the project at around 6.6 children per woman.

Kenya Decentralized Reproductive Health and HIV/AIDS Project (2001–07)

The project development objectives were to improve mother and child health through more integrated delivery of child survival, reproductive health, and HIV/AIDS services; slow the increase in HIV prevalence rates; and create an enabling environment for decentralized managed delivery of child survival, reproductive health, and HIV/AIDS services to and within districts. The reproductive health and integrated management of childhood illness components were to be assessed using the following indicators: infant mortality rate, child mortality rate, vaccination coverage statistics, percentage of births attended by qualified health workers, total fertility rate, contraceptive prevalence rates (by age, per district), and median age of first sexual intercourse. The project failed to meet its overall objectives and was then restructured but never got underway afterwards and was finally closed.

Rapid Overview of Open Reproductive Health and HIV/AIDS Projects

Eritrea HIV/AIDS/STI, TB, Malaria and Reproductive Health Project (HAMSET II) (approved in 2005)

This project tries to exploit the synergies between reproductive health and HAMSET diseases (HIV/AIDS, malaria, STIs, and tuberculosis). The project's development objectives are to contain the spread of HIV/AIDS through a focused multisectoral approach; expand directly observed treatment coverage, case detection, and treatment of TB; maintain malaria mortality and morbidity at the current

Projects to Deliver Basic Health Service Packages

Country and project name	Year approved	Amount for population and reproductive health/ Project status
Uganda District Health Services Pilot and Demonstration Project	1995	$9 million/Closed
Côte d'Ivoire Integrated Health Services Development Project	1996	$16 million/Closed
Chad Health Sector Support Project	2000	$11.62 million/Closed
Madagascar Second Health Sector Support Project and Supplemental Financing	2000 2005	$5.60 million (2000) $3.06 million (2005)/ Closed
Yemen Health Reform Support Project	2002	$6.06 million/ Open
Afghanistan Health Sector Emergency Reconstruction and Development Project 1, 2 ,3	2003 2006 2008	$14.30 million (2003) $8.40 million (2006) $5.80 million (2008)/ Open
Democratic Republic of Congo Health Sector Rehabilitation Support Project	2006	$19.50 million/Open

low levels; improve the coverage of effective reproductive health interventions, including family planning; and strengthen the overall health system, including human resources for health. The project intends to promote child spacing through community mobilization and improved access to quality services. Although the project discusses the objective of exploiting the synergies between reproductive health and HAMSET diseases, it does not describe the service delivery mechanism or family planning component.

Rapid Overview of Closed Projects to Deliver Basic Health Service Packages

Côte d'Ivoire Integrated Health Services Development Project (1996–2004)

This project sought to establish the foundation for universally available health services by expanding service delivery for a minimum package of health care and reproductive health services, including family planning. The project also supported health planning and management and health information. The health service delivery components included start-up costs for the minimum package of services in 14 districts, including nutrition, pharmaceuticals, training, reproductive health, and IEC services; and an accelerated program of reproductive health services, including family planning and STIs (including HIV/AIDS), through public sector and nongovernmental organization clinics and the addition of family planning services to nonspecialized public sector health clinics. The project did not achieve its goals, and after a midterm review the Project Development Objectives were revised. Of the 106 targeted reproductive health and family planning centers, the project has succeeded in rehabilitating 95. The Implementation

Completion Report did not see the project ensuring smooth operation of family services. Up to the closing date of the project, the equipment ordered under the project could not be distributed, some because they could not be conveyed by the government to the occupied North, and some because they were seized at customs.

Madagascar Second Health Sector Support Project (2000–07) and Supplemental Financing (2005)

The project's overall development objective was to contribute to improved access to quality health services. Specific objectives were to improve quality of and access to primary health care services with a focus on rural areas; support priority health programs with emphasis on endemic infectious diseases, reproductive health (including family planning, STIs,and HIV/AIDS), and nutrition; and strengthen sector management and administrative capacity within the ministry of health, enabling decentralization and sector reform. The project also supported reproductive health activities, including the delivery of quality and decentralized family planning, safe motherhood, and STI/HIV/AIDS services. One of the main successes of the project was improving family planning services, which were financed through its third component. During the project's life cycle, total fertility rate decreased (from a baseline of 6 in 2000 to 5.2 in 2003/04), partly due to increased demand and supply of family planning services. In 1997, the Demographic Health Survey (DHS) survey found that in rural areas only 34 percent of the demand for family planning was satisfied (64 percent in urban areas). In 2003 the DHS found a demand satisfaction of 48 percent in rural areas and 68 percent in urban areas. These surveys also found an increase in the national contraceptive prevalence rate from 9.7 in 1997 to 18.3 in 2003/04. The supplemental financing for the project covered additional costs resulting from the 2000 cyclone, the 2002 political crisis, and increased decentralization activities.

Rapid Overview of Open Projects to Deliver Basic Health Service Packages

Yemen Health Reform Support Project (approved in 2002)

The objectives of this project are to increase access for women and children to a package of integrated maternal and child health services and improve the effectiveness of national public health programs and the resource allocation within the public health sector in Yemen. The project supports the delivery of a package of integrated maternal and child health services, which include family planning. The health education component includes Behavior Change Communication (BCC) campaigns on primary reproductive health and family planning. The project monitors increased birth deliveries attended in district hospitals in the selected districts, increased accessibility as reflected by an increase in utilization of health services in district hospitals, increased health knowledge as reflected by an increase in the intention of currently married women to use family planning, and improved resource allocation as reflected by an increase of the operations and maintenance share of total Ministry of Public Health and Population expenditures.

Afghanistan Health Sector Emergency Reconstruction and Development Project 1, 2, 3 (approved in 2003, 2006, 2008)

This project aims to help the Ministry of Health (MOH) reduce the rates of infant and child mortality, maternal mortality, child malnutrition, and fertility through expanding delivery of the basic package of health services; strengthen the MOH's stewardship over the sector, including a greater role in health care financing, coordination of partners, and overseeing the work of nongovernmental organizations; and build the capacity of Afghan health workers to provide and manage health services. The family planning component has been bundled with other primary health care and maternal and child health activities. Contraceptive prevalence is one of the key indicators used for project monitoring and evaluation. The supplemental financing expands the coverage of the basic package, including support for mass immunization campaigns aimed at eradicating polio and controlling measles and neonatal tetanus; introduces activities to strengthen the management of hospitals; and enhances capacity building activities in the Ministry of Public Health particularly related to training more female frontline health workers and monitoring and evaluation.

At the end of the first project, Health Management Information System (HMIS) data show increases in the number of outpatient consultations, the number of trained female health care workers, and the number of deployed community health workers. Results also show increases in prenatal care from 32.4 percent to 59 percent and skilled birth attendance from 2.9 percent to 7.5 percent. Individuals who accepted family planning services increased from 27,180 to 68,940, a gain of 153 percent. At the end of the first supplemental financing, the project showed continuing good performance on key indicators. The second supplemental financing was completed in 2009.

Democratic Republic of Congo Health Sector Rehabilitation Support Project (approved in 2006)

The Project Development Objective is to ensure that the target population of selected health zones has access to and uses a well-defined package of quality essential health services, including reproductive health. Family planning services are included in the package and will be supported by the project. A package of preventive services to reduce the heavy burden of maternal mortality includes: family planning as a crucial service for prevention of unintended pregnancies and its consequences on maternal and child health, and quality family planning and reproductive health services available at both the community level and at existing service delivery points. A particular emphasis will be on ensuring availability of contraceptive commodities at all times to reduce huge unmet needs. However, the project does not include population and reproductive health performance indicators. A SWAp was considered for this operation, but government capacity was too weak to manage a sector-wide operation.

Population and Reproductive Health Projects as Part of Poverty Reduction Support Credits

Poverty Reduction Support Credits		
Country and project name	**Year approved**	**Status**
Benin Poverty Reduction Support Credit 1	2004	$3.40 million/Open
Uganda Fourth Poverty Reduction Support Operation	2005	$30 million/Closed

End Notes

1 Lakshminarayanan and others 2007.

2 The total fertility rates used to define the countries to be included in the study were compiled from a list for the period 2000–05. This list identified 35 countries, 33 of which are in Sub-Saharan Africa. See annex 2 for a complete list.

3 Lakshminarayanan and others 2007.

4 This number is based on the 2006/07 fertility status data used in Lakshminarayanan and others 2007.

5 Singh and others 2003.

6 Greene and Merrick 2005.

7 Singh and others 2003.

8 Speidel and others 2009.

9 Ahman and Shah 2002.

10 Greene and Merrick 2005.

11 Lakshminarayanan and others 2007.

12 Speidel and others 2009.

13 Epp and Ringheim. 2004.

14 Within the Health, Nutrition and Population sector, "population" refers to reproductive, maternal, and sexual health issues, and the health services that are concerned with addressing them, and levels and trends in births, deaths, and migration that determine population growth and age structure (World Bank 2007).

15 Fair 2008.

16 World Bank 1993.

17 World Bank 1994.

18 World Bank 1997.

19 World Bank 2000.

20 World Bank 2005.

21 Launched in 1997, the Country Assistance Strategy (CAS) is the Bank's operational strategy for a client country. It is prepared on a four-year cycle with a midterm progress report and a CAS Completion Report. Prepared in consultation with country authorities, development partners, and other stakeholders, it aims to identify the key areas for World Bank support to achieve greater and more sustainable development and poverty reduction. For countries not ready for a full CAS, an Interim Strategy Note is prepared. This review will use the generic term CAS, which refers to both Country Assistance Strategy and Interim Strategy Note.

22 High-fertility countries are defined as countries with a total fertility rate of 5 and above for the period 1994 through 2008 (see annex 2 for a list).

23 The percentages do not add up to 100 percent because certain CASs mention multiple effects of high fertility.

24 Examples are drawn from Lakshminarayanan and others 2007.

25 This portfolio review did not examine Poverty Reduction Strategy Papers. Examples given here are drawn from Lakshminarayanan and others 2007.

26 Themes correspond to the goals/objectives of Bank Activities. Theme 69 represents Population and reproductive health—

programs and policies that recognize the interrelationships between population and development including programs to reduce maternal morbidity and mortality and improve reproductive health. However, the distinction between primary and secondary themes is no longer used in Bank projects.

27 Pathmanathan and others 2003.

28 Mills and others 2007.

29 Themes correspond to the goals/objectives of Bank Activities. Theme 69 represents Population and reproductive health—programs and policies that recognize the interrelationships between population and development including programs to reduce maternal morbidity and mortality and improve reproductive health. However, the distinction between primary and secondary themes is no longer used in Bank projects.

30 See annex 8.

31 The sector-wide approach is meant to encompass six principles of project development that support a "broad sector approach to lending": (1) sector-wide in scope, covering all current and capital expenditures; (2) based on a clear sector strategy and policy framework; (3) run by local stakeholders, including government, direct beneficiaries, and representatives of the private sector; (4) adopted and financed by all main donors ; (5) based in common implementation arrangements among all financiers; and (6) reliant on local capacity, rather than on technical assistance, for implementation

32 Independent Evaluation Group 2009.

33 Independent Evaluation Group 2009.

34 Vaillancourt 2009.

35 Recommendations are drawn in part from Lakshminarayanan and others 2007.

36 See annex 5 for a list of countries whose CASs mention population issues.

37 CASs for these countries were not available for review, either because they did not qualify for a full CAS or because the CAS was in preparation.

38 The World Bank's thematic code 69 includes programs and policies that recognize the interrelationships between population and development, including programs to reduce maternal morbidity and mortality and improve reproductive health. It also includes activities that: support demographic analysis of population growth, structure, and distribution (including migration and urbanization); support population data, census, and statistical capacity-building; support population policy analysis and multisectoral linkages, including links to poverty, girls' education, female autonomy, urbanization, water, and the environment; provide access to family planning services; provide contraceptives and condoms; care for women during and after pregnancy; train midwives and other reproductive health providers; provide essential and comprehensive obstetric care; prevent and control sexually transmitted diseases, including HIV (within reproductive health components); prevent and treat cervical cancer; promote the reproductive health of adolescents; promote safe sexual behavior through information, education, and life skills; or prevent violence against women and girls, including female genital mutilation.

39 Afghanistan, Benin, Burundi, Chad, Democratic Republic of the Congo, Republic of the Congo, Côte d'Ivoire, Eritrea, Ethiopia, Guinea, Kenya, Liberia, Madagascar,

Malawi, Mali, Mauritania, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Timor-Leste, Uganda, and Republic of Yemen.

40 See annex 6 for a list of countries.

41 Vaillancourt 2009.

42 Independent Evaluation Group 2009.

THE WORLD BANK
1818 H Street, N.W.
Washington, DC 20433