MATERNAL AND CHILD HEALTH: THE WORLD BANK GROUP'S RESPONSE TO SUTAINABLE DEVELOPMENT GOAL 3: TARGET 3.1 & 3.2

DISCUSSION PAPER **SEPTEMBER 2017**

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WORLD BANK GROUP
Health, Nutrition & Population

MATERNAL AND CHILD HEALTH*:*

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Health, Nutrition and Population (HNP) Discussion Paper

Maternal and Child Health:
The World Bank Group's Response to Sustainable Development Goal 3: Target 3.1 & 3.2

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Abstract: The aim of this paper is to explore the advances made in maternal and child health (MCH) over the past 25 years, analyzing World Bank Group (WBG) operational investments in MCH, as countries shift their focus to the sustainable development goals (SDGs). Maternal mortality decreased by 44 percent over the past 25 years with an annual rate of reduction of 2.4 percent, yet to reach SDG target 3.1, the global maternal mortality ratio (MMR) must decrease by 7.5 percent per year by 2030. Maternal mortality has negative consequences as it leads to greater family financial instability, loss of education, and increased child mortality. Evidence shows that skilled birth attendance and maternal education reduces the likelihood of maternal mortality (UNESCO, 2013). When comparing primary school net enrolment and primary school completion with maternal mortality, it appears that national MMR averages are influenced by education. Also, MMR is influenced by the delivery of health care and socioeconomic indicators, which may lead to inequities at the national and subnational levels. While significant progress has been made in reducing the under-five mortality rate (U5MR), neonatal mortality rate (NMR) reduction has lagged. The WBG has 86 active projects that include activities that improve women and children's health. Many projects focus on antenatal care and delivery services, followed by children under 5 years, and family planning. As part of the operationalization of the *Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030)*, the WBG could develop an inclusive Women's, Children's, and Adolescents' Health Action Plan. The new, inclusive Action Plan would comprehensively build on the existing platforms and elements of the WBG, including the Global Financing Facility; Civil Registration and Vital Statistics; the *World Bank Group Gender Strategy (2016-2023): Gender equality, poverty reduction and inclusive growth*; fragility, conflict and violence; and the International Development Association (IDA18) commitments and all WBG client countries, supporting them across varying levels of need and income, targeting the poorest and most vulnerable.

Keywords: maternal health, under-five and neonatal health, maternal mortality, child mortality, family planning

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ACRONYMS

Antenatal care	ANC
Civil Society Organization	CSO
Corporate results indicators	CRI
Civil registration and vital statistics	CRVS
Fragility, conflict, and violence	FCV
Gender-based violence	GBV
Global Financing Facility	GFF
Health, Nutrition and Population	HNP
Health Results Innovation Trust Fund	HRITF
International Bank of Reconstruction and Development	IBRD
International Development Association	IDA
Internally Displaced Persons	IDPs
Infant mortality rate	IMR
Latin America and the Caribbean	LAC
Maternal mortality ratio	MMR
Maternal and child health	MCH
Millennium Development Goal	MDG
Neonatal mortality rate	NMR
Out-of-pocket	OOP
Population and development global solutions area	P&D GSA
Reproductive health action plan	RHAP
Reproductive, maternal, newborn, and child health	RMNCH
Reproductive, maternal, newborn, child, and adolescent health	RMNCAH
Reproductive, maternal, newborn, child, and adolescent health and nutrition	RMNCAH-N
Sustainable Development Goal	SDG
Sexual and reproductive health	SRH
Sahel Women's Empowerment and Demographic Dividend Project	SWEDD
Total fertility rate	TFR
Under-five mortality rate	U5MR
Universal health coverage	UHC
World Bank Group	WBG

PART I – INTRODUCTION

1. **Maternal and child health (MCH) have improved worldwide over the past 25 years, driven in part by efforts to achieve Millennium Development Goals (MDG) 4 (reduce child mortality) and 5 (improve maternal health)**. As the MDGs concluded in 2015, countries are now working towards the achievement of the Sustainable Development Goals (SDGs) (2016-2030). The SDGs build upon the advances made by the MDGs, and go one step further by offering an integrated and intersectoral plan for ending extreme poverty and ensuring the health and wellbeing of all. This includes addressing the economic, social, and environmental dimensions that underpin poor health and development outcomes, while at the same time promoting human rights, equity, and empowerment.

2. **Low - and middle - income countries have experienced uneven development gains over the past twenty-five years, with women and children not benefiting to the same degree from advances in development.** Despite a decline in poverty, extreme poverty remains concentrated in some settings. Furthermore, violence, conflict, fragility, and an economic slowdown could push more people into extreme poverty and threaten advances made towards the SDGs. For example, it is projected that the number of extreme poor living in fragility, conflict, and violence (FCV) settings (approximately 20 percent) will double by 2030. Meanwhile, countries that face–or are expected to face– demographic dividends could experience an increase in the unemployed population due to a lack of employment opportunities. Similarly, demographic imbalances, social persecution, forced displacement, corruption, and a lack of services are forcing people to migrate in search of better opportunities. Gender disparities persist with women experiencing gender-based violence (GBV), and facing large inequalities in paid and unpaid work, poorer access to health services, greater financial instability, and a lack of access to assets and limited voice and agency. Indeed, countries cannot build sustainable societies without ensuring equal distribution of opportunities, resources, and choices for both males and females (WBG, 2016a) (IDA, 2017).

3. **The World Bank Group (WBG) has set two goals to achieve by 2030:** "end extreme poverty by decreasing the percentage of people living on less than $1.90 a day to no more than 3 percent"; and "promote shared prosperity by fostering the income growth of the bottom 40 percent for every country" (WBG, 2015). Investing in health is key to achieving these goals. In fact, the WBG's aim in health, nutrition and population is to accelerate progress toward universal health coverage (UHC) – ensuring that by 2030 everyone, including the most vulnerable and marginalized, has equitable access to essential, quality health care, regardless of their ability to pay. Not only does this lead to improved health and longer and more productive lives, but it also translates to higher earnings, longer-term inclusive growth, averted health care costs, and poverty reduction.

4. **To this end, the WBG has been investing heavily in reproductive, maternal, newborn, child, and adolescent health (RMNCAH) and human capital**. Although the WBG Reproductive Health Action Plan (2010-2015) concluded in 2015, the WBG has been undertaking analytical and operational projects that are responding to client country's national and local needs. The WBG provided inputs into the *Global Strategy for Women's, Children's, and Adolescents' Health,* which serves as a roadmap that addresses the health challenges facing women, children, and adolescents. Within this frame, a new WBG

Women's, Children's, and Adolescents' Health Action Plan will provide an innovative and transformational framework for WBG teams to operationalize both the Global Strategy and twin goals and achieve the SDGs. It would complement the Global Financing Facility (GFF), the multi-stakeholder public-private financing partnership platform, in support of the *Global Strategy for Women's, Children's, and Adolescents' Health*, that operates in 62 high-burden low-and lower-middle income countries, by responding to the varying levels of need and filling in gaps where the GFF is not operational. In addition, the new, inclusive WBG Health Action Plan will provide an opportunity to address other critical issues such as women's cancers and GBV.

5. **The objectives of this discussion paper are to explore the advances made** in MCH over the past twenty-five years, examine factors that influence RMNCAH, and provide a broad analysis of the WBG response to RMNCAH while advancing the sustainable development agenda.

PART II– MATERNAL HEALTH

Key Findings

- In examining trends (1990-2015) and current rates of maternal mortality by region and subregion, Africa has the highest MMR, with Sierra Leone, Central African Republic, and Chad registering the highest rates in the world.
- Five countries have experienced an increase in their MMR since 1990: Guyana, Jamaica, Suriname, Tonga, and North Korea.
- To reach SDG Target 3.1 by 2030, the global MMR must decrease by 7.5 percent per year. The global MMR decreased by 2.4 percent per year over the last 25 years.
- When looking at national average rates of maternal mortality and skilled birth attendance with primary school enrolment and completion, the evidence is mixed.

6. **According to the most recent estimates by the WHO et al (2016), globally, the maternal mortality ratio (MMR)[*] has decreased by 44 percent over the past 25 years (1990-2015) with an average annual rate of reduction of 2.4 percent**. However, the MMR varies at regional, subregional, and country levels, as illustrated in Table 1.1 (highlighting selected countries with the highest MMR per sub-region, classified according to the United Nations macro geographical regions and subregions) (UNDESA, 2016). Africa has the highest regional MMR with Sierra Leone having the highest MMR in the world (1,360 maternal deaths per 100,000 live births), followed by the Central African Republic (882 maternal deaths per 100,000 live births) and Chad (856 maternal deaths per 100,000 live births). Moreover, on progress made towards MDG 5A, most African countries made no or insufficient progress in reducing their MMR by 75 percent from 1990 to 2015. At the same time, the MMRs in Guyana, Jamaica, Suriname, Tonga, and North Korea are reported to have increased since 1990. In contrast, three countries in Asia: Timor-Leste, Lao People's Democratic Republic, and Mongolia have achieved the MDG5A target of reducing their national MMR by 75 percent (Table 1.1).

7. **In 2015, the adult lifetime risk of maternal mortality for women living in sub-Saharan Africa was estimated at 1 in 36** (1 in 17 in Sierra Leone and 1 in 18 in Chad); for women in fragile states, the lifetime risk was estimated at 1 in 54. By comparison, the global average was estimated at 1 in 180 and developed countries reported an adult lifetime risk of 1 in 4900 (WHO, 2015a).

8. **Greater investments need to be made in maternal health in order to achieve SDG target 3.1 (reduce the global maternal mortality ratio to less than 70 per 100,000 live births) and avert this largely preventable cause of death**. The global MMR decreased by 2.4 percent per year over the past 25 years, yet in order to reach the goal of 70 deaths per 100,000 live births by 2030, the global MMR must decrease by 7.5 percent per year (WHO, 2015a). According to the WHO, in order to do that no country should have an MMR greater than 140 maternal deaths per 100,000 live births (WHO, 2015b). For countries like

[*] Maternal mortality ratio is defined as the "annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of duration and site of the pregnancy, expressed per 100,000 live births, for a specified time period" (WHO, 2015c).

Sierra Leone, this would require an annual percent decrease in the MMR of 14.1 percent between 2016 and 2030. Currently the annual percent decrease is at 2.7 percent.

9. **Of the five countries that experienced an increase in MMR, three–Guyana, Jamaica, and Suriname–are in Latin America and the Caribbean (LAC)**. In fact, despite the region experiencing significant economic growth over the past 25 years, maternal mortality continues to lag behind other regions. In looking at the percent decline in the highest burden countries in LAC in comparison to other regions, the MMR has declined at a slower pace than other regions. This points to the inequities that exist in the Region between and within countries, with averages masking enormous inequalities as those that need health care the most do not have adequate access or coverage.

10. **There are extensive social and economic development consequences related with maternal mortality.** Maternal death is associated with greater financial instability, due to the health care and funeral costs, as well as the loss of income. Newborns that survive childbirth when the mother dies have a lower likelihood of surviving the first 60 days of life. Moreover, surviving children face nutritional deficits and are less likely to access health care services. Families may be unable to pay for children's school fees, or the child may have to work on the family land, thus leading to a loss of education. At the same time, older children may drop out of school to take care of younger siblings (Belizan and Miller, 2015).

11. **Evidence illustrates that maternal deaths can largely be prevented by ensuring that the pregnant mother has access to antenatal care (ANC) services in pregnancy, skilled care during childbirth, and postpartum care in the weeks following childbirth**. Skilled birth attendance (access to care by a doctor, nurse, or midwife) is a critical component of care, as maternal deaths generally occur due to a lack of timely management and treatment of bleeding and infection (Bhalotra and Clarke, 2013). Table 1.1 illustrates that when examining national MMR average rates with skilled attendance at birth, evidence was mixed. For example, although Timor-Leste and Lao PDR achieved their MDG target, skilled birth attendance was low (at 30 and 42 percent, respectively). Meanwhile, Sierra Leone and Central African Republic reported skilled birth attendance at 60 percent and 54 percent respectively. This may illustrate the influence of other determinants on MMR, the quality of the health care provision, as well as inequalities at the subnational level that are masked by national level averages.

12. **Oftentimes, women's access to skilled health care is constrained due to demand- and supply-side factors.** On the demand side, this is associated with poverty, limited mobility, gender norms, religious and cultural practices, and lack of/limited knowledge about maternal health and pregnancy care. There also might be a preference for sons, which leads to higher infant and child mortality. On the supply side, women's lack of access to skilled birth care is associated with a lack of available and accessible health services, a breakdown in the health care system to detect at-risk pregnancies, which is associated with a lack of quality health care services (WBG, 2016a).

13. **Importantly, inequalities in maternal health care persist among vulnerable groups,** including indigenous populations, adolescents, those living in poor and remote areas, areas with low levels of skilled health workers, and those with limited or no education (WHO, 2016c). The section below explores the association between MMR and skilled birth attendance with maternal primary school enrolment and completion.

EDUCATION

14. **Studies have shown that education has a beneficial effect on maternal health, as educated women are more likely to delay marriage, use contraception, and choose when they want to give birth in comparison to their counterparts with no education.** Educated women have greater opportunities for improved health through increased income and resources, social benefits, and have a higher likelihood of healthy behaviors. (Adam et al, 2012; Bishai et al, 2014; Caramani and Eugster, 2014; Frost and Pratt, 2014; E4A et al, 2014; Luthra, 2007). According to UNESCO (2013), if all women completed primary school worldwide, there would be a 66 percent decrease in maternal deaths. In fact, in Sub-Saharan Africa alone, maternal deaths would decrease by 70 percent if this were the case (UNESCO, 2013). According to the United Nations (2015) progress report on MDG 2 (achieve universal primary education), Sub-Saharan Africa was the only subregion that experienced moderate progress in primary school enrolment, whereas all other regions made good progress or achieved their enrolment target (UN, 2015).

15. **SDG 4 focuses on quality education, with target 4.1 aiming to ensure that all girls and boys complete free, equitable and quality primary and secondary school**. As can be seen in Table 1.1, among the countries with the highest MMR for each of the UN geographical subregions, the top three female adjusted primary school net enrolment rates were Nicaragua (99.7 percent), Timor-Leste (99.4 percent), and Morocco (98.8 percent), well above the global average of 90.3 percent. Timor-Leste also achieved its MDG 5 goal of reducing its MMR by three-quarters; Morocco made some progress but Nicaragua made no progress. In contrast, the countries with the lowest female net enrolment rates, that is, South Sudan (33.7 percent), Liberia (37.1 percent), and Sudan (56.1 percent), also had high MMR in 2015 at 789, 725 and 311 maternal deaths per 100,000 live births respectively. Nevertheless, Sierra Leone had the highest MMR burden globally and yet had a high female primary school net enrolment rate at 98.7 percent.

16. **Similarly, the relationship between education and births attended by skilled health staff was mixed. Among the three countries in table 1.1 with the lowest female net enrolment rates, South Sudan and Sudan also had a low percentage of births attended by skilled health staff** (at 19 and 23 percent respectively) but in Liberia births attended by skilled health staff was estimated at 61 percent. Morocco and Nicaragua had high female adjusted primary school net enrolment rates and high births attended by skilled health staff (at 74 and 88 percent respectively) while in Timor-Leste births attended by skilled staff was 30 percent.

17. **The two countries with the highest female primary school completion rate Kiribati (119.8 percent) and Ukraine (111.6 percent) also had low MMR** (at 90 and 24 maternal deaths per 100,000 live birth respectively) and high percentage of births attended by skilled health staff (at 80 and 99.6 percent respectively).

18. **Globally, there were 23 countries that had a female primary school net enrolment rate above the global average while eleven countries had a female primary school completion rate above 100 percent**. Meanwhile, 17 countries had a completion rate that was lower than the net enrolment rate, demonstrating that greater investments need to be made in keeping girls in school, particularly as the primary school completion rate is also the gross intake rate and includes girls that are over- and under-aged.

19. **Overall, the data illustrate that some countries are advancing towards 100 percent female enrolment**. Of the 49 selected countries, 17 reported a net enrolment rate[†] above 95 percent, while 26 had a female enrolment rate below the global average. At the same time, primary school completion[‡] does not fair better: twelve countries had over 100 percent female primary school completion, while 18 countries had a rate over 75 percent. This is particularly important for the African region, as only 2 countries had a female primary school completion rate above 100 percent and 3 countries had the lowest completion rate among the selected countries.

20. **As to why the relationship between MMR, skilled birth attendance, and primary school enrolment and completion were mixed, there are several possible reasons**. The quality of health care services is critical for maternal health and impacts maternal mortality, regardless of education level (Bhalotra and Clarke, 2013). Furthermore, there is limited evidence on the differentiation between educational inputs, outcomes, participation, and efficiency with MMR and other health-related indicators, requiring further research in this area (Sajedinejad et al., 2015). At the same time, women in developing countries have on average more pregnancies than women in developed countries, increasing their lifetime risk of death due to pregnancy. Therefore, despite having primary education, an additional birth per mother is associated with an increased risk of maternal mortality. Moreover, the association between maternal mortality, fertility, and the prevalence of adolescent births is stronger than the association of either health interventions or education. In addition, education reforms may influence MMR, with evidence from Nigeria illustrating that a reform in the 1970s that expanded schooling years for women led to a decline in the MMR (Bhalotra and Clarke, 2013). This is also related to the quality of education that young women receive. In Ethiopia, for example, women who attended secondary education were more likely to know about the danger signs during pregnancy than those with a lower education (Bililign and Mulatu, 2016). At the same time, potential inequalities at the subnational level could be masking national level averages. Moreover, women's limited decision-making power and constrained resources in some countries may influence her ability to seek health services, contributing to delays in accessing health care, regardless of education level (Ahmed et al., 2010).

21. **Maternal health and neonatal health are intrinsically linked.** The pattern of neonatal deaths is similar to maternal deaths. In 2015, it was estimated that approximately 2.7 million newborn babies died and an additional 2.6 million were stillborn (WHO, 2016b). The next section will explore trends and advances in under-five mortality (U5MR) and neonatal mortality rates (NMR).

[†] Adjusted net enrollment, female (%) provided by WBG World Development Indicators (2016) available between 2000-2015): The number of pupils of the school-age group for primary education, enrolled either in primary or secondary education, expressed as a percentage of the total population in that age group.

[‡] Primary completion rate, female (%) provided by WBG World Development Indicators (2016) available between 2000-2015): Total number of new female entrants in the last grade of primary education, regardless of age, expressed as percentage of the total female population of the theoretical entrance age to the last grade of primary. This indicator is also known as "gross intake rate to the last grade of primary education." The ratio can exceed 100% due to over-aged and under-aged children who enter primary school late/early and/or repeat grades.

Table 1.1 Maternal Mortality Ratio and Female Primary School Enrolment and Completion Rates by Region, Subregion, and Selected Highest MMR Burden Countries*

	Countries	Progress in Maternal Health†	Health					Education		
			Maternal Mortality Ratio (per 100,000 live births)			Percent Average Annual Change in MMR	Births Attended by Skilled Health Staff (%) [a]	Pop of primary school aged girls, female (N)ˇ	Female adjusted net enrolment rate, primary school (%)	Female Primary School Completion (%)
			1990	2000	2015	1990-2015				
Africa										
East Africa	Burundi	Insufficient progress	1,220	954	712	-2.2	60	890,197	96.6	70.3
	Somalia	Insufficient progress	1,210	1,080	732	-2.1	-	885,235	-	-
	South Sudan	Making progress	1,730	1,310	789	-3.2	19	-	**33.7**	**27.0**
Central Africa	Central African Republic	No progress	1,290	1,200	882	-1.6	54	389,948	62.4	34.5
	Chad	Insufficient progress	1,450	1,370	856	-2.2	24	1,142,528	74.1	29.6
	Democratic Republic of Congo	No progress	879	874	693	-1.0	80	7,151,957	-	60.0
Southern Africa	Lesotho	No progress	629	649	487	-1.1	78	181,882	82.5	84.9
	Namibia	No progress	338	352	265	-1.0	88	169,902	92.2	89.2
	Swaziland	No progress	635	586	389	-2.0	88	99,225	78.3	79.7
North Africa	Algeria	No progress	216	170	140	-1.8	97	1,644,766	96.4	108.7
	Morocco	Making progress	317	221	121	-3.9	74	1,784,934	98.8	100.9
	Sudan	Making progress	744	544	311	-3.6	23	**3,208,927**	**56.1**	**54.2**
West Africa	**Liberia**	Insufficient progress	1,500	1,270	725	-3.0	61	**445,811**	**37.1**	**54.0**
	Nigeria	No progress	1,350	1,170	814	-2.1	38	13,888,655	60.0	71.6
	Sierra Leone	Insufficient progress	2,630	2,650	1,360	-2.7	60	554,916	98.7	67.6
Asia										
Central Asia	Kyrgyzstan	NA	80	74	76	-0.2	98	205,031	97.5	104.4
	Turkmenistan	NA	82	59	42	-2.7	-	145,003	-	-
	Uzbekistan	NA	54	34	36	-1.7	-	1,124,957	90.7	94.8
Eastern Asia	China	NA	97	58	27	-5.2	100	46,540,526	-	-
	North Korea	**NA**	**75**	**128**	**82**	**0.4**	**100**	582,673	97.0	96.9
	Mongolia	Achieved	186	161	44	-5.8	99	111,420	95.0	108.2
South Central Asia	Afghanistan	Making progress	1,340	1,100	396	-5.0	39	2,821,976	-	-
	Nepal	Making progress	901	548	258	-5.1	56	1,810,168	96.4	111.2
	Pakistan	Making progress	431	306	178	-3.6	52	9,871,167	66.9	67.0
South-Eastern Asia	Lao PDR	Achieved	905	546	197	-6.2	42	354,665	94.3	99.0
	Myanmar	Making progress	453	308	178	-3.8	71	1,984,378	87.3	86.0
	Timor-Leste	Achieved	1,080	694	215	-6.5	30	122,542	99.4	99.9

Western Asia	Jordan	Insufficient progress	110	77	58	-2.6	100	436,998	87.1	86.1
	Syria	Insufficient progress	123	73	68	-2.4	96	1,519,510	70.1	68.6
	Yemen	No progress	547	440	385	-1.5	45	2,259,344	78.2	61.0
Latin America and the Caribbean										
Caribbean	Dominican Republic	Making progress	198	79	92	-3.1	98	650,626	85.3	90.4
	Haiti	No progress	625	505	359	-2.3	37	716,397	-	-
	Jamaica	**NA**	**79**	**89**	**89**	**0.5**	**99**	153,650	93.4	89.1
Central America	Honduras	Making progress	272	133	129	-3.1	83	551,329	95.2	92.7
	Nicaragua	No progress	173	202	150	-0.6	88	390,455	99.7	89.3
	Panama	No progress	102	82	94	-0.3	91	201,825	96.1	101.2
South America	Bolivia	Insufficient progress	425	334	206	-3.0	85	712,042	95.0	101.8
	Guyana	**No progress**	**171**	**210**	**229**	**1.2**	**92**	36,091	83.6	81.5
	Suriname	**No progress**	**127**	**259**	**155**	**0.8**	**91**	24,186	91.8	100.1
Europe										
Eastern Europe	Romania	Making progress	124	51	31	-5.6	99	399,019	91.1	94.5
	Russia	NA	63	57	25	-3.8	100	2,874,738	96.9	100.9
	Ukraine	NA	46	34	24	-2.7	99	802,943	97.6	111.6
Oceania										
Melanesia	Papua New Guinea	Insufficient progress	470	342	215	-3.2	-	592,083	83.6	72.4
	Solomon Islands	Making progress	364	214	114	-4.7	-	40,224	79.3	87.7
	Vanuatu	Making progress	225	144	78	-4.3	89	18,227	-	97.8
Micronesia	Kiribati	Making progress	234	166	90	-3.9	80	7,005	-	119.8
	Micronesia (Federated States)	Insufficient progress	183	153	100	-2.5	100	7,817	88.3	-
Polynesia	Samoa	Making progress	156	93	51	-4.6	83	12,803	98.1	98.1
	Tonga	**NA**	**75**	**97**	**124**	**2.1**	**98**	6,953	98.6	106.4
Global			**385**	**341**	**216**	**-2.4**	**70**		**90.3**	**75.7**

Source: WHO World Health Statistics (2016); WHO, UNICEF, UNFPA, World Bank Group and United Nations Population Division (2015); and World Development Indicators (2016) available (between 2000 and 2015)
Table presents the three countries with the highest MMR in each subregion; highlighted in red, the highest values and in purple/bold, the lowest values or an increase seen over timeframe
*Countries grouped by United Nations macro geographical regions and geographical subregions (2016)
†Progress in maternal health provided by WHO Trends in maternal mortality: 1990 to 2015
[a] Births attended by skilled health staff provided by World Bank Group World Development Indicators (last year available between 2008-2015): Births attended by skilled health staff are the percentage of deliveries attended by personnel trained to give the necessary supervision, care, and advice to women during pregnancy, labor, and the postpartum period; to conduct deliveries on their own; and to care for newborns.
Population of primary school aged girls (N) provided by World Bank Education Statistics Core Indicators (2016) with official school ages for primary school calculated by UNESCO Institute for Statistics; ages vary according to primary school age by country (last year available between 2000 and 2015).

PART III – UNDER-FIVE AND NEONATAL HEALTH

Key Findings

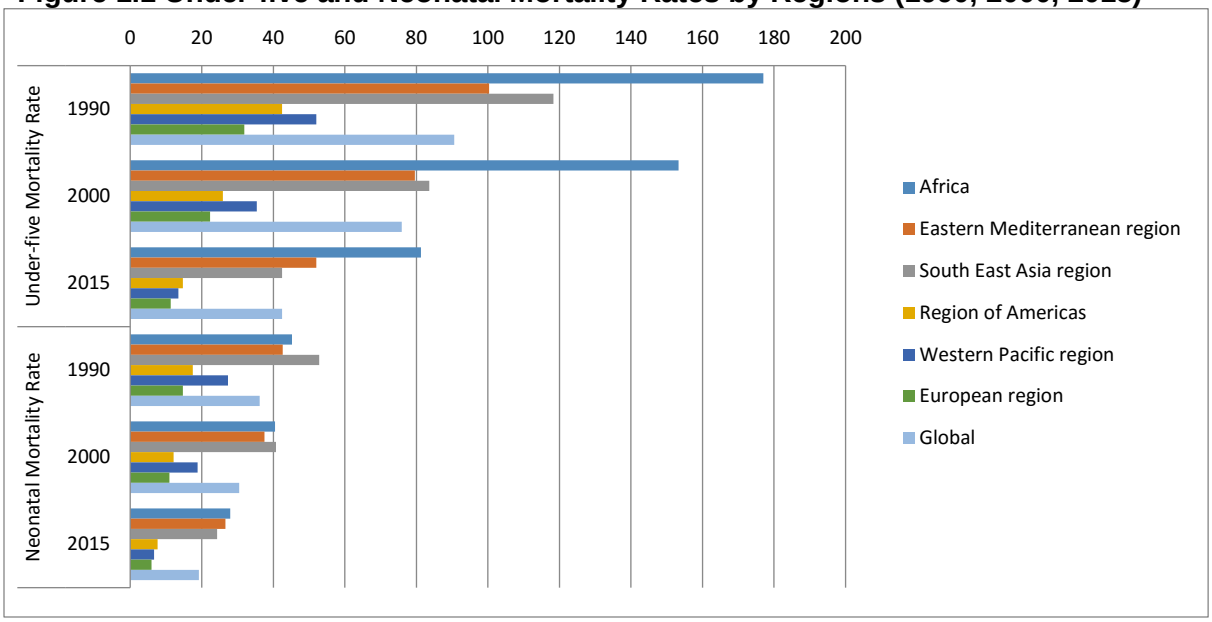
- When examining trends in U5MR, there was an over 50 percent decline in all regions between 1990 and 2015, while the share of neonatal mortality to under-five mortality increased during this time span.
- Dominican Republic, Somalia, and Central African Republic experienced the smallest decline in NMR over the time frame.

22. **At the global level, the U5MR fell by 53.1 percent between 1990 and 2015.** At the same time, there was an over 50 percent decline in U5MR in all of the regions between 1990 and 2015, with the greatest percent decline in the Western Pacific (52 in 1990 to 13.5 per 1,000 live births in 2015), followed by the Americas (42.5 in 1990 to 14.7 per 1,000 live births in 2015), Europe (31.9 in 1990 to 11.3 per 1,000 live births in 2015), South East Asia (118.3 in 1990 to 42.5 per 1,000 live births in 2015), Africa (177 in 1990 to 81.3 per 1,000 live births in 2015), and the Eastern Mediterranean region (100.3 in 1990 to 52 per 1,000 live births in 2015) (WHO, 2016) (figure 1.1).

23. **Target 3.2 states that by 2030, all countries should aim to reduce their neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 35 per 1,000 live births.** While significant progress has been made in reducing U5MR, neonatal mortality remains high (experiencing a 47 percent decline over the past 25 years). In fact, as the under-five mortality decreased, the share of neonatal mortality to under-five deaths increased over the past 25 years, with neonatal mortality representing more than 50 percent of under-five deaths globally and in all regions except Africa and the Western Pacific. The region that experienced the greatest percent decline over the time frame was the Western Pacific region (27.3 in 1990 to 6.7 per 1,000 live births in 2015), followed by Europe (14.7 in 1990 to 6.0 per 1,000 live births in 2015), the Americas, South East Asia, the Eastern Mediterranean region, and Africa (WHO, 2016).

24. **At the country level, Timor-Leste experienced the greatest decline in U5MR at 70.1 percent, followed by Bolivia (69.1 percent), and India (62.1 percent) between 1990 and 2015.** In contrast, Somalia, Central African Republic, and Angola experienced the smallest decline in U5MR over the time period. Neonatal mortality did not experience as great of a decline as under-five mortality. Bangladesh experienced the greatest decline in NMR at 63.1 percent, followed by Azerbaijan (49.3 percent), and Lao (50.0 percent). Meanwhile, the Dominican Republic, Somalia, and the Central African Republic experienced the smallest declines in NMR over the time frame (table 2.1) (WHO, 2016).

Figure 1.1 Under-five and Neonatal Mortality Rates by Regions (1990, 2000, 2015)



Source: WHO World Health Statistics (2016)

Table 2.1 Under-Five Mortality Rate and Neonatal Mortality Rate by Region and Selected Countries (1990 and 2015)

Region and Countries	Under-five Mortality Rate (per 1,000 live births)		Region and Countries	Neonatal Mortality Rate (per 1,000 live births)	
	1990	**2015**		**1990**	**2015**
Africa	177.0	81.3	***Africa***	45.2	28.0
Angola	226.0	156.9	Angola	59.0	48.7
Chad	214.6	138.7	Central African Republic	51.3	42.6
Central African Republic	176.5	130.1	Guinea-Bissau	65.4	39.7
Eastern Mediterranean	100.3	52.0	***Eastern Mediterranean***	42.6	26.6
Somalia	180.2	136.8	Pakistan	64.3	45.5
Afghanistan	181	91.1	Somalia	45.1	39.7
Pakistan	138.6	81.1	Afghanistan	52.8	35.5
South-East Asia	118.3	42.5	***South-East Asia***	52.8	24.3
Timor-Leste	175.7	52.6	India	57.4	27.7
Myanmar	109.9	50	Myanmar	40.6	26.4
India	125.8	47.7	Bangladesh	63.4	23.3
Americas	42.5	14.7	***Americas***	17.5	7.7
Haiti	145.8	69	Haiti	39.2	25.4
Guyana	60.4	39.4	Guyana	30.1	22.8
Bolivia	124.4	38.4	Dominican Republic	24.6	21.7
Western Pacific	52	13.5	***Western Pacific***	27.3	6.7
Lao	162.4	66.7	Lao	54.7	30.1
Papua New Guinea	89.4	57.3	Papua New Guinea	31.8	24.5

Kiribati	96.0	55.9	Kiribati	36.1	23.7
Europe	31.9	11.3	***Europe***	14.7	6
Turkmenistan	90.5	51.4	Turkmenistan	30.1	22.6
Tajikistan	108.4	44.8	Tajikistan	32.3	20.5
Uzbekistan	71.5	39.1	Azerbaijan	35.9	18.2
Global	**90.6**	**42.5**	**Global**	**36.2**	**19.2**

Source: WHO World Health Statistics (2016)

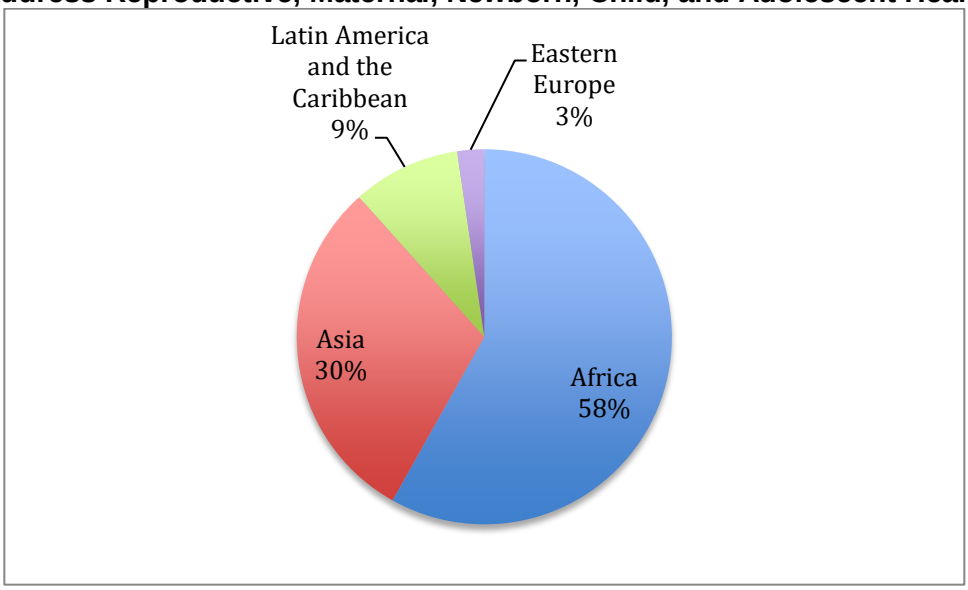
25. **Evidence has found an association between parental education and better cognitive development of the child** (Smith et al, 1997; Guo and Harris, 2000; Aughinbaugh and Gittleman, 2003; Baum, 2003; Ruhm, 2004; Paxson and Schady, 2005; Taylor et al, 2004). In a study by Paxson and Schady (2005), in households where the parents completed secondary education, older children's cognitive development was higher than younger children. In poorer households where parents had limited/no education, the child's cognitive development was underdeveloped. Indeed, children from poorer households are less likely to go to school and gain the knowledge and skills they need to join the workforce, leading to lower income in adulthood, which influences the next generation's cognitive skills (Paxson and Schady, 2005).

PART IV – WORLD BANK GROUP'S RESPONSE

WORLD BANK GROUP'S INVESTMENTS IN MATERNAL AND CHILD HEALTH

26. **In May of 2017, the WBG had 86 active projects that included components or activities to improve the health of mothers and children, and contributed directly or indirectly to the reduction of maternal and child mortality and morbidity**. As shown in table 3.1, most health projects with RMNCAH activities are implemented in Africa, with an estimated 58 percent of WBG RMNCAH projects implemented in this region. This is followed by Asia with 30 percent of the RMNCAH projects, Latin America and the Caribbean (9 percent), and Eastern Europe (2 percent). Within Africa, most RMNCAH projects are implemented in West Africa (42 percent), followed by East Africa (38 percent), Central Africa (14 percent), Southern Africa (4 percent), and North Africa (2 percent). However, more operational investments are needed in countries that have a high burden of maternal, under-five, and neonatal mortality, including Somalia, Sudan, and Namibia, where there are currently no active projects. There should also be greater investments in countries in other regions including Afghanistan and the countries of Western Asia where recent political insecurity has resulted in large populations of internally displaced persons (IDPs) and refugees; as well as LAC, where there are nine active MCH projects in the entire region, despite experiencing an increase in MMR in three of its countries, two of which have no active projects.

Figure 1.2 Active World Bank Group Projects with Components or Activities that Address Reproductive, Maternal, Newborn, Child, and Adolescent Health



Source: Based on authors' calculation of WBG Portfolio

27. **Most projects are in the Health, Nutrition and Population (HNP) sector (74 projects), followed by Social Protection and Labor** (7 projects), Agriculture (2 projects), Social, Urban, Rural & Resilience (1 project), Education (1 project), and Water (1 project). The majority (66 projects) support antenatal care and delivery services, followed by 48 projects on children under 5 years of age, 48 projects on family planning, and 38 projects on

postnatal services. It should be noted that there were few projects (9 projects) that specifically addressed cervical cancer prevention, pointing to an area of greater investment at the WBG.

28. **Among the most significant instruments and initiatives implemented by the WBG are the GFF in support of the *Global Strategy for Women's, Children's and Adolescents' Health***, which aims to provide smart, scaled-up, and sustainable RMNCAH and nutrition (RMNCAH-N) financing. Each country spearheads the process by providing a set of prioritized RMNCAH-N issues that they would like to see improvements on and the investments needed to achieve those results, as outlined in an Investment Case. The GFF's objective is to close the financing gap in RMNCAH-N, using "evidence-based, high-impact interventions that equitably reduce morbidity and mortality while progressively realizing the rights of women, children, and adolescents, and broader health-system issues, such as governance and supply chain management, and the extent to which investments in non-health sectors may positively impact RMNCAH-N results." The process is done in collaboration with RMNCAH-N stakeholders[§], and resources are mobilized through "current financing and by attracting additional resources through multiple sources". At the same time, the GFF Trust Fund leverages WBG financing to the poorest countries: "existing World Bank Group procedures determine the allocation of International Development Association/ International Bank of Reconstruction and Development (IDA/IBRD) financing to countries, and each government determines how its IDA/IBRD resources are allocated among different national priorities in its development agenda." (GFF, 2017a) To date, 8 countries have completed the Investment Case process and 4 others have nearly completed the process.

    Furthermore, "as of May 2017, WBG projects have been approved in 9 countries, totaling almost $1.2 billion in concessional financing and $292 million in grant resources from the GFF Trust Fund. Nine other projects are under preparation, totaling approximately $1.3 billion in concessional financing and $122 million from the GFF Trust Fund. More than $125 million of IDA/GFF Trust Fund financing has been disbursed as of May 1, 2017and the disbursements are on track and are expected to be over $200 million by the end of 2017, and more than $500 million by the end of 2018." In total, 16 countries are actively part of the GFF (Bangladesh, Cameroon, Democratic Republic of Congo, Ethiopia, Guatemala, Guinea, Kenya, Liberia, Mozambique, Myanmar, Nigeria, Senegal, Sierra Leone, Tanzania, Uganda, and Vietnam). Tanzania is already exhibiting promising results from the program. After a year of implementation, "the availability of 10 tracer medicines increased from 30 to 46 percent; the number of pregnant women receiving two doses of intermittent preventive therapy improved from 34 to 57 percent; and the number of women receiving iron and folic acid increased from 56 to 67 percent (WBG, 2017b). The WBG has also implemented the Sahel Women's Empowerment and Demographic Dividend Project (SWEDD), which aims to empower women and adolescent girls and increase their access to reproductive, maternal, newborn, and child health services (RMNCH) in Burkina Faso, Chad, Cote d'Ivoire, Mali, Mauritania, and Niger; the Program to Support Saving One Million Lives in Nigeria, which aims to increase the utilization and quality of high

[§] Stakeholders include the WBG; UN agencies; the Partnership for Maternal, Newborn, Child and Adolescent Health (PMNCH); Gavi, the Vaccine Alliance; the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund); the Bill & Melinda Gates Foundation; bilateral donors, private sector partners including MSD for Mothers, and a wide range of civil society organizations

impact reproductive, child health, and nutrition interventions; and the Income Support Program for the Poorest Project in Bangladesh, which provides income support to the poorest mothers in selected Upazilas (or boroughs) in order to increase mothers' use of child nutrition and cognitive development services and enhance local level government capacity to delivery safety nets.

REPRODUCTIVE HEALTH ACTION PLAN (2010-2015)

29. **The most recent *Reproductive Health Action Plan (RHAP) (2010-2015)* was concluded in 2015.** It aimed to improve reproductive health in 57 high MMR and total fertility rate (TFR) burden countries[**], by focusing on improving reproductive health outcomes through health system strengthening and leveraging partnerships with governments, civil society organizations (CSOs), academia, and bilateral and multilateral organizations. Thus, sexual and reproductive health (SRH) was reflected more prominently in the Bank's lending and technical assistance. Between 2009 and 2014, the Bank committed USD $5 billion for MDGs 4&5 (with $3.03 billion committed to child health and $1.99 billion for reproductive health) through IDA and IBRD funding and health systems contributions, excluding funding from the Health Results Innovation Trust Fund (HRITF). High-burden regions, as well as middle-income countries with a need to invest in women and children, were the focus with $1.1 billion invested in Africa, $1.2 billion in South Asia, and $1.5 billion in Latin America. As a result, there was an increased proportion of poor women with access to lifesaving antenatal and postnatal care, safe births, and family planning services. The Bank also increased its support for reproductive, maternal, newborn, and adolescent health (RMNAH) in December of 2014 with USD $170.20 million in IDA funds[††] for women and girls in the Sahel (in commitment to the *Regional Initiative in the Sahel*); and in 2015 an additional $641 million in IDA for results-based financing focusing on MDGs 4 and 5 (in commitment to *The Global Strategy for Women's Children's and Adolescents Health 2016-2030*) excluding HRITF funds (WBG, 2014; WBG, 2015b).

30. **Through the previous RHAP, the Bank supported countries by prioritizing key RMNCAH interventions** in the following regions with specific successful country examples:
    a. In *South Asia*, the Bank supported efforts to improve adolescent SRH, skilled birth attendance, neonatal health, and nutrition. For example, through the Karnataka Health System Reform and Development project, 86 percent of births were delivered in a health facility, 78 percent of children were fully immunized, and 89 percent of primary health care facilities had a functional labor room.
    b. In *Africa*, the Bank supported innovative financing for MCH programs, analytical work on the demographic dividend to place population at the center of economic development, and global partnerships for enhancing nutrition innovations to improve MCH outcomes. For example, through the Burundi Health Sector Development Support project, there was a 25 percent increase in facility-based births, 20 percent increase in prenatal consultations, 35

[**] Twelve of those countries by 2014 had progressed out of the high MMR and high TFR category, bringing the number of high MMR and high TFR to 45 countries.

[††] Operations portal consulted on 11 September 2017

percent increase in curative care consultations for pregnant women, and 27 percent increase in family planning services obtained through health facilities. Through the Burkina Faso Reproductive Health Project, contraceptive prevalence more than doubled from 15 percent to 33 percent, and skilled assistance at delivery increased from 67 percent to 82 percent.

c. In the *Middle East and North Africa*, the Bank supported efforts to emphasize accountability and equity in its approach to MDGs 4&5;
d. In *Latin America and the Caribbean*, the Bank supported innovative financing mechanisms to protect the lives of mothers and newborns, the prioritization and prevention of neonatal mortality and teen pregnancy, as well as improving quality of care. For example, through Plan Nacer in Argentina, more than one million previously uninsured pregnant women and children were given basic health insurance and secure access to services. This led to a decrease in stillbirths, low birth weight babies, and in-hospital neonatal deaths. Furthermore, there was a 65.7 percent increase among pregnant women receiving their first ANC visit before the 20th week of pregnancy. The Family and Community Project in Nicaragua increased the percentage of individuals with access to basic preventive and promotional health and nutrition services by 127 percent, the percentage of first-time consultations by 26 percent, and follow-up health care consultations by 74 percent. Also, adolescent pregnancies decreased by 22 percent in the 32 municipalities of the project.
e. In *East Asia and the Pacific*, the Bank supported countries to reach remote populations to overcome both demand- and supply-side barriers to health services. For example, through the Second Health Sector Support Program in Cambodia, the percentage of children immunized increased from 60 to 75 percent between 2007 and 2011, and there was an increase in pregnant women receiving ANC (from 68 to 74 percent between 2009 and 2011).
f. In *Central Asia*, the focus was on improving the quality of care to address MCH. For example, through the *Family Medicine* assessment in Turkey, the country experienced significant improvements in key health outcomes around the introduction of the program. The infant mortality rate (IMR) fell from 28.5 deaths per 1,000 live births in 2003 to 10.1 deaths per 1,000 live births by 2010 at the national level with substantial narrowing of regional disparities. The MMR fell from 61 deaths per 100,000 live births in 2003 to 16.4 deaths in 2010.

TOWARDS A WORLD BANK GROUP'S NEW, INCLUSIVE HEALTH ACTION PLAN

31. **The WBG currently does not have a Health Action Plan.** To support and complement the implementation of the recently launched *World Bank Group Gender Strategy (2016-2023): Gender equality, poverty reduction and inclusive growth* and to assist client countries in making progress towards the SDG targets 3.1 (reducing MMR), 3.2 (reducing U5MR), and 3.7 (universal access to sexual and reproductive health-care services) the WBG should develop a new, inclusive Women's, Children's, and Adolescents' Health Action Plan (2017-2023). This plan should address women's, children's, adolescents', and men's health and the gaps in RMNCAH investments, especially in areas where the GFF is not operational or the supply does not meet the growing demand, working towards the achievement of the WBG's goals of poverty reduction and shared prosperity. It should reflect support to the *Global Strategy for Women's, Children's, and Adolescents' Health*. Building upon the lessons learned from the previous RHAP, the new Action plan should include:

a. Scaling up the most effective ways to incentivize much needed supply and demand approaches for women's, children's, adolescents', and men's health (including RMNCAH) and addressing issues of behavior especially demand and supply at the country level;
b. Delivering on the continued need to strengthen country-level capacity while leveraging analytical support, policy dialogue, financial support, and strategic partnerships (including the private sector);
c. Ensuring full leverage of the WBG's multi-sectoral advantage by investing in multi-sectoral approaches to improve women's, children's, adolescents', and men's health and women's empowerment, working with government ministries, and strategic partners to improve results;
d. Reaching the poorest and the most vulnerable populations, including adolescents and youth, to facilitate their access to health services and promote universal coverage of health services.

32. **Importantly, the Bank's new, inclusive Health Action Plan will focus not only on improving the health of populations in low-income countries, but also those in middle-income countries that face a "middle income trap" and reach those affected by inequalities in health**. That is when countries experience constrained development prospects and are not eligible to receive significant external financing and aid from donors and the international development community. This inhibits the opportunities that vulnerable populations, such as women, adolescents, and children, those living in the poorest income quintile, ethnic minority communities, those living in rural areas, and those with no or limited education, would have in accessing quality social and economic services creating inequalities.

33. **The new Action Plan should focus on hard to reach and marginalized populations, especially adolescents (10-19 years of age).** Representing 1.2 billion people (or 1 in 6 individuals) in the world today, most of the world's adolescents are growing up in low-and middle-income countries. The exposures and experiences during this stage of life lay the foundations for future health, education, and employability, influencing the social and economic development of a country. Although not a focus of the current report, adolescents will be explored in a forthcoming report on adolescent health at the global and LAC regional levels.

34. **At the same time, internally displaced persons (IDPs) and refugees should be targeted** as they are among the most vulnerable of the poor and a focus of IDA18. In fact, 65 million people today are reportedly displaced (representing approximately 1 percent of the world's population), including 21 million refugees many of whom have been driven by their homes due to conflict and violence. According to a report by the WBG (2017c), there are an estimated 24 million refugees and asylum-seekers and approximately 41 million IDPs globally, although these numbers could be much higher as the availability and quality of data on forced displacement is limited. There is a need to strengthen data collection and dissemination mechanisms at all levels. Furthermore, the delivery of health services to forcibly displaced persons may be underfunded, overwhelmed, and stretched, creating a shortage of health providers and medical supplies, worsening quality of care. The spread of disease is also a potential danger. Accommodating forcibly displaced persons requires scaling up health service supply. In alignment with IDA18, the new Action Plan can help build capacity and finance infrastructure and operations and maintenance expenditure in the short term, while developing an adequate system that can be sustained in the medium term (WBG, 2017c).

35. **The WBG should continue to build upon interventions that bridge the gap in access to quality services, including RMNCAH services.** This would include supporting countries to invest in multi-sectoral interventions that address demand and supply side service delivery barriers (including the development of alternative modes of delivery through the community health workforce), health financing, and governance. Furthermore, to develop a better understanding of what works, continued emphasis should be placed on developing and implementing monitoring systems and conducting impact evaluations (WBG, 2016a; IHP, 2017).

    a. *Multi-sectoral Service Delivery.* According to the previous RHAP, the aim would be to double the proportion of poor people in developing countries that have access to basic services (that is, immunization of children or skilled health personnel available at childbirth), from 40 percent in 2014 to 80 percent by 2030. In addition, by 2030, 80 percent of the poor should have access to other essential health services (for example, treatment for high blood pressure, diabetes, mental health, and injuries). To achieve these targets the following activities should be considered for the new Action Plan:

        i. Invest in skilled community and primary health workers, as this will ensure better outreach, follow-up, and early detection and prevention of poor health outcomes, particularly among vulnerable population groups. Recent evidence indicates that by 2030, there will be a needs-based gap of skilled health professionals of 10.1 million, of which there will be a deficit of 3.7 million health workers in sub-Saharan Africa (IDA, 2017). By investing in skilled health care providers, this would also provide employment opportunities for women and unemployed youth (WBG, 2016a).
        ii. Improve the quality of health services and patient safety
        iii. Measure access to medicines and health technologies
        iv. Engage patients in the service delivery process
        v. Engage non-state providers in the provision of services

    b. *Health Financing* determines the health systems ability to operate efficiently and equitably, to respond to the needs of women, children, adolescents and men, and spread financial risk. In supporting, functioning health financing arrangements, the new Action Plan should consider the following activities:

        i. Promote efforts to mobilize resources for health, including RMNCAH, through progressive taxation and prioritization of health while promoting the efficient use of those resources.
        ii. Expand pooling arrangements to improve financial protection for all. According to the previous RHAP, the aim would be that by 2020, there would be a 50 percent reduction in the number of impoverished people due to out-of-pocket (OOP) health care expenses, and by 2030, no one would fall into poverty because of OOP health care expenses. To achieve this target, this would require moving 100 million impoverished people every year in 2014 to 50 million by 2020 and to 0 by 2030.
        iii. Strategic purchasing of services to increase health spending efficiency

c. *Governance*, particularly good governance, is critical for all health systems. The new Action Plan could support good governance of health services by promoting the following:

    i. Strengthen strategic information systems, surveys and censuses, and the quality of data. This would also allow for accurately tracking the elimination of inequities in health outcomes, including MMR, U5MR, and NMR between and among subpopulations within all countries. It would include ensuring that countries have well-functioning civil registration and vital statistics (CRVS) systems so that all births and deaths are counted and vital statistics are generated, disaggregated by equity stratifiers.
    ii. Promote efforts to ensure data is free and accessible to all
    iii. Support the development of intersectoral health platforms
    iv. Develop platforms for women and children's voices
    v. Support countries to adopt legal and legislative frameworks that support access to quality health services
    vi. Engage global partners in improving the health of women, children, adolescent, and men

36. **The Bank's new Action Plan will support all 189 WBG client countries across their varying levels of need,** and include and coordinate with all the existing WBG instruments, areas, and strategies. This includes the GFF, the Gender Strategy, CRVS, FCV, and the Population and Development Global Solutions Area (P&D GSA). The P&D GSA aims to support countries in influencing their demographic transition and its impact on UHC, poverty, and inequality through health sector reform, accumulation of human capital, and accurate measurement and identification of the population. There are two main (interrelated) areas: (i) demographic change, health, and development; and (ii) measurement. Current priorities for the P&D GSA include: ageing and health, gender in health, adolescents, the demographic transition, and RMNCAH in crisis situations. The P&D GSA supports operational work, cultivates internal and external partnerships, promotes knowledge and learning, and cross GP collaboration (WBG, 2017a). Furthermore, the P&D GSA is also leading the work to ensure that all operations with funding from IDA18 for maternal and reproductive health target improving the availability of reproductive health services, including for survivors of GBV. Furthermore, the P&D GSA is also contributing towards ensuring that all applicable operations with funding from IDA18 for primary and secondary education will address gender-based disparities, as well as, that three out of every four operations for skills operations funded under IDA18 have considered how to support women's participation in and improvement in the productivity of their economic activity, and/or will have considered how to reduce occupational segregation.

37. **In fact, the new Action Plan will align well with IDA18 commitments, as all financing operations for maternal and reproductive health will target improving the availability and affordability of reproductive health services**. There are three IDA indicators that specifically address SRH, including: MMR; adolescent fertility rate; and the contraceptive prevalence by modern methods. Financing operations will also target primary and secondary education to address gender-based disparities, by incentivizing enrolment, attendance, and retention of girls. Also, IDA will be monitoring lower secondary gross completion rate and lower secondary enrolment rate (IDA, 2017).

38. **Services that focus on mental health, non-communicable diseases such as breast and cervical cancers, high blood pressure, diabetes, and dementia should also be prioritized** in the new Action Plan. This is particularly important not only for women of reproductive age, but also older women, as they are less likely to receive proper health care, due in part to lack of empowerment, greater financial vulnerability, and uneven labor force participation (WBG, 2016a).

39. **There has been progress in closing health and education gaps between men and women over the past two decades, yet critical gaps persist in women and girls' voice and agency**[‡‡] **and economic opportunities**. Key voice and agency issues include limited control and voice over household resources, fertility, and decision-making, and exposure to GBV, among others. Indeed, at the global level approximately one-third of women have experienced physical or sexual violence, although this number may not illustrate the real extent of GBV, as 6 in 10 women state that they have never sought help or reported violence to anyone. Health services are an important point of entry for both responding to the needs of GBV survivors and for preventing further violence and poor physical and mental health outcomes. To this end, the Bank's new Action Plan should support integrated health care and counseling services for GBV survivors, strengthen referrals for legal assistance and economic support, promote the collection of data on GBV in order to build the evidence, and promote advocacy efforts on these issues (WBG, 2016a).

40. **There has been an increase in gender-informed projects at the WBG.** Between July 2016 and June 2017, 58 percent of projects were gender-informed. Most of these were in Africa, followed by East Asia and the Pacific, South Asia, LAC, Eastern Europe and Central Asia, and the Middle East and North Africa. The majority of gender-informed projects were carried out in Social, Urban, Rural and Resilience, followed by Agriculture, Transport and ICT, and Energy and Extractives. Addressing gender disparities and closing these gaps is critical towards developing human capital. It leads to more positive norms and gender expectations about female and male roles, changed power relations, and increased peace and security (WBG, 2016a). The implementation of the Gender Strategy ensures ongoing efforts towards the inclusion of gender approaches in a more diverse spectrum of Bank Projects.

41. **The WBG should continue to invest in early childhood development programs (ECD), ensuring the provision of affordable care and education** in limited resource settings. Evidence has found that this leads to better physical development, stronger cognitive, language, and socioemotional development, and overall better school preparedness (WBG, 2016a). In addition, further research on the association between education and maternal health outcomes should be conducted to inform targeted multisectoral investments in health and education.

42. **At the same time, the Action Plan should promote the generation of evidence to understand the multi-sectoral links** between maternal health, education, and other social and economic factors that influence maternal death. Moreover, the plan should promote the generation of evidence to understand how the changes in population demographics and global disease burden will impact MCH risks.

[‡‡] Agency is defined as the ability to make decisions about one's own life and act on them to achieve desire outcomes (WBG, 2016a)

43. **The results framework for a new Health Action Plan should draw on internationally agreed indicators such as the SDG indicators, the WBG IDA results measurement system indicators, the Corporate Results Indicators (CRI), the Global Financing Facility Core Indicators, and Indicators for the Global Strategy for Women's, Children's, and Adolescents' Health (see Annex I).** The data collected should be disaggregated, where relevant, by income, sex, age, race, ethnicity, geographic location, religion, and disability, among other equity stratifiers. Indicators that should be considered for the Health Action Plan could be on the following themes: health status indicators (for example, MMR, U5MR, NMR, adolescent fertility rate); risk factor indicators (condom use at last sex with high-risk partner, intimate partner violence prevalence, anemia prevalence in children); service coverage indicators (vitamin A supplementation coverage, demand for family planning satisfied with modern methods, births attended by skilled health personnel); and health system indicators (OOP health expenditure as percentage of total health expenditure, birth registration coverage, death registration coverage).

Table 3.1 World Bank Group Active Investments in Reproductive, Maternal, Neonatal, and Child, and Adolescent Health by Region, Subregion, and Country from 2006 to Present

Region/ Subregion	Country	Name of Project	Duration of Project		Maternal and Child Health						
			Begins	Ends	Pregnancy (ANC and delivery)	Institutional Births	Postnatal	FP	Cervical Cancer Prevention	Children <2 years	Children <5 years
Africa											
	Burundi	1. Health Sector Development Support	2009	2017	X			X			X
		2. Maternal Child Nutrition Enhancement Project	2017	2020						X	
	South Sudan	Health Rapid Results Project	2012	2017	X						X
	Somalia	N/A									
	Uganda	1. Reproductive Health Voucher Program	2014	2017	X	X	X			X	
		2. Improving Delivery of Maternal Services	2016	2021	X	X					X
		3. Multisectoral Food Security and Nutrition Project	2015	2019						X	
		4. Health Systems Strengthening Project	2010	2017	X			X			
	Zimbabwe	Health Sector Development Support Project	2011	2017	X	X		X			X
	Madagascar	Emergency Support to Critical Education, Health and Nutrition Services Project	2012	2017	X						X
	Kenya	1. Transforming Health Systems for Universal Care	2016	2021	X			X		X	
		2. Health SWAP	2010	2016	X	X					X
East Africa	Tanzania	Strengthening Primary Health Care for Results	2015	2020	X	X					X

Central Africa	Djibouti	1. Crisis Response – Social Safety Net Project	2012	2019	X						X
		2. Improving Health Sector Performance	2013	2018							
	Comoros	Social Safety Net Project	2015	2019	X	X		X			X
	East Africa	Great Lakes Emergency Sexual and Gender Based Violence & Women's Health Project	2014	2018	X			X			
	Zambia	Health Services Improvement Project	2014	2019	X					X	
	Mozambique	Health Service Delivery	2009	2016	X	X				X	
	Malawi	Nutrition and HIV/AIDS Project	2012	2018	X			X			X
	Democratic Republic of Congo	Health System Strengthening for Better Maternal and Child Health Results Project	2014	2019	X			X			
	Central African Republic	Health Systems Support Project	2012	2019	X	X		X		X	
	Chad	Mother & Child Health Services Strengthening	2014	2018	X			X			X
	Angola	Municipal Health Service Strengthening	2010	2017	X	X				X	
	Cameroon	1. Health System Performance Reinforcement Project	2016	2021	X			X		X	
		2. Health Sector Support SWAP	2008	2017	X			X			
	Republic of Congo	Health Sector Project	2013	2019	X			X			X
	Swaziland	Health, HIV/AIDS & TB Project	2011	2018	X	X	X	X			

	Namibia	NA									
Southern Africa	**Lesotho**	Maternal & Newborn Health Performance Based Financing	2013	2017	X	X	X	X			X
	Sudan	NA									
North Africa	**Algeria**	NA									
	Morocco	Health Sector Support	2015	2019	X	X					X
	Sierra Leone	1. Health Service Delivery & System Support Project	2016	2019	X					X	
		2. Reproductive & Child Health II Project	2010	2016	X	X					
	Nigeria	1. Program to Support Saving One Million Lives	2015	2019	X	X	X	X			X
		2. AF Nigeria State Health Investment Project	2016		X	X				X	
		3. States Health Investment Project	2012	2020	X					X	X
		4. Polio Eradication Support	2012	2018						X	
	Liberia	Strengthening Liberia Health System	2016		X	X		X		X	
	West-Africa	1. Sahel Women's Empowerment and Demographic Dividend Project	2014	2019	X			X			X
		2. Sahel Malaria and NTDs Project	2015	2019							X
	Benin	1. Health System Performance	2010	2017	X						X
		2. Multisectoral Food Health Nutrition Project	2013	2019							X
	Burkina Faso	1. SWEDD – AF Burkina Faso	2015		X			X			X
		2. Reproductive Health Project	2011	2018	X		X	X			
	Niger	Population and Support Health Project	2015	2021	X			X			X
West Africa	Guinea	Primary Health Services Improvement Project	2015	2020	X						X

	Gambia	Maternal and Child Nutrition and Health Results Project	2015	2019	X			X	X			X
	Ghana	Maternal, Child Health and Nutrition Project	2014	2020	X				X			X
	Mali	Strengthening Reproductive Health	2011	2017	X	X		X	X			
	Senegal	1. Health & Nutrition Financing	2013	2018	X				X		X	
		2. Social Safety Net Project	2012	2019	X							X
	Cote d'Ivoire	Health Systems Strengthening and Ebola Preparedness Project	2014	2020	X	X			X			X
Asia												
	Kyrgyzstan	Kyrgyz Health Results Based Financing	2013	2017	X	X					X	
	Turkmenistan	NA										
	Uzbekistan	NA										
Central Asia	Tajikistan	1. Health Services Improvement Project	2013	2019	X				X			X
		2. JSDF Nutrition Grant Scale Up	2013	2018								X
	North Korea	NA										
Eastern Asia	**Mongolia**	NA										
	China	NA										
Southern Asia	**Afghanistan**	System Enhancement for Health	2013	2018	X				X			X
	Pakistan	1. Enhanced Nutrition for Mothers and Children	2014	2018	X							X
		2. Punjab Health Sector Reform Project	2013	2017	X	X			X			X
		3. National Immunization Support Project	2016	2021							X	
		4. FATA Temporarily Displaced Persons Emergency Recovery Project	2015	2019							X	

	Nepal	Community Action for Nutrition Project	2012	2017	X							X
	India	1. Karnataka Health System Development and Reform Project	2006	2017		X			X		X	
		2. ICDS Systems Strengthening & Nutrition Improvement Program	2012	2017							X	X
	Sri Lanka	Second Health Sector Development Project	2013	2018	X				X			X
	Bangladesh	1. Income Support Program for the Poorest	2014	2020	X							X
		2. Health Sector Development Project	2011	2017	X	X	X		X			X
	Timor-Leste	NA										
	Lao PDR	Health Governance and Nutrition Development Project	2015	2020	X	X			X			X
	Myanmar	Essential Health Services Access Project	2014	2019	X	X	X				X	
	Cambodia	1. AF – Second Health Sector Program	2014		X	X			X			X
	Indonesia	National Program for Community Empowerment in Rural Areas Healthy and Bright Generation	2013	2017	X							X
	Philippines	Social Welfare Development and Reform Project II	2016	2019								X
	Vietnam	1. Northern Mountain Child Nutrition	2015		X							X
South-Eastern Asia		2. Results-based Scaling Up RSWS Program	2015	2021	X							
	Yemen	1. Health & Population	2011	2017	X	X			X			X
		2. Maternal and Newborn Voucher Project	2014	2019	X	X			X			
	Syria	NA										
	Jordan	NA										
Western Asia	Lebanon	Emergency Primary Healthcare Restoration Project	2015	2018	X							X

	Turkey	Health System Strengthening and Support Project	2015	2020					X			
	Armenia	Disease Prevention and Control Project	2013	2019	X				X			
Latin America and the Caribbean												
	Haiti	Improving Maternal and Child Health	2013	2018	X	X		X				X
	Dominican Republic	NA										
Caribbean	Jamaica	Early Childhood Development Project - SWAP	2008	2018								X
	Honduras	NA										
	Panama	NA										
	Nicaragua	Strengthening the Public Health Care System	2015	2020	X		X		X	X		
	El Salvador	Strengthening Public Health Care System	2011	2017	X			X	X			X
Central America	Guatemala	Pilot to Improve the Development and Nutrition	2014	2018						X		
	Guyana	NA										
	Bolivia	NA										
	Suriname	NA										
	Argentina	AR Provincial Public Health Insurance Development Project	2010	2017	X				X			X
South America	Brazil	1. Bahia Health and Water Management (SWAP)	2010	2017		X						X
		2. Rio Grande do Norte: Regional Development and Governance	2011	2019	X	X	X		X	X		
Europe												
	Russia	NA										
	Romania	Health Sector Reform	2013	2020					X			
Eastern Europe	**Ukraine**	Serving People, Improving Health Project	2015	2020					X			

Source: World Bank Operations Portal
Countries highlighted in orange have the highest MMR per subregion

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ANNEX I: REPRODUCTIVE, MATERNAL, NEWBORN, CHILD, AND ADOLESCENT INDICATORS

SDG Goal 3. Ensure healthy lives and promote well-being for all at all ages
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
3.1.1 Maternal mortality ratio
3.1.2 Proportion of births attended by skilled health personnel
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
3.2.1 Under-five mortality rate
3.2.2 Neonatal mortality rate
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs
3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods
3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and most disadvantaged population)
3.8.2 Number of people covered by health insurance or a public health system
IDA18 Results Measurement System Indicators
Tier 1 indicators
Ratio of female to male labor force participation rate
Legal changes that increase gender parity over the past two years
Lower secondary gross completion rate (%) - Ratio of girls' to boys' completion rate (%)
Lower secondary enrolment rate (%) - Ratio of girls' to boy's enrolment rate (%)
Maternal mortality ratio (per 100,000 live births)
Adolescent fertility rate (births per 1,000 women ages 15-19)
Contraceptive prevalence (% of women ages 15-49)
Under 5 mortality rate (per 1,000 live births)
Prevalence of stunting among children under 5 years of age
Births attended by skilled health staff (% of total births)
Tier 2 indicators
Number of children immunized (millions)
Number of deliveries attended by skilled health personnel (millions)
People who have received (1) essential health, (2) nutrition and (3) population services (millions)

Number of IDA countries that were provided statistical capacity building support by the WBG for the implementation of household surveys
Number of lending operations with civil registration and vital statistics
HNP Corporate Results Indicators
People who have received essential health, nutrition, and population (HNP) services (millions)
Number of children immunized (millions)
Number of deliveries attended by skilled health personnel (millions)
Number of women and children who have received basic nutrition services (millions)
GFF Core Programmatic Indicators
Maternal mortality ratio
Under 5 mortality rate
Neonatal mortality rate
Adolescent birth rate
Percentage of the most recent children age 0-23 months who were born at least 24 months after preceding birth
Prevalence of stunting among children under 5 years of age
Prevalence of children that are developmentally on track
Global Strategy for Women's, Children's, and Adolescents' Health Indicators
Survive (End Preventable Mortality)
Maternal mortality ratio
Under-5 mortality rate
Neonatal mortality rate
Stillbirth rate
Adolescent mortality rate
Thrive (Promote Health and Wellbeing)
Prevalence of stunting among children under 5 years of age
Adolescent birth rate (10-14, 15-19)
Coverage index of essential health services (index based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access) (including RMNCAH: family planning [met need], antenatal care, skilled birth attendance, breastfeeding, immunization, childhood illnesses treatment)
Out-of-pocket health expenditure as a percentage of total health expenditure
Current country health expenditure per capita (including specifically on RMNCAH) financed from domestic sources
Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information and education
Proportion of population with primary reliance on clean fuels and technology
Transform (Expand Enabling Environments)
Proportion of children under 5 years of age whose births have been registered with a civil authority
Proportion of children and young people (in schools): (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex

Proportion of ever-partnered women and girls aged 15 and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months and proportion of young women and men aged 18-29 who experienced sexual violence by age 18
Percentage of population using a safely managed sanitation services including a hand-washing facility with soap and water

The aim of this paper is to explore the advances made in maternal and child health (MCH) over the past 25 years, analyzing WBG operational investments in MCH, as countries shift their focus to the sustainable development goals (SDGs). Maternal mortality decreased by 44 percent over the past 25 years with an annual rate of reduction of 2.4 percent, yet to reach SDG target 3.1, the global maternal mortality ratio (MMR) must decrease by 7.5 percent per year by 2030. Maternal mortality has negative consequences as it leads to greater family financial instability, loss of education, and increased child mortality. Evidence shows that skilled birth attendance and maternal education reduces the likelihood of maternal mortality (UNESCO, 2013). When comparing primary school net enrolment and primary school completion with maternal mortality, it appears that national MMR averages are influenced by education. Also, MMR is influenced by the delivery of health care and socioeconomic indicators, which may lead to inequities at the national and subnational levels. While significant progress has been made in reducing the under-five mortality rate, neonatal mortality rate reduction has lagged. The WBG has 86 active projects that include activities that improve women and children's health. Many projects focus on antenatal care and delivery services, followed by children under 5 years, and family planning. As part of the operationalization of the *Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030)*, the WBG could develop an inclusive Women's, Children's, and Adolescents' Health Action Plan. The new, inclusive Action Plan would comprehensively build on the existing platforms and elements of the WBG, including the Global Financing Facility; Civil Registration and Vital Statistics; the *World Bank Group Gender Strategy (2016-2023): Gender equality, poverty reduction and inclusive growth*; fragility, conflict and violence; and the International Development Association (IDA18) commitments and all WBG client countries, supporting them across varying levels of need and income, targeting the poorest and most vulnerable.

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