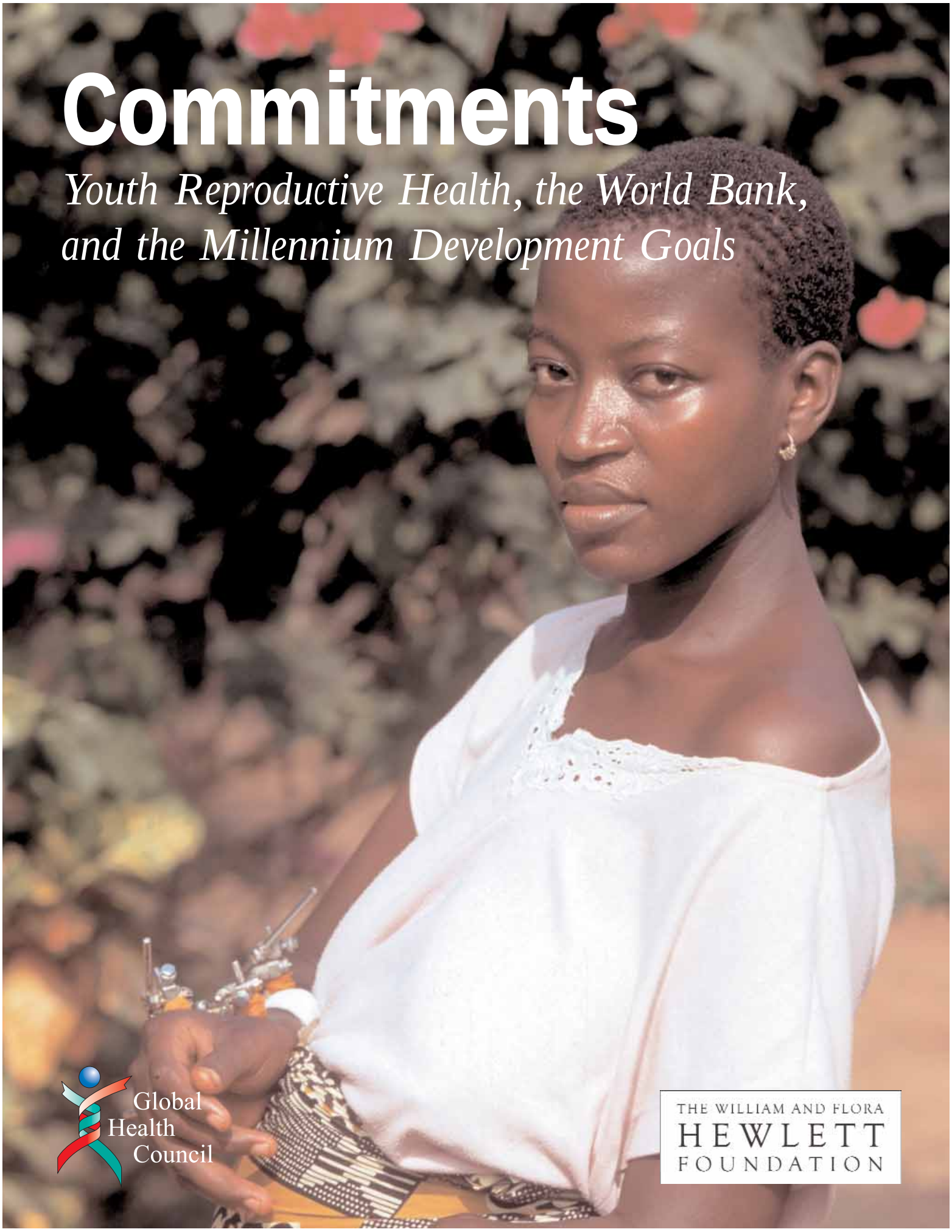
Commitments
Youth Reproductive Health, the World Bank, and the Millennium Development Goals
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# Foreword

With the largest generation of young people in the history of the world now coming of age, the attention paid to their immediate and long-term health needs will do much to define the status of global health over the next quarter century. The set of issues that relate to the sexual and reproductive health of these young people is central to their likelihood of avoiding HIV infection as well as unplanned pregnancies, both of which have enormous consequences for their personal well-being and the economic health of their societies.

The World Bank has emerged as the single largest force in directing policy and financing across a range of critical global health issues. Using a variety of strategic and policy platforms–from the global Millennium Development Goals to country-specific poverty reduction strategies–as well as a variety of programmatic initiatives such as the Multi-Country HIV/AIDS Program, the World Bank often sets direction and mobilizes resources that can have profound consequences for the health of the more than a billion people living in extreme poverty.

This analysis is intended to assess and appraise the Bank's processes and work in this emerging arena. Through it, the Global Health Council hopes to provide a framework for enhancing the priority and effectiveness of the World Bank's programs directed toward improving the sexual and reproductive health of young people, and ultimately to assist civil society to engage constructively and actively in the Bank's decision-making and resource-allocation processes.

Two billion young people coming of age in a complex global society is a daunting challenge, and one worthy of the resources and expertise of the World Bank, the global health community, and all those interested in a healthy, peaceful and stable world for the 21st century.

Nils Daulaire, MD, MPH

President and CEO
Global Health Council

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# Executive Summary

This report has two objectives. The first is to further the case for youth reproductive health as essential to achieving the Millennium Development Goals (MDGs) and reducing poverty. The second is to underscore the importance of the World Bank's role to promote responsible progress toward the goals among its client countries, and to provide leadership on behalf of youth in this effort. This report draws on Bank documents and interviews with Bank staff, as well as from the youth reproductive health and education literature.

In 2000, a global contract was struck between rich and poor countries to eliminate extreme poverty and many of the factors associated with it. In the poorest countries, 30 to 40 percent of the entire population are youth between the ages of 10 and 24. One in four youth lives on less than US$1 per day. Today's youth become – in one short decade – tomorrow's parents, leaders, labor force and armies. But many will not survive to adulthood due to the devastation caused by HIV/AIDS, consequences of early pregnancy, and unsafe abortion. And far more will not thrive due to low levels of education, poor livelihood skills, and gender inequities. These factors increase the vulnerability of youth to reproductive health problems, and together they will perpetuate the poverty of the next generation.

The World Bank embraced the achievement of the MDGs as a corporate priority. As the world's largest lender for development, the Bank's leadership in helping countries set development priorities according to the MDGs and in identifying the resources necessary to meet the targets is essential. If the goals are to be more than rhetoric, vast new financial resources must be raised from the Bank's donor countries, most notably from the United States.

This report builds the case that improving the reproductive health of youth will facilitate the achievement of all eight MDGs. For each youth reproductive health issue, a link is made between the issue and the particular goal or goals affected by it. The report notes that the empirical evidence is often weak. If the self-perpetuating cycle of poverty and disease is to be broken, the causal links among reproductive health, poor education and lack of livelihoods must be made more explicit. The Bank must invest to ensure that its client countries have the necessary information, tools, technical expertise and models to better understand their poverty situations and where it is most productive to invest.

The report identifies the Bank's comparative advantage to address poverty reduction and reproductive health, and makes a number of recommendations. These include that the Bank must maximize the productive use of its power to convene and conduct high-level policy dialogue in support of youth and the MDGs. The Bank must join with other international agencies, donors and governments to estimate, generate and distribute resources, and to monitor their effective deployment to make the achievement of the MDGs a reality. The Bank's internal monitoring and evaluation capacity, as well as that of its client countries, must be improved to strengthen the evidence base of effective strategies to improve health and to advance development.

The Bank should further encourage its recent efforts to promote the meaningful participation of youth in policy dialogue, health reform and national poverty eradication planning. Through investments in sound multisectoral programs and support of civil society organizations, including those that serve and employ youth, the Bank will substantially contribute to the improvement of youth reproductive health and the achievement of the MDGs. Without the Bank's commitment to these efforts, these critical development goals will not be reached, and the survival and well-being of this giant generation of youth will be endangered.

## Introduction

In 2000, a remarkable global contract was drawn up between the world's rich and poor countries, pledging, for the first time with quantified goals and a realistic timetable, to greatly reduce extreme poverty and many of the factors associated with it. The commitment of 189 countries to the Millennium Development Goals (MDGs) is beneficial to the World Bank, since its own mission of more than a decade has been to reduce poverty. Furthermore, many of its own goals for education, health, gender equity and the environment are closely aligned with those of the MDGs. Achieving the Bank's mission is, therefore, greatly facilitated by working to ensure that every recipient country is upholding its commitments by working toward development outcomes that contribute to meeting these goals. As the world's largest international lender in health, the Bank is in a unique and powerful position to assist countries in understanding what must be done to achieve the MDGs, and providing the funds to carry out those actions.

The MDGs, all of which depend in some sense on a healthy, productive and stable population, cannot be achieved without investing in youth. Almost half of the world's population is under the age of 25. In the world's poorest countries, 30 to 40 percent are between the ages of 10 and 24, the age group identified as "youth.[i]" Today's youth will become – in one short decade – tomorrow's parents, leaders, labor force and armies. Youth must endeavor to thrive in a rapidly changing world confronted by HIV/AIDS, urbanization, rapidly altering family structures, increased migration, and civil and international conflict. However, they are often lacking in education and marketable skills, and girls face gender discrimination.[1] A quarter of the world's youth population lives on less than US$1 per day.[2] If poverty is defined as more than just a lack of income, and includes low levels of education and health, an insufficient political and social voice, and powerlessness, young people suffer from a lack of these assets more than any other group.[3] Working to improve the well-being of youth is an obvious step in the goal to reduce global poverty.

Children born into poor families tend to become poor adults and to raise impoverished children who continue the cycle of poverty. The investments countries make in health, education and training for this generation of youth will reap benefits over time, in terms of improved productivity, higher incomes, lower health costs and improved social capital.[4] They will also be reflected in the well-being and productivity of the generation to follow.

Six years prior to the MDG agreement, 179 nations participating in the International Conference on Population and Development (ICPD) held in Cairo agreed to a 20-year Programme of Action to improve reproductive health, including that of youth. This plan was ratified at the ICPD Plus Five meeting in 1999. Governments and donors were called upon to meet the needs of youth for information, and for user-friendly, confidential and accessible services to effectively address their reproductive and sexual health needs. Today, five years later, it is evident from the growing HIV/AIDS epidemic among youth that these needs have not been adequately addressed.

> "Governments…should, by 2005, ensure that at least 90 percent and by 2010, at least 95 percent, of young men and women aged 15 to 24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods such as female and male condoms, voluntary testing, counseling and follow-up. Governments should use, as a benchmark indicator, HIV rates in persons 15 to 24 years of age, with the goal of ensuring that by 2005 prevalence in this age group is reduced globally, and by 25 percent in the most affected countries, and that by 2010 prevalence in this age group is reduced globally by 25 percent."
>
> *Source: ICPD Plus Five, 1999, Paragraph 70.*

The MDGs do not explicitly state an overarching reproductive health goal, yet many of the goals cannot be achieved without directing attention to the reproductive health of youth. As the largest lender in health and a signatory to the ICPD, the Bank has the ability to influence how countries work to achieve both the ICPD goals and the MDGs to which they have agreed, as well as the level of resources with which they have to work.

Neither improved youth reproductive health nor the MDGs can be met without significant advances in gender equity and support for the human rights of girls. Increasingly, as HIV devastates the population of young girls in worst-affected countries, it is recognized that gender inequity and poverty are key forces driving the disease. Equally important are the links between the socialization of boys into traditional masculine roles and domestic violence, conflict, loss of productivity due to accidents and substance abuse, and abuse of girls' rights.[5] The lives and health of women and girls can only be improved in parallel with the sensitization of men and boys.

This report draws on Bank documents and interviews with Bank staff as well as from the youth reproductive health and education literature. It aims 1) to further the case for youth reproductive health as essential to achieving the Millennium Development Goals and reducing poverty; and 2) to underscore the importance of the Bank's role to promote responsible progress toward the goals and to provide leadership on behalf of youth in this effort. This report will not prescribe specific youth reproductive health interventions that the Bank should implement or support. Rather, it encourages the Bank to use its comparative advantage to identify, evaluate and scale up interventions that offer advantages to youth.

Part I of this report examines the major reproductive health challenges faced by youth, and their relationship to poverty and the MDGs. Part II discusses what the Bank is currently doing to address youth development as well as its comparative advantage to proactively encourage greater investments in youth. Part III concludes with some recommendations for action.

[i] *This report defines youth as those 10 to 24 years of age. WHO defines adolescence as ages 10 to 19.*

## PART I

# Youth Reproductive Health and the Millennium Development Goals

> *"We will spare no effort to free our fellow men, women and children from the abject and dehumanizing conditions of extreme poverty to which more than a billion of them are currently subjected."*
>
> *Source: UN Millennium Declaration, September 2000.*

Youth face greater reproductive health risks than adults for many reasons, including a willingness to take greater risks in general, such as having unprotected sex, and a greater vulnerability to sexual pressure, coercion and exploitation. Adolescents represent a disproportionately high percentage among those who undergo unsafe abortions and who suffer the complications that ensue. Young girls have a greater biological and social susceptibility to HIV and sexually transmitted infection (STI).[6,7] The weakening of social structures due to instability, poverty and HIV/AIDS has left youth with fewer resources and support systems in place to help them navigate the path to adulthood.

Poor reproductive health among youth is a poverty issue. Low levels of youth reproductive health can and do negatively impact economic development. When early and high-risk pregnancies, STIs and HIV/AIDS stop or delay an adolescent's progression to healthy, productive adulthood, it is not only the individual who suffers the consequences. Poor youth are less likely to finish school and more likely to marry earlier. Poor adolescent females are three times more likely to give birth than wealthier females of the same age.[8] Moreover, poor youth are more vulnerable to sexual exploitation, as they may resort to transactional sex to support themselves and their families.

Investing in youth is cost-effective.[9] Without preserving the health of youth, investments made earlier to improve child survival can be lost. Investments are more cost-effective and result in greater public health savings when they meet the needs of high-risk groups,[10] such as poor youth who are disproportionately affected by reproductive health problems. These include HIV/AIDS and other STIs, early pregnancy, early marriage, unmet need for contraceptives, unsafe abortion and lack of access to reproductive health services and information. Factors that imperil the reproductive health of youth such as gender inequity, inadequate education and lack of livelihood skills must also be addressed.

While it is clear that some of the MDGs, such as halting the spread of HIV, cannot be achieved in the absence of improved youth reproductive health, each of the eight MDGs contains one or more targets that would be more rapidly achieved through such improvements. As illustrated in Table 1, improvements in the factors that influence youth reproductive health, including education and livelihoods, will contribute to progress in 11 of the targets set for reaching the MDGs (specifically targets 1-8, 10, 11 and 16). For each of the reproductive health issues described below, this report makes a link between the problem and the particular goal or goals affected by the problem, based on our assessment of the available evidence.

There are admittedly many gaps in what is known about the economic benefits of investing in youth, and much of the available evidence comes from behavioral studies. Empirically, evidence for economic returns on investments in youth is strongest for educational interventions. Returns on investments in health, nutrition and HIV prevention tend to be highest where poverty and incidence of malnutrition and HIV are highest.[11] This argues in favor of targeted, pro-poor investments in the poorest countries and those worst-affected by HIV/AIDS. It also highlights the urgency of filling these significant gaps with new research that is more sensitive to costs as well as impacts, and that considers that youth investments in one area are likely to have an impact on investments and behaviors in other areas.[12]

**Table 1: Millennium Development Goals and Targets Relevant to Youth Reproductive Health**

| | |
|---|---|
| Goal 1: | Eradicate extreme poverty and hunger |
| | Target 1: Halve between 1990 and 2015 the proportion of people whose income is less than US$1 a day |
| | Target 2: Halve between 1990 and 2015 the proportion of people who suffer from hunger |
| Goal 2: | Achieve universal primary education |
| | Target 3: Ensure that by 2015, all children will be able to complete a full course of primary schooling |
| Goal 3: | Promote gender equality and empower women |
| | Target 4: Eliminate gender disparity in primary and secondary education by 2005, and in all levels of education by 2015 |
| | • Improve the ratio of literate females to males among 15-to-24-year-olds |
| | • Increase the share of women in wage employment in the non-agricultural sector |
| Goal 4: | Reduce child mortality |
| | Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate |
| | • Reduce infant mortality rates |
| Goal 5: | Improve maternal health |
| | Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio |
| Goal 6: | Combat HIV/AIDS, malaria and other diseases |
| | Target 7: Halt by 2015, and begin to reverse the spread of HIV/AIDS |
| | Target 8: Halt by 2015, and begin to reverse the incidence of malaria and other diseases |
| Goal 7: | Ensure environmental sustainability |
| | Target 10: Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation |
| | Target 11: Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers |
| Goal 8: | Develop a global partnership for development |
| | Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth |

*Source: www.developmentgoals.org*

## Youth Reproductive Health Issues

### HIV/AIDS

Millennium Development Goal 6, calling for halting and reversing the spread of HIV/AIDS by 2015, is the goal most clearly unattainable without immediate effort to improve youth reproductive health. No other need is as compelling or necessary as the need to end this tragic loss of young life. About half of the 42 million people living with HIV/AIDS today are under age 25. Half of all new HIV infections occur in young people ages 15 to 24.[13] Half of 15-year-old youths in worst-affected countries may die of AIDS.[14] The devastation that HIV/AIDS has caused, particularly among youth, would have been unimaginable even a decade ago. In sub-Saharan Africa, of the approximately 30 million people living with HIV/AIDS, 10 million are aged 15 to 24 and more than 58 percent are female.[15]

HIV/AIDS also reflects the influence of extreme gender disparity and poverty on the timing and nature of the first sexual experience. Poverty is significantly associated with early sexual initiation among girls, but not among boys. As the age of sexual debut continues to decline around the world to as young as 10 years in some parts of the world,[16] girls in the countries most severely affected are two-to-six times more likely to become infected than boys of the same age.[17] For unmarried girls, vulnerability to HIV is aggravated by poverty. The source of infection is often either coerced sex or transactional sex with older men to pay for food, school fees or to support their families. For married girls, marriage does not offer protection against HIV. Research in several countries with high levels of early marriage indicates that the great majority of HIV-infected women were married, and most had never had sex with anyone but their husbands.[18]

The relationship between HIV/AIDS and poverty is also particularly clear-cut. The costs of health care, absenteeism, lost training investments and lost productivity pale beside the human toll, yet they also have a measurable impact. It is projected that AIDS is costing Africa one percent of per capita growth per year.[19] In South Africa, AIDS is expected to reduce annual growth of the gross domestic product (GDP) by 0.3 percent to 0.4 percent per year for the next 15 years. Some companies will lose up to half their workforce.[20] The estimated benefit from one averted HIV infection in a poor country (US$1,000 average annual earning) would be approximately US$34,600.[21]

The actions that prevent infection or lessen the effects of HIV/AIDS for youth have multiple benefits. Delaying sexual activity reduces early and unwanted pregnancy. Reducing the number of sexual partners and using condoms help prevent the spread of other STIs and avoid unwanted pregnancy. Reducing unwanted pregnancy decreases the incidence of mother-to-child transmission of HIV, unsafe abortion, and maternal and infant mortality. Indeed, HIV prevention activities are sound public investments Table 2 summarizes the consequences of not investing in HIV prevention and other youth reproductive health issues.

### Other STIs

Far more common than HIV among youth are other sexually transmitted infections (STIs). One in every 20 adolescents contracts an STI every year. The 330 million annual cases of the four most common STIs (chlamydia, gonorrhea, syphilis and trichomoniasis) are curable if treated early. Young women often suffer more serious consequences of STIs because the infections are not manifested in obvious symptoms until the disease is well advanced. Even when aware of the STI, youth may not seek treatment due to shame, embarrassment and stigma. For a multiplicity of factors including their lack of information about how diseases are transmitted, poor understanding of the risks of unprotected sex and lack of negotiating power to resist sexual coercion, young women are several times more likely to contract an STI than older women.[22]

STIs during pregnancy can lead to ill-health for the newborn, low birth weight, and premature delivery. Left untreated, the costs and consequences of STIs are very high, and include cancer and increased risk of HIV. Complications of STIs are also the cause of half of all cases of infertility, affecting some 60 to 80 million couples per year and creating, especially for women, severe social and emotional consequences.[23]

### Early Pregnancy

Millennium Development Goal 5 calls for a reduction of the 1990 maternal mortality ratio by three-quarters by 2015. This goal will not be achieved without reducing adolescent pregnancy. Because the risk of malaria is far greater for pregnant than non-pregnant women,[24] efforts to reach Target 8 of Goal 6 to reduce the incidence of malaria will also be impeded by early pregnancy. Females under the age of 20 are estimated to account for 17 out of every 100 births in the least-developed countries.[25] The risks for poor pregnant youth are increased by consequences of poverty, such as malnutrition and anemia. Adolescent mothers are twice as likely as older mothers to die from pregnancy-related causes.[26] Due to physical immaturity and less access to skilled attendance at birth, adolescents face greater risk for obstructed labor, damage to the reproductive tract, and severely debilitating conditions with lifelong consequences, such as vaginal fistula.

Early pregnancy contributes to the intergenerational transmission of poverty through a variety of pathways.[27] Pregnant girls may be expelled from school, either by law or from the failure of schools to enforce the rights of girls. Without education or employable skills, unmarried pregnant girls are often poorly prepared to take on the responsibilities of childrearing and face diminishing prospects for income generation. In Latin America, studies documented that girls who became mothers in adolescence were more likely to remain poor throughout their lifetimes, and their children were more likely to be poor.[28]

Early pregnancy is also associated with higher infant mortality, affecting the achievement of MDG 4 to reduce infant mortality rates. Infant mortality is highest in countries with the largest proportions of adolescent births.[29] Babies born to mothers 20 years old or younger are significantly more likely to die than those born to mothers aged 20 to 29 years (Table 3).

## Table 2: Consequences of Not Investing in the Reproductive Health of Youth

| | *Contributing Factors* | *Consequences for Individuals* | *Consequences for Families, Society and National Development* |
|---|---|---|---|
| **Early Pregnancy and Childbearing** | Poverty<br>Lack of education<br>Early marriage<br>Gender discrimination and role expectations of submissiveness and ignorance for girls<br>Lack of economic and personal security<br>Low access to contraceptive information, education, counseling and services.<br>Lack of negotiation power to use contraception<br>Myths/misconceptions about contraceptive safety<br>Lack of male responsibility for pregnancy prevention<br>Lack of reproductive rights | Reduced chance for self-development and skills-building to break out of poverty<br>School drop out/expulsion<br>Diminished options for employment and income<br>Pressures of too early childbearing/rearing<br>Limited mobility<br>Single motherhood<br>Pregnancy/delivery-related complications and death<br>Vaginal fistula, incontinence, stigma and discrimination<br>Complications/death from unsafe abortion<br>Larger than desired family size<br>Increased risk of malaria, anemia, malnutrition | Reduced skilled human capital for socio-economic development; less skilled workforce; reduced earnings<br>Intergenerational transmission of poverty<br>Lower investments in children's needs and development<br>Higher infant morbidity and mortality<br>Higher health and social welfare costs<br>Large health expenditures to treat complications of pregnancy and abortion<br>Reinforced gender inequality<br>Increased population momentum<br>Reduced prospects for demographic bonus<br>Failure to develop women's full economic and social potential |
| **STIs / HIV / AIDS** | Poverty (transactional/intergenerational sex)<br>Lack of information on safer sex, HIV<br>Gender discrimination<br>Lack of access to methods of protection<br>Sexual abuse, violence, exploitation<br>Multiple sexual partners | Increased poverty<br>Self-development and productivity curtailed<br>Stigma, loss of job, support<br>Infertility<br>Cervical cancer<br>Orphanhood<br>Premature death | Lost productivity and investments<br>Hopelessness and anomie<br>Disruption of social and economic systems<br>Overburden of health care system<br>Destruction of family networks<br>National stability and security undermined. Social unrest, conflict, violence, crime. |
| **Lack of Livelihoods** | Poor education, illiteracy<br>Weak job creation<br>Low entrepreneurial skills<br>Socio-economic exclusion<br>Gender discrimination in pay and employment | Poverty, hunger and malnutrition<br>Lack of skills development<br>Child labor, sexual exploitation, transactional sex<br>Increased risk of HIV, unwanted or early pregnancy | Growth of slums<br>Economic growth and social development hampered<br>Increased marginalization, low social mobility<br>Poor health, nutrition and education<br>Perpetuation of poverty |

*Source: Adapted from UNFPA (2003). Making One Billion Count.*

Reducing early pregnancy is also important to MDG 1 (Target 2), to halve the percentage of people who are hungry. In the Philippines, children born to mothers younger than 18 are twice as likely to be underweight as are children whose mothers are 20 to 21 years old.[30] Women and girls are often the last to eat, and thus are disproportionately represented among those who are hungry. In some countries, nearly one-third of poor adolescent mothers aged 15 to 19 years old have low body mass indexes, indicating undernourishment.[31]

**Table 3: Infant Mortality Rates Compared by Age of Mother**

| Country | Females ages <20 | Females ages 20-29 |
|---|---|---|
| Mali | 181 | 111 |
| Tanzania | 164 | 88 |
| Nepal | 108 | 68 |

*Source: "Too Young To Wed," International Center for Research on Women, 2003. (Deaths per 1,000 live births).*

## Early Marriage

The achievement of MDG 3 for gender parity in school enrollment, and Goals 4, 5 and 6 to reduce maternal and infant mortality and HIV, are all made far more feasible by promoting policies to discourage early marriage. In many parts of the world, girls are married during adolescence: about half in sub-Saharan Africa; 50 to 75 percent in India and Bangladesh; less than 30 percent in the Middle East and North Africa (MENA), and 20 to 40 percent in Latin America and the Caribbean (LAC).[32] Poor families facing limited life prospects look to early marriage for economic and social security, and girls often have no voice in the decision. Early marriage is strongly associated with poverty within countries, and where there are few resources and employment opportunities to encourage investing in girls' schooling or employment training.[33]

Worldwide, most adolescent childbearing occurs within marriage and is considered socially desirable by families. There are great risks, however, attached to this social norm. Maternal mortality by age at first birth among young women ages 15 to 19 is about twice that of 20 to 34 year olds (Figure 1). Early and frequent exposure to sex and inability to negotiate condom use also place married girls at high risk for STIs, including HIV, and unsafe abortion.[34] The husbands of 15-year-old girls are, on average, at least 10 years older,[35] and these girls have little negotiating power for safe sexual practices or contraceptive usage in their marriages. They are also vulnerable to violence, abuse and abandonment.[36] A recent study in Kenya and Zambia challenges the assumption that marriage offers protection to young women from STIs, including HIV.[37]

Early marriage severely limits girls' educational, social and developmental opportunities, compromises their rights, and limits their mobility and full participation in society. Young married girls are, therefore, unlikely to benefit from educational and economic policies and programs encouraging secondary school enrollment, credit opportunities or participation in the paid work force.

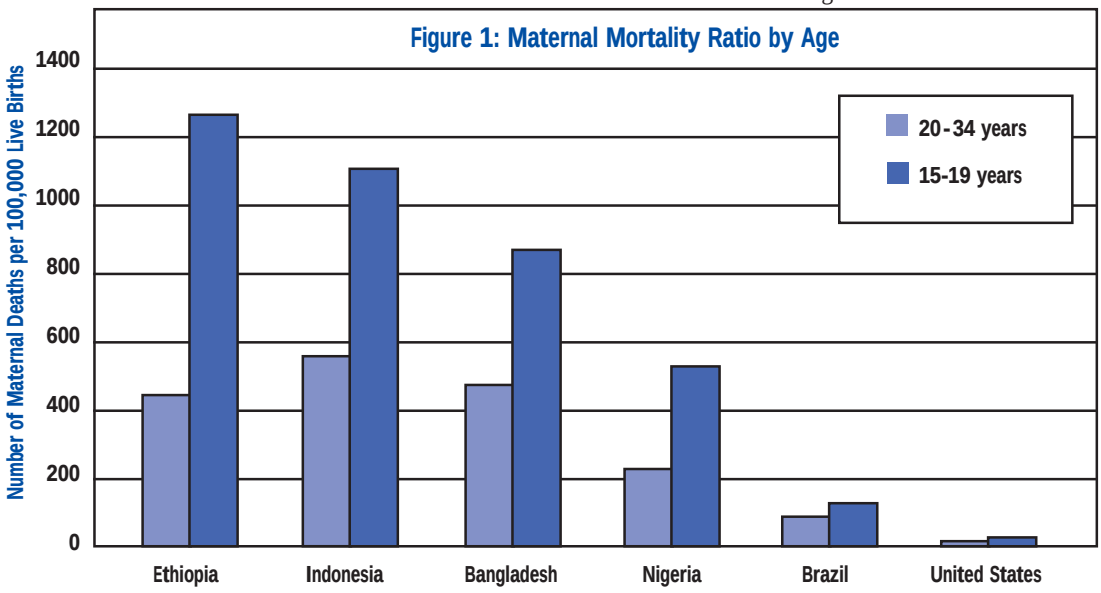
## Unmet Need for Contraception

MDG 5 to reduce maternal mortality cannot be met in the absence of improved reproductive health for women of all ages, including adolescents. Many married adolescents report that their first birth was unplanned and unwanted. Predictably, those countries with the highest level of adolescent childbearing also have the lowest rate of contraceptive use by married women; among women ages 15 to 19, it is below 10 percent.[38] An estimated 28 percent of all pregnancies occurring between 1995 and 2001 were unwanted or unplanned.[39] While up to 80 percent of 15 to 19 year old married girls from 18 African countries indicated that they would be unhappy if they were to become pregnant in the next few weeks, most were not using contraception.[40] Similarly, a national survey in India found that as many as 30 percent of women ages 15 to 19 wanted to delay their next birth but were not using contraception.[41] Serving the unmet need for contraception in developing countries would prevent 52 million unintended pregnancies per year, also preventing maternal deaths that affect 505,000 children.[42]

DHS data from 94 surveys in 69 countries over the past decade indicate that, on average, unmet needs to space births among young people are 2.3 times higher than for the adult population as a whole.[43]

## Unsafe Abortion

Achieving MDG 5 to reduce the 1990 maternal mortality ratio by three-fourths by 2015 depends significantly on reducing deaths due to unsafe abortions. About 14 percent, or 78,000[44] of the 550,000 annual maternal deaths worldwide are due to complications of unsafe, induced abortion. The risk of death is highest in sub-Saharan Africa, where one in 150 women undergoing unsafe abortion dies.[45] The vast majority of abortions are due to unwanted pregnancies. More than one-fifth of all pregnancies are terminated each year




*Source: Family Care International 1998; Centers for Disease Control and Prevention 2002.*

(approximately 46 million), attesting to the estimated 120 million women with an unmet need for contraception. Abortion and the availability of contraception are inextricably linked, and the lack of access to contraceptives is greatest for young women and the poor. Of the nearly 700,000 women who died between 1995 and 2001 because of an inability to prevent an unintended pregnancy, approximately 440,000 deaths (68 percent) resulted from unsafe abortions.[46]

Young women aged 15 to 19 account for at least one-fourth of the estimated 20 million unsafe abortions performed each year, and 40 percent of all unsafe abortions are performed on young women aged 15 to 24.[47] Youth are disproportionately represented among those who resort to unsafe abortions, due to the limited availability and high cost of safer medical abortion procedures.[48] In many African countries, adolescents hospitalized with abortion complications have occupied up to 68 percent of all obstetrical beds.[49] For example, a study in Tanzania found that nearly a third of those hospitalized with complications of unsafe abortion were adolescents, and half of these were 17 or younger.[50]

Treating complications from unsafe abortions requires the use of financial resources and health personnel that otherwise might be used to prevent disease and improve health. Where such data are available, hospital costs for treating complications from unsafe abortions have been found to be very high. Some studies have shown that up to a third of all hospital gynecological expenditures were spent treating abortion complications, and many of the patients were adolescents.[51] Reducing reliance on abortion can be done cost effectively, through improving youth knowledge of and access to reproductive health services and information. However, attention to girls' lack of power to control the circumstances under which sex takes place and vulnerability to transactional sex must also be addressed.

### Lack of Access to Services and Information

Girls' education, smaller family size, delayed marriage and prevention of early pregnancy are all closely associated with access to sexual and reproductive health information and services. Thus, improved access can contribute to the achievement of MDGs 2,3,4,5 and 6. The HIV/AIDS pandemic indisputably presents the rationale for reaching young adolescents with reproductive health programs and services. Youth often become victims of the disease before their cognitive skills and judgment are sufficiently developed to understand the devastating and irreversible threat that HIV represents.[52] Married adolescents may be subject to cultural norms stipulating that newlyweds should not consider any form of family planning until they have had at least one child. Cross-regional evidence from Ghana, India and Egypt shows that when married adolescent females approach health services for contraceptives, they face great resistance from health care providers.[53]

Youth in need of reproductive health services are particularly reluctant to seek services when they think that confidentiality may not be maintained.[54] Other factors limiting access include laws and policies that restrict services by age or marital status, inconvenient hours, lack of transportation or mobility, costs, concern that the staff will be hostile, disrespectful or judgmental, and embarrassment at needing services at all.[55] In the wake of the HIV epidemic, a number of countries have developed national youth policies that specifically endorse the rights of adolescents to receive confidential reproductive health information and services. Some providers are unaware of the laws and assume that they are required to notify parents, even if they are not. Others apply their own cultural or religious standards when serving adolescent clients.[56] These barriers to youth access can be deadly.

As the fastest growing population of those newly infected with HIV, 15 to 19 year old girls cannot afford to be misinformed about HIV/AIDS. Yet, studies have shown that the percentage of girls with at least one misconception about HIV/AIDS or who have never heard of the virus is alarmingly high: Bolivia, 74 percent; Dominican Republic, 62 percent; Somalia, 99 percent; Togo, 73 percent; Cambodia, 58 percent; and Indonesia, 84 percent.[57] By not being in school, particularly beyond the primary grades, girls miss out on the most frequent venue to become educated about HIV/AIDS. Girls who do not develop literacy skills are also unable to read newspapers, brochures or other sources of information that might provide instruction about how to protect themselves.

## Factors Affecting Youth Reproductive Health

### Gender Inequity

Gender inequity has been identified as the driving force behind the HIV epidemic,[58] and thus reducing gender inequity is clearly necessary to achieve MDG 6. MDG 3 is devoted to promoting gender equity and empowering women, yet a case can be made that gender issues are relevant to all of the MDGs.[59] The disparities in the ways that boys and girls are raised and treated are at the root of many sexual and reproductive health problems and development challenges.[60] For example, prevailing gender inequality suggests that as antiretroviral treatment for HIV becomes more widely available, women and girls are unlikely to have equal access without explicit goals and careful monitoring.[61]

> "Closing the gender gap also means confronting the reality of sexual violence and harassment that is responsible for underachievement and high [school] drop out rates."
>
> *Source: UNESCO, 2003*[62]

An exclusive focus on empowering girls without also addressing the boys and men with whom they must interact is unlikely to lead to greater equality between the sexes. Adolescence may be one of the last opportunities for youth to learn and practice alternative behaviors. In most societies, boys and men have more opportunities and privileges, greater autonomy, sexual freedom, mobility and power in decision-making than girls and women do. However, these privileges are also associated with health risks for both sexes. Compared to women, men are more likely to be incarcerated, have drug and alcohol problems, die of homicide or suicide, and be involved in violence. These risks contribute substantially to men's shorter life expectancies. Traditional male roles lead to poor health consequences for girls and women, including violence, STIs, unwanted pregnancy, depression and limited opportunities for seeking health services.

Many gender sensitization programs overlook the need to transform the beliefs and behaviors of boys and men that is required if they, along with girls and women, are to achieve safe, healthy and productive lives. The World Health Organization (WHO) estimates that 70 percent of premature deaths among adults are due to behavioral patterns that emerge in adolescence, including smoking, accidents, violence and unsafe sexual behavior.[63]

Boys and young men must learn to see the advantages to themselves and their families in having more equitable relationships with girls and women. Helping boys and young men to reflect on how they are socialized – for example, to be violent and aggressive, ignore their own health needs, or practice unsafe sex – can ultimately lead to changes beneficial for both young women and men.[64] The needs of young boys and girls may have to be addressed through separate strategies and progress tracked through indicators disaggregated by age and sex.

### Girls' Education

In addition to Millennium Development Goals 2 and 3, calling for universal primary education for all and an end to gender disparities in enrollment through secondary school by 2015, a girl's education can be seen as central to the achievement of all of the MDGs, and to the eradication of poverty. About 150 million primary school-age children ages 6 to 11, of whom 90 million are girls, are not in school.[65] While girls are making gains in primary school enrollment, the gender imbalance in enrollment becomes increasingly unequal with each grade, and is especially distorted at the secondary level.

Recent research on the costs and benefits of investing in youth shows that the investment with the largest multiplier effect is education. The effects include an increase in labor productivity, reduction in youth unemployment, decrease in child labor, lower rates of adolescent pregnancy, decline in HIV infection and other STIs, improved mental and physical health, less likelihood of drug or alcohol abuse, less physical or sexual abuse, increased fertility control for adolescent females, less chance of social exclusion and less chance of civil conflict/violence.[66]

Studies have documented that a girl's education offers returns for both her and her future children, in terms of a smaller family, larger investments in each child's health and education, and greater earning potential for better-educated girls – leading to disruption in the intergenerational transmission of poverty.[67] A girl's education delays marriage and childbearing, and expands her opportunities for the development of her full potential as a citizen and productive contributor to her country's economy. For countries with high population growth rates, girls' education carries extra benefits: for every extra year of schooling that girls receive, fertility rates drop by 5 to 10 percent.[68]

Achieving universal education and gender parity between boys and girls is not simply a matter of lessening the barrier of school fees for girls, and encouraging parents to let daughters attend school. Girls have been shown to be disproportionately the victims of intolerance, violence and discrimination in schools.[69] Teachers must be sensitized to the gender-based discrimination that they perpetuate or allow in the classroom; sexual exploitation of girls by teachers must end; gender-biased materials must be replaced; and appropriate and private facilities to meet girls' needs must be made available.

Eliminating gender disparities in education is a very effective development strategy. One study showed that "if the countries of South Asia, sub-Saharan Africa and the Middle East and North Africa had closed the gender gap in schooling between 1960 and 1992 as quickly as East Asia did, their income per capita could have grown by an additional 0.5 to 0.9 percentage points per year. In Africa, this would have meant close to doubling of per capita income growth."[70]

### Livelihoods

The first MDG, to halve the proportion of the population who live on less than US$1 per day and suffer from hunger, is directly dependent on improving the economic prospects of youth, since a quarter of all youth survive on this income. Target 16 of MDG 8 calls for the development and implementation of strategies for decent and productive work for youth. Efforts to support the economic independence of women are also essential to meeting MDG 3, to foster gender equity in non-agricultural employment, and MDG 6, to reduce the toll of HIV/AIDS, malaria and other diseases.

The links between extreme poverty and poor youth-reproductive health are no more apparent than in the slums that surround major metropolitan areas in the developing world. Goal 7, to improve the lives of at least 100 million slum dwellers by 2020, must also address youth, since a large share of slum residents are youth, especially young men who have migrated to the city in search of work. For example, in Nairobi, nearly 50 percent of slum residents are between 15 and 24 years of age. These youth are extremely vulnerable to STIs, including HIV/AIDS, and have higher incidences of reproductive health problems than their non-slum urban counterparts.[71]

*Bonus or Penalty? The Demographic Implications of a Large Youth Cohort*

The time for investment in youth is now. A large youth population presents a special opportunity in some countries if the proper investment in youth development has been made. In countries that have undergone a demographic transition, that is, where fertility and mortality have declined, the proportion of the population who are of working age (15 to 60) has increased relative to the population of dependents (ages birth to 15 and over 60). The effect of the favorable age structure creates the potential for a demographic window of opportunity or bonus. If countries have invested in education and health of youth and aligned their economic policies accordingly, they can facilitate a period of high productivity and economic growth such as occurred in several of the East Asian "economic tiger" countries in the early 1990s. Under this scenario, youth can realize their potential as healthy productive members of society and boost their countries' economic and development status.[72] Countries must invest early to take advantage of this situation because a large uneducated, unhealthy and unskilled youth population provides not a bonus, but a deficit to society and a threat to its stability.

High rates of youth unemployment and poverty can be both a cause and a consequence of poor health, especially poor reproductive health. It is well-established that HIV/AIDS and STIs, and complications from abortion and pregnancy, all disproportionately affect the poor. At the same time, all of these also take

tremendous tolls on productivity and income, contributing to a downward spiral from which it is difficult to recover. In situations where formal employment is limited to begin with, opportunities for youth are even more scarce.[73] In most countries, youth unemployment rates are double those of adults.[74] Gender discrimination results in higher unemployment and lower wages for young women.[75] For young men, youth unemployment has been linked to increased conflict, frustration, idleness, drug usage, gangs and militias, violence and risky sexual behavior.

The relationship between youth reproductive health and income-generating opportunities is being examined in other ways. A study in India estimates that addressing women's health problems alone would increase the female labor participation rate by 20 percent.[76]

### Transactional Sex / Violence / Exploitation

For many adolescent girls, the timing of sexual initiation is not a choice made freely but one driven by poverty and lack of power in gender relations. This reality requires that far greater emphasis be paid to alleviating poverty through increasing girls' livelihood skills and access to micro-credit. An entire generation of girls is being lost to HIV/AIDS in some countries, largely driven by economic vulnerability. Developing viable job skills and livelihoods for out-of-school youth and keeping girls in school are important strategies to save lives. Dire poverty can also drive families to sell children to those trafficking in sex work, or to young girls being unwittingly trafficked.

As important as employment is for young people, illegal child labor keeps young people out of school and frequently at work in hazardous conditions. Effective efforts to address poverty generally are essential to reducing child labor. Lifting legal and policy barriers such as high school fees and required uniforms can help poor families choose school over work.[77]



## Interrupting the Intergenerational Transmission of Poverty

Table 4 shows key population and reproductive health indicators for some of the world's most heavily-indebted poor countries (HIPCs), a designation given countries that receive debt forgiveness in response to explicit poverty reduction strategies. In each HIPC country, 30 to 40 percent of the population are between the ages of 10 and 24, and a high percentage of girls has not completed even a primary education. These countries have among the highest rates of population growth and lowest levels of contraceptive use, lowest percentage of skilled attendance at birth, and highest levels of maternal mortality in the world. In the majority of HIPC countries, HIV prevalence has already exceeded one percent among the youth population ages 15 to 25. When faced with so many challenges, it is difficult to know where to invest. Within individual countries, it is easy to see the high correspondence between the percentage living below poverty, and the unfavorable indicators for primary school completion and health. How then is it possible to interrupt the reinforcing cycle of poverty and poor health and begin to advance economic development?

The evidence is clear that early fertility is linked to larger completed family size and lower educational attainment. A mother's low educational attainment is correlated with lower wages, lower participation in the paid labor force, diminished health and survival of her children, as well as with lower educational levels achieved by her children.[78] This intergenerational transmission of poverty or inequality must be disrupted if health and development are to be improved. Investment in preventing early pregnancies would then seem to offer a promising pay-off. Recent evidence indicates that preventing pregnancy-related school drop-outs in sub-Saharan Africa will significantly narrow the education gap between boys and girls, thus contributing to MDG 3 to achieve gender parity in education. Ultimately, universal primary education, accompanied by the changes in societal attitudes that would be necessary to achieve it, will enhance the payoffs from preventing pregnancy-related drop-outs, which generally occur in secondary school.[79] These findings suggest that universal primary education is the bedrock on which progress in reproductive health and economic development depends.

At the same time, with HIV/AIDS representing such a threat to the survival of youth, the need for broader reproductive health services has not been given enough analytical attention. Multisectoral interventions that aim to reduce fertility, keep girls in school and improve livelihood skills and earnings may have synergistic effects that empower women through broadening their information networks and control over financial resources.[80]

## Table 4: Heavily-Indebted Poor Countries (HIPCs) with Key Population / Reproductive Health Indicators for Adolescents and Youth

| | Total Population Millions (2001) | Gross National Income per capita (2001) | Population Below the National Poverty Line % | Population % Ages 10-24 (2005 projections) [ii] | Avg. Annual Population Growth (2001-2005) | Total Fertility Rate (2001) | Adolescent Fertility Rate Births per 1,000 Women Ages 15-19 (2002) | Births Attended by Skilled Health Staff, % of Total | Contraceptive Prevalence Rate, % of Women ages 15-19 (1990-2001) | Maternal Mortality Ratio per 100,000 Live Births (2000) | Prevalence of HIV, % of Ages 15-25 (2001) | | Primary School Completion Rate for Girls, % of Age Group (2000-2001) [iii] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | MALE | FEMALE | |
| Benin | 6.4 | 380 | 33 | 34.7 | 2.4 | 5.4 | 103 | 60 | 16 | 850 | 1.17 | 3.71 | 15 |
| Bolivia | 8.5 | 950 | 63.2 | 31.7 | 1.8 | 3.8 | 75 | 59 | 49 | 420 | 0.11 | 0.05 | N/A |
| Burkina Faso | 11.6 | 220 | 44.5 | 34.1 | 2.1 | 6.4 | 133 | 27 | 12 | 1,000 | 3.97 | 9.73 | 20 |
| Cameroon | 15.2 | 580 | 40 | 33.9 | 1.7 | 4.7 | 127 | 56 | 19 | 730 | 5.44 | 12.67 | 39 |
| Chad | 7.9 | 200 | 64 | 36.6 | 2.9 | 6.3 | 182 | 16 | 4 | 1,500 | 2.38 | 4.28 | 9 |
| Côte d'Ivoire | 16.4 | 630 | 36.8 | 34.3 | 1.6 | 4.7 | 118 | 47 | 15 | 690 | 2.91 | 8.31 | 33 |
| Ethiopia | 65.8 | 100 | 45.5 | 33.4 | 2.1 | 5.6 | 143 | 10 | 8 | 850 | 4.39 | 7.82 | 12 |
| Gambia, The | 1.3 | 320 | 64 | 29.5 | 2.0 | 4.9 | 139 | 51 | .. | 540 | 0.52 | 1.35 | 47 |
| Ghana | 19.7 | 290 | 31.4 | 35.4 | 1.6 | 4.1 | 79 | 44 | 22 | 540 | 1.36 | 2.97 | 54 |
| Guinea | 7.6 | 410 | 40 | 34.3 | 1.9 | 5.1 | 153 | 35 | 6 | 740 | 0.57 | 1.43 | 24 |
| Guinea-Bissau | 1.2 | 160 | 48.7 | 31.3 | 2.2 | 5.7 | 182 | 35 | .. | 1,100 | 1.06 | 2.98 | 24 |
| Honduras | 6.6 | 900 | 50 | 33.2 | 2.1 | 4.1 | 110 | 55 | 62 | 110 | 1.2 | 1.5 | 63 [iv] |
| Madagascar | 16 | 260 | 73.3 | 32.9 | 2.5 | 5.3 | 157 | 46 | 19 | 550 | 0 | 0 | 26 |
| Malawi | 10.5 | 160 | 54 | 32.5 | 1.8 | 6.2 | 137 | 56 | 31 | 1,800 | 6.35 | 14.89 | 58 |
| Mali | 11.1 | 230 | .. | 34.0 | 2.1 | 6.2 | 167 | 24 | 7 | 1,200 | 1.37 | 2.08 | 18 |
| Mauritania | 2.7 | 360 | 50 | 32.0 | 2.3 | 4.5 | 135 | 57 | 8 | 1,000 | 0.38 | 0.59 | 43 |
| Nicaragua | 5.2 | .. | 50.3 | 34.2 | 2.1 | 3.5 | 124 | 61 | 60 | 230 | 0.23 | 0.08 | 70 |
| Niger | 11.2 | 180 | 63 | 32.4 | 2.8 | 7.2 | 205 | 16 | 8 | 1,600 | 0.95 | 1.5 | 16 |
| Rwanda | .. | 220 | 51.2 | 39.0 | 1.6 | 5.8 | 52 | 31 | 13 | 1,400 | 4.91 | 11.2 | 35 [iv] |
| Senegal | 9.8 | 490 | 33.4 | 33.8 | 2.0 | 5.0 | 89 | 51 | 11 | 690 | 0.19 | 0.54 | 34 |
| Tanzania | 34.4 | 270 | 51.1 | 34.6 | 1.7 | 5.2 | 115 | 35 | 25 | 1,500 | 3.55 | 8.06 | 54 |
| Uganda | 22.8 | 260 | 55 | 34.3 | 2.4 | 6.1 | 179 | 38 | 15 | 880 | 1.99 | 4.63 | 44 |
| Zambia | 10.3 | 480 | 69.2 | 35.7 | 1.2 | 5.2 | 129 | 47 | 26 | 750 | 8.06 | 20.98 | 75 |

*Source: "World Indicators Report, 2003, World Bank" with additional data from sources cited below. List of HIPC countries from: www.worldbank.org/hipc*

[ii] *Population 10-24 calculated from World Bank HNP demographic projections for 2005 from: http://devdata.worldbank.org/hnpstats/DPselection.asp*
[iii] World Bank (2003). *Little Data Book, Quick Reference Guide to the World Development Indicators.* The World Bank, Washington, D.C.
[iv] *1990 data*

## PART II

## What is the World Bank Doing to Address Youth Reproductive Health?

In this section, existing World Bank mechanisms to benefit youth are discussed. The Bank's comparative advantage to improve youth reproductive health and advance achievement of the Millennium Development Goals is then highlighted.

### Investments in Youth Health and Development in Health, Nutrition and Population, Social Protection and Education Sectors

Recognizing youth as both stakeholders and assets in the development of country assistance plans is relatively new for the Bank. While youth development and reproductive health are being addressed in a variety of formats, an effort to mainstream attention to children and youth is being proposed. As background for that decision, Bank staff analyzed projects funded between 1990 and 2002 in the Bank's Health, Nutrition and Population (HNP), Social Protection and Education sectors and found that 70 percent of 543 projects contained a "child and youth" component. The Bank's financial tracking mechanisms do not, however, enable it to determine the exact percentage of loans directed toward youth. It was possible to determine that most of the investments in each of the sectors were focused on younger children (10 and under). Social Protection projects supported interventions focused on children in poor and deprived social environments, including AIDS orphans and other vulnerable children, and on prevention of mother-to-child transmission of HIV.

From 1990 to 2002, HNP projects primarily benefited children under five through mass immunization coverage, improved nutrition, increased coverage and access to basic health services, and integrated management of childhood illness (IMCI) programs. However, a wide range of youth reproductive health issues were also addressed,[81] including education, gender, advocacy and policy development, reproductive health education for in-school and out-of-school youth, social marketing of condoms, service provision, care and support for AIDS-affected youth and orphans, and behavioral and other research.[82] Most HNP-managed projects also involved other sectors, such as education and transportation.

In the education sector, investment by the Bank from 1990 to 2002 predominantly benefited children younger than 10 in primary, rather than secondary, education. Spending on education increased during the 12-year period, particularly in Africa and the LAC region, and was focused on improving access to learning material, enhancing teacher effectiveness, and increasing physical school space in low-income urban areas.

### Girls' Education

The education of girls and women has been demonstrated to be a top-ranked social investment. Following the Cairo and Beijing conferences, the Bank substantially increased its investments in girls' education, and the ratio of expenditures for girls and boys became more equitable. Since 1995, girls' education as a total of all education lending at the Bank has been at 43 percent or higher. However, total spending for basic education has declined substantially from its peak in 1998. The Bank's Girls' Education Initiative recommends strategies to place emphasis on improving quality and relevance of education for girls, including efforts to increase the proportion of well-trained female teachers, gender sensitization for teachers, textbook revision to eliminate gender biases, development of gender-sensitive curricula and awareness campaigns to increase parental and community knowledge of the importance of girls' education. It also recommends improvements in school infrastructure, such as the construction of toilets and water sources, as well as the provision of nursery and pre-school centers attached to schools to allow girls to leave their children or younger siblings to be cared for while they attend classes.[83]

The Girls' Education Initiative Strategies, if implemented, have the potential to greatly influence the quality and quantity of education that girls receive. However, the decline in overall support for basic education, including girls' education – an investment with such a well-documented payoff – is difficult to understand, in light of the Bank's commitment to the World Education Forum in 2000 and to the MDGs.

### The Multi-Country HIV/AIDS Program (MAP)

The HIV/AIDS pandemic has brought increased lending and grants for youth reproductive health to the forefront, largely through the Bank's Multi-Country HIV/AIDS Program (MAP). MAP was launched in 2000 to help countries that have not been able to make progress in reversing the spread of the disease, due to a variety of factors including inadequate financing, poor government commitment and leadership, slow support for scaling-up effective programs, a lack of resources at the community level, and programs that have focused too narrowly on the health sector. All eligible countries have now applied for MAP funding. Nearly one billion dollars in financing has been made available.

The overall development objective of MAP is to scale-up access to HIV/AIDS prevention, care and treatment programs, with an emphasis on vulnerable groups including youth, reproductive-aged women, and other high-risk groups. MAP programs are generally multisectoral in nature, and nearly always include a youth component. Country programs are designed to be very flexible and to give the decision-making power to the stakeholders. A key feature of MAP is direct support to community organizations, nongovernmental organizations (NGOs) and the private sector for local HIV/AIDS initiatives.[84] Forty to 50 percent of all grants are for civil society, and 20,000 NGOs are now receiving small grants through the MAP mechanism. In Ghana, for example, MAP funding reaches an estimated 3,000 NGOs.

HIV/AIDS is, without question, a development crisis that must be addressed multisectorally, and must involve youth. MAP would appear to be a good entry point for initiating work on youth reproductive health within qualifying countries. As with the poverty reduction strategies, MAP projects are country-designed and owned. While this is a positive attribute, the Bank's disengagement from the projects' design or focus means that the Bank cannot assume that youth reproductive health is being adequately covered by MAP. For example, MAP now provides funds for antiretroviral drugs (ARVs) to treat AIDS. To what extent does the Bank monitor accessibility of these lifesaving drugs to poor youth and particularly to women and girls?

MAP is providing an avenue for increased Bank collaboration with youth. MAP representatives recently participated in a Pan-African Youth Forum at an AIDS conference in Senegal. The event was organized by the "Big 7"— International Federation of the Red Cross and Red Crescent Societies, World Organization of the Scout Movement, World Association of Girl Guides & Girl Scouts, World Alliance of the YMCA, World YWCA, International Award Association and the International Youth Foundation – representing more than 100 million young people worldwide. It aimed to encourage participants to develop and implement joint national youth AIDS prevention programs, and to seek youth involvement in an African coalition against AIDS. MAP staff provided information on the MAP program in language easily accessible to youth. They covered how to apply for MAP funding, and conducted a training of trainers on how to mobilize the MAP with a focus on youth.

## New Focus on Children and Youth

World Bank President James Wolfensohn's intention to invest more Bank resources in youth was signaled by the creation of the position of Child and Youth advisor in 2002. This position was charged with coordinating existing activities on youth and developing a comprehensive and multisectoral strategy for mainstreaming youth issues into the Bank's work. Attached to the Bank vice president's office in the Human Development Network, the advisor and team are developing more in-depth analyses of the links between poverty reduction and child and youth welfare. Most regions also have staff, including an Africa Child and Youth regional coordinator appointed by the Bank's office of the vice president, working directly on youth issues.

At a "Youth, Development and Peace" meeting providing young people with a forum to express their concerns and priorities for development and the World Bank,[85] Wolfensohn proposed creating a Youth Advisory Group (YAG) with representatives from at least two countries per region. These groups would give youth a platform to advocate for inclusion of their needs in country assistance and poverty reduction strategy documents. Interest in the YAGs has exceeded expectations: to date, 12 YAGs are operational, and 10 more are expected by the end of 2004. The Child and Youth advisor and team provide support to these groups.

## The Child and Youth Strategy

The World Bank Child and Youth Strategy (still in draft form at the date of this publication), was presented in Paris in January 2004 to international agencies, including the United Nations, NGOs and European bilaterals. The strategy addresses youth development and protection mainly through investments, including poverty reduction programs directed primarily toward achieving three MDGs: reducing child mortality, achieving universal primary education and eradicating poverty. The strategy does not place great emphasis on reproductive health.

The report highlights that parental investments in children (e.g., through education) may not be well-informed. For example, the well-documented association between girls' schooling and reduced risk of child mortality, and between improved child health and increased child schooling, may either be unknown or undervalued by the parents, or they may simply be too poor to invest, despite their best intentions. Therefore, the strategy recommends that public investments in children must be made to overcome these constraints. The country teams are advised to collaborate with government to identify obstacles to investment in children, and remove them, through donor and government financing.

The draft strategy calls for investing in children, especially those who are most vulnerable, as early in life as possible because these children are most at-risk for perpetuating poverty and for being denied their most basic rights. It recommends that the Bank support design of policies and investments that will achieve positive outcomes for youth, "particularly concerning progress toward fulfilling country obligations in the implementation of the Convention on the Rights of the Child and the achievement of the MDGs."[87] The draft strategy suggests that the Bank work on large-scale preventive activities, while supporting the efforts of other more specialized international and national agencies to mitigate the effects of negative outcomes at the local level.

Whether the draft Child and Youth Strategy paper becomes the blueprint for multisectoral mainstreaming of child and youth issues within the Bank depends in great part on continued high level political will to expand investments in youth. It also depends on buy-in from country managers and governments, and continued advocacy on the part of civil society seeking to advance child and youth issues.

### Youth Advisory Groups Lending New Voices to Bank Operations

A particularly active YAG called "New Voices"[86] is bringing a youth perspective to the Bank's operations in Peru. The first group of 13 students and young professionals, chosen for their experience as active leaders of youth organizations, consulted with Bank staff for several months on organizational capacity-building and proposals for youth-related policies. They also provided input to Bank staff on young people's needs, interests and expectations for development projects, and issues relevant to Peru and the region. In exchange, the youth received training on development topics, the regional and country portfolios, country assistance strategy preparation and Bank lending, indicators and assessment tools. Issues of gender, social inclusion and indigenous concerns were addressed through specific activities and guided access to the Bank's knowledge resources. Participation in YAG has increased the members' access to government and other development agents. While the number of direct youth beneficiaries is small, it is anticipated that when YAG members return to their own youth organizations, they will help build civil society capacity as they share the information and skills they learned with their colleagues.

## What is the Bank's Comparative Advantage?

The commitments made at international conferences over the past 15 years have called for multisectoral approaches to improve youth reproductive health. Both direct (e.g., services, supplies, drugs) and indirect (e.g., education, information, participation, legal framework) measures are required. Through its role as the largest lender for health, and its comparative advantage in the areas discussed below, the Bank has unequaled capacity to provide the leadership that will enable the international community to rise to the challenge of reducing poverty and improving youth reproductive health.

## Involvement in PRS Process

The preparation of Poverty Reduction Strategy Papers (PRSPs) by borrower countries presents a key opportunity for ensuring that youth reproductive health needs are integrated into national poverty eradication plans. PRSPs are the mechanisms through which borrower governments of highly-indebted poor countries (HIPCs) describe their macroeconomic, structural and social policies and programs to promote growth and reduce poverty, as well as associated external financing needs. PRSPs are to be prepared through a participatory procedure involving government bodies, civil society and other development partners, including the Bank. The PRSPs are assessed in part according to how well they build country ownership through participation, including that of civil society and the private sector. They should focus on achieving outcomes for the poor through accurately diagnosing the determinants of poverty, determining and setting appropriate targets, indicators and monitoring systems, and by prioritizing actions.[88] The PRSPs are evaluated by a Joint Staff Assessment (JSA) conducted by the Bank and the International Monetary Fund (IMF), which help the Board of the Bank's Executive Directors determine if a country's PRSP provides a sound basis on which to proceed with lending assistance and debt relief. The PRSP documents whether a poor country intends to address youth reproductive health. The PRSP leads to the preparation of the Country Assistance Strategy (CAS) and to lending.

HNP has undertaken an analysis of the extent to which PRSPs recognize reproductive health more broadly, and youth reproductive health specifically, as an investment necessary to reduce poverty. The HNP analysis has shown that youth development issues are often absent from poverty reduction strategies for a variety of reasons, including a lack of accurate data on the costs and benefits of interventions.[89] Few PRSPs identify youth as a vulnerable group, and very few link their action plans to specific youth targets and budget outlay.[90] The HNP analysis is useful in pointing out the vulnerability of a country-driven process that is not sufficiently well-informed of the links described above, or the importance of youth reproductive health to achieving the MDGs.

## Policy Dialogue

Youth are a country's most important asset. The Bank has tremendous power to shape development policy through its dialogue with borrower countries. One of its strengths is its convening power to bring together high-level officials and other development stakeholders to analyze a country's poverty situation, and the policies and institutions that exist or need to be created to improve development outcomes. Through loan negotiations, PRSP review and CAS preparation, as well as through large scale, high-level meetings, the Bank has ample and unparalleled opportunities to share critical development information that can influence how policies are created and implemented. For example, a regional workshop on girls' education held in Africa in the early 1990s was the impetus for major educational reforms in a number of countries. As a direct result of the participation of its Minister of Education in this meeting, Malawi initiated intensive efforts to increase the enrollment of girls in school.[91]

## Health Sector Reform

For more than a decade the Bank has worked with governments on health sector reform to create policies and institutions to improve health outcomes. Although youth reproductive health is a multisectoral issue encompassing gender, education, social protection, and other sectors, the health sector has a very influential role to play.

Most of the Bank's funding for reproductive health now flows through health reform projects. Areas of health sector reform that require special attention for youth include priority-setting, financing, service provision and quality. When countries are undergoing reforms, the question of how priorities are set features prominently. Priority-setting in health is always difficult, from both an economic and epidemiological perspective. In settings with great resource constraints, health issues are forced to compete with one another. Because youth have very little in place to serve their health needs at present, priority-setting for reproductive health of youth is especially difficult. Youth historically have not had specific services directed toward meeting their needs in the manner of maternal and child health services. Adolescence is perceived as a time of low health risks and costs. Furthermore, the health needs of youth are often not disease – but prevention-oriented, falling out of the typical calculus used to set health priorities.

Certain financing issues are of particular relevance to youth. Poor youth have little access to money to pay for user fees. If a country has insurance schemes in place to protect the poor, youth rarely have direct access to them. Governments need to make the delivery of health services more equitable by targeting services to the poorest and most vulnerable groups, including poor youth. Service provision and quality are particularly important for youth. Having staff trained to be responsive to the needs of youth and having the services provided in youth-friendly settings are quality issues. Health care providers need specific training and guidelines to help them deal with health issues that may conflict with their own values or local cultural norms. Gender sensitization and training in the requirements to protect the rights to privacy and confidentiality of all clients, including adolescents, are essential to remove many of the existing barriers to service utilization by youth.

## Multisectoral Work

A strength that the Bank potentially brings to the fight for improved youth reproductive health is its ability to work with all sectors relevant to a country's development, and its access to the leaders and institutions that can work synergistically to achieve development goals. The importance of a multisectoral perspective is illustrated in a recent case in which the Bank was invited to help

prepare a national strategy on children and youth. The Bank team included a macroeconomist, public health specialist, youth education specialist and child labor specialist. The team noted that girls' school enrollment was only 20 percent in rural areas. An earlier assessment had found that girls were carrying water and caring for younger siblings for up to 10 hours daily, leaving no time for school. An enormous Bank-supported water and sanitation project was underway in urban areas, but was not able to address the water and sanitation issues that kept rural girls out of school. The missed opportunities of the situation illustrate that all issues need to be analyzed from the household perspective, and all sectors that influence the decisions and options that youth have must be included.

## Research and Knowledge Sharing

The Bank has nearly 60 years of development experience and is a significant source of the international community's information base for carrying out development activities. The Bank has specialized expertise in economic and financial analysis, but has also contributed greatly to the evidence base across many other sectors. The Bank did groundbreaking work, for example, to help establish HIV/AIDS as a development issue. The Bank has an important role and responsibility to both further the research and to establish partnerships with the world's youth reproductive health experts in identifying the best available evidence. If the most salient information is properly disseminated, client countries and partners, as well as staff, will be in a better position to make decisions based on the empirical evidence rather than on ideological or political considerations.

In an effort to address the gaping lack of evidence for understanding where to best invest in youth, HNP commissioned the discussion paper, "Assessing the Economic Returns to Investing in Youth in Developing Countries."[92] The authors developed a life-cycle approach using cost-benefit analyses to examine 41 investments in broad categories, such as formal schooling, school-based reproductive health education for HIV/AIDS prevention, civilian and military training, and others. The evidence suggests that some types of investments, for example, in formal schooling, school-based health investment and efforts designed to reduce tobacco consumption, "yield economic returns that are at least as high as those for many investments in other sectors." The paper calls for further and better research on the effects of investments for youth as meriting the highest priority. It stresses the need to collect longitudinal data, give significant attention to measurement issues, and define and identify effective instruments.[93]

HNP also prepared an adolescent health and development (AHD) "Resource Guide for World Bank Operations Staff and Government Counterparts," which examines adolescent health more broadly than reproductive health alone. The guide is intended to support Bank staff in their policy dialogue with country counterparts, and to help them advocate for more attention to the needs of youth.[94] The guide provides an overview of AHD issues and their links to poverty, and provides examples of good practices from the Bank and other organizations. While the guide is a commendable step in furthering the Bank's work in youth health, the challenge will be to disseminate this information to audiences that need it most. The resource guide will be presented internally, announced through email correspondence and available on the Bank's web site.

In the 1990s, the Bank, in collaboration with WHO and other partners, built an extensive body of work on the societal burden of disease and the costs of prevention and treatment. The Global Burden of Disease initiative and the complementary Disease Control Priorities for Developing Countries project were very useful for estimating the health impact of major diseases and conditions, and the cost-effectiveness of various interventions for disease treatment and prevention.

More recently, Bank staff have played a leadership role in understanding the disease burden of the global poor. Proxies for wealth indicators were identified for the Demographic and Health Surveys, enabling health indicators to be examined by income quintile. The results are striking and make clear the extent to which poor health, unwanted pregnancies, child malnutrition, early childbearing and many other indicators are disproportionately more prevalent for those in the lowest quintiles of the income distribution. These data are used to illustrate that without specific policies and interventions that target the poor, overall health averages can improve without significant benefit to the poorest and most in need.[95]

This strategy was applied in a Bank series of papers entitled, "Inequalities in Health, Nutrition and Population," which provide an evidence base for policy recommendations for the PRSPs and CAS, by profiling the links between poverty and reproductive health. The papers examine youth reproductive health among other topics. They provide data, disaggregated by sex, age and wealth, on the nutritional status of adolescent girls, early marriage and childbearing, adolescent fertility, contraceptive use, and knowledge of sexual transmission of HIV/AIDS. Thus far, papers are available for 11 countries and Rajasthan State in India, on the Bank's website.[96]

In response to a request by the Caribbean Community and Common Market (CARICOM), Bank staff prepared a report entitled, "Caribbean Youth Development, Issues and Policy Directions." The objectives are to identify the risk and protective factors and determinants of youth behavior and development, demonstrate that negative behaviors have costs for youth and society, and identify key intervention points.[97] The report's rough estimations of the economic costs of negative outcomes for youth, such as school drop-out, adolescent pregnancy, HIV, youth unemployment and youth violence, are significant steps in making the case for investment in youth as a means to poverty reduction and development.

## The World Bank Institute

The World Bank Institute's (WBI) learning programs in reproductive health and poverty reduction are examples of the Bank's strength in knowledge-sharing through training. Beneficiaries include country clients, other development agencies and its own staff. The courses bring together health care practitioners, government officials, civil society and other interested parties from different sectors to share knowledge and expertise, and to build partnerships towards achieving the ICPD and the MDGs. The course, entitled, "Achieving the Millennium Development Goals: Poverty Reduction, Reproductive Health and Health Sector Reform," aims to build capacity for countries to improve reproductive health outcomes by strengthening participant skills and capacity to make their reproductive health programs more equitable,

efficient and financially sustainable. The course builds the epidemiological, demographic, business and rights case for working on reproductive health. It provides tools to conduct prioritization, cost-benefit and stakeholder analyses, and gives an overview of health sector reform issues. Some youth issues are addressed, e.g., gender equity, power relations and belief systems as they relate to adolescent pregnancy. The course is offered globally and regionally, with some regional courses having a specific session on youth reproductive health.

Another learning activity entitled, "Gender, Health and Poverty," was designed to assist countries in analyzing, designing, and developing more gender equitable health policies and programs, and to help members of PRSP teams enhance their understanding of how gender and health issues can be integrated into sectoral programming for achieving the MDGs. The course uses the life cycle approach to identify critical gender and health links. It covers topics such as gender and HIV/AIDS, violence, lack of access to services for the poor, early marriage, female genital mutilation, exploitation of young girls by older men, male responsibility, and other subjects critical for youth, although these are not explicitly identified as youth reproductive health topics.

## Encouraging Innovation

The search for better ways to carry out development projects is an ongoing process. The Bank is involved in some small-scale activities that both encourage and incubate innovation. These projects are opportunities for learning and, if determined through rigorous evaluation to be successful, can be scaled up with additional Bank support. While these projects are small, they capitalize on existing investments and present opportunities to incorporate reproductive health activities into non-health projects.

As an example, the Youth Information and Technology pilot project in Uganda is providing 550 in- and out-of-school youth with skills for obtaining employment and creating new businesses. The project links training with entrepreneurship skills development at 11 pre-existing Internet Learning Centers established by the World Links Organization (originally a Bank program, and now an independent NGO). This training has been extended to local women's groups. This project will also examine the links between youth livelihood and HIV/AIDS, and help identify indicators to demonstrate the relationship between livelihoods and behavior change relative to HIV/AIDS. In that sense, this small project can be a pilot study for more ambitious efforts.

# PART III

# Recommendations to Further the Bank's Work on Behalf of Youth Reproductive Health and Meeting the MDGs

## Increase Lending and Grants to Achieve the MDGs

The Bank must identify and supply the financial resources countries need to meet the MDGs. Countries can be held accountable to the extent that they have sufficient resources to meet the MDGs. The resources needed to meet the goals have yet to be identified on a country-by-country basis. Capitalizing on the Bank's expertise in economic and financial analysis of development issues, the Bank can contribute substantially to establishing the financial needs and objectives for youth reproductive health spending. The Bank can help lead a comprehensive study of global investments. It must then use these investment needs to petition for more funds from its members, particularly the United States.

## Improve Financial Tracking and Reporting by Target Beneficiaries

The Bank's financial tracking systems must be improved to enable reliable estimates about how much is being spent on youth and youth reproductive health. Mechanisms must be set in place to monitor whether budgets are being allocated and spent on interventions for youth reproductive health within and across sectors. The Bank can establish accounting mechanisms capable of tracking such spending, enabling it to monitor country commitments to youth.[98] Internally, the Bank should monitor its own overall spending (on loans, research, training, etc.) for youth development, and for youth reproductive health specifically. The Bank tracks its financial information in a system called the "Business Warehouse." This system requires project managers to code their projects according to themes such as transportation, health, education, agriculture, etc. It does not allow for categorization based on project beneficiaries such as youth or women. Therefore, unless youth are the sole project target group, it is extremely difficult for those within or outside of the Bank to determine how much is being spent or loaned on youth and development. Unless the coding system of the Business Warehouse is changed, or a new system put in place that enables such calculations, the Bank will not be able to demonstrate to the international community how its spending correlates with its new stated emphasis on youth and development issues. Such a change will benefit the Bank's internal operations, as well as make it feasible for those outside the Bank to track expenditures. This will increase the Bank's accountability and transparency.

## Identify New Funds for Youth Reproductive Health

The Bank, in collaboration with its partners and member countries, should create a trust fund to support innovative efforts to mainstream youth reproductive health issues into Bank projects. Achieving the MDGs will require more focused sectoral work specifically on youth reproductive health, and more funding within the HNP, Education, and Gender sectors, as well as HIV/AIDS, including MAP. Special funds should be made available to staff to encourage innovation in mainstreaming youth issues into the Bank's work. Some of the Bank's current research on gender, with specific implications for youth reproductive health, has been financed through the Norwegian/Dutch Fund for Gender Mainstreaming (GENFUND). GENFUND is supporting research on young men and behavior change communication (BCC), social roles in HIV/AIDS and violence, and a study examining gender issues in relation to youth and HIV/AIDS in Uganda and Ethiopia. Targeted trust funds can serve as an incentive for staff to seek creative solutions for improved youth reproductive health and development outcomes.

## Expand Engagement with and Support of Civil Society

The Bank should provide the resources and guidance to enable and encourage greater involvement of civil society organizations (CSOs). The Bank has expressed its desire to work more openly and effectively with CSOs.[99] CSOs with expertise in youth and reproductive health issues should be encouraged to be active in the PRS process. Civil society is not only a primary driving force behind social and policy reform; when governments undergo changes in leadership or structure, CSOs can serve as the mechanism through which issues, including youth reproductive health, remain prominent. Without such continuity, policies can backslide. In Kenya, the development of a national Adolescent Reproductive Health and Development Policy was driven by a network of advocacy and research organizations. The Bank can learn from this experience. (See Kenya Case Study, Page 22).

To be effective, CSOs must have access to information, a voice in policy dialogue and input into how those policies are implemented. They also need financial resources. For example, MAP provides significant support to CSOs, but many youth-focused organizations need specific guidance on how to develop proposals and apply for funds. Support for organizations that work for and with youth is also needed from sources other than MAP. The Bank has some funds within its population and reproductive health capacity-building program that are not sufficiently publicized. In 2003, the program's budget was US$2 million and 16 grants were made. This program should be made more accessible and expanded. Other funding mechanisms, such as the Small Grants Program disbursed through the Bank's country offices, should be used to help local communities learn about youth and development issues. The Bank should also draw on trust funds such as the Japan Social Development Fund, specifically set up to strengthen the ability of CSOs to access Bank funding.

## Expand and Apply the Evidence Base

The Bank should expand the evidence base on the synergies among youth reproductive health, poverty reduction and economic growth, and apply the knowledge throughout its lending and analytical processes. The authors of the report, "Assessing the Economic Returns to Investing in Youth in Developing Countries" recommended that the Bank carry out further research on investing in youth, and broadly implement investments where quantifiable effects to particular youth reproductive health interventions had been demonstrated.[100] Continued research to show the economic and social benefits of improved youth reproductive health is necessary to enable the Bank's own staff to advocate for these issues, as well as to help countries make decisions about how to invest in their own youth.

The Bank must apply its strengths in analyzing the costs and benefits of health outcomes, and the services required to improve and sustain those outcomes to the field of youth reproductive health. The Bank should maximize use of its health equity analyses, particularly by country, to further understanding of and action for pro-poor policies and interventions. Without specifically targeting the poor, the benefits of most interventions will flow first to those less severely affected and more able to pay.[101] The Bank should ensure that papers such as the "Inequities in Health, Nutrition and Population" series are prepared for all countries undergoing the PRS process. These papers can also be used for cross-country and cross-regional analyses. The Bank should use its global view to study regional challenges and trends, as it did in the Caribbean Youth Report, and use the findings to influence policy dialogue. The Bank should continue its work (and support the work of its partners) on the creation of new measurement tools to assess both the medical and non-medical benefits of improved youth reproductive health.

## Improve Evaluation of Development Effectiveness

All Bank activities – for youth reproductive health and in general – should include sufficient investment in evaluation of outcomes to enable sound decision-making. Failure to learn from investments should not be an option for those managing or receiving development assistance. A paucity of sound empirical evidence is frequently cited as a reason that youth reproductive health interventions are not considered cost-effective, or are simply not considered at all.[102] All organizations investing in youth reproductive health, including the Bank, must improve the evaluation of interventions if progress is to be made in understanding what works or does not work to improve youth reproductive health. Youth survival depends on empirically sound investments.

The Bank has acknowledged its own shortcomings in being able to demonstrate the effectiveness rather than merely the volume of its lending programs.[103] Evaluation capacity within many of the Bank's client countries is also known to be weak. The Bank has stated that it wants to increase its focus on the results of its development efforts. In order to "rectify a lack of statistical capacity in developing countries,"[104] the Bank announced in early 2004 that (subject to approval by the Executive Board) it was considering a new project called STATCAP. STATCAP may enable an opportunity to establish baselines, collect youth reproductive health data disaggregated by age and sex, and measure progress

## Civil Society and The Adolescent Health and Development Policy in Kenya: A Case Study

Kenya has a history of strong church-based opposition to sex education in the schools and a history of reproductive health service provision being "unfriendly" to the cause of youth reproductive health. The Centre for the Study of Adolescence (CSA) in Nairobi had conducted more than a decade of research to identify the reproductive health problems faced by adolescents. Despite the documentation of need, references to youth reproductive health in the proposed National Population Policy were very contentious, and church-led opposition to family life education in the schools held up approval of the policy for a couple of years. Advocates began to develop a separate youth reproductive health and development policy that would serve as a step toward implementation of the population policy.

The Kenya Association for the Promotion of Adolescent Health (KAPAH), a coalition of 45 organizations that conduct ARH policy research and advocacy, analyzed the gaps in legislation and policy in 2001, and identified the areas where advocacy was needed to implement the policy. Together with CSA, KAPAH developed research brochures and fact sheets on adolescent reproductive health (ARH) issues to inform and influence the policy debate.

KAPAH trained respected adults as youth advocates to lobby opinion leaders and parents, and to speak out against early marriage and other violations of gender equity. KAPAH sought input from youth on what the policy should address and drafted language that became the core of the policy. This draft was reviewed by subcommittees on research and reproductive health of the National Council for Population and Development, by technical experts and by representatives of ministries, NGOs, universities and faith-based organizations. Foundations and NGOs working in Kenya supported the process. The policy was approved in 2003. The ARH policy is now seen as a subset of a more broadly focused National Youth Policy for 15 to 29-year-olds which was drafted in 2003.

While the creation of the ARH policy was a major breakthrough, a number of implementation challenges remain. A condom policy provision stipulates that information on HIV and condoms should be available to all sexually active people, regardless of age. However, the effectiveness of condoms has continued to be denigrated by the Catholic hierarchy. Conservative faith-based leaders have persisted in their efforts to make sex education taboo, but the HIV epidemic is softening this opposition. The Return to School policy gives pregnant girls the right to return to school, but expulsion remains the norm. A Children's Parliament, in which all members are under age 21, has representative counterparts for the full government portfolio, but ownership of the youth program remains in the hands of adults.

Additionally, in order for young people to be involved in advocating on their own behalf, they need training in advocacy skills to overcome reticence and to understand their rights. Skills are needed to enable both teachers and students to address gender inequities. Little is being done to expose boys to more gender-equitable norms and roles. Financial and technical support are needed to implement the plan.[105]

How the Bank can help implement and further development of youth RH policies in Kenya and elsewhere:

- Identify and financially support reputable advocacy, policy, research, service and youth CSOs that formulate or implement progressive and fact-based ARH policies and programs.
- Engage in policy dialogue on youth with governments and appropriate ministries.
- Disseminate successful processes that have led to national youth policies.
- Support UN agencies and donors working to influence the development and implementation of youth policies.
- Directly support youth and reproductive health service providers, through mechanisms such as MAP.
- Conduct or support analytical work to build the empirical base on youth reproductive health.

Chip Thomas, Global Health Council

towards the MDGs. While this new lending program, if successful, will be one step toward building capacity in borrower countries to gather and analyze statistics for policy development, other steps must be taken. Few PRSPs include indicators related to adolescent health.[106] The Bank must help HIPC countries clearly define indicators and benchmarks for monitoring and evaluation of youth interventions.

Good data can contribute to good governance by demonstrating that funds were effectively used to achieve the desired outcome. This applies to countries, as well as to the Bank itself. Improving the Bank's own data collection and monitoring and evaluation processes and presenting the information in a transparent format would be advantageous for the Bank, enabling it to show the international community exactly how it is implementing its commitment to poverty reduction and the MDGs.

MAP presents an important learning opportunity for the Bank and the international community. Because three to five percent of MAP funds have been stipulated for monitoring and evaluation, the Bank and its UNAIDS partners have the opportunity to collect data and conduct cross-country analyses to evaluate the success of youth-focused approaches. The Bank and other organizations should assure that MAP's successes and failures are documented and disseminated to those most in need of the information. Sound evaluation demonstrating effectiveness is the best evidence on which to base decisions to replicate or scale-up interventions.

## Increase and Improve Knowledge-Sharing Efforts

For the Bank to be a true "knowledge bank" it must ensure that its information is comprehensive, and reaches those who need it most. In 1996, the Bank announced its commitment to develop a "world-class knowledge management system to improve and expand the sharing of development knowledge with its clients and partners."[107] An internal evaluation by the Bank's Operations Evaluation Department concluded that while the Bank is good at generating research, it falls short when it comes to disseminating the information on a large scale.[108] If is to be a knowledge bank for the world, and not just for its own staff and members, it is important to rectify this. The Bank's research on youth and on youth reproductive health must be distributed to those who need it, including youth, in the appropriate media, and in national and local languages as necessary. All research budgets should include a funded dissemination strategy. For those with Internet access, the Bank's website provides reasonable access to most project documents and sector reports. The Bank's 'Youthink!' website **http://youthink.worldbank.org/** offers news, photos and networking information for youth and teachers. However, those who might benefit the most from such information, e.g., civil society organizations representing poor youth, may lack access to electronic dissemination.

All of the Bank's publications should be available free of cost in both print and electronic formats. For example, the Caribbean Youth Report is currently available only for purchase, whether in hard copy or on-line. It is counterproductive to the Bank's own objectives to create financial barriers that restrict access to such a report.

The World Bank Institute (WBI) course, "Achieving the MDGs," is the Bank's largest learning forum for helping countries make progress toward the ICPD goals and MDGs related to reproductive health. If the Bank is to mainstream youth issues into its work, it must ensure that youth are appropriately addressed through WBI learning activities, so that all staff and other stakeholders have basic familiarity with the issues. This will require collaboration among the Child and Youth advisor, the HNP unit, MAP and other sectors, and may be facilitated by hiring a youth specialist to coordinate this effort. Without the youth dimension, essential information that WBI participants need to develop appropriate responses to meeting the MDGs is missing. Similarly, the "Gender, Health and Poverty" course presents an opportunity to address gender inequity as central to the reproductive health challenges youth face. The course can make much more explicit how the linkages translate into differentiated policy solutions to empower girls and socialize boys in more gender-equitable norms and behaviors. The Bank should draw on the expertise of civil society organizations on these issues.

## Leverage the PRS Process in Support of the MDGs

Where a rigorous poverty analysis does not identify youth reproductive health as central to poverty reduction and progress towards the MDGs, the Bank must facilitate this understanding to ensure that countries do not overlook and exclude youth issues. The Bank must ensure that countries have the necessary information, tools, technical expertise, models and resources to accurately diagnose and address their poverty situations. PRSPs are an important opportunity for the Bank to help countries determine if their strategies will move them closer to meeting the MDGs. The right stakeholders must be identified, and their needs addressed through the appropriate resources. PRSPs often demonstrate weak understanding of the relationship between youth reproductive health and poverty. Even where the connection is noted, specific interventions may not be proposed or indicators included to measure progress. While the Bank has shown reluctance to intervene in this country-driven process despite notable gaps in the poverty analysis, the MDGs present the impetus for the Bank to more proactively seek action on commitments that governments have given to make progress toward the goals. The HNP series on inequalities in health is an excellent resource for dialogue, as the papers demonstrate the importance of pro-poor strategies. The Bank must ensure that the issues identified have realistic implementation plans and budgets, and that the focus on youth reproductive health is maintained in the country assistance strategy.[109]

Progress toward achieving the MDGs will be most efficient if poverty reduction strategies adopt a synergistic multisectoral approach. For example, 27 of the World Bank's 31 Girls' Education Target Countries are also HIPC countries and thus participate in the PRS process. The targeted countries were identified on the basis of especially large gender disparities in enrollment. The Bank prepared baseline profiles of each country to monitor progress and found that some countries were not on track to meet the MDG for girls' education. As Table 4 (Part I) illustrates, HIPC countries also have among the highest levels of adolescent fertility, maternal mortality and several other interrelated indicators of poor health. The Bank should undertake and support more rigorous analyses directly related to youth reproductive health and its links to education. The Bank must help identify how these interrelationships can most usefully be addressed through multisectoral approaches that maximize progress toward the MDGs.

## Use Health Sector Reform Mechanisms to Serve the Reproductive Health Needs of Youth

The Bank must help countries analyze and address youth reproductive health issues as part of the health sector reform process. Health sector reform may have done little to help achieve the ICPD Program of Action goals,[110] but enabling youth perspective and participation in the redesign of health systems is one way the Bank can help governments meet the needs of youth. Through increasing youth access and utilization, health sector reform may enhance progress toward the MDGs. Most of the Bank's non-HIV reproductive health lending now occurs through health sector reform projects. If youth are to be included in reproductive health services and assessments, they must be brought to the forefront of the health sector reform process. The Bank must help governments understand how the reforms benefit or exclude the most vulnerable groups and why they should invest in policies and institutions that benefit youth. Attention to the needs of youth, for example, through involvement of youth stakeholders, provision of free or reduced-cost youth-friendly services, and observing youth rights to privacy and confidentiality, will increase youth demand for and use of services.[111] The Bank should also encourage countries undergoing reform to strengthen their public and private partnerships with civil society organizations as a means of reaching more youth with services.

## Include Rights Conventions in Policy Dialogue

The Bank must raise its voice in support of the human rights of youth. Nearly every country in the world is a signatory to the Convention on the Rights of the Child, and other international agreements that protect the human rights of children and youth. The Bank's draft Child and Youth Strategy states that the Bank cannot hold countries accountable for upholding the human rights commitments to which they have agreed, (i.e., through lending restrictions based on the country's human rights record) but recommends that these obligations can and should be brought into the policy dialogue. The Bank should not ignore situations where rights are being denied or are not being upheld/enforced; for example, where young women are not protected from early marriage or do not have legal recourse for rape. Human Rights Watch has documented the extent of HIV/AIDS-related human rights abuses of girls and women, and indicated that the failure of states to protect women and girls from such abuse is fueling the AIDS epidemic.[112] It is incumbent upon the Bank to maximize opportunities to raise these issues in high-level meetings and to make its own position in support of the rights of youth, as well as adults, very clear and public.

## Support Youth Involvement

The Bank should encourage the meaningful participation of youth in all phases of developing and implementing policies and poverty eradication strategies. It is clear that youth involvement can range from token representation to true shared decision-making. Engaging youth as partners in development builds capacity and empowerment among youth themselves, and contributes to sustainability of efforts.[113] The creation of the Youth Advisory Groups, (YAGs), is a positive step for the Bank. Opening its procedures and processes to youth, and allowing them to voice their needs and opinions in the development of country assistance and poverty reduction strategies, establishes youth as viable stakeholders in a country's development. Furthermore, it increases transparency, enhances Bank access to civil society represented by youth, and has the potential to strengthen civil society organizations addressing youth concerns. As the groups become more experienced, the Bank should document the extent to which YAGs are allowed true participation in PRSP and CAS preparation, where and how the members influence policy development, and the impact those policies have on the intended development beneficiaries and outcomes.

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*'The Bank should encourage the meaningful participation of youth...'*

## CONCLUSION

### Commitments to the World's Youth

The achievement of the Millennium Development Goals will entail doing more development, and doing development differently. Nowhere are the challenges and the potential returns greater than in the area of youth reproductive health and development.

By virtue of its role as the largest lender for health, and its unique capacity for analysis, policy dialogue and partnership development, the World Bank is well-positioned to provide the global leadership required for the achievement of the MDGs. So too is it uniquely able to coalesce and support the broad international partnerships required to advance the health and educational status of young people.

This report highlights some steps already taken by the Bank to place youth more prominently on the global development agenda. The advocacy of the Bank's most senior leadership and its investments in policy and economic analysis speak to a growing institutional commitment to youth. The test of global leadership on the MDGs will be in their translation from national and international political commitment into results at the community level. Without results, global commitments can give rise to global cynicism, ultimately undermining future development endeavors.

There is clearly much more to be done.[114] According to a 2004 analysis by the World Economic Forum, few countries are presently on track for achieving the MDGs. Some governments are "scarcely trying," ranking three to four on a 10-point scale, in terms of pursing policies and programs that are needed to meet the goals.[115] And many of those countries that embrace the concept of the MDGs lack the funding to realize them in the proposed timeframe.

The challenge to the Bank is as immediate as it is formidable. Supporting countries in achieving their goals will not only require more money: it will entail developing inclusive partnerships to address technically and socially complex issues, policies that enable coherent strategies across multiple sectors, strengthened institutional capacity for program delivery, and sustainable and equitable financing approaches.

In each of these areas, the Bank has an influential role to play in addressing the needs of the poor and in championing the well-being of young people. The Bank's commitment to youth – to their reproductive and general health, their education and their livelihoods – is recognition that this giant generation is a critical asset to the achievement of the Millennium Development Goals.

Photo by UNHCR

*'There is clearly much more to be done.'*

## Acronyms and Abbreviations

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ARH | Adolescent Reproductive Health |
| ARV | Antiretroviral Drugs (for AIDS) |
| BCC | Behavior Change Communication |
| CARICOM | Caribbean Community and Common Market |
| CAS | Country Assistance Strategy |
| CSA | Centre for the Study of Adolescence |
| CSO | Civil Society Organization |
| DALY | Disability-adjusted life year |
| DHS | Demographic and Health Surveys |
| GENFUND | Norwegian/Dutch Trust Fund for Gender Mainstreaming |
| HIPC | Heavily-Indebted Poor Countries |
| HIV | Human Immunodeficiency Virus |
| HNP | Health, Nutrition and Population |
| IMCI | Integrated Management of Childhood Illnesses |
| ICPD | International Conference on Population and Development |
| JSA | Joint Staff Assessment |
| KAPAH | Kenya Association for the Promotion of Adolescent Health |
| MAP | Multi-country AIDS Program |
| MDG | Millennium Development Goal |
| MMR | Maternal Mortality Ratio |
| LAC | Latin America and the Caribbean |
| NGO | Nongovernmental Organization |
| PRS | Poverty Reduction Strategy |
| PRSP | Poverty Reduction Strategy Paper |
| RH | Reproductive Health |
| STATCAP | Statistical Capacity Building Program |
| STI | Sexually Transmitted Infection |
| UN | United Nations |
| UNAIDS | United Nations Programme on HIV/AIDS |
| UNESCO | United Nations Education, Scientific and Cultural Organization |
| UNFPA | United Nations Population Fund |
| WBI | World Bank Institute |
| WHO | World Health Organization |
| YAG | Youth Advisory Group |
| YMCA | Young Men's Christian Association |
| YWCA | Young Women's Christian Association |

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