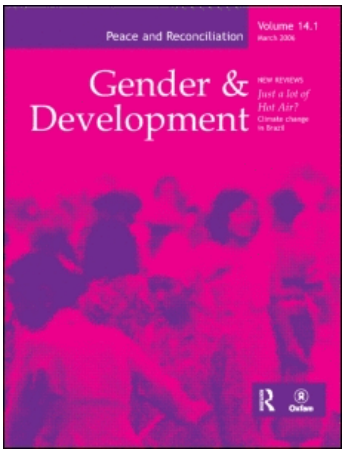

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Mapping multilateral development banks' spending on reproductive health and HIV and AIDS

Suzanna Dennis and Elaine Zuckerman

This article draws on recent research by Gender Action, presented in a ground-breaking report investigating multilateral development banks' (MDBs) spending on reproductive health and HIV and AIDS. Gender Action demonstrates a decline in World Bank loans and grants for reproductive health and HIV and AIDS, and little contribution to this sector from the African Development Bank, Asian Development Bank, or Inter-American Development Bank. Mapping also charts unmet MDB commitments to reproductive health and HIV and AIDS, and harmful loan conditions such as restricting public spending, which undermine poor countries' ability to address these key public-health issues.

Introduction

Reproductive health and HIV and AIDS are gender issues. Women constitute half of the 34 million people who, by UNAIDS estimates, are living with HIV worldwide. In sub-Saharan Africa, 57 per cent of adults with HIV are women, and in Africa as a whole, 74 per cent of young people with HIV are women. Shortages in reproductive and sexual health care account for nearly 20 per cent of illness and premature death worldwide, and one-third of illness and death among women of reproductive age (UNAIDS 2006). Violence, poverty, inequality, and lack of basic rights all need to be addressed to increase women's and girls' access to quality reproductive health and to tackle HIV and AIDS. Addressing men's and women's gender roles is integral to this process.

Most of the multilateral development banks (MDBs) have pledged to help achieve the Millennium Development Goals (MDGs). To achieve these commitments, the MDBs – including the Asian Development Bank (ADB), African Development Bank (AfDB), Inter-American Development Bank (IDB), the International Monetary Fund (IMF), the European Bank for Reconstruction and Development (EBRD), the European Investment Bank (EIB), and the World Bank and its private-sector lending arm, the International Finance Corporation (IFC) – which together spend over a hundred

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billion dollars each year in 'development aid', must address the nexus of poverty, reproductive health, and HIV and AIDS. Therefore, this article asks: what are the largest multilateral 'development institutions', collectively owned and controlled by governments, doing to improve the status of reproductive and sexual health and rights; prevent and treat HIV and AIDS; and impede progress in these areas? Are they meeting their promises to reduce poverty, and HIV and AIDS, and improve reproductive health?

Scanning the health, reproductive health, and HIV and AIDS policies and investments of the MDBs and the IMF, we found only four MDBs address reproductive health and HIV and AIDS to any extent.[1] Among MDBs, the World Bank invests most in reproductive health and HIV and AIDS, although this funding is decreasing. Average World Bank expenditures on reproductive-health and HIV and AIDS projects and components constituted less than 6 per cent of total spending annually from 2003 to 2006, and we estimate the actual figure is much lower.[2] The ADB, AfDB, and IDB support considerably fewer reproductive- health and HIV and AIDS projects than does the World Bank. During 2003 to 2006, average spending on reproductive health and HIV and AIDS at the AfDB, ADB, and IDB was less than 1 per cent of total spending.

Our findings reflect previous research findings from Gender Action, and others, demonstrating the MDBs' overall failure to address gender inequality and help the neediest members of society. Our qualitative analysis revealed gender sensitivity within some MDB projects, but the majority of projects fail to integrate gender issues. Many projects describe the plight of women or discuss gender inequality, but fail to address these issues in project design. In fact, MDB operations often increase poverty and gender inequality, contribute to the spread of HIV, and undermine reproductive health, despite MDB promises to the contrary.[3]

While significant other funders – such as The Global Fund to Fight AIDS, Tuberculosis and Malaria, and private foundations – are outspending MDBs on reproductive health and HIV and AIDS, we argue that so long as the MDBs continue to operate, they should spend a larger proportion of their vast resources on grants addressing these pressing issues. They should also improve the quality of their existing reproductive-health and HIV and AIDS investments by making them more gender-sensitive, and do away with harmful conditions that undermine poor governments' ability to confront these challenges.

The first part of this article briefly maps all MDB and IMF commitments regarding reproductive health and HIV and AIDS. The second part tracks MDB funding for reproductive health and HIV and AIDS from 2003–2006. The third part is an analysis of the quality of MDB reproductive-health and HIV and AIDS projects. We then examine MDB and IMF practices that undermine the achievement of reproductive-health rights and the prevention and treatment of HIV and AIDS. Finally we offer concluding thoughts.

The article summarises the report 'Mapping Multilateral Development Banks' Reproductive Health and HIV/AIDS Spending', published by Gender Action in September 2007 (Dennis and Zuckerman 2007).[4] For a full list of the MDB reproductive health and HIV and AIDS projects analysed, as well as more detailed financial and gender analyses, please see the full-length report.

Commitments

MDB commitments in all sectors are embodied in their policies. Out of eight MDBs and the IMF, only four MDBs – the ADB, AfDB, IDB, and World Bank – have policies, strategies, and action plans to improve reproductive-health services and/or treat and prevent HIV and AIDS. These are also the only MDBs that provide loans and grants for reproductive health and HIV and AIDS. The ADB has a health-sector policy that incorporates reproductive-health and HIV and AIDS issues, as well as a separate population policy, and an HIV and AIDS strategy. The AfDB has a policy on population, as well as a health-sector policy, guideline, and an HIV and AIDS strategy, most of which are not available for review on their website. The IDB has a public-health policy, which discusses reproductive health but fails to address HIV and AIDS, and a population policy. The World Bank has a health, nutrition, and population strategy, which includes reproductive health and HIV and AIDS.[5] The Bank also has a 'Global HIV/AIDS Program of Action', and five regional HIV and AIDS strategies.

The EBRD, IMF, and Islamic Development Bank do not have health-sector strategies. The IFC and the EIB have health-sector strategies that do not address reproductive health or HIV and AIDS.[6] These institutions do not provide loans or grants for reproductive-health and HIV and AIDS services, and therefore will be discussed minimally.

In endorsing the MDGs, the majority of the MDBs and the IMF have implicitly committed to promote reproductive health, curb the spread of HIV, and treat HIV or AIDS-related illnesses. The MDGs include goals relevant to this article: Goal 5: Improve maternal health, which is related to reproductive health; and Goal 6: Combat HIV-AIDS, malaria, and other diseases.

Funding

Gender Action compiled a list of dedicated MDB reproductive-health and HIV and AIDS projects, and projects with reproductive-health and HIV and AIDS components, to assess the quantity and quality of MDB funding for these two issues. In this section, we try to calculate the quantity of MDB funding for projects addressing reproductive

health and HIV and AIDS, in the four years from 2003 to 2006. The next section examines the quality of this funding.

Since the World Bank is by far the largest MDB funder for reproductive health and HIV and AIDS, and its HIV and AIDS funding is declining, we begin by discussing trends in World Bank funding for these themes from 2003 to 2006, and continue from largest to smallest funder.

The World Bank

While World Bank rhetoric on HIV and AIDS is strong, the number of projects and funding is steadily declining. The World Bank approved, on average, 15 reproductive-health projects and components per year between 2003 and 2006, for a total of $4.7bn. World Bank funding for HIV and AIDS decreased from a high of $1.3bn for HIV and AIDS projects and components in 2004 to a low of $405m in 2005, and increased slightly in 2006. World Bank reproductive-health or HIV and AIDS investments are often components of larger health, education, and public-administration projects. As previously stated, we looked at entire project amounts in our research, because the World Bank does not routinely value component amounts independently of total projects. This results in a large overestimate of World Bank funding for these two areas. World Bank figures are also inflated because the Bank's project database does not distinguish between projects with reproductive-health components and those with a

Table 1: Total MDB Funding for Reproductive Health and HIV and AIDS Projects and Components, 2003–2006 (US$)

	Reproductive Health*		**HIV and AIDS****		
	Loans	Grants	Loans	Grants	Total
AfDB	$105,300,000	$2,850,000	$14,570,000	$29,270,000	$151,990,000
ADB	$0	$1,357,000	$2,020,000	$44,950,000	$48,327,000
IDB	$71,600,000	$2,169,000	$0	$2,274,840	$76,043,840
World Bank	$3,686,360,000	$1,041,150,000	$2,120,500,000	$1,328,400,000	$8,176,410,000
Total:	$3,863,260,000	$1,047,526,000	$2,137,090,000	$1,404,894,840	$8,452,770,840

*For ADB, AfDB, and IDB, approved projects compiled from keyword searches of each MDB project database and/or website for 'reproductive', 'maternal', 'population'. World Bank approved projects obtained by compiling projects in the World Bank project database that matched the theme 'population and reproductive health'. World Bank project amounts are highly inflated due to a large number of projects with small reproductive-health components.

**For ADB, AfDB, and IDB, approved projects compiled from keyword searches of each MDB project database. World Bank approved projects obtained by compiling projects in the World Bank project database that matched the theme 'HIV and AIDS'. World Bank project amounts are highly inflated due to the presence of large projects with small HIV and AIDS components.

population focus. More research is needed to disaggregate these amounts, but that depends on the World Bank refining its thematic financial reporting.

Chart 1 reveals a striking recent decline in World Bank investments for HIV and AIDS. The amount of funding and number of HIV and AIDS projects and components has clearly declined from a peak of $1.3bn for 23 projects in 2004 to $790m for ten projects in 2006. That is a 40 per cent decline in funding and a 57 per cent decline in the number of projects. Funding for population and reproductive-health projects and components has also declined, albeit less dramatically: in 2003 the Bank allocated $1.8bn but by 2006 the Bank decreased this amount by nearly 30 per cent to $1.3bn. The number of World Bank projects for reproductive health has remained steady each year, at between 14 and 16.

World Bank spending on reproductive health and HIV and AIDS projects and components *as a percentage of total World Bank spending* was 5.7 and 4 per cent on average, respectively, from 2003 to 2006. Starting in 2000, World Bank funds for reproductive health and HIV and AIDS as a percentage of total spending began to climb, and spiked in 2003 and 2004, respectively. Funding then declined, but has started to rise again. As mentioned above, these averages reflect total project amounts, which often far exceed reproductive health and/or HIV and AIDS component amounts.

African Development Bank[7]

The AfDB is the second largest funder of reproductive health and HIV and AIDS projects and components. From 2003 to 2006, it approved $108m for three reproductive-health projects and components, and $44m for six HIV and AIDS projects and components. Its portfolio is heavily weighted in favour of loans for reproductive-

Chart 1: Approved World Bank Funding for Reproductive Health (RH) and HIV and AIDS Projects and Components, 1986
Source: Dennis and Zuckerman 2007:11. World Bank funding for population/reproductive health and HIV and AIDS projects and components remained fairly steady from 1990 to 2002, spiked in 2003 and 2004, declined, and has started to rise again.

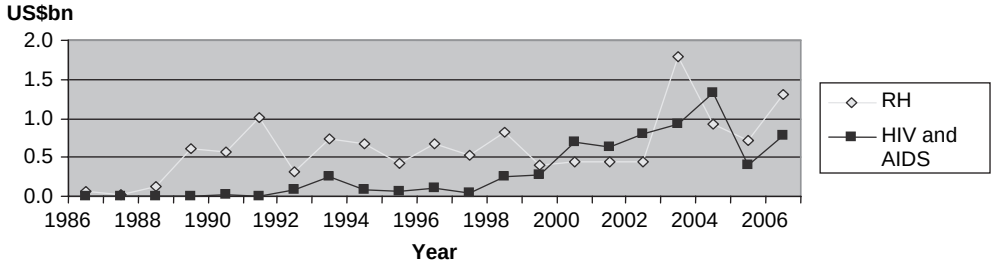
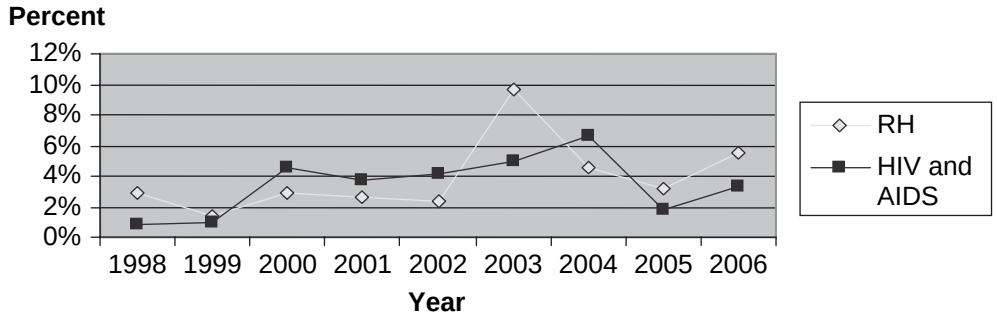


Chart 2: Approved World Bank Funding for Reproductive Health (RH) and HIV and AIDS Projects and Components as a Percentage of Total Approved Lending, 1998–2006
Source: Dennis and Zuckerman 2007:11. Approved World Bank population/reproductive health and HIV and AIDS projects and components as a percentage of total, approved projects spiked between 2003 and 2004 and have declined, with a slight increase in funding for both in 2006.



health projects and components, which cumulatively totalled $105m between 2003 and 2006. The AfDB approved no HIV and AIDS projects and components in 2003 and 2006, and three each year in 2004 and 2005, for a total of $44m. Grants comprised 66 per cent of the funds that AfDB allocated to HIV and AIDS from 2003 to 2006. The average share of AfDB funding for reproductive-health and HIV and AIDS projects and components as a proportion of total AfDB commitments was 0.75 and 0.28 per cent, respectively. We flag the scarcity of AfDB funding for HIV and AIDS as a serious problem, because the AfDB is not meeting its commitment to address Africa's HIV and AIDS crisis that claims so many lives.

Inter-American Development Bank

The IDB spent $72m in loans for reproductive-health projects and components between 2003 and 2006. It also provided a small amount of grant funding for dedicated reproductive-health and HIV and AIDS projects, with a cumulative total of $2.2m and $2.3m respectively, for the years 2003 to 2006. The IDB has increased the number of HIV and AIDS projects and components over the same time period from one to five, while the number of reproductive-health projects and components has remained steady at around three per year. On average, approved IDB investments in reproductive health composed 0.3 per cent (or three-tenths of 1 per cent) of total approved annual IDB investments, while funding for HIV and AIDS constituted less than one-hundredth of 1 per cent of total approved IDB investments.

Asian Development Bank

The ADB is the smallest MDB funder for reproductive health and HIV and AIDS that we reviewed, and has a strong focus on HIV and AIDS over reproductive health. In the four years under review, ADB funding for two small reproductive-health projects, totalling $1.4m, represented a mere 2 per cent of the ADB's $47m in funding for 12 HIV and AIDS projects and components during this period. The ADB's annual allocations to HIV and AIDS projects ranged from a low of $1m in 2004, to a high of $35m in 2006. Average ADB investments in HIV and AIDS from 2003 to 2006 constituted a mere 0.15 per cent of the ADB's average annual $6.9bn in approved loans and grants. The percentage of investments in reproductive health is insignificant.

Quality of funding

To undertake our in-depth gender analysis, we identified four reproductive-health and/or HIV and AIDS projects and components for each MDB, approved between 2003 and 2006. We tried to balance the projects selected by region, and between reproductive health and HIV and AIDS. We selected larger projects (in terms of funding). For projects containing reproductive-health and HIV and AIDS components, we generally focused on the relevant component, not the entire project. We examined such projects across a wide spectrum of sectors. For example, at the ADB and AfDB we looked at projects in health, transportation, and education. Additionally, for the World Bank, we included different types of lending instruments.

We identified the following spectrum of gender sensitivity in the 16 projects reviewed:

- *Highly gender-sensitive*: these projects have a strong focus on women's and men's gender issues throughout the project background, objectives, components, and monitoring and evaluation.
  - 'HIV/AIDS Prevention Among Youth' in Viet Nam
  - 'Support to Maternal Mortality Reduction' in Tanzania
- *Gender-sensitive*: these projects include gender issues of men and women in the project components and monitoring and evaluation.
  - 'HIV/AIDS Prevention and Capacity Development' in the Pacific
  - 'Support to Health Sector Strategic Plan Project II' in Uganda
- *Mention gender issues*: these projects discuss gender issues in the background section or include gender-sensitive data, but fail to mention, or gloss over, gender issues in the project or components. This category also includes projects that exclusively focus on women's issues.
  - 'Maternal Mortality Reduction Project' in Mongolia
  - 'Education Sector Support Project' in the Democratic Republic of Congo

  - ○ 'Teen Reproductive Health Program' in Medellín, Colombia
  - ○ 'Improving Maternal and Child Health' in Nicaragua
  - ○ 'Reproductive & Child Health Second Phase' in India
- *Fail to integrate gender issues*: these projects completely fail to mention gender issues, or briefly mention women in the background section, objectives, or annexes.
  - ○ 'Preventing HIV/AIDS on Road Projects in Yunnan Province' in China[8]
  - ○ 'Tombo-Gbessia Road Improvement Project' in Guinea
  - ○ 'Support the National Strategic Plan for HIV/AIDS' in Surinam
  - ○ 'Caribbean Education Sector HIV/AIDS Response Capacity Building Program'
  - ○ 'Second Multisectoral STI/HIV/AIDS Prevention Project' in Madagascar
  - ○ 'Fiscal Management and Accelerating Growth Program' in Malawi
  - ○ 'Health Sector Reform 2 Project' in Romania

The overwhelming majority of projects examined – 13 of 16 projects, or 81 per cent – fail to integrate gender issues, or merely mention gender issues. Only one project examined at the AfDB is gender-sensitive, and two projects – one at the ADB and one at the AfDB – are highly gender-sensitive. Half of the IDB projects reviewed simply mention gender issues, while the remaining two projects fail to integrate gender issues. Of the four World Bank projects reviewed, only one is somewhat gender-sensitive. While this sample of selected projects is not necessarily representative of MDB projects in reproductive health and HIV and AIDS, these figures are dismal.[9]

Of the nine projects examined that have any gender sensitivity, four of them – one each at the ADB and World Bank, and two at the IDB – exclusively focus on women, and never mention men. This reflects an outdated approach to development, that overlooks male–female gender relations and men's gender issues. By ignoring men's role in family planning, sexual and reproductive health and rights, and HIV prevention, these projects fail to recognise men's important influence on women's health, and men's own reproductive-health needs. In many communities, men serve as gatekeepers to women's access to reproductive-health services, and recent studies have found that marital sex is the single greatest HIV risk factor for women around the world.

We uncovered a few positive examples of gender-sensitive MDB projects addressing men's reproductive-health and HIV and AIDS concerns. The AfDB's 'Support to Health Sector Strategic Plan Project II' in Uganda and the 'Support to Maternal Mortality Reduction Project' in Tanzania both target men for gender sensitisation, and seek to increase men's involvement in promoting maternal health. The ADB's 'HIV/AIDS Prevention Among Youth' in Viet Nam provides equal access to training and employment opportunities to men and women. The other projects examined fail to integrate men's gender issues.

Nearly all MDB projects provide loans or grants for capital, or one-off expenditures in infrastructure facilities, equipment, research, and training, which limits their

sustainability. With rare exceptions, MDB project funding is limited to capital costs. Among the projects we analysed, for example, the AfDB's 'Support to Health Sector Strategic Plan Project II' in Uganda claims that it will reduce maternal mortality – not by hiring much needed health professionals – but by financing remodelling, construction, and equipping of health facilities. While both staff and facilities are important, the MDBs' lack of funding for critical recurrent costs such as salaries and repairs means that many MDB projects end up as understaffed, under-used, or decayed facilities.

Only two projects in our sample clearly support recurrent costs, both funded by the IDB. The grant for a 'Teen Reproductive Health Program' in Colombia pays for nursing staff in health centres for 12 months. The 'Improving Maternal and Child Health' loan finances the provision of health services in Nicaragua, with an emphasis on care for mothers and children during the three to five year life of the project.

The World Bank projects reviewed incorporate gender issues very poorly. Only one project – the 'Reproductive & Child Health Second Phase' in India – even mentions gender issues. However, the Bank notes that the government's 'intensive focus on family planning services for population stabilisation may lead to a disregard of principles of client choice and voluntary acceptance of family planning'. While the government has reaffirmed its commitment to promote a 'voluntary, non-coercive and (sterilisation) target free programme', the government's previous plan included female sterilisation targets (World Bank 2006).

Despite World Bank claims that its investments in health are highly gender-sensitive, the poor quality of World Bank reproductive-health and HIV and AIDS investments should not be surprising. In the health, nutrition, and population (HNP) sector, the ranks of regular or open-ended staff members decreased by 40 per cent between fiscal years 1999 and 2006. These permanent staff have been replaced by Junior Professional Associates, consultants, and seconded staff, financed mostly by donor trust funds, and they tend to lack institutional memory and experience. Bank project teams rated the outcomes of one-third of HNP projects 'unsatisfactory', making HNP consistently the worst performer of all the Bank's 19 sectors from 2001 to 2006 (World Bank 2007).

Obstacles to providing reproductive health services and preventing the spread of HIV

Despite MDB commitments to provide reproductive-health services and prevent the spread of HIV, MDBs and the IMF have a number of policies and practices that undermine meeting these commitments and undercut their promises to help countries achieve the MDGs. This section describes these obstacles.

Crippling debt

Poor-country governments around the world are crippled by sovereign debts to the MDBs and IMF, and are forced to pay their rich-country creditors instead of financing basic health services for their citizens. Many of these debts are illegitimate because they arose from irresponsible lending to corrupt dictators. Other debts are illegitimate because countries cannot afford to pay them and also meet basic human needs of men and women. For example, despite having one of the highest rates of maternal mortality in the world, for years Malawi was forced to service its $3.5bn in external debt, instead of investing in essential services. As a result, Malawi currently has vastly inadequate numbers of medical workers: merely 2,200 nurses – or one nurse for every 5,864 people – and fewer than 200 doctors, representing one doctor for every 64,500 Malawians. After receiving debt relief, countries are able to invest more in the health and well-being of their people. Tanzania, Uganda, and Zambia abolished school fees after receiving debt relief, which increased girls' enrolment rates. The more education girls attain, the less likely they are to contract the HIV virus.

Privatisation and user fees

Privatisation, requiring governments to divest state-owned enterprises, is one of the most harmful and common loan 'conditionalities', or requirements, mandated by MDB and IMF policy-based loans. For example, in Malawi, the World Bank's 'Fiscal Management and Accelerating Growth Program' identifies increasing HIV and AIDS as a potential risk of the loan, and therefore incorporated an HIV and AIDS component. But the project fails to integrate HIV and AIDS concerns in the other project components which include privatisation and restructuring of ADMARC, Malawi's Agricultural Development and Marketing Board, which is used to keep the price of corn affordable. Privatisation of ADMARC increased food insecurity during a famine, and women were primarily responsible for securing food for their families. Research demonstrates that in Malawi, privatisation of ADMARC led desperate women into sex work and early marriage, which increased the transmission of the HIV virus.

User fees and other cost-recovery mechanisms – which often accompany MDB projects that increase private-sector involvement in public services – can also contribute to the spread of HIV, prevent people living with HIV and AIDS from accessing treatment, and curtail public reproductive-health services for poor people. The World Bank-funded 'Multisector HIV/AIDS Project' in Ghana includes government cost recovery programmes such as patient user fee co-payments for anti-retroviral drugs, which makes these drugs unaffordable for poor people. The new World Bank HNP Strategy includes language promoting user fees, despite Bank assurances that it does not support user fees for primary education and basic health care for poor people. The IDB's public-health policy requires borrowers to impose user fees whenever possible, and to increase taxes when user fees are not possible.

Limiting the 'wage bill'

Obtaining IMF loans and passing-grade surveillance reports are often conditioned on a country limiting its national budget through minimising recurrent costs, curbing inflation, and keeping debt low. These conditions limit how much countries can spend on the public 'wage bill', including salaries of doctors and other health workers. The IMF fears that without a low ceiling on the wage bill, a government will hire more employees than it can afford in the long term, and veer away from its agreed budget. If national revenue or aid drops after a wage-bill increase, a government could fall into a deficit unacceptable to the IMF when it pays these wages and other expenditures.

IMF-imposed wage-bill ceilings have constrained countries from recruiting and retaining health-care professionals who are necessary to halt the spread of HIV, to treat people living with HIV and AIDS, and to provide reproductive-health services. Wage-bill ceilings contribute to a 'brain drain' of skilled health professionals leaving their home countries in search of higher wages abroad, often in Europe and the USA. For example, in 2004 Zambia went 'off track' on its IMF Programme when it increased the government wage bill above the IMF-imposed 8 per cent of its gross domestic product to 9 per cent, by introducing a housing-allowance system designed to make staying and working in Zambia more attractive to health workers, among other spending increases (Rowden 2004). Because of the IMF's powerful role as gatekeeper to donor funds, in the end the Zambian government complied with IMF mandates after losing IMF support for part of 2004.

Harmful ideology

Recently, some World Bank officials have been using their power to impose their anti-family-planning ideology on the global South. Early versions of the World Bank's 2007 HNP Strategy were reportedly 'censored' by a managing director, who removed references to family planning and sexual and reproductive health and rights from the Strategy. Effective advocacy by civil society across the globe forced the Bank to re-insert language on sexual and reproductive health. But before the HNP Strategy could be approved, the World Bank Executive Director for the United States allegedly tried to weaken language on reproductive rights and insert the phrase 'age-appropriate reproductive health care' (Sippel 2007).[10] Civil society thwarted these attempts. The final HNP Strategy affirms the World Bank's commitments to reproductive health, but does so in an isolated section late in the Strategy. It fails to mention reproductive health and HIV and AIDS in the first 63 of its 80 pages.

Country programming at the World Bank is, similarly, in danger of backpedalling on reproductive health and rights. In a separate incident, the same World Bank managing director sought to remove all references to family planning in a country strategy document for Madagascar.

Conclusions

This initial research has revealed some startling trends concerning MDB funding for reproductive health and HIV and AIDS, and the quality of MDB investments. On average, the regional MDBs devote less then 1 per cent of their entire budget to either of these themes. The largest MDB funder for both reproductive health and HIV and AIDS – the World Bank – is diminishing its funding for both. This is occurring simultaneously with conservative political appointees trying to weaken World Bank commitments and investments in reproductive health. The other MDBs that fund reproductive-health and HIV and AIDS projects provide relatively little support. In particular, the IDB and AfDB provide little funding for HIV and AIDS, and the ADB provides astonishingly few resources for reproductive health.

It can be argued that in the medium to long term, foundations and agencies such as The Global Fund to fight AIDS, Tuberculosis and Malaria are taking up the slack, as World Bank funding for reproductive health and HIV and AIDS diminishes. But the urgent need for investments to improve reproductive health, halt the spread of HIV, and treat AIDS, requires that all funders including the World Bank and other MDBs should increase their grant funding to address these imperatives in the short term. So long as the MDBs continue to operate, the public must hold these taxpayer-supported institutions accountable, to increase the proportion and improve the quality of their spending on reproductive health, HIV and AIDS, and other poverty-reducing investments.

In terms of the quality of MDB funding for reproductive health and HIV and AIDS, we found a handful of gender-sensitive MDB projects. However, the overwhelming majority of projects lacked a gender analysis of the issues they aim to address. This gender analysis is essential to enable projects to be developed and implemented which actually improve reproductive health and rights and halt the spread and feminisation of HIV and AIDS and related violence against women. Furthermore, most MDBs still focus primarily on maternal health issues, over reproductive and sexual health and rights more broadly.

The report on which this article is based also identified endemic challenges regarding project sustainability. These challenges result from the type of support for reproductive health and HIV and AIDS provided by the MDBs. Since an adequately staffed public sector is necessary to fulfil the human right to health, the nearly exclusive MDB investments in facilities and training will not solve the current global health crisis. Governments must have access to funding for public-sector employee wages either through locally generated funds or reliable, long-term grants.

We also identified a number of MDB and IMF practices that undermine reproductive- health and HIV and AIDS goals. Harmful conditionalities and project components, such as privatisation of state-owned enterprises, wage-bill ceilings, and user fees commonly imposed by the MDBs and IMF, all limit governments' ability to

address reproductive health and HIV and AIDS imperatives, and undermine women's and men's ability to realise their right to a healthy life. The MDBs and IMF must end policy-based lending, and refocus their projects to prioritise poor women and men.

Only a massive civil-society advocacy campaign could overcome the foregoing impediments to deploying the world's largest development assistance programmes toward improving reproductive health, ending HIV and AIDS, and achieving these and other MDGs. Gender Action hopes to collaborate with other groups in using this research to develop such a campaign.

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Elaine Zuckerman is Founder and President of Gender Action. Gender Action is currently carrying forward advocacy to pressure the multilateral development banks to increase and improve their spending on reproductive health and HIV and AIDS. Email: elainez@gender action.org.

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Notes

1 For comprehensiveness, in this article we categorise the EIB as a development bank despite the fact that it is an investment bank lacking a development mandate.
2 We are likely to have bloated World Bank expenditures on reproductive health and HIV and AIDS since Bank data do not regularly disaggregate spending by components and sub-components.
3 See, for example, S. Dennis and E. Zuckerman (2006) 'Gender Guide to World Bank and IMF Policy-Based Lending', Gender Action, www.genderaction.org/images/Gender%20Guide%20032007.pdf (last accessed March 2008).
4 This work was supported by Population Action International.
5 In the health sector, the term 'population' generally refers to two areas: 1) reproductive, maternal, and sexual health; and 2) demographic trends such as levels of births, deaths, and migration. In this analysis we focus on the former.
6 The IFC has a programme called, 'IFC Against AIDS' which works with companies to establish workplace and community HIV-intervention programmes. For more information, please see: www.ifc.org/ifcagainstaids (last accessed March 2008).
7 The AfDB project database is difficult to search, therefore some projects may have been overlooked. Financial data for the AfDB is limited since it does not isolate funding for

reproductive health and HIV and AIDS components from total project cost in multi-sector projects. More research is needed to calculate the amounts dedicated exclusively to these areas, and the AfDB should improve its reporting.

8 The ADB tries to address HIV and AIDS issues in all transportation-sector projects.

9 More research is needed to assess gender sensitivity in a representative sample of MDB projects. Analysis of project documents only presents a portion of the picture; more work is needed to determine gender sensitivity in project implementation. For example, a project that ignores gender issues may be implemented in a gender-sensitive manner, although this rarely happens, and similarly a project that appears gender-sensitive on paper may neglect gender issues upon implementation.

10 The alleged managing director was Juan José Daboub, former Arena Party finance minister of El Salvador and a strong supporter of the Bush anti-family planning agenda.

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