GenderAction

GenderEquality Women'sRights

Banking on Health:

World Bank and African Development Bank Spending on Reproductive Health and HIV/AIDS in Sub-Saharan Africa

NAWAD

LUKMEF

THE WILLIAM AND FLORA HEWLETT FOUNDATION

TIDES
WHAT'S POSSIBLE

Publication prepared by:	Claire Lauterbach, Programs Associate, Gender Action
With contributions from:	Elaine Zuckerman, President, Gender Action
	Elizabeth Arend, former Programs Coordinator, Gender Action
	Patience Nyangoma, Executive Director, NAWAD
	Christian Tanyi, Chief Executive Officer, LUKMEF
With support from:	The William and Flora Hewlett Foundation
	The Tides Foundation

About Gender Action

Gender Action was established in 2002. It is the only organization dedicated to promoting gender justice and women's rights in all International Financial Institution (IFI) investments such as those of the World Bank.

Gender Action's goal is to ensure that women and men equally participate in and benefit from all IFI investments.

Gender Action

1875 Connecticut Avenue NW
Suite 500
Washington DC 20009, USA
Tel: 202 939 5463
Email: info@genderaction.org
http://www.genderaction.org

Table of Contents

List of Abbreviations

AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CFA	Central African Francs (Cameroon)
DHS	Demographic and Health Survey (Uganda)
FGM	Female Genital Mutilation
HEF	Health Equity Funds
HIV	Human Immunodeficiency Virus
IFI	International Financial Institution
IHC	Integrated Health Center
IM	International Monetary Fund
ISRR	Implementation Status and Results Report (World Bank)
IUD	Intrauterine Device
LUKMEF	Martin Luther King Jr. Foundation (Cameroon)
MDBs	Multilateral Development Banks
MDGs	Millennium Development Goals
NAWAD	National Association for Women's Action in Development (Uganda)
NHIS	National Health Insurance System (Ghana)
PAD	Project Appraisal Document
PID	Project Information Document (World Bank)
PRH	Population and Reproductive Health
RHAP	Reproductive Health Action Plan (World Bank)
SAPs	Structural Adjustment Policies
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
UA/UAC	Units of Account (AfDB bank units)
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
US	United States
USD	United States Dollar
UGX	Shillings (Uganda)
VCT	Voluntary Counseling and Testing (HIV/AIDS)
WB	World Bank
WHO	World Health Organization

Executive Summary

Global reproductive health has improved significantly over the past 20 years. The number of women dying from pregnancy-related complications and childbirth has dropped sharply and the rate of new HIV infections has slowed worldwide. However, sub-Saharan Africa (SSA) still shoulders the greatest percentage of maternal deaths – 56 percent of total maternal deaths worldwide, despite representing 15 percent of the world's population (WHO 2012:1) – and the highest estimated number of persons living with HIV/AIDS – 68 percent of the global HIV burden (UNAIDS 2010c). For decades, African governments have received billions of dollars in development aid from donor countries, private foundations and multilateral development banks (MDBs) to combat these problems.

The World Bank and African Development Bank (AfDB) are the two key MDBs financing African countries' health sectors. This Gender Action report evaluates the quality and quantity of the multilateral World Bank and AfDB reproductive and HIV/AIDS investments in sub-Saharan Africa from 2006 to 2012. With our partners, the Martin Luther King Jr. Memorial Foundation of Cameroon (LUKMEF) and the National Association for Women's Action in Development (NAWAD), Gender Action conducted qualitative assessments of these banks' PRH and HIV investments in Cameroon and Uganda, respectively.

The World Bank and AfDB spend infinitesimally small amounts on reproductive health and HIV/AIDS programs in sub-Saharan Africa compared to their annual budgets, despite the region's almost unparalleled demand for improved health services. The banks' health sector support is overwhelmingly in the form of loans that incur new debts, perversely squeezing funding for health services. A full 45 percent of the World Bank's reproductive health and 60 percent of its HIV/AIDS investments in sub-Saharan Africa from 2006-2012 were loans. At the AfDB this figure is 60 percent.

Despite reproductive health and HIV/AIDS policies that increasingly recognize women's rights, the World Bank and AfDB risk undermining their own health-related goals by overlooking women's rights and needs. For example, few projects measure whether women benefit to the same extent as men, and many impose fees on basic project-financed services like antenatal care visits. The case studies in Cameroon and Uganda demonstrated that there has been too little to show on the ground for the World Bank's and AfDB's investments in reproductive health and HIV/AIDS.

The challenges to providing affordable, high-quality reproductive and HIV care in resource-poor countries are immense. The publicly-funded World Bank and AfDB, as key health sector supporters worldwide, have a duty to address the flaws in their projects that prevent low-income women in particular from benefitting from them. Gender Action recommends an approach that would prioritize grants over loans, abolish user fees in bank-supported projects; promote sustainable, gender-sensitive staffing of projects; and address gendered barriers to access and use throughout project cycles.

Better World Bank and AfDB spending to improve health care systems as a whole, and reproductive health and HIV/AIDS services in particular, will go a long way in reducing poor patients' burden of formal and 'informal fees' and ensure access to reproductive and sexual health for all, especially women.

Introduction

Global reproductive health has improved significantly over the past 20 years. The number of women dying from pregnancy-related complications and childbirth has dropped sharply and the rate of new HIV infections has slowed worldwide. However, sub-Saharan Africa still shoulders the greatest percentage of maternal deaths – 56 percent of total maternal deaths worldwide, despite representing 15 percent of the world's population (WHO 2012:1) – and the highest estimated number of persons living with HIV/AIDS – 68 percent of the global HIV burden (UNAIDS 2010c). For decades, African governments have received billions of dollars in development aid from donor countries, private foundations and multilateral development banks to combat these problems. At the International Family Planning Summit in July 2012, donors pledged a total of US$ 2.6 billion towards 'family planning' and reproductive health initiatives in developing countries (DFID and Gates Foundation 2012).

International Financial Institutions (IFIs) like the World Bank and African Development Bank (AfDB) are key donors that aid in financing many African countries' health sectors. This Gender Action report evaluates the quality and quantity of these banks' contributions to efforts from 2006 to 2012 towards achieving good reproductive health and fighting HIV/AIDS in sub-Saharan Africa. This introduction focuses on the evolution of approaches to reproductive health and HIV/AIDS in sub-Saharan Africa and the AfDB's and World Bank's current policies. It explores the extent to which they incorporate gender issues into investments in reproductive health and HIV/AIDS care. Section I quantifies the World Bank and AfDB's investments and examines spending trends. Section II analyzes the gender sensitivity of both banks' PRH and HIV/AIDS investments throughout sub-Saharan Africa. Section III evaluates World Bank and AfDB projects in Uganda and Cameroon, based on research with Gender Action partners the National Association for Women's Action in Development (Uganda) and Martin Luther King Jr. Foudnation of Cameroon (LUKMEF). Section IV discusses the report's findings, followed by recommendations.

Population and reproductive health at the IFIs

As early as the 1970s, elements of family planning and population control were incorporated into IFI-financed 'structural adjustment' programs, particularly in Africa. In line with neoliberal economic logic, IFI-financed structural adjustment programs were designed to adjust developing nations' fiscal imbalance (debt) by mandating privatization and deregulation of industries, agriculture and natural resource extraction for export, and social services such as health. These changes were financed by loans from banks such as the World Bank and AfDB, as well as the International Monetary Fund (IMF). In retrospect, 'structural adjustment' policies caused immense damage to African public sectors, healthcare in particular, as client governments rushed to reduce spending through laying off public sector workers, privatizing key services, and imposing user fees for healthcare.

Early World Bank and AfDB investments in reproductive health echo gender-insensitive structural adjustment priorities. Achieving good reproductive health was often framed as a strategy to promote economic health rather than as a human right. For example, the World Bank in its 1986 "Health and Population Project" in Sierra Leone justified its prioritization of maternal and child health because "fertility decline in the short-term would also have immediate beneficial implications for the economy" (2.03). Nowhere do available project documents mention women's rights or gender inequality as relevant (WB 1986a, b; WB 1996). Evaluators of the project in 1996 even considered "gender issues" as "not applicable" in assessing the Bank's achievement of project goals (WB 1996:11).

Adapting to a world with AIDS

The focus on 'reproductive health' took on a new meaning worldwide in the late 1980s and early 1990s in light of the HIV/AIDS crisis. Since the early 1990s, the rate of HIV infection grew to pandemic proportions in many African countries. The highest rate was in Swaziland, which was estimated at 25.9 percent of the adult population in 2009. In 2009, an estimated 22.5 million people infected with HIV resided in sub-Saharan Africa, representing 68 percent of cases worldwide (UNAIDS 2010c). HIV infection rates are particularly high among women in sub-Saharan Africa: about 76 percent of all HIV-positive women in the world live in this region (UNAIDS 2010c). However, the number of people newly infected with HIV in sub-Saharan Africa fell from 2.2 million people in 2001 to 1.8 million in 2009 (UNAIDS 2010c). This is credited to aggressive health information campaigns on preventing infection as well as programs providing contraceptives and anti-retroviral therapy (ART) for those already infected, partly financed by IFIs.

The World Bank has made HIV/AIDS-related investments in 39 sub-Saharan African[1] countries including several multi-country initiatives. Currently, the World Bank works to combat HIV/AIDS primarily in six ways: (i) enhancing efficiency in funding allocation; (ii) enhancing program/technical efficiency; (iii) carrying out studies of program effectiveness; (iv) carrying out studies of financing and sustainability of programs; (v) supporting strategic planning on HIV/AIDS at the national level; and (vi) providing financing (grants and loans). The World Bank claims that since 1989, its financing for HIV/AIDS has totaled nearly US$ 4.6 billion worldwide, including integrating an HIV/AIDS focus into investments in other sectors, such as education, transport, energy, and infrastructure (WB 2012c).

The AfDB has been active on HIV/AIDS since at least July 1987, when it established an inter-departmental AIDS Study Group to examine the epidemic's progression in Africa and propose Bank activities (AfDB 2001b:3). Current AfDB objectives are to assist member countries in developing and implementing HIV/AIDS control activities and support the programs prepared and led by the UN specialized agencies and other partners. Concretely, this support translates to (i) building institutional capacity; (ii) developing human capital to enable national AIDS strategies through training and technical assistance support; (iii) advocacy; and (iv) partnerships (AfDB 2010d). The AfDB claims that it has provided some US$ 223 million funding to HIV-related projects on the continent between 1997 and 2007 (AfDB 2010b). The AfDB has funded PRH and/or HIV programs in 25 countries, with several multi-country initiatives.

Current WB and AfDB policies on reproductive health and HIV/AIDS

Comparing the two Banks' early reproductive health and HIV/AIDS investments with their current policies shows a significant evolution in both towards recognizing gender and women's rights within reproductive health and HIV/AIDS.

The World Bank's current Reproductive Health Action Plan (RHAP) (2010-2015) explains that projects will work to increase access to family planning services and skilled attendance at births, train health care workers, and expand girls' education (WB 2012d). As during the decades of structural adjustment, the goals of reducing maternal mortality and women's fertility rates remain part of a broader economic strategy. However, the RHAP acknowledges that reproductive health is not purely a health issue and that "it is important to recognize and leverage cross-sectoral linkages (transport, communications, gender, especially women's empowerment, girls' education, and *human rights*, and poverty)" (WB 2012d: 42, emphasis added). In response to civil society consultations, including Gender Action

[1] A list of what countries the World Bank considers part of sub-Saharan Africa can be found at: http://www.worldbank.org/projects/country?lang=en

advocacy, the Plan later proposes that its own reproductive health framework consider "women and women's rights at the outer circle but then focuses in to maternal health and attempts to drive specific changes in concrete measurable outcomes" (WB 2012d:43).

The AfDB's current Policy on Population and Strategies for Implementation addresses PRH as it relates to socioeconomic development, as well as "environment, gender, and community participation" (AfDB 2000). Like the World Bank, the AfDB policy discusses PRH also from a human rights perspective, citing "legal frameworks and policies that… subordinate adolescents' and women's sexual and reproductive health and rights, including gender-based discrimination and cultural practices that increase women's risks of illness or death" (AfDB 2000). The AfDB's HIV strategy includes increasing health sector financial accountability; enhancing social protection and inclusion programs; increasing collaboration with partner organizations such as UNAIDS; and supporting African medical schools and "centers of excellence" to train high quality medical staff (AfDB 2011).

As World Bank and AfDB policies show, enhancing population and reproductive health as well as combating the spread of HIV/AIDS are now integral parts of their development agendas. The following section examines whether or not the World Bank's and AfDB's actual spending reflects their professed commitments. Knowing how much and where IFI money is spent is the first step towards evaluating the extent to which these banks address gender inequality when they design, implement and monitor their PRH and HIV/AIDS investments.

I Quantifying PRH and HIV Investments

In this section, Gender Action assesses how much money the World Bank and AfDB spent on reproductive health, or what the World Bank terms "population and reproductive health" (PRH) and HIV/AIDS during 2006-2012.[2]

Methodology

Gender Action replicated the World Bank's and AfDB's own methodologies for calculating spending commitments on PRH and HIV/AIDS.[3]

A single World Bank project can contain many thematic or sectoral components. Many projects, like Nigeria's "Abidjan-Lagos Trade and Transport Facilitation Project" or Ethiopia's "Rural Capacity-Building Project" do not appear by their titles to be health-related though they do have PRH and/or HIV/AIDS components. The World Bank calculates spending on each "theme", such as "HIV/AIDS" or "PRH", by estimating the proportion of that project devoted to the theme and multiplying that proportion by the total project commitment.[4] Total calculations for World Bank spending by theme are the sum of all the relevant components of all individual projects containing that theme. The World Bank argues that this methodology underestimates how much they actually spend on PRH and HIV since patients seeking PRH and HIV services benefit directly or indirectly from projects supporting broader health sector reform. However, the Bank reports that this is the same methodology it uses to calculate its spending by theme featured in its annual report (Reynolds & Wilson 2012).

[2] Fiscal year 2006- Fiscal Year 2012. The World Bank fiscal year runs from 1 July through 30 June (i.e. Fiscal year 2006: 1 July 2005- 30 Jun 2006). The AfDB fiscal year runs from 1 January through 31 December.

[3] The World Bank's and AfDB's projects are published online. Project information is available on their respective websites: http://www.worldbank.org/projects and http://www.afdb.org/en/projects-and-operations/project-portfolio/

[4] For example, the Bank's total commitment to a Health Sector project may be US$ 100 million, 40 percent of which is coded as devoted to the "HIV/AIDS" theme. The Bank's commitment to "HIV/AIDS" in this instance would be US$ 40 million.

By contrast, the AfDB does not disaggregate the amount of money spent on themes like PRH or HIV from total project costs. To calculate AfDB spending commitments to PRH and HIV/AIDS, Gender Action measured the total amount of money committed to projects across all sectors that include PRH and/or HIV components.[5]

World Bank PRH investments

The World Bank's PRH commitments in sub-Saharan Africa are infinitesimal compared to its total annual commitments. According to Gender Action calculations, the World Bank committed only US$ 140 million to PRH projects in sub-Saharan Africa in 2012, or just 0.27 percent of its total US$ 52.6 billion in commitments during this year (Table 1). The World Bank claims that its spending is generally much higher at "at least US$ 529 million" on "maternal and reproductive health programs" in 2011 worldwide (Gender Action 2012)[7]. This still would amount to just 1.23 percent of the World Bank's total 2011 commitments. Despite the fact that sub-Saharan African countries overwhelmingly rank low on the scale of gross domestic product (GDP), almost half of the World Bank's PRH projects (45 percent) in this region from 2006-2012 were issued as loans, rather than grants.[8] These loans can have negative impacts on the people they are intended to help, as poor governments cut social spending to pay back their debts, as discussed in section II.

Table 1: Estimated World Bank PRH Commitments in sub-Saharan Africa (SSA) 2006-2011 (USD)[6]

Year	2006	2007	2008	2009	2010	2011	2012	Total
Total World Bank commitments	23.6 billion	24.7 billion	24.7 billion	46.9 billion	58.8 billion	43 billion	52.6 billion	*274.3 billion*
Total PRH commitments in SSA	83.84 million	47.3 million	25.9 million	49.61 million	58.84 million	23.82 million	140.72 million	*430.02 million*
PRH as percent of total annual commitments	0.36%	0.19%	0.10%	0.11%	0.10%	0.06%	0.27%	*0.16%*

World Bank HIV investments

The World Bank claims that it "pioneered global HIV/AIDS financing" (WB 2011b), paving the way for other multilateral funding channels such as the Global Fund for AIDS, TB and Malaria and the President's Emergency Plan for AIDS Relief. Although the World Bank claims that it spent a cumulative US$ 4.6 billion for HIV-related activities between 1989 and 2011 (WB 2011b), this represents just 0.8 percent of its total commitments during this period.[9] The World Bank spent US$ 30 million on HIV in 2012, or just

[5] Projects were included in the analysis if they outlined specific activities addressing any of the following terms: HIV, AIDS, maternal (health), reproductive (health), sexual (health), and family (planning). Analysis was conducted in French and English with equivalent search terms. Projects were *not* included if the only mention of the search terms was in relation to expected benefits of the project while no operations described specifically address the search term.

[6] Projects were included in the analysis if: 1. IDA or IBRD commitment was greater than US$ 0; 2. The project date of approval is on or after 1 July 2005 (beginning of FY 2006) through 30 June 2012. Figures are based on the World Bank's commitment to the project funds, *not* the total project cost, which may be higher, as many projects are funded by combined commitments by the World Bank and other donors such as the United Nations and recipient governments. Margin of error due to rounding is +/- 2 million.

[7] This claim was made by World Bank staff in an online comment thread, which responded to Gender Action's op-ed piece on World Bank investments to reduce maternal mortality (Gender Action 2012). They did not explain the methodology that was used to determine the US$ 529 million in funding.

[8] See Annex 1, Table 1. Of 55 PRH-related commitments, 25 were in the form of loans, 24 in the form of grants, and 6 contained both loan and grant elements. The World Bank only made loans for decades. In response to Gender Action and other civil society advocacy, it now makes some grants, though loans predominate.

[9] According to World Bank Annual Reports 1989-2011, the World Bank committed a total of US$ 585.1 billion to borrower countries. For FY 2012 figures, see WB 2012e.

0.06 percent of its US$ 52.6 billion in total commitments that year (Table 2). From FY 2006-2012, 60 percent of the World Bank's HIV investments were issued as loans.[10]

Table 2: Estimated World Bank HIV Commitments in sub-Saharan Africa (SSA), 2006-2011 (USD)[11]								
Year	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**Total**
Total World Bank commitments	23.6 billion	24.7 billion	24.7 billion	46.9 billion	58.8 billion	43 billion	52.6 billion	*274.3 billion*
World Bank HIV commitments in SSA	65.84 million	124.13 million	40.19 million	193.09 million	122.15 million	81.90 million	30.25 million	*657.55 million*
HIV in SSA as percentage of total annual commitments	0.28%	0.50%	0.16%	0.41%	0.21%	0.19%	0.06%	*0.24%*

AfDB PRH and HIV investments

As noted above, the AfDB does not disaggregate its spending by theme. This section analyzes AfDB spending on PRH and HIV/AIDS in the context of its PRH and HIV/AIDS policies.

Projects that contained PRH and/or HIV components comprise just two percent of total AfDB commitments during 2006-2011 (Table 3). When asked about how much was spent on PRH, the AfDB replied that this information was not available (Kgosidintsi 2012). However, on World AIDS Day in 2010, the AfDB claimed that it had provided US$ 223 million funding to HIV-related projects on the continent between 1997 to 2007 (AfDB 2010b). This would represent just 0.68 percent of the total US$ 32.77 billion that the AfDB committed during this period.[12] From FY 2006-2012, 60 percent of the AfDB's PRH and HIV investments were issued as loans.[13]

Table 3: Estimated AfDB Commitments with PRH/HIV Components in sub-Saharan Africa (SSA), 2006-2011 (Units of account (UA)/USD)[14]							
Year	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	***Total***
Total AfDB commitments	2.6 billion UA/ 3.9 billion USD	3.1 billion UA/ 4.9 billion USD	3.5 billion UA/ 5.4 billion USD	8.1 billion UA/ 12.7 billion USD	4.1 billion UA/ 6.3 billion USD	6.7 billion USD[15]	*39.9 billion USD*
Total project commitments containing PRH and/or HIV components in SSA	129.51 million UA/ 193.2 million USD	0.25 million UA/ 0.34 million USD	270.6 million UA/ 437.74 million USD	6 million UA/ 9.42 million USD	23.9 million UA/ 36.82 million USD	76.45 million UA/120.49 million USD	*798.01 million USD*
Project commitments with PRH/HIV components as percentage of total annual commitments	4.95%	0.01%	8.10%	0.07%	0.58%	1.80%	*2.00%*

II Assessing the Gender Sensitivity of WB and AfDB PRH and HIV Investments

Gender Action conducted gender analyses of World Bank project appraisal documents (PADs) and AfDB project appraisal reports (PARs), as well as other key project documents to examine the degree to which

[10] See Annex 1, Table 2. Of 50 HIV-related commitments, 30 were in the form of loans, 15 in the form of grants, and 5 contained both loan and grant elements.

[11] According to World Bank Annual Report (2011a).

[12] See AfDB (2004) and AfDB (2010a) for the AfDB's total commitments for the period 1997-2007.

[13] Of 20 PRH and/or HIV-related commitments, 12 were in the form of loans, 6 in the form of grants, and 2 contained both loan and grant elements.

[14] The AfDB expresses its commitments in its units of account (UA). Exchange rates: 2011: 1 UA= 1.54 USD (est.); 2010: 1 UA=1.54 USD; 2009: 1 UA=1.57 USD; 2008: 1 UA=1.54 USD; 2007: 1 UA=1.58 USD; 2006: 1 UA=1.5 USD. Amounts rounded to one decimal place. FY 2012 is not included as it is still ongoing.

[15] Estimate based on January 2012 Investor Presentation (AfDB 2012a).

their PRH and HIV investments address critical gender issues.[16] Gender Action applied its "Essential Gender Analysis Checklist" (Box 1), a tool to assess gender sensitivity in Bank projects.[17]

Box 1. Gender Action's Essential Gender Analysis Checklist

This qualitative checklist reveals the extent to which gender-related issues are addressed in a development project, specifically the extent to which a project:

1. Approaches gender issues from a human rights perspective (**gender and human rights**);
2. Acknowledges and seeks to redress inequalities between men and women, boys and girls; explicitly promotes equality between men and women, boys and girls (**gender in/equality**);
3. Provides and analyzes sex-disaggregated data as part of the background/justification for the project's existence and design; includes sex-disaggregated indicators for project monitoring purposes (including data on gender participation in planning, implementation and monitoring and evaluation (**gender data**);
4. Analyzes gender relations, dynamics and inequalities within relevant political, legal, geographic, economic, historical and/or social contexts to be considered throughout the project cycle (**gender in context**);
5. Examines how gender inequalities uniquely affect men and women/boys' and girls' abilities to participate in the project cycle and benefit from project outputs and outcomes, including whether user fees and other harmful conditions promoted through the project may differentially affect access to services for men and women, boys and girls (**gender access**);
6. Promotes the equal opportunity for those who are directly or indirectly affected by the project to participate throughout the project cycle—from planning to implementation to monitoring and evaluation—including women, marginalized men, and other vulnerable groups, as appropriate; collect data on participation by gender (**gender inputs**);
7. Plans project outputs and outcomes that accommodate and respond to the differential needs of men and women, boys and girls (**gender outputs**); and
8. Considers the differential longer-term impacts of projects and/or IFI-endorsed policies on women and men, boys and girls (**gender impact**).

Inconsistent attention to gender roles and inequalities

Women's poor health outcomes often stem from their unequal access to income, education, and health care. For example, cultural norms may prohibit women from traveling alone to a health clinic for antenatal care (ANC) or women may not be in a position to negotiate contraception use or deliver in a health facility (WHO 2011). Since women are less likely to access education and have control over financial resources, they are also less likely to access health care (UNICEF 2005).

Some World Bank and AfDB projects pay significant attention to gender inequality in project design and implementation. The World Bank's US$ 44.6 million "Health Service Delivery Project" in **Mozambique** (WB 2009e) allocates approximately US$ 6.7 million to PRH and includes a detailed gender analysis and list of specific activities to respond to gender inequity in each project component. Likewise, the AfDB's US$ 12.3 million "Project to Support the Fight against HIV/AIDS" in **Mali** explicitly addresses HIV "with an orientation toward the question of gender." It references gender issues – specifically issues related to women – in almost every project component (AfDB 2005a).

[16] Qualitative analysis in Section II covers projects from 2000 through 2012 though the quantitative analysis of Section I focused on the period 2006-2012. Projects were selected to represent the Bank's range of sensitivity to gender issues, in line with the report's goal of highlighting best and worst practices in gender sensitivity.

[17] The checklist, part of our "Gender Toolkit for International Finance Watchers," guided this analysis. The Toolkit helps civil society organizations to incorporate a gender perspective into their work on IFIs and in other sectors.

World Bank

Yet most World Bank and AfDB PRH and HIV investments reviewed do not address gender roles and inequalities that create barriers to maternal health care. With regard to the World Bank, PRH and HIV projects often acknowledge gender roles and inequalities as project context, but do not address relevant gender roles and inequalities in actual programming. Box 2 below displays selected World Bank PRH investments with inconsistent attention to gender roles and inequalities.

Box 2: Selected World Bank PRH projects with inconsistent attention to gender roles and inequalities

- 2011 US$ 30 million "Strengthening Reproductive Health" project in **Mali**

  This project aims to "improve access to and use of quality reproductive health services by women of reproductive age." The PAD notes that project preparation included an analysis of the "gender aspects of reproductive health and family planning," which included the ministry in charge of women affairs and focus group discussions with women in peri-urban and rural areas. Women revealed that they often use contraceptives in secret because of their husbands' and in-laws' disapproval. Although these discussions revealed the "power of peer education and support from women's groups," the project does not mobilize women's groups or other peer support that participants revealed were crucial to their use of modern contraceptives (WB 2011c), missing a crucial opportunity to mobilize women to support each other in contraceptive use.

- 2004 US$ 25.5 million "Multisectoral AIDS Project" in **Mali**

  This project supports AIDS-related communication, education and awareness-raising, and expanded access to HIV testing, counseling and treatment. It acknowledges that "gender inequities and traditional cultural norms" like early marriage and female genital mutilation have led to higher HIV rates among Malian women and girls, the project does not measure changes in cultural attitudes and norms (the intended result of the project's education component), nor does it monitor whether women and girls have equal access to project-supported HIV testing and treatment facilities (WB 2004a).

- 2011 US$ 20 million "Health, HIV/AIDS and TB" project in **Swaziland** (WB 2011d)

  The project promises to integrate "gender sensitivity principles at all levels and stages." Yet although the project measures the number of health centers that provide PRH services, it does not address whether women and girls will have access to these services due to "pervasive gender inequality," which often undermines women's decision making and access to health care (UNDP 2007).

The World Bank's HIV investments also ignore some key gender concerns that undermine HIV prevention and treatment. Although gender inequality challenges women's and girls' ability to negotiate protected sex and impedes their access to HIV information, testing and treatment (WHO 2011), many World Bank and AfDB HIV investments ignore this critical issue. Box 3 displays selected World Bank HIV investments with such inconsistencies.

Box 3: Selected World Bank HIV/AIDS projects with inconsistent attention to gender roles and inequalities

- 2011 US$ 36 million "Additional financing for Health Sector Support and Multisectoral AIDS Project" in **Burkina Faso**

The project does not mention gender inequality among the factors that contribute to the country's HIV epidemic (WB 2011e).

- 2007 US$ 80 million "Total War against HIV/AIDS" Project in **Kenya**

The project aims to "promote socio-cultural norms, values, and beliefs" in support of HIV prevention a behavior change communication campaigns (WB 2007a). Project indicators only measure the number of people reached by behavior change communication campaigns (WB 2011f), without attempting to measure changes in societal attitudes, norms and beliefs about female gender roles, which have a significant impact on women and girls' HIV risk.

- 2009 US$ 225 million "HIV/AIDS Program Development Project II" in **Nigeria**

Citing a "lack of gender empowerment" that fuels the country's HIV epidemic, among women and girls who are more likely to engage in sex work and/or suffer from sexual abuse, the PAD notes that women's lower status undermines their ability to negotiate condom use and that they suffer more from HIV-related discrimination. Yet the project does not indicate that women, including HIV-positive women, were equally involved in project design or have equal access to project activities like HIV counseling, testing, care and support services (WB 2009c).

AfDB

Like the World Bank, the AfDB acknowledges that gender inequality is a "major cause of inequity" in African health systems. The AfDB notes that women also wait longer to seek health care compared to men, partly because they are unwilling to disrupt the function of their households. According to the AfDB, this "signifies a need to address gender inequality in health sector interventions" (AfDB 2009). The AfDB Gender Policy notes that women are biologically more susceptible to HIV compared to men, and that the "structure of gender roles and relations" contribute to women's disproportionately high rates of HIV infection (AfDB 2001a). Similarly, the AfDB's HIV Strategy Paper for Bank Group Operations states that "gender issues" are important to HIV control, as women "are particularly vulnerable for biological, economic and social reasons" (AfDB 2001b).

Yet despite the AfDB's impressive gender equality rhetoric, its PRH and HIV investments inconsistently address gender inequality in project design and implementation. A handful of projects explicitly acknowledge gender concerns as an obstacle to project performance. But even in these, AfDB PRH and HIV investments, however, do not adequately address gender inequality in programmatic response. Box 4 displays selected AfDB PRH and HIV investments with these inconsistencies.

Box 4: Selected AfDB PRH and HIV/AIDS projects with inconsistent attention to gender roles and inequalities

- 2005 US$ 35.75 million "Health Care Development Support Project" in **Burkina Faso**

The project aims to "sensitize" men and women with regard to safe motherhood, family planning, HIV and other STIs and promises "better information [for women] resulting in increased birth control," with the idea that increased access to information on HIV will offer "better knowledge of HIV and better protection" (AfDB 2005b). However, the project does not discuss how this information alone will not necessarily lead to higher contraceptive use and lower HIV infection rates. It also does not discuss critical gender issues that influence contraceptive use and HIV infection, such as Burkinabe women's frequent inability to negotiate when and how many children they bear (SIDA 2004; Social Institutions and Gender Index 2012).

- 2004 US$ 36.2 million "Health Support Project" in **Democratic Republic of Congo**

The project aims to improve health coverage and reduce morbidity and mortality associated with STIs, including HIV. Project documents briefly mention women's gender inequality and commendably promise to support grassroots organizations that help HIV-positive women, female rape victims and women who have undergone female genital mutilation (FGM) (AfDB 2005c). However, the project ignores critical gender issues among Congolese men and boys, many of whom have also been subjected to or carried out sexual assault in the midst of the DRC's ongoing conflict. While men and boys may contract STIs from sexual assault, reports suggest that they are less likely to seek help compared to women (Seruwagi 2011).

- 2008 US$ 23.5 million "Health System Development Support Project" in **Equatorial Guinea**

The project intends to increase health services utilization primarily among pregnant women and women of child-bearing age. Although the AfDB consulted women during project design and supports gender-equitable healthcare worker training, the project does not discuss how it will address gender inequalities that may impede women's health care access and utilization (AfDB 2008a). These include widespread domestic violence, women's frequent inability to negotiate the number of children they bear and their timing, and fees women must pay to access care as many do not have control over household finances (US Department of State 2011).

- 2006 US$ 59 million "Support to Maternal Mortality Reduction Project" in **Tanzania**

The project aims to reduce maternal and newborn deaths in four regions. Though the project discusses gender inequality leading to maternal mortality, most project funds are allocated to building and refurbishing health facility infrastructure (AfDB 2006a). The project appraisal report claims that this will increase access to maternal health services but it does not address gender inequalities, such as Tanzanian women's frequent inability to negotiate control of household finances and their economic dependence on their male partners (USAID 2008). Both of these factors may inhibit women from receiving care at the newly refurbished facilities.

Inconsistent use of sex-disaggregated data

Without collecting sex-disaggregated indicators on project performance, it is impossible to determine whether women and girls have participated in SRH and HIV project design, accessed project benefits and experienced positive outcomes and impacts.

Since most of the World Bank's and AfDB's PRH interventions are implemented as part of broader health system-strengthening projects, these projects tend to focus on just two or three core PRH-related indicators, such as the percentage of facility-based births, the percent of deliveries with a skilled attendant, and the percent of women who attend at least four antenatal care visits. While HIV/AIDS programs more frequently focus on specific HIV-related activities rather than broader healthcare reform, there is surprising lack of sex-disaggregated data. This is particularly concerning given strong gender roles around sexual relations, as well as women's more frequent involvement in sex work, which

puts them particularly at risk of contracting HIV. Box 5 contains examples of World Bank PRH and HIV/AIDS projects lacking sex-disaggregated indicators. Box 6 contains examples of AfDB PRH and HIV/AIDS projects lacking sex-disaggregated indicators.

Not all investments fail to collect sufficient sex-disaggregated data. A minority of AfDB and World Bank projects demonstrate good gender monitoring systems that measure project activity participation and outputs among both men and women. These include the World Bank's US$ 20 million "Second Population and AIDS Project" in **Chad**, whose project indicators align with the more gender-sensitive UN-approved indicators (WB 2010d). However, more often only a few key indicators are sex-disaggregated.

Box 5: Selected World Bank PRH and HIV/AIDS projects lacking sex-disaggregated indicators

- 2010 US$ 100 million "Health Sector Support Project" in **Kenya**

The project acknowledges "persistent" gender inequalities in Kenya. Despite its promise to "promote greater equity" in health service distribution and quality, the project's monitoring framework does not include any indicators to measure whether gender inequalities – including women's frequent lack of financial resources – affect their access to PRH services. Maternal health indicators are included in a separate framework, they "are not formally part of the project's Results Framework for which the project [is] accountable" (WB 2010e).

- 2008 US$ 50 million "National HIV/AIDS Prevention Support Project" in **Botswana**

Although the PAD includes sex-disaggregated data to describe the country's HIV epidemic, none of the project's key indicators is disaggregated by sex. These include indicators that measure the prevalence of concurrent sexual relationships, HIV knowledge, sexual activity and condom use among youth, and the prevalence of inter-generational sex (WB 2011h).

- 2001 US$ 17 million "Multisectoral HIV/AIDS Project" in the **Central African Republic**

The project emphasizes "gender inequity [as] a key problem in the AIDS epidemic" (WB 2001a) but only collects sex-disaggregated data to on rates of voluntary counseling and testing (VCT) among men and women. Key indicators are not sex-disaggregated, such as rates of anti-retroviral treatment (ART) and the number of HIV-positive people who receive support from civil society associations (WB 2011i).

- 2004 US$ 102 "Multisectoral AIDS Project" in the **Democratic Republic of Congo**

The project acknowledges that "women, orphans, and young girls [are] the most vulnerable to the epidemic, mostly because their isolation and weak economic power," increasing the likelihood that they will engage in sex work and other risk behaviors (WB 2004b). The project completion report does not include any sex-disaggregated indicators. It is therefore impossible to determine whether men and women, boys and girls received equal access to project benefits, including HIV counseling and STI treatment (WB 2011j).

Box 6: Selected AfDB PRH and HIV/AIDS projects lacking sex-disaggregated indicators

- 2005 US$ 21.8 million "Support to the Health Sector Program" project in **Malawi**

  The project appraisal report includes sex-disaggregated data to describe Malawi's HIV epidemic, but does not include any sex-disaggregated indicators to measure project activities, outputs and impacts (AfDB 2005d).

- 2003 US$ 48.6 million "Health Systems Development Project" in **Nigeria**

  The project includes a maternal mortality indicator in its monitoring framework but does not disaggregate other key indicators by sex such as access to health care services (AfDB 2002a).

- 2002 US$ 8.6 million "Rehabilitation of the Health System Project" in **Angola**

  The project aims to improve health care access and support reproductive health and HIV services, with a special focus on women and young children (AfDB 2002b). The limited monitoring framework only measures maternal and infant mortality; it does not include any other key PRH or HIV indicators such as health care access and utilization (AfDB 2002b).

- 2001 US$ 7.5 million "Strengthening the Health System and Fight against HIV/AIDS and Epidemic Diseases" project in **Chad**

  The project does not contain *any* indicators by which to measure the project's progress and impact. Despite the absence of a monitoring framework, the project appraisal report still claims that the project will increase health care accessibility, decrease morbidity and thereby lead to a "significant increase in household incomes" (AfDB 2001c).

- 2004 US$ 38.75 million "Project Support Health PDDS in Eastern Province" in **Democratic Republic of Congo**

  The project aims to improve the population's overall health status with a focus on vulnerable groups and infectious disease, including HIV. None of the project's key indicators are sex-disaggregated, neither the population that benefit from basic community health services, the number of childhood malaria deaths, vaccination coverage rates, nor community participation in training (AfDB 2003).

Promotion of user fees for PRH and HIV services

The World Health Organization (WHO) estimates that the inability to pay health care costs causes an estimated 150 million to face financial catastrophe each year, particularly women and girls. This phenomenon occurs worldwide, but is most severe in low-income countries (WHO 2005a; WHO 2008). Despite this evidence, many governments and donor-funded projects depend on "user fees," fees payable by patients as a condition for receiving care to recover project costs.

Proponents of user fees argue that they incentivize patients to carefully consume health services, thereby reducing the burden on the health system. Yet numerous studies demonstrate that user fees drastically reduce health care access (James et al. 2006), exacerbate poverty (Ponsar et al. 2011) and undermine efforts to reduce maternal mortality (Campbell et al. 2009). Although the World Bank's 2001 policy on user fees "supports the provision of free basic health services to poor people" (Kattan and Burnett 2004), several World Bank and AfDB PRH and HIV investments still promote user fees in the form of health insurance schemes, voucher systems and other mechanisms that establish a "market

relationship" between provider and patient (Institute of Development Studies 2011). Health care user fees disproportionately impact health care access for women and girls, whose lack of financial resources and often limited scope for setting priorities for household spending, make it more difficult to pay for out-of-pocket health care costs (Nanda 2002). While biological and socioeconomic factors increase women's risk of HIV and other STIs compared to men (Global Campaign for Microbicides 2011), user fees may prevent women and girls from seeking timely and appropriate medical care.

Several studies in sub-Saharan Africa confirm that once user fees are eliminated, health care utilization significantly increases among women and girls (Malama et al. 2002; Abdu et al. 2004; El-Khoury et al. 2011; Ponsar et al. 2011). Despite the disproportionately negative impact on health care access for women and girls, the World Bank and AfDB continue to promote user fees by explicitly funding voucher and insurance schemes, ignoring ineffective user fee exemption systems for the poor, and overlooking so-called "informal" user fees that also burden the poor.[18] Box 7 contains selected examples of World Bank PRH and HIV/AIDS projects promoting user fees. Box 8 contains selected examples of AfDB PRH and HIV/AIDS projects promoting user fees.

[18] "Informal" user fees refer to both direct and indirect health care-related expenses. These may include payments for supplies, medicines, and laboratory services, and/or payments made directly to health care workers in exchange for better care, shorter wait times, or as a general condition of service (Sharma et al. 2005).

Box 7: Selected World Bank PRH and HIV/AIDS projects promoting user fees

- 2007 US$ 15 million World Bank investment in **Ghana**'s National Health Insurance Scheme (NHIS)

The World Bank's investment in the NHIS was intended to "protect citizens" against HIV (WB 2007b). Such insurance schemes, however, often fall far short of universal coverage and have little to no impact on quality of care (Ekman 2004; Kalk 2008). A recent assessment found that "despite attempts to portray the NHIS as pro-poor," Ghana is "struggling to enroll poor segments of the population, with the rich at least twice as likely to enroll compared to the poor." NHIS enrolment is estimated to be as low as 18-34 percent nationwide (Dixon 2011), and mostly composed of better-off citizens.

- 2005 US$ 20 million "Multi-Sectoral AIDS Program" in **Ghana**

This project depends on universal "cost recovery programs already in place, including patient co-payments for [ART]" to cover the cost of health services. The project not only forces patients to pay for HIV medications, but also does not allocate funding to treat opportunistic infections, relying instead NHIS-funded treatment. The 2005 PAD claimed that this approach would "guarantee equal access" to care (WB 2005b). Yet as stated above, the NHIS has failed to cover health care services for the vast majority of the population (Dixon 2011).

- 2004 US$ 102 million "Multisectoral AIDS Project" in the **Democratic Republic of Congo**

The project "encourages the development of a *cost recovery culture* by providing targeted groups with productive activities, and asking modest contributions in time, labor, and materials" (emphasis added). Considering this a form of "community empowerment," the project forces beneficiaries to pay for materials and spend uncompensated time on the project, though in 2006 up to 72% Congolese lived below the national poverty line (UN 2006).

- 2000 US$ 22 million "Health Sector Development Program" in **Tanzania**

The project "strengthen[s] proven health financing modalities (e.g. user fees, community health funds, drug revolving funds, and national health insurance)" in order to increase health facility revenue (WB 2000). Although this project includes "an exemption policy for the very poor" (WB 2004c), the World Bank ultimately reported that effective measures had not been put in place to ensure that poor patients could still access to health services once user fees were imposed (WB 2009f). Exemption fees often fail to provide for the most vulnerable, according to a recent review of user fee practices in low and middle-income countries (Lagarde and Palmer 2011).

- 2007 US$ 4.3 million "Reproductive Health Vouchers in Western **Uganda**"

This project requires patients to purchase vouchers that entitle them to facility-based maternal health care (WB 2007c). The voucher costs about US$ 1.22, a prohibitive amount considering that half of Ugandans live on less than US$ 2 per day (WB 2009g; WB 2011l).

- 2010 US$ 22.8 million "Health Systems Performance Project for **Benin**"

The project promotes user fees by inadequately responding to the failure of Health Equity Funds (HEFs) that are supposed to exempt the poor from payment. The PAD acknowledges that while HEFs should fund fee exemptions for poor patients, health care workers do not have enough incentive to provide care for the poor, so they "mostly use the Fund's budget to exempt their friends and relatives." In response, the PAD simply acknowledges that "a more reliable process to identify the poorest is necessary" (WB 2010b).

- 2009 US$ 25 million "Health Sector Development Support Project" in **Burundi** (WB 2009b)

The project offers certain health services for free or "for only a low cost" to increase access for pregnant women. While the PAD acknowledges cost as a barrier to maternal health care, it relies on "women's groups that help pregnant women to access prenatal and obstetric services at health centers" (WB 2009b) to increase health care utilization. The project's monitoring framework does not measure whether the project actually achieves increased access to maternal health care.

Box 8: Selected AfDB PRH and HIV/AIDS projects promoting user fees

- 2005 US$ 31.46 million "Health Systems Development Support Project" in **Benin**

The project recognizes that "women experience the greatest financial obstacles to health care since they are the hardest-hit by poverty". It tries to enhance maternal and child health care access in part by developing the country's health insurance system (AfDB 2005e). This approach has proven to be highly inequitable without effective fee exemptions for the poorest patients, many of whom are women (WB 2010b).

- 2005 US$ 35.75 million "Health Care Development Support Project" in **Burkina Faso**

In light of the population's "inadequate financial resources," this project promises to improve health care access by enrolling 18,000 people in at least 400 new "alternative health financing systems" (AfDB 2005b). Despite low rates of enrollment (3-6 percent) in existing health funding schemes, the project claims that the system will reduce inequalities that prohibit access to quality health care and increase facility revenue at the same time. The project appraisal report does not indicate whether the poorest patients are exempt from fees, even though over 70 percent of the population lives on less than US$ 2 per day (WB 2012a).

- 2008 US$ 20.8 million "Health System Development Support" project in **Equatorial Guinea**

This project supports health sector capacity-building to control communicable diseases and deliver maternal health care. Despite the government's enormous oil revenues (about US$ 6.74 billion in 2010 for a population of 650,000) (US Department of State 2012a) the majority of the population lives in poverty. The AfDB claims that poverty – not Equatorial Guinea's health care user fees – is the primary reason that people are excluded from the health system (AfDB 2008a). The project therefore includes a study to explore "health financing alternatives," even though less than 20 percent of revenue supporting health care is generated from user fees (Witter 2010).

- 2005 US$ 21.8 million "Support to the Health Sector Program" project in **Malawi**

This project aims to reduce maternal morbidity and mortality. It notes that even though services included in Malawi's "essential health package" are supposed to be free, user fees are charged in government and private facilities (AfDB 2005d). Although the project acknowledges that user fees comprise approximately 26 percent of all out-of-pocket expenditure for Malawian households, none of the project components directly address how user fees limit poor women's access to maternal health care services.

- 2003 US$ 48.64 million "Health Systems Development Project IV" in **Nigeria**

This project promises to "improve health care financing" by funding the purchase of equipment, drugs and other medical supplies, and improving health sector financial management. Although the project acknowledges that a lack of incentives for health care workers "has led to the practice of informal user fees, on top of formal fees" (AfDB 2002a), the project does not address user fees and its impact on patients' health care access, especially for the poor who are *not* exempt from the user fee system.

III Country Case Studies

The preceding two sections show how little the World Bank and AfDB spend on HIV/AIDS and PRH and their routine lack of attention to relevant gender dynamics, including overlooking restrictive gender roles and collection of sex-disaggregated data. The following section takes a closer look at World Bank and AfDB projects and 'beneficiary' perceptions of the projects' impacts in two countries, Cameroon and Uganda. In the first half of 2011, Gender Action staff conducted capacity-building workshops for civil society partner organizations, the National Association for Women's Action in Development (NAWAD) in Uganda and the Martin Luther King Jr. Foundation (LUKMEF) in Cameroon. These countries were chosen to represent an Anglophone and a francophone sub-Saharan African country, respectively, and because both had active World Bank- and AfDB-funded PRH and HIV projects with vastly different policies with regard to user fees. While Cameroon imposes health care user fees in all public facilities, the government of Uganda abolished them in 2001. Gender Action worked with our civil society partner organizations to develop and test semi-structured interview tools, which NAWAD and LUKMEF used to gather qualitative data from patients and health care workers at public health facilities during 2011.[19]

Healthcare in Uganda

Shortly after President Yoweri Museveni came to power in 1986, the IMF and World Bank mandated structural adjustment policies in Uganda as a condition of receiving loans. These policies included conditions such as the reduction of tariffs, elimination of import bans, and the privatization of state-owned industries. The IMF claims that these efforts to "liberalize" Uganda's economy would contribute to poverty alleviation and "reduce impediments to economic growth by improving the quality of, and access to, physical and social infrastructure" including health facilities (IMF 1998). The IMF's and World Bank's fiscal requirements and high debt repayments made it difficult for governments like Uganda's to channel funds to services like health care and public education (Action Aid 2005:27-28). The Ugandan government subsequently implemented a "cost sharing" system that required patients to pay for a portion of health care and education services. The burden of these costs was devastating for the

[19] Data were collected by trained researchers who lived in the projects' target areas and were familiar with the public health system; they were also able to conduct interviews with patients and health care providers in local languages. Due to limited resources, however, researchers were not able to travel and conduct interviews in all project-funded facilities. Patients form the bulk of respondents since most health care workers were either unwilling or unable to participate at the time interviews were conducted. Since all data were collected at public health facilities, these case studies do not capture the views and experiences of patients outside the public health system (i.e. traditional birth attendants or patients who seek care solely through traditional medicine or at private facilities). All participants gave informed consent prior to the interviews.

poor (Naiman and Watkins 1999).

By 1998, Uganda was burdened by US$3.6 billion in debt. It became the first country to qualify to join the IMF's "heavily indebted poor country" (HIPC) initiative (WB 2011k). It was also the first country to qualify for the IMF's Enhanced HIPC Initiative in 2000. The combined US$ 1 billion saved through HIPC debt relief allowed the Ugandan government to increase spending on primary health care and other critical social services, but key health indicators, including maternal and infant mortality, remained worrying (Kuteesa and Nabbumba 2004).

Shortly before presidential elections in March 2001, the government formally abolished health care user fees at first-level government health facilities in Uganda. Although health care utilization among poor Ugandans rose dramatically once user fees were removed, a WHO study found a catastrophic lack of essential drugs in government health facilities (WHO 2005:7). According to Uganda's most recent Demographic and Health Survey (DHS), almost two-thirds of the women who reported problems accessing health care cited their inability to afford health care services. They also reported difficulty traveling long distances to health facilities, paying for transport and accessing essential drugs. The significant disparity in access to ante-natal care (ANC) and facility-based deliveries between Uganda's lowest and the highest economic quintiles underscores the fact that cost remains a barrier to women accessing essential PRH services (Uganda DHS 2007).

With an estimated HIV prevalence of 6.5 percent, about 1.2 million Ugandans are HIV-positive, including 610,000 women and 150,000 children (Government of Uganda 2010). HIV prevalence is highest among women at 7.3 percent (WB 2011l). Less than half of the population has access to treatment leading to 64,000 AIDS-related deaths per year in Uganda (UNAIDS 2010b). Fertility is high at about 6.7 births per woman, with the highest birth rates among women in the lowest socioeconomic quintiles. Given the low rate of contraceptive use (24 percent) and the extremely high unmet need for contraception (41 percent), it is unsurprising that unsafe abortion is fairly common. An estimated 297,000 abortions occur each year, resulting in tens of thousands of life-threatening complications (Uganda DHS 2007). While approximately 90 percent of pregnant women in Uganda access some facility-based ANC services, less than half receive the recommended four or more ANC visits[20] and deliver their babies in a facility with skilled attendance from a doctor, nurse or midwife. Most Ugandan maternity services are in "poor condition and health facilities lack the basic necessities like water, power, equipment and supplies" (WB 2011).

It is good news that Uganda's maternal mortality ratio dropped to 310 deaths per 100,000 live births in 2010 from 435 deaths in 2006 (WHO and UNICEF 2012). Yet for women's rights activists in Uganda, this is not good enough. The Centre for Health Human Rights and Development, a Ugandan NGO, spearheaded a case against the Government of Uganda, challenging the government's failure to provide basic maternal health facilities in hospitals. In early June 2012, the Constitutional Court dismissed the case against the government arguing that it is outside the Court's jurisdiction as a political question. The activists report that they will appeal the decision by filing an application for redress by the High Court under Article 50 of the Constitution (Green 2012; Nansubuga 2012). Amid the legal battles, there is a hint of progress in President Museveni's July 2012 pledge at the International Family Planning Summit that the Ugandan government would commit US$ 5 million over the 2012-2017 period towards improving reproductive health services (Mwesigwa Kizza 2012). Still, there is a long way to go in addressing Ugandan women's restricted access to adequate health care and high rates of HIV/AIDS.

[20] A minimum of four ANC visits are recommended by the World Health Organization (Lincetto et al. 2011).

World Bank and AfDB PRH and HIV investments in Uganda

During the report time frame, there were five Bank-supported projects with PRH and/or HIV/AIDS components operating in Uganda. These five projects, summarized in Table 4, are described below:

1. The AfDB's "Support for the Health Sector Strategic Plan Project II," financed by a US$ 29.4 million loan, aimed to improve reproductive health and mental health service delivery in Mbarara District, in the western region of Uganda. Among several benefits, the project was supposed to lead to "community empowerment and mobilization for health and increased utilization of reproductive health services." It has also intended to "improv[e] access to quality health care for rural populations" (AfDB 2006b).

2. The AfDB's "Support Mulago Hospital and Improvement of Kampala Health Services" project aims to improve access to quality and affordable health care services for the Kampala area by upgrading Health Centers at Kawempe and Kirrudu into General Hospitals. The project also aims to revitalize the referral system and patient transportation system, and address the "serious human resources crisis in the health sector."

3. The AfDB's "Post Primary Education and Training Expansion and Improvement Project- Education IV" focuses on revitalizing Uganda's education system, though its HIV awareness-raising activities are relevant to this report.

4. The World Bank's "Reproductive Health Voucher Project" in Western Uganda, which was implemented by Marie Stopes International (MSI) Uganda, sold vouchers to pregnant women that they could redeem for ANC services, delivery and post-natal care. Vouchers cost 3,000 Ugandan shillings (UGX), about US$ 1.22. When the project closed in December 2011, the World Bank claimed that the project had provided services for 136,000 people, including 46,348 safe delivery packages and 31,658 STI treatments (World Bank 2012b). MSI explains that "the objective of voucher schemes is to utilize the large but unregulated private sector, by incentivizing providers to deliver key health services at greatly improved standards, and to make them affordable" (MSI 2010).

5. The World Bank's "Health Sector Strengthening Project" aims to strengthen Uganda's health workforce, enhance the infrastructure of existing health facilities, improve "leadership, management, and accountability for health service delivery" and maternal, newborn and family planning services (World Bank 2010c).

Table 4. World Bank and AfDB Investments in Uganda with PRH and HIV components, approved in FY 2006-2012

Project Title	Cost (USD)	Timeline	Summary
AfDB: Support for the Health Sector Strategic Plan Project II	$29.4 million loan	Aug 2006-ongoing	Aims to improve the delivery of reproductive health services and improve mental health in Mbarara District, including Mbarara Hospital, 13 Health Center IVs and 26 Health Center IIIs.[21]
AfDB: Support Mulago Hospital and Improvement of Kampala Health Services	$ 73.6 million loan	Nov 2008 - ongoing	Aims to improve access to quality and affordable health care services for the Kampala area by upgrading Health Centres at Kawempe and Kirrudu into General Hospitals. The project also aims to revitalize the referral system and patient transportation system, and address the "serious human resources crisis in the health sector."
AfDB: Post Primary Education and Training Expansion and Improvement Project- Education	$ 80.08 million loan	Jul. 2011-ongoing	Primary aim is to improve the education system through the improvement and expansion of school facilities and teacher quality, though the project includes supporting an

IV			HIV awareness campaign towards secondary education students and in strengthening this priority as a cross cutting issue in the Science and Management curriculum.
World Bank: Reproductive Health Vouchers for Uganda	$4.3 million grant	Oct 2007- Mar 2012	Intends to improve mother and child health and to effectively treat STIs in Western Uganda.
World Bank: Health Systems Strengthening Project	$130 million loan	2010-2015	Supports the delivery of Uganda's Minimum Health Care Package, focusing on maternal health and family planning.

NAWAD's Qualitative Research Findings

In order to conduct research on the World Bank and AfDB's PRH and HIV investments in Uganda, Gender Action partnered with the National Association of Women's Action in Development (NAWAD). NAWAD researchers focused their qualitative data collection on health facilities in Uganda's Western region, which allowed them to concentrate on assessing the impacts of the AfDB's "Support for the Health Sector Strategic Plan Project II" and the World Bank's "Reproductive Health Vouchers for Uganda" project. NAWAD researchers interviewed a total of 60 patients at four randomly selected health centers in Kiruhura Health Center IV and Kanyaryeru Health Center III (Kiruhura District) and Kinoni Health Center IV and Nyakayojo Health Center III (Mbarara District).

Patients and healthcare workers identified five key obstacles to achieving good reproductive and HIV/AIDS care: the chronic shortage of drugs; inadequate referral system and transportation; poor quality of care due to understaffing and poor pay; limited availability of delivery kits; and men's limited involvement in reproductive health care. These five factors are discussed below.

It is important to note that these problems are deeply-rooted and that the World Bank and AfDB are but two institutions addressing Uganda's healthcare weaknesses. This section seeks to evaluate if, through the eyes of patients and healthcare providers, World Bank and AfDB projects have had their intended effects of strengthening reproductive health and HIV/AIDS services.

I. Chronic shortage of drugs

According to Uganda's Health Sector Strategic Plan (2005/6- 2009/10) mid-term review report (2008), Uganda's National Drug Policy aims to ensure availability, accessibility and affordability of essential appropriate, safe and efficient drugs. However, in this report, all 60 patients interviewed lamented a chronic shortage of essential drugs, which not only prevented patients from accessing timely medical care, but also caused financial hardship. The patients explain:

> Sometimes you may not be having money and you decide to go to the government health center for medicine. And if you come there and there is no medicine then there will be no help but to die with your sickness.
>
> – Female, age 26, Kinoni Health Center IV

> You come here for treatment and when you reach the pharmacy, they tell you there are no drugs or they give you one type and they tell you to go buy the others from the clinic… you can imagine you spent time and walk a very long distance with a sick child but you reach here and they tell you that there is no medicine… so you are forced to go back home and look for the money and if you are lucky and you know the clinic owner they can give you the drugs and you pay later.
>
> – Female, age 30, Kiruhura Health Center IV

Despite being pleased with building construction and renovation, several patients commented that the shortage of drugs was the biggest problem in regard to accessing health care:

> There are new buildings that have been put up. There are also old ones that have been renovated. But despite the good-looking buildings, there are no drugs within the facility. You come today and they give you some, but the following day they are not there and the situation repeats itself often. When there are drugs, they treat us very well. The doctors are good. But if there are no drugs, that is when we have to go to other places.
>
> – Female, age 31, Kanyaryeru Health Center III

> Most times I don't find the drugs. The biggest problem is the delay to attend to patients. You have to wait for them, and if they tell you to go and buy drugs then you have to go and buy them… if you would find all the services you needed here, then there would be no problem.
>
> – Female, age 24, Kiruhura Health Center IV

> The government should give health facilities drugs… when there are drugs here, they treat us very well and give us all the drugs related to our illnesses. The doctors are good. But if there are no drugs, that is when we have to go other places.
>
> – Female, age 35, Kanyaryeru Health Center III

For the money needed for essential drugs at private clinics during government facility shortages, one female patient at Kiruhura Health Center IV said that she lied to her husband:

> Private clinics are very expensive. This has taught me to lie to my husband. He increases on the money he leaves at home for use per day if I tell him that food is now expensive at the market, the prices have doubled. He then gives me more, which helps me save some for health services.
>
> – Female, age 25, Kiruhura Health Center IV

> I don't know how much we earn. My husband is in full control and he cannot tell me. Sometimes he gives me money and sometimes he does not.
>
> – Female, age 30, Kiruhura Health Center IV

Other patients coped by taking traditional medicine until they could afford drugs, turned to their families for help, or simply stayed home until the facility restocked:

> I walk a long distance and then there are no drugs at the facility. I lack money to buy drugs. I just go back and wait until I get money to buy drugs while taking some herbs.
>
> – Female, age 23, Kiruhura Health Center IV

> I try to provide myself with essential drugs through buying them from other clinics… my family tries to raise funds for me.
>
> – Female, age 30, Nyakayojo Health Center III

> The problem is that when there are no drugs at the facility some patients don't buy. Instead, they remain with their illness and wait until there are drugs at the facility.
>
> – Male, age 24, Kanyaryeru Health Center III

Although one male patient at Kinoni Health Center IV claimed that drug stockouts were "not as bad as before," more patients at Kinoni Health Center IV reported that drugs were usually out of stock. One

health care worker at Kinoni Health Center IV blamed chronic drug shortages on patients seeking to 'stock up', by:

> … pretending to be sick, [they] get drugs and keep them at home so that in case they fall sick when there are no drugs, they self-administer. When they don't fall sick, those drugs will expire and be thrown away. So basically, that's the situation.
>
> – Healthcare worker at Kinoni Health Center IV

However, a senior clinical officer at Nyakayojo Health Center III claimed that the main reason that drugs ran out was because they were disbursed according to a faulty formulary along Uganda's hierarchy of clinics:

> [They say] that Health Center IIIs get these drugs and Health Center IIs get these drugs… For us, they send us what they call essential drugs. Then when we find we don't have [them], we're supposed to refer to Health Center IV and above. We have been longing to meet with people at the Ministry of Health and national medical stores and tell them that for some of the drugs, we don't use them! They can bring IV fluid, boxes and boxes, yet we use four boxes a quarter, and that's why drugs expire… the drugs they send us are not enough. They send us drugs that should last three months but they last three weeks. Some drugs we never have and are only equipped with [malaria drug] Coartem, but not every patient has malaria.
>
> – Senior Clinical Officer, Nyakayojo Health Center III

II. Inadequate referral system and transportation

The realization of a rational and effective referral system for health care cases has remained a challenge for the Ugandan health care system. In cases where health units have ambulances, these are not sufficient to address the increasing number of referral cases and coordination challenges. AfDB funds in particular were supposed to "equip health facilities with ambulances and strengthen their communication system" but most patients reported that while ambulances were available, they were not free of charge. Patients reported prices of between 10,000-50,000 UGX (approximately US$ 4-20) for an ambulance or taxi ride, a prohibitive amount given that the average income in Uganda is less than $ 2 per day. This discriminates particularly against women, who frequently have less access to cash. Patients reported:

> The cost of fuel for the ambulance is a challenge. You see for us women, you may have no money. You come here and they refer you to Mbarara Hospital or Itojo Hospital, but to use the ambulance they may ask you to pay 20,000, 30,000 UGX, which is hard for some women who may not have the money.
>
> – Female, age 30, Nyakayojo Health Center III

> You may come late at night and they tell you that you need a referral, then they check the ambulance and there is no fuel, so this may lead to the death of the patient on your hands.
>
> – Male, age 32, Kinoni Health Center IV

> You pay 30,000 from here to Mbarara [District Hospital]. If you don't have the money the patient may die in your hands or else you hire another car for 60,000. When you call them, they ask if you have the fuel.
>
> – Female, age 40, Kinoni Health Center IV

The records officer at Kiruhura Health Center IV confirmed that patients had to pay to use the ambulance in the event of a transfer, where the patient's family is expected to contribute the fuel.

One patient reported never having seen an ambulance, which she felt put women with complicated deliveries at risk:

> I have not seen ambulances here, but we need one. Many women come here for deliveries and some get referred [to the district hospital] but to look for a vehicle takes some time and at night it is very difficult to get a vehicle, so I think there is a need for an ambulance to help referrals move very fast.
>
> – Female, age 29, Kanyayeru Health Center III

The chronically inadequate transportation system raises questions about the effectiveness of the AfDB's project, which specifically aim to improve the patient referral and transportation system.

III. Poor quality of care due to understaffing and poor pay

Both World Bank and AfDB healthcare investments in Uganda aim to improve the quality and training of healthcare workers. The World Bank's 2010 "Uganda Health Systems Strengthening Project" aimed to support the "creation of a Central Job Bureau in the Ministry of Health, short-term training of personnel officers (designated officers) including hospital administrators and other health managers in relevant areas of personnel management, and provide equipment and technical support" for selected districts and hospitals (WB 2010c).The AfDB project provides funding to "support on the job training of health staff in emergency obstetric care and other reproductive health issues," as well as supervision activities at national, regional and district levels.

Nevertheless, patient respondents had strong complaints about the quality of health care they received from health care workers, with many claiming that facilities were still critically understaffed:

> The medical attendants, especially doctors, are few compared to the patient population… we find it challenging to tell the medical attendants our real problems as they also tend not to have time due to the large number of patients.
>
> – Female, 33, Kanyaryeru Health Center III

> There are delays and sometimes the health care workers are not in sight. Last time, when there was no nurse to attend to us, women quarreled.
>
> – Female, age 43, Kiruhura Health Center IV

> More health workers should be employed in the hospital to handle the patients' problems.
>
> – Male, 40, Kanyaryeru Health Center III

Other patients had serious complaints about the health care workers' motivation and performance, claiming that the workers sometimes "don't care." This took a particular toll on women seeking maternal health and delivery services:

> The patients are treated well here but sometimes when you come here and the nurses are not there the women are there crying, you come and you find there are no services for family planning… sometimes women come for ANC and there is no one to take care of them, so that is a problem. Women go to the clinic when they have no choice.
>
> – Female, age 40, Kinoni Health Center IV

> I have realized that the health care workers don't care sometimes… they forget that for us patients, we are villagers and we need help. You may come and they do not care for you. For example, there is that lame woman you saw, she came last night but there was no nurse to attend to her so eventually those who brought her are the ones who helped her deliver. As a woman, such experience is not good and I felt bad. I imagined it was me.
>
> – Female, age 26, Kinoni Health Center IV

> The government is the first to be responsible as it has not yet fully helped us women to provide us with good health services in our villages where we come from. Women still die in numbers while delivering there. The government is no help. Health care workers are after making money instead of saving our lives.
>
> – Female, age 25, Kiruhura Health Center IV

> For me it is better to alternate the health care workers because when they stay at a place for a long time, they tend to relax in service delivery. In fact I told you that today I got express service but it is because the health workers that were there before me are not the ones I found. There are new ones now.
>
> – Female, age 26, Kiruhura Health Center IV

A midwife at Kiruhura Health Center IV acknowledged that some women thought they didn't care for patients, but explained this stemmed from being overworked and understaffed:

> We are two midwives but then one goes on leave and the one who remains has a big work load. You may have a delivery at night and then you are supposed to work the following day and when you delay to come, the mothers start complaining and say that you don't care for them, but you are actually so tired.
>
> – Midwife at Kiruhura Health Center IV

IV. Limited availability of delivery kits

The AfDB's "Support for the Health Sector Strategic Plan Project II" project funded 400,000 "delivery kits" for pregnant women, which were all used. However, several female patients reported that the facilities ran out too quickly to help them. The delivery kits include essential tools for a safe delivery including a bar of washing soap, gloves, plastic sheeting, cotton, wool, and razor blades. According to the UNFPA, health care workers in Uganda often ask mothers to purchase the kits themselves, which adds an "extra hurdle for those women who would have wanted to deliver at a health care facility with the help of a skilled birth attendance but can barely afford the transport costs to the health facility on top of their own supplies" (UNFPA 2011). Indeed, several female patients reported that they would not be admitted to the facility to give birth if they did not bring their own supplies, and that this was a significant financial hardship. A midwife at the same facility also confirmed a chronic lack of supplies:

> We improvise… we lack instruments, there are no delivery kits, and these mothers know that we have them. You can have a mother without anything, and she comes to deliver at midnight. What do you do? There is one now who has just delivered and has practically nothing to dress up the baby.
>
> – Midwife at Kiruhura Health Center IV

Health care workers claimed that patients did not always compensate for a facility's lack of materials. Nyakayojo Health Center's senior clinical officer, who also acts as the facility accountant, explained how the facility itself compensated for inadequate government support:

> This is a big unit… and my funding allocation for last year was only 3 million UGX. It becomes difficult to run a unit, so it is a challenge when it comes to funds. Funds also come late. That means that during the quarter we need to use our own money to keep activities running. We must have soap and detergent, we must have paraffin to sterilize equipment, and other basic necessities. Sometimes they dispatch less of the expected amount and so if you used your own money, you lose. That is a problem… but we just squeeze and we do the work.
>
> – Senior Clerical Officer, Nyakayojo Health Center III

The clinical officer also explained that in the absence of adequate funding, including fuel for transport when the clinic conducted outreach in surrounding villages, he saved money by only sending one person

to conduct outreach on a motorcycle. This tactic, however, compromised the quality of care in the villages, as one person conducting outreach could not singlehandedly meet each village's needs. A nursing officer from Kanyaryeru Health Center III expressed similar concerns. Although he reported an increase in patients coming for ANC, HIV/STI testing and family planning services, he noted that the funds from the central government were not enough to provide transport to outreach programs, or to address the facility's drug shortages and inadequate water and electricity supply. A clinical officer from Kiruhura Health Center IV said that he and his fellow employees "improvised" without adequate human resources and materials, including protective gear, water and electric power.

V. Men's limited involvement in reproductive health and HIV services

While the AfDB's "Support for the Health Sector Strategic Plan Project II" project aims to "revitalize" Uganda's male involvement program in regard to reproductive health and HIV, virtually all respondents claimed that men only sought health care when they fall ill, and almost never accompany their wives when they received ANC, STI testing or family planning services. Some women did not perceive antenatal care or family planning as concerning them:

> Men do not participate in family planning, maternal care, HIV services in this community. Most of them do not want family planning. They just want us to continuously give birth.
>
> – Female, age 28, using IUD for family planning, Kinoni Health Center IV

> Men are not involved in these activities even if you push them. Very few of them come… many don't want even their wives to use family planning. They just want them to produce and produce [children].
>
> – Female, age 30, using IUD for family planning, Nyakayojo Health Center III

> Men normally don't want to attend family planning services along with their wives. Men say its women who are supposed to be checked, especially those who stay home to nurture children.
>
> –Female, age 33, uses condom, Kanyaryeru Health Center III

> The majority of men do not want to come for family planning services, thinking it is only important for women who give birth. But again what amuses me is, who makes women pregnant?
>
> – Female, 30, not using any form of family planning, Nyakayojo Health Center III

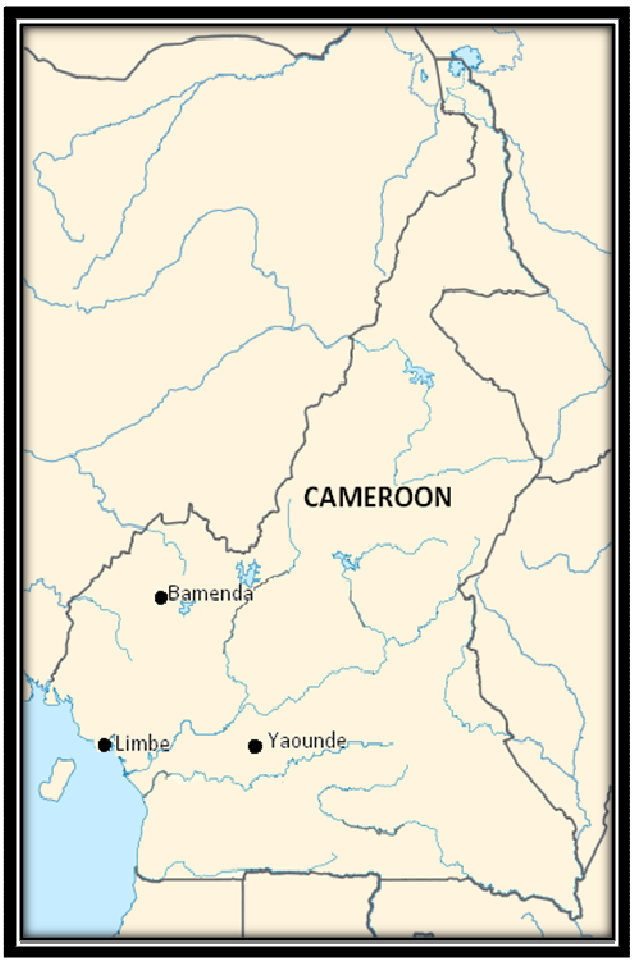
With regard to HIV and other STI testing, respondents explained that most men were afraid to learn their STI status in front of their wives:

> Women usually come alone for HIV testing because men fear to know [their HIV status] because they may have cheated on their wives. So if there is mistrust, the man refuses.
>
> – Male, age 32, Kinoni Health Center IV

> Men are always few [in the clinic]. They do not want to attend in big numbers like women. Also men fear their spouses to know their HIV status before them as they can divorce them.
>
> – Female, age 30, using birth control pills, Nyakayojo Health Center III

> Men do not frequently join us for family planning and maternal health care, STI and HIV services in this community because of stigma. Even when health care workers encourage it, they don't come.
>
> – Female, age 34, using IUD for family planning Nyakayojo Health Center III

Healthcare in Cameroon



Cameroon, the second case study, and Uganda share a similar national health profile. According to the World Bank, one-third of Cameroonians live on less than US$ 1.25 per day (WB 2011m). Cameroon first began charging health care user fees in 1982 as part of a broader primary health care policy implemented in conjunction with World Bank-imposed structural adjustment reforms. Research shows that health care user fees in Cameroon have negative consequences on low-income households, and that "in order to ensure that these charges do not cut access, there is a need for adequate implementation of exemption policies that work for the poor" (Ntembe 2009).

In October 2010, the World Bank and IMF determined that Cameroon met the criteria for US$ 1.26 billion in debt relief under the IFIs' HIPC initiative, which intended to "improve public services in education, health, social development, urban sanitation and rural development" (IMF 2006). Today, however, Cameroon's health care system is marked by decaying infrastructure, a lack of trained specialists, outdated equipment, and poor sanitation (US Department of State 2012).

Although Cameroon's health facilities use a "cost recovery scheme" to offer extra financial incentives to motivate staff, the World Bank reports that this system "appears to generate more problems than it solves" (WB 2008). The system operates in the absence of transparent staff evaluation procedures and a failure to provide sufficient financial incentives for staff to improve their performance, since many healthcare providers already supplement their low salaries with work outside the public health sector (WB 2008).

With an HIV prevalence rate of 5.3 percent, approximately 610,000 Cameroonians are HIV-positive, including 320,000 women and 54,000 children. Cameroon experiences an average 37,000 AIDS-related deaths every year (Government of Cameroon 2010). While overall HIV prevalence is declining, Cameroonian women are much more likely to be HIV infected compared to men (6.8 percent and 4.1 percent, respectively) (WB 2011m).

Cameroon's total fertility rate decreased slightly from 5.8 births per woman in 1991 to 5 in 2004, but remains high. Women who are poor, uneducated and located in rural areas give birth to 1.5 to 2 times as many children compared to their wealthier and more educated urban counterparts. Birth rates among Cameroonian adolescents are also high: 138 births per 1,000 women occur among girls aged 15-19 (WB 2011m). Cameroon's high fertility rate is partly explained by its low rate of contraception coverage. Just 12 percent of Cameroonian women use some form of contraception and varies widely among women according to education and economic status (WB 2011m). Cameroon's unmet need for contraception is high at 20 percent (WB 2011m).

Cameroon has a high maternal mortality ratio (600 deaths per 100,000 live births). This is fueled by a lack of accessible, quality emergency obstetric care. While the majority of pregnant women complete at least one ANC visit with a doctor, nurse or midwife, only 62 percent give birth in a health facility with skilled attendance. The poorest and least educated women are the least likely to give birth in a health facility with trained personnel (WB 2011m).

World Bank and AfDB PRH and HIV/AIDS investments in Cameroon

At the time of this assessment, there were two active IFI-financed health care projects in Cameroon and one debt-relief grant with a PRH component in 2006 (Table 5). The World Bank's "Health Sector Support Investment," which is financed by a US$ 25 million loan, channels funds to districts in order to "meet the day-to-day requirements of a district health system (e.g. supervision, community outreach, recruitment of contractual staff, bonus payments, consumables)" (WB 2008). The project also aims to improve district-level accountability and health care management, provide special funds for health promotion, and procure required drugs, reagents and commodities at the national level. Project indicators measure the percentage of deliveries attended by a trained health professional; pregnant women who have attended at least three ANC visits; facilities with drug shortages; and "people with access to a basic package of health, nutrition, or population services" (WB 2011n).

Table 5. World Bank and AfDB PRH and HIV Investments in Cameroon, approved in FY 2006-2012

Project Title	Cost (USD)	Timeline	Summary
World Bank: Health Sector Support Investment (SWAP)	$25 million loan	Jun 2008-Mar 2014	Aims to raise health care utilization and improve quality of services; focus on child/maternal health and communicable diseases. Targets Northwest, Southwest and Littoral provinces. Addresses barriers to health care access by "rationalizing the cost recovery system [and] expanding risk pooling mechanisms" (World Bank 2008).
World Bank: Debt Relief Grant Under the Enhanced HIPC Initiative	$ 31.5 million grant	Apr 2006	This grant under the HIPC (Heavily Indebted Poor Countries) Initiative, combined with debt relief, aimed to allow Cameroon to repay its outstanding debt. The successful completion of the grant was conditional, as per Cameroon's Poverty Reduction Strategy Paper (PRSP), on increased spending for social and other priority sectors. As such, 20 percent of financing under the grant was accorded to Health Sector (WB 2007e).
AfDB: National Reproductive Health Programme Support Project (PASR)[22]	$10.2 million loan; $1.9 million grant	2010-2015	Intended to reduce maternal and infant-child mortality by improving women's and adolescents' access to "quality reproductive health services." Also provided reproductive health training to health committees, community representatives and health personnel (AfDB 2010c).

The AfDB's "National Reproductive Health Programme Support Project (PASR)" has a more specific objective of reducing maternal and infant-child mortality among the population in general and among women, children and adolescents, in particular. The five-year project, with an end date of 2015, aims to construct and equip seven Integrated Health Centres (IHCs), rehabilitate five district hospitals and one regional hospital, and train health committees, community representatives and health personnel in reproductive health services.

LUKMEF's Qualitative Research Findings

Gender Action partnered with the Martin Luther King Jr. Memorial Foundation (LUKMEF), located in Limbe, Cameroon, in order to examine the impact of World Bank and AfDB's PRH and HIV investments.

LUKMEF researchers interviewed a total of 59 patients at Bamenda Regional Hospital in Bamenda (Northwest Province); 34 patients at Bota District Hospital in Limbe (Southwest Province); 24 health care workers and 44 patients at Limbe Regional Hospital in Limbe (Southwest Province).

Patients and healthcare workers identified five key obstacles to achieving good reproductive and HIV/AIDS care: the chronic shortage of necessary drugs; inadequate equipment and infrastructure; low quality of care from underpaid and overworked healthcare staff; and inadequate emergency transportation for women undergoing pregnancy complications. These are discussed below.

As in the Uganda case, it is important to note that these problems are deeply-rooted and that the World Bank and AfDB are but two institutions addressing Cameroon's healthcare weaknesses. This section seeks to evaluate if, through the eyes of patients and healthcare providers, the IFI s'projects have had their intended effects of strengthening reproductive health and HIV/AIDS services.

I. Chronic shortage of drugs

Most patients described hospital drug prices as either "cheap" or "moderate" compared to drugs at private pharmacies, but some reported that "in some cases, the drugs are expensive." One 60 year-old male patient claimed that he used "traditional medicine since drugs are expensive." Almost half of patients reported that drugs are often out of stock. One female patient stated that since "most important drugs are not available at the hospital pharmacy," she has to find alternative sources for medicine.

Three patients explained that they saved money by purchasing drugs from unlicensed dealers who sell drugs by the roadside. Several others reported not having any choice but to purchase drugs from nursing staff:

> Nurses prescribe drugs separate from the doctor's prescription and sell [drugs] to patients. We are obliged to buy them. If not, they will not attend to us.
>
> – Female patient

> Nurses in the maternity sector have to request certain incentives from patients. Patients buy drugs from the nurses since patients believe they cannot do without them.
>
> – Female patient

Several patients at Limbe Regional Hospital complained that many drugs were out of stock at the hospital, which meant they had to find the drugs elsewhere and go back to the hospital for them to be administered. The cost of drugs, however, seemed to be patients' most significant challenge. Three female patients claimed that they only purchased the "essential" drugs, and then tried to purchase the rest later. Instead of purchasing drugs herself, a mother of three explained that she tries to borrow them from a friend who has a similar illness. A widow said that she went to the hospital for all of her health needs when her husband was still alive, but since his death she did not have enough money and relied on traditional medicine instead.

Almost three-quarters of patients at Bota District Hospital reported that the hospital pharmacy always lacked essential drugs. As a result, patients said, they pay for them elsewhere. Compared to the patients in the Limbe region, patients who could not access affordable drugs in the Bota district hospital tended to use traditional medicine or buy drugs from unlicensed dealers. Many patients reported going to the hospital for a diagnosis, and then seeking care elsewhere in order to save money. As these patients said:

> Most of the time, drugs are expensive, so I turn to where it is cheaper. A guy in the market, Bertrand – we get drugs from him.
>
> – Female patient, Bota District Hospital

> Some of the drugs are being sold, whereas we hear that they are supposed to be for free… that is why most people buy drugs from the roadside because they are cheaper, and they also get the wrong drugs for their illnesses… so you just get diagnosed and go and get a drug to help your situation.
>
> – Female patient, Bota District Hospital

> I mostly come just to know what is wrong with me. Then I use herbs as a substitute for drugs. At times I just stay home and get drugs at the roadside, which seems cheaper.
>
> – Female patient, Bota District Hospital

Other patients coped by rationing their drug supply, taking only those that they could afford:

> Drugs are too expensive… I try to afford the most important drug and then start to look for means to purchase the remaining ones.
>
> – Female patient, Bota District Hospital

> You purchase the essential ones then later struggle to get the other ones.
>
> – Female patient, Bota District Hospital

Several patients noted that drugs were often expensive because nurses sold them in the wards for personal profit:

> You come with your pregnancy, and you must be asked to purchase their expensive drugs. The nurses don't treat me fairly. Many times when your drugs aren't finished, they take them and sell them to others for their personal interest… nurses should stop taking remaining drugs from patients for their private sale.
>
> – Female patient, Bota District Hospital

> Nurses sell us drugs at higher prices as compared to the pharmacy. They sell behind the doctor's back.
>
> – Female patient, Bota District Hospital

> None of the drugs are free and many at times the nurses who sell drugs double the prices in the wards. And those who buy from them become their friends from that moment, but those who don't buy from them become their enemies.
>
> – Female patient, Bota District Hospital

II. Poor equipment and infrastructure

Despite the World Bank and AfDB's significant investments in healthcare infrastructure in Cameroon, 40 percent of the 59 patients interviewed at Bamenda Regional Hospital complained about its equipment and infrastructure, including a lack of running water, poor sanitation, inadequate toilets, "poor maintenance," "worn-out" beds and lack of mosquito nets to prevent malaria. One male patient, whose wife is a nurse, commented that "equipment is outdated and they are not replaced." However, two female patients said that the hospital had good equipment, but other factors interfered with its use: one female patient said "the hospital has good equipments but you must have money to enjoy the equipment."

Several patients at Limbe Regional Hospital echoed these concerns, citing the hospital's lack of basic equipment, including x-ray machines, incubators, scales, and mosquito nets, as well as inadequate

infrastructure. One male patient explained that he was sent to another hospital to get his own supplies prior to his son's delivery. Another patient described a lack of stretchers and wheelchairs in the emergency room, while several pregnant women said there were not enough benches for women waiting for ANC services. Several patients described the wards as "extremely dirty," pointing out the lack of running water and adequate sanitation facilities. Two in-patients also worried about their safety and security, since the hospital did not have adequate lighting or overnight security guards.

Almost all of the 24 health care workers interviewed at Limbe Regional Hospital reported that they did not have adequate equipment to perform their jobs. This forced them to "improvise" in order to carry out their day-to-day work. A diabetes specialist commented that the hospital does not have the equipment to measure patients' blood sugar, while an HIV counselor said the hospital lacked gloves and other protective equipment to use when dealing with HIV positive patients. Similarly, a midwife reported that she does not have basic equipment, including forceps and bed pans, while another reported that the hospital did not have any incubators for premature babies. Although several health care workers at Limbe Regional Hospital claimed that they purchased necessary supplies themselves, a nurse who had worked at the facility for two years reported that "health care workers provide the care, and patients provide the materials." A midwife who had worked at the facility for six years said "we try to use what we have, begging patients to bring the necessary materials for delivery."

Just over half of the patients interviewed at Bota District Hospital complained about the hospital's poor equipment and poor infrastructure, including its lack of running water, adequate toilets, and mosquito nets in the maternity ward to prevent malaria among pregnant women. As one mother of five children said, "I have never been given a mosquito net… most women are given a mosquito net only after they are diagnosed with malaria." Two patients explained that due the hospital's poor infrastructure and lack of equipment, they were sometimes forced to seek care elsewhere and shoulder higher costs:

> Machines are lacking, so doctors send patients to their private hospitals to carry out the tests… they should bring in more efficient equipments, which are working.
>
> – Male patient

> You are sent elsewhere to do the HIV test, which makes it more expensive. The hospital has no equipment for that.
>
> – Female patient

Two patients in the maternity ward described their difficulty coping with crowded conditions and no running water:

> The ward is shared between women who are pregnant and patients who are sick with other diseases. The ward should be for mothers and babies only.
>
> – Female patient

> The hospital is so dirty…there is no water. Women who give birth cannot rest—they have to go around looking for water and at the same time, take care of their babies. It is too stressful. There are also a lot of mosquitoes and there are no nets given to us.
>
> – Female patient

III. Inadequate transportation

While most Bamenda Regional Hospital patients said they were unaware of whether the hospital had an ambulance, several explained that "there is an ambulance, but it is not accessible to the population because they cannot afford it." One mother said that she knew the hospital had an ambulance but "believe[d] it is for the rich." The ambulance's reliability only worried one male patient, who advised: "look for a taxi because you can die at home waiting for a hospital ambulance."

Similarly, most patients at Limbe Regional Hospital were not aware of whether the hospital had an ambulance, but five patients commented that the ambulance was "meant for doctors only." One mother of two children said that when a friend had called for an ambulance, she was asked to present her hospital card and pay a fee before being transported to the hospital. Another patient said that the ambulance is so slow and demands so many documents that "a patient might die in the process, so they often use a taxi." Patients at Bota District Hospital also were either not aware that an ambulance was available or said that it was not accessible to them. Two patients reported that they saw hospital staff using an ambulance "for their own private cars." As one mother of three children said, "I know there are ambulances available here at the hospital but they are not accessible to us patients. Personnel use it as their own private property."

IV. Poor quality of care due to understaffing and poor pay

Many patients at Bamenda Regional Hospital reported receiving poor treatment. Both patients and healthcare workers viewed this largely as a result of understaffing and poor pay which encouraged many among them to charge 'informal' fees for services.

Eleven health care workers at Limbe Regional Hospital claimed that understaffing was a significant challenge at the facility, which forced them to work long hours that were not always compensated. As one nurse in the casualty unit commented, there were only two nurses available to run the night shift for over 50 patients. A pediatrics nurse who had worked at the facility for almost a year said staff simply had "no choice." "At times, she said, "we work from 7 am to 5 pm, and we receive no benefit for the overtime." Interviews suggested that it was not uncommon for health care workers to operate private practices outside the hospital in order to supplement their public sector income: one nurse reported that she operated a private practice out of her home, and referred patients there once they were discharged.

Health care workers gave different reports of their performance incentives, including salary. Although some health care workers mentioned receiving their salary and their "quotes part" (commission), which a midwife said ranged from 10,000 to 20,000 CFA monthly, others reported that they did not receive any additional incentives at all. Two staff members reported receiving their quotes part in addition to "annual motivation." Two health care workers complained that they received their quotes part, but did not receive any other benefits, such as staff housing and transport.

Although training opportunities could be used as a performance incentive, one nurse who had worked at the facility for two years claimed that "selection for training and seminars is done based on relationships with management." Another nurse confirmed that "criteria for [training] selection are not transparent." While several nurses said they attended "scientific meetings," they did not receive any additional training opportunities at all.

Several health care workers discussed poor management practices at the facility, including a lack of "discipline" and systematic performance evaluation. As one nurse who had worked at the hospital for

five years commented, “day-to-day evaluation is done, but there is no reward. Verbal feedback is provided to improve staff performance, but our motivation remains the same.” Another nurse complained that hospital policies seemed to change on a regular basis: “we work under confused policies, which at times brings conflicts with authorities.” Another nurse, who had worked at the facility for over ten years, cited “discipline ranging from top to bottom,” as the biggest challenge.

These human resource challenges translate to poor patient care. One female patient in her twenties said she preferred to use private health care facilities because “the nurses are wild and do not take care of patients very well.” Recalling the birth of her first child, the woman said she was “abandoned during labor” and that nurses did not assist until the baby was almost born. Other patients stated:

> Some nurses are brutal when you do not obey them. Some are money-minded, even when a patient is in labor pain.
>
> – Female patient

> Patients have no option. You have to dance the tune of the health workers in the hospital since you need medical attention.
>
> – Female patient

> Health workers are not welcoming compared to private hospitals. Their harsh nature scares people away.
>
> – Female patient

Almost half of Bamenda Regional Hospital’s patients reported that it is “difficult to see a doctor” because of the hospital’s “overpopulation” and recommended that the hospital hire more doctors, particularly specialists. While some attributed the high number of patients to a lack of health care workers, one woman said the hospital was overcrowded because there are too many “personal relationships” between some health care workers and patients they knew on a personal basis who received preferential care. Two patients said that doctors often were late or did not show up at all. As one female patient said, “doctors should respect appointments and call to let patients know they will not be around.”

Several patients at Limbe and Bota Regional Hospitals complained about a lack of competent health care workers. Nurses, who many patients claimed would not treat them unless they received a bribe, were described as “not welcoming” and “insulting” and “negligent”:

> Nurses are interested in receiving money even before attending to you, even if you are dying.
>
> – Female patient, Limbe Hospital

> The nurses do not pay attention. It is your family member who has to constantly remind them if your drip gets finished, if you are in any pain.
>
> – Female patient, Bota District Hospital

> The nurses give special treatment and choose their own people they know to attend to rather than taking into consideration those that came earlier.
>
> – Female patient Bota District Hospital

> The nurses don't do anything, and they insult you before they give you treatment. They are so rude. We have a doctor who does not even pass around to check on us.
>
> – Female patient Bota District Hospital

> Some doctors own their own private clinics where they spend more time so patients come and lament here.
>
> – Female patient Bota District Hospital

Several maternity patients commented on the frequency of caesarian sections, which generated higher fees than vaginal deliveries. As one patient explained:

> The issue of operation has become a sort of business. Out of 20 who give birth, ten will be an operation (caesarian section). Most of the time they just want to arrange just because they want to tax you. I was operated on and it cost about 250,000 CFA and many times there is a doctor's fee. How can a doctor who is under the government say he wants a doctor's fee? The system is so polluted. There is no mercy.
>
> – Female patient

V. The true cost of care: Formal user fees

According to the World Bank, household financial burdens in Cameroon stem from "the large number" of formal and informal health care user fees. Patient interviews support this assertion, as the vast majority of respondents at Bamenda Regional Hospital reported experiencing financial difficulties, which were exacerbated by consultation fees, "informal" fees, and the cost of transport to and from the hospital. At Bota District Hospital, two thirds of the 34 patients interviewed reported that the cost of services – including registration fees, consultation fees, lab tests and drugs – was too expensive. Two patients said that they preferred to save their money and use private hospitals, where they received better treatment, but the majority of patients said they had no choice but to pay the fees.

Everywhere, patients consistently reported paying 600 CFA to see a nurse, 1,000 CFA for a doctor, and 2,000 CFA[23] to see a specialist, although one female patient stated that she did not have to pay any consultation fee at all. Pregnant women reported having to pay 7,500 CFA upfront for ANC services and delivery, in addition to the cost of drugs. Some patients described how financial difficulties either compromised their quality of care, or prevented them from receiving care altogether. For women, this problem is compounded by dependence on husbands for funds to visit healthcare centers.

> At times, my husband says he does not have money for clinic visits.
>
> – Female patient

Many patients reported that as an alternative to hospital or clinic care, they sought out less expensive traditional medicine, prayed or simply forwent medical care altogether:

> Each time you come, a test costs at least 8,000 CFA. I was assigned a test for 8,000 CFA so I tried to do the test and buy drugs later because I have no money for drugs now.
>
> – Female patient

> If you are sick or your baby is sick and you don't have the money, you will not receive any treatment and they just abandon you.
>
> – Female patient

> I was at the hospital in time but I was not attended to by the nurses because I didn't have enough money to pay for treatment. My child died.
>
> – Female patient

"Informal" User Fees

Apart from the cost of care, many patients at Bamenda Regional Hospital discussed having to pay bribes in order for staff to attend to them, and that patients with staff received better treatment. Patients reported:

> Nurses are rude to patients and delay attending to patients, but when patients have money, they attend to them. There is a lot of tribalism and personal relationships with the health workers… midwives should be more polite and caring. They should not focus all their attention on money.
>
> – Female patient

> Nurses need to be bribed before they take care of patients… Nurses should not take bribes and should treat patients equally because you are saving lives.
>
> – Female patient

> When patients are not rich, the care that is directed toward them is poor… patients have no choice.
>
> – Female patient

Despite the financial difficulties imposed by the health care system, several patients at Bamenda Regional Hospital claimed that they had "no choice" but to use public services compared to more expensive private clinics. As one mother of three commented, "we just manage because [the hospital] is cheap." One female patient commented that "one just needs to look for money and get to the hospital no matter what the situation," while a father of three children explained that he had to "come to the hospital by all means, even by selling personal property."

At Limbe Regional Hospital, 26 of the 44 patients interviewed reported that user fees and other health care costs presented their greatest challenge in accessing health care. Patients complained about high consultation fees, particularly during emergencies, as well as the price for ANC services. One female patient claimed "we have no choice but to visit this place, since the prices are lower than private hospitals." Several patients complained that even after they pay a consultation and clinical fees, "you still need to pay some money when meeting with the doctors." A mother of four claimed that patients had to pay for vaccination services, which were supposed to be offered for free. Cost clearly acted as a barrier to care: one pregnant patient said she had to cut the number of ANC visits since she could not afford them, while another female patient said that she had to use traditional medicine and buy drugs on the roadside because she could not afford the hospital's fees.

At Nkwen Bamenda Medical Center, although patients complained about long wait times, poor treatment by nurses and inadequate equipment, the patients' main concerns were financial. Two thirds of the 25 patients interviewed reported that they experienced financial difficulties, either with consultation fees (ranging between 600-700 CFA) or drug costs. As one male patient said, "[e]ven though the drugs are subsidized, they are too expensive for someone with a low income level."

Similarly, patients at Bota District Hospital explained that patients needed to bribe nurses in order to receive care. Patients noted that since the hospital never seemed to have the supplies and materials it needed, nurses would fill the gap by selling materials to patients.

> Nurses go ahead and do their practices such as if you are asked to bring a needle or cotton and you say you don't have, nurses remove them from their bags and sell them to you for their interest."
>
> – Female patient

> The nurses are not caring at all. I have birth here, and the nurses have not passed to find out how my baby is doing or if I am having any complications. All they know is sitting and talking rather than working. Even to come around and bathe the child, they leave everything for the mothers, who are in pain. They ask us for 100 CFA if we want them to wash our babies.
>
> – Female patient

Evaluating the World Bank's and AfDB's health impacts in Cameroon and Uganda

While more time may be needed to truly gauge the affects of these projects, in light of the testimonies of patients and healthcare workers in this report, there is reason to doubt the effectiveness of World Bank and AfDB investments in increasing access for Cameroonian patients.

In Cameroon, the World Bank has spent at least 25 million in a loan to the government through the Bank's Health Sector Support Investment (SWAP) project which financed consolidated annual district action plans to include services to address childhood illnesses, maternal and reproductive health, and HIV/AIDS among others. The AfDB likewise has lent its support to the Cameroonian government to finance health sector improvements, with specific goals of improving training for reproductive health workers and promoting "quality reproductive health services." As the above cases have shown, these projects are ineffective faced with overwhelming demand. Few patients cited any improvement in their health situation since these projects were initiated.

Furthermore, many PRH and HIV investments still do not take gender into account, and beneficiary voices are not represented. One project stands out as an example. Prior to this report, from 2000-2010 the AfDB had spent committed over US$ 11 million to a "Health System Development Project (PDSS)" in Cameroon. With this money, the Government of Cameroon and AfDB built a health observatory, revamped biomedical equipment, trained biomedical technicians, and trained staff on emergency obstetrical and neo-natal care, according to their Project Completion Report (WB 2010i). The completion report notes in its project assessment that the "the gender output obtained…are not taken into account." Women are mentioned once – women's groups, along with others, received some training on primary care.[24] But the monitoring and evaluation rubric of the project – such as increased bed capacity, equipment functionality – do not measure access of poor to project benefits. By contrast, the World Bank's SWAP project does. It measures such indicators as percentage of births attended by skilled professionals, child immunization rates and people with access to a basic package of health, nutrition or population services (WB 2012f) that more accurately reflect whether people are benefiting from its project. These indicators, however, should be disaggregated by sex in order to truly capture if women are benefitting from the project.

In Uganda, the World Bank has provided targeted small-scale interventions in its "Reproductive Health Vouchers for Uganda" grant, yet target beneficiary patients reported not being able to benefit from these at all. The World Bank has also provided broader financial support to the Ugandan Ministry of Health through its "Health Systems Strengthening Project" loan. This latter approach has also been adopted by the AfDB, which loaned the Ugandan government US$ 29.4 million to improve the delivery of reproductive and mental health services particularly in Mbarara district, specifically promising "community empowerment and mobilisation for health and increased utilization of reproductive health services; improved access to quality health care for rural populations; and increased access to comprehensive mental health care" (AfDB 2006b). An appraisal of the project's implementation so far is

not available, making it difficult hard to judge its effectiveness. Yet as in Cameroon, despite the World Bank's and AfDB's commitments in Uganda, there has not been a substantial, measurable difference for patients according to them.

The healthcare challenges in both countries are deeply-rooted and cannot be fully addressed through donor aid alone, let alone the IFIs' alone. However, the persistently poor state of health services, particularly for women, several years into current IFI projects' operations raises important questions about the effectiveness of World Bank and AfDB investments.

IV Discussion

This report began by documenting how little the World Bank and AfDB spend on reproductive health and HIV/AIDS programs in sub-Saharan Africa relative to their total budgets, despite the region's almost unparalleled demand for improved health services . It also noted how the banks' health sector support is usually in the form of loans that incur new debts that perversely squeezes healthcare spending. The second section documented how the World Bank and AfDB risk undermining their own health-related goals by overlooking women's needs. For example, few projects measure whether women accessed project benefits to the same extent as men, and many impose fees on basic project-financed services like antenatal care visits. Finally, qualitative case studies in Cameroon and Uganda demonstrated little to show on the ground for World Bank and AfDB investments on reproductive health and HIV/AIDS.

This last section suggests key challenges the World Bank and AfDB must face in order to make reproductive health and HIV/AIDS financing effective, particularly for sub-Saharan African women.

Increasing grant funding

Of the 92 World Bank projects throughout sub-Saharan Africa from FY 2006-2012 containing PRH and/or HIV/AIDS components, 50 percent were loans, 40 percent were grants and 10 percent contained a mix of grant and loan elements. Of 20 African Development Bank projects in sub-Saharan Africa from FY 2006-2012 containing PRH and/or HIV/AIDS components, 60 percent were loans, 30 percent were grants and 10 percent contained grant and loan elements.

For decades the burden of World Bank and AfDB loan conditions have caused many African governments to cut back public sector spending, including on healthcare infrastructure, services, medicine and staff, which has both contributed to and compounded the problems that the Cameroonian and Ugandan patients and healthcare workers identify. If sub-Saharan African countries are going to fulfill the Millennium Development Goals, the World Bank and AfDB must dramatically increase grant funding for PRH and HIV investments. Specifically, this funding must be used to remove obstacles impeding women's access to health care, as they are least likely to control the funds needed to pay for medical care and are often the first in their families to forgo medical treatment under economic duress.

Addressing gender inequalities in project design, implementation and monitoring

This report identified how World Bank and AfDB projects often fail to incorporate clear gender concerns into project design, implementation and monitoring. Few projects facilitate men's and women's participation in project planning and design, promote gender equitable access to project benefits, and collect sex-disaggregated indicators to measure the project's outputs and impacts on men and women, boys and girls.

As the Cameroon and Uganda case studies have shown, chronic health service resource scarcity negatively impacts all low-income patients, male and female. These include the chronic shortage of appropriate drugs; inadequate and obsolete equipment; and unavailable or nonexistent low-cost transportation to health care facilities. Poor quality of care from underpaid and undertrained health care workers in understaffed hospitals lead to widespread "informal" user fees.

Yet women suffer more than men from poor healthcare availability and quality, as the World Bank itself has noted in the 2012 World Development Report, which commendably focused on Gender Equality and Development. Quality PRH and HIV aid must incorporate women's concerns at all project cycle stages to be effective and reduce inequalities between male and female beneficiaries.

All IFI projects should incorporate gender concerns more fully by involving women in consultation and planning; ensuring equal access to women through cost-free and convenient care; and monitoring project effects on women both in the short- and long-terms.

Confronting user fees

Health is a human right enshrined in the Universal Declaration of Human Rights.[25] This report's findings confirm that quality aid must promote the sustainable elimination of healthcare user fees to ensure that the poorest exercise their human right to health. Section II documented that both the World Bank and AfDB promote user fees in a variety of contexts. But as the case studies in Cameroon and Uganda (Section III) show, even marginal costs, whether formal or informal fees, often prevent low-income patients from seeking care, leading them to make heart-wrenching decisions to choose only the minimum care that they can afford, or select among many family members' urgent healthcare needs or between food and healthcare.

Both the Bank and its implementing agency, MSI Uganda, declared their "Reproductive Health Vouchers for Uganda" project to be successful. MSI claims that the project sold more than 100,000 vouchers to poor women for "the cost of a loaf of bread," proving that poor women "can in fact afford the vouchers" (Gender Action 2012). Such voucher schemes, according to MSI, support private sector health care providers while they "play a significant role" in overall health system strengthening (MSI 2010). However, this report suggests that several aspects of this scheme are problematic.

For example, potential Ugandan women project beneficiaries underlined that men, who usually control household finances, sometimes do not value maternal and reproductive health services in the same way as women do. Paying for health care services, even when equivalent to "the cost of a loaf of bread," may therefore present a significant barrier for poor women who do not control their household income and have to meet other, more immediate needs—including buying loaves of bread or other essential goods. Women who do have the necessary funds may not be able to spend them on health care if their husbands do not approve.

Secondly, the project's voucher scheme is unsustainable. Gender Action and NAWAD interviewed Dr. Jennifer Wanyana, Assistant Commissioner for Health Services in the Uganda Ministry of Health's Reproductive Health Division, who claimed that the while program was successful and very popular, once World Bank funding disappeared, the Ministry would not have the funds to sustain or expand the program (Wanyana 2011). This highlights the need to invest in sustainable, longer-term approach.

In both Uganda and Cameroon, informal health care user fees strain household resources, force patients to reduce other essential household expenditures, compel patients to search for less expensive and

potentially dangerous alternatives (like medications purchased by the road side), or prevent patients from accessing health care altogether. Some parents reported that their inability to pay hospital user fees led to their children's death. The availability of free health care and essential drugs is essential for delivering satisfactory health care to the poor.

Both the World Bank and AfDB must use their considerable influence to promote the sustainable elimination of health care user fees, including the elimination of fees for essential drugs and emergency transport, as a critical first step toward improving access to health care.

Recommendations

The challenges to providing affordable, high-quality reproductive and HIV care in resource-poor countries are immense. The World Bank and AfDB, as key public funders of health sectors in countries worldwide, have a duty to address the flaws in their projects that prevent low-income women in particular from benefitting from them. In light of these findings Gender Action offers the following recommendations:

Grants, not loans

Considering how little the World Bank and AfDB spend on PRH and HIV/AIDS, they should dramatically increase funding through grants – not loans – in a comprehensive range of SRH services and HIV prevention/treatment services, particularly in African countries with high maternal mortality, HIV prevalence and AIDS-related mortality.

Abolish user fees

At the project level, the most important step that the World Bank and AfDB could take to improve their PRH and HIV/AIDS investments in sub-Saharan Africa would be to abolish all user fees attached to projects. These contribute little to covering program costs and disproportionately disadvantage poor women, who often rely on male partners for the funds necessary to access healthcare. A more sustainable pro-poor funding strategy would be for the banks to prioritize investments in sustainable interventions using national or community-level institutions (from government hospitals to women's healthcare NGOs) that also encourage men's participation in PRH and HIV/AIDS projects.

Sustainable, gender sensitive staffing

The World Bank and AfDB should take care to not create programs or structures that cannot be adequately serviced by national staff. The banks' headquarters and country offices must ensure that *all* reproductive health and HIV/AIDS project staff have a high level of gender training given the sensitivity surrounding the topics of sex and reproduction.

Address gendered barriers to access and use

All projects need to address gender roles and inequalities – such as women's frequent dependence on male partners for funds needed to purchase healthcare, or inability to negotiate contraceptive use – that may undermine women and girls' ability to access PRH/HIV services. It is not enough to merely invest in healthcare system strengthening if half of the population, women, are not able to access it equally. Addressing gendered barriers to healthcare would include conducting gender analyses for every proposed health sector investment in order to address gender roles and inequalities within project design, implementation and monitoring; collecting sex-disaggregated data within project monitoring frameworks in order to determine project outputs and impacts on women and men, boys and girls; and involving male and female beneficiaries in equal proportion during project consultations. Enhancing

men's involvement in reproductive care and sexual health is important to ensure access for women to health care services as well as sexual health for their partners and themselves.

By making it more affordable and safe to seek care when needed, multilateral development banks like the World Bank and AfDB can play a role in enhancing women's ability to negotiate safe sex, choose if and when to bear children, and deliver healthy children safely. The entire population's sexual health would benefit from access to STI testing and treatment. More and better IFI spending to improve country health care systems and reproductive health and HIV/AIDS services in particular, will go a long way to reduce the burden of 'informal fees' and ensure access to reproductive and sexual health for all, especially women.

Annex 1: World Bank and AfDB PRH and HIV Spending

Table 1. World Bank PRH commitments in sub-Saharan Africa (FY 2006-2012)

Country	Project Name and Source of Funding (L = Loan; G = Grant; G/L= mix of grant and loan elements)	Timeframe[26]	Commitment (amount designated PRH, millions USD)	Total by country (amount designated PRH, millions USD)[27]	Population of women ages 15-49 (millions)[28]	GDP (billions USD)[29]	Maternal Mortality Ratio (per 100,000 live births)[30]; ranking (hi-low MMR)
Total WB PRH commitment in SSA (FY 2006-2012)				***430.02***			
Angola	Municipal Health Service Strengthening (Revitalizaçao) **(L)**	Jun 2010- Dec 2015	25.5	25.5	4.3	84.4	610 (16 of 44)
Benin	Malaria Control Booster Program **(G)**	Jun 2006-Jun 2011	6.2	12.1	2.1	6.6	410 (37 of 44)
	Second Multisectoral HIV/AIDS Control Project **(L)**	Apr 2007-Jun 2012	5.9				
Burkina Faso	Health Sector Support & Multisectoral AIDS Project **(G)**	Apr 2006- Dec 2014	6.7	31.6	3.9	8.8	560 (22 of 44)
	Strengthening community participation for the fight against female genital cutting (FGM/C) **(G)**	Jul 2009- Nov 2013	1.8				
	Reproductive Health Project in Burkina Faso **(G)**	Dec 2011- Dec 2016	23.1				
Burundi	Health Sector Development Support **(G)**	Jun 2009- Dec 2012	5.3	5.3	2.2	1.6	970 (5 of 44)
Cameroon	Health Sector Support Investment (SWAP) **(L)**	Jun 2008	3.3	3.3	4.8	22.4	600 (18 pf 44)
Central	Health System Support Project **(L)**	May 2012- Mar 2018	3.4	3.4	1.2	2.1	1500 (1 of

African Republic							44)
Chad	Population and HIV AIDS Additional Financing **(G)**	Jun 2010	4.4	10.5	2.5	7.6	1200 (2 of 44)
	Second Population and AIDS Project **(L)**	Jul 2010- Jun 2013	6.1				
Congo, Democratic Republic	Health Sector Rehabilitation Support Project **(G)**	Sep 2005-Jun 2013	19.5	55.2	14.9	13.1	670 (15 of 44)
	Polio Control Additional Financing to Health Sector Rehab Support **(G)**	Jun 2011	5.7				
	DRC Additional Financing Primary Health Care **(L)**	Jul 2012	30				
Congo, Republic	Health Sector Services Development **(G)**	May 2008-Dec 2013	8	8	1.0	11.9	580 (21 of 44)
Cote d'Ivoire	Emergency Multi-Sector HIV/AIDS Project **(G)**	Jun 2008- Sep 2012	3.4	3.4	4.6	22.8	470 (32 of 44)
Ethiopia	Second Multi-sectoral HIV/AIDS Project **(G)**	Mar 2007- Sep 2011	5.1	5.1	20	29.7	470 (31 of 44)
Ghana	Multi-Sectoral HIV/AIDS Program **(L)**	Nov 2005- Jun 2011	3.4	3.4	6.0	31.3	350 (39 of 44)
Kenya	Health Sector Support **(L)**	Jun 2010- Mar 2015	16	16	9.8	31.4	530 (26 of 44)
Lesotho	New Hospital PPP **(G)**	Nov 2007- Dec 2012	1.5	2.6	0.5	2.1	530 (27 of 44)
	Health Sector Reform Project Phase 2 **(L)**	Oct 2005- Sep 2009	1.1				
Liberia	Health Systems Reconstruction **(G)**	Jun 2007- Oct 2011	1.5	1.7	0.9	1.0	990 (4 of 44)
	Pilot Project to Strengthen the Sexual and Reproductive Health and Rights for the War-Affected Vulnerable Youth in Liberia **(G/L)**	May 2008- Oct 2010	0.2				
Madagascar	Second Multisectoral STI/HIV/AIDS Prevention project **(L)**	Jul 2005- Dec 2012	8.7	12.4	4.9	8.7	440 (34 of 44)
	Sustainable Health System Development Project **(L)**	May 2007- Dec	2.2				

		2009					
	Second Multisectoral STI/HIV/AIDS Prev II Additional Financing **(L)**	Jun 2012	1.5				
Malawi	Nutrition and HIV/AIDS Project **(G/L)**	Mar 2012- Aug 2017	8	8	3.3	5.1	510 (30 of 44)
Mali	Strengthening Reproductive Health **(G)**	Dec 2011- Feb 2017	30	30	3.5	9.3	830 (9 of 44)
Mauritania	Health and Nutrition Support Project **(L)**	Jun 2006- Jun 2011	1.4	1.4	0.9	3.6	550 (23 of 44)
Mozambique	Health Service Delivery **(L)**	Apr 2009- Feb 2014	6.7	12.6	5.6	9.6	550 (24 of 44)
	Health Commodity Security Project **(L)**	Sep 2010- Dec 2012	5.9				
Niger	Institutional Strengthening & Health Sector Support Program (ISHSSP) **(L)**	Jan 2006-Jun 2011	10.2	13.1	3.4	5.5	820 (10 of 44)
	Multi-Sector Demographic Project **(L)**	Jun 2007- Mar 2013	2.9				
Nigeria	Malaria Control Booster Project **(L)**	Dec 2006- Jun 2013	25.2	97.5	36.4	193.7	840 (8 of 44)
	Second Health Systems Development II - Additional Financing **(L)**	Sep 2008	22.5				
	Malaria Control Booster Project - Additional Financing **(L)**	Jun 2009	12				
	Community Health Systems Strengthening for Malaria Control in Anambra and Akwa Ibom, Nigeria **(G)**	Mar 2011	0.3				
	States Health Program Investment Credit **(L)**	Apr 2012- Jun 2018	37.5				
Rwanda	First Community Living Standards Grant **(G)**	Apr 2009- Jun 2010	0.6	2.6	2.6	5.6	540 (25 of 44)
	Second Community Living Standards Grant **(G)**	Mar 2010- Jun 2011	1				
	Third Community Living Standards Grant **(G)**	Mar 2011-Jun	1				

		2012					
Senegal	Nutrition Enhancement Program II **(L)**	Nov 2006- Jun 2013	2.1	3.1	3	13	410 (38 of 44)
	Additional Financing Nutrition Enhancement Project (PRN2) **(L)**	Mar 2012	1				
Sierra Leone	Reproductive and Child Health Project - Phase 2 **(G)**	Jun 2010- Oct 2013	8	9.2	1.5	1.9	970 (6 of 44)
	Reproductive and Child Health - Phase I **(L)**	Oct 2006- Dec 2008	1.2				
Somalia	Puntland Primary Health Services **(G)**	Nov 2005- Aug 2009	0.01	0.01	10.5	N/A	1000 (3 of 44)
Sudan	Multi-donor Trust Fund for Decentralized Health System Development Project **(G)**	Oct 2006- Jun 2012	1.2	35.2	10.5	62	750 (14 of 44)
	Southern Sudan Umbrella Program for Health System Development **(G/L)**	Mar 2006- Jun 2010	15				
	Additional Financing North Sudan Decentralized Health System Development Project **(G)**	Oct 2009	2.1				
	South Sudan MDTF HIV/AIDS Project **(G/L)**	Nov 2007- Jun 2012	5.2				
	Fifth Population Census of Sudan **(G/L)**	May 2006- Jun 2009	11.7				
Swaziland	Health, HIV/AIDS and TB Project **(L)**	Mar 2011- May 2016	4.8	7.4	0.3	3.6	420 (36 of 44)
	Delivering Maternal Child Health Care to Vulnerable Populations in Swaziland **(G/L)**	Mar 2009	2.6				
Uganda	Reproductive Health Vouchers in Western Uganda **(G)**	Oct 2007- Mar 2012	4.3	4.3	7.3	17	430 (35 of 44)
Zimbabwe	Health Results Based Financing **(G)**	Dec 2011-Jul 2014	6.2	6.2	3.2	7.5	790 (12 of 44)

Table 2. World Bank HIV commitments in sub-Saharan Africa (FY 2006-2012)							
Country	**Project Name and Source of Funding (L = Loan; G = Grant; G/L= mix of grant and loan)**	**Timeframe**	**Spending (amount designated HIV, millions USD)**	**Total (millions USD)**	**Total population (millions)[31]**	**World Bank per capita HIV spending (USD)**	**HIV prevalence (percent)[32]; ranking in SSA (hi-low)**
Total WB HIV commitment in SSA (FY 2006-2012)				***657.6[33]***			
Africa regional	IGAD Regional HIV/AIDS Partnership Program (IRAPP) Support Project **(G)**	Jun 2007-Jun 2012	10	16.8	N/A[34]	N/A	5
	Abidjan-Lagos Trade and Transport Facilitation Project (ALTTFP) **(G/L)[35]**	Mar 2010-Sep 2016	6.8				
Benin	Second Multisectoral HIV/AIDS Control Project **(L)**	Apr 2007-Jun 2012	11.6	15	8.85	1.69	1.2 (34 of 44)
	Health System Performance Project **(G/L)**	May 2010-Dec 2015	3.4				
Botswana	National HIV/AIDS Prevention Support Project **(L)**	Jul 2008-2013	42.5	42.5	2.01	21.14	24.8 (2 of 44)
Burkina Faso	Health Sector Support and Multisectoral AIDS Project **(G)**	Apr 2006-Dec 2014	13.8	31.8	16.5	1.93	1.2 (33 of 44)
	Additional financing: Health Sector Support and Multisectoral AIDS Project for Burkina Faso **(G)**	Jun 2011	18				
Burundi	Second Multisectoral HIV/AIDS **(G)**	May 2008-Jun 2011	10.1	10.9	8.38	1.29	3.3 (21 of 44)
	Public Health Laboratory Networking Project **(L)**	May 2012	0.8				
Cameroon	Health Sector Support Investment **(L)**	Jun 2008-Mar 2014	3.2	7.6	19.6	0.39	5.3 (13 of 44)

	Debt Relief Grant Under the Enhanced HIPC Initiative **(G)**	Apr 2006-Dec 2006	4.4				
Cape Verde	HIV/AIDS MAP Supplemental **(L)**	Dec 2006	1.6	1.6	0.5	3.3	N/A
Chad	Population and HIV AIDS Additional Financing **(G)**	Jun 2010	4.4	10.5	11.23	0.94	3.4 (20 of 44)
	Second Population and AIDS Project **(L)**	Jul 2010-Jun 2013	6.1				
Congo, Democratic Republic	Health Sector Rehabilitation Support Project **(G)**	Sep 2005-Jun 2013	19.5	26.5	73.6	0.36	1.6 (30 of 44)
	Emergency Demobilization & Reintegration - Additional Financing **(G)**	Apr 2008	7				
Congo, Republic	HIV/AIDS & Health - Additional Financing **(G)**	Jun 2009	2.2	2.2	4.04	0.54	3.4 (19 of 44)
Cote d'Ivoire	Emergency Multisector HIV/AIDS Project **(G)**	Jun 2008-Sep 2012	6.6	6.6	19.74	0.33	3.4 (18 of 44)
Ethiopia	Second Multi-sectoral HIV/AIDS Project **(G)**	Mar 2007-Sep 2011	9.9	17.5	82.95	0.21	2.1[36] (25 of 44)
	Rural Capacity Building Project **(L)**	Jun 2006-Jun 2012	7.6				
Ghana	Multisectoral HIV/AIDS Program **(L)**	Nov 2005-Jun 2011	6.6	6.6	24.39	0.27	1.8 (28 of 44)
Kenya	Education Sector Support Program **(L)**	Nov 2006-Dec 2010	12.8	76	40.51	1.88	6.3 (11 of 44)
	Total War Against HIV and AIDS (TOWA) Project **(L)**	Jun 2007-Jun 2013	26.4				
	Total War Against HIV & AIDS (TOWA) - Additional Financing **(L)**	Dec 2010	19.8				
	Health Sector Support **(L)**	Jun 2010-Mar 2015	17				
Lesotho	Health Sector Reform Project Phase 2 **(L)**	Oct 2005-Sep 2009	1.0	12.8	2.17	2.76	23.6 (3 of 44)
	Poverty Reduction Support Credit **(G/L)**	May 2008-	2.7				

		Mar 2009					
	2nd Poverty Reduction Support Credit **(L)**	Mar 2010-Mar 2011	3.7				
	Third Poverty Reduction Support Credit **(L)**	Jun 2011-Jan 2012	3.1				
	HIV and AIDS Technical Assistance Project **(G)**	Aug 2009-Jan 2015	2.3				
Madagascar	Second Multisectoral STI/HIV/AIDS Prevention Project **(L)**	Jul 2005-Dec 2012	8.7	10.2	20.71	0.49	0.2 (42 of 44)
	Second Multisectoral STI/HIV/AIDS Prev II Additional Financing Project **(L)**	Jun 2012	1.5				
Malawi	MAP Additional Financing **(G)**	Aug 2009	30	58	14.9	3.89	11 (9 of 44)
	Nutrition and HIV/AIDS Project **(G/L)**	Mar 2012-Aug 2017	28				
Mali	Additional funding to MAP **(L)**	May 2009	4.5	17.1	15.37	1.11	1.0 (37 of 44)
	Second Transport Sector Project **(L)**	May 2007-Dec 2014	12.6				
Mozambique	Technical and Vocational Education and Training **(L)**	Mar 2006-Sep 2014	4.2	25.9	23.39	1.11	11.5 (8 of 44)
	Health Service Delivery **(L)**	Apr 2009-Feb 2014	6.7				
	National Decentralized Planning and Finance Program **(L)**	Mar 2010-Jun 2015	3.3				
	Health Commodity Security Project **(L)**	Sep 2010-Dec 2012	11.7				
Namibia	Education and Training Sector Improvement Program – ETSIP **(L)**	May 2007-Dec 2008	1.3	1.3	2.28	0.57	13.1 (7 of 44)
Niger	HIV/AIDS Support Project II **(L)**	Apr 2011-Jun 2016	20	20	15.51	1.29	0.8 (39 of 44)
Nigeria	HIV/AIDS Program Development Project II **(L)**	Jun 2009-Nov 2013	137.3	161.8	158.42	1.02	3.6 (17 of 44)
	HIV/AIDS Additional Financing **(L)**	May 2007	24.5				

Rwanda	Multisectoral AIDS Project—Additional Financing **(G)**	Feb 2007	5	5	10.62	0.47	2.9 (23 of 44)
Sao Tome and Principe	Social Sector Support (Additional Financing) **(G)**	May 2010	0.4	0.4	0.17	2.35	N/A
Sudan	South Sudan MDTF HIV/AIDS Project **(G/L)**	Nov 2007-Jun 2012	10.6	10.6	43.5	0.25	1.1 (35 of 44)
Swaziland	Health, HIV/AIDS and TB Project **(L)**	2011-2016	3.2	3.2	1.19	2.69	25.9 (1 of 44)
Tanzania	Zanzibar Basic Education Improvement Project **(L)**	2007-2013	8.4	8.4	44.84	0.19	5.6 (12 of 44)
Uganda	Health Systems Strengthening Project **(L)**	May 2010-Jul 2015	50.7	50.7	33.43	1.52	6.5 (10 of 44)

Table 3. Estimated AfDB Commitments with PRH/HIV Components in sub-Saharan Africa, FY 2006-2012 (UA/USD)[37]						
Country	Project Name and Source of Funding (L-Loan; G=Grant; G/L= mix of grant and loan)	Timeframe[38]	Spending (millions UA/USD)[39]	Total Spending (millions USD)[40]	Population (in year of project approval, millions)	AfDB per Capita Spending (USD)
Total AfDB PRH and HIV commitment in SSA (FY 2006-2012)				***798.01***		
Multi-country	Transportation Facilitation Project for the Bamenda-Mamfe-Ekok-Mfum-Abakaliki-Enugu Corridor[41] (*Projet de facilitation des transports sur le corridor Bamenda-Mamfe-Ekok-Mfum-Abakaliki-Enugu*) **(G/L)**	Nov 2008-ongoing	204.8 UA/ 336.4 USD	336.4	N/A[42]	N/A
Botswana	Support for Fast Tracking the Implementation of Vision 2016 **(G)**	Mar 2007-ongoing	0.25 UA/ 0.34 USD	0.34	1.93	0.17
Cameroon	National Program to Support Reproductive Health **(G/L)**	Jan 2010-ongoing	12.13 UA/ 16.98 USD	16.98	20.13	0.84
Equatorial Guinea	Health System Development Support **(L)**	Oct 2008-ongoing	13.50 UA/ 20.80 USD	20.80	0.64	32.5
Gabon	MIC- Implementation of Demographic and Health Survey 2010 (*MIC-Réalisation de l'enquête démographique et de santé 2010*) **(G)**	Feb 2011-ongoing	0.45 UA/ 0.69 USD	0.69	1.51	0.46
Ghana	Afram Plains District Agricultural Development Project **(L)**	May 2006-ongoing	19.97 UA/ 29.96 USD	29.96	22.17	1.35
Guinea Bissau	Additional support to the national health development (Health II) **(L)**	Jul 2009- ongoing	6 UA/ 9.42 USD	10.19	1.5	6.79
	MIC Strengthening of National Health Insurance and Social Security (CNMAGS)	Oct 2010-ongoing	0.50 UA/ 0.77 USD			

	(*MIC - Renforcement de la caisse nationale d'assurance maladie et de garantie sociale (CNMAGS)*) **(G)**					
Madagascar	Support to the Promoting Women Project (*Appui à l'amelioration situation femmes*) **(L)**	Jul 2011- ongoing	15 UA/ 23.1 USD	23.1	21.9	1.05
Mali	Support for Community Development in Kayes and Koulikoro Regions (PADEC) (*Projet d'appui au développement communautaire dans les régions de Kayes et Koulikoro (PADEC)*) **(L)**	Mar 2006- ongoing	15 UA/ 22.5 USD	40.98	15.37	2.67
	Project to Widen the Carrefour de la Paix-Woyowayanko Bridge-Point Y Urban Road Section in Bamako (*Aménagement de la section de route Urbaine point Y-Pont Woyowanko à Bamako*) **(L)**	Sep 2010- ongoing	12 UA/ 18.48 USD			
Mozambique	Women's Entrepreneurship and Skills Development for Food Security - Pilot Project **(G)**	Jan 2006- ongoing	2.51 UA/ 3.77 USD	3.77	21.81	0.17
Niger	Improvement of Health Services Project (Health III) (*Projet d'amélioration de l'offre des soins (Santé III)*) **(L)**	Mar 2010	11.41 UA/ 17.57 USD	17.57	15.51	1.13
South African Development Community (SADC)	Support for Communicable Disease Control[43] **(G)**	May 2006- ongoing	20 UA/ 30 USD	30	203.65	0.14
Swaziland	MIC Grant to Map HIV/AIDS Interventions **(G)**	Jan 2008- closed	0.3 UA/ 0.46 USD	0.46	1.03	0.45

Tanzania	Support to Maternal Mortality Reduction Project **(L)**	Nov 2006-ongoing	40 UA/ 60 USD	83.1	44.84	1.85
	Alternative Learning & Skills Development Project (ALSD II) **(L)**	Jun 2011-ongoing	15 UA/ 23.1 USD			
Uganda	Support to Health Sector Strategic Plan Project II **(L)**	2006-2011	20 UA/ 30 USD	183.68	33.43	5.49
	Support Mulago Hospital and Improvement of Kampala Health Services **(L)**	Jun 2011-ongoing	52 UA/ 80.08 USD			
	Post Primary Education and Training Expansion and Improvement Project-Education IV **(L)**	Nov 2008-ongoing	46 UA/ 73.6 USD			

References

Abdu, Z., Mohammed, Z., Bashier, I. et al. 2004. 'The impact of user fee exemption on service utilization and treatment seeking behavior: the case of malaria in Sudan.' *International Journal of Health Planning and Management* 19:S1, S95-S106.

Action Aid. 2005. 'Changing Course: Alternative Approaches to Achieve the Millennium Developmetn Goals and Fight HIV/AIDS'. http://www.actionaid.org.uk/doc_lib/131_1_changing_course.pdf

AfDB. 2000. 'Policy on Population and Strategies for Implementation.' http://www.afdb.org/fileadmin/uploads/afdb/Documents/Policy-Documents/10000010-EN-POLICY-ON-POPULATION-AND-STRATEGIES-FOR-IMPLEMENTATION.PDF

AfDB. 2001a. 'Gender Policy.' http://www.afdb.org/fileadmin/uploads/afdb/Documents/Policy-Documents/10000003-EN-THE-GENDER-POLICY.PDF

AfDB. 2001b. 'HIV Strategy for Bank Group Operations.' http://www.afdb.org/fileadmin/uploads/afdb/Documents/Policy-Documents/10000018-EN-HIV-AIDS-STRATEGY-PAPER-FOR-BANK-GROUP-OPERATIONS.PDF

AfDB. 2001c. 'Project Appraisal Report: Strengthening the Health System and Fight against HIV/AIDS and Epidemic Diseases' (Chad). http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/TD-2001-138-EN-ADF-BD-WP-COMPLETE-CHAD-AIDS-CONTROL-FINAL.PDF

AfDB. 2002a. 'Project Appraisal Report: Health Systems Development Project' (Nigeria). http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/NG-2002-050-EN-ADF-BD-WP-NIGERIA-AR-HEALTH-IV-PROJECT.PDF

AfDB. 2002b. 'Project Appraisal Report: Rehabilitation of the Health System Project' (Angola). http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/AO-2002-100-EN-ADF-BD-WP-ANGOLA-HEALTH1.PDF

AfDB. 2003. 'Project Appraisal Report: Health Project I: Eastern Province Healthcare Development' (DRC). http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/CD-2004-011-EN-ADF-BD-WP-DRC-AR-HEALTH-I.PDF

AfDB. 2004. Annual Report. http://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/01884256-EN-ANNUALREPORT2004-FULLVERSION.PDF

AfDB. 2005a. 'Project Appraisal Report: Project to Support the Fight against HIV/AIDS' (Mali). http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/ML-2001-135-EN-ADF-BD-WP-COMPLETE-MALI-HEALTH-AND-SOCIAL-DEVELOPMENT-PROGRAMME.PDF

AfDB. 2005b. 'Project Appraisal Report: Health Care Development Support Project (Center-East and North Regions)' (Burkina Faso). http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/BF-2005-042-EN-ADF-BD-WP-BURKINA-FASO-AR-HEALTH-DEVELPT-PROJECT.PDF

AfDB. 2005c. 'Health Support in Orientale Province' (DRC). http://www.afdb.org/en/projects-and-operations/project-portfolio/project/p-cd-ibd-001/

AfDB. 2005d. 'Project Appraisal Report: Support to the Health Sector Program' (Malawi). http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/MW-2005-020-EN-ADF-BD-WP-REV.1-MALAWI-AR-SUPPORT-TO-TO-THE-HEALTH-SECTOR-PROGRAMME-REV-1.PDF

AfDB. 2005e. 'Project Appraisal Report: Health System Development Support Project' (Benin). http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/BJ-2005-016-EN-ADF-BD-WP-BENIN-AR-PADS.PDF

AfDB. 2006a. 'Project Appraisal Report: Support to Maternal Mortality Reduction Project' (Tanzania). http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/TZ-2006-100-EN-ADF-BD-WP-TANZANIA-AR-SUPPORT-TO-MMRP.PDF

AfDB. 2006b. "Project Appraisal Report: Support to the Health Sector Strategic Plan II" (Uganda). http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/UG-2006-112-EN-ADF-BD-WP-UGANDA-APPRAISAL-REPORT-SHSSPPII-BOARDVERSION.PDF

AfDB. 2008a. 'Project Appraisal Report: Health System Development Support Project' (Equatorial Guinea). http://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/GQ-2008-155-EN-ADB-BD-WP-EQUATORIAL-GUINEA-AR-HEALTH-SYSTEM-DEVELOPMENT-SUPPORT-PROJECT.PDF

AfDB. 2009. 'Gender Mainstreaming Checklist for the Health Sector.' http://www.afdb.org/fileadmin/uploads/afdb/Documents/Policy-Documents/Gender-health-chklist-sunita-12-01-09%20(2).pdf

AfDB. 2010a. Annual Report. http://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/Annual%20Report%202010%20EN.pdf

AfDB. 2010b. 'AfDB Reiterates Commitment to HIV/AIDS Campaign.' http://www.afdb.org/en/news-and-events/article/afdb-reiterates-commitment-to-hiv-aids-campaign-7552/

AfDB. 2010c. 'The AfDB and Cameroon: Forty Years of Partnership.' http://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/rapport%20Cameroun%20Anglais.pdf

AfDB. 2010d. Assessment of the African Development Bank Group's Assistance to the Prevention and Control of HIV/AIDS, 1997-2006. http://www.afdb.org/fileadmin/uploads/afdb/Documents/Evaluation-Reports/Assessment%20of%20the%20African%20Devt%20%20Bank%27s%20Assist%20%20to%20the%20Prevention%20and%20Control%20of%20HIV-AIDS%201997-2006%20EN.pdf

AfDB. 2011. 'African Development Bank marks 2011 World AIDS Day.' http://www.afdb.org/en/news-and-events/article/african-development-bank-marks-2011-world-aids-day-8637/

AfDB. 2012a. Investor Presentation: The African Development Bank Group. January. http://www.afdb.org/fileadmin/uploads/afdb/Documents/Financial-Information/Investor%20Presentation%20-%20January%202012%20updated.pdf

AfDB. 2012b. 'Health.' http://www.afdb.org/en/topics-and-sectors/sectors/health/

Atinc, T. 2012, January. Personal communication with Elizabeth Arend.

Bill and Melinda French Gates Foundation. 2012, 11 July. 'Landmark Summit Puts Women at Heart of Global Health Agenda'. http://www.gatesfoundation.org/press-releases/Pages/summit-women-global-health-120711.aspx

Campbell, J., Oulton, J., McPake, B. et al. 2009. 'Removing user fees? Engage the health workforce'. *The Lancet* 374 (9706):19-66. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)62118-8/fulltext

Central Intelligence Agency. 2012a. 'Map of Cameroon.' https://www.cia.gov/library/publications/the-world-factbook/geos/cm.html

Central Intelligence Agency. 2012b. 'Map of Uganda.' https://www.cia.gov/library/publications/the-world-factbook/geos/ug.html

CORE Group. 2009. 'Community Approaches to Child Health in Cameroon: Applying the Community-based Integrated Management of Childhood Illness (C-IMCI) Framework.' http://www.coregroup.org/storage/documents/Workingpapers/CORE_Cameroon_final.pdf

DFID and Bill and Melinda French Gates Foundation. 2012. 'New Financial Commitments by Donors and Private Sector at the London Summit on Family Planning (USD Millions).' http://www.londonfamilyplanningsummit.co.uk/1530%20CommitmentSummary_Final_.pdf

Dixon, J. 2011. 'Financing National Health Insurance in Ghana.' http://www.africaportal.org/sites/default/files/Backgrounder%20No.%208-Financing%20National%20Health%20Insurance%20in%20Ghana_0.pdf

Ekman, B. 2004. 'Community-based health insurance in low-income countries: a systematic review of the evidence.' *Health Policy and Planning* 19(5): 249–270.

El-Khoury, M., Gandaho, T., Arur, A. et al. 2011. 'Health Systems 20/20, Improving Access to Life Saving Maternal Health Services: The Effects of Removing User Fees for Caesareans in Mali.' http://www.healthsystems2020.org/content/resource/detail/2837/

Gender Action. 2007. 'Mapping Multi-lateral Development Bank Spending on Reproductive Health and HIV/AIDS.' http://genderaction.org/images/Gender%20Action%20MDBs%20RH-AIDS%202007.pdf

Gender Action. 2011. Gender Toolkit for International Finance Watchers. http://genderaction.org/publications/IFI-Watcher_Toolkit.pdf

Gender Action. 2012. 'World Bank must re-evaluate its strategies to cut maternal mortality.' *The Guardian*, Poverty Matters Blog, 6 March. http://www.guardian.co.uk/global-development/poverty-matters/2012/mar/06/world-bank-strategy-maternal-health

Global Campaign for Microbicides. 2011. 'Women and HIV Risk.' http://www.global-campaign.org/womenHIV.htm

Government of Cameroon. 2010. 'Report progress on the Declaration of Commitment on HIV/AIDS UNGASS.' Published by UNAIDS. http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/cameroon_2010_country_progress_report_fr.pdf

Government of Uganda. 2005. Health Sector Strategic Plan II for 2005/6-2009/10. Ministry of Health.

Government of Uganda. 2008. Health Sector Strategic Plan II for 2005/6-2009/10: Mid-Term Review. Ministry of Health.

Government of Uganda. 2010. "UNGASS Country Progress Report, Uganda." Published by UNAIDS. http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/uganda_2010_country_progress_report_en.pdf

Green, A. 2012. 'Ugandan Activists Pressure Government to Reduce Maternal Deaths.' *Voice of America*, 11 June. http://www.voanews.com/content/ugandan-activists-pressure-government-to-reduce-maternal-death/1205834.html

IMF. 1998. 'Uganda—Enhanced Structural Adjustment Facility Policy Framework Paper, 1998/99-2000/01.' http://www.imf.org/external/np/pfp/uganda/102998.htm

IMF. 2006. 'Cameroon: Enhanced Heavily Indebted Poor Countries (HIPC) Initiative—Completion Point Document and Multilateral Debt Relief Initiative (MDRI).' http://www.imf.org/external/pubs/ft/scr/2006/cr06190.pdf

Institute of Development Studies. 2011. 'The World Bank's 'No Blanket Policy''. http://www.eldis.org/go/topics/resource-guides/health-systems/key-issues/user-fees/background/the-world-bank-s-no-blanket-policy

James C.D., Hanson K., McPake B. et al. 2006. 'To retain or remove user fees?: Reflections on the current debate in low- and middle-income countries.' *Applied Health Economics and Health Policy* 5(3):137-53.

Kalk, A. 2008. 'Health insurance in sub-Saharan Africa: a call for subsidies.' http://www.who.int/bulletin/volumes/86/3/07-042135/en/index.html

Kattan, R. and Burnett, N. 2004. 'User Fees in Primary Education.' Published by World Bank. http://siteresources.worldbank.org/EDUCATION/Resources/278200-1099079877269/547664-1099079993288/EFAcase_userfees.pdf

Kavuma, R. 2009. 'Uganda's healthcare system explained.' *The Guardian,* 1 April. http://www.guardian.co.uk/katine/2009/apr/01/uganda-healthcare-system-explained

Kgosidintsi, N. March 2012. Personal communication with Elizabeth Arend via email.

Kuteesa, F. and Nabbumba, R. 2004. 'HIPC Debt Relief and Poverty Reduction Strategies: Uganda's Experience.' http://www.fondad.org/uploaded/HIPC%20Debt%20Relief/Fondad-HIPC-Chapter3.pdf

Lagarde M and Palmer, N. 'The impact of user fees on access to health services in low and middle-income countries (Review).' The Cochrane Collaboration http://apps.who.int/rhl/reviews/CD009094.pdf

Lincetto et al. 2011. 'Antenatal Care.' In *Opportunities for Africa's Newborns*. World Health Organization. http://www.who.int/pmnch/media/publications/aonsectionIII_2.pdf

Malama, C., Chen, Q., De Vogli, R. et al. 2002. 'User fees impact access to health care for female children in rural Zambia.' *Journal of Tropical Pediatrics* 48(6): 371-372.

Malinga, K. and Ford, L. 2010. 'Calls for Katine men to take more interest in family planning.' *The* Guardian, 22 February. http://www.guardian.co.uk/katine/2010/feb/22/male-attitudes-family-planning

Marie Stopes International. 2010. 'Voucher schemes for sexual and reproductive health services: a Marie Stopes International (MSI) perspective.' http://www.mariestopes.org/documents/publications/Voucher-Factsheet.pdf

Mwesigwa Kizza, Catherine. 2012, 13 July. 'Summit promises 4.6 billion for family planning.' *New Vision*, http://www.newvision.co.ug/news/632934-summit-promises-4-6-billion-for-family-planning.html

Nanda, P. 2002. 'Gender dimensions of user fees: implications for women's utilization of health care.' *Reproductive Health Matters* 10(20): 127-34. http://www.ncbi.nlm.nih.gov/pubmed/12557649

Naiman, R. and Watkins, N. 1999. 'A Survey of the Impacts of IMF Structural Adjustment in Africa: Growth, Social Spending, and Debt Relief.' Published by Center for Economic and Policy Research. http://www.cepr.net/a-survey-of-the-impacts-of-imf-structural-adjustment-in-africa/#uganda

Nansubuga, R. 2012. 'Court dismisses case against govt on maternal mortality.' *The Monitor*, 7 June http://www.monitor.co.ug/News/National/Court+dismisses+case+against+govt+on+maternal+mortality/-/688334/1421922/-/10qngqrz/-/index.html

NAWAD. 2011. 'Organization Profile.' http://www.ugandangodirectory.org/index.php?option=com_mtree&task=viewlink&link_id=240

Ntembe, N. 2009. 'User Charges and Health Care Provider Choice in Cameroon.' *International Review of Business Research Papers* 5(6): 33-49. http://www.bizresearchpapers.com/3.Augustine.pdf

Okwero, P. March 2011. Personal communication with Elizabeth Arend via email.

Ponsar, F., Van Herp, M., Zachariah, R., Gerard, S., Philips, M., and Jouquet, G. 2011. 'Abolishing user fees for children and pregnant women trebled uptake of malaria-related interventions in Kangaba, Mali.' *Health Policy and Planning* 26(suppl 2): ii72-ii83.

Reynolds, C. and Wilson, D. February 2012. Personal communication with Elizabeth Arend via email.

Schiffman, J. and Quissell, K. 2012. 'Family Planning's Contentious History.' Population Association of America 2012 Annual Meeting. San Francisco, CA: 23 March. http://paa2012.princeton.edu/download.aspx?submissionId=120716

Seruwagi, M. 2011. 'Congo-Kinshasa: Unreported Horrors - Male Rape.' *Interpress Service* News, 13 November. http://allafrica.com/stories/201111140001.html

Sharma, S et al. 2005. 'Formal and Informal Fees for Maternal Health Care Services in Five Countries: Policies, Practices and Perspectives.' USAID Policy Working Paper Series, no. 16. http://www.policyproject.com/pubs/workingpapers/WPS16.pdf

Social Institutions and Gender Index. 2012. 'Burkina Faso.' http://genderindex.org/sites/default/files/pdfs/BFA.pdf

Swedish International Development Cooperation Agency (SIDA). 2004. 'A Profile on Gender Relations: Toward Gender Equality in Burkina Faso.' http://lnweb90.worldbank.org/Caw/CawDocLib.nsf/vewAfrica/A4A9090DAC3381848525706100313AC0/$file/GP+Burkina+Faso,+english.pdf

Uganda Demographic and Health Survey. 2007. 'Uganda: Fifty-eight percent of women give birth at home.' http://www.measuredhs.com/Who-We-Are/News-Room/Fifty-eight-percent-of-women-give-birth-at-home.cfm

UN. 2006. 'Population below national poverty line, total, percentage.' http://data.un.org/Data.aspx?d=MDG&f=seriesRowID%3A581

UN. 2012. 'Goal 5: Improve Maternal Health.' United Nations Millennium Development Goals. http://www.un.org/millenniumgoals/maternal.shtml

UNAIDS. 2006. '25 Years of AIDS.'
http://www.unaids.org/en/media/unaids/contentassets/restore/20060428_fs_25yearsofaids_en.pdf

UNAIDS. 2008. 'Fast Facts About HIV/AIDS.'
http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/factsheet/2008/20080519_fastfacts_hiv_en.pdf

UNAIDS. 2010a. 'Global Report: Annexes.'
http://www.unaids.org/documents/20101123_GlobalReport_Annexes1_em.pdf

UNAIDS. 2010b. 'UNAIDS Report on the Global AIDS Epidemic.'
http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf

UNAIDS. 2010c. 'Global Report: Factsheet: Sub-Saharan Africa.'
http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2010/20101123_FS_SSA_em_en.pdf

UNAIDS. 2010d. 'Global Report: Factsheet: Women, girls, gender equality and HIV.'
http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120217_FS_WomenGirls_en.pdf

UNAIDS. 2010e. 'Report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS 2010: Federal Democratic Republic of Ethiopia.'
http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/ethiopia_2010_country_progress_report_en.pdf

UNDP. 2007. 'Gender Equality and Empowering Women: Swaziland.'
http://www.undp.org.sz/index.php?option=com_content&view=article&id=7%3Agender-equality&catid=48%3Agoal3-news&Itemid=61

UNFPA. 2010. 'Population of women aged 15-49 (thousands).'
http://data.un.org/Data.aspx?d=PopDiv&f=variableID%3A25

UNFPA. 2011. 'Delivery of Maama Kits.'
http://countryoffice.unfpa.org/uganda/2011/03/31/3198/delivery_of_maama_kits/

UNICEF. 2005. 'World Health Report: Make Every Mother and Child Count.'
http://www.who.int/whr/2005/whr2005_en.pdf.

UNICEF. 2010. 'Information by country and programme.' http://www.unicef.org/infobycountry/

USAID. 2008. 'Gender Based Violence in Tanzania: an Assessment of Policies, Services and Promising Interventions.'
http://www.mcdgc.go.tz/data/PNADN851.pdf

US Department of State. 2011. 'Country Reports on Human Rights Practices: Equatorial Guinea.'
http://www.state.gov/documents/organization/160119.pdf

US Department of State. 2012a. 'Background Note: Equatorial Guinea.' http://www.state.gov/r/pa/ei/bgn/7221.htm

US Department of State. 2012b. 'Cameroon: Country Specific Information.'
http://travel.state.gov/travel/cis_pa_tw/cis/cis_1081.html#medical

Wanyana, J. March 2011. Personal communication with Elizabeth Arend via email.

Witter, S. 2010. 'Mapping User Fees for Health Care in High Mortality Countries: Evidence from a Recent Survey.' Published by HLSP Institute. http://www.hlsp.org/LinkClick.aspx?fileticket=BmlwPoRonho%3D&tabid=1570

WB. 1986a. 'Sierra Leone - Health and Population Sector Support Project: Staff Appraisal Report.' http://documents.worldbank.org/curated/en/1986/04/740951/sierra-leone-health-population-sector-support-project

WB. 1986b. 'Sierra Leone - Health and Population Sector Support Project: Memorandum & Recommendation of the President.' http://documents.worldbank.org/curated/en/1986/04/739849/sierra-leone-health-population-sector-support-project

WB. 1996. 'Sierra Leone - Health and Population Sector Support Project: Implementation Completion and Results Report.' http://documents.worldbank.org/curated/en/1996/07/733392/sierra-leone-health-population-project

WB. 2000. 'Project Appraisal Document: Health Sector Development Program' (Tanzania). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2000/07/08/000094946_00060705301924/Rendered/PDF/multi_page.pdf

WB. 2001a. 'Project Appraisal Document: Multisectoral AIDS Project' (Central African Republic). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2002/01/17/000094946_01120804004581/Rendered/PDF/multi0page.pdf

WB. 2001b. 'Project Appraisal Document: Second Population and AIDS Project' (Chad). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2006/09/05/000160016_20060905132153/Rendered/PDF/22003.pdf

WB. 2003. 'Project Appraisal Document: Multisectoral AIDS Project' (Malawi). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2003/07/18/000012009_20030718104156/Rendered/PDF/261420MAI0PAD.pdf

WB. 2004a. 'Project Appraisal Document: Multisectoral AIDS Project' (Mali). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2004/06/16/000160016_20040616182722/Rendered/PDF/285540orig.pdf.

WB. 2004b. 'Project Appraisal Document: Multisectoral AIDS Project' (DRC). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2004/03/16/000090341_20040316104517/Rendered/PDF/28029.pdf

WB. 2004c. 'Implementation Status and Results Report: Health Sector Development Program' (Tanzania). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2004/07/01/000012009_20040701141308/Rendered/PDF/29517.pdf

WB. 2004d. 'OP 8.60 - Development Policy Lending.' http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/EXTPOLICIES/EXTOPMANUAL/0,,contentMDK:20471192~pagePK:64141683~piPK:64141620~theSitePK:502184,00.html

WB. 2005a. 'The World Bank's Global HIV/AIDS Program of Action.' http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1127498796401/GHAPAFinal.pdf

WB. 2005b. 'Project Appraisal Document: Multisectoral AIDS Program' (Ghana). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2005/10/28/000090341_20051028121024/Rendered/PDF/33917.pdf

WB. 2005c. 'Project Appraisal Document: Health Sector Rehabilitation Support Project' (DRC). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2005/08/10/000090341_20050810100414/Rendered/PDF/30855.pdf

WB. 2007a. 'Project Appraisal Document: Total War against AIDS Project' (Kenya). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2007/05/16/000020953_20070516091903/Rendered/PDF/34002.pdf

WB. 2007b. 'Project Appraisal Document: Health Insurance Project' (Ghana). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2007/06/14/000020439_20070614085937/Rendered/PDF/39198.pdf

WB. 2007c. 'Integrated Safeguards Data Sheet: Reproductive Health Vouchers in Western Uganda.' http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2007/02/22/000310607_20070222100506/Rendered/PDF/387220ISDS0Uganda0Health.pdf

WB. 2007d. 'The World Bank's Commitment to HIV/AIDS in Africa: Our Agenda for Action.' http://siteresources.worldbank.org/INTAFRREGTOPHIVAIDS/Resources/WB_HIV-AIDS-AFA_2007-2011_Advance_Copy.pdf

WB. 2007e. 'Implementation Completion and Results Report: Cameroon - Debt Relief Grant Under the Enhanced HIPC Initiative.' http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2007/08/16/000310607_20070816134148/Rendered/PDF/ICR567.pdf

WB. 2008. 'Project Appraisal Document: Health Sector Support Investment Project' (Cameroon). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2008/06/04/000333037_20080605000843/Rendered/PDF/426430PAD0P1041ly10IDA1r20081018111.pdf

WB. 2009a. 'Project Appraisal Document: Health Service Delivery Project' (Mozambique). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2009/04/01/000334955_20090401033324/Rendered/PDF/466760PAD0MZ0P101Official0Use0Only1.pdf

WB. 2009b. 'Project Appraisal Document: Health Sector Development Project' (Burundi). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2009/05/21/000333038_20090521015520/Rendered/PDF/472600PAD0P101101Official0Use0Only1.pdf.

WB. 2009c. 'Project Appraisal Document: Second HIV/AIDS Program Development Project' (Nigeria). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2009/06/01/000333037_20090601001723/Rendered/PDF/463430PAD0P102101Official0Use0Only1.pdf

WB. 2009d. 'Project Appraisal Document: Multisectoral AIDS Project (Additional Financing)' (Malawi). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2009/08/10/000334955_20090810015403/Rendered/PDF/431210PJPR0P10101Official0Use0Only1.pdf

WB. 2009e. 'Project Appraisal Document: Health Service Delivery Project' (Mozambique). http://www-wds.worldbank.org/external/default/main?pagePK=64193027&piPK=64187937&theSitePK=523679&menuPK=64187510&searchMenuPK=64187283&siteName=WDS&entityID=000334955_20090401033324

WB. 2009f. 'Health Sector Development Project Paper (Tanzania).' http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2009/11/25/000333037_20091125222709/Rendered/PDF/515910PJPR0P11101Official0Use0Only1.pdf

WB. 2009g. 'Poverty Headcount Ratio at $2 a day.' http://data.worldbank.org/indicator/SI.POV.2DAY

WB. 2010a. 'Reproductive Health Action Plan.' http://siteresources.worldbank.org/INTPRH/Resources/376374-1261312056980/RHActionPlanFinalMay112010.pdf

WB. 2010b. 'Project Appraisal Document: Health Systems Performance Project' (Benin). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2010/04/20/000333038_20100420015644/Rendered/PDF/539300PAD0IDAR101Official0Use0Only1.pdf

WB. 2010c. 'Project Appraisal Document: Uganda Health Systems Strengthening Project' (Uganda). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2010/05/07/000333037_20100507001705/Rendered/PDF/531510PAD0P1151ly10IDA1R20101012711.pdf

WB. 2010d. 'Project Appraisal Document: Second Population and AIDS Project: Additional Financing' (Chad). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2010/06/09/000333037_20100609023215/Rendered/PDF/413200PJPR0P07101Official0Use0Only1.pdf

WB. 2010e. 'Project Appraisal Document: Health Sector Support Project' (Kenya). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2010/06/13/000333037_20100613235455/Rendered/PDF/539880PAD0P074101Official0Use0Only1.pdf

WB. 2010f. 'Reproductive Health Action Plan Brief.' http://siteresources.worldbank.org/INTPRH/Resources/RHAPBriefMarch30.pdf

WB. 2010g. 'Project Information Document: Reproductive and Child Health Project - Phase 2' (Sierra Leone). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2010/04/14/000020953_20100414103714/Rendered/PDF/540250Africa0P1ctive0and00child0rev.pdf

WB. 2010h. 'Gross domestic product 2010.' http://siteresources.worldbank.org/DATASTATISTICS/Resources/GDP.pdf

WB. 2010i. 'Project Completion Report: Health System Development Project (Cameroon)' http://www.afdb.org/fileadmin/uploads/afdb/Documents/Evaluation-Reports/Cameroon_HEALTH%20SYSTEM%20DEVELOPMENT%20PROJECT_PCR-11-04-2011.pdf

WB. 2011a. 'Annual Report.' http://web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/EXTANNREP/EXTANNREP2011/0,,contentMDK:22969490~menuPK:8121330~pagePK:64168427~piPK:64168435~theSitePK:8070617,00.html

WB. 2011b. 'HIV/AIDS Projects.' http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/0,,contentMDK:23069655~pagePK:210058~piPK:210062~theSitePK:282511,00.html

WB. 2011c. 'Project Appraisal Document: Strengthening Reproductive Health Project' (Mali). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2011/12/01/000333037_20111201234747/Rendered/PDF/637430PAD0P1240Official0Use0Only090.pdf

WB. 2011d. 'Health, HIV and TB Project' (Swaziland). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2011/02/18/000370910_20110218092237/Rendered/PDF/528750PAD0P1101560R20111003711.pdf

WB. 2011e. 'Project Information Document: Health Sector Support and Multisectoral AIDS Project -Additional Financing' (Burkina Faso). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2011/03/18/000001843_20110321143500/Rendered/PDF/BF0P1252850PID1sal0Stage00301802011.pdf

WB. 2011f. 'Implementation Status and Results Report: Total War against AIDS Project' (Kenya). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/AFR/2011/06/29/3FBC5AA24C6DC376852578BE006BE6C8/1_0/Rendered/PDF/P0817120ISR0Di029201101309376314708.pdf

WB. 2011g. "Implementation Status and Results Report: Emergency Multi-Sector HIV/AIDS Project" (Cote D'Ivoire). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/AFR/2011/12/24/37BB20F9090E2A5E85257970005331 71/1_0/Rendered/PDF/P0716310ISR0Di024201101324739321318.pdf

WB. 2011h. 'Implementation Status and Results Report: National HIV/AIDS Prevention Support Project' (Botswana). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/AFR/2011/09/20/DF8819A19C91E17C85257911005B41A5/1_0/Rendered/PDF/P1022990ISR0Di020201101316536605834.pdf

WB. 2011i. 'Implementation Status and Results Report: Multisectoral AIDS Project' (Central African Republic). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/AFR/2011/12/17/83899BF30AA8FF5D85257969003749C2/1_0/Rendered/PDF/P0735250ISR0Di017201101324116233390.pdf

WB. 2011j. 'Implementation Completion and Results Report: Multisectoral AIDS Project' (DRC). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2012/01/24/000386194_20120124232557/Rendered/PDF/ICR20560P082510C0disclosed010230120.pdf

WB. 2011k. 'Heavily Indebted Poor Country Initiative (HIPC).' http://go.worldbank.org/XEFZ3PAJ20

WB. 2011l. 'Reproductive Health at a Glance: Uganda.' http://siteresources.worldbank.org/INTPRH/Resources/376374-1303736328719/Uganda42111WEB.pdf

WB. 2011m. 'Reproductive Health at a Glance: Cameroon.' http://siteresources.worldbank.org/INTPRH/Resources/376374-1303736328719/Cameroon42111web.pdf

WB. 2011n. 'Implementation Status and Results Report: Health Sector Support Investment' (Cameroon). http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/AFR/2011/10/25/69CCF05D6E2D63EB85257934007029B1/1_0/Rendered/PDF/P1045250ISR0Di025201101319574306851.pdf

WB. 2012a. 'Poverty Headcount Ratio at $2 per day' (Burkina Faso). http://data.worldbank.org/indicator/SI.POV.2DAY/countries/BF?display=graph

WB. 2012b. 'Lessons Learned: Uganda Reproductive Health Voucher Scheme.' http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2012/03/06/000386194_20120306011928/Rendered/INDEX/673260BRi0P1040Health0updated0Mar05.txt

WB. 2012c. 'Overview: HIV/AIDS.' http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTHIVAIDS/0,,contentMDK:21546262~menuPK:376479~pagePK:210058~piPK:210062~theSitePK:376471,00.html

WB. 2012d. 'Population and Reproductive Health: Overview.' http://go.worldbank.org/KRWFZXBMZ0

WB. 2012e. 'World Bank Group Support to Promote Growth and Overcome Poverty in Developing Countries Hits Nearly $53 Billion in 2012.' http://www.worldbank.org/en/news/2012/06/29/world-bank-group-support-promote-growth-overcome-poverty-developing-countries-hits-nearly-billion-2012

WB. 2012f. 'Cameroon Health Sector Support Investment (SWAP): Results".
http://www.worldbank.org/projects/P104525/cameroon-health-sector-support-investment-swap?lang=en

WHO. 2005a. 'World Health Report 2005.' http://www.who.int/whr/2005/whr2005_en.pdf.

WHO. 2005b. 'The elimination of user fees in Uganda: impact on utilization and catastrophic health expenditures.'
http://www.who.int/health_financing/documents/dp_e_05_4-user_fee_elimination_uganda.pdf

WHO. 2008. 'World Health Statistics 2008: Part 1.' http://www.who.int/whosis/whostat/EN_WHS08_Part1.pdf

WHO. 2011. 'Why Gender and Health?' http://www.who.int/gender/genderandhealth/en/index.html

WHO, UNICEF, UNFPA & WB. 2012. 'Trends in maternal mortality: 1990 to 2010.'
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf

WHO and UNICEF. 2012. 'Countdown to 2012: Maternal, Newborn and Child Survival.'
http://www.countdown2015mnch.org/documents/2012Report/2012-Complete.pdf

GenderAction

1875 Connecticut Avenue NW
Suite 500
Washington, DC 20009, USA

(202) 939-5463
www.genderaction.org
info@genderaction.org