



Enrolled Nurse, Miriam Chisizwa, at work in the post-natal ward at a public sector hospital in Lilongwe, Malawi. In 2005, with support from international donors, the Malawi government implemented a comprehensive programme to address critical shortages of health workers in the public sector. Photo: Abbie Trayler-Smith/Oxfam 2007

INVESTING FOR THE FEW

The IFC's Health in Africa initiative

The International Finance Corporation (IFC)'s Health in Africa initiative is at odds with the World Bank Group's welcome commitment to universal and equitable health coverage and to shared prosperity. The \$1bn initiative, which promotes private sector healthcare delivery, is extremely unlikely to deliver better health outcomes for poor people. Furthermore, the IFC's failure to measure the extent to which Health in Africa impacts on people living in poverty is inexcusable.

Instead of investing in risky private sector solutions, the World Bank Group should focus on supporting African governments to expand publicly provided healthcare – a proven way to save millions of lives worldwide and to drive down inequality – and help them to abolish user fees and strengthen their capacities to regulate the private sector.

1 INTRODUCTION

World Bank Group President Jim Yong Kim has publicly stated that achieving universal health coverage (UHC) and equity in health are central to reaching the two new overarching World Bank Group goals to end extreme poverty by 2030 and boost shared prosperity.¹ Jim Kim has also rightly emphasized the need to close the gap in access to quality health services for the poorest 40 percent of the population and to eliminate point-of-service payments that impoverish people in every country.²

The World Bank Group's commitment to such goals is welcome, but are all members of the Group aligned? In this report, which puts the spotlight on the International Finance Corporation (IFC)'s Health in Africa initiative, Oxfam questions whether this initiative of the rapidly expanding private sector investment arm of the World Bank Group may actually be working at odds with the Bank's goal to advance UHC.

UHC means that everyone – whether rich or poor – gets the healthcare they need without fear of falling into poverty. To achieve UHC, health sector reforms must be explicit about reducing inequality in access to health services and about ensuring that public health systems mitigate the impact of economic and political inequalities. As Oxfam has argued in a recent paper on health insurance schemes, equity must be built into the system from the beginning, ensuring that people living in poverty benefit as much as those who are better off.³

Evidence suggests that prioritizing for-profit private healthcare delivery is extremely unlikely to deliver better health outcomes for poor people and achieve UHC.⁴ Private health systems have been shown to be highly regressive, serving the richest far more than the poorest. Data from 44 low- and middle-income countries suggest that higher levels of private sector participation in primary healthcare have been associated with higher levels of exclusion of poor people from treatment and care.⁵ While the wealthy receive the best medical care, many poorer people are forced to rely on low-quality healthcare administered by unqualified staff and make out-of-pocket payments for treatment, or simply do without.

Despite their numerous challenges, publicly financed and delivered healthcare services continue to dominate in higher-performing, more equitable health systems. In Asia, for example, a study comparing health data in the region found that no low- or middle-income country has achieved universal or near-universal access to healthcare without relying predominantly on tax-funded public sector delivery.⁶ In Nepal, for example, dramatic improvements in access to healthcare were achieved after user fees were removed for primary healthcare services in public facilities in 2008.

Universal public services are one of the strongest weapons in the fight against inequality. They mitigate the impact of skewed income distribution, and redistribute wealth by putting 'virtual income' into the pockets of the poorest women and men.⁷ Furthermore, when people enjoy good health they are more likely to realise their potential by participating in income-generating activity and community life. Everyone benefits and the poorest people benefit most of all. In the face of growing inequality in sub-Saharan Africa⁸ urgent and dedicated action is needed to strengthen public health systems. Instead of investing in risky private sector solutions to public health challenges, the World Bank Group should focus on supporting African governments

to expand publicly provided healthcare – a proven way to save millions of lives worldwide and drive down inequality – and help them to abolish user fees and strengthen their capacities to regulate the private sector.

2 THE IFC'S HEALTH IN AFRICA INITIATIVE

In 2007, the IFC launched a report sponsored by the Bill & Melinda Gates Foundation and researched by McKinsey & Company.⁹ The report, 'The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives', outlined the IFC's laudable aim of developing and enforcing quality standards for private healthcare, but also made significant claims on the role of the private sector in healthcare in the continent as a key complement to the public sector. In the 2007 report as well as in subsequent related publications, the IFC states that the private sector already delivers half of all healthcare in sub-Saharan Africa and even more for the poorest people,^{10,11} and that private healthcare is often more affordable for poor people than government provision.^{12,13} The report asserts that private sector enterprises can 'stimulate higher efficiency and quality standards' through competition, and set national benchmarks for higher-quality healthcare.¹⁴ The report also says that up to two-thirds of the investment needed to scale up and improve health services in sub-Saharan Africa may need to come from non-state actors.¹⁵ Such claims about the superior performance and potential of the private sector in health remain largely unsubstantiated, and many have since been challenged by the evidence available especially in relation to the for-profit private sector.¹⁶

In 2008, the IFC launched the Health in Africa initiative – a \$1bn investment project which aimed to 'catalyze sustained improvements in access to quality health-related goods and services in Africa [and] financial protection against the impoverishing effects of illness', with an 'emphasis on the underserved'.^{17,18,19} Health in Africa would achieve these objectives by harnessing the potential of the private health sector, specifically by improving access to capital for private health companies, enabling them to grow and expand, and through assisting governments to incorporate the private sector into their overall healthcare system.²⁰ Health in Africa would aim to ensure that the private health sector became 'an additional and powerful instrument to progress towards the MDGs [Millennium Development Goals]',²¹ with extra efforts to 'improve the availability of healthcare to Africa's poor and rural population'.²²

Health in Africa aimed to generate \$1bn via three main investment mechanisms: a \$300m equity vehicle; a \$500m debt facility, mobilizing loans from local banks to private healthcare actors; and \$200m in technical assistance.²³ The equity and debt schemes aimed to provide capital for nascent small and medium-sized enterprises (SMEs) by channelling smaller, more manageable investments than the average large endowments made directly to companies by the IFC.²⁴

Health in Africa's equity vehicle comprises investments in two private equity funds: the Africa Health Fund, managed by the Abraaj Group;^{25,26} and the Investment Fund for Health in Africa (IFHA), established by the Dutch PharmAccess Foundation in February 2007.^{27,28}

Health in Africa has had the backing of many international actors, including the governments of France, Japan and the Netherlands, and the Bill & Melinda Gates Foundation.²⁹ Other partners include the African Development Bank and the German development finance institution DEG.³⁰ Within the World Bank Group, the initiative was characterized as 'a new direction ... in health', and formed part of the

World Bank Group's wider health strategy.^{31,32}

In recent years, the IFC has begun marketing its own direct health investments in sub-Saharan Africa as part of the initiative.³³ Moreover, the World Bank Group recognized in the management response to the mid-term review that 98 percent of the IFC's health investment and advisory work has been through Health in Africa.³⁴

Due to this change, and the lack of clarity provided by the IFC's literature, Oxfam's analysis of Health in Africa has, by necessity, assumed that all IFC health investments in sub-Saharan Africa since 2008 officially fall within the initiative.

3 CAUSE FOR CONCERN: THE IFC'S TRACK RECORD IN HEALTH

The IFC does not have a long track record in health. Until the early 1990s, it had only a few, sporadic health projects and no health department or specialized health staff.³⁵ From 1997 to 2007, the IFC approved only 54 investment projects in the health sector, with total new commitments of around \$580m.³⁶ By comparison, the IFC's current investment commitments total \$50bn, involving nearly 2,000 companies in 126 countries.³⁷

In a 2009 assessment, the World Bank Group's Independent Evaluation Group found a number of IFC health projects implemented between 1997 and 2002 where operations resulted in abandonment of project construction, or complete failure of the business and bankruptcy of the sponsor company.³⁸ Development outcomes were also initially low, with a number of hospital projects reporting significant underutilization of facilities.³⁹ Far from benefiting the underserved, IFC health projects were found to have 'benefited primarily upper- and middle-income people at the 'top of the pyramid'.⁴⁰ With regards to its hospital projects, among 12 hospitals for which information was available '3 were mainly targeted to expatriates and 6 were aimed at high- and middle-income populations.'⁴¹ Only a third of IFC advisory services met or exceeded expected outcomes and the cost-effectiveness of projects was considered low.⁴² The IFC's experience in health projects was assessed as limited, sporadic, and predominantly based on its experience outside of Africa in low-risk middle-income countries.⁴³

This pattern of low performance has continued with the Health in Africa initiative. The independent mid-term review of the initiative published in 2012 identified some areas of success, but overall found that its performance had been uneven, with a failure to deliver across a number of key objectives.⁴⁴ Areas of success identified by the review included: bringing international attention to the role of the private sector in health; promoting dialogue in a small number of countries on the same issue; and the production of some analytical products – although the timeliness and practical use of these products is questioned. The review also commends the IFC for establishing a new equity fund that aims to provide incentives for health sector investments that will benefit hard-to-reach people, the so-called 'base of the pyramid'. However, as discussed below, a closer look at this incentive mechanism reveals serious flaws that render it largely meaningless as a tool to ensure that poor people benefit from equity fund investments.

4 FAILING TO MEET ITS COMMITMENT TO THE UNDERSERVED

The IFC's literature has repeatedly emphasized Health in Africa's focus on benefiting 'underserved' populations in sub-Saharan Africa. Its plan – presented to the World Bank Board in 2007 – emphasized improving the 'availability of healthcare to Africa's poor and rural population'.⁴⁵ Such a focus is to be expected, not only due to the unacceptable healthcare gap between rich and poor people across Africa, but also because anything contrary would be at odds with the World Bank Group's overall mandate to tackle poverty. Despite this, the independent mid-term review of the Health in Africa initiative found systematic failings across all workstreams to impact on poor people.⁴⁶

Oxfam's own analysis of the limited and sporadic investment information made available by the IFC and its partners supports these findings. They include a failure to analyse how to reach poor people effectively via the private sector; failure to direct investments for the benefit of poor people; and failure to even measure whether poor people are being reached.⁴⁷ A further concern is the apparent lack of consideration of gender equity, both in terms of whether the initiative seeks to promote gender equity and, if so, how this will be measured. Given that women are disproportionately represented among poor and rural populations, this is a worrying oversight and is at odds with the World Bank Group's commitment to promote gender equity.

The independent mid-term review found that Health in Africa's analytic work completely failed, 'either by omission or by design, to engage with the most single important global controversy with regard to the role of the private sector in health in Africa: the role – if any – that the private health sector can and should play in achieving development impacts...'.⁴⁸ Despite the stated focus on the 'underserved', the IFC had made no attempt to answer the question: 'does strengthening the private health sector improve health outcomes for the poor?'.⁴⁹ The authors of the mid-term review explain that not only is this a major failing against the IFC's own stated objectives, but it also throws into question the dedication of considerable World Bank Group resource to an initiative whose critics have long argued will 'primarily benefit the rich'.⁵⁰

Publicly available information shows that Health in Africa's investments to date have, in practice, predominantly been in expensive, high-end, urban hospitals offering tertiary care to African countries' wealthiest citizens and expatriates. In fact, the intention to target the elite – including those rich enough to seek healthcare overseas – is actually made explicit in some investment descriptions. For example, Clinique La Providence in Chad was to receive an IFC loan of \$1.5m to make available 'healthcare services for which Chadians are currently travelling abroad'.⁵¹ Togo's already well-established Clinique Biasa received a \$1.7m investment and describes itself as 'one of Lomé's top three private health facilities'.⁵² Hygeia's Lagoon Hospitals in Nigeria – benefiting from at least \$7.68m in Health in Africa loans and investments – boast of their 'luxury accommodation' and of performing operations only available in 'very few specialised hospitals in the United Kingdom and USA'.^{53, 54} While Nigeria bears 14 percent of the entire global maternal mortality burden,⁵⁵ the Africa Health Fund has invested \$5m in West Africa's first in vitro fertilization (IVF) centre, aiming to 'provide world class infertility treatments'.⁵⁶ The clinic charges over \$4,600 for one cycle of IVF.⁵⁷

Health in Africa's investments consistently prioritize urban hospitals despite the IFC's own research finding that less than 12 percent of households in the poorest wealth quintile access healthcare in hospitals,⁵⁸ and despite Health in Africa's commitment to improve the availability of healthcare for rural populations.⁵⁹

Far from prioritizing small-scale private providers that are struggling to access finance through other means, IFC's biggest Health in Africa investment to date has been in Life Healthcare – South Africa's second largest company, with services spanning a network of 63 hospitals plus other facilities across the country.^{60,61} Life Healthcare's services remain unaffordable even for many comparatively wealthy South Africans – only selected services are covered by health insurance⁶² and only 15 percent of South Africans have any kind of health insurance at all.⁶³ Moreover, Life Healthcare is rapidly expanding outside of African markets; its main growth since the \$93m⁶⁴ Health in Africa investment has been the 2011 acquisition of a 26 percent stake in one of the largest hospital groups in India.⁶⁵

Box 1: Unaffordable maternity services at Nairobi Women's Hospital

At the Health in Africa-supported private Nairobi Women's Hospital,⁶⁶ even the most basic maternity package would cost an average Kenyan woman three to six months' wages, at \$463.^{67,68} This goes up by almost \$280 if an obstetrician is involved and by more again if a caesarean section is required.⁶⁹ The hospital claims to cater for low- and middle-income Kenyan women and their families,⁷⁰ yet their average reported inpatient cost was \$845 in 2011.⁷¹ Two-thirds of Kenyans would have to forgo at least their entire income for well over a year to pay such a fee.⁷² In contrast, maternity care in the public sector is free, following the abolition of user fees for maternity services in 2013 by the Kenyan government.⁷³

Any genuine availability of services for poor and underserved people in Health in Africa's investment portfolio seems to be limited to tokenistic corporate social responsibility (CSR) schemes on a tiny scale, such as the donation of 250 blankets;⁷⁴ sponsorship of eight water pumps in schools;⁷⁵ and two days of free eye screening for 200 people (over a third of whom were referred for further tests, which may or may not have involved out-of-pocket costs).⁷⁶

5 TURNING A BLIND EYE TO MEASURING IMPACT

The IFC's approach to Health in Africa seems to be at odds with World Bank Group President Jim Kim's emphasis on evidence-based approaches and the 'science of delivery'.⁷⁷ The independent mid-term review of the Health in Africa initiative states that 'the topic of the private health sector is controversial, and this should have led Health in Africa to be more engaged with defining its anticipated results and then assessing them. This has not happened, and as a result it is now difficult to assess the extent to which Health in Africa has had any real impact.'⁷⁸

The particular failure of the IFC to measure the extent to which Health in Africa impacts on people living in poverty is nothing less than surprising. The performance indicators outlined in the Business Plan for Health in Africa and applied to the IFC's direct and indirect investments include the value of the financing mobilized, tax revenues generated, jobs created and the number of people receiving services.

According to the mid-term review, these indicators are inadequate to measure any development impact specifically on the underserved.⁷⁹

As an IFC Fact Sheet explains, the Health in Africa equity funds are tasked with ‘investing in socially responsible private health companies serving underserved and low-income people.’⁸⁰ However, neither fund targets the underserved in practice, nor do they measure their attempts to do so, to any acceptable degree:

- The Investment Fund for Health in Africa simply requests its portfolio companies to complete a questionnaire on environmental, social and development impact⁸¹ and makes a series of assumptions, including that extension of insurance, telemedicine and other products and services will automatically increase equitable access to healthcare.⁸² A telemedicine provider supported by the Fund (a South African company called ‘Hello Doctor’) was branded unethical by the Health Professions Council of South Africa, forcing the organization to withdraw its services.⁸³
- The Africa Health Fund boasts of the success of its innovative incentive framework, which specifically rewards portfolio companies for reaching patients at the ‘base of the pyramid’.⁸⁴ However, the target income thresholds used to define those at the base of the pyramid are meaningless – in some cases they include anyone earning \$3,000 or less.⁸⁵ According to the IFC’s own estimates, this in effect includes all but the top five percent of earners in sub-Saharan Africa.⁸⁶ Even the lowest target income threshold used – \$1,000 per person – would include more than 70 percent of the population in most African countries.⁸⁷

The mid-term review notes that a results framework has ‘finally been developed’ for Health in Africa but despite Oxfam’s requests to date, the IFC has not yet made this available for us to review.⁸⁸

6 HIGH-COST, LOW-IMPACT INVESTMENTS

Health in Africa has failed across its investment portfolio to prove claims of superior efficiency and cost-effectiveness in the private healthcare sector. Instead, there are numerous examples of high-cost, low-impact investments that make a negligible contribution to the overall scale of health coverage.

The \$1.7m Health in Africa investment in Clinique Biasa in Togo aimed to more than triple the hospital’s existing bed capacity, in order to continue Clinique Biasa’s ‘significant contribution to quality health provision in a country which has less than one hospital bed per thousand people’⁸⁹ However, even in the most generous scenario,⁹⁰ the increase in bed capacity at Clinique Biasa represents a rise in the total number of beds in the country of only 1.26 percent.⁹¹ In Tanzania, Health in Africa invested in a health insurance provider, Strategis Insurance,^{92,93} despite the fact that its own literature showed the company had just 30,000 members – 0.06 percent of the population.⁹⁴ The East Africa-wide health maintenance organization, AAR Healthcare Holdings Ltd, has benefited twice from IFC investments,⁹⁵ yet currently provides outpatient services for only 500,000 people per year across the region.⁹⁶ AAR Healthcare’s growth target to serve an additional 600,000 outpatients per year by 2018⁹⁷ would see it reaching a mere 1.9 percent of the total population of the three countries in which it operates.⁹⁸

Box 2: Hygeia Nigeria and the Lagos IT Workers Health Insurance Scheme

A series of schemes partnering with the IFC-supported company Hygeia⁹⁹ in Nigeria have been celebrated for extending health coverage to low-income Nigerian communities.¹⁰⁰ One Health In Africa scheme, receiving \$6.1m from the IFC, set out to subsidize health insurance for 22,500 low-income information technology (IT) workers in Lagos over five years starting in 2008.^{101,102} It can be assumed that the pilot scheme excludes the poorest and most vulnerable Nigerians, as enrollees are required to be in formal employment (automatically excluding approximately 80 percent of Lagos workers).¹⁰³

The cost of membership is also prohibitive. In the first year, enrollees pay \$10 to join the scheme.¹⁰⁴ By year five, as the IFC subsidy is reduced, the cost rises to \$53.¹⁰⁵ Beyond the project's five-year term, it can only be assumed that the full cost of the \$93 insurance premium will fall to individual members unless the government could be persuaded to take it on. To cover all Nigerians under a scheme like this would require tripling the current government per capita health expenditure.¹⁰⁶

Even at this high cost, the insurance scheme excludes a number of key healthcare services, including cancer treatment, intensive care, family planning, any major surgery, as well as several other essential health services.¹⁰⁷ As such, the scheme fails to protect members from the risk of impoverishing healthcare costs.

According to the information available, the scheme has, unsurprisingly, failed to reach its target number of enrollees.¹⁰⁸ Today, a year after the project was due to close, fewer than 40 percent of the planned beneficiaries have been reached and only 54 percent of the IFC funding has been disbursed.¹⁰⁹ In Nigeria, scaling up to achieve universal health coverage via this route would take over 100,000 years.¹¹⁰

7 UNACCOUNTABLE AND OPAQUE: HEALTH IN AFRICA'S USE OF FINANCIAL INTERMEDIARIES

The apparent absence of any IFC appetite to measure genuine development impact through Health in Africa is compounded by the initiative's use of financial intermediaries to invest on its behalf, specifically the Africa Health Fund and the Investment Fund for Health in Africa.

Oxfam's research has identified several worrying problems with the use by the IFC of financial intermediaries in general.¹¹¹ These include opacity, complexity, a focus on financial returns over development impact, a focus on financial risk over environmental and social risk, lack of oversight or ability to influence the business practices of investee companies, and remoteness from the projects ultimately financed and their impacts on poor people.¹¹²

A 2013 report from the World Bank Group's Compliance Advisor Ombudsman (CAO) concurred with Oxfam's research.¹¹³ The report found that the IFC was unable to track whether its investments via financial intermediaries are causing harm to poor people and the environment, let alone measure whether they bring development benefits.¹¹⁴ It found serious irregularities and compliance issues within the existing standards used by the IFC.¹¹⁵ It found inadequate transparency, and reported that legitimate concerns were being raised regarding a near-total absence of public access to information at times.¹¹⁶ This dearth of information can make it impossible for communities to even find out if the IFC is involved in a project, much

less know that they can access grievance and redress mechanisms through the CAO.¹¹⁷ The IFC's initial response to the audit report¹¹⁸ failed to acknowledge the gravity of the issues raised or to commit to properly addressing them.¹¹⁹

Following significant pressure from civil society and the Bank's own Board, the IFC is now trying to deal with some of these issues,¹²⁰ but it is still not addressing the broader systemic issues with its model of lending through financial intermediaries.¹²¹ Considering this problematic track record, the IFC's choice to use financial intermediaries in the health sector, where there has already been a failure to demonstrate impact, should be a serious concern for World Bank Group shareholder governments and their tax paying publics, and importantly, beneficiaries to whom the Bank is also accountable.

8 WORLD BANK GROUP MANAGEMENT RESPONSE TO HEALTH IN AFRICA'S MID-TERM EVALUATION

The official World Bank Group response¹²² to the critical findings of Health in Africa's mid-term evaluation was largely to emphasize the pilot nature of the initiative and that the IFC team was committed to an approach of 'learning by doing'.¹²³ This defence is later undermined by their admission that monitoring and evaluation (M&E) – a prerequisite for learning by doing – did not receive sufficient attention in the first year.¹²⁴ In fact, Health in Africa did not have an overarching results framework until 2011, three years after the launch of the initiative.¹²⁵ Further emphasizing the IFC's poor understanding of the need of M&E to be used for learning, the response commits to defining verifiable criteria for judging the success of Health in Africa 'by the time it concludes'.¹²⁶

In their defence of the initiative's pro-poor credentials, the World Bank Group management highlights the incentive framework used to reach the so-called 'base of the pyramid', yet they fail to acknowledge the inadequacy of the income thresholds used.¹²⁷ World Bank Group management has also claimed that the initiative 'did not intend to have a direct focus on the underserved in everything that it did, especially its policy work',¹²⁸ which is at odds with its own literature. It would also be at odds today with the two new corporate goals of ending extreme poverty and promoting shared prosperity. They go on to assert that its work would have indirect benefits on the underserved by improving the operating environment for the private sector,¹²⁹ seemingly based on the unsubstantiated assumption that the improvement and growth of the private health sector will automatically benefit poor people.¹³⁰

9 CONCLUSION AND RECOMMENDATIONS

President Jim Yong Kim's emphasis on UHC and the need to prioritize policies that reduce disparities in health coverage marks a crucial and welcome turning point for the World Bank Group. However, the available evidence suggests that the IFC's Health in Africa initiative is working at odds to the World Bank Group's commitment to UHC and its overarching goals to end extreme poverty and promote shared prosperity.

Of greatest concern is the lack of focus on poor people, especially women. The absence of any robust and comprehensive framework within which to measure impact, particularly on people living in poverty, undermines the IFC's claims that it has taken a 'learning by doing' approach. Furthermore, the use of financial intermediaries to invest in healthcare makes it even more difficult to measure poverty impact due to a lack of transparency, and it blurs the lines of accountability to the Bank's shareholders and beneficiaries. The IFC has done nothing to convincingly challenge the weight of evidence demonstrating the risks and inequity of healthcare commercialization. There was little, if anything, in the official World Bank Group response to the mid-term evaluation of Health in Africa to reassure critics that the IFC is committed to a pro-poor, evidence-based approach going forward.

UHC provides the opportunity to accelerate progress on the health-related Millennium Development Goals (MDGs), to address the growing burden of non-communicable diseases, and to drive down inequality in access to healthcare in Africa. But to achieve UHC, health sector reforms must be explicit about reducing inequality in access to health services. Despite their problems in many countries, publicly financed and delivered health services continue to be the main vehicle to achieve UHC in higher-performing, more equitable health systems. Prioritizing for-profit private sector healthcare delivery is extremely unlikely to deliver better health for poor people and to achieve UHC.¹³¹

Oxfam makes the following recommendations to the World Bank Group:

- Publish the final review of the Health in Africa initiative, as announced in the World Bank Group management response to the mid-term review, and discuss implications of the findings with the Board, civil society organizations and other stakeholders;
- Refrain from making any new Health in Africa investments until and unless a robust, transparent and accountable framework is put in place to ensure that such investments are pro-poor and are geared towards meeting unmet need;
- Cease IFC investments via financial intermediaries in the health sector until transparency in these deals can be guaranteed and their pro-poor impacts demonstrated;
- Conduct a full review of the IFC's operations and impact to date in the health sector in low- and middle-income countries to investigate how they are aligned with, and are accountable to, the overarching goals of the World Bank Group, which are to end extreme poverty and promote shared prosperity;
- Continue to support African governments to strengthen state capacities to regulate the private sector;
- Focus on supporting African governments to expand publicly provided healthcare and abolish user fees – a proven way to save millions of lives worldwide and drive down inequality.

NOTES

All links were last accessed in June 2014, unless otherwise stated.

- 1 World Bank Group President Jim Yong Kim, Speech at the Government of Japan-World Bank Conference on Universal Health Coverage, Tokyo, 6 December 2013, <http://www.worldbank.org/en/news/speech/2013/12/06/speech-world-bank-group-president-jim-yong-kim-government-japan-conference-universal-health-coverage>
- 2 World Bank Group President Jim Yong Kim, Speech at World Health Assembly 'Poverty, Health and the Human Future', Geneva, 21 May 2013, <http://www.worldbank.org/en/news/speech/2013/05/21/world-bank-group-president-jim-yong-kim-speech-at-world-health-assembly>
- 3 Oxfam International (2013) 'Universal Health Coverage: Why insurance schemes are leaving the poor behind', Oxfam Briefing Paper 176, Oxford: Oxfam International, <http://oxf.am/UHV>
- 4 E.g. S. Basu, J. Andrews, S. Kishore, R. Panjabi and D. Stuckler (2012) 'Comparative performance of private and public healthcare systems in low- and middle-income countries: a systematic review', PLOS Medicine 9(6): e1001244. doi:10.1371/journal.pmed.1001244. For a summary of available evidence, also see Oxfam International (2009) 'Blind Optimism: Challenging the myths about private healthcare in poor countries', Oxford: Oxfam International, <http://oxf.am/QKQ>
- 5 M. Koivusalo and M. Mackintosh (2004) 'Health Systems and Commercialization: In Search of Good Sense'.
- 6 R. Rannan-Eliya. and A. Somantnan (2005) 'Access of the Very Poor to Health Services in Asia: Evidence on the role of health systems from Equitap.' UKK: DFID Health Systems Resource Centre.
- 7 Oxfam International (2014) 'Working for the Many: Public services fight inequality', Oxfam Briefing Paper 182, Oxford: Oxfam International, <http://oxf.am/5TZ>
- 8 The World Bank Group (2013) 'Africa's Pulse: An Analysis of Issues Shaping Africa's Economic Future', volume 7, April, http://www.worldbank.org/content/dam/Worldbank/document/Africa/Report/Africas-Pulse-brochure_Vol7.pdf
- 9 IFC, The Business of Health in Africa – Partnering with the Private Sector to Improve People's Lives (hereafter referred to as The Business of Health), Washington DC: IFC, p.v.
- 10 Ibid. p.vii.
- 11 World Bank (2011) Healthy Partnerships: How Governments Can Engage the Private Sector to Improve Health in Africa (hereafter referred to as Healthy Partnerships), Washington DC: The International Bank for Reconstruction and Development/The World Bank, p.14.
- 12 IFC and World Bank, The Business of Health – Policy Notes, Issue 1, January 2010 (hereafter referred to as 2010 Policy Note), p.2.
- 13 IFC, The Business of Health, p.26.
- 14 Ibid. p.17, and p.11.
- 15 Ibid. p.52.
- 16 E.g. Oxfam International (2009) op. cit.; and Basu et al. (2012) op. cit.
- 17 World Bank Group Investment Climate Advisory Services, The Health in Africa Initiative: Improving the Role of Private Sector in Healthcare (hereafter referred to as 2013 Factsheet), p.1, https://www.wbginvestmentclimate.org/advisory-services/health/health-in-africa/upload/HIA-Factsheet_October-2013.pdf
- 18 IFC and World Bank, 2010 Policy Note.
- 19 IFC and World Bank (2012) Health in Africa Initiative – Factsheet, August 2012, p.1 (hereafter referred to as 2012 Factsheet), https://www.wbginvestmentclimate.org/advisory-services/health/health-in-africa/upload/HIA-FACTSHEET-SEPTEMBER-2012_ENGLISH.pdf (last accessed June 2014).
- 20 IFC videocasts, 'IFC Invests in Private Healthcare in Africa', October 2011, <http://www.youtube.com/watch?v=ZYAw9hGFxcc>
- 21 IFC (2007) Board paper 'Health Strategy for Sub-Sahara Africa', quoted in Brad Herbert Associates (2012) Health in Africa Mid-Term Evaluation – Final Report, p.11, <https://www.wbginvestmentclimate.org/advisory-services/health/health-in-africa/upload/HiA-Mid-Term-Evaluation-Final-Report-Sept-2012.pdf>
- 22 Ibid. p.11.
- 23 IFC and World Bank, 2010 Policy Note; and IFC and World Bank, 2012 Factsheet, p.4.
- 24 World Bank Group (2012) World Bank Group Management Response – Health in Africa Independent Mid-Term Evaluation, (hereafter referred to as Management Response), p.1.
- 25 IFC, 'IFC Backs Africa Healthcare Fund', press release, 4 June, http://www.ifc.org/wps/wcm/connect/region_ext_content/regions/sub-saharan+afrika/news/health_equity_fund
- 26 The Abraaj Group (2012) 'Press Release: Abraaj Capital Announces Acquisition of Aureos Capital', 20 February, <http://www.abraaj.com/news-and-insight/news/press-release-abraaj-capital-announces-acquisition-of-aureos-capital/>
- 27 The IFC has subsequently invested \$10m in an additional Bill & Melinda Gates Foundation-sponsored fund,

- 'Global Health Investment Fund', investing in the development of medicines and other health products. IFC Projects Database, 'GHIF – Summary of Proposed Investment', <http://ifcext.ifc.org/IFCExt/spiwebsite1.nsf/DocsByUNIDForPrint/7062F2FE8E6BA8BA85257AAE0066A86A?open document>
- 28 IFC Projects Database, 'Investment Fund for Health in Africa – Summary of Proposed Investment', http://ifcext.ifc.org/ifcext/spiwebsite1.nsf/ProjectDisplay/SPI_DP26516
- While the IFHA pre-dates the launch of the Health in Africa initiative, it is clear that the IFC was engaged in discussions around participation in IFHA from its outset. Brad Herbert Associates op. cit. p.36.
- 29 IFC and World Bank, 2012 Factsheet, p.1.
- 30 IFC (2014) 'IFC Backs Africa Healthcare Fund' op. cit.
- 31 World Bank Group, Management Response, p.1.
- 32 IFC and World Bank, 2012 Factsheet, p.1.
- 33 Ibid. p.4.
- 34 World Bank Group, Management Response, p 2
- 35 IEG World Bank op. cit. p.77.
- 36 Ibid. p.77.
- 37 http://www.ifc.org/wps/wcm/connect/CORP_EXT_Content/IFC_External_Corporate_Site/What+We+Do/Investment+Services
- 38 Independent Evaluation Group (IEG) World Bank (2009) 'Chapter 5 – IFC's Health Strategy and Operations', in *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population – An Evaluation of World Bank Group Support Since 1997*, Washington DC: The International Bank for Reconstruction and Development/The World Bank. pp.82–83.
- 39 Ibid. pp.82–83.
- 40 Ibid. p.90.
- 41 Ibid. pp. 90
- 42 Ibid. p.86.
- 43 Ibid. p.77 and p.81.
- 44 Brad Herbert Associates (2012) *Health in Africa Mid-Term Evaluation – Final Report*, p.11.
- 45 IFC (2007), quoted in Brad Herbert Associates op. cit. p.11.
- 46 Brad Herbert Associates (2012) *Health in Africa Mid-Term Evaluation – Final Report*
- 47 Ibid. p.4, p.18 and p.41.
- 48 Ibid. p.18.
- 49 Ibid. p.4 and p.18
- 50 Ibid. p.4.
- 51 IFC Projects Database, 'Chad Clinic – Summary of Investment Information', <https://ifcndd.ifc.org/ifcext/spiwebsite1.nsf/78e3b305216fcd8a85257a8b0075079d/fb9298fb97103a0885257b5d005f5948?opendocument>
- 52 Private Equity Africa (2012) 'Aureos in \$1.7m Clinique Biosa deal', 4 July, <http://www.privateequityafrica.com/wp/uncategorized/aureos-in-1-7m-clinique-biosa-deal/>
- 53 IFC Projects Database, 'Hygeia II – Summary of Proposed Investment', http://ifcext.ifc.org/ifcext/spiwebsite1.nsf/ProjectDisplay/SPI_DP26806, and 'Hygeia Equity – Summary of Proposed Investment' <http://ifcextapps.ifc.org/ifcext/spiwebsite1.nsf/78e3b305216fcd8a85257a8b0075079d/95fd41ae25e87b9b852578780074b35c?opendocument> .
- For details of Investment Fund for Health in Africa investment in Hygeia, see Investment Fund for Health in Africa, 'Sourcelink: an investment by IFHA' <http://www.afdb.org/fileadmin/uploads/afdb/Documents/Generic-Documents/PPT%20SourcelinkPharma%20by%20IFHA.pdf> p.4. EUR2 million converted to US\$2.68 million xe.com July 2014.
- 54 Lagoon Hospitals Hygeia, 'Patient Guide' <http://www.hygeiagroup.com/lagoon/Medical-Services/Care-Guide.aspx> and Lagoon Hospitals Hygeia ;Company Overview', <http://www.hygeiagroup.com/lagoon/About-Us/Company-Overview.aspx>.
- 55 United Nations Population Fund (UNFPA) (2012) 'Maternal Deaths Halved in 20 Years, but Faster Progress Needed', press release, 16 May, <http://www.unfpa.org/public/home/news/pid/10730>
- 56 The Abraaj Group (2012) citing Jacob Kholi, Managing Partner of the Africa Health Fund, in 'Aureos managed Africa Health Fund invests US\$5 million in Nigerian assisted reproductive centre' press release, 4 February, <http://www.abraaj.com/news-and-insight/news/aureos-managed-africa-health-fund-invests-us5-million-in-nigerian-assisted/>
- 57 NGN 758,000 converted at xe.com, June 2014. The Bridge Clinic, 'The Bridge Clinic – Pricing' <http://176.32.230.1/thebridgeclinic.com/pricing.php>
- 58 World Bank, *Healthy Partnerships*, p.17 (Figure 1.7).

- 59 IFC (2007), quoted in Brad Herbert Associates (2012) op. cit. p.11.
- 60 IFC Projects Database, 'Life Healthcare – Summary of Proposed Investment', http://ifcext.ifc.org/ifcext/spiwebsite1.nsf/ProjectDisplay/SPI_DP29199
- 61 See Life Healthcare's website for details of services offered and hospitals, <http://www.lifehealthcare.co.za/>
- 62 See Life Healthcare's website for examples of the additional costs of private doctors (outside of medical aid schemes) at Life Hospitals: Life Westville Hospital, <http://www.lifehealthcare.co.za/Hospitals/DisplayHospital.aspx?nHospitalId=61>; Life East London Private Hospital, <http://www.lifehealthcare.co.za/Hospitals/DisplayHospital.aspx?nHospitalId=14>; Life Faerie Glen Hospital, <http://www.lifehealthcare.co.za/Hospitals/DisplayHospital.aspx?nHospitalId=20>
- 63 D. McIntyre (2010) 'Private sector involvement in funding and providing health services in South Africa: implications for equity and access to healthcare', Equinet Discussion Paper 84, July, p.1.
- 64 The IFC has subsequently invested a further \$57m in Life Healthcare, bringing the total IFC investment to \$150m. IFC Projects Database, 'Life Healthcare – Summary of Proposed Investment', <http://ifcextapps.ifc.org/ifcext/spiwebsite1.nsf/78e3b305216fcdba85257a8b0075079d/506cc3293fedb7f385257721006b201f?opendocument> (last accessed July 2014)
- 65 M. Hasenfuss (2011) 'South Africa's Life Healthcare picks 26% in Max', *Business Standard*, 13 October, http://www.business-standard.com/article/finance/south-africa-s-life-healthcare-picks-26-in-max-111101300095_1.html
- 66 T. Minney (2010) 'Africa Health Fund makes first investment', *African Capital Markets News*, 29 January, <http://www.africacapitalmarketsnews.com/233/africa-health-fund-makes-first-investment/>
- 67 Nairobi Women's Hospital's 'shortmat' maternity package costs KSh 40,000 (confirmed in correspondence with Nairobi Women's Hospital February 2014, and converted xe.com March 2014).
- 68 The average monthly Kenyan salary has been estimated at between \$76 and \$141 per month. J. Macharia (2013) 'Kenyan MPs defy president, hike pay to 130 times minimum wage', Reuters, 28 May, <http://www.reuters.com/article/2013/05/28/us-kenya-reform-idUSBRE94R0MW20130528>, and BBC News (2013) 'Kenya's Nairobi city hit by pig protest over MPs pay', 14 May, <http://www.bbc.co.uk/news/world-africa-22522846>
- 69 The Nairobi Women's Hospital, 'Maternity packages', <http://nwch.co.ke/maternity-packages-2/> (last accessed June 2014). KSh 24,000 obstetrician cost converted xe.com March 2014.
- 70 The Nairobi Women's Hospital, 'The Nairobi Women's Hospital – About us', <http://nwch.co.ke/about-us/>
- 71 S. Mbogo and R. Otini (2011) 'Kenya: Broker jolts hospital with new pricing index', *allAfrica*, 24 November, <http://allafrica.com/stories/201111250017.html> KSh 72,843 converted on xe.com September 2013.
- 72 67.2 percent of Kenyans live on \$2 a day or less. World Bank Data, 'Poverty headcount ratio at \$2 a day (PPP) (% of population)' for Kenya, 2005, <http://data.worldbank.org/indicator/SI.POV.2DAY/countries/KE?display=graph>
- 73 'Kenya: Will Free Delivery Reduce the High Mortality Rate?' 19 April 2013 <http://allafrica.com/stories/201304210016.html?viewall=1>, and 'Kenya's Mothers Shun Free Maternity Health Care' 9 July 2013 <http://www.ipsnews.net/2013/07/kenyas-mothers-shun-free-maternity-health-care/>
- 74 Nakasero Hospital, 'NHL News', July–September 2012, p.4 <http://www.nakaserohospital.com/images/documents/nhlnews.pdf>
- 75 Life Healthcare, Life Healthcare – Integrated Annual Report 2012, p.55, http://www.lifehealthcare.co.za/IR/Financial_Info/Life%20Healthcare%20Integrated%20Annual%20Report%202012.pdf
- 76 Nakasero Hospital, 'Nakasero Hospital (NHL) – Deseret International Eye Camp', p.1. and p.4, <http://www.nakaserohospital.com/images/documents/eyeclinic.pdf>
- 77 World Bank Group President Jim Yong Kim, Speech at the Annual Meeting Plenary Session, Tokyo, 11 October 2012, <http://www.worldbank.org/en/news/speech/2012/10/12/remarks-world-bank-group-president-jim-yong-kim-annual-meeting-plenary-session>
- 78 Brad Herbert Associates op. cit. p.4.
- 79 Brad Herbert Associates op. cit. p.32.
- 80 IFC and World Bank, Health in Africa Initiative – Factsheet, June 2011, p.4, <https://www.wbginvestmentclimate.org/advisory-services/health/upload/FINAL-HiA-factsheet.pdf>
- 81 Investment Fund for Health in Africa, Environmental, Social and Development Performance Report 2012, pp.16-17, <http://www.ifhafund.com/uploads/ESDPR%202012%20FINAL.pdf>
- 82 Ibid. p.15, p.19 and p.29.
- 83 R. Sheik Umar and L. Rondganger (2011) 'Hello Doctor under fire', *IOL News*, 10 May, <http://www.iol.co.za/news/south-africa/kwazulu-natal/hello-doctor-under-fire-1.1066992#.UkrU1K416eZ>
- 84 J. Kholi and R. Wanjiro (2013) 'Private Sector Opportunities in Developing Country Healthcare', *Private Sector & Development (Proparco's Magazine)*, Issue 17, July, pp.21–24.
- 85 In 2002 international dollars at purchasing power parity (PPP). Brad Herbert Associates op. cit. pp.34–35.
- 86 World Resources Institute and IFC, *The Next 4 Billion: Market Size and Business Strategy at the Base of the Pyramid*, 2007, p.20, quoted in Brad Herbert Associates op. cit. p.35.
- 87 Brad Herbert Associates op. cit. pp.34–35.
- 88 Ibid. p.4.

- 89 The Abraaj Group (2012), 'Press Release: The Africa Health Fund managed by Aureos invests in Togolese private hospital', <http://www.abraaj.com/news-and-insight/news/press-release-the-africa-health-fund-managed-by-aureos-invests-in-togolese/>
- 90 This scenario assumes the current number of beds (30) has yet to be tripled as per the investment plans, and will be tripled to 90 beds. See Clinique Biosa website <http://www.cliniquebiossa.org/>. A less optimistic scenario would assume the tripling of bed capacity has already happened, from 10 to 30 beds.
- 91 Calculation of 1.26% figure: current population in Togo: 6,817,000 (World Bank Data, 'Togo', <http://data.worldbank.org/country/togo>) and Togo currently has 0.7 beds per 1000 people (World Bank Data, 'Hospital beds (per 1,000 people)' <http://data.worldbank.org/indicator/SH.MED.BEDS.ZS>). This makes the total number of hospital beds 4,772. Increasing this by 60 beds gives 4,832, an increase of 1.26%.
- 92 Investment Fund for Health in Africa, 'Private Equity – Strategis Insurance (Tanzania) Limited', <http://www.ifhafund.com/index.php?page=strategis-insurance-tanzania-limited>
- 93 IFC, *The Business of Health*, p.71, Figure A2.4.
- 94 Tanzania's 2012 population was 47.78 million. The World Bank, 'Data – Tanzania', <http://data.worldbank.org/country/tanzania>.
- 95 A \$4m equity investment due to be disbursed (IFC Projects Database, 'AAR Healthcare – Summary of Investment Information', <https://ifcndd.ifc.org/ifcext/spiwebsite1.nsf/78e3b305216fcdba85257a8b0075079d/571e1e97915da5ca85257b6b006a2541?opendocument>), and an additional purchase of a 20 percent stake by the Investment Fund for Health in Africa ('IFHA injects funds into East African healthcare', Private Equity Africa, 15 December 2010, <http://ifcext.ifc.org/ifcext/pressroom/IFCPressRoom.nsf/0/2F42686363308FFE85257B9C004550F1>
- 96 IFC (2013) 'IFC Invests in AAR to improve health services in East Africa', 2 July <http://ifcext.ifc.org/IFCExt/pressroom/IFCPressRoom.nsf/0/2F42686363308FFE85257B9C004550F1>
- 97 Ibid.
- 98 Not factoring in population growth across Kenya, Tanzania and Uganda to 2018, which would see this percentage diminish even further. Based on the assumption that insurance coverage incrementally increases over the period 2013–18 (i.e. by adding 100,000 in the first year, 200,000 in the second year, 300,000 in the third year, etc.), reaching an additional 600,000 per year by 2018. See endnotes 107 and 111 respectively for the population of Uganda and Tanzania, and for details of Kenya's population of 43.18 million see The World Bank, 'Data – Kenya', <http://data.worldbank.org/country/kenya>. It is unclear how many of these outpatients would be covered by AAR's own insurance scheme.
- 99 IFC and World Bank, 2012 Factsheet, p.4.
- 100 See, for example, E. Gustafsson-Wright and O. Schellekens (2013) *Achieving Universal Health Coverage in Nigeria one State at a Time – A Public–Private Partnership Community-Based Health Insurance Model*, Global Economy and Development at Brookings – Working Paper 2, June, Washington DC: Brookings.
- 101 Funding is channelled via the Global Partnership on Output-Based Aid (GPOBA), which gives a grant to the Dutch Health Insurance Fund. World Bank, GPOBA, IFC (2008) 'World Bank-administered GPOBA launches pre-paid health insurance scheme in Lagos, Nigeria', News release, 30 October, http://www.gpoba.org/sites/gpoba.org/files/Nigeria_health_Oct08_revised.pdf
- 102 GPOBA website, 'Pre-paid health scheme pilot in Nigeria', <http://www.gpoba.org/project/P104405>
- 103 R. Neuwirth (2011) 'The 'Informal Economy' Driving World Business', NPR Books, 19 October, <http://www.npr.org/2011/10/26/141503411/the-informal-economy-driving-world-business>
- 104 Health Insurance Fund and GPOBA, op. cit. p.6.
- 105 Ibid.
- 106 According to WHO figures, the Nigerian government spent \$29.6 per capita in 2011. WHO Global Health Expenditure Database, 'Health Systems Financing Country Profile: Nigeria, 2011', http://apps.who.int/nha/database/StandardReport.aspx?ID=REPORT_COUNTRY_PROFILE
- 107 Including high technology services (CT scan, MRI, etc.); epidemics affecting more than 10 percent of the population; injuries resulting from natural disaster, war or riots; dialysis; congenital abnormalities; provision of spectacles, hearing aids, or dental care; and drug abuse. See Health Insurance Fund and GPOBA, op. cit. p.29.
- 108 At least in part due to the increase in co-payment for enrollees, which saw 34 percent of enrollees (4,611 of 13,473 persons) leave the scheme between January 2012 and May 2013. The start of the project was also heavily delayed, due to mistrust in the community of the initiative. The World Bank (2013) *Implementation Status & Results Nigeria, Pre-paid Health Scheme Pilot in Nigeria P104405*, 30 November, p.2
- 109 The scheme had 8,862 enrollees out of a target of 22,500 as of May 2013. Ibid. p.2 and p.4.
- 110 The project secured 8,862 enrollees between October 2007 and May 2013, Ibid. p.2. Scaling up 8,862 to reach the entire Nigerian population of 169,000,000 would take 104,886 years at the same rate (169,000,000 / 8,862 = 19,070. 19,070 x 5.5 = 104,886). WHO, 'WHO African Region, Nigeria', <http://www.who.int/countries/nga/en/>.
- 111 Oxfam International (2012) 'Risky Business: Intermediary lending and development finance', Issue Briefing, 18 April, Oxford: Oxfam International, p.1, <http://oxf.am/oFE>
- 112 Ibid. pp.3–6; and R. Nash (2013) 'Does the World Bank speak with forked tongue on land grabs', 15 April, <http://oxfamblogs.org/fp2p/does-the-world-bank-speak-with-forked-tongue-on-land-grabs/>
- 113 Office of the Compliance Advisor Ombudsman (CAO) for the International Finance Corporation, Multi Investment Guarantee Agency (MIGA), Members of the World Bank Group (2012) *CAO Audit of a Sample of IFC Investments in Third-Party Financial Intermediaries*, 10 October, http://www.cao-ombudsman.org/documents/Audit_Report_C-I-R9-Y10-135.pdf

- 114 Ibid. pp.24–25.
- 115 Ibid. p.31 and p.41.
- 116 Ibid. pp.25–26.
- 117 R. Nash op. cit.
- 118 The World Bank/IFC/MIGA (2013) Office Memorandum – Report on Audit of a Sample of IFC Investments in Third-Party Financial Intermediaries (IFC Response), 31 January, <http://www.cao-ombudsman.org/newsroom/documents/FINALIFCResponsetoCAOReport1-31-2013.pdf>
- 119 R. Nash op. cit.
- 120 E&S Risk Management of Financial Institutions at the IFC. Presentation to the Committee on Development Effectiveness, September 4th 2013, <http://www.cao-ombudsman.org/documents/IFCpresentationforCODE-ESRMforFIs-final.pdf> (last accessed June 2014)
- 121 The Bretton Woods Project (2014) op. cit,
- 122 World Bank Group, Management Response. <https://www.wbginvestmentclimate.org/advisory-services/health/health-in-africa/upload/Mgt-Response-to-MTR-Rev-S-082412-2.pdf>
- 123 Ibid. p.2 and p.4.
- 124 Ibid. p.6.
- 125 Ibid. p.6
- 126 Ibid. p.6
- 127 Ibid. p.5.
- 128 Ibid. p.4.
- 129 Ibid.. p.4.
- 130 Ibid.. pp.4–6.
- 131 E.g. Oxfam International (2009) op. cit.; and Basu et al. (2012) op. cit.

© Oxfam International September 2014

This paper was written by Anna Marriott and Jessica Hamer. Oxfam acknowledges the assistance of Ceri Averill, Katie Malouf, Nicolas Mombrial and Charlotte Souлары in its production. It is part of a series of papers written to inform public debate on development and humanitarian policy issues.

For further information on the issues raised in this paper please e-mail advocacy@oxfaminternational.org

This publication is copyright but the text may be used free of charge for the purposes of advocacy, campaigning, education, and research, provided that the source is acknowledged in full. The copyright holder requests that all such use be registered with them for impact assessment purposes. For copying in any other circumstances, or for re-use in other publications, or for translation or adaptation, permission must be secured and a fee may be charged. E-mail policyandpractice@oxfam.org.uk.

The information in this publication is correct at the time of going to press.

Published by Oxfam GB for Oxfam International under ISBN 978-1-78077-664-4 in September 2014.

Oxfam GB, Oxfam House, John Smith Drive, Cowley, Oxford, OX4 2JY, UK.

OXFAM

Oxfam is an international confederation of 17 organizations networked together in more than 90 countries, as part of a global movement for change, to build a future free from the injustice of poverty:

Oxfam America (www.oxfamamerica.org)
Oxfam Australia (www.oxfam.org.au)
Oxfam-in-Belgium (www.oxfamsol.be)
Oxfam Canada (www.oxfam.ca)
Oxfam France (www.oxfamfrance.org)
Oxfam Germany (www.oxfam.de)
Oxfam GB (www.oxfam.org.uk)
Oxfam Hong Kong (www.oxfam.org.hk)
Oxfam India (www.oxfamindia.org)
Oxfam Intermón (Spain) (www.oxfamintermon.org)
Oxfam Ireland (www.oxfamireland.org)
Oxfam Italy (www.oxfamitalia.org)
Oxfam Japan (www.oxfam.jp)
Oxfam Mexico (www.oxfammexico.org)
Oxfam New Zealand (www.oxfam.org.nz)
Oxfam Novib (www.oxfamnovib.nl)
Oxfam Quebec (www.oxfam.qc.ca)

Please write to any of the agencies for further information, or visit www.oxfam.org. Email: advocacy@oxfaminternational.org

www.oxfam.org



OXFAM