

Abstract

The majority of World Bank donors are States parties to the main international human rights conventions. This article uses the right to health as a lens for examining the obligations of donor States parties with respect to their involvement in the World Bank's development activities, which use the Poverty Reduction Strategy Paper (PRSP) process as their framework. The article uses the concept of core obligations to examine and assess public expenditure budgeting in the health care sectors of Mozambique, Rwanda, and Uganda, as provided for in the PRSP process. It argues that the current PRSPs make it impossible to fund public health care at a level that satisfies the requirements of core obligations. It concludes by calling on donor countries to comply with their international human rights obligations.

La majorité des bailleurs de fonds de la Banque Mondiale sont des États signataires des principaux accords et contrats sur les droits de l'homme. Cet article se sert du droit à la santé comme d'une lunette grossissante en vue d'examiner les obligations des États bailleurs de fonds dans leur participation aux activités de développement de la Banque mondiale, auxquelles le Cadre stratégique de réduction de la pauvreté (CSRП) sert de cadre juridique. Cet article part du concept des obligations de base pour examiner et évaluer la budgétisation des dépenses publiques dans le domaine de la santé au Mozambique, au Rwanda et en Ouganda, telle qu'elle apparaît dans le CRSP. Il démontre que les CSRP actuels empêchent le financement des soins de santé publique à un niveau satisfaisant les exigences des obligations fondamentales. Il conclut en appelant les pays bailleurs de fonds à honorer leurs obligations internationales en matière de droits de l'homme.

La mayoría de los donantes del Banco Mundial son Estados que participan en las principales convenciones y acuerdos internacionales sobre los derechos humanos. Este artículo utiliza el derecho a la salud como una lente para examinar las obligaciones de los Estados donantes respecto a su papel en las actividades de desarrollo del Banco Mundial, las cuales operan dentro del marco del Documento sobre Estrategias para Reducción de la Pobreza (PRSP, por sus siglas en inglés). El artículo utiliza el concepto de obligaciones fundamentales para examinar y evaluar la elaboración de los presupuestos de gastos públicos en los sectores de atención de la salud de Mozambique, Rwanda y Uganda, como se dispone en el proceso del PRSP. Argumenta que el marco de los PRSPs actuales imposibilita el financiamiento de la atención de la salud pública a un nivel que satisfaga los requisitos de las obligaciones fundamentales. Concluye instando a los países donantes a que cumplan sus obligaciones para con los derechos humanos internacionales.

WORLD BANK POLICIES AND THE OBLIGATION OF ITS MEMBERS TO RESPECT, PROTECT AND FULFILL THE RIGHT TO HEALTH

Rachel Hammonds and Gorik Ooms

Much of the discourse surrounding the relationship between human rights and the World Bank's development assistance activities focuses on the extent to which the provisions of international human rights treaties and international human rights law have legal effect on the World Bank.¹

This article will take a different approach and examine the obligations of World Bank donor members, the majority of whom are States parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC), both intended to ensure the right to health.^{2,3} We contend that, by supporting World Bank policies that contribute to violations of human rights in developing countries, these states fail to meet their international human rights obligations.⁴ We intend for this article to promote discussion about how States parties that are World Bank donors can be pressured to meet their international human rights obligations at the World Bank. States parties cannot support and collectively pursue World Bank policies that violate their international human rights obligations.

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The article examines the consequences of the International Monetary Fund (IMF)/World Bank Poverty Reduction Strategy (PRS) process for the right to health in three sub-Saharan African countries. In comparison to earlier programs, the PRS process has led to increased country ownership of aid programs and greater civil society engagement in poverty policy debates, which are welcome changes. Yet, as we argue below, financing of public health in the countries examined is constrained due to the macroeconomic concerns voiced by the World Bank and IMF. We argue that there is a conflict between the World Bank's policies under the PRS process and the right to health as defined in the ICESCR and the CRC, and elaborated on by the Committee on Economic, Social and Cultural Rights (the Committee). Further, World Bank policies undermine progress in respecting, protecting, and fulfilling the right to health by restricting health care budgets. This exposes the dilemma faced by World Bank donor members that are also States parties to the ICESCR and the CRC. As long as World Bank policies fail to recognize that the respect, protection, and fulfillment of all human rights is integral to equitable, sustainable development, States parties that support World Bank policies undermine the respect, protection, and fulfillment of the human rights of some of the world's most vulnerable populations.

Focus on the Right to Health

This discussion uses the right to health as a lens for examining the obligations of donor States parties with respect to their involvement in the World Bank's development activities. Most of our analysis and conclusions apply to other economic, social, and cultural rights affected by World Bank policy, which are integral to realizing the right to health. The right to health cannot be realized in isolation from other rights because good health is dependent on factors other than those just related to access to health facilities—including education, clean water, sanitation, and adequate housing.⁵ For example, women's increased educational attainment is key to improving health, not only their own, but that of their children—especially in developing coun-

tries. This interconnectedness between the right to health, right to education, and right to non-discrimination on the basis of gender is documented in the World Bank study, *Engendering Development*:

Mother's illiteracy and lack of schooling directly disadvantage their young children. Low schooling translates into poor quality of care for children and then higher infant and child mortality and malnutrition. Mothers with more education are more likely to adopt appropriate health-promoting behaviors, such as having young children immunized. Supporting these conclusions are careful analyses of household survey data that account for other factors that might improve care practices and related health outcomes.⁶

An adequate level of funding directed toward health and health services is a necessary but not sufficient condition for the health of individuals and populations and for realizing the right to health. Despite the obvious limitations, we have chosen to focus on the funding for this one right as this makes it easier to isolate and analyze spending.⁷ We believe that this approach has value as it helps to identify non-compliance and suggest solutions.

Focus on Core Obligations

One of the biggest obstacles in assessing the efficacy of development aid and policies is the lack of appropriate comprehensive statistical indicators.⁸ We have decided to use the human rights concept of "core obligations" as the basis for assessing World Bank policies by examining budgeting for the health care sector.⁹ There is no blueprint for financing a system that allows a state's citizens to realize the right to health. The concept of the right to health, as the entitlement to the highest attainable standard of physical and mental well-being, is relative, as it varies over time and place. Furthermore, the optimal balance of funding for health, education, sanitation, and other key sectors varies by country and community. The Committee on Economic, Social and Cultural Rights has stated that core obligations related to the right to health are non-derogable, and we believe that under-funding of the health sector results in core obligations relating to health not being realized.¹⁰

Focus on the International Development Association

Throughout this article, we use the term “World Bank,” assuming that whatever is said and published about or by the World Bank applies to the International Development Association (IDA). The IDA is one of five legally independent institutions, which together form the World Bank Group.¹¹

We focus on the policies of the World Bank rather than those of the IMF, although they often operate in tandem, and it could be argued that the IMF is the prime mover of some of the policies that they promote jointly. While the IMF operates relatively independently, however, the IDA arm of the World Bank depends on continuous fresh funding (“replenishments”), which makes it easier to assess the responsibilities of its donors and to call for changes in behavior.¹² This difference doesn’t imply that States parties aren’t responsible for IMF policies that they approve. It is, however, easier to assess responsibility and call for change in their support for World Bank policies that they approve of and fund on a continuing basis rather than policies promoted by the IMF that they approve without funding.

Moving From the Era of Structural Adjustment to the Era of Poverty Reduction

From the early 1980s until the end of the 1990s, IMF and World Bank macroeconomic policy was known as “structural adjustment.”¹³ Following criticism that structural adjustment fueled poverty, the IMF and World Bank launched a new policy in 1999, “poverty reduction.”¹⁴ Also in 1999, the IMF and World Bank agreed that “Poverty Reduction Strategy Papers” (PRSPs) would become the cornerstone of future IMF and World Bank development aid.¹⁵ The 1999 IMF and World Bank “Enhanced Highly-Indebted Poor Countries” (HIPC) debt relief initiative introduced the PRSP as the pre-condition for all Bank and IMF concessional lending. PRSPs are “national planning frameworks for low-income countries,” which the World Bank and IMF claim are country-driven with broad-based civil society participation.¹⁶

A key distinction between structural adjustment and PRSPs is the importance placed on “country ownership” and participation. Before 1999, it was the World Bank and IMF that developed the structural adjustment programs and conditions, and these had to be approved by recipient countries. Since 1999, the World Bank and the IMF invite recipient countries to develop their own PRSPs, to then be approved by the World Bank and IMF.¹⁷ This new approach suggests a shift in the leadership role in developing policies. Some argue that this shift is purely cosmetic, but it is generally perceived to be significant, and we will treat it as such.¹⁸

The World Bank’s Approach to Human Rights: Grow Now and Realize Human Rights Later

On the 50th anniversary of the Universal Declaration of Human Rights,¹⁹ the World Bank published *Development and Human Rights*, which opens with this quote from World Bank President, James D. Wolfensohn: “The message for countries is clear: educate your people; ensure their health; give them voice and justice, financial systems that work, and sound economic policies, and they will respond....”²⁰

For countries that had been strongly encouraged to adopt structural adjustment policies, the message was not clear. What if sound economic policy, as defined by the World Bank and the IMF, included public expenditure reform that made it impossible to “educate your people,” “ensure the health of your people,” or “give them a voice and justice”? Which part of the message was to take precedence: the health and education of the population or the need to reduce public expenditure?

A 1996 World Bank study examining the social dimensions of structural adjustment revealed a consistent reduction in public health expenditure in most sub-Saharan African countries that had been subject to structural adjustment.²¹ A 1989 World Bank report about the impact of structural adjustment in Mozambique admitted that “the provision of health and education services has been severely affected.” But at the same time, the report stressed that this

was "consistent with macroeconomic objectives."²² This observation suggests that the World Bank placed more importance on the Mozambican government's pursuing sound economic policies than maintaining education and health services. Curtis Doebbler argues, "... even in the midst of the debt crisis that precipitated SAPs [Structural Adjustment Policies] it was recognized that 'economic growth does not necessarily help the poorest section of the population, whose health is most at risk.' In fact, Gro Harlem Brundtland, former Director-General of WHO, has suggested that the converse is true."²³

Alfredo Sfeir-Younis, a Senior Advisor at the World Bank who leads and coordinates its work in relation to human rights, summarized the Bank's vision on human rights in 2004: "Without wealth creation it would be impossible to see human rights being realized. And it is here where the Bank is playing a fundamental role."²⁴

Other development experts are less positive about the World Bank's role. At the launch of the 2003 Human Development Report, the United Nations Development Programme (UNDP) Administrator, Mark Malloch-Brown, said a "guerrilla assault" is needed on the so-called Washington Consensus that sets out the general policies of the IMF and the World Bank: "Rather than being told to lower their sights, [developing countries] should be aided in achieving the [Millennium Development] Goals, with the IMF and World Bank helping to mobilize the needed additional assistance."²⁵

The World Bank's attitude toward human rights can be summarized as: Grow now, and realize human rights later. The main difference between the strategies articulated by Malloch-Brown and Sfeir-Younis lies with the funding source. While Malloch-Brown insists on international assistance, Sfeir-Younis seems to rely almost entirely on domestic resources, which explains why he sees wealth creation as the prerequisite for the realization of human rights. As we will discuss below, the World Bank encourages countries to decline or not seek the maximum international assistance necessary to provide essential social services, if its analysis suggests that additional international assistance could have negative macroeconomic implications.²⁶

Conflicts Between the World Bank's Structural Adjustment Policies and the Right to Health

The right to health, as enshrined in international human rights instruments, suffers from vague normative definition, which has made it hard for States parties to understand what standards they must fulfill and for citizens and human rights advocates to hold them accountable. Under Article 12(1) of the ICESCR, States parties must “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” This broad language has been fleshed out by the Committee in its General Comment on the Right to Health.²⁷

Article 24 of the CRC provides more guidance and establishes norms for governments regarding the right to health of children. With regard to development assistance, Article 24(4) states:

States parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.²⁸

The UN Committee on the Rights of the Child has interpreted Article 24 as requiring:

governments to take some specific actions to ensure the right to health of children. First, a government must provide certain data on the health of children to the Committee on the Rights of the Child. Second, a government must show that it is taking steps to ensure that it adequately invests in the health of children. Third, a state must take steps to ensure that the health of children is respected.²⁹

Progressive Realization

Article 2(1) of the ICESCR and Article 24(4) of the CRC recognize that the right to health will be achieved progressively. With regard to the right to health under the ICESCR, the Committee notes: “The concept of progressive realization constitutes a recognition of the fact that full realization of all economic, social and cultural rights will generally not

be able to be achieved in a short period of time.”³⁰ The principle of progressive realization is “critical for resource-poor countries that are responsible for striving towards human rights goals to the maximum extent possible.”³¹

At first sight, it appears that there is no conflict between economic, social, and cultural rights, as defined in the ICESR and the CRC, and the strategy followed by the World Bank—progressive realization within a growing economy. The concept of progressive realization, however, should not be misinterpreted as justifying endless delays in the realization of economic, social, and cultural rights, while waiting for economic growth and sufficient domestic resources to become available. It is not to be viewed as “an escape hatch (for) recalcitrant states.”³² Such an interpretation would deprive economic, social, and cultural rights of any meaningful value, especially for the disadvantaged and vulnerable. Thus, the Committee noted that States parties have “an obligation to move as expeditiously and effectively as possible.”³³ Progressive realization also applies to resource-rich countries, namely World Bank donors.³⁴

To counter interpretations of “progressive realization” as implying “no immediate obligations,” the Committee emphasizes a series of principles that define the nature of States parties’ obligations: the principle of non-retrogression, the principle of core obligations, and the obligation to provide international assistance. We have chosen to focus on the principle of core obligations, as it provides us with standards that can be used to assess World Bank policies.³⁵

The Principle of Core Obligations

In clarifying the content of economic, social, and cultural rights, the Committee drew on its experience, noting that “the Committee is of the view that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party.”³⁶ The principle of core obligation is one of immediacy, which applies irrespective of the availability of resources.

Regarding the right to health, the Committee noted these core obligations include at least the following obligations:

- (a) To ensure the right of access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- (c) To ensure access to basic shelter, housing, and sanitation, and an adequate supply of safe and potable water;
- (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- (e) To ensure equitable distribution of all health facilities, goods, and services;
- (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.³⁷

These non-derogable core obligations echo Article 24 of the CRC, which has been ratified by all countries except the United States and Somalia, pointing to the level of international acceptance of these standards.^{38,39} In accordance with this, we base our analysis of World Bank policies on the belief that a human rights approach requires that development aid should be directly linked to the fulfillment of core obligations as a matter of priority.

Structural Adjustment and Core Obligations

As stated earlier, the IMF and World Bank's macroeconomic policies from the early 1980s until the late 1990s were realized through structural adjustment. According to a 1993 World Bank study, a budget of US\$13 per capita, per year, was the minimum required to provide an "essential health services package" in a low-income country.⁴⁰ With regard to HIV/AIDS, the essential health services package in

a low-income country does not provide for treatment and appears to target only commercial sex workers.⁴¹ The package provided substantially less than what the Committee later defined as core obligations regarding health. For example, the Committee has cited the obligation "To take measures to prevent, treat and control epidemic and endemic diseases; to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them."⁴² During this period, sub-Saharan African countries, which were strongly encouraged to adopt structural adjustment programs, were far from realizing their core obligations, and their budgets were far below the US\$13 figure required for the essential health services package.⁴³

During the structural adjustment era, the World Bank developed and implemented policies that resulted in already insufficient budgets being further reduced in most sub-Saharan African countries. A World Bank study compared public health expenditure before, during, and after structural adjustment in 15 sub-Saharan African countries. Only Uganda saw an increase in public health expenditure under structural adjustment. On average, public health expenditure fell 20% during structural adjustment and stagnated after structural adjustment.⁴⁴ In Mozambique, per capita health expenditure fell from US\$3.50 in 1986 to US\$0.68 in 1988—after the introduction of a structural adjustment program in 1987.⁴⁵ If one accepts that US\$13 per person is insufficient to realize core obligations related to health, then one can only conclude that SAPs resulted in retrogression in realizing the right to health in many developing nations. In this respect, structural adjustment policies violated the concept of progressive realization of health found in the ICESCR and the CRC.

Persistent Conflicts under the World Bank Poverty Reduction Strategy: New Ceilings on Public Health Expenditure

In a lecture at the World Bank in November 2003, UNAIDS Executive Director Dr. Peter Piot complained about public health expenditure ceilings that hamper adequate funding of AIDS programs.⁴⁶ Bank President James

Wolfensohn replied: "... we are currently, and for the last several months, working with the [International Monetary] Fund on this issue of limits on medium-term expenditure framework for things that cannot be put aside and for which grant funding very often is available. And I hope quite soon that we will have some movement on that issue, because it is a very real issue."⁴⁷

This is a remarkable admission from the World Bank. Until then, World Bank and IMF staff members had regularly denied their involvement in setting such ceilings. For example, in 2002, the Ugandan Finance Ministry initially stated that the grant that Uganda had received from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) would be included as part of the existing health care budget (not as an addition to that budget).⁴⁸ The ministry stated that the GFTAM grant would not be used to increase health care expenditures. Instead, the Ministry would reduce funds coming to health care from other sources, in order to maintain the predetermined expenditure ceiling for health care. This in effect negated the goal off the GFATM grant—namely increasing resources for health care in Uganda. The Director of the IMF's External Relations Department rejected suggestions that the Finance Ministry stance might have been influenced by the IMF: "It is not true that Uganda may have to refuse aid for health or any other poverty-eradication programs in order to adhere to IMF-imposed guidelines."⁴⁹ The World Bank's admission that limits on expenditure for "things that cannot be put aside and for which grant funding very often is available" is indeed "a very real issue," and, the fact that it is working with the IMF to find solutions sheds a different light on the IMF's denial.

Wolfensohn's comments, quoted above, refer to Medium-Term Expenditure Frameworks (MTEFs), which a World Bank working paper defines as:

a top-down resource envelope, a bottom-up estimation of the current and medium-term costs of existing policy and, ultimately, the matching of these costs with available resources ... in the context of the annual budget process.⁵⁰

Of the 6 stages required to complete an MTEF, Stage 4 involves “Setting medium-term sector budget ceilings (cabinet approval)” and Stage 5, “Medium-term sectoral programs based on budget ceilings.”⁵¹ Furthermore, the working paper explains the importance of MTEFs:

Medium-Term Expenditure Frameworks are receiving renewed attention in the context of the formulation of Poverty Reduction Strategy Papers (PRSPs). Conceptually, MTEFs are the ideal tool for translating PRSPs into public expenditure programs within a coherent multi-year macroeconomic and fiscal framework.⁵²

Almost all PRSPs include or refer to an existing MTEF. An IMF review found that “virtually all PRSP financial frameworks were identical to those in the programme previously agreed with the IMF.”⁵³

A World Health Organization (WHO) report about the impact of PRSPs on health describes PRSPs and their new conditionality as follows:

The World Bank emphasizes that PRSPs should be written and produced by countries themselves and should go beyond macroeconomic stabilization and liberalization to address issues of poverty and equitable growth. However, PRSPs must also be approved by the Boards of the World Bank and the International Monetary Fund (IMF) before access to debt relief and concessional lending is granted. Moreover, Bank and Fund consultants often assist in the drafting of PRSPs. This suggests—and country experience confirms—that to a certain extent PRSPs must conform to Bank/Fund interpretations of “sound economic policy.”⁵⁴

Once included in an agreed PRSP, countries are no longer free to adapt their MTEF if a new essential need arises or if they can obtain a grant that wasn’t foreseen (for example, a grant from the GFATM) without IMF and IDA approval to change the PRSP.⁵⁵

How flexible are the IMF and the IDA toward renegotiating a previously agreed MTEF? The outcome of the above-mentioned dispute between the Ugandan finance and health ministries—the finance ministry finally agreed to accept the GFATM grant—suggests that the ceilings are flexible.⁵⁶

Other reports suggest, however, that this flexibility should not be taken for granted. A report on the Rwandan PRSP process explains how the Rwandan government tried using the PRSP process to move away from the existing MTEF by proposing two new expenditure frameworks—one based on real needs (the “unconstrained” scenario), and the other based on a modest increase of international grants (the “constrained” scenario).^{57,58} Both new scenarios are included in the final PRSP paper, and both foresee a substantial increase in public health expenditure, including the purchase of drugs to treat AIDS.⁵⁹ But as the report indicates, “the higher scenarios—with the major increases in poverty-reducing expenditures—were not discussed.” Furthermore, “The long-run question of financing anti-poverty expenditures out of increased external resources remained unsettled. As a result, the IMF Poverty Reduction and Growth Facility document specifies that if expenditures can be identified with ‘no macroeconomic impact’ and financed by extra grants, the programme may be revised in future years to accommodate this.”⁶⁰

To be allowed to provide the health care it wants to its citizens, the government of Rwanda will need to demonstrate that it has secured additional grants, and it will need to demonstrate that accepting these grants won’t have a macroeconomic impact.⁶¹ Only IMF and World Bank macroeconomists will perform the authoritative assessment of whether or not there is a macroeconomic impact.^{62,63} This, together with the fact that some countries might be reluctant to demand a renegotiation, is the real significance of the ceilings.

Costing Core Obligations and MTEF Ceilings

In January 2000, Gro Harlem Brundtland, then Director-General of WHO, established the Commission on Macroeconomics and Health (CMH).⁶⁴ The purpose of the CMH was “to analyze the impact of health on development and to produce reports and scholarly studies on health-related interventions and their impact on economic growth and equity in developing countries.”⁶⁵

One of the CMH’s working groups addressed the technical options, constraints, and costs for mounting a major

global effort to improve the health of the poor. The cost analysis estimated the cost of scaling up the coverage of 49 priority health interventions in 83 developing countries. The target coverage levels were set in accordance with internationally agreed upon targets, such as the Millennium Development Goals, and targets were set for the years 2007 and 2015.⁶⁶

The CMH estimated that sub-Saharan African low-income countries would need to spend US\$40 per capita to reach the target coverage levels set for 2007, and US\$50 per capita to reach the target coverage levels set for 2015.⁶⁷ It estimated that these countries would be able to mobilize domestic resources of US\$15 per capita in 2007 and US\$20 per capita in 2015. It concluded that contributions from the international community would be needed to support the financing gap of US\$25 per capita in 2007 and US\$30 per capita in 2015.⁶⁸⁻⁷⁰

Although the CMH costing exercise didn't explicitly refer to the core obligations as defined by the Committee, the interventions considered and targets set by the CMH fell within the scope of these core obligations. (See Table 1)⁷¹ The CMH considered only those interventions for which the required medicines are included in the WHO model list of essential drugs. Therefore, these interventions fall within the scope ensuring the right of access to health facilities..." and "... providing essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs" of the core obligations.⁷² We consider the targets set by the CMH as "expert advice" on what is reasonable and achievable, and for the purposes of this article, we shall use the US\$40 per capita figure as the minimum expenditure level currently needed to comply with the core obligations to realize the right to health.

One argument against using this US\$40 figure as a benchmark to measure compliance with core obligations is that this amount assumes that the international community will provide more than half (US\$25), while sub-Saharan African low-income countries will contribute US\$15 from domestic resources. However, the governments of every sub-Saharan African low-income countries cannot possibly

Commission on Macroeconomics and Health Interventions ¹⁰³	Core Obligations ¹⁰⁴
Tuberculosis Treatment: • Directly observed short course treatment for smear negative patients	To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs
Malaria Prevention: • Insecticide treated nets • Residual indoor spraying	To take measures to prevent, treat, and control epidemic and endemic diseases
HIV/AIDS Prevention: • Youth-focused interventions • Strengthening of blood transfusion systems • Treatment for sexually transmitted diseases • Interventions working with sex workers and clients • Condom social marketing and distribution • Workplace interventions • Voluntary counselling and testing • Prevention of mother-to-child transmission • Mass media campaigns	To take measures to prevent, treat, and control epidemic and endemic diseases. To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs
HIV/AIDS Care: • Palliative care • Clinical management of opportunistic illnesses • Prevention of opportunistic illnesses • Home-based care	To take measures to prevent, treat, and control epidemic and endemic diseases. To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs
HIV/AIDS HAART: • Provision of HAART	
Maternal conditions-related interventions (ante- and intra-partum): • Antenatal care • Treatment of complications during pregnancy • Skilled birth attendance • Emergency obstetric care • Post-partum care (including family planning)	To ensure equitable distribution of all health facilities, goods, and services
Childhood disease-related interventions (care): • Treatment of various conditions (acute respiratory infections, diarrhoea, causes of fever, malnutrition, anaemia)	To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care. To ensure access to the minimum essential food which is nutritionally adequate and safe; to ensure freedom from hunger to everyone
Childhood disease-related interventions (prevention): • Vaccinations (BCG, OPV, DPT, Measles, Hepatitis B, HiB)	To provide immunization against the major infectious diseases occurring in the community

Table 1. The CMH's priority health interventions and core obligations.

be expected to “obtain” US\$25 in the form of international aid and provide US\$15 from domestic sources. They could at most be required to make best efforts to secure such grants from wealthy states.

The Committee anticipated this problem when it defined the core obligations. The primary duty holder with regard to realizing international human rights for those under their authority is the national state. Under the ICESCR, however, wealthier countries have progressive obligations toward the citizens of developing countries to ensure that all people can realize their, economic, social, and cultural rights.⁷³ Regarding the level of this assistance, the Committee has suggested that wealthier countries should devote 0.7% of GDP to international development assistance.⁷⁴

This obligation to provide assistance creates a kind of collective obligation for “wealthier” States parties (those “in a position to assist”) toward all developing countries; however, from the viewpoint of the developing country, it is impossible to identify which countries should help them and to what extent. We can therefore summarize the core obligation of sub-Saharan African low-income countries, with regard to financing the right to health, as the obligation to raise at least US\$15 per capita domestically and to request an additional US\$25 per capita from wealthy countries.

Core Obligations and Spending Ceilings

With this financial interpretation of core obligations in mind, we now turn to an examination of spending, which can be found in the MTEFs. Some PRSPs include MTEFs or provide the ceilings set in the MTEF, including the PRSPs for Mozambique, Rwanda, and Uganda. These three countries are all low-income sub-Saharan African countries that are favored by donors, and the content of many of their discussions with the IMF and World Bank is publicly available.^{75,76} Sub-Saharan Africa is the poorest region in the world; HIV/AIDS is the leading cause of death, and malaria and tuberculosis remain major problems.⁷⁷

The Ugandan PRSP, which includes an MTEF ceiling, establishes a health budget of less than US\$8 per capita for 2002-2003.⁷⁸ The Rwandan PRSP also includes an MTEF

ceiling and includes a health budget of less than US\$3 per capita for 2004.⁷⁹ The Mozambican PRSP includes an MTEF ceiling as well, and it provides for a health sector budget of just below US\$9 per capita in 2005.⁸⁰

It is important to understand that these ceilings include both domestically sourced funds and international donor funds. Thus, these ceilings prevent the governments of Mozambique, Rwanda, and Uganda from meeting the US\$15 per capita for health expenditure target that the CMH specified they should raise domestically. In addition, the ceilings make it impossible for these governments to request the US\$25 per capita from donor countries. It is highly unlikely that donor countries will provide financial assistance for interventions that aren't foreseen in the PRSP, as the PRSP is, in theory, comprehensive and country-driven. It is equally unlikely that countries like Mozambique, Rwanda, and Uganda will seek funding outside the PRSP because the PRSP is supposed to be country-owned—that is, the recipient countries are supposed to be driving the process. To undermine this understanding would undermine the whole PRSP process and possibly endanger the funding that is available through the PRSP. Further, several donor countries, including the Netherlands and the United Kingdom, have already declared that they will use the PRSP as the main framework for their support.⁸¹ The European Commission has indicated that its "Accelerated Action on HIV/AIDS, Malaria and Tuberculosis" action program is striving for coherence with PRSPs.^{82,83}

The possibility of countries applying for grants beyond the MTEF and the PRSP, however, isn't entirely excluded. The GFTAM does not use PRSPs as a framework. It works through Country Coordination Mechanisms (CCMs), which include different stakeholders, including civil society, private and public sector representatives, and development partners.⁸⁴ These CCMs can prepare applications outside PRSPs, which is what happened in Mozambique, Rwanda, and Uganda, creating serious tensions. Even the World Bank acknowledges that these tensions exist: "The availability of additional, earmarked grant funds for health—from mechanisms such as the Global Fund—can and has led to tensions

between financial ceilings set by ministries of finance aiming to maintain macroeconomic stability on one hand, and the need to expand the resource envelope in the health sector, on the other hand.”⁸⁵

As explained above, the IMF and the World Bank can approve an MTEF modification, and they can raise the ceilings, as appears to have been the case with Uganda. The Rwandan case suggests that two conditions must be satisfied: additional funds must come from grants, and they must not create macroeconomic distortions, (for example, causing “Dutch disease”).^{86,87} The concern of the IMF and World Bank is that the Dutch disease effects of aid will increase inflation, lower growth, and inhibit the development of the tradable goods sector.⁸⁸ In an IMF working paper, the authors argue that several African countries benefiting from HIPC debt relief will soon build up unsustainable debt levels, leading to an increase in non-debt creating grants, rather than loans. But they immediately warn: “In some cases, external financing may even be detrimental to sectors necessary to promote growth and reduce poverty—for example, to agriculture and manufacturing—due to Dutch disease effects.”⁸⁹ Thus, the IMF and the World Bank might refuse to renegotiate an agreed MTEF, even if a donor grant is available and badly needed to realize minimum essential levels of the right to health, when they feel that the acceptance of an additional grant might cause Dutch disease.

The impact of the fear of Dutch disease on aid policy led a senior official at the Ugandan Health Ministry to complain, “The IMF, World Bank and Ugandan Finance Ministry have decided that protecting against inflation is more important than protecting peoples’ lives.”⁹⁰ It is clear that the World Bank and IMF believe that Dutch disease is a real problem; however, Gustav Ranis argues that its potential affects are probably overstated.⁹¹ Whether aid-induced Dutch disease is a real threat to developing economies or “a bogus theory,” as former US Treasury Secretary Paul O’Neill labeled it, is an interesting question, although it falls beyond the scope of this article.⁹² General Comment 14 on the right to health makes it clear that, from a human rights perspective, even the threat of macroeconomic distortions like Dutch disease

cannot justify public health expenditure below the level necessary to comply with core obligations.⁹³ To summarize:

- World Bank policy prohibits the governments of Mozambique, Rwanda, and Uganda from raising the US\$15 per capita domestic share of the resources required to comply with their core obligations to realize the right to health;
- World Bank policy prohibits the governments of Mozambique, Rwanda, and Uganda from requesting US\$25 per capita development assistance from donors—the donor share of the resources required to comply with their core obligations to realize the right to health;
- World Bank policy might even prohibit the governments of Mozambique, Rwanda, and Uganda from accepting development assistance whenever the World Bank and the IMF believe that accepting such grants might cause macroeconomic distortions.

Based on the above analysis, we argue that World Bank policies play a role in the inability of these countries to comply with their core obligations to realize the right to health. We consider non-achievement of the CMH target of \$40 per capita as non-compliance with core obligations because a public health expenditure budget that doesn't provide for the achievement of CMH targets is a public health expenditure budget that does not allow a state to comply with its core obligations.

Other sub-Saharan African low-income countries, less popular with donor states, face the same challenges, or even worse, because they receive less international aid and technical support. Therefore, what is true for these three countries is probably even more so for other sub-Saharan African low-income countries. We believe that, despite improving on structural adjustment, the PRS process continues to result in underfunding of the health sector in sub-Saharan African low-income countries.

A Dilemma for World Bank Members That Are Also States Parties to the ICESCR

World Bank policies can be changed, and the majority of World Bank members are also States parties to the ICESCR and the CRC giving them the power to influence World Bank policy.⁹⁴ The IDA's dependence on regular contributions from donors, known as "replenishments," means that donors can exercise this power every couple of years. Also, the IDA is ruled by a "one dollar, one vote" principle rather than a "one country, one vote" principle, and, as of 2004, States parties to the ICESCR together controlled 76.28% of the votes on the IDA Board, giving them significant influence.^{95,96} The latest replenishment raised approximately US\$24 billion over three years, including about US\$13 billion in promised new donor contributions, beginning in July 2002.⁹⁷

This creates an ambiguous situation for donor States parties to the ICESCR and the CRC. While individually they might strive to realize the right to health domestically and internationally, collectively they support an institution that neither respects, nor protects, let alone fulfills, the right to health in recipient states. States parties contributing to the IDA's budget not only support the IDA through their representation on the IDA's Board of Governors, they also fund the IDA. As discussed earlier, these funds can act as an incentive for developing countries to adopt retrogressive measures, to cap public health expenditure at levels insufficient to meet their core obligations to respect, protect, and fulfill human rights, and deter them from seeking additional development assistance.

Do countries violate their obligations under the ICESCR and the CRC if collectively they support a multi-lateral institution that implements strategies that their obligations prevent them from implementing individually? The question is particularly relevant when applied to public health expenditure ceilings, which deter developing countries from seeking or accepting additional development assistance. We believe that when States parties support IMF and World Bank policies, and in particular when they make financial contributions to the IDA, they collectively support

policies that result in human rights violations in developing countries that cannot simultaneously comply with World Bank macroeconomic prescriptions and the core obligations related to realizing the right to health. Our contention is supported by the Committee's assertion that States parties have an obligation "to ensure that their actions as members of international organizations take due account of the right to health."⁹⁸ The World Bank acknowledges that improving health contributes to economic growth, although in an analysis of 21 PRSPs, the World Health Organization found "none mention health as a human right."⁹⁹

Conclusion

The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights offer a conceptual guide to the interpretation of rights protected by the ICESCR.¹⁰⁰ They specifically address the obligations of States parties, acting collectively through international organizations, urging states "to use their influence to ensure that violations do not result from the programmes and policies of the organizations of which they are members."¹⁰¹

A change in World Bank policy requires pressure from States parties that are World Bank members. States parties to the ICESCR control over 75% of IDA votes, so as both donor and recipient countries they can "use their influence" to make the IDA respect, protect, and fulfill economic, social, and cultural rights. Thus far, any attempts to use this influence have not been very effective as evidenced in the underfunding of the Rwandan, Mozambican, and Ugandan health care sectors.

If attempts to use their influence fail, donor States parties also have the option to withhold contributions to future IDA replenishment rounds because funding World Bank policies and programs would be in violation of their international human rights obligations. As an intermediate solution, donor States parties should condition their contribution to the next IDA replenishment on the requirement that it only be used to fund loans to countries that develop a PRSP that, in theory, allows them to comply with their core obligations to realize economic, social, and cultural rights.

If they contribute to PRSPs that respect the human rights obligations of recipient countries, they would not be supporting policies that violate human rights—even as implementation may fall short. Finally, they have the option of suspending or threatening to suspend their membership in the IMF and World Bank, which is far more realistic for donor States parties, than recipients who are dependent on concessional loans. The legal status of States parties that continue to fund World Bank policies that contribute to human rights violations in third states requires further research. Accountability may encourage donor States parties to push for change.

World Bank donor members that are States parties need to take the initiative by informing the World Bank that, regardless of the extent of its obligations under international human rights law, the majority of its members have the responsibility to respect, protect, and fulfill human rights domestically and internationally, and that they will not financially support policies and programs that fail to do so. It is a moral imperative, and fundamental to their obligations as States parties, to comply with their international human rights obligations. Are wealthy States parties willing to do this, or is their support of IMF and World Bank macroeconomic policies just “a fancy way to tell poor countries not to come to us with their problems, and certainly not to ask for more financial help?”¹⁰² Donor States parties can withdraw their support of the IMF and the World Bank, and from a legal perspective we believe they should, so long as these institutions’ programs and policies violate economic, social, and cultural human rights.

References

1. See, for example, S. Skogly, *The Human Rights Obligations of the World Bank and International Monetary Fund* (London: Cavendish, 2001); M. Darrow, *Between Light and Shadow: The World Bank, The International Monetary Fund and International Human Rights Law* (Oxford: Hart Publishing, 2003); and International Council on Human Rights Policy, *Duties Sans Frontieres, Human Rights and Global Social Justice*. Available at <http://www.ichrp.org/ac/excerpts/137.pdf> (Retrieved December 4, 2004).
2. The most relevant international human rights instruments include the International Covenant on Civil and Political Rights (ICCPR), G.A. Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316

(1966); International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966); Convention on the Elimination of All Forms of Discrimination against Women, G.A. Res. 34/180, UN GAOR, 34th Sess., Supp. No. 46, at 193, UN Doc. A/34/46 (1979); and Convention on the Rights of the Child (CRC), G.A. Res. 44/25, UN GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/25 (1989).

3. This article focuses exclusively on treaty-based obligations as the source of international human rights obligations. For a thorough discussion of other potential sources of international human rights obligations (e.g., international customary law, *jus cogens*, and general principles of international law), please see S. Skogly, *Extra-National Obligations Towards Economic and Social Rights*, International Council on Human Rights Policy (2002). Available at <http://www.ichrp.org/ac/excerpts/92.doc> (Retrieved December 4, 2004).

4. The state, no matter how poor, remains the primary duty holder in relation to human rights respect, protection, and fulfillment for those within its jurisdiction. The duty of other states is triggered when a nation-state cannot meet its obligations. See the discussion in International Council on Human Rights Policy, *Duties Sans Frontieres* (see note 1).

5. Numerous UN declarations and resolutions have affirmed the universality and indivisibility of all human rights.

The Proclamation of Teheran affirms:

The Universal Declaration of Human Rights states a common understanding of the peoples of the world concerning the inalienable and inviolable rights of all members of the human family and constitutes an obligation for the members of the international community, proclaimed by the International Conference on Human Rights at Teheran on May 13, 1968, UN Doc. A/CONF.32/41 (1968), endorsed by G.A. Res. 2442 (XXIII) (1968), para. 2.

The Declaration on the Right to Development provides:

All human rights and fundamental freedoms are indivisible and interdependent; equal attention and urgent consideration should be given to the implementation, promotion, and protection of civil, political, economic, social, and cultural rights, adopted December 4, 1986, G.A. Res. 41/128, UN GAOR, 41st Sess., at 3, Annex, art. 6(2).

The Vienna Declaration and Programme of Action states:

All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural, and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms. World Conference on Human Rights, 48th Session, 22d plenary meeting, UN Doc. A/CONF.157/24 (1993), reprinted in 32 I.L.M. 1667 (1993), para. 5.

6. World Bank, *Engendering Development Through Gender Equality in Rights, Resources and Voice*. Available at <http://www.worldbank.org/gender/prr/englishversion.htm> (Retrieved December 4, 2004).

7. An adequate level of health funding and expenditure is no guarantee that the right to health will be realized in a given country. Improvements in funding will do little to sustainably improve the health of vulnerable and disadvantaged groups. However, an inadequate level of funding and expenditure practically guarantee that the right to health cannot be realized. We aim to prove that World Bank policies contribute to under funding of the health care sector in developing countries, which prevents the realization of even the core obligations related to the right to health.
8. A. Chapman, "A New Approach to Monitoring the International Covenant on Economic, Social and Cultural Rights," International Commission of Jurists, *The Review* 55/23 (December 1994).
9. Core obligations are defined as including at least minimum essential levels of each of the rights in the ICESCR and are outlined in Committee on Economic, Social and Cultural Rights (ESC Committee), General Comment No. 3, *The Nature of States Parties' Obligations*, UN Doc. No. E/C.12/1991/23 (1990), and General Comment No. 14, *The Right to the Highest Attainable Standard of Health*, UN Doc. No. E/C.12/2000/4 (2000).
10. "It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable." ESC Committee, General Comment No.14 (see note 9): para. 47.
11. The other four are the International Bank for Reconstruction and Development (IBRD), the Multilateral Investment Guarantee Agency (MIGA), the International Finance Corporation (IFC), and the International Centre for the Settlement of Investment Disputes (ICSID). Comments on the policies and activities of the World Bank Group seldom distinguish among these five institutions, mainly because they share a single operational structure and because they often refer to themselves as the World Bank Group ("the World Bank" or "the Bank").
12. The IMF relies mainly on its own resources and repayments of earlier loans.
13. IMF Concessional Financing through the ESAF (Enhanced Structural Adjustment Facility) Fact Sheet (April 2004). Available at <http://www.imf.org/external/np/exr/facts/esaf.htm>.
14. In 1999, the IMF created its "Poverty Reduction Growth Facility," which replaced the "Enhanced Structural Adjustment Facility." See Poverty Reduction and Growth Facility Fact Sheet. Available at <http://www.imf.org/external/np/exr/facts/prgf.htm> (Retrieved December 4, 2004). Also see *World Bank Policies*. Available at <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/0,,contentMDK:20205580~menuPK:354639~pagePK:148956~piPK:216618~theSitePK:336992,00.html> (Retrieved December 4, 2004).
15. The five principles underlying the PRSP approach are: "country-driven, involving broad-based participation by civil society and the private sector in all operational steps; results-oriented, focusing on outcomes that would benefit the poor; comprehensive in recognizing the multidimensional nature of poverty and the scope of actions needed to effectively reduce poverty; partnership-oriented, involving coordinated participation of development partners (bilateral, multilateral, and non-gov-

ernmental); and based on a long-term perspective for poverty reduction." See <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPRS/0,,contentMDK:20175659~menuPK:490516~pagePK:148956~piPK:216618~theSitePK:384201,00.html>. See also World Bank, *Source Book for Poverty Reduction Strategies*. Available at <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPRS/0,,contentMDK:20175742~pagePK:210058~piPK:210062~theSitePK:384201,00.html> (Retrieved December 4, 2004); IMF, Poverty Reduction Strategy Papers Fact Sheet. Available at <http://www.imf.org/external/np/exr/facts/prsp.htm> (Retrieved December 4, 2004).

16. Others argue they are really a World Bank initiative with the illusion of country ownership. See *Where Is the Impact?* Joint NGO Briefing Paper—CAFOD, Oxfam International, World Vision, Christian Aid, Bretton Woods Project, EURODAD, Save the Children, WaterAid. Available at http://www.oxfam.org.uk/what_we_do/issues/debt_aid/downloads/wb_imf_impact.pdf (Retrieved December 4, 2004); F. Stewart and M. Wang, "Do PRSPs Empower Poor Countries and Disempower the World Bank, Or Is it the Other Way Round?" Available at <http://www.yale.edu/yicas/globalization/stewart.pdf> (Retrieved December 4, 2004). Also see The Bretton Woods Project. Available at <http://www.BrettonWoods Project.org> (Retrieved December 4, 2004).

17. Following a three-year consultative process, the World Bank updated its lending policy in August 2004, adopting Operational Directive 8.60. This new policy moves the Bank from adjustment lending to development policy lending. As with PRSPs, one of the main focuses is on country ownership, and the policy notes that research shows "the importance of designing policy-based lending to reflect the country's development priorities." World Bank Operations Policy and Country Services, "From Adjustment Lending to Development Policy Lending: Update of the World Bank Policy" (August, 2004). Available at <http://lnweb18.worldbank.org/SCSL+Dev/OD+8.60/CW-OD-860.nsf/F0ADFBB30FC702BD85256BDC004D7896/0F2C0558A36E474285256BDC00502215?Open Document>, p. 5 (Retrieved December 4, 2004).

18. See sources cited in note 16 and ActionAid USA/ActionAid Uganda, *Questions for Civil Society about the Limits of Participation in PRSPs*. Available at http://www.actionaidusa.org/pdf/rethinking_participation_april04.pdf (Retrieved December 4, 2004).

19. Universal Declaration of Human Rights (UDHR), G.A. Res. 217A (III), UN GAOR, Res. 71, UN Doc. A/810 (1948).

20. The World Bank, *Development and Human Rights: The Role of the World Bank* (Washington, DC: 1998). Available at <http://www.worldbank.org/html/extdr/rights/> (Retrieved December 4, 2004).

21. C. Jayarajah, et al., *Social Dimensions of Adjustment: World Bank Experience 1980-93* (Washington, DC: World Bank, 1996): p. 132.

22. J. Hanlon, *Mozambique: Who Calls the Shots?* (London: James Currey, 1991): p.137.

23. C. F. Doeblner, "The Right to Health of Children and the World Bank," *Health and Human Rights* 5/2 (2001): p.132, citing H. Helberg, "The Impact of Recession and Adjustment on Health in Developing

- Countries," in K. Haq and U. Kirdar (eds), *Human Development, Adjustment and Growth* (Islamabad: NRST/UNDP 1987): pp. 208, 216.
24. A. Sfeir-Younis, interview on the World Bank web site. Available at <http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20143686~menuPK:34457~pagePK:34370~piPK:34424~theSitePK:4607,00.html> (Retrieved December 4, 2004).
25. N. Koppel, "Programs to Help Poor Nations Criticized," Associated Press (July 8, 2003). Available at <http://www.globalexchange.org/campaigns/wbimf/770.html> (Retrieved December 4, 2004).
26. These include inflation, Dutch Disease, and other effects on domestic demand. See J. Mackinnon, A. Thomson, I. Hakizinka, and L. Rugwabiza, *The Impact of Increases in Public Expenditure on Poverty in Rwanda; PRSP Monitoring and Synthesis Project, Poverty and Social Impact Analysis, Country Study: Rwanda*. Available at http://www.prspsynthesis.org/Rwanda_Final_PSIA.doc. pp. 21-29 (Retrieved December 4, 2004).
27. ESC Committee, General Comment No. 14 (see note 9).
28. Convention on the Rights of the Child (see note 2): art. 24/4.
29. See note 23: p. 125.
30. ESC Committee, General Comment No. 3 (see note 9): para. 9.
31. S. Gruskin and D. Tarantola, Health and Human Rights, François-Xavier Bagnoud Center for Health and Human Rights Working Paper Series, No. 10, December 2000.
32. S. Leckie, "Another Step Towards Indivisibility: Identifying the Key Features of Violations of Economic, Social and Cultural Rights," *Human Rights Quarterly* 20/1 (1998): p. 94.
33. ESC Committee, General Comment No. 3 (see note 9), para. 9.
34. Articles 55 and 56 of the UN Charter provide that all states are obliged to cooperate in the realization of universal respect for and observance of human rights and to further conditions of economic and social progress and development. The international community recognized this obligation in the Declaration on the Right to Development, adopted December 4, 1986, G.A. Res. 41/128, UN GAOR, 41st Sess., at 3.
35. With regard to core obligations, the Maastricht Guidelines state, "Violations of the Covenant occur when a State fails to satisfy what the Committee on Economic, Social and Cultural Rights has referred to as 'a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights [...]. Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, *prima facie*, violating the Covenant.' Such minimum core obligations apply irrespective of the availability of resources of the country concerned or any other factors and difficulties." (para. 9) "The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights," adopted January 22-26, 1997, reprinted in *Human Rights Quarterly* 20 (1998): pp. 691-704.
36. ESC Committee, General Comment No. 3 (see note 9): para. 10.
37. The Committee also confirms that the following are obligations of comparable priority:

- (a) To ensure reproductive, maternal (pre-natal as well as post-natal), and child health care;
- (b) To provide immunization against the major infectious diseases occurring in the community;
- (c) To take measures to prevent, treat, and control epidemic and endemic diseases;
- (d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
- (e) To provide appropriate training for health personnel, including education on health and human rights.

ESC Committee, General Comment No. 14 (see note 9): paras. 43, 44.

38. "It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable." *Ibid.*: para. 47.

39. CRC article 24 states: States parties shall pursue full implementation of this right and, in particular shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the framework of primary health care, through *inter alia*, the application of readily available technology and through the provision of adequate nutritious food and clean drinking water, taking into consideration the dangers and risks of environmental pollution; (d) To ensure appropriate pre-natal and post-natal health care for mothers; (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; (f) To develop preventive health care, guidance for parents and family planning education and services.

40. The World Bank Group, *The Minimum Package of Health Services: Criteria, Methods and Data* (1995) Available at http://www.worldbank.org/html/extdr/hnp/health/hlt_svcs/pack2.htm (Retrieved December 4, 2004).

41. "The AIDS prevention intervention is based on 2.5% of the adult population aged 15-59 classified as commercial sex workers, who need bi-monthly AIDS prevention visits." *The Minimum Package of Health Services, Public Health Interventions*, The World Bank Group, 1995. Available at http://www.worldbank.org/html/extdr/hnp/health/hlt_svcs/pack2c.htm#interventions (Retrieved December 4, 2004).

42. ESC Committee, General Comment No. 14 (see note 9): para. 44.

43. The World Bank Group, *The Minimum Package of Health Services, Overall Results* (1995). Available at http://www.worldbank.org/html/extdr/hnp/health/hlt_svcs/pack2d.htm#results (Retrieved December 4, 2004)

44. See note 21: pp.195-196.

45. See note 22: p.180.

46. This lecture and the following discussion were published in their entirety on the World Bank web site. See P. Piot, *AIDS: The Need for an*

Exceptional Response to an Unprecedented Crisis, Presidential Fellows Lecture at the World Bank (November 2003). Available at <http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:20140527~menuPK:34476~pagePK:34370~piPK:34424~theSitePK:4607,00.html> (Retrieved December 4, 2004).

47. Ibid.

48. C. Wendo, "Uganda Stands Firm on Health Spending Freeze," *The Lancet* 360/9348 (2002). Available at <http://www.thelancet.com/journal/vol360/iss9348/artid/23508> (Retrieved December 4, 2004).

49. T. Dawson, *The Debate on Aid Flows to Uganda: The IMF's Point of View* (July 7, 2002]. Available at <http://www.imf.org/external/np/vc/2002/060702.htm> (Retrieved December 4, 2004).

50. P. Le Houerou and R. Taliercio, *Medium Term Expenditure Frameworks: From Concept to Practice*. Preliminary Lessons from Africa, Africa Region Working Paper Series No. 28 (February 2002). Available at <http://www1.worldbank.org/publicsector/pe/MTEF-final.doc> (Retrieved December 4, 2004).

51. Ibid.

52. Ibid.

53. Cited in Oxfam Briefing Paper, "The IMF and the Millennium Goals: Failing to Deliver for Low Income Countries" (September 2003). Available at http://www.oxfam.org.uk/what_we_do/issues/debt_aid/downloads/bp54_imfmndgs.pdf (Retrieved December 4, 2004).

54. R. Dodd, E. Hinshelwood, and C. Harvey, *PRSPs: Their Significance for Health: Second Synthesis Report* (WHO, 2004). Available at http://poverty.worldbank.org/files/14032_whohdpprsp.pdf (Retrieved December 4, 2004).

55. An outline of PRSP requirements and PRSP revisions based on Annual Progress Reports can be found at <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPRS/0,,menuPK:384209~pagePK:162100~piPK:159310~theSitePK:384201,00.html> (Retrieved December 4, 2004). Also see the discussion of renegotiating PRSP terms in "The Process of Negotiation" in J. Mackinnon et al. (see note 26): p. 23.

56. C. Wendo, "Uganda and the Global Fund Sign Grant Agreement," *The Lancet* 361/9361(2003). Available at <http://www.thelancet.com/journal/vol361/iss9361/full/llan.361.9361.news.24945.1> (Retrieved December 4, 2004). Also see C. Wendo, "Ugandan Officials Negotiate Global Fund Grants," *The Lancet* 363/9363 (2004). Available at <http://pdf.thelancet.com/pdf-download?uid=llan.363.9404.news.28415.1&x=x.pdf>.

57. See note 26.

58. See discussion on PRSPs as planning versus fundraising instruments in Poverty Reduction Strategy Paper: Their Significance for Health: Second Synthesis Report: p. 13. Available at <http://www.who.int/hdp/en/prspssig.pdf> (Retrieved December 4, 2004).

59. The Government of Rwanda, Poverty Reduction Strategy Paper. Available at http://poverty.worldbank.org/files/Rwanda_PRSP.pdf (retrieved December 4, 2004).

60. J. Mackinnon (see note 26).

61. Ibid.: p. 24.

62. In many countries only the IMF and World Bank have the capacity to perform the required detailed economic analysis in a short time. In this example, “the government did not have the capacity to produce its own scenarios to compare with the IMF model, so that the macroeconomic scenarios used in the negotiations were prepared by the IMF and understandably reflected the IMF’s concerns.” *Ibid.*: p. 23.

63. “Uganda and Tanzania both provide striking examples where the Government was able to persuade the IMF to accommodate higher expenditure by procuring independent macroeconomic analysis that commanded the respect of IMF staff.” *MDG-Orientated Sector and Poverty Reduction Strategies: Lessons from Experience in Health*. Available at <http://www.hlfhealthmdgs.org/Documents/MDGorientedPRSPs-Final.pdf> (Retrieved December 4, 2004). This confirms the preeminence of macroeconomic concerns and the fact that IMF economists need to be persuaded before changes are approved. The IDA generally supports policies that the IMF has approved.

64. The CMH was composed of 18 of the world’s leading economists, public health experts, development professionals, and policymakers and was chaired by Professor Jeffrey Sachs, then director of the Center for International Development at Harvard University, now of the Earth Institute of Columbia University.

65. Commission on Macroeconomics and Health. Available at http://www.cmhealth.org/cmh_desc.htm (Retrieved December 4, 2004).

66. L. Kumaranayake, C. Kurowski, and L. Conteh, *Costs of Scaling up Priority Health Interventions in Low-income and Selected Middle-income Countries: Methodology and Estimates*, CMH Working Paper Series, WG 5/18. Available at http://www3.who.int/whosis/cmh/cmhpapers/e/pdf/wg5_paper18.pdf (Retrieved December 4, 2004).

67. The costing exercise included some access to AIDS treatment, but the cost of reaching the “3 by 5” target would increase the amount required. “3 by 5” is a WHO/UNAIDS initiative providing a detailed and concrete plan to provide antiretroviral treatment to 3,000,000 people living with AIDS in developing countries and those in transition, by the end of 2005. Available at <http://www.who.int/3by5/en/> (Retrieved December 4, 2004).

68. This paper focuses on the level of international aid required to satisfy core obligations. However, if the debt burden of developing nations were significantly reduced or eliminated, and terms of trade were fairer, the amount of aid required would diminish. See Jubilee Research. Available at <http://www.jubilee2000uk.org/> (Retrieved December 4, 2004).

69. WHO Commission on Macroeconomics and Health, *Macroeconomics and Health: Investing in Health for Economic Development, Appendix 2: Analysis of the Costs of Scaling Up Priority Health Interventions in Low-and Selected Middle-Income Countries*. Available at http://www3.who.int/whosis/cmh/cmhp_report/e/pdf/157-176.pdf (Retrieved December 4, 2004).

70. A separate team of WHO researchers finalized another costing exercise, using an entirely different approach. They analyzed the relation between levels of population health (mainly healthy life expectancy) and health expenditure and concluded that “efficiency is positively related to health expenditure per capita. Performance increased greatly with expen-

diture up to about \$80 per capita a year, suggesting it is difficult for systems to be efficient at low expenditure. There seems to be a minimum level of health expenditure below which the system simply cannot work well. We estimate it would cost just over \$6bn a year (<0.3% of global annual health expenditure) to increase health spending to this threshold in the 41 countries with lowest expenditures." D. Evans et al. Available at <http://bmj.bmjjournals.com/cgi/reprint/323/7308/307> [Retrieved December 4, 2004]. (Evans et al., used 1997 US dollars adjusted for the cost of a generic basket of goods in different settings, while the CMH used 2002 US dollars; therefore, the two different figures do not necessarily contradict each other—they reinforce one another.)

71. See Annex 1 for a comparison of the CMH's priority health interventions and core obligations.

72. How should we understand the core obligation, "To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs?" ESC Committee, General Comment No. 14 (see note 9): para. 43. If we understand it as an obligation to provide as many of these essential medicines as possible, to as many people who need them as possible, then it becomes just one of the elements of the right to health to be realized progressively. Then it wouldn't make any sense to call it a core obligation for which "a State party cannot, under any circumstances whatsoever, justify its non-compliance." Ibid.: para. 47. If, however, we understand it as an obligation to provide all essential drugs (as defined by the WHO) to all people who need them, without any delay, then it might be an unreasonable demand on some States parties, where a large proportion of the population has no access to health facilities. If a State party fails to meet CMH targets, then a significant number of its inhabitants are deprived of essential primary health care. If anything, the CMH targets fall short of the obligation to provide essential primary health care, as they "tolerate" a significant number of individuals being deprived of essential primary health care. However, we consider the CMH targets to be "expert advice" on what is reasonable and achievable. States parties cannot, under any circumstances whatsoever, justify non-achievement of these targets, taking into account "that it is particularly incumbent on States parties and other actors in a position to assist, to provide 'international assistance and cooperation, especially economic and technical' which enable developing countries to fulfil their core and other obligations ..." Ibid.: para. 45. Thus, we argue that achieving CMH targets is a core obligation. To accept that the achievement of CMH targets is anything less than a core obligation would deprive the concept of core obligations of its meaningful content. As the Committee notes, "a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, *prima facie*, failing to discharge its obligations under the Covenant." General Comment No. 3 (see note 9): para. 10.

73. General Comment No. 3 (see note 9), para.13, outlines when the responsibility of other (wealthier) states is triggered: "A final element of article 2 (1), to which attention must be drawn, is that the undertaking given by all States parties is 'to take steps, individually and through in-

ternational assistance and cooperation, especially economic and technical.” The Committee notes that the phrase “to the maximum of its available resources” was intended by the drafters of the Covenant to refer to both the resources existing within a State and those available from the international community through international cooperation and assistance.” Ibid.: para. 13.

74. For example, in its concluding observations to Belgium, “The Committee notes with concern that, in 1998, Belgium devoted only 0.35 per cent of its gross domestic product (GDP) to international cooperation, while the United Nations recommendation in this regard is 0.7 per cent of GDP for industrialized countries.” Concluding Observations of the Committee on Economic, Social and Cultural Rights on Belgium’s second periodic report on the implementation of the International Covenant on Economic, Social and Cultural Rights, UN Doc. E/C.12/1/Add.54 (2000): para. 16. In contrast, in its concluding observations to Sweden, “The Committee acknowledges that the State party for many years has allocated 0.7 per cent or more of its gross domestic product to development assistance, thereby meeting and sometimes surpassing the United Nations goal and contributing to the realization of economic, social and cultural rights in other countries.” Concluding Observations of the Committee on Economic, Social and Cultural Rights on Sweden’s fourth second periodic report on the implementation of the International Covenant on Economic, Social and Cultural Rights, UN Doc. E/C.12/1/Add.70 (2001: para. 7.

75. All are major development aid recipients. See OECD/DAC Aid Statistics. Available at <http://www.oecd.org/dataoecd/40/27/7504863.PDF> (Retrieved December 4, 2004).

76. A Poverty and Social Impact Analysis (PSIA) has been conducted for all three, which provides additional data for analysis. “PSIA aims to improve policy formation in low-income countries and is hailed as a key element both of national PRS processes, and in the design of IMF and World Bank lending programmes. PSIA is an approach for assessing the effects of policy change on the well being of different groups in society ... The focus is primarily on poor groups, but not exclusively; in some cases it is the (politically influential) non-poor that lose out most from a change in policy ... PSIA performs several roles in improving policy formation: Making the assumptions about all linkages between poverty and reform decisions as clear and explicit as possible; Ensuring that policies are not judged solely on long-term aggregate economic efficiency grounds, and Improving the quality of debate over reforms, opening up an avenue for negotiation between different stakeholders, and in particular between (and within) government, civil society and donors,” *Briefing Notes*. Available at <http://www.prspsynthesis.org/> (Retrieved December 4, 2004).

77. The region has made little or very slow progress toward achieving the Millennium Development Goals. See http://www.developmentgoals.org/Sub-Saharan_Africa.htm (Retrieved December 4, 2004).

78. The 2002/2003 health budget was 300 billion Ugandan Shillings. At a current exchange rate of 1,860 Ugandan shillings to US\$1 and a population of 21 million, this is a per capita budget of less than US\$ 8. The

Government of Uganda, Poverty Reduction Strategy Paper. Available at <http://poverty.worldbank.org/files/Uganda%20IPRSP.pdf> (Retrieved December 4, 2004). The MTEF ceilings are found on page 62.

79. The health budget for 2004 is set at 10.6 billion Rwandan francs, which at the current exchange rate of 470 Rwandan francs to US\$1 and a population of 8 million, results in a per capita health budget of less than US\$3. The Government of Rwanda, Poverty Reduction Strategy Paper. Available at http://poverty.worldbank.org/files/Rwanda_PRSP.pdf (Retrieved December 4, 2004). The MTEF is referred to on page 126.

80. The health sector budget for 2005 is 4,340 billion Mozambican meticais, or US\$161 million (based on an estimated exchange rate of 26,937 Meticais per US\$1), which is just below US\$9 per capita (the population of Mozambique is 18 million). Government of Mozambique, Action Plan for the Reduction of Absolute Poverty, April 2001. Available at http://poverty.worldbank.org/files/Mozambique_PRSP.pdf (Retrieved December 4, 2004). The MTEF is referred to on page 124.

81. The World Bank Group, *PRSPs Questions and Answers*. Available at <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPRS/0,,contentMDK:20175659~menuPK:490516~pagePK:148956~pPK:216618~theSitePK:384201,00.html>.

82. European Commission, *Update on the EC Programme for Action: Accelerated Action on HIV/AIDS, Malaria and Tuberculosis in the Context of Poverty Reduction* (February 2003). Available at http://europa.eu.int/eur-lex/en/com/cnc/2003/com2003_0093en01.pdf#zoom=100 (Retrieved December 4, 2004).

83. The United Nations Development Group recently reaffirmed "the central and growing importance of PRSPs in national development and international cooperation" and reaffirmed its engagement in the PRSP process. Guidance Note on UN Country Teams Engagement in PRSPs, UN Development Group (August 30, 2004). Available at <http://www.undp.or.id/mdg/documents/Guidance%20for%20UNCT%20in%20PRS.P.pdf> (Retrieved December 4, 2004).

84. The Global Fund, *Country Coordinating Mechanisms*. Available at <http://www.theglobalfund.org/en/apply/mechanisms/> (Retrieved December 4, 2004).

85. WHO and World Bank, *Resources, Aid Effectiveness and Harmonization*. Prepared for the High-Level Forum on the Health Millennium Development Goals. Available at <http://www.who.int/hdp/en/IP2-resources.pdf> (Retrieved December 4, 2004).

86. See note 26: p. 24.

87. "In the 1960s, the Netherlands experienced a vast increase in its wealth after discovering large natural gas deposits in the North Sea. Unexpectedly, this ostensibly positive development had serious repercussions on important segments of the country's economy, as the Dutch guilder became stronger, making Dutch non-oil exports less competitive. This syndrome has come to be known as 'Dutch disease.' Although the disease is generally associated with a natural resource discovery, it can occur from any development that results in a large inflow of foreign currency, including a sharp surge in natural resource prices, foreign assistance, and foreign direct investment." C. Ebrahim-Zadeh, "Dutch Disease: Too Much

Wealth Managed Unwisely," *Finance & Development* 40/1 (2003). Available at <http://www.imf.org/external/pubs/ft/fandd/2003/03/ebra.htm> (Retrieved December 4, 2004).

88. For a comprehensive examination of aid-induced Dutch Disease see, C. S. Adam and D. L. Bevan, *Aid, Public Expenditure and Dutch Disease*, (February 7, 2003). Available at <http://econwpa.wustl.edu/eps/dev/papers/0409/0409027.pdf> (Retrieved December 4, 2004).

89. A. Fedelino and A. Kudina, *Fiscal Sustainability in African HIPC Countries: A Policy Dilemma?*, IMF Working Paper WP/03/187. Available at <http://www.imf.org/external/pubs/ft/wp/2003/wp03187.pdf> (Retrieved December 4, 2004).

90. Professor Omaswa, as quoted in W. Nyamugasira and R. Rowden, *New Strategies, Old Loan Conditions* (April 2002). Available at <http://www.brettonwoodsproject.org/topic/adjustment/ugandaanalysis.pdf> (Retrieved December 4, 2004).

91. "It is sometimes claimed that foreign capital, like an abundance of natural resources, can have a negative influence on developing country performance via the so-called "Dutch Disease" which, in its narrow definition, focuses on the exchange rate, rendering it unduly strong and thus discouraging possible labor-intensive exports. Given the diminishing role of World Bank lending in most countries, this relatively narrow interpretation of the Dutch Disease probably does not carry a lot of weight." G. Ranis, *Ownership, Dutch Disease, and the World Bank*, (New Haven, CT: Yale University, April 2003). On file with authors.

92. See *Financial Times*, "US Treasury Secretary Rejects IMF Claim that Uganda Cannot Absorb Further Aid." Available at <http://www.jubilee2000uk.org/worldnews/africa/uganda290502.htm> (Retrieved December 4, 2004).

93. "It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable." ESC Committee, General Comment No.14 (see note 9): para. 47.

94. World Bank members include both donor and recipient countries. Recipient nations that are States parties to the International Covenant and CRC have the obligation to respect, protect, and fulfill the human rights of those under their jurisdiction. In many cases they require the assistance of wealthy nations (e.g., World Bank donors) to fulfill their obligations. Donor States parties have an obligation to assist developing countries in realizing their international human rights obligations. The ability of recipient nations to lobby for policies allowing them to respect, protect, and fulfill, at a minimum, their core obligations, would be greatly enhanced if donor States parties joined forces with them.

95. IDA, *Votes and Subscriptions, Voting Power of Member Countries*. Available at <http://web.worldbank.org/WBSITE/EXTERNAL/EXTABOUTUS/ORGANIZATION/BODEXT/0,,contentMDK:20124822~isCURL:Y~menuPK:64020035~pagePK:64020054~piPK:64020408~print:Y~theSitePK:278036,00.html> (Retrieved December 4, 2002).

96. The 76.28% includes both donor and recipient countries. Office of the United Nations High Commissoner for Human Rights, *Status of*

Ratifications of the Principal International Human Rights Treaties (As of June 9, 2004). Available at <http://www.unhchr.ch/pdf/report.pdf>.

97. *IDA, Report from the Executive Directors of IDA to the Board of Governors—Additions to IDA Resources: Thirteenth Replenishment* (July 2002). Available at <http://siteresources.worldbank.org/IDA/Resources/FinaltextIDA13Report.pdf> (Retrieved December 4, 2004).

98. "States parties have an obligation to ensure that their actions as members of international organizations take due account of the right to health. Accordingly, States parties which are members of international financial institutions, notably the International Monetary Fund, the World Bank, and regional development banks, should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions." ESC Committee, General Comment No.14 (see note 9): para. 39.

99. *Poverty Reduction Strategy Papers: Their Significance for Health: Second Synthesis Report*. Available at <http://www.who.int/hdp/en/prspsig.pdf>, p. 5 (Retrieved December 4, 2004).

100. See note 35.

101. "The obligations of States to protect economic, social and cultural rights extend also to their participation in international organizations, where they act collectively. It is particularly important for States to use their influence to ensure that violations do not result from the programmes and policies of the organizations of which they are members. It is crucial for the elimination of violations of economic, social and cultural rights for international organizations, including international financial institutions, to correct their policies and practices so that they do not result in deprivation of economic, social and cultural rights. Member States of such organizations, individually or through the governing bodies, as well as the secretariat and nongovernmental organizations should encourage and generalize the trend of several such organizations to revise their policies and programmes to take into account issues of economic, social and cultural rights, especially when these policies and programmes are implemented in countries that lack the resources to resist the pressure brought by international institutions on their decision-making affecting economic, social and cultural rights." Ibid.: point 19.

102. J. Sachs, *A New Global Consensus on Helping the Poorest of the Poor* (April 2000). Available at http://www.worldbank.org/research/abcde/washington_12/pdf_files/sachs2.pdf (Retrieved December 4, 2004).

103. Lilani Kumaranayake, Christoph C.Kurowski, and Lesong L. Conteh, Costs of Scaling Up Priority Health Interventions in Low-income and Selected Middle-income Countries: Methodology and Estimates, Working Group 5 Paper No. WG5: 19 (2001). Available at http://www.cmhealth.org/docs/wg5_paper19.pdf.

104. ESC Committee, General Comment 14 (See note 14): paras. 43-44.

tries that lack the resources to resist the pressure brought by international institutions on their decision-making affecting economic, social and cultural rights ." Ibid, point 19).

102. J. Sachs, A New Global Consensus on Helping the Poorest of the Poor, April 2000, available at http://www.worldbank.org/research/abcde/washington_12/pdf_files/sachs2.pdf (retrieved December 4, 2004).