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Citation for published version

Haastrup, Toni and Sekalala, Sharifah (2018) What have Rights got to do with it? Evaluating 'Human Rights' as a practice within the Global Fund. Global Health Governance, 12 (1). pp. 75-86.

DOI

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What Have Rights Got To Do With It?
Evaluating 'Human Rights' As A Practice Within the Global Fund

Sharifah Sekalala and Toni Haastrup

INTRODUCTION

New Global Health initiatives, such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), Global Alliance on Vaccines and Immunisations (GAVI), UNITAID, Joint United Nations Program on HIV/AIDS (UNAIDS), and foundations such as the Bill and Melinda Gates Foundation, have been critical to the increase in global health financing. From 2000 to 2010, global health financing grew by 11.4 percent annually. Although this growth slowed from 2010 to 2015, global health financing is still high, with US$ 36.5 billion of financing disbursed in 2015. Some of the largest providers have been the US and UK governments (US$ 13.1 billion and US$ 4.1 billion, respectively) and the Gates Foundation (US$ 2.9 billion).[1]

The bulk of health financing is administered through global health organizations, making them formidable players in the field of global health.[2] Much of the previous focus on these initiatives and organizations has been on their efficacy, but, as the editors of this Special Issue argue, the contribution of these global health organizations to advancing other normative areas, such as human rights, has been overlooked. This is particularly important, because we generally know that international organizations can shape important normative practices of actors, including states, at the domestic level.[3]

In this article, we focus on the inclusion of human rights within the remit of the GFATM. The GFATM is a global health governance organization, which was established in 2002 to disburse funds to developing countries to enable them to fight AIDS, tuberculosis, and malaria. Human rights have always been integral to this, as using a rights approach at the national level can tackle discrimination, which helps people to overcome barriers to contracting these diseases domestically, and enables states to create better access to services. Additionally, human rights approaches not only help to fight against discrimination and stigma but they can also contribute to improvements of social determinants of health, such as food, water, sanitation, housing, and education, all of which are essential in creating effective responses to these diseases. Consequently, the GFATM has sought to integrate human rights within its financing.

Most states that receive GFATM funding are already signatories to numerous human rights treaties, which illustrates some willingness to integrate human rights norms within their health governance practices. However, evidence suggests that there is a still a lack of "sustained behaviour and…practices that conform to …international human rights norms."[4]

In this article, we want to understand the relationship between states and global health financing organizations and how they seek to advance human rights in their grant programs. We therefore ask: to what extent can global financing institutions shape human rights practices at the domestic level? The article uses the case study of the GFATM's experience of adopting human rights as an institutional norm and analyzes the implications for the institution's new role as a human rights actor within states. In particular, we argue that the institutional design of the institution impacts on the ability of the GFATM to substantively enhance human rights agendas within local health governance contexts.

The article will proceed as follows: we first present a short history of the GFATM and its processes of integrating human rights concerns within its work. Through the application of sociological institutionalism in the following section, the article elaborates on the motivations and implications of the GFATM's practices. The sociological

institutionalism framework can give us a better understanding of the implications of including new norms within global health governance institutions. The final section highlights the tensions between the primary aims of the GFATM as a funding agency, its obligations as a human rights norm entrepreneur, and how it has adapted in these situations. Thus, we argue that the GFATM has had to adapt its institutional system in order to meaningfully promote a human rights agenda in global health governance, particularly at the domestic level. In the conclusion, we underscore the importance of institutional context for understanding the constraints and opportunities for attaining health-related human rights.

ADOPTING HUMAN RIGHTS IN THE GFATM: MOTIVATION AND MECHANISMS

The GFATM is a public private partnership (PPP) and not a traditional international organization. PPPs are defined as "voluntary and collaborative relationships between various parties both State and non-State in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks, responsibilities and benefits."[5] As a PPP, the GFATM relies on several UN agencies, which have specific expertise to help in the grant implementation process. These include three ex officio members without voting rights: UNAIDS, the World Health Organization (WHO), and the World Bank, which acts as a trustee to the GFATM. Other organizations—including the United Nations Children's Fund (UNICEF), the United Nations Development Program (UNDP), the United Nations Population Fund (UNFPA), the United Nations' Refugee Agency (UNHCR), and the World Food Program (WFP)—all play distinct roles in ensuring health services are delivered to domestic contexts. These UN agencies have human rights obligations under international law and must bear some responsibility for human rights violations on GFATM funded programs.[6]

As a PPP, the legal personality of the GFATM is ambiguous under international law. When international organizations have legal personality, they can conclude treaties, bring claims under international law, and be held responsible for violations of this law (including human rights violations). There is nothing in the GFATM bylaws, however, that indicates that its founders ever intended to give it these powers.[7]

In this context, it is not party to the International Covenant on Economic Social and Cultural Rights (ICESCR), which enshrines the right to health. There is, however, a positive duty under *General Comment No 14* for international organizations to cooperate effectively with States in order to realize the legal obligations that would enable them to maintain a right to health.[8] This was the view taken in 2012 by the Special Rapporteur on the right to health, who argued that, international funders should ensure that their financial assistance enables countries to achieve the right to health. This is a positive duty and the onus still remains on the state to fulfill any human rights obligations.

Benjamin Mason Meier noted the new era of normativity in global health that allows for consideration of human rights in how the GFATM works with states.[9] This is manifested through the ways in which global health actors instigate new normative frameworks with the aim of transforming global health governance. Human rights norms are particularly attractive for these global actors because of their universal nature, as most countries have signed the nine core human rights treaties.

From the GFATM's inception in 2002, it was clear that it espoused human rights values of non-discrimination in its foundational documents.[10] In 2008, the GFATM introduced a Gender Equality Strategy, and in 2009, it approved a Sexual Orientation and Gender Identities Strategy as part of its burgeoning human rights strategies. These strategies demand that countries applying for financing illustrate how the grant attempts to address some of the human rights challenges of women and sexual minorities to create better responses to AIDS, malaria, and tuberculosis.

For any of this to work, it is worth examining how the GFATM understands its own role within the global health governance arena that it seeks to operate. In order to be eligible for grants, countries applying for GFATM programs submit proposals, which are reviewed by a panel of independent experts known as the Technical Review Panel (TRP) and are considered for approval by the GFATM Board. The TRP is a board of independent experts who assess the proposal for things, including potential for impact and soundness of approach. They look at human rights implications of the proposal as part of this process.[11]

When the GFATM restructured its funding mechanism to include human rights, its aim was to ensure better human rights outcomes in funded projects and create more accountable forms of funding for health outcomes. This would include new stakeholders at the domestic level. These new stakeholders, Key Affected Populations (KAPs), are a central component of the new funding mechanism. As part of the new procedure for applying for funding, each country is given a fixed allocation of resources. The Country Coordinating Mechanism (CCM), which should have a wider number of participants from KAPs, is then tasked with engaging in a country dialogue process. This deliberative process aims to consider the epidemiological data, national health strategic plans and the past performance of health programs in order to draft a concept note and budget. These are then submitted to the GFATM for consideration.[12] The TRP reviews each country submission and may recommend that the country make changes to areas of the concept note in order to prioritize better the needs of the KAPs.[13]

The GFATM has also hired evaluators who are conversant in human rights practice to ensure that members of the KAPs can meaningfully participate in the design, implementation, and monitoring of GFATM-funded programs. To make this possible, the GFATM Board provided US$ 15 million to support broader inclusion through greater representation when making concept notes. Furthermore, the GFATM tightened its rules, stating that greater participation of civil society and community groups as primary and sub recipients of grants would be essential to better service delivery and implementation of grants.

The broadening of participation has been successful in some countries. For instance, in Morocco, the CCM now has a selection of 5 voting members (out of 33) to represent vulnerable and most-at-risk populations (the other two represent people living with HIV and affected by tuberculosis). Creating broader participation was particularly tricky in a country where there were no existing associations representing these groups, because homosexuality, prostitution, and drug use are all illegal. The successful incorporation of these groups was due to civil society involvement. [14]

The GFATM also stipulated minimum requirements human rights standards in Global Funded programs, particularly non-discriminatory access to services; respecting and protecting informed consent; confidentiality and the right to testing and treatment; the use of only scientifically sound and approved medicines and medical practices; not employing methods that constitute torture or cruel, inhuman, or degrading treatment; and the use of medical detention only as a last resort. Furthermore, the GFATM also created more stringent mechanisms for reporting human rights violations.[15] By creating these human rights strategies, and making it fundamental to its routinized practices, the GFATM has been pushing a human rights agenda within health funding for HIV/AIDS, malaria, and tuberculosis.

Yet, despite these many commitments, the PPP structure of the GFATM means that it is not an implementing organization, so it relies on the principle on country ownership, which transfers the role of implementation to domestic actors. This means that countries are supposed to drive the process of deciding their domestic health priorities, with the GFATM acting merely as a financing agent. This aims to make programs more sustainable. Many stakeholders, including donors, activists, and scholars, were critical of the fact that some countries who had received GFATM funding for HIV/AIDS were

persisting with discriminatory laws and policies, which jeopardized AIDS-related programs. There were also serious concerns regarding the long-term sustainability of GFATM funding in countries where human rights were being routinely violated.

So why has the human rights implementation been difficult in the context of this global health institutional configuration? In the following section, we consider the institutional contexts, and especially constraints, in institutional design that impact on the GFATM's ability to influence domestic actors who also function within the global health institution.

ADOPTING HUMAN RIGHTS: INSIGHTS FROM SOCIOLOGICAL INSTITUTIONALISM

New institutionalist theory understands institutions to be formal and informal "sets of *mutual expectations* between people, that have become more or less *enduring*, and that have crystalized into *rule systems*."[16] The practices that determine the outcome of a particular institution's policies are therefore determined by the routinized behaviors and actions that have been embedded as part of the design of the institution – this is, its core identity.[17]

Taking this definition of institutions for granted, the global health institution under consideration includes the GFATM, its funders, and the recipient states it funds.

At the time of institutional design, the founders of the GFATM were mainly concerned with efficient financing mechanisms to recipient countries. Human rights were an additional consideration with regards to the efficiency and sustainability of this new mode of funding. If there was a normative element to the establishment of the GFATM, it was simply to establish the standards through which other global health organizations and initiatives could fund pressing health problems. There was an idea that it needed to deal with notions of discrimination, but the onus was really on other actors and states to achieve this. As part of institutional set up, the GFATM relied on CCMs for implementation and as the means to achieving local ownership. CCMs include a wide range of stakeholders that prepare the funding application to the GFATM.[18] The CCM is intended to ensure local ownership by designing health initiatives that are most suited to local needs.[19]

Health financing and local ownership may be considered the GFATM's core organizational norms, since they serve as "standards of appropriate behaviour"[20] endogenously and exogenously in its relationship with states. Human rights are central to delivering this financing. In adding on this new norm, however, the GFATM is attempting to renegotiate the standards of appropriate behavior for actors within global health governance structures. In so doing, there is a direct attempt to change states' behavior "through both instrumental choice and social learning to adhere to these new values."[21] Further, this adoption of human rights norms raises expectations on the part of the states about the remit of the funder.

Sociological institutionalism suggests that the way through which new norms become transposed is through institutional isomorphism. Institutional isomorphism is the process whereby institutions adopt new practices because it is seen as the right thing to do. Given the proactive discourse around the right to health in the ICESCR and in General Comment 14, the GFATM arguably had a moral obligation, as a health-related agency, to consider what human rights means for its own area of global health governance. However, as an international funder, how far should the GFATM go in assuming responsibility for human rights violations in its funded programs?

While the introduction of new norms like human rights within the GFATM introduced new rules of appropriate behavior, there was no guarantee that other stakeholders would accept them, and we see some evidence of this later when we show how states challenged these norms through half-hearted compliance. In other words, it is possible to deviate from the intended rules, as the ultimate duty-bearer of human rights

obligations remains the state party. For the GFATM's aims to work, they needed to be fully accepted by the CCMs (in principle these are more inclusive than state parties, creating problems in implementation). Consequently, despite the efforts of certain actors (or agents) within the GFATM, there were gaps between norm commitment and compliance.

In the past, this lack of compliance by states that receive global funding manifested itself through domestic human rights failures in implementing GFATM grants. For instance, despite several attempts to try and make the CCMs representative, in order to ensure that the grants included suitable human rights initiatives for these groups, a 2010 survey of all the GFATM grants revealed that only eight percent of representatives on the CCMs came from people living with HIV/ AIDS.[22] This failure was acknowledged by the then head of the GFATM, Michel Kazatchkine, who argued that, "the lack of support for programs that protect and promote human rights is one of the failures in the response to AIDS."[23]

> The mismatch between the priorities of the actors within this institution, the GFATM, on the one hand, and the states on the other, can be explained by the actors within that institution. It is assumed that:
> actors may be 'rule makers' but take existing rules as a starting point for defining their own identities and interests. Conversely, actors may also be 'rule takers', but nonetheless modify or even overturn those rules from time to time.[24]

Institutionalization is a dynamic process that demands an understanding of the perspectives of all actors involved. In response to these failures that were critical to achieving effective grant implementation, the GFATM changed its grant model, explicitly committing to human rights in its 2012-2016 strategy.[25] As a result, the GFATM now aims to i) integrate human rights considerations through the grant cycle, ii) increase investments in programs that address human rights-related barriers to access, and iii) ensure that the GFATM does not support programs that infringe upon human rights.[26]. By explicitly asking for the inclusion of human rights considerations within its programs, the GFATM was also demanding that its recipient states take human rights seriously. Increasingly, therefore, we see the role of the GFATM changing to that of a "gatekeeper," creating a series of human rights safeguards, such as greater participation of key minority groups, or efforts to deal with discriminatory laws and policies, before it will allocate funding.

The GFATM inclusion of human rights processes and procedures into the core of what the institution does can be thought of as institutional layering. Institutional layering refers to a process where new elements are attached to old processes, not with the intention of replacing the core elements of an institution but in addition to it.[27] In this sense, whereas the GFATM is a funding initiative whose core aim is to fund and promote local ownership, it also champions the inclusion of human rights aimed at transforming the global health governance institution. In other words, it promotes human rights consciousness from states in order to enhance local participation.

According to Van der Heijden, layering is motivated by the desire to close the gap between intentions and outcomes.[28] In the GFATM's case, there are huge reputational costs for grants that are not complaint with human rights norms even though the obligation may be on the state party. Thus, the adding of extra human rights obligations on state parties enables the GFATM to realize its core aims and retain its legitimacy. In doing so, the GFATM has contended with several challenges. In the next section, we explore the limitations and adaptations that the GFATM has engaged in as a means to promote human rights.

THE CHALLENGES OF ADOPTING HUMAN RIGHTS BY A GLOBAL INSTITUTION

Although it has achieved a lot in terms of human rights, there are a number of constraints within the institution that make it difficult for the GFATM to achieve all its aims. First, organizations like the GFATM have often faced challenging institutional contexts, due to their reliance on donors and other UN agencies, which can have an impact on institutional capabilities. Second, the organization's focus on local (country) ownership as a model of governance has made it difficult to implement human rights in practice. Third, the organization had to contend with the amorphous nature of human rights, which is at odds with its performance-based funding model. Last, we argue that human rights are holistic, which means that it is hard for an organization to fund some rights at the expense of others.

Challenging Institutional Context

As we discussed above, the institutional design of the GFATM means that it not an implementing agency, relying on its donors to finance it adequately and state parties and other UN organizations to implement grants, which distances it from human rights obligations. All the partners have different agendas, which can make it difficult to prioritize human rights norms sufficiently. However, as an organization, the GFATM bears huge reputational costs if there are human rights violations on any of its grants.

For instance, in 2012, when human rights were introduced as an explicit norm of the GFATM, the institution also undertook a major restructuring, aimed at cutting costs, in order to try to appease its donors. This led to the departure of the executive director, Michel Kazatchkine. His departure precipitated the departure of many key personnel with human rights expertise and who had developed the gender and sexual minorities programmes.[29] This upheaval inevitably harmed implementation in many countries. Subsequently, the GFATM recruited new staff with longstanding expertise in human rights and introduced a Staff Human Rights Task Force.[30] The reality of being a funding agency as opposed to an implementation agency means that staff lack the resources necessary to police human rights behavior in all 140 countries at the same time.[31] To counter this, the GFATM has now given the Office of the Inspector General power to investigate human rights violations.[32] In instances where the Inspector General cannot investigate, the GFATM can share information with the relevant UN agencies that may have a normative institutional mandate to investigate.[33]

Reliance on Domestic Partners

The ability of an institution to implement human rights norms depends on states buying into the process. However, these states also must deal with competing interests from different stakeholders at the ground level, which makes it hard to use human rights to address inequality, as this approach often involves some redistribution of resources. A human rights focus that sticks to recognizing these vulnerabilities at the domestic level would be particularly problematic in countries where minorities, such as women in largely patriarchal societies, gay and lesbian groups, and drug users, are seeking rights that are currently enjoyed by the majority of citizens, as this often involves redistributing resources from the entrenched majority to minority groups.

Because of these considerations, states often refuse to prioritize human rights considerations when applying for grants from the GFATM. Data from UNAIDS' Fast-Track modeling illustrates that, in many instances, countries are simply not requesting funding for human rights interventions.[34] Tinashe Mundawarara, who is with Zimbabwe Lawyers for Human Rights, explained the rationale behind this within the South African context,

arguing that "there is less appreciation of the need to cultivate human rights-based responses in Southern Africa and, hence, less inclination to include them in proposals."[35]

The GFATM has, for instance, always tried to get the voices of minority groups in the application process of the grant, so that the human rights approaches countries apply are those that are most useful to communities. However, this process has sometimes been unsuccessful, and, even in those cases where the institution was able to attract more participants, this did not always translate to the prioritization of programs that focused on the specific human rights needs of people from KAPs.[36]

Moreover, greater participation does not necessarily translate into greater human rights protection, especially in health. Human rights participants and health professionals may have different agendas, and different human rights groups may also have different priorities for resource allocation.[37] Human rights advocacy groups are not homogenous. To use an example, a women's rights group may not automatically support the rights of female sex workers. Because the HIV/AIDS epidemic affects women who contracted AIDS, often from their husbands, sex workers may be perceived as part of the problem. There is thus no incentive to work toward the same outcomes, and they may even work at cross-purposes.[38] This raises questions about the practicalities of effecting changes in the context of existing domestic practice. In response, the GFATM is increasingly funding programs to enable traditionally vulnerable groups to access information, health services, and treatment.[39]

The GFATM has also tried to address the issue of repressive environments by creating spaces for these groups. For instance, the GFATM has arranged to fly representatives belonging to criminalized groups out of their home countries in order to give them the space to consult on human rights issues. This consultation period has been useful in raising awareness about the human rights issues of the LGBT population[40] in some countries.[41]

Other efforts to encourage participation include the introduction of alternative funding and targeted schemes to encourage participation of human rights groups. This includes funding for regional groupings, which has tended to focus primarily on issues affecting KAPs. For instance, in 2016, 15 Regional concept notes were submitted to the GFATM, which dealt with a diverse range of interventions, such as harm reduction for people who inject drugs, and the removal of legal barriers and supportive services for people with disabilities, and community system strengthening.[42]

In these cases, the GFATM has also used its public role to reaffirm that the commitment to human rights is contingent upon improving legal, policy, and social environments that hinder the scale-up of effective responses to HIV/AIDS, malaria, and tuberculosis. For instance, when Uganda passed its 2014 law on homosexuality, the GFATM was a vocal critique of these anti-discriminatory laws. The GFATM decried the new legislation for providing "significantly tough[er] punishments against gay people" with "grave implications for public health".[43] This kind of signaling is important in the promotion of human rights, as it adds to the universal understanding of what protections are necessary for minority groups in order to make the most of GFATM programs.

The Problem of Measuring Human Rights Effectiveness

As a funding organization, the GFATM prides itself on its "results-based model". This means that it only finances health initiatives whose results it can measure. This focus on accountability by focusing on performance has been integral to its success as an organization. Its website proudly proclaims that the institution can measure impact in many ways, through the number of lives that are saved and the rate of decline in HIV/AIDS, tuberculosis, and malaria. Under the new funding guidelines, the GFATM wants to see what it calls "smart programming that creates the strongest impact," which refers to programs that reach the most affected populations.

When the institution approves a grant proposal, countries receive their disbursements in installments. Only when they have illustrated that they have performed adequately can they access the next disbursement.[44]
Previously the GFATM relied on indicators that were not specific to human rights; rather, the focus was on measuring whether interventions worked.[45] These were known as Key Performance Indicators (KPIs). Unfortunately, these indicators took about 15 months to take effect. When finally approved in mid-2013, the KPIs of the GFATM consisted of 19 indicators, three of them were strategic and 13 were activity-based, and these helped to assess the GFATM's grants against the 2012-2016 Strategy.[46] The Secretariat reported to the Board against these indicators twice a year. The most closely related strategic objective on human rights was number 4, on promotion and protection of human rights. In response to this, the GFATM measured this criteria against its human rights investments.

Some of the KPIs were criticized for not reflecting the challenges posed by the Fund's strategy or not allowing corrective action when it was found necessary. For instance, strategic action 4.3 on integrating human rights considerations throughout the grant cycle was not measured with a KPI.[47] Although a report of the Office of the Inspector General found that data collection on KPIs was generally good, even then, they were found by the OIG to be poorly designed, and not a good measure of the impact the Fund was having in the countries it supports.[48]

In response to these concerns, on June 15, 2017, the GFATM board launched the 2017-2022 Strategic Key Performance Indicator Framework. A number of these indicators focus on human rights in relation to the Strategy. KPI 5 tracks coverage of services for key populations, KPI 6 and 7 deal with resilient and sustainable health systems, and KPI 8 and 9 deal with gender and age disparities and human rights barriers to access.[49] Apart from 12 KPIs that will measure the Fund against its strategic objectives, "the new implementation KPIs will track specific inputs, outputs and outcomes needed to meet those objectives; and the thematic reporting will provide results across the full results chain, drawing on financial, procurement, and programmatic data."[50]

The Realities of Funding a Limited Number of Rights

As a funding institution, the GFATM's focus is not extensive. Due to increasingly limited resources, it has a clear mandate about what it must fund. This in effect focuses on a narrow range of rights. However, it is difficult to separate human rights from the underlying determinants of health. For instance, to ensure that women get tested for HIV/AIDS or malaria during antenatal health visits to counter discrimination, it is necessary to invest in health centers, community awareness to enhance knowledge about services, labor protections that compel employers to give them adequate time off for antenatal visits, and transport services to easily access the health centers. Doing all this is, of course, expensive, and consequently unattainable as a practice of GFATM, despite its obvious benefits. Giving this link between the underlying determinants of health and the ability to shape human rights practice, some scholars have suggested that the GFATM would have to broaden from just three diseases and move toward becoming a "Global Health Fund."[51] The GFATM has tried to address this through the establishment of its new KPIs, which will move beyond focusing on specific projects to a more holistic approach, aimed at ending the three epidemics. Furthermore, the notion of "thematic reporting" will also help the GFATM to measure sector-wide progress, which includes other global health actors who are working toward similar aims at the country level.

CONCLUSION

In this article, we have assessed the uptake of human rights as a norm of the GFATM. Although present in the founding documents of the GFATM, human rights have developed as only a secondary norm of the GFATM. As the analysis shows, the secondary nature of human rights within the GFATM initially created challenges in the transposition of human rights norms within domestic contexts. Through the application of the sociological institutionalist framework of "layering," we illustrated how the GFATM is countering states' deviation from human rights norms by strengthening the conditional nature of its funding against much stricter human rights criteria that it wants to see in its grant applications. Furthermore, the GFATM now signs agreements with countries that include five minimum standards for human rights. Anyone who witnesses a human rights violation can report to the Office of the Inspector General, who has an obligation to investigate. These safeguards create much more stringent human rights standards that are prudent for the long-term survival of the GFATM, because the increased accountability embedded in its institutional design exposes it to increased scrutiny. The success of these new norms remains to be seen in practice.

However, the low percentage of resources spent on human rights against total GFATM funding still illustrates the secondary nature of the human rights norm. In 2016, the GFATM was spending approximately 2.3 percent of AIDS funding on human rights initiatives.[52] This is still very low, and in order to be more effective, this would need to rise substantially. Arguably, this will be a tough sell for its donors, especially in an environment where there is a push back against global responses to health problems. However, human rights remain a normative good, and so cannot be discarded. Indeed, the work of the GFATM will remain crucial to ensuring that human rights is mainstreamed as part of health governance in its recipient countries.

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[4] Finnemore, Martha. "International Organisations as teachers of Norms: The United Nations Educational, Scientific and Cultural Organisation and Science Policy," *International Organization,* 47 no. 4 (1993): 565-97.
[5] UN General Assembly, 60th Session. *Enhanced Cooperation between the United Nations and all Relevant Partners, in Particular the Private Sector – Report of the Secretary General.* UN Doc A/60/214, August 10 2005, para 8.
[6] In General Comment No 2, the Economic and Social Cultural Rights Committee argues that the specialized UN agencies should have an active role in the promotion of human rights particularly in the case of economic social and cultural rights. These duties are based on respect and not violating human rights and would vary considerably depending on the purpose of the international organization. Thus, if we argue that IO's have a duty to promote international human rights law then these organizations have a duty to ensure that their activities in implementing GFATM grants are compliant with human rights. See also Meier, Benjamin Mason and Gostin, Lawrence, O. "Introduction: Responding to the Public Health Harms of a Globalizing World through Human Rights in Global Governance" In *Human Rights in Global Health Rights-Based Governance for a Globalizing World* edited by Benjamin Mason Meier and Lawrence O Gostin. New York, NY: Oxford University Press, 2018, 1-18.
[7] Global Fund. *Bylaws of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.* https://www.theglobalfund.org/media/6007/core_globalfund_bylaws_en.pdf?u=636486807150000000.
[8] General Comment No 14 provides a normative understanding for the obligations of parties under the right to health.
[9] Meier, Benjamin Mason. "Global Health takes a normative turn: The expanding purview of international health law and global health policy to meet the public health challenges of the 21st century." *The Global Health Community Yearbook of International Law and Jurisprudence,* 1 (2011): 86, 98.
[10] The third founding principle of the Global Fund stated that it aimed to support proposals for funding that aimed, 'to eliminate stigmatization of and discrimination against those infected and affected by HIV/AIDS especially for women, children and vulnerable groups.'
[11] Human Rights is considered by the TRP when looking at soundness of approach and the body is requested to analyse, "whether a proposal addresses issues of human rights and gender equality..."
[12] This was part of a much wider restructuring process, which introduced a new model that was supposed to streamline the process of health financing in order to make it more flexible and ensure that there was better alignment with country budgeting processes. See Global Fund. "Funding Model." Accessed November 23 2016. http://www.theglobalfund.org/en/fundingmodel/.
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The World Bank and The Right to Health: A Study of the Institution's Rights-Based Discourse

Yusra Ribhi Shawar and Jennifer Prah Ruger

While the World Bank has integrated rights-based principles in the implementation of some health programs that it finances, it continues to deny a formal legal obligation for human rights. Employing thematic and discourse analyses, this study analyzes the ways in which rights-based approaches are incorporated into World Bank health development discourse, examining achievements, obstacles, and opportunities. We describe the evolution of human rights discourses in the World Bank's health engagement, beginning at the time of its establishment before it was formally involved in health sector lending. We find five key institutional factors that challenge the advancement of rights-based approaches in the World Bank's health work: unresolved legal obligations stemming from the institution's founding documents, the World Bank's economist-dominated culture, its staff's lack of knowledge about human rights application and policy, opposition by some country stakeholders, and competition with emerging development banks. Despite this, there are three opportunities for integrating right to health approaches within the World Bank: internal research activity supporting human rights commitments in development, pressure exerted by NGOs and civil society through their monitoring of the institution, and the establishment of the Nordic Trust Fund, which serves to increase staff awareness of human rights and its application to their work. Given the World Bank's historical legal resistance to a rights-based approach, we end by arguing for an ethical demand for health equity, which may be effectuated by a policy framework rather than a legal "right to health" approach.

INTRODUCTION

Over the last several decades, the World Bank has played a central role in global health development lending and practice and is increasingly recognized as a prominent global health governance leader.[1] While the Bank has had an impact on the health of those residing in low and middle-income countries (LMICs),[2] it is also critiqued for its human rights record. Philip Alston, the United Nations Special Rapporteur on extreme poverty and human rights, has proclaimed the World Bank to be a "human rights free zone";[3] an estimated 3.4 million people were economically or physically displaced by Bank-funded projects between 2004 and 2013;[4] and individuals affected by Bank-funded interventions report not feeling safe to ask questions or express their feelings about the impacts that World Bank projects have on their well-being.[5]

The Bank's human rights discourse, however, is neither clear-cut nor well understood. There are instances where World Bank health programming and policies are perceived as fundamentally supporting or detracting from a rights-based approach. On one hand, the Bank is committed to improving the wellbeing and health of the poor in LMICs, given its pledge to help countries achieve universal health coverage and as reflected in its "twin goals" of ending extreme poverty and promoting shared prosperity, which contribute to the realization of social and economic rights. On the other hand, the Bank is historically resistant to adopting a formal rights-based framework due to guidelines laid out in the institution's founding documents, which explicitly prohibit the institution from meddling in a state's internal political affairs.

We examine the Bank's rights-based discourse in its engagement with global health over time. While the World Bank was absent in global health efforts in the first several decades following its establishment, it presently manages an active Health, Nutrition, and

Population (HNP) portfolio of $11.5 billon,[6] has been the world's leading funder of programming and policies that address HIV/AIDS,[7] and plays one of the most significant roles in global health cooperation.[8] An understanding of the Bank's "right to health" discourse is critical given its pivotal role in the global governance of health and in its determination of health investments, institutional developments and policies of LMICs, and the broader global health agenda.

We begin by discussing the origins and meaning of a "rights-based" approach, considering the implications that a commitment to a "right to health" might have in practice for the World Bank before describing the methodology employed in this study. We then describe the evolution of right-based approaches in the Bank's health discourse and analyze the factors that present opportunities for advancing rights-based approaches in the Bank, as well as those that have historically challenged its institutional advancement. We conclude by arguing that the World Bank's embrace of an ethical demand for health equity, rather than the pursuit of a rights-based discourse, will better enable the Bank to deliver improved health development outcomes, given that such a reconceptualization transcends the identified challenges that persistently impede institutional advancement of rights-based approaches.

METHODOLOGY

Framework for Understanding the "Right to Health"

The "right to health"—enshrined in the Constitution of the World Health Organization (1946), the International Covenant on Economic, Social and Cultural Rights (1976), and the Declaration of Alma-Ata (1978), among other formal documents—is understood as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[9] It is both a freestanding right and constitutive of other rights, given that its realization is a precondition to the enjoyment or definition of rights related to various types of economic, political, social, cultural, and civil rights.[10] Practically, a rights-based approach to development seeks to ensure that human rights criteria (i.e., affordability, accessibility, acceptability, quality, and availability) and principles (i.e., accountability, participation, non-discrimination, sustainability, and access to information) are accounted for during the course of development.[11] In addition, rights-based approaches support rights-holder capacity to claim their human rights and duty-bearer ability to meet their responsibilities.[12] We accounted for these criteria, principles, and obligations in our analysis of the World Bank's "right to health" discourse.

Data and Analysis

We adopted a two-level case study methodology of the World Bank and its HNP Department. Unlike quantitative methodologies, the case study method is ideal for this research question given that we seek to study a complex social phenomena, have no possibility of controlling the events that unfolded, and are interested in answering "how" and "why" questions.[13] In order to minimize bias and increase the validity of our findings, we triangulated across various sources of data that were drawn from different sources and at different times.[14] This included archival data, World Bank strategies and reports, peer-reviewed literature, as well as relevant reports and statements from the media, NGOs, other international organizations, and civil society monitoring World Bank activity. We also conducted semi-structured interviews with key-informants within the World Bank: from the Legal Department, Nordic Trust Fund, and the HNP Department.

Employing thematic and discourse analyses, this study analyzed the ways in which rights-based approaches are incorporated into World Bank health development discourse,

examining achievements, obstacles, and opportunities. We constructed a historical narrative of key events and conducted a discourse analysis[15] of relevant Bank statements and formal strategies by analyzing the conscious and unconscious agendas and meanings of selected texts. We also undertook a thematic analysis[16] of the collected data. We used an iterative process in developing the codes,[17] with the coding evolving as additional data were collected. Initial codes for analyzing global health discourse at the World Bank were based on the identified human rights criteria (affordability, accessibility, acceptability, quality, and availability) and principles (accountability, participation, non-discrimination, sustainability, and access to information). This enabled us to examine how discourse derived from World Bank publications, speeches, and decisions reflected the Bank's rights-based actions and policy decisions (or lack thereof) in its health policies and programming. Initial codes for analyzing the factors shaping the opportunities and challenges for the Bank's rights-based progress were based on a policy determinant framework,[18] which describes five general types of factors that are hypothesized or have been found to influence implementation outcomes: 1) characteristics of the implementation object (in this case, human rights); 2) characteristics of the user/adopter (the history, internal policies, and culture of the World Bank); 3) characteristics of the end users (the nation states and populations affected by World Bank intervention); 4) characteristics of the context (the global political and policy environment, including the actions, policies, and strategies of other international financial institutions, international organizations, and NGOs); and 5) the characteristics of the strategy or other means of facilitating implementation (the research conducted, legal opinions crafted, and entities/policies constructed internally by the World Bank that are relevant to human rights).

THE EVOLUTION OF RIGHTS-BASED APPROACHES IN WORLD BANK DISCOURSE

The World Bank's Governance, Establishment, and Early Years (1945-1960s)

An understanding of the World Bank's rights-based discourse in health requires an examination of the institution's governance and establishment, well before its engagement in health lending. Established in July 1944 and beginning operations in 1946, the World Bank's original goal was to finance the post-war European country economy, focusing on large physical capital and infrastructure projects. A specialized agency of the UN, the World Bank Group is composed of five "member institutions". The largest of these institutions are the International Bank for Reconstruction (IBRD), which offers loans to middle-income countries, and the International Development Association (IDA), which offers concessional loans and grants to the world's poorest developing countries. Both institutions share the same leadership and staff and have a mandate to assist development efforts in their member states. The World Bank's 189 country shareholders are represented by a Board of Governors, which is composed of member countries' ministers of finance or ministers of development.[19] These governors delegate specific duties to the Bank's Board of 25 Executive Directors (ED), who are responsible for selecting the President for a five-year, renewable term and approving all institutional loans and policies.[20] ED designations are based on member state financial contributions (e.g., the United States is represented by one ED, while forty-seven sub-Saharan African countries are collectively represented by only two EDs).[21]

At its establishment and over the first couple decades of its existence, the World Bank was explicitly resistant to considering human rights. As stipulated in its Articles of Agreement, the institution's founding documents, the World Bank saw itself as an economic development agency and clearly forbid the institution from intervening in any country's internal political affairs or engaging in decision-making based on political considerations.[22] Article VIII, Section 5(f) of the Articles of Agreement states that:

> The Bank, its President, officers and staff shall not interfere in the political affairs of any member, nor shall they be influenced in their decisions by the political character of the member concerned. Only economic considerations shall be relevant to their decisions. Such considerations shall be weighed impartially in order to achieve and carry out the purpose and functions of the Bank.[23]

The World Bank's unwillingness to uphold principles of human rights in its policies and lending practices became particularly evident in the 1960s, when the institution decided to – in defiance of a series of UN resolutions – approve several loans to Portugal and South Africa, despite their respective colonial and apartheid policies.[24] The World Bank overlooked the human rights violations occurring in these countries and cited its apolitical character for its decision to move forward with its loan support.[25]

The World Bank's Increasing Engagement in Politics and Interest in Health (1970s)

Robert McNamara's presidency (1968-81) marked several unprecedented shifts in World Bank policy – having direct implications on its health and human rights discourses. Under his leadership, the Bank moved from project to policy-based lending,[26] began venturing into areas of social development that aimed to improve the health and well-being of LMIC populations, and became centrally engaged in areas of national politics and law that historically were understood to be outside of the scope of its Articles of Agreement (i.e., the promotion of "good governance" as critical to development),[27] recognizing that such "political" efforts were fundamental to ensuring the success and sustainability of development initiatives. Despite these transformations, the World Bank resisted acknowledging a formal link between political and civil rights, economic development, and good governance.[28]

Two policy areas and one approach – population, environment, and basic needs respectively – emerged during this time and served as precursors to the World Bank's involvement in health. We examine how developments in each of these areas reflected and shaped the institution's right to health discourse.

The World Bank's Population Projects Department (PNP) began operations in September 1969 and provided the Bank's first population loan to Jamaica in 1970.[29] As noted by Dr. Kanagaratnam, PNP's first director, the Bank decided to enter the population field primarily because "it became convinced that the attempt to raise living standards in a great many developing countries was being seriously undermined by population growth."[30] Instead of advancing a population agenda because of a concern for the intrinsic sexual and reproductive rights of women in LMICs, the Bank's involvement in this area was largely instrumental: seeking to "achieve fertility decline in the quickest and most effective way consistent with the realization of national socio-economic development objectives."[31]

The Bank's interest in the environment also developed during the 1970s. The relationship between the Bank's development initiatives, the environment, and the health and well-being of the populations that were impacted was of particular concern to the appointed environmental advisor, Dr. James Lee.[32] He drew attention to the traumatic effects that Bank supported projects were having on indigenous populations in LMICs. Dr. Lee's concern and outside NGO pressure to address the situation ultimately led the Bank to develop a tribal policy and practical handbook, which member countries resisted because it infringed upon their sovereign rights regarding their people.[33]

In 1976, the basic needs approach (BNA) in development emerged, introduced by the International Labor Organization's World Employment Conference,[34] and was rapidly taken up by the World Bank because historical policy approaches that focused on maximizing GNP per capita were not facilitating the automatic "trickle down" of economic growth to the poor.[35] BNA, which promotes the satisfaction of basic material needs for food,

material, health, shelter, etc. before moving on to other "higher" needs, was seen as a means of directly addressing poverty reduction among the most vulnerable populations.[36] An approach that continues to dominate development discourse, some scholars characterize BNA as a forerunner to the human rights approach (HRA). However, there are several fundamental differences: BNA focuses on inputs and meeting needs, while HRA focuses on processes, outcomes, and realizing rights; BNA addresses proximate causes of problems, while HRA addresses structural causes; and in a BNA, individuals are "objects of development interventions" and "deserve assistance," while in HRA, individuals are "empowered to claim their rights" and are "entitled to assistance."[37]

Establishment of the Health, Nutrition, and Population Department (1980s – mid-1990s)

Health became a formal area of institutional focus in October 1979 with the establishment of the Population, Health, and Nutrition Department, which was ultimately renamed as the Health, Nutrition, and Population (HNP) Department.[38] A background paper for the 1980 World Development Report[39] identified five factors that led to the World Bank's increased interest in and commitment to health, one of which was a concern for human rights and meeting the basic needs of the poor that arose in the mid-1970s.[40] In fact, the World Bank's lending in health and the social sector broadly and also its incorporation of poverty reduction strategies are cited in Bank publications as major contributions to advancing social and economic rights in LMICs.[41]

However, the Bank's motivation for health lending was also largely instrumental. As described by the World Bank's Independent Evaluation Group, its involvement in health was expressed as a means to an end, rather than an end itself (e.g., an intrinsic concern for population rights), given that the institution sought to improve HNP outcomes in order to increase poor productivity and national economic growth.[42] Furthermore, HNP's establishment and early years coincided with the advancement of three Bank-wide policies that represented a fundamental derogation from a rights-based discourse: the promotion of structural adjustment lending, user fees, and privatization.

Throughout the 1980s and 1990s, the Bank compelled countries to implement structural adjustment policies.[43] At the time, the Bank believed that structural adjustment would lead to poverty reduction through trade liberalization, increased competition from the private sector, and devaluing of overvalued currencies.[44] In reality, between 1980 and 1992, world debt rose from $0.5 trillion to $1.2 trillion, with many of the countries adopting structural adjustment policies shouldering the greatest debt.[45] Moreover, the policy led to growing health inequalities and disrespect for the human rights of LMIC populations,[46] resulting in half a million young children dying over a one year period.[47]

At around the same time, the World Bank highlighted user fees, which involves levying a fee for using public sector health services, as an instrument for mobilizing resources.[48] Research concerning user fees has since revealed that the policy resulted in a decline of service utilization, especially among women and socioeconomically deprived populations.[49] Despite the World Bank claiming that it does not support user fees in its 1997 sector strategy,[50] many NGOs and health experts continue to blame the World Bank for its introduction, advancement, and failure to put out a policy that rejects its use.[51]

Finally, privatization in World Bank policies began growing during this time. Loans with privatization as a condition tripled between 1990 and 2002, despite the World Bank advancing that it does not force privatization on the poor.[52] Critics expressed concern about the negative effects that the institution's backing of privatization was having on LMIC health,[53] since successfully working through private-sector providers necessitates intricate health information systems and administrative capabilities that a majority of LMICs typically lack.[54] Privatization also promotes the fragmentation of the health system, which makes a state's implementation responsibilities more difficult and "complicates oversight

and the promotion of a rights-based approach to health."[55] In fact, private healthcare institution aims often diverge considerably from human rights principles.[56]

The Wolfensohn Era: A Shift in Human Rights Discourse (mid-1990s – mid-2000s)

Under the leadership of President James Wolfensohn (1995-2005), the World Bank increasingly became one of the world's largest global HNP financiers, with annual commitments of $1.3 billion in 1999.[57] Despite making significant contributions to health services and policies across the world and becoming a central actor in global health policy debates,[58] it was also increasingly critiqued for undermining rights-based principles in its health initiatives. For example, the DALY (disability-adjusted life year), a measure of overall health and life expectancy of different countries, was introduced by the World Bank in 1993,[59] and was widely criticized for violating rights-based principles by discriminating against the disabled, young, and elderly, as well as women and future generations.[60] In addition, the rights-based criteria and principles of quality and accountability were perceived to be undermined, since the World Bank's Operation's Evaluation Department concluded that only 64% of HNP projects were satisfactorily completed between 1975 and 1998, with most of health projects insufficiently "defining and monitoring progress toward HNP development objectives" and accounting for and addressing health determinants generally.[61] Also, the Bank's health work was insufficiently open to outside scrutiny, detracting from rights-based principles of access to information and accountability, given that as of 1998, there had only been two reviews commissioned externally by the Bank of its health activities.[62]

Despite these critiques, Wolfensohn's presidency catalyzed unprecedented discussion on human rights more broadly within the World Bank. For example, his appointment coincided with the early years of the Inspection Panel, established in 1993. The Panel investigates – when prompted – the World Bank's compliance with its own procedures and policies as a means to safeguard people and the environment impacted by its projects.[63] Because it empowers those marginalized by World Bank projects, the Inspection Panel forced the institution for the first time to confront and address cases that raised human rights concerns. Several Panel decisions concerning underlying determinants of health have highlighted instances in which World Bank procedures and policies may necessitate the Bank to account for human rights issues.[64] These cases have directed the institution to: consider the wider consequences of human rights violations, not just when they have a direct economic effect on the project;[65] evaluate a country's general state of human rights and governance when planning and carrying out its projects;[66] and account for the human rights protections covered in a country's constitutions or laws and ensure that institutional funding does not violate a country's international human rights commitments.[67]

A second key development during Wolfensohn's tenure was the legal opinions of General Counsels Ibrahim Shihata (1983-2000) and Roberto Dañino (2003-2006), which created the legal space for the institution's engagement in topics that were once considered too political and recognized the relevance of human rights within the World Bank's development work.[68] Both recognized that the "Articles of Agreement permit, and in some cases require, the Bank to recognize the human rights dimensions of its development policies and activities."[69]

Dañino and Shihata also advanced that the World Bank may help a country realize its own human rights legal obligations (in the instance that it communicates such a desire), given that these commitments "have an economic impact or relevance," and that the Bank should take human rights into consideration when "a country has violated or not fulfilled its obligations" – again in the instance that they have an economic impact.[70] However, Dañino went further in an internal legal opinion that he distributed on his last day as General

Counsel, advancing that the World Bank should disengage in "egregious situations, where extensive violations of human rights reach pervasive proportions" – no longer requiring an economic impact justification.[71] His legal opinion, however, would have little impact. Given long-standing disagreements about human rights among Bank staff and leadership, the opinion was not presented to the Bank's Board of Directors, representatives in the Legal Department were reluctant to discuss it openly among themselves, and the succeeding General Counsel Ana Palacio (2006-2008) interpreted it as permitting but not requiring the Bank to act in relation to human rights.[72]

The World Bank's 1998 publication *Development and Human Rights: The Role of the World Bank,*[73] which commemorated the fiftieth anniversary of the Universal Declaration of Human Rights, also signaled an increasing institutional recognition of human rights. The report recognized that national growth requires some respect for human rights, human rights progress in the World Bank should be measured by the extent to which economic growth occurs with increased citizen realization of economic and social human rights, and that the institution should support the human rights goals of the United Nations, its parent organization.[74] While human rights advocates considered the report's message to be "good for public relations but devoid of practical effect,"[75] a growing collection of World Bank research emerged subsequent to its publication that advanced a link between the promotion of civil liberties and rights and stronger economic performance.[76] Also, subsequent to the report's publication, Wolfensohn circulated a proposal for a Comprehensive Development Framework to World Bank staff, calling for a "holistic approach to development" that acknowledged the protection of "human and property rights" and a comprehensive framework of laws as critical for equitable development.[77]

The Present: The World Bank's "Right to Health" Discourse (mid-2000s – present)

Over the last decade, there has been renewed optimism, as well as pessimism, concerning the World Bank's progress in advancing rights-based approaches in health as reflected in several recent developments.

One of the greatest points of optimism for the advancement of rights-based approaches in the Bank was the establishment of the Nordic Trust Fund (NTF) in 2009. Originally proposed in 2006, it was created with contributions from Denmark, Iceland, Norway, Finland, Sweden, and Germany as an internal "knowledge and learning initiative" to assist in showing Bank staff how human rights relate to their work and goals.[78] To overcome initial opposition from the Bank's leadership,[79] lawyers working on the trust funds' plan of action strategically advanced an instrumental approach to rights and a focus on pilot projects instead of advocacy for an institution-wide human rights policy.[80] Totaling $34.8 million, the NTF educates World Bank staff about human rights issues and provides Bank teams, through a grant program, the financial and technical support to examine the role of human rights in their work. Several of the 122 grants supported by the NTF have explicitly sought to advance "right to health" discourse at the Bank by examining the operationalization of gender in health, considering what a human rights approach can offer maternal and reproductive health projects, and producing standards of practice that add a human rights perspective in adolescent sexual and reproductive health projects.[81]

Representing "a break from the Bank's past leadership,"[82] Jim Kim's appointment as World Bank president in 2012 also created optimism among many global health and human rights advocates. Unlike past Bank leaders that have typically been experts in finance, economics, or politics,[1] Kim is a clinician and anthropologist, with extensive humanitarian global health experiences as the co-founder of Partners in Health, and was

[1] James Wolfensohn was another exception; he was a lawyer by training.

previously a major critic of the World Bank.[83] Despite expanding the institutional boundaries of the World Bank's mandate[84] and being outspoken in his rhetoric concerning the "right to health,"[85] human rights proponents argue that Kim's advancement of institutional discourse on human rights has fallen short.[86]

Some of the criticism toward Kim is associated with the World Bank's revision of its safeguard policies, which he oversaw and made official on August 4, 2016. While the newly approved Environmental and Social Framework (ESF)[87] explicitly references human rights in its overarching vision statement, its language presents human rights as aspirational values and is non-binding – excluding any human rights commitments and standards.[88] In addition, the new policy effectively shifts responsibility and liability for harms away from the Bank and onto borrower countries that often lack the political will, as well as the financial and technical ability, to ensure that monitoring and/or grievance mechanisms operate effectively to protect vulnerable populations.[89] Also, the new ESF shifts much of the World Bank's due diligence on projects until after they are approved.[90] Despite these criticisms, ESF incorporated some important reforms to the previous ad hoc and burdensome policies, such as requiring stakeholder engagement throughout the project lifecycle and placing greater focus on strengthening borrower frameworks and capacity building.[91] In fact, one of the ten Environmental and Social Standards (ESS) explicitly addresses the "health, safety, and security risks and impacts on project-affected communities" (ESS4), with special attention to vulnerable populations.[92]

During the development of the ESF, the World Bank's human rights reputation was significantly tainted by its handling of the Uganda Transport Sector Development Project (UTSDP). In 2015, the Bank initially dismissed problems reported by the community related to community safety, sexual violence, child labor, and insufficient compensation for those who lost land to the project. [93] Of particular concern was the sexual abuse and exploitation of women and children in the community by unmonitored project construction workers, resulting in an increase in unintended pregnancies and women contracting HIV/AIDS. The Inspection Panel ultimately initiated an investigation,[94] prompting the Bank to eventually cancel the project, suspend all new lending to the government of Uganda, and institute remediation measures.[95] Especially concerning to human rights and health advocates were: the Bank's failure to account for the local context and accordingly classify the risk of the project appropriately, its initial denial and slow response to serious allegations raised by the local community, and the Bank's absence of a systematic method for providing support to the individuals impacted by the project.[96]

Finally, the World Bank's recent support of governments to achieve universal health coverage (UHC) is favorable to the advancement of institutional rights-based approaches [97] given that UHC may be viewed as rooted in the right to health, as set out in the International Covenant on Economic, Social and Cultural Rights.[98] In support of UHC targets in Sustainable Development Goal (SDG) 3, the World Bank has committed $15 billion over the next five years to undertakings fundamental to UHC.[99] Despite this commitment to UHC, the World Bank is accused of undermining the human right to universal health care given its promotion of public-private partnerships (PPPs) in health.[100] A 2016 Independent Evaluation Group report on healthcare PPPs found several problems with the ways in which the Bank has implemented PPPs in the health sector. Especially concerning was little evidence demonstrating that PPPs actually helped improve access to health services for poor communities.[101] In addition, human rights advocates are concerned with the Bank's approach to universal healthcare coverag*e*, which involves the creation of health insurance schemes that allow people to access healthcare facilities, but that works through insurance schemes that are typically only available to people working in the formal sector (not the most marginalized individuals in LMICs working in the informal sector).[102] These advocates prefer a policy of universal healthcare provision, which dictates that a government guarantees the provision of healthcare services to all, irrespective of income

and status. Finally, critics raise concerns with the impact that the Bank's blanket promotion of performance-based financing has on advancing UHC, given some emerging evidence that it does not necessarily improve the practice of health workers and the performance of health facilities.[103]

FACTORS SHAPING WORLD BANK RIGHTS-BASED DISCOURSE IN HEALTH

The World Bank's right-based discourse in its global health initiatives is shaped by several institutional factors. Five institutional factors have historically challenged a World Bank commitment to the issue. A principal barrier to human rights integration in the World Bank is the Articles of Agreement. The World Bank's founding member countries purposefully restricted its mandate to economic activities as a means to protect country sovereignty. By explicitly prohibiting the World Bank's engagement in political activity, the Articles of Agreement have historically thwarted the Bank's involvement with human rights, which have been understood as "political considerations." Interpretation of the Articles, which is determined by a majority vote among the Executive Directors, have not altered with respect to engagement with human rights issues even as various legal counsels have taken no issue with the World Bank's engagement with political issues such as governance, corruption, citizen security, justice, and the rule of law.[104] Human rights—of all the political issues that the World Bank engages in—continues to be classified as "political" rather than economic. Furthermore, the human rights taboo continues to be "policed" within discussions in the Executive Board and the broader institution by the Legal Department.[105]

A second factor challenging human rights mainstreaming concerns the World Bank's institutional culture, which is dominated and largely influenced by an economist perspective. Economists occupy most senior management positions and their way of thinking reigns, influencing how institutional goals are crafted and justifications articulated within the institution.[106] From an economist perspective, rights are "perceived as being rigid, anti-market, and overly State-centric."[107] Accordingly, there is an uneasy tension in balancing the World Bank's inherent aim of efficiency (swiftly designing and implementing projects with little obstructions and impediments) and an explicit commitment to human rights (making these projects participatory, transparent, etc.). This institutional culture has challenged incorporation of human rights into the World Bank because doing so "forces employees into a struggle between principles and pragmatism, creating a tension between normative, intangible values and goals, and practical ways to solve problems."[108]

A third factor challenging the World Bank's engagement with human rights is the lack of knowledge that staff have concerning human rights application. As reported by the NTF Progress Report, "World Bank teams…are not well informed about how human rights could be applied in their work…and are uncertain about how human rights can help provide better concrete answers . . . ."[109] Evidence of this lack of knowledge was substantiated in an internal 2009 survey, which revealed that World Bank staff see human rights as relevant to their work but are uncertain how to integrate human rights in their work. Specifically, the survey found a staff knowledge gap around the definitions, laws, institutions, and standards governing human rights.[110] While a 2013 follow-up survey found some improvement in staff knowledge and awareness of human rights,[111] the UN Special Rapporteur on extreme poverty and human rights has noted the persistence of this challenge: "Human rights are not well understood by a great many officials within the Bank. They have a passing acquaintance, but no real sense of the overall picture."[112]

A fourth factor impeding the World Bank's engagement with a rights-based approach is country resistance. While some key World Bank stakeholders are supportive of a formal policy on human rights, other countries such as China strongly oppose it.[113] Some countries oppose the World Bank's engagement in human rights on the grounds that it interferes with state sovereignty, while others resist it because they already face challenges

with gender equality and/or accounting for the existing, basic governance indicators required by the World Bank.[114] These countries are concerned that a rights-based approach at the World Bank would expose their human rights records and require them to undertake rigorous assessments as part of the loan process. In addition, some member countries believe that a formal World Bank endorsement of human rights could result in demands for political "democracy" that could threaten non-democratic governments and unnecessarily destabilize states lacking democratic institutions.[115] Relatedly, there are some within the Bank that advance that a human rights discourse needs to be avoided because the World Bank is already viewed as commanding Western values and interests on non-Western countries, and that a human rights discourse would further complicate existing sensitivities.[116]

The final challenge to adopting rights-based principles concerns the World Bank's emergent rivalries from other development banks that are increasingly being supported by its traditional backers.[117] These new multilateral investment banks (e.g., the Asian Infrastructure Investment Bank and the New Development Bank, both launched in 2014) and emergent national development banks in countries such as Brazil, China, and India currently do not have the same social standards as the World Bank. Accordingly, there are rising suspicions and legitimate fears that the World Bank will increasingly be swayed from integrating human rights requirements in their lending in order to remain competitive and be perceived as the most efficient institution, with the fastest speed of fund disbursement and least project requirements offered to country borrowers.[118]

Despite these challenges, three factors are likely to support the World Bank's future engagement in rights-based approaches in its health initiatives. The first is the work of the NTF, which sidesteps the World Bank's lack of institutional policy on human rights by improving project-level rights protection. Although NTF cannot lobby for official World Bank policy changes, it provides an important platform to increase awareness about human rights and to showcase the application of a rights-based approach in projects within the organization. This can be an important catalyst in expanding acceptance for and operationalization of human rights policy at the World Bank.

A second factor is the continued NGO pressure on the World Bank to engage in human rights principles in its work.[119] The World Bank's development of its initial safeguard policies in the 1980s is largely attributed to the pressure that NGOs applied.[120] Presently, organizations such as Human Rights Watch, the International Consortium of Investigative Journalists (ICIJ), the Bretton Woods Project, and the Bank Information Center serve as important accountability mechanisms by monitoring and reporting on the negative impacts that some World Bank projects have on the human rights of certain populations. By uncovering the adverse impacts that some World Bank projects have on human rights, these NGOs not only contribute to improvement of the institution's existing accountability mechanisms (i.e., the Inspection Panel and the safeguard policies), but they also help create the evidence for considering an alternative, more sustainable channel of accountability: an explicit institutional commitment to human rights.

Finally, the growing body of research within the World Bank that concerns human rights represents a potential opportunity for greater World Bank engagement. Some of this research comes out of the World Bank's Development Research Group, which has published studies on the use of legal strategies in bringing about social change and achieving economic and social rights,[121] the determinants of compliance with human rights treaties,[122] the relevance of human rights indicators for development,[123] and the benefits, risks, and limitations of human rights-based approaches to development.[124] This research builds on studies conducted by the World Bank in the past, which have found large and statistically significant effects of civil liberties on investment project rates of return.[125] Collectively, this work provides important evidence for the institution to consider a stronger commitment to human rights in its operations.

DISCUSSION

Despite growing recognition of the relevance of human rights to its work, the World Bank continues to lack systematic and formal integration of rights-based approaches into its health policies and programming. The World Bank's evolving engagement with rights-based discourse is fundamentally shaped by a deep-seated friction between its legal obligations, as set out in the Articles of Agreement, and its changing practical mandate, as reflected in the goals and type of health work that it pursues. While the institution's NTF, its monitoring by NGOs, and growing research supporting human rights commitments in development are promising for better integrating rights-based approaches in the World Bank's health work, five key institutional factors persist in challenging its advancement: unresolved legal obligations, the institution's economist-dominated culture, its staff's lack of knowledge about human rights application and policy, opposition by some country stakeholders, and competition with emerging development banks.

Given the World Bank's historical *legal* resistance to a rights-based approach, we argue for an *ethical* demand for health equity, which may be effectuated by a policy framework rather than a legal "right to health" approach. A rights-based approach is often understood within a legal framework, with a delineation of responsibilities based on legal commitments and liability for satisfying the rights of individuals through judicial processes.[126] In contrast, an ethical approach demarcates requirements based on moral obligations and accountability for ensuring justice and equity for individuals and populations.

While the judicialization of the right to health has been promoted by some scholars as a means to secure better health outcomes for the most marginalized,[127] we argue that it is an insufficient and ineffective means to promote health equity at the World Bank. For one, legal right to health approaches are critiqued for regularly not empowering individuals, as intended, and contributing to or reinforcing paternalistic practices.[128] Because human rights are considerably dependent on existing societal power relations, human rights systems have historically benefited those with the most power.[129] In fact, male-dominant understandings of human rights are mainstream, and states ultimately hold legal power over people.[130] Accordingly, powerful actors, including financial institutions such as the World Bank, are prone to reinforce the status quo in their pursuit of "rights-based" approaches,[131] especially since the most marginalized communities are either out of reach or lack the power to effectuate legal, rights-based approaches.

Second, and relatedly, legal right to health approaches often may unintentionally deepen existing inequalities for access to healthcare.[132] For example, right to health litigation in Brazil has compromised the advancement of health equity because it disregards resource restraints that can only be supported at the cost of universality. Accordingly, only a small number of individuals are granted this unlimited right to any benefits – over the rest of the population. Furthermore, health inequity is perpetuated where it is often the most privileged communities that are the ones that access the judiciary, an accessibility that marginalized communities (whose health conditions are comparatively worse and who have less than adequate access to other social determinants of health) typically do not possess.[133]

Third, right to health approaches tend to be top-down and one-size-fits-all in nature.[134] In practice, they often pay insufficient attention to circumstantial social, political, and historical conditions and tend to generalize.[135] In fact, right-based approaches are critiqued for often detracting from implementation "when policy making becomes an end in itself and does not follow its operationalization in a culturally sensitive manner."[136]

Accordingly, we contend that an ethical demand for health equity—rather than a legal demand for a right to health—will better enable the Bank to deliver improved health development outcomes, given that it is in line with the Bank's political economy perspective and transcends the identified challenges that have persistently impeded institutional

advancement of rights-based approaches.[137] In line with its political economy lens, the World Bank is designed to implement structural interventions to advance ethical demands for health equity – interventions that change finances, incentives, and power systems often well beyond the health sector.[138] Furthermore, the World Bank is in the best position to effectuate policy—rather than legal changes—given its significant engagement with and influence on policymakers in LMICs, representing various ministries.[139] Finally, application of an ethical approach to health equity is in accordance with current World Bank reforms and initiatives. This includes the NTF, which is prohibited from advancing legalistic right-based modifications to Bank policy, but has been instrumental to creating normative change in the institution by building knowledge and best practices around the incorporation of right-based principles in the institution's programming. Relatedly, the World Bank's implementation of its new Social and Economic Framework—a policy, not legal, framework—will be instrumental to advancing ethical, rather than legal, demands for health.

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International Health Assistance and Human Rights in Ethiopia

Hiwote Fantahun

This article examines the responsibility of external funders to ensure respect for human rights in their health assistance in highly repressive and politicized countries, using Ethiopia as a case study. Ethiopia's experience is particularly instructive, as it is highly dependent on international assistance for health, and ruled by one of the most repressive regimes in the world today. International assistance, even though has played a vital role in improving health outcomes in Ethiopia, has been a tool to discriminate among populations based on their political affliction, as revealed by research findings on major World Bank-administered programs. Bank safeguards were inadequate to prevent or detect such discrimination. The article recommends that health program funders consider countries' enabling legal and policy environment as a major factor in their funding decisions, recognizing the importance of a holistic approach to human rights to protect the right to health.

Ethiopia is one of the top recipients of international health assistance, yet also one of the world's most repressive countries.[1] The question, then, is whether—in such a repressive regime—health assistance can be provided in a way that is not undermined by the political repression. The answer, at least for Ethiopia, is that it cannot. This commentary demonstrates how health aid is politicized, and how donor approaches to accountability are insufficient in Ethiopia, and, indeed, undermined by donors taking a technical rather than political framing to the issue. Yet, there are steps providers of assistance could take to lessen the risk of aid being misused.

Human Rights and Right to Health In Ethiopia

Ethiopia has ratified major international treaties recognizing civil, political, and socio-economic rights.[2] The Ethiopian constitution obliges the government "to allocate ever-increasing resources for public health and other social services with equal access to every citizen."[3] Yet, domestic legislation that runs counter to international and constitutional human rights obligations of the state serve the government as a tool to crush dissent, suppress freedom of expression, and frustrate human rights-related work in the country.[4]

International Health Assistance

From emergency food aid to agricultural imputes, from primary education to building government institutions, aid to Ethiopia is an endeavor worth billions of dollars. International health assistance has played a vital role during the past two decades in helping Ethiopia improve health outcomes.[5] Even though the total national health expenditure has increased, government's contribution is declining, substituted by international health assistance.[6]

International cooperation is sanctioned by international human rights law.[7] These instruments do not explicitly state the nature of this duty, although principles governing extraterritorial obligations require, at the very least, that it should not contribute to impairing people's rights.[8] This commentary focuses on non-discrimination and accountability, two core principles of the right to health, in relation World Bank-led multi-donor projects that have been implemented in Ethiopia over the past ten years.

International Health Assistance: Discrimination

In 2014-2015, Ethiopia received US $3.6 billion in Official Development Assistance, a quarter of which was allotted for health.[9] The World Bank's contribution ($0.8 billion) for the same period is the highest of any funder, followed by that of the United States ($0.7 billion) and the United Kingdom ($0.5 billion).[10] The Bank plays an important role in setting the framework for donor engagement through its country partner strategy (CPS), and in administrating their contributions to joint programs.

Among active multi-donor programs led by the World Bank is the Promoting Basic Services (PBS) program. The PBS, now in its third iteration (which runs until January 2019), was first approved in May 2006.[11] PBS was established partly with the objective of preventing "a reversal in gains made in human development (through) delivery of critical basic services to the poor..in the midst of political governance and macroeconomic fragility."[12] The program annually transfers an average of $1 billion to the federal government in block grants. Projects under this program, designed to support the delivery of service in the agriculture, education, health, and road sectors, are implemented nationwide.

A second World Bank-led project, the Productive Safety Net Program (PSNP4), launched in 2005 and running until 2020, providing regular food or cash transfers to food insecure households in chronically food insecure districts benefiting more that 8 million people.[13] The program channels on average half a billion dollars to the government annually.

Human Right Watch have published a series of investigative reports that outline how the Ethiopian government utilizes PBS, PSNP4, and other similar programs as political weapons to control the population, punish dissent, and undermine political opponents. These reports record systemic exclusion of people from accessing emergency food aid, agricultural imputes, and farmland based on their real and perceived political membership.[14]

The PBS also supports Ethiopia's flagship health extension program, paying the salaries of the 38,000 community health workers who go door-to-door to deliver health services such as immunization; malaria, TB, and HIV prevention and control; family planning; and civic education.[15] These workers receive mandatory political instructions from the ruling party two evenings per month.[16] More disturbingly, perhaps, allegations of discriminatory population control through long-acting contraceptive and deceptive sterilization targeting the ethnic Amhara women are becoming frequent. The region, which is predominately inhabited by the Amhara, arguably the most politically disfavored group under the current regime, exhibits the highest uptake of contraceptives of all the nine regions of the country, other than the capital city Addis Ababa.[17] Scholars are calling for a thorough and impartial investigation to the allegations.[18]

International Health Assistance: Accountability

Monitoring and evaluations mechanisms implemented for the PBS focus mainly on administrative and financial aspects of accountability. The 2008-2011 World Bank country assistance strategy introduced social accountability mechanisms to improve the interface with government.[19] The Bank's Independent Evaluation Group concluded that such schemes are of limited impact in the context of restrictive laws governing the media and civil society.[20]

The World Bank implements social and environmental safeguards with the objective of preventing and mitigating undue harm to people and their environment in development processes. The current safeguards are concerned with forests, pest control,

dam safety, natural habitat, involuntary resettlement, and indigenous people. However, only the indigenous people safeguard has an explicit human rights policy objective.[21]

In September 2012, 26 representatives from the Anuak community in the Gambela region challenged the PBS III before the World Bank Inspection Panel.[22] They claimed that the World Bank is responsible for forceful eviction from their land by PBS-sponsored Ethiopian government officials. The Panel vindicated the Bank of wrongdoing, affirming that the eviction was conducted under a separate government villagization program, which happens to run concurrently with PBS III. The Panel, however, recognized the failure of the program to trigger the Bank's applicable safeguard on protecting the rights of indigenous peoples at the appraisal and during implementation of PBS III.

CONCLUSION

The World Bank monetary and technical assistance to developing countries is of vital importance to economic progress and human development. Yet, respect for fundamental human rights is a necessary condition for development.

Despite a decade of double-digit economic growth, Ethiopia is unable to adequately feed several million of its people. The government's brutal response to citizens' attempt to exercise their civil and political rights often results in destruction of resources and livelihoods, putting social development gains at risk of reversal. PBS was a reaction from the international donor community to prevent such setback in the aftermath of the landmark 2005 national election. A decade later, Ethiopia is currently experiencing similar unrest, which has already claimed hundreds of lives.[23]

The World Bank should thoroughly incorporate human rights into its social safeguard mechanisms. Such mechanisms would enable the Bank to assess national laws and policies in terms of the Bank's ability to operate in a manner that is consistent with these universal obligations. For example, the introduction of Civil Society law by the Ethiopian government has not only unduly limited freedom of association but also the integrity of the social accountability mechanisms implemented by PBS.[24] Human rights safeguards would have led the Bank to pressure the government to revise such legislation, or discouraged passing it in the first place. If international assistance providers continue to support the Ethiopian government with no mechanism to challenge its human rights records, their actions will contribute to continuing, deepening repression in the country.

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