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PROMOTION ET PROTECTION DE TOUS LES DROITS DE L'HOMME, CIVILS, POLITIQUES, ÉCONOMIQUES, SOCIAUX ET CULTURELS, Y COMPRIS LE DROIT AU DÉVELOPPEMENT

Rapport du Rapporteur spécial sur le droit qu'a toute personne de jouir du meilleur état de santé physique et mentale possible, M. Paul Hunt

Additif

Missions effectuées auprès des services de la Banque mondiale et du Fonds monétaire international à Washington (20 octobre 2006) et en Ouganda (4 au 7 février 2007)[*] [**]

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[*] Le résumé du présent rapport est distribué dans toutes les langues officielles. Le rapport proprement dit est joint en annexe au résumé, et il est distribué dans la langue originale.

[**] La soumission tardive de ce document s'explique par le souci d'y faire figurer des renseignements aussi à jour que possible.

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Résumé

En 2006, le Rapporteur spécial sur le droit qu'a toute personne de jouir du meilleur état de santé physique et mentale possible a effectué une mission en Suède. Cette mission avait pour principal objectif l'élaboration d'un rapport sur l'application par le Gouvernement suédois du droit au meilleur état de santé physique et mentale possible sur son territoire. Toutefois, elle a également permis d'étudier l'impressionnant arsenal de politiques internationales touchant au développement et à la promotion des droits de l'homme, dont le droit à la santé. Le Rapporteur spécial a soumis son rapport sur cette mission au Conseil des droits de l'homme en 2007 (A/HRC/4/28/Add.2).

Par la suite, le Gouvernement a accepté que le Rapporteur spécial examine plus en détail la mise en œuvre des politiques internationales de la Suède qui ont une incidence sur le droit à la santé. En octobre 2006, le Rapporteur spécial s'est rendu à Washington pour s'entretenir avec les Directeurs exécutifs des services de la Banque mondiale et du Fonds monétaire international (FMI) chargés des pays nordiques et des États baltes, ainsi qu'avec d'autres membres du personnel, de la manière dont ils s'efforcent de tenir compte dans leurs travaux des politiques internationales de la Suède en matière de droits de l'homme . En février 2007, le Rapporteur spécial s'est rendu en Ouganda afin d'analyser comment la Suède, notamment l'Agence suédoise de coopération internationale au développement (ASDI), contribue à la réalisation du droit au meilleur état de santé possible en Ouganda. Le présent rapport a été établi sur la base de ces missions et entretiens.

La première partie du rapport décrit les obligations d'assistance et de coopération internationales dans le domaine du droit fondamental à la santé. Celles-ci s'appliquent généralement à l'ensemble des donateurs et des membres de la Banque mondiale et du FMI. Le rapport applique ensuite ce cadre aux éléments de la politique et de la pratique suédoises en Ouganda, ainsi qu'aux travaux des Directeurs exécutifs de la Banque mondiale et du FMI concernés.

Le rapport accorde une large place à la question du renforcement de la responsabilité aux fins du respect par les donateurs de leurs obligations d'assistance et de coopération internationales dans le domaine des droits de l'homme en général et de la santé en particulier. Il comprend de nombreuses recommandations à l'intention d'un large éventail d'acteurs.

Annexe

MISSIONS TO THE WORLD BANK AND THE INTERNATIONAL MONETARY FUND IN WASHINGTON, D.C. (20 OCTOBER 2006) AND UGANDA (4-7 FEBRUARY 2007)

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I. INTRODUCTION

Background: the Special Rapporteur's visit to Sweden in 2006

1. In January 2006, the Special Rapporteur undertook a mission to Sweden. While the primary objective of this visit was to examine Sweden's right to health duties within its jurisdiction, the visit also provided an opportunity to consider how Sweden gives effect to the right to health in its international policies and programmes.

2. In his report on the mission (A/HRC/4/28/Add.2), which he presented to the Human Rights Council in 2007, the Special Rapporteur commended the Government of Sweden for its commitment to mainstreaming human rights in its foreign policies, including those on international development. This commitment is enshrined in an important document, *Human Rights in Swedish Foreign Policy*, which was adopted in 2003.

3. In his mission report, the Special Rapporteur raised the following two fundamental questions about the operationalization of Sweden's international human rights policy:

(a) To what degree has this policy actually been brought to bear upon all aspects of Sweden's foreign policy? For example, while the policy has been given careful consideration by the Swedish International Development Cooperation Agency (Sida), has it also been given due attention in relation to Sweden's policies regarding the World Bank, International Monetary Fund (IMF) and international trade?

(b) To what degree has the policy actually been operationalized? Has Sida, for example, managed to operationalize the policy on the ground in developing countries?

4. In his report, the Special Rapporteur remarked that if these questions were to be subject to close examination, they should not only be put to public officials in Stockholm, but also to some of those working overseas.

5. The Special Rapporteur is therefore very grateful to the Government of Sweden for inviting him to pursue these questions by meeting those Executive Directors who represent Sweden's interests in the World Bank and IMF, and by visiting the Swedish Embassies in Uganda and Zambia, two countries where Sida provides significant support for health-related activities.

6. The Special Rapporteur subsequently wrote to the Governments of Uganda and Zambia requesting to undertake visits to these countries. While the Government of Uganda agreed to the Special Rapporteur's visit, to his regret the Government of Zambia did not extend an invitation. Therefore the Special Rapporteur met with the Executive Directors representing Sweden in the IMF and World Bank in Washington, D.C. and visited Uganda but not Zambia.

7. The Special Rapporteur undertook a mission to Uganda in March 2005. The primary objective of this visit was to address the issue of neglected diseases in relation to the right to the highest attainable standard of health in Uganda. One of the objectives of the Special Rapporteur's visit to Uganda in February 2007 was to follow up on the recommendations made

in the report on his mission undertaken in 2005 (E/CN.4/2006/48/Add.2). The Special Rapporteur will pursue this very important right to health issue by way of letter to the Government of Uganda. The letter and all subsequent correspondence will be included in next year's Communications report.

Visit to Uganda

8. The Special Rapporteur visited Uganda from 4 to 7 February 2007. The central objective of the mission was to understand how Sweden, in particular Sida, contributes to the realization of the right to the highest attainable standard of health in Uganda. In other words, the report considers Sweden's human rights responsibility of international assistance and cooperation in health in the Ugandan context.

9. During the mission, the Special Rapporteur met with the Minister for Health and officials at the Ministry of Health. He also met the Minister of State and senior officials of the Ministry of Foreign Affairs and of the Ministry of Finance, Planning and Economic Development. The Special Rapporteur held extensive discussions with senior staff at the Swedish Embassy, including the Chargé d'Affaires and the First Secretary responsible for health. He held meetings with a number of representatives of international organizations and United Nations agencies working in Uganda, including the World Health Organization (WHO), the Office of the United Nations High Commissioner for Human Rights (OHCHR), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Joint Programme on HIV/AIDS (UNAIDS) and the United Nations Children's Fund (UNICEF). He also met other international organizations and donors, including the World Bank, European Commission, Belgian Technical Cooperation and the Danish International Development Agency. The Special Rapporteur met with the Uganda Human Rights Commission. He also held consultations with representatives of numerous civil society organizations, including the Ugandan Medical Association.

10. The Special Rapporteur visited Mpingi district, where he met with the District Director of Health Services, as well as a village health team. He also visited three civil society organizations working on sexual and reproductive health issues and supported by Sida, namely TASO, the Straight Talk Foundation, and the Naguru Teenage Information and Health Centre.

Visit to Washington, D.C.

11. On 20 October 2006, the Special Rapporteur held meetings with the Executive Directors and other staff of the Nordic-Baltic countries at the World Bank and the IMF in Washington, D.C. The central objective of this visit was to understand the role of Sweden in relation to its membership of the World Bank and IMF and in the context of the right to the highest attainable standard of health. In other words, the report considers Sweden's human rights responsibility of international assistance and cooperation in health in the context of its membership of the World Bank and IMF.

The present report

12. The Special Rapporteur takes this opportunity to thank all those whom he met on his visits to Uganda and Washington, D.C.

13. While much of this report focuses on these visits, the following section has general application. It outlines the human rights responsibility of international assistance and cooperation in health. This is not only relevant to Sweden, but all donors, as well as members of the World Bank and IMF.

14. The human rights responsibility of international assistance and cooperation in health extends to all States, both developed and developing. All States, for example, have a human rights duty to "do no harm" to their neighbours. This report, however, focuses on the human rights responsibility of international assistance and cooperation in relation to high-income countries, such as Sweden.

15. There is increasingly rich discussion about what international assistance and cooperation means when this phrase is used in international human rights instruments.[1] International assistance and cooperation is easier to grasp when focusing on specifics. Thus, this report looks at international assistance and cooperation in relation to one sector (health), one donor (Sweden), and one recipient country (Uganda). Its focus is practice, rather than doctrine. The report aims to give practical guidance about the application of the human rights responsibility of international assistance and cooperation in health.

16. One of the recurrent themes in the Special Rapporteur's reports since 2003 has been the human rights responsibility of international assistance and cooperation in health. He has looked at this issue in several thematic reports (such as E/CN.4/2005/51, A/59/422 and A/60/348) and country reports (such as E/CN.4/2006/48/Add.2 and E/CN.4/2004/49/Add.1). The present report aims to build on, and further particularize, this work.

II. THE HUMAN RIGHTS RESPONSIBILITY OF INTERNATIONAL ASSISTANCE AND COOPERATION IN HEALTH

17. Health is not just a matter of domestic laws, policies and circumstances. The policies of other States, including in trade and development, as well as the policies of intergovernmental organizations such as the World Bank and the IMF, also have a profound impact on health. The control of infectious diseases, the dissemination of health research and so on has an international dimension. In practice, the realization of the right to the highest attainable standard of health is dependent upon international assistance and cooperation. This is especially crucial in relation to low-income countries. Thus, it is very important to clarify the contours and content of the human rights responsibility of international assistance and cooperation in health.

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[1] See for example S. Skogly, *Beyond National Borders: States' Human Rights Obligations in International Cooperation*, 2006; M. Salomon, *Global Responsibility for Human Rights*, 2007; M. Salomon, A. Tostensen and W. Vandenhole (eds.), *Casting the Net Wider: Human Rights, Development and New Duty-bearers*, 2007; the work of the Special Rapporteur on the right to food e.g. E/CN.4/2005/47; and the work of the Working Group on the Right to Development e.g. A/HRC/4/WG.2/2.

18. The right to the highest attainable standard of health is recognized in international human rights treaties ratified by Sweden, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC). As a State party to ICESCR and CRC, Sweden not only has a duty to give effect to the right to health domestically, but also through “international assistance and cooperation”.[2] This human rights responsibility of international assistance and cooperation is reflected in other important international instruments, not least the Charter of the United Nations, the Universal Declaration of Human Rights and the Declaration on the Right to Development. Moreover, this human rights responsibility resonates with other international commitments, such as Millennium Development Goal 8.

19. In recent years, the Committee on Economic, Social and Cultural Rights and others have developed a way of analysing or “unpacking” the right to the highest attainable standard of health with a view to making it easier to understand and apply.[3] The Special Rapporteur and others have refined this analytical approach and, more importantly, applied it to specific health issues (e.g. mental disability, the skills drain, and maternal mortality) and particular country situations (e.g. Peru, Romania and Mozambique).

20. Drawing upon this analytical approach, as well as experience gained from its application, the following paragraphs outline the contours and content of the human rights responsibility of international assistance and cooperation in health.

21. *A supplementary responsibility*: Sweden’s human rights responsibility of international assistance and cooperation in health does not qualify, limit or condition the obligation of the Government of Uganda to do all it can to realize the right to the highest attainable standard of health within its available resources and consistent with its other human rights responsibilities.

22. *Responsibilities to seek and provide assistance*: International assistance and cooperation includes a responsibility on States to seek appropriate assistance and cooperation, and a responsibility on States in a position to assist to provide appropriate assistance and cooperation.

23. *Resource availability*: States are required to take targeted steps to progressively realize the right to health, subject “to the maximum of its available resources”.[4] This includes resources available from the international community. Hence the responsibility of a developing State to seek appropriate international assistance and cooperation.

24. Equally, however, the human rights responsibility to *provide* international assistance and cooperation is also subject to the resources available to a donor. This gives rise to difficult questions. For example, how much should a donor be expected to contribute in the light of its resource availability? When addressing this question, it can be very instructive to consider the

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[2] ICESCR articles 2.1 and 12; CRC article 4. Also see the Charter of the United Nations, articles 55 and 56 and the Universal Declaration of Human Rights, articles 22 and 28.

[3] General comment No. 14 (2000), in particular paras. 38-42.

[4] ICESCR, art. 2, para. 1.

record of comparable donors. It is because international assistance and cooperation give rise to complex, sensitive and important issues that it should be subject to appropriate mechanisms of accountability (see below).

25. *Financial assistance*: The human rights responsibility of international assistance and cooperation includes a duty on high-income States to urgently take deliberate, concrete and progressive measures towards devoting a minimum of 0.7 per cent of their gross national product (GNP) to development assistance.[5] In 2001, the Committee on Economic, Social and Cultural Rights commended Sweden for meeting and sometimes surpassing this target.[6]

26. *Non-financial dimensions of assistance and cooperation*: Crucially, international assistance and cooperation must not be narrowly understood as a duty to provide financial assistance. States must ensure their various international policies do not obstruct, but support, the realization of the right to the highest attainable standard of health in other countries. They have a responsibility to work actively towards an equitable multilateral trade, investment and financial system conducive to the reduction of poverty and the realization of human rights, including the right to the highest attainable standard of health.

27. *Key right-to-health features that international assistance and cooperation should support*: International assistance and cooperation should be directed to give effect to key features of the right to the highest attainable standard of health, including the following:

(a) *Freedoms and entitlements*: Freedoms include the right to be free from discrimination. Entitlements encompass medical care and underlying determinants of health, such as safe drinking water and adequate sanitation. The right to health includes specific entitlements to maternal, child and sexual and reproductive health. Guaranteeing such freedoms and entitlements should be central to States' development and other international policies. The Committee on Economic, Social and Cultural Rights confirms that donors should give particular priority to helping low-income countries realize their "core obligations" arising from the right to health;[7]

(b) *Equality and non-discrimination*: These are integral to the right to the highest attainable standard of health. In their international policies, States should give particular attention to securing the right to health for disadvantaged individuals, communities and populations, such as women, ethnic minorities, indigenous peoples, persons with disabilities, the elderly, children, persons living with HIV/AIDS, sexual minorities, and those living in poverty;

(c) *Participation*: Those affected are entitled to participate in health-related policymaking and implementation. Thus, in the recipient country, international assistance and cooperation in health should promote such participation, especially by those who are

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[5] See Millennium Development Goal 8, target 32.

[6] Concluding observations on Sweden (E/C.12/1/Add.70).

[7] General comment No. 14, para. 45.

disadvantaged. Also, donors' policies of international assistance and cooperation in health should themselves be designed and implemented with the participation of such groups;

(d) *Monitoring and accountability*: Without monitoring and accountability, the right to health can be no more than window dressing. Accordingly, international assistance and cooperation in health should promote effective monitoring and accountability in recipient countries. Also, donors should themselves be held to account for the discharge of their human rights responsibilities of international assistance and cooperation in health (see below).

28. *Obligations to respect, protect* and *fulfil*: The right to health gives rise to three layers of obligations on States: to *respect, protect* and *fulfil*. In the context of international assistance and cooperation in health, States must ensure that their actions *respect* the right to health in other countries. They must also, so far as possible, *protect* against third parties undermining the right to health in other countries. Depending on resource availability, States' obligations to *fulfil* the right to health include responsibilities to facilitate access to essential health facilities and services in other countries.[8]

29. *Procedural fairness*: The requirements of procedural fairness extend to international assistance and cooperation. For example, donors have a responsibility not to withdraw critical right-to-health aid without first giving the recipient reasonable notice and opportunity to make alternative arrangements.[9]

30. *Coherence*: The international right to health must be applied consistently and coherently across all relevant national and international policymaking processes.[10] This includes, for example, the policies of international financial institutions, such as the World Bank and the IMF, as well as States' international development, trade and other policies that bear upon health.[11]

III. SWEDEN'S POLICY FRAMEWORKS ON DEVELOPMENT, HEALTH AND HUMAN RIGHTS

Sweden's national policy commitments

31. During his mission to Sweden in 2006, the Special Rapporteur was impressed by the commitment to human rights in Sweden's foreign policies, including its international

[8] General comment No. 14, para. 39.

[9] See press release of 22 June 2006, "UN health rights expert criticizes donors for failing to fulfil the humanitarian responsibilities in the Occupied Palestinian Territories". Also see UNDP, *Human Development Report 2005: International Cooperation at a Crossroads.*

[10] See E/CN.4/2004/49/Add.1, para. 9, and Commission on Human Rights resolution 2004/27, para. 6.

[11] General comment No. 14, para 39. See E/CN.4/2004/49/Add.1.

development policies. *Human Rights in Swedish Foreign Policy* emphasizes that human rights are a primary concern of Swedish foreign policy. The document includes a commitment to mainstream human rights into the work of global and regional organizations.

32. Human rights are also one of four key objectives in *Shared Responsibility: Sweden's Policy for Global Development.* The policy includes an important commitment to mainstream human rights across all areas of policy connected to international development. Sweden's key health and development policy, *Health is Wealth*, as well as *Sweden's International Policy on Sexual and Reproductive Health and Rights*, also both include commitments to a human rights-based approach to health and development issues.

Sweden's international policy commitments

33. In addition to Sweden's national policies, it has globally agreed commitments on development and health. Only some of these commitments explicitly embrace human rights.

34. Global commitments which have shaped the development and international agenda include the Programme of Action of the International Conference on Population and Development (1994), the Platform for Action of the Fourth World Conference for Women (1995), the Millennium Declaration (2000), the Monterrey Consensus on Financing for Development (2002), and the Plan of Implementation of the World Conference on Sustainable Development (2002). These commitments explicitly recognize the links between development, health and human rights. They have informed, and support, Sweden's international development assistance policies.

Millennium Development Goals

35. The Millennium Development Goals have come to play a defining role in international development, including the policies of donors such as Sida, as well as those of international organizations such as the World Bank and the IMF, and developing countries such as Uganda. Three of the Millennium Development Goals are directly focused on health - the reduction of child mortality, improvement of maternal health and combating HIV/AIDS, malaria and other diseases. While the Millennium Development Goals do not explicitly include a commitment to human rights, they have great potential to support the realization of the right to health (see A/60/438).

Paris Declaration on Aid Effectiveness

36. The Paris Declaration, agreed in 2005 by 90 States, including Sweden, and 26 multilateral organizations, enshrines 56 commitments to make aid more effective. The commitments are organized around five main principles:

(a) *Ownership*: Partner countries exercise effective leadership over their development policies and strategies, and coordinate development actions;

(b) *Alignment*: Donors base their overall support on partner countries' national development strategies, institutions and procedures;

(c) *Harmonization*: Donors' actions are more harmonized, transparent and collectively effective;

(d) *Managing for results*: Donors and partners manage and implement aid in a way that focuses on the desired results and uses information to improve decision-making;

(e) *Mutual accountability*: Donors and partners are accountable for development results.

37. In 2007, the Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD) published the *Action-Oriented Policy Paper on Human Rights and Development*, in which it emphasized the "potential for the international human rights framework and the Paris Declaration to reinforce and benefit from each other".[12] The Paris Declaration has the potential to support the realization of the right to health, while in turn the right to health can support the realization of the Declaration.

38. However, if the Paris Declaration is to support the right to health, then this fundamental human right must help to define the processes and outcome of development. Without a concerted effort to protect and integrate the right to health in the context of national ownership, alignment and harmonization, there is a danger that the right to health will be sidelined. There is a risk that the Paris Declaration will lead to the "lowest common denominator", whereby consensus is achieved at the expense of the promotion and protection of the right to health, including particularly sensitive issues such as sexual and reproductive health rights.

39. All States have ratified at least one international treaty recognizing the right to health. Many also have national constitutional and other legal or policy commitments towards the right to health. The right to health therefore represents a shared commitment of donors and aid recipients. It can act as a common platform for development partnerships in contexts of national ownership, alignment and harmonization. As such, the right to health can and should be integrated into development agreements and policies.

The challenge of implementation

40. Sweden's policies on health, development and human rights are among the best in the world and deserve applause and support. On the whole, Sweden's policies are consistent with its human rights responsibility of international assistance and cooperation in health. The challenge is to put these policies into practice.

41. While some of Sweden's international development commitments explicitly recognize the links between health, human rights and development, regrettably the Millennium Development Goals and the Paris Declaration do not. **The Special Rapporteur recommends that Sweden give particular attention to ensuring that its human rights policies and international human rights obligations are given central attention in the context of implementation of the Millennium Development Goals and the Paris Declaration.**

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[12] Page 9.

IV. INTERNATIONAL ASSISTANCE AND COOPERATION IN HEALTH: SIDA'S EXPERIENCE IN UGANDA

42. This section considers Sweden's human rights responsibility of international assistance and cooperation in health (outlined above in section II) in the specific context of Uganda. It focuses on the work of Sida.

A. The right to health in Uganda

43. Uganda is - like Sweden - a State party to international human rights instruments recognizing the right to the highest attainable standard of health, including ICESCR, CRC and the Convention on the Elimination of All Forms of Discrimination Against Women.

44. Uganda's national Constitution also provides that "all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits",[13] and makes special reference to the human rights of women, children and persons with disabilities.

45. **In view of Sweden's responsibilities under ICESCR and CRC, the principle of alignment enshrined in the Paris Declaration, and Uganda's domestic and international right to health obligations, the Special Rapporteur welcomes Sweden's international assistance and cooperation in health, which helps the Government of Uganda to fulfil its constitutional and international obligations towards the right to health.**

46. The Ugandan health and development context provides important background to understanding how Sweden contributes to the realization of the right to health in this country. Due to the word limits of this report, the Special Rapporteur refers readers to the analysis of health and development provided by the report on his mission to Uganda in 2005.[14]

B. How does Swedish development assistance support the realization of the right to health in Uganda?

Sida's development assistance strategy in Uganda

47. Sweden's *Country Strategy for Development Cooperation, Uganda: 2001-2005* remained the basis for Sida's development assistance to Uganda at the time of the Special Rapporteur's mission. The Strategy emphasizes that combating poverty in accordance with Uganda's Poverty Eradication Action Plan (PEAP) is Sweden's overall objective for development collaboration with Uganda. Key elements of the Strategy include support to the social sector, including health, and to democratic development and the promotion of fundamental human rights. The Strategy places particular emphasis on strengthening the rights of women and children.

48. Despite its commendable focus on health and human rights, the Strategy does not explicitly recognize the right to health. Human rights are not mainstreamed consistently throughout

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[13] Constitution of the Republic of Uganda, 1995, section XIV (b).

[14] E/CN.4/2006/48/Add.2, paras. 10-14.

Sweden's development cooperation in Uganda, including in Sida's support to the health sector. **Sida should mainstream human rights, including the right to health, in its Uganda Country Strategy. Consideration of the key features of the right to health will help Sweden realize its human rights responsibility of international assistance and cooperation in health.**

49. The Special Rapporteur was pleased to learn that Sida's staff in Kampala is committed to integrating a human rights-based approach into Sweden's forthcoming Uganda Country Strategy. An adequate understanding of human rights, including the right to health, by Sida staff in country offices such as Uganda is vital if the organization is to operationalize its excellent policies on health, human rights and development in Uganda and elsewhere. **The Special Rapporteur recommends that Sida enhance its provision of training, resources and advice on health and human rights that is available to its staff in country offices, including in Uganda.**

50. **As far as possible, Sida should also extend training and capacity-building on human rights to Ugandan health policymakers and other health development partners in Uganda.**

The level of assistance for the right to health provided by Sweden to Uganda

51. A large number of international organizations, donors and non-governmental organizations (NGOs) are engaged in development assistance in Uganda. Between 1994 and 2004, aid flows averaged 11 per cent of gross domestic product (GDP). However, the Uganda health sector remains seriously underfunded. While African heads of State and Government have set a target of devoting at least 15 per cent of their budgets to health,[15] the Government of Uganda currently devotes only 9 per cent. Without more funds, many of Uganda's impressive health policies, including many elements of the Health Sector Strategic Plan II (HSSPII), will not be operationalized.

52. In terms of volume of aid for health, Sida is one of the largest donors working in Uganda, providing significant assistance to the health sector. In 2006, Sida provided US$ 55 million development assistance to Uganda, including US$ 13 million for health, as well as US$ 13 million for humanitarian assistance, which encompassed health.

53. While commending the Government of Sweden, the Special Rapporteur urges Sida to continue to provide generous support to health in Uganda, and to work together with the Government of Uganda and other donors to ensure that adequate funding is provided to the health sector.

Sida's support to key right-to-health stakeholders in Uganda

54. Sida provides support to a range of actors who have a critical role in operationalizing the right to health in Uganda, including the Government, international organizations, the Uganda Human Rights Commission and civil society.

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[15] Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases, para. 26.

Government

55. *The right to health in Sweden's agreements with the Government of Uganda*: Four agreements form the basis of this support: the Memorandum of Understanding between the Government of Sweden and the Government of Uganda on Development Cooperation (2001-2003);[16] the Specific Agreement between the Government of Sweden and the Government of Uganda on Health Sector Support (July 2003-June 2007); the Partnership Principles between the Government of Uganda and its Development Partners (2003); and the Memorandum of Understanding between the Government of Uganda and various health partners for the Implementation of the National Health Policy and the HSSPII (2005-2010).

56. Significantly, none of these agreements refer to the right to health. Only the first agreement includes human rights as a point of reference. **The Special Rapporteur recommends that the right to health, and other human rights, are explicitly and consistently integrated into Sida's development cooperation agreements with Uganda.**

57. *Sector and direct budget support*: Concerned by fragmented planning and delivery of aid, the Government of Uganda is keen to ensure that aid is aligned with national policies and administrative processes. With this in mind, the Government has encouraged donors to commit to budget or sectoral support, rather than project-based support.

58. The health-related development cooperation agreements between the Government of Uganda and Sida emphasize that Sida's support to the Government will be primarily provided by way of health sector support and direct budget support. In 2006, Sida delivered approximately one third of its development assistance by way of direct budget support, and one third by way of sectoral support to the health sector.

59. The provision of development assistance by way of sector or budget support means that much of Sida's development assistance to the Government is aligned to the priorities identified in Uganda's national health-related policies. In order to understand how Sida supports the right to health in Uganda, it is therefore important to understand how the right to health is promoted and protected in the context of Uganda's national health-related policies.

60. In recent years, the Government and its development partners, including Sida, as well as international organizations and civil society, have begun to give attention to the relationship between the Government's health policies and human rights. The Government, with support from WHO and OHCHR, convened a health and human rights stakeholders' meeting in 2006. In the same year, the Ministry of Health and other partners established a Health and Human Rights Team, to be coordinated by the Ministry of Health. During his mission, the Special Rapporteur participated in a workshop organized by the Ministry of Health, Sida, WHO and OHCHR on the issue of a human rights-based approach to health.

61. The workshop provided important insights into the strengths and weakness of HSSPII from the point of view of the right to health, such as:

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[16] This agreement was amended and extended until June 2007.

(a) *Explicit commitment to the right to health and other human rights*: The HSSPII does not explicitly recognize the right to health, or mainstream a right to health approach. However, the Plan does include explicit commitments to the rights of people with psychosocial disabilities (“the mentally ill”) and to sexual and reproductive health rights;

(b) *Attention to key right to health issues*: Although the right to health is not explicitly mainstreamed throughout HSSPII, the document nevertheless includes commitments to important right to health issues, including health systems strengthening. While the document includes a commitment to sexual and reproductive health rights, with a particular focus on reducing maternal mortality, it does not give adequate attention to important but particularly sensitive sexual and reproductive health rights issues in Uganda, such as the high rate of unsafe abortion, and the right to health of particular groups, including men who have sex with men;

(c) *Equality and non-discrimination*: HSSPII includes gender as a cross-cutting theme. It enshrines the right to health principles of equality and non-discrimination through attention to the rights of children, women and other vulnerable groups, including people living in poverty;

(d) *Participation*: HSSPII includes important commitments to participation. Civil society was involved in the development of the policy, and is also playing an important role in implementation and monitoring. HSSPII includes important commitments to community participation in the development and delivery of health care and promotion, including through the mechanism of Village Health Teams (VHTs). VHTs usually constitute five volunteers from the community and trained by the Ministry of Health. The teams help deliver drugs and health information. They have a potentially important role to help identify communities’ health needs. The VHTs serve as the first link between the community and the formal health providers. HSSPII states that the establishment of functional VHTs is a priority;

(e) *Monitoring and accountability*: HSSPII includes a focus on monitoring and accountability. However, from the point of view of the right to health, some features should be strengthened. For example, indicators are not consistently disaggregated, making it difficult to monitor the human rights principles of equality and non-discrimination.

62. **In order to support the realization of the right to health in Uganda, the Special Rapporteur encourages Sida to support the Government of Uganda in its endeavours to mainstream the right to health in HSSPII, as well as other health-related policies, such as the Poverty Eradication Action Plan (PEAP).**

63. **The Special Rapporteur also recommends that Sida endeavour to ensure that important right to health issues which are not fully captured in the Governments policies, such as sexual and reproductive health rights, are given attention in its dialogue and agreements with the Government and other actors.**

64. **Despite the merits of HSSPII, the Special Rapporteur emphasizes that some of the Plan’s priorities remain underfunded. He urges Sida to work with the Government of Uganda to ensure adequate funding for implementation of the Plan.**

65. *Harmonization between donors*: As well as promoting donor alignment with national policies, the Government of Uganda promotes harmonization of development assistance between

donors. This has led, for example, to the Health Sector Wide Approach (2000), the Partnership Principles for the PEAP (2003) and, most recently, the Uganda Joint Assistance Strategy (UJAS: 2005-2009) prepared by seven donors including Sida. The UJAS will form a framework for Sida's development cooperation with Uganda until 2009.

66. **Alignment and harmonization have reportedly led to greater coordination between donors in planning and delivery of aid, and have also lessened administrative burdens on the Government of Uganda. From this point of view, the Special Rapporteur commends the efforts of donors.**

67. **The Special Rapporteur encourages Sida to ensure that the right to health informs harmonization and is not neglected in the search for common ground between donors.**

International organizations

68. In Uganda, Sida provides financial support for programmes and activities of, and engages in dialogue with, a range of international organizations, including WHO, UNFPA, UNAIDS and UNICEF. Many of them support important programmes, or provide technical advice, relating to the right to health in Uganda.

69. Since 2005, Sida has provided funding for the appointment of a Health and Human Rights Officer in WHO Uganda, who played an important role in promoting awareness of health and human rights issues in Uganda and supporting initial steps towards the integration of human rights in policy and development planning within the health sector. **The Special Rapporteur warmly commends this important collaboration between Sida and WHO Uganda. The Special Rapporteur encourages Sweden to continue to provide strategic support to international organizations working on health and human rights in Uganda. He encourages Sida to continue to provide support to WHO in Kampala by ensuring funding for the post of a Health and Human Rights Officer.**

Uganda Human Rights Commission

70. The Uganda Human Rights Commission is active on issues such as human rights education, complaints handling, visits to places of detention, and the situation of disadvantaged groups, such as women, children and people living with HIV/AIDS. In 2005-2006, Denmark, Ireland and Sweden contributed US$ 1.4 million to the Commission by way of a basket-fund.

71. To its great credit, the Commission has recently established a right-to-health unit to monitor, and hold to account, national and international actors in the public and private health sectors. However, currently the unit has negligible funding. **The Special Rapporteur**

emphasizes that accountability provided by national human rights institutions has an important role to play in holding duty bearers to account for the right to health. He therefore vigorously encourages Sida and other development partners to support this important new initiative.

Civil society organizations

72. Civil society organizations (CSOs) play an important role as health service providers in Uganda. In recent years, they have also become increasingly engaged in advocacy. They have engaged with the Government in formulating, implementing and monitoring key health policies, such as HSSPII and PEAP. Through their advocacy, they have enhanced awareness of human rights issues in the health sector.

73. **The Special Rapporteur recommends that Sida support the participation of CSOs in policymaking forums and monitoring mechanisms, such as health sector working groups, Joint Review Missions and the National Health Assembly.**

74. In 2005, Sida contributed approximately US$ 15 million for organizations working on HIV/AIDS and also on young people. **The Special Rapporteur had the opportunity to visit three of these organizations during his visit (see above) and commends Sida for its support to these excellent organizations, which are making important contributions to realizing sexual and reproductive health rights, including for adolescents.**

75. During his visit, the Special Rapporteur learned that some donors, including Sida, were discussing the establishment of a basket-fund (i.e. pooled funding) for health-focused CSOs. While the details were not finalized at the time of the Special Rapporteur’s visit, some CSOs were concerned that a basket-fund would jeopardize their funding. **If or when a basket-fund is established for health NGOs, this must not jeopardize Sida’s support for CSOs working on right to health issues, including those committed to sensitive initiatives, such as the provision of sexual and reproductive health information for adolescents.**

Health professionals

76. While health professionals have a pivotal role to play in realizing the right to health, they require human rights training. The Ugandan Medical Association recently established a Health and Human Rights Committee that will examine the issue of human rights training for health professionals. Similarly, the Action Group for Health, Human Rights and HIV/AIDS recently co-organized an international training course on human rights for health professionals in Kampala. **The Special Rapporteur encourages Sweden and other development partners to support such initiatives.**

Accountability for Sweden’s human rights responsibility of international assistance and cooperation in health

77. Accountability is a vital feature of human rights, including the right to health. In the development context, accountability has focused on recipient countries. Recipients have had to show that aid is spent as intended and with the desired outcomes. Such accountability is vitally important. However, the right to health (and other human rights) also demands the accountability

of donors. Donors' accountability moves in two directions. Firstly, they are accountable to their taxpayers, usually through Parliament. Secondly, they are accountable to recipients and the international community. These paragraphs focus on donors' accountability to recipients. For recipients the key question is: has the donor honoured its pledges and policies? In other words, has the donor discharged its human rights responsibility of international assistance and cooperation in health?

78. In Uganda, many stakeholders - including the Government, international organizations, civil society and donors - impressed upon the Special Rapporteur how important it is that all duty bearers, including donors, are held to account in relation to their duties arising from the right to health.

79. Commendably, Sweden and some other donors have produced Millennium Development Goal Reports, highlighting how they are supporting the fulfilment of the Millennium Development Goals. The OECD Development Assistance Committee also has a peer review process that assesses the development policies and efforts of its members. The Paris Declaration on Aid Effectiveness enshrines a commitment to "mutual accountability", in other words, a commitment to mutual assessment by donors and partners regarding implementation of agreed undertakings. The accountability of donors to the Governments of recipient countries is beginning to receive serious attention.

80. A lack of information about donors' policies and programmes, as well as a scarcity of accountability mechanisms, present significant obstacles to donors' accountability in Uganda.

81. **The Special Rapporteur recommends that Sida prepare and distribute accessible information about its programmes in Uganda and their implementation. Pamphlets in local languages could be made publicly available, and newspapers could be invited to carry articles and notices. The Special Rapporteur also recommends that Sida work with the Government of Uganda and other development partners to enhance public access to information on national health policies and processes, such as HSSPII and the JRMs, since these initiatives are vital vehicles for donors' international assistance and cooperation in health.**

82. As well as access to information, appropriate mechanisms are required to hold Sida accountable. The following paragraphs signal a range of complementary mechanisms that may be developed to enhance the accountability of donors, such as Sida.

83. *Government*: Joint Review Missions (JRMs) annually assess the performance of the health sector. They also monitor implementation of the Memorandum of Understanding between the Government of Uganda and its health development partners. The Missions are composed of representatives from the Ugandan Government and its health development partners. The JRMs already provide an opportunity to assess and hold donors to account for their sectoral budget support. They could be developed to deepen donors' public accountability.

84. *Parliament*: The Ugandan Parliament could provide a forum to hold Sida accountable. The Sessional Committee on Social Services of the Ugandan Parliament is mandated to oversee the activities of the Ministry of Health, as well as other health-related government bodies, such as the Uganda AIDS Commission. This Committee could play a role in exercising parliamentary

accountability not only for the performance of national ministries, but also for the support provided by health donors. The Swedish Ambassador, for example, could be invited to make a presentation to the Committee and answer questions.

85. *Uganda Human Rights Commission*: **The Special Rapporteur recommends that the Commission's right-to-health unit monitor the policies of Uganda's donors, as well as those of the national Government, with a view to deepening accountability.**

86. *Civil society*: Sida should be encouraged to report to key civil society meetings.

87. *Multi-stakeholder forums*: The National Health Assembly meets every two years. A range of stakeholders attends: health-related ministries, local health authorities, parliamentarians, international organizations and civil society. The Assembly reviews health sector performance and strategizes about future work. With appropriate information, the Assembly could review donors' contributions to the realization of the right to health in Uganda.

88. **Sida should be accountable to Uganda for its initiatives that impact upon the health of the Ugandan people. The Special Rapporteur recommends that Sida, and others, actively seek practical, realistic ways to enhance accountability to the Ugandan Government, Parliament and public. For example, Sida could submit reports to a Committee of the Ugandan Parliament, as well as to the National Health Assembly. The Uganda Human Rights Commission could monitor Sida's health-related initiatives. These and other possibilities - some of them signalled in the preceding paragraphs - should be actively explored in close consultation with the Government of Uganda.**

V. WORLD BANK AND THE INTERNATIONAL MONETARY FUND

89. The World Bank is a significant source of financial and technical assistance to developing countries. The institution provides low-interest loans and interest free credit and grants to support developing countries, including in relation to health. Poverty reduction is a central objective of the Bank.

90. The mandate of the IMF includes the promotion of international monetary cooperation, fostering economic growth and high employment, and providing temporary financial assistance to countries to help ease balance-of-payments adjustments.[17] In recent years, IMF policies and activities have been adapted to support the context of poverty reduction policies in developing countries.

91. World Bank and IMF policies and programmes have sometimes a significant impact on the right to the highest attainable standard of health, in particular in low-income countries.[18] For instance under the Heavily Indebted Poor Countries (HIPC) initiative the World Bank and IMF provide concessional lending and debt relief to poor countries. To receive debt relief, countries

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[17] IMF, Articles of Agreement, art. 1.

[18] For further discussion, see R. Hammonds and G. Ooms, "World Bank Policies and the Obligation of its Members to Respect, Protect, and Fulfil the Right to Health", *Health and Human Rights*, 2004, p. 46.

must prepare a poverty reduction strategy paper (PRSP) for approval by the IMF and World Bank, who then periodically assess implementation. Most strategy papers include a multi-year budget projection called a medium-term expenditure framework (MTEF), which includes spending targets for various sectors of the Government. While the HIPC provides debt relief to countries with unsustainable debt burdens, and thereby helps in accelerating progress towards the attainment of the Millennium Development Goals, in some countries health-spending targets identified in the MTEF have functioned, at least temporarily, as health-spending ceilings.[19]

92. The Special Rapporteur's meetings with the Executive Directors representing Sweden at the IMF and World Bank provided him with an opportunity to discuss how Sweden is implementing its policies on health, development and human rights in the context of its membership of these institutions, as well as obstacles encountered.

93. In 2001, the Committee on Economic, Social and Cultural Rights encouraged Sweden, as a member of international financial institutions, in particular the World Bank and IMF, to "do all it can to ensure that the policies and decisions of those Organizations are in conformity with the obligations of States parties to the Covenant, in particular the obligations contained in articles 2.1, 22 and 23 concerning international assistance and cooperation". [20]

94. The Special Rapporteur's meetings with the Executive Directors also provided him with an opportunity to discuss how Sweden is implementing the Committee's recommendation.

A. Governance of the IMF and World Bank: Sweden's role and human rights responsibilities

95. The decision-making procedures of the IMF and World Bank have a significant bearing on Sweden's opportunities to mainstream its international policies on development, health and human rights in the context of its membership of these organizations.

Boards of Governors

96. Both the World Bank and IMF are composed of 185 shareholding member States. The highest decision-making body of each institution is a Board of Governors, which consists of representatives from each shareholder's Government. The Boards of Governors meet on an annual basis.

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[19] G. Ooms and T. Schrecker, "Expenditure ceilings, multilateral financial institutions, and the health of poor populations", vol. 365, Lancet, pp. 1821-1823.

[20] Concluding observations on Sweden (E/C.12/1/Add.70, para. 24).

97. The Minister for Finance represents Sweden on the World Bank Board of Governors, and Sweden's Alternate Governor to the World Bank is the Minister for International Development Cooperation. The governor of the central bank in Sweden represents Sweden on the IMF Board of Governors, and Sweden's Alternate Governor to the IMF is the State Secretary to the Minister for Finance.

98. **The Special Rapporteur emphasizes that Sweden's representatives on the Boards of Governors should ensure that their votes and other activities are informed by Sweden's international human rights obligations, including its human rights responsibility of international assistance and cooperation in health.**

Executive Directors and Executive Boards

99. The Governors delegate responsibility for overseeing the day-to-day business of the institutions to their designated representatives on the World Bank and IMF Executive Boards. The Executive Boards for the World Bank and IMF are each made up of 24 Executive Directors representing the 185 member countries.

100. The Executive Directors are based in Washington and normally meet twice a week to oversee day-to-day business, including approving loans and guarantees, new policies, the administrative budget, country support strategies, and borrowing and financial decisions. Even though Executive Directors are accountable to the Governments which they represent, it is anticipated that they exercise their functions independently.

101. Sweden shares its representation on the Executive Board of the Bank and IMF with Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, and Norway. Mr. Svein Aass (Norway) is currently the Executive Director representing these countries on the Executive Board of the World Bank, and Mr. Tuomas Saarenheimo (Finland) is the incumbent Nordic-Baltic Executive Director at the IMF. Each Executive Director is supported by an Alternate Executive Director and a team of advisors from the member countries.

102. The decisions of the Executive Boards are, by and large, based on consensus. In situations where there is a conflict of views amongst the Executive Directors, the issue is decided by a simple majority of the voting power. Votes are weighted among the Executive Directors on the basis of the size of the shareholding of the countries that they represent.

103. As a rule, Executive Directors representing more than one country must cast a single block vote for the member countries that they represent. The joint voting share of Sweden and the other Nordic and Baltic countries on the Executive Board of the World Bank (International Bank of Reconstruction and Development) is 3.34 per cent of the total votes and 3.45 per cent of total votes on the Executive Board of the IMF.

104. The meetings that the Special Rapporteur held with the Executive Directors confirmed that support and political guidance from constituency countries play an important role in defining Nordic-Baltic policy positions in deliberations of the Executive Boards. However, since the decisions of the Boards are based on consensus, and the positions of individual Executive Directors or the countries that they represent are normally undisclosed, it is difficult to assess

Sweden's impact on the overall decisions made by the Board. **The Special Rapporteur encourages Sweden to make publicly available the views and positions taken by its Executive Directors in Executive Board discussions.**

105. In a move to create greater transparency and accountability, the Spanish Parliament has recently passed a motion requiring its World Bank and IMF Executive Directors to report annually to Parliament on the positions taken by them on behalf of Spain at the World Bank and IMF. **The Special Rapporteur encourages Sweden to establish a transparent, accessible and effective mechanism to monitor and hold to account their Executive Directors in respect of human rights and their functions at the World Bank and the IMF.**

106. All the countries represented by the Nordic-Baltic Executive Directors have ratified ICESCR and CRC, and all therefore have a human rights responsibility of international assistance and cooperation in health. **The Government of Sweden should do all in its power to ensure that the positions taken by the Nordic-Baltic Executive Directors in Executive Board meetings promote policies and decisions that are in conformity with the obligations of States parties to ICESCR and CRC. The Special Rapporteur encourages other member countries of the Nordic and Baltic office to support Sweden in implementing human rights-based policies and programmes.**

B. Human rights and the World Bank and IMF: institutional obstacles

107. While Sweden's international policies on development, health and human rights are among the best of the world, there are some institutional barriers in the operationalization of these programmes and policies in the World Bank and the IMF.

The mandates of the World Bank and IMF to address human rights

108. Over the years, some senior World Bank and IMF staff have argued that their institutions have neither the mandate nor competence to address human rights issues. For instance, in 2001 the IMF General Counsel François Gianviti, in an informal opinion, rejected the applicability of the International Covenant on Economic, Social and Cultural Rights to the Fund on the grounds that the obligations imposed by the Covenant applied only to States, not to international organizations.[21] Regrettably, these views have tended to discourage other staff from examining the human rights dimensions of their work.

109. These views are being challenged from both within and outside these institutions. In a recent analysis it is argued that the IMF, as a subject of international law, has human rights obligations; economic, social and cultural rights are a part of general international law that is binding outside the treaty regimes and therefore create binding obligations for the IMF.[22]

[21] E/C.12/2001/WP.5.

[22] A. Clapham, *Human Rights Obligations of Non-State-Actors*, 2006, pp. 147-149. Also see S. Skogly, *The Human Rights Obligations of the World Bank and IMF*, 2001.

110. Similarly, Roberto Danino, the then General Counsel of the World Bank, argued that the Bank's objectives and activities are deeply supportive of human rights and that a more explicit approach to human rights is not only consistent with the organization's Articles of Agreement, but is essential if the institution is to fulfil its poverty reduction mission of economic growth and social equity in a changing world.[23] More recently, the new World Bank General Counsel, Ana Palacio, also expressed support for the incorporation of human rights concepts into the work of the organization.[24] **The Special Rapporteur supports this view and encourages Sweden to use its influence on the Governing and Executive Boards of the World Bank and IMF to ensure that these institutions respect human rights in force in borrowing countries, and to promote and integrate human rights within their policies and programmes in accordance with their mandates.**

Familiarity with human rights within the World Bank and the IMF

111. Certain institutional and cultural barriers within the World Bank and IMF impede the integration of human rights dimensions within their policies, programmes and projects.[25] For instance, the Bank and IMF primarily consist of economists and financial experts who specialize in lending techniques that can be measured quantitatively. This approach regards economic and financial variables as the ones that matter and largely ignores their critically important social context. In addition the "approval culture" in the Bank reflects an emphasis on the approval of large projects with large amounts to the neglect of negative environmental and social impacts of these projects.[26]

112. Another obstacle in the development of human rights policies and programmes within the Bank and IMF is the lack of human rights training opportunities for the staff, as well as the members of the Executive Boards of these organizations. The lack of understanding of human rights contributes to internal resistance in the Executive Board to the application of human rights in these institutions.[27] As a result, human right concerns are not adequately considered by the Executive Board. Even when they are, their scope is generally limited to civil and political rights only.

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[23] R. Danino, *Legal Opinion on Human Rights and the Work of the World Bank*, Senior Vice-President and General Counsel, World Bank, January 2006.

[24] A. Palacio, "The Way Forward: Human Rights and the World Bank", *Development Outreach*, October 2006, pp. 35-37.

[25] M. Darrow, *Between Light and Shadow, 2003*, p. 196.

[26] Ibid., p. 197.

[27] Ibid., p. 200.

113. **The Special Rapporteur encourages Sweden to provide its Executive Directors, as well as other staff in the Nordic and Baltic office, with human rights training, resources and advice. He also calls on the Government of Sweden and Sweden's Executive Directors to support the provision of human rights training for other World Bank and IMF Executive Directors and the staff in their respective offices, and staff working in the World Bank and IMF themselves.**

The Paris Declaration on Aid Effectiveness

114. The World Bank and many of its members, including Sweden, are signatories to the Paris Declaration on Aid Effectiveness. As the Special Rapporteur has already emphasized, there is significant potential for mutual reinforcement between human rights and the Paris Declaration. However, a restrictive interpretation of the Paris commitments to national ownership, alignment and harmonization, whereby progressive policies are watered down to a "lowest common denominator", could obstruct promotion and protection of the right to health in the context of the Bank's operations.

115. Similarly, "new aid modalities" are often interpreted as leading towards a diminishing support for CSOs. CSOs play an important role in the promotion and protection of human rights and in ensuring donor accountability. **The Special Rapporteur calls upon Sweden to ensure that "new aid modalities" do not lead to diminishing support for CSOs.**

116. The "managing for results" requirement under the Paris Declaration is about promoting a results-oriented approach in aid relationships. Human rights should be used to define the results to be achieved and the strategies needed to achieve them.

117. **The Special Rapporteur encourages the Government of Sweden to ensure that its Executive Directors and Governors support the right to health in the contexts of national ownership, alignment, harmonization, managing for results and mutual accountability. In other words, they should ensure that the Bank supports countries to realize their right-to-health commitments, and that Bank policies and strategies are also supportive of the right to health.**

118. Along these lines, the Special Rapporteur was pleased to learn that the Nordic-Baltic Executive Directors, and several other Executive Directors, recently acted to ensure that the Bank's Strategy for Health, Nutrition and Population (2007) incorporated sexual and reproductive health and rights, issues which had been marginalized in the earlier draft strategy.

Unequal representation on the Executive Boards

119. The programmes and policies of the World Bank and the IMF affect the lives of people living in developing countries in many ways. However, decision-making in respect of these programmes and policies often fails to take into account particular circumstances existing in these countries. Unequal representation of developing countries on the Executive Boards could be seen as one of the reasons for such a failure. For instance, while Sweden has 1.09 per cent of the total voting power on the Executive Board of the IMF, Mozambique has only 0.06 per cent.

120. There is a need to strengthen the voice of developing countries in decision-making processes. There is therefore a need to make the process more democratic and transparent by giving equal voice to developing country members, in terms of both their voting capacity and their membership on the Board. **The Special Rapporteur recommends that Sweden support the development of more democratic decision-making structures on the Executive Boards of the World Bank and the IMF.**

C. Conclusions and recommendations

121. To take the human rights agenda forward in the World Bank, Sweden and the other Nordic countries have proposed a trust fund for justice and human rights in this institution for a five-year period.

122. Initially, the proposed fund will finance capacity-building for World Bank staff on human rights issues, selected pilot projects linked to the national Poverty Reduction Strategies and the development of indicators for efficient human rights and justice programmes. In addition, it will contribute to promoting the participation of the World Bank in donor coherence dialogues on human rights and related issues.

123. The Nordic fund aims to enhance the World Bank's capacity to undertake human rights analysis. It also aims to support the Bank's launch of some pilot projects to test the relationship between human rights, democratic processes and poverty reduction. **The Special Rapporteur warmly commends all those involved in this initiative and encourages them to work towards implementing this proposal, and to develop a similar fund for building the capacity of the IMF on human rights issues.**

124. The activities of the World Bank and IMF affect human rights outcomes in developing countries in positive and negative ways. Their policies and programmes can reinforce societal divisions and exacerbate conflict if issues such as race, ethnicity and gender are not taken into consideration. The World Bank and IMF should therefore promote human rights, equity and social inclusion in their policies and programming. **The Special Rapporteur encourages Sweden to work with other members of the World Bank and IMF to ensure that human rights are integrated in the policies and programmes of these institutions.**

125. In the longer term, the Special Rapporteur considers that there is a need for the IMF and the World Bank to adopt human rights policies. This would give greater legitimacy to difficult and contested policy choices, and strengthen policy coherence and coordination among donors. **The Special Rapporteur encourages Sweden to work proactively with other members of the World Bank and IMF to support the development of human rights policies for these organizations.**

126. **The policy decisions taken by the Executive Directors are dependent on the guidance received from the countries they represent. In this regard the Special Rapporteur calls on Sweden to ensure that in its interactions with the Executive Directors, economic, social and cultural rights, such as the rights to health, housing, food and education, are given due consideration.**

127. The Country Policy and Institutional Assessment (CPIA) annually assesses the quality of IBRD and IDA borrowers' policy and institutional performance in areas relevant to economic growth and poverty reduction. In the past the CPIA process has privileged a limited category of rights. **The Special Rapporteur calls on Sweden to ensure that economic, social and cultural rights are given due consideration in the CPIA.**

128. **At present, there is a fragile link between the World Bank and the IMF and the people that are affected by their operations. The only formal recourse available to a recipient country to express its discontent in relation to a particular programme or policy is at the annual meeting of the Board. The Special Rapporteur encourages staff and members of the Nordic-Baltic office representing Sweden to use these meetings as an opportunity to ascertain and take on board the developing country perspectives on their programmes and policies.**

129. **The Special Rapporteur encourages Executive Directors representing Sweden at the World Bank and the IMF to devise mechanisms to deepen their dialogue with all stakeholders in developing countries. For example, they should engage with CSOs at both global and national levels. Further, they should consider developing accountability arrangements comparable to those outlined in paragraphs 76 to 87.**

VI. CONCLUSION

130. **This report has taken a practical, specific and detailed approach with a view to exploring the scope of the human rights responsibility of international assistance and cooperation in health. In conclusion, however, a few words are needed about one fundamental legal issue.**

131. **Throughout his mandate, the Special Rapporteur has taken the position that the human rights responsibility of international assistance and cooperation is underpinned by legal obligation. The Committee on Economic, Social and Cultural Rights, and others, adopt the same position. The legal obligation can be traced from the Charter of the United Nations, through to the Universal Declaration of Human Rights and binding human rights treaties, such as the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities.**

132. **Sweden does not accept that it has a legal obligation of international assistance and cooperation. While other high-income States share Sweden's view, middle-income and low-income countries disagree.**

133. **However, if there is no legal obligation underpinning the human rights responsibility of international assistance and cooperation, inescapably all international assistance and cooperation fundamentally rests upon charity. While such a position might have been tenable in years gone by, it is unacceptable in the twenty-first century.**

134. **From the right-to-health perspective, Sweden's international policies on development, health and human rights are among the best in the world. Generally, Sweden provides very significant support for developing States. While there is scope for improvement, Sida's**

programmes in Uganda are broadly consistent with Sweden's human rights responsibility of international assistance and cooperation in health.

135. **Recognition of a legal obligation underpinning its human rights responsibility of international assistance and cooperation in health would primarily serve to reinforce Sweden's existing international policies and practices. For a country with Sweden's commendable record, recognition of a legal obligation would not demand a significantly different approach. Accordingly, the Special Rapporteur encourages Sweden to play a leading role in exploring the contours, content and legal nature of the human rights responsibility of international assistance and cooperation.**