

Abstract

The right to health of children is recognized by every country in the world. Nevertheless, the resources necessary to achieve respect for this right are lacking in many countries. Realizing this, the international community has increasingly recognized the role of intergovernmental actors in promoting health. The World Bank is one of these intergovernmental actors. In recent years, the World Bank has become the largest investor in health in Africa. At the same time, the Bank remains constrained by its mandate and policies. These constraints are in part a result of the Bank's failure to adopt a human rights approach to child health. The Bank's policy emphasizes temporal needs and competing priorities that often undermine the right to health.

Le droit à la santé des enfants est reconnu dans tous les pays du monde. Néanmoins, les ressources nécessaires permettant le respect de ce droit manquent dans de nombreux pays. À partir de ce constat, la communauté internationale a reconnu de plus en plus le rôle des acteurs intergouvernementaux dans la promotion de la santé. La Banque Mondiale est un de ces acteurs intergouvernementaux. Ces dernières années, la Banque Mondiale est devenue l'investisseur le plus important dans le domaine de la santé en Afrique. Au même moment, la Banque reste gênée par son mandat et sa politique. Ces contraintes sont en partie liées à l'échec de la Banque d'adopter une approche des droits de l'homme en matière de santé de l'enfant. La politique de la Banque met l'accent sur des besoins temporaires et des priorités concurrentes qui sapent souvent le droit à la santé.

El derecho de los niños y las niñas a la salud es reconocido en todos los países del mundo. No obstante, en muchos países se carece de los recursos necesarios para lograr que se respete este derecho. Consciente de esta situación la comunidad internacional reconoce y le da cada vez mayor importancia al papel que desempeñan los actores intergubernamentales en la promoción de la salud. El Banco Mundial es uno de esos actores intergubernamentales. En los últimos años el Banco Mundial se ha convertido en la mayor fuente de financiamiento en el campo de la salud en África. Sin embargo, las inversiones del Banco Mundial están limitadas por su mandato y sus políticas. Estas limitaciones se deben en parte a que el Banco Mundial no ha logrado adoptar un planteamiento de salud infantil basado en los derechos humanos. La política del Banco Mundial hace énfasis en necesidades temporales y en prioridades que compiten entre sí y que con frecuencia socavan el derecho a la salud.

THE RIGHT TO HEALTH OF CHILDREN AND THE WORLD BANK

Curtis Francis Doebbler

The child must be given the means requisite for its normal development, both materially and spiritually.

Article I of the Declaration of the Rights of the Child (1923).

Human rights may often appear to be *nonsense on stilts* to World Bank policymakers, just as they did 200 years ago to English philosopher Jeremy Bentham. But the many changes that have taken place in the last 200 years would undoubtedly have converted Bentham's skepticism into staunch support. Perhaps the most important reason is that today there is widespread consensus on the right to health. There is, to borrow from Bentham's famed language, *a greatest number of the world's population who believe that their right to health provides them with the greatest good for the greatest number of them*. In other words, most people throughout the world expect their government to provide them with an adequate level of health care. This is an expectation that has been acknowledged and confirmed in legally binding treaties by most of the world's governments. One might conclude that there is an overwhelming consensus that there is a human right to health. This is nowhere more true than in the case of the right to health of children.

This article considers the World Bank's role in respecting, protecting, and fulfilling the child's right to health. It starts by briefly suggesting why a focus on child health is

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important. It then proceeds to describe how the Bank's approach to development differs from a human rights approach and what such an approach requires. Next, the mandate of the Bank is described, followed by its activities related to child health. These sections are followed by criticism of the Bank's activities. The article concludes by examining how the Bank could contribute to improving child health outcomes and how a human rights approach could help shape these contributions.

Why Focus on Child Health?

There are a number of reasons why a focus on children is appropriate when discussing the right to health. First, indicators of children's health, particularly infant and child mortality and nutrition, have long been accepted as the best readily available evidence of the health of a nation. Even a brief glance at the World Health Organization's annual World Health Report, the United Nations Development Program's annual Human Development Report, or the World Bank's World Development Report illustrates the importance of these indicators.^{1, 2, 3, 4} Second, there is a widely shared understanding of the moral importance of child health. This has been stressed by the late James P. Grant, former Executive Director of UNICEF, who relentlessly advocated that "[t]he care of children is a practice and an ethic rooted deep in the wisdom and culture of all societies."⁵ Third, children's health has been normatively recognized as a priority by governments in several international legal instruments. Primary among these instruments is the Convention on the Rights of the Child (CRC), which has been ratified by every country in the world with the exception of Somalia and the United States.

A Human Rights Approach to Child Health

A human rights approach is a strategy requiring that actors view the entitlements of individuals as rights rather than as discretionary concessions.⁶ This means that states are held to obligations that they have voluntarily agreed to abide by in the international agreements they have ratified.

A human rights approach means that legal claims exist against the state under whose jurisdiction the person is found. Governments thus have legal obligations to respect these claims, and international organizations have responsibilities to ensure that states recognize the basic human rights that have been agreed upon in treaties.

The value of a human rights approach for health specialists within the Bank was cogently stated by the late Jonathan Mann, one of the world's leading public health advocates, when he wrote that:

[t]he health and human rights linkage, as seen from the public health side, proposes—based at this time more on insight and experience than data—that modern human rights provides a better guide for identifying, analysing and responding directly to the critical societal conditions than any framework inherited from the biomedical or recent public health tradition.⁷

While acknowledging its practical advantages, this statement also recognizes the most serious misgivings about a human rights approach. These misgivings are voiced in arguments that one must “prove” the benefit of a human rights approach for improving health and human rights. Such arguments are usually made by professionals in disciplines, such as physics and economics, in which cause and effect governs the choice of action. In contrast, a human rights approach requires one to think at another level. It is a prescriptive approach whose starting point is the body of human rights that have been unequivocally agreed to by governments. A human rights approach thus hypothesizes nothing, but rather assumes that human rights must be achieved because they are the birthright of every human being. While such an approach can have powerful normative persuasive effect, because human rights refer only to the most fundamental rights of individuals, they are not enough to ensure adequate human development. They are, rather, a starting point. The adoption of a human rights approach, therefore, does not provide overbearing restraints on the World Bank's policy making, but provides a framework that can influence policy choices. It could, for example, require

the Bank to condition a loan on a government's ensuring a decrease in infant mortality rates, rather than on adherence to a particular repayment schedule.⁸

One can see how this manner of reasoning might cause problems for the professionals determining policy at the World Bank. Their primary concern is usually whether specific economic objectives are being achieved, not whether basic human rights are being respected. They therefore balance health outcomes with economic outcomes. The result is often that health outcomes are compromised to achieve economic outcomes. Such compromises are natural in a decision-making process where there are two or more competing priorities of apparently equal validity. A human rights approach, however, prioritizes human rights over other concerns. It thus catapults the right to health above the fray of compromise and negotiation, and excludes the possibility that the basic right to health can be compromised for economic reasons. In most cases, a human rights approach will, therefore, strengthen the position of health-based arguments. The justification for this approach is that states have explicitly agreed to this prioritization.

What Does a Human Rights Approach Require?

The principal starting point for a human rights approach to child health is the CRC. When adopted, this treaty was considered an innovation, as indicated by former UNICEF Executive Director James Grant:

[f]or almost all of human history, when malnutrition or diarrhoea, or pneumonia claimed the life of a child ... or when a child lost his sight due to lack of vitamin A or polio paralysed his or her limbs ... it simply would not have occurred to anyone to say a violation of human rights had taken place. Today, ending the massive violation of children's rights still taking place around the world is one of the central moral imperatives of our time.⁹

Since entering into force, the CRC has become the most widely ratified human rights treaty in the world and thereby one of the most authoritative.

Article 24 of the Convention provides a general, but lengthy, legal definition of the right to health. However, as

several commentators have pointed out, the definition of the right to health in Article 24 is not fully settled.¹⁰ Nevertheless, Article 24 does provide some rather specific guidelines for governments that have subsequently been elaborated upon by international human rights bodies interpreting the right to health.¹¹ The UN Committee on the Rights of the Child has, for example, persuasively interpreted this Article. This Committee, created by the CRC, promotes the human rights in the Convention through a series of activities that include reviewing State Party reports, providing concluding comments and recommendations, and encouraging human rights education. Although the Committee does not have the authority to make binding decisions, its decisions do carry significant persuasive weight.

According to the CRC, Article 24 requires governments to take some specific actions to ensure the right to health of children.¹² First, a government must provide certain data on the health of children to the Committee on the Rights of the Child.¹³ Second, a government must show that it is taking steps to ensure that it adequately invests in the health of children. Third, a state must take steps to ensure that the health of children is respected. The World Bank can play a central role in enhancing a government's ability to take each of these actions, but to date it has played only a marginal role. To become a more active participant, some changes are necessary in the Bank's approach to child health. To understand what those changes are, it is first necessary to understand how the Bank operates.

The World Bank's Mandate

Describing the World Bank's activities in the area of child health first requires an understanding of the Bank's situation as an international actor. The World Bank Group claims that it is a multifaceted development institution whose mission is to fight poverty and improve living standards for people in the developing world.¹⁴ This is a good starting point. While this goal is frequently found in the Bank's rhetoric and even etched into the wall of its headquarters entrance hall in Washington, D.C., there is little in the Bank's formal legal mandate that supports this claim.

According to international law, the World Bank Group is made up of five independent intergovernmental organizations (IGOs), each created by its own treaty. In accordance with Article 57 of the UN Charter, these IGOs have signed agreements making them specialized agencies of the United Nations.

Each member of the World Bank Group has a slightly different goal. These goals are interpreted by the governments who contribute capital for lending, with the consequence that the largest contributors have the greatest say.¹⁵ This creates a situation in which the United States government—the only functioning government that has failed to ratify the Convention on the Rights of the Child and whose performance in providing for the right to health for its own population has been less than admirable—has the greatest say in the World Bank's interpretation of its mandate.¹⁶

The most prominent of the organizations in the World Bank Group is the International Bank for Reconstruction and Development (IBRD), whose purpose is largely confined to economic development and encouraging economic growth.¹⁷ Formed in the aftermath of World War II, this organization was intended as a financial institution responsible for reinvigorating the war-torn economies of Europe through the disbursement of money provided primarily by the United States' Marshall Plan. This role is reflected in the five articles that define the IBRD's purposes.¹⁸ It is thus notable that the World Bank Group's oldest and most prominent member is not formally mandated to encourage a broad range of social development and particularly not to promote child health or even human rights in general.

The situation of the International Development Association (IDA) is very similar to that of the IBRD. Although the IDA's much shorter statement of purposes directs attention toward the less-developed areas of the world, it refers to the more lengthy list of economic development purposes in the IBRD's Articles of Agreement as the goals to be achieved.¹⁹ The same is true of the International Finance Corporation (IFC), which was established to encourage private enterprise.²⁰ In addition, there is the International Monetary Fund (IMF), which cooperates with

the World Bank Group to establish general criteria that countries should meet in order to borrow from the World Bank Group. Although the IMF is not discussed in this article, it also could play an important role in ensuring respect for children's right to health.

Although there is no explicit reference to human rights anywhere in the Bank's mandate, as an affiliated agency of the United Nations, the Bank should respect the general principles of that organization. Indeed, in 1993, the World Conference on Human Rights, representing a majority of countries in the United Nations, as well as the World Bank, called upon "prominent international and regional finance and development institutions to assess also the impact of their policies and programmes on the enjoyment of human rights," and furthermore, recognized "that relevant specialized agencies...of the United Nations system...play a vital role in the formation, promotion and implementation of human rights standards, within their respective mandates...."²¹ The UN Committee on Economic, Social and Cultural Rights has envisioned a similar role for the Bank in ensuring respect for the right to health.²² Although some commentators have argued that the Bank is not legally bound to ensure respect for international human rights law, when the Bank ignores concerns of human rights it runs the risk of being identified as an adversary of these rights.²³

What Is the World Bank Doing to Improve Child Health?

Despite the limitations of its formal mandate and in part because of public pressure, the World Bank has begun to recognize that it has a responsibility to contribute to the right to health of children around the world.²⁴ In a 1998 report entitled "Development and Human Rights: The Role of the World Bank," the Bank recognizes that as part of the United Nations family it should contribute to advancing human rights.²⁵ This report also states that the Bank has done this by encouraging investment in health and education with investments totalling \$665 US dollars in 1998.²⁶ Nevertheless, the World Bank has yet to adopt a human rights approach to its work. This does not mean, however,

that the Bank has not been active in promoting child health. The result is that the Bank's record in promoting child health appears mixed and depends very much on whom one asks to describe it. Bank employees staunchly defend activities that they claim have benefited child health, while critics point to Bank actions that they claim have offset any gains because of their harmful effects on child health.

Because there is controversy about the Bank's effect on child health, it is valuable to examine the Bank's activities from two perspectives. The first section describes the Bank's own claims about its activities. The second section takes a more critical perspective on these claims based on the views of commentators who argue that some of the Bank's activities have been harmful for child health. Neither of the following descriptions of activities and arguments is exhaustive, but both are concerned with the Bank's effect on child health. And both provide a baseline for determining how a human rights approach might influence the Bank's activities in the area of child health.

The Bank's Views About Its Work in Areas Related to Child Health

If the Bank's contribution to child health is measured in investment dollars, it appears to be quite substantial. By the year 2000, the Bank had become the largest financier of the health care sector in developing countries.²⁷ This funding has included loans to countries for, among other things, projects to enable undernourished children to purchase food, government activities concerning child protection, funding for the purchase of vaccinations, and the training of child health care workers.^{28, 29, 30, 31} Despite this spending, the Bank does not earmark projects specifically for child health. Instead, child health concerns are often attached to broader health projects and to projects spanning a broader social sector.³² In fact, the Bank's recent contribution to the United Nations Special Session on Children states that "the World Bank has given increasing attention to the needs of children by devoting more of its resources to poverty reduction, human and social development, and supporting programs specifically addressing the needs of children."³³ The

Bank's claims to promote child health thus seem to be inseparable from its overall activities in the area of development according to the Bank's documents.

The Bank's approach allows it to claim that many of its interventions concern child health, including: basic education, particularly girls' education; early childhood development programs; child labor; street children; street youth; and poverty reduction.^{34, 35, 36, 37, 38, 39} The Bank's own descriptions of its lending programs often include only vague references to child health. The Bank does not itself implement these activities, but rather provides funding or guarantees for funding so that governments can do so. Governments then carry out these activities, often in coordination with UNICEF. Among the activities implemented by governments with the approval, and sometimes the encouragement of the Bank, have been a recent flurry of vaccination campaigns, the adoption of the Integrated Management of Childhood Illness strategy, and the "Triple A" approach to nutrition.⁴⁰

Perhaps the most important Bank-wide effort to contribute to improving child health has been the effort to focus the organization's attention on poverty reduction. This effort has led to increased attention to the situation of children under 15 years of age, who make up a significant proportion of the world's poor. In addition, the analysis of the "burden of disease" disaggregated by income level has highlighted the fact that communicable diseases account for a large share of the disease burden among the poorest people, and that mortality differences between rich and poor quintiles of populations are largest in the group of children under five years of age.⁴¹ The more well-known Heavily Indebted Poor Countries (HIPC) initiative is also an attempt by the Bank to address environmental influences on health by eliminating debt or at least reducing it to a sustainable level.

The Bank's economic advisory services are also a means of encouraging governments to prioritize child health. These services consist of advice given to governments and pre-loan assessments of the economic and social conditions of a country. The advice that is given to countries as a result

of the assessments may also include policy advice from health personnel as to what health interventions might be valuable for improving child health. This advice is often given by members of the Bank's Health, Nutrition, and Population (HNP) unit, which is part of the Human Development Network (HDN). The Human Development Network also includes other units of the Bank that may provide advice that promotes the inclusion of child health projects within the Bank's activities. At the first tier of units, the HNP is joined by units concerned with Education and Social Protection. These three units include subunits concerned with Early Childhood Development and the Core Team on Hunger and Food as well as joint initiatives with other United Nations bodies; for example, the Inter-Agency Group for Safe Motherhood. All of these Bank units and subunits attempt to draw the attention of governments to concerns for health, often specifically child health.

Because the Bank's decision process for lending is dominated by economists and financial specialists, the internal training and education of Bank staff is important to increasing attention for child health. The Bank attempts to direct the attention of its staff toward the plight of children through its own internal policy formulation, including the establishment of formal and informal internal guidelines for its staff. An example of a particularly relevant policy instrument is the Health, Nutrition, and Population Sector Strategy.⁴² This 100-page document outlines the Bank's strategy while cataloguing a mixed record of achievements in the 148 HNP projects.⁴³ While falling short of endorsing a human rights approach, the document does establish that the Bank is active in areas relating to child health.

A wide range of the Bank's activities, including some of those mentioned above, could be seen as relevant to ensuring the human right to health of children.⁴⁴ The major criticisms of the Bank's role in ensuring child health, however, lie not in a denial of the benefits that some of these Bank-financed projects provide, but rather in the overall impact of the Bank's policies on child health.

Critical Views About the Bank's Work in Areas Related to Child Health

A wide range of observers have criticized the Bank's role in promoting social development in general and health in particular—and by implication child health, because children are often the most vulnerable to inadequacies in health care. One can hardly miss the prominent media coverage given to the thousands of protesters who greeted Bank meetings in Washington and Prague in 2000 or the growing number of academics who have expressed their criticism in writing. Because criticisms vary, it would be an error to categorize them too rigidly. Nevertheless, some examples are valuable for assessing the Bank's role in encouraging greater respect for child health. Civil society movements such as "50 Years is Enough" in the United States, "Focus on the Global South" in Thailand, "Jubilee 2000" in South Africa, the "National Free Union of Students" in Germany, the "Alternative Association" in Russia, the "Human Rights Law Network" in India, and "Rede Brasil" in Brazil have repeatedly articulated some common concerns. Among these are: that the Bank is not achieving social justice or social development through its programs, the lack of transparency in the Bank's workings, and their lack of concern for individuals who are affected by governmental policies the Bank and the IMF encourage.⁴⁵ The last concern particularly relates to the child's right to health.

The strongest arguments are directed against structural adjustment and user fee policies. Both of these are policies that the World Bank has promoted in its advice, lending, and assessment activities.^{46, 47} Structural Adjustment Programs (SAPs) refer to lending described by the Bank as "rapidly disbursing and policy-based lending."^{48, 49} SAPs impose conditions that are agreed to by governments, usually with some degree of pressure from the World Bank. The conditions attached to these loans, according to the Bank, include policies that enhance social development of populations as a whole.⁵⁰ Critics argue that the Bank does not enhance social development, including health, by encouraging countries to

adopt SAPs.⁵¹ Some of these critics claim that instead of enhancing development, SAPs have “adversely affected the living standards and health of vulnerable groups, such as women and children.”⁵² These criticisms have struck a chord with James Wolfensohn, the Bank’s President, who has recognized that:

We live in a world scarred by inequality. Something is wrong when the richest 20 percent of the global population receives more than 80 percent of the global income. Something is wrong when 10 percent of a population receives half of the national income—as happens in far too many countries today. Something is wrong when the average income for the richest 20 countries is 37 times the average for the poorest 20—a gap that has more than doubled in the past 40 years. Something is wrong when 1.2 billion people still live under less than a dollar a day and 2.8 billion still live on less than two dollars a day.⁵³

Recognition, however, has not yet led to successful action. SAPs do not appear to have provided a sufficient answer. As Table 1 indicates, infant mortality and under-five child mortality, while decreasing in low-income countries, including sub-Saharan Africa, has decreased much less in developing countries despite the SAPs to which the majority of these countries have been subjected. Furthermore, in countries where the economic situation appears to have improved, there often remain significant disparities between the poor and the rich in the health care benefits they acquire.⁵⁴

While recent evidence has suggested that SAPs may have enhanced child health, the prevailing view—even in recent research—is that SAPs have been detrimental to child health.^{55, 56} This may be due to the rationale for SAPs’ contribution to child health. SAPs are intended to improve child health by increasing economic growth. Nevertheless, even in the midst of the debt crisis that precipitated SAPs, it was recognized that “economic growth does not necessarily help the poorest section of the population, whose health is most at risk.”⁵⁷ In fact, Gro Harlem Brundtland, Director General of WHO, has suggested that the converse is true:

We are increasingly recognizing that the full economic cost of disease within poor communities has been under-

Country Categories	Infant Mortality			Under 5 Mortality		
	1980	1998	Decrease	1980	1998	Decrease
High Income	12	6	50%	15	6	60%
Middle Income	60	31	48%	89	39	56%
Low Income						
All Countries	97	68	30%	150	92	39%
Excluding China & India	114	83	27%	117	125	29%
Sub-Saharan Africa	115	92	20%	188	151	20%

Table 1. *Infant and Under-Five Child Mortality Around the World.*⁹⁰

estimated. HIV prevalence rates of 10–15%—which are no longer uncommon—can translate into a reduction in growth rate of GDP per capita of up to 1% per year. TB is estimated to take an annual economic toll equivalent to \$12 billion dollars from the incomes of poor communities. What would Africa’s GDP be now if malaria had been tackled 30 years ago, when effective control measures first became available? Probably about \$100 billion greater than it is now, according to a report on the economic consequences of malaria presented to African leaders in Abuja earlier this year.⁵⁸

It is true that economic growth may enhance a government’s ability to deal with vulnerability or provide a social safety net.⁵⁹ This requires both responsible government commitment and ensuring that resources saved through the implementation of structural adjustment programs will be directed toward these purposes. Instead, however, governments have tended to use the resources saved by SAPs to repay their loans. In fact, this is exactly what is intended when SAPs are agreed to between a government and the World Bank. Some critics have even questioned the impact of SAPs on economic growth.⁶⁰ If, indeed, SAPs do not really contribute to economic growth, they cause a double hardship on the countries to which they are applied: stripping them of resources needed to provide safety nets for vulnerable children while making no contribution to replenishing these resources.

A specific aspect of SAPs that has been particularly criticized is the “user fees” that are often required, encouraged,

or tolerated.⁶¹ These are cost-recovery schemes that charge the users of a particular service for their access to the service. If a user cannot pay the fee, he or she cannot access the service. The effects of user fees have been criticized for exacerbating existing inequities in health care financing unless adequate medical insurance or mechanisms to protect the poor and exempt them from payment are established.⁶² While the Bank has recently pulled back from condoning user fees, they still exist in many countries because of the Bank's initial promotion of them.⁶³

The Bank's critics have also pointed out that "structural adjustment programs" and "user fee initiatives" have sometimes been the cause of a state's failure to invest in or provide adequate health care.⁶⁴ Structural adjustment, it is argued, tends to force governments to stop spending money on social programs in favor of greater spending on profit-making activities.⁶⁵ User fees also allow governments to become complacent about their responsibility to provide adequate health care because individuals who need health care, but cannot afford the user fee or do not wish to pay it, are eliminated from the health care system. It thus appears that the system is less burdened than would be the case if the right to health care was provided to all individuals.

There is still much research to be done concerning SAPs. In this regard, the World Bank has agreed to work with critical NGOs to investigate the effects of SAPs. This investigation started in 1997 and is still ongoing.⁶⁶ Even so, the allegations concerning the detrimental effects of SAPs reached such proportions that the United Nations Commission on Human Rights created an open-ended Working Group, an Independent Expert, and a Special Rapporteur all focusing on indebted countries and the consequences of their debts.^{67, 68, 69, 70}

Improving the World Bank's Contribution to Child Health Through a Human Rights Approach

The World Bank is likely to remain an important actor in the field of child health for the foreseeable future. Unlike adult health care, where private investment is increasingly preferred to World Bank loans, most governments, especial-

ly those with the greatest need, still frequently seek the support of the Bank. As a consequence of its lending, the Bank has achieved prominence as an international financier of child health interventions. To date, however, the Bank has lent its support to projects based on a mix of health "need" and economic "viability." In other words, when a government is able to demonstrate a child health need and the government is able to convince the Bank that it will repay a loan, a loan agreement may be forthcoming.

The weakness of this approach, especially in light of the Bank's avowed commitment to combating poverty and ensuring human development, is that it does not provide the Bank the means to provide help to the most needy cases, nor does it recognize a responsibility for the Bank to provide such assistance. Yet, to achieve its self-stated goal, both this means and this responsibility are necessary. A human rights approach makes both possible.

An example of how this approach might work was recently provided when Malawi refused a loan for 40 million dollars from the World Bank, with the Deputy Health Minister, Philip Bwanali, stating that his government felt that it was "unthinkable to accept such a loan for non-productive usage like the fight against AIDS. It could be immoral for us because the country is already heavily indebted. The best thing the World Bank can do is to give us a grant."⁷¹ The Deputy Minister underlined in his statement that Malawi already had an external debt of more than two billion US dollars and that a larger debt incurred for essential services may cause more harm than benefit. Research on the effect of external debt on government spending on health appears to confirm the Malawian Deputy Minister's fears.⁷² Responding to such concerns, governments have come up with schemes for replacing some Bank loans with grants, an action which has been argued to be a more efficient use of Bank resources.⁷³ The Italian government has suggested such an approach to health and education to the G7/8.⁷⁴ The Italian proposal foresees a Trust Fund for Health containing over a billion dollars and spanning about a dozen years that would be administered by the World Bank and World Health Organization. As might be expected, the

Italian proposal concentrates on supporting health interventions that are of special concern to children.

While this proposal appears to involve developing governments redirecting resources toward child health, it may not satisfy its critics. Human rights advocates are likely to point out that: the proposal still depends on voluntary contributions; it can be politically manipulated as only vague criteria for the grants have been proposed; and that it is in any case a token effort rather than a structural change that would push governments to prioritize the protection of the right to health. There are also policymakers who do not think that the Bank should be involved in making grants. These critics argue that the Bank's lending will be handicapped to the detriment of developing countries if it gives away money because developed countries are less willing to provide "grant" capital than they are "loan" capital.⁷⁵ A human rights approach could contribute to defending schemes such as that suggested by the Italian government to provide the basis for the recognition that all governments must provide for human rights. This duty, it may be argued, justifies taking all necessary steps—even grants—to ensure that governments can provide for the human rights of persons under their jurisdiction.

At the level of internal Bank activity, a human rights approach could provide guidance for policy decisions. For example, a human rights approach might raise questions about the Bank's concept of Disability Adjusted Life Years (DALY) as adopted in its World Development Report.⁷⁶ This concept has been criticized among other reasons for containing a bias toward adult health because of the higher value it assigns to the life years of middle-aged adults and the elderly.⁷⁷ In addition, Bank publications such as "The Health of Adults in Developing Countries" may be criticized as contributing to shifting international health priorities away from child survival during the eighties and toward adult health in the nineties.^{78, 79} A human rights approach might therefore require that the Bank use an approach that better reflects the priority of child health.

Finally, it is not clear that the inclusion of health, nutrition, and population concerns in Bank projects has actually

had a practical impact. The Operations Evaluation Department of the Bank recently assessed 30 years of World Bank experience in health, nutrition, and population, finding that there is little evidence of the impact of Bank investment on health system performance or health outcomes, including child health.⁸⁰ A human rights approach would require the Bank to re-evaluate its investment and direct it toward investments that have a greater impact on child health.

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The Bank can contribute to ensuring the promotion of the right to health through its policy dialogue with borrowing countries. For example, in discussions with the leading ministries of a government the Bank can stress the responsibility that governments have for ensuring children's right to health. Pressured in the recent Prague meetings of the World Bank Group by NGOs and civil society, the Bank agreed to specifically refer to human rights as part of its responsibilities in official documents. World Bank President James Wolfensohn stated that the organization would begin making explicit reference to human rights in Bank documents.⁸¹

The incorporation of a human rights approach would provide the Bank with an enhanced normative framework from which to encourage the direction of a government's health policies in favor of children. A simple statement by the Bank's President indicating that the "education, good health, security, and opportunity ... and respect for human rights" that people "want," are what every child deserves as a legal right would cause governments to give more attention to international human rights obligations, including the child's right to health, when making proposals for project funding to the World Bank.⁸² Governments constantly search for indicators of Bank priorities so as to present successful funding proposals, so the influence of such a statement could be significant. At the same time, such a statement would also send a message to Bank staff who work with governments to establish the projects that will be funded by loans. Such a change by the Bank could be followed by internal Bank action such as staff training in a

human rights approach to development and the establishment of clear incentives for staff who contribute to encouraging respect for child health in their dealings with countries. The introduction of internal policy instruments, such as Operational Policies, Bank Procedures, and Good Practices, promoting concern for child health could also have a significant impact on highlighting this issue on the Bank's agenda.

Within the Bank, HNP is the primary, although not the exclusive, unit concerned with promoting child health. This is mainly done through a needs-based approach that attempts to advocate attention for child health against other interests. Although the HNP unit plays an influential role in encouraging greater concern for the health of children within the Bank, it has fought an uphill battle against other interests. This is not surprising considering that this unit competes with other Bank units and a senior management that has a distinct bias toward economic concerns. In part, this is because almost all the senior management in the Bank as well as the regional representatives have backgrounds as economists, financial advisors, financial planners, or administrators. As a result, concerns for social and economic rights as relevant to child health are thus often viewed as uninteresting or irrelevant. The Bank's recruitment, or promotion, of at least a few child health specialists and human rights experts to managerial positions could undoubtedly contribute to addressing this imbalance and providing child health a greater voice within the Bank.

Even as a lone and rather recent voice, the HNP unit seems to have had some success in redirecting the Bank's priorities.⁸³ For example, the HNP Group has contributed to greater awareness among Bank staff of health policy and the effects of Bank policies on health. This has been translated into some commitment by the Bank to the Global Alliance for Vaccines and Immunization (GAVI) and the Bank's support for the introduction of the Integrated Management of Childhood Illness (IMCI) and nutrition interventions in several countries. The HNP Group's work has also encouraged the Bank to cooperate with other agencies that have competence for suggesting and evaluating health interventions.

WHO, for example, has seconded staff to the Bank and contacts have been established with UNICEF and the Pan American Health Organization. However, the extensive resources and experience of the many NGOs that work in the field of child health have not yet been tapped. Cooperation with NGOs might also enhance the Bank's ability to encourage its lenders to support nongovernmental interventions and provide valuable evaluation data and input. Some NGOs, like Save the Children, have been at the forefront of the child's rights movement. Cooperative arrangements with this NGO and others like it could be very beneficial. Again, a human rights approach calls for greater cooperation between all actors to achieve goals like the improvement of child health. Although such cooperation can come through the ad hoc coincidence of mandates, a human rights approach provides an overarching framework where state actors and nonstate actors can justify their cooperation, even in the absence of other agreements, on the basis of a common commitment to human rights.

This is equally true as concerns cooperation with United Nations human rights bodies. Many of these bodies have expertise in the elaboration and interpretation of human rights relating to child health.⁸⁴ Foremost among the United Nations human rights bodies that have dealt with the right to health of children is the Committee on the Rights of the Child. By virtue of the CRC, this Committee has broad authority to cooperate with specialized agencies of the United Nations to achieve greater protection of children.⁸⁵ In addition, the Committee on Economic, Social, and Cultural Rights has made a valuable contribution to the development and implementation of the right to health more generally.⁸⁶ These bodies have both the mandate and the interest to provide the Bank with strategies to draw greater attention to child health.

On a technical level, greater cooperation with UNICEF and WHO could entrench concerns for child health within the Bank and translate into the inclusion of child health interventions in more projects.

Last, but perhaps most important, is the input of affected populations: children and their parents. Although the

Bank has been pushed to pay greater attention to the voices of affected populations on some of the projects it supports through its lending activities—indeed the creation of the Bank’s Panel was intended to provide a greater voice for affected populations and Bank officials have recently met with representatives of affected populations on the Cameroon Pipeline Case—the results have still been unsatisfactory from the perspective of human rights defenders.^{87, 88}

Greater attention to human rights in the Bank could be a substantial step toward the concessions that civil society has recently, and with an increasingly louder voice, demanded of the Bank. It could provide the Bank with a contemporary focus to replace the references to post–World War II reconstruction that are found in the Bank’s history and often remain in its documents. It would also better align the World Bank with other members of the United Nations family that subscribe to the shared principles of the Charter of the United Nations and the common mandate of serving the increasingly globalized international community. In terms of globalization itself, the Bank is in a prime position to mitigate and even redirect resources to prevent the harmful consequences of globalization for marginalized populations. Applying an approach that accepts a common standard of human dignity must be assured as a *conditio sine qua non* for other Bank activities, and could help the Bank to regain some of the moral high ground it has lost to the social justice movement.

Conclusion

The starting point for improvement within the Bank is a willingness to recognize that it has a major responsibility and a significant capacity for encouraging governments to prioritize children’s right to health, particularly in the poorest countries of the world. Although the Bank has not yet publicly acknowledged this responsibility, it has taken some steps in this direction. Adopting a human rights approach could accelerate these steps.

After recognizing its responsibility for human rights, the next step is to translate the “rhetoric” of conceptual frameworks into action. The World Bank is well placed to lead a discussion on prioritizing the human right to child

health in many countries. In developing countries that rely on its funding, the Bank is often one of the most influential actors.

Perhaps the Bank could benefit from words of warning spoken about the war against HIV/AIDS, one of the greatest health threats facing the children of the world. Speaking about the responsibility of international actors, James Harmon reminds us that “[c]learly, the humanitarian need challenges all of us to set aside business as usual ... [t]o win this war, it will take all of us tackling this vast humanitarian crisis, and doing what is in our power to make a difference.”⁸⁹ The World Bank might ask itself if it is doing all that is in its power, and what it could do better to encourage governments to prioritize and respect children’s human right to health. The children of the world await a reply.

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1. The 1995 to 2000 reports are available at the WHO’s web site: <http://www.who.ch>, accessed September 23, 2000.
2. The report for the year 2000 is available at: <http://www.undp.org/hdro/>, accessed September 23, 2000.
3. World Bank, *World Development Report 2000/2001: Attacking Poverty* (2001). See particularly Table 2 concerning “Quality of Life” indicators at pp. 276–277.
4. Cf. World Bank, *Annual Report 2000* (2000). Although it mentions health at several places in the report the primary measure of achievement appears to be the amount of monetary investment. For example, in a section entitled Health, Nutrition, and Population at pages 88–89, the discussion centers on the amount of money that the Bank has lent, not on the impact the lending has had on the admittedly still “unacceptably high levels of maternal mortality in poor countries.”
5. J. P. Grant, “Forward,” in: G. A. Corina, R. Jolly, and F. Stewart (eds), *Adjustment with a Human Face: Protecting the Vulnerable and Promoting Growth* (Oxford: Clarendon Press, 1987, reprinted 1990), p. vi.
6. See United Nations Development Program, *Human Development Report 2000* 21–23 (2000). Chapter 1 of this report is particularly instructive on indicating how human rights can contribute to development as well as how development can contribute to human rights. This chapter was authored by Amartya Sen.
7. J. Mann, “Health and Human Rights: If Not Now, When,” *Health and Human Rights* 2/3 (1997): 14.
8. Other international organizations have used their power in similar fora. See Commission of the European Communities, “Proposal for a decision of the Council and the Commission on the conclusion of a Euro-Mediterranean Agreement establishing an association between the European Communities and their Member States, of the one part, and the

- Republic of Tunisia, of the other part," COM[95]235, final, (May 31, 1995), p. 4 (imposing respect for human rights as one condition required for receiving assistance from the European Union). There is no evidence that the Bank has systematically pursued policies aimed at lowering child mortality or malnutrition in a manner that has made states aware that this is not optional or preferred, but obligatory. The Bank's Operating Directives allow for conditionality, but do not provide for human rights to be taken into consideration. See OD 8.60 at paras. 47–51 (December 1992).
9. J. Grant, Statement to Third Committee of 49 General Assembly of UN, New York, November 1994.
 10. V. A. Leary, "The Right to Health in International Human Rights Law," *Health and Human Rights: An International Journal* 1/1 (1994), accessed at <http://www.hsph.harvard.edu/fixcenter/V1N1leary.htm> on September 23, 2000, and B. C. A. Toebes, *The Right to Health as a Human Right in International Law* (Antwerp: Intersentia, 1999), p. 4.
 11. See Toebes (see note 10) at Chapter IV for a discussion of case law concerning the right to health in general.
 12. These actions are apparent from the Committee's comments on state reports.
 13. UN Doc. CRC/C/5 (initial reports) and UN Doc. CRC/C/58 (periodic reports—those after the first report).
 14. Mission Statement at <http://www.worldbank.org/html/extdr/about/mission.htm>, accessed October 10, 2000.
 15. The Group of Seven developed states (the United States, the United Kingdom, Japan, Germany, France, Canada, and Italy) controls over 40% of the voting power in the World Bank because of their contributions.
 16. The other government that has failed to ratify the Convention is Somalia, which has not had a functioning government due to the civil war that has raged through the country.
 17. Art. 1 of the IBRD Articles of Agreement, as amended effective February 16, 1989.
 18. *Ibid.*
 19. Art. 1 of the IDA Articles of Agreement, as amended effective September 24, 1960.
 20. Art. 1 of the IFC Articles of Agreement, as amended effective April 28, 1993.
 21. Art. 2 of the Vienna Program of Action, UN Doc. A/49/668 adopted June 25, 1993.
 22. General Comment 14, UN Doc. E/C.2/2000/4 (July 4, 2000) at para. 64.
 23. Shihata, I., *The World Bank in a Changing World* (Dordrecht, The Netherlands: Martinus Nijhoff, 1991), p. 105.
 24. Treacle, K., "The World Bank and ESC Rights," in: *International Human Rights Internship Program and Asian Forum for Human Rights and Development, Circle of Rights: Economic, Social and Cultural Rights Activism: A Training Resource* (2000), pp 520–534.
 25. This report is available at <http://www.worldbank.org/html/extdr/rights/index.htm>, accessed October 10, 2000.
 26. *Ibid.*, 6.
 27. T. Johnston and S. Stout, Investing in health. Development effectiveness in the health nutrition and population sector (World Bank, 1999).

Somewhat contradictorily, International Financial Corporation approvals of health sector projects declined from 61 million in 1994 to 1 million in 1996, according to the Bank's own statements. See World Bank, Sector Strategy Health, Nutrition, & Population (World Bank, 1997), p. 71.

28. A part of the US\$150 million loan for a Human Capital Protection Project in Columbia, World Bank Project No. P069964.

29. A part of the US\$19 million loan for a Child Welfare Reform Project in Bulgaria, World Bank Project No. P064536.

30. A part of a US\$142.6 million loan for an Immunization Strengthening Project, World Bank Project No. P067330.

31. A part of the US\$49 million loan for an Integrated Early Childhood Development Project in Eritrea, World Bank Project No. P068463.

32. Searches of the Bank's "Projects" database thus turn up between 25 and 368 projects that relate to child health depending on what search terms are used and which parts of the database are accessed.

33. World Bank, *Keeping the Promise: Promoting Children's Well-being* (2001), p.1. This document was supplied to the author by the World Bank's Health and Population Advisory Service, 1818 H Street, NW, MSN G3-302, Washington, DC 20433, USA, healthpop@worldbank.org, Tel: 202-473-2256 Fax: 202-614-0657. The Special Session on Children will be a special meeting of the United Nations General Assembly that is dedicated to discussing the situation of children and adolescents in the world.

34. *Ibid.*, 4.

35. *Ibid.*, 5.

36. *Ibid.*, 7.

37. *Ibid.*, 6.

38. *Ibid.*, 17.

39. *Ibid.*, 21.

40. Triple A refers to "assessment, analysis and action."

41. D. R. Gwatkin, "Health inequalities and the health of the poor: what do we know? What can we do?" WHO Bull. 78/1 (2000): 3-15.

42. World Bank, Sector Strategy Health, Nutrition, & Population (World Bank, 1997).

43. The Bank has invested US\$13.5 billion in these projects at 1996 prices, according to the report. See *ibid.*, p. ix.

44. More than 300 documents relating to health interventions supported by the World Bank can be found by searching the Bank's website, which can be accessed at <http://www.worldbank.org>.

45. Prague Declaration (28 September), accessed at <http://www.50years.orgs26/prague.html> on November 23, 2000.

46. Structural adjustment loans comprise about 25% of the Bank's total lending.

47. This paper only refers to the structural adjustment programs of the World Bank, although they are often complemented by the Stabilization Loans by the IMF. See D. Turk, *The Realization of Economic, Social and Cultural Rights, A Final Report* submitted to the UN Subcommission on Prevention of Discrimination and Protection of Minorities, UN Doc. E/CN.4/Sub.2/1992/16 (July 3, 1992) at para. 41.

48. Although in the late 1990s the Bank replaced SAPs with Poverty Reduction Strategy Papers (also referred to as PRSPs), the effect has been

the same, thus the old name will be retained herein to describe both programs. See Report of the Independent Expert on the effects of structural adjustment policies and foreign debt on the full enjoyment of all human rights, particularly economic, social, and cultural rights, UN Doc. E/CN.4/2000/56 (January 18, 2001) at paras. 21–23.

49. World Bank, *The World Bank Operation Manual*, Operational Directive OD 8.60 (December 1992) at para. 3.

50. See World Bank/UNDP Report (1989) and UNICEF, *Absorbing Social Shocks, Protecting Children and Reducing Poverty* (January 2000). Accessed at <http://www.unicef.org/reseval/pdfs/shocks.PDF> on November 7, 2001.

51. See, for example, T. W. Parfitt, “Lies, Damned Lies and Statistics: The World Bank/ECA Structural Adjustment Controversy,” *Review of Political Economy* 90/47 (1990): 128 (containing a discussion of the ECA report and the WB/UNDP Report).

52. *Ibid.*, 130 (citing G. A. Cornia, “Adjustment Policies 1980–1985: Effects on Child Welfare,” in: G. A. Cornia, R. Jolly, and F. Stewart (eds) (see note 5), pp. 48–72).

53. J. A. Wolfensohn, “Building an Equitable World,” address to the Board of Governors, Prague, Czech Republic (September 26, 2000). Accessed at <http://www.worldbank.org/html/extdr/am00/jdwsp/jdwsp-en.htm> on November 7, 2001.

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55. M. Garenne, “Health Effects of Structural Adjustment in Sub-Saharan Africa,” (Paris: French Center for Population and Development Studies working paper, 2000).

56. See G. A. Cornia, R. Jolly, and F. Stewart (eds) (see note 5) at note 52. Also see A. B. Zack-Williams, “Social consequences of structural adjustment” in: G. Mohan, E. Brown, B. Milward, and A. B. Zack-Williams (eds.), *Structural Adjustment: Theory, Practice and Impacts* (New York: Routledge, 2000), p. 59.

57. H. Hellberg, “The Impact of Recession and Adjustment on Health in Developing Countries,” in K. Haq and U. Kirdar (eds), *Human Development, Adjustment and Growth* (1987), pp. 208, 216.

58. G. H. Brundtland, “Why Invest in Health?” Speech delivered to the Third International Conference on Priorities in Health Care in Amsterdam (November 23, 2000). Accessed at http://www.who.int/director-general/speeches/2000/20001123_amsterdam.html on November 7, 2001.

59. *Ibid.*

60. W. Easterly, “The effect of IMF and World Bank programs on poverty,” a paper presented to the IMF Research Conference on November 9–10, 2000, in Washington, D.C. (October 31, 2000) Accessed at http://www.jubilee2000uk.org/analysis/articles/easterly_programs_poverty.pdf on November 7, 2001. The author concludes that he finds “no evidence for a direct effect of structural adjustment on growth.” *Id.* at 1, 22–23).

61. See Public Law No. 106-429 (United States) stating in Section 596 that: The Secretary of the Treasury shall instruct the United States

Executive Director at each international financial institution ... to oppose any loan of these institutions that would require user fees or service charges on poor people for primary education or primary healthcare, including prevention and treatment efforts for HIV/AIDS, malaria, tuberculosis, and infant, child, and maternal well-being, in connection with the institutions' lending programs.

62. See S. Russell and L. Gilson, "User Fee Policies to Promote Health Service Access for the Poor: A Wolf in Sheep's Clothing?" *Int. J. of Health Serv.* 27/2 (1997): 359–379.

63. Several NGOs have quoted World Bank President Wolfensohn as representing this verbally in at least three meetings with United States Congressional representatives.

64. H. Hellberg (see note 57), pp. 214–215.

65. See *supra* notes 68, 69, 70 and 716968, 7069, 7170 and 7271 (the reports of the United Nations bodies cited therein).

66. K. Rafferty, untitled article in the World Bank's in-house newspaper *Bank's World* 1/1 (July 21, 1997), accessed at <http://www.igc.org/dgap/saprin/bank.html> on November 25, 2000.

67. See Commission on Human Rights decision 1996/103 of 11 April 1996, U.N. Doc. E/CN.4/DEC/1996/103 establishing the open-ended Working Group on the effects of structural adjustment policies on the full enjoyment of human rights.

68. See Commission on Human Rights decision 1997/103 of 3 April 1997 creating the post of independent expert to study the effects of structural adjustment policies on economic, social and cultural rights.

69. See Commission on Human Rights resolution 1998/24 of 17 April 1998 creating the post of Special Rapporteur on the effects of foreign debt on the full enjoyment of economic, social and cultural rights.

70. In 2000, the mandates of the Independent Expert and the Special Rapporteur were combined into a single mandate for the Independent Expert on the Effects of Structural Adjustment Policies and foreign debt on the full enjoyment of all human rights, particularly economic, social, and cultural rights. UN Doc. E/CN.4/RES/2000/82 (April 27, 2000). The Working Group continues to function.

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72. Joint Report of the UN Commission on Human Rights' Special Rapporteur, Mr. Reinaldo Figueredo, and the Independent Expert, Mr. Fantu Cheru, to the Commission on Human Rights, UN Doc. E/CN.4/2000/51 (January 14, 2000). At paragraph 2 of this report the joint authors make the point about debt very explicitly when they write: "To repay this debt, Governments shift scarce financial resources away from the necessary investments in human, social, and physical infrastructure including schools, health services, roads, agriculture, and other areas that lay the foundation for sustainable development". G. A. Cornia, "Adjustment Policies 1980–1985: Effects on Child Welfare," in: G. A. Cornia, R. Jolly, and Stewart, F. (eds) (see note 5), pp. 48–72. See also J. P. Drèze and A. K. Sen, *Hunger and Public Action* (Oxford: Oxford University Press, 1989), pp. 34, 183, and 273–74 and J. H. Drèze, A. Kervyn de Lettenhove, J. P. Platteau, and P. Reding, "A Proposal for 'Cooperative

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74. Italian Government, *Beyond Debt Relief* (2001). A copy of this public report is on file with the author.

75. A. Lerrick (see note 73), pp. 2–3. Lerrick argues that \$1 dollar "granted" equals \$17 dollars "loaned" and he points out that at the moment the World Bank possesses almost \$30 billion dollars from paid-in capital and retained earnings and has a total of \$133 billion in paid-in equity, while the IDA has over \$104 billion in equity. By investing this money, the Bank could generate an income of over \$10 billion a year.

76. World Bank (see note 3).

77. World Bank, *World Development Report 1993. Investing in Health* (World Bank, 1993).

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80. *Ibid.*

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82. J. A. Wolfensohn (see note 53).

83. World Bank Group, *Health, Nutrition, and Population Sector Strategy* (World Bank, 1997).

84. Among the relevant human rights bodies are: the Committee on Economic, Social, and Cultural Rights; the Human Rights Committee, the Committee on the Rights of the Child, the regional African Commission on Human and Peoples' Rights, the African Committee of Experts on the Rights and Welfare of the Child, and the Inter-American Commission on Human Rights.

85. See, for example, S. Detrick, *The United Nations Convention on the Rights of the Child* (1992).

86. B. C. A. Toebes (see note 10).

87. See Chapter 1 of the Chad/Cameroon Development Project Annual Project Update, accessed at <http://www.esso.com/eaff/esso Chad/> on March 1, 2001.

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