CHILD HEALTH IN AFRICA:
FEASIBLE OR A BROKEN PROMISE?

Impact of poverty on a child’s right to access HIV/AIDS treatment; political and policy responses at the international, regional, and national levels in Ethiopia

Wubet Gerawork Hiruye
Advisor: Kirsten Sandberg
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DEDICATION

I would like to dedicate this thesis to my two beloved elder sisters Aster Gerawork Hiruye and HassabKefay Gerawork Hiruye whose professional performances as a judge and a lawyer inspired me to follow their foot steps.
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May 30, 2006
Oslo, Norway
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACHPR</td>
<td>African Charter on Human and People’s Rights 1981</td>
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<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ART</td>
<td>Anti-Retroviral Treatment</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
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<td>CHIP</td>
<td>Childhood Poverty Research and Policy Centre</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child 1989</td>
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<td>FDRE</td>
<td>Federal Democratic Republic of Ethiopia</td>
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<td>HIV</td>
<td>Human Immunodeficiency Syndrome</td>
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<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights 1966</td>
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<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights 1966</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>NAC</td>
<td>National Aids Council</td>
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<td>NEPAD</td>
<td>New Partnership for Africa’s Development</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
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<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<tr>
<td>PEPFAR</td>
<td>The President’s Emergency Plan for AIDS Relief</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>SDPRP</td>
<td>Ethiopian Sustainable Development and Poverty Reduction Programme</td>
</tr>
<tr>
<td>SPM</td>
<td>Ethiopian Strategic Plan for intensifying Multi-Sectoral HIV/AIDS Response</td>
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<tr>
<td>UNICEF</td>
<td>The United Nations Children’s Fund</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>WHO</td>
<td>World Health Organization</td>
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“Only as we move closer to realizing the rights of all children will countries move closer to their goals of development and peace.”

Kofi A. Annan: United Nations Secretary General

Source: The State of the World’s Children 2005,
UNICEF
1 INTRODUCTION

1.1 Background

It has been more than 20 years since the world began to witness one of the most devastating epidemics, HIV/AIDS. Ethiopia is one of the Sub-Saharan countries worst hit by the HIV/AIDS epidemic, having the sixth highest number of infections in the world. In 2003, it was estimated that 2.2 million people were living with HIV/AIDS, out of which 200,000 were children under the age of 15.

Together with the fragile economic situation and the absence of a social safety net in Ethiopia, for vulnerable groups like children, the effect of HIV/AIDS is catastrophic. It has led to rising child mortality rates, sharp reduction in life expectancy and millions of orphans.

Human rights instruments have not addressed the HIV/AIDS epidemic even though it is one of the greatest problems. The present human right instruments stipulating the right to health were adopted before the devastating effects of the epidemic became apparent. Nevertheless, interpreting the right to health in a broad way in addressing this crisis is crucial for the survival of a large part of the population, especially children.

When a child’s access to HIV/AIDS treatment is expressed in the language of a right, it is a matter of entitling children the right to affordable, accessible, quality HIV/AIDS treatment. It also empowers them to demand its fulfilment. The right to health is stipulated in different international and regional human rights instruments. Article 12 of ICESCR recognised the right of everyone to the “highest attainable standard of physical and mental health” and states that everyone has the right to health facilities, goods and services. The provision of essential drugs from time to time defined under the WHO’s Action Programme on Essential Drugs, is the core obligation of states under ICESCR Article 12.

Antiretroviral (ARV) medicines are now included in WHO essential drugs list. This lays a legal ground to make the provision of the treatment obligatory. However, the introduction of
these classes of medicine is dependent to adequate resources and specialists who can reiterate the question of poverty reduction, justice and fairness in resource distribution both at the national and the international level.

During the past two years, access to HIV/AIDS treatment has been improved elsewhere. However, despite the availability of different initiatives in providing HIV/AIDS treatment, the situation in Ethiopia differs. Out of 211,000 people in need of antiretroviral therapy in December 2004, only 16,400 (age 15-49) received treatment by April 2005. In regard to paediatric HIV/AIDS treatment, less than 1% of children in urgent need of ARV had access to HIV/AIDS treatment. This was due to limited financial and human resources as well as limited infrastructure through which Paediatric HIV/AIDS treatment to children in need is delivered.

In most of developing countries and especially in Sub-Saharan Africa, the economic and the social stress associated with having HIV/AIDS reduces the life chances of many infants and young children growing up in an impoverished environment not conducive to their development. For a child living with HIV/AIDS, being poor means more than simply not having enough income. Their lives are affected by poverty in a unique way. Child poverty destroys the capacity they require to survive and develop by depriving them access to HIV/AIDS treatment, ending millions of children’s life prematurely and shattering the hope of future generations.

This paper explores what can be done in order to frame effective political and policy responses to the right in question. By unfolding the impact of poverty on the enforcement of the right in question, I argue that the most effective response to HIV/AIDS treatment for impoverished children is, establishment of sustainable, equitable development on a rights based approach which places children’s interest first in the process of poverty eradication.

1.2 Thesis Objectives and Research Question

1.2.1 Objectives

To make an assessment of the impact of poverty in ensuring a child’s right to access HIV/AIDS treatment and to political and policy responses at the international, regional and nationals levels in Ethiopia;

To explore what can be done in order to give effective political and policy responses to the right in question.
1.2.2 Research Question

Main research question:
In what ways does a country’s poverty affect a child’s right in accessing health service in the context of HIV/AIDS treatment?

Sub-questions
1. How is children’s right in accessing health services/ accessing HIV/AIDS treatment protected by international, regional and national legal frameworks?
2. In what ways does child poverty affect a child’s right in accessing HIV/AIDS treatment?
3. What are the political and policy responses given at the international, regional and national levels in Ethiopia in making access to HIV/AIDS treatment available to poor children?
4. Are children put first in the delivery of HIV/AIDS treatment services?
5. Are children given priority in existing health and development policies?
6. For whom to mind the gap between the need and access to HIV/AIDS treatment for children living in poverty?
7. What does it take to make sense of a child’s right to access HIV/AIDS treatment?
8. In what ways do political and policy responses in rights based approach to poverty reduction strategy impact the realization of a child’s right to access HIV/AIDS treatment?

1.3 Hypothesis, Justification, Audience

1.3.1 Hypothesis

Making sense of access to HIV/AIDS treatment for children is a question of making a shift from a “charity” perspective to a focus on “legal obligations” at the national and international levels by:
- Placing the rights of children living with HIV/AIDS on the development agenda;
- Putting children living with HIV/AIDS first in political and policy responses to HIV/AIDS, poverty reduction strategies, and budget allocation.
1.3.2 Justification

The reason I picked up this thesis topic is manifold. First and for most, being born in Sub-Saharan Africa, Ethiopia, I have witnessed the deaths of many people affected by HIV/AIDS and the sufferings of the families left behind. If antiretroviral therapy had been available to them, most would probably still be alive today. The available HIV/AIDS treatment in Ethiopia is formulated in adult oriented way. Because it is designed in this manner, provisions are stretched too thin to reach out to the many poor children. This problem is compounded with the scarcity of treatment. In the past, little attention has been given to the impact of poverty on children living with HIV/AIDS and their ability to access HIV/AIDS treatment. Second, Ethiopia is my country, Ethiopians are the people I intend to go to and serve.

1.3.3 Audience

The targeted audiences of this thesis are;

A. At the international, regional and national level in Ethiopia offices responsible for,
   - Designing policies and programmes relating to poverty reduction and HIV/AIDS
   - Allocating resources and drawing up budgets;
   - Implementing child rights programmes.

B. Ethiopian Parliamentarians (The House of Peoples’ Representatives): Because they play a decisive role in government budgeting.

C. Child rights advocacy groups, other organizations interested in the right in question.

1.4 Thesis Scope and Limitation

This thesis will analyse international and regional human rights documents at the African level that stipulate a right to health and a child’s right to health with a special focus on the child’s right to HIV/AIDS treatment access. It analyses the political and policy responses to HIV/AIDS treatment at the international, regional and national levels with a special emphasis on the impact of poverty on the realization of the rights in question.

This thesis will be limited to analyzing the impact of poverty on the enforcement of access to HIV/AIDS treatment with respect to children. At the national level, it is limited to analysing the laws and policies of Ethiopia.
1.5 Thesis Methodology

The methodology applied on this thesis is a mix of legal and multidisciplinary approaches. As for the legal method, the analysis of positive law will be conducted. The rest of the thesis analysis will be conducted by applying a multi disciplinary approach.

As the research is qualitative in nature, the methodology will be focused mainly on desktop research. Statistics will be used for illustration purposes in relation to the analysis. While analysing the existing laws relating to the right to health in general and in the context of the child’s right to access HIV/AIDS treatment, General Comments and different literatures will be used. For the rest part of analysis, different literatures on human rights, philosophy, child rights, health and development will be used.

This thesis examines different political and policy documents related to poverty reduction and HIV/AIDS. At the international level, The MDG, A World Fit for Children, The 3 by 5 Initiative and The G8 2005 Summit will be examined. At the regional level, the NEPAD Health Strategy will be examined. At the national level, The Ethiopian Sustainable Development and Poverty Reduction Programme (SDPRP) and Strategic Plan for intensifying Multi-Sectoral HIV/AIDS Response (SPM) will be examined.

The thesis has five parts. The first chapter introduces the subject of the research and problem statement.

Chapter two sets a legal framework within which a child’s right to access HIV/treatment will be analyzed.

In chapter three, the concept of poverty in general and with respect to children; the reinforcing factors of HIV/AIDS and child poverty; the impact of child poverty on children’s access to HIV/AIDS treatment will be discussed.

Chapter four discusses the political and policy responses given at the international, regional and national levels in Ethiopia in addressing access to HIV/AIDS treatment.

Chapter five presents a discussion on how to make sense of access to HIV/AIDS treatment for children in Africa by addressing the hypothesis given above. The hypothesis will be followed by a discussion of a rights based approach to poverty reduction strategy and its implication as well as application in addressing a child’s right to access HIV/AIDS treatment. Conclusion and recommendation is presented at last section of chapter five.
A great number of United Nations human rights instruments refer to people’s right to health. Article 12 of ICESCR defined the right to health as the “highest attainable standard of physical and mental health”. As there are a lot of different factors determining the health of a person, a right to health cannot be meaningfully interpreted as “a right to be healthy”.

This chapter discusses international and regional human rights treaty provisions as well as the Ethiopian constitution stipulation of the right to health in general and in the context of a child’s right to access HIV/AIDS treatment. Right to health, as it is laid down in international and regional human rights instruments will be presented in the first section. The second section presents analysis of the normative content of the right to health with a special reference to the right to access health services. The analysis of the obligation of states will be presented in the third section. Section four presents analysis of the right to access health services and provisions related to children under the Ethiopian Constitution.

2.1 Right to Health under International and Regional Human Rights Instruments

The right to health is enumerated in a series of major international and regional human rights instruments. It is embedded in Article 25 of the UDHR, Article 12 of the ICESCR, Article 24 of the CRC, Article 16 of the ACHPR and Article 14 of the African Charter on the Rights and Welfare of the Child.

Article 25 of the UDHR puts the right to health in combination with other social issues under a provision of the “right to an adequate standard of living”. It recognizes the right to security to every one in the event of “sickness”. Article 12 of the ICESCR recognizes the right of every one to “the enjoyment of the highest attainable standard of physical and mental health”. Article 24 of the CRC extends provisions of the right to health enumerated in the ICESCR to children. It recognizes “the right of the child to the enjoyment of the highest attainable standard of physical and mental health”.

1. ICESCR General Comment 14, para. 8.1
2. A child is every human being below the age of 18.
of health and to facilities for the treatment of illness and rehabilitation of health”. Article 24(1) of the CRC is the only human rights instrument in explicitly recognizing the child’s right to access health services. Article 24 of the CRC gives a more elaborated provision of the right to health to a child. The right to health of children is tied up with several other issues like the right to information and education.

At the regional level, Article 16 of the ACHPR similarly affirms that “every individual shall have the right to enjoy the best attainable state of physical and mental health”. The African Charter on the Rights and Welfare of the Child, 1990 is another regional instrument which made explicit the right to health to children. Article 14 of the same instrument draws its inspiration from Article 12 of the ICESCR, Article 24 of the CRC and Article 16 of the ACHPR in its definition of the right to health. It recognizes the right to “enjoy the best attainable state of physical, mental and spiritual health”.

Contrary to the ICESCR, the CRC and the ACHPR, the health definition of article 14 of the African Charter on the Rights and Welfare of the Child, 1990 includes “spiritual health”. By including this phrase in its definition of the right to health, the African Charter on the Rights and Welfare of the Child “seems to be inclined to open up the concept of the right to health to African tradition.” However, the inclusion of this phrase in this article is problematic. The concept “spiritual health”, encompasses a very broad social, cultural and spiritual element. Also, views concerning what is meant by “spiritual health” vary considerably across various societies and among different groups within the society, which makes the child’s right to spiritual health intangible.

2.2 Scope and content of the right to health

Health is a very broad concept influenced by different factors like geography, the culture and the socio-economic situations of the person or the society in question. It is difficult to define

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exactly what the right to health contains and what lies in its scope. The encompassing “elements that make up the right to health” are “health care” and “underlying preconditions for health”

Health care includes both curative and preventive health care, whereas the elements of “safe drinking water, adequate sanitation, nutrition, health-related information, environmental and occupational health” lie under underlying preconditions for health. As the elements underlying preconditions for health are beyond the scope of the issues raised in this chapter, the remaining part of this chapter focuses only on elaborating the contents of health in respect to health care and a special reference to HIV/AIDS treatment access.

2.2.1 Right to access health service

Article 12(2)(D) of the ICESCR states the right of everyone to health facilities, goods and services. Article 24 (1) of the CRC recognizes the right of a child to access health care services.

ICESCR General Comment No. 14 has made important contributions in interpreting the right to health care where by one can drive the contents of the right to health care from it. It delineates the components of right to health care among other things as “access to health facilities” and provision of “essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs”. The right to health facilities, goods and services include;

Provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; ...Improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector...participation in political decisions relating to the right to health taken at both the community and national level.

2.2.2 Guiding principles of the right to access health service

ICESCR General Comment 14 has set four standards by which to evaluate the attainment of the right to access health services. These are: availability, accessibility, acceptability and quality.

**Availability:** Refers to the availability of “public health and health care facilities, goods and services, personnel, programmes and essential drugs, as defined by the WHO Action Programme on Essential Drugs” in sufficient quantity.

**Accessibility:** Refers to safe physical available of health services to all sections of the population, especially to vulnerable or marginalized groups. Accessibility also refers to “economic affordability”. That is, health services should be affordable for all, including “socially and economically disadvantaged groups”.

**Acceptability:** Refers to the requirement that all health facilities, goods, and services be “respectful of medical ethics” and be “culturally appropriate”. That means health service should be provided in the manner it is culturally acceptable by the individual or the society in question. This includes among other things, respecting the “confidentiality” of the health status of the person.

**Quality:** Refers to the need for health facilities, goods and services to be “scientifically and medically appropriate and of good quality”.

2.3 Obligation

2.3.1 General Obligation

Article 2 of the ICESCR provides the progressive realization of the rights recognized in the covenant “assuming the valid expectations of realization of these rights are not uniform but relative to levels of development and available resources”\(^5\). Article 2(1) of the same instrument mandates a state party;

..to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present covenant by all appropriate means, including particularly the adoption of legislative measures.

This article acknowledges limitation of available resources at national level. The concept of progressive realization has been criticised for its complication of the rights and the process of

monitoring them. But the obligations stated in the ICESCR Article 2 are immediate as long as resources are available. One only needs to ensure when monitoring the realization of the rights in question, whether resources were available when such resources are required.

Article 4 of the CRC immediately calls for the implementation of the rights enshrined in the instrument. It mandates states to undertake all appropriate legislative, administrative and other measures;

“to the maximum extent of their available resources and where needed within the framework of international co-operation”.

Article 1 of the ACHPR obligates states parties “to adopt legislative or other measures to give effect to” the rights enshrined.

Article 1 of The African Charter on The Rights and Welfare of the Child obliges states to;

Undertake necessary steps, in accordance with their constitutional processes and with the provisions of the present Charter, to adopt such legislative or other measures as may be necessary to give effect to the provisions of this charter.

CRC Article 3 imposes an obligation that the best interests of the child be “a primary consideration” on any action taken concerning children. The question whether to make the principle of the best interests of the child “a primary” or “the primary” consideration had been the core of debate between the drafters of the CRC. There is also no consensus among the scholars of child rights over this aspect. Those who supported the inclusion of “a primary” consideration at the time of its drafting, argued that Article 3 of the CRC should give a space to other competing interests like “justice and society at large”. Alston is the one who supports the argument that the principle of the best interests of the child be “a primary” consideration. He argues that by making the best interests of a child “a primary” consideration, Article 3 of the CRC aims to ensure,

“..there is sufficient flexibility, at least in certain extreme cases, to enable the interests of those other than the child to prevail”.

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6 Supra note 5, pp. 4 and 197.
7 Supra note 4, pp. 22-28.
9 Supra note 8, p. 13.
In contrast to Alston, McGoldrick argues that the inclusion of “a primary” consideration in Article 3 of the CRC has made evaluation of “the operations of national laws and practices against this standard” difficult.\(^\text{10}\)

The object of the inclusion of the principle of the best interests of the child in the CRC is to give due attention and protection to children’s interest. Making this principle “a primary” consideration, weakens the protections sought to avail to children under the CRC. It leaves a loophole for the interests of children not to be seen as important as intended to be when taking decisions affecting them. In my opinion, the interests of the child should be “the primary” consideration in order to make the principle and the overall provisions of the CRC viable and meaningful in terms of giving due account of children’s rights and ensuring that other competing interests do not adversely impact upon children’s rights.


The Obligation to Respect, Promote and Fulfil

The analytical framework developed by Asbjorn Eide concerning states’ obligation in relation to economic social and cultural rights, classifies state’s obligation into “the obligation to respect, protect and fulfil”.\(^\text{11}\)

The obligation to respect requires states to refrain from interfering in the enjoyment of economic, social and cultural rights. The obligation to protect requires states to prevent violations of such rights by “third parties”. Finally the obligation to fulfil requires states to take appropriate legislative, administrative, budgetary, judicial and other measures towards the full realization of such rights.

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\(^\text{11}\) Supra note 4, p. 23.
Minimum Core Obligation

As stated above, the progressive realization of economic, social and cultural rights cannot be interpreted as a mean through which to provide “a loophole large enough in practical terms to nullify the covenant’s guarantee”. The normative concept of progressive realization is that states have a continuing obligation towards the full realization of economic, social and cultural rights as much as possible.

ICESCR General Comment 3 states the minimum core “obligation to ensure the satisfaction of the very least” of which, “minimum essential level of each of the right is incumbent upon every state party”. A minimum essential level of fulfilment of rights covers essential elements without which the right in question “loses its substantive significance as human right or the absence of which a state party should be considered to be in violation of its international obligation”. The same General Comment stresses that,

in order for a state to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources, it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.

International obligation

The question of identifying duty holders of economic, social and cultural rights always raises issues of resources. The interpretations of “available resources” under ICESCR Article 2 and CRC Article 4, includes resources both at the national and international levels. Therefore, these covenants underline the international obligations of states in making resources available to poorer countries.

In order to achieve the full realization of the rights recognized in the covenant, Article 2 of the ICESCR mandates states;

“to take steps, individually and through international assistance and cooperation specially economic and technical to the maximum of its available resources”.

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12 Supra note 5, p. 5.
13 ICESCR General Comment 3, para. 9.
14 Supra note 5, p. 9.
Article 4 of the CRC mandates states to undertake measures; “if needed within the framework of international cooperation”

By recognizing the resource constraints of poor countries in meeting their treaty obligations; the above mentioned articles call for the provision of available resources at the international level for the resource constrained countries. The Committee on Economic, Social and Cultural Rights has also reiterates the international obligations of states in its General Comment 3 and 14.

In the light of the above mentioned provisions of the ICESCR, the CRC, ICESCR General Comments 3 and 14 as well as the analytical framework made by Asbjorn Eide regarding obligation of states, for the better purpose of this thesis, the following four analytical framework analyses concerning the international obligations of states is drawn. These are: the obligation to provide, the obligation to protect, the obligation to respect and the obligation to oversee.

The obligation to provide includes the promotion of development cooperation, economic provisions and technical assistance available at the international level. These can be done through development cooperation (credit, grants, technical assistance).

The obligation to protect includes protecting the rights of individuals from being infringed by “third parties” which are beyond the jurisdictions of the state in question. This includes preventing third parties from violating the right in question in other countries if other states are “able to influence these third parties by way of legal or political means”.

The obligation to oversee include, duties of states to check whether economic social and cultural rights in another state are realized or whether the state has made every effort to use the maximum resources available at the national level in order to realize the economic, social and cultural rights in question. This can be done through monitoring mechanisms.

The obligation to respect include respecting national initiatives in order to fulfil their obligations.

With respect to the hierarchy of obligations, the primary obligation to realize a child’s right to access HIV/AIDS treatment lies on the state in question. It is only after it is demonstrated that the state in question has made every effort to use all resources at its disposition to meet its

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15 Supra note 1, para. 39
minimum obligation towards this right and found economically and technically unable to realize the right in question that international obligations of states to provide economic and technical assistance will take place.

2.3.2 Obligation with respect to the right to health under ICESCR AND ACHPR

Article 12 of the ICESCR mandates states to take steps for the,

..reduction of the stillbirth-rate and infant mortality and for the healthy development of the child; prevention, treatment, and control of epidemic, endemic, other diseases; creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Article 16 of the ACHPR mandates state parties to “undertake the necessary measures to protect health” and ensure that their people “receive medical attention when they are sick” without enumerating clear undertakings for the state.

The right to health imposes the obligation\textsuperscript{16} to respect, protect and fulfil on states at the national level as well as the obligation to respect, provide, protect and oversee at the international level.

At the national level, the obligation to respect requires states to refrain from preventing the enjoyment of individual’s rights to health directly or indirectly. The obligation to protect requires states to take measures in order to prevent the violation of the right to health by “third parties”. The obligation to fulfil requires states to adopt appropriate legislative, administrative, budgetary, promotional and other measures in order to realize the right to health.

At the international level, the obligation to respect requires states to respect other states national initiatives, and to refrain from preventing access to health services in another country. The obligation to provide requires states to make both economic and technical assistance available to the states in need in order to facilitate access to health service. The obligation to protect requires states to prevent 3rd parties which are under their “political and legal capacity to influence” from violating the right to access health service in another country. The obligation to

\textsuperscript{16} ICESCR General Comment 14 has dealt with states national and international obligations regarding the right to health. I hereby make a reference to this General Comment concerning my analysis in this respect.
oversee requires states to monitor states’ performance in achieving the realization of the right to
health in other countries through international organizations of they are members.

2.3.3 Obligation with respect to Child Right to health under CRC and the African
Charter on the Rights and Welfare of the Child

The responsibilities of the states with respect to the right to health in CRC Article 24(2)
éar,

To take appropriate measures to diminish infant and child mortality, to ensure the
provisions of necessary medical assistance and health care to all children with
emphasis on the development of primary health care, to combat diseases and
malnutrition, to provide clean drinking water and to combat the dangers and risks
of environmental pollution.

The African Charter on the Rights and Welfare of the Child Article 14(2) enumerates
similar responsibilities of states stated in CRC. But in the case  of states obligation in addressing
infant and child mortality, Article 24(2)(A) of CRC obliges states to “diminish infant and child
mortality” where as the African Charter on the rights and welfare of the Child reduce states
obligation to the status of reducing infant and child mortality. On the other hand, the African
Charter on the Rights and Welfare of the child has extended the states responsibility,

“to ensure the meaningful participation of non-governmental organizations, local
communities and the beneficiary population in the planning and management of a basic service
programme for children”.

This is the innovative and unique character of this instrument. It also states the
responsibility of states to,

“support through technical and financial means the mobilization of local community
resources in the development of primary health care for children”.

Article 24(1) of CRC obligates states to “ensure that no child is deprived of his or her
right of access to health care services”. The African Charter on the Rights and Welfare of the
Child does not expressly provide the right of a child to access health care services. However,

18 Supra note 17.
such right and its corresponding obligation are included in its general provision of the right to health.

Both the CRC and the African Charter on the Rights and Welfare of The Child represent the most significant commitment to children’s rights ever made. Unlike other human rights instrument, both documents explicitly recognize that children have legal rights. They identify children’s basic needs and set obligations in meeting them. In the case of health, they offer one of the principal obligations that are in averting preventable death and illness of children.

Children face the same health challenges as adults. But unlike adults children may require different solutions for the challenges they face. Children are the most vulnerable groups among the world population. They can not take care of themselves. Therefore introducing crucial obligations on the family, community and states to ensure that children live and develop are the decisive elements in the life of children. The health provisions of the CRC and the African Charter on the Rights and Welfare of the Child aim to empower individuals, households and communities with a means to acquire and sustain good health of children. Both documents specify how children should be treated in order to realize their rights by demanding the best interest of the child be the fundamental principle for every act done concerning children. They have strong messages for governments that child issues are not needs but are rights which hold governments liable if not meet.

The adoption of these two child rights instruments has led governments to give children’s issues political priority. It is also my conviction that both these instruments can become crucial in bringing an end to many of the inexcusable failures of the society both at national and international levels in addressing the most basic survival, protection, development and participation needs of children, if lobbied effectively.

2.3.4 Obligation with respect to a Child’s Right to access HIV/AIDS Treatment\textsuperscript{20}.

According to General Comment 14 of the Committee on Social, Economic and Cultural rights, the right to health facilities, goods and services includes among other things; “Provision of equal and timely access to basic preventive, curative, rehabilitative health service” on a non-discriminatory basis. The same general comment states that ensuring the provision of essential drugs “as from time to time defined under the WHO Action Programme on Essential Drugs” are the core obligation of states under ICESCR Article 12.

Antiviral medicines are now included in WHO essential drugs list which lays the legal ground in making the provision of the treatment obligatory according to ICESCR Article 12 (D), CRC Article 24(1), ACHPR Article 16(2) and Article 14(2) of the African Charter on the Rights and Welfare of the Child. The provision of HIV/AIDS treatment (Antiviral medicines) according to WHO, are subject to available resources and professionals. As stated above, the question of “available resources” includes resources at the national and international levels. Therefore, a child’s right to access HIV/AIDS treatment imposes obligation at the national and international levels specifying the best interest of the child be a primary conditions for its realization.

At the national level, the obligation to respect requires states to refrain from preventing a child’s access HIV/AIDS treatment. It includes respecting children as a primary consideration.

The obligation to protect requires states to take measures in order to prevent the violation of the child’s right in accessing HIV/AIDS treatment by a 3\textsuperscript{rd} party. This includes controlling the prices of treatment and actions of private health sectors at the national level.

The obligation to fulfil requires “states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures”\textsuperscript{21} in order to make access to HIV/AIDS treatment real to all economically and politically marginalized children.

At the international level, the obligation to respect requires states to respect other states initiatives in manufacturing and producing quality but significantly cheaper versions of

\textsuperscript{20} HIV/AIDS treatment is a treatment with Antiretroviral (ARV) medication used to treat HIV virus in the body. The service includes provision of antiretroviral drugs, screening, confirmation and monitoring tests.

\textsuperscript{21} Supra note 13, para. 33.
HIV/AIDS treatment medicines for the protection of public health. This includes refraining from taking actions that stop the dissemination of technology in developing countries.

The obligation to protect requires states to prevent 3rd parties, which are under their political and legal capacity to influence, from violating a child’s right to access HIV/AIDS treatment.

The obligation to provide requires states to make both economic and technical assistance available to states in need in order to facilitate access to HIV/AIDS treatment to poor children, if the state in question is economically and technologically unable to deliver the service.

The obligation to oversee requires states to monitor whether states have used their limited resources effectively in order to realize a child’s rights to access HIV/AIDS treatment, and whether the economic and technical assistances given are spent properly without discrimination in order to deliver HIV/AIDS treatment to poor children.

2.4 Right to access health service under the Ethiopian Constitution

Ethiopia is party to the ICESCR, the CRC, the ACHPR and the African Charter on the Rights and Welfare of the Child. With regard to the incorporation of human rights norms in domestic laws, Ethiopia follows the Monist approach.22 Accordingly treaties ratified by Ethiopia form part of the domestic laws of Ethiopia upon their ratification by the House of People’s Representatives. As to the status of international human rights instruments under Ethiopian legal system, the Ethiopian constitution recognizes international legal documents as sources of law of the country. All treaties ratified by Ethiopia are integral parts of the law of the land.23 In its Article 9(1), the Ethiopian constitution proclaims itself as the supreme law of the country. Human rights instrument ratified by Ethiopia have inferior status from the constitution. On the other hand, different human rights norms have been imbedded in chapter three of the Constitution. Article 13(2) of the constitution recommends the interpretation of the rights in chapter three of the constitution to be in “a manner conforming to the principles of the Universal

22 The monist theory upholds that a ratified treaty or international agreement does not need any further legislative act in order to have legal effect in the domestic action. Therefore according to this theory publication of international agreement is sufficient to make it applicable in domestic courts.

23 The Constitution of the Federal Democratic Republic of Ethiopia, 1995, Article 9(4)
Declaration of Human Rights, International Covenants on Human Rights and international instruments adopted by Ethiopia”.

Chapter three Article 41 of the constitution enumerates economic, social and cultural rights. According to sub section 4 of the same article, the state is obliged to;

“allocate ever increasing resources to provide to the public health, education and other services”

The rights pertaining to children are also embedded in chapter three under Article 36 of the constitution. Sub section 2 of the same article stipulates that the best interest of the child are “the primary consideration” in all actions concerning children undertaken by public and private welfare institutions, courts of the law, administrative authorities or legislative bodies. Article 41 (5) also obliges the state that,

“within the available means to allocate resources to provide rehabilitation and assistance to children who are left with out parents or guardian.”.

To sum up, the above discussed provisions of the Ethiopian Constitution and international and regional human rights instruments stipulate the child’s rights to access HIV/AIDS treatment. It is clear that the Ethiopian government has obligation to protect, provide and fulfil the realization of children’s right to access HIV/AIDS treatment by taking steps “individually and through international assistance and cooperation specially economic and technical to the maximum of its available resources”.

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24 ICESCR article 2(1).
3 POVERTY VERSUS HIV/AIDS

The concept of poverty has undergone many changes in the last 50 years or so. Its understandings has shifted over a period of time from viewing poverty as a shortage of income, lack of material needs, to viewing poverty as a denial of the opportunities and choices most basic to human development, as a failure of basic capabilities to reach certain minimally acceptable level, and a violations of human rights.

The first section of this chapter will analyse the concept of poverty in general, child poverty and the health dimension of child poverty. In section two, the analysis of HIV/AIDS in the context of children and its relation to poverty will be discussed. The impact of poverty on children’s access to HIV/AIDS treatment will be discussed in the third section.

3.1 The concept of poverty

3.1.1 What is poverty?

Poverty as a shortage of income:

When poverty is seen from an income perspective, it is understood as the lack of income or resources to generate income. The state of being poor is a lack of income for providing material needs or having an income too low to be able to buy the essential goods and services for life. According to this concept, poverty is related to the lack of command over economic resources. It sees poverty as the condition of possessing an income insufficient to maintain a minimal standard of living. Hence, views an increase in income of the poor as the major solution in ending poverty.

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Poverty as a lack of material needs:

When poverty is examined in terms of material needs, it is considered a deprivation of goods and services that are essential for minimally acceptable human needs. Essential goods and services are food, clothing, shelter, education and health services.

Poverty as capability deprivation:

The capability approach\textsuperscript{26} views poverty in terms of the opportunities and choices given to a person to live “the kind of life the person has reason to value”. It views poverty as a lack of opportunities and choices to “functioning”\textsuperscript{27} in order to live a valuable life. These opportunities and choices include among others, “the opportunities to lead a healthy, creative life and the opportunities to enjoy a decent standard of living”.

Amarthye Sen is the first scholar to pioneer the functioning and capability approach in development economics.\textsuperscript{28} In his book “Development as freedom”, he views poverty as “deprivation of basic capabilities”\textsuperscript{29} in reaching certain minimally acceptable levels. Capability is the “substantive freedom to achieve alternative functioning combinations, or the freedom to achieve various lifestyles”.\textsuperscript{30}

In his argument in favour of capability approach over income based approach, Sen points out that the former;

“...enhances the understanding of the nature and causes of poverty and deprivation by shifting

\textsuperscript{26} It is an approach “to quality of life assessment.” Its main question is not how much one is satisfied or how much one is able to have a command on resources, but it is about how much one is able to do or to be. Nussbaum Martha, Women and Human development, 2000, pp. 70 to 71.

\textsuperscript{27} Functioning refers to the various things the person can do or be. See Supra note 22, p. 2.

\textsuperscript{28} Amartya, Sen, Equality of What? The Tanner Lecture on Human Values Delivered at Stanford University, 1979, p. 24.

\textsuperscript{29} Amartya, Sen, Development as freedom, 1999, p. 86.

\textsuperscript{30} Supra note 29, p. 75. Capabilities, in Sen’s terms, could be seen as a combination of rights, freedoms and opportunities that help to advance the general capability of a person. They may include “political freedoms, economic opportunities, transparency guarantees and protective security”.

29
the primary attention from income (means) to the ends which people has a reason to pursue”.  

He argues that poverty could only be identified sensibly in terms of capability deprivation as there are factors other than income that influence the capability of the person in question.

Martha Nussbam, another advocate of the capability approach, argues that certain functions are particularly “central in human life; their absence or presence is marked as the presence or absence of human life”. She provides lists of ten central human functional capabilities. She considers these lists as the basis for determining a “basic social minimum” that needs to be secured for all citizens. She emphasizes the complementary nature and interrelation of all ten capabilities. She argues the lists to have a more “demarcated” account of the minimum threshold level, where by;

“..beneath a certain level of capability, a person has not been enabled to live in a truly human way”.  

Poverty as a violation of human rights:

When poverty is seen from the human rights perspective it is the consequences of non-fulfilment of a person’s human rights to a range of basic capabilities. These basic capabilities include: “being adequately nourished, avoiding preventable morbidity and premature mortality, being adequately sheltered, and having basic education”. The rights, the non-fulfilment of which causes poverty varies depending on each case. Poverty can result in the violation of the right to an adequate standard of living (food, clothing, and housing); right to education, right to decent work, right to health, right to personal security, political rights and freedoms, and right

31 Supra note 29, p. 90. Sen, in his argument Poverty as “capability deprivation” on page 109, admits the essentiality of income in generating capabilities but confides its role to a means to reach a life that people has a reason to value. He further shows the contingent and conditional impact of income in generating capabilities due to the “personal heterogeneities, environmental diversities, difference in relational perspectives and distribution within the family”. In other words he argues that the “conversion” of income in to “functioning” we can achieve varies depending up on the above mentioned factors.

32 Supra note 26, p. 71.

33 Supra note 26, p. 74.

to international assistance and cooperation. Such rights can be said to be violated, if states fail to fulfil their obligations while economic resources are available.

The justification in viewing poverty as a violation of human rights lies in the notions of human dignity and individual freedom. Respect for human dignity and individual freedom are the main principles of human rights. Human rights constitutes a minimum core standard of human dignity and individual freedom that every person possesses simply because they are human beings. Poverty is a violation of human rights to basic capabilities. Because lacking those capabilities would make a dignified human life impossible. Hence, poverty can be considered as “degradation of human dignity” because, “poor people lack the freedom to lead a life with dignity” 35

The human rights perspective of poverty sees poverty as a result of systematic social deprivation, neglect of public facilities and the non fulfilment of states international human rights obligations. Tomas Pogge argues that the present global economic orders cause poverty by violating the right to “basic necessities”. He argues that,

“Sever poverty could have been reduced through feasible reforms that would modify the more harmful features of this global order or mitigate the impact of these features” 36

The Committee on Social, Economic and Cultural Rights has defined poverty as;

... a human condition characterized by sustained or chronic deprivation of resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights 37

Poverty from human rights perspective can also be analysed as deprivation of some basic rights. Henry Shue argues that basic rights are those rights the enjoyments of which are essential to the enjoyment of all other rights. Hence, he considers basic rights as,


“everyone’s minimum reasonable demands upon the rest of humanity”.38

The basic rights defined by Henry Shue are “full physical security” and “subsistence or minimal economic security”. Subsistence or minimum economic securities include a right to “unpolluted air and water, adequate food, clothing, shelter, and minimal preventive public health care”. He argues that the fulfilments of the basic rights are dependent on a successful defence against “standard threats”.

To sum up, the analysis of poverty as income deprivation has been criticized for giving too much attention to income inequality and the generation of income as the way to eradicate poverty.

The above traditional concept of poverty has been challenged by the capability approach which views poverty as “capability deprivation”. This approach seeks to reflect the multi-dimensional character of human poverty by defining poverty in a broad sense, as “capability inadequacy”. It emphasises the functioning that a person can do or be; given the opportunities a person has had in identifying that person’s state of poverty. This is in opposition to the income-based or needs based assessment. It puts its focus on the “freedom and opportunities” given to lead a humanly life in defining poverty. It acknowledges income as an important means to capabilities but rejects viewing income as the only factor in assessing poverty.

The advantage of viewing poverty as human rights violation is that it delineates clearly the rights and duties as well as the right-holders and duty-bearers. It introduces “international dimension of legal obligation”39 on states to be bound by international law in providing obligatory assistance and co-operation in order to remove poverty in other countries. It recognizes the importance of “equality and non-discrimination” and “calls for the reorientation of poverty reduction strategies from a tendency to focus on narrow economic issues towards a broader strategy that also address socio-cultural and political-legal institutions that sustain the structure of discrimination”.40

39 Supra note 34, p. 8.
40 Supra note 34, p. 8.
Poverty as a denial of capabilities, rights, opportunities and resources:

I am convicted that poverty in its broader scope embraces the question of freedoms, opportunity, rights, and capabilities, resources as its cause and effect as well as the necessity of resources in eradicating poverty. While holding this conviction, for the better purpose this thesis, I adopt the following working definition based on the different concepts of poverty discussed above.

Poverty is a denial of capabilities, rights and opportunities that impede people from living a life in dignity\(^{41}\) and a direct and systematic deprivation of a command over a resource which is vital as a means to lead life with dignity.

Poverty is a denial of capability because poverty reflects the state of being powerless to live a life in dignity and inability to live a life one has a reason to value. It is a denial of rights to a range of basic capabilities and opportunities which make a dignified life possible. Poverty is also a systematic or direct deprivation of a command over resources which are essential as means in eradicating poverty.

3.1.2 Understanding poverty from a Child’s perspective

Childhood is a critical period in life for the development of a future adult person. What children’s gain or loose in this critical period of their age determines much of the fate or the existence of their future life. Unlike adults, children are vulnerable to many evil things the world and nature offer. They have special developmental needs and rights. Therefore, children’s experience of poverty is unique and different from adult’s experience. This begs for special attention, partly because children are powerless in terms of taking care of themselves and are dependent on adults for their wellbeing and security. Viewing poverty in a child’s perspective adds another dimension to the traditional conceptual analysis of poverty in general.

Child poverty is a poverty experienced during childhood. It has different dimensions depending up on a child’s personal, environmental, geographical and social circumstances. A child can be said to be in poverty if he or she is growing up “without adequate livelihood, 

\(^{41}\) A life in dignity includes among other things, having a long, creative and healthy life not interrupted by bodily and mentally affliction or preventable death, acquiring skills to be able to participate in any kind of fulfilling social life, having a respect simply by the fact that one is a human being. Reference is made to Martha Nussbaum’s discussion of ten capabilities. Supra note, 26, from pp. 70-86.
without opportunities for human development, without family and community structures that nurture and protect them”.  

A child is said to be in poverty if he is deprived of access to the financial resources needed for survival and development which can be understood as income poverty. When child poverty is expressed in terms of basic needs, it is a matter of defining and identifying child poverty “by focusing on children’s access to a set of basic needs and services”.  

The human development dimension of child poverty reflects the deprivation of opportunities (capability deprivation) to develop the potential children need for life. These opportunities include education, health, and opportunity to develop one’s talent or opportunity in acquiring life skills. Lack of opportunity to be heard or lack of voice also can be the cause and effect of child poverty as it underpins adult poverty. A lack of opportunity to be heard makes children to be powerless while undermining their right to lead a life with dignity.

The social dimension of child poverty delineates children’s experience of childhood without having parents, guardians, family to take care of them. It also expresses the absence of a community or a state’s provision for the care and protection of children. This dimension of child poverty encompasses the emotional, personal and spiritual aspects of child development in addition to economic and physical security.

The Childhood Poverty Research and Policy Centre (CHIP), defines children in poverty as those children,


45 Supra note 42, p. 1.
“growing up without access to different types of resources those are vital for their wellbeing and for them to fulfil their potential”.\textsuperscript{46}

CHIP’s definition of child poverty offers different aspects of child poverty by delineating the social and cultural aspect of resources which are vital for the child’s “emotional, personal and spiritual development”.\textsuperscript{47}

The State of The World’s Children 2005, UNICEF defines child poverty as a,

“deprivation of the material, spiritual and emotional resources needed to survive, develop and thrive, achieve their full potential or participate as full and equal members of the family”.\textsuperscript{48}

The UNICEF’s definition of child poverty encompasses the many dimensions of deprivation that result in child poverty without completely denying the role of income as a means in ending child poverty.

Viewing child poverty from a human rights perspective takes the dimension of child poverty as a violation of children’s human rights. Article 27 of the CRC accords children the right to “a standard of living adequate for the child’s physical, mental, spiritual, moral and social development”. This article incorporates the necessary ingredients the lack of which lay a ground for child poverty. Therefore, Article 27 of CRC is an example of the existence of a link between the concept of child poverty and children’s rights.

The advantage of viewing child poverty from human right perspective is that, it empowers children with a claim to their rights. It also shifts the traditional concept of applying charity perspective in eradicating child poverty to an obligation perspective by clearly setting an obligation on the state, community, family and individuals for a fulfilment of the child’s rights. It has a strong message for the above mentioned duty bearers, that the child’s issues are not a matter of donation or charity! But of \textit{a right}!

Taking to consideration the special dimension added to child poverty discussed above, I have adopted the following definition of child poverty for the better purpose of this thesis. While doing so I take the deprivational definitions of UNICEF and add them to the above mentioned definition of poverty in section 3.2.1 of this chapter.

\textsuperscript{46} Supra note 43, p. 1.
\textsuperscript{47} Supra note 43.
\textsuperscript{48} UNICEF, The state of the world’s children 2005, P. 18.
Child poverty is a denial of capabilities, rights and opportunities that impede children from living a life in dignity and a direct and systematic deprivation of material, emotional and spiritual resources needed to lead a life with dignity that is; to survive, develop and thrive, achieve their full potential or participate as full and equal members of the family.

The overall concept and definitions of child poverty are based on the deprivation of basic capabilities while taking note of the necessity of economic security as one of the many ways in addressing child poverty.

3.1.3 The health dimension of Child poverty

Health is one of the essential ingredients for the survival and development of a child. The status of a child health is measured by looking at the infant mortality and the child mortality rate.

Child poverty destroys the capacity required to maintain a child’s health by depriving them access to health service and the underlying preconditions of a health which are safe drinking water, adequate sanitation, nutrition, and health related information. Even though there is a close correlation between poor health and income poverty; the health of a child can be affected through other direct and systematic basic capability deprivations related to access health services or the above mentioned underlying preconditions of health. Therefore, by denying the right to health, child poverty “threatens childhood in the most tangible way of all: by jeopardizing their right to survival”. 49

3.2 HIV/AIDS epidemic in the context of children

HIV/AIDS is an epidemic which has caused the death of millions, leaving many more behind to deal with this long and devastating illness. It has become one of the greatest challenges for the international community since it threatens both human and economic development.

For vulnerable groups like children the effect of HIV/AIDS is catastrophic. While the epidemic has a profound impact on both children living with HIV/AIDS and children losing their parents to the epidemic, (but fortunately not infected); the remaining part of this section will focus only on the impacts of the epidemic on children living with HIV/AIDS.

49 Supra note 48, p. 17.
Children become infected by HIV/AIDS: through birth and through breast feeding from their HIV positive mothers, through transfusions with infected blood, through injection by equipment contaminated with infected blood, and due to sexual abuse.

The epidemic affects children’s life, their survival, security, rights and development in a unique way. Its effect on children varies depending on the socio-economic status of a child and its age. The disease has economic, social and psychological impact on children.\(^{50}\)

The “very fabric of children life” begins to be torn apart “when HIV/AIDS enters a household by infecting one or both parents”.\(^{51}\) Children take the responsibility of heading the household by taking care of the remaining members of the family in case of death or sickness of parents, while struggling to cope living with the virus themselves.

The epidemic has led to rising child mortality rates and sharp reduction in life expectancy. Children under the age of 15 die of “AIDS-related illness every minute of every day”.\(^{52}\) By taking away their parents, the disease causes millions of children to be orphans.\(^{53}\) It deprives them the living environment which is conducive to their human development. It exposes them to discrimination and stigmatization which result in “isolating them from others at a time when they are most vulnerable and need as much care and support as possible”.\(^{54}\)

It exerts a financial pressure on the people caring them, on the society, on the state and more profoundly, on children themselves. This results in children dropping out of school, engaging in hazardous working environment and exploitation at critical period in their life for the development of their future adult person. A lack of education affects their chances of achieving functional literacy (capability).

It affects their health in a unique way as they lack the familial, social and economic safety net to provide them with the underlying preconditions of health and access to health.

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\(^{51}\) Supra note 47, p. 67.

\(^{52}\) A call to action: Children the missing face of AIDS, UNICEF, 2005, p. 4.

\(^{53}\) The meaning of an orphan for the purpose of this thesis is a child under the age of 18 who has lost one or both of his/her parents.

\(^{54}\) Supra note 48, p. 69.
facilities. In places where the majority of society is affected by the epidemic, “health systems are increasingly losing their capacity to treat and care for children and their families”.

It makes many children orphans. As orphan, they suffer from emotional sickness, psychological and physical insecurity which affects their mental development and overall health. Even when parents are sick and alive, their chances of getting essential resources to grow are low and in extreme cases impossible as sick parents can neither remain productive nor maintain the household’s income. The parents can even die leaving the children in debt due to the costly expenses of the treatment of the epidemic and its related illness. This in turn reduces a child’s chances of accessing health care, food and education.

In general, HIV/AIDS has become a “voiceless weapon”, devastating children by taking away their lives and by eliminating their familial protective environment through the sickness and death of their parents which tears apart their livelihood and means of subsistence. It “undermines efforts at poverty reduction, income and asset distribution, productivity and economic growth”.

Hence, perpetuating the existing child poverty.

3.3 Impoverishing the impoverished: The impact of child poverty on access to HIV/AIDS treatment

According to AVERT “children, HIV & AIDS” analysis, children have a high risk of dying more quickly than adults as “HIV progresses in their body towards AIDS rapidly”. The analysis also showed that,

> Drug treatment for HIV in children cannot use 'the same drugs, but less - although this is something that often happens in many resource-poor countries, where paediatric treatments are unavailable. Pills, broken into smaller pieces, are given to children - meaning that there is no way of ensuring that the child gets the correct dose of the drug - or even if the child gets the same dose of the drug from one occasion to another. These practises can lead to resistance or death.”

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55 Supra note 48, p. 4.
This fact makes it important that children have access to specially trained medical staff, with a capacity (in terms of knowledge and material) to provide HIV/AIDS treatment fit for children. Providing children with ARV treatment requires “cheap, feasible diagnostic tests, trained health personnel and affordable child-friendly ARV drugs”.  

HIV/AIDS treatment is beyond the reach of the many poor children as the cost of treating one child is often as much as six times more than an adult. The lowest cost of adult antiretroviral fixed-dose combination treatment is $140.00, (one hundred and forty US Dollars). WHO in its background paper on “Aids treatment for Children” states that;

*the global market for paediatric AIDS drug formulations is not attractive for originator or generic companies; in wealthy countries very few children are being born with HIV, and in developing countries where most of the infected children are, paediatric formulations are not considered a priority or lucrative market. Drug companies have made little progress to date in developing new or reformulating adult tablets and fixed-dose combinations to breakable or chewable tablets.*

This causes a systematic deprivation of the opportunities and rights of children in poverty from making use of products of technology (access to HIV/AIDS treatment).

Having command over economic resources is essential as a means in making HIV/AIDS treatment available to all children. Poor children lack the economic capacity to afford HIV/AIDS treatment which amounts to economic deprivation or lack of a command to material resources.

Therefore, child poverty in light of access to HIV/AIDS treatment is;

*A direct or systematic deprivation of capabilities, opportunities, rights and a command over economic resources that impede children living with HIV/AIDS from accessing HIV/AIDS treatment.*

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59 Supra note 58.

60 Supra note 52, p. 7. The paper states that, “comparable paediatric formulations cost four to eight times more, depending on the age and weight of the infant”.

61 Supra note 58.
For a child living with HIV/AIDS being poor means more than simply not having enough income. Their lives are affected by poverty in a unique way. Poverty kills the capacity they require to survive and develop by depriving them of the essential goods and services for life.\textsuperscript{62} HIV/AIDS threatens the very existence of the person living with it. This makes access to HIV/AIDS treatment one of the essential goods for children living with it. Child poverty shatters the hope of the present and future generations by denying access to this essential good for children living with HIV/AIDS. For these children, being poor means not only being unable to afford HIV/AIDS treatment, but also being cut off from life prematurely in the absence of life prolonging treatment.

Therefore, the economic and social stress associated with having HIV/AIDS reduces the life chances of many infants and young children as children growing up in an impoverished environment not conducive to their development.

In general, child poverty deprives children living with HIV/AIDS their rights to survive and develop by denying them the basic good, HIV/AIDS treatment. It hinders them to live a life with dignity that is a life which is not interrupted by \textit{preventable death}. Hence, the impact of child poverty on access to HIV/AIDS treatment amounts to impoverishing the already impoverished.

\begin{footnotesize}
\begin{itemize}
\item The basic goods and services for the child’s survival and development includes, adequate nourishment, adequate shelter, basic education, access to health service, security (physical, economic, conducive environment to live without fear of danger or survival) and child friendly institutional arrangements.
\end{itemize}
\end{footnotesize}
4 POLITICAL AND POLICY RESPONSES

This chapter provides analysis of the political and policy responses given at the international, regional and national levels in Ethiopia in scaling up access to HIV/AIDS treatment in the light of children living with HIV/AIDS. While conducting the analysis, I hold the assumption that the greater availability of the issue of children living with HIV/AIDS in the documents examined reflects the greater political commitment.

Section one presents the analysis of the Millennium Development Goals, A world fit for children, The 3 by 5 initiative and The G8 2005 summit at the international level. At the regional level, the NEPAD Health strategy will be analysed in section two. Section three presents, an analysis of poverty in Ethiopia and its impact on the realisation of children’s right to access HIV/AIDS treatment. This will be followed by an examination of the political and policy responses given by the Ethiopian government.

4.1 International level

4.1.1 Millennium Development Goals

The year 2000 has seen the birth of the Millennium Declaration by world leaders as an international political response to the worldwide crises due to poverty, conflict, diseases, environmental degradation and human rights abuses. The Declaration has set out time-bound goals and targets among other things to eradicate extreme poverty, to reduce child mortality and to combat HIV/AIDS. These goals and targets are known as the Millennium Development Goals (MDG) and are to be fully implemented in 2015.

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64 Supra note 63.
65 Supra note 63.
Though the MDG are meant to be fulfilled for all human kinds, they have some important implications for children as they are “the most vulnerable and the first to die when basic needs are not met”.  

It is indicative that the MDG has added value to the efforts of mitigating HIV/AIDS epidemic by acknowledging it as an international problem which needs global response. However, Children living with HIV/AIDS have received little attention in the MDG despite the large magnitude of problems they encounter day to day. This can be identified from the following analysis of the MDG.

**Eradication of extreme poverty versus poverty reduction**

The overall objective of the MDG is to address world poverty in its many dimensions, in income poverty, diseases, hunger and exclusion. While setting goals and targets, it has made a distinction between poverty and extreme poverty by defining the later as people living with less than one dollar a day and those who are in hunger. Since poverty is the non-fulfilment of human rights to a range of basic capabilities, the writer assumes that making this distinction in such a highly political document is problematic. Because such a distinction may raise the counter arguments, that whether it is justifiable to tolerate a poverty which does not fall under the given definition of extreme poverty or not and may lower the already established minimum human rights standards. However, I do not completely object to the idea of making such a distinction with a view of offering immediate solutions to situations which needs immediate action in framing policies, given the limitation of resources at hand. What I try to reflect on the analysis is that whether the targets set up to eradicate extreme poverty in goal one have implications on addressing the impact of child poverty on children living with HIV/AIDS or not.

As argued in chapter 3, a child’s experience of poverty is unique and different from an adult’s experience, thus begging for special attention. For a child living with HIV/AIDS, being poor means more than simply having income less than one dollar a day. Their lives are affected by poverty in a unique way. For them there is no difference between the deprivation of food and

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67 Millennium Development Goal one is meant to address the world extreme poverty. The rest of the goals reflect the political commitment to reduction of poverty and sustainable development in many dimensions.
the deprivation of HIV/AIDS treatment. The consequences of both actions would result in preventable death. Because in the absence of provision of life prolonging treatments, a child living with HIV/AIDS will soon die as HIV progresses to AIDS rapidly in the case of children. Most children living with HIV/AIDS today are far from the reach of HIV/AIDS treatment as the cost of treating one child is six times more than treating an adult.68 Therefore, millennium development goal one, that is, eradication of extreme poverty and its targets are stretched too short to address the special dimensions of child poverty in the context of children’s access to HIV/AIDS treatment.

When the rest of the MDG are seen in the light of children living with HIV/AIDS, they have also failed to consider the special dimension of poverty in the context of children living with HIV/AIDS. Children living with HIV/AIDS by the nature of their situation demand much more attention, which reiterates the need to analyse poverty from their perspective and put them first in the political commitments and policy responses to poverty reduction. Without recognizing child poverty as global problem and taking a firm political commitment in encompassing the impact of child poverty on children living with HIV/AIDS in the poverty reduction strategies, it is impossible to make life possible for them.

**HIV/AIDS epidemic and access to HIV/AIDS treatment.**

The MDG do not explicitly hold the international community responsible for providing ARV treatment. This is because of the fact that provision of ARV treatments were believed to be unmanageable and economically intangible at the time the document was formulated. As a result, goal six focuses only on preventing the spread of the HIV/AIDS epidemic without making a clear political commitment on the provision of HIV/AIDS treatment. Also the MDG did not give attention to the impact of HIV/AIDS on children and specifically on children infected by it. The lack of such proper attention has frustrated the efforts to meet MDG in reducing poverty, in providing universal primary education, and in reducing mortality.69

The millennium declaration has considered orphaned children living with HIV/AIDS implicitly while making a resolution to “provide special assistance to children orphaned by

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68 Chapter 3, 3.4.
69 Supra note 52.
Even this resolution has failed to be transformed into broader targets and indicators in the MDG so as to give a multi-dimensional response in terms of empowering orphaned children living with HIV/AIDS access to treatment.

HIV/AIDS threatens the very existence of children infected by it. This results in the rise of child mortality rates. Reduction in child mortality rates is the fourth Millennium Development Goal. Unlike other children, the main cause that brings death to children living with HIV/AIDS is a lack of proper HIV/AIDS treatment. Therefore, what is targeted to save other children’s life can not benefit children living with HIV/AIDS. This reflects the necessity of taking into account the different economical, social and psychological needs of children living with HIV/AIDS in order to reduce child mortality among them.

While framing goal four, the main cause that brings death to children living with HIV/AIDS that the lack of HIV/AIDS treatment is not dealt. Given the fact that HIV/AIDS kills millions of children, without taking the issue of children living with HIV/AIDS first and without making the provision of HIV/AIDS treatment as one of the targets in reducing child mortality rates; goal four remains ineffective when it comes to saving the lives of millions of children infected by the epidemic.

Addressing the issue of provision of HIV/AIDS treatment to the world’s poor children requires global partnership and political commitment in terms of material and human resource mobilisation. Developing global partnerships for development is the eighth goal of the millennium agenda. In order to meet this goal, a target has been set up to provide access to affordable essential drugs in developing countries in cooperation with pharmaceutical companies.

If this target is met as promised it might have some added value to the provision of HIV/AIDS treatment in general as HIV/AIDS treatment drugs are essential drugs included in the WHO essential drugs list. When its validity is analysed in the light of children living with HIV/AIDS, it still falls short of addressing the special needs of these children in the production and provision of child-friendly and affordable HIV/AIDS treatment. Provision of child-friendly

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70 Millennium Declaration, para. 19, Resolution adopted by the General Assembly, without reference to a Main Committee (A/55/L.2).
71 See Millennium Development Goal 6, the target and its indicators.
72 See Millennium Development Goal 8, Target 17 and Indicators.
and affordable HIV/AIDS treatment requires specific analysis of the growth and impact of the epidemic on children infected by it. It also requires consideration of the need to look into alternative methods of providing treatment suitable to children. This can not be achieved without putting children infected by the epidemic first in the production and service delivery of the treatment.

In general, the MDG has failed to put children living with HIV/AIDS first on its millennium agenda. The goals and targets set to eradicate extreme poverty and to reduce poverty in different dimensions fall short of taking into account to address the many dimensions of impoverished children living with HIV/AIDS. As a result, “the needs of children are being overlooked when strategies regarding HIV/AIDS are drafted, policies made and budgets allocated”. 73

As a global policy document, the MDG does not place children living with HIV/AIDS at the centre of poverty reduction targets. It also does not demonstrate a strong commitment towards addressing the impact of child poverty on children right in accessing HIV/AIDS treatment. Nevertheless, as an international political document, its overall objective that is: to address the world “poverty in its many dimensions,” 74 has been a good start in setting the international political framework in the struggle to end world poverty.

4.1.2 A World Fit for Children

The 2002, UN General Assembly resolution called for a “global movement” in making the world fit for children by: following the principles of putting children first in all actions related to children, providing the best possible care in the start of their life, and protecting them and their families from the devastating impact of the HIV/AIDS epidemic. 75

73 Supra note 52, p. 7.
This resolution has set up time bound goals which fall into the areas of promoting healthy lives; providing quality education; protecting against abuse, exploitation, violence; and combating HIV/AIDS. While addressing the issue of promoting healthy lives, a resolution has been made to “reduce infant and under five mortality rate by 2015”.

Concerning HIV/AIDS, a target has been set up to reduce the proportion of infants infected with HIV by providing “effective treatment to reduce the mother-to-child transmission of HIV” as well as anti-retroviral therapy for HIV infected women and infants.

Concerning orphans infected and affected by HIV/AIDS, a target has been set up to develop by 2003 and implement by 2005,

National policies and strategies to build and strengthen governmental, family and community capacities to provide supportive environment; including by providing appropriate counselling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children.

The resolution clearly stated that achieving these targets is affordable to the global economy. Hence, the necessity of mobilizing and allocating additional resources both at the national and international levels is stressed.

This resolution is based on the norms and values set out by the CRC. It has given explicit recognition to the four general principles which underpin the provisions of the CRC. The resolution has also recognised the importance of family in the protection, and development of children and called for appropriate assistance to be given to them. This is central to keep the familial tie so that children will grow in a safe environment.

The overall objective of this resolution is to address world child poverty in its many dimensions. Its implications in changing children’s life are numerous if the goals and targets are met. However, the commitments made in this resolution have still fallen short of taking into account the different needs of children living with HIV/AIDS, and the different experiences of

76 Supra note 75, para. 36.
77 Supra note 75, para. 46.
78 Supra note 75, para. 46.
79 Supra note 75, para. 48-58.
80 Supra note 75, para. 15.
poverty they encounter which require special treatment for impoverished children living with HIV/AIDS. It is critical to identify the appropriate mode of intervention in ending the impact of child poverty on children’s right to access HIV/AIDS treatment, and in bringing sustainable development to them.

The goals and targets set to combat the impact of HIV/AIDS have many implications for children living with HIV/AIDS. This is in the area of prevention of mother-to-child transmission of HIV, provision of paediatric treatment, protection and support of children living with HIV/AIDS.

However, the fulfilments of these objectives are subject to national, regional and international actions in terms of rendering strong political leadership, along with commitment in placing children’s first in the health and development agenda, in resource mobilization and budget allocation.

4.1.3 The 3 by 5 Initiative

The 3 by 5 initiative is a strategy framed by WHO and UNAIDS to provide antiretroviral treatment by the end of 2005 to three million people living with AIDS in developing and transitional countries.\(^\text{81}\) The core principles that guide this initiative include “urgency, equity and sustainability”.\(^\text{82}\) Its main goal was to create universal access to AIDS treatment “for those in need of care, as a human right and within the context of a comprehensive response to HIV/AIDS”.\(^\text{83}\)

In order to achieve this goal, the following 5 strategies were framed.\(^\text{84}\)

- Development of global leadership, strong partnership and advocacy.
- Provision of urgent, sustained country support.
- Simplification of standardized tools for delivering antiretroviral therapy while ensuring quality treatment;

\(^\text{82}\) Treating 3 million by 2005, Making it happen, the WHO strategy, WHO 2003, pp. 9-10.
\(^\text{83}\) Supra note 82, p. 9.
\(^\text{84}\) Supra note 82, p. 11.
o Creation of effective, reliable supplies of medicines and diagnostics;

o Identification and reapplication of new knowledge and success.

However, the progress in achieving these goals were “much slower than ever hoped” as only around 1.3 million people in low and middle-income countries were receiving ARV medication at the end of 2005. Concerning sub-Saharan Africa, 810,000 people were being treated out of an estimated 4.7 million who needed treatment by the end of 2005. Out of the 152 countries targeted by the 3 by 5 initiative, only 18 have managed to provide the treatment by the end of 2005. In Ethiopia, out of the 100,000 people targeted by the initiative, only 16,400 people were receiving the ARV therapy by April 2005.

According to the final report released in March 2006, the main obstacles in meeting the 3 by 5 goals were,

*poorly harmonized partnerships; constraints on the procurement and supply of drugs, diagnostics and other commodities; strained human resources capacity and other critical weaknesses in health systems; difficulties in ensuring equitable access; and lack of standardized systems for the management of programmes and monitoring progress.*

Nevertheless, the experience of 3 by 5 initiative at national level have proven that, “large-scale HIV treatment access is achievable, effective and increasingly affordable, even in the poorest and most challenging settings”, provided there is expanded political will at the international and national level in terms of providing access in an equitable manner, while mobilizing resources and building health systems.

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85 Progress on Global Access to HIV Antiretroviral Therapy - A Report on "3 by 5" and Beyond, WHO, 28th March 2006.
86 Supra note 85.
87 Supra note 85.
89 Supra note 85.
When the 3 by 5 initiative is seen in the light of children living with HIV/AIDS, once again we find children missing out. The initiative did not place the needs of children living with HIV/AIDS at the centre of all its programs. The rights of children living with HIV/AIDS were hardly mainstreamed in this initiative. The initiative holds no express commitment to ensure access to ARV treatment to children by placing children first in the policy formulation and service delivery. As a result, the need to take urgent account of the special needs of children living with HIV/AIDS and making child-friendly and affordable HIV/AIDS treatment available to children was overlooked in target setting, resource mobilization, and budget allocating.

4.1.4 G8 2005 Summit: Towards Universal Access?

In July 2005, members of G8 countries, pledged to ensure as near as possible universal access to ARV treatment world wide by 2010. They made a commitment to work with African governments in order to address the problem of limited health system capacity and to work with WHO, UNAIDS and other organizations to;

*develop and implement a package for HIV prevention, care and treatment....to ensure that all children left orphan by AIDS or other pandemics are given proper support including through the replenishment of the Global Fund to fight HIV/AIDS....*  

The G8 pledges is a significant step in the efforts done to provide HIV/AIDS treatment world wide. However, achieving this goal require action to turn such commitments to reality. When the implications of the pledge are examined in the light of ensuring access to HIV/AIDS treatment, it has failed to empower people living with HIV/AIDS the ability to claim the treatment as a right. It is not based on states’ international obligation to ensure access to HIV/AIDS treatment on a “right” perspective.

The document has recognized the need for additional resources in providing HIV/AIDS treatment to the needy. But it has failed to make a political commitment to ensure full funding of HIV/AIDS treatment which is affordable to the global economy. The document did not address

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92 Supra note 91, Para. 18 (D).
the role of trade rules in making the provisions of affordable HIV/AIDS treatments difficult. Without making proper intervention in order to remove such obstacles in the provision of affordable HIV/AIDS treatment, universal access to such treatment can not be realized.

The document has no clear targets where by vulnerable groups like children living with HIV/AIDS can benefit from it. There is no clear commitment made to put children living with HIV/AIDS first in policy formulation, target setting and service delivery of HIV/AIDS treatment.

It is my opinion that, there are lessons to be learnt from the shortfalls of the 3 by 5 initiative and making expanded political commitment globally to place children living with HIV/AIDS first in the policy formulation, strategy setting and service delivery of HIV/AIDS treatment based on rights based approach. This will inhibit repeated ambiguous commitment the fulfilment of which is uncertain and not mandatory.

4.2 Regional Level: The NEPAD Health Strategy

NEPAD is the name for the New Partnership for Africa’s Development. It is a pledge made by African leaders based on the common vision they hold to eradicate extreme poverty, bring sustainable development and to be able to participate in the world economy.

NEPAD has framed a health strategy in response to the existing preventable disease burden in the region. The object of this strategy is to establish or strengthen health systems and services; reduce disease burden from the continent; strengthen maternal; adolescent and child health programmes; empower individuals to improve their health; strengthen and develop traditional medicines and to strengthen the role of government in mobilising the essential inputs of health related sectors, civil societies and partners.93

In order to translate these objectives in to action, NEPAD has set up targets based on the MDG. These are: to halt and began to reverse the spread of HIV/AIDS, reduce infant and under five mortality rate, ensure that 80 percent of the population has access to quality health care and that all governments spent 15 percent of their public expenditure on health.94 These targets are to be met by 2015.

94 Supra note 93, p. 8.
The strategy has made recognition of the impact of HIV/AIDS on human and economic development, as well as the interrelatedness of poverty and ill health. It has made a recommendation concerning the prioritization of the development of human resources at the national level, ensuring the availability of essential medicines and supplies, taking into consideration the role of different stakeholders in developing country specific plans and monitoring progress regularly.\textsuperscript{95}

The strategy has made its priority to reduce the burden of HIV/AIDS disease and “envisaged a massive scaled up HIV/AIDS prevention effort”.\textsuperscript{96} By making the CRC its guiding principle, it has made a commitment to reach out to children who are affected by HIV/AIDS and orphans.\textsuperscript{97}

It is imperative that the implementation of such strategies is “contingent up on the achievement of innovative and effective partnership between African government and health development partner’s”.\textsuperscript{98} Therefore, the strategy called for the strengthening of institutions and governance. It has also stressed that the strategies can only be achieved through, \textit{“increased resource mobilization, strengthened management and more equitable distribution and allocation of financial and human resources”}\textsuperscript{99}

As a self initiated regional political document pledged by “African’s for Africans”, the NEPAD health strategy plays a significant role in framing a political frame work for the establishment of a viable health system in Africa. It also shows the existence of political will among African leaders to remove the disease burden from the continent. However, given the fragile socio-economic status of the continent and peace instability, it has been a challenge to make these strategies real for millions of people in Africa.

In the absence of strong health systems to meet the health needs of the people, for vulnerable people like children in Africa, the effect of the disease burden especially in the case of HIV/AIDS is catastrophic. The children of sub-Saharan Africa have been hardest hit by AIDS

\textsuperscript{95} Supra note 93, p. 9.
\textsuperscript{96} Supra note 93, p. 10.
\textsuperscript{97} Supra note 93, p. 11.
\textsuperscript{98} Supra note 93, p. 13.
\textsuperscript{99} Supra note 93, p. 13.
as they account for more than 85 per cent of all children under the age of 15 living with HIV/AIDS in the world. Improving the health of children is one of NEPAD’s health strategies. But there are no clear strategies which put children first in the developments of health policies, child friendly health systems, in resource mobilization as well as budget allocation. The absence of such priority for children in the NEPAD health strategy creates a loop-hole for children living with HIV/AIDS to be overlooked in the policy making and service delivery of HIV/AIDS treatment.

4.3 National Level – Case Study Ethiopia

4.3.1 Analysis of Child poverty in Ethiopia

Ethiopia with a population of 70 million is the tenth poorest country in the world as 44% of its population live on less than one dollar a day. The average annual income in the country is $90.00.

Children below the age of 17 account for half of the population. Most of these children suffer from hunger, malnutrition and preventable diseases. The child mortality rate, the persistence of preventable diseases, school enrolment and attendance rate, malnutrition and the increase in the number of children without familial or societal protective environments are some of the basic indicators of child poverty in Ethiopia.

Ethiopia ranks twentieth in the world in terms of the mortality rate of children under the age of five with 166 deaths per 1000 live births. The rate of infant mortality is 110 deaths per

100 Supra note 52, p. 6.
1000 live births. Malnutrition is “a common health problem affecting significant numbers of children”. The percentage of new primary school enrolment according to the 2004 survey is 31%. The percentage of primary school entrants reaching grade 5 is 65%. The number of children orphaned in Ethiopia has reached 4.5 million out of which 720,000 have lost one or both parents due to HIV/AIDS. The “social situations” of children in Ethiopia is becoming “deteriorated,” and the number of street children has “swelled to 0.5 million”.

The emergence of HIV/AIDS has eroded the country’s limited social infrastructure and set back achievements made “with respect to health care, life expectancy and productivity.” The experiences of child poverty among children living with HIV/AIDS in Ethiopia are catastrophic. The epidemic has perpetuated their poverty by threatening their very social and economic fabric. Given the limited social safety net, provision of social services and the absence of familial protective environments as a result of the deaths or sickness of their parents, most children lack the physical, psychological, social and economic power to mitigate the impacts of the epidemic on their life. As a result, there is an increase in the child mortality rate, dropping out of school and orphanage among them. Like other people living with HIV/AIDS, children living with HIV/AIDS too suffer from stigma and exclusion hence, forced to find their way of life on the streets.

In general, a large number of children in Ethiopia are far from the reach of the basic capabilities for their survival and development. Children living with HIV/AIDS are the most vulnerable of all.

105 Supra note 104.
107 Supra note 104.
108 Supra note 104, p. 114.
109 Supra note 104, p. 110.
110 Supra note 104.
4.3.2 Effects of poverty on the Child’s right to access HIV/AIDS treatment

Ethiopia is one of the Sub-Saharan countries worst hit by the HIV/AIDS epidemic, “with the sixth highest number of infections in the world”. In 2003, it was estimated that 2.2 million people were living with HIV/AIDS, out of which 200,000 were children under the age of 15.

In the past two years, access to HIV/AIDS treatment has been improved elsewhere. However, despite the availability of different initiatives to provide HIV/AIDS treatment, such as the Global Fund, the 3 by 5 initiative, World Bank Multi-country AIDS programme, the President’s Emergency Plan for AIDS Relief (PEPFAR) and the MDG, the situation in Ethiopia differs. Out of 211,000 people in need of antiretroviral therapy in December 2004, only 16,400 (age 15-49) were receiving the treatment up to April 2005.

Shortages of human and financial resources are the main factors explaining the limited administration of HIV/AIDS treatment. Ethiopia has a critical shortage of human resource even in delivering basic health services. The total annual cost of providing antiretroviral treatment per patient is $705.00, out of which, ARV drugs accounts for 67% of the total cost, monitoring tests 29%, laboratory equipment, staff salary 2% each and training accounts for less than 1% out of the total cost.

Without government subsidy, “98% of the total $ 705.00 annual antiretroviral treatment cost is borne by patients”. The cost of antiretroviral treatment is more than seven times the average individual annual income of $90.00. Therefore, the present available HIV/AIDS treatment provision in Ethiopia is not in line with the economic capacity of almost more than 90

113 Supra note 111.
114 Supra note 112.
115 Supra note 112, p. 9-17.
116 Supra note 112, p. 4. The current (2003) doctor-to-patient ratio in Ethiopia is 1:34,000 which are five times lower than the sub-Saharan Africa average. Concerning nurses-to-patients ratio, it is 1:4,900 which is four times lower than the sub-Saharan Africa average.
117 Supra note 112, p. 15.
118 Supra note 112, p. 19.
percent of the people in need of the treatment, given the fact that 44% of the population lives on less than one dollar a day.

The situation is worst when it comes to the provision of HIV/AIDS treatment to children. The infrastructures to deliver care and treatment to HIV exposed and HIV infected children are limited.\textsuperscript{119} The federal ministry of health “lack expertise in paediatric care and treatment”.\textsuperscript{120} Only less than 1% of children in need of antiretroviral treatment have access to such treatment so far.\textsuperscript{121} Out of 63,000 children in need of immediate antiretroviral therapy in December 2005, only 515 were receiving the treatment.\textsuperscript{122} PMTCT services are not “widely available and linked to care and treatment for the mother or the infant”.\textsuperscript{123}

The diagnosis of infants (less than 18 months) with HIV is “severely constrained by the lack of virology testing (PCR)”.\textsuperscript{124} The availability of the CD4 cell count\textsuperscript{125} service has improved the provision of antiretroviral treatment for adults. But children lack this benefit because the machines used to CD4 count “do not provide CD4 percentage, which is required to assess antiretroviral treatment eligibility of children below the age of six”.\textsuperscript{126}

In general, the use of antiretroviral drugs for children in Ethiopia is “costly and complex”.\textsuperscript{127} There is also considerable lack of human resource in providing paediatric HIV/AIDS treatment throughout the country. The presence of the above mentioned constraints have made access to HIV/AIDS treatment beyond the reach of many poor children. In the

\begin{thebibliography}{99}
\bibitem{120} Supra note 119, p. 6. There are 200 paediatricians throughout the country where by most of them are concentrated in Addis Ababa private sector.
\bibitem{121} Supra note 119.
\bibitem{122} Supra note 119.
\bibitem{123} Supra note 119, p. 7-10.
\bibitem{124} Supra note 119, p. 8.
\bibitem{125} CD4 Cell Count is a measure of the number of disease fighting cells in the body. CD4 test is a blood test that measures the number of CD4 cells in the blood. It is an indicator of how HIV is progressing in the body and overall health status of the person living with HIV/AIDS.
\bibitem{126} Supra note 119, p. 9.
\bibitem{127} Supra note 119, p. 3.
\end{thebibliography}
absence of antiretroviral treatment to children, “75% of HIV-infected children die before their fifth birthday in the country.”

4.3.3 Evaluation of the Ethiopian government response to HIV/AIDS and poverty reduction

General

Political and policy responses in addressing the issue of HIV/AIDS have been given by the government of Ethiopia. In 1998 the national HIV/AIDS policy was issued with the objective of guiding the implementation of programs in preventing and controlling the spread of the disease. This was followed by the development of a strategic framework for the national response 2000-04. The national AIDS council (NAC) was established in 2000 under the chairmanship of the country’s president. The HIV/AIDS Control and Prevention Office was established in 2002. In 2004, the Ethiopian Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response 2004-08 (SPM) has been developed.

This section will present a child-focused analysis of the political and policy responses given in reducing poverty and scaling up HIV/AIDS treatment in Ethiopia. The purpose of this analysis is to assess how the government has responded to the above mentioned human and economic resource constraints by incorporating the rights and needs of children living with HIV/AIDS in the Ethiopian Sustainable Development and Poverty Reduction Program 2002-05 (SDPRP), as well as in the Ethiopian Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response 2004-08 (SPM).

These two documents have been selected because they are highly political documents. They are central for extending HIV/AIDS treatment to children. The analysis considers the policy responses given with regard to economic capacity building and human capacity building.

Economic capacity building:

Economic constraints in receiving HIV/AIDS treatment can be seen in terms of an individuals’ capacity in accessing the treatment and the government’s capacity in delivering the

128 Supra note 119, p. 13.
service to all in need. Therefore, addressing the economic constraints in the provision of HIV/AIDS treatment to children should be twofold. On the one hand, it should focus on increasing the availability of health facilities with a capacity to deliver affordable child-friendly ARV drugs to children. On the other hand, it should focus on empowering children living with HIV/AIDS with the ability to access the treatment.

In both the SDPRP and the SPM policies, there is no explicit commitment to enhance access to HIV/AIDS treatments to children. The SDPRP policies on HIV/AIDS as well as the overall SPM objectives are mainly focused on decreasing the spread of the disease. The needs of children living with HIV/AIDS are hardly mainstreamed in health strategies of the SDPRP. Concerning the SPM, its health sector strategies include furnishing “all health care facilities with improved diagnostic, medical equipment and supplies” and “ensuring the availability of standardized minimum essential packages of HIV/AIDS services”. The provision of ARV is one of the components of minimum essential packages in selected health care centres and hospitals. Nevertheless, the need to equip health centres with the capacity to provide cheap, feasible diagnostic tests and affordable child-friendly ARV drugs for children is missing from the health policies of the SDPRP and the SPM.

As discussed in chapter three, child poverty in the light of access to HIV/AIDS treatment is a direct or a systematic deprivation of capabilities, opportunities, rights and a command over economic resources that impede children living with HIV/AIDS from accessing HIV/AIDS treatment. Therefore empowering children living with HIV/AIDS to access HIV/AIDS treatment requires addressing child poverty in its many dimensions while respecting, protecting and fulfilling their rights to survival and development.

The SDPRP poverty analysis suffers from defects as it fails to analyse poverty in terms of the deprivation of basic capabilities or non-fulfilment of rights to a range of basic capabilities.

130 Supra note 106, p. 131.
131 Ethiopian Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response 2004-2008 (SPM), December 2004, p. 5. The main objectives of SPM are reducing the spread of HIV infection and its social and economic impact by enhancing and strengthening the ongoing multi-sectoral prevention and control activities. Capacity building is one of its six strategic framework.
132 Supra note 106, p. 100.
133 Supra note 131, pp. 12 and 14.
Rather it has analysed poverty in terms of income, infrastructure and services. Concerning the conceptualization of child poverty, despite the extensive availability of data on child malnutrition, child mortality, education,\textsuperscript{134} it lacks a clear analytical framework for analysing the causes and effects of child poverty in its many dimensions with respect to the violation of rights, exclusion, discrimination and the lack of an opportunity to be heard. As criticized by child right organizations, it has failed to provide a separate chapter for children.\textsuperscript{135}

The HIV/AIDS epidemic is one of the main factors that perpetuate child poverty. This requires the need to define poverty-HIV/AIDS analysis in order to break the HIV/AIDS-poverty cycle. The SDPRP offered a broad discussion of the social and economic impacts of HIV/AIDS.\textsuperscript{136} However, it failed to provide specific analysis of the impacts of HIV/AIDS on infected children. In fact, the HIV/AIDS analysis itself started with explicitly taking the epidemic as;

\begin{quote}
\textit{``an adult disease with significantly demographic impact''}.\textsuperscript{137}
\end{quote}

Concerning the SPM’s, despite its mere acknowledgment of the relationship between HIV/AIDS and poverty in general, without making specific reference to children’s experience of the epidemic, it does not at all have any detailed analysis of poverty.\textsuperscript{138}

The education sector is one of the main targets in empowering children. But the SDPRP strategic framework on education does not address the psychological and economic problems of orphaned, poor and street children infected by the epidemic in terms of school enrolment and the ability to remain in school after enrolment.\textsuperscript{139} Though it referred to the need to protect particular groups of children like orphans and street children, the attention given to the different needs of children living with HIV/AIDS was inadequate.\textsuperscript{140}

\begin{flushleft}
\textsuperscript{134} Supra note 106, PP 5-20.
\textsuperscript{135} Supra note 104, p. 22.
\textsuperscript{136} Supra note 106, pp. 128-30.
\textsuperscript{137} Supra note 106, p. 128.
\textsuperscript{138} Supra note 131, pp. 8 and 10.
\textsuperscript{139} Supra note 106, pp. 92-97.
\textsuperscript{140} Supra note 106, pp. 125 and 127.
\end{flushleft}
Improving the quality of life of people living with HIV/AIDS, orphans and other vulnerable children (OVC) are one of the objectives of the SPM. The strategies framed under this objective have some implication in improving the life of children living with HIV/AIDS in terms of providing “vocational skill training, income generating opportunities and social security models”.\textsuperscript{141} Nevertheless, it still lacks specific consideration of the economic impacts of HIV/AIDS on children living with HIV/AIDS. For example, empowering families is empowering children living with HIV/AIDS. The SPM does not provide any strategy in improving the lives of families or communities who takes care of infected children.

Ensuring the rights of people living with HIV/AIDS with respect to “employment and associational facilities, education and training facilities” and to appear in public without shame were targets set up under the SDPRP’s HIV/AIDS policy.\textsuperscript{142} The SPM has also made a strategy to protect the rights of “individuals infected and affected by the epidemic”.\textsuperscript{143} These targets have some implications to children living with HIV/AIDS. But such protections given in these documents are not child-centred. In addition to ensuring their education and associational rights, empowering children living with HIV/AIDS to overcome the effects of HIV/AIDS requires ensuring their inheritance rights, right to access health services, access HIV/AIDS treatment, other basic services, and the economic coping capacity of their families or communities they are under care. Thus, the protections given to ensure the rights of people living with HIV/AIDS in both documents are inadequate in fulfilling the rights of children living with HIV/AIDS.

In general, both policy documents lack incorporating a specific analysis on child poverty as well as HIV/AIDS-poverty analysis with respect to impoverished children. HIV/AIDS analysis is vital in terms of stopping the generational transmission of poverty and determining child-centred development policies. As a result, the efforts made to empower children living with HIV/AIDS with access HIV/AIDS treatment are few.

\textsuperscript{141} Supra note 131, p. 16.
\textsuperscript{142} Supra note 106, p. 132.
\textsuperscript{143} Supra note 131, p. 13.
Human Capacity Building

The lack of expertise in paediatric HIV/AIDS treatment is one of the main factors for the limited provision of HIV/AIDS treatment for children in Ethiopia. This calls the need to expand national paediatric training resources.

The issue of strengthening human resource in terms of paediatric treatment is never addressed in the SDPRP human resource development policies of health, HIV/AIDS and education, and the SPM health sector capacity building. Developing human resources by training of health workers at all levels of health care systems has been one of the main objectives of the SDPRP\textsuperscript{144} and SPM\textsuperscript{145} health polices. But no specific targets in developing human resources for paediatric treatment with respect to HIV/AIDS were made in both documents. This is due to the lack of giving priority to children’s needs and rights in the overall SDPRP and SPM policy.

In sum, the analysis of the above mentioned political and policy responses given at different levels, shown that children living with HIV/AIDS have not been put first in poverty reduction strategies and in access to HIV/AIDS treatment. Their rights and needs are referred within the context of children, orphans, families or people living with HIV/AIDS. Yet children living with HIV/AIDS have distinct rights, distinct experiences of poverty and HIV/AIDS. These children need special attention.

Without a firm commitment in placing children first in policy formulation, target set up and the budget allocation of poverty reduction, it is impossible to make access to HIV/AIDS treatment real to many African children. In the absence of such political commitments and child-centred policy responses to end child poverty, the right accorded to children to have the highest attainable standard of health will be \textit{a broken promise}!
5 DISCUSSION AND CONCLUSION

This section brings a discussion regarding what kind of political and policy responses should be given in order to ensure a child’s right to access HIV/AIDS treatment at the international, regional and national levels. The first section presents a discussion regarding how to make real access to HIV/AIDS treatment for children based on the obligations of states as discussed in chapter two. The second section presents a discussion on how to make sense of access to HIV/AIDS treatment to children through rights based approach to poverty reduction strategies. This will inform the targeted audiences on how to address the rights and the needs of children living with HIV/AIDS in the strategies of poverty reduction and HIV/AIDS treatment. Conclusion and recommendations will be drawn in section four.

5.1 Between the Ideal and the Reality: For whom to mind the gap?

The HIV/AIDS epidemic threatens children’s right to survival. It has led to rising child mortality rates and sharp reduction in life expectancy. Children under the age of 15 die of AIDS-related illness every minute of every day. This makes providing HIV/AIDS treatment to children urgent.

The previous chapters have reflected how children’s right to access HIV/AIDS treatment is being hampered by poverty. Yet children living with HIV/AIDS are missing out from the political and policy responses given to poverty reduction so far. HIV/AIDS treatment is beyond the reach of the many poor children as the cost of treating one child is six times more than treating an adult.

A child’s right to access HIV/AIDS treatment imposes obligations at the national and international levels with the best interest of the child being a primary consideration for its realization. It imposes an obligation on states “to take steps, individually and through international assistance and cooperation, especially economic and technical” towards the full realization of the right in question.146 At the national level, Ethiopia has the obligation to put

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146 General Comment 3 and 14 of the Committee on Economic, Social and Cultural Rights.
children first in the political and policy responses being given to poverty reduction strategies and HIV/AIDS. It is also the obligation of the government of Ethiopia to take measures to the maximum extent of their available resources, and where needed within the framework of international co-operation in order to fulfil a child’s right to access HIV/AIDS treatment.

Making resources needed to fulfil the right in question available in resource constraint countries is the obligation of states at international level. They have obligation to prevent 3rd parties under their political and legal capacity to influence from violating a child’s right to access HIV/AIDS treatment. This includes influencing manufacturers to produce child-friendly affordable HIV/AIDS medicines for developing countries and creating an atmosphere for a state with a capacity to produce such medicines to use an invention for public purposes on such conditions as may be agreed upon with the manufacturer or the patentee. In the absence of the willingness by the manufacturer or the patentee for such an agreement, states are obliged to ensure the patenting of medicines used for treatment of HIV/AIDS by creating laws, whereby compulsory licensing of medicines is legitimized for the public interest of the state in need.

The purpose behind granting patent is to “reward an inventor in return for making the invention available to the public”. I agree that, patent rights should be protected within the bounds of the purpose it is created. Nevertheless, the legal protection given to a patent right should not override the legal protection given to the right to life. Because keeping HIV/AIDS treatment beyond the reach of the poor in order to protect the benefits of few business sections, amounts to violations of the person’s right to life.

States have international obligation to provide technical and economic assistant to poor countries in order to facilitate access to HIV/AIDS treatment for children. This includes promotion of development cooperation, granting aids, allowing child-friendly affordable, or free


148 Patent right is a right given to an inventor “for a limited period of time to stop others from making, using or selling an invention without the permission of the inventor”. Source, Intellectual property: What is patent right? <http://www.intellectual-property.gov.uk/faq/patents/what.htm>. (visited April 30, 2006)
access to HIV/AIDS treatment, framing workable strategy for eliminating poverty and empowering the society in question both economically and technologically.

States at the international level also have an obligation to oversee whether children living with HIV/AIDS are put first in policy analysis, target set up and budget allocation in the provision of HIV/AIDS treatment and poverty reduction strategies.

5.2 Making sense of a Child’s right to access HIV/AIDS treatment: What does it take?

Making sense of access to HIV/AIDS treatment for poor children requires making a shift from a “charity” perspective to a focus on “legal obligation” at national and international levels; by placing the rights of children living with HIV/AIDS in the development agenda; putting children living with HIV/AIDS first in the political and policy responses to HIV/AIDS, and poverty reduction strategies as well as in budget allocations. This can be addressed through a rights based approach to poverty reduction strategies. The human rights based approach to poverty reduction adds value to efforts in eradicating poverty.\textsuperscript{149} It introduces international dimension of obligation by bringing the issues of poverty to the international agenda. Its recognition of the importance of the principle of equality and non-discrimination, complementarities between civil and political right on one hand and economic, social and cultural rights on the other hand add another value to the current poverty reduction strategies. Contrary to the traditional approach to poverty reduction strategies, it “attaches as much importance to the processes through which developmental goals are achieved as to the goals themselves”.\textsuperscript{150}

5.2.1 The concept of a rights based approach to poverty reduction strategy

The rights based approach to poverty reduction is based on the principle of empowerment and participation of the poor with equality, non-discrimination and accountability of duty-bearers.\textsuperscript{151}

\textsuperscript{149} Supra note 34, para. 25-31.
\textsuperscript{150} Supra note 34, para. 29.
\textsuperscript{151} Supra note 34, para. 4-24.
It suggests that poverty reduction strategies and efforts begin with identification of the poor, and what constitute poverty.\textsuperscript{152} It also suggests that poverty reduction strategy is “concerned at the very least with the common set of basic capabilities” and should be based on a “relevant national and international normative framework.”\textsuperscript{153} This serves for reminding the obligations to duty bearers, thus, reiterating the question of implementation. This approach states the necessity of inclusion of the principle of equality and non-discrimination in poverty reduction strategy.\textsuperscript{154} This is because poverty primarily affects “socially disadvantaged groups” and “in most cases poverty is aggravated by some sort of discrimination”, \textsuperscript{155} thus, calling for the abolition of \textit{de jure} and \textit{de facto} discriminations.

Empowerment and participation of the poor is another main future of the rights based approach to poverty reduction strategies. Participation demands “active and informed participation of the poor at all stages of formulation, implementation and monitoring”.\textsuperscript{156} Empowering the poor can be achieved through the fulfilment of certain civil and political rights which emphasis the need to recognize the “complementarities between on one hand economic, social and cultural right and on the other hand civil and political rights”.\textsuperscript{157} This approach also demands accessible, transparent and effective monitoring mechanisms at all levels in holding duty-bearers accountable.\textsuperscript{158}

5.2.2 Implication of a rights based approach

Traditionally, political and policy responses of development considered children issues as needs rather than rights. Contrary to this traditional view, the rights based approach to poverty reduction views children as right holders. It implies respecting, promoting and fulfilling a child’s

\begin{itemize}
  \item \textsuperscript{152} Supra note 34, para. 5.
  \item \textsuperscript{153} Supra note 34, para. 8-11.
  \item \textsuperscript{154} Supra note 34, para. 12-14.
  \item \textsuperscript{155} Supra note 34, para. 12.
  \item \textsuperscript{156} Supra note 34, para. 15-18
  \item \textsuperscript{157} Supra note 34, para. 18. Some of the civil and political rights that are fundamental for the empowerment of the poor are, “the right to information, right to freedom of expression, right to association and assemble, right to equal access to justice, right to take part in the conduct of public affair including the right to vote”.
  \item \textsuperscript{158} Supra note 34, para, 22-24.
\end{itemize}
right to basic capabilities for survival and development as main targets eradicating a child poverty. Avoiding *preventable morbidity* and *premature mortality* are one of the basic core capabilities that children need for their survival and development. From a human right perspective, child poverty violates the child’s right to basic capabilities (to avoid preventable morbidity and premature mortality). Addressing children’s access to HIV/AIDS treatments through a rights based approach to child poverty reduction empowers children living with HIV/AIDS to demand HIV/AIDS treatment. It makes the obligation to provide the treatment international as opposed to the traditional way of viewing such an obligation as a concern of the state in question. Thus, it makes access to HIV/AIDS treatment a focus of international development cooperation as well as of national policy making.

A rights based approach to poverty reduction is central to the integration of the principle of the best interests of the child, a child’s right to survival, development, protection and participation in the formulation, implementation, monitoring of poverty reduction strategy and the overall pan aroma of the development agenda. Mainstreaming the needs of children living with HIV/AIDS through a right based approach also helps to remove stigma and discrimination.


5.2.3 Application of a rights based approach

Facts to consider

Rights based approach to child poverty reduction strategies should begin by acknowledging the reinforcing factors between HIV/AIDS epidemic and poverty. This can be called poverty/epidemic cycle.\(^{159}\) Child poverty increases the spread of HIV by making them vulnerable to the virus. Poor children who have no meaningful protective family environment in terms of economic security could be exposed to sexual abuse, and in extreme cases young girls may be forced to be engaged in the sex industry. Child poverty also undermines a child’s capacity in accessing HIV/AIDS treatment.

\(^{159}\) Supra note 56, pp 313–332.
On the other hand, HIV/AIDS perpetuates the existing poverty while creating new poverty dimensions through stigmatization and discrimination. As discussed above in section 3.3, the epidemic tears apart the very fabric of a child’s life in many ways. A family, whose members are profoundly affected by HIV/AIDS, could not provide the necessary goods and services to family members. By killing and robbing the productive capacities of citizens infected and affected by HIV/AIDS, the epidemic has a profound impact on the economic capacity of the state to meet the demands of its citizens. This implies that without mitigating the impacts of HIV/AIDS on children, it is impossible to meet the goals of child poverty reduction strategies. Therefore, child poverty reduction strategies should also address the impacts of HIV/AIDS on children.

**Identification of the targeted group**

A strategy in addressing children’s access to HIV/AIDS treatment through a rights based approach to child poverty reduction should begin with acknowledging that children living with HIV/AIDS have different needs according to their age, the progress of the HIV in their body, and their socio-economic situation. This will help to formulate child-friendly programmes.

Identifying children living with HIV/AIDS includes defining what constitutes child poverty. Defining child poverty helps to identify those who are included within the ambit of the definition and those who are not. In order to address children’s access to HIV/AIDS treatment, child poverty should be put in its broader definition as a violation of children’s rights to basic capabilities.

**Identification of intrinsic and instrumental right/s**

Addressing children’s access to HIV/AIDS treatment through a right based approach to child poverty reduction strategy requires identification of intrinsic and instrumental right/s that need to be fulfilled on the basis of their special relevance in meeting the objective. Avoiding preventable morbidity and premature mortality are among the basic core capabilities for the survival and development of a child. The non-fulfilment of a child’s right to access HIV/AIDS treatment hampers a child’s ability to avoid preventable morbidity and premature mortality which can be said capability inadequacy or deficiency. Therefore the intrinsic rights for the
fulfilment of a child’s access to HIV/AIDS treatment are the right to life and the right to highest attainable standard of health through the right to access health service.

The instrumentally relevant rights based on their centrality in making the child’s access to HIV/AIDS treatment real are, but not limited to: a right to education, a right to employment (the families), a right to economic and physical security, a right to equal access to justice and a right to international assistance and cooperation.

Identification of the problem

Once the targeted group and their rights are identified, the next step should be analysing the extent and depth of poverty within the targeted group. Making such analysis helps to identify the impact of poverty on the enforcement of child rights in accessing HIV/AIDS treatment and the method of intervention in order to draw short and long term strategies in addressing the issue in question.

Identification of problems also includes taking note of the mutually reinforcing factors between HIV/AIDS and poverty. It is vital to break the poverty/epidemic cycle, bring sustainable development, and to identify the proper way of intervention in long term strategies.

Identification of stakeholders

Addressing children’s access to HIV/AIDS treatment through a rights based approach to child poverty reduction strategy requires identification of stakeholders at the national, regional and international levels according to human right norms. This will help bridge the gap between need and access. Stakeholders include states, international community, civil society, community and families.

160 ICCPR Article 6, ACHPR Article 4.
162 ICESCR Article 6.
163 ICESCR Article 9 and 11.
164 ICCPR Article 9
165 ICCPR Article 26.
166 ICESCR Article 2.
Identification of area, method and means of intervention

Identification of the areas of intervention includes identifying the areas that are vital in order to empower children living with HIV/AIDS to overcome the problem they face in accessing HIV/AIDS treatment. For example prolonging the lives of parents and empowering them economically can be identified as one area of intervention in addressing the right in question.

Identification of appropriate methods and means of intervention for providing access to HIV/AIDS treatments to children are essential for giving effective responses. Mainstreaming the needs and rights of children living with HIV/AIDS in poverty reduction strategies is a basis for child-centred intervention. The mainstreaming task should emphasise the special dimensions of child poverty within children living with HIV/AIDS and should stress the need to address these special dimensions specifically by putting these children first in the effort to eradicate poverty. It should also focus on the need to treat children living with HIV/AIDS differently to that of children in poverty in general. Children with HIV/AIDS have different needs and different experiences of poverty which require special treatment than other children living in poverty.

Accordingly, this leads to the task of identifying the method of intervention which is child-centred approach. A child-centred approach means prioritising and responding to children’s needs to access HIV/AIDS treatment by upholding the right of children living with HIV/AIDS and involving their participation in the work (with children infected having a say). Prioritising children includes putting them first in the policy formulation, resource mobilisation and budget allocation.

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167 Supra note 48, p. 117.
168 Child participation means the active and informed participation of older children in the implementation of care and support service. It includes encouraging their participation in assessing their needs, and the development and implementation of services and programmes. It includes giving freedom to express their views by taking into consideration their age and capacity to express themselves and respecting their views.
Setting target and indicators

The basic goal should be establishing children’s legal entitlement to treatment as well as strengthening their capacity to equally access the treatment by strongly focusing on participation of children and civil society in the process and by requiring the obligation and accountability of states in cases of non-fulfilment.

Setting a target of addressing children’s access to HIV/AIDS treatment through rights based approach to child poverty reduction should be two fold: First, it should focus on mobilising resources at all levels while mitigating the cost of treatment and putting children first in the delivery of HIV/AIDS treatment. Second, it should emphasise on the establishment of sustainable, equitable development which places children’s interest first in the process of poverty reduction in long term strategies of empowerment.

In order to monitor the performance of the strategy, indicators should be set for every defined long term and short term targets. In this particular case, the indicators can be a reduction of child mortality rate or the proportion of poor children with access to HIV/AIDS treatment and number of health services with human and material capacity to provide HIV/AIDS treatment to poor children.

Developing a strategy for achieving the specified targets

After setting the targets and indicators the last step would be the identification of the “elements of strategies that are most likely to achieve the targets set out”. When framing a strategy for short term targets, questions regarding how to mobilise needed resources, how to calculate the costs of the affordable and accessible medicines to all by advocating for the production of cheap but quality medicines for children, and how to put children first in the service delivery need to be taken into account.

For long term strategies, questions like, how to economically, socially and politically empower children, who are the key people who develop a child’s human development, how to

\[169\] Supra note 34, para. 40.

\[170\] The first core point to economically, socially and politically empower children is to recognize that children have right independent of their physical and mental vulnerability and dependency on adult that demands respect and fulfilment. The second core point is acknowledging their self-esteem as basic good for their human development.
maintain the tie of a protective family environment and focus on prolonging the life’s of these parents by providing medicines, how to economically, socially and politically empower the families of these children in order to make them able to provide for the necessary goods and service for their children, need to be addressed.

The human rights based approach to poverty reduction “attaches as much importance to the processes through which developmental goods are achieved as to the goals themselves”. \(^{171}\) People or the public will no more be passive recipients of what the state offers. Instead strategies are performed by active and informed participation of the poor children, families, civil societies, NGO’s at all stages of formulation, implementation and monitoring. “People! For People! By People!” Also, the whole process as well as the result should be open to public scrutiny, hence, the issue of accountability. This is to be done by stretching accessible, transparent and effective monitoring mechanisms. \(^{172}\)

5.3 CONCLUSION AND RECOMMENDATIONS

The HIV/AIDS epidemic has caused the death of millions, leaving behind many more to deal with the devastating illness. For vulnerable groups like children, the effect of HIV/AIDS is catastrophic. It threatens their rights to survival and development. It eliminates their familial protective environment through the death of their parents and tears apart their livelihood and means of subsistence, perpetuating child poverty.

The provision of essential drugs as defined by the WHO Action Programme on Essential Drugs is the core obligations of the states under Article 12 of the ICESCR. HIV/AIDS treatment has now been included in the WHO list of essential drugs, constituting obligation on states for its provision. When a child’s access to HIV/AIDS treatment is expressed in the language of a right, it is a matter of entitling children in need the right to child-friendly, affordable, accessible, quality HIV/AIDS treatment and empowering them to demand its fulfilment.

Providing children with ARV treatments requires “cheap, feasible diagnostic tests, trained health personnel and affordable child-friendly ARV drugs”. HIV/AIDS treatment is beyond the reach of poor children as the cost of treating one child is often as much as six times more than that of treating an adult. For children living with HIV/AIDS, being poor means not

\(^{171}\) Supra note 56.

\(^{172}\) Supra note 34, para. 24.
only being unable to afford HIV/AIDS treatment but also being cut off from life prematurely in the absence of life prolonging treatment (provision of antiretroviral therapy).

Child poverty is a denial of capabilities, rights and opportunities that impede children from living a life in dignity and a direct and systematic deprivation of material, emotional and spiritual resources needed to lead a life in dignity that is; to survive, develop and thrive, achieve their full potential or participate as full and equal members of a family.

When child poverty is linked to access to HIV/AIDS treatments, it is a direct or systematic deprivation of capabilities, opportunities, rights and a command over economic resources that impede children living with HIV/AIDS from accessing HIV/AIDS treatment. Child poverty destroys the capacity they require to maintain their health by depriving them access to HIV/AIDS treatment. Hence the impact of child poverty on access to HIV/AIDS treatment amounts to impoverishing the already impoverished.

The traditional political and policy responses of development have treated children issues as needs rather than rights. The analysis of the above mentioned political and policy responses given at different levels, shows that children living with HIV/AIDS have not been put first in poverty reduction strategies and access to HIV/AIDS treatment. As a result, the needs of children are being overlooked while strategies on poverty eradication/reduction and HIV/AIDS are set up and budgets allocated. Their rights and needs are considered generally within the context of children, orphans, families or people living with HIV/AIDS. Yet children living with HIV/AIDS have distinct rights, distinct experiences of poverty and HIV/AIDS. They require special attention.

Children living with HIV/AIDS by the nature of their situation demand much more attention, which reiterates into the need to analyse poverty from their perspective and put them first in the political commitments and policy responses of poverty reduction. Unlike other children, the main cause that brings death to children living with HIV/AIDS is a lack of proper HIV/AIDS treatment. Therefore, what is targeted to save other children’s life can not benefit children living with HIV/AIDS. This reflects the necessity of taking into account the different economical, social and psychological needs of children living with HIV/AIDS in order to reduce child mortality among them.

A World Fit for Children goals and targets on HIV/AIDS have a lot of implications for children living with HIV/AIDS. However, the fulfilments of these objectives are subject to
national, regional and international actions in terms of rendering strong political leadership and commitments in placing children’s first in the health and development agendas, in resource mobilization and budget allocation.

Addressing the issue of provision of HIV/AIDS treatment to the world poor children requires global partnership and political commitments in terms of material and human resource mobilisation. The efforts being made internationally in this respect fall short of addressing the special needs of these children in the production and provision of child-friendly and affordable HIV/AIDS treatment.

The experience of the 3 by 5 initiative at the national level has proved that, “large-scale HIV treatment access is achievable, effective and increasingly affordable”. This is provided there is expanded political will at the international and national levels in terms of providing the access in an equitable manner, mobilizing resources and building health systems. But the initiative holds no express commitment in ensuring access to ARV treatments to children by placing children first in policy formulation and service delivery. Hence, it has failed to focus on making child-friendly and affordable HIV/AIDS treatment available to children.

The G8 pledge is not based on states’ international obligations in ensuring access to HIV/AIDS treatment on a right based approach. Its commitment for the provision of treatment is still the traditional charity perspective. It does not ensure the full funding of the Global Fund to fight HIV/AIDS which is affordable to the global economy. The document is silent on the role of trade rules in making access to affordable HIV/AIDS treatments to the poor difficult. The document has no clear targets whereby vulnerable groups like children living with HIV/AIDS can benefit from them. There is no clear commitment made to put children living with HIV/AIDS first in the provision of HIV/AIDS treatment.

As a self initiated regional political document pledged by “Africans’s for Africans”, the NEPAD health strategy plays a significant role in creating a political framework for the establishment of a viable health system in Africa. It also shows the existence of political will among African leaders in removing the disease burden from the continent. However, given the fragile socio-economic status of the continent and peace instability, it has been a challenge in making these strategies real for millions of people in Africa.

The NEPAD health strategy has no clear targets in putting children first in the development of health policies, child friendly health systems, resource mobilization and budget
allocation. The absence of such prioritization of children in this document creates a loophole for children living with HIV/AIDS to be overlooked in the policy making and service delivery of HIV/AIDS treatment.

The use of antiretroviral drugs for children in Ethiopia is “costly and complex”. There is also a considerable lack of human resource for providing paediatric HIV/AIDS treatment throughout the country. This has made access to HIV/AIDS treatment beyond the reach of many poor children. In the absence of antiretroviral treatment to children, “75% of HIV-infected children die before their fifth birthday.

Both the SDPRP and the SPM policies in Ethiopia fail to incorporate a specific analysis on child poverty as well as poverty-HIV/AIDS analysis with respect to impoverished children which are vital in terms of stopping the generational transmission of poverty and determining child-centred development policies. There is no explicit commitment in their policies in ensuring access to children’s HIV/AIDS treatment as their objectives are mainly focused on decreasing the spread of the disease.

The rights and needs of children living with HIV/AIDS are hardly mainstreamed in the health strategies of these documents. In both documents no specific targets are made in developing human resources for paediatric treatment with respect to HIV/AIDS. The need to equip health cares with the capacity to provide cheap, feasible diagnostic tests and affordable child-friendly ARV drugs for children is missing from their health policies. This is due to the lack of prioritizing children’s needs and rights in the overall SDPRP and SPM policies.

In general, without a firm commitment in placing children first in policy formulation, target set up and budget allocation of poverty reduction, it is impossible to make access to HIV/AIDS treatment real to the many African children. In the absence of such political commitment and child-centred policy responses in ending child poverty, the right accorded to children living with HIV/AIDS to have the highest attainable standard of health will be a broken promise!

Fulfilling a child’s right in accessing HIV/AIDS treatment raises the question of resources. The interpretation of “available resources” in Article 2 of the ICESCR and Article 4 of the CRC includes resources both at the national and international levels.

The child’s right to access HIV/AIDS treatment imposes on states the obligation to respect, protect and fulfil at the national level as well as the obligation to respect, provide,
protect and oversee at the international level. At the national level, Ethiopia has the obligation to adopt legislative and other measures to give effect to the right in question. It has the obligation to integrate the rights of children living with HIV/AIDS in its development and health agendas and put them first in the political and policy responses being given to poverty reduction strategies and to the provisions of HIV/AIDS treatment. It also has the obligation to take “measures to the maximum extent of its available resources, and where needed within the framework of international co-operation” in order to fulfil a child’s right to access HIV/AIDS treatment. Above all, the government of Ethiopia is required to expand its political commitment from focusing only on the prevention of HIV/AIDS to the provision of HIV/AIDS treatment which is child-centred.

Making resources needed available to fulfil the right in question in resource constraint countries is the obligation of states at the international level. This can be done through development cooperation, granting aids, allowing child-friendly affordable or free access to HIV/AIDS treatment for the poor, framing workable strategies for eliminating poverty and empowering the society in question both economically and technologically.

States have international obligation to prevent 3rd parties which are under their political and legal capacity from violating a child’s right to access HIV/AIDS treatment. I agree that patent needs to be protected but, only within the bounds of the purpose it is created. The legal protection given to patent should not override the legal protection given to the right to life. Keeping HIV/AIDS treatment beyond the reach of the poor, in order to protect the benefits of businesses, amounts to violations of children’s rights to life. Therefore, if manufacturers refuse to produce child-friendly affordable HIV/AIDS treatment for the majority of the world poor children, it is the obligation of states with a capacity to influence these manufacturers to intervene and make the treatment available to the needy children. States also have international obligation to oversee whether children living with HIV/AIDS are put first at national level policy analyses, targets set up, and budget allocation in the provision of HIV/AIDS treatment and poverty reduction strategies.

With respect to the hierarchy of obligation, the primary obligation to realize a child’s right to access to HIV/AIDS treatment lies on the state in question (in this particular case on Ethiopian government). It is only after it is demonstrated that the state in question has made every effort to use all resources at its disposition to meet its minimum obligation towards this
right and found to be economically and technically unable to realize the right in question that international obligations of states to provide the necessary resources to the state in question will take place.

Making sense of the access to HIV/AIDS treatment for poor children requires making a shift from a “charity” perspective to a focus on an “obligation” perspective at national and international levels by placing the rights of children living with HIV/AIDS on the development agenda. It is a matter of putting children living with HIV/AIDS first in political and policy responses to HIV/AIDS, poverty reduction strategies, and in budget allocation at the national, regional and international levels. This can be addressed through a rights based approach to poverty reduction strategies.

Contrary to the traditional view, the rights based approach to poverty reduction views children as right holders. It implies respecting, promoting and fulfilling children’s rights to basic capabilities for their survival and development. Addressing children’s access to HIV/AIDS treatment through a rights based approach to child poverty reduction empowers children living with HIV/AIDS to demand the treatment. It makes the obligation to provide the treatment international as opposed to viewing such an obligation as a concern of a state in question. It makes access to HIV/AIDS treatment a focus of international development cooperation as well as national policy making.

Child poverty is a violation of human rights which have a strong relation to political and civil rights on one hand and economic, social and cultural right on the other hand. In order to make a child’s health feasible to the many poor children living with HIV/AIDS in Africa, the most effective response to access HIV/AIDS treatment for children in poverty is the establishment of sustainable, equitable development on a rights based approach which places children’s rights and interest first in the process of poverty eradication.

Therefore, I recommend that;

1. States at the international, regional, and national levels should demonstrate a strong political commitment towards addressing the impact of child poverty on a child’s right in accessing HIV/AIDS treatment by putting children’s first in the political and policy responses of
HIV/AIDS, poverty reduction strategies, and in budget allocations. This requires giving special attention to the impact of poverty on children living with HIV/AIDS.

2 The rights and needs of children living with HIV/AIDS have to be integrated in the health and development policies at all levels.

3 States at the international level has to make political commitment to take measures economically and technically to ensure on a rights based approach, the development and provision of affordable paediatric/child friendly HIV/AIDS treatment to the world poor children. This is achieved by putting children’s living with HIV/AIDS first in the production and service delivery of HIV/AIDS treatment and by ensuring monitoring the fulfilment of the obligation to provide the treatment to children at the national level.

4 The African Union has to consider making clear strategies in terms of developing child friendly health policies and health systems in the region through its NEPAD health strategy.

5 At the national level, the Ethiopian government has to take measures to put children living with HIV/AIDS first in its political and policy response to poverty reduction by giving special consideration to the impact of poverty on children living with HIV/AIDS.

5 The Ethiopian government has to make a political commitment to put children living with HIV/AIDS first in the HIV/AIDS treatment service by framing child friendly HIV/AIDS treatment policy.

6 The Ethiopian government has to consider strengthening its human resource capacity in the area of paediatric HIV/AIDS treatment service and use its maximum available human and economic resources in providing HIV/AIDS treatment suitable to children.
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