

A RIGHTS-BASED APPROACH TO REDUCING CHILD MORTALITY IN ETHIOPIA

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Dedication

This work is dedicated to my parents and siblings for their unconditional love and care for me. I also dedicate this to the remembrances of all children died of avoidable fatalities, either because their parents, other caregivers, and or states fail to prevent their death.



Acknowledgements

I thank God for giving me the power to believe in my passion and pursue my dreams to accomplish this work. I could never have done this without the faith I have in Him. There are, however, several others to whom I am indebted for their contribution.

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Summary

A milestone provision introduced for the first time under the Convention on the Rights of Child, and subsequently under the African Charter on the Rights and Welfare of the Child, is children's right to maximum survival. Meaningful realization of this right, *inter alia*, imposes an obligation on states parties to these instruments and other actors to prevent avoidable child mortality and morbidity during and after childbirth. Since the adoption of the Millennium Development Goals in 1990, child mortality and morbidity rates have decreased globally from nearly 13 million a year to just over 6 million. This means that the number of children worldwide who die before the age of five has more than halved in the last quarter of a century. Despite the significant reductions made, children are still dying, particularly in vulnerable communities.

Concerned with the unfinished agenda of child mortality in many parts of the world and faced with the fact that a significant portion of under-five mortality is from preventable causes (an indication that avoidable child fatalities is potentially a violation of human right constituting social injustice) the international community has recently reached a broader consensus that under-five mortality is no longer just an issue of public health, but also a human rights concern. Under-five mortality as a human rights concern is now gaining momentum.

A human rights-based approach to reducing child mortality and morbidity draws attention to barriers to successfully addressing this problem, and highlights the range of actors responsible for reducing child mortality. It also provides a legal framework to strengthen public health efforts, facilitates identification of child populations at risk, and enables analysis of gaps in protection, participation and accountability. In this way, applying human rights to child survival not only helps governments comply with their obligations, but also contributes to improving survival of children.

In this thesis, I interrogate the currency attained by human rights-based approaches to reducing child mortality and morbidity, within the context of Ethiopia. I examine Ethiopia's normative and institutional child health-related framework critically, measure achievements

and identify challenges for meaningful implementation of child survival and its complimentary rights. I conclude that there are positive signs to demonstrate that Ethiopia has started to comply with its obligation to realize children’s survival rights. Despite these achievements, I find that current laws, policies and strategies lack a coherent conceptual framework and do not employ an intelligible human rights ‘lens’ that would allow government to respond to child health issues. In practice, preventable newborn deaths remain the main challenge. Furthermore, the country is a place of stark contrasts in terms of child survival rates. Relying on the requirements of human rights law, I conclude by arguing the potential for the operationalization of the human rights-based model to further reduce or eliminate child mortality in Ethiopia, post-2015.

Keywords: human rights-based approach, infant and under-five mortality, accountability, courts, child survival, child health.

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Acronyms / Abbreviations

AAAQ	Availability, Accessibility, Acceptability and Quality
AAAS	American Association for the Advancement of Science
ACHPR	African Charter on Human and Peoples' Rights
ACPF	African Child Policy Forum
ACRWC	African Charter on the Rights and Welfare of the Child
APAP	Action Professional Association for the People
AU	African Union
BBC	British Broadcasting Corporation
CCM	Country Coordinating Mechanism
CEDAW	Convention on the Elimination of Discrimination against Women
ChSA	Charities and Societies Agency
CIDA	Canadian International Development Agency
CRC	Convention on the Rights of the Child
CRC Committee	Committee on Rights of the Child
CRPWD	Convention on the Rights of Persons with Disabilities
CRR	Center of Reproductive Rights
CSA	Central Statistical Authority
CSOs	Civil Society Organizations
E/HRCO	Ethiopian/Human Rights Council
ECHR	European Convention on Human Rights
EDHS	Ethiopian Demographic and Health Survey
EIO	Ethiopian Institution of Ombudsman
ENSCS	Ethiopian National Strategy for Child Survival
EPRDF	Ethiopian Peoples' Revolutionary Democratic Front
EU	European Union
EWLA	Ethiopian Women Lawyers' Association
F/MoE	Federal/Ministry of Education (Ethiopia)
F/MoH	Federal/Ministry of Health (Ethiopia)

F/MoJ	Federal/Ministry of Justice (Ethiopia)
FAO	Food and Agriculture Organization
FDRE	Federal Democratic Republic of Ethiopia
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FSC	Federal Supreme Court
GDP	Gross Domestic Product
GTP	Growth and Transformation Plan
HDR	Human Development Report
HEP	Health Extension Program
HEWs	Health Extension Workers
HIV/AIDS	Human Immune Deficiency Virus / Acquired Immune Deficiency Syndrome
HoF	House of Federation
HPR (s)	House of Peoples' Representative (s)
HRBA	Human Rights-Based Approach
HSDP	Health Sector Development Programme
HSEP	Health Services Extension Program
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination Against Women
ICESCR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labor Organization
KNCHR	Kenya National Commission on Human Rights
MDG (s)	Millennium Development Goal (s)
MMR	Maternal Mortality Rate
MNCH	Maternal, New-born and Child Health
MoLSA	Ministry of Labor and Social Affairs (Ethiopia)
MoWYCA	Ministry of Women, Youth and Children's Affairs (Ethiopia)
NGOs	Non-Governmental Organizations
NHAPCC	National HIV/AIDS Prevention and Control Council

NHRIs	National Human Rights Institutions
NPPO (s)	National Policy Principles and Objective (s)
NSA	Non-State Actors
OAU	Organization of African Unity
OECD/DAC	Organisation for Economic Cooperation and Development/Development Assistance Committee
ORS	Oral Rehydration Salts
PHC	Primary Health Care
PHM	People's Health Movement
PIL	Public Interest Litigation
PLWHA	People Living with HIV/AIDS
REBSP	Right to Enjoy the Benefits of Scientific Progress
RHB (s)	Regional Health Bureau (s)
SDG (s)	Sustainable Development Goal (s)
SNNPRS	South Nations, Nationalities and Peoples' Regional State
SSC (s)	State Supreme Courts (s)
TAC	Treatment Action Campaign
TDCA	Trade, Development and Cooperation Agreement
TPLF	Tigray Peoples' Liberation Front
UDHR	Universal Declaration of Human Rights
UHCW	Union of Health Work Committees
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFP	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN/OHCHR	United Nations /Office of High Commissioner for Human Rights
WHO	World Health Organization
WWII	Second World War

Chapter 1

Introduction

1.1 Background and problem statement

In slums and shantytowns the children cry
And die – they die who earth should beautify!¹

The foregoing is an excerpt from a poem by Herbert Dhlomo, a KwaZulu-Natal writer, who writes this in relation to his account of the importance of the health of children. The right to health care is vital for children, for they are vulnerable beings, more at risk to illness and health complications than others. They are the first to die when basic needs are not met. It is when children are protected from disease, malnutrition and others threats that they can grow into healthy adults. In this way, children can ultimately contribute to the development of dynamic and productive societies.²

Despite the significant growth in academic interest in children's socio-economic rights³ over the last two decades, children's health care and their other socio-economic rights are a relatively neglected area compared to their civil and political rights.⁴ Although the world reached consensus, at Vienna in 1993, that human rights are interdependent, indivisible and interrelated,⁵ civil and political rights have dominated academic and legal discourse and gained a better level of protection and enforcement by the various organs of governments. Partly due

¹ A Hassim *et al Health and Democracy: A Guide to Human Rights, Health Law and Policy in Post-Apartheid South Africa* (2007) 4.

² Humanium 'The right to health: Understanding children's right to health' available at: <http://www.humanium.org/en/fundamental-rights/health/> (accessed 12 October 2013).

³ I discuss what I mean with socio-economic rights more fully at n 94 below.

⁴ A Nolan *Children's Socio-Economic Rights, Democracy and the Courts* (2011) xxix-xxx; M Freeman 'Children's health and children's rights: An introduction' (2005) 13 *The International Journal of Children's Rights* 1-10.

⁵ See *Vienna Declaration and Program of Action* (A/CONF.157/23), adopted by the World Conference on Human Rights, held in Vienna, 14–25 June 1993.

to lack of attention and political will of governments, millions of infants across Africa face deprivation of such basic health care needs that will help them to survive and develop.⁶

Hunt underscores that ‘human rights are not just about torture, they are also about avoidable deaths from preventable health conditions’.⁷ Health as it applies to newborns, children, women, and adolescents is a human right and at the heart of a people-centered approach to sustainable development.⁸ Health care as a human right is recognized in numerous international instruments.⁹ Equally, the right in question has also been proclaimed by resolution 1989/11 of the Commission on Human Rights (CHR) and the Vienna Declaration and Program of Action of 1993. The right to health, in the context of the obligation of states to reduce infant and child mortality, has also been recognized in the Millennium Development Goal (MDG) IV.¹⁰

⁶ In 2009, the total number of infant deaths in Africa, excluding North Africa, amounted to 2.5 million. This represents a staggering 97 percent of infant deaths that occurred on the continent as a whole. DRC, Ethiopia, Tanzania, Nigeria, and Uganda accounted for about 50 percent (2.0 million) of the deaths in that year. The major causes for deaths are measles, pneumonia, diarrhea, malaria, and AIDS. For detail information on this, visit ‘Section II: Tracking progress’ available at: <http://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/Goal4%20Eng.pdf> (accessed 23 March 2013). To analyse the case of South Africa’s failure to curb mortality and the need for the political will address the problem, see ‘political will necessary to end high child mortality rate in South Africa’ available at: <http://www.truth-out.org/archive/item/91235:political-will-necessary-to-end-high-child-mortality-rate-in-southafrica> (accessed 13 June 2013).

⁷ Statement by Paul Hunt ‘Panel on maternal mortality and the human rights of women’ June 5, 2008, UN Human Rights Council, available at: http://www2.essex.ac.uk/human_rights_centre/rth/pressreleases.shtml (accessed 22 May 2013).

⁸ WHO ‘The partnership for maternal, newborn and child health (PMNCH) full statement’ available at: http://www.who.int/pmnch/media/events/2014/tc_statement.pdf?ua=1 (accessed 13 May 2014).

⁹ Article 25(1) of the Universal Declaration of Human Rights (UDHR) provides that: ‘everyone has a right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services’. Also, article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, and to that end mandates the countries that have ratified or acceded to the covenant, to undertake steps for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child to achieve his or her full realization. Additionally, the right to health is recognized in article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination Against Women (ICERD) of 1965; in articles 11(1)(f) and 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) of 1979; and in article 24 of the CRC of 1989. In the context of regional human rights instruments, the right to health has been recognized in article 16 of the African Charter on Human and People’s Rights (ACHPR) of 1981; in articles 11, 13 and 15 of the European Social Charter (ESC) of 1961 as revised; and in article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (APACHR) of 1988.

¹⁰ There are eight Millennium Development Goals (MDGs) that the United Nations UN Member states have agreed to try to achieve by the year 2015. Signed in September 2000, each of the goals has specific stated targets and dates for achieving those targets. Several of these relate directly to health. Millennium Development Goal IV is

Currently, many countries are signatories and parties to the above mentioned International Bill of Human Rights¹¹ and other treaties that contain provisions with respect to health care as a human right. When one considers the CRC alone, the Convention has been ratified by all nations with the exception of the United States of America.¹² On becoming a party to those human rights treaties, governments are obliged to translate the rights of children into reality. Governments shall strive to ensure that no child is deprived of his or her right of access to health care services and shall pursue full implementation of this right and, in particular, shall take appropriate measures to do so.¹³ In order to ensure survival of the child, states parties are under an obligation to implement health rights of the child by reducing the rate of stillbirth and infant mortality. In order to attain survival of development of the child, Skelton notes that state services must ensure that babies are born healthy and thrive in the first five years of their birth.¹⁴

Despite the fact that many states are parties to the International Bill of Human Rights,¹⁵

dedicated to reducing child mortality rates. MDG IV requires UN member states to target for reduction of the under-five mortality rate, by two-thirds, between 1990 and 2015. For details, see WHO 'Millennium Development Goals (MDGs)' available at: <http://www.who.int/mediacentre/factsheets/fs290/en/> (accessed 10 May 2013).

¹¹ The International Bill of Human Rights consists of the Universal Declaration of Human Rights (1948), the International Convention on Economic, Social and Cultural (1966), and the International Convention on Civil and Political Rights (1966) and its two Optional Protocols. See Fact Sheet No. 2 (Rev1) 'The international bill of human rights' available at: <http://www.ohchr.org/Documents/Factsheet2Rev1.en.pdf>. (accessed 19 October 2013).

¹² The CRC has been ratified by 195 states – only the United States of America has not yet ratified although it has signed it. The United States considered it unlikely that the Convention will pass the difficult and complex domestic procedure for ratification – for 'ratification of treaty requires two-thirds majority vote in the Senate to pass, and a number of Republican senators, claiming concerns about U.S. sovereignty, have consistently opposed ratification'. See 'Why won't the U.S. ratify the U.N.'s child rights treaty?' available at: <https://www.washingtonpost.com/blogs/post-partisan/wp/2014/11/21/why-wont-the-u-s-ratify-the-u-n-s-child-rightstreaty/> (accessed 16 November 2015); B Hafen & J Hafen 'Abandoning children to their autonomy: The UN Convention on the Rights of the Child' (1996) 37 *Harvard International Law Journal* 449.

¹³ S Lewis 'Promoting child health and the Convention on the Rights of the Child: Health and human rights' (1997) 2 *Health and Human Rights* 78.

¹⁴ A Skelton 'Girls' socio-economic rights in south Africa' (2010) 26 *South African Journal of Human Rights* 144.

¹⁵ Under International Bill of Human Rights, especially under the ICCPR and ICESCR, states parties have the obligation to implement the rights provided for in those instruments. They assume the responsibility to respect, protect and fulfil all the rights recognized by the specific convention. In the context of the right to health care of children, states' obligation to respect requires that states refrain from introducing laws, policies, or actions that are likely to result in bodily harm or other kinds of avoidable morbidity and mortality. The obligation to protect mainly entails obligations of governments to make efforts to minimise risks to health and to take all necessary measures to safeguard the population from infringements of the right to health by third parties. On the other

partially because many governments cannot provide adequate medical care and living conditions for all their citizens, their populations suffer disproportionately from diseases that are routinely preventable or curable. The Committee on Economic, Social and Cultural Rights has further reaffirmed that for millions of people throughout the world, the full enjoyment of the right to health remains a distant goal.¹⁶

Owing to challenges of child health protection, the scale of under-five death is at an unacceptable level.¹⁷ Due to insufficient prenatal and early childhood health care, as well as lack of nutrition, developing nations manifest high mortality rates for children under- five years old.¹⁸ According to a recent report, every year nearly 6.3 million children around the world die before reaching their fifth birthday.¹⁹ Almost all these deaths occur in developing countries as a result of preventable causes where millions could otherwise have been saved with access to basic health services.²⁰ Preventable child mortality constitutes another form of a tragic loss of

hand, the obligation to fulfil implies that governments are required to take positive measures, such as by providing relevant services, to enable children to enjoy the right to health in practice. In other words, this obligation requires that all necessary steps be taken to ensure that the benefits covered by the right to health are provided and that appropriate legislative, administrative, budgetary, judicial, promotional and other relevant measures are adopted to ensure its full realization. For a comprehensive engagement on this, see J Asher *The Right to Health: A Resource Manual for NGOs* (2004) 35-36.

¹⁶ Committee on Economic, Social, and Cultural Rights (ESCR), *General Comment No. 14, The Right to the Highest Attainable Standard of Health*, .08/11/2000, E/C.12/2000/04, para 5, twenty-second session Geneva, 25 April-12 May 2000 Agenda item 3.

¹⁷ World Bank 'Reduce child mortality by 2015' available at: www.worldbank.org/mdgs/child_mortality.html (visited 10 May 2013).

¹⁸ University of Minnesota Human Rights Center 'A study guide: The right to means for adequate health' (2003) available at: <http://www1.umn.edu/humanrts/edumat/studyguides/righttohealth.html> (accessed 2 September 2012).

¹⁹ This implies that well over 17,000 children under the age of five died each day in 2013. By 2050, the global number of under-five deaths may stagnate or even increase without more progress in sub-Saharan Africa. See United Nations Inter-agency Group for Child Mortality Estimation (UN IGME) *Levels and Trends in Child Mortality* (2014) 1; WHO 'Children: reducing mortality' available at: <http://www.who.int/mediacentre/factsheets/fs178/en/> (accessed 4 September 2014).

²⁰ The cause for the deaths is not a natural event, but the developing countries' failure to make basic life-saving interventions a reality to their people. This is characterized by shortages of health care workers, a lack of basic health service equipment, and inadequate infrastructure such as clinics and health facilities. For instance, sub-Saharan Africa, where 24% of the global burden of disease is accounted for, has only 3% of the world's health workforce. See 'Maternal and child health' available at: <http://www.one.org/c/international/issue/951/>, (accessed 4 March 2013). Also, this region is characterised by inadequate food intake, infections, HIV, malaria, micronutrient deficiency, and frequent reproductive cycle. As a result many children die every year, which calls for governmental accountability. See further on this, A Larte 'Maternal and child nutrition in sub-Saharan Africa: Challenges and interventions' (2008) 67 *Proceedings of the Nutrition Society* 105-108.

humanity which is mostly the result of lack of strong political leadership. When it was grandly declared in the middle years of the last century that history should not be allowed to repeat itself, that it means that every human counts, no one suggested that this excluded the child.

Taking cognizance of the challenges of high under-five mortality rates above, in its General Comment issued in 2013, the Committee on the Rights of the Child recognizes that ‘most mortality, morbidity and disabilities among children could be prevented if there were political commitment and sufficient allocation of resources directed towards the application of available knowledge and technologies for prevention, treatment and care’.²¹ A few months later, the United Nations Human Rights Council adopted without a vote a historic resolution entitled ‘Preventable mortality and morbidity of children under-five years of age as a human rights concern’.²² This, in turn, triggered a process that led to the preparation and completion (in 2014) of the ‘UN Technical guidance on the application of a human rights-based approach (HRBA) to the implementation of policies and programs to reduce and eliminate preventable mortality and morbidity of children under-five years of age’ (the ‘UN Technical Guidance’).²³ In a nutshell, under-five mortality as a human rights concern is gaining momentum.

The central theme of this thesis is to examine the problem of infant and child mortality in the Ethiopian context through a human rights lens. The Ethiopian situation is not an exception to what has been described above. The problem is similar to that of many countries in sub-Saharan Africa, which is characterized by a high infant and child mortality rate – a violation of human right constituting social injustice.²⁴ Although it is difficult to ascertain the exact figure and data variations exist from one source to another, figures from the Ministry of Health (MoH)

²¹ UN Committee on the Rights of the Child (CRC), *General Comment No. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* (art. 24), 17 April 2013, para 1, CRC/C/GC/15.

²² See Human Rights Council resolution 24/11 of 26 September 2013 on ‘Preventable mortality and morbidity of children under 5 years of age as a human rights concern’ available at: <http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=15110&LangID=E#sthash.IV7u43Pl.dpuf> (accessed 11 May 2015).

²³ UN Human Rights Council, *Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under-five years of age* available at: <http://www.ohchr.org/Documents/Issues/Children/TechnicalGuidance/TechnicalGuidancereport.pdf> (accessed 13 December 2014).

²⁴ L Dube *et al* ‘Determinants of infant mortality in community of Gilgel Gibe Field Research Center, South West Ethiopia: A matched case control study’ (2013) 13/401 *BMC Public Health* 1-2.

of Ethiopia alone shows that about 196,000 Ethiopian children die each year before their fifth birthday.²⁵ This figure places Ethiopia among the countries of the world exhibiting highest number of child deaths.²⁶ Although the number of deaths in the country has reduced in the past few decades, the situation shows infant mortality is still a paramount concern. The Committee on CRC in its concluding observations in Ethiopia's report is deeply concerned that infant, under-five and maternal mortality rates remain very high.²⁷ It is also concerned 'at the low coverage of vaccinations, the prevalence of malaria, low breastfeeding rates and the high incidence of malnutrition'.²⁸ Despite the significant reduction of under-five deaths, recent reports also show the country still registers among those countries with a high rate of under-five deaths.²⁹ The progress does not allow complacency, as reducing preventable child mortality effectively remains an unfinished job. One in every 13 infants born in Ethiopia does not survive to celebrate his or her first birthday and one in every eight children dies before its fifth birthday.³⁰

The above background problem of infant and child mortality rates raises a critical concern in the global, regional, and national human rights discourse. Whether a HRBA could make a potential contribution to child health gains becomes a fundamental issue. In this thesis, I aim to advance argument on this issue. A HRBA, whether it is applied to poverty reduction, trade, infant or maternal mortality or HIV/AIDS, requires *inter alia* that effective mechanisms of accountability be established.³¹ A HRBA in the context of the right to the highest attainable standard of health offers individuals and communities the opportunity to understand how

²⁵ FDRE Ministry of Health (MoH), Maternal and Child Health Directorate *National Strategy for New-born and Child Survival in Ethiopia 2015/16-2019/20* (2015) 9.

²⁶ Ibid.

²⁷ Committee on the CRC, Forty-third session, Consideration of reports submitted by states parties under article 44 of the convention, *Concluding Observations* (Ethiopia), CRC/C/ETH/CO/3, para 53, 1 November 2006.

²⁸ Ibid.

²⁹ According to Central Intelligence Agency's (CIA's) 2013 estimate on infant mortality rates, Ethiopia is ranked as the 29th country that has the highest rate of infant mortality out of the 224 countries surveyed. For details, see Central Intelligence Agency *The World Fact Book, country comparison: Infant mortality rate* available at: <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091.html> (accessed 11 May 2013).

³⁰ See D Mekonnen 'Infant and child mortality in Ethiopia: the role of socio-economic, demographic and biological factors in the previous five years period of 2002 to 2005' *unpublished Master's thesis, University of Lund*, 2011 5.

³¹ P Hunt, Forward to, H Potts *Accountability and the Right to the Highest Attainable Standard of Health* (2008) 2.

governments and others have discharged their right to health obligations.³² In order to maintain the highest possible standards of children's health care, international law requires effective and transparent mechanisms aimed at holding all actors responsible for their actions.³³

Nevertheless, the essential question of implementation of state responsibilities and the contribution that the human rights framework could make with regard to child health rights is open to further clarification. Until very recently, the evidence of impact of governmental human rights-shaped initiatives on children's health has received very little attention.³⁴ For instance, the human rights literature devotes relatively little attention to accountability for the right to health.³⁵ There are few written engagements with the concept of accountability in the context of the right to the highest attainable standard of health of children. Chapman, for instance, argues that there is little systematic assessment of the performance taking place regarding implementation of health rights, against countries that have ratified or acceded to the major international human rights conventions.³⁶ For obvious reasons, children's cases are not an exception to this problematic concern of measuring implementation of their right to health or survival.

Human rights tools and approaches are, therefore, to be utilized to monitor the *lacuna* and frame child mortality as a human rights issue. Developing and using indicators for human rights monitoring becomes a cutting-edge area for potentially vindicating the right to health of the child. In this thesis, I measure whether the legislative, policy and institutional mechanisms in Ethiopia have achieved the same resonance in terms of both visibility and implementation in the light of human rights standards and norms. It comes from a realization that, despite the ratification by the country of major international instruments applicable to combat child

³² Ibid., 4.

³³ CRC Committee, *General Comment No. 15* (n 21 above) para 92.

³⁴ F Bustreo *et al Women's and Children's Health: Evidence of Impact of Human Rights* (2013) 13.

³⁵ Ibid.

³⁶ AR Chapman 'Monitoring women's right to health under the International Covenant on Economic, Social And Cultural Rights' (1995) 44 *The American University Law Review* 1157.

mortality, many under-five children have continued to be at the receiving end of discrimination in terms of access to health goods and service, or they lack access to these goods and services, and that another layer of protection was needed.

It would be a mistake for me to argue that a HRBA is an absolute remedy to the challenges of deprivation that under-five children face in terms of their access to the underlying determinants of health. However, I take as a point of departure that a HRBA to child mortality has the potential to enhance the further reduction or elimination of avoidable child deaths. Based on this argument, I chart that a HRBA to child mortality needs to be explored to address this social injustice effectively, through navigating a complementary approach of child health and human rights. Of course, how and to what extent navigation of this path can be accomplished is a major concern. In dealing with this concern my inquiry is guided by the questions outlined in section 1.6 below.

1.2 Definitions of terms

The following terms and phrases are used throughout the thesis and their meanings are defined accordingly, which meanings apply generally, unless a particular other meaning is attached to it or the context provides otherwise.

‘Child’ the term ‘child’ is traditionally defined as an individual who is not yet an adult.³⁷ The term ‘child’ is also defined in global and regional law and the domestic law of various countries. The CRC defines it as any person under the age of 18 unless majority can be attained earlier in accordance with national law of a country.³⁸ The CRC therefore sets two ages for childhood. On the other hand, Africa’s counterpart to the CRC, that is, the ACRWC, provides one set of age as the end of childhood: 18.³⁹ In Ethiopia, a child or minor is defined under the Revised Family Code of 2000 as a person of either sex who has not attained the full age of eighteen

³⁷ G Van Bueren *The International Law on the Rights of the Child* (1998) 33.

³⁸ CRC, article 1.

³⁹ ACRWC, article 2.

years.⁴⁰ There are however exceptions to the eighteen years as the age of majority under the Family Code. This occurs where the minor is emancipated in accordance with articles 311-313 of this Code. For the purpose of this thesis, however, because I focus on children under the age of five, the term ‘child’ refers to a person under the age of five unless construed otherwise.

‘**Child mortality**’ refers to the death of infants and children under the age of five.⁴¹

‘**Child mortality rate or under-five mortality rate**’ is the probability of dying between birth and exactly five years of age expressed per 1,000 live births.⁴²

‘**Infant**’ the word ‘infant’ originates from the old French *enfant* and Latin *infans*.⁴³ It denotes the status of being ‘unable to speak’. The Oxford Dictionary of English defines an infant to mean a very young child or baby, a child between the ages about four and eight, in their first year at infant school and something in an early stage of its development.⁴⁴ Black’s Law Dictionary, on the other hand, defines an infant to refer a new-born baby; minor.⁴⁵ The latter does not state any specific age limit. For the purpose of the thesis, the word infant refers to a human person of less than one year old. This latter definition is recognized under the works or statistical reports of the WHO, UNICEF, Save the Children and most other agencies working on health care of children.⁴⁶ I prefer to follow the same approach employed by these international agencies since they are authoritative sources and are often used by domestic authorities for adopting and implementing national policies and strategies regarding infant health care matters.

‘**Infant mortality**’ is the risk for a live-born child to die before his or her first birthday.⁴⁷

⁴⁰ Revised Family Code of Ethiopia, Proclamation No. 213/2000, article 215.

⁴¹ UNICEF ‘Definitions of the indicators’ available at: http://www.unicef.org/infobycountry/stats_popup1.html (accessed 14 May 2013).

⁴² Ibid.

⁴³ A Stevenson *Oxford Dictionary of English* (2010) 894.

⁴⁴ Ibid.

⁴⁵ B Garner *Black’s Law Dictionary* (1999)781.

⁴⁶ UNICEF (n 41 above).

⁴⁷ See Dube *et al* (n 24 above) 1.

'Infant mortality rate' is the probability of dying between birth and exactly one year of age expressed per 1,000 live births.⁴⁸

'Survival': an online webpage defines the term survival as 'the act or fact of surviving, especially under adverse or unusual circumstance; a person or thing that survives or endures, especially an ancient custom, observance, belief, or the like.'⁴⁹ In human rights language, however, the term 'survival' includes a child's right to life and the right to meet the needs that are the most basic to a child's very existence.⁵⁰ An adequate standard of living, shelter, nutrition, and access to medical services are some of these basic needs to ensure the survival of children.⁵¹

'Implementation' refers to all measures aimed at putting the substantive norms of human rights into operation.⁵² The term is often used to convey the process of converting paper or formal human rights guarantees into practical realities. It should, however, be noted that human rights lawyers argue as to the deficiency of a consistent terminology of implementation despite the fact that the concept is widely used in the human rights literature.⁵³ The problem is partly because the term is frequently used interchangeably with notions as different as 'enforcement', 'monitoring' and 'protection' of human rights.⁵⁴ Viljoen also appreciates the polarization of approaches of scholars regarding these terms. Viljoen argues that different terms are used, in human rights literature, in order to convey the process of converting paper or formal human rights guarantees into practical realities, to make human rights more

⁴⁸ UNICEF (n 41 above).

⁴⁹ Dictionary.com 'Survival' available at: <http://dictionary.reference.com/browse/survival?s=t> (accessed 21 May 2013).

⁵⁰ See G Odongo 'Caught between progress, stagnation and a reversal of some gains: Reflections on Kenya's record in implementing children's rights norms' (2012) 12 *African Journal of Human Rights Law* 120. See, also, S Detric *A Commentary on the United Nations Convention on the Rights of the Child* (2009) 130.

⁵¹ Ibid.

⁵² T Opsahl 'Instruments of implementation of human rights' (1989) 10:13 *Human Rights Law Journal* 14.

⁵³ F Viljoen 'The realization of human rights through inter-governmental institutions in Africa' *unpublished LLD thesis, University of Pretoria*, 1997 10-11.

⁵⁴ S Parmentier 'The significance of mechanisms to monitor human rights at the international level' in E Verhellen (ed) *Understanding Children's Rights* (1996) 412.

meaningful.⁵⁵ He further notes that the terms ‘realization’, ‘implementation’ and ‘enforcement’ are the most commonly used to refer to the process of converting human rights guarantees in papers into practical realities.⁵⁶ For purposes of this thesis, I prefer to use the term ‘implementation’ for the following reasons: ‘implementation’ is more neutral than terms like ‘guarantee’ or ‘enforcement’ of human rights; ‘enforcement’ could capture concepts like force, attack or defense. As I highlight in section 1.5 below, the aim of using the human rights framework for monitoring implementation of the obligation to reduce infant or child mortality is not confrontational. In addition, a focus on the term ‘implementation’ is important because the word is frequently used in the context of monitoring of states’ performance in respect of health care rights. Nevertheless, the other terminologies might be utilized in the main body of the thesis according to the needs of a specific context.

1.3 Significance

This thesis mainly supplements the existing legal scholarship aimed at effectively promoting and protecting children’s right to be free from preventable death. However, I am motivated by the following considerations.

The conventional claim is that the birth of a child brings a time of joy to families.⁵⁷ Yet, research shows that this is not always true. It rather turns out to be a time of sorrow for many families every year. Children are also at the same time offered with the opportunity to grow and live in the society they belong to. This thesis is significant in comprising an in-depth analysis of why unacceptably high numbers of children are facing deprivation of the opportunity to survive. It sets out the potential factors beyond the domain of those relating to general socio-economic development determinants for child survival. It again describes the importance of analyzing this often-neglected human right from a rights perspective. Such mechanism helps the country identify the gaps and failures in existing policies and programs and gives it an opportunity to

⁵⁵ Viljoen (n 53 above) 5.

⁵⁶ Ibid., 5-6.

⁵⁷ A Jackson ‘A time for tears, a time for joy and a time for strong women to take a stand’ (13 November 2012) available at: <http://www.micahchallenge.org/blogs/42> (accessed 12 March 2013).

improve them.⁵⁸ If this approach is to be followed strictly, it can, among other things, potentially call for actions of the legislative, executive and judicial organs of the government or beyond to think new ways of addressing the problem in their respective areas of competence.

Furthermore, as I discuss in section 1.1 above, infant and child mortality is a comparatively serious problem in the developing world, especially in sub-Saharan Africa. Taking the situation of Ethiopia as an example, I argue that a HRBA to monitoring implementation of the obligation to reduce infant and child mortality can potentially protect the right to survival of children. If the proposals advanced in this thesis are realized in practice, it could be used as a model in other jurisdictions with similar problems and can potentially contribute to the successful reduction of infant and child mortality in such jurisdictions.

As I discuss in section 1.1 above, children's socio-economic rights is an emerging field of children's human rights law. From an academic perspective, the study may, therefore, contribute to the discourse on trends on infant and child mortality, and the need for human rights-based monitoring of governmental accountability, particularly for child health care rights, upon which other scholars can further build on their studies.

In this thesis, I mainly argue the need for a system of mainstreaming of human rights principles and norms for child health care or survival rights in Ethiopia. Hence, I hope to encourage popular involvement in the process of participation, equality and non-discrimination, and accountability. If the objective of a HRBA is to bring about changes in the child survival crisis, civil society's involvement leading to constructive demands at national and international levels is necessary to achieve this goal. It is further expected that sensitization of the concern among practitioners, law students and the public at large would add value to encourage for the initiation of such demands.

⁵⁸ Center for Reproductive Rights (CRR) 'Reproductive rights: A tool for monitoring states obligation' available at: <http://www.reproductiverights.org> (accessed 25 March 2013).

The significance of the HRBA, if applied properly, does not result only in the reduction of infant and child mortality. It has a further significance. It can lead to better family planning, particularly in the developing world. Research shows that reduction of child mortality can change the attitudes of parents or families in planning births. Where parents become aware that the risk that their child may die at infant stage is minimal, they tend to limit the number of fertilities or births.⁵⁹

1.4 Literature review

The human rights dimension of under-five mortality and morbidity is a relatively recent development in the global and regional human rights discourse. A growing literature on human rights measurement has now emerged in response to an increasing demand for rigorous monitoring of state accountability in meeting their obligations of maternal and child health.⁶⁰ Most of the literature I discuss below focuses on the role of one of the key principles of a HRBA: accountability for health as a human right entitlement provided in national and supra-national laws. My emphasis on literature on accountability is mainly because this principle is the heart of a HRBA and this centrality is projected to be a potentially useful mechanism to deliver on promises made by states to end preventable under-five mortality.

In this regard the People's Health Movement (PHM), for instance, stresses the importance of assessing governmental responsibilities as the best strategy for the attainment of health for all.⁶¹ The PHM argues that standards are to be used to measure government's accountability for what it does or does not do to prevent and reduce health problems.⁶² For the PHM, an

⁵⁹ See, for instance, L Rosero-Bixby 'Child mortality and the fertility transition: Aggregated and multilevel evidence from Costa Rica' in MR Montgomery & B Cohen (eds) *From Death to Birth: Mortality Decline and Reproductive Change* (1998) 384-410.

⁶⁰ See, for instance, UNOHCHR & Centre for Economic and Social Rights *Who will be Accountable?: Human Rights and the Post-2015 Development Agenda* (2013) 42; P Hunt & T Gray (eds) *Maternal Mortality, Human Rights, and Accountability* (2013); AE Yamin 'Toward transformative accountability: Applying a rights-based approach to fulfill maternal health obligations' (2010) 7 *SUR International Journal on Human Rights* 94-120; CRR 'Broken promises: Human rights, accountability and maternal death in Nigeria' (2009). Available at: http://www.Reproductiverights.org/sites/crr.civicaactions.net/files/documents/pub_nigeria2.pdf (accessed 12 May 2014).

⁶¹ 'The assessment of the right to health and health care at the country level: A people's health movement guide' (2006) available at: http://www.phmovement.org/files/RTH_assmt_tool.pdf (accessed 12 June 2012).

⁶² *Ibid.*

examination of international covenants to which a specific country is a party, its national constitution, national laws and policy agendas concerning the right to health can be used as tools for measurement of accountability. However, the tools considered by PHM as important for measuring governmental responsibility pertains to health as a human right in general and are not specific to child health rights.

According to a book published by the American Association for the Advancement of Science (AAAS) and Physicians for Human Rights, monitoring the behavior of both individuals and institutions in the health sector is essential to assess their conformity with human rights standards and to identify problems.⁶³ For AAAS monitoring conveys the meaning of ‘systematic and relatively comprehensive efforts to collect appropriate data with a purpose to determine whether the performance of individuals and institutions conforms to international human rights standards’.⁶⁴ The AAAS also underlines that the primary aim of a monitoring procedure is to assist the state in protecting enumerated rights, not to criticize the inadequate performance of the state or particular professional sectors.⁶⁵ The AAAS’s definitional scope of monitoring seems broad as it covers different levels of monitoring, including monitoring of the individual behavior of health professionals, institutional practices of hospitals, prisons, and teaching facilities.

From a related perspective, some other writers, as I discuss below, try to deal with health care rights in the context of their enforcement before domestic, regional and global judicial and quasi-judicial bodies.

Byrne examines whether the non-codification of the right to health in domestic law entails that health rights are incapable of adjudication and enforcement by the courts.⁶⁶ To investigate and

⁶³ American Association for the Advancement of Science (AAAS) *Human Rights and Health: The Legacy of Apartheid* (1998) 161.

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ I Byrne ‘Enforcing the right to health: Innovative lessons from domestic courts’ in I Clapham & M Robinson (eds) *Realising the Right to Health* (2009) 525-557.

analyze judicialization of health as a human right, he makes a survey of the right to health jurisprudence across Commonwealth countries and beyond.⁶⁷ Based on this survey, he concludes that non-codification of the right to health in domestic law is not necessarily a bar to both consideration and enforcement by the courts of health care.⁶⁸ However, in order for this to be realistic he maintains the need for innovative approaches taken by jurists in deciding cases relating to health rights.⁶⁹

In an almost similar approach to Byrne, Ferraz discusses the debate on the proper role of courts in the enforcement of the so-called socio-economic rights such as the right to health. By citing landmark cases decided by the courts of Brazil and South Africa, he points out the two issues of legitimacy and institutional competence⁷⁰ that the courts are challenged from within the legal enforcement of these rights. He tries to distinguish the South African courts' approach of being cautious, and that of the Brazilian court's position in being assertive in making health care rights issues.⁷¹ In either of the approaches, he argues that courts will inevitably face the charges of abdication or usurpation, when they are called upon to adjudicate

⁶⁷ The survey that Byrne (n 66 above) makes in the Commonwealth and beyond includes socio-economic rights court cases from the following countries: Chile, South Africa, Peru, Venezuela, Argentina, Brazil, Ecuador, India, Canada, United Kingdom and cases decided by the European Court of Human Rights.

⁶⁸ Ibid.

⁶⁹ According to Byrne, an innovative approach by judges is understood as a dynamic role of judges to improve the legal protection of individuals' or groups' right to health in respect of the state and its bodies, particularly by giving them the possibility to enforce their fundamental right and freedom to health before court, in instances where there is no express recognition of the right to health in the domestic constitution. Byrne (n 66 above) 525 *et seq.*

⁷⁰ Since the adoption of the ICESCR in 1966, there have been persistent objections that the obligations engendered by the rights in the ICESCR were incapable of judicial enforcement. The objections take two dimensions. The first dimension is described as the legitimacy dimension, and the second is the institutional competence dimension. The objection on ground of legitimacy is rooted in traditional conceptions of whether it would be legitimate to confer socio-economic rights as part of human rights norms in constitutions given their nature: that they supposedly do not impose a negative duty on the state. The legitimacy is further contested on the ground that socio-economic rights involve redistribution of resource and allow the intervention of the state in the free market economy. On the other hand, the institutional competence objection pertains to the belief that the judiciary is viewed as inappropriate to deal with the complex matters of social justice. Social justice issues are viewed as matters whose determination is within the jurisdiction of the representatives of the people and not the unelected judges. For details see, C Mbazira *Litigating Socio-Economic Rights in South Africa: A Choice between Corrective and Distributive Justice* (2009) 15-41. See, also, M San Giorgi *The Human Right to Equal Access to Health Care* (2012) 81.

⁷¹ O LM Ferraz 'Between usurpation and abdication? The right to health in the courts of Brazil and South Africa' in O Vilhena *et al* (eds) *Transformative Constitutionalism: Comparing the Apex Courts of Brazil, India and South Africa* (2013) 375-404.

constitutionalised socio-economic rights.⁷² Ferraz supports the position that courts should be cautious in entertaining socio-economic rights claims.⁷³ In his view, facing critics in the form of impatient rights activists and commentators is preferable to overstepping into the legitimate powers of the political decision making body of the government.

Ferraz's thought above was earlier well accounted by other academics, for instance, Brand. Brand raises issues related to institutional capacity, legitimacy and security, which the South African Constitutional Court shall consider in adjudicating socio-economic rights litigation.⁷⁴ He points out and warns that, to a certain extent, courts should defer in their judgments on complex technical matters or politically intractable questions to the other branches of government in situations where the latter can properly engage with it.⁷⁵

There are, however, critics to the deferential positions held by the South African Constitutional Court in giving effect to the socio-economic rights provisions of the constitution. For instance, Mbazira cites the case of the *Government of the Republic of South Africa v Grootboom and Others*⁷⁶ as a point of reference to uphold this position. Using this court case as an example, Mbazira argues against the failure of the Constitutional Court to exercise supervisory

⁷² Ibid.

⁷³ Ibid.

⁷⁴ See D Brand 'Courts, socio-economic rights and transformative politics' *unpublished LLD thesis, University of Stellenbosch*, 2009 122, 186, 190 & 261.

⁷⁵ Ibid.

⁷⁶ South Africa has celebrated jurisprudence in the area of the socio-economic rights. One of such reflection is the case of *Government of the Republic of South Africa v Grootboom*. The *Grootboom* case involves a group of adults and children who were moved onto private land from an informal settlement. They were subsequently evicted from the private land, and camped on a sports field in the area. They applied to the Cape of Good Hope High Court for an urgent order, against all levels of government, to be provided with temporary housing. This case was instituted under sections 26(1) & 28(1) (c) of the South African Constitution to enforce everyone's right of access to adequate housing and the children's rights to shelter, basic nutrition and health care respectively. The Court found that the children and, through them, their parents were entitled to shelter under section 28(1)(c) and ordered each level of government to provide them with temporary housing in the form of tents, portable latrines and a regular supply of water. An appeal was subsequently formed by government to the South African Constitutional Court. In its judgment, the Constitutional Court came to the conclusion that Section 26 of the Constitution does not, as of right, entitle any person housing at the state expense. Rather, it held that Section 26(2) 'requires the state to devise and implement within its available resources a comprehensive and co-ordinated program progressively to realize the right to adequate housing, and that such a program must include measures...to provide relief for people who have no access to land.....and who are living in intolerable conditions'. The court found that, to the extent that the state's existing housing program did not make provision for such people, it was found to be unconstitutional. For details of this case refer, *Government of the Republic of South Africa and Others v Grootboom and Others* 2000 (11) BCLR 1169 (CC).

jurisdiction over the executive branch of the government to make sure that the latter carries out the judicial orders handed down by the court.

A more focused discussion on the HRBA as applied to health in general is well explained in an account by London. He classifies three aspects of the nature of health as a right that are relevant to shaping a human rights approach to health, namely: '1) the indivisibility of civil and political rights, and socio-economic rights; 2) active agency by those vulnerable to human rights violations; and 3) the powerful normative role of human rights in establishing accountability for protections and freedoms'.⁷⁷ Unlike London's work, a HRBA approach very specific to child health is rightly discovered in an account by Bustreo *et al*, and later on through the adoption of the UN Technical Guidance. As I discuss mainly in section 2.3.2, Bustreo *et al* contribution underlines how human rights-shaped laws and policies not only helps governments comply with their binding obligations, but also contributes to improving the health of women and children.⁷⁸

In the Ethiopian context, one generally finds engagements in connection with justiciability⁷⁹ of socio-economic rights, such as the right to health, in terms of their constitutional recognition and the approach followed by judges in applying these rights as part of the Bills of Rights stipulated under the Ethiopian Federal Constitution (1995). Put differently, scholars attempt to evaluate the extent to which the legislative framework of the country and the approach of the judges are conducive to the protection of socio-economic rights. Children's health rights, which fall within this broad category of rights, receive a similar scholarly discourse for

⁷⁷ L London 'What is a human-rights based approach to health and does it matter?' (2008) 10:1 *Journal of Health and Human Rights* 65-80. For a related discussion on a human rights perspective on health, see S Gruskin & D Tarantola 'Health and human rights' in Detels *et al* (eds) *The Oxford Textbook of Public Health* (2002) 311–335.

⁷⁸ See Bustreo *et al* (n 34 above) 1-136.

⁷⁹ Justiciability of human rights means that a court of law or another type of supervisory body deems the right concerned to be amenable to judicial scrutiny, and presence of mechanisms to make complaints and get redress where there are violations. See MJ Dennis & DP Stewart 'Justiciability of economic, social, and cultural rights: Should there be an international complaints mechanism to adjudicate the rights to food, water, housing, and health?' (2004) 93 *American Journal of International Law* 485 & 515. See also, C Curtis *The role of judges in the protection of economic, social and cultural rights* Human Rights Office, Development, Economic and Social Issues Branch Research and Right to Development Division Office of the United Nations High Commissioner for Human Rights, South African Chief Justices Forum Annual Meeting (Kasane, Botswana 7 - 8 August 2009) 5.

evaluating their protection through legislative and judicial mechanisms.⁸⁰ From this point of view, contributors such as Yeshanew, and Human Rights NGOs in Ethiopia like Action Professional Association for the People (APAP) argue that article 41 of the Constitution⁸¹ formulates loosely economic, social and cultural rights. They acknowledge the Constitution's inadequacy in specifically listing and clearly defining the content of these rights.⁸² Yeshanew further argues that the poor construction of the rights provided in article 41 increases the ambivalence regarding the justiciability of this group of rights as it is difficult to clearly delineate the precise scope of the rights. It is also held that the human rights provisions of the Constitution are rarely invoked and applied by Ethiopian courts, which is another predicament for protecting socio-economic rights.⁸³

Abebe has also noted that, in a similar manner to a state's policy principles and objectives provided in a constitution,⁸⁴ the socio-economic rights provisions of the Ethiopian Constitution simply create the government's responsibility to progressively realize the rights, rather than asserting individual or collective rights.⁸⁵

⁸⁰ See, for instance, AB Gebreamanuel 'The recognition and implementation of children's socio-economic rights in Ethiopian law' *unpublished LLM mini-dissertation, University of North West*, 2014 21-58.

⁸¹ Constitution of the Federal Democratic Republic of Ethiopia, proclaimed in *Negarit Gazette*, 1st year, No. 1, (1995).

⁸² See S Yeshanew 'The justiciability of human rights in the federal democratic republic of Ethiopia' (2008) 8 *African Journal of Human Rights Law* 276.

⁸³ (As above) 293. See also, TS Bulto 'Judicial referral of constitutional disputes in Ethiopia: From practice to theory' (2011) 19 *African Journal of International and Comparative Law* 100.

⁸⁴ The Directive Principles of State Policy (DPSP) are stated in many countries' constitutions, like Bangladesh, Ethiopia, Ghana, India, Ireland, Nigeria and Spain. The DPSP lay down that the state shall strive to promote the welfare of people by securing and protecting as effectively as it may a social order, in which justice - social, economic and political - shall form in all institutions of national life. It proclaims the manner in which the state aims to secure the right of all men and women to an adequate means of livelihood, securing the right to work, education, health and to public assistance in the event of unemployment, old age, sickness and disability, equal pay for equal work, within limits of its economic capacity and development. For details, see 'The directive principles of state policies: Important details CLAT 2013' available at: <http://www.gyancentral.com/forum/law-preparation/legal-aptitude-preparation/7264-directive-principles-state-policies-important-details-clat-2013-a.html> (accessed May 28 2013). See, also, 'What are directive principles of state policy?' available at: <http://www.preservearticles.com/201012251613/directive-principles-of-state-policy.html> (accessed May 28 2013).

⁸⁵ A Abebe 'Human rights under the Ethiopian Constitution: A descriptive overview' (2011) 5 *Mizan Law Review* 55-56.

Given the inadequate design of the Constitution as it stands now, the above scholars seem to be of the opinion that the constitutional protection of socio-economic rights, such as the right to health, could potentially face challenges of enforceability. The protection of these rights will not be materialized unless judges interpret, proactively, and give proper meaning to such rights in accordance with the applicable laws and policies adopted to protect health and other socio-economic rights.⁸⁶

Quite simply, their approach to socio-economic rights is limited to only analysis of the existing Constitutional provisions. This reflects only an examination of a single aspect of human rights indicators⁸⁷ (i.e., part of structural indicators) for monitoring implementation of human rights that I discuss in depth in the subsequent chapters of the thesis.⁸⁸ However, an exception to this approach is an engagement by Tadesse. He emphasizes the need to establish a platform for implementing a HRBA in relation to HIV in Ethiopia. Interestingly, he analyses the HIV prevention, care, support and treatment-related laws, policies and strategic plans of Ethiopia through a rights-based perspective, based on which he identifies the challenges that exist in the law, policy and practice, inclusive of problems of accountability.⁸⁹

Briefly, Yeshanew and others above argue as to the inadequate formulation of socio-economic rights under the Constitution, and the limited role that the Ethiopian courts play in giving effect

⁸⁶ Action Professional Association for the People (APAP) 'Problem and prospects in enforcing economic, social and cultural rights in Ethiopian courts' (Awareness, Vol. 5, Issue 1, June 2001) available at: [http://www.apapeth.org/Articles/Problems EnforcingESC Rights.html](http://www.apapeth.org/Articles/Problems%20Enforcing%20ESC%20Rights.html) (accessed 22 March 2013).

⁸⁷ For the most part, indicators are essentially statistical in nature and need technical expertise for objectivity, quantifiability and accuracy. See HJ Steiner & P Alston *International Human Rights in Context: Law, Politics, Morals* (2000) 317. In the context of human rights monitoring, indicators are a way of measuring the state's implementation of its obligations required by a specific human right (like the right to health), using data from questionnaires, surveys or censuses. Such indicators can be managed directly by the state or by regional or local governments, or by an external body, e.g. international or local NGOs or UN organization. See *Monitoring implementation of the right to water: A framework for developing indicators* Global Issue Papers No. 14 (2005) 9. Also, it is argued indicators are seen as useful tools in making the normative content of human rights more concrete, in articulating and advancing claims on the duty-bearers and in providing the benchmarks to identify, guide and monitor appropriate policy responses to bridge the gaps in the realization of human rights. See Office of the United Nations High Commissioner for Human Rights (UNOHCHR) *et al Report Asian Sub-Regional workshop: Using indicators to promote and monitor the implementation of human rights* (26-28 July 2007) 3.

⁸⁸ See section 3.5.1.

⁸⁹ MA Tadesse 'A rights based approach to HIV prevention, care, support and treatment: A review of its implementation in Ethiopia' *unpublished Doctoral dissertation, University of Alabama, Tuscaloosa, 2012.*

to constitutionally protected human rights.⁹⁰ My view is not different from theirs in that regard. I share the view that the courts in Ethiopia do not play a similar role as, for instance, the South African⁹¹ and Columbian⁹² constitutional courts, in interpreting socio-economic provisions of the Constitution. Nevertheless, my thesis takes a comprehensive path to addressing protection of the right to health care of the child. Although they continue to have an important role to play, I do not limit myself to exploring the meaning, content, judicial action, and justiciability of human rights for the protection of child health care rights in Ethiopia. Crucially, I argue the potential of a HRBA to advancing children's survival or health care rights in Ethiopia. To do so, it imposes on me a duty of identifying and using appropriate human rights indicators for measuring government's compliance for implementing these rights.

My engagement with the existing literature above shows there is a substantial amount of research done in the area of socio-economic rights in the context of their justiciability, litigation and the approach that courts should follow in adjudicating them. However, none of the literature discussed in the foregoing deal specifically with a HRBA to child mortality and little attention has been directed to the protection of child survival rights and the obligation of the

⁹⁰ See Yeshanew (n 82 above) 276.

⁹¹ The South African Constitutional Court has decided landmark cases in the area of health rights and other socio-economic rights. In the sphere of children's health care rights, the case of *Treatment Action Campaign and others (TAC) v Minister of Health and others* is a paradigmatic example. For an in-depth discussion of this case, see section 2.3.2 of this thesis; Nolan (n 4 above) 153.

⁹² The Constitutional Court of Columbia, since its establishment in 1991, has made very dramatic decisions in the area of socio-economic rights. Among the many, Decision T -760 of 2008 is of particular relevance for this study. The review of *tutela* actions is among the function of the Columbian Constitutional Court. *Tutela* is a special constitutional writ of protection of human rights introduced by the Constitution. By virtue of the *tutela* any citizen may directly request any judge in the country to protect one's fundamental right when they are being violated by a state agent or individual. The Constitutional Court reviews some of the *tutela* action decided by the lower courts. In decision T – 760, the Court addressed a legal issue whether regulatory failures detected in 22 *tutela* actions resolved by the lower courts represented a violation of the competent authorities' constitutional obligations to respect, protect and fulfill the right to health. The court, finally, ordered remedies for the 22 individual cases by compelling authorities including the health supervision and regulatory agencies, to change regulation that cause structural problems in the health care system, to expedite allocation of resources in the health system and the update, clarification and unification of health coverage plans. In one of its earlier decisions (SU 225/98), the Court has adopted some sweeping decisions with regard to public health measures, such as vaccination campaigns for poor children. For details of the case, see Judgment T – 760/08 rendered 31 July 2008, available at: http://www.escri-net.org/sites/default/files/english_summery_T-760.pdf (accessed 11 June 2013). See, also, AE Yamin 'The role of courts in defining health policy: The case of the Colombian Constitutional Court' available at: http://www.law.harvard.edu/programs/hrp/documents/Yamin_Parra_Working_paper.pdf (accessed 23 May 2013).

Ethiopian government under global, regional and national standards. There is a dearth of comprehensive research, which examines the implementation of measures against infant and child mortality in Ethiopia from a rights perspective. In this thesis, therefore, I aim to fill this *lacuna*.

1.5 Purpose

Equally as important as establishing normative standards for human rights through human rights instruments is monitoring the performance of governments and evaluating their compliance for the promotion and protection of the enumerated rights. Borrowing vocabulary from Hunt for drawing analogies, the purpose of a HRBA for child survival and health is to find out what works, so it can be repeated, and what does not, so it can be revised.⁹³ It is not motivated by blaming, confrontation and *naming* and *shaming* of the government.

In the above light, the ultimate aim of this thesis is to contribute to the improvement of child health care rights conditions that will potentially lead to a better implementation of children's survival rights in Ethiopia. To do so, I examine the responsibilities allocated to the government for child survival rights as enshrined in the numerous legally binding global and regional instruments and national laws. Further, I also investigate the practical implementation of child survival rights and the challenges in Ethiopia. In this exercise, my aim is to indicate possible ways forward to address, post-2015, of the problems identified in the course of my research. This problem identification, in turn, assists government and non-governmental actors to re/examine the gaps in existing policies, programs and their implementation, thereby giving them the opportunity to improve the inadequacies identified. It has also the potential to inform the right holders to identify legal, policy and regulatory barriers and make a claim for their entitlement to health care services.

1.6 Research questions

⁹³ P Hunt & G Backman 'Health systems and the right to the highest attainable standard of health' in M Grodin *et al* (eds) *Health and Human Rights in a Changing World* (2013) 72.

Many writers argue that the twenty first century is the age of socio-economic rights.⁹⁴ Child health care rights, as one subsidiary of this broad category of rights, have attracted the attention of many scholars, human rights treaty bodies, non-government organizations (NGOs) and others, with the purpose to protect the health care rights of children in every country, particularly in developing countries. Child health care rights are fundamental human rights and are indispensable for the exercise of other human rights. Their realization may be pursued by numerous complementary approaches, including but not limited to, the adoption of specific legal instruments, the formulation of health policies or the adoption of health programs.⁹⁵

The thesis focuses on a HRBA in the context of reducing infant and child mortality in Ethiopia. Analysis of the subject from a rights lens could trigger a number of legal questions demanding thorough investigation and answer. The main research question to be addressed is whether the Ethiopian government is discharging its responsibility for reducing infant and child mortality in accordance with global, regional and domestic norms and standards, and what the country must address in post-2015, where it is faring from complying with norms and standards of a HRBA to child mortality.

In order to respond to the main research question above, the following subsidiary questions are analyzed:

- i. What is a HRBA, in general, and as applied to child mortality, in particular, and the impact it offers for improving children's health?
- ii. What are the human rights norms and standards that protect children's survival or health and their other complimentary rights, and the nature and extent of the

⁹⁴ In the context of the African Charter on Human and Peoples' Rights (1981) these rights include equitable and satisfactory conditions of work (art. 15), right to health (art. 16), right to education (art. 17), protection of the family (art. 18), right to self-determination (art. 20), right to dispose of wealth and natural resources (art. 21), right to economic, social and cultural development (art. 22), right to peace (art. 23), and right to a satisfactory and favourable environment (art. 24). These are rights to the basic material things that people need to survive and live well; See Brand 'Courts, socio-economic rights and transformative politics' (n 74 above) 1. See, further, F Viljoen *International Human Rights Law in Africa* (2007) 8.

⁹⁵ Committee on Economic, Social, and Cultural Rights, *General Comment No. 14* (n 16 above) para 1.

obligations imposed on states and non-state actors under these human rights norms and standards?

- iii. What are the national legal and policy commitments, and institutional mechanisms that exist in Ethiopia relevant to reducing infant and child mortality, and the extent to which these mechanisms comply with the norms and standards of a HRBA to preventable child mortality?
- iv. In light of HRBA indicators, to what extent Ethiopia took measures to comply its obligation of reducing child mortality and the challenges that lie ahead to meaningfully overcome child mortality post-2015?
- v. What steps should be taken on the part of the government of Ethiopia and other stakeholders to further reduce preventable infant and child mortality post-2015?

1.7 Methodology

The methodology that I adopt to conduct the research mainly includes use of human rights indicators or principles and standards. To do so, I review books, journals, articles, and general comments of the relevant UN treaties bodies, as they are available in print copy or websites. I also conduct interviews and gather feedback from concerned offices. For avoidance of doubt, my aim of using interview is not to make an empirical study through utilization of sampling techniques to determine results on factors affecting child mortality in Ethiopia. Rather, interview is deployed to gather additional information from the concerned authorities with regards to laws, policies and practices affecting implementation of a HRBA to child mortality.⁹⁶

For monitoring human rights, the ICESCR provides the system of ‘progressive realization to the maximum of available resources’.⁹⁷ However, this standard is challenged for its inadequacy in concretely measuring performance of states’ obligation for implementing human rights.⁹⁸ The

⁹⁶ For the full list of interviewees, see Bibliography.

⁹⁷ See ICESCR, article 2(1).

⁹⁸ Steiner & Alston (n 87 above) 313.

current trend is monitoring a state's action or inaction through the use of certain human rights indicators.

Indicators are specific information on the state of an event, activity or an outcome, including but not limited to human rights norms and standards; that address and reflect human rights concerns and principles; and can be used to assess and monitor the promotion and protection of human rights.⁹⁹ They can be categorized as structural, process, and outcome indicators. Structural indicators refer to ratification and adoption of legal instruments and the existence of basic institutional mechanisms deemed necessary for facilitating the realization of human rights.¹⁰⁰ It attempts to draw attention, whether domestic law and the institutional mechanisms established to promote and protect a right concerned, resonates from norms and standards embodied in human rights law.¹⁰¹ It further focuses on the presence of policy frameworks, indicated strategies of the state, and the number of non-governmental organizations and other personnel formally involved in the protection of human rights, as relevant to the specific right in question.

Process indicators refer to the effort of the duty-holders (mainly states) in meeting or making progress in attaining the identified outcome.¹⁰² Outcome, on the other hand, deals with individual or collective attainments and reflects the state of realization of human rights in a given context.¹⁰³

Indicators do not apply in a cross cutting fashion in all countries for measuring implementation of human rights. This is because countries differ in terms of their level of development and realization of human rights and the indicators may have to be customized according to their

⁹⁹ International Human Rights Instruments *Report on indicators for promoting and monitoring the implementation of human rights* (2008) para 18-22, HRI/MC/2008/3.

¹⁰⁰ *Monitoring implementation of the right to water: A framework for developing* (n 87 above) 29.

¹⁰¹ International Human Rights Instruments *Report on indicators for promoting and monitoring the implementation of human rights* (n 99 above). 3.

¹⁰² *Ibid.*

¹⁰³ UNOHCHR *et al Report Asian Sub-Regional workshop: Using indicators to promote and monitor the implementation of human rights* (n 87 above) 29.

appropriateness in different countries.

In order to address the human right perspectives of infant and child death in the Ethiopian context, I use the following indicators as methodologies to measure the government's responsibility:

- Investigate global and or regional human rights treaties ratified by Ethiopia, relevant to the right to child mortality.
- Explore the status of domestication or coverage of the right to health provisions provided in the global and regional human rights treaties in the Ethiopian Constitution, or examine whether the national normative framework adequately guarantees children's right to health care or underlying determinants of health.
- Interrogate the existence and the role of national human rights institutions and non-governmental organizations involved for a meaningful promotion and protection of the right to health care.
- Examine whether courts are practically capable of disposing children's right to health care.
- Assess the adoption and content of national policies and strategies aimed at protecting child survival rights.
- Assess government expenditure on public health care versus actual needs.
- Planned rate of reduction of the mortality rate of children under-five in accordance with post-2015 goal versus infant mortality rate and children under-five age deaths. And examine;
- Availability, accessibility, acceptability and quality of health care goods and services.

My justification for using the indicators is, firstly, that I find them to be feasible and appropriate for measuring steps taken by the Ethiopian government in respect of child survival rights and identifying the gaps of implementation. Secondly, the human rights community recognizes indicators as a relevant mechanism in the current discourse of monitoring implementation of

socio-economic human rights, for instance in the area of the right to health. As I describe in section 1.1 above using indicators for human rights monitoring has become a cutting-edge area for potentially vindicating the right to health of the child. The indicators also implicitly acknowledge the conventional measurement for state's obligations to human rights: respect, protect, and fulfill human rights.

In order to measure some of the indicators stated above, it is imperative to use publicly available statistical information designed to promote and monitor the implementation of measures to address the infant and child mortality situation in Ethiopia. Accordingly, I avail quantitative information compiled and disseminated by the government, through its administrative records and statistical surveys, usually in collaboration with national statistical agencies and under the guidance of international and specialized organizations.

However, as data or reports supplied by states can sometimes be prepared as a camouflage rather than to reveal the real problems and inadequacies,¹⁰⁴ I further use feedback gathered from non-government sources, to a strike a balance with governmental sources. The intention here is to explore and exhaust the use of commonly available information, particularly from objective data sets, for tracking human rights implementation.

1.8 Scope and limitation

Following a new federal constitutional order in 1995, the Ethiopian Federal Constitution ordains a federal system, which divides competence between federal and state governments.¹⁰⁵ There are currently nine regional states and two administrative cities, where the nine federal units have their own constitutions and distinct legislative, executive and judicial organs. Throughout the thesis, unless explicitly mentioned otherwise, any reference to government pertains to the federal government, and the scope of monitoring applies to the

¹⁰⁴ See Chapman (n 36 above) 1160.

¹⁰⁵ Constitution of the Federal Democratic Republic of Ethiopia (n 81 above), articles 51 & 52.

national government as a whole. This is based on General Comment on the Committee on the CRC, which states that a 'state which ratified or acceded to the Convention remains responsible for ensuring the full implementation of the Convention throughout the territories under its jurisdiction'.¹⁰⁶

In this thesis, I do not make a detailed analysis on all the underlying causes of child health rights-related problems in Ethiopia. I focus only on child mortality as a human right concern and the obligations it entails in the Ethiopian context, and analyze laws, policies and practices in the light of human rights standards and norms. I do not deal with the various underlying determinants of proper child health care and adoption of basic health intervention. Outlining the scientific causes of child mortality and suggesting the needed medical treatment for curbing child mortality rates does not fall within the scope of the study. In my view, medical professionals and health workers are better placed to deal with these matters, and that is not covered in my discussion.

As far as the limitation is concerned, finding accurate and up-to-date statistical data and baseline reports from governmental and non-governmental sources concerning measures taken by the government in relation to children's health care are a challenge. It is not possible, for instance, to locate the actual child mortality rates from any source, apart from some estimation that are available. In this light, it is not possible to show the real picture of the problem on the ground. Further, the absence of court cases relating to the failure of the Ethiopian government's relevant offices to address child health care, despite the fact that there is a huge problem of access to the underlining determinant of child health, is a gap. Where courts and quasi-judicial bodies decide that governments are liable for preventable child death, it would potentially enhance the capacity of rights-holders to claim their rights using the example of decided cases, and the capacity of the government to fulfil its obligations as well.

¹⁰⁶ Committee on the CRC, *General Comment No. 5 (2003) General measures of implementation of the Convention on the Rights of the Child* (arts. 4, 42 and 44, para 6), para 41, CRC/GC/2003/5.

1.9 Overview of chapters

In order to deal with the research questions bulleted in section 1.6 above, this thesis is organized into six chapters – this introductory chapter and five others.

In chapter two, I present the currency attained by, the theoretical framework for and the definitional problems and the core principles of a HRBA. I also illustrate how this approach is important to child mortality and the meaning it conveys in the context of child survival. This is followed by a demonstration to show evidence of impact of applying the approach by locating good practices of some countries. Whilst acknowledging the various interpretations of what constitutes a HRBA, I conclude the chapter by emphasizing the need on the part of states and other stakeholders to pay particular attention to the core principles in a HRBA which are also incorporated in the UN Technical Guidance, in order to foster the efforts of further reducing or eliminating preventable under-five mortality and morbidity.

In chapter three, I describe the normative framework of children's survival rights and discuss critically the extent to and the manner in which child survival and its complimentary rights are recognized in the global and regional human rights treaties, declarations, goals and the relevant UN bodies' comments. I then draw attention to the nature and scope of state and non-state actors' obligations under the ICESCR and CRC in greater detail through review of literature and UN human right bodies' general comments. This chapter is also intended to provide a framework for subsequent chapters. After a comprehensive discussion of the nature and extent of obligations emanating from those instruments, I conclude by arguing that implementation of infant survival should be regarded as a minimum legal condition, and if this condition is implemented properly, it can significantly contribute to the protection of child survival rights and ultimately to the reduction of under-five mortality.

In chapter four, I investigate the various normative and institutional frameworks based on which the Ethiopian government is accountable to respect, protect, and fulfil the right to health and health care of children. Here, I examine global and regional covenants signed by Ethiopia,

provisions in the Constitution, national laws and policy agendas that the government is bound to implement regarding children's survival rights. I also identify the various institutional mechanisms currently in place for monitoring implementation of children's right to health or survival in Ethiopia. I conclude that the Constitution, laws and policies do not explicitly recognize child survival as a human right, and the government owns child mortality as a development concern and not a human rights issue. However, I argue that since international treaties ratified by the country are an integral part of the law of the land, per article 9(4) of the Federal Constitution, the relevant provisions of the CRC and ACRWC applying to child health and survival can be invoked to avoid ambiguity in the domestic law.

In chapter five, I strengthen the discussions I make in chapter four and present, in light of HRBAs, the opportunities and challenges of eliminating preventable child mortality post-2015. I mainly argue that there is an indication that the government is taking child mortality as a priority agenda, and developing collaboration with other governments and global agencies to improve child survival rates further. Despite the positive developments charted, I identify the potential challenges that lie ahead of addressing the unfinished agenda of child mortality in post-2015. These include the absence of detailed laws and practices capitalizing child survival and health as a human right entitlement, weak coordination, participation, and accountability mechanism to implement child health. This is compounded by challenges, including availability, accessibility, acceptability, and weak quality of child and maternal health care goods and services, affected, *inter alia*, by inadequate budgeting and a dearth of skilled health professionals. I conclude by arguing that overcoming these challenges could have the potential to protect against preventable child death.

In the last part, chapter six, I summarize the discussions and draw conclusions, and indicate the way forward through recommendations as to how better implement children's survival and health rights in Ethiopia.

Chapter 2

Human rights-based approaches and child survival: Background and concepts

2.1 Introduction

Towards the end of the twentieth century, many children in the developing world continued to be deprived of the most fundamental needs.¹ Infant and child mortality was considered to be unacceptably high despite the global decline in the child mortality rate in the preceding two to three decades.² Like many of our fellow human beings, children were exposed to situations of extreme deprivation owing partly to neglect, marginalization and discrimination.

On the other hand, the 1990s mark the United Nations (UN) conferences on human rights, which came to represent a system and a movement to address these and other human concerns.³ The conferences raised a fundamental question on how to use a human rights

¹ The concept of child rights was new to most at the start of the 1990s. The national legal and institutional protection mechanisms of children's basic rights were in their infant stages. During the same period, children were too often the victims of the ugliest and most shameful human activities and failures - hit heavily by the HIV/AIDS pandemic, suffering stigma and discrimination, malnourished, exploited, and owing to the weakness of public health systems they were affected by the resurgence of major child-killers, such as malaria and cholera. See generally on this, United Nations Children's Fund (UNICEF) *We the Children: Meeting the Promises of the World Summit for Children* (2001) 9-12. It is argued that due to misguided leadership and dereliction of duty the available wealth and resources have not been harnessed to deliver the world fit for children in the 1990s. For an elaborated discussion on this see, C Bellamy *UNICEF: The State of the World's Children 2002* (2002) 17.

² Levels and trends in the number of deaths of children under age five over the years is as follows: 12 million in 1900, 10.8 million in 1995, 9.5 million in 2000, 8.4 million in 2005, 7.6 million in 2010, and 6.3 million in 2013, worldwide. Since 1990 the global under-five mortality rate has dropped 49 percent—from 90 (89, 92) deaths per 1,000 live births in 1990 to 46 (44, 48) in 2013. Despite the declining rate over the years, many countries still have very high rates, particularly in sub-Saharan Africa. For further reports on this see, UNICEF *Levels & Trends in Child Mortality* (2014) 2; World Bank 'Reduce child mortality by 2015' available at: http://www.worldbank.org/mdgs/child_mortality.html (last accessed 20 June 2015).

³ These conferences conducted under the auspices of the UN system have been of critical importance in helping to clarify the linkages between health and human rights. Individually and collectively, they have been of critical importance in helping to elaborate provisions relevant to vulnerable groups, to women's human rights, and to broader concepts of health and human rights. They include, the World Summit for Children, held in 1990 in New York (USA), the 1993 World Conference on Human Rights (UN 1993b) held in Vienna (Austria), the 1994 International Conference on Population and Development held in Egypt (Cairo), and the 1995 Fourth World Conference on Women held in Beijing (China). For an elaborated discussion on these conferences, see S Gruskin & D Tarantola 'Health and human rights' rights' in R Detels *et al* (eds) *Oxford Textbook of Public Health* (2002).

framework to make life better for everyone.⁴ This thinking led to the emergence of human rights-based approaches (HRBAs) to development, health, gender equality, women, children, unmarried fathers, etc.⁵ Such approaches incorporate the understanding that human rights are a central framework of ‘reference in policymaking and political choices by ensuring that people have the political, institutional and material means to demand, exercise and monitor their human rights, and to participate actively in decision-making with respect to them’.⁶ Setting the realization of human rights as a backbone of social, economic, legal and political development, a HRBA has become the dominant development paradigm.⁷ Also, the UN member states, at the World Summit in September 2005, gave unparalleled political support and drive to the UN’s efforts to bring human rights to the front and center of all its work.⁸ Over the years, a HRBA is used increasingly and mainly in the developing world.⁹

More generally, what a HRBA to programming facilitates is that it enables a sharp focus on results, in line with the international human rights treaties and other internationally agreed goals, targets, norms and standards. The relevance of this approach further lies in assisting

⁴ The context in which the conferences aim to tackle include, population, environment, food, human rights, social development and women's rights. Each of the 1990s conferences resulted in a declaration outlining the commitments by the governments of the world to work cooperatively to promote sustainable development and to respect and protect human rights. In a bid to address children’s wellbeing heads of state and governments at the World Summit for Children to commit set some of the following goals: neonatal tetanus elimination by 1995, reduction of deaths due to diarrhea by 50%, reduction by one third in infant mortality and under-five mortality, dissemination of knowledge and supporting services to increase food production, universal access to education with an emphasis on primary education for girls and literacy training for women, access by all pregnant women to prenatal care, access by all pregnant women to referral facilities for high-risk pregnancies and obstetric emergencies, universal access to safe drinking water. As regards UN conferences in the 1990s and other, see generally, UN Department of Social and Economic Affairs ‘Major conferences and summits’ available at: <http://www.un.org/en/development/desa/what-we-do/conferences.html> (accessed 2 May 2015).

⁵ For instance, a HRBA is a conceptual framework that UNICEF employs, since 1998, for its commitments to the protection and promotion of children’s rights. UNICEF identifies guidelines on rights based programming, classified into the following six principles: ‘obligations’, ‘special characteristics of the CRC’, ‘the four general principles of the CRC’, ‘characteristics of the CRC that are especially important’, ‘implementation’ and ‘the relationship between the CRC and CEDAW’. See generally, UNICEF *A Human Rights Approach to UNICEF Programming for Children and Women: What It Is, and Some Changes It Will Bring* (CF/EXD/1998-04) (1998).

⁶ International Human Rights Network *Our rights, Our Future Human Rights Based Approaches in Ireland: Principles, Policies and Practice* (2005) 6.

⁷ J Mertus *The United Nations and Human Rights: A Guide for a New Era* (2009) 25.

⁸ L Arbour, forward to UNOHCHR *Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation* (2006) III.

⁹ CÓ Cuanacháin, preface to International Human Rights Network *Our rights, Our Future Human Rights Based Approaches in Ireland* (n 6 above) IV.

countries in translating such goals and standards into time-bound and achievable national results, and it promotes participatory and inclusive processes of development.¹⁰ By doing so, a HRBA ultimately contributes to improving the situation of people, focusing on their needs, problems and potential. In this sense, a HRBA ‘relates to the same issues as most development initiatives such as those related to food, water, shelter, health care, education, security, freedom to pursue life goals etc.’.¹¹ Tobin notes that ‘much of the literature on rights based-approaches today is concerned with the model that applies within the global development context’.¹² Thus, a HRBA conceptually enjoys a wide range of subjects, of which health care is one aspect. It is no wonder its application in the area of health or child survival rights is logical.

In the context of child survival, both at the global and regional levels, there is a growing understanding that reducing under-five mortality is not to be entirely dealt with as a technical issue of health and development, but is a matter of human rights.¹³ In its historic resolution A/HRC/22/32, the Human Rights Council also affirmed ‘the importance of applying a human-rights-based approach to reducing and eliminating preventable maternal and child mortality and morbidity’, and requested all states ‘to renew their political commitment in that respect at all levels’.¹⁴ In addition, in a recent study by the World Health Organization (WHO) submitted to the UN Human Rights Council in accordance with the latter’s resolution 22/32, express

¹⁰ Information Note 5 ‘Human rights-based approach to development programming’ available at: https://www.un.org/esa/coordination/pdf/information_note_5-human_rights-based_approach.pdf (accessed 15 April 2014).

¹¹ J Boesen & T Martin *Applying Rights Based Approaches: An Inspirational Guide for Civil Society* (2007) 10.

¹² J Tobin ‘Understanding a human rights based approach to matters involving children: Conceptual foundations and strategic considerations’ in A Invernizzi & J Williams (eds) *The Human Rights of Children: From Visions to Implementation* (2011) 63.

¹³ For details, visit: http://www.bayefsky.com/themes/human_concluding-observations.pdf: Brazil, ICCPR, A/51/40 vol. I (1996) 44; Mali, ICESCR, E/1995/22 (1994) 64; Morocco, ICESCR, E/2001/22 (2000) 82; Paraguay, ICESCR, E/1997/22 (1996) 22; Peru, ICESCR, E/1998/22 (1997) 33; Portugal, CRC, CRC/C/111 (2001) 48; Romania, ICCPR, A/49/40 vol. I (1994) 28; Senegal, ICESCR, E/2002/22 (2001) 61; Solomon Islands, ICESCR, E/2000/22 (1999) 40 (last accessed 16 May 2015).

¹⁴ UN General Assembly, *Human Rights Council: resolution / adopted by the General Assembly*, 17 April 2013, A/RES/22/32, available at: http://ap.ohchr.org/documents/alldocs.aspx?doc_id=21600 (accessed 1 April 2014).

mention is made of the need for the Council's support concerning the articulation and adoption of a human-rights-based approach to eliminating preventable under-five mortality.¹⁵

In this chapter, I discuss aspects of the conceptual background of a HRBA and the core principles embodied in it, including but not limited to accountability. I emphasize the ways in which the UN, some governments, and non-governmental organizations have incorporated human rights into public health efforts. The aim is to provide in this chapter a basic framework for understanding HRBA's, on the basis of which I, in later chapters, evaluate the laws, policies and actions of the Ethiopian government to determine whether they reflect and abide by the human rights commitments stated under supra-national and domestic laws and policies.

2.2 Human rights-based approaches (HRBAs)

The prominence and currency of a HRBA in the context of development is underscored in the introductory section above. Nevertheless, its conceptual foundations have largely escaped detailed attention. Conceptual clarity is necessary in order to highlight the distinctive opportunities and challenges brought by a HRBA. In this section I seek to examine the concept of a HRBA through identification of the principles upon which a coherent and persuasive account of the conceptual foundations of a HRBA to child mortality can be constructed in the subsequent sections. However, this does not mean that this section will be able to avoid any confusion over the concept of a HRBA. The conceptual discussion on the approach is done to understand how the principles embodied in a HRBA interlink to make possible intervention against current challenges to children's right to survive. Before I do so, I examine how the approach has emerged, and the possible debates that the approach faces despite its proliferation over the past few decades.

¹⁵ *Study by the World Health Organization on mortality among children under five years of age as a human rights concern*, available at: www.ohchr.org/EN/HRBodies/HRC/.../A-HRC-24-60_en.doc CachedShare (accessed 28 March 2014).

2.2.1 The emergence of a HRBA

Although the ‘rising tide’ of the unprecedented economic development and democratization in the 1990s lifted the proverbial more boats,¹⁶ the number of people living on less than 1 pound a day worldwide dropped only slightly during those years, and 3.6 million people died in civil wars and ethnic violence.¹⁷ A sharp increase in inequalities continued to exist between and within countries, echoing major consequences for peace and development prospects. Inequalities breed inequalities: for instance, policies in important areas such as health and education favor the wealthy and often neglect the poor.¹⁸

The occurrence of a vicious cycle of inequality as a result of development failure leaves the disadvantaged in no way to place much faith in the charitable benevolence of the wealthy, or to patiently await the rising tide that lifts *all* boats. The inequality or poverty incapacitates the disadvantaged to realize certain freedoms that are themselves fundamentally valuable for minimal human dignity. The problem led to thinking that empowerment is a key for the poor to benefit from development process. The intimate interlink of development with disadvantaged peoples’ lives was increasingly recognized, and it was underlined that exploring the relevance of human rights concepts and standards in development works is compelling - for the concepts and standards shed light on what the poor had to say about the requirements for a dignified and valuable life. Human rights concepts and standards then begin to usher in the discourse of development to contribute to the challenge of tackling the increased poverty and inequality.

In the main, a HRBA emerged during the latter part of the twentieth century. Numerous events and actors have made important contributions to the evolution of a HRBA and its related concepts and practices. The role of UN’s agencies, in particular, has been crucial. Initially recognized in the context of development, a HRBA is grounded in the concept that human

¹⁶ M Darrow & A Tomas ‘Power, capture, and conflict: A call for human rights accountability in development cooperation’ (2005) 27 *Human Rights Quarterly* 473.

¹⁷ *Ibid.*, 476.

¹⁸ *Ibid.*, 475.

rights and development are closely interrelated and mutually reinforcing.¹⁹ The UN's first attempt to highlight the link between human rights and development was made in the 1968 Teheran World Human Rights Conference. The conference underscored that the implementation of human rights is dependent upon sound and effective international and national social and economic development policies.²⁰ Later on, this understanding developed from the Declaration on the Right to Development (1986) and was further endorsed by the 1993 World Conference on Human Rights held in Vienna. It is also 'enshrined in the Millennium Declaration and has been taken up by major development actors such as the UN System, the OECD/DAC and the EU'.²¹

These discourses of development and human rights were the result of two major developments. According to Darrow and Tomas, the first factor was the increasing recognition within the development realm that the existing models of development, which had a narrow focus on economic development, had been inadequate in alleviating poverty.²² The other factor was the understanding that the principles of 'good governance, participation and accountability' cannot be fostered without addressing their human rights dimension.²³ Equally, as Koskeniemi underscores, the growing strategic awareness among human rights activists and lawyers of the need to expand their agenda beyond the narrow window of human rights doctrine and their proposal for 'mainstreaming' human rights into an aspect of the regular business of government, played an important role.²⁴ It was the combination of these major factors that contributed to the emergence of the concept of a rights-based approach to development.

¹⁹ M Ussar *The Human Rights-Based Approach: A More Effective Framework for International Development Policies in New EU Member States* (2010) 4.

²⁰ The Proclamation of Teheran, para 13 in final Act of the International Conference on Human Rights, UN doc. A/Conf. 3241/ (1968).

²¹ Ibid.

²² Darrow & Tomas (n 16 above) 471–538. See, also, J Theis & Raddabarnen (Society) *Promoting Rights Based Approaches: Experiences and Ideas from Asia and the Pacific* (2004).

²³ HJ Steiner *et al International Human Rights in Context: Law Politics and Morals* (2008) 1433-1434; J Tobin 'Understanding a human rights based approach to matters involving children: Conceptual foundations and strategic considerations' in A Invernizzi & J Williams (eds) *The Human Rights of Children: From Visions to Implementation* (2011) 62.

²⁴ M Koskeniemi 'Human Rights Mainstreaming as a Project of Power' unpublished paper (2006) 1.

The two discourses - human rights and development - continued to expand in the late 1990s and early twenty-first century. For instance, the UN, through its then Secretary-General Kofi Anan, issued a directive that human rights should be mainstreamed into the activities of all UN agencies - an approach that was endorsed and expanded by the UN High Commissioner for Human Rights, Mary Robinson. Soon after this directive, UNICEF and numerous other UN agencies adopted their guidelines on a HRBA to programming. Academic commentators have invoked a HRBA in a range of contexts, including the protection of migrant workers, the protection of religious and cultural property, education, food insecurity, health, public space, indigenous affairs and urban planning and early childhood, and many more.

The foregoing represents a brief overview of how a HRBA evolved. But what constitutes a HRBA?

2.2.2 A HRBA: In search of its meaning

Research has shown that there is no universally accepted definition of a HRBA, nor is there a uniform approach to it.²⁵ A variety of HRBAs are formulated by different multilateral institutions, bilateral donors and Civil Society Organizations (CSOs). From the various definitions suggested by different organizations, one international development organization defines its HRBA as an approach that ‘ensures that the rights of poor and excluded people are respected, promoted, protected and fulfilled’.²⁶ Another one describes it as a ‘deliberate and explicit focus on enabling people to achieve the minimum conditions for living with dignity, in other words, achieving their human rights’.²⁷ The former one seems to focus on the need for application of typologies of state obligation²⁸ for human rights with a view to realize the human

²⁵ ‘Information Card 1: History and definitions of the human rights-based approach’ available at: https://www.unfpa.org/webdav/site/global/shared/documents/publications/2010/hrba/ic_1_.pdf (accessed 10 April 2014).

²⁶ Ibid.

²⁷ Ibid.

²⁸ Typologies of states obligation for human rights include the duty to *respect, promote, protect* and *fulfill*. They are more fully discussed in the third chapter of this thesis.

rights of impoverished and marginalized people. The latter, in turn, aims to work on development processes that ensure access to basic material needs to persons such as health, education, food, water, work and others. Although they incorporate broader terms, both approaches, however, seem to convey the same objective, i.e., improving the lives of the most disadvantaged groups in a society.

Darrow and Tomas, on the other hand, note that a HRBA ‘has come to mean different things to different people, depending upon thematic focus, disciplinary bias, agency profile, and the external political, social, and cultural environment’.²⁹ The purpose of this section is not to propose a single comprehensive definition of a rights-based approach for all purposes. Rather, my aim here is to identify a minimum set of essential characteristics around which methodologies could be customized, more specifically as it can be employed in child mortality or children’s health, in the Ethiopian context.

In this section I draw attention to the statements made by the UN system for the purpose of shedding light on the meaning of a HRBA. Under considerable pressure from donors towards a more unified approach to harmonize their policies and practices insofar as a HRBA was concerned, the UN agency representatives at the Second Inter-agency Workshop on Implementing a RBA in the Context of UN Reform reached agreement for the first time on a statement of Common Understanding embodying key elements of a rights-based approach to development of the UN system.³⁰ These elements of a HRBA are:³¹

- i. All programs of development co-operation, policies and technical assistance should further the realization of human rights as laid down in the UDHR and other international human rights instruments.
- ii. Human rights standards contained in, and principles derived from, the UDHR and other international human rights instruments guide all development

²⁹ Darrow & Tomas (n 16 above) 483.

³⁰ ‘The human rights based approach to development cooperation: Towards a Common Understanding among UN Agencies’ available at: <http://hrbportal.org/the-human-rights-based-approach-to-development-cooperation-towards-a-common-understanding-among-un-agencies#sthash.joaeGoe0.dpuf> (accessed 18 May 2015).

³¹ Ibid.

cooperation and programming in all sectors and in all phases of the programming process.

- iii. Development cooperation contributes to the development of the capacities of “duty-bearers” to meet their obligations and/or of “rights-holders” to claim their rights.

The above three concepts are considered as fundamental components forming a HRBA in a general context. They are quite explicit on the centrality of international human rights standards to development, in terms not only of the objectives of UN development cooperation and programming, but also the process through which those objectives are to be achieved. I briefly discuss below the meaning of each of the three concepts embodied in the elements of a HRBA.

The first concept in a HRBA stresses that the aims of all activities are meant to contribute directly to the realization of one or several human rights. Realization of human rights should not be an incidental contribution of HRB-development programming. This entails that the relevant staff need to be familiar with the international human rights framework. Their familiarity with the international human rights framework should help them to ‘be able to conduct a human rights analysis that will enable the establishment of human rights objectives whose implementation can then be measured against human rights standards and norms’.³²

The second element of a HRBA underlines the need to focus ‘on basic human rights principles of equality and non-discrimination as the broad overall objective of the development effort, as well as on participation and inclusion, and accountability and the rule of law’.³³ Obviously, these principles are neither necessarily new to development, nor exclusively legal principles.³⁴ Nevertheless, except for empowerment which has no legal equivalent, these principles have a specific human rights and legal meaning.³⁵ They are discussed, comprehensively, in the next

³² A Frankovits *The Human Rights Based Approach and the United Nations System* (2006) 24.

³³ BI Hamm ‘A human rights approach to development’ (2001) 23 *Human Rights Quarterly* 2018.

³⁴ Ibid.

³⁵ W Vandenhole & P Gready ‘Failures and successes of human rights-based approaches to development: Towards a change perspective’ (2014) 32 *Nordic Journal of Human Rights* 294.

section. Focusing on rights rather than needs, a HRBA is intended to mainstream human rights into development programming. Such an approach aims ‘to achieve a conceptual shift from development, as an externally devised and charity-based aid provided to passive recipients, to looking at development as a process that empowers people through an inclusive and participatory approach’.³⁶

The third concept requires strengthening the capacities of rights-holders to claim their rights and of duty bearers to meet their obligations. It underscores the need to resort to a comprehensive claim-holder/duty-bearer analysis. In order to effectively claim their rights, right holders must be able to access information, resources, organize and participate, advocate for policy change and obtain redress.³⁷ International law places obligations on states to ensure the well-being of their people and the realization of human rights in their domestic jurisdiction. As such states, functioning through their various agencies, are the main duty bearers. However, donor states also have the responsibility to follow human rights in their development policy and owe the obligation to assist the receiving states when their demand so requires.³⁸ It, therefore, necessitates the cooperation of agents and institutions to better serve the human rights of rights holders.

While the statement of Common Understanding above represents an agreed framework for further consensus-building efforts within the UN system, it is in and of itself no panacea. It only constitutes broad principles to create an enabling framework for an application of a HRBA. It rather mandates UN agencies to adopt, in their work, the Common Understanding definition of a HRBA. Each agency is thus to utilize the Common Understanding definition in the way that fits most closely with its mandate and chosen areas of focus.³⁹ As highlighted in the preceding sections UNICEF, for instance, is mainly guided by the Convention on the Rights of the Child

³⁶ M Ussar *The human rights-based approach: A more effective framework for international development policies in new EU member states* (n 19 above) 6; Tana Copenhagen *A human rights based approach* Background Paper (18 June 2014, Copenhagen) 3-4.

³⁷ WHO ‘A human rights based approach to health’ available at: <http://www.who.int/gender-equity-rights/knowledge/hrba-to-health-en.pdf> (accessed 23 December 2014).

³⁸ Hamm (n 33 above) 2016.

³⁹ Information Card 1: History and definitions of the human rights-based approach (n 25 above).

(CRC) to base its work to promote children's rights. This means that human rights standards - in particular the CRC and on the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) - are a decisive reference for the work of UNICEF.⁴⁰ On the other hand, the World Health Organization (WHO) supports governments towards applying a HRBA in national health policies and strategies through a designated health and human rights team.⁴¹

Most importantly, one finds a more recent and explicit elaboration on the meaning of a HRBA in the context of under-five mortality under the UN Technical Guidance relating to such mortality. Similar to the UN Common Understanding on a HRBA discussed in the preceding sections, the UN Technical Guidance recognizes that a HRBA requires systematic attention to a range of human rights standards and principles.⁴² The range of human rights standards and principles captured in this Technical Guidance are discussed in section 2.2.4.

Despite the different principles that various UN agencies or organizations may utilize in adopting their HRBA to their development program or work on human rights, there are certain questions that need to be considered generally in formulating a specific HRBA. As rightly pointed by Mary Robinson, one must ask the following questions when dealing with a situation that calls for a HRBA:⁴³

In each situation we confront, a rights-based approach requires us to ask: *What* is the content of the right? *Who* are the human rights *claim-holders*? *Who* are the corresponding *duty-bearers*? Are claim-holders and duty-bearers *able to*

⁴⁰ These two instruments permeate the organization's activities including but not limited to in advocacy, and in its cooperation with governments. For a more focussed discussion on this, see M Santos-Pais *A Human Rights Conceptual Framework for UNICEF* (1999) 1-17.

⁴¹ WHO works to advance health as a human right in close collaboration with UNOHCHR and the UN's Independent Special Rapporteur on the right to health. Visit the following website for details 'WHO: A human rights-based approach to health' available at: <http://www.who.int/gender-equity-rights/knowledge/hrba/en/> (accessed 12 December 2014).

⁴² UN Human Rights Council *Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under-five years of age*, para 18. Available at: <http://www.ohchr.org/Documents/Issues/Children/TechnicalGuidance/TechnicalGuidancereport.pdf> (accessed 13 December 2014).

⁴³ International Human Rights Network *Our Rights, Our Future Human Rights Based Approaches in Ireland* (n 6 above) 1.

claim their rights and fulfill their responsibilities? If not, how can we help them to do so? This is the heart of a human rights based approach.

That preceding was an advice given by Mary Robinson, the former UN High Commissioner for Human Rights at the 2nd Interagency Workshop on Implementing a Rights-Based Approach in the Context of UN Reform, in May 2003. In order to address those questions relating to the adoption of a certain human rights based framework by a particular agency or organization, it is important that such agency or organization must focus on examining the normative content of a right in focus. Equally important, a review of authoritative interpretations of human rights treaty bodies must be conducted for an understanding of the normative content of rights and duties. Nevertheless, there are internationally agreed core minimum principles for HRBAs, which I discuss in what follows.

2.2.3 Minimum core principles of a HRBA

According to the second statement of the Common Understanding definition of a HRBA described above, human rights principles guide all programming in all phases of the programming process. These principles are necessary conditions to enable the actual enjoyment of rights through the development process. On this basis, such principles should: '(a) help define development objectives; (b) guide the formulation of policies, laws, strategies, and other appropriate measures in the administrative, budgetary, judicial, educational, political, social, and other fields; (c) direct the establishment of corresponding benchmarks and indicators; and (d) be incorporated within every stage in the development process'.⁴⁴ The selection of principles has usually been guided in practice by a considerable degree of discretion. In other words, in order to ensure its effectiveness, the practice of selecting principles of a HRBA varies according to certain factors, including but not limited to, the

⁴⁴ United Nations Development Program (UNDP) *Workshop on the implementation of a rights-based approach to development: Training manual*, UNDP 6–7, (2002) 149, available at: www.undp.org/governance/cd/documents/713.pdf (accessed 21 February 2015).

different actors seeking to employ HRBA, the particular sector being addressed, and the social and political context.⁴⁵

Although different organizations have tailored their 'own' approach of a HRBA within the general understanding of a HRBA, there are many commonalities within the different formulations of a HRBA. These formulations are united by a common purpose and core principles, despite their differences. These principles are internationally agreed legal principles which underpin a HRBA. But what are those core principles?

2.2.3.1 Express application of the international human rights framework

The concept of express application of the international human rights framework underscores the need to define the goals of all development in terms of the relevant international human rights commitments of the state. It considers these relevant international human rights commitments as legally enforceable entitlements on the national level. It necessarily draws 'on the legal codification of human rights norms and standards at every stage of national and local development processes from the policy and program identification, formulation and implementation, through to monitoring and evaluation'.⁴⁶ Not only this principle requires acknowledgment of the range of binding human rights obligations, but also the jurisprudence and other pronouncements elaborating upon treaty provisions over the past decades.⁴⁷

A HRBA requires that a binding legal obligation to be stated explicitly, for to do otherwise risks undermining awareness of the human rights standards. The word 'explicit' is important. The requirement of 'explicit recognition' is an instruction to stakeholders to avoid the use of

⁴⁵ For instance, The UN Human Rights Strengthening (HURIST) Programme uses the acronym PANEL representing *participation; accountability; non-discrimination; empowerment; linkage to normative standards*. Also, various types of definitions employed by range of actors can be available at: http://www.crin.org/docs/resources/publications/hrbap/Interaction_analysis_RBA_definitions.pdf (accessed 24 June 2014).

⁴⁶ See Vandenhoe & Gready (n 35 above) 293-294.

⁴⁷ For instance, concluding observations or reports of the international bodies established to supervise compliance with the treaties are useful sources for states to comply in their implementation of human rights in their national jurisdiction. Concerning international bodies established to supervise compliance with the treaties, visit: <http://www2.ohchr.org/english/bodies/treaty/index.htm> (accessed 12 May 2015).

euphemisms instead of the language of human rights law in adoption of development laws and policies.⁴⁸ For instance, the words, ‘needs’, ‘equity’, ‘good governance’ etc. to describe matters that are human rights or ‘citizens’ rights’ are used in a way that avoids reference to applicable human rights standards.⁴⁹ The employment of such euphemisms has been described as an ‘attempt to depoliticise development discourse’. They ‘dilute the universal legal clarity provided by explicit use of human rights terminology’.⁵⁰

In addition to the requirement that it be explicitly stated, the human rights language used must be legally accurate. Law and policy documents must accurately set out the *hierarchy of relevant norms and standards*. The example mentioned below quoted from European Union (EU) policy document on children illustrates the hierarchy of norms and standards relevant for promotion of children’s rights:⁵¹

Children’s rights are a part of universal human rights that the EU is committed to respect under international and European treaties, in particular the UN Convention on the Rights of the Child (CRC) and its two Optional Protocols. The CRC establishes four general principles that apply to all actions affecting children: non-discrimination (Article 2), the best interests of the child (Article 3), the right of the child to survival and development (Article 6) and respect for the views of the child (Article 12). The European Union also embraces the Millennium Declaration and the Millennium Development Goals.

Despite the good example of the *hierarchy of relevant norms and standards* as one may find in the manner addressed above, there exists confusion concerning the hierarchical relationship between human rights law and the Millennium Development Goals (MDGs) or Sustainable Development Goals (SDGs) in dealing with policies. MDGs or SDGs were not envisioned to, nor should they be offered, as a substitute to states’ binding legal obligations in relation to health,

⁴⁸ International Human Rights Network *et al Human Rights-Based Approaches and European Union Development Aid Policies* (2008) 21.

⁴⁹ *Ibid.*

⁵⁰ *Ibid*; J Giffen, *The British Overseas NGOs for Development (BOND) Ensuring Civil Society Participation in EC Development Assistance Programmes* (2004).

⁵¹ Commission Communication *A Special Place for Children in the EU External Action*, COM (2008) 55 final, 3-4. The full pdf version of this policy document can be found at: http://ec.europa.eu/echo/files/policies/sectoral/children_2008_Special_Place_en.pdf (accessed 24 May 2015).

education, poverty, food, water, sanitation or others.⁵² A HRBA requires that the MDGs or SDGs be interpreted and applied so as to help vindicate human rights.⁵³ One finds a typical misunderstanding of this in the following example:⁵⁴

The purpose of the EU's action is to work in partnership with the nations of Africa to promote peace and prosperity for all their citizens. In this EU Strategy for Africa, the principal objective is, therefore, to *promote the achievement of the UN Millennium Development Goals (MDGs) in Africa*. This objective is strengthened and complemented by the specific objectives pursued within the Cotonou Agreement ... [and] the TDCA,... (Emphasis mine).

The above common objective of the EU *Strategy for Africa* fails to draw attention to adopting a HRBA to development as the basis for achieving the MDGs. It fails to capture human rights as the overarching meaning and goal of development. Policy documents should not envisage MDGs or SDGs as an alternative to the human rights legal framework. Instead, development policies must be subjected to the pre-existing binding legal obligations.

On top of the above, accurate use of human rights requires recognition of the indivisibility, interdependence and interrelatedness of rights: civil, cultural, economic, political and social.⁵⁵ There is a need to attach the same importance to economic, social and cultural rights as to civil and political rights. The use of 'human rights' as a synonym for civil and political rights and a general failure to acknowledge the legally binding status of socio-economic rights is against the principle of accurate and explicit application of human rights language to issues of development.

⁵² International Human Rights Network *et al Human Rights-Based Approaches and European Union Development Aid Policies* (n 48 above) 22.

⁵³ International Human Rights Network 'Human rights based approaches to development: An overview' available at: http://tdh-cp-org.terredeshommes.hu/rcpp_content/country_pages/eu/hrba_overview_ihrn.pdf (accessed 1 June 2015). This document is adapted from *Our Rights Our Future*, A report authored by IHRN commissioned by Amnesty International (Ireland) in 2005 to advance understanding of HRBA in Ireland.

⁵⁴ Commission Communication, *EU Strategy for Africa: Towards a Euro-African pact to accelerate Africa's development*, COM (2005) 489 final, 3. Again, the full pdf version of this policy document can be found at: <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52005DC0489&from=EN> (accessed 24 May 2015).

⁵⁵ 'UNICEF Toolkit on diversion and alternatives to detention 2009, Part A: 'UNICEF position on a human rights-based approach to programming in relation to children' available at: www.unicef.org/tdad/unicefcrba.doc (accessed 20 April 2014).

Furthermore, the express application of the human rights framework goes beyond the recognition of the interrelated and interdependent nature of human rights in laws and policies alone. It is also intended to ensure that all sectors of national planning, including but not limited to education, health, housing, political participation and justice administration, reflect the human rights framework. Courts, through their decisions, and health professionals and others working on health issues at grass roots level have emphasized the need for such an integrated analysis of human rights by recognizing their interrelationship and interdependence.⁵⁶ Courts in a wide range of countries and legal systems, such as India⁵⁷, Ireland⁵⁸, and South Africa⁵⁹ have been giving meaning to obligations associated with economic, social and cultural rights, apart from their assertion of civil and political rights. In addition, a commitment to the express application of the human rights framework involves building the capacity of public representatives, civil servants and local officials.⁶⁰ It helps them to apply the human rights framework in their work, *inter alia*, through recruitment, training and specialized advice.

2.2.3.2 Empowerment

When the idea of development through a HRBA was conceived after the cold war, a shift of focus was made from the fact that poor people have needs to the fact that poor people have

⁵⁶ International Human Rights Network *Our rights, Our future Human rights based Approaches in Ireland* (n 6 above) 29.

⁵⁷ See, for instance, *Mullin Franciscoralie v The Administrator, Union Territory of Delhi*, (1981) 2 SCR516 at 529, cited in S Liebenberg 'The Protection of Economic, Social and Cultural Right in Domestic Legal System' in A Eide *et al* (eds) *Economic Social and Cultural Rights: A text book*, 2nd ed (2001) 73.

⁵⁸ See, for instance, *Airey v Ireland* (1979) 32 Eur Ct HR Ser A (1979): (1979) 2 E.H.R.R. 305.

⁵⁹ See, for instance, *Governing Body of the Juma Masjid Primary School v Essay NO* (*Centre for Child Law as Amicus Curiae*) 2011 (8) BCLR 761 (CC); *Khosa v Ministry of Social Development*; and *Mahaule v Ministry of Social Development* 2004 (1) SA 505 (CC), cited in A Skelton 'South Africa' in T Liefgaard & JE Doek (eds) *Litigating Children's Rights: The UN Convention on the Rights of the Child in Domestic and International Jurisprudence* (2014) 18–19. Also, for further and comprehensive engagement on various socio-economic or livelihood rights cases decided before the Constitutional Court of South Africa, see D Brand 'The South African Constitutional Court and livelihood rights' in O Vilhena *et al* (eds) *Transformative constitutionalism: Comparing the apex courts of Brazil, India and South Africa* (2013) 414-441.

⁶⁰ International Human Rights Network *Our rights, Our future Human rights based Approaches in Ireland* (n 6 above) 8.

human rights. The idea stems from the fact that the human being's inherent dignity entitles them to a core set of human rights that cannot be given or taken away. Such entitlement enables them to challenge vested interests and power structures using human rights *language*.

A HRBA to development serves to empower communities and individuals.⁶¹ Community empowerment, according to Wallerstein, is 'a social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life'.⁶² The World Bank, on the other hand, defines empowerment as 'the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes'.⁶³ This definition is criticized for failing to address essential issues of power, such as control over resources, or the ability to make decisions on the direction of one's life.⁶⁴

Empowerment presents to individuals and communities the opportunity to know, claim and defend their rights and to discharge their correlative responsibilities. This requires 'identifying those responsible legally or morally for respecting, protecting and fulfilling their human rights, and holding them *accountable* for such responsibilities'.⁶⁵ It further emphasizes the human person or beneficiaries as the centre of the development process either directly or through their advocates and organizations of civil society.⁶⁶

The ultimate goal of empowerment is to give people the power, capacities, capabilities and access needed to change their own lives, improve their own communities and influence their own destinies.

⁶¹ 'International Human Rights Network: Core principles' available at: http://www.ihrnetwork.org/what-are-hr-based-approaches_189.htm (accessed 10 April 2014).

⁶² N Wallerstein 'Powerlessness, empowerment, and health: Implications for health promotion programs' (1992) 6 *American Journal of Health Promotion* 197-205.

⁶³ WHO *Empowerment in practice: Analysis and implementation* (2007) viii.

⁶⁴ M Mayo & G Craig 'Community participation and empowerment: The human face of structural adjustment or tools for democratic transformation?' in G Craig & M Mayo (eds) *Community Empowerment: A Reader in Participation and Development* (1995) 1-12.

⁶⁵ International Human Rights Network 'Background: Legal and policy commitment' available at: http://ihrnetwork.org/what-are-hr-based-approaches_189.htm (accessed 10 May 2014).

⁶⁶ UNICEF Toolki on diversion and alternatives to detention 2009 (n 55 above).

Empowerment is one of the critical issues in the discourse of the right to health. According to De Vos *et al* 'today's rights-based approaches to health have evolved from empowerment concepts that, in turn, were built on the concept of participation enshrined in the Alma-Ata Declaration'.⁶⁷ An instant question would be how empowerment proves its importance in relation to the right to health? As discussed above, empowerment is also about power. Empowerment recognizes *that power* exists within the context of a *relationship* between people or things. It can be illustrative if one considers power relations of marginalized groups and classes. When such group and classes organize themselves they can influence power relations and pressure the state into action. This kind of widespread influence, when conducted through organized communities and people's organizations, can 'play an essential role in ensuring the implementation of adequate government policies to address health inequities'.⁶⁸

The experience of Palestine suggests the central role that people's organizations play in any process of genuine empowerment and its impact on health works. Palestine's Union of Health Work Committees (UHWC), formed since the late 1970s, was one of people's organizations that emerged from the many popular committees. Through a process of empowerment UHWC is accounted for organizing and reaching basic health services for local populations.⁶⁹

2.2.3.3 Participation

Hunt, the United Nations Special Rapporteur on the right to health (2002-2008), has emphasized that participation in decision-making is an essential element of the right-to-health framework, and is of great importance in achieving long-term gains in core areas, and in

⁶⁷ P De Vos *et al* 'Health through people's empowerment: A right based approach to participation' (2009) 11 *Health and Human Rights* 26.

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*, 28-29.

particular in further lowering maternal and under-five mortality rates.⁷⁰ But what does participation imply?

The principle of participation implies that all people are entitled to participate in society to the maximum of their potential to enable them to develop and express their full potential and creativity.⁷¹ Put differently, a high degree of participation, including from communities, civil society, minorities, indigenous peoples, women and others is one of the cornerstone principles of a HRBA. In a participation process, everyone affected by a certain policy will have an opportunity to be involved in developing and evaluating the policies.⁷² For reasons of practical impossibility, this does not mean that every citizen will be involved in drafting the strategy. However, the requirement for such participation to be ‘active, free and meaningful’ is underscored by the UN Declaration on the Right to Development.⁷³ Participation does not, therefore, occur by a mere formal consultation with beneficiaries of a right.

According to Freedman, the key issues that need to be addressed in developing meaningful community participation include:⁷⁴

who are the different groups of stakeholders; how should representatives be chosen; who from a facility or local government should be involved; what issue do they address and with what level of decision-making power; and how does the group relate to other political structures and power dynamics in the community?

⁷⁰ Human Rights Council ‘Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover’ A/HRC/17/25/Add.3., para 81 (2011) available at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G11/121/97/PDF/G1112197.pdf?OpenElement> (accessed 13 May 2014).

⁷¹ ‘A human rights-based approach to development programming in UNDP – Adding the missing link’ available at: http://www.handicap-international.fr/bibliographiehandicap/3ApprocheDroit/Approches/HR_Pub_Missin_glink.pdf (accessed 20 April 2014).

⁷² Physicians for Human Rights *The Right to Health and Health Workforce Planning: A Guide For Government Officials, NGOs, Health Workers and Development Partners* (2008) 13.

⁷³ See, second Preamble; article 2(1) & (3); article 8(2) of the 1986 Declaration on the Right to Development, adopted by UN General Assembly Resolution 41/128 on 4 December 1986.

⁷⁴ LP Freedman ‘Human Rights, constructive accountability and maternal mortality in the Dominican Republic’ (2003) 82 *International Journal of Gynaecology and Obstetrics* 111-114; K Hawkins *et al Developing a Human Rights-Based Approach to Addressing Maternal Mortality* (2005) 12.

Particular attention is drawn in this core principle of participation to issues of social class, mainly the existence of conflicting interests among social groups. This necessitates the need to involve the poor and other marginalized groups (such as women, children and poor people) as decision makers in the policies that affect their communities.⁷⁵

The right to freedom of assembly and political participation is enshrined in the UDHR. Of particular importance in relation to the principle of participation is the Declaration of Alma Ata, signed by 134 states and 67 international organizations in 1978. The Declaration states that ‘the people have the right and duty to participate individually and collectively in the planning and implementation of their health care’.⁷⁶ Similarly, participation of the population in all health-related decision-making at the community, national and international levels is considered as an important aspect of the right to health by the Committee on the CESCR.⁷⁷ Active participation in health-related policy-making at community, national and international levels is, therefore, an integral part of the right to health as interpreted in formal human rights law.⁷⁸

In the context of under-five mortality, participation is conceived as granting parents of children or their representatives’ access to all relevant and necessary information to ensure an informed opinion, and including them in the decision-making processes which affect their children’s survival and health.⁷⁹ Participation, however, requires empowerment of parents or other representatives to claim their rights and those of their children. It further requires them to be able to participate in policy discussions and in processes that allow them to hold service providers to account.

⁷⁵ Pol De Vos *et al* (n 67 above) 26.

⁷⁶ World Health Organization, Declaration of Alma Ata, para IV. Geneva, 1978, available at: http://www.who.int/publications/almaata_declaration_en.pdf. (Accessed 17 March 2014).

⁷⁷ UN Committee on Economic, Social and Cultural Rights (ESCR), *General Comment No. 14* (2000), 11 May 2000, para 11, *The Right to the Highest Attainable Standard of Health*, Doc. E/C.12/2000/4.

⁷⁸ Freedman ‘Human rights, constructive accountability and maternal mortality in the Dominican Republic’ (n 74 above) 111-112.

⁷⁹ *Study by the World Health Organization on mortality among children under five years of age as a human rights concern* (n 15 above) para 64.

It is not only involving children's parents or their representatives through participation that has an impact on children's survival and health, but also the participation of broader communities and non-governmental organizations (NGOs). Researchers in this area have proved that such broader participation in health related activities such as developing women's skills in problem identification and prioritization, strengthening women's organizations, training community members in safe birthing techniques and mobilizing women's groups to recognize and treat malaria effectively at home can reduce under-five mortality.⁸⁰

From the foregoing it is noted that the role of participation and its impact on child survival and health cannot be seen lightly. As a result, it is difficult to maintain a rights based program if it does not demonstrated an explicit commitment to this principle, although it might not be an easy exercise to apply in practice.

2.2.3.4 Non-discrimination and vulnerable groups

The term discrimination implies 'any distinction, exclusion, restriction or preference that is based on any ground, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status and that has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing of all rights and freedoms'.⁸¹

Discrimination exists in all societies. Mostly, it is manifested in treating an individual or group of people less well because of who or what they are – for instance because one is a child or girl. It is practiced by governments against their subjects, one community against another or by one group of children against another, and could take forms such as restricted levels of child

⁸⁰ M Rosato *et al* 'Community participation: Lessons for maternal, newborn, and child health' (2008) 372: 9642 *Lancet* 962–971; D S Manandhar *et al* 'Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial' (2004) 364: 9438 *Lancet* 970-975.

⁸¹ Human Rights Committee, CCPR *General Comment No. 18, Non-discrimination*, 10 November 1989, para 13.

nutrition, care and attention.⁸² Research has shown that the source of discrimination includes the following factors:⁸³

- prejudice and fear of unfamiliar people, such as the fear that one ethnic group threatens society or jobs of another group or that a specific group may lose its cultural identity.
- superstition, religious or cultural taboos, such as the belief that a child with a disability is the result of a curse.
- lack of willingness and capacity to change and adapt to new circumstances, such as immigration; and
- unequal power structures in society (for example, boys are more valued than girls in patriarchal societies and poor children have fewer opportunities than rich children in all societies).

The experience of South Asia shows that most girls and boys grow up with an understanding that, as children, their status is inferior to that of adults.⁸⁴ The Committee on Rights of the Child also finds out that many 'other children face different forms of discrimination because they are girls, they have disabilities or they belong to an ethnic or religious minority or because of their social status'.⁸⁵

It is because of taking cognizance of discrimination as a major problem that international human rights law provides that all human beings are entitled to enjoy and exercise their human rights on the basis of equality and free from discrimination.⁸⁶ Prohibition of discrimination is a cross-cutting issue in all human rights treaties. Because of its ill-implication for child survival

⁸² J Theis *Promoting Rights-Based Approach: Experiences and Ideas from Asia and the Pacific* (2004) 65; UN Convention on Rights of the Child Committee, *General Comment No. 7* (2005), *Implementing Child Rights in Early Childhood*, 20 September 2006, para 11, CRC/C/GC/7/Rev.1.

⁸³ *Ibid.*, 66.

⁸⁴ *Ibid.*, 65-66.

⁸⁵ *Ibid.*

⁸⁶ See ICCPR, article 3; ICESCR, article 3; Convention on the Elimination of All Forms of Discrimination against Women, articles 1 & 2; CRC, article 2. Also, the following UN treaty body general comments incorporate elaborations concerning this right: Human Rights Committee, *CCPR General Comment No. 28* (2000); Committee on ESCR, *General Comment No. 16* (2005); and Committee on ESCR, *General Comment No. 20* (2009).

and health, states have an obligation to ensure equality and protect children against discrimination.

One of the significant factors that contribute to the vulnerability of children and bring adverse effects on children's health is discrimination.⁸⁷ Child survival inequities, studies show, are shaped by ethnicity and geographical location. It exemplifies the need for the collection and use of appropriately disaggregated routine health information to help to target areas or populations that are underserved or that have particularly poor health outcomes. This, in turn, makes it easier to identify vulnerable children, analyse the gaps in their protection, and measure where there are inadequacies in the context of participation and accountability.⁸⁸ It also promotes the identification of wide-ranging and workable solutions. To use an example for illustration, identifying the areas and population groups which experience a disproportionately high burden of pneumonia can help focus investments on improving access to effective interventions, through participatory processes and other factors. This will eventually help to bridge the equity gap and accelerate the rate of decrease in under-five mortality.⁸⁹

Analyzing the root causes of discrimination and the cycle of reproducing inequalities in society helps understand the human rights principle of non-discrimination better. Taking an example of the situation of Kenyan children living with HIV/AIDS, a study by Human Rights Watch identified a range of barriers and forms of discrimination which such children faced in accessing HIV testing and treatment. 'HIV-positive mothers who were victims of violence and property rights abuses were unable to access treatment for themselves or their children because they could not afford transport to health centers or enough food to avoid serious side effects from

⁸⁷ Committee on Rights of the Child, *General Comment No. 15* (2013), *the right of the child to the enjoyment of the highest attainable standard of health* (art. 24), 17 April 2013, para 8, CRC/C/GC/15.

⁸⁸ *Study by the World Health Organization on mortality among children under five years of age as a human rights concern* (n 15 above) para 60.

⁸⁹ M Chopra *et al* 'Ending of preventable deaths from pneumonia and diarrhoea: An achievable goal' (2013) 381: 9876 *Lancet* 1499-1506; *Study by the World Health Organization on mortality among children under five years of age as a human rights concern* (n 15 above) para 60.

the drugs'.⁹⁰ Because of stigma and discrimination Kenyan parents or care givers lacked accurate information about medical care for children, or avoided testing and treatment.⁹¹As a result, Kenya's HIV care programs have failed to deliver lifesaving drugs to the majority of children who needed them. This has had a significant negative impact on the programs that are aimed at reducing child mortality.

From the foregoing it is noted that discrimination is an enemy in a move towards the realization of child health rights. When developing laws, regulations, policies, programs and services for children's health, it is hence important for governments and non-state actors to collect and use appropriately disaggregated routine health information and design mechanisms to combat discriminatory practices with a view to ensuring equality in health services. Whenever access to child health care is limited by factors such as discrimination, governments assume accountability for breaching human rights obligation. In the next section I discuss what accountability means as one of the core principles in a HRBA.

2.2.3.5 Accountability

Accountability is central to a HRBA. Hunt notes that 'human rights can become no more than window-dressing without accountability'.⁹² When accountability operates in a system, duty-bearers are answerable for their acts or omissions in relation to their duties. As a procedure, 'accountability provides right-holders with an opportunity to understand how duty-bearers have discharged, or failed to discharge, their obligations, and it also provides duty-bearers with an opportunity to explain their conduct'.⁹³ Accountability does not necessarily imply

⁹⁰ Human Rights Watch *Discrimination, Inequality, and Poverty: A Human Rights Perspective* (2012) 13.

⁹¹ Ibid.

⁹² P Hunt, forward to H Potts *Accountability and the Right to the Highest Attainable Standard of Health* (2008) 2; P Hunt & S Leader 'Developing and applying the right to the highest standard of health' in J Harrington & M Stuttaford (eds) *Global Health and Human Rights: Legal and Philosophical Perspectives* (2010) 37; R Khosla & P Hunt 'Human Rights Responsibilities and Pharmaceutical Companies' in L Forman & J Kohler (eds) *Access to Medicines as a Human Right: Implications for Pharmaceutical Industry Responsibility* (2012) 37.

⁹³ International Human Rights *Our rights, Our future Human Rights based Approaches in Ireland* (n 6 above) 56.

punishment or blaming but it constitutes elements of responsiveness, monitoring, independent review, answerability and remedial action.

Different types of international and national accountability mechanisms can be envisaged within and outside the health systems that aim to hold all actors responsible, identify gaps and failures of institutions and programs, as well as provide remedy and redress for those (such as children) whose rights have been violated. According to the UN Office of High Commissioner for Human Rights (UNOHCHR), four broad categories of accountability mechanisms are identified : **Judicial**, e.g. judicial review of executive acts and omissions; **Quasi-judicial**, e.g. NHRIs, international human rights treaty-bodies; **Administrative**, e.g. the preparation, publication and scrutiny of human rights impact assessments; and **Political**, e.g. parliamentary processes.⁹⁴ Potts, on the other hand, identifies a fifth type of accountability mechanism, i.e., **Social** e.g., independent involvement or in cooperation with government of the civil society in budget monitoring, health centre monitoring, public hearings and social audits.⁹⁵

One can find the different types of accountability mechanisms mentioned above at the community, national, regional and international by *level*; and judicial, quasi-judicial, and non-judicial by *type*. The following table shows these mechanisms in detail:

	Judicial	Quasi-Judicial	Non-Judicial
Community	*Local courts *Traditional Courts	*Health Tribunals	*Maternal death reviews *Health facility complaint procedures

⁹⁴ UNOHCHR, *Principles and Guidelines for a Human Rights Approach to Poverty Reduction Strategies* (2006), para 77, UN Doc HR/PUB/06/12.

⁹⁵ Potts (n 92 above) 17.

				<ul style="list-style-type: none"> *Community-based monitoring *Participation *Media
National	<ul style="list-style-type: none"> *Constitutional Court *National Court *Civil and Criminal Tribunal 	<ul style="list-style-type: none"> *National Human Rights Institutions *Political and Legislative Processes 		<ul style="list-style-type: none"> *Human Rights Impact Assessments *Civil society organisations *Professional Associations *Media
Regional	<ul style="list-style-type: none"> *Regional Courts *Regional Parliamentary Resolutions 			<ul style="list-style-type: none"> * Civil society organisations *Professional Associations *Media
International		<ul style="list-style-type: none"> *Treaty Monitoring Body Committees *Optional Protocols 		<ul style="list-style-type: none"> *Universal Periodic Review *Civil society organisations *Special Procedures *Media

Table 1: Human rights accountability mechanisms categorized by systemic level and type.

The above accountability mechanisms have been making progress in health rights both at national and international⁹⁶ levels. In the following section I discuss how judicial and quasi-

⁹⁶ The Committee on CEDAW in 2011 rendered two innovative decisions regarding maternal mortality. These cases are paradigmatic examples of the practice of accountability at international level. *Alyne da Silva Pimentel v Brazil* is the first case. In its decision, the committee affirmed the obligation of states to guarantee all women the right of access to timely, non-discriminatory and appropriate maternal health services, without having regard to

judicial mechanisms made useful contributions, using examples of court cases and particular studies from some selected national jurisdictions.

A. Judicial – national courts

The direct or indirect entrenchment of the justiciable right to health in the national law/s of a given country presents a specific right to health accountability mechanism, which can provide access to the courts to enable rights-holders to challenge government legislation and policy through litigation. As a result, litigation is increasingly employed to seek accountability and redress for violation of constitutional and international human rights law dealing with the right to health.

Litigation of health rights, however, requires certain strategies to become effective. The use of public interest litigation has been one of the most used and successful ways of enforcing health rights at national level.⁹⁷ Definition wise, public interest litigation constitutes legal action brought to protect or enforce a legal principle or right that is of public importance and aimed

their income or racial background. The second case, *L.C. v Peru*, concerned a 13-year-old rape victim who was denied a therapeutic abortion and had an operation on her spine delayed that left her seriously disabled as a result. The Committee established that the state should 'guarantee access to abortion when a woman's physical or mental health is in danger, decriminalize abortion when pregnancy results from rape or sexual abuse, review its restrictive interpretation of therapeutic abortion and establish a mechanism to ensure that reproductive rights are understood and observed in all health care facilities'. Both cases are crucial in the sense that they affirm that accessible and good quality health services are vital to women's human rights. They also expand states' obligations in relation to these. They also affirm that 'states must ensure national accountability for sexual and reproductive health rights, and provide remedies and redress in the event of violations'. The decisions are also indicative of the importance of international human rights bodies as alternative paths for ensuring accountability for sexual and reproductive rights violations, especially where national accountability is absent or ineffective. Implementation of these decisions will have significance from the domestic perspective and the perspectives of the families affected. In addition, they also make a significant contribution in the global normative development in relation to maternal health obligation. For details on the first case, (CEDAW/C/49/D/17/2008), visit: <http://reproductiverights.org/sites/crr.civactions.net/files/documents/Alyne%20v.%20Brazil%20Decision.pdf> (accessed 13 July 2014), and the second case, (CEDAW/C/50/D/22/2009), at: [http://reproductiverights.org/sites/crr.civactions.net/files/documents/CEDAW-C-50-D-22-2009%20English%20\(clean%20copy\).pdf](http://reproductiverights.org/sites/crr.civactions.net/files/documents/CEDAW-C-50-D-22-2009%20English%20(clean%20copy).pdf) (accessed 13 July 2014).

⁹⁷ XA Ibanez 'The role of international and national courts: Human rights litigation as a strategy to hold states accountable for maternal deaths' in P Hunt & T Gray (eds) *Maternal Accountability, Human Rights, and Accountability* (2013) 47.

at social transformation.⁹⁸ Although how public interest litigation could be conducted varies amongst different legal systems, the aim of this kind of litigation is to change the circumstances of litigants and those that have a similar interest. This strategy of litigation, therefore, has greater potential than private litigation to address systematic violations of the right to health care and other human rights.

Recent experience from India shows the positive results gained in using public interest litigation to seek governmental accountability for the systematic failure to prevent maternal mortality. In the public interest lawsuit, *Sandesh Bansal v Union of India and Others*, the petitioner argued that the state of Madhya Pradesh has failed to implement the state's (Madhya Pradesh) policies in relation to maternal health.⁹⁹ The state in question exhibited a high maternal mortality ratio with 498 deaths for every 100,000 live births, which constitutes the third highest in India.¹⁰⁰ Mention was made in the petition of the poor conditions of primary health care centres in the state that frequently lack electricity, water and basic sanitation. The petition further mentioned the failure of the state's relevant body (Rogi Kalyan Samiti) to discharge its responsibility to ensure that funds are properly expended for services needed by pregnant women.¹⁰¹ The plea, accordingly, requested the court to order the following:¹⁰²

- that the state government establish health facilities and to ensure that they are fully functional by taking measures such as appointing relevant personnel, assuring the availability of proper equipment and drugs, providing emergency transportation, ensuring the quality of services and its monitoring mechanisms;
- that the state guarantee that no pregnant woman shall be denied free health services and set up monitoring mechanism to identify and review maternal mortality.

⁹⁸ Center for Reproductive Rights 'Litigating reproductive rights: using public interest litigation and international law to promote gender justice in India', 2006, 24, available at: http://reproductiverights.org/sites/crr.civicaction.net/files/documents/media_bo_India1215.pdf. (accessed 12 April 2014).

⁹⁹ *Sandesh Bansal v Union of India and Others*, W.P. (Civ.) No.9061 of 2008, (M.P. High Court) para 5.13.

¹⁰⁰ Ibanez (n 97 above) 48.

¹⁰¹ *Sandesh Bansal* (note 99 above) para 34. 6.

¹⁰² *Ibid.*

Having received the petition the court issued three interim orders. The first one was an order requiring a visit by government officials and members of the court's bench to ascertain the veracity of the petitions.¹⁰³ The second one was an order for the provision of blood banks to address emergencies and electricity for public health centres at which women need health care.¹⁰⁴ And the third one was an order requiring a government official to explain to court why running water and electricity continue to be absent at some primary health care facilities.¹⁰⁵

The Court, in its final decision in 2012, pronounced that the state of Madhya Pradesh had violated women's right to life by failing to provide proper prenatal care and maternal health care services in a timely and appropriate condition. Accordingly it, among other things, ordered the state to apply the national policies that are designed to protect maternal health. The state was further ordered to ameliorate the conditions in health facility centres by ensuring 24-hour delivery, make basic infrastructure improvements, secure 24-hour availability of emergency vehicles for all health centres and provide vaccination of pregnant women and their newborns.¹⁰⁶

Although the implementation of the High Court decision is yet to be seen through time, its implication is multifarious. It re-emphasized the importance of judicial accountability mechanisms to have a potential remedy when the executive organ fails to discharge its role for reducing maternal mortality. It further reaffirmed the close relationship between the fundamental right to health of women and the right to life. Also, it exemplifies the appropriateness of public interest litigation strategy in times where there exists a widespread failure of a health system in a certain state. Finally, but most importantly, it had the impact of reducing child mortality, as the court ordered the state to provide vaccination to new-born children in addition to their mothers.

B. Quasi - judicial – National human rights institutions

¹⁰³ Ibid., para 7(g).

¹⁰⁴ Ibid.

¹⁰⁵ *Sandesh Bansal v Union of India and Others*, High Court Order Sheet, 1.A. No. 10315/2008 (2009).

¹⁰⁶ Ibanez (n 97 above).

National human rights institutions (NHRIs) are state-funded public organizations that are established in line with the UN Paris Principles, which mostly require governments to establish the entities through a legislative mechanism.¹⁰⁷ It is through a country's constitution or acts of parliament that most of NHRIs are established and entrenched. The international community has been increasingly recognizing NHRIs 'as mechanisms that are integral to ensuring respect for, and effective implementation of international human rights standards at national level'.¹⁰⁸ The importance of NHRIs also lies in addressing thematic issues and particular categories of specific persons or groups such as children and women, and issues that cut across civil, political, economic, social and cultural rights.¹⁰⁹

NHRIs have different mandates and powers in accordance with the particular law through which they were constituted. To act as watch dog and making advices on human rights issues are their basic roles. Their specific roles, *inter alia*, include initiation of their own investigations to address systematic violation of human rights through public inquiries and giving recommendations to government.¹¹⁰ These form a basis for holding governments accountable to their obligations for human rights.

The role played by the Kenya National Commission on Human Rights (KNCHR) in holding the Kenyan government accountable to health rights (reproductive health), through public inquiry, is taken as an example to advocate the need for quasi-judicial accountability. The KNCHR had earlier successfully made two other inquiries, which were used to give recommendations in the form of advisories to the government and its institutions, civil society organizations, private entities and individuals.¹¹¹ Luckily, the Commission's recommendations have, to a large extent,

¹⁰⁷ *Principles Relating to the Status and Functioning of National Institutions*, UN Doc. E/CN.4/1992/54. Annex (1992).

¹⁰⁸ UNDP-UNOHCHR Toolkit 'National human rights institutions' (2010) 2. Also available in pdf. at: <http://www.ohchr.org/Documents/Countries/NHRI/1950-UNDP-UHCHR-Toolkit-LR.pdf> (accessed 10 April 2014).

¹⁰⁹ *Ibid.*, 7.

¹¹⁰ *Ibid.*

¹¹¹ Ibanez (n 97 above) 61.

been complied with, and to ensure its proper implementation the Commission makes continuous follow-ups.

The recent public inquiry conducted by the KNCHR involves reproductive health. The process was initiated following KNCHR's receipt from the Federation of Women Lawyers working in partnership with the CRR of a complainant on alleged violations of women's health rights at health facilities in Kenya. A preliminary investigation was conducted by them into Puwmani maternity hospital at which middle-class citizens, the poor and vulnerable people are served. The findings of the report noted the Kenyan government's responsibility for severe violations of reproductive rights on the following grounds: ¹¹²

- There was delay in access to medical services owing to different reasons, such as a lack of qualified health professionals.
- The health facilities were underfunded and there were shortages of the relevant equipment and supplies.
- The mechanisms of accountability for violations in access to health care facilities are lacking and victims of violations were not provided with redress or remedy by the government.
- Women fail to get medical assistance during birth. Nurses used very abusive words and in some instances physical abuse of women at times where medical assistance is offered. And;
- The fee charged for access to health services was a limitation to the poor which resulted in serious delays and denials of care which, in some cases, caused the death of women.

The above findings of the public inquiry were submitted to parliament for discussion and adoption for implementation. For accountability and educational purposes, copies of the report and the findings were made available to victims and other witnesses, to all stake holders and the public at large. By doing so, the KNCHR used the inquiry as a mechanism to hold the

¹¹² Ibid.

Kenyan government to account to the commitments made in international, global and national human rights law.

2.2.4 A HRBA to child mortality

As I introduced in the beginning of this chapter, reducing under-five mortality is not solely an issue of health and development, but also a human rights concern. Preventable death during infancy and childhood violates children's rights to life and survival, dignity, health and non-discrimination, all guaranteed in the global and regional human rights instruments. Also, child mortality represents one of the most telling instances of inequality between rich and poor countries and between rural and urban areas. A HRBA is thus acclaimed to be at the center of response to potentially address this challenge.¹¹³ In this section I seek to maintain a position regarding the meaning of a HRBA as applied to children's health or survival.

A HRBA conceptually applies to a wide range of subjects of which children's health care is one. Essentially, a HRBA to children's health aims to realize children's right to the highest attainable standard of health (or 'right to health') and other health-related complementary rights. I discussed in section 2.2.2 above that the range of HRBAs are defined in terms of the three elements of the UN Common Understanding of a HRBA and the core principles from which organizations or units can cascade the elements according to context. HRBAs share in common the essential principles that provide a baseline for human rights protection. Does a HRBA to children's health recognize these essential principles as well?

For the purpose of this thesis I adopt the various aspects that inform a HRBA to child health promulgated jointly by World Health Organization (WHO), and the Office of the High Commissioner for Human Rights (OHCHR) (the 'WHO-OHCHR'), and the recent Technical

¹¹³ For instance, in 2013, WHO submitted to the Human Rights Council, pursuant to Human Rights Council resolution 22/32, its study on 'Mortality among children under five years of age as a human rights concern'. See *Study by the World Health Organization on mortality among children under five years of age as a human rights concern* (n 15 above).

Guidance issued by the UN Human Rights Council. The WHO-OHCHR understanding of a HRBA resonates with definitions adopted by other UN agencies, national development agencies and NGOs.¹¹⁴ This WHO-OHCHR approach is based on seven key principles: availability, accessibility, acceptability and quality of facilities and services, participation, equality and non-discrimination, and accountability. The principle of explicit application of the international human rights framework does not seem to be included in WHO-OHCHR listing of the principles. This does not, however, entail that this principle is irrelevant to a HRBA to child health for the following two main reasons. Firstly, this core principle is promoted by these two agencies and numerous scholars working on a HRBA to health.¹¹⁵ Secondly, it could have been considered unnecessary or redundant to mention it, for a HRBA is generally understood as the adoption of an approach that is explicitly shaped by human rights and human rights principles or introducing human rights principles into development thinking and practice.¹¹⁶ Nevertheless, it can be noticed that most of the WHO-OHCHR adopted principles share or are united in common with the essential principles that provide a baseline for human rights protection.

The little 'dilemma' above about whether a HRBA includes principle of interdependence and interrelatedness of human rights within the context of children's right to health attains an explicit clarity later on with the adoption of the UN Technical Guidance on the application of a HRBA to children under-five years of age. This Technical Guidance incorporates the following norms and standards : (a) indivisibility, interdependence and interrelatedness of all human rights; (b) non-discrimination; (c) availability, accessibility, affordability, acceptability and quality of health facilities, goods and services; (d) participation; (e) the best interests of the child; and (e) accountability.

¹¹⁴ F Bustreo *et al* *Women's and Children's Right to Health: Evidence of Impact of Human Rights* (2013) 29.

¹¹⁵ For instance, WHO supported publication above (Bustreo *et al*), which I consider one useful reference for my discussion in this chapter, underscores the contribution of laws, policies and programmes explicitly or implicitly shaped human rights, on children and sexual, reproductive and maternal health gains in four countries namely, Nepal, Malawi, Brazil, and Italy. See, further, Bustreo *et al* (n 114 above) 28-29, 36-39, 44-47 & 54-48.

¹¹⁶ Vandenhole & Gready (n 35 above) 292.

Not only that the human rights principles mentioned under the UN Technical Guidance hereinabove capture the various HRBA norms and principles elaborated in the preceding section (2.2.3), but also, they are very specific to the situation of under-five mortality - vitally important to address avoidable under-five death. The elaboration given to the core principles of HRBA discussed in section 2.2.3 above apply equally to the norms and standards under the UN Technical Guidance. However, there are norms and standards that are incorporated additionally under the UN Technical Guidance under deserve a discussion here.

I describe below the principles of availability, accessibility, acceptability and quality (AAAQ) of facilities and services, which were not part of the discussion in the preceding section. The AAAQ are drawn from the Committee on ESCR reiterated in its General Comment No. 14 – a pertinent instrument often used to delimit the normative content of the right to health. Together with the other key principles, the AAAQ are critical to address children’s health needs and can contribute to improving children’s survival and development.

General Comment No. 14 provides an in depth articulation of the four interrelated and essential elements (AAAQ) which can equally be applied to children’s right to health as follows:¹¹⁷

- **Availability:** Structures, goods and services necessary for children’s health have to be made available. Availability signifies that health care facilities, goods and services essential for children’s health have to be available in sufficient quantity as necessary for the whole of the population within a state. This includes hospitals, clinics and other health related buildings, medical and professional personnel, drugs and other equipment. However, the availability of such goods and services cannot be put into specific quality and quantity across all jurisdictions. They rather depend on the level of development of a state and the demand for health care within that particular state.
- **Accessibility:** Accessibility relates to child health goods and services which are both physically and financially accessible. Structures, goods and services have to be accessible to all children without discrimination - addressing discriminatory laws, policies, practices and gender inequalities in health care and in society that prevent

¹¹⁷ Committee on ESCR, *General Comment No. 14 (2000), the Right to the Highest Attainable Standard of Health*, para 12, 11 May 2000, Doc. E/C.12/2000/4.

children from accessing good quality services. Accessibility has four dimensions: non-discrimination, physical accessibility, economic accessibility and information accessibility.

- **Acceptability:** Structures, goods and services are to be respectful of medical ethics and culturally appropriate.
- **Quality:** Structures, goods and services are to be scientifically and medically appropriate and of good quality.

The best interests is the second principle incorporated uniquely in the context of a HRBA to children's right to health or their other rights. One observes that the requirement of applying the best interest in matters affecting children is nothing recent given the widespread use of this principle in family law and its recognition under children's human rights law. Pursuant to the CRC 'best interests principle' requires that in 'all actions concerning children, whether undertaken by public or private social welfare institution, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration'.¹¹⁸ On the other hand, the ACRWC goes one step further by stating that the best interests principle shall be the primary consideration.¹¹⁹ However, what is very important for the purpose of this discussion is that the explicit recognition of the need to apply the best interests to determine child health outcomes. The UN Technical Guidance underlines the need for this principle to be assessed and 'taken as a primary consideration in all actions affecting children, including actions concerning their health, and should guide decisions on issues ranging from individual treatment options to policy and regulatory frameworks'.¹²⁰ More precisely, this principle enjoins states to place children's interests at the centre of all decisions affecting their health and survival, including decisions on the allocation of resources and on the development and implementation of policies and interventions that affect the underlying determinants of health.¹²¹

¹¹⁸ CRC, article 3(1).

¹¹⁹ ACRWC, article 4.

¹²⁰ UN Human Rights Council *Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under-five years of age* (n 42 above) para 31.

¹²¹ *Ibid.*

In addition to the core principles discussed in section 2.2.2, the AAAQ along with the best interests principle described above are useful indicators in a HRBA to child mortality to measure state response aimed at reducing infant and child mortality and ensuring the provision of necessary medical assistance and health care for all children. Taken as a whole, a HRBA to infant or under-five mortality, therefore, implies that, firstly, it requires states to enact appropriate laws and policies, explicitly shaped by human rights, and that enable unhindered access to high-quality health services to children. This, in turn, helps for the identification of relevant duty-bearers and rights-holders, and building the capacity of the former to fulfil their obligations, and of the latter to claim their rights relevant to child health and survival.¹²² Secondly, it requires the state and non-state actors to ensure non-discrimination in the realization of children's right to survival and development. Thirdly, it underscores that child health-related services and facilities have to be available, accessible, acceptable and of good quality. Fourthly, it implies that programming in all health-related sectors should be guided by human rights standards and principles, such as participation, best interests of the child, equality, non-discrimination and accountability, at all stages of the process. Fifthly, framing child mortality as a human rights violation underscores the importance of holding governments accountable for their failure to prevent child deaths.

2.3 Why a HRBA to child mortality?

As I proclaimed elsewhere in this chapter, many stake holders have increasingly turned to a HRBA including in the health sector programming. What potential grounds are available to establish a HRBA in the child health sector? In this section I examine the forces that attract an increasing focus to governments' human rights shaped child health interventions.

I chart the following interrelated factors that draw attention to the human right implications of child health. The first reason to consider an adoption for a HRBA is the concern over *state*

¹²² Ibid.

of *under-five mortality*, more specifically, an overview of its scale, direct causes and underlying determinants. Despite the substantial global progress that has been made in reducing child deaths since 1990, progress remains insufficient. For instance, in a 2014 report, Ethiopia's number of neonatal deaths (per 1000) is 42 times higher than that of Gambia. Under-five deaths are increasingly concentrated in sub-Saharan Africa and Southern Asia. Globally, nearly half of under-five deaths are attributable to malnutrition, which in turn is marked by poverty and inequality.¹²³ Children die before their fifth birthday, mostly from preventable causes and treatable diseases, even though the knowledge and technologies for lifesaving interventions are available.¹²⁴ The number of preventable deaths among children under five suggests a systematic failure to provide access to high-quality services needed by children, and may constitute a violation of children's right to life, health and other interrelated rights.¹²⁵ The state failure or inability to comply with the obligation to eliminate preventable child death calls stake holders, among other things, to *integrate* consideration of the human rights dimensions of preventable under-five mortality into their respective mandates.

The second ground, essentially related with the previous concern, that motivates advocating a HRBA to child health, is *discrimination* in access to children's health care services. Children's right to non-discrimination is important for the realization of children's right to survive. Nevertheless, significant inequities in under-five mortality between and within countries continue to exist. The greatest gaps persist in the poorest and most fragile contexts and countries, but a country's wealth alone does not necessarily guarantee a small health gap.¹²⁶ The 'pervasive disparities in the health and wellbeing of children are detrimental not only to the poorest and most vulnerable children and their families and communities, but also to the whole of society'.¹²⁷ These are not only driven by poverty,¹²⁷ but are intrinsically linked to social

¹²³ UNICEF *et al Levels and Trends in Child Mortality* (2014) 2.

¹²⁴ *Ibid.*

¹²⁵ *Study by the World Health Organization on mortality among children under five years of age as a human rights concern* (n 15 above) para 24.

¹²⁶ World Vision *The Killer Gap: A Global Index of Health Inequality for Children* (2013) 1-19; Child Survival 'Closing the killer gap in children's health inequality' available at: http://www.childsurvival.net/?content=com_articles&artid=2493 (accessed 26 May 2014).

¹²⁷ Child Survival 'Closing the Killer Gap in Children's Health Inequality' (n 126 above).

exclusion and *de jure* and *de facto* discrimination, and must be systematically addressed by states.¹²⁸

Weak *accountability* systems are the other potential ground to consider a HRBA to child mortality. To focus the on African context alone, there has been substantial progress in promoting human rights in women's and children's health.¹²⁹ Nevertheless, child health problems highlighted in the above two paragraphs represent an on-going human rights and accountability challenge on the continent. These deaths mentioned above have their roots in the under-prioritization of women's and children's health services and commodities, lack of accountability mechanisms to respond to preventable maternal and child deaths, and a denial of human rights that exacerbate inequity and violence against women and children. Accountability is central to a HRBA to health and can be a powerful tool for improving the health and well-being of women and children in the African region. Applying HRBA accountability could bring far reaching effects in the strengthening of health systems and transforming the rights discourse into practical health policy and programming.

A *legal and policy barrier* is another cause of concern. Legal and policy instruments provide the critical link between rights and duties and are important for ensuring children's wellbeing. Women's and children's human rights, including their rights to health, are protected under international human rights law, as well as various regional human rights instruments. Nevertheless, legal barriers, such as the non-recognition of the right to health in national laws exist in Africa and other parts of the world.¹³⁰ This points to a need to assess the legal and policy environment in order to integrate human rights into laws, policies and programs related to maternal, new-born and child health.

¹²⁸ Study by the World Health Organization on mortality among children under five years of age as a human rights concern (n 15 above) para 4.

¹²⁹ African Union (AU) 'Using human rights to enhance accountability for women's and children's health' available at: http://www.who.int/pmnch/media/events/2013/au_policy_brief_human_rights.pdf (accessed 6 May 2015).

¹³⁰ Ibid.

A different consideration for a support of a HRBA pertains to *participation*. The obligation to ensure that children have the opportunity to participate actively in planning and programming affecting their own health and development is at the heart of human rights law. In this way, participation will lead to much better health outcomes of children. Although there is some degree of paucity of research in this area, there is evidence of an association between children and women's participation and improved health and health-related outcomes.¹³¹ Decisions concerning children in the health care setting can have a significant impact on them.¹³² Closely looking at the meaning of article 12 of the CRC, such decisions are noticeable ones that 'affect them'.¹³³ It follows that the context in which article 12 could be realised includes listening to children and taking their views into account. In fact, children are also able to take decisions that affect their health as the below instance suggests:¹³⁴

Children with serious conditions, such as diabetes, learn to take responsibility very early. For example, three-year-old Maisie was able to warn her mother when she was feeling shaky from low blood sugar. Ruby at four years of age could be trusted not to eat chocolates when her friend did and no adults were present, and by the age of five she was able to test her own blood sugar and decide how much cake she could eat.

Nevertheless, research suggests children's involvement in decision making affecting their health care is generally limited.¹³⁵ They are largely excluded. Furthermore, a study found that such exclusion exists between parents and health care providers, and that children are generally not involved in discussions or decisions about their care.¹³⁶ Children are seen as 'objects' that had things done to them rather than being involved in their treatment or having

¹³¹ Bustreo *et al* (n 114 above) 68-80.

¹³² J Phillips & M Grahn-Farley 'International child rights at home and abroad: A symposium on the UN Convention on the Rights of the Child. IV. Children's rights to health care and participation: United States Implementation of the UN Convention on the Rights of the Child' (2002) 693 *Capital University Law Review* 700-01.

¹³³ *Ibid*.

¹³⁴ G Lansdown *Every Child's Right to Be Heard: A Resource Guide on the UN Committee on the Rights of the Child General Comment No.12* (2011) 92.

¹³⁵ U Kilkelly & M Donnelly *The Child's Right to be Heard in the Healthcare Setting: Perspectives of Children, Parents and Health Professionals* (2006) 10.

¹³⁶ *Ibid*; DB Angst & JA Deatrick 'Involvement in healthcare decisions: Parents and children with chronic illness' (1996) 2:2 *Journal of Family Nursing* 174-94.

a voice. This is an indication that implementing article 12 of the CRC in children's health care is a particular challenge.

A number of factors may explain why children's participation is minimal affecting their health. Children's supposed lack of capacity and the fact that their legal representatives, such as a parent, may be involved when the patient is a child, play a role.¹³⁷ Furthermore, it may be that many parents are not convinced children have the right to participate in such community issues as decision-making. All these can be seen to complicate the process of ensuring the child's participation is given attention in the health care setting. What is needed is to set up practical strategies for listening to children in health care and to actually empower children or their representatives to participate in decision making affecting them.

Coupled with other interrelated factors such as lack of information, and education of women and children, the gaps identified above contribute to meaningfully implementing children's right to survival during birth or the few years following their birth. I argue that a HRBA to child mortality has the potential to draw attention to barriers to successfully addressing this problem; highlight the range of actors responsible for reducing child mortality; provide a legal framework to strengthen public health efforts; facilitate identification of child populations at risk; and enable analysis of gaps in protection, participation and accountability.

2.3.1 Critics on integrating a HRBA

In the above sections I have discussed the key concepts embodied in a HRBA and the importance of adopting this framework to promote health development agenda. However, to what extent is it really feasible and desirable to integrate the HRBA in the health development? Could there be critics of attempting to employ a HRBA? In this section I discuss the possible challenges that are generally raised against adopting a HRBA and respond to these critics.

¹³⁷ KilKelly & Donnelly (n 135 above).

The first critique against adopting a HRBA is grounded on the idea of cultural imperialism. Some argue human rights are doctrines of the West and their discourse could not be effective elsewhere except in Europe. Due to its origin outside of the development context, application of the HRBA to development is criticised as ‘globalization of policy making’, with Western powers behind it.¹³⁸ This is a culturally grounded objection where, for instance, many in developing countries argue that some human rights are simply not relevant to their societies, such as the right to political pluralism. This is not the place for me to discuss in any detail the philosophy of universality of human rights as this has been extensively elaborated and needs no repeating.¹³⁹ My central response to these critics is that, although there are cultural differences and different approaches to human rights, the concepts of justice and law, the dignity of the individual, protection from oppressive or arbitrary rule, and participation in the affairs of the community are found in every society on the face of this earth.¹⁴⁰ In addition, ‘the principles of human rights have been widely adopted, imitated, and ratified by developing countries’.¹⁴¹ For instance the CRC is adopted by almost all countries of the world and some of the provisions of the CRC are the contribution from non-Western countries. An example is the provision of the CRC dealing with children’s right to survival and development, which was included in the CRC on the initiative of India, and consequently agreed to by other member states of the international community.¹⁴² In this light, the objection against the adoption of a HRBA on grounds of non-universality of human rights seems to me to lose force.

Some others argue that applying a HRBA in a development context is not a straight forward exercise. They maintain that the ‘HRBA is a relatively new approach to development and concrete tools and the conceptual clarity necessary for its practical application have only been

¹³⁸ D Kennedy *The Dark Sides of Virtue: Reassessing International Humanitarianism* (2004)111.

¹³⁹ For a general and critical discourse on universality of human rights see, for instance, R Arnold (ed) *Universality of Human Rights* (2013); J Donnell *Universal Human Rights in Theory and Practice* (2003).

¹⁴⁰ S Tharoor ‘The universality of human rights and their relevance to developing countries’ (1990) 59 *Nordic Journal of International Law* 139–152.

¹⁴¹ S Tharoor ‘are human rights universal?’ (1999/2000) Vol. XVI, No. 4 *World Policy Journal*. Available at: <http://tembusu.nus.edu.sg/docs/Shashi%20Tharoor.pdf> (accessed 20 May 2014).

¹⁴² S Detrick *A Commentary on the United Nations Convention on the Rights of the Child* (1999) 131; *Report of the Working group on a Draft Convention on the Rights of the Child*, UN Commission on Human Rights, 44th sess, Agenda item 13, UN Doc.E/CN. 4/1988/28 (1988).

developed over recent years'.¹⁴³ Accordingly, they question the application of this approach as a challenge to bring an impact on social changes. Nevertheless, this position in turn can be subjected to critique. Importantly, the past two years have seen burgeoning academic engagement to address the conceptual clarity necessary for the practical application of a HRBA. Rather than rejecting the approach, filling gaps in knowledge and skills, and dealing with difficulties in translating human rights norms into concrete programming guidance applicable in diverse policy contexts and national circumstances would reinforce the endeavor of adopting a HRBA. Empirical evidence also shows that numerous UN agencies and development partners have succeeded in practically adopting the approach in various development initiatives.¹⁴⁴ UN agencies and development partners have been introducing the approach in their policies and practices. Some stakeholders have addressed or are addressing the concern through organizational changes. For instance, UNICEF promotes the value of a HRBA through the hiring of staff with legal or similar backgrounds to build capacity in rights issues.¹⁴⁵

The third critique relates to the concept of progressive realization of human rights. It is argued that a more fundamental tension exists between the HRBA and the principle of progressive realization of human rights. That is to say 'human rights tradition finds itself in full-blown contradiction to the classical planning and programming tradition, and that the HRBA to development denies that any prioritization of rights is possible'.¹⁴⁶ Detractors who consider this tension further inquire whether, if there can be no hierarchy of rights, a human rights-based organization can choose its strategic priorities? My counter argument is that there cannot be a hierarchy of rights, primarily because there are no small rights and all rights are equally important – they are interdependent. Furthermore, any policy or program must aim to achieve all human rights and should not be prioritized as no human right is intrinsically inferior to any

¹⁴³ M Ussar *The Human Rights-based Approach: A More Effective Framework for International Development Policies in New EU Member states* (2011) 14.

¹⁴⁴ Some of the UN agencies that adopted a HRBA in their programming include, UNFP, UNICEF, and UNDP. Similarly, some of the development partners that employed a HRBA in their development cooperation include - the European Union (EU), the International Initiative on Maternal Mortality and Human Rights and German Federal Ministry for Economic Cooperation and Development.

¹⁴⁵ LT Munro 'The 'Human Rights-Based Approach to Programming': A Contradiction in Terms?' in S Hickey & D Mitlin (eds) *Rights-Based Approaches to Development: Exploring the Potential and Pitfalls* (2009) 198.

¹⁴⁶ Ibid.

other. On top of that, even if a state has to ultimately make a choice to preserve certain rights over others due to resource constraints, the cogency of this critique in the context of child survival is questionable. This is because, if a state is to prioritize rights for the purpose of resource allocation, the first right to be attended is the right to survival, followed closely by the right to security of the person.¹⁴⁷ The theory of human rights has a long pedigree of accepting this view going back from the days of Thomas Hobbes.¹⁴⁸ On another ground, although the principle of ‘progressive realization’ recognizes that some rights may have to be given priority over others, due to resource limitations, ‘yet states have a core obligation, derived from the rights to life, food and health, to ensure that all individuals within their jurisdictions are free from starvation’.¹⁴⁹ Given that the principle of progressive realization is not a trump over the state obligation to meet this core obligation, it follows that the present critique bears no impact over HRBA aimed to address child mortality. This is mainly because what takes the state to meaningfully address the problem of child mortality is to comply, primarily, with its minimum core obligation,¹⁵⁰ and that the principle of progressive realization requires state prioritizing to address the underlying causes of this challenge, such as malnutrition.

A further critique, perhaps a recently emerging engagement mainly adopted by countries of East Asia and staunchly flagged by the current Ethiopian ruling party, relate to developmental state theory. The ‘developmental state’ theory is an ideological shift toward a focus on the commitment of states to economic growth at the sacrifice of civil and political freedoms of the citizenry.¹⁵¹ Based on an experience emulated from the East, the Ethiopian Peoples’

¹⁴⁷ Munro ‘The ‘Human Rights-Based Approach to Programming’: A Contradiction in Terms?’ (n 145 above) 201.

¹⁴⁸ *Ibid.*

¹⁴⁹ UNOHCHR *Frequently Asked Questions on A Human Rights-Based Approach to Development Cooperation* (2006) 12.

¹⁵⁰ R J Cook ‘Human rights and infant survival: A case for priorities’ (1986) 18 *Columbia Human Rights Law Review* 41.

¹⁵¹ There is no clear meaning as to ‘developmental state’ and the term does not enjoy any consensus. However, developmental state is conceived as an institutional, political cum ideological arrangement that evolved from Japan’s post war economic recovery and that was later adopted by some East Asian countries. Following the global economic crisis in 2008/2009, there seems to be a growing interest in the developmental state particularly in the developing world. A belief has developed that ‘without a developmental state, no development could be achieved’. The developmental objective is more of a political decision backed by the ideological rationale of nationalism. As such this ideology emphasizes the state’s capacity to play a transformative role with an

Revolutionary Democratic Front (EPRDF) - the ruling party in power - has adopted an ideological shift towards the 'democratic developmental state' which explains the government's commitment more towards the socio-economic sector than civil rights and political freedoms.¹⁵² The adoption of this approach and the potential impact that it would bring about, if implemented properly, to child health gains as a social right can be well underlined.

Nevertheless, in my view and similar others, the developmental state ideology of 'economic growth first and rights next' should be subjected to criticism. Firstly, the theory adopts a restrictive approach to development. Development is not merely about improvements in the socio-economic sector, crucial in itself, but also includes the enjoyment of other freedoms.¹⁵³ The end goal of development is the enjoyment of all spectrums of human rights. Often, development is conceived as a comprehensive concept. Fulfilling human rights (economic, social and cultural as well as civil and political freedoms) obligations are sought to be encompassed within the notion of development. Secondly, the approach disregards with the importance and implication of indivisibility, interdependence and interrelatedness of human rights. A commitment to civil and political freedoms is equally important to achieve social and economic welfare. There is a remarkable empirical connection that links freedoms of different kinds with one another. According to Sen, political freedoms such as free speech and elections help to promote economic security.¹⁵⁴ Freedoms of different kinds can strengthen one another. For instance, state and non-state actors focus on the application of the right to non-discrimination, equality, and participation is considered to potentially bring a better outcome in children's social right to health. Thirdly, the means used to achieve growth does not seem to justify the end. The developmental state constrains individuals as mere passive recipients of the benefits of cunning development programs. The developmental state disregards the

assumption that a developmentally oriented political elite is in the driver's seat of the economy that also has the mission of creating development oriented ideological hegemony. To further understand some of the key features of this state see, for instance, A Fiseha 'Ethiopia: Development with or without freedom?' in E Brems *et al* (eds) *Human Rights and Development: Legal Perspectives from and for Ethiopia* (2015) 99-138.

¹⁵² Ibid.

¹⁵³ A Sen *Development as Freedom* (1999).

¹⁵⁴ Ibid.

imperatives of people’s participation both as a means and a goal, and its empowering virtue than disempowering. People are not recognized as key actors in their own development for the state and its agencies control the direction and pace of economic development through extensive regulation, long-term planning and often tight political control. This, indeed, misses ‘the strong rationale for recognizing the positive role of free and sustainable agency- and even of constructive impatience’.¹⁵⁵

A question may arise as to what evidence is available, apart from its theoretical constructs, to show that interventions backed by a HRBA have an impact on children’s health gains? In what follows I discuss best practices of some selected countries where human rights-shaped interventions have contributed to improvements in women’s and children’s health.

2.3.2 Adopting a HRBA: Examples of best practices

As I point out in the previous section, it has been questioned whether a HRBA to health is the ideal mechanism to potentially improve access to care and uphold the right to health of children or others. In this section I highlight whether adoption of a HRBA to child health has an impact on achieving health development. There is growing academic recognition that a HRBA has a role to play in the realization of the right to health. Gauri & Brinks¹⁵⁶ and Yamin & Gloppen,¹⁵⁷ for instance, have noted the beneficial impact that human rights based judicial decisions have had on women’s and children’s health. This is one area in which the impact of a HRBA has been clear. I discuss below some selected land-mark court cases decided in three countries, namely South Africa, Brazil and Nepal, to illustrate the role that courts can play in the realization of the right to health. I analyze what types of services and interventions have been the subject of successful litigation and what remedies have been ordered by courts.

¹⁵⁵ Ibid.

¹⁵⁶ See V Guari & D Brinks (eds) *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (2008).

¹⁵⁷ See A Yamin & S Gloppen (eds) *Litigating Health Rights. Can Courts Bring More Justice to Health?* (2011).

The first country is South Africa. The South African experience of translating into practice the constitutional promise of human rights for all its people is a paradigmatic example to illustrate that human rights and a HRBA do matter.¹⁵⁸ South Africa is perceived to be one of the places where HIV/AIDS infection is most prevalent in the world.¹⁵⁹ By 1998, it was estimated that up to 70, 000 South African children were being born every year with HIV and there were already signs that rising infant mortality was being caused by mother-to-child HIV transmission (MTCT).¹⁶⁰ Most of these children lived short painful lives, with HIV infection carrying a terrible toll for both parents and children. In addition, public health efforts to address prevalence of the transmission from mothers to their children were not to the desired level. Rather, the state policy that confined Nevirapine (an antiretroviral drug) to research and training sites failed to address the needs of mothers and their new-born children who did not have access to these sites. Furthermore, ‘the state policy failed to distinguish between the evaluation of programs for reducing mother-to-child transmission and the need to provide access to health care services required by those who do not have access to the sites’.¹⁶¹

Amid this challenge, Treatment Action Campaign (TAC) was founded in 1998. One of the primary objectives of the TAC was to demand that the government implement a program to prevent MTCT. Not satisfied with the government for its failure to develop or implement a comprehensive anti-retroviral drug program after enormous negotiations with Mbeki government, the TAC finally launched legal action to demand broader access to Nevirapine in 2001. The TAC, together with its allies, Save Our Babies (a coalition of paediatricians), and the Children’s Rights Centre, filed a constitutional claim against the government in Durban. What the parties sought in the TAC case was a declaration that the then applicable policy was unconstitutional and further that the government be ordered to make Nevirapine available, in the public health sector, to pregnant women with HIV who give birth, and to their babies,

¹⁵⁸ L London ‘What is a human rights-based approach to health and does it matter?’ (2008) 10:1 *Health and Human Rights* 74.

¹⁵⁹ ‘HIV/AIDS in South Africa’ available at: <http://www.medwiser.org/hiv-aids/around-the-world/hiv-aids-in-south-africa/> (accessed 23 May 2015).

¹⁶⁰ South African Ministry of Health Demographic and Health Survey (1998).

¹⁶¹ *Minister of Health v Treatment Action Campaign (TAC)* (No 2) 2002 (5) SA 721 (CC) para 67.

where indicated medically.¹⁶² The government opposed the application, arguing that their Nevirapine ‘pilot programme’ was reasonable, rational and not a violation of constitutional rights.

The Court rendered its judgement on the TAC case and related matters on 5 July 2002. Remarkably, the Court decided ‘that the government’s policy had not met its constitutional obligations to provide people with access to health care services in a manner that is reasonable and takes account of pressing social needs’.¹⁶³ It further declared that when ‘the prospects of the child surviving if infected are so slim and the nature of the suffering so grave . . . the risk of some resistance manifesting itself at some time in the future is well worth running’.¹⁶⁴ In addition, the Court supported TAC’s view that the policy discriminated against poor people noting that ‘there is a difference in the positions of those who can afford to pay for services and those who cannot. State policy must take account of those differences’.¹⁶⁵

A question to ask is what is the significance of the TAC case in relation to the theme of a HRBA to health? The outcome of the case is important in many ways in relation to the rights based discourse. Firstly, it validates the Constitution and confirms to women and new-borns who still suffer marginalisation and deprivation that the Constitution can materially impact on and better their lives. Here the Court deploys the Constitution to determine the health rights entitlement of women and children. The Court’s reliance on Constitutional provisions for its judgement is, in turn, suggestive of the impact of an explicit recognition of the health right of children and women in national laws to advance their health rights. Agreeing with London’s view, constitutional recognition of ‘human rights standards can and do inform more powerful methods to establish accountability for realising basic human needs’.¹⁶⁶ Secondly, this was the first example of a case demonstrating how the fact of commencing litigation created pressure

¹⁶² M Heywood ‘Preventing mother-to-child HIV transmission in South Africa: Background, strategies and outcomes of the Treatment Action Campaign case against the Minister of Health’ (2003) 19 *South African Journal of Human Rights* 294 -295.

¹⁶³ *Minister of Health v Treatment Action Campaign* (n 161 above) para 130.

¹⁶⁴ *Ibid.*, para 59.

¹⁶⁵ *Ibid.*, para 70.

¹⁶⁶ London ‘What is a human rights-based approach to health and does it matter?’ (n 158 above) 68.

on national and provincial governments and resulted in immediate and tangible benefits for people with HIV. As Pieterse notes the TAC ‘decision may directly be credited for a significant, actual increase in individual access to Nevirapine by pregnant, HIV-positive women across the country’.¹⁶⁷ Thirdly, the merits of the case demonstrate that discriminatory policies and practices could be the source of violation of children’s and women’s health. This helps to understand the underlying causes for access to treatment as a human right entitlement. Fourthly, the Court’s decision confirms that human rights accountability can generate policy changes. It underscored the capacity of courts to issue instructions to government to amend policies, where policies are found to be unconstitutional or discriminatory.

The power of agency or representation is another important dimension of the TAC case. London emphasizes that active agency by those vulnerable to human rights violations is an aspect of health as a right relevant to shaping a human rights approach to health.¹⁶⁸ The fact that the TAC was a civil society organization acting in the public interest suggests that without an active civil society, paper commitments to rights mean very little. It further informs, in order to address conditions that create vulnerability, a HRBA must seek to give voice to those who are vulnerable and provide them with decision-making scope to change their conditions of vulnerability. It also puts forward the emancipatory or transformative potential of civil society action to challenge state neglect or omission of health rights of children and women.

The second country example is Brazil. Brazil is the largest country in both South America and the Latin American region. Its economy is the world's seventh largest by nominal Gross Domestic Product (GDP). After 21 years of military dictatorship the country was subsequently returned to democracy in 1985. The current constitution of Brazil, formulated in 1988, defines the country as a federal republic composed of the union of the Federal District, the 26 states, and the 5,564 municipalities.

¹⁶⁷ M Pieterse *Can Rights Cure? The Impact of Human Rights Litigation on South Africa’s Health System* (2014) 82.

¹⁶⁸ London ‘What is a human rights-based approach to health and does it matter?’ (n 158 above) 65.

Why is Brazil taken as another example in the context of the HRBA discussion here or what benefits does the focus on a HRBA bring about where it could be taken as a learning experience?

Recently, Brazil is one of the countries considered by WHO and others as a champion in improving the health status of its women and children. A HRBA is considered to have contributed to improving the health status of these categories of persons. How? Firstly, Brazil committed itself to increasing legal recognition of human rights in its national laws and policies. In 1988, Brazil adopted its landmark Constitution which explicitly recognizes economic, social and cultural rights. Social rights include ‘health ... and the protection of motherhood’.¹⁶⁹ Hence, the right to health is proclaimed and special guarantees for family planning are guaranteed under the Constitution, which in turn enables individuals and groups to claim for their enforcement before courts in case of violation.¹⁷⁰

On top of above, Brazil exhibited explicit recognition of a HRBA in its maternal and child health policies. For instance, one of the crucial national documents on maternal health, the National Pact to Reduce Maternal Mortality (2004), clearly projects to achieve the goals for reducing maternal mortality through mobilisation of all 27 states in the country.¹⁷¹ Among other things, the Pact underlines that ‘the high rates of maternal and neonatal mortality in Brazil are a violation of the human rights of women and children’.¹⁷² Also, its guiding principle includes the following:¹⁷³

...respect for human rights of women and children, ‘the inclusion of gender, race and ethnicity considerations in all strategies and measures’, and ‘the consideration of social inequalities in decision making processes’.... ‘women and men have the right to decide freely and consciously about family planning’, that they ‘have the right to lead a sexual life that is positive, healthy and safe’ and that “these prerogatives, called sexual and reproductive rights, are the object

¹⁶⁹ O Ferraz ‘The right to health in the courts of Brazil: Worsening health inequities?’ (2009) 11 *Health and Human Rights* 33-45.

¹⁷⁰ The Constitution of Brazil (1988), article 226(7).

¹⁷¹ Bustreo *et al* (n 114 above) 38.

¹⁷² *Ibid.*, 39.

¹⁷³ *Ibid.*

of commitments assumed by Brazil and are guaranteed in the Federal Constitution.

There is evidence that government interventions in Brazil have been explicitly shaped by human rights, which in turn have contributed to considerable health improvements for women.¹⁷⁴ For instance, ‘women in stable relationships using modern contraceptive methods increased from 57% (1986) to 78.5% (2006–07) (5, 8); antenatal care coverage increased from 74.7% (1981) to 98.7% (2006–07) (5); and institutional deliveries increased from 79.6% (1981) to 98.4% (2006–07)’.¹⁷⁵ Furthermore, a study published in *Lancet* in 2011 concluded that, while the official MMR had been stable for the previous 15 years, estimates based on modelling suggested that ratios were declining.¹⁷⁶

Secondly, the courts in Brazil frequently hear and decide cases on children’s and women’s health-related provisions. Enacting health rights through the courts is an important aspect of a HRBA, for the absence of courts that could deliver judgements on health issues weakens the enforcement of health-related laws, leaving people unable to promote their own health rights and manage their own health risks.¹⁷⁷ Also, it opens space for discriminatory distribution of resources for health, and a lack of attention to defenceless groups. Brazilian court decisions in relation to the right to health include the process of requiring the government to take measures, such as ensuring equal access to pharmaceutical and medical services for all, including people living with HIV. Although the benefits of ‘courting’ health rights in the country look controversial in some ways,¹⁷⁸ litigation concerning this right is a widespread phenomenon in Brazil¹⁷⁹, and is an alternative pathway for accessing health care. However, there is evidence

¹⁷⁴ Ibid.

¹⁷⁵ Ibid., 40-41.

¹⁷⁶ Ibid.

¹⁷⁷ AE Yamin ‘Social justice and health1’ available at: <http://fxb.harvard.edu/health-rights-of-women-and-children/> (last accessed 12 June 2015).

¹⁷⁸ For instance, F Octavo argues about the right-to-health litigation prevalent few years in Brazil likely to have worsened health inequities. For an elaborated discussion on this, see Octavo ‘The right to health in the courts of Brazil: Worsening health inequities?’ (n 169 above).

¹⁷⁹ One finds a growing phenomenon of the right to health litigation in Brazil in the past two decades. Thousands of claims demanding the enforcement of the right to health against the state have reached the Brazilian courts every year. In the period between 2002 and 2000, the annual number of health-related lawsuits against the state of Rio Grande do Sul alone increased from 1,126 to 17,025. For a further discussion on this, see J Biehl ‘Between

that following court decisions, government pharmaceutical programs are struggling to fulfil their goal of expanded access and rational use of medicines.¹⁸⁰

Thirdly, the participation of the Brazilian civil society in those policies affecting health of children and women was crucial. Brazil has a very dynamic civil society, including a vibrant women's rights movement. I have discussed in the TAC case above how agency or representation by the civil society was useful in a HRBA for the realisation of maternal and child health rights in South Africa. Not only civil society mobilisation is important for public interest litigation, but also their participation in legislative and policy making processes representing women, children and other vulnerable group in a community is demanding. For instance, the active participation of civil society led to the drafting of the ground-breaking Brazilian National Policy for Comprehensive Assistance to Women's Health (PNAISM) (2004). The Policy is explicitly shaped by a human rights framework. Among other things, the Policy underlines 'the character of health care as being a right' and promotes the 'advancement of women's health by guaranteeing their access to rights that are legal obligations of the State'.¹⁸¹ The Policy is explicit in recognizing health as an enforceable human rights entitlement and the obligation of the state to realize same.

Nepal is my third country example. For most of its history, Nepal was an absolute monarchy before it became a constitutional monarchy in 1991. After a decade-long Civil War involving the Communist Party of Nepal (Maoist) and several weeks of mass protests by all major political parties, a federal multi-party representative democratic republic was established on 28 May 2008.¹⁸² Nepal has recently been considered by the WHO as good example in the context of the influence of a human rights-based approach on the country's maternal and child

the court and the clinic: Lawsuits for medicines and the right to health in Brazil' (n 180 below). In addition, in an interview conducted between WHO and F Octavio (16 April 2013), he revealed that at the federal government level, the right to health litigation in Brazil has increased from 387 in 2001 to 12811 in 2001. The interview can be found at: <http://einstitute.worldbank.org/ei/webinar/right-health-litigation-brazil> (accessed 12 June 2015).

¹⁸⁰ J Biehl 'Between the court and the clinic: Lawsuits for medicines and the right to health in Brazil' (2012) 14 *Health and Human Rights* E36-52.

¹⁸¹ Bustreo *et al* (n 114 above) 38.

¹⁸² Nepal 'Wikipedia -The Free Encyclopedia' available at: <http://en.wikipedia.org/wiki/Nepal> (accessed 12 April 2014).

health gains. In what context does the focus on a HRBA contribute to achieving children and women's health in this country?

Firstly, similar to the experience of Brazil alluded above, Nepal has increasingly given legal recognition to human rights in its national laws. In 2007, Nepal adopted an Interim Constitution which explicitly incorporates justiciable economic, social and cultural rights, inclusive of the right to health and food sovereignty.¹⁸³ Exhibiting a 'commitment to the promotion of women's health and children's health, the Interim Constitution recognizes women's reproductive rights, as well as children's rights to nourishment and basic health'.¹⁸⁴ Furthermore, it also explicitly recognizes several economic, social and cultural rights that are enforceable by courts.¹⁸⁵ On top of that, Nepal displays an emerging recognition of a HRBA in its maternal and child health policies. The country's legal and policy framework has navigated from absent or implicit human rights influences on maternal and child health policy, to an adoption of a clear and explicit HRBA in the past two decades (from 1991-2011). For instance, the revised National Safe Motherhood and Newborn Health – Long Term Plan (2006–2017) (NSMNH-LTP) places explicit emphasis on a human rights-based approach as noted below:¹⁸⁶

Rights-based approaches are therefore included as fundamental and cross-cutting to all outputs of the NSMNH-LTP, with the aim of increasing accountability for maternal and neonatal health, strengthening local capacity of duty-bearers to fulfill women's rights, strengthening women's voices and their ability to demand their rights to maternal health and transforming the distribution of power and resources that maintain inequalities across society, in families, communities and health systems.

Secondly, apart from the increasing legal recognition of human rights and the emergence of a HRBA to maternal and child health policies, Nepal has remarkably employed a HRBA to address maternal, new-born and child health priority programs, and there is record of evidence of their

¹⁸³ For an in-depth discussion concerning constitutional protection and jurisprudence in socio-economic rights in Nepal, see M Langford & A M Bhattarai 'Constitutional rights and social exclusion in Nepal' (2011)18 *International Journal on Minority and Group Rights* 387–411.

¹⁸⁴ See Interim Constitution of Nepal (2007), articles 20(2) & 22(2).

¹⁸⁵ For instance, article 16(1) and (2) of the Interim Constitution guarantees every citizen the right to live in a healthy environment and the right to basic health services free of cost from the state, as provided in law.

¹⁸⁶ Bustreo *et al* (n 114 above) 29.

impact on access to health care of children and women. The community-based integrated management of childhood illness – ‘Bal Bachau’ Child Survival Project - is a good example. With an aim to improve marginalized communities and child health in four western districts of Nepal, the ‘Bal Bachau’ Child Survival Project (2004–2007) was explicitly shaped by a HRBA.¹⁸⁷ A ‘focus on gender and child rights issues and on disadvantaged groups and women empowerment’¹⁸⁸ was included in the key cross-cutting strategies of the project. In addition, the principles of participation, equality and non-discrimination, and accountability were included as elements of the HRBA in this Child Survival Project.

The application of the HRBA is considered to have contributed to achieving positive outcomes for the health of women. In one project district, for example, ‘there was an increase in the rates of exclusive breastfeeding for 6 months from 50% to 88%; an uptake of iron and folic acid supplementation by women increased from 26% and 6%, to 85% and 60%, respectively’.¹⁸⁹ The approach has also contributed to an increase in availability, accessibility and utilization of child survival services.¹⁹⁰

Thirdly, in the area of accountability, judicial accountability mechanisms are meaningfully entrenched in Nepal. There are court decisions that hold the government accountable for health rights. By way of example, in the case *Prakash Mani Sharma & Others v Government of Nepal* (13), a case before the Supreme Court of Nepal, the applicants sought accountability for the government’s failure to address the high incidence of uterine prolapse.¹⁹¹ The Supreme Court ruled that the government had violated women’s constitutional right to reproductive health by failing to develop and implement policies and programs to address this severe form of maternal morbidity effectively.¹⁹²

¹⁸⁷ Ibid.

¹⁸⁸ Ibid., 32.

¹⁸⁹ Ibid.

¹⁹⁰ Ibid., 33.

¹⁹¹ ‘Reproductive rights in Nepal’ available at:

<http://reproductiverights.org/sites/crr.civicaactions.net/files/documents/RR%20in%20Nepal%20Factsheet%20FINAL.pdf> (last accessed 19 May 2015).

¹⁹² Ibid.

Overall, there is evidence that human rights have contributed positively to women's and children's health interventions in South Africa, Brazil, and Nepal, and that the human rights-shaped interventions contributed to significant health improvements for women and children. However, the adoption of the approach is not a panacea to curb children's and women's health needs in those countries. Implementation challenges to operationalize a HRBA in the health sector are still great.

2.4 Conclusion

An understanding on the need for using a HRBA in the various state policies and programs is gaining momentum. A HRBA offers both a vision and route. However, its application is not straight forward as there is a challenge of placing boundaries on what can be legitimately described as a HRBA. In this chapter, I explore the theoretical basis of a HRBA as a process which calls for the application of the minimum core human rights principles and aims to ensure the full enjoyment of human rights by all. An adherence to these core principles makes the potential of the enjoyment of human rights more feasible for each and every one of us.

I indicate the principles and principles as set out in international human rights law, which, in turn, inform the underlying basis of a HRBA framework. Under the following overarching standards and principles of express application of international human rights law; availability, accessibility, acceptability and quality of health facilities, goods and services; best interests of the child; empowerment; participation; non-discrimination; and accountability, a HRBA guides and directs all state processes. This framework forces the state to demonstrate tangible results that benefit all equally, for instance, real and quantifiable improvements in child health or education. It further provides the method to bring about sensible justice and equality. This process involves empowerment and participation of society, through to the ultimate accountability of those who have been elected or delegated to function in the best interest of the society.

In this chapter I also find the ways where the potential of a HRBA can be replicated for addressing problems of child survival or children's rights to health. I emphasize the possibilities that this approach can be a useful mechanism to address health challenges through an identification of the relevant human rights norms and principles and an assessment of evidence gained in good practical examples.

In order to ensure that all efforts to reduce under-five mortality and morbidity fully conform to recognized global and regional human rights standards and principles, which I more fully discuss in chapter 3 below, there is a need on the part of states and other stakeholders to pay particular attention to the standards and principles in a HRBA to child mortality provided under the UN Technical Guidance, and ensure their systematic application in the development, implementation and review of laws, policies, budgets and programs related to child health and survival.

Chapter 3

Legal protection of child survival rights and obligations of states and non-state actors

3.1 Introduction

In chapter two, I show that express application of a human rights framework is one pillar in a HRBA development activity. In a HRBA, human rights determine the relationship between individuals and groups with valid claims (rights-holders) and state and non-state actors with correlative obligations (duty-bearers).¹ Furthermore, ‘it works towards strengthening the capacities of rights-holders to make their claims, and of duty-bearers to meet their obligations through identification of rights-holders, their entitlements, and corresponding duty-bearers and their obligations’.²

Numerous global and regional treaties and the national laws of many countries incorporate the right to survival of children and a multiplicity of complimentary rights,³ which, if neglected, contribute to infant and child fatalities. States have, *inter alia*, committed themselves to respecting, protecting and fulfilling these rights by participating in the international human rights system. Analysis of the global and regional normative framework in the area of child survival rights and their concomitant obligations, hence, constitutes one important aspect of a HRBA to child survival.

¹ HRBA Portal ‘The human rights based approach to development cooperation: Towards a Common Understanding among UN agencies’ available at: <http://hrbaportal.org/the-human-rights-based-approach-to-development-cooperation-towards-a-common-understanding-among-un-agencies> (accessed 12 May 2014). As was noted in the previous chapter, the statement of Common Understanding (CU) was developed at the Inter-Agency Workshop on a human rights-based approach in the context of UN reform, 3 to 5 May 2003. The purpose behind developing the CU was to ensure that UN agencies, funds and programmes apply a consistent HRBA to common programming processes especially at the country level.

² Ibid.

³ Complimentary rights include the right to life provided under article 6(1) and article 5(2) of the CRC and ACRWC, respectively; a standard of living adequate for the child’s physical development provided under article 27(1) of the CRC; right to health provided under articles 24(1) and 14(1) of the CRC and ACRWC, respectively; women’s reproductive rights provided under articles 24(2) (d) and 12(20) of the CRC and CEDAW, respectively. I discuss them more fully in section 3.4 of this chapter.

In order to advocate for improved reduction of infant and child mortality, it is imperative that policy-makers, planners, administrators, health professionals, caregivers, children and civil society have a clear understanding of children's survival and the complimentary rights. Often, clarification of the content, scope and significance of separate socio-economic rights is of crucial importance in order to enhance implementation of these rights.⁴ Clarifying the content of rights is not enough, nonetheless. It is equally important that those who design, plan and deliver these services understand their international and constitutional obligations in realising the right.

My aim in this chapter is, firstly, to contribute to existing child survival initiatives through strengthening the understanding of children's rights at early age and to draw states parties' attention to their obligations with respect to such children. Secondly, using this chapter as background, I analyse, in the subsequent chapter, the extent to which these instruments are mirrored in Ethiopian laws and policies and assess their impact for the realization of child survival or reduction of under-five mortality in Ethiopia from a rights perspective.

The themes I am interested in, apart from this introductory part, are the following: In the next two sections, I analyse the conceptual framework of children's survival rights and discuss critically the extent to which child survival and its complimentary rights are recognized in the global and regional human rights treaties, declarations, goals and the relevant UN bodies' comments. I give particular emphasis to the various child survival rights-related provisions of the *Convention on the Rights of the Child (CRC)* and the *African Charter on the Rights and Welfare of the Child (ACRWC)*, as Ethiopia is a State Party to both these instruments. The particular focus on these two documents is mainly because they provide strong protection to children, as they make specific reference to child survival.⁵ It is only through emphasising child survival/mortality as a human right provided in these and other related documents that one

⁴ B Toebes *The Right to Health as Human Right in International Law* (1999) 7.

⁵ See, articles 6(2) & 5 of the CRC and the ACRWC, respectively. It does not however imply that other human rights instruments are less irrelevant or irrelevant at all to address child survival rights.

can question governments to implement, seriously, their obligations emanating from these rights. Having discussed the legal framework of child survival rights in the subsequent two sections, I then analyse the legal obligations of state parties and non-state actors flowing from those instruments. This is followed by a section dealing with monitoring mechanisms for implementation of child survival rights. In the last section, I conclude the chapter.

3.2 Understanding child survival

In this section I describe the meaning attached to child survival. Notably, child survival is a dynamic concept.⁶ It is not an entirely juridical concept nor is its origin human rights law. In addition, the concept of 'survival' lacks precise meaning in a general legal context.⁷ The word is used in the fields such as anthropology,⁸ medicine, public health⁹ and human rights. Although human rights law does not offer a specific definition of child survival, the human rights movement post 1945 considers child survival as a matter of human right and health issue where different actors¹⁰ have the responsibility to intervene in their area of mandate. But, how is child survival understood?

The phrase child survival constitutes two distinct words; 'child' and 'survival'. The CRC defines a child as 'every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier'.¹¹ At least three interrelated ideas are incorporated in

⁶ G Van Bueren *The International Law on the Rights of the Child* (1995) 293.

⁷ D Hodgson 'The child's right to life, survival and development' (1994) 2 *International Journal of Children's Rights* 383.

⁸ For instance, focussing on evolutionary science, O'Manique draws on theories of evolution to describe human survival. He notes 'the goal of humans has to be the survival of the species'.⁸ He further notes that there would be universal agreement with the statement, 'Humans ought to survive'. For his comprehensive discussion, see J O' Manique 'Universal and inalienable human rights: A search for foundations' (1990) 12 *Human Rights Quarterly* 473; A Heard 'Human rights: Chimeras in sheep's clothing?' (1997), available at: <http://www.sfu.ca/~aheard/intro.html> (accessed 05 June 2014).

⁹ Child survival is mostly utilized in the context of child health wellbeing in the field of public health and medicine.

¹⁰ The different actors responsible for child survival include governments departments, global and regional agencies working on children's health matters, such as a WHO, UNICEF, FAO, USAID, and Save the Children. It also includes national human rights institutions, the civil society, and children's rights committees at various levels. This party is an indication that any meaningful child survival requires joint work and coordination of stakeholders where the state has the primary responsibility to respect, protect and fulfil children's right to survival and health under national and supra-national law.

¹¹ CRC, article 1.

this definition: first, a child is a ‘human being’; second, childhood is understood as that space below 18 years of life; and third, childhood as envisaged in the CRC is a purely legal question determined on the basis of the ‘law applicable to the child’.

For the purpose of this section, attention is specifically drawn to the second element, i.e., the age limit. The CRC indicates a child as a human being who has not attained 18 years of age. For policy convenience, the drafters of the CRC opted for an overarching definition of childhood and setting an upper age limit to distinguish between childhood and adulthood.¹² The lower limit - when childhood should start - was left to the ‘margin of appreciation’ of member states taking into consideration their economic, socio-political and socio-cultural peculiarities.¹³

On the other hand, the word survival as defined in chapter one, includes a child’s right to life and the right to meet the needs that are the most basic to a child’s very existence.¹⁴ When the two words combine, child survival refers to the right to meet the needs that are the most basic to the very existence of children under the age of eighteen. It is the right of children to all the prerequisites of their full physical and moral development. Hence, per the CRC, the term ‘survival’ was intended for the advancement of children of all ages.

Nevertheless, the notion of child survival is largely open to a restricted interpretation or different meaning for at least the following two reasons. The first relates to the programs adopted by global agencies working on the children’s health or survival. Child survival programs of the United Nations Children’s Fund (UNICEF), the World Health Organisation (WHO), the United Nations Development Programme (UNDP), the World Bank and other

¹² S Detrick *The United Nations Convention on the Rights of the Child: A guide to the Travaux Préparatoires* (1992) 115.

¹³ See UN Human Rights Committee (HRC), the International Convention Civil and Political Rights *General Comment No. 17, Rights of the Child, (art. 24)* para 4, 7 April 1989. The Committee on the CRC has also alluded to this reason. See, R Hodgkin & P Newell *Implementation Handbook for the Convention on the Rights of the Child* (2007) 1.

¹⁴ See G Odongo ‘Caught between progress, stagnation and a reversal of some gains: Reflections on Kenya’s record in implementing children’s rights norms’ (2012) 12 *African Journal of Human Rights Law* 120. See, also, S Detrick *A Commentary on the United Nations Convention on the Rights of The Child* (1999) 130.

international agencies focus mainly on children under five years.¹⁵ The second ground narrates to biomedical approach to child mortality. 'Child survival is predominantly understood within a biomedical framework in terms of mortality (deaths and related causes of death) and morbidity (diseases and disease patterns) of children under-five years'.¹⁶ Put differently, child survival initiatives are dominated by the key burden of disease categories, namely communicable diseases, non-communicable diseases and childhood trauma and injuries.¹⁷ Child survival initiatives and programs therefore generally focus on children younger than five years old. This seems odd when one analyses it in the light of the age limit of a child set by global, regional and national law of almost all jurisdictions.

My focus for the purpose of this study is those categories of children under-five as keeping these children healthy is a challenge in the first five years of their life unless it receives a concerted action of different actors.¹⁸ Thus, I depend on the narrow definition of child survival adopted by the UN agencies I underlined above.

In defining child survival, it is also equally important to underline the relationship between parents, children and the state. Under the law of nature and human rights, children have the right to maintenance, support and comfort from their parents and, failing that, the state. Children's survival should be understood as the child's right to be maintained and provided with the necessities as well as the things nature furnishes for the support of life by their parents. Child survival is thus concerned with those minimum requirements or basic needs which must be met to sustain human life or to avoid death from preventable causes, which include but are not limited to, breastfeeding, immunization, adequate nutritious food, safe drinking water, sanitation facilities and adequate shelter.

Most importantly, the relation of the state and parent should define the meaning and scope of child survival. In the relation of parent/child concerning the latter's survival, the state and

¹⁵ Dutschke, M & K Abrahams *Rights brief: Children's Right to Maximum Survival and Development* (2006) 1.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ UNICEF *Child Survival: A Global Challenge* (2008) 2, 15.

the society must intervene as a matter of duty in the event the former is unable to discharge his/her natural and legal duties to their under-five children.¹⁹ However, as many of the risks of child survival or child mortality are associated with poverty and inequality or disease prevention, the context in which the state will be primarily engaged on survival needs of children is most apparent.

However, the above-mentioned does not imply children's right to maximum survival has no significance for other children beyond the first five years threshold. Undoubtedly, child survival development is inextricably linked. The right to maximum survival and development relates to a continuum that begins at maximum survival and progresses to an endpoint represented by the optimum development of the child, ensuring the conditions that enable them to develop their potential.²⁰ All children under eighteen therefore have the right to survive under conditions that enable them to develop to their full potential.

3.3 Legal protection of child survival rights

Child survival is the unfinished agenda particularly of the developing world. Current academic discourse indicates that child survival should remain at the heart of global goals in the post-2015.²¹ In this section I draw attention to the question why law matters for child survival. The discussion on children's survival rights is crucial, for rights establish legal obligations for states to provide services to individuals that are not able to obtain or provide them on their own.²² My argument is not that adequate protection of child survival in law alone can be a solution to the child survival problem. However, I point out that both global and regional instruments provide the legal framework on children's right to survival and argue that, if seriously implemented, they could significantly contribute to reduction of child mortality. In what

¹⁹ I discuss more fully on the obligations imposed on states and non-state actors in sections 3.5.7 & 3.5.7.2 below.

²⁰ M Freeman *et al* *Law and Global Health: Current Legal Issues* (2014) 283.

²¹ J Bryce *et al* 'The unfinished agenda in child survival' (2013) 382 *Lancet Review* 1049; JH Requejo & ZA Bhutta 'The post-2015 agenda: Staying the course in maternal and child survival' (2015) 100 (Suppl 1) *Archives of Disease in Childhood* 2015 s76–s81.

²² FC Johnson 'USAID child survival programmes: Adopting a human rights Approach' (1997) 5 *The International Journal of Children's Rights* 293.

follows I analyse the most relevant instruments dealing with child survival and evaluate to what extent these instruments effectively address it.

3.3.1 The CRC (1989)

The world has recognized the need to address fundamental issues of food, health care, and shelter as rights to which every world citizen is entitled. This is especially true beginning from the 1948 *Universal Declaration of Human Rights* (UDHR). The UDHR was adopted in order to recognize that international human rights protect not only communities but also every individual, which obviously includes children. It, *inter alia*, proclaims human beings to enjoy freedom, including freedom from fear and want.²³ As a global document that aspires to promote respect for these and other rights and freedoms, many more human rights instruments have been developed with corresponding enforcement mechanisms in order to meet UDHR's aspirations. On this basis, in 1979, the UN General Assembly convened a committee to draft a new international treaty on the rights of the child. 'In a rather political and complicated process with an open-ended working group of the then UN Commission on Human Rights', the CRC was drafted between 1980 and 1989.²⁴ In 1989, the General Assembly adopted the CRC, which strengthened former human rights declarations with regard to children's rights.²⁵ It came into force in 1990, and has now been ratified by 195 states including

²³ F Roosevelt of the US President has enunciated 'four freedoms' - the freedom of speech and expression; the freedom of a person to worship God in his own way; the freedom from want, and the freedom from fear. The third - freedom from want - refers to economic understandings which will secure to every nation a healthy peacetime life for its inhabitants. And, according to Wikipedia – the free encyclopaedia, 'freedom from fear means a world-wide reduction of armaments to such a point and in such a thorough fashion that no nation will be in a position to commit an act of physical aggression against any neighbour'. The 'four freedoms' finally evolved into the UDHR. The third freedom – freedom from want- is the most important for children's survival rights as it has socio-economic connotations. Freedom from want promotes children access to basic material things to help them survive. This freedom is generally regarded as the basis for the formulation of socio-economic rights in international treaties and the constitution of different countries. For further discussion see, CA Toebes *The Right to Health as a Human Right in International Law* (1999) 14-15.

²⁴ JE Doek 'The UN Convention on the Rights of the Child: An Instrument for Creating a Healthy Environment for the Child' in J Garbarino & G Sigman (eds) *A Child's Right to a Healthy Environment* (2010) 139.

²⁵ Two international commitments aiming for the protection of children's rights, that take the form of Declaration, preceded the CRC. The very first was the Declaration on the Rights of Child, known as the 'Declaration of Geneva', which adopted by the League of Nations in 1924. This Declaration was further revised and extended in 1948 and in 1959 led to the UN Declaration on the Rights of Child, which was adopted unanimously by the General Assembly

Somalia. The CRC is the over-arching framework for children's rights. It 'was the first treaty specifically concerned with the rights of children and marked an important shift in thinking towards a 'rights-based approach' which held governments legally accountable for failing to meet the needs of children'.²⁶ Again, it embraces a new vision of children as bearers of rights and responsibilities appropriate to their age and not mere recipients of charity.

Like any other human rights, many of the children's rights in the CRC are also natural rights, which include the right to be fed and to survive. Scholars, such as Van Bueren & Cook, note that the right of the child to survive at birth and infancy is the most basic of human rights, since survival is a precondition of all their other rights.²⁷ The CRC is the first binding global instrument that explicitly provides a legal framework to promote child survival. The provision of the CRC that is directly applicable to child survival reads as follows:²⁸

States Parties shall ensure to the maximum extent possible the survival and development of the child.

Kaime notes that the recognition of the right to survival and development of the child in the CRC is a relatively recent incorporation in international law.²⁹ The *travaux préparatoires* of the CRC shows that it was India's delegate who, working closely with UNICEF, introduced a proposal to the Working Group on the draft CRC which effectively sought to impose on states parties an obligation to ensure 'the survival and healthy development of the child'.³⁰

of the United Nations (20 November 1959). The 1959 Declaration was further extended and changed into a binding treaty, the CRC.

²⁶ Z Javaid *et al* 'Child Protection in Disaster Management in South Asia: A Case Study of Pakistan' (2011) 26 *Journal of South Asian Studies* 196.

²⁷ G Van Bueren *The International Law on the Rights of the Child* (1995) 293; R J Cook 'Human rights and infant survival: A case for priorities' (1986) 18 *Columbia Human Rights Law Review* 1.

²⁸ CRC, article 6(2).

²⁹ T Kaime *The African Charter on the Rights and Welfare of the Child: A Socio-Legal Perspective* (2009) 119.

³⁰ Kiame has noted that the original proposal, which was submitted to the Working Group for consideration, reads: 'The states parties to the present Convention undertake to create an environment, within their capacities and constitutional processes, which ensures to the extent possible, the survival and healthy development of the child'. See Kiame (n 29 above) 119. See, also, Draft Convention on the Rights of the Child as adopted by the open ended Working Group on 16 October 1987, E/CN.4/1988/WG.1/WP1; Van Bueron (n 27 above).

Structurally, the insertion of child survival next to the provision of the right to life of children (article 6(1) of the CRC) shows the unquestionable link between child survival rights and the right to life. Despite the prudent link between the two, a question could be why survival is included in the children's right to life provision when it appears that other provisions in the CRC already provide for survival requirements stated under articles 24(2) and 27(3) of the CRC? Two potential reasons can be proposed. First, despite the similarity of child survival requirements as stated in the meaning of 'survival' by the WHO/UNICEF³¹ and the ones provided for in articles 24(2) and 27(3), there are some survival requirements that are missing in the CRC. These omitted elements include child spacing, growth monitoring, oral rehydration, and immunization. The second reason is that ensuring survival is a condition precedent for the fulfillment of the right to an adequate standard of living.³² In other words, an effort to improve the standard of living of an individual would be meaningless without first ensuring his survival.

Once more, the inclusion of the child survival provision in the human rights system is crucial. Hodgson underscores the significance of incorporating child survival in the above article as it acknowledges the fact that more human beings die daily on account of hunger and disease than persons killed for other reasons, and envisions how to respond to this challenge.³³ Two-thirds of child deaths occur from preventable causes,³⁴ and the inclusion of the child survival rights marks the obligation of states to take steps for the full realization of the rights and to assume accountability in case of violation of this right. The recognition of survival would clearly expand the range of positive measures required to be taken on behalf of the child. The measures include, *inter alia*, provision of access to health care facilities and services, safe drinking water and adequate shelter, clothing and sanitation facilities. The drafting history of the Working Group of the CRC indicates that the aims of taking these positive measures were

³¹ The term survival had a special meaning within the UN agencies. For WHO/UNICEF 'survival' includes growth monitoring, oral rehydration and disease control, breastfeeding, immunization, child spacing, adequate nutritious food and female literacy. See Hodgson (n 7 above); S Detrick *A Commentary on the United Nations Convention on the Rights of the Child* (1999) 131.

³² D Hodgson 'The child's right to life, survival and development' (1994) 2 *International Journal of Children's Rights* 383.

³³ *Ibid.*, 384.

³⁴ UNICEF 'Young child survival and development' available at: <http://www.unicef.org/childsurvival/> (accessed 23 June 2014).

to reduce infant mortality and maintenance of the survival of the child. More apparently, where governments fail to deliver the basic survival requirements it would potentially constitute passive killing of children.

Obviously, the child survival right falls within the category of rights classified as socio-economic in nature. The qualifying phrase, 'the maximum extent possible' in the above article is an indication that the obligation of states to ensure the survival to every child is not unqualified, as with other economic, social, and cultural rights contained in the Convention. The rationale for not making it unqualified is the fact that infant deaths and injuries may, in some instances, be the unavoidable results of uncontrollable forces of nature and human character.³⁵ In addition, child survival is a right of which the realization is dependent on fulfilment of other basic rights, such as the right to health and the underlying determinants of the right to health. Taken together, it could be said that the survival right is to be progressively³⁶ or programmatically implemented or that its fulfilment is not required to be as immediate³⁷ as that of a civil right such as the right to life. Nevertheless, the fact that survival is placed in the same article as the right to life of children could indicate that the drafters intended states parties to accord top priority to the satisfaction of survival requirements. Furthermore, as I

³⁵ Cook (n 27 above).

³⁶ There is a plethora of literature and judicial pronouncement clarifying the concept of 'progressive realization'. The human rights regime attaches meaning to this term in relation to states' obligations in connection with economic, social and cultural rights. It recognized states obligation to these rights is to take appropriate measures towards the full realization of the rights to the maximum of their available resources. However, the concept of progressive realization is sometimes misinterpreted as if states did not have to protect economic, social and cultural rights until they have sufficient resources. The treaties, rather, impose an immediate obligation to take appropriate steps towards the full realization of economic, social and cultural rights. States parties cannot defend their inaction or indefinite postponement of measures to implement these rights based on lack of resources. States must demonstrate that they are making every effort to improve the enjoyment of economic, social and cultural rights, even when resources are scarce. For instance, irrespective of the resources available to it, a state should, as a matter of priority, seek to ensure that everyone has access to, at the very least, minimum levels of rights, and target programmes to protect the poor, the marginalized and the disadvantaged. See generally on this, UNOHCHR 'Key concepts on ESCRs - What are the obligations of states on economic, social and cultural rights?' available at: [http://www.ohchr.org/ EN/Issues/ESCR/ Pages/ What aretheobligation sofStatesonESCR .aspx](http://www.ohchr.org/EN/Issues/ESCR/Pages/What%20are%20the%20obligations%20of%20states%20on%20ESCR.aspx) (accessed 23 June 2015).

³⁷ Nevertheless, there are obligations imposed on states under human rights law that are immediate. Even though states may realize child survival rights progressively, they must also take immediate action, irrespective of the resources they have, in five areas: elimination of discrimination; economic, social and cultural rights not subject to progressive realization; obligation to 'take steps'; non-retrogressive measures; and minimum core obligations. See further on this, UNOHCHR 'Key concepts on ESCRs: What are the obligations of states on economic social and cultural rights?' (n 36 above).

underlined above, child survival is a precondition for the exercise of all other children's rights provided in the CRC. Despite the qualify phrase above, it is thus necessary that implementation of child survival rights should be accorded priority over others in order to combat child mortality.

3.3.2 The ACRWC (1999)

The ACRWC or Children's Charter was adopted by the Organisation of African Unity (OAU) in 1990 (the OAU became the African Union (AU) in 2001). The Charter entered into force in November 1999. It was adopted within a year of the adoption of the CRC. Akin to the CRC, 'the Children's Charter is a comprehensive instrument that sets out rights and defines universal principles and norms for the status of children'.³⁸ The ACRWC and the CRC are the only regional and global human rights treaties, respectively, that address all rights holistically, i.e., covering the whole spectrum of children's civil, political, economic, social and cultural rights.³⁹

There were two main reasons for adopting a separate African Children's Charter. Firstly, it was believed that Africa was under-represented during the drafting of the CRC. Secondly, it was considered important to address some issues that are peculiar to Africa but that were omitted in the CRC, such as issues on the African conception of the community's duties and responsibilities, practices and attitudes that have a significant impact on the life of the girl child, the particular socio-economic conditions of the continent, and concerns on internally displaced persons due to civil wars.⁴⁰

Although the Children's Charter originated because the member states of the AU believed that the CRC missed important socio-cultural and economic realities particular to Africa as noted

³⁸ V Odala 'The spectrum for child justice in the international human rights framework: From 'Reclaiming the delinquent child' to restorative justice' (2012) 27:3 *American University International Law Review* 565; UNICEF 'The African Charter on the Rights and Welfare of the Child: For children and youth' available at: http://www.unicef.org/esaro/children_youth_5930.html (accessed 12 May 2014).

³⁹ K Williams *African Parents Must Know: Child Protection and Welfare Issues in the United Kingdom* (2013) 55.

⁴⁰ WHO, Health and Human Rights 'The African Charter on the Rights and Welfare of the Child' available at: <http://www.who.int/hhr/African%20Child%20Charter.pdf> (accessed 20 June 2014).

above, this is not the case in regard to the child survival right as the relevant provision of the ACRWC reads below:⁴¹

States Parties to the present Charter shall ensure, to the maximum extent possible, the survival, protection and development of the child.

In a similar construct to the CRC's child survival provision, two separate but closely related concepts, namely, the right to survival and the right to development are engendered under the African Children's Charter.⁴² The African Children's Charter formulation of survival and development intimately follows the precedent set by CRC.

As I highlighted above, the concept of survival is dynamic and incorporates all the necessary steps that a state party must undertake in order to ensure the healthy development of children. Specific programs and plans of action are vitally important to maximize child survival. By becoming a party to the African Children's Charter, African governments are required to adopt appropriate measures aimed at increasing life expectancy and lowering infant mortality. This requires states to fully ensure the right to nutrition, an adequate standard of living for children, including the right to housing, and the highest attainable standard of health. These are complimentary or corollary rights of child survival, which I discuss more fully below.

3.3.3 Complementary rights

Several provisions of global and regional human rights instruments, whether directly or indirectly, consistently call for the assurance of children's survival. The Committee on the Rights of the Child also notes that 'the right to survival and development can only be implemented in a holistic manner, through the enforcement of all the other provisions of the CRC'.⁴³ The right to survival is dependent on the realisation of a multiplicity of complimentary

⁴¹ ACRWC, article 5(2).

⁴² Kiame (n 29 above) 120.

⁴³ CRC Committee, *General Comment No. 7, Implementing Child Rights in Early Childhood* (2005), para 10, 20 September 2006, CRC/C/GC/7/Rev.1.

rights of such provisions, which if neglected, contribute to infant and child morbidity and mortality. In what follows I examine the meaning and content of these corollary rights essential for the enjoyment of child survival rights.

3.3.3.1 The right to life

The International Bill of Human Rights (more specifically, article 3 of the UDHR and article 6 of the International Covenant on Civil and Political Rights (ICCPR or Civil and Political Covenant)) guarantees every person's right to life. It is the only right under the ICCPR recognized as inherent. The right to life is also enshrined under the regional conventions and is incorporated in article 4 of the ACRWC, article 4 of American Convention on Human Rights (ACHR) and article 2 of the European Convention on Human Rights (ECHR).

According to the Civil and Political Covenant '[e]very human being has the inherent right to life. This right shall be protected by law...'.⁴⁴ In relation to the right to life, the Human Rights Committee (HRC) in its General Comment No. 6 has underscored that: '...the expression 'inherent right to life' cannot properly be understood in a restrictive manner, and the protection of this right requires states' adoption of positive measures'.⁴⁵ The Committee further commented that 'it would be desirable for states parties to take all possible measures to reduce infant mortality and to increase life expectancy'.⁴⁶ A reaffirmation has also been made in the CRC, which recognizes that '...every child has the inherent right to life'.⁴⁷ A failure to provide access to high-quality services needed by children is the cause of preventable deaths among children under five. Therefore, the human right violated by avoidable infant death is the right to life.

⁴⁴ International Covenant on Civil and Political Rights (ICCPR), adopted in 1966, article 6(1).

⁴⁵ UN Human Rights Committee (HRC), *CCPR General Comment No. 6, Right to Life (art. 6)*, 30 April 1982, para 5.

⁴⁶ *Ibid.*

⁴⁷ CRC, article 6.

There was, however, a debate whether to follow a restrictive or non-restrictive approach concerning article 6 above, before the Human Rights Committee finally reached the position of a non-restrictive interpretation of the right to life. Dinstein, for instance, argues for a narrow reading of article 6. He believes ‘failure to reduce infant mortality is not within article 6, while practicing or tolerating infanticide would violate the article’.⁴⁸ Against the narrow reading approach is Ramcharan. He uncovers that the restrictive approach is insufficient and is contradicted by the available evidence of practice.⁴⁹

I am of the view that a restrictive approach is not necessarily right. Today human rights are maturing. Governments are also assuming more responsibilities than at any time before. In the last two decades international law and practice has evolved to restrain governments from actively abusing their citizens. There is also a better understanding and demonstrated State commitments of mainstreaming human rights principles into child health laws, policies and strategies. Although it will be over-simplistic to argue that every instance of states’ failure to reduce infant mortality could constitute a violation of the right to life, passive abuse of the life and health of citizens, particularly infant citizens, through neglect should be assimilated to violation of the right to life. Every country at risk of having high levels of infant mortality, like Nigeria, Ethiopia, Afghanistan etc, is obliged to create and maintain appropriate preventive and remedial programs. Measures to achieve these programs only require low-cost intervention efforts. A country that does not plan to address right to life issues through such intervention efforts manifests itself utterly careless of the human right to life.⁵⁰

3.3.3.2 The right to health care

Access to health care is not only what children need, but also their fundamental human right provided for in the leading global and regional human rights instruments. The earlier

⁴⁸ Y Dinstein ‘The right to life, physical integrity, and liberty’ in L Henkin (ed) *The International Bill of Rights: The Covenant on Civil And Political Rights* (1981) 116.

⁴⁹ B Ramcharan *The Concept and Dimensions of the Right to Life in International Law* (1985) 4.

⁵⁰ Cook (n 27 above) 14.

international movement for the legal protection of the physical, social and spiritual health of children can be traced to the Geneva *Declaration on the Rights of the Child* (GDRC), adopted by the League of Nations on 26 September 1924. It stated, amongst other things, that children must be given ‘the means requisite for normal development’.⁵¹ Following WWII and the adoption of the UDHR, the *International Convention on Economic, Social and Cultural Rights* (ICESCR) recognizes in article 12.1 ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’, which applies also to children. It obliges states to use their health resources according to utilitarian ideals.⁵² Article 12(2) states that the steps to be taken to achieve the full realization of this right shall include those necessary for:

- (a)...the provision for the reduction ...of the stillbirth rate and of infant mortality and for the healthy development of the child ...
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases.

In a similar fashion, article 24 of the CRC recognizes the right of the child to the enjoyment of the highest attainable standard of health. It explicitly obliges states parties to take appropriate measures to reduce infant and under-five mortality.⁵³ It further requires states parties to take appropriate measures to ensure the provision of necessary medical assistance and health care for all children, with emphasis on the development of primary health care; to combat disease and malnutrition through, *inter alia*, the application of readily available technology and

⁵¹ Geneva Declaration of the Rights of the Child of 1924, adopted Sept. 26, 1924, League of Nations O.J. Spec. Supp. 21, (1924) 43, item No.1.

⁵² According to J Bentham & J Stuart Mill, utilitarian ideals aim to measure governmental action as right or wrong according to a principle of ‘the greatest happiness of the greatest number’. In other words, utilitarianism is the creed which accepts as the foundation of morals, the greatest happiness principle. It is fundamentally welfarist in its philosophy. Its relation to health right, it focuses on the need for addressing of health services to the majority. It might eventually disadvantage some persons. Taking an example given by P Mack, a program of vaccination might save millions of lives but harm or even kill a few persons who would have escaped the disease anyway. Similarly, policies concerning drug testing necessarily involve trading off greater pleasure, convenience, economy, and even life for many against risk of harm or death for a few. For this reason, utilitarianism is often accused of being too collectivist in spirit and that it aims at maximising an aggregate measure of individual utilities without regard to their distribution. See further, P Mack ‘Utilitarian ethics in healthcare’ (2004) 12 *International Journal of the Computer, the Internet and Management* 63-72.

⁵³ CRC, article 24 (a).

through the provision of adequate nutritious foods and clean drinking-water, and to ensure the provision of information and education on child health and nutrition.⁵⁴ The right to the highest attainable standard of health has also been reaffirmed in other human rights instruments.⁵⁵

The main contents of the provisions on the right to health are elaborations of measures that state parties shall take from their duties under the ICESCR or CRC or ACRWC. Although the provisions are broad and general, they are relatively detailed compared to many of the other provisions. Their generality and broadness, however, leaves room for different arguments. As a result guidance needs to be sought from other sources for ascertaining their interpretation. The pertinent sources are mainly the decisions and recommendations of the CESCR and CRC Committees.

Failure to fulfil the right to health accounts for a major part of preventable under-five mortality. Acknowledging this as a major problem, the right to the highest attainable standard of health creates a specific obligation on states to address under-five mortality and ensure that child-friendly health services, goods and facilities are made available, accessible and acceptable and are of high quality (AAAQ).⁵⁶

The most important aspect within the element of accessibility is access to services and health-related information to promote healthy behaviour and appropriate care-seeking. In this regard, 'States must ensure that health services and information are accessible to the entire population, especially those who are most marginalized'.⁵⁷ Where access is constrained for some populations due to vulnerability (such as discrimination), measures must be taken to identify and address the underlying reasons and ensure targeted responses. The measures may

⁵⁴ Ibid, article 24 (b) & (c).

⁵⁵ For instance, ACHPR, article 16; ACRWC, article 14; *Alma Ata Declaration* (1978).

⁵⁶ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14, The Right to the Highest Attainable Standard of Health (article 12 of the Covenant)*, 11 August 2000, paras 13-14 & 21-22, E/C.12/2000/4.

⁵⁷ Ibid., para 12(b).

include social insurance or waiver schemes to guarantee financial accessibility. Devices to ensure continuity of such schemes are, however, crucial. Moreover, providing information to parents and other caregivers on how best to prevent diarrhoeal disease and other childhood illnesses is equally important.

In section 2.2.4 of chapter two, it was pointed out that medical facilities, goods and services should be medically and culturally acceptable. Of importance in this principle is the acceptability of child health services to users. Use of oral rehydration salts (ORS) can be taken by way of example for illustration on acceptability. The use of ORS, a low-cost but life-saving product, has been widely promoted since the 1970s and endorsed by national health programs across the developing world. Research, however, has shown out that only 34% of children under-five years of age with diarrhoea receive ORS.⁵⁸ This low coverage was due to factors including ORS' unpleasant taste and inconvenient one-litre packaging, which have made traditional formulations unpopular with children and caregivers alike. As a result, to improve the acceptability, ORS are increasingly offered in flavoured varieties and smaller sachets for children, and new distribution mechanisms are being promoted.⁵⁹

Ensuring quality of health services is another responsibility of states under international human rights law. In connection with this principle of quality, states are required to train and equip an appropriate mix of health workers to address major sources of under-five mortality such as diarrhoea and ensure adequate geographical coverage throughout the country. In addition, ensuring the quality and accuracy of health information can require regulation of the private sector or other interested parties. The promotion of exclusive breast feeding may, for instance, require regulation of the marketing of breast-milk substitutes and promotion of

⁵⁸ S Isanaka *et al* 'Bridging the gap from knowledge to delivery in the control of childhood diarrhea' (2012) 90/9 *Bulletin of the World Health Organization* 635-635A. Also, available at: <http://www.questia.com/library/journal/1G1-304168168/bridging-the-gap-from-knowledge-to-delivery-in-the-control-of-child-diarrhea> (accessed 2 May 2014).

⁵⁹ *Ibid.*

workplace policies that support breastfeeding as well as the provision of health information for new mothers.⁶⁰

Despite the various obligations attached to children's right to health, similar to other economic, social and cultural rights, the right to the highest attainable standard of health is subject to the principles of progressive realization and resource availability. States are required to fulfil these rights to the maximum extent of their available resources and, where needed, within the framework of international cooperation.⁶¹ While recognizing the principle of progressive realization and constraints due to the limits of available resources, treaty monitoring bodies have emphasized that there are certain obligations which are of immediate effect. For example, according to the ICESCR, states parties have immediate obligations in relation to the right to health such as ensuring that the right will be exercised without discrimination of any kind (article 2(2)) and taking steps (article 2(1)) towards the full realization of the highest attainable standard of health. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health.⁶² This requires states parties to ensure access to essential health services for the child and his or her family, including prenatal and postnatal care for mothers. In all policies and programs aimed at guaranteeing the right to health of children, their best interests shall be a primary consideration.⁶³ A further obligation on the part of the State that has a similar nature is states parties' duty to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children, including such harmful practices as child marriage, which impair women's and girls' ability to make decisions about their sexual and reproductive lives.⁶⁴

⁶⁰ UN Human Rights Council *Study by the World Health Organization on mortality among children under five years of age as a human rights concern*, 6 September 2013, A/HRC/24/60, para 45.

⁶¹ See CRC, article 4; UN Committee on Rights of the Child (CRC), *General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, 17 April 2013, CRC/C/GC/15, paras 71-72.

⁶² UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 13 (1999)* para 43; *General Comment No. 14* (n 56 above) para 30.

⁶³ CRC, article 3(1).

⁶⁴ CRC, article 24 (3).

The right to health does not stand alone for its realization. According to CRC Committee, children's right to health is dependent on the realization of many other rights, including the rights to nutrition, water and sanitation, an adequate standard of living, non-discrimination and equality.⁶⁵ At the same time, realization of the right to health is important for realization of other human rights outlined in the CRC, such as children's right to life, to education, to association, to leisure and others.⁶⁶ This reaffirms the indivisibility and interdependence of children's rights that enable all children to develop their mental and physical abilities, personalities and talents to the fullest extent possible.

3.3.3.3 Women's rights

Speaking of 'women and children's health' among health professionals and policy planners is well entrenched. Women and children's health are highly interrelated, mainly in the sense that the economic and social conditions of women have a profound effect not only on women's own health but also on that of their children and families and on subsequent generations.⁶⁷ Generally, the health and nutritional status of children is determined by the education, health status during pregnancy, income and time of women rather than men.⁶⁸ It means that a mother's education, her health during pregnancy and her freedom from violence have a direct impact on her children's health. Statistically, research shows mothers who have more than 12 years of education are 2.7 times less likely to die than children of mothers with no education.⁶⁹ Low rates of literacy and education among women correlate strongly with high rates of under-

⁶⁵ CRC Committee, *General Comment No. 15* (n 61 above) para 7.

⁶⁶ *Ibid.*, para 7. The fact the important of the right to health is, generally, important for the realization of the right to health can be found in numerous court judgements. See, for instance, the Indian case of *Paschim Banga Khet Mazdoor Samity v State of Bengal* ((1996) AIR SC 2426/ (1996) 4 SCC)), where the court emphasised that lack of providing lack of adequate medical facilities violates the right to life.

⁶⁷ Review and Appraisal of Progress Achieved & Obstacles Encountered at the National Level in the Realization of the Goals & Objectives of the UN Decade for Women: Equality, Development & Peace, Health and Nutrition, Report of the Secretary-General, U.N. doc. A/ CONF.1 15/5/Add.3 (1984).

⁶⁸ *Ibid.*

⁶⁹ S Karlsen *et al* 'The relationship between maternal education and mortality among women giving birth in health care institutions: Analysis of the cross sectional WHO global survey on maternal and prenatal health' (2011) 11 *BMC Public Health* 606.

five mortality.⁷⁰ Not only mothers' education has an impact on child health, early marriage and pregnancy also have a similar influence on the health and mortality of children. The world is challenged with millions of forced early marriages, which results in high-risk pregnancies and child birth.⁷¹ This means that women's rights to be protected against these practices are also closely related to children's health rights.

It is because of this interrelation that any effort in making sustained progress in reducing child deaths requires addressing gender inequality and ensuring that women's rights are respected, protected and fulfilled.⁷² In addition, emphasis has been placed on the salience of realizing women's rights in relation to under-five mortality by various treaty monitoring bodies and Special Rapporteurs. Addressing harmful practices, such as child marriage, and ensuring access to the information and services needed by women and girls to make informed decisions about their sexual and reproductive lives, is the messages frequently addressed to states by these UN bodies.⁷³

Furthermore, the CRC underlines the need for states parties to take appropriate measures to ensure prenatal and postnatal health care for mothers.⁷⁴ Women's reproductive rights include 'the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth'.⁷⁵ Also, the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW) requires states parties to 'ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation'.⁷⁶ Moreover, the CRC Committee General Comment No. 15 on the right of the child

⁷⁰ Ibid.

⁷¹ UN Population Fund 'Marrying too young: End child marriage' (2012). Available at: <http://unfpa.org/endchildmarriage> (accessed 12 May 2014).

⁷² Human Rights Council *Study by the World Health Organization on mortality among children under five years of age as a human rights concern* (n 60 above) para 55.

⁷³ See, www.bayefsky.com: India, CRC, CRC/C/137 (2004) 75 (accessed 25 May 2014).

⁷⁴ CRC, article 24(2)(d).

⁷⁵ UN Population Fund 'Programme of Action of the International Conference on Population and Development', para 7.2 (1995), available at: <http://www.unfpa.org/public/home/sitemap/icpd/International-Conference-on-Population-and-Development/ICPD-Programme> (accessed 10 May 2014).

⁷⁶ CEDAW, article 12(20).

to the enjoyment of the highest attainable standard of health states that ‘special measures should be taken to promote community and workplace support for mothers in relation to pregnancy and breastfeeding, and feasible and affordable childcare services, and compliance with the *International Labour Organization Convention No. 183 (2000)*’.⁷⁷

The contradiction is that while societies depend heavily on women to provide health care, women's own health-care needs are frequently neglected. Over a quarter of a million pregnant women and girls die every year, and as many as 98% of these deaths are estimated to be preventable.⁷⁸ Adopting efforts to address the maternal mortality crisis is critical not only for eliminating preventable deaths, but also for help reduce infant mortality.⁷⁹

3.3.3.4 The right to enjoy the benefits of scientific progress

Ending preventable child and maternal deaths will require more than resources. It requires a new model of development that harnesses the power of science and business to push the boundaries of possibility. In South Asia, for example, we supported randomized control trials and feasibility studies demonstrating that chlorhexidine could cut new-born mortality by 23%.....having an impact on the ground — from stopping the transmission of HIV/AIDS to infants to helping new-borns take their first breath.⁸⁰

The forgoing is USAID Administrator, Rajiv Shah’s, statement in 2014 concerning the need to end preventable child and maternal mortality. The relevance of his statement to this section is that he underscores the significance of harnessing science to reduce child mortality. Access to the benefits of scientific progress allows improving one’s socio-economic situation and also gives the opportunity to take a meaningful part in the life of communities. To maximise the conditions of life of peoples and nations, scientific and technological developments provide

⁷⁷ CRC Committee, *General Comment No. 15* (n 61 above) para 44.

⁷⁸ UNOHCHR ‘Maternal mortality and morbidity and human rights’ (2013) available at: http://www2.ohchr.org/english/issues/women/docs/Maternal_mortality_morbidity.pdf (accessed 18 Mach 2014).

⁷⁹ For details on the profound effects of a maternal death on child health and family well-being, see AE Yamin *et al* ‘Costs of inaction on maternal mortality: Qualitative evidence of the impacts of maternal deaths on living children in Tanzania’ (2013) available at: <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0071674> (accessed 18 April 2014).

⁸⁰ R Shah, Forward to *Acting on the call: Ending preventable child and maternal deaths* (2014) 1.

ever increasing opportunities, in a variety of ways.⁸¹ In the context of child and maternal health, it implies that as science progresses, the enjoyment of same by children and their mothers is likely save them from preventable or premature death.

Enjoying the benefits of scientific progress and its applications is a human right. The right to enjoy the benefits of scientific progress and its applications (REBSP) is enshrined in various international and regional instruments. It was proclaimed for the first time in the *American Declaration of the Rights and Duties of Man*, which states that ‘every person has the right [...] to participate in the benefits that result from intellectual progress, especially scientific discoveries’.⁸² The REBSP was further enshrined in the UDHR which stipulates that ‘everyone has the right [...] to share in scientific advancements and its benefits’.⁸³ This right became a binding norm when it was incorporated in the ICESCR, which recognizes ‘the right of everyone to enjoy the benefits of scientific progress and its applications’.⁸⁴ Also, the World Conference on Human Rights reaffirmed the right to benefit from scientific Progress.⁸⁵ The Special Rapporteur in the field of cultural rights on the right to benefit from scientific progress and its applications, F Shaheed, identifies as ‘one core principle’ the right of everyone, in particular marginalized populations, to ‘innovations essential for a life with dignity’.⁸⁶ Here, access to innovations essential for a life with dignity is one element of the right in question. Furthermore, for states parties to make the benefits of science physically available and economically affordable, on a non-discriminatory basis, is another core content of the right.

The right to benefit from scientific progress is also recognized in the domestic law of some countries. China could be taken as a good example. The Chinese law on Maternal and Infant Health Care provides that the ‘State (China) shall encourage and support education and

⁸¹ *UN Declaration on the Use of Scientific and Technological Progress in the Interests of Peace and for the Benefit of Mankind* (1975), proclaimed by *General Assembly resolution 3384 (XXX)*, 2nd Preamble.

⁸² *American Declaration of the Rights and Duties of Man* (1948), article 3.

⁸³ UDHR, article 27.

⁸⁴ ICESCR, article 15.

⁸⁵ *The Vienna Declaration*, para 11 (1993).

⁸⁶ American Association for the Advancement of Science (AAAS) *Defining the right to enjoy the benefits of scientific progress and its applications: American scientists’ perspectives* (2013) 6.

scientific research in the field of maternal and infant health care, popularize the advanced and practical technique for maternal and infant health care and disseminate the scientific knowledge in this field'.⁸⁷ In order to encourage scientific research the law goes on to state that 'wards shall be granted to organizations and individuals that have made remarkable achievements in the work of maternal and infant health care or achieved significant results in scientific research of maternal and infant health care'.⁸⁸

Although everyone is entitled to enjoy the benefits of scientific progress fully pursuant to the human rights instruments mentioned above, its accessibility remains the main issue at stake. Numerous reasons can be identified for the failure to implement this right. The fact that science rarely operates on a human rights basis and that the human rights community has rarely systematically addressed the requirements of this right is one factor.⁸⁹ In addition, the overwhelming majority of international human rights bodies, governments, and human rights advocates appear to be unaware of the existence of the right. Although there are a few attempts to clarify the scope and content of the right,⁹⁰ its interpretation and application is neglected. Moreover, implementation of many of the obligations related to the right to the benefits of science is unlikely to be within the capabilities of whole groups of states. This is mainly attributable to lack of availability of resources, capabilities, and infrastructure necessary to engage in research and development, particularly in the developing countries.⁹¹ This in turn reduces the ability to enjoy human rights, including the ability to hold governments accountable for the direction of scientific progress and its human rights implications.

⁸⁷ Law of the People's Republic of China on Maternal and Infant Health Care, adopted at the Tenth Meeting of the Standing Committee of the Eighth National People's Congress on October 27, 1994, promulgated by Order No. 33 of the President of the People's Republic of China on October 27, 1994, and effective as of June 1, 1995, Chapter I, article 5.

⁸⁸ *Ibid.*, article 5.

⁸⁹ A Chapman 'Towards an understanding of the right to enjoy the benefits of scientific progress and its applications' (2009) 1 *Journal of Human Rights* 1.

⁹⁰ United Nations Educational, Scientific and Cultural Organization (UNESCO) *The Right to Enjoy the Benefits of Scientific Progress and its Applications* (2009) 6, 8.

⁹¹ *Ibid.*, 7 & 14; Chapman (n 89 above) 31.

Nevertheless, global and regional instruments are clear about the fact that REBSP is a human right and imposes different layers of responsibilities. From Rajiv Shah's statement above it can be realized that conducting scientific research and making use of its outcomes makes possible reduction in child mortality. As it has a direct relation with their survival, children may have a special claim, through their representatives, to the benefits of scientific progress in health care. A human rights approach to the benefits of scientific progress and its applications would, therefore, be able to bring benefits for ensuring child survival rights, which will ultimately enable reduction in under-five mortality.

3.3.3.5 Other rights

A further right that is closely connected with child survival is the right to an adequate standard of living. The CRC guarantees 'the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development'.⁹² It also requires governments to assist parents and others responsible for the child to implement this right through taking appropriate measures, particularly with regard to providing nutrition, clothing and housing.⁹³ Similarly, this has been emphasized in the ICESCR, which recognizes the 'right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions'.⁹⁴ Reading from both documents, this right at a minimum requires that everyone shall enjoy the necessary subsistence rights: adequate food and nutrition, clothing, housing and the necessary conditions of care when required.⁹⁵ The Committee on ESCR has issued several General Comments explaining the components of this right, including the right to adequate housing (General Comments No. 4 and No. 7), the right to food (General Comment No. 12), the right to water (General Comment No. 15) and the right to social security (General Comment No.19).

⁹² CRC, article 27.

⁹³ Ibid.

⁹⁴ ICESCR, article 11.

⁹⁵ 'The right to an adequate standard of living' available at: <http://www.humanrights.is/the-human-rights-project/humanrightscasesandmaterials/humanrightsconceptsideasandfora/substantivehumanrights/therighttoanadequatestandardofliving/> (accessed 20 June 2014).

The importance of the right to an adequate standard of living pertains to its potential for preventing under-five deaths and promoting the healthy development of the child. Key factors for a healthy upbringing and development mainly include adequate housing, including safe cooking facilities, adequate space and protection from overcrowding, a smoke-free environment, appropriate ventilation, effective management of waste and the disposal of rubbish from living quarters and the immediate surroundings, the absence of mould and other toxic substances, and a good standard of family hygiene. Under-five mortality and morbidity are highly implicated by absence of these guarantees given that many of these factors have a direct relationship with pneumonia and diarrhoea. As discussed previously these diseases are leading causes of under-five mortality.⁹⁶

Other provisions that complement the right to survival of children include a healthy and safe environment, education and play (provided in articles 28, 29 and 31 of the CRC). In addition to the binding global and regional instruments discussed in the preceding sections, there are also Declarations made by governments to strengthen implementation of child survival rights further. I provide an overview of these below.

3.3.4 The World Declaration on the Survival, Protection, and Development Children (1990) and others

The drafting and adoption of the *World Declaration on the Survival, Protection and Development of Children* (hereinafter ‘the World Declaration’) follows the CRC and predates that of the ACWRC. The World Declaration is a non-binding document in relation to child survival and development, in contrast to the two binding Children’s instruments discussed above. Similarly to these to instruments, the World Declaration aims to providing a better future for every child.

⁹⁶ CRC Committee, *General Comment No. 15* (n 61 above) para 49.

The *World Declaration* acknowledges children as ‘being innocent, vulnerable and dependent and that their time should be of joy and peace, of growing, playing and learning’.⁹⁷ It also states the challenges that children of the world face owing to the scourges of poverty, hunger, homelessness, illiteracy, epidemics, malnutrition, environmental degradation, lack of clean water, inadequate sanitation and others.⁹⁸ Equally important, the Declaration notes the opportunities that exist in our world to ensure respect for children’s rights and welfare. It identifies these opportunities to include that nations of the world have the means and the knowledge to protect the lives and reduce enormously the suffering of children and to promote the full development of their potential. A further opportunity is improvements in the international political climate that could make possible concrete results to prevent the spread of fatal and crippling diseases and to achieve greater social justice through international cooperation and solidarity.

The Declaration was also accompanied by a *Plan of Action* for its implementation. The *Plan of Action* was intended as ‘a guide for national governments and international organizations, NGOs, bilateral aid agencies and all other sectors of society in formulating their own program of action for the implementation of the *Declaration of the World Summit for Children*’.⁹⁹ It calls for specific action to be taken with respect to the CRC and on questions such as child health, food and nutrition, the role of women, maternal health and family planning, the role of the family, basic education, literacy and others.

The *Plan of Action* calls for concerted national action and international co-operation to strive for the achievement, in all countries, of the following major goals for the survival, protection and development of children by the year 2000:¹⁰⁰

⁹⁷ *World Declaration on the Survival, Protection and Development of Children*, agreed to at the World Summit for Children on 30 September 1990, para 2, available at: <http://www.unicef.org/wsc/declare.htm> (accessed 10 June 2014).

⁹⁸ *Ibid.*, paras 5-6.

⁹⁹ *Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s*, para 1, available at: <http://www.unicef.org/wsc/declare.htm> (accessed 10 June 2014).

¹⁰⁰ *Ibid.*, para 5.

- (a) Reduction of 1990 under-5 child mortality rates by one third or to a level of 70 per 1,000 live births, whichever is the greater reduction;
- (b) Reduction of maternal mortality rates by half of 1990 levels;
- (c) Reduction of severe and moderate malnutrition among under-5 children by one half of 1990 levels;
- (d) Universal access to safe drinking water and to sanitary means of excreta disposal;
- (e) Universal access to basic education and completion of primary education by at least 80 per cent of primary school age children;
- (f) Reduction of the adult illiteracy rate to at least half its 1990 level (the appropriate age group to be determined in each country), with emphasis on female literacy;
- (g) Protection of children in especially difficult circumstances, particularly in situations of armed conflicts.

Furthermore, in order to realize the goals mentioned above, the *Plan of Action* provides for specific action to be taken at the national level and at the international level. At the national level, the *Plan of Action inter alia* requires governments to prepare national programs of action, and to 'encourage and assist provincial and local governments as well as NGOs, the private sector and civic groups to prepare their own programs of action; to re-examine in the context of its national plans, programs and policies, budgets, how it might accord higher priority to programs for the well-being of children in general and to ensure that such programs are protected in times of economic austerity and structural adjustments'.¹⁰¹ In addition, it encourages 'families, communities, local governments, NGOs, social, cultural, religious, business and other institutions, including the mass media, to play an active role in support of the goals enunciated; to establish appropriate mechanisms for the regular and timely collection, analysis and publication of data required to monitor relevant social indicators relating to the well-being of children'.¹⁰² The indicators include 'neonatal, infant and under-5 mortality rates, maternal mortality and fertility rates, nutritional levels, immunization coverage, morbidity rates of diseases of public health importance, school enrolment and achievement and literacy rates - which record the progress being made towards the goals set forth in this *Plan of Action* and corresponding national plans of action'.¹⁰³

¹⁰¹ Ibid., para 34(i).

¹⁰² Ibid., para 34(iv).

¹⁰³ Ibid., para 34(v).

At the international level, the *Plan of Action* among other things urges ‘all international development agencies - multilateral, bilateral and non-governmental, to examine how they can contribute to the achievement of the goals and strategies, and requests full co-operation and collaboration of all relevant United Nations agencies and organs, other international institutions, all regional institutions, including regional political and economic organizations’¹⁰⁴ in the implementation of the Declaration and the *Plan of Action*. It also requests the assistance of the United Nations to institute appropriate mechanisms for monitoring the implementation of the *Plan of Action*, using existing expertise of the relevant UN statistical offices, the specialized agencies, UNICEF and other UN organs.¹⁰⁵ UNICEF is further ‘requested to prepare, in close collaboration with the relevant specialized agencies and other UN organs, a consolidated analysis of the plans and actions undertaken by individual countries and the international community in support of the child-related development goals for the 1990s’.¹⁰⁶

In general, the goals pronounced in the *World Declaration* and its *Plan of Action* were ambitious and the commitments required to implement them will demand consistent and extraordinary effort on the stake holders. Despite the ambitious nature of these documents, globally, child survival and development has shown decline due to control of various diseases and renewed political commitment of governments.

However, within the context of one goal leading to another, the World Declaration was followed by another declaration. As a result, literally all the nations of the world sat in New York and endorsed the *UN Millennium Development Declaration* in the year 2000 through the UN General Assembly Res/55/2. The *Development Declaration* addresses a broad spectrum of subjects in its eight chapters from laying down values and principles, to Peace, Security and Disarmament Development and Poverty Eradication, to protecting our Common Environment, to Human Rights, Democracy and Good Governance, to protecting the Vulnerable, to Meeting the Special Needs of Africa and to strengthening the UN. Within

¹⁰⁴ Ibid., para 35(i).

¹⁰⁵ Ibid., para 35 (iv).

¹⁰⁶ Ibid., para 35 (v).

the chapter dealing with development and poverty reduction, the 189 countries that adopted the *Development Declaration*, resolved further to have reduced under-five child mortality by two third of their current rates (in 1990) by the year 2015.¹⁰⁷

Despite the significant achievements made globally in the area of under-five death reduction, very recently in June 2014, initiatives are gaining momentum that recognize under-five mortality as still high in many countries, especially in sub-Saharan Africa, and the need for the world to come together to craft a global goal to end preventable child deaths by 2035.¹⁰⁸

At the AU level, a Declaration, proposed by the government of Ethiopia to end preventable maternal and child deaths within a generation in the continent, was adopted at the end of the 23rd AU summit in Malabo, in June 2014. Using this Declaration as a road map, the African governments have committed to ending preventable maternal and child deaths on the continent through universal access to quality maternal, new-born and child health (MNCH) services across the continent primarily by developing a 20-year Pan-African MNCH road map.

This makes clear that despite encouraging progress, ending preventable under-five mortality continues to be a human rights challenge and health development concern for Ethiopia and the rest of sub-Saharan Africa in general. Although the declarations discussed above show governments' commitment to address the challenge, as Alston argues, they fail to incorporate, among other things, the advantage of building upon legal obligations already voluntarily undertaken by governments which have ratified human rights treaties and the mobilising potential of rights discourse.¹⁰⁹ It is also doubtful to see the added value and credibility brought to the goals by applying norms of non-discrimination and equality to ensure that aggregated approaches do not neglect individuals. In addition, the goals fail to recognize the specificity

¹⁰⁷ UN General Assembly, *UN Millennium Declaration, Resolution Adopted by the General Assembly*, 18 September 2000, A/RES/55/2, para 19, available at: <http://www.refworld.org/docid/3b00f4ea3.html> (accessed 3 September 2014).

¹⁰⁸ *Acting on the call: Ending preventable child and maternal deaths report* (n 80 above).

¹⁰⁹ P Alston 'A human rights perspective on the Millennium Development Goals: Paper prepared as a contribution to the work of the Millennium project task force on poverty and economic development' 3. Also available at: www.ohchr.org/english/issues/development/docs/millennium.doc (accessed 12 May 2013).

given to vague terms such as participation and empowerment when particular civil and political rights norms are invoked. More so, they omitted the potential role of human rights institutions which already exist at the national level in many countries, and the potential contribution of increasingly sophisticated international accountability mechanisms in the human rights arena. Furthermore, it is open to doubt whether countries bind themselves by their commitment, to anything more than attempting to achieve the goals. There is a risk that the goals may be backed by no more than a moral or political commitment.

Complicating matters further, achievement of governments regarding the measures they have taken to reduce child mortality in accordance with goals set mainly depend on reports provided by the governments themselves. There is no independent mechanism for monitoring accuracy of the information provided. The fact that the governments concerned do not have appropriate records on birth and death of children signifies the questionability of data submitted. It is a rare case that governments will admit violation of human rights in their own domestic jurisdiction and reports presented are usually contested. It is in view of this that Chapman notes that in most cases reports by states appear to be designed to camouflage, rather than reveal, problems and inadequacies.¹¹⁰ This entails a limitation to measure the extent to which children under five are challenged with their right to survive.

Despite the failure of the foregoing declarations in making explicit reference to the application of human right norms and setting appropriate accountability or monitoring mechanisms, the goals stated in them cannot be under-estimated. They have significant impact in ensuring child survival rights and its complimentary rights discussed in section 3.3.3.

Overall, in this section 3.3 I demonstrate that child survival is a cross-cutting and multidisciplinary affair that affects a number of different rights in both the global and regional human rights law and is subjected to state political commitments. The incorporation of child survival and its complimentary rights is a step forward to address child mortality. Nevertheless,

¹¹⁰ A Chapman 'Monitoring women's right to health under the International Covenant on Economic, Social And Cultural Rights' (1995) 44 *The American University Law Review* 1160.

mere absorption of the law in paper cannot in itself end child mortality. Simultaneously, there is also a need to develop crosscutting and multi-disciplinary responses in terms of domestic law and policy, programme implementation, service delivery and research, to better enhance child survival.

3.4 State parties and non-state actors' obligation with respect to child survival

In the preceding section I set out the human rights framework affecting the child survival right. Human rights law, simultaneously, provides for a spectrum of obligations binding upon states in relation to this right. The task of establishing a legally constituted human right to child survival requires establishment of legal duties to serve that right. These obligations require governments in the main to perceive the danger to their young populations from preventable causes, and the failure to so do constitute a breach of the obligation to fulfil children's right to survive, to health and their other human rights. In this section I describe state obligations with respect to child survival or to reduce child mortality.

As opposed to development programs and goals, which generally aim to generate attention, mobilise resources and contribute technical health monitoring approaches, human rights offer a legal grounding of commitments.¹¹¹ These legal obligations emanate either from human rights treaties, global or regional, and/or from national legislation. Human rights treaties create legally binding obligations for the State that has ratified the instrument (the State Party). In other words, the ratification of the treaties implies that the State Party assumes obligations to implement them.

Depending on the particular right in focus, the obligation that emanates from a human rights treaty could be categorized to be achieved by state parties *immediately* or *progressively*. For instance, the ICCPR imposes, without exception, immediate obligations to 'respect' and

¹¹¹ The Partnership for Maternal, Newborn and Child Health (PMNCH): Knowledge Summary 23 *Human Rights and Accountability* (2013) 1.

‘ensure’ the rights proclaimed, and to take the required action to bring about results (obligations of result).¹¹² The ICESCR, on the other hand, obliges the State to undertake steps with a view to achieve progressively the full realisation of the rights recognised by the Covenant. Progressive realization, however, does not mean it fully excludes obligations of immediate effect. For instance, adoption of legislation and formulation of policies for the gradual realisation of the rights concerned is an *immediate* obligation. In addition, irrespective of the level of development, there is also an immediate obligation on the State Party to ensure, at the very least, *minimum levels* of each of the rights of a treaty, that is, as much as realistically can be achieved at a given time within the resources of the State in question.¹¹³

Notwithstanding the discussion I make in section 3.4.2 concerning the qualifying ‘progressive realisation’, the right to child survival and its complimentary rights, except the right to life, obliges state parties to the relevant global and regional treaties to undertake steps with a view to achieve progressively the full realisation of the rights. Seen from a comprehensive perspective, a RBA accountability framework with respect to child mortality requires a clear understanding of the multiple obligations relating to child survival and its complementary rights. Where such obligations are concretely addressed by states, they obviously can significantly contribute to reduction of under-five child mortality.

3.4.1 Protect, respect, and fulfil

Every country is party to at least one of the treaties discussed in this work and has obligations to respect, protect and fulfil the rights outlined. These treaties in addition to the UDHR form the foundation for a rights-based approach to child survival.

¹¹² Human Rights Committee, *General Comment No. 31, Nature of the General Legal Obligation on States Parties to the Covenant* (2004), para 5, U.N. Doc. CCPR/C/21/Rev.1/Add.13, available at: <http://www1.umn.edu/humanrts/gencomm/hrcom31.html> (accessed 16 July 2014).

¹¹³ K Young ‘The minimum core of economic and social rights: A concept in search of content’ (2008) 33 *The Yale Journal of International Law* 135. See, also, section 3.4.4.

The obligation to respect requires states to refrain from interfering directly or indirectly with children's right to survival and the complimentary rights. For example, states should refrain from denying or limiting access to health-care services; from marketing unsafe drugs; from imposing discriminatory practices relating to children's health status and needs; from limiting access to contraceptives and other means of maintaining sexual and reproductive health; from withholding, censoring or misrepresenting health information; and from infringing the right to access to food, safe drinking water and other underlying determinants of health.¹¹⁴ In addition, Alston affirms that in terms of international law, the obligation 'to respect' requires states 'to refrain from any actions which would violate any of the rights of the child under the CRC'.¹¹⁵

Furthermore, the duty to respect entails that a state may not take someone's life – and the right to life is an 'inherent' and 'non-derogable' right. It requires states Parties to enforce the laws that prevent and punish state actors who kill people.

The obligation to protect requires states to prevent third parties from interfering with children's right to survival and their complimentary rights. It also further requires states to 'adopt legislation or other measures to ensure that private actors conform with human rights standards when providing health care or other services; control the marketing of medical equipment and medicines by private actors; and ensure that privatization does not constitute a threat to the availability, accessibility, acceptability and quality of health-care facilities, goods and services'.¹¹⁶ The state is also bound to protect children 'from acts by third parties that may be harmful to their right to health and ensure that third parties do not limit people's access to health related information and services, including environmental health'.¹¹⁷ This has been affirmed by the Committee on ESCR in its General Comment No. 14, which stressed that states parties should prevent third parties from violating the right to health in other countries.¹¹⁸ It

¹¹⁴ UNOHCHR *The right to health* Fact sheet 31 (2008) 26.

¹¹⁵ P Alston 'The legal framework of the Convention on the Rights of the Child' (1992) 91:2 *Bulletin of Human Rights* 5.

¹¹⁶ UNOHCHR *The right to health* (n 114 above) 27.

¹¹⁷ *Ibid.*

¹¹⁸ *General Comment No. 14* (n 56 above) para 39.

further notes that, when negotiating international or multilateral agreements, states parties should take steps to ensure that these instruments do not have an adverse impact on the right to health.¹¹⁹

The obligation to fulfil, on the other hand, requires states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to fully realize the right to health of children. States must, for instance, adopt a national health policy or a national health plan covering the public and private sectors; ensure the provision of child health care, including immunization programs against infectious diseases and services designed to minimize and prevent further disabilities.¹²⁰ Also, states must ensure ‘equal access for all to the underlying determinants of health, such as safe and nutritious food, sanitation and clean water; ensure that public health infrastructures provide for sexual and reproductive services and that doctors and other medical staff are sufficient and properly trained; and provide information and counselling on health-related issues, such as HIV/AIDS, domestic violence or the abuse of alcohol, drugs and other harmful substances’.¹²¹

3.4.2 Obligation to undertake legislative, administrative and other measures

To recognize children as holders of human rights brings about certain responsibilities. When states ratify the conventions discussed above, they take upon themselves the obligations to implement them within their jurisdiction. Regarding states obligations for children’s survival or other rights, the text of article 4 of the CRC reads as follows:

States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international cooperation.

¹¹⁹ Ibid.

¹²⁰ UNOHCHR *The right to health* (n 114 above) 28.

¹²¹ Ibid.

The above article of the CRC provides the overall obligation of states to implement all the rights in the CRC, of which child survival is one. It requires not some but all states to take ‘all appropriate legislative, administrative, and other measures’. However, the CRC makes no clarification as to what constitutes legislative or administrative measures to be undertaken by states parties to the Convention. Fortunately, the Committee on the Rights of the Child has given some guidance on this. Although the Committee does not clearly define legislative measures by state parties, mention is made that ‘ensuring that all domestic legislation is fully compatible with the Convention and that the Convention’s principles and provisions can be directly applied and appropriately enforced is fundamental’.¹²² Harmonization of domestic law in line with the CRC through legislative measures is therefore a key element in the implementation of the Convention. This basically needs a comprehensive review of all domestic legislation against the CRC’s provisions, article by article, by recognizing the interdependence and indivisibility of human rights. According to the Committee, the review process should not be done in a once-off manner, but continuously.¹²³ The review should also ensure the participation of all relevant government departments, parliamentary committees and hearings, national human rights institutions, NGOs, academics, affected children and young people and others.¹²⁴

Despite the requirement to take legislative measures, in many countries the CRC is still not fully incorporated into national law.¹²⁵ This partly implies that violations cannot be challenged through the national courts.¹²⁶ This is the case for economic, social and cultural rights, which

¹²² CRC Committee, *General Comment No. 5, General Measures of Implementation of the Convention on the Rights of the Child* (articles 4, 42 and 44, para 6), para 5, UN Doc CRC/GC/2003/5 (2003).

¹²³ *Ibid.*, para 18.

¹²⁴ *Ibid.*

¹²⁵ Save the Children ‘Improving accountability for child rights: The need for a new international mechanism-Save the Children’ available at: http://www.savethechildren.org.uk/sites/default/files/docs/OP_Briefing_very_final_1.pdf (accessed 24 June 2014).

¹²⁶ There are, however, countries where non-domestication of the CRC is not a bar for enforcement of children’s rights provided in the CRC. South Africa could be a paradigmatic example. Despite South Africa not having domesticated the CRC, its impact has been significant and there have been numerous challenges to violations of the rights contained in the CRC. See, A Skelton ‘South Africa’ in T Liefwaard & JE Doek (eds) *Litigating Children’s Rights: The UN Convention on the Rights of the Child in Domestic and International Jurisprudence* (2014) 13–30;

include children's right to survival and an adequate standard of living and health. As a result, these rights are rarely legally enforceable in national courts and the vast majority of violations of child rights go unchallenged in certain jurisdictions.¹²⁷

On the other hand, taking administrative and other measures to implement the Convention is another obligation of states under the CRC. Through its on-going dialogue with governments and with the UN and UN-related agencies, NGOs and other competent bodies, the Committee has distilled what it believes would constitute administrative measures necessary for the effective implementation of the Convention. The administrative and other measures that state parties should take in order to comply with article 4 of the Convention includes the following. First, governments should develop a comprehensive national strategy built on the framework of the Convention.¹²⁸ This implies that if governments are to respect and promote children's rights as a whole and at all levels, they need to develop a comprehensive and rights based national strategy rooted in the Convention.¹²⁹ The strategies need to relate to the situation of all children, and all rights in the Convention. In the context of children's health, it implies that there is a need to develop and implement a comprehensive national strategy for promoting their right to health throughout their life span. In order for a strategy to be effective, it has to be prepared through a process of consultation including with children and those living and working with them. Special child sensitive materials and processes are necessary for consultation to be meaningful.¹³⁰

The second administrative measure that must be taken by states is coordination of implementation of children's rights among central government departments, among different provinces and regions, between central and other levels of government and between government and civil society, and decentralization, federalization and delegation of power for

and J Sloth-Nielsen & H Kruuse 'A maturing manifesto: The constitutionalisation of children's rights in South African jurisprudence 2007-2012' (2013) 21:4 *The International Journal of Children's Rights* 646 – 678.

¹²⁷ Save the Children 'Improving accountability for child rights: The need for a new international mechanism-Save the Children' (n 125 above).

¹²⁸ CRC Committee, *General Comment No. 5* (n 122 above) paras 28-29.

¹²⁹ O De Schutte *International Human Rights Law: Cases, Materials, Commentary* (2014) 542.

¹³⁰ *Ibid.*

effective implementation of the Convention.¹³¹ As it is not often possible to keep all the matters or services affecting children in a single department, the role and responsibilities for ensuring children's needs is delegated to different departments or units of a state. Thus, the issue of ensuring coordination among these cross-sectional units becomes necessary. With a view to ensuring effective coordination among these various departments and agencies, many states have developed specific departments or agencies close to the heart of the government, in some cases in the president's, prime minister's or cabinet office.¹³² If that special department or unit is given a high-level of authority such as the power to report directly to the prime minister or the president or any other organ that has the ultimate say, it can contribute to effective coordination to ensure respect for and fulfilment of children's rights across government and at all levels of government.¹³³ As I discuss in chapter four, the responsibility to coordinate children's affairs in Ethiopia is conferred upon the Ethiopian Federal Ministry of Women, Children's and Youth Affairs whose responsibility is explicitly mentioned under Proclamation No. 691/2010.

Monitoring implementation of children rights by several bodies, such as by parliamentary committees, NGOs, academic institutions, professional associations, youth groups and independent human rights institutions is the third administrative and other measures that the CRC Committee prescribes for states to help them ensure effective implementation of the Convention.¹³⁴ Monitoring is quite remarkable in the sense that these several bodies have the potential to ensure accountability for the realisation of children's rights. As I emphasised in the previous chapter, a HRBA to accountability has an impact and is an alternative path to improve health gains for children and women, and ensure policy changes that are discriminatory. In fact, it is mainly through utilization of the work of these institutions that we can justify that government has taken effective actions and its action is monitored by independent bodies that can impose a high political cost on governments for not doing enough. In order for this role to

¹³¹ *General Comment No. 5* (n 122 above) paras 37-41.

¹³² De Schutte (n 129 above) 544.

¹³³ *Ibid.*

¹³⁴ *General Comment No. 5* (n 122 above) paras 45-47.

occur, states are bound first to ensure that there exists an enabling environment for these independent bodies and institutions to be established and function without interference.

Collection of sufficient and reliable data on children, disaggregated to enable identification of discrimination and/or disparities in the realization of rights could be the fourth measure states must take effectively to implement the Convention. The significance of this administrative measure to be taken by states was earlier prescribed by the Committee on CESCR where the same body reminded state parties to the ICESCR to gather disaggregated data concerning health of their population. The CESCR Committee considered disaggregation of health and socio-economic data according to sex essential for identifying and remedying inequalities in health.¹³⁵ If states have to comply with their obligations to address inequalities in access to child health, it is important that they also ensure disaggregated data on children's health and socio-economic data is available according to the requirements of general measures provided under article 4 of the CRC.

Providing training and capacity-building for all those involved in the implementation process including government officials, parliamentarians and members of the judiciary, and for all those working with and for children is within the fifth measure that states must work to comply with article 4 of the Convention. This obligation reflects one of the aims of a HRBA to health – building the capacity of duty bearers, discussed in section 2.2.2 & 2.2.3.1 of this thesis. I discuss in there the salience of building the capacity of the state at all levels (local, regional/federal) and other categories of duty-bearers in relation to health, including policy makers, hospital managers, and health professionals, in order facilitate the realization of the right to health of children.

On top of above, a point worth noting concerning article 4 of the CRC pertains to its second proviso. It suggests a distinction between civil and political rights and economic, social and

¹³⁵ *General Comment No. 14* (n 56 above) para 20.

cultural rights.¹³⁶ With regard to economic, social and cultural rights it reveals a practical acceptance that lack of resources can limit the full implementation of these rights in some states. This brings about the concept of ‘progressive realization’, which requires states to be able to demonstrate that they have implemented such rights ‘to the maximum extent of their available resources’ and, where necessary, have sought international cooperation. It thus imposes an obligation to move as expeditiously and effectively as possible towards that goal. Except the slight difference in the qualifying phrase used, the sentence seems similar to the wording used in article 2 of the ICESCR.¹³⁷ The full realization of all economic, social and cultural rights will generally not be achieved in a short period of time, and the concept of progressive realization constitutes recognition of this fact.¹³⁸ In this sense the obligation differs significantly from that contained in article 2 of the ICCPR, which embodies an immediate obligation to respect and ensure all of the relevant rights.¹³⁹

Despite the similarity in the wordings of the CRC and ICESCR, it is worth to interrogate whether children’s socio-economic rights are, like those adults, subject to progressive realization or maximum extent of available resources. Whether the qualification of ‘progressive realization’ applies to children’s socio-economic rights is subject to different views. One observes two notable differences of opinion – between scholars and relevant UN body explanations. One the one hand, defending an earlier position by Hammerberg¹⁴⁰, Skelton argues that the maximum extent of available resources did not imply that poorer countries could avoid responsibilities except that the notion of progressive realization does apply in specific articles of the CRC. For Hammerberg & Skelton, article 4 of the CRC is rather a call for prioritisation of children within the state budget.¹⁴¹ To support her position, Skelton further analyses the

¹³⁶ *General Comment No. 5* (n 122 above) para 6.

¹³⁷ *Ibid.*, para 8.

¹³⁸ Committee on Economic, Social and Cultural Rights, *General Comment No. 3, The Nature of States Parties’ Obligations* (Fifth session, 1990), para 39, U.N. Doc. E/1991/23, annex III at 86 (1991).

¹³⁹ *Ibid.*

¹⁴⁰ Among other things, Hammerberg made a comparison between article 4 of the CRC and article 2(1) of the ICESCR. He maintained that the latter allows for progressive realisation, but the former does not, except in specific articles. For his elaborated discussion, see T Hammerberg ‘Children’ in A Eide *et al* (eds) *Economic, Social and Cultural Rights* (2001) 366.

¹⁴¹ A Skelton ‘Girl’s socio-economic rights in South Africa’ (2010) 26:1 *South African Journal of Human Rights* 143-144.

distinction that exists between the various sections stipulated under the South African (SA) Constitution. Section 28(1)(c) of the SA Constitution states that every child has the right ‘to basic nutrition, shelter, basic health care services and social services’. This clause does not have any ‘internal qualifiers’. However, other socio-economic rights such as, s 26 (right to housing) and s 27 (right to health care, food, water and social security- and social assistance), which apply to everyone including children, have various internal qualifiers. Comparing these three sections of the Constitution, Skelton argues that children’s rights to basic health care services and other services are immediately realisable and not subject to progressive realisation. She also records the premises taken when drafting s 28(1)(c) i.e., it was based on an understanding that international law did not envisage progressive realisation in relation to children’s socio-economic rights.¹⁴²

The second school of thought is one adopted by the CRC Committee in its General Comment No. 5. This UN treaty relevant body’s document provides guidance to states on general measures of implementation of the CRC. Contrary to some prevailing view prior to its issuance, paragraph 5 of the General Comment limited the possibility of an interpretation that article 4 of the UNCRC was not qualified by progressive realisation. It reads that: ‘The second sentence of article 4 reflects a realistic acceptance that lack of resources – financial and other resources – can hamper the full implementation of economic, social and cultural rights in some States; this introduces the concept of ‘progressive realization of such rights’.¹⁴³ This interpretation seems unfortunate for children as it pours cold water on the interpretation given by Hammerberg & Skelton.

The fact that progressive realization over time is foreseen under the CRC should not, however, be misinterpreted as depriving the obligation of all meaningful content. The CRC rather tries to strike a balance between the realities in the observable world with difficulties involved for any country in ensuring full realization of economic, social and cultural rights on the one hand, and the need to establish clear obligations for states parties in respect of the full realization of

¹⁴² Ibid.

¹⁴³ *General Comment No. 5* (n 122 above) para 7.

the rights in question, on the other.¹⁴⁴ Equally important is that states cannot make any deliberate retrogressive measures against their obligation to progressively realize the rights. Any such measure 'would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources'.¹⁴⁵

3.4.3 Obligation of non-discrimination

Concerning non-discrimination, the CRC provides that 'States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind ...'.¹⁴⁶

The above provision, together with articles 2(3) and 4 of the CRC, constitutes a fundamental obligation of states parties in relation to child survival and other rights stated under the CRC. The Human Rights Committee proposes that the term 'discrimination' should be understood to imply 'any distinction, exclusion, restriction or preference which is based on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms'.¹⁴⁷

As with other rights of children in the Children's Convention, states have the obligation to ensure that the right to child survival is implemented without discrimination, within their domestic jurisdiction. To implement the obligation of non-discrimination states, for instance, must ensure that health care facilities, goods and services are accessible to everyone within the state's jurisdiction, especially the most vulnerable and marginalized group of children.

¹⁴⁴ Committee on Economic, Social and Cultural Rights, *General Comment No. 3* (n 138 above) para 9.

¹⁴⁵ *Ibid.*

¹⁴⁶ CRC, article 2(3).

¹⁴⁷ UN Human Rights Committee, *CCPR General Comment No. 18: Non-discrimination*, para 7 (1989).

Addressing non-discrimination may also require changes in legislation, administration and resource allocation, as well as educational measures to change attitudes.

The obligation of non-discrimination is also provided for in other human right instruments. For instance, under articles 2(2) and 3 of the ICESCR, states undertake to ‘guarantee’ and ‘ensure’ immediately that the rights in the ICESCR can be exercised without discrimination on prohibited grounds. Non-discrimination is arguably the ‘single dominant theme’ of the ICESCR and is regarded as particularly important in relation to child survival’s fundamental complimentary right, i.e. the right to health. Similarly, states are obliged to protect individuals from discrimination by third parties especially in view of the fact that private actors are playing a significant role in the state’s health care system.¹⁴⁸ This is an absolute obligation which requires the state to prohibit and provide a process for remedying discrimination by third parties, such as if a private hospital were to deny services on various grounds. In a particular instance in Chile where women were discriminated against by private health care providers in their attempts to access reproductive services in Chile, the Committee on CESCRC was concerned and recommended that anti-discrimination training be provided to the private sector.¹⁴⁹

Moreover, in the area of children’s rights, the non-discrimination obligation requires states to actively disaggregate groups of children the recognition and realization of whose rights may demand special measures. Data collection on children and disaggregation of same enables discrimination or potential discrimination to be identified.¹⁵⁰ The application of the non-discrimination principle of equal access to rights does not, however, mean identical treatment. There are times where it is important to take special measures in order to diminish or eliminate conditions that cause discrimination.¹⁵¹

¹⁴⁸ See section 3.5.7.2 of this chapter for further discussion regarding the role of the private sector in relation to the right to health.

¹⁴⁹ Committee on Economic and Social Rights, *Concluding Observations: Chile*, 33rd sess, UN Doc E/C.12/1/Add.105 (2004) (48), (57).

¹⁵⁰ *General Comment No. 5* (n 122 above) para 48.

¹⁵¹ *Ibid.*, para 12. Such instances include affirmative action measures taken, through policies or program, by states to improve the status of a disadvantaged group. The purpose of affirmative action is to achieve substantial

Furthermore, in countries where federal arrangements are in place, for example countries like Ethiopia and Nigeria, the Committee on the CRC requires that the ‘governments of states parties must retain powers to require full compliance with the Convention by devolved administrations or local authorities and must establish permanent monitoring mechanisms to ensure that the Convention is respected and applied for all children within its jurisdiction without discrimination’.¹⁵² It further underlines the need to put in place appropriate guarantees to ensure that decentralization or devolution does not lead to discrimination in the enjoyment of rights by children in different regions.¹⁵³

Against the principle of non-discrimination, it is quite often possible to see states and the private sector denying equal access to basic social rights of children and adults. In this regard, the Committee on the CRC notes:¹⁵⁴

Potential discrimination in access to quality services for young children is a particular concern, especially where health, education, welfare and other services are not universally available and are provided through a combination of state, private and charitable organizations. As a first step, the Committee encourages States Parties to monitor the availability of and access to quality services that contribute to young children’s survival and development, including through systematic data collection, disaggregated in terms of major variables related to children’s and families’ background and circumstances. As a second step, actions may be required that guarantee that all children have an equal opportunity to benefit from available services. More generally, States Parties should raise awareness about discrimination against young children in general, and against vulnerable groups in particular.

3.4.4 Core obligation

equality. In China, for instance, its education policy admits minorities to universities on the basis of grades and examination scores below those of Han (Chinese) nationality. For details, see Li Weiwei *Equality and Non-Discrimination under International Human Rights Law* (2004) 22-25.

¹⁵² *Ibid.*, para 41.

¹⁵³ As above.

¹⁵⁴ Committee on the CRC, *General Comment No. 7, Implementing Child Rights in Early Childhood* (2005), para 12, CRC/C/GC/7/Rev.1.

In the foregoing section I indicate that the obligation of states for child survival or other socio-economic rights of children, provided under the CRC or ICESCR, is assumed to be realized over time, or in other words progressively. Despite this threshold, there is a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights incumbent upon every State Party, irrespective of their level of development.¹⁵⁵

The core obligation is a very difficult concept to capture in international human rights law.¹⁵⁶ However, attempts to give its meaning underscore that the requirement of core obligation includes that a state must not deprive any significant number of individuals of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education.¹⁵⁷ Conversely, a state is considered to have failed to discharge its minimum core obligation for socio-economic rights when any significant number of individuals is deprived of these essential material needs for human beings.

Further attempts to elaborate the meaning of ‘core obligation’ or ‘obligations of comparable priority’ is made through the ICESCR Committee General Comment, more specifically, in the context of health as a social right. Although the Committee fails to make a clear distinction between the two,¹⁵⁸ these core obligations or obligations of comparable priority include at least the following:¹⁵⁹

access to the minimum essential food which is nutritionally adequate and safe; access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; the reduction of the still-birth rate and infant mortality, and provision for the healthy development of the child; access to health facilities,

¹⁵⁵ *General Comment No. 3* (n 138 above) para 11.

¹⁵⁶ A Chapman & S Russel *Core Obligations: Building a Framework for Economic Social and Cultural Rights* (2002) 8-19.

¹⁵⁷ *General Comment No. 3* (n 138 above) para 10.

¹⁵⁸ L Formal *et al*, while praising the ESCR Committee’s attempt to clarify the content of essential primary health by identifying ‘obligations of comparable priority’, point to the Committee’s failure to distinguish the relationship between these and the minimum core obligations. For their comprehensive discussion on this, see L Formal *et al* ‘What could a strengthened right to health bring to the post-2015 health development agenda?: Interrogating the role of the minimum core concept in advancing essential global health needs’ (2013) 13 *BMC International Health Human Rights* 1-12.

¹⁵⁹ *General Comment No. 14* (n 56 above) paras 43(a)-(d) & 44(c)-(d).

goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; the provision of essential drugs, as defined under the WHO Action Program on Essential Drugs; and the provision of education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.

The minimum core obligations of states or obligations of comparable priority are inextricably intertwined with child survival. As I point out elsewhere in this thesis,¹⁶⁰ the cause of under-five mortality includes malnutrition and diseases such as pneumonia and diarrhoea, diphtheria, and measles, which are treatable through low-cost intervention efforts. On the other hand, in the foregoing paragraphs I have indicated that the minimum core content or obligations of comparable priority require states, at least, to ensure access for children to the minimum essential food which is nutritionally adequate and safe, to reduce the still-birth rate and infant mortality and to ensure the prevention, treatment and control of epidemic, endemic, occupational and other diseases and the provision of essential drugs. It follows that, if states are able to meet their minimum core obligations or obligations of comparable priority, child survival rights will potentially be implemented and preventable child mortality will be reduced significantly.

3.4.5 Budgetary measures

In the traditional classification of rights, socio-economic rights are regarded as ‘positive’ rights as opposed to civil-political rights which are ‘negative’ rights. Their difference being, despite the problematisation in making proper distinction regarding the duties they entail, that positive rights in the main oblige others to act whereas negative rights require others to restrain themselves from acting.¹⁶¹ For example, the right of the child to survival is a positive

¹⁶⁰ See, for instance, the causes for child mortality in Ethiopia in section 4.3.

¹⁶¹ It is not always the case that positive rights impose positive duties. Essentially, the duty to *respect* positive rights, such as the right to health, also imposes the duty on actors to refrain. Taking an example given by D Brand, the state may not limit or take away people’s existing access to housing, without good reason and without following proper legal procedure. Brand further notes, ‘in reality, the distinction between positive and negative duties is little more than a semantic distinction between acting and not acting’. For an elaborated discussion as

right which mostly incorporates all the necessary steps that a state party must undertake in order to fulfil the healthy development of children. Although rights appear on a ‘justiciability spectrum’, so that one needs to approach the implementation of each right on its own terms,¹⁶² ‘positive rights’ more often than not have serious resource implications for their progressive realization. Budget is one the mechanisms which states deploy, in addition to foreign cooperation and assistance, to fulfil positive rights.

Article 4 of the CRC envisages different types of measures to be taken by states for proper implementation of children’s rights. As indicated in section 3.4.2 above, the Committee on the CRC has through time tried to distil the various implementation measures. Adequate budgeting is one set of such measures that states need to consider in order to address the rights of children. States are committed to utilise the maximum of their available resources to realise the rights and wellbeing of children. But how does it relate to child survival outcomes?

Any outcome for improved child survival would not materialize without adequate budget allocation. A commitment by governments to delivering child survival under the CRC and ACRWC requires state budgeting for child rights. Budget is a crucial instrument for advancing the survival, protection and development of children. It is for this reason that, as discussed in chapter two (section 2.4), international conference processes have brought about a substantial increase in attention and resources devoted to the implementation of health and human rights within virtually all UN development agencies and programs.¹⁶³ Addressing resource issues is particularly important for Africa, where the capacity of most families to finance and provide for their children is very limited and where there are huge unmet needs for access to basic services.

to the problematisation of making a distinction of duties, see D Brand ‘Introduction to socio-economic rights in the South African Constitution’ in D Brand & CH Heyns (eds) *Socio-economic rights in South Africa* (2005) 9-12.

¹⁶² See A An-Naim ‘To affirm the full human rights standing of economic, social and cultural rights’ in Y Ghai & J Cottrell (eds) *Economic, Social and Cultural Rights in Practice: The Role of Judges in Implementing Economic, Social and Cultural Rights* (2004) 7-16. On the discussion that positive rights or socio-economic bring serious resource implication, see R Peerenboom ‘Economic and social rights: The role of courts in China’ (2011) 12 *San Diego International Law Journal* 329.

¹⁶³ S Gruskin & D Tarantola ‘Health and human rights’ rights’ in R Detels *et al* (eds) *Oxford Textbook of Public Health* (2002).

Research shows that many child and maternal deaths could be prevented if strong political commitment were supported by sufficient allocation of resources to secure the implementation of laws, policies and programs designed to improve maternal and child health.¹⁶⁴ Equally important is capacity building on child rights for planning and budgeting officers as well as communities that will significantly contribute to ensure greater accountability around budget allocations to child and maternal health. The importance of increasing budget allocation for implementation of children's rights was also affirmed by the CRC Committee when it made a recommendation that:¹⁶⁵

The State Party (Ghana) pay particular attention to the implementation of article 4 of the Convention by increasing and prioritizing budgetary allocations to ensure at all levels the implementation of the rights of the child and that particular attention is paid to the protection of the rights of children belonging to vulnerable groups including children with disabilities, children affected or/and infected by HIV/AIDS, street children and children living in poverty...

Despite the importance of allocation of budgets to improve child health, in many countries budget does not seem to receive much attention. In an event organized involving the WHO, the OHCHR, the Zambian government and Save the Children, the Zambian experience shows that the government makes no specific budget allocation to child and maternal health, despite Zambia's government's commitment to the Abuja Declaration,¹⁶⁶ which stipulates that at least 15% of the national budget needs to be allocated to health. Furthermore, Ms P Mayeya,

¹⁶⁴ Save the Children 'Budgets, rights, maternal and child health' side event summary' (2012) 1. Available at: https://www.savethechildren.net/sites/default/files/report%20side-event_short.pdf (accessed 21 June 2014).

¹⁶⁵ Ghana CRC/C/GHA/CO/2, para 18 (2002). The Committee also expressed a similar concern on budget issues when it asserted that economic or structural arrangement policies affecting budget should accommodate the best interest of the child. This was expressed in the Committee's recommendation in the case of Peru ((See Peru CRC/C/15/Add.8, para 19)) and Ukraine (see Ukraine CRC/C/15/Add.42, para 20).

¹⁶⁶ *The Abuja Declaration*, adopted in 2001, highlights the importance for governments in AU countries of giving greater weight to health in the allocation of at least 15% of government revenues, while at the same time urging donor countries to increase their funding levels up to 0.7% of their GNP (Gross National Product). Research, however, shows that there has not been appreciable progress in terms of the commitments the AU (African Union) governments make to health, or in terms of the proportion of GNI the rich countries devote to ODA (Official Development Assistance). See, further, WHO 'The Abuja Declaration: Ten years on' available at: <http://www.who.int/healthsystems/publications/Abuja10.pdf> (accessed 11 June 2014).

Deputy Country Director at Save the Children in Zambia, commented that ‘health does not receive full attention in national budget setting, often due to competing priorities’.¹⁶⁷

From the preceding it is noted that implementation of child survival rights or reduction of child mortality cannot be materialized without proper funding allocated by governments. Allocation of resources is the responsibility of governments. This is mainly because the CRC and ACRWC set a sound legal foundation in which every state must strive to implement children’s socio-economic rights through budgetary or other measures. Any budget allocation measure, whether it aims to child survival or any other socio-economic rights of children, should generally look at: how much is being allocated to children’s programs in the sectors particularly important for child rights realisation; the extent to which child targeted allocations are translating into efficient and effective services; the extent of discrimination in access to child focused budget inputs and outputs; and the extent to which fiscal policy is conducive to delivering child socio-economic rights.¹⁶⁸

Acutely aware of the fact that many states may face resource constraints in their attempts to realize children’s socio-economic rights, international and regional instruments provide the framework where other states shall bear responsibility to provide co-operation and assistance to the less developed nations with resource limitations. In the next section I discuss the legal framework governing international co-operation for realization of socio-economic rights.

3.4.6 International assistance and cooperation

Accountability with respect to children’s rights is not confined to the state in which a child resides. Rather, the realization of economic, social and cultural rights is an obligation of all states. When states ratify the CRC or ICESCR, ‘they take upon themselves obligations not only to implement it within their jurisdiction, but also to contribute, through international

¹⁶⁷ As above.

¹⁶⁸ J Streak ‘The South African children’s budget unit (CBU)’, Presentation for the exploratory dialogue on applied budget analysis for the advancement of economic, social and cultural rights (2001) 5.

cooperation, to global implementation'.¹⁶⁹ The significance of international cooperation to ensure for the realization of socio-economic rights was underscored by the Committee on the CESCR when the same body stressed that states which are in a position to assist others should fulfil their obligation to international cooperation for development and thus for the realization of socio-economic rights.¹⁷⁰ It thus becomes less controversial that states that are in position to assist states with high child mortality rates have the obligation to assist for health development of these states with high mortality rates.

Although the precise nature of this obligation is still contentious, the obligation of international cooperation dates back to the Charter of the UN. States parties have a joint and individual responsibility, in accordance with the Charter of the UN and relevant resolutions of the UN General Assembly and of the World Health Assembly to cooperate in providing disaster relief and humanitarian assistance, such as provision of safe and potable water, food and medical supplies, and financial aid to the most vulnerable or marginalized groups of the population.¹⁷¹ Furthermore, concerning international cooperation and assistance the relevant provisions of the UDHR provide:¹⁷²

Everyone ... is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity ... Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

In addition, article 4 of the CRC¹⁷³ also provides 'States Parties shall undertake... the implementation of the rights to the maximum extent of their available resources and,

¹⁶⁹ *General Comment No. 5* (n 122 above) para 7.

¹⁷⁰ *General Comment No. 3* (n 138 above) para 13.

¹⁷¹ *General Comment No. 14* (n 56 above) para 40.

¹⁷² UDHR, articles 22 & 28.

¹⁷³ It is important to note that the construction of article 4 of the CRC is different from its counter provision of article 1 of the ACRWC in relation to the obligation of international cooperation and assistance. The latter instrument omits the obligation of other members of the international community to assist low income countries in their move to implement socio-economic rights of children. The potential justification could be that the ACRWC binds only African governments and cannot speak of obligations ergo omnes as to implementation of the socio-economic enunciated. A different reason could be that African governments find themselves in a similar level of economic development (low-income countries) where one African country does not have the capacity to assist

where needed, within the framework of international cooperation'. This article emphasizes that implementation of the Convention is a cooperative exercise for countries of the world. The need for international cooperation is explicitly underlined in this article and others¹⁷⁴ in the Convention. In a similar fashion, the ICESCR recognizes 'international assistance and cooperation as an obligation arising from economic, social and cultural rights'.¹⁷⁵ Moreover, other human rights documents and the UN World Conferences address the issue of human rights and concrete commitments to international assistance and cooperation by high income countries.¹⁷⁶ There is also a growing understanding within human rights bodies as to the need for international cooperation and assistance to develop a multifaceted approach to improve the situation of children and prevent and combat infant and under-five mortality.¹⁷⁷

In view of the international commitments made through the documents discussed above, the right to child survival or measures aimed to reduce child mortality, therefore, require high-income states to assist low-income states in their efforts to reduce child mortality. In their human development programs, high-income states should ensure that reducing child mortality is adequately reflected in their development assistance contributions and policies. Furthermore, they should assume other measures, for example, abstaining from the recruitment of health professionals from low income countries where this would result in shortages of skilled human resources that, in turn, hampers the reduction of child mortality.

In order for the international cooperation and assistance obligation to be applied effectively, low income countries must seek assistance and cooperation from aiding governments. On the

the other in need of technical and material support for implementation of children's socio-economic rights in their own domestic jurisdiction. It seems to assume the source of obligation to be capacity.

¹⁷⁴ See, for instance, articles 23(4) & 28(3) of the CRC.

¹⁷⁵ ICESCR, article 2.

¹⁷⁶ These include *World Conference on Human Rights; The Vienna Declaration and Programme of Action*. A/CONF.157/23; the Millennium Declaration. A/RES/55/2; and Monterrey Consensus of the International Conference on Financing for Development. A/Conf.198/11.

¹⁷⁷ *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, Paul Hunt - Addendum - Missions to the World Bank and the International Monetary Fund in Washington, D.C. (20 October 2006) and Uganda (4-7 February 2007), A/HRC/7/11/Add.2., available at: <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G08/114/25/PDF/G0811425.pdf?OpenElement> (accessed: 16 October 2014).

other hand, the donor governments are also encouraged to ‘ensure that their aid programs follow the lines of the CRC and establish a clear priority for children’.¹⁷⁸ It is, nonetheless, quite significant to note that the duty of high-income states to assist low-income states does not deprive the latter of their own obligations to progressively realise the right to child survival. Also, it is the primary responsibility of low-income states to undertake measures within their domestic resources. It is only where necessary and possible that they must supplement domestic with international resources.

3.4.7 Obligation of non- state actors

Like any other human rights obligation, a state’s obligation to protect children’s survival rights includes ensuring that non-state actors do not infringe upon human rights. With respect to the health of children, where the failure of its implementation is the major cause of under-five death, states should, *inter alia*, adopt legislation or other measures ensuring equal access to children’s health care provided by third parties. In addition, there is an increasing concern about the extent to which other actors in society such as individuals, intergovernmental organisations and NGOs, health professionals, and business entities have responsibilities with regard to the promotion and protection of children’s right to survival or their other complementary human rights.

In the section that follows, I draw attention to the role of parents and NGOs in the context of children survival and development. This is not to say that others may not have relevant responsibilities where, for example, the ex-Special Rapporteur on the Right to Health, Paul Hunt, has highlighted the indispensable role of health professionals in the promotion and protection of the right to health.¹⁷⁹

¹⁷⁸ *General Comment No. 5* (n 122 above) para 61.

¹⁷⁹ ‘The right to health: An interview with Professor Paul Hunt’ (2004) 2:1 *Essex Human Rights Review* 157.

3.4.7.1 Parental responsibilities

The adoption of a HRBA with respect to children involves the imposition of accountability upon an entity other than states.¹⁸⁰ Such is the responsibility of parents or, as the case may be, other care givers in relation to child survival. Upon birth, children critically need proper treatment and care to ensure their survival and development. Naturally and where they are able to do so, parents or other care givers are the first to be called upon to provide food, shelter, and other material needs necessary for the proper upbringing of the child. It is in view of this that the responsibilities of parents or, as the case may be, other caregivers are expressly referred to in several provisions of the CRC and ACRWC. The relevant text of CRC provides:¹⁸¹

1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.
2. For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.

The first sentence of sub-article 1 underscores the obligation of states to ensure, to their level best, that both parents of the child have common responsibilities for upbringing and development of the child. This provision confers common responsibilities on both parents.

¹⁸⁰ J Tobin 'Understanding a human rights based approach to matters involving children: Conceptual foundations and strategic considerations' in A Invernizzi & J Williams (eds) *The Human Right of Children from Visions to Implementation* (2011) 69.

¹⁸¹ CRC, article 18. CRC's counterpart of the ACRWC, in its article 20, also provides parental responsibilities and the obligation of states to extend assistance to parents and other persons responsible for the child's rearing. It states 'Parents or other persons responsible for the child shall have the primary responsibility of the upbringing and development the child and shall have the duty to ensure that the best interests of the child are their basic concern at all times and to secure, within their abilities and financial capacities, conditions of living necessary to the child's development' (article 20(1)(a)&(b)). It further provides 'states parties to the present Charter shall in accordance with their means and national conditions the all appropriate measures to assist parents and other persons responsible for the child and in case of need provide material assistance and support programmes and to assist parents and others responsible for the child in the performance of child-rearing and ensure' (article 20(2)(a)&(b)). Furthermore, the second and third sentences of article 18(1) of the CRC are identical to paragraph 2 of Principle 7 of the 1959 UN General Assembly, *Declaration of the Rights of the Child*. The latter is available at: <http://www.refworld.org/docid/3ae6b38e3.html> (accessed 12 May 2014).

The aim here is to ensure equality in rights and responsibilities of spouses in matters affecting children unless the law provides otherwise in particular circumstances.¹⁸² For the purpose of my discussion in this section, however, the second and third sentences of the sub-article are worth considering. They constitute an assertion that the primary responsibility for proper upbringing of the child lies in the parents and that they shall be guided by the principle of the best interest of the child in matters affecting the child's upbringing, such as health and access to basic material things. Taking the child's evolving capacity into account, parents and caregivers should nurture, protect and support children to grow and develop in a healthy manner.

There are, however, situations where the parents may not be able to discharge their child rearing responsibilities. Acutely aware of this fact, article 18 of the CRC is an attempt to strike a balance of responsibilities between the child's parents and the state. It particularly emphasizes state support for parents in the performance of their responsibilities. This provision of state support for parents must be read in conjunction with article 5 (parental and family duties and rights, the child's evolving capacities) and articles 3(2) & 27 (the state's responsibility to assist parents in securing that children have adequate protection and care and an adequate standard of living). Close reading of these four articles of the CRC makes it clear that parents have primary responsibility for securing the best interests of the child as their 'basic concern'. However, this responsibility is circumscribed by the child's rights under the CRC and may be shared with others, such as members of the 'wider family'.¹⁸³

The duty that the state must take appropriate steps to assist families or to secure the child's rights and needs where the parents cannot manage fulfilling their responsibilities is also recognized in other human rights instruments. For instance, the ICESCR provides that:¹⁸⁴

¹⁸² The equality in rights and responsibilities of spouses is also stated in article 16(1) of the UDHR & article 23(4) of ICCPR.

¹⁸³ Hodgkin & Newell (n 13 above) 231.

¹⁸⁴ ICESCR, article 10(1) & (3).

[t]he widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children” and “Special measures of protection and assistance should be taken on of all childrenpersons without any discrimination for reasons of parentage or other conditions.

The SA Constitutional Court judgement on the *Treatment Action Campaign* (TAC) case, discussed in section 2.3.2, is another relevant source to illustrate the responsibility of the state when parents are not in position to discharge their familial duties towards their children in their child rearing capacities. The Court found out that mothers are not expected to access anti-retroviral to prevent mother to child transmission of HIV/AIDS without intervention of the state.¹⁸⁵

However, an issue that needs to be addressed is what kind of assistance/s states should extend to parents or families in order to protect the best interests of the child during its upbringing and development. The CRC does not give clear guidance on this issue. Luckily, the ACRWC provides some indication. State assistance to parents includes nutrition, health, education, clothing and housing.¹⁸⁶ However, the assistance measures are not exhaustively listed. Research on children’s rights indicates that state assistance measures include financial benefits, housing, day care, home help, equipment and so forth, as well as psychological and professional support.¹⁸⁷

In the preceding I explore the primary role of parents or other care givers for child survival and development. I then discuss the obligation of states under the CRC and ACRWC to assist parents or caregivers, when the latter are unable to undertake their child-rearing responsibilities. The realization of child survival and development does not, however, always

¹⁸⁵ Much has been written about the TAC case in relation to its implication on identifying the measures that a state must take when parents are nor in a position to discharge their parental duties. For a comprehensive engagement, see in particular P Proudlock 'Children's socio-economic rights' in T Boezaart (ed) *Child Law in South Africa* (2009) 291-295; A Skelton 'Children’s Rights’ in I Currie & J de Waal *The Bill of Rights Handbook*, 6th ed (2013).

¹⁸⁶ ACRWC, article 20(2)(a).

¹⁸⁷ Hodgkin & Newell (n 13 above) 237.

depend on the action or non-action of states and parents alone. The private sector or non-state actors also have a vital role to play with respect to child survival rights. In the section that follows I illustrate their role from a rights based framework.

3.4.7.2 The role of the private sector or non-state actors (NSAs)

Most of the time implementation of child survival calls for taking measures aimed at reduction of child mortality. The latter, in turn, requires realization of children's rights to health or access to the *underlying determinants of health*.¹⁸⁸ In many countries, the private sector or NSAs (currently, the human rights system classifies these actors as private parties to make them distinct from public authorities)¹⁸⁹ provide a very significant proportion of health services, including to the poor and most marginalized. It is in the light of this role that they must assume responsibilities for child survival or children's health rights.

In human rights law, the responsibility for protecting individuals' fundamental rights lies in the positive¹⁹⁰ obligations of the state. Nevertheless, NSAs are continuously growing in power and influence, especially those that take over traditionally public functions or operate within the public sphere. Furthermore, due to their rising authority and changing functions, some of these private actors are also in a position to protect some of individuals' fundamental rights. There is accordingly a growing recognition, through the horizontal effect doctrine,¹⁹¹ that private actors carry at least a negative duty not to infringe human rights or other fundamental rights.

¹⁸⁸ The underlining determinants of health embraces a wide range of socio-economic factors that promote healthy conditions to people (or children) such as adequate supply of safe food, nutrition, and housing, access to safe and portable water and adequate sanitation, safe and healthy occupational or working conditions and a healthy environment, and access to health-related education and information, including on sexual and reproductive health. See CESCR, *General Comment 15, The Right to Water*, UN Doc E/C.12/2002/11; K Cook 'Environmental rights as human rights' (2002) 2 EHRLR 196-215; CESCR Committee, *General Comment No. 14* (n 56 above), paras 4 & 11.

¹⁸⁹ A Hallo de Wolf *Reconciling Privatization with Human Rights* (2011) 289-301.

¹⁹⁰ The word 'positive' here refers to obligations that require certain action to be taken by states, as opposed to 'negative' obligations which simply require states to refrain from taking certain action.

¹⁹¹ The horizontal effect doctrines try to address respect and protection of fundamental rights. Also, they underscore the binding effect of human rights provisions on private parties. See A Reinisch 'The changing international legal framework for dealing with non-state actors' in P Alston (ed) *Non-State Actors and Human Rights* (2005) 37-92.

In the area of health service too, the private sector continues to play a significant role in many jurisdictions. The proportion of coverage of health services by the private sector, however, varies amongst countries. For instance, in countries such as Vietnam, Thailand, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, and Philippines the private sector provides more than half of all health services and covers the important part of the primary health care services. The involvement of the private sector clearly presents an impact on the human rights requirements of assuring quality, affordability, and accessibility of medical treatment, especially for poor children. Use of private sector providers is nearly always linked to out of pocket payments. This often leaves the problem of affordability of access to health care services to the poor families. Furthermore, where lower-level private health service providers work in relatively poorer areas the quality of care is likely to be compromised. The cumulative effect is that it essentially results in them failing to meet the key elements of the right to health care, i.e., availability, accessibility, acceptability and quality.

Although the legally binding obligations arising from the right to health fall upon each state party, which in effect includes all those in its direct employment within the public sector, the responsibility to advance the right to health also applies outside the public sector. It is in recognition of this that CESCR General Comment No. 14 stipulates with regard to obligations of actors other than states parties as follows:¹⁹²

While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society — individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector — have responsibilities regarding the realization of the right to health. States parties should therefore provide an environment which facilitates the discharge of these responsibilities.

It is shown that, in addition to states parties, a wide range of NSAs that provide information and services related to health and its underlying determinants have specific responsibilities.

¹⁹² *General Comment No. 14* (n 56 above) para 42.

The NSAs must incorporate and apply to the design, implementation and evaluation of their programs and services all relevant provisions of the CRC, as well as the criteria of availability, accessibility, acceptability and quality of child health services. The committee on the CRC also calls on:¹⁹³

all non-state actors engaged in health promotion and services, especially the private sector, including the pharmaceutical and health-technology industry as well as the mass media and health service providers, to act in compliance with the provisions of the CRC and to ensure compliance by any partners who deliver services on their behalf. Such partners include international organizations, banks, regional financial institutions, global partnerships, the private sector (private foundations and funds), donors and any other entities providing services or financial support to children's health, particularly in humanitarian emergencies or politically unstable situations.

In this section I show that a wide range of different duty bearers need to be involved if children's right to survive is to be fully realized. Although the central role for the proper upbringing of children lies with the parents or other care givers and the state, the private sector need also to be engaged to, at least, fill gaps in health service delivery. The work of the private sector presents both an opportunity and an obligation within the framework of the CRC and other instruments. However, states must ensure that all other duty bearers have sufficient awareness, knowledge and capacity to fulfil their obligations and responsibilities. Governments must interact with private actors in the health sphere so as to advance the rights, survival, development and protection of children. Equally, the state is supposed to play an important *role* in regulating this *sector*.¹⁹⁴ In discharging its obligation to protect under human rights law, the state must ensure that the private sector does not breach health and other

¹⁹³ *General Comment No. 15* (n 61 above) para 77.

¹⁹⁴ Apart from the government sector, it is crucial also to regulate the other actors in health sector. It is increasingly argued that other actors besides the state, such as the private sector, have the obligation under human rights law. This is especially so *in the contemporary health landscape, where health services are increasingly delivered through private health sector institutions, and governments often lack direct control over some or many components of the health system*. It is impossible, however, to give an exhaustive account of the human rights responsibilities of all the actors in the private health sector. For an insightful engagement on the human rights responsibility of the private actors in the health sector see, B Toebe's 'Human rights and health sector corruption' in J Harrington & M Stuttaford (eds) *Global Health and Human Rights: Legal and Philosophical Perspectives* (2010) 102-134; A Chapman 'The Impact of reliance on private sector health services on the right to health' (2014) 16 *Health and Human Rights Journal* 122-133.

human rights of individuals or groups seeking access to health goods and services. Concerned with the possible corrupt acts that may ensue from this sector, the Committee on ESCR requires states to take legislative and other measures that prevent third parties, including private insurers, private health care providers and suppliers from interfering with the right to health care.¹⁹⁵

I further argue that identification of the right holders and duty bearers in a rights framework, helps better understand and protect a given right. In this chapter I mainly address this approach in the context of child survival rights. Nevertheless, having a clear understanding of the rights alone is not enough. In order for child survival rights to have a feasible outcome on child mortality, procedures that help to channel efforts for vindication of the right must be present and remedies must be available when the right is violated. The obligation to provide remedies for human rights violations is examined in the section that follows.

3.4.8 Legal remedies

A right carries with it a correlative duty to redress its violation. No protected right has a meaning to its claimant without a provision for effective mechanisms to give effect to it, including an effective remedy when breached.¹⁹⁶ States have the obligation to establish accountability mechanisms and procedures for seeking legal remedies. The human rights Conventions¹⁹⁷ include various measures aimed at ensuring effective remedies for persons whose human rights have been violated. A person's right to legal remedies has also been included in the provision of regional instruments. For instance, the ECHR stipulates the right to access to court, which is an important element in remedying violations, the right to an effective remedy and actual reparations.¹⁹⁸ The ACHR also contains a general legal obligation to respect

¹⁹⁵ *General Comment No. 14* (n 56 above) para 35.

¹⁹⁶ M Musila 'The Right to an effective remedy under the African Charter on Human and Peoples' Rights' (2006) 6 *African Human rights Law Journal* 443.

¹⁹⁷ Please refer to the Conventions discussed in section 2.3 of chapter 2 of this thesis.

¹⁹⁸ *The European Convention on Human Rights* (1963), articles 6, 13 & 41.

the Convention and a provision on the right to judicial protection.¹⁹⁹ Awkwardly, the African counterpart, i.e., the ACHPR, does not contain a specific provision on the right to an effective remedy. This deficiency was however subsequently bridged through the adoption of the *Protocol to the African Court on Human and Peoples' Rights*. The *Protocol* recognizes remedy or redress:²⁰⁰

If the Court finds that there has been a violation of human and peoples' rights, it shall make appropriate orders to remedy the violation, including the payment of fair compensation or reparation.

The above provision not only incorporates the obligation to award a remedy but also gives wide discretion to the African Court by mandating it to make 'appropriate' orders other than compensation and reparations. Such trend of widening of the power of the Court, Musila argues, draws on the experience of other international human rights oversight bodies such as the Inter-American and European Court of Human Rights.²⁰¹

Coming to children's case, states are obligated under global and regional laws to provide legal remedies for violations of human rights of children. In other words, in order for effective implementation of children's survival rights, remedies must be available to redress violations. Relevant human rights treaty bodies' interpretations are also available, which recognize the need for legal remedies for violation of human rights. They have a significant contribution to vindicate child survival rights. The CESCR Committee has, for instance, explicitly recognized the rights of individuals to legal remedies for violations of the right to health and 'adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition'.²⁰² In a similar vein, the Human Rights Committee has emphasized the obligation to ensure 'accessible and effective remedies' for human rights violations and to take

¹⁹⁹ *The American Convention on Human Rights* (1950), articles 1 & 25.

²⁰⁰ *Protocol to the African Charter on Human and Peoples' Rights* relating to the Establishment of the African Court on Human and Peoples' adopted in Addis Ababa, Ethiopia, in June 1998; entered into force in January 2004, article 27(1).

²⁰¹ Musila (n 196 above) 462.

²⁰² *General Comment No. 14* (n 56 above) para 59.

into account 'the special vulnerability of certain categories of person'.²⁰³ Notably, the Committee has also emphasized that 'a failure by a State Party to investigate allegations of violations could in and of itself give rise to a separate breach of the Covenant'²⁰⁴ and that 'cessation of an on-going violation is an essential element of the right to an effective remedy'.²⁰⁵ In general, the failure of a state to establish accountability mechanisms and procedures for seeking legal remedies for preventable child deaths violates the obligation to guarantee legal remedies for violations of human rights.

The CRC does not make explicit reference to the right to remedy for violation of children's rights. However, it does implicitly address it.²⁰⁶ This, together with the global and regional instruments, interpretations made by the treaty bodies and national mechanisms discussed herein, can be used as essential tools to seek remedy for violation of children's survival rights before courts or other competent bodies.²⁰⁷ Nevertheless, due to children's special and dependent status, pursuing remedies for breaches of their rights often presents real difficulties for them. This, hence, calls on states to ensure that child sensitive and effective procedures and access to independent complaints systems and to the courts with necessary legal and other assistance are available to children and their representatives.

In the entire section 3.4 above, I discuss the legal obligations of states and non-state actors with respect to child health rights and, more importantly, their obligation to ensure child survival. Any meaningful reduction of child mortality requires concerted effort. The responses of the various duty-bearers must be co-ordinated and integrated and must filter through all levels of government and civil society. However, states primarily assume an explicit obligation under the human instruments discussed in this part of the thesis. When the state is not doing what it can to prevent under-five deaths, it is defaulting on its legal and moral obligations to

²⁰³ Human Rights Committee, *General Comment No. 31, Nature of the General Legal Obligation on States Parties to the Covenant*, para 15, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004).

²⁰⁴ *Ibid.*

²⁰⁵ *Ibid.*

²⁰⁶ *General Comment No. 5* (n 122 above) para 24.

²⁰⁷ *Ibid.*

its own people.²⁰⁸ There is a need to measure whether the state is doing the best to facilitate implementation of its obligation to child survival rights. In the following section I explore the concept of monitoring and its relevance for improving implementation of this right.

3.5 Monitoring implementation of child survival rights

Of equal importance to the substance of global and regional instruments on child survival and other complimentary rights are the enforcement and monitoring mechanisms that accompany them. Monitoring involves a process of tracking or measuring what is happening and includes situation monitoring and performance monitoring. Situation monitoring, on the one hand, measures change in a condition or a set of conditions (or lack of change), while performance monitoring measures progress in achieving specific objectives and results of the implementation of plans, on the other hand.²⁰⁹ More specifically and in the context of the right to health, monitoring involves assessing the laws, policies, actions and/or omissions of a government, its institutions, organizations, bodies or agents with a view to determine the extent to which the right to health can be enjoyed by individuals and communities.²¹⁰ The ultimate goal of monitoring is learning and accountability. This becomes especially true when the results of monitoring are made public to the rights holders for information purposes and the results are used to engage accountability of governments.²¹¹

Monitoring takes place at various levels and through different strategies. These ideally include global, regional, and government monitoring, monitoring by state institutions and statutory bodies as well as monitoring by NGOs and civil society. At the global level, various bodies within the United Nations system monitor the compliance of states with their human rights

²⁰⁸ UNOHCHR 'State officials answerable to the public on preventable child mortality – UN human rights chief', available at: <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15058&LangID=E#sthash> (accessed 23 March 2015).

²⁰⁹ UNICEF *Program Policy and Procedure Manual* (2002) 101.

²¹⁰ J Asher *The Right to Health: A Resource Manual for NGOs* (2010) 140.

²¹¹ H Potts *Accountability and the Right to the Highest Attainable Standard of Health* (2008) 15.

obligations. These are in particular the so-called treaty bodies,²¹² the Human Rights Council, the General Assembly and the Security Council.²¹³ International human rights NGOs are likewise essential for monitoring human rights practices. On the regional level, the organs of the European, Inter-American, and African human rights protection system are important since the rulings of regional human rights courts are binding on the member states. At the national level, human rights monitoring is mainly conducted through national human rights institutions (NHRIs) and courts.

Like other human rights, the right to child survival requires that effective monitoring and accountability devices be established, not with a view to blame and punishment, but with a view to identifying what works so it can be repeated and what does not so it can be revised.²¹⁴ In this respect, the concept of monitoring, accordingly, goes to the very heart of this thesis. This is mainly because the gap between the current state of child survival (i.e., despite the reduction yet there exists an unacceptable rate of mortality) and the requirements of global and regional law often strikes academic interest to question whether a HRBA to monitoring for child survival has the potential to address child mortality.

Upon ratification of the CRC and the ACRWC, governments are held accountable for respecting, protecting, promoting and realizing child survival and other complimentary rights of all

²¹² The treaty bodies are expert panels formed on the basis of the respective human rights treaty. Their mandates include examination and evaluation of state reports about states' implementation of treaty obligations and subsequently issue their comments in so-called Concluding Observations. Most treaty bodies also decide upon individual complaints and some may take the initiative to initiate themselves inquiries into human rights violations. Eight treaty bodies review implementation of the *International Covenant on Civil and Political Rights*; *International Covenant on Economic, Social and Cultural Rights*; *Convention on the Elimination of All Forms of Racial Discrimination*; *Convention on the Elimination of All Forms of Discrimination Against Women*; *Convention Against Torture*; *Convention on the Rights of the Child*; *Convention on the Protection of the Rights of Migrant Workers*; and *Convention on the Protection of the Rights of Persons with Disabilities*. See, for details, BG Ramcharan *International Human Rights Monitoring Mechanisms* (2009) 25-117; 'Human rights monitoring mechanisms' available at: http://www.theadvocatesforhumanrights.org/human_rights_mechanisms_2 (accessed 15 July 2014).

²¹³ 'What is the role of the United Nations for the monitoring of human rights?' available at: <http://www.institut-fuer-menschenrechte.de/en/topics/development/frequently-asked-questions/6-what-is-the-role-of-the-united-nations-for-the-monitoring-of-human-rights.html> (accessed 13 July 2014).

²¹⁴ *Report of the Office of the UN High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights*, (16 April 2010), para 36, UN Doc. A/HRC/14/39.

children in their jurisdiction. Lessons on attempts made to address maternal mortality indicate that ‘regular monitoring of the health system and the underlying physical and socio-economic determinants of health that affect women’s health and ability to exercise their rights is a critical component of accountability’.²¹⁵ This understanding similarly applies to monitoring child mortality for similar socio-economic and other factors that are the underlying causes of maternal and child mortality. In other words, monitoring women’s health rights is essential in the same way that monitoring children’s health is. In the absence of monitoring state performances, systematic failures in reducing child health cannot be corrected.²¹⁶ But how do we measure monitoring?

3.5.1 Using indicators

It is to be noted that there is general agreement in literature that a rights based indicator differs from other types of indicators, for instance, statistical measures used to measure economic and development by institutions or agencies. Monitoring in a human rights framework requires use of indicators, not all of which are quantitative or relate to the health sector.²¹⁷ My investigation so far shows that there are no currently specific indicators developed for measuring compliance with child survival rights.²¹⁸ However, there are attempts made in the area of the right to the highest attainable standard of health. As I discuss in the various sections of this chapter, child survival rights are inextricably linked to the right to health in the sense that adequate implementation of the latter ensures child survival. In view of this

²¹⁵ Ibid.

²¹⁶ Ibid.

²¹⁷ Commission on Information and Accountability for Women’s and Children’s Health ‘Keeping promises, measuring results: WHO report’ (2011). The report is also available at: http://www.who.int/topics/millennium_development_goals/accountability_commission/Commission_Report_advance_copy.pdf (accessed 23 July 2014).

²¹⁸ There are, however, recent trends that seem to be praised by the CRC Committee as to the need to develop indicators, benchmarks, and child rights-based budget analysis and child rights impact assessments for monitoring children’s economic and social rights (ESR) in general. For details on the methodologies followed by the CRC Committee and the shortcomings, see A Nolan ‘Economic and social rights, budgets and the Convention on the Rights of the Child’ (2013) 21 *International Journal of Children’s Rights* 248–277.

relationship, I consider most of the indicators regarding the right to health to apply to child survival rights as well.

The ex-Special Rapporteur on the right to health (Paul Hunt) has proposed three types of indicators or factors. I describe these indicators in a way that they can be best utilized for monitoring child survival rights.

A. Structural factors

As I state in chapter one, structural indicators more specifically examine whether a country has ratified a relevant treaty/treaties, established institutions (NHRIs, courts etc), constitutional provisions, laws, policies, strategies and plans of action necessary for the realization of a given right. In the context of child survival rights the following structural indicators are relevant to measuring compliance with the obligation of the states to realize this right and require a positive response to the following questions: has the state ratified at least the following treaties that directly or indirectly apply to child survival rights, i.e., the CRC, ACRWC, ICESCR, and CEDAW? Does the state constitutionalise the child survival rights and its complimentary rights? Does the state adopt express laws, policies, strategies and national plans of action to reduce child mortality? Do the laws, policies and strategies provide primary health care services and medicines to children under five? Do the strategies and plans of action expressly recognize child survival rights?²¹⁹

B. Process indicators

Process indicators measure the degree to which activities that are necessary to attain specific rights-related objectives are being implemented and the progress of these activities over time.²²⁰ They require statistical data for monitoring and they monitor efforts rather than outcomes. In the context of child survival rights the following process indicators are relevant

²¹⁹ Asher (n 210 above) 142.

²²⁰ Ibid., 143.

to measure obligation of states to realize this right: the number of reports the state has submitted to the treaty based bodies monitoring the above mentioned treaties, the number of judicial decisions rendered concerning child survival rights in the last few years; the percentage of budget allocated to child health and more specifically to child survival; the proportion of new-borns attended by skilled medical professionals during the prenatal period; the availability and use of comprehensive essential neonatal and postnatal care, availability of vaccination, adequate nutrition and medicine to children under five; and the data that the state collected and disaggregated adequate to evaluate performance under the strategy or plan of action prepared with respect to vulnerable children.²²¹

C. Outcome indicators

As the phrase indicates, outcome indicators assess individual and collective attainments of realization of human rights in a given context. In other words, this indicator is a more direct measurement of the realization of a human right. Often, this indicator is characterized as a slow-moving indicator, less sensitive to capturing momentary changes than a process indicator would be.²²² In the context of child survival rights the following outcome indicators are relevant to measure state compliance with the obligation to realize this right: state compliance with treaty bodies' recommendations based on reports submitted by a state; actual expenditures made to child survival programs; the number of infant deaths per 1,000 live births; and the number of under-five child mortality per 1,000 live births.

With regards to reporting obligation under the CRC, Ethiopia has a good record of submitting periodical reports 'timely' to the Child Rights Committee under the CRC. As I indicate in section 4.6.2, the country has currently submitted the Fourth and Fifth Consolidated Periodic Report to the CRC Committee. While submitting is one thing, the crucial concern is whether the country is in compliance with its obligations per the Committee's recommendations. The

²²¹ Ibid.

²²² UN Human Right Instruments (UNHRI) *Report on indicators for promoting and monitoring the implementation of human rights*' HRI/MC/2008/3, para 21 (2008).

practice shows, it is dubious whether the country does so. For instance, the Committee expressed its concern over the restrictions imposed upon civil society since the 2005 elections.²²³ Accordingly, the Committee recommended Ethiopia to respect the role played by civil society for the implementation of the CRC. In addition, the Committee also called upon Ethiopia to encourage the active, positive and systematic involvement of civil society, including NGOs, in the promotion of children's rights.²²⁴ Despite this well intentioned and reasoned recommendation, ironically, the government rather passed in 2009 the controversial CSO law that I make reference to it in the various sections of the subsequent chapters.

In a nutshell, in the preceding I try capture the narrative on the normative content of child survival rights into a few characteristic attributes and a configuration of structural, process and outcome indicators. The indicators identified bring to the fore an assessment of steps taken by the State Party in addressing its obligations - from commitment to international human rights standards (structural factors) to efforts being undertaken by the primary duty-bearer, the state, to meet the obligations that flow from the standards (process indicators) and on to the results of those efforts from the perspective of rights-holders (outcome indicators). The indicators serve as powerful supporting tools for the implementation of child survival rights-obligations of states.

3.6 Conclusion

In this chapter, I explore the existing legal protection mechanisms on child survival rights from the purview of both the global and regional frameworks. Seen from the relevant provisions of the CRC and ACRWC, I show that there is a sound legal basis for protecting child survival rights and the obligation of states to implement the right. A rights-based approach to child survival requires the integration of the right and the complementary rights into all national laws, policies, programs, strategies, and plans of action. After all, if the right to child survival is neither an established feature of domestic law, nor integrated into national health-related

²²³ Committee on the Rights of the Child (CRC), *Concluding Observations of the Committee on the Rights of the Child: Ethiopia*, 1 November 2006, para 22, CRC/C/ETH/CO/.

²²⁴ *Ibid.*, para 23.

policies, it does not really serve a useful purpose. Further, I note that these instruments, together with other relevant core human rights instruments, offer the mechanisms through which states parties are held accountable to the right holders.

Moreover, I investigate that meaningful child survival or reduction of under-five mortality requires making available to children the underlying determinants of the right to health, such as access to nutrition, vaccination, safe and portable water, and education of mothers. Fulfilling these demands urge only low-cost intervention efforts by states. It may compel us to the conclusion that implementation of infant survival should be regarded as a minimum legal condition. If the condition is implemented properly, it can significantly contribute to the protection of child survival rights and ultimately to reduction of under-five mortality. If we provide for the survival and development of children everywhere and protect them from preventable death, we will surely build the foundation of the just society we all want and that children deserve.²²⁵ What it needs is good governance and a system that holds governments accountable for their promises. Independent monitoring of the extent of avoidable infant death and the cost of saving each life compared to the costs each country incurs for other purposes such as ‘saving life’ through military expenditure and accountability through judicial and non-judicial bodies is also crucial.

²²⁵ PDHRE: The People’s Movement for Human Rights Learning ‘Convention on the Rights of the Child’ available at: <http://www.pdhre.org/conventionsum/crcsum.html> (accessed 22 July 2014).

Chapter 4

Overview of the legal, policy and institutional framework affecting child survival rights in Ethiopia

4.1 Introduction

Ethiopia is one of the countries that have pledged to end preventable child mortality by the year 2035. This was made clear in the *Child Survival Call to Action Conference*, which was co-convened by the governments of Ethiopia, India and the United States in collaboration with UNICEF, in 2012. The *Call to Action*, while acknowledging the decline in child mortality rates that has been registered since 1990, urged countries to further reduce their national rates of child mortality to 20 or fewer deaths per 1,000 live births by 2035.¹

A battle for the diversification of the processes available for the realisation of child survival rights is thus imperative. Setting proper laws, policies, programs and institutions that will ensure enforcement and accountability is significant in the course of reducing neonatal or child deaths. As I have discussed in section 2.6 of chapter two, adoption of laws, policies, programs and other interventions explicitly or implicitly shaped by human rights is particularly relevant.

In this chapter I aim to examine the manner in and the extent to which Ethiopian laws, policies and strategies incorporate the protection of children's right to survive or its complementary rights discussed in the previous chapter, critically. More specifically, the position of these domestic instruments is analyzed in the light of core principles embodying a human rights-based approach. Furthermore, a similar exercise is conducted as to the role of an array of institutional arrangements that are mandated to promote, monitor and ensure accountability for implementation of child health or survival rights in Ethiopia. However, before I delve into

¹ United States Agency for International Development (USAID) *et al Acting on the call: Ending preventable child and maternal deaths* (2014) 8, 10; USAID 'Leaders invest in Africa's future through renewed focus on child survival' (2013) available at: <http://www.usaid.gov/news-information/press-releases/leaders-invest-africas-future-through-renewed-focus-child-survival> (accessed 23 April 2014).

the discussion of laws and policies, in what follows, I try to introduce briefly some general facts about the country, followed by a critical situation analysis of child and infant mortality in the country.

4.2 Geography, population and socio-economic situation

Ethiopia is situated on the horn of Africa, sharing borders with Kenya in the south, the Sudan and South Sudan in the west, the Federal Republic of Somalia in the east and Eritrea in the north. It has a total surface area of 1.1 million square kilometers. It is the oldest independent African nation, having never been colonized by a European country and was the first independent African member of the League of Nations and the United Nations (UN).² Paleontological studies identify Ethiopia as one of the cradles of humankind. The country is the home of more than 80 different ethnic groups having their own distinct languages and cultures constituting 12 Semitic, 22 Cushitic, 18 Omotic, and 18 Nilo-Saharan languages.³

By a 2012 estimate Ethiopia had a total population of 91.73 million.⁴ Of these, 50.5% and 49.5% are males and females, respectively. According to a recent national survey, 50%, which translates to more than 45 million of the Ethiopian population, are under the age of 18.⁵ If that 45 million was a country, that would actually be the 28th largest country in the world. Furthermore, the country is the second-most populated nation on the African continent and the most populous landlocked country in the world since 1993. The Oromo and Amhara regional states⁶ constitute the first and second largest populous regions in the country. The

² Wikipedia: the free Encyclopedia 'Ethiopia' available at: <http://en.wikipedia.org/wiki/Ethiopia> (accessed 10 April 2014).

³ Encyclopedia of Nations 'Ethiopia' available at:

<http://www.nationsencyclopedia.com/economies/Africa/Ethiopia.html> (accessed 12 April 2014).

⁴ The World Bank 'Ethiopia' available at: <http://www.worldbank.org/en/country/ethiopia> (accessed 8 April 2014).

⁵ Ethiopian Government report to the UN General Assembly On Agenda Item 64: Promotion and Protection of the Rights of Children on the 69th Session of the United Nations General Assembly (2014) 1, available at: <https://papersmart.unmeetings.org/media2/4653319/ethiopia.pdf> (accessed 20 November 2014); Z Haile *Review of the Legal and Policy Frameworks Protecting the Rights of Vulnerable Children in the Federal Democratic Republic of Ethiopia* (2008) 4.

⁶ At present Ethiopia is administratively structured into nine regional states—Tigray, Afar, Amhara, Oromiya, Somali, Benishangul-Gumuz, Southern Nations, Nationalities and Peoples', Gambela, and Harari—and two city administrations, that are, Addis Ababa and Dire Dawa Administration Councils.

two dominant religions are Christianity and Islam. About half of the population are Orthodox Christians, one-third are Muslims, about one in every five (18 %) are Protestants, and 3% are followers of traditional religion.

In recent years, the country has registered rapid economic growth. The real Gross Domestic Product (GDP) of the country grew by approximately 11% per annum between 2003/04 and 2011/12.⁷ Poverty declined significantly: the head count poverty index decreased from 45.5% in 1995/96 to 29.6% in 2010/11.⁸ 'Per capita GDP increased, in nominal terms, from 387 USD in 2010/11 to 513 USD in 2011/12. In 2011/12, in the economic structure, the agriculture and service sectors accounted for about 44% and 45% of the country's GDP, respectively'.⁹ Being in its infant stage of development, the country's industrial sector currently contributes to only 13% of the GDP of the country.¹⁰

Notwithstanding the rapid and high economic growth, the development of the country's economy is challenged by key factors such as a high rate of inflation and high degree of inequality. According to the UNDP human development report issued in 2013, Ethiopia ranks 173rd out of 185 countries with a HDI of 0.396.¹¹ This positions the country within the categories of governments that have low human development with marked disparity between the rural and urban population, where the former continue to have little access to state-sponsored services, such as health care, sanitation services and education, while the growing population of urban poor is also under-served by government programs.

⁷ FDRE MoFED *Ethiopia's progress towards eradicating poverty: An interim report on poverty analysis study* (2010/11); FDRE MoH *Ethiopia's fifth national health accounts 2010/2011* (April 2012) 1.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Human Rights Development Report 2013 *The rise of the South: Human progress in diverse world* (2013) 142. The full is available at: <http://hdr.undp.org/en/> (accessed 2 May 2014). The HDI is published each year as of 1990 by the United Nations Development Program. HDI is meant to measure 'the average achievements in a country in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living'.

Historically, Ethiopia was ruled by successive emperors and kings for hundreds of years, with a monarchical system of government which claimed its members to have patrilineal descent from King Solomon of Israel and the Queen of Sheba. Tradition asserts that the latter gave birth to Menelik I after her biblically described visit to King Solomon in Jerusalem.¹² In 1974, the military took over power from the monarchical government by force and administered the country until May 1991. Through the current Federal Democratic Republic of Ethiopia (FDRE) Constitution, a federal system of government, composed of nine member states¹³ and two self-administering cities (Addis Ababa and Dire Dawa), was established in 1995. More than one third of the Constitution is dedicated to human rights provisions.¹⁴ The government is made up of two tiers of parliament; the House of Peoples' Representatives and the House of the Federation.¹⁵ The members are elected every five years.

4.3 Situation analysis of child and infant mortality

Infant and child mortality is very high in less developed countries. As one of the least developed countries in the world, Ethiopia is faced with many social and economic problems of which infant and child mortality is one. One in every 17 Ethiopian children die before the first birthday, and one in every 11 children die before the fifth birthday.¹⁶ According to the EDHS 2011, the neonatal mortality rate was 37 deaths per 1,000 live births, the post-neonatal mortality rate was 22 deaths per 1,000 live births, and the perinatal mortality rate was 46 per 1,000 pregnancies.¹⁷ These numbers, however, are not accurate as they are estimates collected based on the birth history section¹⁸ of the woman's questionnaire and may not necessarily reflect the grim realities of the problem.

¹² Wikipedia 'Solomonic Dynasty' available at: http://en.wikipedia.org/wiki/Solomonic_dynasty (accessed 28 October 2014).

¹³ The nine regional states are mentioned in (n 6 above). See, also, FDRE Constitution, articles 47-48.

¹⁴ FDRE Constitution, articles 13- 44.

¹⁵ FDRE Constitution, article 53.

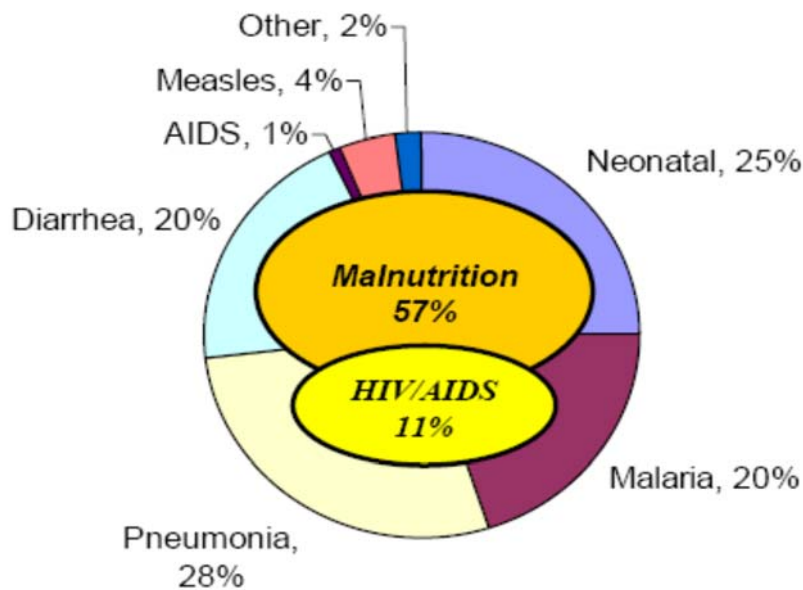
¹⁶ Central Statistical Authority (Ethiopia) & ICF International *Ethiopia demographic and health survey 2011* (2012) 109.

¹⁷ Ibid.

¹⁸ Ibid. This section deals with questions as to the number of sons and daughters living with the mother, the number who live elsewhere, and the number who have died.

Child mortality is a complex phenomenon and it is caused by a multiplicity of factors.¹⁹ It includes lack of access to basic services,²⁰ poor socio-economic conditions and high levels of trauma and violence. Based on data compiled by the FDRE MoH, the causes of under-five mortality in Ethiopia were categorized as follows: pneumonia (28%), neonatal conditions (e.g. Sepsis and asphyxia) (25%), malaria (20%), diarrhoea (20%), measles (4%), HIV/AIDS (1%) and others (2%), respectively.²¹ The underlying causes are malnutrition and HIV infection, which constitute 57% and 11% of deaths, respectively. Poverty, inadequate maternal education, lack of potable water and sanitation, high fertility and inadequate birth spacing also worsen the levels of mortality.²² It is represented in diagram as below:

Figure 1: Causes of infant and child mortality



Source: Ethiopian Child Survival Situation Analysis, 2004

Although the precise size of the decline varies across data sources, remarkable reduction of infants and child mortality has been registered over the past years.²³ The following source

¹⁹ K Abrahams *Making a case for child survival in South Africa's 'age of hope'* (2006) 6.

²⁰ Such as, water and sanitation, health services, including comprehensive HIV/AIDS interventions.

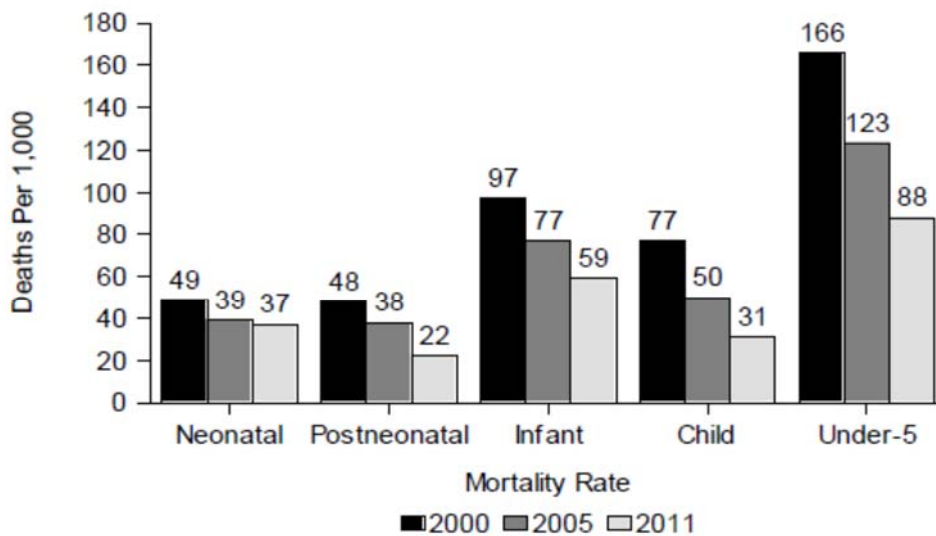
²¹ D Mekonnen 'Infant and child mortality in Ethiopia: The role of Socio-economic, demographic and biological factors In the previous five years period of 2000 and 2005 ' *unpublished MSc thesis, Lund University*, 2011 9.

²² FDRE MOH, Family Health Directorate *National Strategy for Child Survival in Ethiopia* (2005) 1.

²³ AS Susuman 'Child mortality in Ethiopia' (2012) 3: *Iranian Journal Public Health* 9-19.

indicates that child mortality declined 35% in Ethiopia between 2000 and 2005; infant mortality declined 21% and under-five mortality declined 26% during the same period. The declining trend inclusive of 2011 data is indicated in the graph below:

Figure 2: Trends in early childhood mortality, EDHS 2000, 2005, and 2011



Source: Second, third and fourth round National Health Accounts, Ethiopia

In spite of the significant progress made in recent years to reduce under-five mortality, child mortality rates are still high in Ethiopia. This is well acknowledged by the Ethiopian government. Ethiopia's current Minister of Health, Dr. Kesenbirhan Admasu, while welcoming the positive results that Ethiopia has achieved in meeting the Millennium MDG IV, underlined that:²⁴

'despite the improvements, Ethiopia is still considered a high-mortality country: If you look at the absolute number of children dying in Ethiopia, it is still huge. We have committed to end all preventive child deaths in a generation by 2035. And we have developed a roadmap to reach that ambitious target'.

²⁴ Voice of America (VOA) 'Ethiopia cuts child mortality by two – thirds' (2013) available at; <http://www.voanews.com/content/ethiopia-cuts-child-mortality-by-two-thirds/1749290.html> (accessed 12 March 2014).

In a similar manner, while appreciating Ethiopia's achievement in reaching MDG IV, Dr. Peter Selama, UNICEF country representative for Ethiopia further pointed out the difficulty of sustaining the reduction as below:²⁵

...further progress in cutting child deaths will be increasingly difficult to achieve. An increasing number of the remaining child deaths (*in Ethiopia*) are attributed to new-born deaths – those in the first 28 days of life. These new-born deaths are intrinsically linked to maternal health and nutrition [which is] more complicated to deal with because it implies much more high-skilled service delivery. Without addressing this, it's going to be hard to see the same level of progress that has been made in the last decade. (Emphasis mine).

Again, according to SOS Children's Villages webpage on its update on Ethiopia's reduction of child mortality, while noting the progress achieved, it at the same time underlines:²⁶

.....However, health officials in Ethiopia (*should*) understand that the 'easier wins' for cutting child deaths through better medical services have been made. Many child deaths in Ethiopia now occur in the first 28 days of life and they understand that improving survival rates for new-borns will be much harder to reduce. This is because such deaths are often linked to poor maternal health and nutrition, which require much more highly-skilled services to improve. (Emphasis mine).

Furthermore, according to a recent report by Save the Children, Ethiopia is placed as the 6th highest country out of the ten countries that contribute nearly two-thirds of all new-born deaths across the world.²⁷ In addition, significant inequities and disparities in the child mortality rate continue to exist within Ethiopia. According to EDHS, the 'regional variation in

²⁵ Global Development 'Ethiopia achieves development target on reducing child mortality' (2013), available at: <http://www.theguardian.com/global-development/2013/sep/13/ethiopia-achieves-development-target-child-mortality> (accessed 20 March 2014).

²⁶ 'Ethiopia reaches Millennium Development Goal to reduce child mortality' available at: <http://www.soschildrensvillages.org.uk/news/archive/2013/09/ethiopia-reaches-millennium-development-goal-to-reduce-child-mortality> (accessed 14 June 2014).

²⁷ Save the Children *Surviving the first day: State of the world's mothers 2013* (2013) 19.

under-five mortality rates varied from lowest record of 56 deaths per 1000 live births in the capital city of Addis Ababa to highest of 169 deaths per 1000 live births in Benishangul-Gumuz, followed by 127 deaths per 1000 live births in the Gambela region'.²⁸ The disparities of child mortality also range from the lowest 14 deaths per 1000 live births in Addis Ababa to the highest of 76 deaths per 1000 live births in Benishangul-Gumuz.²⁹ Similarly, infant mortality varied from 40 to 101 deaths per 1000 live births in Addis Ababa and Benishangul-Gumuz region, respectively.³⁰ These wide disparities indicate that there exist wide variations of health infrastructure and communication and disease prevalence conditions within regions of Ethiopia.

Mothers' level of education is also highly associated with infant and child mortality. In Ethiopia, significant disparities of infant and child mortality have been found according to the differing education levels of mothers. Under-five mortality rates are 121 and 46 deaths per 1000 live births for children born to illiterate mothers and those with secondary and higher levels of education, respectively.³¹ According to an interview made with Mrs. Jeweler Mohammed, it was noted that one of the reasons mothers in the Harari regional state did not get their under-five vaccinated is associated with some mothers' failure to attend scheduled or non-scheduled child vaccination services.³² This could be related to mother's low level of education as regards to relevance of timely seeking child health care.

The problem of child mortality is not only driven by poverty, but is also intrinsically linked to social exclusion and *de jure* and *de facto* discrimination, lack of appropriate accountability mechanisms and other issues. Besides, available data on the primary causes of child death

²⁸ Central Statistical Authority (Ethiopia) & ICF International (n 16 above) 112.

²⁹ Ibid., 113.

³⁰ Ibid.

³¹ Ibid.

³² Interview conducted with Mrs. Jeweler Mohammed, Maternal and Child Case Team Officer, Harari regional state Health Office, 24 February 2015, Addis Ababa, Ethiopia.

reveal that many Ethiopian children die annually from preventable causes.³³ Therefore, efforts to eliminate preventable under-five mortality require a comprehensive and holistic approach, which explicitly recognizes and integrates relevant human rights standards.

4.4 Ethiopia's response: The legislative framework relevant to child survival

No current applicable domestic law in Ethiopia explicitly guarantees children's survival rights or the right to health of children,³⁴ unlike some other countries with such national laws, such as Kenya's Children Act and the Chinese Law on Maternal and Infant Health Care.³⁵ There are, however, provisions that complement the realization of this right. These provisions can be interpreted to be applicable in the context of child survival rights. The Constitution of the FDRE provides for the rights of all persons, including men, women and children alike. Put differently, one of the pillars of the Constitution is the right to equal protection of the law. It provides for race, nation, nationality, or other social origin, colour, sex, language, religion, political or other opinion, property, birth or other status as prohibited grounds of discrimination.³⁶ Consequently, children have the same rights as everyone else, save certain age-related exceptions including in the sphere of the right to stand for election.³⁷ The FDRE Constitution

³³ Further to the discussion in this section underlining that preventive causes are challenges to infant death in Ethiopia, see UNICEF Ethiopia 'Thousands more mothers, babies can be saved in Ethiopia' available at: <https://unicefethiopia.wordpress.com/2014/11/24/thousands-more-mothers-babies-can-be-saved-in-ethiopia/> (last accessed 21 June 2015).

³⁴ This is without the prejudice to the laws that address matters of health which apply also to children. These laws include such as articles 31 and 32, Proclamation No. 117/2005, the Amhara National Regional State Health Service; articles 12 and 13, Proclamation No. 84/2004, the Southern Nations, Nationalities and Peoples' Regional State Health Service Delivery, Administration and Management Proclamation; and, articles 18 & 19, Proclamation No. 10/2003, a Proclamation to provide for the Addis Ababa City Government Health Service Delivery, Administration and Management Proclamation.

³⁵ Chapter 141 of the Laws of Kenya is dedicated to Children. The Children Act of Kenya was promulgated in 2007. Part II, Section 4(2) of the 2010 revised version of this Act guarantees child survival rights. The full text of the revised Act can be available at: <http://www.kenyalaw.org> (accessed 12 June 2014). Similarly, Chinese law on Maternal and Infant Health Care which was effective since 1995 also incorporates several provision that aim to address child and maternal survival. This Law was enacted in accordance with the Chinese Constitution with a view to ensuring the health of mothers and infants and improving the quality of the new-born population (article 1). The entire provision of this law can be available at: http://china.org.cn/china/2010-03/04/content_19522945.htm (accessed 24 August 2014).

³⁶ FDRE Constitution, article 25.

³⁷ For instance, the following provisions of the FDRE Constitution equally apply to children: articles 25 (the right to equality), 29 (freedom of opinion and expression), 37 (right of access to justice), 41 (economic, social and cultural rights) & 44 (environmental rights). Furthermore, children are entitled to the rights enshrined under the

recognizes the vulnerable position of children and guarantees their right to protection.³⁸ The Constitution further stipulates that ‘human rights and freedoms, emanating from the nature of mankind, are inviolable and inalienable’.³⁹ In what follows, I discuss in more detail the relevant laws that implicitly apply to a rights framework for addressing reduction of child mortality.

4.4.1 Children’s rights under the FDRE Constitution and other special legislation

Ethiopia ratified the CRC in 1991 and, four years after the ratification, a relatively democratic Constitution was adopted. More than one third of the contents of Constitution’s incorporate provisions on fundamental human and people’s rights.⁴⁰ In addition to recognising everyone's fundamental human rights, the FDRE Constitution dedicates important provision to the rights of children.⁴¹ In particular, the full text of article 36 of the Constitution incorporates rights of children in the supreme law of the land as follows:

1. Every child has the right:
 - (a) To life
 - (b) To a name and nationality
 - (c) To know and be cared for by his or her parents or legal guardians;
 - (d) Not to be subject to exploitative practices, neither to be required nor permitted to perform work which may be hazardous or harmful to his or her education, health or well-being;
 - (e) To be free of corporal punishment or cruel or inhuman treatment in schools and other institutions responsible for the care of children.

CRC and ACRWC as the country has ratified these treaties and courts are citing the provisions provided in these instruments in their judgments.

³⁸ For instance, articles 36(5) & 41 (5) of the Constitution require the country to take measures, within available means, to allocate resources to provide rehabilitation and assistance and accord special protection to orphans and children who are left without parents or guardian.

³⁹ FDRE Constitution, article 10 (1).

⁴⁰ FDRE Constitution, Chapter 3, articles 13 – 44.

⁴¹ Apart from article 36, provisions that FDRE Constitution speaks about children’s rights include articles 34(1) & 41 (5).

2. In all actions concerning children undertaken by private and public institutions, courts of law, administrative authorities or legislative bodies, the primary consideration shall be the best interests of the child.
3. Juvenile offenders admitted to corrective or rehabilitative institutions, and juveniles who became wards or who are placed in public or private orphanages, shall be kept separately from adults.
4. Children born out of wedlock shall have the same rights as children born of wedlock.
5. The state shall accord special protection to orphans and shall encourage the establishment of institutions which ensure and promote their adoption and advance their welfare, and education.

In an exactly similar way, the constitutions⁴² of the nine federal units also stipulate the same rights of children. As can be seen above, the Constitution incorporates numerous rights of children including the right to life. The recognition of children's right to life under the FDRE Constitution is important, owing to the fact that measures aimed at protecting or respecting the right to life of children also entails reduction of preventable infant and child mortality. Although it has been a long established principle in family law, the Constitution also incorporates the 'best interests' principle. In this regard, the Constitution meets one of the human right standards and norms of a HRBA to under-five mortality. As was highlighted in section 2.2.4, this principle enjoins the Ethiopian government and the private sector to place children's interests at the centre of all decisions affecting their health and survival, including decisions on the allocation of resources and on the development and implementation of policies and interventions that affect the underlying determinants of health.

Nevertheless, none of the provisions stated above mention the right to survival, health, and development of children. The package of rights mentioned above and to which all children are entitled do not include children's right to basic health care services, basic nutrition, shelter and social services. The Constitutions fail to recognise a range of human rights which have a direct bearing on under-five mortality. Its counterpart in the SA Constitution is explicit in regard to

⁴² See, for instance, articles 35 & 37 of the Revised (2002/3) Constitutions of Afar and Gambela regional states, respectively.

children's right to health. The SA Constitution provides that 'Children have the right to basic nutrition.... basic health care services and social services'.⁴³ Similarly, the Kenyan Children's Act also clearly provides for child survival rights when it reads 'every child shall have an inherent right to life and it shall be the responsibility of the Government and the family to ensure the survival and development of the child'.⁴⁴ This provision is close to a word for word emulation of the CRC⁴⁵ and ACRWC.⁴⁶ In this respect, the Act exemplifies Kenya's commitment to harmonize global and regional instruments in the domestic system, which is an important step for the realization of children's right to survive in Kenya. The conclusion that can be drawn is, unlike the SA Constitution and the Kenyan Children's Act, the Ethiopian counterpart fails to acknowledge the interdependence, interrelatedness and indivisibility of children's rights by failing to give equal weight to children's socio-economic rights under article 36 above. Consequently, one of the crucial elements of a HRBA to under-five mortality – the principle of indivisibility, interdependence and interrelatedness of all human rights - does not seem to be taken into account under the children rights provisions.

There are, however, other provisions in the Constitution that deal with health as a social right in the provisions dealing with Economic Social and Cultural Rights and in the National Policy Principles and Objectives (NPPOs) section (articles 85-92). Like other individual citizens, these provisions also apply to children. The Constitution provides that 'every Ethiopian national has the right to equal access to publicly funded social services'.⁴⁷ It further states that 'the state has the obligation to allocate ever increasing resources to provide to the public health, education and other social services'.⁴⁸ Although the NPPOs have no binding effect as an obligation of the government, the Constitution provides that 'government shall endeavour to

⁴³ Constitution of the Republic of South Africa (1996), section 28(1)(c). The 1999 Mexican Constitution provides a similar protection. Article 4 of the same document stipulates 'Children have the right to the satisfaction of their needs with respect to nutrition, health care, education and healthy leisure, to allow for their integral development'. Unfortunately, none of these rights are incorporated children's rights provision of the FDRE Constitution.

⁴⁴ Part II, Section 4(2), the Children Act of Kenya (2010).

⁴⁵ CRC, article 6.

⁴⁶ ACRWC, article 5(1) & (2).

⁴⁷ FDRE Constitution, article 41(3).

⁴⁸ Ibid., sub-article 4.

protect and promote the health, welfare and living standards of the working population of the country'.⁴⁹ Most importantly, one of the NPPOs underscores that 'to the extent the country's resources permit, policies shall aim to provide all Ethiopians access to public health and education, ... food and social security'.⁵⁰ This provision is crucial as it incorporates a key concept of availability of resources for the realization of socio-economic rights, which is well entrenched in global and regional human rights law. I discuss this more fully in the preceding chapter.⁵¹

Parallel to the Constitution, the Revised Family Code is another pertinent instrument in which particular attention is paid to the health of children. The Code imposes obligations on guardians to be responsible for the health of the minor.⁵² Family law by its very nature generally governs rights and obligations emanating from a family relationship. As such, this law often imposes various duties on the part of the guardians, which are mostly the biological parents of the minor, for the proper upbringing of the child. It does not generally impose such an obligation on the state. Furthermore, the Code recognizes the best interests principle in its numerous provisions. Importantly, article 82 of the Code provides that the court needs to take in to consideration the interests of children when giving orders relating to the maintenance of the spouses, custody and maintenance of children and the management of the property of the spouses. Also, article 113(2) of the Code requires courts of law to consider the interests of children in relation to decisions concerning custody following pronouncement of divorce. Similarly, articles 194(2) & 188(2) of the Code requires courts of law to verify whether or not adoption is in the best interests of children before approving adoption agreements, and to take into consideration the effects of other children of the adopter on the well-being and best interests of the adopted child, respectively.

⁴⁹ Ibid., article 89(8).

⁵⁰ Ibid., article 90(1).

⁵¹ See, sections 3.3.3.2 & 3.4.2, Chapter 3.

⁵² The Revised Family Code (2000), article 257. The Revised Family Code came in to force in 2000. Before it came in to force, matters affecting the right of children were governed by the Civil Code of Ethiopia (articles 198-338 & 550-825), promulgated in 1960, and individual items of legislation. The Revised Code in general updated the 1960 Civil Code regarding familial relations by describing the rights and duties of minors and their guardians the rights.

The Revised Criminal Code of Ethiopia is another special legislation that has a bearing on infant or under-five mortality. This legislation explicitly prohibits infanticide. The Code states as follows:⁵³

(1) A mother who intentionally kills her infant while she is in labour or while still suffering from the direct effect thereof, is punishable, according to the circumstances of the case, with simple imprisonment.

Where the crime is attempted, the Court shall mitigate the punishment (Art. 180) if no injury has been done to the infant.

(2) A mother who kills her child, either intentionally or by negligence, in circumstances other than those specified under sub-article (1) of this Article shall be tried according to the relevant provisions of this Code regarding homicide.

As the discussion in section 4.6.8 of this chapter uncovers, infanticide is one problem that courts are busy with in the country's major cities, such as Addis Ababa, as are problems of child exposure or abandonment. These latter acts are also punishable under article 574 of the Criminal Code.⁵⁴ In addition to the crime of infanticide and child exposure or abandonment, abuse and neglect of children by their custodians or persons in charge of minors is another punishable act under the Criminal Code. Article 576(1) of the Criminal Code prohibits the maltreatment of children. It stipulates that 'whosoever, having the custody or charge of a minor, ill-treats, neglects, over tasks or beats him for any reason or in any manner is punishable with simple imprisonment not exceeding three months'. Also, article 576(2) of the Criminal Code further submits that the punishment shall be, in addition to the deprivation of family rights of the criminal, simple imprisonment for not less than one year where the crime causes grave injury to the health, well-being, education or physical or psychological development of the minor.

⁵³ The Criminal Code of the Federal Democratic Republic of Ethiopia, Proclamation No. 414/2004, article 544 (1) & (2).

⁵⁴ Article 574 stipulates that 'Whoever, having the custody or charge, on no matter what grounds, of a person incapable of protecting himself, whether on account of his health, his age, his situation or any other circumstance, intentionally: a) exposes him, thereby putting him in imminent danger of life or health; or b) abandons him when in like situation, is punishable, according to the circumstances of the case, with rigorous imprisonment not exceeding five years, or with simple imprisonment for not less than six months, without prejudice to the deprivation of the criminal's family rights where necessary. (2) Where the crime is committed against an infant, the punishment shall be rigorous imprisonment not exceeding seven years.

For obvious reasons, the stipulation of the above provisions of the Family and Criminal Codes which impose civil and criminal obligations on the part of parents or others contribute to the protection of children's survival. However, these parental obligations do not imply that the Ethiopian state is exonerated from assuming responsibility for children's right to survival or health. It entails only that this article calls for the interpretation of the relevant provisions of the CRC and ACRWC to convey that the government is responsible to assist families of the minor in case the guardian is unable to provide support to their children in terms of fulfilling children's right to health.⁵⁵ Focusing on government's responsibility for provisioning and fulfilling of children's right to health is very important in view of the fact that governments are key agents for economic and social transformation in the context of children's rights, particularly in Africa.⁵⁶

Last, but not least, an important legislation worth discussing in the context of child health protection, is the National HIV/AIDS Prevention and Control Council and the HIV/AIDS Prevention and Control Office Establishment Proclamation.⁵⁷ This Proclamation is significant in the sense that it aims to address HIV/AIDS which represents one of the underlining causes of child mortality in the country – indicated in Figure 1. The proclamation canvasses a number of provisions which can be utilized to address prevention, care and treatment of children vulnerable to this disease. This legislation establishes the Council of National HIV/AIDS Prevention and Control that has different objectives which includes creating conducive environment whereby people living with HIV/AIDS and orphans obtain health... as well as the provisioning of necessary assistance and ensure the full protection of their rights; and mobilizing local and external resources for implementing programs in a strengthened and

⁵⁵ The duty that the state must take appropriate steps to assist families or to secure the child's rights and needs where the parents cannot manage fulfilling their responsibilities is also recognized in human rights instruments mainly in the CRC (article 18(2)), ACRWC (article 20(2)(a)) & ICSECR (article 10(1) & (3)). See a discussion on this, section 3.4.7.1 of this thesis.

⁵⁶ Presentation by Dr. A Baquele at UNICEF meeting on the issues of 'The effort to make further progress on implementing the Convention on the Rights of the Child (CRC)' (October 2009) available at: <https://www.youtube.com/watch?v=HYS--5BdVeA> (accessed 23 September 2014).

⁵⁷ National HIV/AIDS' Prevention and Control Council and the HIV/AIDS Prevention' and Control Office Establishment Proclamation, Proclamation No. 276/2002.

integrated manner'.⁵⁸ In addition, the Council had various powers and duties that have linkages to promote child health or survival. It includes but not limited to extending a call on local and external donors to provide assistance; guide and overseeing the utilization thereof; evaluating the execution of HIV/AIDS programs and the concerted actions of governmental and non-governmental organizations; and generating ideas for the improvement and enhancement of same.⁵⁹

4.4.2 Non- discrimination

Because of their general application, it is often conceived that the prohibitions against discrimination and equality before the law are considered to be general express principles of a HRBA.⁶⁰ I have discussed the concept of non-discrimination and its relevance in relation to child survival in section 2.5.3.4. As was pointed out in the discussion, the CRC requires states parties to 'respect and ensure the rights enshrined in the instrument to each child without discrimination of any kind, irrespective of the child's or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status'.⁶¹ Non-discrimination has a special place in the CRC and is obviously a corner stone for the realization of rights of children for it is one of the cardinal principles and fundamental pillars of the CRC.⁶²

Discrimination, however, does not constitute all forms of differentiation, in particular if they are based on reasonable and objective grounds and aim to achieve legitimate purposes. Affirmative action or positive discrimination is one such example that legitimatizes differential treatment on objective grounds. The benefits of affirmative action mainly lie in its ability to

⁵⁸ Ibid., article 5(3) & (5).

⁵⁹ Ibid., article 6(2-3).

⁶⁰ J Tobin 'Understanding a human rights based approach to matters involving children: Conceptual foundations and strategic considerations' in A Invernizzi & J Williams (eds) *The Human Rights of Children from Visions to Implementation* (2011) 70.

⁶¹ CRC, article 2(1).

⁶² S Besson 'The principle of non-discrimination in the Convention on the Rights of the Child' in M Freeman (ed) *Children's Rights Progress and Perspectives: Essays from the International Journal of Children's Rights* (2011) 101-102; R Hodgkin & P Newell *Implementation Handbook for the Convention on the Rights of the Child* (2007) 17; G Alemu & Y Birmeta *Handbook on the Rights of the Child in Ethiopia* (2012) 38-39.

reduce and eradicate the immediate, root and underlying causes perpetuating discrimination. It is in view of this benefit that the Committee on the CRC also makes a recommendation as to the need for affirmative action or positive discrimination on behalf of disadvantaged and vulnerable children.⁶³

In a similar vein, the FDRE Constitution provides that ‘all persons are equal before the law and are entitled without any discrimination to the equal protection of the law’.⁶⁴ It further states ‘that the law shall guarantee to all persons equal and effective protection without discrimination on grounds of race, nation, nationality, or other social origin, colour, sex, language, religion, political or other opinion, property, birth or other status’.⁶⁵ As the country is structured into nine regional states, the constitutions of the several federal units also prohibit any form of discrimination on the basis of race, nation, nationality or other social origin and colour and other prohibited grounds.⁶⁶

Moreover, lawful differential treatment is also recognized in other provisions of the FDRE Constitution. Article 36(5) of the FDRE Constitution provides that ‘the State shall accord special protection to orphans and shall encourage the establishment of institutions which ensure and promote their adoption and advance their welfare, and education’. In addition, article 35(3) of the Constitution, by taking into account the historical legacy of inequality and discrimination suffered by women in Ethiopia, provides for women’s entitlement to affirmative measures in order to remedy this legacy. The essence of this provision pertains to the special attention it gives to women so as to enable them compete and participate on the basis of equality with men in political, social and economic life as well as in public and private institutions.⁶⁷

⁶³ Ibid., Hodgkin & Newell, at 23; Committee on the Rights of the Child, *General comment No. 5 (2003), General Measures of Implementation of the Convention on the Rights of the Child*, 27 November 2003, para 30, CRC/GC/2003/5.

⁶⁴ FDRE Constitution, article 25.

⁶⁵ Ibid.

⁶⁶ In a similar wording with that of the FDRE Constitution, the respective Revised Constitutions of all the nine regional states mentioned (n 6 above) also stipulate the principle of non-discrimination or equality.

⁶⁷ Hodgkin & Newell (n 62 above).

The incorporation of these principles of non-discrimination and equality into the FDRE Constitution and that of the nine regional units reveals the government's commitment to harmonize them with the standards provided in the CRC and other human rights treaties discussed in this work. By incorporating the principles into the domestic regime the government of Ethiopia assumes the obligation to guarantee the exercise and enjoyment of child survival and other complimentary rights without discrimination. This obligation is an immediate and cross-cutting one in the CRC and ICESCR.⁶⁸ It further requires states to ensure that all individuals, including children and women living in informal settlements and rural areas have equal access to adequate housing, water and sanitation. The question is to what extent the obligation of non-discrimination is implemented for child survival in the country concerned? In Chapter five I show that this obligation is not fully implemented by Ethiopia.⁶⁹

4.4.3 Participation

As was elaborated in section 2.3.3.2 above, the concept of participation is always identified as a key feature of a general HRBA within the literature. Child participation is fundamental in the sense that a system that truly promotes children's rights and wellbeing is based on a government's obligations to respect, protect and fulfil children's right to protection and is guided by the right to participation.⁷⁰

Although it is argued that there is no explicit right to participation in international law,⁷¹ elements of participation can be found in various human rights instruments. Principally, the ICCPR provides the legal foundation of participation, where mention is made in it that every individual has a right and an opportunity to take part in the conduct of public affairs directly or through freely chosen representatives.⁷² The right to participation is complemented by the

⁶⁸ Committee on Economic, Social and Cultural Rights (ESCR), *General Comment No. 20, Non-Discrimination in Economic, Social and Cultural Rights* (art. 2, para 2), para 8(b), U.N. Doc. E/C.12/GC/20 (2009).

⁶⁹ See section 5.3.2 of this thesis.

⁷⁰ Save the Children *Building rights-based national child protection systems: A concept paper to support Save the Children's work* (2010) 8.

⁷¹ L Ehlers & C Frank 'Child participation in Africa' in J Sloth-Nielsen (ed) *Children's Rights in Africa: A Legal Perspective* (2008) 112.

⁷² ICCPR, article 25.

rights to freedom of expression (article 19), freedom of association (article 22) and freedom of peaceful assembly (article 21) of the ICCPR.⁷³

Current literature shows, children's right to participation is otherwise referred to as the right of the child to be heard.⁷⁴ Freeman observes that the CRC is the first international instrument explicitly to state that children have a right to have a say in all matters⁷⁵ that affect their lives.⁷⁶ More specifically, article 12⁷⁷ of the CRC, which deals with children's right to form their views and the opportunity to be heard is relevant to participation of children in matters affecting their concern. This right is also complemented by other provisions of the CRC, most importantly, children's right to freedom of expression (article 13) and freedom of thought, conscience and religion (article 14), and freedom of association and peaceful assembly (article

⁷³ J Tobin *The Right to Health in International Law* (2012) 215.

⁷⁴ To promote the implementation of article 12 of the CRC, considerable progress has been achieved at the local, national, regional and global levels in the development of legislation, policies and methodologies since the adoption of the Convention in 1989. One such development is the emergence of the term 'participation' although it does not appear in the text of article 12. The term is used to describe on-going processes in which children can learn how their views and those of adults are taken into account and shape the outcome of such processes. See on this, Committee on CRC, *General Comment No. 12* (2009), *The Right of the Child to be Heard*, para 3. See, also, Alemu & Birmeta (n 62 above) 52.

⁷⁵ The phrase 'all matters' encompasses a broad range of issues which may affect children. However, the practice including the World Summit for Children demonstrates that a wide interpretation of matters affecting the child and children helps to include children in the social processes of their community and society. For details, consult CRC Committee, *General Comment No. 12* (n 74 above) para 26-27; Alemu & Birmeta (n 62 above) 53.

⁷⁶ Citizens participate in the conduct of public affairs by exerting influence through public debate and dialogue with their representatives or through their capacity to organize themselves. As such, this participation is supported by ensuring freedom of expression, assembly and association. In other words, freedom of expression, assembly and association are essential conditions for people to participate directly and effectively in the conduct of public affairs when they choose or change their constitution or decide public issues through a referendum or other electoral process conducted in accordance with applicable legislation. For a discussion on the complementarity of these rights, see Human Rights Committee, *General Comment No. 25* (1996) on article 25 (Participation in public affairs and the right to vote), paras 6 & 8, *Official Records of the General Assembly, Fifty-first Session, Supplement No. 40*, vol. I (A/51/40 (Vol. I)), annex v.; M Freeman 'The Convention: An English perspective' in Freeman *Children's Rights: A Comparative Perspective* (1996) 96; M Flekkoy & N Kaufman *The Participation Rights of the Child and Responsibilities in Family and Society* (1997) 88.

⁷⁷ Article 12 reads as follows:

1. States parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

15). In a similar fashion, articles 7⁷⁸ and 4(2)⁷⁹ of the ACRWC provide for the principle of respect for the views of the child.

The implementation of the principle of the right of the child to be heard may be direct or indirect. That is, in some cases the principle affords children the opportunity themselves to be heard in matters affecting them (directly), while in others, where procedural law, perhaps does not allow direct participation for children, children may be heard through their representatives (indirectly). The representatives may include, among others, parents, lawyers or social workers.

There is no lower age limit on the exercise of children's right to participation. Therefore, this right imposes a duty on all adults to listen to all children. Its 'full implementation requires the use of a range of approaches and methods including verbal and non-verbal communication, using play, art and drawing, and the use of dolls and other props to communicate effectively with children'.⁸⁰ In addition, this right recognizes the children's right to express his or her views 'in all matters affecting the child'. The latter phrase implies that participation is to be broadly applied, including in matters affecting children's health, whether participation is to be made in the public or private settings.

Under the Ethiopian legal framework, article 27(1) of the FDRE Constitution guarantees the right of everyone to freedom of thought, conscience and religion. This same article further states that the right includes the freedom to adopt a religion or belief of one's choice, and the freedom either individually or in community with others, and in public or private, to manifest

⁷⁸ Article 7 reads:

Every child who is capable of communicating his or her own views shall be assured the rights to express his opinions freely in all matters and to disseminate these opinions subject to such restrictions as are prescribed by laws.

⁷⁹ Article 4(2) reads as follows:

2. In all judicial or administrative proceedings affecting a child who is capable of communicating his/her own views, and opportunity shall be provided for the views of the child to be heard either directly or through an impartial representative as a party to the proceedings, and those views shall be taken into consideration by the relevant authority in accordance with the provisions of appropriate law.

⁸⁰ U Kilkelly & M Donnelly *The Child's Right to be heard in the Healthcare Setting: Perspectives of children, parents and health professionals* (2006) 17.

his religion or belief in worship, observance, practice and teaching. A further article that serves to promote the right to be heard is article 30 of the FDRE Constitution. This article recognizes that everyone has the right to assemble and demonstrate together with others peaceably and unarmed, and to petition. This article is supplemented by article 31 of the FDRE Constitution, which guarantees everyone the right to association for any cause or purpose.

Chapter ten of the FDRE Constitution is another section of the Constitution worth mentioning. It deals with National Policy Principles and Objectives - that which in countries like India and Nigeria is referred to as Directive Principles of State Policy.⁸¹ This chapter of the Constitution consists of provisions dealing with principles of external relations and national defense and economic, social, cultural and environmental objectives. It is within the article that deals with the economic objectives that the Constitution makes reference to people's participation in decision making affecting their interest. It reads: 'Government shall at all times promote the participation of the people in the formulation of national development policies and programs; it shall also have the duty to support the initiatives of the People in their development endeavours'.⁸² In a similar fashion, the environmental objective of the Constitution further reads that '[p]eople have the right to full consultation and to the expression of views in the planning and implementation of environmental policies and projects that affect them directly'.⁸³ Finally in this respect, the Constitution obliges any organ of government (federal or state) to be guided by the objectives in the implementation of the Constitution, other laws and public policies.⁸⁴ Although they are not strictly binding, these provisions are cornerstones for the realization of people's right to participation. Moreover, although these provisions are not children specific, they also apply to them in their capacity like every other human being or person. Children are thus entitled to the protection of these applicable laws and principles.

⁸¹ See n 84 in chapter one of this thesis.

⁸² FDRE Constitution, article 89(6).

⁸³ *Ibid.*, article 92(3).

⁸⁴ *Ibid.*, article 85.

In addition to the Constitution, a more child specific *right to participation or right to be heard* in legal matters affecting the *child* is echoed in the Revised Family Code. Most importantly, article 249⁸⁵ grants the court the authority to hear the minor himself where the court sees fit, thus providing a discretionary opportunity for the child to be heard directly before the court makes a decision, for example about appointing or removing a person as guardian or tutor of the minor. One finds also other important provisions in the FDRE Constitution and the Ethiopian Civil Code which complements the right to be heard. Article 14(1) of the Civil Code affirms the right of everyone to freedom to think and express his or her opinion.

Moreover, the idea of public participation is similarly incorporated in the plans and programs of the Ethiopian government. I take here two of them because they are major plans and programs of the government, which partly aim to ensure health development of citizens of the country. The Growth and Transformation Plan (GTP) for the period 2010/11-2014/15 is one such plan. It makes explicit reference to the need for ensuring women's participation, engagement and involvement in health service delivery.⁸⁶ Furthermore, this same document envisions improving community participation and ownership as one of the implementation strategies for fulfilling the objectives of the health policy (i.e., improving the health of the population through provision of promotive, preventive, curative and rehabilitative health services).⁸⁷ The other relevant document is the Health Sector Development Programme IV for the period that runs through 2010/11 – 2014/15. The program consists of ten strategic objectives (SOs) intended to make a significant impact on health service delivery and quality of care. From these ten SOs, the second one pertains to improving community ownership. The aims of this specific SO are creating awareness and changing behaviour of the community with

⁸⁵ Article 249 reads as follows:

- 1) Where the court is to appoint or to remove a person as guardian or tutor of a minor, it shall, before making its decision, consult, in so far as possible, the ascendants and the brothers and sisters of the child who have attained majority.
- 2) Where it thinks fit, it may hear the minor himself.
- 3) The court shall decide having regard solely to the interest of the minor and without being bound by the information which it has obtained.

⁸⁶ FDRE Ministry of Finance and Economic Development *Growth and Transformation Plan 2010/11-2014/15* (November 2010) 96-98.

⁸⁷ *Ibid.*

an aim to ensure their full participation in health policy formulation, planning, implementation, monitoring and evaluation (M & E) as well as regulation of health services and resource mobilisation in the health sector.⁸⁸

Besides, a landmark Ethiopian Supreme Court decision recognizes the right to be heard of the child. In the Supreme Court case *Etsegenet Eshetu*,⁸⁹ the Cassation bench of the Federal Supreme Court of Ethiopia seized the case involving the principle of respect for the views of the child in cassation case File No. 35710. The case was presented before the Cassation Bench of the Federal Supreme Court based on a petition that the judgment of the Cassation Division of Addis Ababa City Government Court suffers a fundamental error of law. The applicant at the Federal Cassation Court requested basically for invalidation of a will made by the deceased (*Zenebe Nigussie*); sought for the determination by the Federal Court that the respondent is not entitled to a property stated in the will made by the deceased; and for a grant of decision appointing the applicant to be a guardian and tutor of the child (*Samuel Zenebe*). In determining the guardian, the court most importantly referred to relevant provisions and principles of the CRC, ACRWC, the FDRE Constitution and the Revised Family Code of Ethiopia. The right to be heard and the best interest of the child were the primary consideration given by the Federal Cassation Court for determining the appropriate guardian of the child. The court cited article 12 of the CRC, article 4 of the ACRWC and article 249 of the Revised Family Code. All of these articles specifically deal with the right to be heard of the child in judicial and other proceedings affecting the child. The Court ordered the appearance of the child and received his view and finally appointed the applicant to be guardian and tutor of the child according to the view of the latter.

In practice, there has been an effort at engaging children in participation in the country. Model child parliaments established in different parts of the country can be considered here as

⁸⁸ FDRE MoH *Health Sector Development Programme IV 2010/11 – 2014/15* (Final Draft) (October 2010) 43.

⁸⁹ *Ms. Etsegenet Eshetu v Ms. Selamawit Nigussie*, Federal Supreme Court Cassation Division, Cassation File No. 35710, 25 December 2009. The working language of Federal courts in Ethiopia is Amharic. The Amharic pdf. version of the full text of the decision is available at: <http://chilot.files.wordpress.com/2012/10/federal-supreme-court-decisions-volume-8.pdf> (accessed 24 August 2014).

important mechanisms to drive children's right to participation in matters affecting their interests. Based on experience taken from the government of Norway, the Ethiopian Institute of Ombudsman established the first model child parliament in the *Konso Woreda*, located within the SNNPRS. There are currently 11 model child parliaments in the nine regions and two city Administrations established by the Institute. Besides, more than 60 child parliaments have been established at *woreda* level. According to an interview conducted with the Ethiopian Children and Women Affairs Ombudsman, Mrs. Sania Sani,⁹⁰ the establishment of the 11 model parliaments throughout all the regions of the country help to guarantee children's right to be heard and ensures their participation for democratic governance. Responding to a question about the potential role that these child parliaments can play, she explained the experience that these child parliament representatives openly discuss instances of maladministration with the executive organs of the state. She raised the accountability exercise that has been conducted between child parliament representatives, school administration and local government officials when instances of shortage of water, corporal punishment, child abuse and maltreatment occur at schools. The formation of the model parliaments is a significant step for designing policies and programs and monitoring the full implementation of human rights affecting child mortality in the country.

From the preceding discussions it can, however, be noted that none of the provisions stipulated in the Revised Family Code or in the other laws explicitly guarantee to children the right to be heard in *all* matters affecting their lives, in the same language as used by article 12 of the CRC. The more general right of the child to have his or her views taken into account in all matters affecting him or her is completely absent in the national laws or policies discussed in this section. On the other hand, although government plans and program documents make reference to participation, they are non-binding sources and fail to recognize participation as a human right that the government is responsible to realize. Nevertheless, these do not in any case imply children's right to be heard has no legal backing in the country. The provisions of

⁹⁰ Interview conducted with Mrs. Sania Sani Ahmed, Ombudswoman for Women and Children (Ethiopia) 20 January 2015, Addis Ababa, Ethiopia.

the FDRE constitution that relate to the right to participation equally apply to children. Further, since the country has ratified the CRC and courts are using it in their judgments, children have their right to be heard in accordance with article 12 of this Convention.

An important issue is whether the legal and policy provisions and the practice on child participation could be harnessed to improve the health needs of under-five children in the country? Certainly, one can establish a potential correlation between participation rights of children and efforts to foster their health or survival rights. How? Child participation rights enable children to express their views in 'all aspects of health provisions, including, for example, what services are needed, how and where they are best provided, barriers to accessing or using services, the quality of the services and the attitudes of health professionals'.⁹¹ Further, children can exercise this right concerning how to strengthen their capacities to take increasing levels of responsibility for their own health and development, and how to involve them more effectively in the provision of services, as peer educators.⁹² Also, participation better informs children's health care decisions in health hospitals or other health care centres. In addition, owing to their immaturity children are represented by their parents or legal representatives in some matters affecting them. Hence, participation grants parents of children, or other representatives, access to all relevant and necessary information to ensure an informed opinion in the decision-making processes which affect their children's survival and health.⁹³

The duty to listen to children in matters affecting their health is a legal one. Children, even at their very low age, are capable of forming their views. Despite the critical importance of children's right to participation and its potential for improving their survival and growth, engaging children in participation or consultation is underdeveloped.⁹⁴ This could be

⁹¹ CRC Committee, *General Comment No. 15 (2013), The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art. 24)*, 17 April 2013, para 19, CRC/C/GC/15.

⁹² Ibid.

⁹³ UN Human Rights Council *Study by the World Health Organization on mortality among children under five years of age as a human rights concern*, 6 September 2013, A/HRC/24/60, available at: <http://www.refworld.org/docid/523061aa4.html> (accessed 30 February 2015).

⁹⁴ Ehlers & Frank (n 70 above); DB Angst & JA Deatrck 'Involvement in healthcare decisions: Parents and children with chronic illness' (1996) 2:2 *Journal of Family Nursing* 174-94.

manifested in different ways. For instance, research shows ‘conflict can arise between the parent and the health professional regarding the process of consulting and informing the child about their health and health care.⁹⁵ A perception that children and young people did not have the capacity to participate fully in decision-making is also another factor’.⁹⁶ Among other things, there is a need to promote and protect children’s right to participation in matters affecting their health. To facilitate this, state and other actors should strongly encourage mainstreaming of theoretical and practical knowledge as to how to communicate effectively with children. Further, research should be conducted and data must be readily available into the extent to which children are listened to in the health care setting.

4.4.4 Accountability

Modern democratic governance is characterized by different values. Accountability is one such value and lies at the heart of a HRBA. When those in power cannot be held accountable in public for their acts or omissions, for their decisions, their expenditure or policies, democracy remains clichéd.⁹⁷ Accountability functions, *inter alia*, to: (a) effect democratic control, improve institutional learning and service delivery; (b) enable the public to judge the performance of the government by the government giving account in public; and (c) assure public confidence in government and bridge the gap between the governed and the government and ensure public confidence in government.⁹⁸

Arguably, accountability is also a constitutional value in the present Ethiopia. The FDRE Constitution and its nine state-level counterparts lay a foundation for accountability of the government. The Federal Constitution spells this out in no uncertain terms, as follows: ‘[A]ny

⁹⁵ KilKelly & Donnelly (n 80 above) 54.

⁹⁶ Ibid., 10; NYCI *Taking the initiative: The involvement of young people in decision-making in the Republic of Ireland* (2001). Available at: www.carnegieuktrust.org.uk (last accessed 08 June 2015).

⁹⁷ Parliament of the Republic of South Africa *Oversight and accountability model: Asserting parliament's oversight role in enhancing democracy* (2009) 4. Also, available at: http://www.parliament.gov.za/content/Microsoft%20Word%20-%20OVAC%20Model%20edited%20Word%20version%20-%20Replaced%20Diagrams,Chapter%20Upper%20case_27-Jan-09~1~1.pdf (accessed 23 August 2014).

⁹⁸ Ibid.

public official or an elected representative is accountable for any failure in official duties'.⁹⁹ The drafters of the FDRE Constitution make this provision in such a peremptory manner to stress that accountability is something more than ethical behaviour in all spheres of public service.

The recognition of accountability of public officials in the law asserts their responsibility for failure to deliver services in accordance with the domestic, regional and global standards. It is for this reason that primary and secondary legislation and governmental action stipulate disciplinary penalties ranging from simple warnings, to grave ones, including dismissal from employment as well as criminal and civil sanctions over public officials for failure to discharge their mandates.¹⁰⁰ In connection with accountability for under-five mortality, UN High Commissioner Zeid Ra'ad Al Hussein has said:¹⁰¹

State officials are answerable to the public when children die of preventable causes. If local officials, relevant ministries, head of government or head of State are not doing what they should to uphold the rights of these – the smallest, the most vulnerable of their people - then such omissions may well amount to criminal negligence.

Ethiopian law also recognises that failure to deliver public goods and services gives constitutional authorization to the electorate to remove public servants from office under the FDRE Constitution.¹⁰² The Constitution paves the way towards accountability of public officials more sensibly through the requirement of transparency of their action or non-action to the wider population.¹⁰³ This, incidentally, ensures individuals or groups' right of access to information on matters affecting their interest.

⁹⁹ FDRE Constitution, article 12 (2).

¹⁰⁰ MA Tadesse 'A rights based approach to HIV prevention, care, support and treatment: A review of its implementation in Ethiopia' *unpublished Doctoral dissertation, University of Alabama, Tuscaloosa*, 2012 265.

¹⁰¹ UNOHCHR 'State officials answerable to the public on preventable child mortality – UN human rights chief' available at: www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15058&LangID=E (accessed 25 January 2015).

¹⁰² FDRE Constitution, article 12(3).

¹⁰³ *Ibid.*, article 12(1).

When accountability is present in a system, individuals' right to seek a remedy against violation of a right or rights often exists. This important issue is well considered under the FDRE Constitution when it guarantees victims of human rights violations the right to take their cases to judicial and quasi-judicial bodies to seek judgment on their side.¹⁰⁴

The ratification by Ethiopia of the treaties discussed in section 2.9.3 herein obligates the state to respect, protect, promote and fulfil human rights within its jurisdiction, including in the context of child survival rights. These ratified treaties are categorically regarded by the Constitution as part and parcel of domestic or national laws of the country.¹⁰⁵ The provisions of these treaties therefore are reference points for the work of institutions or mechanisms such as courts, the Ethiopian Human Rights Commission (EHRC) and Ethiopian Institution of Ombudsman (EIO) and civil society organizations (CSOs), in evaluating and monitoring the conduct of the government and to hold it accountable when it fails to live up to its obligations.

On the top the Constitution, various laws, policies and plans of action recognize the principle of accountability of government bodies in connection with their public duties. With regards to legislation dealing with accountability, Proclamation No. 276/2002 could be a paramount example to mention. This proclamation provides for the establishment of the principal organs that do play a crucial role in HIV/AIDS governance. It sets up the National AIDS Prevention and Control Council (NHAPCC) chaired by the president of the Republic, consists of members from government institutions, CSOs, People Living with HIV/AIDS (PLWHA) associations and private sector and is responsible for giving policy guidance and overseeing the overall national response to HIV/AIDS.¹⁰⁶ At least on paper, NHAPCC is a good forum to ensure accountability at the highest level. Since major sectors are represented at NHAPCC, NHAPCC meetings give the different actors the opportunity to jointly evaluate what has been done and what has not been done. Established by the same proclamation, the Federal HIV/AIDS Prevention and Control Office (FHAPCO) has, however, the real power to hold sectors accountable in respect

¹⁰⁴ Ibid., article 37.

¹⁰⁵ Ibid., article 9(4).

¹⁰⁶ Proclamation No. 276/2002 (note 57 above), articles 4 & 5.

of implementing HIV/AIDS programs than the NHAPCC. Endorsed to serve as a secretariat to the NHAPCC and accountable to the prime minister, FHAPCO coordinates HIV-related activities of federal and regional government agencies, donors and CSOs.¹⁰⁷ The coordination jurisdiction of FHAPCO gives it the power to control what sectors are doing relative to what they expected to do.

Media is another mechanism that has a potential to enhance accountability for children's right to health or survival. News and social media may be the most responsive mechanisms to ensure that state and all non-state actors engaged in health promotion and services act in compliance with children's rights provided in the relevant provisions of the CRC or ACRWC.¹⁰⁸ Although one of the most debatable legislation in terms of its restriction on freedom of speech and press, Ethiopia promulgates a legislation to govern broadcasting service which, *inter alia*, recognizes in its Preamble the importance of the role of broadcasting service in exercising the basic constitutional rights such as freedom of expression, and access to information. The proclamation in article 16 (2)(1-2) states broadcasting to include services of 'enhancing the participation of the public through the presentation of government policies and strategies as well as activities related to development, democracy and good governance; and presenting programs which inform, educate and entertain the public'.

There are different forms of media which mainly include government owned television stations, radio broadcasting and print media, which utilize different languages to educate, inform the public on governmental and other activities. Although the significance of the media for ensuring accountability is highlighted above, the impact that it would bring has suffered by ill commitment by the government to liberally govern this sector. The government struggles to justify its draconian control over the media by stipulating misleading liberal Preamble as a cover for restricting media.¹⁰⁹

¹⁰⁷ Ibid., article 11(3).

¹⁰⁸ The Partnership for Maternal, Newborn and Child Health (PMNCH): Knowledge Summary 23 'Human Rights and Accountability' (2013) 2-3.

¹⁰⁹ See S Hailemariam 'Constitutionally questionable, global journalist', Dec. 1, 2008, available at: <http://www.globaljournalist.org/stories/2008/12/01/constitutionallyquestionable/> (accessed 12 October 2015).

Apart from the media and other legislation discussed in the preceding, it is argued that the Ethiopian Growth and Transformation Plan (GTP) is of paramount importance in terms of putting forth the blueprint for accountable government in the country.¹¹⁰ It is believed by the FDRE government that the GTP will bring about the fast-tracking of rapid socio-economic development in the country. In the Plan, seven fundamental strategies to achieve the development of the country are envisaged. These strategies are: maintaining agriculture as a major source of economic growth; building capacity and deepening good governance; sustaining faster and equitable economic growth; creating favourable conditions for the industry to play a key role in the economy; enhancing quality of infrastructure and social development; and promoting women and youth empowerment and equitable benefit.¹¹¹ Intended to build the capacity of institutions and consolidate good governance, the Plan also incorporates several other strategies, which include guaranteeing transparency and accountability of public institutions, as well as the independence of the judiciary; enhancing public participation; guaranteeing access to information; strengthening complaint handling mechanisms; providing effective systems for solving disputes; and improving the role of CSOs.¹¹²

The foregoing uncovers that Ethiopian law and policies evince recognition that accountability is an important element to ensure proper delivery of public services such as health, education, availability of safe drinking water and others. To have no proper system of accountability in practice is therefore destructive of the goals of the Constitution. The high number of preventable child deaths signifies the presence of the state's non-delivery or failure to deliver health goods and services, for which the public administration must held accountable.

The laws governing accountability have an important contribution to make for meeting certain standards of children's health services. For instance, using the different types of accountability

¹¹⁰ FDRE Ministry of Finance and Economic Development (n 86 above) 96-108.

¹¹¹ *Ibid.*, 22.

¹¹² *Ibid.*, 57-70.

mechanisms discussed in section 2.2.3.5, the country may be compelled to ensure child ‘health services to be sufficiently available, accessible (physically, economically and to all), acceptable (sensitive to cultural or gender differences, for example) and of adequate quality (AAAQ)’.¹¹³ Further, those laws could potentially be employed to eliminate discriminatory state programs and expenditures, and ensure substantive equality in the enjoyment of children’s right to survival and health.¹¹⁴ The TAC case is one of the paradigmatic cases discussed in section 2.3.2 used to illustrate that judicial accountability could enable the elimination of discriminatory state policies on health goods and ensure increased access to life saving drugs to women and their new-born children.

4.4.5 Right of access to justice

Recent Bar studies in the United States have found that over four-fifths of the legal needs of the poor there remain unmet.¹¹⁵ This is indicative of the need to focus on the right of access to justice to less advantaged people, which will better enable them, at least, to realize their livelihood rights.¹¹⁶ The right of access to justice is a fundamental human right. It serves as a mechanism to ensure fulfilment of other human rights. Accessibility, affordability, satisfaction and trust in the formal and informal institutions of the justice system are major components of this right.¹¹⁷

¹¹³ UNOHCHR & Centre for Economic and Social Rights *Who will be Accountable?: Human Rights and the Post-2015 Development Agenda* (2013) 13.

¹¹⁴ *Ibid.*

¹¹⁵ Stanford Law School ‘Newsletter of the Center on the Legal Profession: 2014 update’ Vol. 1/ 2 (2014) 1.

¹¹⁶ According to D Brand, livelihood rights or redistributive rights – rights to the conditions or resources required for material survival and well-being rights. In the Context of the 1996 South African Constitution, these rights include, affirmative rights of everyone to a clean and healthy environment, land, housing, health care, food, water, social security and assistance and education; negative labour guarantees; affirmative rights of children to family, parental or alternative care, basic nutrition, shelter, health care and social services; and affirmative rights of detained persons to adequate accommodation, medical treatment, reading material and nutrition. For details, see D Brand ‘The South African Constitutional Court and livelihood rights’ in O Vilhena *et al* (eds) *Transformative Constitutionalism: Comparing the Apex Courts of Brazil, India and South Africa* (2013) 415.

¹¹⁷ C Hackmann ‘Legal empowerment of the poor and its relation to pro-poor growth’ in OECD *Poverty Reduction and Pro-Poor Growth: The Role of Empowerment* (2012) 201-222; UNICEF *et al* *Informal Justice Systems: Charting a Course for Human Rights-Based Engagement* (2009).

Child mortality is often a problem of impoverished communities in most parts of sub-Saharan Africa. On the other hand, it is quite obvious to imagine the contribution that easy and affordable access to justice will make to create the entitlements to material basic things that are necessary to prevent avoidable deaths of infants or children under five. Ensuring a right of access to justice is thus pivotal for the poor to realize other rights, such as health care rights.

The current Ethiopian legal system recognizes access to justice as a constitutional right. Articles 37 & 25 of the FDRE Constitution expressly guarantee the right of access to justice and equality before the law, respectively, to all citizens. The possibility that citizens might nevertheless not, in certain circumstances, have a means to access legal representation has also received attention under the Constitution and other special legislation. To state some of provisions provided in this regard, article 20 of the Constitution imposes an obligation on the state to provide legal aid to accused persons who do not have sufficient means to pay for an advocate, where 'substantial' injustice would otherwise ensue. In the same vein, the Criminal Procedure Code, the Federal Court's Advocates Licensing and Registration Proclamation (Proclamation No.199/2000) and the Federal Court's Advocates Code of Conduct (Regulation No. 59/1999) provide similar protection. While, on the one hand, the Criminal Procedure Code reinforces the right to legal aid of accused persons in cases where the accused is a minor, or when the accused couldn't defend his/her case because of his/her mental or physical disability, the Federal Court's Advocates Licensing and Registration Proclamation (Proclamation No.199/2000) and the Federal Court's Advocates Code of Conduct (Regulation No. 59/99), on the other, require advocates to provide at least 50 hours of free legal aid service to the needy per year. Further, the legislation that addresses free legal aid before courts is Proclamation No. 691/2010. It provides for the definition of powers and duties of the executive organs of the FDRE. This legislation unequivocally mandates the MoJ to represent citizens, in particular women and children, who are unable to institute and pursue their civil suits before federal courts.¹¹⁸ In addition, children may be represented by their guardian or tutor for matters

¹¹⁸ Definition of Powers and Duties of the Executive Organs of the FDRE Proclamation No. 691/2010, article 16(11).

affecting their interest.¹¹⁹ Worth mentioning here is the role of legal aid clinics and some NGOs. ‘Legal aid clinics in law faculties at public universities’¹²⁰ established by these academic institutions are licensed to render legal aid services for those persons who cannot afford to pay legal fees which includes minors who have lost their parents due to HIV/AIDS and persons living with HIV/AIDS and unable to move from place to place to pursue their case. In addition, ‘special advocacy license’¹²¹ given to some NGOs enables them to advocate for general interests and rights of the society, without receiving any payment from their clients. These institutions provide free advocacy services to the poor and could be potentially crucial to challenge children’s right to health or life violations. They are, however, yet to demonstrate they actively engage in ensuring that government agencies are responsible to fulfil child health obligations.¹²²

The justice demand for fulfilling children’s right to health in Ethiopian is significant. As highlighted in section 4.3 above, hundreds of thousands of children in the country die every year of preventable causes, and these deaths could be averted if children had access to

¹¹⁹ The Revised Family Code, article 216. For pecuniary matters the minor is represented by his tutor, whereas he is represented by his guardian for non-pecuniary matters. It implies, a child’s claim, such as his right of access to health, vaccination, food can be lodged by the guardian in as much it does not involve payment for compensation or monetary claim.

¹²⁰ Over the past few years, more than 15 public universities have initiated and expanded legal aid clinics in collaboration with the EHRC and other stakeholders. Among these, two notable ones are law faculties at Mekelle and Bahirdar Universities. Following their establishment, the legal aid clinics have been rendering legal assistances to vulnerable women, children, people with disabilities, the aged and prisoners in accordance with a special advocacy license issued by regional authorities. However, there is no clear legal framework which governs operation of legal aid clinics in law schools, and they lack the full integration of these clinics with the curriculum of public universities. For a further discussion on this see, for instance, G Metiku ‘Access to justice and legal aid in Ethiopia’ available at: <http://www.abysinnialaw.com/blog-posts/item/1448-access-to-justice-and-legal-aid-in-ethiopia> (accessed 10 November 2015).

¹²¹ At Federal level, the special advocacy license is governed under Federal Courts Advocates' Licensing and Registration Proclamation No. 199/2000, article 7(c) & 10(1). However, this license does not seem to apply to foreign NGOs in Ethiopia as the latter article makes reference applying only to ‘Ethiopian’.

¹²² Interview conducted with Dr. Biruk Haile, Head of School of Law, Addis Ababa University, 11 December 2015, Pretoria, South Africa, indicates that there are no strict rules and regulations governing legal representation by legal clinics at his University level. According to him, although the legal clinic presents itself as part of the law school’s undergraduate program, there are gaps in placing clear guidelines as to, for instance, how court cases are to be handled by the students and what responsibilities they assume and to whom they are answerable. He mentions the experience of legal clinics in the USA that function to the extent of litigating for change of laws in the interest of the public. However, he mentioned how our legal clinics in Ethiopia should go a long way to provide free legal service to the poor comparing the experience of other countries. The interview conducted 11 December 2015, Pretoria, South Africa.

adequate health interventions. The high number of premature deaths may constitute social injustice and potentially violates children's right to survival. Despite the demand, no claim has reached to courts, as at the time of writing this thesis, requesting a local, state or federal government to guarantee access to food, sanitation, safe drinking water or medical services. Clearly, these laws have a pivotal role to play, at least, to initiate children's social rights claims before courts, which could have the potential, *inter alia*, to result in social policy changes on children's health; ensure availability of essential public health services; mobilize sufficient resources for children to overcome the barriers of access to health care services; and to seek remedy where damage is proved.

Despite the recognition of the right of access to justice as a fundamental human right under the Constitution, various factors militate against the realization of the right. The problem partly emanates from the current procedural law relating to access to justice. One example is the law relating to *locus standi* or standing. Abebe notes the strong correlation that exists between standing and the right of access to justice.¹²³ Nevertheless, the rules that apply in relation to standing are relatively strict in Ethiopia, in the sense that Ethiopian laws generally require a personal vested interest in a particular action for a person to be allowed to bring a case before court.¹²⁴ The following are the most apparent laws that follow the traditional approach of requiring a vested interest in a particular claim for *locus standi*: the Ethiopian Civil Procedure Code (1965);¹²⁵ the FDRE Constitution;¹²⁶ the Council of Constitutional Inquiry Proclamation 250/2001;¹²⁷ and the Consolidation of the House of Federation and Definition of Powers and Responsibilities Proclamation 251/2001.¹²⁸ The cumulative effect of these rules inhibits human rights NGOs and other entities from challenging governmental action or inaction towards their human rights obligations.

¹²³ A Abebe 'Towards more liberal standing rules to enforce constitutional rights in Ethiopia' (2010) 10 *African Human Rights Law Journal* 408.

¹²⁴ One finds exception to the general requirement of standing in the Environmental Pollution Control Proclamation No. 300/2002 (article 11(1)), Human Rights Commission Establishment Proclamation No. 210/2000 (article 22(1)), and the Institution of the Ombudsman Establishment Proclamation No. 211/2000 (article 22(1)).

¹²⁵ See article 33(2).

¹²⁶ See article 37(2).

¹²⁷ See article 23(1).

¹²⁸ See article 19.

The significance of lenient standing rules in the context of protecting children's and maternal health mortality can be garnered from the Indian case of *Sandesh Bansal v Union of India and Others*.¹²⁹ This was a public interest case litigated by a human rights NGO (named Human Rights Law Network) on behalf of others in relation to an acute shortage of trained health care providers, services, and equipment for pregnant women seeking care in the state of Madhya. The state was ordered to ameliorate the conditions in health centers by ensuring 24-hour delivery services, making basic infrastructure improvements, ensuring 24-hour availability of emergency vehicles for all health centers and providing vaccination of pregnant women and their new-born.¹³⁰ It is noticed that since the filing of this case a blood bank has now been set up at *Bhind* Hospital and water well at *Supurna* Public Health Centre.¹³¹

The above case – having essentially been brought by an NGO in the public interest - is evidence of the potential of liberal standing rules to improve maternal and child health services through initiation of claims against the responsible state or its agents. If the above case were brought before an Ethiopian court by a human right NGO, it could have been dismissed subject to an objection for lack of standing or mandate. Despite the improvement that has been seen over the years, the Ethiopian health sector is characterized by a shortage not only of the infrastructure but of the manpower. In many cases, these problems affect not only an individual child but also all children in demand of the same service. Overhauling the legal framework on standing in a manner allowing human rights NGOs to represent the interest of others has the potential to improve maternal and child health in the country. Liberal standing rules will potentially allow children to have increased access to court, which, in turn, will better enable them to ensure implementation of their health rights or prevent infant mortality.

¹²⁹ I discuss in section 2.2.3.5 of this thesis.

¹³⁰ XA Ibanez 'The role of international and national courts: Human rights litigation as a strategy to hold states accountable for maternal deaths' in P Hunt & T Gray (eds) *Maternal Accountability, Human Rights, and Accountability* (2013) 47.

¹³¹ Human Rights Law Network (HRLN) *Sandesh Bansal v Union of India and Others* W.P. No. 9061/08, available at: <http://hrln.org/hrln/reproductive-rights/pils-a-cases/634-sandesh-bansal-v-union-of-india-wp-no-906108.html#ixzz3gfrVPQzQ> (last accessed 24 June 2015).

It should not be left out that the lack of liberal standing rules mentioned above is by no means the only factor that limits vulnerable peoples' access to justice in Ethiopia. There are a range of other problems in this respect, including licensed lawyers' failure to provide, every year, the minimum 50 hours of the required legal services, free of charge or upon minimum payment (*Pro Bono Publico Service*);¹³² ouster clauses stipulated in various administrative laws/matters;¹³³ physical inaccessibility of courts to the rural population, and unpredictable court decisions and procedures.¹³⁴ Nevertheless, I focus the discussion on the limits of standing rules for the reason that this problem in particular affects the possibility of strategic litigation for the rights of children as a vulnerable group in need of legal representation through the work of NGOs and activist groups, as I explain more fully below.

Although a flexible system of standing rules does not in and of itself ensure active human rights litigation, strict rules of standing in any legal system certainly have repercussions for the development of public interest litigation. In some countries it has been shown that strict rules of standing are major legal constraints to the protection of human rights.¹³⁵ In a bid to curb this challenge, the law of some countries has developed. For example, section 38 of the Constitution of SA allows standing for persons acting in their own interest, on behalf of those

¹³² Article 49 of the Council of Ministers Regulations No. 57/1999, a Regulation which provide for the Federal Court Advocates Code of Conduct, stipulates licensed lawyers to provide a minimum of 50 hours *Pro Bono* (free legal aid or with minimal payment) service to the indigent and a similar others, annually. Despite this, these lawyers fail to comply with their legal duties which negatively affect the right of access to justice to the needy. In his presentation at Churchill Hotel on 22 October 2014 concerning access to justice in Ethiopia, Mr *Demissie*, Advocate License Administration Directorate Director at the Ministry of Justice (Ethiopia), further revealed that only 668 lawyers have provided the *Pro Bono* service out of the 2300 advocates licensed to operate in federal courts, during the period 2013/14. See See 'Access to justice' *The (Ethiopian) Reporter* (n 134 below).

¹³³ For instance, the country's current tax law (Proclamation No. 859/2014, article 155(2)) states that tax and duties assessment made by the Ethiopian Revenues and Customs Authority (ERCA) can be appealed before the Tax Appeal Commission only after depositing the disputed amount of tax or duty levied by the said Authority. Similarly, legislations such as those dealing with foreclosures, land lease, government housing and business licensing and registration are other predicaments for proper realization of right of access to justice.

¹³⁴ It is argued that slow and unpredictable court procedures on issues such as on granting bail and ordering temporary injunctions affects the right to timely and quality justice to a party/parties in litigation. See 'Access to justice' *The (Ethiopian) Reporter*, 08 November 2014: Presentation made by F Aynalem on 'The practical challenges of access to justice in Ethiopia' (22 October 2014, Addis Ababa, Ethiopia).

¹³⁵ For instance, Obiagwu & Odinkalu note that strict rules of standing as the major legal constraint to the protection of human rights in Nigeria. For details, see C Obiagwu & CA Odinkalu 'Combating legacies of colonialism and militarism' in AA An-Na'im (ed) *Human Rights in African Constitutions: Realising the Promise for Ourselves* (2003) 233.

who cannot act for themselves, on behalf of a group or class of persons or in the public interest. Equally, standing rules in India and Nigeria have been adapted so as to allow freer access to court in human rights cases involving the public interest. Their difference being that, unlike the South African model where the Constitution has brought about an innovative approach to public interest litigation, the development of public interest litigation in India¹³⁶ and Nigeria is the result of judicial activism.¹³⁷ In Ethiopia, there is a demand for broader and more liberal standing rules or judicial activism that could allow public interest litigation on children's or other vulnerable group in the society.

As can be garnered from the above, there are instance where parents, guardians, and children's rights representatives can bring violations of children's right to health directly to the relevant bodies. Nevertheless, access to justice in connection with violation of children's rights to health and their other rights is a challenge. This is not the place to discuss in any comprehensive manner access to justice for children and the potential challenges in Ethiopia. However, the factors that generally affect the right of access to justice in the country, discussed above, do the same to children's health or survival claims as well. Also, there is no child justice friendly procedural law and practice throughout the country.¹³⁸ Despite the fact that many children in the country are in dire need of justice for fulfilment of their basic rights to health and the underlining determinants of the right to health, judicial representation of children's socio-economic rights before courts is limited.¹³⁹ There is an experience that Ethiopian children have received and receive legal representation from NGOs, such as African Child Policy Forum (ACPF) or Children's Legal Protection Centre (CLPC). However, compared to the need, only

¹³⁶ The Indian Supreme Court is known for incessantly accepting and encouraging complaints from public interest litigants. See, also, Abebe 'Towards more liberal standing rules to enforce constitutional rights in Ethiopia' (n 123 above).

¹³⁷ Abebe 'Towards more liberal standing rules to enforce constitutional rights in Ethiopia' (n 123 above) 112-115, 130-131; C Okpaluba 'Justiciability and standing to challenge legislation in the commonwealth: A tale of the traditionalist and judicial activist approaches' (2003) 36 *The Comparative and International Law Journal of Southern Africa* 26.

¹³⁸ White & Case LLP Report *Ethiopia: Access to justice for children* (November 2013) 6-7. Available at: <https://www.crin.org/en/library/publications/ethiopia-access-justice-children> (accessed 4 June 2014).

¹³⁹ Interview conducted with Mrs. Fasika Hailu, Coordinator for Child Justice Project Office of the Federal Supreme Court of Ethiopia, 26 January 2015, Addis Ababa, Ethiopia. Also, interview conducted with Mr. Leul Hagos, Director for Public Relations Office, Federal Supreme Court of Ethiopia, 13 January 2015, Addis Ababa, Ethiopia.

insignificant numbers of cases are represented by such mechanisms and these cases are in relation to child custody, child physical abuse and neglect by their parents or caretakers. None of the cases brought before courts relate to claims made for implementation of children's right to health or socio-economic rights by the state.

Research on poverty - for instance, research conducted by the World Bank¹⁴⁰ – emphasizes that poverty is not just a lack of income. It rather constitutes multiple forms of vulnerability, of which lack of access to justice is one. Lack of access to justice mainly affects the poor and other vulnerable groups in society. Children in the developing world are in this category. As I discussed above, under-five child mortality is a phenomenon strongly affecting children of families, particularly the poor and the ignorant. The latter are often themselves helpless victims of violations and have little or no means from accessing judicial bodies. In Ethiopia, the situation of poor children and their families is not an exception to this limitation. A workshop conducted in 22 October 2014, in Addis Ababa, among academics, practitioners, judges and other stake holders showed that access to justice remains a serious challenge to the country.¹⁴¹ In this light, it is worth to address how liberal standing rules, the involvement of CSO's and public interest litigation will support the existing initiatives for demanding from government the judicial enforcement of human rights. There is a need to develop a more liberal approach to standing rules if violation of rights of vulnerable groups such as children, is to be challenged through judicial or quasi-judicial means.

4.4.6 Global and regional treaties ratified by Ethiopia relating to child survival

As was discussed in chapter three, children's right to survive and their complementary rights are recognized in various human rights instruments. Numerous global and regional instruments have incorporated provisions on child survival and the measures to be taken by states and non-state actors for the realization of children's survival right. These instruments

¹⁴⁰ World Bank *What the Poor Say* (May 2001) 43. Available at: <http://siteresources.worldbank.org/INTPOVERTY/Resources/poor.pdf> (accessed 16 June 2015).

¹⁴¹ *The Ethiopian Reporter* (n 134 above).

impose legally binding obligations on those countries that ratified them. At the time of writing of this thesis, Ethiopia is a State Party to such global and regional human rights instruments that are explicitly and implicitly connected with child survival. More specifically, the country has ratified:¹⁴² the International Covenant on Civil and Political Rights (in 1993); the International Covenant on Economic, Social and Cultural Rights (in 1993); the Convention on the Elimination of All Forms of Discrimination against Women (in 1993); the Convention on the Rights of the Child (in 1991); the African Charter on Human and Peoples' Rights (in 1998); and the African Charter on the Rights and Welfare of the Child (in 2002).

The enjoyment of the rights as enshrined in these instruments depends on the implementation measures taken by the states parties. Most of the instruments mentioned above require state parties to take appropriate measures for the implementation of the particular convention concerned. For instance, article 4 of the CRC imposes obligations on member states to undertake all appropriate legislative, administrative, and other measures for the implementation of the rights enshrined in the Convention. In the same way, the ACRWC spells out the obligations of the member states to recognize the rights and freedoms enunciated in the Charter and to undertake the necessary steps to adopt legislative and other measures necessary for giving legal effect to the provisions of the Charter.¹⁴³ However, international law, in general, does not specify any particular way in which states should implement their general obligations.¹⁴⁴ That is left to be decided by the state concerned. This is further reaffirmed, for instance, by the Charter of the UN, when mention is made that once a state has voluntarily acceded to and ratified a treaty; that the state is obliged to adopt the same in good faith.¹⁴⁵

¹⁴² In addition, Ethiopia has also ratified International Convention on the Elimination of All Forms of Racial Discrimination (ICERD); Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT); Convention on the Rights of Persons with Disabilities. For details of those Conventions signed by Ethiopia, visit the following website: <http://www1.umn.edu/humanrts/research/ratification-ethiopia.html> (last accessed 21 May 2014).

¹⁴³ ACRWC, article 1.

¹⁴⁴ Committee on Economic, Social and Cultural Rights, *General Comment No. 9 (1998), The domestic application of the Covenant* (Nineteenth session, 1998), U.N. Doc. E/C.12/1998/24, paras 1-3; For detailed discussion on this, see also I Byrne *Making the right to health a reality: Legal strategies for effective implementation* Paper presented to Commonwealth Law Conference (2005) 1-4.

¹⁴⁵ The Charter of the UN (1945), article 1.

Having become a State Party to the above instruments, Ethiopia has assumed the obligation to undertake legislative, administrative and other measures (discussed in section 3.5.2) to realize all children's survival rights. Accordingly, in the area of legislative measures, the country has taken various measures to ensure the realization and observance of the rights of children as enshrined under the CRC, ACRWC and other treaties. These measures range from recognition of the rights of children under the FDRE Constitution (discussed in section 4.4.1 above), the harmonization of certain legislation¹⁴⁶ and reporting to treaty bodies,¹⁴⁷ to various steps taken with a view to give the provisions of the two treaties legal effect in Ethiopia. Nevertheless, as I discuss in section 4.4.1, the FDRE Constitution and the regional state counterparts fail to recognize children's rights to survival, health, nutrition and an adequate standard of living explicitly in the provisions dealing with children's rights. As such, the harmonization efforts of the country fall short of addressing these critically important and interconnected rights necessary for the reduction of child mortality.

4.4.7 Incorporation and application of global and regional instruments ratified by Ethiopia

Quite often, the simplest way in which a national court might refer to global or regional human rights principles would be where the national constitution authorizes specific use of global or regional law.¹⁴⁸ In other words, the enforcement of international treaty obligations in municipal

¹⁴⁶ I take here three national laws that reflect attempts made by the government to harmonize laws that affect children's rights, namely, the FDRE Constitution and the nine regional states counterparts, the Revised Family Code, and the Revised Criminal Code of Ethiopia. Article 36 of the Constitution echoes relevant fundamental principles incorporated under the CRC and ACRWC. Articles 9(4) and 13(2) of the Constitution also give status to the provisions of CRC and ACRWC as part and parcel of the law of the country, although their implementation is debatable due to seemingly technical requirements. Equally, one finds that the sections of the regional constitution dealing with fundamental rights, including children's rights, are provided in the same as in the FDRE Constitution. The regional states are bound by treaties concluded by the federal government (Article 50(8) *cum* 51(8)) and the human rights provisions in their own constitutions. On the other hand, the country has promulgated the Federal Family Law of July 2000 (which apply only in Addis Ababa and Dire Dawa), and the Criminal Code of May 2004. Various provisions of these new codes have brought significant changes in the legal framework in terms of protecting children's rights enshrined in the child rights treaties and the Constitution. For an insightful account on this, see S Yohannes & A Assefa *Harmonisation of National and international laws to protect children's rights: the Ethiopia Case study African Child Policy Forum* (2006).

¹⁴⁷ For more details on the Ethiopian reporting record to the CRC Committee, see section 4.6.7 of this thesis.

¹⁴⁸ M Kirby 'Domestic courts and international human rights law the on-going judicial conversation' (2010) 6 *Utrecht Law Review* 171; M Killander (ed) *International Law and Domestic Human Rights Litigation in Africa* (2010).

courts is governed by the jurisprudence of individual countries. Despite this, many domestic tribunals will find that duties do exist to observe basic human rights.¹⁴⁹ This could arise directly from international conventions or indirectly through such legal instruments as national constitutions or human rights codes, the interpretation of which may be influenced by treaty provisions. On top of that, interpretation may be reinforced by presumptions that countries intend in good faith to give effect to their international commitments, and that they do not intend that their municipal laws should violate them.¹⁵⁰

In order to evaluate the Ethiopian situation, an examination of the relevant provisions of the FDRE Constitution is of great importance. Article 9(4) of the 1995 FDRE Constitution deserves discussion. It stipulates that '[i]nternational agreements ratified by Ethiopia are an integral part of the law of the land.' However, there is debate about whether ratification alone suffices for domestication or whether publication in the Federal *Negarit Gazeta*¹⁵¹ is required in order to apply international human rights instruments before courts. Despite the explicit nature of article 9(4), opponents of the view that ratification alone is sufficient for the application of a given international treaty argue otherwise on the basis of article 71(2) of the Constitution, which provides for the powers and functions of the President. This article reads, '[h]e shall proclaim in the *Negarit Gazeta* laws and international agreements approved by the House of Peoples' Representatives in accordance with the Constitution'. To support their position they further rely on Proclamation No. 3 of 1995, which reads: [A]ll federal or regional legislative, executive and judicial organs as well as any natural or juridical person shall take judicial notice of Laws published in the Federal *Negarit Gazeta*'. Despite their stand, whether or not publication is a requirement for incorporation is not indicated in the relevant provisions of the Constitution mentioned above.

¹⁴⁹ A Brudner 'The domestic enforcement of international covenants on human rights: A theoretical framework' (1985) 35 *University of Toronto Law Journal* 224-225.

¹⁵⁰ *Ibid.*, 221.

¹⁵¹ *Negarit Gazeta* is the official law gazette of the federal and the preceding Ethiopian governments. Its name is changed from *Negarit Gazeta* to *Federal Negarit Gazeta*, after the current government established the country in to a federal state in 1994/1995.

The better view would be to argue that publication in the Federal *Negarit Gazeta* is not a question of legality, but one of practicality. It would be impractical if not impossible to meaningfully engage: (a) publication of the entire text of any international human rights covenant or treaty; (b) incorporating it into national legislation for implementation; and (c) translating it into the various languages¹⁵² in which the courts work. For that reason, so far, Ethiopia has published only the CRC, although not a single line of the actual text of the CRC was published in the *Negarit Gazeta*.

There are, however, bright spots that look to settle the prevailing debate in favor of the application of human rights instruments before courts. The role of the Ethiopian Human Rights Commission (EHRC) is worth mentioning here. With a view to minimizing the controversy over the application of human right instruments ratified by Ethiopia before courts, the EHRC recently, in 2012, translated ten global and regional human rights instruments ratified by Ethiopia into three major languages of the country.¹⁵³ The EHRC does this job in accordance with one of its powers and duties provided for in its establishing Proclamation No. 210/2000 which reads ‘translate into local vernaculars, international human rights instruments adopted by Ethiopia and disperse same’.¹⁵⁴

¹⁵² As noted in section 4. 2 herein, following adoption of a federal setting, nine state governments are recognized that form the federal government of Ethiopia. Furthermore, the country is a constituent of more than 80 languages and different ethnic backgrounds. Accordingly, the constitution in each of these states explicitly determines the working language of a particular state, which courts in these states are bound to use in their work. Except for the Amharic language, which is a working language of courts in four states (Amhara, Southern Nations, Nationalities and Peoples, Gambela, and Benshangul Gumuz), the other states use distinct languages, based on religion, ethnic lines and language dominance.

¹⁵³ These ten instruments are: the Universal Declaration of Human Rights; International Convention on Civil and Political Rights, International Convention of Economic, Social and Cultural Rights, Convention on the Elimination of All forms of Discrimination Against Women, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; Convention on the Right of the Child, International Convention on the Elimination of All Forms of Racial Discrimination, African Charter on Human and Peoples’ Rights, African Charter on the Rights and Welfare of the Child and Convention on rights of Persons with Disabilities. These instruments have been translated in to Amharic, Oromiffa and Tigrigna languages. For details, visit: <http://www.ehrc.org.et/LinkClick.aspx?fileticket=nVHdDn60Ln4%3d&tabid=116> (accessed 13 May 2014).

¹⁵⁴ See the Proclamation which provides for the Establishment of the Human Rights Commission, Proclamation No. 210/2000, article 6(8).

Similarly, the role of the Cassation divisions of the Federal Supreme Court is also pivotal in this regard. This bench of the court has rendered various decisions relying on the Children's Convention and the African Children's Charter. For instance, in the case *Tsedale Demisse v Kifle Demisse*,¹⁵⁵ the Cassation Bench of the Federal Supreme Court passed a landmark decision, basing its argument on article 3 of the CRC when reversing the decision passed by lower courts on a certain child custody case. The Cassation Court has set precedent by recognising the principle of the 'best interest of the child' as the fundamental standard to be considered when deciding the issue of child custody and other concerns affecting the welfare of children. In addition, in the case of *Ethiopian House of Federation and Tesfahun Getahun v Mamo Yitaferu*, the Cassation Court explicitly mentioned that death of a certain minor constitutes a violation of his right to life, a right stipulated in the treaties ratified by Ethiopia, in particular in articles 3 and 6(1) of the CRC, and articles 4(1) and 5(1) of the ACRWC.¹⁵⁶

The good part of decisions of the Federal Cassation Court is that the courts of law below it at the federal and regional level are increasingly following the lead of such decisions.¹⁵⁷ This happens by virtue of Proclamation No. 454/2005, which states that 'interpretation of the law by the Federal Supreme Court rendered by the cassation division with no less than five judges shall be binding on federal as well as regional courts at all levels'.¹⁵⁸

Despite the positive developments above, the application of international human rights before courts has a long way to go as the progress is currently limited by various other factors. The meaning and content of the treaty provisions is not well captured by courts. Yohannes & Assefa further note the difficulty Ethiopian courts face to obtain the texts of treaties.¹⁵⁹ This is true in the light of the fact that problems of availability of legal resource materials are generally common place in Ethiopia. Current research conducted by the Ethiopian Lawyers Association

¹⁵⁵ Ethiopian Federal Supreme Court Cassation File No. 23632, decided in November 2007.

¹⁵⁶ Ethiopian Federal Supreme Court Cassation File No. 35710, decided in December 2013.

¹⁵⁷ H Tura 'Uniform application of law in Ethiopia: Effects of cassation decisions of the Federal Supreme Court' (2014) 7 *African Journal of Legal Studies* 204.

¹⁵⁸ Proclamation No. 454/2005, A Proclamation to re-amend the Federal Courts Proclamation No. 25/96, article 2(4).

¹⁵⁹ Yohannes & Assefa (n 146 above) 8.

and Ethiopian Young Lawyers' Association reaffirms that, by and large, most of the courts and prosecution offices in Ethiopia are in a dire situation in terms of accessing legal resource materials.¹⁶⁰ A related challenge is that most of the courts work in their own local language and are thus challenged by their inability to find translated versions of the treaties in the languages in which the courts do their work. On top of this, at times when courts show a tendency to interpret human rights treaties, they are faced with dearth of enabling national laws which stipulate for the substance and content of rights.¹⁶¹ Although the country has made significant efforts to domesticate human rights treaties, the legislative review process to harmonize laws in the light of human rights treaties has not been completed. I discuss in more detail, in the next chapter¹⁶² the factors that potentially limit the courts' duty to protect children's right to health or their socio-economic rights more broadly.

4.5 Policies and strategies relevant to child survival

The global and regional human rights instruments and other non-binding documents described in chapter three convey the standard of action that the participating states have committed themselves to undertake in order to protect the human rights of each individual. At the national level, Ethiopia has developed various policies and strategies to guide its standard of health-care provision for all segments of the population, including those specifically geared towards the provision of child health care. While these policies are not legally enforceable, they serve as guidelines for conscientious governments, and as concrete measuring tools for holding inefficient governments accountable. The relevant policies that relate to children's health are identified and discussed in this section.

¹⁶⁰ Ethiopian Lawyers' Association & Ethiopian Young Lawyers' Association *Needs assessment report on the availability of legal resource materials in Adama, Assosa, Bahir Dar, Jijjiga and Mekele* (August 2014) 18-19.

¹⁶¹ Yohannes & Assefa (note 146 above) 7-8.

¹⁶² See section 5.3.9, Chapter 5.

Shortly after the fall of the *Derg* or *Dergue* regime¹⁶³ in May 1991, Ethiopia witnessed a wide variety of reforms in the social, economic and political spheres. As the country emerged from prolonged civil war, the Transitional Government of Ethiopia (1991-1995) was faced with the task of setting a new direction for social rehabilitation and economic reconstruction of the poverty-stricken and war affected country. Thus, it was during the Transitional Period that a set of new policies and strategies setting forth priorities, goals and implementing instruments were introduced. Among the different policies that were developed during this period were the National Policy on Health and the National Policy on Women and the Policy on HIV/AIDS. Attention is given to these policies because the former is the mother of all health policies, strategies, programs and plans of action related to health and the latter are inextricably related to child survival or health. I briefly discuss both in the section below.

4.5.1 The national health policy

The National Health Policy, which was adopted in 1993 and is currently under revision,¹⁶⁴ has been the umbrella for the development of the National Health Policy on Women and other health related policies and strategies. The National Health Policy is an overarching policy document, which is aimed at the democratisation and decentralisation of the health system; development of preventive and promotive components of the health service; ensuring accessibility of health care by the whole population; promoting inter-sectoral collaboration and involvement of NGOs and the private sector in health care; and promoting and enhancing

¹⁶³ The Amharic word *Dergue*, literally, conveys the meaning Committee. The regime took power after dethroning Emperor Haile Selassie I in 1974. Without a constitutional period for 13 years the regime subsequently adopted the Constitution of the People's Democratic Republic of Ethiopia (PDRE) in 1987. The 1987 Constitution gives more attention to economic, social and cultural rights due mainly to the regime's ideological influence from the then socialist block, more specifically from Union of Soviet Socialist Republics (USSR). Nevertheless, exercise of these and other human rights was not a reality as the regime was busy with internal and external conflict which leaves no room for respect, protection and fulfilment of the rights. See, further, A Abebe 'Human rights under the Ethiopian Constitution: A descriptive overview' (2011) 5 *Mizan Law Review* 42-43.

¹⁶⁴ Currently, Ethiopia is working to update the existing health policy. The revision is motivated by the need to address new circumstances arising globally and locally and ensure the health sector is guided by the country's future aspiration of achieving the health outcomes of a lower-middle-income country by 2025 and a middle-income country by 2035. For details visit, Federal Ministry of Health 16th National Annual Review Meeting Group Discussion *Crossing the finish line and visioning beyond: Towards equitable and better quality health services in Ethiopia' Visioning beyond: Revised policy and health sector transformation'* available at: www.moh.gov.et/...Policy.../ee5a9f11-c735-469a-9fa7-0d5a228ac092 (visited 12 March 2015).

national self-reliance in health development by mobilising and efficiently utilising internal and external resources.¹⁶⁵

As regards children and women, the special attention that needs to be given to the health needs of these vulnerable groups in society is recognised in the Policy.¹⁶⁶ A similar emphasis is placed on meeting the health needs of other hitherto neglected regions and segments of the population, including the majority of the rural population, pastoralists, and the urban poor and national minorities.¹⁶⁷ In this respect, the Policy's drafters can be applauded for putting women, children and the health of other most vulnerable segments of the population as a matter of priority concern on the national health agenda. Nevertheless, the priorities set do not seem to be met as women, children and the majority of the rural population continue to face inadequate access to quality health care despite the improvements made in the past 10-15 years. There is rising health inequality, and the poor, vulnerable and marginalized groups continue to be excluded from accessing health services.¹⁶⁸

In order to translate the National Health Policy statement into action, the Ethiopian Health Sector Development Programme (HSDP) was first launched in 1997-98. The HSDP determines the shape of the present health system of Ethiopia and adapted at five year intervals. This rolling program is intended to have both a direct and an indirect impact to improve child mortality throughout the country. The first phase (HSDP I) of the programme covered the period 1997/98–2001/02. It identified 'disease prevention as at the centre of the reorganization of the health service delivery system. Its objectives were to increase access to health care from 40% to 50-55%; improve service quality through training and an improved supply of necessary inputs; strengthen the management of health services at federal and

¹⁶⁵ National Health Policy of Ethiopia (1993).

¹⁶⁶ Ibid.

¹⁶⁷ Ibid.

¹⁶⁸ For instance nomadic pastoralists in Ethiopia are often unable to access basic services such as health care because of living in remote areas, migrating regularly with their livestock and having distinct cultures and traditions. Find on this, S Dodgeon *Every mother counts: Reporting health data by ethnicity* (2013) 6.

regional levels; and encourage participation of the private sector and the NGO sector by creating an enabling environment for participation, coordination and mobilization of funds'.¹⁶⁹

The HSDP I did not contain an explicit child survival strategy. However, it focused on the need for improved primary care, which in turn helped address all primary child survival interventions. The improved primary care program aimed to address causes of mortality and morbidity in children, including malnutrition, promotion and the use of oral rehydration therapy (ORT) and continued feeding during diarrhoea episodes, standardized case management for childhood illnesses, vitamin A supplementation for under-fives and growth monitoring for children under 3 years of age.¹⁷⁰

Despite its contribution, the HSDP I faced generic and operational problems, according to the World Bank. The challenges include the limited impact it had on the delivery of basic maternal and child health care; slow progress in implementing child health activities; and lack of essential medical equipment and essential drugs in health facilities, contributing to low demand and perceived low quality of care.¹⁷¹

Subsequently, the HSDP I was replaced by HSDP II in the form of an extension into a second phase from the HSDP I. The general objective of HSDP II was to improve the health status of Ethiopians with a re-focus on poverty-related diseases. This objective was expected to be achieved through development and implementation of the Health Services Extension Program (HSEP).¹⁷² Like its predecessor, the HSDP II did not have an explicit objective to address under-5 mortality nor did it directly address child mortality as a development goal. However, it had

¹⁶⁹ WHO African Region 'Ethiopia' available at: http://www.who.int/countries/eth/coop_strategy/en/index1.html (accessed 7 May 2014).

¹⁷⁰ FMOH/WHO *Child health in Ethiopia: Background document for child survival conference* (2004) 43.

¹⁷¹ *Ibid.*, 44.

¹⁷² The Health Service Extension Program (HSEP) is conceived as innovative health service delivery program. Its aim is to address universal coverage of primary health care. With the goal of providing equitable access to health services, the Program prioritizes prevention and control of communicable disease through the community participation. To succeed in its goal, the Program is projected to expand physical health infrastructure and produce a cadre of Health Extension Workers (HEWs) who will provide basic curative and preventive health services in every rural community.

interim targets to reduce infant mortality from 97 to 85 per 1000 live births for the period (2002/03-2004/05).

Ethiopia is now at its HSDP IV implementation stage, adopted for the period 2010/11 – 2014/15. The HSDP IV acknowledges mortality as a problem in the country by stating that '[d]espite major strides to improve the health of the population in the last one and half decades, Ethiopia's population still face a high rate of morbidity and mortality and the health status remains relatively poor'.¹⁷³ In addition, the HSDP IV sets ten strategic objectives. They are: improve access to health services; improve community ownership; maximize resource mobilization and utilization; improve quality of health services; improve public health emergency preparedness & response; improve pharmaceutical supply and services; improve regulatory systems; improve evidence-based decision making by harmonization and alignment; improve health infrastructure; and improve human capital and leadership. The strategies use various performance indicators, one of which is to decrease the infant mortality rate from 77/1000 live births to 31/1000 in its five year horizon.¹⁷⁴

The HSDP IV is the final five year plan and is expected to end by mid-2015. Currently, the health sector is developing a long term strategy entitled 'Visioning Ethiopia towards universal health coverage through primary health care' and a medium term strategic plan for 2015/16-2019/20 entitled 'The Health Sector Transformation Plan'.

While the National Health Policy has been the umbrella for the development of HSDP IV and its predecessor programs, there exists other health and health related policies and strategies that are relevant to the reduction of child mortality, which I discuss the main ones in what follows.

4.5.2 National policy on women

¹⁷³ FMOH *Federal Ministry of Health of Ethiopia, Health Sector Development Program IV (Final Draft)* (2011) 3.

¹⁷⁴ *Ibid.*, 54.

As was dealt in section 3.3.3.3 of chapter three, ensuring women's right to health and education has a significant effect on the reduction of infant/child mortality. It is in consideration of this link that I am interested to explore, in this section, policy on women in Ethiopia, with an emphasis on how it deals with their health and education.

Emphasizing the need for an institutionalized strategy for enhancing women's development through policy measures, the transitional Government of Ethiopia adopted the first national policy on women in 1993. The policy calls for giving national priority in favor of increasing women's access to basic health care, education and equal employment opportunities with men.¹⁷⁵ Strategies are also set for implementation of the women's policy. The strategies include ensuring the right of women to have access to basic health care and information about family planning methods; creating an atmosphere conducive to the participation of women in all areas of decision making; taking appropriate measures to ensure that women are made beneficiaries on equal basis with men in all social, economic and political activities; and creating women affairs departments within all ministries and governmental organizations with the responsibility of organizing and promoting women's interest.¹⁷⁶

Moreover, eight years after the introduction of the women's policy, a national plan of action was formulated to implement the policy. It identified the following seven critical areas:¹⁷⁷

- Poverty reduction and economic empowerment.
- Education and training of women and girls.
- Reproductive rights and health of women.
- Empowering women in decision making.
- Women and the environment.
- Human rights of women and elimination of violence against women.
- Institutional mechanisms for advancement of women in decision making.

¹⁷⁵ Transitional Government of Ethiopia, Office of the Prime Minister *National policy on Ethiopian Women* (1993) 2.

¹⁷⁶ *Ibid.*, 11-14.

¹⁷⁷ Ethiopian Ministry of Women's Affairs (MoWA), *National Action Plan for Gender Equality (Nap-Ge) 2006-2010* (2006) 2.

From the above, it is clear that the national plan of action is intended to address education and health of women and girls. This is a significant step towards realizing the education and health needs and development of women and girls, if implemented properly. Nevertheless, there are gaps between education and its implementation regarding the status of women and girls. Illiteracy of women is one of the most important socio-economic determinants for infant and child mortality in Ethiopia.¹⁷⁸ Similarly, access to basic health care services, especially to millions of poor women, remains minimal. Our Maternal Mortality Rate (MMR) remains among the highest in the world.¹⁷⁹ The country is near to the bottom of the world ranking in terms of health performance indicators.¹⁸⁰ Unless policies and implementation gaps are harmonized, health and education development of women cannot be addressed. In addition, accountability mechanisms are not properly addressed or loosely considered in these policy and strategy documents. Also, emphasis is not given that women are rights holders and government a duty bearer, so that the former are empowered or entitled to hold accountable the latter for failure to implement what it has promised. Furthermore, there are no meaningful devices to facilitate enforcement of women's rights, especially in the rural areas, where the majority of women live.

4.5.3 Ethiopian national strategy for child survival (ENSCS)

The ENSCS is a more specific child survival document and as such important to consider in this context. How was this strategy developed? What were its objectives? Does it make explicit or implicit reference to the core human rights principles for its application? These are the issue that I investigate in this section.

¹⁷⁸ Mekonnen (n 21 above) 10; FDRE MoH *The National Strategy for Child Survival in Ethiopia* (2005) 1.

¹⁷⁹ Currently, the MMR has been reduced to 420 from 1400 in 1990. However, this rate remains considerable according to global and regional standards. The country is considered not likely to be meeting MDG V, which deals with the goal of reducing maternal mortality by 2/3, by 2015.

¹⁸⁰ Ethiopia is placed as the 180th country at the bottom out of the 190 countries of WHO's ranking table of the world's health systems. WHO's ranking of the world's health systems was last produced in 2000. Due to complexity of the task, WHO no longer produces such a ranking table. The ranking is available at: <http://www.photius.com/rankings/healthranks.html> (accessed 16 September 2014).

Regarding how the strategy was prepared, the ENSCS reads as follows:¹⁸¹

... the Federal Ministry of Health and its partners organised a National Child Survival Conference from 22- 24 April 2004. The conference recommended that a National Strategy and Plan of Action for the reduction of child mortality should be prepared. The Ministry of Health has now prepared this strategy in partnership with WHO, UNICEF, USAID, World Bank and CIDA.

It is clear from the above that the incident that gave rise to the adoption of the ENSCS was a relevant recommendation of a conference. It is also indicated that the strategy was prepared in partnership with five global partners that are directly or indirectly mandated to promote reduction of child mortality. The strategy, nevertheless, fails to mention whether the participation of vulnerable or disadvantaged groups of rural communities or their representatives were included or their feedback heard and addressed in the preparation of the strategy. Although such mention would not necessarily imply that participation was employed in the manner and extent required in human rights terms, the ENSCS also does not mention whether children and the youth or their representatives have participated in forming their views during the drafting process of the Strategy. This is contrary to the Constitution's NPPOs that require community participation as a fundamental component in the development of policies and strategies as discussed in section 4.4.3 above. The participatory process empowers these groups to both assert their human rights and hold accountable those legally responsible for their delivery.¹⁸² By failing to ensure participation of communities, civil society, minorities, women, children and others in its preparation, the strategy demonstrates weaknesses in addressing the core human rights principle of participation.

Having introduced how it was prepared, one of the concerns that the ENSCS dealt with is reiterating its objective. It has both overall and specific objectives. The overall objective is to

¹⁸¹ *National Strategy for Child Survival in Ethiopia* (n 178 above) iv & 1.

¹⁸² International Human Rights Network *Our Rights, Our Future: Human Rights Based Approaches in Ireland: Principles, Policies and Practice* (2005) 6.

reduce child mortality by two thirds in 2015 from 1990's mortality rate. And the specific objectives are four:¹⁸³

- To proportionally reduce the neonatal, infant and child mortality rates while achieving the overall objective.
- To ensure the greatest possible reduction of mortality among the children of the poorest and most marginalized sections of the population.
- To contribute to the reduction of maternal mortality to achieve the Millennium Development Goal¹⁸⁴ by 2015.
- To ensure the availability of quality essential health care for women and children in the community and health facilities.

In order to meet the objectives, the ENSCS uses the country's Health Extension Program (HEP) as its main pillar. The HEP, in particular, aims to scale up coverage of essential health services to the rural community.¹⁸⁵

Recent studies show that the introduction of the HEP has rendered both success stories and challenges. The success includes the contribution it made to reduction of under-five mortality, although the mortality rate is still high. According to a government declaration, this progress is gained due to the training and deployment of 34,383 Health Extension Workers (HEWs).¹⁸⁶ Nevertheless, the challenges are many. They include lack of uniformity in the implementation of the HEP across the country; still high infant and maternal mortality; high turnover of HEWs and medical professionals; lack of medical equipment and supplies; and lack of sufficient capacity to provide supportive supervision/monitoring and evaluation.¹⁸⁷ Accordingly, the ENSCS has achieved only a certain level of success in meeting its specific objectives so far.

¹⁸³ *National Strategy for Child Survival in Ethiopia* (n 178 above) 2.

¹⁸⁴ Millennium Development Goal (MDG) IV sets target governments to reduce under-five mortality rate by two third, between 1990 and 2015.

¹⁸⁵ N Workie & G Ramana *The Ethiopian Health Extension Program: UNICO Studies Series 10* (2013) 3.

¹⁸⁶ WHO *Success factors in women's and children's health: Mapping pathways to progress Ethiopia* (working draft for review) (2014) 11; Speech on youtube by Ethiopian Ministry of Health, Dr. *Kesetebirhan Admasu*, during African countries meeting on African leadership child survival (2013) available at: https://www.youtube.com/watch?v=ZG8K_oW9pJA (accessed 23 June 2014).

¹⁸⁷ FDRE MoH 'Health extension program in Ethiopia' (2013) available at: <http://www.aliveandthrive.org/sites/default/files/Meseret%20Yetube%20Health%20Ext%20Program%20Ethiopia.pdf> (accessed 7 May 2014).

Policy, strategy or program identification as well as implementation requires that human rights obligations be explicitly taken into account at every stage of national and local development processes. An evaluation of the ENSCS shows that no explicit mention is made of human rights. In other words the language of human rights is not addressed. As discussed in this chapter, reducing infant/child mortality is an obligation of governments under global and regional human rights instruments. This is not taken into account in the ENSCS.

The other key human rights principle worth evaluating is accountability. Throughout the ENSCS the word accountability is mentioned only twice. However, even these references are not in the sense of human rights accountability of the government for failure and to fulfil its obligation to reduce infant/child mortality. It instead is mentioned acknowledging the need to improve accountability of the government to ensure public services to the population.¹⁸⁸ Mention is not made, however, as to who is accountable for what and the mechanisms in which accountability can be deployed to remedy for failure to deliver children's public health services.

Two core principles seem to be incorporated in the ENSCS, although these principles are also similarly used in the public health discipline.¹⁸⁹ As indicated in the second bulleted item above, 'ensuring the greatest possible reduction of mortality among the children of the poorest and most marginalized sections of the population' is one of the ENSCS's specific objectives. Here, the principle of equality and non-discrimination seems to be addressed by giving attention to the poorest and marginalized sections of the population. Similarly, the guiding principles of availability and quality of health service are incorporated in the fourth bulleted item of the objectives of the ENSCS. These principles are equally recognized in the public health discipline and their inclusion in the strategy does not necessarily reflect as policy measures taken to

¹⁸⁸ See *National Strategy for Child Survival in Ethiopia* (n 178 above) 21& 29.

¹⁸⁹ One often used term in the area of public health discipline is 'Primary Health Care' (PHC). This term gained the world's attention after the 1978 International Conference on PHC held at Alma Ata (formerly within the USSR, now called Kazakhstan). The term composes five principles of which the two are *accessibility* (equal distribution) and *Community participation*. For the details on the five principles visit: <http://www.open.edu/openlearnworks/mod/oucontent/view.php?id=219&printable=1> (accessed 21 December 2014).

ensure children's health from human rights considerations. Overall, despite the few attempts, the ENSCS fails to address or integrate the core human rights principles sufficiently in its objectives or implementation strategies. The content of the Strategy is incomplete from the human rights perspective.

4.5.4 The 1998 policy on HIV/AIDS

In its various sections, the 1998 Policy on HIV/AIDS has included provisions which address the situation of children in relation to their protection from HIV/AIDS. In the part dealing with 'specific objectives', the policy mentions establishing effectively HIV/AIDS prevention and control as one of such objective desired to be met. It further stipulates promotion of proper institutional, home and community based health care of orphan children. In the section dealing with 'strategy', the policy also emphasizes the need to give adequate attention and priority for health promotion of women and children related to HIV/AIDS. It also underscored that children living with HIV/AIDS to be safeguarded against any form of discrimination and stigmatization. The policy further stipulates as to the necessity of support and encouragement to be given to researchers, and studies to be conducted in all the areas related to preventive, curative and rehabilitative concerns affecting HIV/AIDS. In general, the proper implementation of this policy will benefit children from the country's HIV/AIDS programs in ways of prevention from infection and access to treatment once children are challenged with the virus. It also protects them against any form of discrimination and stigmatization. Hence' measures aimed at prevention and treatment of children without discrimination will have the potential to promote their health and survival.

4.5.5 Other policies and programs

By no means are the above policies and strategy the only ones available in the country in the context of child health or reduction of child mortality and morbidity. I have not discussed them all due to space limitation. The government of Ethiopia has adopted several major policies and plans with an aim to ensure that children are given opportunities, services and facilities to grow in a healthy manner. There are also implementation schemes and strategies designed for the

realization of the rights of children. They include: the *National Health Plan*; the (draft) *Comprehensive National Child Policy*; (Draft) *National Child Policy*; the *National Plan of Action for Children* (2003-2010 and beyond);¹⁹⁰ the *Social Protection Policy*; the *National Nutrition Strategy*; the *National Strategy for Infant and Young Child Feeding* (2004); the *National School, Health and Nutrition Strategy*; the *National Youth Policy* (2012); the *National Population Policy*; the *2007 Guidelines for PMTCT of HIV*; and the *2008 Guidelines for Pediatric HIV/AIDS Care and Treatment in Ethiopia* that address the care and treatment of HIV-exposed and infected infants and children.¹⁹¹ In addition, the *GTP and Poverty Reduction Strategies* are also useful tools to impact the overall health development of the country. While many of these policies and strategic plans have been issued by domestic mechanisms, others are outcomes of international conferences and international agreements to which Ethiopia has endorsed. These policies, plans and strategies, if implemented properly, could bring improvement in child health care that ultimately leads to reduction of infant/child mortality. However, while these documents are significant in recognizing a HRBA to health of children in general, they do not impose explicit legal obligations on the part of the government to implement them.

4.6 Institutional protection mechanisms

4.6.1 The judiciary

In Section 2.5.3.5, I highlight the role of judicial accountability to redress violation of human rights in the area of health rights. In the context of reduction of maternal mortality, Andion argues that human rights litigation is an effective tool for holding states accountable for health system failures and discriminatory practices that are major impediments to successfully reducing maternal deaths.¹⁹² It can potentially assist in rectifying service failures, providing

¹⁹⁰ The *National Plan of Action for Children* comprises four major themes, namely: 'promotion of healthy lives, provision of quality education, protecting children against abuse, exploitation and violence, and combating HIV/AIDS. The action plan was prepared considering the goals and objectives of other international and national programs, such as SDPRP, UN MDGs, ESDP, and HSDP. Among the goals the *Plan of Action* envisages, the following are worth mentioning: promotion of healthy lives, provision of quality education, and protection of children from abuse, exploitation and violence, improving the situation of the CEDC and combating HIV/AIDS'. See, further, FDRE MoWCYA *National Child Policy* (Draft, April 2011) 1-22.

¹⁹¹ FHAPCO & MoH *Guidelines for Pediatric HIV/AIDS Care and Treatment in Ethiopia* (2008)13.

¹⁹² X Andion 'Role of National and in international courts' in P Hunt & T Gray (eds) *Maternal Mortality, Human Rights, and Accountability* (2013) 46.

alternatives and new social services that help narrow gaps in health inequities within a country. I consider, in section 2.5.3.5, the Indian case of *Sandesh Bansal v Union of India and Others* to illustrate on this.

Coming to the Ethiopian situation, do the courts have the power to entertain health rights claims? Have they actually made a contribution in redressing human violations concerning infant or child or maternal mortality? If not, what are the potential factors preventing them from doing so? In this section, I investigate these issues.

The FDRE Constitution establishes two tiers of courts and an independent judiciary both at the federal and state levels.¹⁹³ The Constitution maps the establishment of Supreme, High and First Instance courts both at the federal and state levels, each exercising different jurisdictions.¹⁹⁴ Judicial powers are vested in these courts. Furthermore, the Federal Supreme Court (FSC) has the highest and final judicial power over Federal matters. Similarly, State Supreme Courts (SSCs) have the highest and final judicial power over state matters. The FSC also has a power of *cassation*¹⁹⁵ over any final court decision containing a basic error of law. In the same way, the SSC has a power of cassation over any final court decision on state matters which contains a basic error of law. However, decisions of SSCs at cassation level are appealable to the FSC. It should be noted that cassation divisions of both courts do not have the power to entertain the constitutionality of laws.

¹⁹³ FDRE Constitution, article 78(1).

¹⁹⁴ *Ibid.*, articles 78(2) & 78(3).

¹⁹⁵ In countries such as France, Belgium, the Democratic Republic of the Congo and Greece, the legal systems recognize courts of *cassation*. These courts do not re-examine the facts of a case, they are only competent for verifying the interpretation of the law. Their power is limited to ascertain allegations whether an act or decision of court constitutes fundamental error of law. In this way they differ from other judicial systems which have a supreme court which can rule on both the facts and the law of a case. Within the current Ethiopian judicial system, the Federal and State Supreme Courts have a separate division in them with power of cassation or ascertaining whether a decision of a lower court contains basic error of law. However, the FSC's power of cassation over final decision of SSCs is debatable. For a recent discussion concerning this, see Tura 'Uniform application of law in Ethiopia: Effects of cassation decisions of the Federal Supreme Court' (n 157 above).

Furthermore, article 13(1) of the Constitution establishes the duty of all judicial organs to respect and enforce fundamental rights and freedoms. Article 37(1) also provides that ‘everyone has the right to bring a justiciable matter to court, and to obtain a decision or judgment by a court of law or any other competent body with judicial power’. The judiciary, then, has the duty to enforce human rights.

Courts can therefore clearly play a role in the realization of the human rights that are enshrined in the Ethiopian domestic laws and human rights treaties ratified by Ethiopia, such as the CRC and ACRWC, in as much as the matter before the court does not involve a constitutional dispute.¹⁹⁶ There is an emerging trend that the cassation bench of the FSC is relying on the provisions of the FDRE Constitution and the CRC in deciding child matters, as has been discussed previously in the case of *Tsedale Demisse v Kifle Demisse*, Appeal decision, Cassation File No. 23632.

Despite the judicial power given to the courts under the Constitution there is no registered case, so far, rendered by Ethiopian courts on matters of child or maternal mortality or the right to health in general through the application of the ICESCR, CRC or ACRWC.¹⁹⁷ Concerned with lack of information as to the application of the ICESCR by Ethiopian courts the Committee on ESCR stated as follows:¹⁹⁸

The Committee is concerned that despite the constitutional provision making international agreements ratified by the State Party an integral part of the law of the land, no information has been made available illustrating the actual application of the Covenant (*the ICESCR*). This might indicate that the

¹⁹⁶ Ethiopian ordinary courts at any level do not have the power to make decisions on the constitutionality of disputes. This jurisdiction is given to a political body - the House of Federation constituted under the Constitution. See, for details the FDRE Constitution, article 83.

¹⁹⁷ Interview conducted with Mrs. Fasika Hailu, Coordinator for Child Justice Project Office of the Federal Supreme Court of Ethiopia, 26 January 2015, Addis Ababa, Ethiopia.

¹⁹⁸ UN Committee on Economic, Social and Cultural Rights (ESCR), *Consideration of reports submitted by states parties under articles 16 and 17 of the Covenant: Concluding observations of the Committee on Economic, Social and Cultural Rights- Ethiopia*, 31 May 2012, E/C.12/ETH/CO/1-3, para 5, available at: [http:// www.refworld.org/docid/4ff6d0de2.html](http://www.refworld.org/docid/4ff6d0de2.html) (accessed 10 December 2014).

International Covenant on Economic, Social and Cultural Rights has not been invoked nor applied by the courts. (Emphasis mine).

Compared to civil¹⁹⁹ and political rights the jurisprudence of social and economic rights in general, and the right to health in particular is, therefore, under developed in the current Ethiopia. So far there is only one known case (*APAP v the Ethiopian Environmental Protection Authority (EPA)*) entertained by the different levels of federal courts that had a right to health dimension, although it does not pertain to child health rights.²⁰⁰ Why are court cases regarding right to health care and other social rights under-developed in Ethiopia?

To begin with, courts in many cases show the tendency of failing to invoke and apply human rights provisions in the FDRE Constitution and international human rights treaties ratified by the country which form part of the law of the land.²⁰¹ Ethiopian courts rarely refer to the international human rights Conventions; their reference is minimal at best, none at worst.²⁰² This partly emanates from the confusion regarding the mandate of the House of Federation to 'interpret' the Constitution. Furthermore, there is a misunderstanding amongst the Ethiopian judges regarding the enforceability of socio-economic rights. In an interview conducted with Ethiopian judges the response showed that judges question the enforcement of the economic, social and cultural right against the government arguing that these rights are resource

¹⁹⁹ For instance, in a court case relating to bail, the Addis Ababa First Instance Court (Arada Division) ordered the release on bail of the former Defense Minister, Seeya Abraha, who was arrested on suspicion of corruption.

²⁰⁰ That was the case of *Action Professionals Association for the People (APAP) v The Ethiopian Environmental Protection Authority (EEPA)*, Federal First Instance Court, Case No. 64902. The plaintiff (a local NGO) alleged that the defendant (which is an organ of the state) failed to execute its duty as a department of state to protect the residents, which live along the rivers of 'Akaki' and 'Mojo', from environmental pollution. The plaintiff (APAP) then demanded the court to order, among other things, the Environmental Authority to avert the pollution and to clean up the pollution of the rivers. The defendant argued that APAP *cannot* sue it in accordance with the law that established the EEPA. The First Instance Court finally decided in favour of the defendant, saying that APAP has no legal standing to sue EAP. Appeal was lodged to the Federal High and Supreme Court which, similarly, also held that the EEPA could not be held responsible for the suit made.

²⁰¹ S Yeshanew 'The justiciability of human rights in the Federal Democratic Republic of Ethiopia' (2008) 8 *African Human Rights Law Journal* 279-280.

²⁰² R Messele *Enforcement of human rights in Ethiopia* (2002) 38.

dependent and government is at disposal to provide, progressively.²⁰³ This inclination shows judges do not view these rights as entitlements claimable before courts.

Vagueness or a weak formulation of socio-economic rights in the Constitution is considered as another impediment to enforcing these rights by the Ethiopian courts.²⁰⁴ A further problem relates to an issue of *locus standi*. An *actio popularis* or public interest litigation is not permitted in Ethiopia save with certain exceptions expressly provided for in some legislation.²⁰⁵ Mostly, it is the poorest section of the society that is vulnerable to violations of socio-economic rights. They lack awareness of their rights and the means to enforce their rights before judicial bodies. The absence of public interest litigation obviously inhibits their access to socio-economic rights and further contributes to the perpetuation of the under-development of these rights before courts. A different cause pertains to the limitation imposed on CSOs. Despite the considerable role they play in different jurisdictions²⁰⁶ discussed in chapter two, the role of human rights NGOs in litigating health rights or other rights of children is limited owing to the restriction imposed on such NGOs by the CSO legislation currently in force (the CSO Law is discussed more fully in section 4.6.4).

The preceding does not however inform that the room for ordinary courts to invoke and apply human rights of children is entirely absent. Courts, for instance, through invoking other national legislation such as the civil and criminal codes could indirectly enforce children's right to health. Medical malpractice cases are example of such cases where courts are not stripped of their mandate to ensure the realization of children's right to health through identifying

²⁰³ A Tesfaye *Justiciability of Socio-Economic Rights in the Federal Democratic Republic of Ethiopia* (2010) 112; Also, interview conducted with Mr. Leul Hagos, Director for Public Relations Office, Federal Supreme Court of Ethiopia, 13 January 2015, Addis Ababa, Ethiopia reveals same feedback regarding the enforceability of socio-economic rights before courts. Although Mr. Leul is not a judge in the Supreme Court, he was delegated by the Deputy President of the FSC to respond to inquiries or interviews representing the Court. My observation during my interview shows Mr. Leul seems to have background and nature of cases entertained by this Court.

²⁰⁴ Yeshanew 'The justiciability of human rights in the Federal Democratic Republic of Ethiopia' (note 201 above) 276.

²⁰⁵ For instance, article 10 of the Federal Courts Advocates Licensing and Registration Proclamation No. 199/2000 of Ethiopia deals with the *action popularis*.

²⁰⁶ For instance, in post-apartheid South Africa, CSOs have litigated most, if not all major constitutional human rights cases.

parties responsible and awarding appropriate remedies to victimized children or their representatives. In a recent case, *Hamrawi Kelemu*²⁰⁷, the Ethiopian FSC received final appeal in relation to a an alleged claim regarding damage to health occurring to an under-five child caused by the doctor's failure to comply with standard medical procedures that should be followed during assisted delivery.²⁰⁸ The child, delivered at *Hayat Hospital* in Addis Ababa, was alleged to have sustained a degree of paralysis in both arms because of the attending doctor's negligence while managing the delivery process. Maintaining the allegations of the applicant, the FSC has ruled, on 6 October 2015, the owner of the Hospital to pay Br 1.1 million to the applicant by way of compensation for negligent delivery at the Hospital.²⁰⁹ No further appeal is possible from this decision of the Court as the FSC is the court of apex in the country.

In the above discussion, I highlight that an independent judiciary is guaranteed under the Ethiopian legal framework. This body has a potential for children to seek and obtain reparations when their right to health is violated or at risk as a result of indifference of government or slowness in taking adequate measures to fulfil children's right to health.²¹⁰ Nevertheless, except in limited ways as discussed in a civil suit above, courts have not played any significant role in this regard owing to procedural and other factors mentioned herein above. I discuss in more detail the potential factors that limit the exercise of the courts' mandate in section 5.3.9 of the next chapter. The country should ensure and facilitate access to courts for individual children, their caregivers and authorized representatives, and take steps to remove any barriers to access remedies for violations of children's right to survival or health.

4.6.2 The Ethiopian human rights commission (EHRC)

²⁰⁷ *Hamrawi Kelemu* (represented by Aster Solomon - tutor) v *Hayat Hospital*, Federal Supreme Court Cassation Division, Cassation File No. 98102, 6 October 2015.

²⁰⁸ 'Medical negligence costs hospital owner 1.1 million Birr' available at: [http:// addisfortune.net/articles/medical-negligence-costs-hospital-owner-1-1-million-birr/](http://addisfortune.net/articles/medical-negligence-costs-hospital-owner-1-1-million-birr/) (accessed 10 November 2015).

²⁰⁹ *Ibid.*

²¹⁰ CRC Committee, *General Comment No. 15* (2013), *The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* (art. 24), 17 April 2013, para 103, CRC/C/GC/15.

National human rights institutions potentially provide an easily-accessible avenue for the implementation and enforcement of constitutionally or legislative protected human rights.²¹¹ It is in view of this that the FDRE Constitution requires the House of People’s Representatives (HPRs) to establish a national human rights commission.²¹² The EHRC was established in 2000 through Proclamation No. 210 /2002. Its objectives are ‘to educate the public to be aware of human rights; to see to it that human rights are protected, respected and fully enforced; and to have the necessary measures taken where they are found to have been violated’.²¹³

The said Proclamation provides for the powers and duties of the Commission. It includes the duty of the EHRC to ‘ensure that the human rights and freedoms recognised by the Constitution are respected by all citizens, organs of state, political organizations and other associations as well as by their representative officials’.²¹⁴ It also has the duty to ‘ensure that laws, regulations and directives as well as government decisions and orders do not contravene the human rights of citizens guaranteed by the Constitution’.²¹⁵ Equally importantly, it has the jurisdiction to undertake investigation, upon complaint or its own initiation, in respect of human rights violations.²¹⁶

In order to discharge its duty effectively, the Commission has the power to require the production of evidence and to issue summons as necessary. It can also issue appropriate remedies, including ordering the discontinuation of the act that caused the grievance and remedying the injustice suffered.²¹⁷

Over the past two and half decades, more than 70 countries have established independent human rights institutions for children. Included in their mandate is to monitor actions of government and other actors, promote the implementation of children’s rights, receive

²¹¹ Yeshanew ‘The justiciability of human rights in the Federal Democratic Republic of Ethiopia’ (n 201 above) 289.

²¹² FDRE Constitution, article 55(14).

²¹³ Proclamation No. 210/2000 (2000), article 5.

²¹⁴ *Ibid.*, article 6(1).

²¹⁵ *Ibid.*, article 6 (2).

²¹⁶ *Ibid.*, article 6 (4).

²¹⁷ *Ibid.*, article 26.

complaints, provide remedies for violations and provide space for dialogue about children and society and between children and the state.²¹⁸ Similarly, they have the potential to provide children with relief for violations of their right to health and advocating systemic change for the realization of that right. In this respect, the CRC Committee ‘reminds States that the mandate of children’s commissioners or children’s ombudsmen should include ensuring the right to health, and the mandate holders should be well-resourced and independent of the government’.²¹⁹

In the Ethiopian context, the EHRC has a Commissioner heading Children and Women Affairs specifically responsible for protecting and promoting children’s and women’s rights. However, the Commission has not investigated occurrences of violation of child or maternal mortality, unlike its counterpart in India or Kenya (discussed in section 2.5.3.5 of chapter 2). This was reaffirmed during an interview conducted with the Commissioner heading Children and Women Affairs, at the Commission’s office, Mrs. Ubah Ahmed (ex-Minister of Women’s Affairs of the FDRE), who explained that role of the Commissioner’s office in the area of children’s right to health or reduction of child or maternal mortality is yet to be ascertained.²²⁰

Obviously, the above indicates that the EHRC has numerous powers and duties, which, if exercised properly, could contribute importantly to the realization of child survival or their other human rights. The law provides a wide range of ways in which the Commission could discharge its duties in this regard from promotional activities on children’s health rights to such other activities as may be necessary to attain its objectives.²²¹ Despite this potential, several factors militate against the effectiveness of the EHRC, including but not limited to lack of

²¹⁸ UNICEF Office of Research *Championing children’s rights: A global study of independent human rights institutions for children - summary report* (2012) 5.

²¹⁹ CRC Committee, *General Comment No. 2* (2002), *The Role of Independent National Human Rights Institutions in the Promotion and Protection of the Rights of the Child, Official Records of the General Assembly, Fifty ninth Session, Supplement No. 41 (A/59/41)*, annex VIII; CRC Committee, *General comment No. 15* (n 91 above) para 119.

²²⁰ Interview conducted with Mrs. Ubah Ahmed, former State Minister of Women’s Affairs of the FDRE, and currently, Commissioner for the Children & Women’s Affairs at the Ethiopian Human Rights Commission, 13 January 2015, Addis Ababa, Ethiopia.

²²¹ Proclamation No. 210/2000, article 6.

independence, inaccessibility, and operational inefficiency. I discuss the details of this in the subsequent chapter.²²² I argue that these deficiencies must be addressed in order for the Commission to be utilized as one mechanism to contribute to advancing children's right to health and other interrelated rights through receiving complaints and providing remedies for violations.

4.6.3 The Ethiopian institution of ombudsman (EIO)

The Ethiopian Institution of Ombudsman is the other human rights body vested with the responsibility to promote and protect the rights of children. In accordance with article 55(15) of the FDRE Constitution, the Ethiopian House of People's Representatives (HPRs) established the ombudsman's office through Proclamation No. 211 /2000. Among other things, the preambular provisions of this legislation stress the need 'to ensure that the executive organ carries out its functions in accordance with the law and that its administrative decisions are not rendered in violation of citizens' rights'.²²³ It further introduces the necessity of having an institution before which citizens, having suffered from maladministration,²²⁴ may complain and seek remedies, with easy access.²²⁵ It was, *inter alia*, against this backdrop that the institution was cherished as one of the parliamentary institutions instrumental in the control of the occurrence of maladministration. In no uncertain terms and in the strict sense of an obligation, the law stipulates that the objective of the Institution is to bring about good governance that is of high quality, efficient and transparent, as based on the rule of law, by way of ensuring that citizens' rights and benefits, provided for by law are respected by organs of the executive.

²²² See section 5.3.9, in Chapter 5.

²²³ Proclamation No. 211 /2000, 5th Preamble.

²²⁴ Article 2(5) of Proclamation No. 211/2000 defines 'Maladministration' to include acts committed, or decisions given, by executive government organs, in contravention of administrative laws, the labor law or other laws relating to administration. Obviously, the definition is non-exhaustive and the word could cover omissions omitted contrary to the requirement of laws.

²²⁵ *Ibid.*, Proclamation No. 211/2000, 4th Preamble.

In order to meet its objectives, the institution is organized in such a way that it comprises a Council of the Ombudsman and eight directorates.²²⁶ The Council includes Chief Ombudsman; Deputy Chief Ombudsman; an Ombudsman heading the Children and Women Affairs Office; Ombudsmen heading branch offices; and the necessary staff. These ombudsmen have a term of five years and may be re-appointed upon nomination by a Nomination Committee²²⁷ and upon receipt of the support of a two-thirds vote of the HPRs. Once they have assumed their appointment, the Chief Ombudsman is accountable to the HPRs, and Deputy Chief Ombudsman and other Ombudsmen to the Chief Ombudsman.

Depending on their enabling legal framework, ombudsman institutions have been given different mandates and powers. The Institution under consideration is saddled with extensive powers and duties. This is especially true in the light of article 6(7) of the establishing legislation which entrusts the institution to perform 'such other functions as are related to its objective'. However, the specified duties mainly deal with receiving and investigating complaints; conducting supervision; seeking remedies; and undertaking studies and research in respect of maladministration. It is also vested with the responsibility to make recommendations for the revision of existing laws, practices or directives and for the enactment of new laws and formulation of policies.²²⁸ It is further entrusted to ensure that directives and decisions made by executive organs and the practices thereof do not contravene the constitutional rights of citizens and the law.²²⁹

The duty of investigation of complaints by the Institution follows a receipt of a complaint from a person claiming to have suffered from maladministration, or from his spouse, family member, his representative or another third party. Also the Institution has the power to conduct investigation on its own initiation. When in the process of investigation of alleged acts

²²⁶ African Ombudsman Research Center *A comparative analysis of legal systems governing ombudsman offices in Africa* (2014)53.

²²⁷ The Nomination Committee is composed of the members of the HPRs, HoF and President of the Federal Supreme Court. See Proclamation No. 211 /2000, articles 10 & 11.

²²⁸ Proclamation No. 211 /2000, article 6(6).

²²⁹ Proclamation No. 211 /2000, article 6(1).

of maladministration the Institution finds violation, it has the power and duty to seek remedies.²³⁰

In order to enable it to discharge its powers and duties, the Institution is structured to have its head office at Addis Ababa and branch offices in other places, to be determined by the House. Currently, the Institution has about 120 employees at its head office and about 150 in the branches - a total of 270 employees.²³¹ Also, the Institution has been expanded to six regional branch offices and Dire Dawa city administration.²³² Very recently, the Institution has been engaged in raising public awareness about itself, which lead to an increased number of complaints, investigations and ensuing recommendations.²³³ Some reports note that the recommendations that the Institution made have been accepted by the departments concerned, and that the Institution has continued to supervise specific government departments to ensure implementation of the recommendations made to ameliorate an alleged act of maladministration.²³⁴ These have been portrayed as achievements gained by the Institution.

Moreover, in accordance with article 8(2)(c) of the Office of Ombudsman Establishing Proclamation, an Ombudsman office on Children and Women Affairs has been opened. According to the Ombudsman (under the title of a Deputy Minister) for this office, Mrs. Sania Sani, the Institution has made great strides in establishing model children's parliaments in different schools of the country, such as the one established as the first model to the country located in the *Konso* locality of the SNNPRS.²³⁵ These parliaments bring children's issues before executive organs and children's rights advocacy groups in the community where they feel that there is maladministration in schools.

²³⁰ Proclamation No. 211 /2000, article 6(4).

²³¹ African Ombudsman Research Center (n 226 above) 86.

²³² The six regional branch offices are: Bahir Dar, Dire Dawa, Gambela, Hawassa, Mekelle and Oromiya branch offices.

²³³ *Ibid.*, 98.

²³⁴ *Ibid.*

²³⁵ Interview conducted with Mrs. Sania Sani Ahmed, Ombudsman for Women and Children (Ethiopia), 20 January 2015, Addis Ababa, Ethiopia.

Concerning child and maternal health, the work done by the Institution is noteworthy. Unlike courts and the EHRC, the Ombudsman office has identified access to health and the underlying determinants of health as a major concern in the various referral hospitals in Addis Ababa and in some regional states. It accordingly conducted investigations at Black Lion, Yekatit 12, Menelik II, and Ghandi hospitals in Addis Ababa regarding health care services affecting women, children and persons with disabilities. More specifically, in the Somali regional state, the Institution conducted monitoring and issued a report concerning the steps taken by the said regional state to reduce maternal and child mortality. In its report, while the Institution identifies the efforts that have been made to reduce child and maternal mortality, it uncovered the following gaps:²³⁶

- Health coverage is not expanded to all *zones*²³⁷ and *woredas*²³⁸ within the region.
- Female genital mutilation has not been eradicated.
- Pregnant women do not receive prenatal and postnatal care due to lack of awareness and unavailability of health care centers in all parts of the region.
- Only 42% of children received vaccination.
- Mothers are unwilling to benefit from family planning services.
- There is no electricity in most of the *woredas* of the region. As a result, it was not possible to keep medication in refrigerators within the prescribed temperature limit.

²³⁶ Institution of the Ombudsman (Ethiopia) *Investigation report conducted on works being done to reduce maternal and children mortality by the Somali national regional state* (the original document written in Amharic language) (June 2012).

²³⁷ 'Zone' is an administrative division in Ethiopia. The nine regions of Ethiopia are administratively divided into 68 or more zones. There are about 9 Zones in the Somali region. This number sometimes varies over years through governmental decisions. Zones are again divided into *Woredas*, and the *Woredas* into *Kebeles*. See, generally, Wikipedia 'List of zones of Ethiopia' available at: https://en.wikipedia.org/wiki/List_of_zones_of_Ethiopia (accessed 24 June 2015).

²³⁸ 'Woreda' is another administrative division in Ethiopia (managed by a local government), equivalent to a district with an average population of 100,000. *Woredas* are composed of a number of *kebele*, or neighbourhood associations, which are the smallest unit of local government in Ethiopia. The number of *woredas* varies from time to time but currently there are about 710 *woredas* in the country, of which 68 are in the Somali region. See, for the details on this 'WoredaNet-Ethiopian government network' available at: <http://unpan1.un.org/intradoc/groups/public/documents/un-dpadm/unpan034887.pdf> (accessed 19 May 2015).

Reports such as the above are vitally important, not only in demonstrating the visible activities done by the Institution, but also to potentially help design or improve policies and work practices in the regional state or elsewhere in the other parts of the country having a similar problem. On the top of that, they can be utilized in order to identify the source of the problem and pursue administrative, legal or other action to obtain redress.

Despite the commendable activities done by the Institution, its work needs to be further strengthened. A close examination of the investigation reports show that they do not use global or regional human rights standards and constitutional rights guarantees to assess the information gathered on maladministration. The investigation result of the reports and the solutions proposed do not seem to be pursued from the perspective of human rights standards and corresponding state obligations. This may emanate from the fact that the Institution finds the content of the human right under consideration (i.e., the right to health - a social right) and the obligations it entails for governments not clearly defined. If so, this is problematic. As discussed in chapter three, health is a fundamental human right and its meaning and the obligations it imposes on states has now been clearly defined. Indicators against which to track its implementation were developed with the adoption of the ESCR Committee General Comment No 14. Furthermore, jurisprudence on the right to health has now been developed in the national jurisdictions of both low and middle income countries. Thus, these can be used as important reference points for meaningful monitoring and evaluation of the extent to which the state meets its obligations for human health and other rights in similar activities to be performed by the Institution in the future.

On the top of the above, the monitoring reports prepared by the Institution are not publicized to the general public or to the victims or their families or other stakeholders. The Institution needs to increase its accountability and transparency to the public through publicizing its reports in a proper manner and in various languages.

Like the EHRC, accessibility is another challenge that diminishes the quality of the Institution to become a user friendly protector office of the public. Currently, it is working in only seven

cities, inclusive of its head office situated in Addis Ababa. Physically, it is not reachable to many citizens in the country. A different problem with this Institution, as the Committee on the CRC notes, is that it lacks adequate human and financial resources to run its desired objectives, including but not limited to receiving, monitoring and investigating complaints from or on behalf of children on violations of their rights.²³⁹ There is a need on the part of the Ethiopian state to ensure the efficient operation of the Institution in compliance with the established Paris Principles for Independent National Human Rights Institutions adopted by the General Assembly in 1993. The latter requires NHRIs to be independent, accessible, operationally efficient, transparent and accountable to the public.²⁴⁰

4.6.4 Civil society organizations (CSOs)

The role of human rights advocates for the realization of health and other human rights of children cannot be seen lightly. CSOs play a significant contribution in this regard. Numerous global and regional documents reaffirm this role. To focus on the African human rights system, the African Commission on Human and Peoples' Rights underscores the 'crucial work of human rights defenders in promoting human rights, democracy and the rule of the law'.²⁴¹ Also, the African Charter on Democracy, Election and Governance obliges states to create 'conducive conditions for civil society to exist and operate within the law' and to work in partnership with and foster the participation of CSOs in the areas of social, political and economic governance.²⁴² Ethiopia ratified this Charter in May 2008.

In the area of litigation, CSOs' contribution in litigating constitutional matters is of paramount importance. South Africa's experience could be taken as a paradigmatic example. In post-apartheid South Africa, CSOs have litigated most, if not all, major constitutional human rights

²³⁹ Committee on Rights of the Child, *Concluding Observations* (1 November 2006), Ethiopia, para 15, CRC/C/ETH/CO/3, available at: <http://www.refworld.org/docid/45c30bd60.html> (accessed 10 February 2015).

²⁴⁰ The United Nations Office of High Commissioner for Human Rights (UNOHCHR), *Paris Principles Relating to the Status of National Institutions*, *General Assembly Resolution 48/1998*, section (B) and (C).

²⁴¹ African Commission on Human and Peoples' Rights, Res. (XXXV) 04: *Resolution on the Protection of Human Rights Defenders in Africa* (2004).

²⁴² African Charter on Democracy, Election and Governance (2007), articles 12(3), 27(2) & 28.

cases.²⁴³ In this section, I describe the role of CSOs in Ethiopia and analyse briefly the challenges that affect their effectiveness.

Ethiopian law governing CSOs dates back to 1960. The 1960 Ethiopian Civil Code provides for the legal framework governing associations and others working on a non-profit basis. However, this law was not comprehensive enough to address the peculiar features of charitable organizations and there was a huge demand to come up with a more detailed law. Subsequently, Ethiopia adopted in 2009 legislation to regulate the activities of CSOs (Proclamation No. 621/2009).

Three types of CSOs are classified under this new legislation, namely, 'Ethiopian Charities or Societies'; 'Ethiopian Residents Charities or Societies'; and 'Foreign Charities'.²⁴⁴ The Proclamation defines 'Charitable Purpose' – a defining feature of CSOs recognised in terms of the law - to include 'the promotion of the rights of the disabled and children's rights'.²⁴⁵ It indicates that CSOs are also mandated to promote child survival or health rights in Ethiopia, such as through litigation or advocacy or education. Nevertheless, the Proclamation prohibits Ethiopian Residents Charities or Societies and Foreign Charities from engaging in issues, including but not limited to, the advancement of human and democratic rights, and promotion of the rights of the disabled and children's rights.²⁴⁶ This is restrictive as these activities are left to Ethiopian Charities or Societies alone – which are also required not to generate more than 10% of their funding from foreign sources. Government is aware that these charities are weak in terms of finance (as they cannot receive more than 10% of their funds from foreign sources), experience and activity. The majority of the Ethiopian population lives below the poverty line, and requiring nationals to raise 90% from domestic sources to form charities not only questions their formation but also their sustenance. The restriction on funding has now,

²⁴³ Refer, for example, the case of *Ministry of Health v Treatment Action Campaign* (TAC) (2002) 5 SA 721 (CC), available at: <http://www.saflii.org/za/cases/ZACC/2002/16.html> (last accessed 23 May 2014).

²⁴⁴ Proclamation to Provide for the Registration and Regulation of Charities and Societies, Proclamation No. 621/2009, article 2 (2-4 & 15). To understand the difference between charities and societies, see articles 14(1) & 55(1).

²⁴⁵ *Ibid.*, article 14(2)(l).

²⁴⁶ *Ibid.*, article 14(5).

therefore, crippled the work of Ethiopian charities on human rights and democratization issues. Abebe has for instance concluded that ‘the majority of CSOs working on human rights before the enactment of the new Proclamation has now been changed to Ethiopian resident charities by abandoning their human rights activities’.²⁴⁷ In connection with the limitation that the new CSO law brings about regarding the work of human rights organizations, the Committee on ESCR underscores:²⁴⁸

The Committee notes with concern that certain provisions of the Charities and Societies Proclamation (No. 621/2009) have had a profound obstructive effect on the operation of human rights organizations. It is also concerned that the Charities and Societies Agency has frozen assets of some of those organizations, including the Ethiopian Women Lawyers Association, forcing them to downsize, close regional offices and suspend some of their services.

Overall, although there are no litigation-centred CSOs in Ethiopia, the Proclamation makes the emergence of human rights litigating CSOs more difficult.

Standing is also another factor inhibiting strategic litigation to be employed by CSOs in Ethiopia. There are strict standing rules governing human rights litigation. According to the Council of Constitutional Inquiry Establishment Proclamation, ‘any person who alleges that his fundamental rights and freedoms have been violated by any governmental institution or official may present his case to the Council of Inquiry for constitutional interpretation’.²⁴⁹ Given this provision, it is only those whose rights have been violated that may approach the Council of Constitutional Inquiry (CCI).

There are, however, some situations where the requirement of standing may not be applied. Relevant legislation deserves mention to show these possibilities. The first one is the Federal Courts Advocates Licensing and Registration Proclamation. It stipulates the possibility where

²⁴⁷ A Abebe ‘The potential role of constitutional review for the realization of human rights in Ethiopia’ *unpublished LLD thesis, University of Pretoria*, 2012 200.

²⁴⁸ UN Committee on ESCR, *Concluding Observations* (Ethiopia) (n 198 above) para 7.

²⁴⁹ Council of Constitutional Inquiry Establishment Proclamation No. 250/2001, article 23(1).

an individual can obtain a special advocacy license, which enables the license-holder to defend the general rights and interests of the society.²⁵⁰ The practice, however, shows that NGOs have not been issued with such license from the licensing organ (Ministry of Justice, FDRE).²⁵¹ At the regional level, there is a positive development with regards to licensing. For instance, in the Amhara and Tigray regional states, advocates licensing proclamations in these regions have been amended to enable legal aid centers at law schools in these regions to obtain special advocacy license. Using this license, the legal aid clinics formed in these regions have been rendering free advocacy service to the category of persons discussed in section 4.4.5 above.

Similarly, the two laws (discussed in sections 4.4.2 and 4.4.3 above) that established the EHRC and the EIO allow public interest complaints to be brought to these institutions. Articles 22(1) of both proclamations stipulate: 'A complaint may be lodged by a person claiming that his rights are violated or, by his spouse, family member, and representative or by a third party'. The inclusion of the phrase 'by a third party' makes it possible for complaints to be lodged by a third party without the need to show a vested interest.

The Environmental Pollution Control Proclamation is another relevant instrument. It provides for the right of any person to lodge a complaint, without the need to show any vested interest, at the Environmental Protection Authority or the relevant regional environmental agency against any person allegedly causing actual or potential damage to the environment.²⁵² This law further permits a person to institute a court case if the concerned authority fails to take measures within 30 days or if the applicant is dissatisfied with the decision.²⁵³ In practice, the case *Action Professionals Association for the People (APAP) v Ethiopian Environmental Protection Authority (EEPA)* is the first public interest case litigated before the Federal First Instance Court (the case went up to Federal Supreme Court on appeal) citing the provisions of article 11 of this Proclamation. APAP sued the EEPA, alleging the defendant had failed to take the necessary action to prevent pollution to the Akaki and Mojo Rivers near the capital city,

²⁵⁰ The Federal Courts Advocates Licensing and Registration Proclamation No. 199 /2000, article 10.

²⁵¹ Yeshanew 'The justiciability of human rights in the Federal Democratic Republic of Ethiopia' (n 201 above) 292.

²⁵² Environmental Pollution Control Proclamation No. 300/2002, article 11(1).

²⁵³ *Ibid.*, article 11(2).

Addis Ababa. To the dismay of the human rights community, the case was not successful at the First Instance and appellate courts as the courts accepted EEPA's argument. EEPA argued that APAP had no standing to sue it, but should have sued the polluter. The loss of this case casts a shadow on the possibility that the executive branches of government can be held responsible for violation of human rights through their inaction. Suffice it to say that, had APAP won the case, the decision would have paved avenues for judicial accountability against those who wield power and strengthened the role of NGOs in public interest litigation in the country.

From the foregoing, it is clear that there are important challenges and difficulties inhibiting the potential of CSO for protecting and promoting children's rights. In Ethiopia, the CSO law and practice are not conducive to CSOs conducting public interest litigation affecting survival or health rights of vulnerable children or human rights, more generally, effectively. Although the role of CSOs in human rights litigation in general, was weak even prior to the promulgation of the new law, the EHRC, CSOs and other stakeholders should work for the amendment of the restrictive provisions of the new CSO law to create an enabling environment.

4.6.5 The ministry of health (MoH)

The MoH is the body that is saddled with the responsibility of running the affairs of the health sector in Ethiopia. The MoH has a mandate, which, among other things, includes:²⁵⁴

[to] formulate the country's health sector development programme; follow up and evaluate the implementation of same; support the expansion of health services coverage; ensure adequate supply and proper utilization of essential drugs and medical equipment in the country; direct, coordinate and follow up implementation of the country's health information system; follow up and coordinate the implementation of national nutrition strategies; and expand health education through various appropriate means.

An examination of the mandates given to the MoH indicates that it has numerous powers and responsibilities that have a strong connection to meaningfully reducing or eliminating under-

²⁵⁴ Definition of Powers and Duties of the Executive Organs of the Federal Democratic Republic of Ethiopia Proclamation No. 691/2010, articles 29(1), (2), (3), (5), (7) & (12).

five mortality or to protect children's health in general. Its mandate begins from the very important stage of designing health development programs at the national level. For one thing, this entails that regional states do not have jurisdiction in formulating health policies. However, they can adopt health policies established at the national level through localization processes. This is supported by the FDRE Constitution, when it determines that the formulation and implementation of national standards and basic policy criteria for public health is the jurisdiction given to the federal government, where the latter is represented by the different line ministries and other offices.²⁵⁵

Within its other jurisdiction is the ministry's responsibility to ensure that there is sufficient supply and appropriate utilization of essential drugs or medicines and medical equipment all over the country. According to the WHO, essential medicines are defined as 'those that satisfy the priority health care needs of the population'.²⁵⁶ In functional health systems, such medicines are expected to be available at all times adequately, in the appropriate dosage forms, with assured quality, and at an affordable price to the individual and the community.²⁵⁷ It at the same time has a related obligation of following up the implementation of the nationwide programs.²⁵⁸ The central issue to raise here is whether the ministry has succeeded in warranting supply of drugs and medical equipment in the country.

In order to function properly, the MoH has established a maternal and child health department that is saddled with the responsibility to ensure that the health of women and children are addressed. N Bilal *et al* portray the ministry to have made significant changes through adopting innovative approaches to improve the health needs of the country's population.²⁵⁹ In addition, to ensure fulfilment of ethical standards by health professionals while discharging their obligation to children or adults, the Health Professionals Council Establishment Council of

²⁵⁵ FDRE Constitution, article 51(3).

²⁵⁶ WHO 'Essential medicines and health products' available at: http://www.who.int/medicines/services/essmedicines_def/en/ (accessed 12 January 2015).

²⁵⁷ *Ibid.*

²⁵⁸ *Ibid.*

²⁵⁹ N Bilal *et al* 'Health Extension Workers in Ethiopia: Improved access and coverage for the rural poor' in P Chuhan-Pole & M Angwafo (eds) *Yes Africa Can: Success Stories from a Dynamic Continent* (2011) 433.

Minister Regulation No.76/2002 has been promulgated. The Regulation identifies the organs responsible for handling disciplinary cases and the disciplinary penalties that members of the health profession should retain for violations of ethical standards.²⁶⁰ The Regulation establishes the Ethiopian Health Professionals Council and defines its powers and responsibilities. One of the powers of the Council is to ensure the observance of professional ethics by health professionals. The Council discharges its responsibilities through its executive Committee and several sub-committees that share powers and responsibilities. The Council's Professional Ethics Sub-Committee is given a specific mandate of investigating complaints regarding violations of professional ethics and, if the evidence adduced there to show that the professional breached ethical rules, submitting its findings together with the proposed punishment to the Executive Committee.²⁶¹

Despite these mechanisms, there are various challenges that the ministry has faced in implementing the objectives of its establishment. I discuss them more fully in the chapter that follows.

4.6.6 Regional health bureaus (RHBs)

Following an introduction of a decentralized system of governance post 1991, and with the adoption of the National Health Policy, which emphasizes on core principles of democratization and decentralization of the health care system, the health system in Ethiopia is organized in such a way that devolution of power is made to the nine regional governments and the two self-administrative cities. The fact of decentralization of power in the area of health between the federal and regional bodies has been well articulated within the constitution and in a number of major and supplementary proclamations.²⁶² It largely has

²⁶⁰ See Ethiopian Health Professionals Council Establishment Regulation Council of Ministers Regulations No. 76/2002, *Federal Negarit Gazeta*, 8th Year No. 13, articles 9-12 & 16.

²⁶¹ *Ibid.*, article 16.

²⁶² This can be noted from relevant provisions of the FDRE Constitution and the regional states' counterparts. For instance, article 51(3) mandates the federal government to establish and implement national standards and basic policy criteria for public health. In a bid to implement this provision, the FDRE MoH has been issuing and implementing national policies and standards on health with the scope of powers and duties entrusted to it under

resulted in shifting the decision making for public service delivery from the center to the authority of the regions and down to the district level. Thus, in the area of health service delivery, decision making processes, powers, duties and responsibilities are shared with offices at different levels from the Federal Ministry of Health to Regional Health Bureaus (RHBs) and *Woreda* Health Offices.²⁶³

Decision making is structured in such a way that the MoH and the RHBs mainly deal with policy matters, strategy and technical support, while *Woreda* Health Offices manage and coordinate the operation of the district health system under their jurisdiction.²⁶⁴ The process of implementation of health policies and programs entails some level of responsibility for logistical support between FMOH and the RHB. Where a shortage of manpower or logistic occurs at the *Woreda* level, the matter will be communicated to the RHB for appropriate response.²⁶⁵ Where the issue cannot be resolved within the capacity of the RHB, the latter will request for the intervention of the MoH in order to receive the necessary cooperation and assistance. Despite this channel, there is a lack of strong coordination among the various regional health bureaus and the MoH which contributes to an ineffective response to address health challenges as discussed in the subsequent chapter.

4.6.7 The ministry of women, children and youth affairs (MoWCYA)

The mandate previously given to the Ethiopian Ministry of Labor and Social Affairs under the 1995 proclamations, which define the powers and duties of the executive branches of

article 29 of Proclamation No. 691/2010. Similarly article 47(a) & (q) of the Constitution of the Oromiya national regional state confers similar power on the regional state on matters of health. One finds similar articles in the constitutions of all other 8 remaining regional states. Furthermore, Addis Ababa and Dire Dawa city administrations have their own legislation, policies and standards and also health offices to address health matters.

²⁶³ FDRE MoH *Health Sector Development Programme IV 2010/11 – 2014/15* (Final Draft) (October 2010) 4. See, also, WHO 'Analytical Summary' available at: http://www.who.int/profiles_information/index.php/Ethiopia:Analytical_summary_-_Health_system_outcomes (accessed 25 December 2014).

²⁶⁴ FDRE MoH, as above.

²⁶⁵ According to an interview conducted with Mr. Mihretu Wakjira, Children and Nutrition Officer, 24 February 2015, in the Amhara regional state, South Wollo Zone, Kombolcha, Ethiopia.

government,²⁶⁶ now resides with the Ministry of Women, Children and Youth Affairs (MoWCYA) which is currently the national body at the top level that is saddled with the responsibility of running the affairs of the women, youth and children's sector in Ethiopia. Its mandate includes, but is not limited to, the following:²⁶⁷

to] create awareness and movement on the question (*human rights*) of women, children and youth; collect, compile and disseminate to all stakeholders information on the objective realities faced by women, children and youth; coordinate all stakeholders to protect the rights and well-being of children; and follow up the implementation of treaties relating to women and children and submit reports to the concerned bodies. (Emphasis mine – drawn from the Amharic version of the provision).

A close examination of the mandates given to the MoWCYA in the above excerpted provisions of the enabling law indicates that this office is expected to play an important role in several distinctive ways in the proper realization of the rights of children and women, from provisioning of children's rights in the form of advocacy works and creation of awareness on children's rights to monitoring their actual implementation. As discussed in chapter two of this work, in a HRBA there is a need to enhance the capacities of right holders and duty bearers. The ministry can use its mandate above to ensure that children or their representatives are aware of their rights and at the same time to build the capacity of public representatives, civil servants and local officials working on children's affairs so that the latter may apply the human rights framework in their work.

Data collection on the practical realities of children is the other major duty of this ministry. The importance of disaggregated data on children is discussed elsewhere in this thesis.²⁶⁸ Such data are important both for formulating child protection and monitoring for implementation of children's rights. Nevertheless, the Committee on the Rights of the Child noted its concern on

²⁶⁶ See Definition of Powers and Duties of the Executive Organs of the Federal Democratic Republic of Ethiopia Proclamation No. 4/1995, article 20(8) & (9).

²⁶⁷ Definition of Powers and Duties of the Executive Organs of the Federal Democratic Republic of Ethiopia Proclamation No. 691/2010, article 32(1), (2), (9) & (10).

²⁶⁸ See, for instance, sections 3.4.2, 3.5.1 (B) & 5.3.5.

the lack of data on various issues affecting children in Ethiopia.²⁶⁹ Also, there is currently no comprehensive annual report regarding the state of children in Ethiopia. The Committee in a way makes a recommendation for the country to improve its vital registration system, such as birth registration. All in all these problems will significantly inhibit protection of children's health and other rights.

The obligation to ensure effective coordination between among the stakeholder offices' dealing with children's rights is another responsibility that this ministerial office is mandated to facilitate for implementation of children's rights. By conferring such powers and duties, the enabling legislation has offered an important opportunity for greater guidance and coordination by accurately viewing provisioning and implementation of children's rights as requiring a holistic approach. Coordination of stakeholder public and private offices has a special place in this regard. Despite this mandate, the Committee on the Rights of the Child is 'concerned that the ministry lacks sufficient resources and the ability to establish coordination at the regional, zone and *woreda* levels'.²⁷⁰ The ministry does not have properly established offices with adequate manpower and office facilities. A similar problem exists in the regional states as well.²⁷¹ In an interview conducted with the Head Coordinating Children's and Women's Affairs in this ministry office, Mr. Tilahun GebreTsadik, he mentioned the efforts being exerted to achieve strong coordination between child rights implementing bodies within the country. However, he admitted that this could not be up to the level expected for various reasons, such as inadequate inter-sectoral linkages and coordination. More specifically, he indicated that the vertical and horizontal interfaces between federal and regional structures of people-focused institutions and institutional capacity are weak and that there is a lack of clarity regarding accountability for children's rights.

²⁶⁹ Committee on CRC, *Concluding Observations* (Ethiopia) (n 239 above) para 18.

²⁷⁰ *Ibid.*, para 10.

²⁷¹ For instance, in an interview conducted with Mrs. Nura Mustefa, Officer at Women, Youth and Children's Affairs Office, Benishangul Gumuz regional state Health Bureau, indicates that there is no manpower specifically allocated to children's matters in this regional state. She has also responded that there has not been any specific program targeted to specifically address children's health. The interview was made 26 February 2015, Adama, Ethiopia.

Submission of the country's report as to implementation of children's rights is another jurisdiction that the ministry wields. The country has a relatively good record of submitting periodic reports to the CRC Committee in pursuance of article 44 of the CRC, and to the African Committee of Experts on the Rights and Welfare of the Child, in accordance with article 43 of the ACRWC. The country currently submits the Fourth and Fifth Consolidated Periodic Report to the CRC Committee. At the time of writing this thesis, the report was in the reporting process²⁷² and the CRC Committee had not yet issued its concluding observation and recommendation on it.

4.6.8 The ministry of justice (MoJ)

This ministry is conferred various powers and duties as can be easily read from the law that defines the powers and duties of the executive organs of the federal state of Ethiopia. In connection with its mandate on protection of children's interest before judicial bodies, the enabling law stipulates that the ministry has the powers and duties to represent citizens, in particular women and children, who are unable to institute and pursue their civil suits before the federal courts.²⁷³ The instant issue that may arise from a close reading of this provision is whether this mandate of initiating a civil suit includes the ministry's responsibility to institute before the courts, children's rights cases on the basis of human rights provisions stated in the various legal regimes discussed in this work. Civil suits are generally understood as lawsuits brought with respect to alleged violations of civil rights. Civil rights guarantee individuals the right to receive equal treatment and to be free from unfair treatment or 'discrimination' in different settings, such as access to health care, education and others.²⁷⁴ However, the reference to civil suits must be understood to distinguish it from that of criminal suits and not

²⁷² The reporting process takes the following steps: Submission of state party report->Submission of NGO reports-> Pre-session meeting (Working Group considers NGO and other reports) ->List of issues sent to government->Written replies sent to Committee->Plenary session (all information discussed between Committee and state delegation)->Concluding observation issued by Committee at end of session->Implementation of concluding observations and ongoing advocacy by NGOs ->. For further discussion, visit: <http://www.childrightsconnect.org/connect-with-the-un-2/crc-reporting/> (accessed 23 December 2014).

²⁷³ Proclamation No. 691/2010), article 16 (11).

²⁷⁴ 'What are civil rights?' available at: <http://civilrights.findlaw.com/civil-rights-overview/what-are-civil-rights.html> (accessed 6 February 2015).

to exclude litigation based on the human rights of the individual or groups. Furthermore, in different legal systems, such as Canada, the ministry or department is considered to be a public body that must work to promote respect for rights and freedoms, the law and the constitution and as such its delegation requires protection of vulnerable children's rights before courts.²⁷⁵ The website of the ministry also reveals that the activities that Women and Children's Coordination Office within the ministry undertakes include protecting children's and women's rights within the 10 justice sector offices established in the cities of Addis Ababa and Dire Dawa.²⁷⁶ Like their adult counterparts, children's rights are interdependent, indivisible and interrelated. It follows that the ministry is saddled with the responsibility to ensure that children from poor families are represented in court for the realization of their rights, such as their fundamental right to health and the underlying determinants of the right to health.

A related concern is whether the ministry in actual practice represents needy children before the courts for protection of their rights against government or non-government agencies or individuals. In an interview conducted with the person coordinating the Children's and Women's Affairs unit at the ministry, it emerged that in practice children's cases taken before the courts by the ministry are mainly cases of child custody and maintenance on the basis of the Revised Family Code of Ethiopia, article 36 of the FDRE constitution and relevant provisions of the CRC and ACRWC.²⁷⁷

In its criminal jurisdiction, it also takes numerous cases involving infanticide, child abuse and neglect.²⁷⁸ This is done in accordance with the jurisdiction of the ministry, where this body is vested with the power to 'undertake or order the conduct of investigations where it believes that a crime, the adjudication of which falls under the jurisdiction of the federal courts, has

²⁷⁵ 'Canada's Department of Justice: Our mission' available at: <http://www.justice.gc.ca/eng/rp-pr/cp-pm/about-appro/index.html> (accessed 3 May 2015).

²⁷⁶ 'Women and children coordination office' available at: <http://www.moj.gov.et/MinistryOfJustice/CommonPage.aspx?Id=24> (accessed 10 February 2015).

²⁷⁷ Interview conducted with Ms. Wossenyelesh Admassu, Head Coordinating Women and Children's Affairs, at the Ministry of Justice (FDRE), 27 January 2015, Addis Ababa, Ethiopia.

²⁷⁸ Interview conducted with Mr. Bereket Mammo Entamo, Head of Arada Division - Federal Ministry of Justice, 15 January 2015, Addis Ababa, Ethiopia.

been committed'.²⁷⁹ I discuss here one of the more recent cases that was initiated by the ministry and received judgment in 2014/2015. This case is taken to indicate that infants continue to die unnecessarily during child birth from preventable causes even in the capital city of the county – Addis Ababa.

In the case of the *Federal Public Prosecutor v Aynalem Alemayehu Woldecherkos*, the office of the persecutor sued the defendant for commission of an alleged crime of infanticide in violation of article 544(1) of the Revised Criminal Code of Ethiopia.²⁸⁰ From the facts of the case, the defendant was a domestic servant alleged to have been impregnated forcefully. In her pleading she averred to have delivered the baby in a toilet room. She claimed that she got weak in the process of delivery and that during delivery, the infant accidentally fell into the toilet where it then died. People in the neighborhood were alerted to the event by the baby crying before it died and they then saw what had happened and reported it to the local police, where the investigation was subsequently commenced. Furthermore, the court's file reveals that while the defendant did not admit the falling down of the baby inside the toilet, she pleaded guilty to not reporting the incident to the authorities. Finally, in its judgment delivered on the 1st of January 2015, the court found the defendant guilty of the crime she was accused of, and sentenced her to six months of light imprisonment.

The above case has important implications in relation to child survival/ mortality. In brief, it demonstrates the role that the MoJ could play in prosecuting cases affecting child survival. This would in turn potentially bring reduction of the crime rates of infanticide or infant deaths. In addition, it presents an indication to responsible units to further investigate the various causes of infant mortality, and to design policies and implementation mechanisms to address the various causes of infant mortality in the country.

²⁷⁹ Proclamation No. 691/2010, article 16(5).

²⁸⁰ *Federal Public Prosecutor v Aynalem Alemayehu Wolde Cherkos*, Arada Division Justice Office, Public Prosecutor File No. 00809/07 (2014), Computer File No. 221675.

I have indicated in section 4.3 of this chapter the various causes which contribute to child mortality in Ethiopia. The causes that relate to child infanticide/abuse/neglect would fall in the unspecified category of ‘other causes’, although the classification made by the relevant MoH documents does not consider infanticide as a cause for under-five mortality.²⁸¹ The premise of this work is that every child is owed the right to survive under the various laws. Any meaningful reduction of the under-five mortality rate lies in the understanding that the causes should be studied and new instances must be analyzed for prevention of mortality. This requires the joint effort of the various stakeholder offices, such as the MoLSA, MoH and MoJ, through study, analysis and designing mechanisms of curbing mortality.

On the top of the above enumerated ones, there are other pertinent powers and duties that the ministry is vested with, which, if properly discharged, would significantly contribute to the promotion and protection of children’s survival or other complimentary rights. These include its jurisdiction to ‘undertake legal reform studies and carry out the codification and consolidation of federal laws; collect[ion and consolidation where necessary of] Regional State laws ...; creat[ion] [of] legal awareness through the use of various methods with a view to raising public consciousness in relation to the protection of human rights; [and] cooperat[ion] with the appropriate bodies in relation to legal education and training’.²⁸² This mandate of the ministry can potentially enable to enact constitutional and special law reforms to include children’s right to survive and to health, food and safe drinking water as fundamental rights of every child where the current constitutional setting has failed to address it, as I discussed in section 4.4.1 of this chapter. It also enables it to enhance the capacity of children as holders of these rights and of duty bearers for the realization of the rights through the use of various methods of legal awareness on the protection of their human rights.

²⁸¹ During a meeting (in 15 February 2015, Addis Ababa, Ethiopia) I had with a member of the child health case team within the FDRE Ministry of Health, Dr. Lisanu Tadesse, I raised the court cases filed before courts in Addis Ababa concerning infanticide and inquired of him whether infanticide is also at the center of response within the Ministry. He explained to me that MoH is focused on programs that have high impact on children’s health, and, as such, infanticide is not a focus area of the ministry and is not included explicitly in the list of causes for under-five mortality in the country.

²⁸² Proclamation No. 691/2010, article 16(2) & (15).

4.6.9 The ministry of labor and social affairs (MoLSA)

Following the fall of the *Dergue* regime in 1991, this ministry was the first ministerial office in charge of children's matters under the law (Proclamation No. 4/1995), which define the powers and duties of the executive organs of the government of Ethiopia. The law states that the ministry, in cooperation with the appropriate organs, shall study, and give assistance for the implementation of ways and means for the proper upbringing of children and youth.²⁸³ This legislation was subsequently repealed, and the mandate is currently given to MoWYCA.

No specific article is incorporated concerning children's rights in the amended legislation that delineates the powers and duties of MoLSA. However, there are general provisions which equally protect children from impoverished or socially disadvantaged families. The law that amended Proclamation No. 4/1995 obligates the MoLSA 'to undertake and facilitate the implementation of studies on ensuring and improving the social well-being of citizens, in particular and including, the protection of family and marriage'.²⁸⁴ This legislation gave room for the possibility of ensuring social protection to families and children against deprivation of access to material needs for their survival and development. This legislation was further repealed in 2010 where the previous article was amended by a more general provision which provides that the MoLSA shall 'in cooperation with the concerned stakeholders, undertake and facilitate the implementation of studies on ensuring and improving the social well-being of citizens, in particular and including, the prevention of social problems and provision of rehabilitation services to the affected members of the society'.²⁸⁵ This provision goes in tandem with the framework of the provisions of article 41(5) and other provisions²⁸⁶ of the FDRE Constitution that uphold an approach for the progressive realization of economic, social and cultural rights.

²⁸³ Proclamation No. 4/1995, article 20 (9).

²⁸⁴ Proclamation No. 471/2005, article 32 (7) (a).

²⁸⁵ Proclamation No. 691/2010, article 30 (7) (c).

²⁸⁶ See articles 25, 35(7) & (8), 41(5), 41(7) & 90 of the FDRE Constitution.

Problems such as malnutrition, access to public health care and drinking water are social challenges in most developing countries. These social problems are also common in Ethiopia, a country still struggling to break down the poverty, vulnerability and inequality, where they constitute many of the causes of under-five mortality. In recognition of these social problems and in response to the country's commitment to the Africa Union Social Policy Development Framework,²⁸⁷ the MoLSA in collaboration with stakeholders recently issued the National Social Protection Policy that is designed:²⁸⁸

to *protect* citizens from economic and social deprivation through emergency interventions and targeted cash transfers, *preventive* actions designed to avert deprivation or to mitigate the impact of adverse shocks including health and unemployment insurance, *promotive* actions that aim to enhance assets and human capital and income earning capacity, and transformative actions including legal and judicial reforms, budget analysis and policy evaluations to help the nation better manage social protection.

The country's adoption of the comprehensive social protection framework is a significant step. If properly implemented, it will offer social support and services to strengthen the capacities of families and communities to protect themselves from poverty and vulnerability. However, the social protection statements look very ambitious. Given the current realities of the country these would have to go a long way to fully implement the policy. Millions of Ethiopians live in conditions of abject poverty and in a state of dire need of social protection. Children are the first to be affected. For instance, child malnutrition and access to safe drinking water is still a challenge. Although the country has launched different social support programs and mechanisms,²⁸⁹ existing social protection mechanisms are very weak compared to the needs of the society. In addition, the country until recently did not have a comprehensive social policy. In connection with this the Committee on Economic, Social and Cultural Rights underscored its

²⁸⁷ Signed by Ethiopia in 2010, the Africa Union (AU) Social Policy Development Framework was agreed to by African member states. It requires that national development plans would develop explicit policies, strategies, and action plans for social protection at the time of their next update.

²⁸⁸ FDRE Ministry of Labour and Social Affairs *National Social Protection Policy of Ethiopia* (Final Draft) (2012) 1.

²⁸⁹ Such as the government pension scheme (although the coverage of this scheme is limited to civil servants, the police and military), urban housing and grain subsidies, disaster risk management, the government food security and the national nutrition programs.

concern, in its Concluding Observation (in 2012), that the country has not yet introduced a universal social security system.²⁹⁰ Thus, the introduction of this new Social Policy is a significant step as it demonstrates an attempt to fill this lacuna. It nevertheless requires translation of the Policy into concrete action. Among other things, implementation strategies, institutional arrangements, national action plans, guidelines and directives need to be issued and adequate budget allocated to guide its implementation.

In the foregoing I identify the relevant ministerial offices that are charged with duties to address children's health and their other rights. By no means are they the only ones that should be involved to ensure that the reduction of new-born mortality is high on their agenda. Other ministries with corresponding responsibilities include the Ministry of Agriculture - promoting food security at household, community, district and national levels; the Ministry of Education – reviewing and updating components of the Maternal and New-born Health (MNH) and SRH in various school and pre-service curricula in collaboration with the MoH; the Ministry of Works and Urban Development - improving road networks to facilitate access to health services at primary and referral levels, especially in rural areas; the Ministry of Finance and Economic Development - giving priority to health, especially MNH, in budget guidelines for allocation of itemized resources and increasing financial resources for health to meet the need and especially implementation of MNH activities; the Ministry of Communication and Information Technology - giving priority to messages and educational programs on mass media; and the Central Statistical Authority - collecting demographic data through Censuses and sample surveys, facilitating the establishment of vital registration systems and publishing and disseminating statistical data.

4.7 Conclusion

In this chapter I describe the situation of under-five mortality, and analyze the legislative, policy and institutional response concerning child survival in Ethiopia. A number of conclusions may be drawn from the discussion. First, despite the encouraging results achieved in reducing

²⁹⁰ UN ESCR, *Concluding Observations* (Ethiopia) (n 198 above) para 13.

child mortality, data from government and non-governmental sources show that the country still remains one of the states with the world's highest incidence of child mortality, mainly from preventable causes. The United Nations Special Rapporteur on the right to the highest attainable standard of health has stated that 'preventable maternal mortality also often represents a violation of a woman's right to life'.²⁹¹ By analogy, the fact of unnecessary child deaths occurring in the country constitutes social injustice and potentially violates children's right to life or survival. It is indicative of the fact that government has to exert further efforts to ensure that this injustice to children should be addressed as a matter of priority, not merely calmed by tokenism, but through participatory planning, coordination, implementation, and monitoring of child survival programs and strategies.

Secondly, the country has ratified the CRC, ACRWC, ICESCR and other relevant treaties which promote and protect child survival or health. However, having signed on to a wide array of international human rights laws affecting child survival rights, Ethiopia has not yet seen fit to percolate the relevant provisions of these treaties on child survival into the national laws of the country. Children's right to health, food or access to safe drinking water are not included in the FDRE Constitution or that of the nine regional states counterparts. Although the Constitution was adopted following the country's ratification of the CRC, the former selectively incorporates children's rights by failing to include children's right to health and other interrelated rights which are pivotal to implement the obligation to reduce child mortality. The influence of the CRC or ACRWC on the Constitution is limited. This is an indication that the ratification of the human rights instruments does not guarantee their influence on domestic child health or survival priorities. The absence of an enforceable right to health can increase the difficulty of holding the government accountable for failure to provide life-saving health care services, such as vaccination and nutrition to children and pregnant women. Although the adoption of domestic law governing children's rights to survival and health in itself does not guarantee realization of these rights, it is important to note that the inclusion of such

²⁹¹ P Hunt & JB De Mesquita *Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health* (2008) 8.

provisions in the national legal system could have the potential to prevent many child deaths in the country through accountability and advocacy mechanisms.

The absence of explicit children's rights to health or survival in the FDRE Constitution or a special act does not, however, release the government from its legal obligations to ensure that preventable child deaths do not occur. Indeed, the right to health guaranteed in the CRC and ACRWC have the force of law in Ethiopia under articles 9(4) and 13(2) of the FDRE Constitution. Accordingly, the relevant provisions on child health and survival in these treaties can be utilized to address matters affecting child mortality. Besides, the Constitution's provision of children's right to life could also be used to enact accountability of the government for the deaths of children from preventable causes. However, this approach is not straightforward to deploy before courts or non-judicial bodies, for enforcement of treaty and Constitutional provisions in the domestic system could be subjected to several challenges. For instance, since socio-economic rights stipulated in the CRC are not self-executing, as their application before judicial and administrative bodies could be challenged. But, in the absence of clear enabling domestic laws in the matter, this approach should be considered to promote and protect children's right to survival or health.

Thirdly, while several health policies and strategies affecting child survival have existed in Ethiopia after the fall of the *Derg* regime, the policies and strategies have not been fully designed to meet their goals and objectives in human rights terms. Few policies or strategies have human rights elements. They are not all systematically human rights proofed or lack mainstreaming human rights principles in them and are yet to bring improvements in the material life of hundreds of thousands of under-five children. For instance, a keen assessment of the country's overarching child survival strategy reveals that the philosophy underlying the provision and organization of child survival is not drawn from human rights obligations. It is therefore arguable that Ethiopia's child survival agenda and the implementation thereof has been little influenced by international obligations, and rather that it has been driven by national priorities or health development agenda. It is imperative that the government of

Ethiopia considers a human-rights-based approach to child survival policy, explicitly shaped by human rights norms and principles.

Ethiopia's long term plan will be shaped by its policies, programs and strategies. Furthermore, by participating in the human rights world, Ethiopia has committed itself before the international community to expressly applying international human rights law, and ensuring empowerment, participation, non-discrimination, and accountability. The policies and programs, therefore, must be shaped by active and meaningful participation by all stakeholders, and rooted in these core human rights values.

Fourthly, as regards institutional mechanisms, current laws recognize the need for establishing an independent judiciary. However, the competence of courts to entertain children's socio-economic rights, or human rights in general, are subjected to a myriad of challenges as I set out more broadly in the chapter that follows.²⁹² As it stands today, only sub-category international human rights are protected by Ethiopian courts - mainly civil and political rights, for instance the prohibition of double jeopardy.²⁹³ Economic, social and cultural rights such as the right to health and education are neither sufficiently recognized nor protected. Even with that, the checks and balances to ensure that these rights are protected are not always passable. Despite the fact that the normative framework for the justiciability of human rights exists in Ethiopia, the practice of the judiciary reveals some inadequacies. Ethiopian judges are not known for their judgments in questioning executive acts for failure to protect, promote and fulfil human rights. Owing to their historical subordination to the executive, they have been non-proactive in recognizing their heightened responsibility as guardians of human rights. The untenable nature of this stance is evident in the concluding observations of the Committee on Economic, Social and Cultural Rights, which criticized the non-invocation of the

²⁹² See, section 5.9.3.

²⁹³ The Ethiopian Federal Cassation Court has applied article 23 of the FDRE Constitution (prohibition against double jeopardy) in its numerous decisions. It, for instance, applied in the cases *Deputy Engineer Hailay Asigele & Deputy Commander Yilma Tilahun v Benshangula Gumuz regional state Justice Office* – Federal Supreme Court File No. 60217; *Public Prosecutor of the Atsbi Woreda of Tigray regional State v Student Hagos Woldemichael* – Federal Supreme Court File No. 72304; and *Zekarias Gebre Tsadik v Federal Public Prosecutor* - Federal Supreme Court File No. 85237.

provisions of the ICESCR by Ethiopian courts.²⁹⁴ Similarly, although EHRC and the Institution of Ombudsman are structurally present, they have yet to prove their independence and proactive engagement in sensitive human rights issues calling the government to account. These make accountability mechanisms for child survival remote in Ethiopia. There is a need to reshape the circumventing stance concerning the role of these institutions in the realization of child health and other human rights.

Fifthly, through different stages of amended laws the country has defined the powers and duties of the executive branches of the government. The most recent legislation that does this job is Proclamation No. 691/2010. It assigns a wide range of roles and responsibilities of the various executive branches of government, including in those areas calling for their attention to children's concerns. Their duty extends to promoting and protecting children's rights to survival and health. In this respect, the country can be considered to have made a significant step in the right direction for laying down mechanisms for the effective implementation of children's rights through assigning roles and responsibilities of respective departments. However, the efficacy of these institutions is subject to various factors. For one thing, there is no proper system of accountability or check and balance to ensure whether the various departments and units are doing their tasks according to their mandate and requirements of children. The possession of power and duties by these executive organs necessarily implies *responsibility or they must assume responsibility for their action or/and inaction*. The other limitation pertains to coordination. The CRC Committee believes 'effective implementation of the CRC requires visible cross-sectoral coordination to recognize and realize children's rights across government, between different levels of government and between government and civil society'.²⁹⁵ Despite this, coordinating the work of the various executive departments is one challenge, especially in the lower level of administration – *zones* and *woredas* - owing to lack of skilled manpower, resource and others. Coordination is important to ensure respect for all children's rights within the country and to ensure that children's rights are recognized in the activities of the various departments of the government including child health departments up

²⁹⁴ UN ESCR, *Concluding Observations* (Ethiopia) (n 198 above) para 5.

²⁹⁵ CRC Committee, *General Comment No. 5* (n 63 above) para 27.

to lower level of governance.²⁹⁶ The shortfall of adequate coordination in the country can, among other things, trigger ineffective implementation of children’s survival and health rights in the country. Besides, restrictions placed upon civil society on children’s and women’s human rights advocacy are another limitation to engage accountability through mobilization of the civil society. Overall, the institutional mechanisms for implementation of child survival rights are structurally present. Nevertheless, owing to various grounds, such as the restriction placed on the civil society to engage in children’s and women’s rights issues, their effectiveness to potentially advance child survival agenda is affected.

²⁹⁶ Ibid., para 37.

Chapter 5

Opportunities and challenges of implementing child survival rights in Ethiopia: Post-2015 perspective

5.1 Introduction

Economic, social and cultural rights, generally, have received and continue to receive less attention than their civil and political counterparts. The realization of these rights has encountered a number of challenges. This is in particular apparent on the African continent where, *inter alia*, issues of justiciability, political conflicts and war, lack of political will and the weaknesses of the enforcement mechanism remain current.¹ Despite these shortcomings, factors such as the human rights movement in Africa, the academic struggle for the enforcement of socio-economic rights and robust economic growth in Africa in the past few decades have raised hopes that the future will be better for children in Africa. Numerous African governments have ratified most of the relevant international and regional human rights instruments, which also recognize children's right to survive and its complimentary rights. Furthermore, many African countries have harmonized, or are in the process of harmonizing their national laws with the global and regional instruments.² The adoption of comprehensive children's human rights provisions in their national system in the case of South Africa and Kenya could be taken as an example in this regard, as was highlighted in chapter four.³ The continent's political leaders continue to profess their love for children and their commitment to their cause.⁴ Many long bulleted lists of ratifications exist to reinforce this.

¹ J Oloka-Onyango 'Beyond the rhetoric: Reinvigorating the struggle for economic and social rights in Africa' (1995) 26 *California Western International Law Journal* 50-52; C Mbazira 'The enforcement of socio-economic rights in the African human rights system: Drawing inspiration from the International Covenant on Economic, Social and Cultural Rights and South Africa's evolving jurisprudence' *unpublished LLM Dissertation, Human Rights and Democratisation in Africa, University of Pretoria*, 2003 2-4.

² C Mbazira 'Regional symposium on harmonisation of laws on children in Eastern and Southern Africa, 9-10 May 2007' (2007) 7 *African Human Rights Law Journal* 276-281; ACPF 'Moving Africa from Rhetoric to Accountability' (n 4 below).

³ See section 4.4.1.

⁴ Africa Child Policy Forum (ACPF) 'Moving Africa from rhetoric to accountability' available at: <http://www.africanchildforum.org/site/> (accessed 1 April 2015).

Luckily, some of these promises are kept. For instance, although serious challenges remain, reports show that Africa is making great strides to achieve universal or improved access to health and education of children.⁵ Nevertheless, as Nolan *et al* have rightly underscored child health continues to be subject to neglect and political manipulation at both national and international levels despite many statements.⁶ Survival for millions of Africa's children remains hard, insecure and fragile.⁷ Overall, the situation of child health and other rights of children presents both a promise and challenge.

Over the last two decades, Ethiopia has made major efforts to ensure equitable benefits to children from development initiatives, support vulnerable children, minimize harmful traditional practices that affect children, and protect children's rights and safety.⁸ These efforts included legislative and institutional reforms to protect the rights of children and women. Although progress has been made to improve the social and economic wellbeing of children, there are still challenges, including but not limited to legal, institutional, social and economic factors that inhibit the desired results – ensuring socio-economic rights of children in general. In this chapter I aim to explore the gains achieved while efforts were exerted to reduce child survival in the past two decades – I consider them as 'opportunities'. They represent strong footholds where continued commitment to ensuring child survival can be further built upon. On the other hand, I investigate the gaps and problems relating to the existing laws, policies and practices that impede the full realization of child survival and its complimentary rights – I categorize them as 'challenges'. Crucially, my assessment is grounded on the political and legal imperatives of applying principles and standards of HRBAs in the country, through, among others, examination of the express application of children's rights in the domestic system,

⁵ Ibid; UNDP 'Africa making great strides toward many MDG targets yet serious challenges remain, new report says' available at: <http://www.undp.org/content/undp/en/home/presscenter/pressreleases/2013/05/27/africa-making-great-strides-toward-many-mdg-targets-yet-serious-challenges-remain-new-report-says.html> (accessed 13 May 2015).

⁶ A Nolan *et al* 'Submission on the content of a future general comment on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)' available at: http://www2.ohchr.org/english/bodies/crc/docs/CallSubmissionsTadesse_Art24/ProfNolan-DurhamUniversity-ProfElyYamin-HarvardUniversityandProfMeier-UniversityofNorthCarolina.docx (accessed 23 March 2014).

⁷ Ibid.

⁸ J Boyden & S Dercon *Child Development and Economic Development: Lessons and Future Challenges* (2012) 28, 37.

availability, accessibility, acceptability and quality of facilities and services, participation, non-discrimination and accountability in the context of child health or maximizing children's right to survival.

This chapter is organized around these two tasks. I start, in 5.2 below, by analysing the efforts that have been made to deal with child mortality. Then, in 5.3 below, I consider the challenges that limit the country to implement its obligation of combatting preventable child mortality. I conclude, in 5.4, by arguing that overcoming the challenges could potentially contribute to the existing initiatives of further reducing or eliminating under-five mortality post-2015.

5.2 Opportunities

5.2.1 'Political commitment' and emerging partnership

Seen generally, the promotion and protection of children's rights, like all other human rights, is a legitimate concern of the international community. However, effective implementation of children's rights takes place at domestic level. At the national level, meaningful intervention on children's rights depends on various factors, among which generating national political priority on health development⁹ and heightened recognition by governments of the fundamental human dignity of all children and the urgency of ensuring their well-being and development are potentially contributing factors.¹⁰ This is expressed mainly through ratification of child specific and related human rights instruments and a commitment to the values of these instruments and in all actions taken, living up to the required standard of the best interests of the child.

As highlighted in section 4.4.6 of chapter four, the Ethiopian government affirms its commitment to promote and protect children's rights through ratifying the CRC and ACRWC.

⁹ J Shiffman 'Generating political priority for maternal mortality reduction in 5 developing countries' (2007) *American Journal of Public Health* 796-803.

¹⁰ UNICEF, Convention on the Rights of the Child 'Protecting children's rights' available at: http://www.unicef.org/crc/index_protecting.html (accessed 12 March 2015).

In ratifying these instruments, Ethiopia made the promise not only to recognize children's rights through domestic means, but also to translate these rights in concrete ways. To a certain extent efforts were also made to harmonize these instruments with domestic law.¹¹ Furthermore, child mortality looks to be a priority agenda for the Ethiopian government. There seems to be a commitment to child survival as a development agenda. This has been expressed in the introductory notes of child related policies, plans, strategies, reports and other documents issued by the FMOH. Again, the country's representatives similarly reaffirm child and maternal mortality as a priority agenda in those conferences, meetings and symposiums in which the delegates participate.¹² This is an indication of a certain level of political determination by the government to reduce child and maternal mortality. This is a good basis on which the country could carry on to further the existing initiatives of addressing the mortality problem.

Equally, the introduction of the Health Extension Workers (HEWs) program and the deployment of these Workers in the health care system is another indication of the government's commitment to actualize reduction of child and maternal mortality.¹³ These Workers are grade 10 graduate (or high school graduate) of expressly young women, mostly selected from their community, trained for one year and paid by the government to live within and cover a rural Health Post.¹⁴ They offer a wide variety of services, such as family planning, pre-natal and post-natal care, vaccinations, treatment of minor health issues, and they

¹¹ For a more in-depth discussion of the major legislation that was harmonised by the Ethiopian government, see section 4.4.6.

¹² For instance, Dr. KA Birhane, FDRE Minister of Health, in his speech in the Two Years Anniversary of 'A Promised Renewed: Celebrating Progress and Mapping the Road Ahead, Washington, D.C.' (25 June 2014), mentioned to the participants, among other things, his government's political commitment in implementing MDG IV and MDG V. The details of his speech can be found at: http://www.moh.gov.et/home/-/asset_publisher/R8nRKVXvQAuo/content/h-e-dr-kesetemberhan-admasu-speech-in-the-two-years-anniversary-of-a-promised-renewed-celebrating-progress-and-mapping-the-road-ahead-washington-d-c- (accessed 20 July 2015).

¹³ For a useful reference that the HEW program is considered as an indication of commitment (political), see The World Bank, B Feysa *et al* (eds) *The Health Workforce in Ethiopia: Addressing the Remaining Challenges* (2012) xi, xiii-xiv, xix, 10-11, 24.

¹⁴ Health Posts serve up to 5,000 people within a community in Ethiopia. 2 HEWs are assigned for every Health Post. There are currently 16,000 Health Posts. Every Health Post is linked to a Health Center where expectant mothers are urged to give birth by a trained birth assistant. There are currently 3,500 Health Centers in Ethiopia and only 130 Hospitals, serving about 90 million people.

promote the importance of delivering in a hospital, and exclusive breastfeeding. Reports indicate that 38,000 HEWs have been trained throughout the country with 34,382 based in rural areas, 3,401 in urban areas, and 948 in pastoralist areas.¹⁵ Launched in 2003, the HEWs program has saved many lives. Regarding the contribution of HEWs with respect to the reduction of child mortality rates in the country, USAID Administrator Rajiv Shah, has said:¹⁶

...Between 2006 and 2010, infant mortality decreased by 23 percent and under-5 mortality by 28 percent. These achievements are largely a result of Ethiopia's investment in a community health system and a cadre of 35,000 health workers who provide front-line care.

Due to the work of these HEWs many women have access to better, more informed maternal and pediatric health care services.

On top of above, in order to boost the efforts of addressing child and maternal health, the government of Ethiopia is striving to establish strong partnership with governments and global agencies. One such current example that demonstrates the meeting of minds to collaborate on ending child deaths is the 'Child Survival Call to Action' conference that took place in 14-15 June 2012, in Washington, D.C., convened by the governments of Ethiopia, India and the United States, together with UNICEF. This conference brought together 700 leaders and experts from public and private sectors, as well as religious leaders. Notably, 'this event launched 'The Commitment to Child Survival: A Promise Renewed', a series of activities to monitor progress in child survival efforts and ensure mutual accountability'.¹⁷ The importance of these activities further lies in its aims to mobilize the world toward one ambitious but simple

¹⁵ FDRE MoH *Ethiopia's health sector: Excellent returns on your development funding* (February 2013) 3; P Bartlett *et al The lion: All eyes on Ethiopia's national health extension program* (07 September 2011) 3; Thirdeyemom 'Hope in the struggle for Ethiopian maternal and new-born care' available at: <http://thirdeyemom.com/2014/06/28/hope-in-the-struggle-for-ethiopian-maternal-and-newborn-care/> (accessed 14 January 2015).

¹⁶ USAID, Frontlines *Celebrating a child health revolution* (2012) 28.

¹⁷ For various reports and measures taken to address child and maternal deaths within the framework of 'Commitment to child survival: A promise renewed', see 'Ending preventable child and maternal deaths: A promise renewed' available at: <http://www.apromiserenewed.org/> (accessed 24 March 2015).

goal of ending preventable child deaths.¹⁸ The conference encouraged countries to take ownership of a new international momentum to reduce child mortality. During the conference, governmental and organizational representatives addressed ways to reduce the numbers of children who die before their fifth birthday significantly. In this regard, the important message addressed by the then Ethiopia's Minister of Health, Dr Tedros Adhanom, received attention from the Executive Director of UNICEF, Ms. GR Gupta and others. He stressed:¹⁹

What I really believe, if there is country ownership, if there is ownership, if I own something, it is easier for me to commit to something that I own. And if I commit, I know I can achieve results. But, if somebody is telling me what to do and I do not own it, I do not think I will go an inch.

One initiative leads to another. June 2014 marks the second anniversary of 'the Child Survival Call to Action' when the world came together to craft a global goal. This is what is known as 'Acting on the Call: Ending Preventable Child and Maternal Deaths' that again took place in Washington D.C, on Wednesday 25th June 2014. The meeting was co- hosted by the USAID and the governments of Ethiopia and India, in collaboration with UNICEF and the Bill & Melinda Gates Foundation and other partners. Overall, this meeting had the objective of strengthening the previous approach of making progress on maternal and child health. The Acting on the Call gathering aimed to unveil new global efforts to end preventable maternal and child deaths by 2035.²⁰

The Ethiopian government's commitment to address maternal and child mortality not only brings alliances with countries and agencies to the forefront to work together in the global efforts to address preventable deaths, but also builds confidence among partners and donor

¹⁸ For extended discussion, see UNICEF 'Young child survival and development: Child Survival Call to Action summit closes with commitment to eliminate preventable child deaths' available at: [http:// www.unicef.org/childsurvival/index_62647.html](http://www.unicef.org/childsurvival/index_62647.html) (accessed 23 February 2015).

¹⁹ T Adhanom 'Keynote address, Child Survival Call to Action summit, Washington, D.C., USA on June 15, 2012'. His speech is available on video at: http://www.unicef.org/childsurvival/index_62647.html (accessed 16 February 2015).

²⁰ USAID *Acting on the call: Ending preventable child and maternal deaths report June 2014* (2014) 8.

agencies to enable them to release funds to combat health problems. Ethiopia is one of the 24 sub-Saharan countries to which the US government has shifted its focus in terms of releasing resources to support life-saving interventions that have the greatest impact. The USAID pledged to align up to US\$2.9 billion for 3 consecutive years, following the 'Acting on the Call' meeting, to save up to 500,000 lives and also announced a new US\$500 million child survival and maternal health award.²¹

My interview with Dr. M Shibeshi of Save the Children further shows that there is a growing partnership established between the Ethiopian government and institutions such as USAID and Save the Children and others.²² He underlined that, compared to other sectors of development partnerships, the health sector partnership that the Ethiopian government has built over the last few years is highly encouraging. He is of the opinion that this partnership has brought about changes in health gains throughout the country. It was with the 'support from USAID and other donors that the government's health extension worker program has become a model for other countries in the region where trained health sector personnel and resources are scarce'.²³ Due to the effective development partnership, the '*per capita* health expenditure in Ethiopia has more than quadrupled since 1995'.²⁴ Funding from international development co-operation was the largest source during the past 15 years. The MDG Performance Fund and Component 1 of the Protection of Basic Services (PBS) package are the two forms of financial support recognized by the government. Whereas the former is a multi-donor funding facility owned and managed by the FMOH to fill critical priority gaps in the overall health sector plan, the PBS are distributed by the Ministry of Finance and Economic Development (MoFED) to the regional states and districts based on existing federal resource allocation criteria to fund salaries of public sector workers, social accountability activities and some infrastructure

²¹ USAID 'USAID and partners unveil new efforts to save millions of women and children from preventable deaths' available at: <http://www.usaid.gov/news-information/press-releases/june-25-2014-usaid-and-partners-unveil-new-efforts-save-millions-women-children-preventable-deaths> (accessed 12 March 2015).

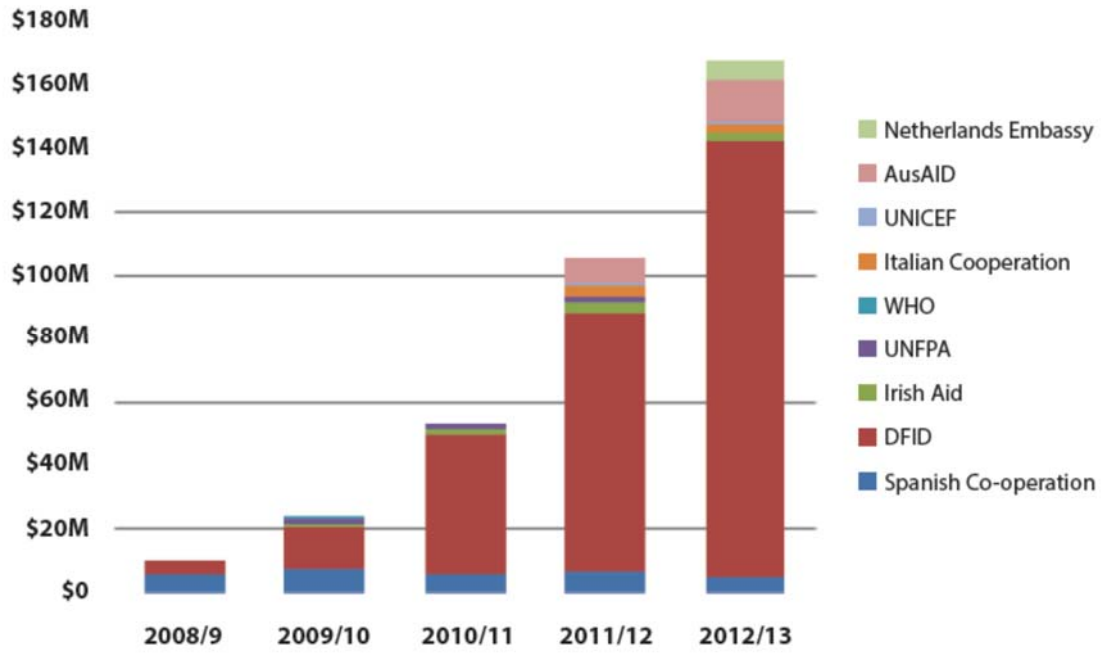
²² Interview conducted with Dr. Million Shibeshi, Head of Nutrition - Save the Children, 15 February 2015, Addis Ababa, Ethiopia.

²³ USAID 'Global health: Ethiopia' available at: <http://www.usaid.gov/ethiopia/global-health> (accessed 12 February 2015).

²⁴ FDRE MoH *Ethiopia's health sector: Excellent returns on your development funding* (n 15 above) 4.

development.²⁵ The following figures show the trend of funding from development partners and a breakdown of its expenditure by priority area.

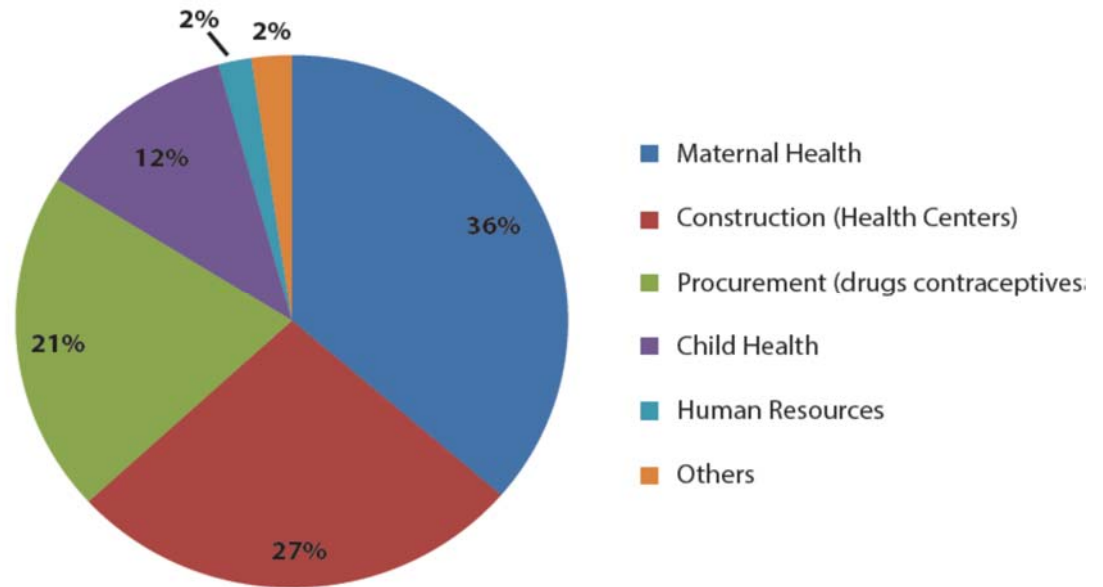
Figure 3: Contributions to the MDG performance fund, 2008/9-2012/13



Source: FMOH, Progress and activity reports for MDG/PF

²⁵ Ibid.

Figure 4: Spending on priority areas, the MDG performance fund (2009-12)



Source: FMOH, Progress and activity reports for MDG/PF

The current report from Global Fund further indicates how Ethiopia is able to receive development aid due to the government's demonstrated success in previous health programs and, at the same time, the development partners' heightened collaboration to combat health problems. According to this report, as of November 2014, Ethiopia had received over US\$1.6 billion in grants since the creation of the Global Fund in 2002.²⁶ Satisfied with the results of its previous funding, Global Fund made further allocations of a total amount of US\$591 million (US\$377 million allocated to AIDS, US\$150 million allocated to malaria, US\$59 million allocated to tuberculosis, and US\$4 million allocated to Health Systems Strengthening), for the period 2014-2016.²⁷

It is neither necessary nor possible to record all assistances, human or technical, and the financial grants that were made available to the government of Ethiopia to address health demands. However, I try to indicate above, based on available sources, that the Ethiopian

²⁶ The Global Fund *Audit report: Global Fund grants to the Federal Democratic Republic of Ethiopia* (25 February 2015) 1.

²⁷ Ibid.

government is receiving very good attention from development partners, which leaves the country with possibilities to further improve the health development agenda and human rights conditions of the most vulnerable rural and urban child population and beyond.

5.2.2 Economic growth and an increase in funding allocation for the health sector

A rights framework of child survival or health imposes an obligation on duty-bearers to work towards their progressive realization. The rights enshrined in the human rights instruments discussed in chapter three automatically put a budgetary obligation on state parties for their implementation. The budget is the nexus between rights and their translation into human well-being outcomes. In the contemporary development discourse, economic growth of a country is a major instrument to improve the well-being of the people.²⁸ For this reason, at times of economic booming of a nation this event brings a general expectation that it will improve the standard of living of its population. Ranis maintains that the UNDP Human Development Report (HDR) is considered to be 'the first major attempt to evaluate a link between growth and the standard of living in countries'.²⁹

Nevertheless, a country's richness or economic growth does not necessarily entail that the human rights condition of that country is at its best. Often, growth does not automatically translate into access to rights and reduction of poverty. Put differently, the growth does not necessarily translate to the wider population in the form of access to rights. This is why children's well-being or child-friendliness is not necessarily found in those countries that are rich in resources, even within the context of Africa.³⁰ Apart from economic growth *per se*, it is the distribution pattern of economic growth that is important to examine in order to determine its impact in human right terms. It means that the nature of the growth is a crucial factor. Growth must be distributed among all income levels of society, particularly those living

²⁸ A Sengupta 'The human right to development' in B Andreassen & S Marks (eds) *Development as a Human Right: Legal, Political and Economic Dimensions* (2008) 40.

²⁹ G Ranis *Human development and economic growth* (2004), Center discussion paper No. 887, available at: http://www.econ.yale.edu/growth_pdf/cdp887.pdf (accessed 16 May 2015).

³⁰ ACPF 'Moving Africa from rhetoric to accountability' (n 4 above).

in poverty for it to translate into access to rights, such as the right to health. Indonesia is taken as a good example to illustrate this. The Indonesian government's commitment to distribute oil revenue among the poor and the wealthy, for thirty years prior to the 1997 crisis, translated into a remarkable poverty reduction in rural areas and the achievement of rights.³¹

Ethiopia's economy is growing by two digits over the past decade.³² The country is the fifth biggest economy in sub-Saharan Africa. The economic boom that Ethiopia has registered over the past consecutive years should leave the country in an optimistic position to increase investments in the health sector also, inasmuch as the progress is sustained. Obviously, a decade of two digit growth has brought some improvement in the standard of living according to the HDR, although Ethiopia's '2012 Human Development Index (HDI) of 0.396 is below the average of 0.466 for countries in the low human development group and below the average of 0.475 for countries in sub-Saharan Africa'.³³ Moreover, this has brought improvements to the level of the poverty in the country. In this regard, the Committee on Economic, Social and Cultural Rights applauds the significant poverty reduction that Ethiopia has 'achieved since 2004, as a result of the prioritization of poverty reduction in the country's development policies, strategies and programs'.³⁴

More specifically, due to the economic growth, Ethiopian government expenditure on health has been increasing in real terms. After four rounds of National Health Accounts (NHA) there

³¹ A Kagman & S Heleba 'Can economic growth translate into access to rights? Challenges faced by institutions in South Africa in ensuring that growth leads to better living standards' (2011) 17 *SUR International Journal of Human Rights* 89.

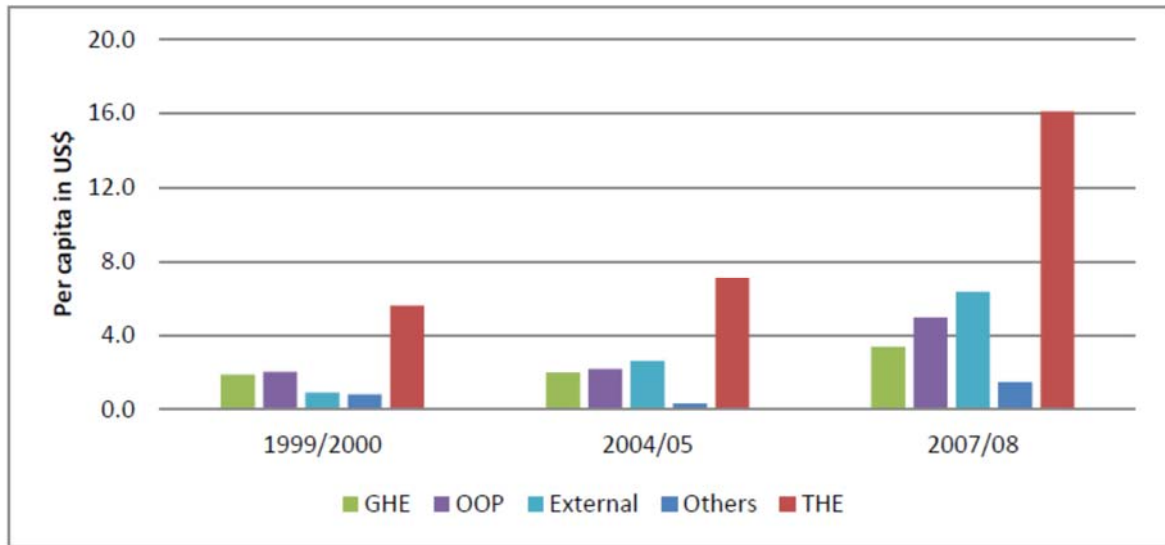
³² In the period (2005/06 - 2009/10), the Real GDP has grown at 11%. For details, see Ministry of Finance and Economic Development *Growth and Transformation Plan (GTP) 2010/11-2014/15* (Final Draft) (September 2010) 4.

³³ According to United Nations Development Program (UNDP), Ethiopia's Human Development Index (HDI) value increased from 0.275 to 0.396, an increase of 44 percent or average annual increase of about 3.1 percent, between 2000 and 2012. During the same period, Ethiopia's HDI value increased from 0.275 to 0.396, an increase of 44 % or average annual increase of about 3.1 %. For details, see UNDP Human Development Report 2013 'The rise of the South: Human progress in a diverse world, Explanatory note on 2013 HDR composite indices: Ethiopia' available at: <http://hdr.undp.org/sites/default/files/Country-Profiles/ETH.pdf> (accessed 7 April 2015).

³⁴ UN Committee on Economic, Social and Cultural Rights (ESCR), *Consideration of reports submitted by states parties under articles 16 and 17 of the Covenant: Concluding Observations of the Committee on Economic, Social and Cultural Rights- Ethiopia*, 31 May 2012, E/C.12/ETH/CO/1-3, para 4(a), available at: <http://www.refworld.org/docid/4ff6d0de2.html> (accessed 17 April 2015).

has been a continued increase in Total Health Expenditure (THE).³⁵ Between 1999/00 and 2007/08 the *per capita* spending on health increased from US\$5.6 to US\$16.09, as is shown in the figure below.

Figure 5: Trends in health expenditure by source of finance



Source: Second, third and fourth round National Health Accounts

The above is an indication that expenditure on health in Ethiopia has steadily increased over time. As I discuss in section 5.3.7, despite the increase in budgeting on health care, the increase is not proportional to or as high as the economic growth rate. In order to ensure continuance of bridging the poverty gap in access to health care, the economic growth needs to be sustained. Furthermore, economic growth should proportionally or meaningfully reflect expenditures on health. If this is met, it will contribute to poverty reduction and produce greater achievements in implementing the right to health.

5.2.3 Increased girls' and women's education

³⁵ NW Workie & G NV Ramana *The Health Extension Program in Ethiopia* (2013) 4.

The inextricable link between level of education and child mortality has been argued elsewhere in this thesis.³⁶ It was noted that the child mortality rate is higher in cases of uneducated women than with educated mothers. A rights approach to educating mothers is thus a key to reducing child mortality in Ethiopia. Generally speaking, educational attainment among women is low in the country, despite its importance. According to recent data, about half of women in the age group 15 to 49 in Ethiopia have no formal education.³⁷ Furthermore, although national data indicates that net enrollment has increased substantially for girls in primary education, the drop-out rates of children from primary school is 13% for the year 2010/11.³⁸ This is 5% higher than the government anticipated rate (i.e. 8 %) for that year. Between 2011 and 2014 at both the primary and secondary levels the net attendance rate and the general attendance rate remained virtually unchanged.³⁹

Luckily, the level of education for girls and women in Ethiopia is increasing steadily, despite the discouraging school dropout rates above. Data from the three previous Ethiopian Demographic and Health Survey (EDHS) surveys show that there has been a 36 % decline in the proportion of women age 15-49 with no education, from 75 % in 2000 to 48 % in 2014. This is an indication that education has become more widespread over the past fifteen years. Again, 41 % of women 15-49 are now literate. This translates into a doubling of literacy among women in the reproductive age group in the past fifteen years. This indicates that further progress is possible in the country as a whole. As the literacy of women increases, among other things, it helps social programmers to design health and family planning messages strategically. The consequence is that more women will have a better awareness than before as to how to handle children and their health, develop children's exclusive breastfeeding practices, engage in proper family planning and understand the need to deliver babies in the health centers. If this

³⁶ See section 4.3.

³⁷ Central Statistical Agency (Ethiopia) *Ethiopia mini-demographic and health survey 2014* (2014) 21.

³⁸ T Woldehanna *Shocks and children's dropout from primary school: Implications for education policy in Ethiopia* Paper presented at the 12th UKFIET International Conference of Education and Development Oxford, (10-12 September 2013).

³⁹ Central Statistical Agency (Ethiopia) *Ethiopia mini-demographic and health survey 2014* (n 37 above).

is done properly, under-five mortality caused by illiteracy of women could further significantly reduce in the next few years.

5.2.4 Expanded health service coverage

A rights-based approach to child survival or health imposes the obligation to ensure health facilities and services are available, accessible, acceptable and of quality. The Ethiopian government has recently received recognition for improving access to health from global and regional agencies working on health development.⁴⁰ Although the road ahead is still there, the health service coverage has been expanded remarkably in the past two decades. The health system has dramatically improved potential access to care through the accelerated expansion of health facilities.

It is believed that the Health Extension Program (HEP), the flagship health program of the government, remains the core strategy to improve household behavior and coverage of basic health care services, which contributed to the achievement.⁴¹ It is viewed as representing a good example for countries struggling to improve health outcomes in a resource-constrained setting.⁴² When the HEP was first designed, it was meant to be the main vehicle for achieving universal coverage of primary health care in the country. Fully integrated into the broader health system, the Program delivers 16 clearly defined packages of preventive, promotive, and basic curative services.⁴³ Since the time it was started in 1997/1998 over every five years, the HEP has shown substantial outcomes in areas related to disease prevention, family health, hygiene, and environmental sanitation. Furthermore, between 2005 and 2011, under-five mortality decreased from 123 per 1,000 live births to 88 per 1,000 live births; the contraceptive

⁴⁰ For instance, research commissioned by the World Bank shows Ethiopia's improved access to health. See generally on this, N Bilal *et al* 'Health extension workers in Ethiopia: Improved access and coverage for the rural poor' in P Chuhan-Pole & M Angwafo (eds) *Yes Africa can: Success Stories from a Dynamic Continent* (2011) 433-443; S El-Saharty *et al* *Ethiopia: Improving Health Service Delivery* (2009) 1-38.

⁴¹ Workie & Ramana (n 35 above) v.

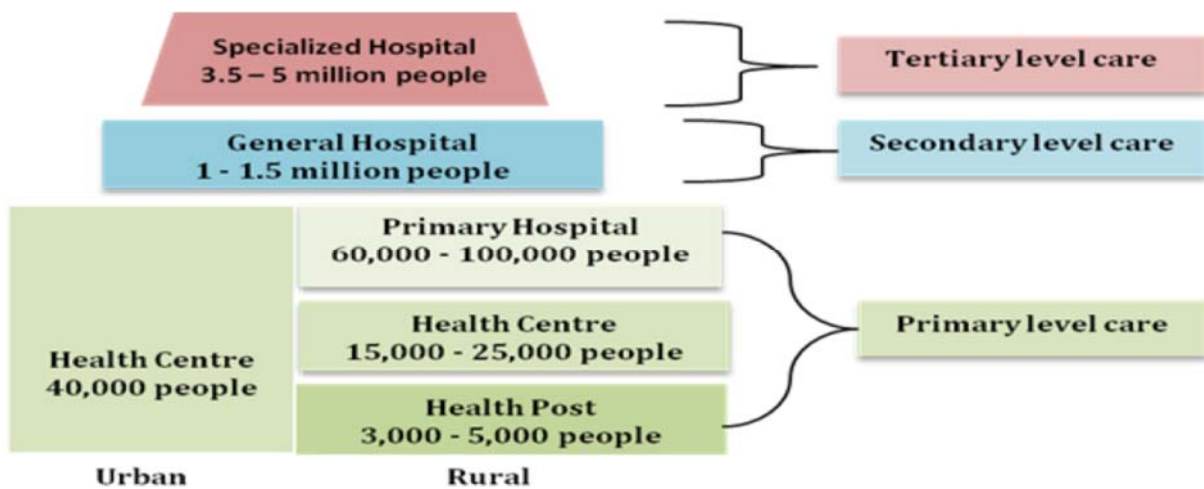
⁴² *Ibid.*

⁴³ *Ibid.*

prevalence rate increased from 15 % to 29 %; and stunting in under-five children declined from 52 % to 44 %.⁴⁴

In order to reach the health needs of the population the country’s health program has introduced a three-tier health care delivery system, the structure of which is clearly captured in the figure below.

Figure 6: Ethiopia’s three-tier health system



Source: Ethiopian Ministry of Health, 2012

Using the three-tier system above, the primary health care delivery has been improved tremendously, resulting in potential health service coverage estimated at 92.2 %. The HEWs are the key players in the implementation of Ethiopia’s health program. They devote much of their time to home visits and outreach. Modelled after the country’s agricultural extension worker programs, the HEWs program was adopted under the principle that if ‘the right health knowledge and skill is transferred, households can take responsibility for producing and maintaining their own health’.⁴⁵ Due to the intervention of HEWs, 9 million households - which translate about 63% of all households in the country, have completed their training on 17

⁴⁴ Ibid., v & 17.

⁴⁵ FDRE MoH *Health Sector Development Programme-IV* (October 2010) 14.

packages of the HEP.⁴⁶ This training, among other things, brings benefits to the rural community in terms of improving the underlying determinants causing child mortality. For instance, data shows that vaccination coverage improved significantly. In villages where HEWs were deployed, a larger proportion of children were vaccinated against diphtheria, polio, and tetanus (DPT); measles; polio; tuberculosis; and main antigens.⁴⁷

Although government is the leading provider of health care, the private health clinics and medical services role, particularly in urban areas, are also growing in importance.⁴⁸ In addition, eight NGO hospitals and about 200 NGO health clinics are supporting the health service delivery, particularly in rural areas. According to surveys, 27% of patients visited private for-profit and NGO providers.⁴⁹ These facts and figures indicate that further improvement in health care delivery is possible should the government and the private sector further expand their services into the difficult-to-reach areas of the rural community, both in terms of ensuring access and providing quality health care.

In the foregoing I acknowledge the efforts that the country has made to address health gains, more broadly. While I applaud the efforts of the government of Ethiopia in reducing under-five mortality in the past two decades and developing health related policies, plans and strategies, there cannot be room for complacency. The state's obligation to children's survival rights or their right to health is broader than these accomplishments. Despite the achievements, efforts to reduce under-five deaths are threatened by a myriad of challenges. Many under-five children still continue to die of preventable causes and many are at risk of dying. In the section that follows I examine concerns over a large number of gaps, problems within the law, policies, systems and practices.

⁴⁶ These 17 packages of the HEP composes 4 major areas of household training on health matters, namely, 'hygiene and environmental sanitation, disease prevention and control, family health services and health education and communication'. For further information on the details of the 17 packages and the outcomes of the training, see N Bilal *et al* 'Health extension workers in Ethiopia: Improved access and coverage for the rural poor' (n 40 above) 334-336.

⁴⁷ *Ibid.*, 336.

⁴⁸ Workie & Ramana (n 35 above) 4.

⁴⁹ *Ibid.*

5.3 The challenges

5.3.1 Lack of explicit recognition of child survival as a human right

I examine in section 2.2.3.1 that express application of the human rights framework necessarily draws on the legal codification of human rights norms and standards at every stage of national and local development processes. A critical examination of major Ethiopian laws, policies, strategies and government development plans obscures child survival as human rights entitlement, by failing to recognize children's right to survive explicitly. At the risk of oversimplification, I maintain that the current legal environment is not essentially supportive for a human-rights-based approach to address under-five mortality effectively. This is not in line with article 4 of the CRC and article 2 of the ACRWC, which stipulate the requirement for 'States Parties to take all necessary legislative measures for the implementation of the rights recognized in the Convention'. The obligation that emanates from these articles includes the duty to incorporate the provisions of these instruments into national legal frameworks.⁵⁰ According to Committee on Rights of the Child, state parties are required to review all their domestic legislation comprehensively in order to comply fully with these instruments. Besides, states are not only required to review their national laws 'article by article, but also, holistically recognize the interdependence and indivisibility of human rights'.⁵¹ The importance of the review process lies, especially, in the very nature of international law, which relies often on persuasion and dialogue, while domestic law employs a monological and coercive process to enforce rights, such as children's right to health and survive. In other words, children's rights enshrined at the global or regional level could bring greater impact on children's wellbeing only if they are domesticated at the national level.⁵² From a practical point of view, I discuss in chapter two the explicit recognition that has been made in the laws and policies of the three selected jurisdictions (India, Malawi and Nepal), where the WHO was able to substantiate evidence of the impact of the application of a rights-based approach to maternal and child

⁵⁰ UN Committee on the Rights of the Child (CRC), *General Comment No. 5 (2003), General Measures of implementation of the Convention on the Rights of the Child*, 27 November 2003, CRC/GC/2003/5, para 18, available at: <http://www.refworld.org/docid/4538834f11.html> (accessed 21 April 2015).

⁵¹ *Ibid.*

⁵² UNICEF *A Guide to General Comment 7: Implementing Child Right in Early Childhood* (2006) 61.

health from the rich experience of these countries. It was noted that ‘applying human rights to women’s and children’s health policies, programs and other interventions not only helps governments comply with their binding national and international obligations, but also contributes to improving the health of women and children’.⁵³

An assessment of existing laws shows that neither the FDRE Constitution, nor those of the regional state counterparts incorporate children’s survival rights, their right to health, food, and access to safe water and other related rights. Equally, the national policies and strategies discussed in chapter four do no better job in recognizing either child survival or its complimentary rights, from a human rights perspective. In connection with whether the human rights framework has guided the first ever National Child Policy (draft), Fasil & Rakeb identify the weakness of this important policy of children in failing to put the CRC as a reference point and apply HRBA in their recent impact assessment work on this particular Child Policy.⁵⁴ As was argued, the overarching national child survival strategy discussed in section 4.5.3 and its successor⁵⁵ also fail clearly to recognize the principles stipulated in the CRC and ACRWC, and the status of these instruments in the domestic law.

It is important that any legislative revision in the future should fill the gap of these omitted rights from the national legal framework. These complimentary rights exist in the global and regional laws that the country is a party to and they should be incorporated into the domestic system for ease of enforcement. Other developing countries similar to Ethiopia have done this.⁵⁶ Where there is a high level of political commitment to the realization of children’s

⁵³ F Bustreo *et al Women’s and Children’s Health: Evidence of Impact of Human Rights* (2013) 1-136.

⁵⁴ F Mulatu & R Messele *Impact assessment report on the draft national child policy of Ethiopia 2011* (2014) ix-x.

⁵⁵ FDRE MoH, Maternal and Child Health Directorate *National Strategy for Newborn and Child Survival in Ethiopia (2015-2020)* (January 2015). This pertinent child survival document was in its final draft stage and was ready for endorsement at timing of writing first draft of this thesis. It was meant to replace the first national child survival strategy, i.e., the ENSCS, which ran for the period 2005-2014. Similar to its predecessor, human rights principles and recognition of the relevance of human rights of children and the obligation of the country has not found a place. It is predominately shaped by public health efforts to reduce child survival - influenced by policy comments like the SDGs, and not complemented by human rights principles, such as explicit recognition of children’s rights.

⁵⁶ For instance, as I discuss in section 4.4.1, Part II, Section 4(2), the Children Act of Kenya (2010) guarantees child survival rights and its complimentary rights.

survival rights, there exists a commitment for the constitutional recognition of children's right to survival and health, and the underlying determinants of the right to health. At the same time, the government needs to place a statutory obligation on the state to provide services, programs, human resources and infrastructure needed to realize these rights of children. It should also incorporate those considered as minimum core obligations of the right to health that states are required to address under ESCR Committee's General Comment No. 14/2000.⁵⁷

The failure in explicitly integrating child survival rights into the country's major laws, policies, strategies and development plans can be construed such that child survival has received and continues to receive little attention as a human rights agenda. While the relevant child-related survival or health policies and strategies acknowledge the country's commitment to align the objectives of these instruments in line with MDG commitments, they make no specific reference to human rights obligations flowing from the country's ratification of the governing human rights instruments. They are not explicitly shaped by human rights standards, contrary to one of the principles in a rights-based approach to health development discussed in chapter two.⁵⁸ As a result, child survival or the right to health is a development issue and not a human rights concern in the country. This conflicts with the growing understanding at the international and regional levels that reducing under-five mortality is not solely an issue of health and development, but a matter of human rights.⁵⁹

5.3.2 Inequities in under-five mortality

⁵⁷ See UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14, The Right to the Highest Attainable Standard of Health (art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4, para 6, available at: <http://www.refworld.org/docid/4538838d0.htm> (last accessed 1 May 2015); UN Committee on Economic, Social and Cultural Rights (ESCR), *General Comment No. 3, The nature of states parties' Obligations (art. 2, Para. 1, of the Covenant)*, 14 December 1990, E/1991/23, available at: <http://www.refworld.org/docid/4538838e10.html> (last accessed 1 May 2015); K Young 'The minimum core content of economic and social rights: A concept in search of content' (2008) 33 *Yale International Law Journal* 113, 154.

⁵⁸ See section 2.2.3.1.

⁵⁹ See, for instance, UN Human Rights Council *Study by the World Health Organization on mortality among children under five years of age as a human rights concern*, 6 September 2013, A/HRC/24/60, para 32, available at: <http://www.refworld.org/docid/523061aa4.html> (accessed 23 March 2015).

Here below is what Anthony Lake, UNICEF Executive Director, has to say about inequity:⁶⁰

Addressing inequities must be embedded throughout the post-2015 development agenda. The agenda should inspire every society to look beyond national averages, and commit to the rights of every person, female and male, young and old – no matter where they live – to have the same opportunity to live a healthy, fulfilling life. [And the agenda should enable] citizens to hold leaders and decision-makers accountable for doing so.

The above remark by Lake underscores the imperative of applying a crucial component of rights: non-discrimination and equality in access to health care. Despite a decline in under-five child mortality over the last two decades in Ethiopia, the reduction has not been experienced to the same degree by all children. Particularly, inequality in access and fragmentation in the governance of health services has been an acute challenge. Survival for hundreds of thousands remains tough, nasty and brutish. As has been thoroughly investigated in chapter four, significant inequities and disparity in the child mortality rate continue to exist within Ethiopia.⁶¹ Data from the EDHS indicate that ‘regional variation in under-five mortality rates varied from the lowest record of 56 deaths per 1000 live births in the capital city of Addis Ababa to the highest of 169 deaths per 1000 live births in Benishangul-Gumuz, followed by 127 deaths per 1000 live births in the Gambela region’.⁶² The disparities in child mortality also range from the lowest of 14 deaths per 1000 live births in Addis Ababa, to the highest of 76 deaths per 1000 live births in Benishangul-Gumuz.⁶³ Similarly, infant mortality varied from 40 to 101 deaths per 1000 live births in Addis Ababa and the Benishangul-Gumuz region, respectively.⁶⁴ Altogether, they manifest that child survival inequities are shaped by ethnicity and geographical location as, for instance, children born from the Afar ethnic group in the Afar regional state have a higher risk of facing child mortality than those born from Tigray or Oromo ethnic groups in Tigray and Oromiya states, respectively.

⁶⁰ ED Gibbons *Accountability for Children’s Rights: With Special Attention to Social Accountability and its Potential to Achieve Results and Equity for Children* (2015) 3.

⁶¹ See section 4.3.

⁶² Central Statistical Authority (Ethiopia) & ICF International *Ethiopia Demographic and Health Survey 2011* (2012) 112.

⁶³ *Ibid.*, 113.

⁶⁴ *Ibid.*

The fact that some children are excluded from the progress being made presents intra-country discrimination against these children who do not have an equal chance to survive or celebrate their fifth birth. The problem is most apparent where children from the poorest families, living in rural areas and whose mothers are less educated, are those more likely to die. This is a stark indication that many under-five children do not have the same opportunity to survive as others, due to the place where they live. As discussed in chapter three, global and regional human rights laws clearly require that the enjoyment and exercise of human rights must be guaranteed to all human beings on the basis of the principles of equality and non-discrimination. Furthermore, they impose a duty on states to ensure equality and protect children against discrimination. Therefore, the presence of inequities that are shaped by ethnicity and geographical location potentially means that the country is accountable under the relevant human rights law. Also, it suggests a systematic failure to provide access to high-quality services needed by children, and may constitute a violation of the right to life. Identifying children who are discriminated against and excluded from services and opportunities is a step towards combating their discrimination and inequity.⁶⁵ Furthermore, it urges a selection of high-risk groups, analysis of the complex gaps in protection, ensuring participation and accountability, and promoting the identification of comprehensive and sustainable solutions.

5.3.3 Limited health services and supplies

I have examined in section 3.4 that the right to health under human rights law creates a specific obligation on states and non-state actors. General Comment No. 14 further clarified the obligation of States to ensure that child-friendly health services, goods and facilities that are needed are available, accessible, acceptable and of high quality in order for states to address under-five mortality.⁶⁶ States are duty bound to ensure that health goods and services have to be available, accessible, acceptable and of high enough quality to reduce under-five mortality.

⁶⁵ UNICEF *Every Child Counts: Revealing Disparities, Advancing Children's Rights* (2014) 5.

⁶⁶ *General Comment No. 14* (n 57 above) para 12.

The state obligation of the right to health should be fulfilled in order to avoid the major part of preventable under-five mortality.

Elsewhere in this thesis I argue that Ethiopia has improved health coverage through deploying the HEP. Nevertheless, health care utilization is still low, with a 0.36% utilization rate, subject to economic, socio-cultural and geographical factors. Health goods and services are threatened by myriad challenges as I point out in more detail below.

5.3.3.1 Availability

I highlight in chapter two that the right to health or a rights-based approach to health incorporates the element of availability of a working public health system and health care facilities, goods and services, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical staff and essential drugs.⁶⁷ However, Ethiopia is not in full satisfaction of these elements.

The World Health Organization identifies Ethiopia as among the 57 countries in the world facing a critical shortage of health workforce. It indicates that per 10,000 population, there are <0.5 physicians, 2 nursing and midwifery workers, <0.5 dentistry workers, <0.5 pharmaceutical personnel, <0.5 environmental and public health workers, 3 community health workers and 2 hospital beds.⁶⁸ In addition, there is low availability of medicines due to the fact that the medicine supply system is unreliable and has long procurement procedures. Essential medicines are only available 52% in the public sector and 88% in the private sector.⁶⁹

Despite the substantial improvement in recent years, access to and utilization of primary health services remain limited in the country. According to the 2011 welfare monitoring survey

⁶⁷ Ibid., para 12(a).

⁶⁸ WHO 'African health observatory: Ethiopia' available at: http://www.aho.afro.who.int/profiles_information/index.php/Ethiopia:Analytical_summary__Health_system_outcomes (accessed 12 March 2015).

⁶⁹ Ibid.

(CSA 2012b), 64.7 % of households are within less than 5 kilometers of the nearest health post, 40.1 % are within 5 kilometers of a health center, and 14.2 % are within 5 kilometers of a hospital.⁷⁰ There is also a significant urban-rural disparity in the distribution of health facilities. For instance, in urban areas, health service providers, that is, health posts, health centers, and hospitals, are available within less than 5 kilometers for about 88.2 %, 87.7 %, and 49.4 % of the households, respectively.⁷¹

In addition, there is limited access to well-equipped health facilities and obstetric care in Ethiopia.⁷² Especially in the rural areas, the problem is very stark as much research conducted in these areas has revealed. In these areas, there are not enough ambulances. As one researcher notes ‘wooden stretchers’ are ambulances. Besides, examination rooms are barren, faced with a dearth of the necessary medical equipment.⁷³ An assessment of quality of health care in Jimma Zone, Southwest Ethiopia, also shows that the human aspect of care was ‘poor’, and that the health institutions were facing shortages of human and material resources.⁷⁴ Similarly, while the HEWs are considered to be affordable and more reachable with a potential to ensure health man power availability to the rural population, their presence in some localities Oromiya is far from the desired level. In Kalu *woreda* of the Amhara regional state, it was indicated that recruiting HEWs from the community is a challenge and the *woreda* was forced to look for from other localities.⁷⁵ Nevertheless, the HEWs deployed from other localities often resign their job and do not demonstrate the commitment to serve for various reasons due to reasons, such as delayed transfer or promotion or dissatisfaction with their wage and career. According to an interview I conducted in the Oromiya Health Office, I gathered that better employment opportunities which are believed to exist in the Middle East

⁷⁰ Workie & Ramana (n 35 above) 8.

⁷¹ Ibid.

⁷² International Medical Corps (IMC) ‘International Medical Corps improves maternal health care in food insecure areas of Ethiopia’ available at: <https://internationalmedicalcorps.org/sslpage.aspx?pid=2294> (accessed 22 March 2015).

⁷³ Thirdeyemom ‘Hope in the struggle for Ethiopian maternal and new born care’ available at: <http://thirdeyemom.com/2014/06/28/hope-in-the-struggle-for-ethiopian-maternal-and-newborn-care/> (accessed 14 January 2015).

⁷⁴ W Beyene *et al* ‘Assessment of quality of health care in Jimma Zone, Southwest Ethiopia’ (2011) 21 (Suppl 1) *Ethiopian Journal of Health Science* 49–58.

⁷⁵ Interview conducted with Mr. Mohammed Seid, Nutrition Officer, Kalu Woreda Health Office, 25 February 2015, in the Amhara regional state, South Wollo Zone, Kombolcha, Ethiopia.

countries have caused a significant number of HEWs to drain out of the region implicating availability of such community health workers in several health posts.⁷⁶

In addition, in connection with assessing implementation of the obligation of the country concerning the right to health care as a social right, the Committee on Economic Social and Cultural Rights reaffirmed the challenges indicated above:⁷⁷

The Committee is concerned that there is no universal health-care coverage. It is also concerned about the low number of qualified health-care professionals per capita in certain regions and critical shortages at health centres, both in medical equipment and staff. The Committee also notes with concern the high rate of maternal and infant mortality, and the low number of births that are assisted by a skilled attendant, especially in rural areas. It is further concerned that access to maternal and infant health care remains poor, in particular in the Somali National Regional State of Ethiopia.

The United Nations Population Fund (UNPF) equally observes:⁷⁸

Most of the health facilities which are far from Addis Ababa are either not fully staffed with skilled service providers or fully equipped with the necessary supplies and equipment that can provide quality services related to complications during pregnancy and childbirth. Limited human resources, especially midwives, hamper efforts to provide adequate services, especially in rural areas. Gaps in training and remuneration have led to attrition and turnover among public sector health care professionals. Public facilities routinely suffer stockouts and obstetric care equipment shortages due to budget deficits and poor management.

The range of limitations above in terms of availability of health care facilities, goods and services restricts the full realization of children's right to health care and the underlying determinants of health care. Non-fulfilment of the right to health is the major cause of under-five mortality, and the unavailability of the health care facilities, goods and services would

⁷⁶ Interview conducted with Mr. Awol Hussein, Maternal and Child Health Expert, Oromiya regional state Health Bureau, 04 March 2015, Addis Ababa, Ethiopia.

⁷⁷ Committee on ESCR, Consideration of reports submitted by states parties under articles 16 & 17 of the Covenant: *Concluding Observations of the Committee on Economic, Social and Cultural Rights - Ethiopia* (31 May 2012), para 25, E/C.12/ETH/CO/1-3.

⁷⁸ Integrated Regional Information Networks (IRIN) 'Ethiopia: Still too many deaths in childbirth' available at: <http://www.irinnews.org/report/95356/ethiopia-still-too-many-deaths-in-childbirth> (accessed 23 May 2014).

significantly affect efforts to further reduce the rate of child mortality. Among other things, Ethiopia needs to intensify its efforts to improve availability of health goods and services, including through the allocation of increased resources and measures to address significant rural and urban disparities in health care provision.

5.3.3.2 Accessibility

Human rights law requires that health facilities, goods and services must be within safe physical reach for all sections of the population, economically affordable for all, must be accessible without discrimination and especially to the most vulnerable or marginalized sections of the population.⁷⁹ Despite this requirement, the country has a long way to go to comply fully with this obligation. As discussed below, studies reveal that coverage of basic health services and infrastructures in Ethiopia has been low and unevenly distributed.⁸⁰

The Ethiopian state is composed of different climatic and geographical settings, where exchange of goods and services and the maintenance of social networks are inherently fragile because of long distance, economies of scale and harsh environments. That this poses serious challenges to the delivery of health services is a well-documented mark of inequity in the country.⁸¹ Particular life style and health challenges exist owing to different geography and background. As a result, for instance, children born in the nomadic communities of the Afar regional state in Ethiopia face their own particular challenges. These communities move regularly with their livestock in quest of water, pasture and other resources, and often in remote areas at great distance from essential services such as health care. Access to the underlying determinants of health care, such as safe and potable water and adequate

⁷⁹ *General Comment No. 14* (n above 57) para 12(b).

⁸⁰ See, for instance, Y Berhan & A Berhan 'Commentary: Reasons for persistently high maternal and perinatal mortalities in Ethiopia: Part Iii–Perspective of the "Three Delays" model' *Ethiopian Journal of Health Science* (Special Issue) (2014) 142.

⁸¹ A Byrne *et al* 'What works? Strategies to increase reproductive, maternal and child health in difficult to access mountainous locations: A systematic literature review' (2014) 9:2 *PLoS One* 3. The full pdf text of this work can be found at: <http://www.plosone.org/article/abstract/doi:10.1371/journal.pone.0087683> & representation=PDF (accessed 12 March 2015).

sanitation facilities, and health care services is not within safe physical reach for most of the vulnerable communities in this region.⁸²

In addition, although the Ethiopian government provides public health services to the uninsured through the different public health institutions, inadequacies in these services have caused many poor Ethiopians to turn to private health services.⁸³ As the cost of private health care is high, this impedes poor families' ability to pay for other necessary health goods or has the result that families are eventually forced to go without health care. Consequently, women and children are at greatest risk in the hours during and following childbirth. Limitations on access to maternal and child health care contributes to a high infant mortality rate, high maternal death rates, and poor health for the surviving children.⁸⁴

Furthermore, despite the improvements made in expanding access to health services, the disease burden is still high and the service utilization rate remains low in the country, partly due to the burden of high out-of-pocket spending that restricts an already poor society from health care utilization.⁸⁵ A recent survey indicates that inaccessibility of transport, long distance from functioning health facilities, and lack of confidence in the services provided at health care facilities are some of the barriers that impede access to maternal health facilities.⁸⁶ Similarly, the 2011 EDHS study shows that the major barriers for pregnant women to access health services were lack of transport to a facility (71%), lack of money (68%) and distance to a health facility (66%).⁸⁷ Among the various reasons, the most important ones were the limited number of health facilities and medical personnel in the rural areas; and the fact that the few government and private hospitals available were constructed around the big towns while more

⁸² Anglican Overseas Aid 'Ethiopia: Maternal and child health' available at: <http://anglicanoverseasaid.org.au/our-work/ethiopia/ethiopia---maternal-and-child-health> (accessed 17 March 2015).

⁸³ VD Nair *et al* 'Private hospital sector development: An exploratory study on providers perspective in Addis Ababa, Ethiopia' 2010 21 *Ethiopian Journal of Health Science* (Special Issue) 60.

⁸⁴ *Ibid.*

⁸⁵ WHO 'African health observatory: Ethiopia' (n 68 above).

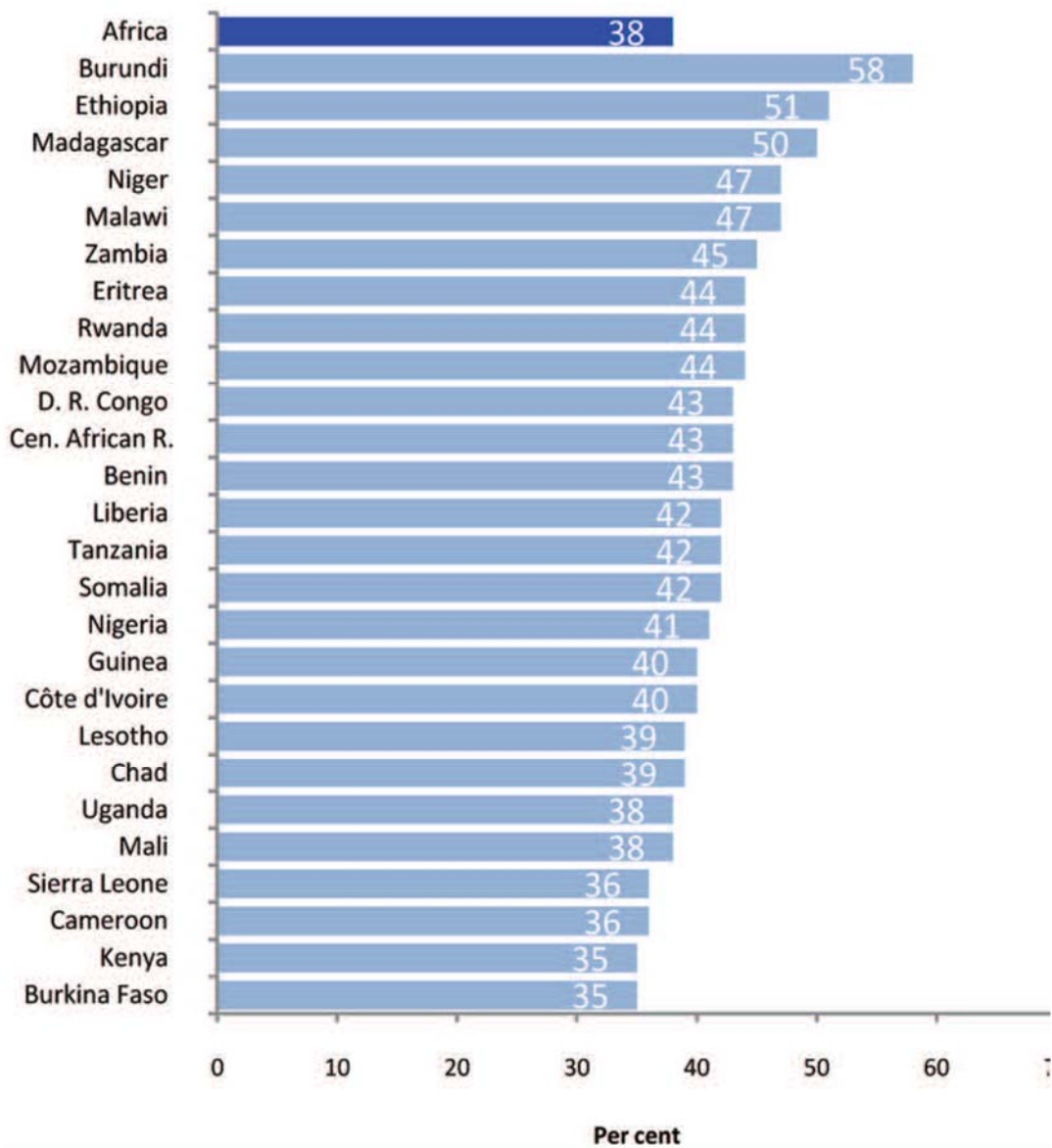
⁸⁶ See Berhan & Berhan 'Commentary: Reasons for persistently high maternal and perinatal mortalities in Ethiopia' (n 80 above).

⁸⁷ Central Statistical Agency (Ethiopia) & ICF International *Ethiopia Demographic and Health Survey 2011* (n 62 above) 132.

than 85% of the population live in the rural areas. The problem is worse in the rural parts and there is regional variation in terms of women's access to health care.

On the top of above, although child malnutrition has declined over the years, many children continue to suffer hunger in Ethiopia. Safe food is considered as one of the underlying determinants of the right to health and should be accessible to prevent malnutrition. The rate of Ethiopia's stunted children (caused by malnutrition) is above the average of other African countries as the table below depicts, although 30% of Africa's population itself suffers from malnutrition.

Figure 7: Prevalence of stunting in Africa (2006-2010)



Source: Africa's Children and the Post-2015 Development Agenda (ACPF, 2014)

Similarly, although there are marked improvements in coverage of access to child vaccination, to clean water, and improved sanitation, the progress remains slow. This is likely to have a negative impact on the reduction of under-five mortality rates.⁸⁸

⁸⁸ For instance, in an audit conducted by the Ethiopian Institute of Ombudsman (EIO) on the regional state of Somali, it was found that only 42% of children had access to vaccination in that particular regional state. It means that more than half of new-born children do not have access to vaccination. The audit was conducted in 2012 and is entitled 'Audit Report Conducted on the Somali national regional state as regards measures taken to reduce maternal and child mortality' (in Amharic language). As discussed in section 5.3.9 of this thesis, the ESCR

5.3.3.3 Acceptability

An important dimension of access to health care is its acceptability in society. More specifically, the acceptance of antenatal care and postnatal care services has a great deal of impact on major causes of infant death and significantly affects trends of mortality in a given population.⁸⁹ For this reason, an important component of efforts to reduce health risks of mothers and children is increasing the proportion of babies that are delivered in health facilities. Nevertheless, under-utilization of modern health care services for various reasons is one of the major challenges for poor health in the developing countries. In Ethiopia too, a very recent study indicates that close to 90% of birth delivery occurred outside of a health service facility for different reasons. 45% of births did not take place in a health facility because the mothers did not think that it was necessary, and for 33% of births, mothers stated that it was not customary.⁹⁰

The acceptance of health services to be delivered has a correlation with the socio-cultural situation of a country. Since Ethiopia is a populous nation constituting several diversities within, giving attention to the many cultural preferences of its people is a key to delivering the highest quality of care.⁹¹ It has been observed that the birthing position used at the health centers (which made the women feel uneasy) was one of the reasons for Ethiopian women choosing to deliver at home rather than at a local health center.⁹² It was later noted that more women felt comfortable coming to the health center for pre- and post-natal care after efforts were made to rectify their birth positioning. The incidence is indicative of the fact that, when government attempts to expand the health facilities, it will be equally crucial to train health care workers to understand and respect the culture of the local community.

Committee, in its Concluding Observation on Ethiopia (n 77 above) was concerned the high mortality rate of children in this regional state.

⁸⁹ N Regassa 'Antenatal and postnatal care service utilization in Southern Ethiopia: A population-based study' (2011) 11:3 *African Health Science* 390–397.

⁹⁰ Central Statistical Agency (Ethiopia) *Ethiopia mini-demographic and health survey 2014* (2014) 50.

⁹¹ The Borgen project 'Maternal and child health in Ethiopia' available at: <http://borgenproject.org/maternal-child-health-ethiopia/> (accessed 24 March 2015).

⁹² *Ibid.*

5.3.3.4 Quality

The final element of the right to health care that is interrelated with the other three mentioned above is quality. The requirement of quality includes that ‘health facilities, goods and services must also be scientifically and medically appropriate and of good quality’.⁹³ Despite this, the country’s quality of health goods and services, for instance, one relating to obstetric and newborn care services is low. Various factors contribute to the low quality of services, especially to the lower segment of the population in the country. Delay in providing treatment is usually the major reason for the poor quality of service.⁹⁴ In any country, health care service is conducted by a team involving staff with different backgrounds, such as administrative and support, clinical, laboratory, imaging and pharmacy staff. The reasons for the delay in giving treatment as early as possible may therefore be multifactorial. In the context of Ethiopia, the following are identified to be the main causes for delay in treatment. Firstly, the number of health professionals is insufficient and this shortage of well-trained health manpower takes the lion's share of responsibility for the delay in providing the medical care for those who have access to a health facility.⁹⁵ It is common to see only one or two midwives, one to three general practitioners and rarely one gynaecologist in hospitals in big towns (outside of Addis Ababa). Understaffing in these hospitals often leaves health professionals under work pressure which is likely to result in burn out and loss of interest to work with full energy. Secondly, the few available health professionals often exhibit poor knowledge and skill. This is associated with poor evaluation and lack of diagnostic skill or lack of qualified health professionals in the rural areas and in some occasions in big towns, which results in wrong diagnosis, leading to delay in getting timely treatment.⁹⁶ In some instances, it can lead to death of mothers or children. In one case, a two year old child had developed tonsillitis and the parents took the child for examination at Semera Health Post, in the national regional state of Afar.⁹⁷ The Nurse in charge prescribed a child amoxicillin pills and the child was taking the drug. However, in the next day

⁹³ *General Comment No. 14* (n 57 above) para 12(d).

⁹⁴ Berhan & Berhan (n 80 above).

⁹⁵ *Ibid.*

⁹⁶ *Ibid.*

⁹⁷ Interview conducted over a telephone with Mrs. Hawa Abdu, Maternal and Child Health Officer, Afar National Regional State Health Office, 26 February 2015, Addis Ababa, Ethiopia.

the child's entire body was found to be swollen and he had to be taken back to the health post. The health professional in charge on that particular day noticed the complication that the child had developed and referred him to a hospital in Dupti— a district in the regional state (Afar). Unfortunately, the child died by the time he reached the hospital. It was noted that the child would not have died had he been immediately referred to the hospital at early stage examination⁹⁸ and that prescription of the inappropriate drug given was purported to have exacerbated his condition.

In connection with the skill of health professionals, an assessment made of 19 hospitals in Ethiopia revealed that only about 40% of the health service providers knew how to prevent, identify, and manage common maternal and perinatal complications like obstructed labor, preeclampsia/eclampsia, postpartum haemorrhage, maternal sepsis, neonatal sepsis and newborn resuscitation.⁹⁹

The third cause for delay in treatment pertains to non-functioning health facilities, due to a lack of medical equipment, drugs, supplies, reagents, a blood bank, oxygen, magnesium sulphate and broad spectrum intravenous antibiotics that are essential to manage obstetric problems. The lack of these essential medical goods in laboratories, imaging facilities, delivery suites, and operating theatres further lowers the quality of treatment. Other factors that lead to delays in the timely provision of treatment for pregnant women are poor leadership in hospital settings, uncooperative behavior of patients or relatives who refuse medication, procedures, blood donation or blood transfusion, and the inability of patients or relatives to afford health service costs.¹⁰⁰

On top of above, although the health infrastructure has been rapidly expanding during the past one decade, the expansion in infrastructure networks has not matched the necessary quality requirements. Government celebrates success in the reduction of under-five mortality rates

⁹⁸ Ibid.

⁹⁹ Berhan & Berhan (n 80 above).

¹⁰⁰ Ibid.

mainly because of its political commitment to train and deploy the HEWs. In fact, these community health workers have widely been engaged to provide care for a broad range of maternal and child health issues. Nevertheless, the HEWs have not received sufficient practical training and lack skills in assisted delivery. HEWs are found to be weak in health facility deliveries, skilled birth attendance, and on-time referral through early identification of danger signs. In a recent study, more than half (54 %) of HEWs had poor knowledge about the contents of prenatal care counselling, and the majority (88 %) had poor knowledge about danger symptoms, danger signs, and complications in pregnancy.¹⁰¹

5.3.4 Participation at lowest ebb

The importance of participation, as one distinctive element of a rights-based approach in relation to the right to health, is underscored in chapter two.¹⁰² It is highlighted there that the ‘participation of the population in all health-related decision-making at the community, national and international levels is an important aspect of the right to health’.¹⁰³ In the context of under-five mortality, participation refers to granting parents of children, or other representatives, access to all relevant and necessary information to ensure an informed opinion, and including them in the decision-making processes which affect their children’s survival and health.¹⁰⁴ Equally, it requires empowerment of parents or other representatives to claim their rights and those of their children, and requires them to be able to participate in policy discussions and in processes that allow them to hold service providers to account.¹⁰⁵

In chapter four, I also examine the relevant Ethiopian laws on the right to participation. The right to participation has legal backing in Ethiopia, although the relevant provisions of FDRE Constitution and the Revised Family Code do not utilize similar wording to the CRC and ACRWC

¹⁰¹ A Medhanyie *et al* ‘The role of health extension workers in improving utilization of maternal health services in rural areas in Ethiopia: A cross sectional study’ (2012) 12 *BMC Health Services Research* 352, 1-9.

¹⁰² See, section 2.2.3.3.

¹⁰³ *General Comment No. 14* (n 57 above) para 11.

¹⁰⁴ UN Human Rights Council *Study by the World Health Organization on mortality among children under five years of age as a human rights concern* (n 59 above) para 64.

¹⁰⁵ *Ibid.*

governing the same matter. A useful question is whether the right to participation is given effect to and whether parents of children or other representatives participate in policy discussions that affect their children's survival and health. The situation on the ground shows that its implementation is at its lowest ebb.

I indicate at various sections in this thesis that women's and children's health are inextricably intertwined. Women's status in society, including their participation in decision making is important to partly inform health gains. The 2011 EDHS survey on the ability of women to make decisions that affect their own health care reveals that only 13 % of currently married women make their own decisions concerning their health care.¹⁰⁶ This figure shows that a small number of women in Ethiopia make decisions affecting their health. For obvious reasons, this negatively affects women's health rights and that of their children. It also demonstrates that if women have a lesser role to participate in decisions affecting them, then it is likely that they play no better role to participate in decision making by representing their children. Women's decision making power at household level, which includes also decision on matters of their health, has a direct effect in decreasing high mortality rates in children. Research conducted at Butajira Demographic Surveillance Site, Ethiopia, concluded that an effort to improve women's involvement in household decision making may contribute to decrease the high child mortality in a setting where levels of poverty are high and no appreciable trend in child mortality decline has been noted.¹⁰⁷

Another scenario where the implementation of the right to participation can be tested is children's or their representatives' participation in policy making affecting them. Here I focus on the extent to which children or their representatives are involved in the most overarching document of children's survival, i.e., the National Strategy for Child Survival of Ethiopia (2005). As I discussed in chapter four, section 4.5.3, this pertinent children's document was an

¹⁰⁶ Central Statistical Agency (Ethiopia) & ICF International (n 58 above) 253.

¹⁰⁷ M Fantahun *et al* 'Women's involvement in household decision-making and strengthening social capital: Crucial factors for child survival in Ethiopia' (2007) 96 *Foundation ActaPædiatrica/ActaPædiatrica* 582–589. The journal can be found at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2049066/pdf/apa0096-0582.pdf> (accessed 24 February 2015).

outcome of the recommendation of a conference conducted from 22-24 April 2004. More importantly, it is clearly stated in the Strategy that the document was prepared in partnership with the WHO, UNICEF, USAID, World Bank and CIDA. It shows that the Strategy was prepared in partnership with five global partners that are directly or indirectly mandated to promote reduction of child mortality as one of their mandates. Nevertheless, the Strategy fails to mention whether the participation of vulnerable or disadvantaged children in rural communities or their representative was included or their feedback heard and addressed in the preparation of the strategy. This conflicts with the FDRE Constitution's National Principles that require community participation as a fundamental component in the development of policies and strategies as discussed in section 4.4.3. Furthermore, despite the rhetorical acknowledgement of participation as a mechanism for enhancing children's rights to entitlement to provisioning of certain material things, much of children's rights activism in Ethiopia continues to emphasize a protectionist approach over rights that actually empowers children. This is mainly because the government does not have a well-developed culture of consultation in policy development and formulation. Generally, policy-making in Ethiopia is characterized by top-down processes.¹⁰⁸ Wolde also notes:¹⁰⁹

Public participation in policy making in the Ethiopian People's Revolutionary Democratic Front (EPRDF) Ethiopia has not so much had public empowerment significance as much as having instrumental value as propaganda. As a result, public participation in the policymaking process has not as yet generated any substantive outcome, precisely because participation is a channel to recruit support and solicit consensus for the policies that have unilaterally been formulated by the party and the executive. Nor has participation provided opportunities for genuine citizens' empowerment.

The above clearly indicates the challenges that citizens are facing in realizing their right to public participation in policy making processes. For one thing, this emanates from the fact that the government is taking an unnecessarily paternalistic approach and does not seem to opt to

¹⁰⁸ See for instance, Ethiopian Economic Association 'Policy making in a federal context: Views from the regions on future agricultures in Ethiopia' available at: <http://www.eeaecon.org/node/5012> (accessed 12 March 2015).

¹⁰⁹ M Wolde 'A critical assessment of institutions, roles and leverage in public policy making: Ethiopia, 1974-2004' *unpublished DPhil Dissertation, Stellenbosch University, 2005* 256.

live with the democratic values of public participation in policy making. This can be inferred, for example, from the country's recently deceased Prime Minister Meles Zenawi's speech during his reaction to an opposition member's inquiry on a land program issue in a parliamentary plenary session. The Prime Minister confirmed his unflinching stand on government policies, saying that: 'Any compromises on such programs as land can only be made on the corpse of the EPRDF'.¹¹⁰ This illustrates that policy or strategy making is mostly the result of government and party-induced participation, which has invariably been structured, monopolistic, and corporatist.¹¹¹

As I discuss in section 4.4.3 of chapter four, the Revised Family Code makes reference to children's rights of participation and the right to have their voice heard in some settings mainly before courts. However, children are not being given the opportunity to express themselves and have their voice heard in accordance with their age and maturity in matters affecting their rights, including in the area of health.¹¹² This is mainly because the community undermines children and due to lack of awareness in the community, in families and in governmental as well as non-governmental organizations.

Another factor for the low level of participation of children in matters affecting their health is an absence of representatives of their interest. This can be related to the role of NGOs. NGOs working on children's matters could play a paramount role in participating in policy formulation and discussion, more importantly, in a country like Ethiopia where a significant portion of particularly the rural population lacks knowledge of the impact of various policies. However, as discussed more fully in sections 5.3.6 and 5.3.9, there is a restrictive environment for human rights NGOs to engage in the promotion and protection of children's or women's rights. 'Foreign' or 'Ethiopian Resident' NGOs are prohibited from participating in a plethora of essential activities reserved exclusively for 'Ethiopian' Charities/Societies, including the promotion of children's rights and the advancement of human and democratic rights. Equally, the participation work of 'Ethiopian' Charities/Societies in the promotion of children's and

¹¹⁰ Ibid., 233.

¹¹¹ Ibid.

¹¹² Federal Ministry of Women, Children and Youth Affairs *National Child Policy* (draft) (April 2011) 4.

other human rights is hampered as the CSO law requires to abdicate almost all of their funding (90%) from foreign sources, in which case they are unable to run their day to day activities with the funds generated from the local sources solely. In short, repressive restrictions on freedom of expression, assembly and association have posed further obstacles to their participation in the country.

In addition, the country's citizenry is highly disorganized and tied up with attending to issues of livelihood, which, as a result, leaves little room for them to participate actively in articulating policy demands and holding government institutions accountable and responsive.¹¹³ It was noted earlier that any meaningful rights-based approach to the reduction of child mortality requires prior consultation of the children's parents or their representatives in the community, and a system that acknowledges the added value of human rights NGOs in policy advocacy. Nevertheless, this does not seem to be addressed in practice by the state.

5.3.5 Insufficient data on children – Weak vital registration systems

According to the former UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, inclusive in his definition of a 'rights-based health system' are the collection of national systems of disaggregated data and the use of human rights-based indicators.¹¹⁴ Despite this, the Ethiopian state lacks fully functioning vital registration systems that accurately record all births and deaths contrary to the requirements of a proper functioning health system. Critical among the obligation of states to ensure implementation of children's rights is their duty to collect sufficient and reliable data on children.¹¹⁵ Disaggregated data is essential, most importantly, for identifying and remedying inequalities in health. Similarly, it provides useful information on how the right to health is realized in a particular country. The national health system must therefore offer an adequate

¹¹³ *Ibid.*, 194-233.

¹¹⁴ P Hunt 'The UN Special Rapporteur on the right to health: Key objective, themes, and interventions' (2003) 7:1 *Health and Human Rights* 1–27; P Hunt *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health A/HRC/7/11* (2008).

¹¹⁵ CRC Committee, *General Comment No. 5* (n 50 above) para 48.

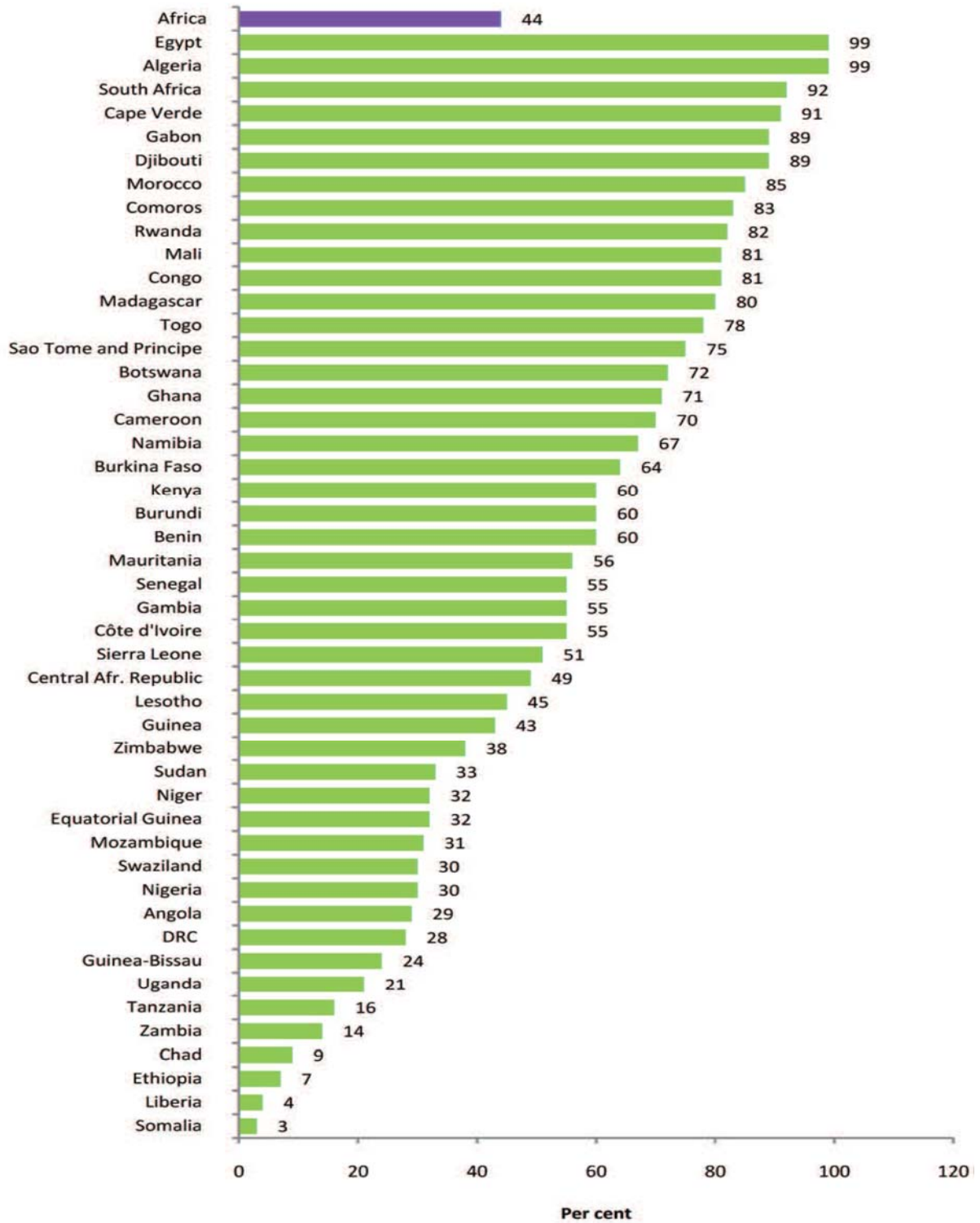
system, with disaggregated data, such as the number of under-five births and deaths, in order to help target areas or populations that are underserved or that have particularly poor health outcomes.

In connection with maternal and child mortality, vital registration systems are the preferred source of data because they collect information as events occur and they cover the entire population.¹¹⁶ Again, such system is preferred for generating accurate estimates of child mortality, which is a considerable challenge due to limited availability of high-quality data. When vital registration coverage is complete and the systems function efficiently, the resulting child mortality estimates will be accurate and timely. Put differently, under-five mortality estimation is challenging in the absence of complete vital registration systems.

Ethiopia is short of fully functioning vital registration systems that accurately record all births and deaths. The figure below depicts that Ethiopia is the third at the bottom of African countries in terms of least birth registration percentages of under-five children.

¹¹⁶ WHO *Monitoring maternal, newborn and child health: understanding key progress indicators* (2011) 5.

Figure 8: Birth registration: %age of children less 5 years old who were registered in Africa (2000-2010)



Source: Africa's Children and the Post-2015 Development Agenda (ACPF, 2014).

In a bid to curb the problem of unavailability of proper vital registration systems, the Ethiopian government (through EDHS) uses household surveys to measure the rate of mortality.¹¹⁷ These surveys, interview women about the survival of each birth at the time of the interview. Unfortunately, such data are based on predictions using statistical models. It may suffer from data errors (for instance sampling and non-sampling errors). It, thus, could not necessarily indicate the actual figure.

The independent monitoring of progress in terms of the implementation of the rights of children is vital. Nevertheless, the absence of proper data collection systems makes the assessment of the extent to which the rights of children have been realized impossible. The lack of disaggregated data makes it difficult to identify the actual disparity. Once more, the country does not, currently, have an annual publication of a comprehensive report on the state of children.¹¹⁸ Regardless of the clear legal provisions of the 1960 Civil Code¹¹⁹ of Ethiopia, the 2000 Revised Family Code¹²⁰ of Ethiopia and the 2012 Proclamation for the Registration of Vital Events and National Identity Card,¹²¹ which have articulated the need to establish a national birth registration system, an effective office necessary to carry out the task of registration is not yet properly set up throughout the country. An appropriate vital statistics registration system has not yet been installed. As a result of this failure, children's right to have a name and nationality, the right to know parents and get their care, the right of the child to be protected against abuse and exploitation, and the right of access to social services have not

¹¹⁷ Three Demographic and Health Surveys have been conducted in Ethiopian health system history - in 2000, 2005 and 2011. Chapters 2 & 3 of these EDHSs deal with household populations, and characteristics of survey respondents. Ethiopia has recently issued mini DHS end of 2014, and in this document too, same chapters are dedicated for household populations, and characteristics of survey respondents.

¹¹⁸ UNICEF Ethiopia *Child protection systems mapping: The case of Ethiopia* (2010) 30.

¹¹⁹ Article 3361 (1) of the Ethiopian Civil Code (1960) provides for the registration of civil status to be established through Order. The law that establishes organs for registration of civil status came to be through Proclamation No. 760/2012.

¹²⁰ Similar to the Civil Code provision mentioned herein above, article 321 of the Revised Family Code targets the possibility of establishing of registration when it proclaims as follows: 'The Federal Government shall, within six months from the coming into force of this Code, issue registration law applicable to the Administrations where this Code is to be enforced and establish the necessary institutions.'

¹²¹ Articles 5 & 6 of Proclamation No. 760/2012 urges for the establishment of appropriate federal and regional organs to, among other things, direct, coordinate and support the registration of vital events. Prior to 2012, there was no clear legal framework for civil registration and vital statistics.

been properly addressed. It is in cognizance of this difficulty that the Committee on the Rights of the Child has made recommendation for the country to improve birth registration and to strengthen its system of collecting disaggregated data in particular in the areas indicated above.¹²² The availability of data and in particular disaggregated data is of paramount importance for the purpose of designing policies for the implementation of children's right to health or their survival rights provided for in the CRC and ACRWC.

5.3.6 Non-transformative civil society

Civil Society Organizations (CSOs) have become important and effective mechanisms, most importantly, in explaining various social movements, promoting and protecting human rights, poverty reduction, sustainable development practices, and in peace building discourses. CSOs, taking forms such as human rights NGOs or sometimes referred as human rights defenders, play a proactive role not only in creating human rights awareness among the people but also in instituting cases on behalf of victims of human rights violations. The role of these NGOs is particularly crucial in resorting to constitutional litigation to advance social and legal change.¹²³ London notes that a human rights approach backed by social mobilization is one that has transformative potential.¹²⁴ In the previous chapter, I discuss in the relevant section that almost all landmark social-economic rights cases in South Africa were litigated by human right NGOs.¹²⁵ Wyngaard equally maintains that 'socio-economic rights enshrined in the South African Constitution would be out of reach for most South Africans if not for the presence of a vibrant

¹²² Committee on Rights of the Child, *Concluding Observations of the Committee on the Rights of the Child* (Ethiopia), 1 November 2006, para 14, CRC/C/ETH/CO/, available at: <http://www.unhcr.org/refworld/docid/45c30bd60.html> (accessed 10 February 2015).

¹²³ For an elaborate engagement on the role of human rights NGOs on public/social interest litigation, see H Hershkoff & A McCutcheon 'Public interest litigation: An international perspective' in M McClaymont & S Golub (eds) *Many Roads to Justice* (2000) 96-97; YM Badwaza 'Public interest litigation as practised by South African NGOs: Any lessons for Ethiopia?' *unpublished LLM thesis, University of Pretoria*, 2005 40; A Abebe 'Towards more liberal standing rules to enforce constitutional rights in Ethiopia' (2010) 10 *African Human Rights Law Journal* 413-414, 416

¹²⁴ L London 'What is a human-rights based approach to health and does it matter?' (2008) 10:1 *Journal of Health and Human Rights* 170. Available at: <http://www.hhrjournal.org/2013/09/13/what-is-a-human-rights-based-approach-to-health-and-does-it-matter/> (accessed 03 March 2015).

¹²⁵ See section 4.6.4.

and active non-profit sector'.¹²⁶ Although there is a current trend coming from South African government factions that criticize the role of this sector, NGOs play a vital part in assisting the government to fulfill its constitutional mandate. South Africa's Treatment Action Campaign (TAC) can be considered an obvious illustration of this. As noted earlier in the *Minister of Health and Others v Treatment Action Campaign and Others*¹²⁷ case, the success of this case has increased the survival rates of new-born children in South Africa as more anti-retroviral drugs were distributed to many victims of HIV following the South African Constitutional Court decision in this land mark case.¹²⁸

In the context of Ethiopia, the transformative potential of NGOs for the realization of children's right to health or their other rights, through judicialisation, is unknown or unclear at best. In chapter four, I examine the current challenges and risks that the civil society is facing in Ethiopia to engage in right to health litigation and litigation with respect to other human rights issues of children and women. Owing to the Charities and Societies Proclamation (CSO law),¹²⁹ CSOs operate in a very restrictive environment and many of them work under the fear of being struck from the registry and having their funds under risk tied up. This seriously constrains their legitimate work and hinders the effective promotion and protection of children's right to survive or their other human rights.

In a recent incident, for example, bank accounts of human rights defenders were frozen after the introduction of the CSO law.¹³⁰ As discussed in chapter four,¹³¹ the CSO law prohibits human rights organizations in Ethiopia from receiving more than 10 % of their funding from foreign sources, although a plethora of international funding and support is available to support

¹²⁶ R Wyngaard 'The South African NPO crisis - time to join hands', SANGO Pulse, 12 March 2013, available at: <http://www.ngopulse.org/article/south-african-npo-crisis-time-join-hands> (accessed 23 July 2014).

¹²⁷ *Ministry of Health v Treatment Action Campaign* (TAC) (2002) 5 SA 721 (CC).

¹²⁸ See, for instance, Section 2.3.2.

¹²⁹ The CSO law is special legislation adopted by the Ethiopian parliament in 2009 to regulate domestic and international civil society organizations. See Proclamation to Provide for the Regulation and Registration of Charities and Societies, No. 621/2009.

¹³⁰ International Service for Human Rights (n 138 below).

¹³¹ See section 4.6.4.

human rights advocacy.¹³² This has deeply affected the ability of national and international organizations to work in the field of human rights. As a result, the majority of independent Ethiopian CSOs working on human rights issues have had to discontinue their work. In 2012, the Office of the United Nations Human Rights Council indicates that out of 127 organizations that advocated for human rights in Ethiopia before the CSO Proclamation enactment, only very few reportedly still operate.¹³³ Consequently, independent human rights activity has almost completely ceased in Ethiopia.¹³⁴ The CSO law has been subjected to legitimate criticism for failing to meet international human rights standards.¹³⁵

The case of the Ethiopian Human Rights Council (EHRCO) or Human Rights Council (HRCO) is taken here as an example to illustrate how the CSO law has crippled the operation of NGOs. The HRCO has been the leading human rights voice in the country since its establishment in 1991.¹³⁶ It has also a strong track record of investigating and reporting on violations and promoting human rights in the country. In December 2009, the Charities and Societies Agency (ChSA), a new regulatory body established under the CSO law, granted HRCO its license as an Ethiopian charity. However, in a letter dated three days before the registration, the ChSA ordered four private banks to freeze all of HRCO's assets, including its private bank accounts

¹³² CSO Law, articles 2(2), 2(15) (defining 'income from foreign source' as a donation or delivery or transfer made from foreign source of any article, currency or security. Foreign sources include the government, agency or company of any foreign country; international agency or any person in a foreign country).

¹³³ See, for instance, UN Human Rights Council, *Report of the Special Rapporteur on the rights to freedom of peaceful assembly and of association, Addendum: Mission to Kazakhstan*, 16 June 2015, para 69 A/HRC/29/25/Add.2.

¹³⁴ Human Rights Watch 'Ethiopia: Future of last remaining human rights monitoring NGO in the balance', Joint Press Statement February 1, 2012, available at: <http://www.hrw.org/news/2012/02/01/ethiopia-future-last-remaining-human-rights-monitoring-ngo-balance> (accessed 3 November 2014).

¹³⁵ Over the past 6 years such criticism speak volumes from governments, such as the US, and global and regional organizations, for instance the UN and African Human Rights Commission. It also receives protests from globally recognized human rights organizations, as the Amnesty International and Human Rights Watch. The International Center for Not-for-Profit Law (ICNL) describes the law as 'one of the most controversial NGO laws in the world'. Comments on this law can be found in, M Zeleke 'Civil society and freedom of association threatened?: A critical examination of Ethiopian charities and societies law' *unpublished Msc thesis, University of Oslo*, 2010 31-49; Human Rights Watch 'One hundred ways of putting pressure: Violations of freedom of expression and association in Ethiopia' (2010) 44, available at: <http://www.hrw.org> (last accessed 20 May 2015); International Service for Human Rights (ISHR) 'The situation of human rights defenders in Ethiopia' available at: http://www.ishr.ch/sites/default/files/article/files/ethiopia_ishr_briefing_on_hrds.pdf (accessed 16 June 2015).

¹³⁶ *Ibid.*

and reserve funds.¹³⁷ As a result of the restrictions in the CSO law and the freezing of its accounts, HRCO has been forced to cut 60 of its staff and continue with only 15 staff members, and to close nine out of its twelve offices. In addition, in August 2012 the ChSA used the CSO law to prohibit fundraising activities by the HRCO. In February 2013, it also banned three other NGOs.¹³⁸

Following the freezing of its bank accounts, the HRCO challenged the lawfulness of the freezing to the Board of the ChSA, and subsequently to the Federal High Court in April 2010. The High Court upheld the decision of the regulatory body on 24 October 2011.¹³⁹ The HRCO then petitioned to the Federal Supreme Court, the highest adjudicating body in the country, to hear its appeal against the decision of the Federal High Court. In October 2012 the Supreme Court upheld a 2010 ChSA decision to freeze US\$1 million in assets of the Human Rights Council and that of the Ethiopian Women Lawyers Association. The Court's decision marks a further erosion of the work of human rights defenders in the country.

The voicelessness of Ethiopian CSOs can best be seen, in current times, in the light of the recent xenophobic violence that erupted again in South Africa, for the second time since 2008. The recent attacks occurred in April 2015 killed at least three foreigners – unluckily three of them were alleged to be Ethiopians. Three policemen were also claimed to have died during the violence. The violence was condemned from many different quarters. One such attempt was made by the Southern Africa Litigation Centre – a South African based NGO. On 23 April, 2015, this NGO wrote an open letter to the African Commission on Human and Peoples' Rights concerning the attack and calling upon the government of South Africa to take concrete steps to prevent such attacks, prosecute perpetrators, protect foreign nationals and prevent the

¹³⁷ Ibid.

¹³⁸ International Service for Human Rights 'The situation of human rights defenders in Ethiopia' available at: http://www.ishr.ch/sites/default/files/article/files/ethiopia_-_ishr_briefing_on_hrds.pdf (accessed 24 March 2015).

¹³⁹ Amnesty International *Stifling human rights work: The impact of civil society legislation in Ethiopia* (2012) 16; 'Ethiopia: Women lawyers Denied of access to foreign funds' (14 November 2011) available at: <http://Allafrica.Com/Stories/201111150689.Html> (accessed 01 May 2015).

mass coerced exodus of foreign nationals from the country.¹⁴⁰ The letter was signed by 129 concerned CSOs based in and working on human rights issues in the African continent. Nevertheless, no single Ethiopian registered CSO signed this letter, whereas by comparison at least three or more CSOs have signed from other African countries, such as Kenya, Malawi and Nigeria.

The foregoing reveals the legal and practical challenges that undermine the independent operation of CSOs in Ethiopia. Compounded by strict vested interest rules for representing a claim, the challenges severely restrict the possibility that CSOs can be deployed to realize children's rights through litigation.

5.3.7 Budgeting

Budgeting for children is primarily about public money for children. It also has a sound human rights law basis. The rights enshrined in the human rights instruments discussed in chapter three automatically put a budgetary obligation on state parties for their implementation. The identification of the proportion of the national and other budget assigned to the social sector, and within that, to children is significant to the determination of the measures taken by a state to fulfil the social, economic and cultural rights of children. However, the fact that budgeting is a politically charged process makes it hard for children to influence the process or make their legitimate claims on resources as they are less vocal, despite the fact that they constitute demographically sizable sections of any population.¹⁴¹

¹⁴⁰ Southern Africa Litigation Centre (SALC) 'Open letter to the African Commission regarding the Xenophobic attacks in South Africa' available at: <http://www.southernafricalitigationcentre.org/2015/04/23/open-letter-to-the-african-commission-regarding-the-xenophobic-attacks-in-south-africa/#> (accessed 2 May 2015); Centre for Human Rights 'Statement by the Centre for Human Rights, University of Pretoria, to the 56th ordinary session of the African Commission on Human and Peoples' Rights, Banjul, the Gambia, 22 April 2015' available at: <http://www.chr.up.ac.za/index.php/centre-news-a-events-2015/1469-statement-by-the-centre-for-human-rights-university-of-pretoria-to-the-56th-ordinary-session-of-the-african-commission-on-human-and-peoples-rights-banjul-the-gambia-22-april-2015.html> (accessed 3 May 2015).

¹⁴¹ MA Kabore & Y Lee, Preface to ACPF *Budgeting for children in Africa: Rhetoric, reality and the scorecard* (2011) viii.

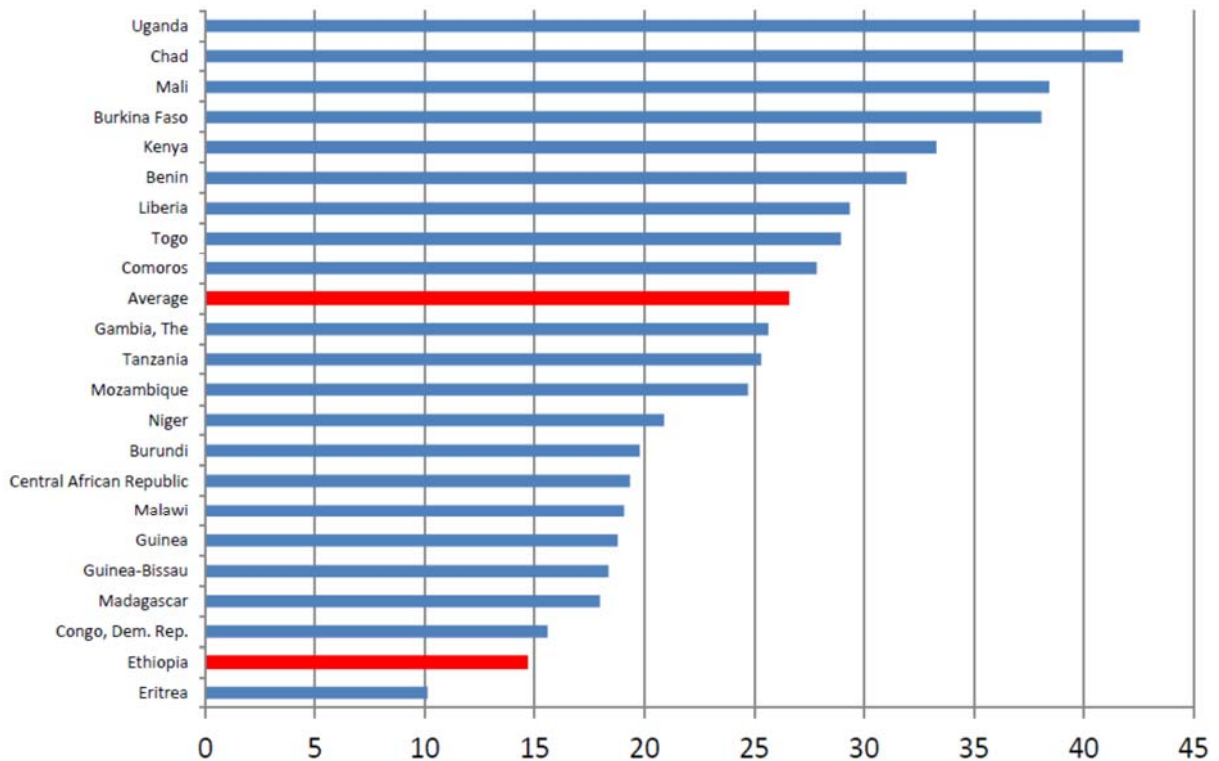
Generally, expenditure on health in Ethiopia has steadily increased over time. Four rounds of NHA show a continued increase in total health expenditure over the years.¹⁴² Per capita spending on health increased from US\$5.6 to US\$16.09 between 1999/00 and 2007/08. As detailed in the fourth round of NHA for 2007/08, the three major financing sources for health in Ethiopia are (a) external assistance, at 39 %; (b) out-of-pocket expenditure, at 37 %; and (c) the government budget, at 21 %. Both public and private financing has increased over the years.¹⁴³ However, spending on health as a proportion of the GDP has remained relatively flat at around 5 % during the same period. Moreover, according to a WHO 2013 report, Government Health Expenditure (GHE) in most African countries is small.¹⁴⁴ Unluckily, the Ethiopian government's financing of the health sector is comparably smaller to those African countries that are recognized as spending less. As the below data reveals, Ethiopia's spending on health is below the average of the Per Capita Expenditure on Health in US\$ in low-income sub-Saharan Africa countries.

¹⁴² Workie & Ramana (n 35 above) 4.

¹⁴³ FDRE MoH & Abt Associates (2010).

¹⁴⁴ The amount ranges from US\$ 4 to US\$ 486 per capita with 17 countries, spending less than US\$ 15 per person per year, 18 countries spending between US\$ 15 to US\$ 45 while only 11 countries have GHEs above US\$ 50. See 'Ending preventable maternal and child deaths in Africa', Provisional agenda item 6 (AU), (AUC/WHO/2014.DOC.4), para 14, available at: www.afro.who.int/index.php?option=com_docman&task (accessed 2 May 2015).

Figure 9: Per capita expenditure on health in US\$ (Low-income sub-Saharan Africa countries)



Source: World Health Summit, 2010

In addition to the above, the limited spending made on health by the government of Ethiopia is not distributed proportionally across all segments of the population in the country. Put differently, there is a great variation in the level of per capita health expenditure across regions of the country.¹⁴⁵ Although each region's per capita health expenditure has increased over the five-year period covered by the figure, the variation across regions is visible. To take an example, in 2009/2010, among all regions, per capita government health expenditure in Harari (Birr 133.1, US\$10.30) was almost five times that of Amhara (Birr 27.1, US\$2.10).¹⁴⁶ This variation could, however, be justified by the small size of the population in Harari relative to that in Amhara and the consequent high unit cost of service provision there (economies of scale).

¹⁴⁵ Workie & Ramana (n 35 above) 7.

¹⁴⁶ Ibid.

Concerning children, Ethiopia's government budgetary commitment follows no different approach than the trend indicated above. The Committee on Rights of the Child welcomed incremental allocation of budgets for children's health and education.¹⁴⁷ However, it expressed its concern over the inadequacy of the budget allocated for the implementation of the *National Plan of Action for Children (2003-2010)*. Although under-five child mortality has reduced due to the incremental increase in budgets, public spending on health remains very low in the country.¹⁴⁸ Also, there is no specific fund budgeted to promote and protect children's health,¹⁴⁹ unlike the annual budget approved in other sectors such as military expenditure.

Overall, Ethiopia's government spending on health as a proportion of GDP remains non-progressive. Financing of the health of children is not in tandem with the stipulated priorities. This reflects that the political rhetoric has seldom found its way into the budget. The metaphor 'a rising tide lifts all the boats' does not seem to work in Ethiopia, as the growth of the economy doesn't implicate a proportional increase in budget allocation for health infrastructure development of the country. The government should examine the budget-making processes under a 'child rights lens', as a matter of standard procedure.

5.3.8 Loose coordination

The CRC stipulates as to the obligation of state parties to take 'all appropriate... administrative and other measures...' with a view to effective implementation of children's rights.¹⁵⁰ The Committee on CRC further interprets this provision to include states parties' obligation to ensure visible cross-sectoral coordination exists between different levels of government, such as between federal and regional levels of government, and between government and civil society in their domestic settings.¹⁵¹ Securing better coordination across health-related sectors

¹⁴⁷ Committee on Rights of the Child (CRC), *Concluding Observations (Ethiopia)* (n 122 above) para 16.

¹⁴⁸ UNICEF *Government of Ethiopia: Report on progress in implementing the world fit for children plan of action in Ethiopia* (June 2007) 11, 70; Workie & Ramana (n 35 above).

¹⁴⁹ Interview conducted with Dr. Lisanu Tadesse, member of the Child Health Case Team at the FDRE MoH, 11 February 2015, Addis Ababa, Ethiopia.

¹⁵⁰ CRC, article 4.

¹⁵¹ R Hodgkin & P Newell *Implementation Handbook for the Convention on the Rights of the Child* (2007) 55.

helps foster the promotion and protection of children's right to survival and their complementary rights. Despite this requirement, the current coordination among the various sectors that deal with children's rights affairs in Ethiopia is relatively weak.

As I examine in chapter four, one of the mandates given to the MoWCYA is to coordinate, at the national level, all stakeholders that are saddled with respective responsibilities to protect the rights and well-being of children.¹⁵² Similarly, there are Women, Children and Youth Affairs Bureaus at regional, zonal and *woreda* level that have the mandate to protect children's rights.¹⁵³ Furthermore, in the same chapter, I also singled out the various stakeholder ministerial offices that are mandated to promote and protect children's rights in the country.¹⁵⁴ By conferring such powers and duties on these executive organs, the legislation which defined the power and duties of these offices, offered an abundant opportunity for greater guidance and coordination of the offices. It also indicates that the law envisions that implementation of children's rights requires a holistic approach where roles and responsibilities assigned to the stake holder public offices has a special place with regard to implementation of the various children's rights including their survival rights.

Despite its mandate to coordinate the various children's rights implementing departments and agencies, the operationalization is affected by many challenges. Absence of accountability mechanisms is the major obstacle caused by uncoordinated efforts to ensure respect of the right and welfare of children.¹⁵⁵ Owing to lack of collaboration among different stakeholders at different levels, the required success in ensuring the respect of the right and welfare of children has not been achieved. It also contributed to the expansion of multiple problems of

¹⁵² Definition of Powers and Duties of the Executive Organs of the Federal Democratic Republic of Ethiopia Proclamation No. 691/2010, article 32(9). See, also, section 4.6.7.

¹⁵³ *Combined 4th and 5th Periodic Reports of the Federal Democratic Republic of Ethiopia to the United Nations Committee on the Rights of the Child (2006 – 2011)* (April 2012). The html version of the report is available at: <http://www2.ohchr.org/english/bodies/crc/docs/CRC.C.ETH.4-5.doc>. (accessed 30 October 2014).

¹⁵⁴ See sections 4.6.5, 4.6.8 & 4.6.9.

¹⁵⁵ See *National Child Policy* (n 112 above) 7.

children. Besides, it is also argued that this problem affects the possibilities that children's issues would have been incorporated into policies and programs of the government.¹⁵⁶

In regard to coordination, the Committee on CRC has also noted that the MoWCYA lacks sufficient resources and the ability to establish coordination in all parts of the country.¹⁵⁷ The ministry does not have a properly established office with adequate manpower and other office logistics which would enable it to run its activities. Also, in an interview conducted with the Head Coordinating Children's and Women's Affairs at this ministerial office, Mr. Tilahun GebreTsadik, mention was made of the efforts being exerted to achieve strong coordination between child rights implementing bodies within the country.¹⁵⁸ However, Mr. Tilahun admitted that this could not reach up to the level expected, for various reasons, such as inadequate inter-sectoral linkages and coordination within the various public and private offices responsible for implementation children's rights. He more specifically mentioned that the vertical and horizontal interfaces between federal and regional structures of people-focused institutions are weak; lack clarity regarding accountability for children's rights and there prevails fragile institutional capacity to implement children's rights.¹⁵⁹ The ministry has established a Directorate of Child Rights Promotion and Protection at the national level. Nevertheless, this Directorate lacks sufficient resources, including man power and this has reduced its ability and efficiency to establish coordination at the regional, zone and *woreda* level.¹⁶⁰ This is basically attributable to lack of knowledge, high staff turnover, lack of communication and overlapping mandates among the different organs for the realization of the rights of children.¹⁶¹ There are also other issues that complicate for attaining the desired

¹⁵⁶ Ibid.

¹⁵⁷ Committee on Rights of the Child (CRC), *Concluding Observations* (Ethiopia) (n 122 above) para 10.

¹⁵⁸ Interview conducted with Mr. Tilahun GebreTsadik, Head Coordinating Children's and Women's Affairs at the Federal Democratic of Republic of Ethiopia MoWCYA, 13 February 2015, Addis Ababa, Ethiopia. Also, similar response was obtained from an interview conducted with Mr. Kibre Hailu, Child Protection Office, MoWCYA, 17 February 2015, Addis Ababa, Ethiopia.

¹⁵⁹ Ibid.

¹⁶⁰ UNICEF *Child protection systems mapping: The case of Ethiopia* (2010) 28; Committee on Rights of the Child (CRC) *Concluding Observations* (Ethiopia) (n 122 above) para 10; See, also, G Aneme & Y Birmeta *Handbook on the Rights of the Child in Ethiopia* (2012) 32.

¹⁶¹ UNICEF *Child protection systems mapping: The case of Ethiopia* (n 160 above) 31.

level of coordination, such as conflict of jurisdiction between federal and local entities that can both be highlighted and resolved over time.

In addition, in areas such as child abuse and exploitation and gender-based violence, research conducted by Save the Children shows that the different sectors dealing with child sexual abuse such as ‘the police, the court, the prosecution office, the hospital, the education office and NGOs often work in parallel with no or little information on who is doing what’.¹⁶² It has happened that each sector has a different strategy that resulted in lack of coordination and fragmented action.¹⁶³ Although attempts have been made to adopt a multi-sector child friendly approach to address this problem in the Oromiya regional state, Addis Ababa, and the SNNPRS, the coordination does not expand up to the local level in every part of the country.

Moreover, the manner in which the coordination activities are structured contributes to the imperfection of coordination. As noted above, at the federal level, the coordination of activities for the realization of the rights of children is vested within the MoWCYA. However, in many regional states the mandate to coordinate such activities is vested with the Labor and Social Affairs Offices or other offices.¹⁶⁴ For instance, in the Tigray regional state, unlike the Addis Ababa City administration and some other federal units, the mandate for coordinating the implementation of children’s rights is conferred upon the region’s Labor and Social Affairs Office.¹⁶⁵ This absence of interface between the federal and regional counterparts not only poses a challenge to effective coordination but also has led to complication in terms of allocation of budget. Overall, these limitations thus have an adverse effect upon the implementation of children, women and youth rights.

¹⁶² Ibid., 28; Save the Children *Building rights-based national child protection systems: A concept paper to support Save the Children’s work* (2010) 13.

¹⁶³ Save the Children, as above.

¹⁶⁴ Aneme & Birmeta *Handbook on the Rights of the Child in Ethiopia* (n 160 above) 33.

¹⁶⁵ Interview conducted with Mr. GebreMichael Workineh, Social and Labour Affairs Officer, at Tigray regional state 03 March 2015 in the Oromiya regional state capital, Adama, Ethiopia. I met him for interview while he was participating in training at the said place.

5.3.9 Accountability

Shortfalls have occurred not because the goals are unreachable, or because time is too short. We are off course because of unmet commitments, inadequate resources and a lack of focus and accountability.¹⁶⁶

The above was a statement by United Nations Secretary-General Ban Ki-moon in a press release SG/SM/12789, dated 16 March 2010. He, among other things, emphasises accountability as cornerstone to better achieve commitments to development goals, such as reduction of child and maternal mortality. It is also underscored in this thesis that accountability is central in a rights-based approach and its impact to further reduce or eliminate under-five mortality or to improve health gains of children or women. In section 2.2.3.5, I also provide an illustrative account of the multifaceted accountability mechanisms which have a pivotal role to ensure protection and promotion of children's rights. I further underline there how these mechanisms can help remove barriers to health service access, and serve to extend the opportunities for rights-fulfilling services to groups of children and women who may otherwise have been excluded. I also highlight how accountability can have far reaching effects in the strengthening of health systems and transforming the rights discourse into practical health policy and programming. Numerous practical examples and case studies are provided there.¹⁶⁷

Arguably, the different types of accountability mechanisms discussed in chapter two are indeed recognized also in Ethiopian laws and policies.¹⁶⁸ One such accountability mechanism is *monitoring* and *evaluation*. Ethiopia has a national monitoring and evaluation framework for child survival programs enshrined in the National Strategy for Child Survival. It provides for selected indicators, source, and level of collection and responsibility for monitoring and

¹⁶⁶ United Nations 'Meetings coverage and press releases' available at: <http://www.un.org/press/en/2010/sgsm12789.doc.htm> (accessed 9 March 2015).

¹⁶⁷ See, for instance, sections 2.2.3.5 & 2.3.2.

¹⁶⁸ The FDRE Constitution (1995) sets out the principles determining the conduct and accountability of government, setting out the requirement of government to be transparent and its officials (and elected representatives) accountable. See, the FDRE Constitution, Proclamation No. 1/1995, *Federal Negarit Gazeta*, 1 Year No.1, article 12.

evaluation of the implementation of the Strategy.¹⁶⁹ However, this monitoring and evaluation system can be criticized as ineffective. Firstly, the Strategy mainly focuses on governmental evaluation and monitoring mechanisms. It ignores the possibility that citizen- or community-led accountability systems can help identify gaps and inadequacies in service delivery or to track progress towards service coverage, quality of care, and impact on children's survival. Secondly, no mention is made in the Strategy as to how and against which body/person accountability can be enforced to ensure remedies in case of identification of failures. This would have strengthened constructive accountability for unfulfilled goals and targets. The manner in which the Strategy is crafted in this regard is a clear indication that the Strategy was not developed from a rights perspective, as such an approach gives particular attention to identification of the right holder and the duty bearers. Thirdly, reliable and timely health information is vital for operational and strategic decision making that saves lives and enhances health. A systematic process of data collection, analysis and interpretation about interventions and their effects linked with a guiding set of evaluation questions is important for program evaluation.¹⁷⁰ However, there is no proper health information system introduced and applied in the Ethiopian health care system. In a survey conducted at the district level in Jimma Zone, in the south-west of Ethiopia, it was shown that health information quality and use remain weak, particularly in district health offices and primary health care facilities.¹⁷¹ Thus, monitoring and evaluation can be significantly affected by this challenge.

The second type of accountability mechanism that is structurally present in the current Ethiopia is *legislative* or *political* accountability. The legislature can generally play two important roles in terms of ensuring government institutions and stakeholders are accountable in their endeavor to realize child survival or children's access to health care services or the underlying determinants of the right to health care. Firstly, it can stipulate legislative standards of accountability, and secondly through evaluating the activities of the other branches of the government periodically.

¹⁶⁹ FDRE MoH *National Strategy for Child Survival in Ethiopia* (2005) 66-70.

¹⁷⁰ FDRE MoH *Health Sector Development Programme IV 2010/11 – 2014/15* (Final draft) (October 2010) 86.

¹⁷¹ S Abajebel *et al* 'Utilization of health information system at district level in Jimma Zone Oromiya regional state, South West Ethiopia' (2011) 21(Suppl 1) *Ethiopian Journal of Health Science* 65–76.

In Ethiopia, there is no comprehensive law that has been put in place by the parliament on children's right to survive or socio-economic rights of children in general.¹⁷² As discussed in section 5.3.1 above, the national legal system is short of explicitly recognizing children's right to survival or other complimentary rights to it. Although the response to child survival is overwhelmingly regulated by a number of policy documents, strategic plans and guidelines, these documents do not impose legal obligations on the government. Again, although a comprehensive Children's Act was drafted years ago, this Act has not been endorsed by the parliament. Problems of implementation of child survival rights could be remedied by an issuance of a legally binding law which, among other things, specifies standards of performance, review mechanisms, monitoring and evaluation frameworks and penalties for intolerable performance.

Review of annual or semi-annual reports is the other mechanism where the political/legislative body could potentially ensure accountability for poor or non-performance of a mandate by an executive organ. The current legislative organ in Ethiopia, the HRPs, is constitutionally required to evaluate whether executive organs, the judiciary or other governmental agencies discharge their obligations or not.¹⁷³ It does so through hearing and evaluating reports presented to the House by the representatives of the respective governmental offices. In this process, the FDRE MoH will have to present the overall health performance of the country - one such area being the measures taken to address child survival and access to health service coverage throughout the country. At regional level, the regional parliament members have similar mandates to hear from responsible offices.¹⁷⁴

¹⁷² AB Gebreamanuel 'The recognition and implementation of children's socio-economic rights in Ethiopian law' *unpublished LLM, University of North-West*, 2014 45-46.

¹⁷³ FDRE Constitution, article 55 (17).

¹⁷⁴ For instance, per article 49(3) (17) of the Oromiya regional state Constitution, the members of the parliament (Chaffee Oromiya) have the power to call and to question the region's President and other officials in the region and investigate conduct of responsibilities of the regional councils.

Following the hearing of reports and after questions and answers have been entertained, the HPRs may make recommendations to take any measures it deems necessary where a certain office fails to discharge its responsibilities.¹⁷⁵ Despite the mandate given to hold those responsible to account, it is unfortunate not to see strong debate in the current Ethiopian parliament on issues affecting the public, such as access to quality of health and education, let alone to expect the HPRs to take measures over ill-functioning in service delivery. This is because almost all ministers that are members of the HPRs belong to the ruling party. As of writing this work, the ruling party takes more than 99 % of the seat in the parliament following the 2010 election. Again, after 25 years in power, the ruling party won 100% of the seats in the May 2015 election, conducted as of writing this chapter. It is thus unlikely to ensure checks and balances as parliamentary control over the executive is weakened by lack of separation of power between these two branches of governance, and in the absence of opposition parties in the House. Ultimately, the legislature's power of oversight over the executive branch is likely to be weak.

Social accountability is the third type of accountability mechanism. Gibbons notes the importance of 'social, or citizen-led, accountability initiatives that engage ordinary citizens, including children themselves, and/or civil society organisations, for advancing the realization of child rights in view of its potential for improving service quality and increasing participation'.¹⁷⁶ Similarly, Potts underscores the importance of social or civil society in budget monitoring, health centre monitoring, public hearings and social audits.¹⁷⁷ Thus, CSOs have a role to play in holding government accountable.

There are numerous CSOs in Ethiopia working on children's socio-economic matters. However, the CSO law as it stands considers them as entities supposed to deal with children's needs and not about their rights. Over the past few years there is a trend from the government side to consider CSOs as aid providers and not promoters and protectors of children's rights or voices

¹⁷⁵ FDRE Constitution, article 55 (18).

¹⁷⁶ Gibbons *Accountability for Children's Rights* (n 60 above) 4.

¹⁷⁷ H Potts *Accountability and the Right to the Highest Attainable Standard of Health* (2008) 5.

of maladministration. Although government appears to promote the involvement of CSOs in public affairs, at times when they participate in the preparation of strategic plans and guidelines their engagement remains superficial.¹⁷⁸ Inputs from CSOs and other stakeholders on draft laws, policies and strategy matters are not often considered by the government as government prepares these documents to impose its will on the governed.

As is discussed more broadly in section 5.3.6 above, the most important factor that crippled the CSOs from working on promotion of human rights is the CSO law or Proclamation. Although this does not necessarily impugn the idea that CSOs in Ethiopia have played a remarkable role in the promotion and protection of human rights before the introduction of this law with the exception of a few,¹⁷⁹ this law restricts the space for the potential role of these organizations from engaging in human rights activism. This restriction affects one other most significant contribution of CSOs - engaging in PIL. Representation in public litigation to challenge the laws, policies and actions of the government that violate human rights before courts or other quasi-judicial bodies is a key role played by CSOs to ensure accountability against violation of rights. Unfortunately, the current legal framework is not a favorable one for PIL in Ethiopia.¹⁸⁰ Consequently, the importance of social accountability is threatened and cannot effectively serve to champion children's and women's rights protection and promotion in the country.

¹⁷⁸ MA Tadesse 'A rights-based approach to HIV prevention, care, support and treatment: A review of its implementation in Ethiopia' *unpublished Doctoral dissertation, Department of Interdisciplinary Studies in the Graduate School, University of Alabama, Tuscaloosa*, 2012 281.

¹⁷⁹ Although informal community-based organizations like the 'idir' and 'iqub' – self-help associations – have a long tradition in Ethiopia, formal civil society is a recent development. It was in the 1930s, and beginning in the 1950s that modern civil society organizations, such as the Ethiopian Red-Cross Organization and faith based organizations were established. More NGOs emerged with a focus on relief and humanitarian service as a result of the 1973-74 and 1984-1985 famines that hit the country hard. Since the fall of the *Derg* regime in May 1991, the number of NGOs has substantially increased. Two of the leading human rights organizations that came in after fall of the regime are the Ethiopian Human Rights Council and the Ethiopian Women Lawyers Association. The former is established in October 1991 by 32 founding members from academia, business and the professions. It is an independent and non-partisan non-governmental organization that has the principal objectives of promoting democratic process, the rule of law and due process and respect for human rights. The latter is also a non-profit and non-partisan voluntary organization founded by a group of Ethiopian women lawyers in 1995. Its mission statement is to promote the economic, political, social and legal rights of women and to that end to assist them to secure full protection of their rights under Constitution of the FDRE and other international human rights conventions. These two organizations were playing an active role in human rights activities until their funds were frozen and down sized their offices and staff following the CSO law.

¹⁸⁰ For an in depth discussion, see section 5.3.6.

National Human Rights Institutions (NHRIs) or independent oversight bodies are the fourth accountability mechanisms that have the potential to ensure state policy making and implementation processes are in accordance with human rights standards and principles. These entities, *inter alia*, ‘monitor actions of government and other entities, advance the realization of children’s rights, receive complaints, provide remedies for violations and offer space for dialogue about children and society and between children and the state’.¹⁸¹ They function as a guardian of human rights through investigation of individual complaints or pursuit of legal redress through amicus interventions and public interest litigation; review or report on the MDGs/SDGs, poverty reduction or budgetary allocations; advocate in favour of strengthened legal protections of human rights, including economic and social rights; advise when they assist officials and other duty bearers to discharge their human rights obligations.¹⁸²

As discussed in chapter four, the Ethiopian Human Rights Commission (EHRC) and the Ethiopian Institution of Ombudsman (EIO) are the two NHRI established, at national level, in accordance with article 55(15) of the Federal Constitution.¹⁸³ They were voted by the HPRs through Proclamations No. 210/2000 & No. 211/2000, respectively. It was noted that the EHRC has extensive powers which include the power and duty to:¹⁸⁴

ensure that the human rights and freedoms recognised by the FDRE Constitution are respected by all citizens, organs of state, political organizations and other associations as well as by their representative officials; to undertake investigation, upon complaint or its own initiation, in respect of human rights violations; and ensure that laws, regulations and directives as well as government decisions and orders do not contravene the human rights of citizens guaranteed by the FDRE Constitution.

¹⁸¹ Gibbons *Accountability for Children’s Rights* (n 60 above) 7.

¹⁸² UNOHCHR & Centre for Economic and Social Rights *Who will be Accountable?: Human rights and the Post-2015 Development Agenda* (2013) 42.

¹⁸³ See, sections 4.6.2 & 4.6.3.

¹⁸⁴ Proclamation to Provide for the Establishment of the Human Rights Commission, Proclamation No. 210/2000 (2000), article 6 (1, 2 & 4).

Obviously, the EHRC has a very broad mandate, which, if exercised properly, could contribute significantly to ensuring accountability for children's rights. The EHRC is organized in such a way that children have a separate Commissioner and a Directorate office within the EHRC that is specifically responsible for protecting and promoting children's and women's human rights. Nevertheless, in its oversight activity, the role so far played by the EHRC when compared to its counterparts in countries such as South Africa¹⁸⁵ and Kenya¹⁸⁶ has no success stories over systematic patterns of human rights violations. For instance, in its 14 years journey since it was established legally in 2000, it did not produce any comprehensive report to the public or the parliament assessing the human rights situation of the country. It has also not so far investigated occurrences of violations of child or maternal mortality-related rights.¹⁸⁷ Although the EHRC has engaged in investigation of numerous cases in connection with violation of human rights, its activity in connection with violation of the right to health is insignificant. Its counterpart for Kenya, the Kenyan National Commission on Human Rights (KNCHR), has made great strides in successfully conducting public inquiries on systemic human rights problems on the right to health.¹⁸⁸ Public inquiry is now accepted as a useful mechanism for investigating violations of economic, social and cultural rights.¹⁸⁹ As discussed in chapter two, the KNCHR investigation into the Pumwani maternity hospital and other facilities and its finding in making the Kenyan government responsible for severe violation of reproductive rights is one such example to show the relevance of NHRIs in ensuring governments are called to account for violation of human rights. The EHRC has no comparable record.

¹⁸⁵ O Afulukwe-Eruchalu 'Accountability for non-fulfilment of human rights obligations: A key strategy for reducing maternal mortality and disability in sub-Saharan Africa' in C Ngwenya & E Durojaye (eds) *Strengthening the Protection of Sexual and Reproductive Health and Rights in the African Region through Human Right* (2014) 141-142.

¹⁸⁶ See section 2.2.3.5(B); *Ibid.* 142-143.

¹⁸⁷ Interview conducted with Mrs. Ubah Ahmed, former state Minister of Women's Affairs of the FDRE, and currently, Commissioner for the Children & Women's Affairs at the Ethiopian Human Rights Commission, 13 January 2015, Addis Ababa, Ethiopia.

¹⁸⁸ W Lichuma 'The Role of national human rights institutions in monitoring human rights: A case study of the Kenya National Commission on Human Rights' in *Maternal Mortality, Human Rights, and Accountability* (2013) 57.

¹⁸⁹ *Ibid.*

Numerous factors have contributed to the limited engagement of the EHRC to ensure accountability of the government from failure to respect, protect and fulfil human rights. Firstly, the Commission is not fully independent to effectively investigate allegations of human rights abuses. According to the Paris Principles on establishment of NHRIs, they shall enjoy a significant degree of independence from the government and other organs.¹⁹⁰ This enables them to discharge their duties autonomously without any interference from other entities. Despite this precondition, the Commission does not have full autonomy during the course of investigation of violations.¹⁹¹ It suffers from political influence from the government in power. Government offices do not cooperate with the Commission in divulging information needed to conduct investigations. Democracy in the country is still under-developed and reports by the EHRC on highly sensitive issues of human rights are not well received as they run in conflict with the interest of the competent authorities that are supposed to follow up on implementing their recommendations.¹⁹² The political will heavily affects the Commission's legitimacy. This profoundly undermines the independent work of the Commission. Furthermore, the fact that the Commission relies on government for its budget affects the independence of this institution. Practice shows that the budget of this office is mainly drawn from government funding, although the establishing law states that it may also be drawn from grant, assistance or other sources than government subsidy.¹⁹³ It also does not have a permanent, owned office and its head office in Addis Ababa moves from building to building over the years.

Secondly, the Commission lacks the capacity in terms of carrying out its mandate. This relates mainly to little experience or limited staff capacity.¹⁹⁴ The staff members lack adequate experience to handle more complaints. Especially, the investigators do not have adequate skills

¹⁹⁰ Principles relating to the Status of National Institutions (The Paris Principles) Adopted by General Assembly Resolution 48/134 of 20 December 1993, available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/StatusOfNationalInstitutions.aspx> (accessed 20 May 2014).

¹⁹¹ Y Kidane 'The roles and the challenges of Ethiopian national human rights institutions in the protection of human rights in the light of the Paris Principles' *unpublished LLM paper, Central European University, Hungary, 2010* 88.

¹⁹² See M Marin *Enhancing the functional protection of human rights in Ethiopia project (UDF-ETH-08-227)*, Mid-term Review (May 2011) i, 3, 6, 24, 27 & 31.

¹⁹³ Proclamation No. 210/2000, article 36.

¹⁹⁴ Marin (n 192 above) 6.

to deal with emotionally distressed and angry complainants.¹⁹⁵ Even if the Commission produces reports after an investigation, it lacks the ability to execute its recommendations in instances where the violations occurred in a remote area. Thirdly, expansion of its operations is another challenge that the EHRC is undergoing. It has been planning to expand its branch offices to reach into underserved areas in terms of access to justice. However, over the years the Commission still runs only six of its branch offices, located in six regions of the country. This affects physical accessibility of the Commission, particularly for the rural population, the most vulnerable group of people. In the rural areas the online filing of complaints is almost impossible due to limitations of access to internet and illiteracy. Again, the already established offices are under-staffed and under-resourced. The EHRC staff members feel the pressure of the workload and lack of capacity to meet all the needs. This is one cause for delays in responding to investigation requests, and inability to self-initiate investigation.¹⁹⁶ The Committee on Rights of the Child is equally concerned about the limitations of the Commission and recommended that this Commission be provided with adequate human and financial resources.¹⁹⁷ Some of the other factors that make the EHRC a weak human rights institution are newness, weak human rights culture, budget constraints, the wrong assumption that human rights work is mainly legal professional's work, incomplete process of hiring staff and low awareness of the Commission's work.¹⁹⁸ To ensure the efficiency of the Commission's operation, in terms of its mandate, independence, and capacities the Committees on CRC and ESCR further recommend the country to take all the necessary steps in order to ensure full compliance with the established Paris Principles for Independent National Human Rights Institutions adopted by the General Assembly in 1993.¹⁹⁹

The EIO is the other NHRI functioning in parallel with the EHRC. Similar to the EHRC, the EIO office too has extensive mandates. This is especially true when considered in the light of article

¹⁹⁵ *Ibid.*, 24.

¹⁹⁶ *Ibid.*

¹⁹⁷ Committee on Rights of the Child (CRC) *Concluding Observations* (Ethiopia) (n 122 above) para 15.

¹⁹⁸ Marin (n 192 above) 7.

¹⁹⁹ Committee on CRC, *Concluding Observation* (Ethiopia) (n 122 above) para 15; Committee on ESCR, *Concluding Observations* (Ethiopia) (n 34 above) para 6.

6(7) of the establishing proclamation, which entrusts the institution to perform ‘such other functions as are related to its objective’. However, the specified powers and duties include: ‘receiving and investigating complaints; conducting supervision; seeking remedies; and undertaking studies and research in respect to maladministration’.²⁰⁰ It is also vested with the responsibility ‘to make recommendations for the revision of existing laws, practices or directives and for the enactment of new laws and formulation of policies’.²⁰¹ These jurisdictions vested in this institution have a pivotal role in ensuring accountability for failure of the executive organ, and commenting on draft laws and policies that have human rights implications.

In the context of child and maternal health, the EIO has made few but pertinent auditing reports and recommendations concerning health service delivery at the country’s major referral hospitals.²⁰² It has also conducted a similar audit to gauge the actions taken to reduce maternal and child mortality by the Somali regional state. In relation with the Somali regional state, mention should be made that the Committee on ESCR in its Concluding Observation once expressed itself about the high mortality of children in the country, most specifically, the marked rate of mortality in the Somali region.²⁰³ On top of that, the Institution has also conducted research in two regional states, namely Benishangul and Gambella national regional states, concerning coverage of health service delivery to the population in these regions.²⁰⁴

Overall, the auditing report findings reiterate achievements and gaps in implementation of access to health care observed in those health service delivering institutions. The challenges identified in delivering health services were discussed in section 5.3.3.2 above. However, the

²⁰⁰ Institution of the Ombudsman Establishment Proclamation No. 211/2000, *Federal Negarit Gazeta*, 6th year No. 41, Addis Ababa, 4 July 2000, article 6(1), 6(2), 6(4) & 6(5).

²⁰¹ *Ibid.*, article 6(6).

²⁰² Those hospitals that the Ombudswoman office audited include, Black Lion Specialised Referral Hospital (in Addis Ababa), Gandhi Hospital (in Addis Ababa), Menelik Hospital (in Addis Ababa) and Yekatit 12 Hospital (in Addis Ababa). These are the oldest and still leading government referrals hospitals in the country.

²⁰³ Committee on ESCR, *Concluding observations* (Ethiopia) (note 34 above) para 26.

²⁰⁴ The EIO audit report was conducted in 2012. It identifies the various gaps that limit to realise the right to health in the two regional states. The report also praised the expansion of health service in the regions over the years while acknowledging the challenges ahead for fully implementing access to health care goods and services.

crux of the matter for the purpose of this section is their inter-link with accountability. They are indicative of duties discharged to hold the executive to account in accordance with the mandate given to the EIO. Given the fact that Ethiopia has a recent history of national human rights institutions, and that democracy is still in its infant stage, the efforts made signify an achievement. Compared to the practice of the EHRC, the EIO's engagement in health right issues is far better. Nevertheless, the investigation reports can be subjected to certain deficiencies as they do not appear to be to the desired level. The findings of the audit reports were not bold enough to constitute a critique in explicit human right terms. They do not comprehensively deal with the specific meaning of the right in question and the corresponding duty of the government towards the right. The content of the audit reports and their recommendations are somewhat softer and do not express in clear human rights language the type of duty that the responsible government office/s fails to fulfil. These could be attributable to capacity and other challenges of the EIO personnel.

As discussed in chapter four, the EIO has also made a significant achievement in establishing model children parliaments.²⁰⁵ These parliaments are also other mechanisms where issues of maladministration can be checked through voices of children. Overall, despite some of the achievements, the EIO is exposed to several challenges, which restrict it in ensuring its accountability mandate is exercised up to the desired level. Unsurprisingly, these challenges are almost similar to the challenges affecting the activities the EHRC. The first challenge relates to its operational independence. Kidane has noted the instance where the EIO had failed to take legal action on six organisations that did not cooperate to provide the required evidence.²⁰⁶ The reasons that affect the independence of the work of EHRC mostly relate to that of the EIO. The other challenge relates to outreach. The EIO is mandated to conduct its business country-wide, across the nation. As the country is vast and possesses diversified people, this presents huge challenges of outreach. For the EIO to be effective in its work, its presence must reach at grass root level, in particular with regard to hearing the voices of those

²⁰⁵ See section 4.4.3.

²⁰⁶ Kidane 'The roles and the challenges of Ethiopian national human rights institutions in the protection of human rights in the light of the Paris Principles' (n 191 above) 64.

poorest living in remote, rural communities. Enhancements of infrastructure and logistics, such as offices, vehicles, and staff might meet some of the challenges of institutionalizing the EIO in the far to reach areas.

A further challenge is continued attrition of EIO's staff. During my visit to conduct research I observed that, apart from the Ombudswoman for Children and Women's Affairs, almost all of the staff members who work under the Ombudswoman's office have been in their current jobs for only a few months. Reasons for such staff migration include but are not limited to work pressure, influence on their independence while discharging their duties, poor communications infrastructure, inadequate payment and benefits, and lack of sufficient transport service and other logistic problems to conduct their work.²⁰⁷

Judicial accountability is the fifth accountability mechanism. Often, accountability is conflated with judicial accountability in the context of human rights.²⁰⁸ Judicial accountability mechanisms for women's and children's health provide avenues for remedies and redress for women, children and their caregivers when their rights are violated. There are practical instances where this kind of accountability mechanism is deployed by courts in middle and low income countries. For instance, in response to two cases of maternal deaths, the Delhi High Court issued a landmark decision that established the right to quality maternal health care as a constitutionally protected right in India.²⁰⁹ The local state governments were required by decisions of the High Court in their implementation of national health programs to ensure that every pregnant woman and new-born had access to quality health care and nutritious food, regardless of socio-economic status.²¹⁰ An important question is whether Ethiopian courts through their judgments play a similar role in making the relevant government agencies

²⁰⁷ Ibid., 70 - 71, 73; F Hando & R Pillay *Multi-Donor democratic institutions programme: Terminal evaluation main evaluation report* (November 2013) 4, 18, 43.

²⁰⁸ UNOHCHR & Center for Economic and Social Rights (n 182 above) 39.

²⁰⁹ 'Using human rights to enhance accountability for women's and children's health' available at: www.who.int/pmnch/media/press/.../accountability_human_rights.pdf (accessed at 24 December 2014).

²¹⁰ Ibid.

accountable for failure to implement children's and women's rights to health or the underlying determinants of the right to health care.

In Ethiopia, the judiciary is vested with the power and stand under a duty to entertain children's rights matters, and the courts are guaranteed, under the FDRE Constitution, to do this job freely from any interference or influence of any governmental body, government official or from any other source.²¹¹ They have jurisdiction over cases arising under the Federal Constitution, Federal Laws and International Treaties.²¹² This jurisdiction extends to both civil and criminal cases. Besides, the FDRE Constitution bestows on courts a specific responsibility for enforcing the human rights provisions of the Constitution.²¹³ According to article 9(4), they can also directly apply global and African regional human rights treaties to adjudicate cases brought before them.

As discussed in chapter four, the Ethiopian legal system recognizes two tiers of courts, namely Federal and State courts.²¹⁴ According to the Federal Constitution, the Federal First Instance Court has the jurisdiction to hear and decide on non-monetary subject matters, such as child custody, maintenance, adoption, inheritance and others.²¹⁵ Similar jurisdiction is also conferred upon the nine regional states *woreda* courts, and the First Instance City Court situated in the city of Addis Ababa. In civil cases, these courts have the power to award damages in the form of financial compensation to the injured party,²¹⁶ order restitution of property,²¹⁷ and order an injunction restraining a party from committing or continuing to commit an action.²¹⁸ An appeal can be lodged from a decision or order of these courts to the high courts. Furthermore, final appeal can be taken to the Federal Supreme Court Cassation bench, the apex judicial chamber of the land, over any final court decision containing a basic error of law.²¹⁹

²¹¹ FDRE Constitution, article 78.

²¹² Federal Courts Proclamation No. 25/1996, article 3(1).

²¹³ FDRE Constitution, article 13(1).

²¹⁴ See section 4.6.1.

²¹⁵ Federal Courts Proclamation No. 25/1996, article 14.

²¹⁶ Civil Code of the Empire of Ethiopia (Civil Code), Proclamation No. 165 of 1960, article 2090.

²¹⁷ Civil Code, articles 2118 & 2119.

²¹⁸ Civil Code, article 2121.

²¹⁹ *Ibid.*, article 10; FDRE Constitution, article 80(3)(a).

In response to my interview question, the Children’s Justice Coordination Office within the Federal Supreme Court replied that, to the best of her knowledge, there were no cases brought to and decided by the Federal Supreme Court or any lower court in the country in connection with pregnant women’s and new-borns’ right of access to quality health care.²²⁰ Cases of child physical abuse, custody and maintenance, medical malpractice, inheritance and adoption are common before Ethiopian courts, yet Ethiopian courts have not entertained the type of court cases (maternal and child health care) with respect to which, for example the Indian courts have made orders against local state governments.²²¹ At the Federal First Instance Court level too, even though there were cases decided by the court similar to the nature mentioned above, such as child custody and maintenance, socio-economic rights of children have never been claimed nor decided by this court.²²²

There are a host of legal and practical challenges that hamper the limited application of judicial accountability for enforcement of children’s health and their other interrelated rights in Ethiopia. Firstly, there are problems with the law. As discussed before, the FDRE and the nine regional states Constitutions each have a specific provision that deals with rights of children. Nevertheless, children’s right to survive, their rights to health, right to access to food, safe drinking water, adequate standard of living and other rights relating to the underlining determinants of the right to health have not been recognized in these Constitutions. Nor are there special laws that address these rights.

Secondly, awareness of children’s rights is crucial for their overall implementation. However, knowledge about the rights of children has been considered as a main challenge.²²³ Parents’ or guardians’ limited knowledge of children’s rights and violations of their rights presents a

²²⁰ Interview conducted with Mrs. Fasika Hailu, Coordinator for Child Justice Project Office at the Federal Supreme Court of Ethiopia, 15 February 2015 Addis Ababa, Ethiopia.

²²¹ Ibid.

²²² Interview conducted with Mr. Halleluya Ayzoh, Judge at Federal First Instance Court, Children’s Matters Bench, 2 March 2015, Addis Ababa, Ethiopia.

²²³ UNICEF Ethiopia (n 118 above) 26.

challenge to developing proper judicial channels of accountability for children's right to health or survival. Despite the progress made to disseminate the provisions of the CRC as widely as possible, many parents and guardians, especially in the rural areas where the majority of the Ethiopian population live, have limited awareness of children's rights. In this regard, the Committee on Rights of the Child has also highlighted the need to undertake further dissemination and awareness raising activities in particular among relevant professional categories, parents and among children themselves, in particular in rural areas.²²⁴ This lack of awareness of children's rights extends also to such professional categories as law enforcement officials, teachers, health personnel, social workers and personnel of childcare institutions.²²⁵ This must have an adverse impact upon children's rights programs and the protection of the rights of the child, including health rights.

The third challenge relates to legal representation. Children are unlikely to be able to bring claims for violations of their rights on their own behalf. Legal claims of infants and under-five children will have to be brought by their parents or children's rights interest representatives or groups. As discussed earlier, human rights NGOs could play a major role in representing children's rights cases before courts. However, they are not able to represent children's rights cases before courts due the restrictions of the CSO law discussed in the foregoing sections.

The fourth challenge relates to the capacity of judges and practitioners, and general perceptions as to the justiciability and enforceability of socio-economic rights before courts. Although the debate over justiciability of socio-economic rights seems to have been settled in many parts of the world,²²⁶ research shows that this is not case within the Ethiopian judiciary

²²⁴ Committee on CRC *Concluding Observations* (Ethiopia) (n 122 above) para 20.

²²⁵ UNICEF Ethiopia (n 118 above) 26; Aneme & Birmeta *Handbook on the Rights of the Child in Ethiopia* (n 160 above) 37.

²²⁶ For a more comprehensive discussion on the settlement of debate over the justiciability of socio-economic right, see S Yusuf 'The rise of judicially enforced economic, social & cultural rights' (2012) 10 *Seattle Journal for Social Justice* 753-791; K McLean *Constitutional Deference, Courts and Socio-Economic Rights in South Africa* (2009) 2; J Mubangizi 'The constitutional protection of socio-economic rights in selected African countries: A comparative evaluation' (2006) 2 *Africa Journal of Legal Studies* 1-19.

and among Ethiopian practitioners.²²⁷ This is unacceptable in the light of the fact that today, as McLean notes, ‘the debates around socio-economic rights have shifted from whether they are in fact justiciable and whether socio-economic rights should be regarded as rights of the same nature and status as civil and political rights, to a discussion as to how courts should engage with socio-economic rights’.²²⁸ The several cases discussed in this thesis are also the result of a reasoned response to the interpretation and enforcement of socio-economic rights. All of the provisions incorporated in the CRC and ACRWC have equal weight and enforceability before courts. Although the FDRE and the regional state Constitutions do not explicitly provide for socio-economic rights of children, Federal Courts have the duty to interpret and enforce the socio-economic rights provisions of CRC and ACRWC using articles 9(4) and 13(2) of the FDRE Constitution. Furthermore, although the Federal Supreme Court is now developing a fledgling jurisprudence on children’s rights using these human rights instruments,²²⁹ its engagement with children’s right to health leaves much to be desired.

In addition to the above, the judicial enforcement of children’s survival or health rights is likely to be worse, especially in rural areas, where the majority of children live and the majority of children’s rights violations happen. For the great majority of the population, particularly in these areas, social or *woreda* courts constitute the most accessible and cost-effective avenue to justice. However, social courts do not have the capacity to deal with complex human rights

²²⁷ S Yeshanew ‘The justiciability of human rights in the Federal Democratic Republic of Ethiopia’(2008) 8 *African Human Rights Law Journal* 293; S Kibret ‘Competence and legitimacy of Ethiopian Courts in the adjudication of socio-economic rights: An appraisal of the challenges and prospects’ *unpublished LLM thesis, Addis Ababa University, 2010* 88; A Tesfaye ‘Justiciability of socio-economic rights in the Federal Democratic Republic of Ethiopia’ *unpublished LLM thesis, Addis Ababa University, 2010* 11; Tadesse ‘A rights-based approach to HIV prevention, care, support and treatment’ (n 178 above) 300; A Abebe ‘The potential role of constitutional review for the realization of human rights in Ethiopia’ *unpublished LLD Dissertation, University of Pretoria, 2012* 174.

²²⁸ McLean *Constitutional Deference, Courts and Socio-Economic Rights in South Africa* (n 226 above).

²²⁹ Cases where the Federal Supreme Court has rendered decisions using the CRC, and/or ACRWC, and the bill of human rights provisions of the Federal Constitution include, *House of Federation and Mr Tesfahun Getahun v Priest Mamo Yitaferu*, Federal Supreme Court Cassation Division, Cass. File No. 92020, 24 December 2014; *BeteZata children’s Home Association and others* (3 applicants) *v None*, Federal Supreme Court Cassation Division, Cass. File No. 25691, 30 April 2010; *Ms Etsegenet Eshetu v Ms Selamawit Nigussie*, Federal Supreme Court Cassation Division, Cass. File No. 35710, 25 December 2009; *Ms Tsedale Demissie v Mr KifleDemissie*, Federal Supreme Court Cassation Division, Cass. File No. 23632, judgment 6 November, 2007; and *Ms Francis Pastorv Mr Duckman Vino & Ms Barbot Latitiva*, Federal Supreme Court Cassation Division, Cass. File No. 44101, 3 March 2010.

issues. Nor do they have the jurisdiction to apply human rights treaties ratified by Ethiopia as this jurisdiction is given to Federal Courts pursuant to article 3(1) of the Federal Courts Proclamation No. 25/1996.

The requirement of vested interest or *locus standi* or standing is a fifth challenge for judicialisation of children's social right to health. According to the procedural law of the country, civil claims may be joined as a single case where they relate to the same transaction or series of transactions.²³⁰ However, the provision does not allow anyone to directly benefit from the judgment²³¹ unless they were a party to a suit. Each plaintiff must have a vested interest in the suit according the civil procedure code. Similarly, the FDRE Constitution does not explicitly allow public interest litigation or acting in the interest of a group or a class of persons unlike, for example the South African Constitution.²³² Article 37(2) of the FDRE Constitution can be interpreted as not allowing any person or entity to bring a justiciable matter before a court of law or any other competent body with judicial power. In addition, one finds the requirement of standing under the Council of Constitutional Inquiry Proclamation No. 250/2001. Article 23(1) of this Proclamation stipulates that 'Any person who alleges that his fundamental rights and freedoms have been violated by the final decision of any government institution or official may present his case to the Council of Inquiry for constitutional interpretation'. Besides, on questions of the right to self-determination the applicable law stipulates that:²³³

[a]ny nation, nationality or people who believes that its self-identities are denied, its right of self-administration is infringed, promotion of its culture, language and history are not respected, in general its rights enshrined in the Constitution are not respected or, violated for any reason, may present its application to the House through the proper channel.

²³⁰ The Civil Procedure Code of Ethiopia, Decree No. 52 (1965), article 35.

²³¹ *Ibid.*, article 33(2).

²³² Constitution of the Republic of South Africa (1996), Section 38 (b - d).

²³³ Proclamation No. 251/2001, Consolidation of the House of the Federation of the Federal Democratic Republic of Ethiopia and Definition of its Powers and Responsibilities, article 19 (1).

Equally, this article authorizes only those whose rights have been infringed to approach the relevant entities for enforcement of their rights.

Despite the above requirements of standing, luckily, there are exceptions to this condition. These exceptions to the standing rule can be found in the Environmental Pollution Control Proclamation,²³⁴ the Federal Courts Advocates Licensing and Registration Proclamation,²³⁵ and the EHRC Establishment Proclamation²³⁶ and the EIO Proclamation.²³⁷ Despite the strength of these laws in allowing standing, the CSO law restriction on the work of human rights NGOs in advocacy and protection of human rights affects the application of the standing rule. For instance, although the Environmental Pollution Control Proclamation stipulates that any person have the right to lodge a complaint at the Authority or the relevant regional environmental agency against any person allegedly causing actual or potential damage to the environment, human rights NGOs mainly funded by foreign sources may no longer engage in making human rights advocacy on environmental or health issue due to their prohibition from participating in a plethora of essential human rights activities.

The sixth challenge relates to the independence of the Ethiopian judiciary. An independent judiciary, especially a non-partisan guardian of the constitution, is a necessary component of a well-functioning and vibrant democracy. Besides, an independent judiciary safeguards against arbitrary use of power and coercion by the executive branch against individuals and groups within a population. Contrary to this, it is argued that the Ethiopian judiciary is not

²³⁴ Environmental Pollution Control Proclamation, Proclamation No. 300/2002, *Federal Negarit Gazeta*, 9th Year No. 12, article 11. Article 11 authorizes anyone, without proving vested interest, to lodge complaints to federal and regional environmental agencies and courts. Using this article, Action Professionals Association for the People (APAP) litigated a case, discussed in the preceding chapter. See, *Action Professionals Association for the People (APAP) v Ethiopian Environmental Protection Authority (EEPA)*, Federal First Instance Court, Arada Bench, F/No. 64902, 21. This case was litigated up to the Federal Supreme Court but, unfortunately, it was decided against APAP.

²³⁵ The Federal Courts Advocates Licensing and Registration Proclamation, Proclamation No. 199/2000. *Federal Negarit Gazeta*, 6thYear No. 27. Article 10(1) of this Proclamation states that any Ethiopian who defends the general interests and rights of the society and who fulfills the requirements specified (under article 10) shall be issued with a federal court special advocacy license’.

²³⁶ Proclamation No. 210/2000, article 22 (1).

²³⁷ Proclamation No. 211/2000, article 22 (1).

independent in practice and is regarded as the weakest branch of the government.²³⁸ As was noted before, the Federal Constitution and that of the regional states counterparts guarantee an independent judiciary. However, mere declaration of independence does not itself produce an independent judiciary.²³⁹ The country does not have a tradition of judges acting independently in their area of jurisdiction against executive maladministration or the legislature's action or inaction.²⁴⁰ The judicial system in Ethiopia is not free from the influence of the ruling party elites. A known case to illustrate this will be an order of an Addis Ababa (the capital city) judge sentencing the minister of justice to jail for four weeks for refusing to hand over a suspect to the courts. However, at the request of the then Prime Minister, the minister was pardoned immediately by the then president and the judge was soon transferred to another place against his will, by way of punishment.²⁴¹ Furthermore, according to surveys, following the May 2005 national election of Ethiopia, due to alleged government interference, judges fled the country. Some of them were arrested, intimidated, pressured to quit their job, or transferred to remote places, a move generally considered as punishment.²⁴² On top of that, currently judges, especially those who are in the rural part of the country, are considered as partisans - loyal to politics of the government.²⁴³ The judicial independence is at its weakest at the local or lower level of administration.

One may argue that children's rights cases are less politically sensitive and that the independence of the judiciary may not be a critical concern. However, this is not always

²³⁸ C Mgbako *et al* 'Silencing the Ethiopian Courts: Non-judicial constitutional review and its impact on human rights' (2008) 32 *Fordham International Law Journal* 268.

²³⁹ K Rossen 'The protection of judicial independence in Latin America' (1987) 19 *University of Miami Inter-American Law Review* 1, 34.

²⁴⁰ A Hammerstad *African Commitments to Democracy in Theory and Practice: A Review Of Eight NEPAD Countries* (2004) 84. Also, for a more insightful engagement on the independence of the judiciary in Ethiopia, see National Judicial Institute for the Canadian International Development Agency *Independence, Transparency and Accountability in the Judiciary of Ethiopia* (October 2008) 1-200; K Roach 'The challenges of crafting remedies for violations of social, economic and cultural rights' in M Langford (ed) *Social Economic Rights Jurisprudence: Emerging Trends in International and Comparative Law* (2009) 46-58.

²⁴¹ R Mzikamanda 'The place and independence of the judiciary and the rule of law in Democratic sub-Saharan Africa' (2007) 14 *South African Institute for Advanced Constitutional, Public, Human Rights, and International Law* 219; Hammerstad (n 240 above) 84.

²⁴² National Judicial Institute for the Canadian International Development Agency (n 240 above) 117.

²⁴³ Hammerstad (n 240 above) 84.

convincing. The question is - are judges bold enough to determine the executive responsible for violations of children's socio-economic rights? The enforcement of socio-economic rights may require mandatory orders against the executive.²⁴⁴ Given this, could the Ethiopian judiciary be charismatic enough to order policy change or decide (within the constitutional jurisdiction) the constitutionality/unconstitutionality of a policy or program affecting children's health and other rights? Again, noting that judicial enforcement of socio-economic rights of children will have resource implication and frequently requires the imposition of positive duties on the State, in that case, would the Ethiopian executive not resist such imposition? Even in relatively democratic systems, the practices of enforcement of socio-economic rights in several jurisdictions have shown resistance from the executive in complying with court orders. For instance, Mbazria notes the reluctance of South African state officials to observe the rule of law and respect court orders in court processes involving the enforcement of socio-economic rights in the country.²⁴⁵ For obvious reasons and given the current state of government interference within the territory of courts as noted above, it would be unreasonably necessary to imagine that the Ethiopian judiciary will act independently, merely because children's socio-economic rights are less political in nature.

Finality or ouster clauses provided in various special laws in Ethiopia represent the last but by no means the least difficult challenge for the purpose of this discussion. Finality clauses degrade the jurisdiction of courts by running into conflict with the FDRE Constitution which declares the exclusivity of judicial powers vesting in courts.²⁴⁶ These laws with ouster clauses have a direct and indirect implication with the implementation of children's socio-economic rights. I discuss two examples of this legislation below.

The Expropriation of Landholdings for Public Purposes and Payment of Compensation Proclamation is one such law with a finality clause. This Proclamation primarily deals with how land can be expropriated by the government from the people (urban or rural) or entities and

²⁴⁴ S Liebenberg *Socio-economic Rights: Adjudication under a Transformative Constitution* (2010) 379-462.

²⁴⁵ C Mbazira *You are the "weakest link" in realizing socio-economic rights: Goodbye* (2008) 1-38.

²⁴⁶ FDRE Constitution, article 79(1). See the Amharic version for the emphasis on the word 'exclusivity' which is not in the same tone in the English version of the Constitution in connection with this provision.

the manner in which compensation can be made after a decision is made to proceed with an expropriation.²⁴⁷ Land is owned exclusively by the state and ‘the peoples of Ethiopia’ under the FDRE Constitution,²⁴⁸ and individuals have no right of ownership to land in Ethiopia. However the decision to expropriate (to dispossess) cannot be arbitrary or taken for any purpose other than to benefit the public. Any allegation of arbitrary or unfair expropriation of land should be subjected to judicial review by victims of eviction or their legal or contractual representatives. Nevertheless, except for possibilities of appealing against the compensation amount, the Proclamation does not guarantee the right of individuals or entities to file an appeal from the decision of a state agent to question the legality of the act of eviction or when land is expropriated for reasons other than for public purposes. The finality clause provided in article 29(3) of this Proclamation totally exonerates a wide range of discretionary decisions of the authority from court review and restricts court powers only to areas related to questions of law on the assessment of compensation. Judicial intervention is hence demanding in view of the fact that many families are increasingly becoming victims of eviction in many parts of the country. This is especially important because government acts of eviction often results in massive violation of individuals or group’s rights, such as the right of access to house, property and the right to choose one’s means of livelihood, to mention but some.²⁴⁹

The CSO law discussed above is the other legislation with an ouster clause. This law empowers the Director General for the Charities and Societies Agency (the Agency) to decide on different activities of the Agency including its activity to license, register and or supervise Charities and Societies.²⁵⁰ In almost all cases, the decision of the Director on the activities of the Agency is final, and appeal is possible to the Board of the Agency. Moreover, only Ethiopian NGOs or

²⁴⁷ Expropriation of Landholdings for Public Purposes and Payment of Compensation Proclamation No. 455/2005, articles 3-5, and 7-11.

²⁴⁸ FDRE Constitution, article 40 (3).

²⁴⁹ Regarding the human right impact of land expropriation in Ethiopia, see Human Rights Council ‘Expropriation in the name of public interest should not usurp citizens’ rights 122nd Special Report’ (2013) available at: <http://ayyaantuu.com/wp-content/uploads/2014/05/HRCO-122nd-Special-Report-English.pdf> (accessed 17 May 2015); L Cotula *Addressing the Human Rights Impacts of “Land Grabbing”* (2014) 1-44; DW Ambaye *Land Rights and Expropriation in Ethiopia* (2015) 1-261.

²⁵⁰ Charities and Societies Proclamation No. 621/2008, 6(1) cum 11(2)(a).

Ethiopian Charities/Societies have the right to appeal against the decision of the Board to the Federal High Court.²⁵¹

Laws that contain finality clauses and, at the same time, deprive review of administrative tribunal decisions by ordinary courts are increasing over time. In some instances, at times when the courts are given the power to review administrative decision, they assume jurisdiction only to investigate whether there is an error of law committed by a responsible administrative tribunal.²⁵² On top of above legislation, one can find other examples of laws with finality provisions, where courts have a narrow power of judicial review. They include the Pension Proclamation,²⁵³ the Electoral Law,²⁵⁴ Property Mortgage and Pledged Law,²⁵⁵ and the Councils Ministers Regulation on the Administration of the Ethiopian Revenues and Customs Authority Employees.²⁵⁶ Some of these illiberal laws with such finality clauses inserted in a range of sensitive areas have stripped the Ethiopian judiciary of its jurisdiction to review the legality or illegality of administrative acts.²⁵⁷

Donor accountability is the six accountability mechanism. More broadly, human rights accountability promotes the responsiveness of all those involved in the development endeavour which includes donor states and aid agencies. Donor accountability aims to ensure that the terms of donor aid does not create challenges for its effective use within countries. To safeguard that countries are able to use health aid effectively to meet country health priorities,

²⁵¹ *Ibid.*, article 104(2 and 3).

²⁵² For instance, any party dissatisfied with the tax appeal commission and who believes that the decision was reached on the basis of erroneous interpretation of law, can appeal to an ordinary court. The court determines the question of law. See Proclamation No. 286/2002, *Federal Negarit Gazeta* 8th year 8th, No. 34, Art. 112 (1), (2); and T Lencho 'The Ethiopian tax system: Excesses and gaps' (2012) 20 *Michigan State International Law Review* 340 & 377.

²⁵³ Proclamation No. 714/2011, *Federal Negarit Gazeta* 17th year, No.78, article 56 (1,3 & 4).

²⁵⁴ Electoral Law of Ethiopia Amendment Proclamation No. 532/2007.

²⁵⁵ Proclamation No. 97/1998 and Proclamation No. 98/1998.

²⁵⁶ Ethiopian Council of Ministers Regulation No. 155/2008, article 37.

²⁵⁷ See, for instance, Abebe 'The potential role of constitutional review for the realization of human rights in Ethiopia' (n 227 above) 175.

the OECD, the Paris Declaration, signed by 114 countries, the Accra Agenda for Action and the High-Level Forum on the Health MDGs have all called for increased donor coordination.²⁵⁸

Ethiopia is one of the biggest recipients of health and other development aid from the leading bilateral and multilateral aid agencies which devoted much of their advisory, grant and lending mechanisms to health-sector institutional reform and health-sector spending. Numerous donor agencies work with the Ethiopian government in the area of child health which include, Global Fund, the World Bank, UNICEF, UNAIDS, Clinton Foundation, and Bill and Melinda Gates Foundation. In section 5.2.1, it was highlighted that funding from international development co-operation was the largest source during the past 15 years.

Given the large sum of aid flowing into the country, one asks whether there exists a mechanism for basing mutual accountability between donor agencies and the Ethiopian government in relation to child health or related projects. Depending on the internal rules and procedures of a particular donor agency, there are various approaches to mutual donor accountability mechanisms aimed at ensuring fund assistances are actually spent on child health or other projects in Ethiopia.²⁵⁹ These accountability mechanisms are established basically through bilateral agreements concluded between the government and aid agencies. However, the terms and conditions vary from one aid agency to another. Some aid agencies have strict terms and conditions as in the case of Global Fund which requires recipient governments, multilateral or bilateral agencies, non-governmental organizations and others to demonstrate that they have mobilized 20% of the amount exceeding US\$ 200,000 from sources other than the Global Fund for the same CCM budget period, for funding requests the a amounts exceeding US\$ 200,000 per two-year period.²⁶⁰

²⁵⁸ See 'Donor harmonization' available at: <http://www.ministerial-leadership.org/policy-area/donor-harmonization> (accessed 7 November 2015).

²⁵⁹ Interview conducted with Dr. Neway Fida, ex- HIV Programme Coordinator for WHO, 08 November 2015, Pretoria, South Africa.

²⁶⁰ Ibid; 'The Global Fund' available at: file:///C:/Users/u11190184/Desktop/CCM_Funding_Policy_en.pdf. (accessed 12 November 2015).

In addition, according to Mrs. Tsedale Debebe, a framework of mutual accountability between government, donor agencies or NGOs and a community exists in Ethiopia.²⁶¹ She, however, note that despite the importance of this framework, community and local government representatives have little knowledge and capacity comparing the experience she galvanized in counties such as Ghana. In Ghana, the community have better monitoring and follow up of discharge of obligation by the donor agencies according agreed terms and standards. This probably is the result of awareness on accountability agenda and knowledge of rights and duties of the community and government representatives. Research further shows that there exists absence of effective mutual donor accountability mechanisms to assess the progress child health development in the light of human rights standards, to identify shortcomings and determine who is responsible for them, and ensure appropriate preventive measures and remedies for those affected children.²⁶² The costs of this failure will pay children under-five to continue to be deprived of access to basic education, adequate housing, nutrition, sanitation, safe drinking water, decent work and other essential elements of a life with dignity.

Some writers argue that the publication of global and regional human rights in the *Negarit Gazette* is another challenge to the application of human rights provisions by the courts.²⁶³ However, for the purposes of judicialisation of children's rights, I do not consider this as a serious challenge, merely because the judicial practice, especially the children's rights related cases decided by the Federal Supreme Court and cited for purposes of discussion in this work, clearly support a conclusion that publication is not a precondition to judicial notice of these instruments. Further, the current trend shows that courts are increasingly relying on human rights instruments in dispensing claims.²⁶⁴

5.3.10 Challenges of 'democratic developmental state' ideology

²⁶¹ Interview with Mrs. Tsedale Kelbessa, Programme Officer for Save the Children, 10 November 2015, Pretoria, South Africa.

²⁶² UNOHCHR & Centre for Economic and Social Rights *Who will be Accountable?: Human Rights and the Post-2015 Development Agenda* (n 182 above) 5.

²⁶³ See, for instance, Yeshanew 'The justiciability of human rights in the Federal Democratic Republic of Ethiopia' (n 227 above) 288; R Messele *Enforcement of human rights in Ethiopia* (2002)15; Mgbako *et al* (n 238 above) 270.

²⁶⁴ Ethiopian Human Rights Commission (2011) 1:5 Issue 3 *Human Rights Bulletin* 7.

As was highlighted in section 2.3.1 that the ‘developmental state’ ideology poses a challenge to the application of a HRBA for this philosophy, *inter alia*, prioritizes socio-economic rights than civil and political freedoms. Among other things, this disregards the very underlining principle of a HRBA – interdependence, indivisibility and interrelatedness of all human rights. The ruling party in power in Ethiopia - the Ethiopian People’s Revolutionary Democratic Front (EPRDF) - since it took power in 1991 after overthrowing the military junta (*Derg*) committed itself to a more ‘active state’ as opposed to the liberal state. More apparently, it was after the 2005 controversial election that the ruling party publicly declared that democratic developmental state was/is the only option that the Ethiopian development and democracy could be achieved through. Based on the experience emulated from some South and East Asian states, such as Singapore, Japan and China, the late prime minister Meles Zenawi has subscribed to the philosophy as his ruling party’s policy, and his successor prime minister, Hailemariam Deslegn, has demonstrated that the ruling party will continue to uphold it.²⁶⁵

Although the past few years Ethiopia is registered to have shown some level of economic progress, critics and opposition are skeptical about the economic transformation and accuse the ruling party of using development as a means to undermine democracy, human rights (particularly civil and political ones) and consolidating the status quo –‘authoritarian rule’.²⁶⁶ This is manifested in practice in terms of, *inter alia*, the tendency of the government of relegating human rights to ‘developmental issues’ through introducing/amending restrictive laws which, notably, include the Amended Electoral Law (No. 532/2007); the Political Parties Registration Proclamation (No. 573/2008); the Freedom of Mass Media and Access to Information Proclamation (No. 590/2008); the Anti-Terrorism Law (No. 652/2009); the CSO Law; and the Electoral Code of Conduct for Political Parties (No. 662/2009).

²⁶⁵ See, for instance, Haliemariam Desalegn’s defending Meles’s ‘democratic developmental state’ at the symposium on ‘The Meles Zenawi symposium on development: African democratic developmental state’ conducted in Kigali, Rwanda, 21 August 2015. Available at on youtube: [https:// www.youtube.com/watch?v=ZfPLWPEmZTQ](https://www.youtube.com/watch?v=ZfPLWPEmZTQ) (accessed 07 November 2015).

²⁶⁶ See, for instance, ‘Ethiopia: Does economic growth amount to national development?’ available at: <http://www.awrambatimes.com/?p=4887> (accessed 20 October 2015).

Although the fate of children's right to survival or health as a social right seem to enjoy a better place within a developmental state ideology, these rights yet continue to suffer equal neglect in an almost same degree like other freedoms. After adoption of the philosophy, the rate of malnutrition in Ethiopia remains among the few highest countries in the sub-Saharan countries – a region one of the worst in the world in itself. If the Chinese model of developmental states has worked properly in Ethiopia, the government of Ethiopia could have, at least, adopted had an impact on having a more robust infant/child health protection legislative or to the least must show its readiness to achieve same.

In addition, as I dwell upon in section 5.2.2, despite the supposed increase in the health sector, investment in the public health sector is disproportionate to the registered economic growth. In addition, the mechanisms which can be utilized to promote these and other complementary rights have been eroded. For instance, vulnerable children's representation and participation before judicial and non-judicial offices has been significantly disabled for the room for civil mobilization has significantly been hampered with the introduction of the CSO law. Further, the government's adoption of party led state policies and programs (such as in the area of health or education welfare) not only relegates the autonomy of the different federal units, but also engenders participation right of citizens at large. This is a result of Ethiopia's current government policy-making characterized generally by a 'top down' process influenced by one party ideology. For instance, land and rural development reforms were typical of policies formulated and executed in a classic Marxist-Leninist style as a result of the government's ideological obsession.²⁶⁷ The EPRDF believes that 'it is the *only* political entity in the country that can forge the *only* acceptable public policies and thereby lead the people and the country to development, peace and democracy'.²⁶⁸ In practice, the country's key policy decisions are made by the central committee and the Politburo. Not only have almost all policies strictly followed the lead of the ideology, but the policymaking institutions were also patterned accordingly.

²⁶⁷ Wolde 'A critical assessment of institutions, roles and leverage in public policy making: Ethiopia, 1974-2004' (n 109 above) 204.

²⁶⁸ *Ibid.*, 211.

Examined in the light of the country's basic law and human rights obligations, the democratic developmental state policy of the government lacks coherence and harmony.

5.3.11 Other barriers – Political instability, poverty, and conflict

The obligation 'to ensure the child such protection and care as is necessary for his well-being' provided under the CRC is an unqualified one.²⁶⁹ Alston correctly argues the terms 'protection and care' have to be read expansively as their objective is not stated in limited or negative terms, such as to protect the child from harm.²⁷⁰ Despite this requirement of protecting children from anything that affects their wellbeing, conflict, corruption, poverty, poor governance and persistent fragility are major challenges to improving child well-being in Africa, and in the developing world more generally. These types of crises inevitability have a significant implication for children's rights, including their right to survive and health.²⁷¹ Countries affected by these factors have the highest levels of poverty, the highest rates of maternal infant and child mortality and malnutrition and the lowest levels of access to education, water and health services.²⁷²

The Ethiopian state is currently governed by one party, the TPLF, and ruled with the complicity of other ethnic elites that were co-opted into the ruling alliance - EPRDF. The party has been in power for almost a quarter of a century, and it is anticipated it will continue to lead the country for the years to come as the political opposition, largely forced into exile, will remain too fragmented and feeble to play a considerable role in the political power exercise. The country's political system and society have grown increasingly unstable largely because the

²⁶⁹ CRC, article 3(2).

²⁷⁰ P Alston 'The legal framework of the Convention on the Rights of the Child' (1992) 91:2 *Bulletin of Human Rights* 9.

²⁷¹ For example, for a recent and more comprehensive engagement on the impact of conflict and political instability on neonatal mortality, see PH Wise & GL Darmstadt 'Strategic governance: Addressing neonatal mortality in situations of political instability and weak governance' (2015) 39:5 *Seminars in Perinatology* 387–392.

²⁷² ACPF *Africa's Children and the Post-2015 Development Agenda* (2013) 18.

regime has often become repressive.²⁷³ It has failed to implement the policy of ethnic federalism effectively. The country exhibits greater political centralisation, with concomitant ethnicisation of grievances. After 25 years in power, the ruling party declared that it had won 100 per cent of the parliamentary seats in the May 2015 national election. One party rule leaves the people with no hope to channel any of their grievances with legitimate means. As a result, there is growing popular discontent and radicalisation along religious and ethnic lines as well. In a nutshell, these divisions and social unrest are likely to represent genuine threats to the state's long-term stability, unity, development and respect for human rights. Children's and women's wellbeing is the first that will be affected in situation of conflict and instability as they are easily vulnerable. Respect for a multi-party system and freedom of expression should be realised to prevent potential challenges of instability. In a way, this is an indication that progress in civil and political rights is vital to promote children's wellbeing.

Poverty is another barrier to ensure children's right to wellbeing in the country that has a significant impact on the enforcement of socio-economic rights of children, including their survival rights.²⁷⁴ Despite the fact that the country has seen great progress in its economy, poverty in Ethiopia remains a major concern. Inequalities widely exist. On top of the prevailing poor health system, the level of child mortality is worsened particularly by poverty.²⁷⁵

The problem of inequality is worsened by limited investment in safety net programs for poor people, which in turn might be affected by several factors. I do not aim to deal comprehensively the various potential factors. I highlight two of them as they are major causes. An emerging pattern in sector level corruption could be one. Although corruption in

²⁷³ International Crisis Group 'Ethiopia after Meles' available at: <http://www.crisisgroup.org/en/regions/africa/horn-of-africa/ethiopia-eritrea/b089-ethiopia-after-meles.aspx> (accessed 23 May 2015).

²⁷⁴ For a more comprehensive elaboration on poverty and children's right to survive, see S Pemberton *et al* 'Child rights and child poverty: Can the international framework of children's rights be used to improve child survival rates?' (2007) 4:10 *PLoS Med* e307. Also, for a more elaborate engagement on poverty and children's socio-economic rights in the context of South Africa, see D Chirwa 'Child Poverty and Children's Rights of Access to Food and Basic Nutrition in South Africa: A Contextual, Jurisprudential and Policy Analysis' (2009). For insightful engagement on poverty and injustice, see generally, D Brand *et al* 'Poverty as injustice' (2013) 17 *Law Democracy and Development* 273-297.

²⁷⁵ FDRE MoH *National Strategy for Child Survival in Ethiopia* (n 169 above) vi, 1,18.

Ethiopia in the delivery of basic services is potentially much lower than other low-income countries, nevertheless studies show that the problem is taking root.²⁷⁶ One finds corruption in the health sector too in its various forms.²⁷⁷ Training is an area where corruption affects efforts to address health development. As commonly known, UN agencies and NGOs organize training and workshops to build the capacity of health workers in the developing countries. In such training the ‘participants might receive daily allowances up to half of their monthly salaries’.²⁷⁸ However, it is observed that some participants attended training who did not qualify to carry out the intended work. In connection with such negative examples observed from South Ethiopia, the following has been said:²⁷⁹

...We know of examples when managers, without medical training, took part in course on how to treat drug resistant tuberculosis. And some staff take part in courses to resuscitate neonates, but never work in a delivery ward. Again, examples of “misuse’ of entrusted power for private gain”.

Apart from in the area of training in the health sector, corruption is becoming common in several other sectors too. For instance, corruption in land distribution and administration is institutionalized.²⁸⁰ Businesses will be asked for facilitation payments as well as bribes when they engage with government offices in relation to land issues. While the country’s salary scale for government officials is among the lowest in the world, several officials become millionaires all of a sudden. According to sources, the country’s long serving ex-prime minister, Meles Zenawi, is estimated to have a net worth of US\$3 billion.²⁸¹ Several ministers and officials are also alleged to have been involved in serious corruption cases, enriching themselves from public money by misusing their powers. The funds and resources allegedly embezzled could

²⁷⁶ J Plummer ‘Overview’ in J Plummer (ed) ‘Diagnosing Corruption in Ethiopia: Perceptions, Realities, and the Way Forward for Key Sectors’ (2012) 1-17.

²⁷⁷ WD Savedoff & K Grépin ‘Health sector corruption in Ethiopia’ in J Plummer (ed) ‘Diagnosing Corruption in Ethiopia: Perceptions, Realities, and the Way Forward for Key Sectors’ (2012) 19-66.

²⁷⁸ International Health Research ‘Do NGOs corrupt health institutions?’ available at: <https://bernt.b.uib.no/category/corruption/> (accessed 23 April 2015).

²⁷⁹ Ibid.

²⁸⁰ Wikipedia, the Free Encyclopaedia ‘Corruption in Ethiopia’ available at: <http://en.wikipedia.org/wiki/Corruption> (accessed 30 April 2015).

²⁸¹ Celebrity Network ‘Richest politicians and presidents, Melese Zenawi Net Worth’ available at: <http://www.celebritynetwork.com/richest-politicians/presidents/meles-zenawi-net-worth/> (accessed 24 April 2015).

have a huge impact in improving the socio-economic condition of the people, if they were invested only for public purposes.

One other factor is associated with the recent increases in food prices in the country. Sharp increase of food prices has had a severe impact on the ability of many families to feed their children adequately. Despite the general reduction in food insecurity, access to adequate food is a distant goal for millions in the country. The living cost is ‘intolerably expensive for Ethiopians in Addis Ababa, the capital, and its outlying towns’.²⁸² As the living cost continues to escalate and the currency, Birr, continues to depreciate, many families are left in greater poverty. To partly address the inequality, attempts have been made to implement government school feeding programs at government schools. However, the program has not been implemented consistently and comprehensively.²⁸³ In addition, although the country has adopted a social protection policy as discussed in chapter three ²⁸⁴ and many lives have been saved by deploying multi-year investments in safety nets, the promise of universal social protection remains to be fulfilled.

In one incident, a woman posted on her Facebook an incident of children who fainted at *Temenja Yaj* School located in the capital of Ethiopia, Addis Ababa.²⁸⁵ The cause of the problem was that they did not eat enough food at home because their parents could not afford to give it to them. Using social media, she called upon her friends to contribute funds and ultimately deliver basic material things including food items and clothing to children at that particular school.²⁸⁶ As freedom of expression is significantly curtailed and censored in the country, social media plays a pivotal role to uncover public concerns and human rights violation. In my current

²⁸² The Economist ‘Ethiopian economics: A peculiar case’ (Mar 2nd 2012). Also, available at: <http://www.economist.com/blogs/baobab/2012/03/ethiopian-economics> (accessed 30 April 2015).

²⁸³ Interview conducted with Mr. Tilahun GebreTsadik (n 158 above).

²⁸⁴ See section 4.6.9.

²⁸⁵ Y Tamrat, available at:

<https://www.facebook.com/photo.php?fbid=764899216867333&set=a.543668778990379.128353.100000417842839&type=1&theater> (last accessed 25 May 2015).

²⁸⁶ Ibid.

email exchange with her to gather further information regarding the number of children affected by the incident and how the situation was attended, the blogger responded:²⁸⁷

It was a lot of them around 70, they literally had nothing to eat so they fainted in the middle of their class, then the teachers feed them their lunch, and they start collecting money from their salary and managed to give them half *enjera with mitmita (local food items)*..... But now thanks to some kind people they feed them proper food and the kids are in better condition....but there are still other schools that have the same problem... (Emphasis mine).

The above incident is simply the tip of the iceberg to indicate the problem that poverty is one of the major factors that vulnerable children are currently facing. To me, these are the kind of vulnerable groups in society whose voice is not heard and who are denied the possibility to live humanly and in dignity. For obvious reasons the incident had direct or indirect significant negative impacts on child survival or health. To restate what I argue earlier in this thesis,²⁸⁸ any meaningful reduction of child mortality cannot occur without addressing challenges of the underlining determinant of the right to health, such as food and safe drinking water. As discussed in section 4.4.6 of chapter four, the country has ratified the relevant treaties in this regard and is bound to implement children's right to an adequate standard of living. The country's poverty reduction program should be implemented to the full and poverty alleviation efforts must play a major role in securing access to food and proper nutrition to the citizenry.

Political instability and poverty are compounded by interlinked factors such as conflicts, disease epidemics, climate change, and droughts. Violent conflicts have disillusioned all efforts to establish food and nutrition security in East Africa, of which Ethiopia is a part.²⁸⁹ Sadly, 88 percent of the global conflict death toll, between 1990 and 2007, occurred in sub-Saharan

²⁸⁷ Y Tamrat, email message to author, 28 May 2015.

²⁸⁸ See, for instance, section 3.3.3.2.

²⁸⁹ Consultancy African Intelligence (CAI) 'Food insecurity and malnutrition in Africa: Current trends, causes and consequences' available at :http://www.consultancyafrica.com/index.php?option=com_content&view=article&id=1122:food-insecurity-and-malnutrition-in-africa-current-trends-causes-and-consequences&catid=61:hiv-aids-discussion%20papers&%20Itemid=268 (accessed 16 May 2015).

Africa.²⁹⁰ In Ethiopia, violent conflicts,²⁹¹ ethnic unrest involving fights over natural resources or resource based violence, land grabbing²⁹² as well as quarrels over border lines due to geo-political implications, have contributed to the displacement of people, and subsequently, lack of access to food and adequate shelter in those areas affected by these incidents. In relation to drought happening currently, 8.2 million people out of an estimated population of 99 million need aid in Ethiopia, according to the UN report in October 2015.²⁹³ This figure could surge to 15 million in 2016 as food stocks run out and rains fail again. The BBC reported that from one small village alone 2 children die every day due to the current famine.²⁹⁴ This incident reveals that children's are the first to be affected – as malnutrition gets high during this time. Although one observes that the country may well have gained the capability to overcome catastrophe compared to the famine in 1984, the country's capacity to resist famine runs counter to that prevailing narrative – double digit economic growth.

5.4 Conclusion

In this chapter I monitor the extent to and the manner in which Ethiopia has made efforts to live up to its commitment to reduce child mortality in accordance with the requirements of

²⁹⁰ Ibid.

²⁹¹ For instance, one that occurred between Afar and Issa that has been taking place for the last six decades, over resource. For a more detailed study on this conflict, see A Menbere 'Resource based violent conflict between pastoralists of Ethiopia: An exploration into Afar-Issa conflict' (2013) 2 *International Journal of Scientific Engineering and Research* 51-64.

²⁹² Recent renewed economic interest in developing countries has given rise to a wave of private and public acquisitions of large-scale farmland for plantation agriculture. Ethiopia is one such country where large land grabbing is taking root. In this country, much land acquisition is led by national parastatal agencies to develop sugar cane plantations, rice and other areas of agriculture. The case of forced displacement in the regional state of Gambella to lease large areas of land for commercial agriculture is an example. Human Rights Watch interviewed over 100 residents affected in the first round of the villagization program in Gambella and found widespread human rights violations including denial of the right to food and food security, right to education of children, right to adequate housing, forced labor and displacement. For details on this, see Human Rights Watch "Waiting Here for Death": Forced Displacement and "Villagization" in Ethiopia's Gambella Region (2012) 39-60; Cotula Addressing The Human Rights Impacts of "Land Grabbing" (n 249 above) 13; The Guardian 'Ethiopians talk of violent intimidation as their land is earmarked for foreign investors' available at: <http://www.theguardian.com/world/2015/apr/14/ethiopia-villagisation-violence-land-grab> (accessed 24 May 2015).

²⁹³ See '22 million people in the Horn will need food aid by year-end' available at: <http://hornaffairs.com/en/2015/10/29/el-nino-22-million-people-need-food-aid/> (accessed 05 November 2015).

²⁹⁴ See 'Can Ethiopia cope with worst drought in decades?' available at: <http://www.bbc.com/news/world-africa-34783604> (accessed 12 November 2015).

global and regional human rights and domestic laws and policies. I have shown that there is an indication that the country is concerned about the high rate of child mortality. This concern is manifested in a variety of ways. Firstly, the government is setting child and maternal mortality as a priority agenda, which can be inferred from the numerous child and maternal health related policy and strategy statements. Secondly, there is strong partnership that the government is able to make with global agencies, like UNICEF, and it is soundly participating in global initiatives to improve child and maternal wellbeing. This partnership and cooperation with donor agencies is to be applauded. Thirdly, the number of health facilities, professionals and budgeting on health of children has been increased in the past few years. Viewed together, progress was achieved over the past few decades in terms of addressing child mortality in Ethiopia. Furthermore, the grounds for optimism are there for further reduction or for eliminating the rate of preventable mortality.

Despite the efforts that the country has made to improve child wellbeing, child mortality or children's access to quality health care remains an unfinished agenda and the country is still among those nations that contribute to the highest mortality rates in the global-South. The rate of neonatal death is almost stagnant over the years. Child health inequity is widely common. Limited cost intervention efforts could have made a huge difference to address this human rights challenge. The country needs to address the bare minimum content of the right to health care that any country, at any level of development, is required to implement, in order to achieve further gains in the health sector.

I identify multifaceted factors that potentially limit the full realisation of child survival and its other complementary rights. Firstly, child survival or health is not owned as a human right concern where government has the responsibility to address. The country does not seem to take it as a serious concern to integrate children's right to survival and health into the national legislation, policies, strategies and plans of action. Express recognition of children's human rights norms is a significant step toward protecting and promoting the rights at risk, as rights create corresponding obligations. Obligations in turn give rise to a system of accountability. Secondly, health services and facilitates are short of availability, accessibility, acceptable and

of quality. Thirdly, the system of accountability is not up to the desired level. The involvement of judicial and quasi-judicial mechanisms in ensuring accountability of those who wield power over children's health rights is insignificant. Fourthly, the budget that goes to the health sector is not proportional to the required need and depends, highly, on foreign aid, which puts in question the sustainability of the existing initiatives to address the problem. Fifthly, one of the greatest and most potent impediments of the child health system in Ethiopia is lack of capacity, including resource, managerial and skill inadequacy, amongst key stake holders. In the face of multiple barriers, lack of equipment and training, and only some health professionals with the requisite knowledge, the task of realizing the aspiration of eliminating child mortality is seemingly an insurmountable one for the government. Other factors such as political instability, poverty, corruption and conflict exacerbate measures to ensure children's right of access to basic material things to live.

There is no easy answer to the question of how to address child health in Ethiopia. I argue that more progress could potentially be achieved should the following be considered:

- There is a need to recognise child survival rights as a human rights agenda. This can be done through integrating children's right to survive and enjoy access to quality health care into national legislation, policies, strategies and plans of action.
- An independent accountability mechanism must be present in the country to enforce these rights. Although the framework of accountability does seem to exist structurally, these mechanisms are beyond reach in practice in current Ethiopia. This represents a key challenge. If the ultimate goal of a post-2015 agenda is to contribute towards the full realization of all human rights for all that includes children, then there is a need to strengthen effective and independent accountability mechanisms. In order to do so, *inter alia*, there is a need to create an enabling environment to engage an independent civil society through amending the current CSO law; the establishment of effective monitoring systems; revision of the health budget; and access to, and implementation of, the decisions of accountability mechanisms that are relevant to health policies and programs.

- Overall, any post-2015 agenda for improving child survival should be informed by a commitment to abide by human rights principles and standards. Borrowing a vocabulary from Joy Phumaphi ‘the country does not need to wait, and that human rights should define the way the state and its various machineries live and work no matter what hat they wear’.²⁹⁵

²⁹⁵ UNOHCHR ‘A human rights approach to reducing child deaths’ available at: [http:// www.ohchr.org/EN/NewsEvents/Pages/Ahumanrightsapproachtoreducingchilddeaths.aspx#sthash.8xFhXO.dpuf](http://www.ohchr.org/EN/NewsEvents/Pages/Ahumanrightsapproachtoreducingchilddeaths.aspx#sthash.8xFhXO.dpuf) (accessed 23 March 2015).

Chapter 6

Summary, conclusion and recommendations

One of the greatest achievements of the Convention on the Rights of the Child (CRC) is the fact that it has become the first global instrument to recognize children's right to maximum survival and development as a human right. This effort to ensure regional protection of the child survival right is further strengthened by the recognition of the right in the African Charter on the Right and the Welfare of the Child (ACRWC). These instruments place obligations of conduct as well as obligations of results on state parties to ensure that children enjoy the maximum survival in their domestic system and through the mechanisms of international cooperation.

It has now become twenty five years since the CRC has envisioned a world in which all children will survive and reach their full potential. Remarkable progress has been seen in increasing survival rates of children globally, yet developing countries, such as Ethiopia continue to grapple with high child mortality rates and far too many children are left behind, without protection. Most of these child deaths are from preventable causes and the world knows that proven, cost-effective interventions for health, nutrition, education, water and sanitation will help reach these children and save them from premature death. Besides, there is a widely held view that a human rights-based approach (HRBA) can also benefit states in the implementation of their policies and programs to reduce and eliminate preventable mortality and morbidity of under-five children.¹

In this thesis, I make a case for the contribution that a HRBA could make to further improve child survival rights through examination of the conceptual framework of a HRBA and the laws,

¹ See, for instance, UN Human Rights Council *Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age*, available at: <http://www.ohchr.org/Documents/Issues/Children/TechnicalGuidance/TechnicalGuidancereport.pdf> (accessed 23 June 2015).

policies and institutional framework in the Ethiopian context. In this respect, I discuss the following themes and indicate the conclusions that are drawn.

6.1 Summary and conclusion

6.1.1 The conception of a HRBA and its implication and application to child survival

I argue in the previous chapters² that socio-economic rights have received and continue to receive less attention than other rights, contrary to a strong desire by many for their implementation. In response to this challenge, the end of the Cold War has supported the emergence of a more differentiated view of both global problems and challenges that mainly had repercussions on these human rights. In chapter two I set out that this development has resulted in the emergence of a human rights approach to development which recognizes primarily the legal obligation of members of human rights treaties to development cooperation and development efforts in all areas of human rights. A wide variety of UN conferences and initiatives in the 1990s have played a significant role in disseminating, legitimating, and deepening the rights-based approach.

Developed in 2003 through the joint effort of UNICEF, the UNDP, and UNOHCHR, the ‘Common Understanding on the Human Rights-Based Approach’ to development is used as the main point of reference for understanding this approach. According to the Understanding, all UN development activities after 2003 were to be structured to advance the principles codified in the Universal Declaration of Human Rights and its associated conventions.³ As a result, the Common Understanding’s basic tenets include an emphasis on the universality, indivisibility, and interdependence of all rights, along with principles of non-discrimination, popular participation, inclusion, accountability, and the rule of law.⁴

² See, for instance, section 5.1.

³ HRBA Portal ‘The human rights based approach to development cooperation towards a common understanding among the un agencies (2003)’ available at: <http://hrbaportal.org/the-human-rights-based-approach-to-development-cooperation-towards-a-common-understanding-among-un-agencies> (accessed 17 May 2015).

⁴ Ibid.

Despite its proliferation over two decades, the approach has gone and continues to go through several challenges. It has suffered from the challenges of conceptual clarity to practical application. In a nutshell, its application is not straight forward as there is a challenge of placing boundaries on what can be legitimately described as a HRBA. Although rights-based development thinking has many variations, most share the following core principles: assess human rights conditions before formulating their plans and projects; identify rights-holders and duty bearers in prospective projects; ensure local participation in project planning and implementation; create and strengthen mechanisms of citizen government accountability; reduce discrimination against marginalized groups; focus on development processes, in addition to outcomes; and, most importantly, engage in local and international advocacy efforts to promote the rights of vulnerable groups.

Despite the impressive progress, child mortality rates remain a human rights failure of our current times. Naidoo avers that ‘it represents the modern face of poverty and inequality today’.⁵ The under-five population around the world are ‘right holders’: they are neither objects of charity, nor obedient, powerless, and voiceless masses. Nevertheless, many such children continue to be a subject of preventable deaths from a small number of diseases and conditions.⁶ Against this backdrop, applying a HRBA to child mortality can be a powerful means to advance child survival rates and to challenge the status quo and the prevailing patterns of discrimination and prejudice. There are different ways in which a HRBA applies to child mortality. Firstly, it implies that states with high child mortality rate must ratify international treaties relevant to neonatal mortality and incorporate them into national laws and policies. Adopting and enforcing laws and policies that promote access to high-quality maternal and new-born care in both the public and private sectors is a key component of a human rights-based approach to preventing neonatal mortality. Secondly, it requires states to critically

⁵ ‘Child mortality is our human rights failure of the 21st century’, *Daily Maverick*, (26 September 2013) available at: <http://www.dailymaverick.co.za/opinionista/2013-09-26-child-mortality-is-our-human-rights-failure-of-the-21st-century/#.VaV7DI-qqko> (accessed 23 May 2014).

⁶ UN Human Rights Council, *Study by the World Health Organization on mortality among children under five years of age as a human rights concern*, 6 September 2013, A/HRC/24/60, para 14, available at: <http://www.refworld.org/docid/523061aa4.html> (accessed 23 March 2015).

attend to health services to neonatal health in the immediate postnatal period, and to pay attention to the availability, accessibility, acceptability and quality of facilities, goods and services. In this regard, attention is also to be paid to other relevant standards and principles of non-discrimination and the best interests of the child, so that actions to address neonatal mortality are sufficiently targeted to marginalized communities to eliminate inequalities, including those in remote areas, and to ensure that children's interests are prioritised in government's budget and other measures. Thirdly, it urges states to ensuring effective community participation in policy making in child health-related activities. Community participation in planning policy design, service delivery, monitoring and evaluation can also contribute to addressing inequalities in neonatal outcomes. Fourthly, ensuring accountability at various levels, including but not limited to the health facility level (to identify any shortcomings in service provision at this level) is also required.

In order to combat child mortality effectively, countries struggling with this challenge must move beyond clinical and public health interventions and address the underlying determinants of health, including half-related rights such as non-discrimination and participation. HRBAs result in not only good public health but also are underpinned by global, regional and national human rights legal obligations that must be respected, protected and fulfilled. Together, they can generate stronger leadership from governments and international organizations to scale up action to address to address child survival.

The explicit use of human rights in the child mortality area (a specific health area) is fairly recent. As such, a call to the rights framework to child mortality does not, therefore, in itself imply that the approach can provide neat answers to the on-going and complex children's health and their other complimentary rights challenges, any more than does any other single approach. Nevertheless, it is not an unmanageable enterprise. It has a profound contribution to make towards building equitable health systems and thereby curbing preventable child

mortality rates. There is growing good practice and evidence suggesting that it does so and showing the ways in which it operates.⁷

6.1.2 The legal protection of child survival and the obligation of actors

In the third chapter, I describe the existing legal protection mechanisms on child survival and its complementary rights from the purview of both the global and regional frameworks. Equally, I investigate the manner and the extent to which child survival is incorporated as part of joint political commitment of governments to give every child a better future. I find that there is a cluster of provisions that are important to protect against child mortality. These include children's right to survive, to health, to life, to an adequate standard of living, to non-discrimination and participation, to information and education and other interrelated rights. This indicates that child survival is a cross-cutting and multidisciplinary affair that affects a number of different rights in both global and regional law. Seen together, it can be argued that there is a sound legal basis for protecting child survival rights. This wide range of rights related to child survival reinforces the importance of human rights realisation for child mortality reduction.

I further investigated the legal obligations flowing from the human rights treaties discussed. These instruments envisaged several duty bearers broadly categorized as state and non-state actors that are responsible for different duties in relation to children's right to survival. By ratifying the relevant treaties, first, states are obliged to integrate the right and its complementary rights into all national laws, policies, programs, strategies, and plans of action, at national and sub national level, and respond in a way consistent with the letter and intent of the law.⁸ After all, if the right to child survival is neither an established feature of domestic law, nor integrated into national health-related policies, it does not really serve a useful purpose. Secondly, states agree to implement these treaties and relevant national laws to be

⁷ F Bustreo *et al Women's and Children's Health: Evidence of Impact of Human Rights* (2013) 1-136.

⁸ See UNICEF 'A Human Rights-Based Approach to Programming for Maternal Mortality Reduction in a South Asian Context: A Review of the Literature' (2003) 6.

accountable for meeting the rights and the needs of their children. Any meaningful reduction of under-five mortality emanating from these obligations demands making available to children the underlying determinants of the right to health, such as access to nutrition, vaccination, safe and portable water, and educating mothers. Fulfilling these requirements urge only low-cost intervention efforts by states. It may compel us to the conclusion that implementation of infant survival should be regarded as a minimum legal condition. If the condition is implemented properly, it can significantly contribute to the protection of child survival rights and ultimately to reduction of under-five mortality. If we provide for the survival and development of children everywhere and protect them from preventable death, we will surely build the foundation of the just society we all want and that children deserve.⁹ What it needs is good governance and a system that holds governments accountable for their promises. Independent monitoring of the extent of avoidable infant death and the cost of saving each life compared to the costs each country incurs for other purposes such as ‘saving life’ through military expenditure and accountability through judicial and non-judicial bodies is also crucial.

6.1.3 The legal, policy and institutional framework on child survival in Ethiopia

In the fourth chapter I examined the legal, policy and institutional framework governing child survival in Ethiopia. With regards to the legal framework, I indicate that the FDRE Constitution dedicates a specific provision on children’s rights. Although it draws on many of the principles of key international human rights instruments, like the CRC, the FDRE constitution does not look to be pro-poor children. I have established that the cluster of provisions in article 36 of the Constitution does not guarantee children’s right to survival, to health, to an adequate standard of living, to safe drinking water and to other underlying determinants of the right to health. Neither does there exist special legislation to govern these matters. My overall analysis of the legal regime applying to child mortality in Ethiopia reveals that children’s right to

⁹ PDHRE: The People’s Movement for Human rights Learning ‘Convention on the Rights of the Child’ available at: <http://www.pdhre.org/conventionsum/crcsum.html> (accessed 22 July 2014).

survival, to health and their other socio-economic rights have suffered from a lack of constitutional protection or discourse in Ethiopia.

Furthermore, while several health policies and strategies affecting child survival have been adopted in Ethiopia after the fall of the *Derg* regime, the policies and strategies have either not been fully implemented or not well designed to meet their goals and objectives. Few policies or strategies have human rights elements but they are not systematically human rights proofed and they are yet to bring improvements in the material life of hundreds of thousands of under-five children.

The conclusion that can be drawn from the foregoing is that the country is short of meeting the requirements to make appropriate legislative measures provided under article 4 of the CRC. Similarly, the failure to explicitly incorporate the relevant provisions that protect children from premature death is an indication that the country is not in compliance with article 1(1) of the ACRWC which requires member states, in accordance with their Constitutional processes, to adopt such legislative measures as may be necessary to give effect to the rights, freedoms and duties enshrined in this Charter.

The forgoing does not imply that there is no legal ground at all to make a case for child survival rights in the country. This is especially because the country has ratified the CRC and ACRWC and that courts have started to deploy these instruments as an interpretive value in their judgments. In the absence of explicit provisions that are relevant to child survival, it can be argued that these treaties, along with the children's right to life provision in the Constitution, can be used a useful tool to protect children from preventable death. This approach, nevertheless, is not straight forward and would need judicial boldness and progressive interpretation of laws.

Concerning the institutional response to address child mortality, I argue that children's right to survival does not operate in a vacuum. It fundamentally needs creating effective institutions

which direct, implement and enforce policy and laws related to survival rights and establishing mechanisms for appropriate redress and recourse in case of violation. I have established that the various current laws of the country recognize several institutions and at the same time empower them on different matters to ensure children have a better future. There is sufficient recognition of the role that institutional mechanisms could play for the realization of children's right to survive. The different institutions that are defined include the office of the judiciary, the Ethiopian Human Rights Commission (EHRC), the Ethiopian Institution of Ombudsman (EIO), and the various ministerial offices whose powers and duties are defined by special legislation. Nevertheless, the contribution of these institutions is not up to the desired level, mainly on account of the following.¹⁰ Firstly, with regards to the different executive organs, ministries, bureaus, governmental and non-governmental institutions and agencies working on issues related to children's rights, it is identified that these organs do not have the required human and financial capacity to function effectively and fulfil their tasks and responsibilities adequately.

Secondly, with regards to the judiciary, the duty to fulfil rights places an obligation on states parties to take appropriate judicial and other measures to the maximum extent of their available resources to ensure that children realize their rights to health care. Studies such as those that emphasize the high child mortality and morbidity rates worldwide provide an important indication for states parties of possible breaches of their duties to ensure children's access to health care. They provide a framework for access to effective, child-friendly legal remedies, both judicial and non-judicial, in the case of human rights violations in relation to child health and survival, and ensure that statutes of limitation are not unduly restrictive. In the Ethiopian context too, most of the causes of under-five death are preventable - potentially indicating dereliction of duty to further reduce child mortality rates by putting in place low cost intervention measures. However, except in criminal matters (as in case of infanticide, and child maltreatment), judicial remedies for violations of child survival and related rights are

¹⁰ M Marin *Enhancing the functional protection of human rights in Ethiopia project (UDF-ETH-08-227)*, *Mid-term Review* (May 2011) 11-25; Y Kidane 'The roles and the challenges of Ethiopian national human rights institutions in the protection of human rights in the light of the Paris principles' *unpublished LLM paper, Central European University*, 2010 51-77.

uncommon in Ethiopia. The limited roles of courts in applying human rights arise mainly from the constitutional uncertainty of their role in enforcing the bill of rights of the Constitution; the inaccessibility of treaty texts to judges and the public in the languages they understand; limited legal support for public interest litigation (PIL); the divided position of judges on justiciability of socio-economic rights; ouster clauses that exclude courts from overseeing decisions of administrative bodies and tribunals; the weak authority of the judiciary to control the executive; and lack of adequate domestic laws that give detailed content particularly to socio-economic rights. Besides, although the notion of separation of powers between the three branches of the government exist in the law books, Ethiopian judges are not known for their judgments in questioning executive acts for failure to protect, promote and fulfil human rights. Owing to their historical subordination to the executive, they have been non-proactive to recognize their heightened responsibility as guardians of human rights. The untenable nature of this stance is evident in the Concluding Observations of the Committee on Economic, Social and Cultural Rights which criticize the fact that the provisions of ICESCR have not been invoked by Ethiopian courts.¹¹

Thirdly, as regards the NHRIs, the EHRC and the EIO are legally and physically present, but have yet to prove their independence and proactive engagement in human rights issues, including children's health matters, calling government to account. Besides, the work of these institutions is debilitated by inadequate staffing, a dearth of skilled manpower and other logistics, and they are not physically accessible to a great majority of the rural population. These, taken together, make accountability mechanisms for child survival remote in Ethiopia.

6.1.4 Opportunities and challenges on child survival in Ethiopia

In chapter five, I monitor the positive developments and challenges ahead pertaining to implementation of child survival rights in Ethiopia, building upon the discussions I made in chapter 4. I have established that, looking ahead post-2015, the fate of child survival in the

¹¹ UN Committee on Economic, Social and Cultural Rights (CESCR), *Consideration of reports submitted by states parties under articles 16 and 17 of the Covenant: Concluding observations of the Committee on Economic, Social and Cultural Rights- Ethiopia*, 31 May 2012, para 5, E/C.12/ETH/CO/1-3.

country is posed with challenges and opportunities which can be manifested in several ways. The opportunities include, firstly, that there is an indication that the country seems to be concerned about the high rate of child mortality. In this connection, the government is setting child and maternal mortality as a priority agenda which can be inferred from the numerous child and maternal health related policy and strategy statements. Secondly, there is strong partnership that the government is establishing with the industrial world and global agencies such as UNICEF, and it is participating in global initiatives to improve child and maternal well-being. This partnership and cooperation with donor agencies is to be applauded. Thirdly, the number of health facilities, professionals and budgeting on health of children has been improved over the past few years. Health service coverage has been expanded over time. Fourthly, the two-digit economic growth that the country has registered over the past decade leaves the country with optimism that same will increase the capacity of the country to shift financial resource to solidify efforts of combating child mortality. Fifthly, despite the problem in the quality, the rate of girls and women education has increased through time. This enables them to better capture health knowledge as regards the precautions they need to make during pregnancy, birth and following it. In other words, it enhances their capacity to make informed decision regarding their own health and that of their children.

Despite the forgoing, there are many and complex factors that potentially limit the full realisation of child survival and its other complimentary rights in the years that lie ahead. Firstly, current national laws, policies and strategies fail to highlight human rights norms and standards which affect child survival. This implies that child mortality is not a human rights concern shaped by these norms and principles. Although they do not provide easy solutions to complex health issues, ignoring these elements in the national system will weaken the mechanisms to ensure government complies with its obligation to promote child survival rights. Besides, it erodes the capacity of rights holder to claim their rights and duty bearers to implement their human rights obligations enshrined in human rights law. It also diminishes the capacity of health professionals and human rights experts to maintain and extend their collaboration to address child mortality or to realize the right to the highest attainable

standard of health for all. It disables the giving of help to advance the health-rights agenda both within health delivering institutions and beyond; and limits the traffic of concepts and experience between health and human rights.

Secondly, inequality in access and fragmentation in governance of health services is a major challenge. There is *prima facie* proof that discrimination in access to children's rights to health is the order of the day, contrary to the lofty principles of non-discrimination and equality. Although inclusive child health cannot be materialized overnight, the inequity indicates that the Ethiopian government has yet to take further steps to move progressively towards establishing such an inclusive health setting.

Thirdly, there is a weak system of accountability for the government's commitment to reduce child mortality. Although very important, the practice of the role of the accountability mechanism in the promotion, protection and fulfilling children and maternal health in the country is insignificant except that one may find few and soft audits and recommendations made by the EIO. Accountability is indispensable so that gaps in policy and practice are fulfilled and addressed.

Fourthly, central to activating accountability for failure of the governmental obligations with respect to health rights of children and women are the efforts of civil society advocates. Despite their contribution, this thesis revealed that existing legal and practical challenges cripple the transformative potential of civil mobilization for children's right to health in the country. The forgoing challenges are compounded by limitations on access to health services and supplies, participation, weak vital registration systems; lack of adequate budgeting; loose coordination on implementation of children's rights; and other barriers, such as political instability, poverty, and conflict.

In a nutshell, from the above discussion it can be gleaned that post-2015 there is both 'hope' and 'hype' for further reducing or eliminating child mortality from the country. There cannot

be a definite answer to achieve a significant reduction or elimination target, but a HRBA model, if implemented properly, has the potential to contribute in this regard. In order for this to happen, a major theme for reform in Ethiopia in terms of child survival and child health generally, is the need for increased interface between health and human rights. It is submitted that these two fields are not ‘uneasy bedfellows.’ They can sit comfortably alongside each other and equally complement each other if appropriately applied.

6.2 Recommendations

In effect, what I discuss in this thesis is how the future of child survival can be in Ethiopia and the role that the human rights framework can play to complement existing health development efforts of the country. A HRBA to child mortality approach offers government to develop a voice that is familiar to its constituency and an identity that fosters a constructive complementarity between public health development and human rights. To do so, it imposes the duty to countervail the myriad of current challenges and those that still lie ahead. Continued innovation in the health and human rights fields is necessary. There are no magic bullets to be utilized. Weston points to the need for a strategy with a ‘multitude of mechanisms and techniques’ at all levels, ‘from the most local to the most global,’ engaging all elements of society and proceeding with imagination and energy to succeed in the abolition of child labor.¹² Given that multiple causes contribute to high child mortality rates, I equally maintain that no single action is enough to address the problem of child survival in the country. An essential cascading of a HRBA to child mortality requires taking several measures. The following recommendations are offered to each of the identified challenges in the forgoing section.

6.2.1 A review of the federal and state constitutions governing children’s rights

My assessment of the legal regime applying child mortality in Ethiopia reveals that children’s right to health and their other socio-economic rights have suffered from a lack of constitutional protection. The overall picture that can be captured is that constitutional discourse in Ethiopia

¹² B Weston ‘Child labor in human rights law and policy perspective’ in J A Gross & L Compa (eds) *Human Rights in Labor and Employment Relations: International and Domestic Perspectives* (2009) 73-121.

concerning children's rights has largely focused on their civil and political rights rather than their socio-economic counterparts. This shows that the notion that rights are indivisible and interdependence is not well entrenched. Retaining the FDRE Constitution and the regional states counterparts in their current form is not an efficient way for the country to promote and protect children's right to survival, health and their other social rights.

To further enhance the ability of the FDRE and state Constitutions to offer better and holistic protection to children in Ethiopia it is recommended, without prejudice to section 6.2.2 and other suggestions below, that both Constitutions should be amended to benefit all rights of children, which include the right to health, food, and access to safe water and other related rights – they have been highlighted in the course of this thesis. These complementary rights to child survival rights exist in the global and regional laws that the country is a party to and they should be incorporated into the domestic system for ease of enforcement. Section 28 of the 1996 South African Constitution, for instance, could be used as a good example to benchmark during any amendment process. Where there exists a high level of political commitment for the realization of children's survival rights, there is a commitment for the constitutional recognition of the right to health of children, access to adequate food and safe drinking water.

6.2.2 Adoption of a comprehensive children's acts rooted in the CRC and ACRWC

Amendment of the FDRE Constitution or that of the regional states suggested above is not a straight forward process, and may not be implemented in any immediate future. Arguably, the FDRE Constitution is one of the stiffest in the world to amend and since its adoption in 1995, there has not been a proposal submitted to the parliament for amending the Constitution's provision/s.¹³ It contains stringent procedures to overhaul it.¹⁴ A relatively easier alternative approach is for the country to adopt a comprehensive children's act which unambiguously

¹³ AK Abebe, 'The potential role of constitutional review for the realization of human rights in Ethiopia' *unpublished LLD thesis, University of Pretoria*, 2012 236.

¹⁴ Pursuant to article 105 of the FDRE Constitution, all rights and freedoms specified in chapter three of the Constitution, which includes children's rights provisions (article 36), can be amended only: (a) when all state councils, by a majority vote, approve the proposed amendment; (b) when the House of Peoples' Representatives, by a two-thirds majority vote, approves the proposed amendment; and (c) When the House of the Federation, by a two-thirds majority vote, approves the proposed amendment. This indicates amending the human rights provisions of the constitution poses stringent requirements.

incorporates children's right to health and their other socio-economic rights. Explicit legal recognition of child survival and its complimentary rights in the domestic acts improves legal certainty and heightens the relevance of right/obligation analysis of the rights. Countries, such as Kenya have children's act which unequivocally guarantees children's right to survival and health in the same wording as the CRC and ACRWC. Achieving children's right to survival is dependent on the realization of many other rights outlined in these instruments, hence the proposed children's act should recognize the interdependence and equal importance of all rights (civil, political, economic, social and cultural) that enable all children to develop their physical and mental abilities.

Further, such proposed comprehensive children's act is recommended to be complemented by special legislation on children and maternal health. The *Law of the People's Republic of China on Maternal and Infant Health Care* discussed in the course of this research would be a viable reference for benchmarking. This law became effective two decades ago, before the country's economy had been booming like today - an indication of the fact that creating better laws for promoting children's health has no necessary correlation to the level of economic of growth of a country. The importance of this law lies in that it is very specific to maternal and child health and aims to address child health by setting comprehensively the types of health service mothers and their children must receive, and identifies the various persons and agencies responsible for delivering and administering the service. It also stipulates accountability for maternal and child health. For instance, the law enshrines medical and health institutions to be accountable for the work of maternal and infant health care within the scope of their functions and duties.¹⁵

6.2.3 Fostering complementarity of health and human rights: Employing human rights standards and norms in state policies, strategies and plans

¹⁵ Law of the People's Republic of China on Maternal and Infant Health Care (1995), article 31.

The Committee on the CRC back in 2003 underlined state parties' obligation to the CRC to develop a comprehensive national strategy or national plan of action for children, built on the framework of the Convention. Despite this, the overarching strategy on child survival in Ethiopia, the ENSCS and its successor (National Strategy for New-born and Child Survival in Ethiopia, 2015-2020), have used neither the CRC nor the ACRWC principles and norms applying to overcome under-five mortality. In some of government strategies and plans, such as the GTP (2010/11-2014/15), Health Sector Development Programme IV (2010/11 – 2014/15), and National Reproductive Health Strategy (2006-2015) reference is made in the treaties ratified by the country or a general reference as to human rights. However, the mere mention of human rights in general context or the treaties ratified by the country in the government policies, strategies and plans is not in any way adequate to make these instruments influenced by human rights principles and norms. I recommend that they should explicitly recognize the specific duties that attach to these treaties – the obligations that the state is required to deliver to ensure access to quality health goods and services. Equally, there is a need to recognize how individuals can have recourse to a remedy where their right of access is hindered or unmet by responsible health centers or institutions or personnel.

Over-reliance on policy commitments, such as the Millennium Development Goals (MDGs) in child health related policies and strategies should not undermine international human rights law obligations. Thus, the Ethiopian government should take bolder steps to use human rights language in shaping policies and strategies affecting child health and other socio-economic rights of children, and stipulate the respective obligation of different departments. The core principles discussed in chapter two should be fully integrated or mainstreamed in the formulation process and content of future policies and strategies. This underscores the shift in focus towards a complementary approach of health and human rights. This in turn urges changing the view of the makers of policy, strategies and plans of action in the manner they handle child health and health related instruments. They must project the human rights implication of policies, strategy and other documents.

6.2.4 Ending selective or elective approach to human rights implementation

Child survival rights stipulated in the CRC and ACRWC, to which the country is a party, are expected to be realized to all children without discrimination. Despite this, in some regions of the country, protection of child survival rights is grossly neglected. This constitutes a selective approach to child survival rights and affects many groups of children that are excluded in practice from the efforts to promote and protect this and children's right to health, life, dignity and non-discrimination. It is vitally important that the country should end selective or elective approaches to child survival rights implementation. The government should address in-country differences in susceptibility to child death and look beyond national averages, and commit to the rights of every under-five – no matter where they live – to have the same opportunity to live a healthy, fulfilling life.

Tackling inequalities in access to health care will help more children survive. In order to combat the elective approach the government at all levels must ensure that the elements of availability, accessibility, acceptability, and quality of health goods and service are at the center of the implementation of all programs and policies on all children's health. In addition, governments at all levels (federal or regional) must implement programs and policies on women's and children's health that respect, protect, and fulfill the rights of children and women. Equally, it is essential to increase access to preventive health interventions, services and life-saving drugs; expand access to services for the integrated management of childhood illnesses at the community level and elsewhere; and establish accessible, transparent and effective mechanisms of monitoring and accountability. Further, appropriate training for community or health extension workers must be given to ensure that they have sufficient capacity to deliver the necessary interventions safely.

On top of above, mothers in labor will most often reach health centers either on foot or if there are complications, by 'traditional ambulance' which basically means the woman is carried on a wooden stretcher for sometimes up to two hours to reach a road. Hence, improving the roads

in rural Ethiopia will save many maternal and new-born lives, potentially decreasing the high child mortality rates in these areas.

6.2.5 Budgetary measures

Among other things, if Ethiopia is to overcome poverty and achieve sustainable development, and if it is to participate effectively and successfully in the global economy, it must create and nurture a healthy and educated workforce. This entails the country to first to invest in the survival and health of its children. In accordance with the imperatives of the FDRE Constitution¹⁶, ever increasing resources must be allocated into the public health care sector, and a better integration between public and private sectors must be ensured. Without adequate and commensurate resources, child survival and health rights that find their way in the treaties ratified by the country remain empty promises. The two-digit growth of the economy trumpeted by the government and its partners must be mirrored in child health financing. A specific budget should be earmarked towards child survival programs. The mere increase in numbers of the budget over the years is not enough; the budget should be reflective of the specific needs according to nationwide assessments of the problem of child mortality. The way of financing the health care system should ensure that the ability to pay does not affect children's families' decision to access necessary health goods and services.

6.2.6 Overcoming cultural barriers

As was discussed in chapter four, child mortality is linked to women's rights and the ability of women to survive pregnancy and childbirth and to exercise autonomy over decisions relating to their reproductive lives and optimal infant feeding practices. It was to address partly this concern that in article 35(9) of the FDRE Constitution and the counterpart provisions of the regional states' constitutions a stipulation is made that, in order to prevent harm arising from pregnancy and childbirth and in order to safeguard their health, women are guaranteed the

¹⁶ Article 41(4) of the FDRE Constitution obliges the country 'to allocate ever increasing resources to provide to the public health, education and other social services'.

right of access to family planning education, information and capacity. Despite this, as discussed in chapter five, about 30% of mothers abstain from going to health facilities, giving culture and beliefs as their reason. Such culture is an enemy to progress on child and maternal health. Thus, the Ethiopian government must work to break down the cultural barriers that prevent women from delivering in health care facilities. A concerted effort to educate women and families about the importance of skilled birth attendance and postnatal care would facilitate achieving this. As President Kikwete of Tanzania said once, 'In my country women who are pregnant are told not to eat eggs. It is a superstition that we need to change through education. We must be able to challenge harmful cultural practices'.¹⁷ Improving women's health rights through education, along with measures to improve their empowerment and incomes is key to solving child deaths and malnutrition.

6.2.7 Enhancing the capacity of child survival implementers and scaling up their engagement

Appropriate institutional reforms and capacity building initiatives, which take into account the existing situations, child service providers and special child related initiatives should be put in place to implement the available laws, policies, and strategies effectively. The overall implementation of these policies and strategies should adopt a multi-sectorial and integrated approach to guarantee the inclusion of all stakeholders working on children's issues. Moreover, the mandate of each structure should be clearly spelled-out and the hierarchy between them should be clearly defined.

Ministries, federal and regional bureaus, governmental and non-governmental institutions and agencies working on issues related to children's rights must also possess adequate human and financial capacity to function effectively and fulfil their tasks and responsibilities adequately.

Government, NGOs, higher learning institutions and other research institutions should be encouraged to conduct research and studies on children's health issues. The Ethiopian science

¹⁷ 'Child mortality is our human rights failure of the 21st century' (n 5 above).

and technology, food and medical research institutes must intensify their research activities to produce cost effective medical facilities and nutrition to be accessible to the majority of the rural population and the urban poor as well.

Besides, all federal and state government departments saddled with responsibility on children's affairs must equally be aware of what their roles are in helping realize the rights of children, especially the right to maximum survival and development. This would require government departments to apply the general principles of the CRC and ACRWC in their decision-making processes at all times concerning child mortality. The principle of the best interests of children is found in the Constitution (article 36(2)). All government departments are bound by the 'best interests' standard and by the other general principles of these instruments. The 'best interests' standard is an implementation tool for the CRC and ACRWC. It, among other things, requires states to conduct child impact assessments on child health. In other words, the standard requires states to measure and assess the impact of their actions, or indeed inaction, upon the rights of children to survival and health, which may take the form of budgets, policies, laws, or any other form of decision-making that may impact upon under-five children.

6.2.8 Ensuring effective collaboration and coordination

Collaboration amongst the various government sectors is needed to fulfil the underlying determinants of health. Governance of child health means ensuring that the appropriate systems and coordination mechanisms are in place within the central and delegated local authorities to facilitate the full realization of all child health-related rights. The constitutional separation of competence between the federal government and states does not exonerate the central government from the implementation of its obligation to child survival under the national and international monitoring bodies. This is made clear by the Committee on CRC when it rightly underscores 'while decentralization or delegation may be required to meet the particular needs of localities, sectors or federal systems, this does not reduce the direct responsibility of the central or national government to fulfil its obligations to all children within

its jurisdiction'.¹⁸ Hence, the FDRE government must ensure that the Ministry of Women, Children and Youth Affairs (MoWCYA) and regional states children's affairs bureaus are in full capacity to implement efficient coordination among the stakeholder departments and units. This includes ensuring collaboration, coordination and dialogue between government ministries, local governments, service providers and communities, and supporting systematic monitoring and follow-up action to ensure that children's health-related rights are realized. Strong governance and coordination mechanisms are particularly critical in the context of a HRBA to child mortality and morbidity. This is true because a wide range of actors are involved, including health and other sectors within government, the private sector, families, communities, civil society and other stakeholders.¹⁹ Building on existing systems, strengthening and adapting them as appropriate can facilitate the realization of child health-related rights and reduce child mortality and morbidity. In this connection, there is a need to identify and remove obstacles to coordination, transparency, partnership and accountability in the provision of services affecting child health and survival.

6.2.9 Enhancing participation

Citizens will always know more than their leaders what the solutions to their problems are. There is a necessity of placing people at the centre of policy making and implementation of programs. The process of developing the child policy should understand the real effect of the policy and the ways in which the policy relates to the real situation of children in Ethiopia. To effectively capture this, a participatory consultation that involves children's themselves and as many segments of civil society as possible should be conducted. This is important not only to understand the real situation of children in the country, but also to create a feeling of ownership and thus facilitate the effective application of the policy once adopted. As a general rule, the broader the participation throughout the process of the development of the policy,

¹⁸ CRC Committee, *General Comment No. 5, General Measures of Implementation of the Convention on the Rights of the Child* (articles 4, 42 and 44, para 6), para 40, UN Doc CRC/GC/2003/5 (2003).

¹⁹ UN Human Rights Council *Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age: Report of the Office of the United Nations High Commissioner for Human Rights*, (n 1 above) para 46.

the greater the likelihood of public support for any policy or legislation that promotes, protects and respects children’s rights, including their right to health.

As children’s health issues are multi-sectoral, the possible range of stakeholders that should be consulted is extensive. Consultation should engage as many different points of view as possible, to ensure the widest possible perspective on the ways in which the policy under consideration affects children’s survival and health. Engaging people who work on children’s health issues on a day-to-day basis both at the federal, regional, *woreda* and *kebele* levels is crucial. Parents, family members and community organizations should be given the opportunity to give their valuable insights and express their views on children’s health.

6.2.10 Alleviating malnutrition

Child underweight and stunting has decreased in Ethiopia over the past two decades. Yet, malnutrition is still the underlying cause of more than 50% of under-five mortality in the country. Combating malnutrition implies under-five death is to be reduced significantly, and has a profound impact on the survival rates of children. It obliges a coordinated inter-sectoral response that is able to address the direct determinant of under-nutrition. Sufficient food production and supply in most affordable terms to the poor is vitally important. The government should scale up implementation of its poverty reduction strategies, Growth Transformation Plan II (2016-2020) and programs (such as school feeding programs) as promised to improve agricultural productivity and food self-sufficiency. Besides, as recurrent drought and food insecurity continues to affect rural areas, which in turn brings more problems of malnutrition, the federal and state governments must enact drought and famine management policies and strategies with legal frameworks to hold individuals or institutions accountable. In addition, public-private partnerships should be promoted as a strategy of engaging the private sector in the food production and processing industry to better understand and incorporate the health and nutritional needs of the population in their products, promotions and distribution mechanisms.

6.2.11 Strengthening data and health information on children

In a rights perspective, children who die during or following birth have the right to be counted. Data on child deaths is a powerful tool in advocacy and influencing, in generating voice and demanding accountability. As was discussed, the country suffers from poor data gathering and interpretation on child birth and death. Hence, the government must develop disaggregated data on child death and birth, as well as indicators and benchmarks to measure progress in guaranteeing children's access to health care and the underlying determinants of the right to health care. Also, it must improve access to information within the health-care system. Government both at the federal and state level should seek to ensure an enabling environment to encourage appropriate health-seeking behaviour by parents and children.

6.2.12 Bolstering accountability

Accountability provides avenues for remedy and redress where obligations are not fulfilled. There are many different forms that accountability can take. The duty to fulfil rights places an obligation on states parties to take appropriate judicial and other measures to the maximum extent of their available resources to ensure that children realize their rights to health care. Despite this, except in criminal matters (as in case of infanticide, and child maltreatment) and medical negligence, judicial remedies for violations of child survival and related rights are uncommon in Ethiopia. The limited role of courts in applying human rights arises mainly from the constitutional uncertainty of their role in enforcing the bill of rights of the Constitution; the inaccessibility of treaty texts to judges and the public in the languages they understand, limited legal support for PIL, the divided position of judges on justiciability of socio-economic rights, ouster clauses that excluded courts from overseeing decisions of administrative bodies and tribunals, the weak authority of the judiciary to control the executive and lack of adequate domestic laws that give detailed content particularly to socio-economic rights.

In order to enhance accountability:

- The legislature (the HPRs) should amend provisions of the CSO law to allow CSOs to engage in human rights advocacy and litigation. Further, it should adopt legislation that creates a supportive and enabling environment for PIL.
- The legislature should amend ouster clauses of the various proclamations that exclude courts from reviewing decisions of administrative bodies and tribunals and adopt adequate domestic laws that give detailed content particularly to socio-economic rights.
- The legislature should ratify the Third Optional Protocol to the CRC, which will allow individual complaints against violation of children's right to survival and health. If ratified, the Protocol will also have the potential to facilitate judicialisation of children's right to health or survival and seek remedy in case of violation, using the provisions of the CRC relating to child mortality.
- The EHRC and the EIO should aggressively work on investigation of violations of children's rights to health and survival and monitoring the extent to which sectors are discharging their child survival mainstreaming responsibilities.
- The EHRC and EIO should be re-established in full compliance with the Paris Principles, ensuring they are equipped with the right to investigate human rights complaints and to monitor state compliance with international human rights obligations. There is a need to enhance the capacity of their staff, and increase their accessibility to rural population.
- Parents or other caregivers of children should be empowered to claim their rights through legal or non-legal remedies over state's responsibility to provide support to them when they lack the means to provide to their children adequate food, medication and the underlying determinants of children's right to health care.
- Children's and women's health rights should be posted prominently and complaint boxes should be provided; clear processes for lodging and redressing complaints should be developed and this information must be readily available to children's representatives or women.
- All health care staff should wear badges with their names and positions clearly displayed.

- Government should create an enabling environment for the judicial enforcement of children’s survival rights by making treaty texts accessible to judges and the public in the languages they understand, putting in place a legal framework for PIL and guaranteeing the independence of the judiciary.
- The FDRE MoJ along with the Federal Supreme Court should organize on-going awareness-raising training to the judiciary, legal professionals and other stake holders on the role of courts in enforcing the bill of rights of the constitution, such as children’s right to life and other human rights treaties in order to prevent child mortality or give remedy when children’s right to survival is found violated.
- Community-based health audits as a component of monitoring and accountability mechanisms should be established.
- The MoJ should contribute to the response to child health and survival through the provision of legal services to vulnerable children and other affected communities.
- The country must ensure parliamentary committees, NGOs, academic institutions, professional associations, youth groups and independent human rights institutions to engage freely on monitoring and evaluation on under-five health.

6.2.13 To the international donor community

The decline of the child death rate is representative of on-going efforts on the part of both the Ethiopian government and international aid organizations to improve child health. The Ethiopian government cannot further succeed on its own concerning its agenda of eliminating preventable child mortality post-2015. Thus, the contribution of technical and financial assistance of the industrialised world and international agencies is equally essential, and these bodies must renew their commitment vigorously. The global community should continue to release funds and extend technical support for child and maternal health intervention. Also, it must monitor the expenditure of grants and demand transparency and accountability in their use.

6.2.14 To global and African human rights bodies

The occasion of Ethiopia's periodic reports to the treaty monitoring bodies should be used to issue strong concluding observations and recommendations in order to reinforce the country's obligations to protect children's and women's rights of seeking underlying determinants of health care, and reproductive health-care services, respectively. Also, the monitoring bodies must consider, in their recommendation, providing redress and remedies for violations of these rights.

2.6.15 To society organisations

To the extent the legal framework of the country allows, advocacy efforts aimed to eliminate preventable child mortality must be heightened and opportunities to bring cases to the courts to determine whether human rights violations have occurred must be identified. Further, strategies to hold the government accountable to its international and regional commitments must be designed.

2.6.16 Resort to UN relevant documents

Policy makers must resort to UN and AU relevant technical guidance or manuals, treaty body general comments, and conclusions and recommendations relating to maternal and child mortality and morbidity in order to assist them in the formulation and the implementation of policies and programs in accordance with human rights norms and standards. Equally, other stake holders such as judges and other legal professionals must, in addition to treaties and national legislation, utilize these treaty body technical guidances and interpretations in their engagement with children's and women's mortality issues or their right to health in general.

6.2.17 Redressing fragility and instability

Under-five children living in conflict affected and fragile areas are particularly at risk of premature death. Research shows that Ethiopia is currently considered as one of the fragile states in Africa, although according to forecasts that it may be one of the countries that might

exit the label of fragility by 2030 or before.²⁰ It is recommended that factors that affect fragility, such as political instability, undemocratic rule, economic inequality, ill distribution of resources, and weak state legitimacy must receive serious attention of the government. Especially, the Ethiopian government should effectively work for greater commitment to peace-building, development and democracy, consolidate state security, build state capacity and transformation, and greater inclusion of minorities and political opposition. This can partly be done through cooperation with other countries and development partners that have a role to play in lifting the most fragile states, such as World Bank and the African Development Bank.

²⁰ Institute for Security Studies (ISS) 'Africa's fragile states need extra help' available at: <https://www.issafrica.org/iss-today/africas-fragile-states-need-extra-help> (last accessed 13 June 2015); J Cilliers & TD Sisk *Long-term state fragility in Africa: Prospects for 26 'more fragile' countries'* (2013) vi, 36.

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