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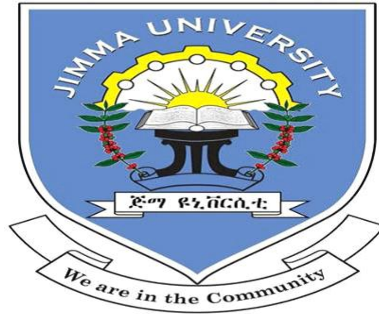

COLLEGE OF LAW AND GOVERNANCE

SCHOOL OF LAW

THE REALIZATION OF THE RIGHT TO HEALTH OF CHILDREN IN STREET SITUATIONS IN JIMMA TOWN, ETHIOPIA: LAW AND PRACTICE

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A THESIS SUBMITTED TO JIMMA UNIVERSITY, SCHOOL OF LAW IN PARTIAL FULFILLMENT OF THE REQUIREMENT OF THE DEGREE OF MASTERS LL.M IN HUMAN RIGHTS AND CRIMINAL LAW

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DECLARATION

Bulcha Neguse, hereby declare that this research paper is original and has never been presented in any other institution. To the best of my knowledge and belief, I also declare that any information used has been duly acknowledged.

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Signature:

This research has been submitted for examination with my approval as University advisor:

Advisor: Alemu Meheretu (PH.D)
Signature:

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Acronyms

CRC: Convection on the Rights of Child

CESCR: Covenant on Economic, Social and Cultural Rights

ACHPR: African Charter on Human and Peoples Rights

ACRWC: African Charter on Rights and Welfare of Child

UNICEF: United Nations International Children's Emergency Fund

UNGA: United Nation General Assembly

GC: General Comment

CO: Concluding Observation

ESCR: Economic, Social and Cultural Rights

WHO: World Health Organization

ILO: International Labor Organization

NGO: Non-governmental Organization

ETB: Ethiopian Birr

FDRE: Federal Democratic Republic of Ethiopia

HSDP: Health Sector Development Plan

GTP: Growth and Transformation Plan

HSTP: Health Sector Transformation Plan

Key Words: Children in Street situations, Right to Health, States' Obligations, Realization of the right to health, Ethiopia

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Annex 3 Interview with Mr. Hafiz Hussien, Coordinator on care and support for vulnerable, Jimma Town Health Bureau, Jimma, Ethiopia

Abstract

This thesis examines the international human rights instruments, Ethiopian legal frameworks and the practical implementations regarding the realization of the right to health of children in street situations. It also examines what impact these frameworks have in practice, adequacy of measures taken by government to realize it, challenges against the realization of the right to health of children in street situations in Jimma Town, Ethiopia and it ultimately forward possible solutions in this regard. Accordingly, data are collected through interviews from sample children in street situations and concerned government organs. Analysis of data and information collected are made with respect to obligations that Ethiopia has undertaken internationally and nationally. Accordingly, the finding reveals that children in street situations are living in a terrible and inhumane conditions, inter alia, shelter problem, and lack of access to adequate food, water and sanitation facilities and inaccessibility healthcare facilities, services and goods are found to be the major underlying determinants that create negative impact on the realization of the right to health of children in street situations. Some children had access to primary healthcare, but it has often been either due to a parent, a compassionate stranger or luck or not due to an efficient government plan or policy that originates from international human rights law and national legislation. Additionally, international human rights instruments that Ethiopia has ratified and respective compliance mechanisms of the international instruments examined indicates how state parties are to implement its obligations with regard to the realizations of the right to health of children in street situations in order to protect them in a sufficient and effective way. The first step that has to be taken to realize human rights by states is recognizing it explicitly in a constitution and other legislative acts. However, the right to health is not explicitly incorporated in Ethiopian constitution, neither are there any other legislative acts that reflect its underlying determinants of health. Rather, it is merely addressed through policies. Generally, this research reveals government of Ethiopia fails to realize the right to health of children in street situations.

CHAPTER ONE

1. Introduction

1.1 Background of the Study

As it is known children are the most vulnerable and marginalized section of the society. They are vulnerable to abuse, violence, neglect and evils of different kinds in their lives. Accordingly, it is recognized that the child by reason of his physical and mental immaturity, needs special safeguard and care. There is not one single definition of children in street situations: both terminology and the extent of the problem have been debated. However, United Nation High commissioner for Human Rights define it as follows:

'Any girl or boy who has not reached adulthood, for whom the street in the widest sense of the word, including unoccupied dwellings, wasteland, and so on, has become his or her habitual abode and/or source of livelihood, and who is inadequately protected, directed, and supervised by responsible adults'.[1]

Many names have used to describe and identify these vulnerable children, including 'Street Connected Children', 'Children in Street Situations' and most commonly 'Street Children'. While all these names refer to the same group of children, some such as 'street child' considered derogatory and contribute to increasing the stigmatization of children. Thus, this thesis has use the term 'children in street situations' to refer to these vulnerable children, as is used in UN documents.[2]

WHO define the term health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[3] Different international human rights instruments have recognized the right to health of everyone including children in street situations. Article 24(1) of CRC assures the right of children to the highest attainable standard of health and to

[1] Report of the United Nations High Commissioner for Human Rights on the protection and promotion of the rights of children working and/or living on the street, UN Doc A/HRC/19/35 GA, HRC 19TH Session, Para 8. (Hereinafter called OHCHR Report 19/35).
[2] Ibid, Para 10-12.
[3] The Constitution of the world health organization adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (Off. Rec. Wld Hlth Org., 2, 100), and entered into force on 7 April 1948, Preamble.

facilities for the treatment of illness and rehabilitation of health.[4] Accordingly, States Parties to the CRC are obligated to ensure that no child is deprived of his or her right of access to such health care services.[5]

The rights contained in the CRC are applicable to all children within the jurisdiction of the state party, and the rights have to be ensured in a non-discriminatory manner.[6] States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.[7] The right to health encompasses a myriad of socio-economic factors necessary to lead a healthy life, and includes the underlying determinants of health such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions.[8] Regarding the nature and types of states' obligations under socio-economic rights, states have undertaken both immediate as well as progressive obligations. While the constraint due to limit of available resource is acknowledged, meanwhile, states are obliged regardless of their level of economic development, to ensure respect for minimum subsistence rights for all. Article 4 of the Convention on the Rights of the Child provides obligations of member States to undertake all appropriate legislative, administrative, and other measures for the implementation of the rights enshrined in the Convention.[9]

The very first article of the ACHPR provides a general obligation upon state parties to 'recognize the rights, duties and freedoms enshrined in the Charter and shall undertake to adopt legislative or other measures to give effect to them'.[10] Similarly, article 14 of the ACHPR provides the obligation of states parties to ensure the right to enjoy the best attainable state of physical and mental health of all individuals. On the other hand, sub-article 2 provides obligation of state parties to undertake measures for the full implementation of this right and in particular states

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[4] See, the right to the highest attainable standard of health is also asserted under Articles 25 and 12 of the (Universal Declaration of Human Rights (UDHR) and the (International Covenant on Economic, Social and Cultural Rights (ICESCR) respectively and article 14 ACHPR.

[5] The Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3 (CRC), art. 24(1).

[6] Ibid. art. 2.

[7] Ibid, art. 24 (1).

[8] CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)', UN Committee on Economic, Social and Cultural Rights, E/C.12/2000/4, 11 August 2000, Para. 4. (Hereinafter called CESCR General Comment No. 14).

[9] CRC, n 5, art. 2.

[10] The African (Banjul) Charter on Human and Peoples Rights (adopted 27 June 1981, entered into force 21 October 1986) (ACHPR), art.1.

shall take measures, inter alia, to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care.[11]

Ethiopia has a good ratification record of international and regional human rights instruments. Accordingly, Ethiopia joined CRC in 1991,[12] ICESCR in 1993,[13] ACHPR in 1998 [14] and ACRWC in 2002.[15] Accordingly, Ethiopia is under obligations to recognize and realize the right to health of children in street situations. These obligations include taking any appropriate steps towards achieving the full realization of rights of the child. Though the realization of socio-economic rights specifically the right to health depends on the availability of resources, the government is expected to take steps to the maximum extent of available resource to achieve full realization. Most importantly, such steps should be deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognized in the Covenant.[16]

It is not known how many children are there globally living in different street situations, however, research has shown that the numbers of these children are increasing, including in richer regions. It is even more serious in developing nations where lack of adequate social infrastructure and socio- economic program threatens the developmental needs of these unfortunate children and the number is estimated hundred million.[17]

In Ethiopia, there is no commonly agreed data about the number of children in street situations. However, according to ministry of labor and social affairs, some 150,000 children live on the streets in Ethiopia, about 60,000 of them in the capital. However, aid agencies estimate that the problem may be far more serious, with nearly 600,000 children in street situations country-wide and over 100,000 in Addis Ababa.[18]

The right to health for every Ethiopian has been guaranteed by the FDRE constitution, which stipulates the obligation of the state to issue policy and allocate ever increasing resources to

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[11] Ibid, art 14(1), 14(2) (b).

[12] https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en, last accessed on 2, August, 2020.

[13] Eva Brems, 'Ethiopia before the united nations treaty monitoring bodies' [2007] Vol. 20, Afrika focus Directory of OAJ, p. 53.

[14] List of state parties to African Charter, https://www.achpr.org/statepartiestotheafricancharter, last access date on, 1 august, 2020.

[15] List of African states that have ratified ACRWC, https://www.acerwc.africa/ratifications-table/, last accessed on 30, July, 2020.

[16] CESCR, General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant), E/1991/23, on 14 December 1990, Para 2. (Hereinafter called CESCR, general comment No.3).

[17] Ibid, Para 12.

[18] https://www.thenewhumanitarian.org/report/48799/ethiopia-focus-street-children-rehabilitation-project, last accessed, on 1, august, 2020.

provide public health services to all Ethiopians.[19] The FDRE Constitution devotes special section specifying rights pertaining to children solely.

Ethiopian government has adopted several major policies which aim at ensuring that children are given opportunities, services and facilities to develop in a healthy manner pointing out the measures and strategies for the realization of the rights of children. In 2017 Ethiopia has developed a Comprehensive National Child Policy,[20] ideally with the consideration of the principles and provisions of the CRC to guide the work of various actors dealing with children and also promote the rights of children.

Despite the existence of rights and state obligations with respect to it, children are suffering different diseases and lack of sufficient access to health facilities. The situations become more severe when we consider the situations of children in street situations. Those children who are living and working in the street are more exposed and susceptible to different problems, especially, when a pandemic disease like COVID-19 occurs.

Although most children who contract COVID-19[21] seem to endure mild or no symptoms,[22] children who spend large parts of their lives on the streets may be more at risk than most. Many health issues that children in street situation normally face could also contribute to their vulnerability during the COVID-19 pandemic. Due to their extreme poverty and the circumstances in which they live, children in street situations are among the most exposed to the risk of contagion. Their living conditions often do not allow physical distancing or self-isolation. The lack of access to sufficient clean water makes good hygiene practices difficult.

Many children in street situations commonly suffer from underlying health conditions. Infectious diseases, including respiratory infections such as pneumonia, malaria, have been shown to be more prevalent among children who live on the street than among their peers who live in a

[19] The Constitution of the Federal Democratic Republic of Ethiopia, Proclamation No.1/1995, Federal Negarit Gazeta, 1st Year, No.1.article 41(4).
[20] FDRE, National children's Policy, April, 2017.
[21] Coronaviruses are a large family of viruses that are known to cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS).
http://www.emro.who.int/health-topics/corona-virus/questions-and-answers.html, last accessed on 4, August, 2020
[22] Dong et al. 'Epidemiology of COVID-19 among Children in China' [2020]
https://pediatrics.aappublications.org/content/145/6/e20200702, last accessed on, 1, July 2020.

house.[23] Asthma, a known pre-condition increasing the likelihood of developing more severe COVID-19 if infected, is also common among "street-connected children".[24] Though, these children need special concern and attention, their rights are neglected; their needs are unfulfilled, their scene become in danger by conditions that threaten their health and undermine their development.

Every child have to access to adequate healthcare and health education to protect themselves and others from the disease. As long as, children in street situations are more vulnerable during such pandemic, preserving, protecting and promoting the right to health of children in street situation must be a priority for a state. The implementation of the right to health during this pandemic requires governments to pay special attention to vulnerable and marginalized groups, inter alia, children in street situations.

The minimum core content stemming from the right to health for state parties is to ensure essential primary health care [… and] the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups.[25] However, the Committee indicates the existence of the violation in Ethiopia and their lack of access to health care.[26] Furthermore, the committee recommends that the State party should make urgent efforts to protect the rights of children currently living and/or working on the street. Similarly, 2015 the committee recommends Ethiopia to facilitate their access to quality health services, including reproductive health services for children in street situations.[27] Parties are also obliged to monitor and assess the extent of the realization or otherwise of the right to health and to devise strategies and programs for its promotion.[28] Recommendable realization of the right to health of children in street situation in Ethiopia is still under question. Thus, this thesis has examined the realization of the right to health of children in street situations in Jimma Town, Ethiopia.

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[23] Cumber et al. 'the Health Profile of street-connected children in Africa: A Literature Review' [2016] JPH in Africa, P. 85– 90.

[24] National Institution for Health Care and Guidance, 'COVID-19 rapid guideline: severe asthma' [2020] NICE guideline NG166, https://www.nice.org.uk/guidance/ng166/chapter/1-Communicating-with-patients-and-minimising-risk, last accessed on, 3, August, 2020.

[25] CESCR General Comment No. 14, n 8, Para. 4.

[26] Concluding observation on the rights of the child, Ethiopia, CRC/C/15/Add.144, [2001], par. 74.

[27] Concluding observations on the combined fourth and fifth periodic reports of Ethiopia, E/C.12/ETH/CO/1, [2015], par. 66(d).

[28] Sharon Detrick, 'A Commentary on the United Nations Convention on the Rights of the Child' [1999] [2001] Vol. 9 Intl journal of children's rights, P. 397. https://www.deepdyve.com/lp/brill/sharon-detrick-a-commentary-on-the-united-nations-convention-on-the-EnTAwb9YaI, last Accessed on, 12, July, 2020.

1.2. Justification for the selection and delimitation of the study area

Various Governmental and NGOs reports and research works indicate the existence and prevalence of children in street situations as a nationwide. Based on that, first and foremost the author tried to consult different Government or NGOs reports or any other documents that could indicate the prevalence of the problem in the area. Unfortunately, there is no governmental or non-governmental report or document that can show the exact or even estimated number and the overall socio-economic conditions and the implementation of the right to health of children in street situations in Jimma town, Ethiopia. However, that doesn't mean this lacuna must be not be filled by a researcher. Accordingly, the author before deciding to select the study area conducted an interview with selected concerned government officials in Jimma town as preliminary inquiry. Accordingly, the finding reveals the existence, prevalence and an indication of increasing rate of the problem in this town. In addition to the above technique employed to choose the study area, based on the observation of the author there are an immense number of children in street situations existed in Jimma town with terrible and undignified way of life contrary to their protection afforded to them in international and regional human rights instruments that Ethiopia has ratified. Investing on today's children is expected from every state so as to sustain its future socio-economic, political and cultural development, therefore, this problem requires urgent attention as it threatens the very fabric of society. Thus, the author based on the above logical reasoning has selected the study area for their possibility to a better future.

1.3. Literature Review

Based on the authors' intensive reading there is no specific legal research conducted specifically on realization of the right to health of children in street situations in Ethiopia and again specifically in Jimma town. However, there are some attempts to deal the issue indirectly. For instance, Sosina Geleta has conducted a research on "*The Realization of Socio-economic Rights of the Child: the Case of Street Children of Addis Ababa*".[29]In this thesis the author assesses and identifies measures taken by the government for the purpose of realizing socio-economic rights in general. In her research Sosina assessed and analyzed the socio-economic conditions of "street

[29] Sosina Geleta, 'The Realization of Socio-Economic Rights of the Child: the Case of Street Children of Addis Ababa' [2011] A thesis submitted to Addis Ababa University, School of Law of Graduate Studies in Partial fulfillment of the requirement of the degree of Masters in Human Rights Law.

children" and response of government to alleviate socio-economic problems against these children. Furthermore, she assessed the sufficiency of measures taken.

The term socio- economic rights is a generic and broad concept that can embrace different but interdependent rights that have to be implemented differently by every state members in their jurisdiction without any discriminatory backgrounds. Thus, examining the realization of every single right that has been recognized by international human rights instruments enhance and helps for their effective full implementation. Accordingly, unlike the above research the author of this thesis focuses on a single right, i.e. the right to health. Thus, examining the realization of the right to health and indicating its gaps helps children in street situations to enjoy a variety of facilities, goods, services and conditions in order to achieve the highest attainable standard of health.

Furthermore, in the above thesis researcher applied a word 'Street children' which is considered derogatory and contribute to the increasing the stigmatization of these children.[30]Accordingly, as indicated in the background of the study, the appropriate and legitimate word, i.e. children in street situations has been applied in this thesis.

International Covenant on Civil and Political Rights and International Covenant on Economic, Social and Cultural Rights of 1966, articulates the rights of all members of human family including children in street situations. These instruments further impose obligations on state parties to respect and ensure rights of all individuals within their territory irrespective of any discriminatory background. Accordingly, children in street situation located anywhere in Ethiopia have the right to exercise their right to health. Thus, thesis has tried to address the realization of the right to health of children in street situation in Jimma Town.

AB Gebreamanuel in his mini- dissertation "*The Recognition and Implementation of Children's Socio-economic Rights in Ethiopian Law"*[31] analyzed the extent to which the socio-economic rights of children are recognized in Ethiopian law. It also investigates whether or not a mere ratification of international children's rights instruments suffices for their implementation. Further, he examines the extent to which domestic laws incorporate obligations of international instruments towards the implementations of socio-economic rights of children. It also

[30] OHCHR Report 19/35, n 1, Para 10-12.

[31] Ab Gebreamanuel, 'The Recognition and Implementation of Children's Socio-economic Rights in Ethiopian Law' [2014] Mini-dissertation submitted in partial fulfillment of the requirements for the degree Magister Legum in Comparative Child Law at the Potchefstroom Campus of the North-West University.

investigates the current reality of Ethiopian children's life and obstacles to the implementation of international instruments on children's socio-economic rights.

However, this research was not directly dealt with the realization of the right to health rather the author applied a generic term of socio-economic rights which may leave a shade on each protected rights as stated above. Additionally, what makes this thesis different from the above is, it focuses on specific vulnerable group, i.e. children in street situations with a practical assessment on the realization of their right to health in Jimma Town.

1.4. Statement of the Problem

As mentioned earlier, the right to health of the children are recognized and provided under various international human rights instruments. Consequently, state parties have assumed legal obligation to realize such rights of the child. As a matter of fact, recognizing, respecting and realizing children's rights matters for the prospective development and overall progress of the country.

The physical and mental immaturity of children means that children need special measures for their growth. There are categories of children who are more susceptible to violation of their rights than others, inter alia, children in street situations fall in the category of vulnerable children. They lack basic needs and/or parental care and are more susceptible to violation of rights. These children live in the streets, public places, abandoned houses, and unhealthy shelters. This jeopardizes their right to healthy growth and development. The very existence of the phenomenon of children in street situations and their violation of rights represents a flagrant infringement of human rights recognized by international as well as regional human rights laws.

As stated above, Ethiopia ratifies the right of the child to the highest possible standard of health and to facilities for the treatment of illness and rehabilitation of health. However, more than ratification of treaties and incorporation of the right to health of these children in the constitutional provisions and other legislations there needs a commitment to the full realization of this right in practice. Recognition of rights is meaningless unless it is backed by practical application for its full realization at the grass root level. Though, the right to health exists and states obligation to recognize and realize the right to this vulnerable children, they are still suffering from preventable disease, lack of sufficient health care and unequal access to medical care. The government gives less concern and attention to these most disadvantaged groups.

States raise economic constraint as a defense for the full realization of economic, social and cultural rights. The fact that the right to health should be a tangible programmatic goal does not mean that no immediate obligations on States arise from it. In fact, States must make every possible effort, within available resources, to realize the right to health and to take steps in that direction without delay.

ICESCR committee in its general comment imposes an obligation on states to move as expeditiously and effectively as possible towards its full realizations.[32] Both the duty of progressive realization and the duty to use the maximum of available resources require a prioritization of services and in times of resource constrains, the most vulnerable and disadvantaged members of society should be prioritized. In addition, in times of severe resource constraints whether caused by a process of adjustment, of economic recession, or by other factors the vulnerable members of society can and indeed must be protected by the adoption of relatively low-cost targeted programs.[33]Accordingly, no State can justify a failure to respect its obligations because of a lack of resources. States must guarantee the right to health to the maximum of their available resources, even if these are tight.

In Ethiopia, when socio-economic problem alleviation programs launched, even though, the measures taken do not meet the requirement of international legal obligations, its implementation measures are mostly, limited to the capital city of the country. For instance, an urban safety net program, launched in 2017 and supported by the World Bank, now helps some of the capital city's most destitute, including "street children", by giving them a small cash handout.[34] However, state has an obligation to recognize, respect and realize the rights of all citizens in its jurisdiction without any kind of discriminatory backgrounds.

Jimma town is considered by many people, including teenagers, as cash crop area and trade center. As a result of this, children and adolescents migrate to the town for job opportunities; but many end up living on the street. Different pulling factors lead to the gradual increment of "street children" in the town from time to time. Most of them are confronted with harsh realities of

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[32] CESCR, General Comment No.3, n 16, Para 9; CESCR General Comment No. 14, n 8, para.31.
[33] Ibid, Para 12.
[34]https://www.theguardian.com/global-development/2019/jan/07/homeless-children-struggle-to-survive-on-streets-of-ethiopia-capital-addis-ababa, last accessed on, 1, august, 2020.

psychological, social and economic challenges.[35] Growing up in poverty and difficult socio-economic conditions undermines children's wellbeing to the extent of affecting their basic right to life. It is clear that, right to survival and development can only be implemented through the enforcement of certain indispensable rights especially the right to health. Thus, lack of commitment and failure to act according to binding obligations are clear violations of international human rights law against the right to health of these children.

Ethiopia being state party to various international human rights instruments recognizing the right to health of everyone including children in street situations, has assumed legal obligations to take legislative, administrative, and judicial and any other appropriate measures for its full realization. Accordingly, this thesis has attempt to examine the extent of measures taken by Ethiopian government to realize its international human rights obligations and to what extent children in street situations in Jimma town can access their right to health in practice.

1.5. The Objectives of the Study

1.5.1. General Objective

The general objective of the study is to examine the law and practice to the realization of the right to health of children in street situation in Jimma Town, Ethiopia.

1.5.2. Specific Objectives

1. To examine the legal measures taken by Ethiopian government to the full realization of the right to health of children in street situations.
2. To assess the extent of practical realization of the right to health of children in street situations in the study area.
3. To examine the adequacy of measures taken in light of international human rights legal instruments which Ethiopia has ratified to the full realization of the right to health of children in street situations. Both the law and the practice.
4. To explore challenges against the full realization of the right to health of children in street situations in the study area.

[35] Berhanu Nigussie Worku, 'Psychological conditions and resilience status of street children in Jimma Town' [2019], P 2.

5. To forward possible way outs for the full realization of the right to health of children in street situations.

1.6. Research Questions

The thesis is structured in four parts that has found an appropriate answer to each of the research questions:

1. What are the legal measures taken by Ethiopian government to the full realization of the right to health of children in street situations?
2. To what extent does this right realized practically based on international human rights instruments in the study area?
3. Are the measures taken adequate in light of international human rights legal instruments which Ethiopia has ratified to the full realization of the right to health of children in street situations? Whether both the legal and practical implementations are adequate or not?
4. What are the challenges to the realization of the right to health of children in street situations in the study area?
5. What will be the possible way outs to the challenges against the full realization of the right to health of children in street situations?

1.7. Significance of the Study

This thesis, first and for most, will have a contribution for the better enforcement and full realization of the right to health of children in street situations for the possibility of their better future. Furthermore, the final outcomes of this thesis will also create awareness about the right to health among children in street situations themselves, families, societies and concerned bodies to fully realize the right to health of children in street situations.

It will also help the government, NGOs, civil societies and any interested body to know the current socio-economic conditions of street children, specifically, the level of realization of the right to health in the study area. Besides, this work has a contribution in improving the less attention accorded to children living and working on street by conveying where exactly the problems/challenges of realizations are. Accordingly, it may serve as a source for the Government and stakeholders to figure out possible solutions to the problems that has been pointed out in this research.

1.8. Scope of the Study

This study has focused on children in street situations in Jimma town, Ethiopia, for their possibility to a better future. Accordingly, this study is only limited to the right to health recognized under international human rights instruments which Ethiopia has ratified. Besides, delimitation for this study is the age of the children based on Ethiopian civil code[36], i.e. children under age who are living and working on the street of Jimma town, Ethiopia are the subject of this study.

1.9. Methodology

The approach adopted to undertake this research is doctrinal and qualitative research method. Accordingly, Intensive analysis has been conducted on pertinent international, regional human rights instruments and national legislations pertaining to the subject matter at hand. As a complement to the above primary sources, journal articles, UN documents and various reports of UN agencies and NGOs has been consulted as secondary sources. Further, this thesis has compiled and analyzed the practice of the treaty monitoring bodies that correspond to each treaty. Therefore, general comments were used in examining and analyzing the treaty monitoring bodies' interpretation of the provisions related to the right to health.

Furthermore, qualitative method is important to uncover data regarding people‘s personal accounts, feelings, opinions, and experiences. Thus, data was collected and an attempt was made to answer the major questions posed under the statement of the problem.

Interviews were conducted with the right holders (children in street situations) themselves to see how the legal framework has been transposed in real life. The data collection and its subsequent analysis was aimed at providing normative content by defining gaps or suggesting possible improvements as to how the right to health for children in street situations can be better realized. Besides, the purpose of the interviews were in order for the voices of the right holders themselves to be heard and to examine how they experience deprivation of their rights as well as to examine how the duty-bearers are responding to the problems and implementing the right to health of children in street situations in the study area.

[36] Civil Code of the Empire of Ethiopia Proclamation No. 165 of 1960, Negarit Gazeta, Article 198.

Individual interviews were conducted, as opposed to the use of group discussions, as they are good for revealing personal or unique experiences. Interviews were conducted by the author in *Afaan Oromoo and Amharic*, alternatively. These languages are the lingua Franca of the study area. Accordingly, the author has writing, listening, reading and speaking skill of these two local languages.

1.9.1. Data Gathering Tools

The data was collected from children in street situations and the duty bearers in the study area, i.e. Jimma Town Children, women's and Youth Affairs Office and Jimma Town Health Office. To this end the researcher has used the following data gathering mechanisms.

1.9.2. Primary Methods of Data Collection

1.9.2.1. Semi-structured Interview

The researcher had employed semi-structured interviews, in that open-ended questions were prepared beforehand to be answered by children in street situation. The structure allows for follow-up questions or additional comments made by informants that was important and relevant for the purpose of this thesis. Prior to the interviews, the children were informed that participation had neither harm nor benefit them individually. This information was vital in order for the children not to have unrealistic expectations on the outcome of the interviews, for instance, receiving further assistance from the author or NGOs, if any. They were encouraged to ask any questions they might have about the interviews and research.

1.9.2.2. Sampling Technique

To identify respondents, i.e. children in street situations, non-random sampling technique which includes both snowball and purposive sampling technique were employed. It is not easy to find an accurate number of these children from which the researcher could select a proper scientific sample by random method because of lack of current statistical data in the study area. The snowball sampling technique was used to identify these children and helped to begin with those who were familiar and volunteer to cooperate with the researcher previously to create relation, and then the researcher used them to find other respondents who they know. The main objective of using snowball sampling technique for children in street situation was only to identify them.

After identification, the informants were selected through purposive sampling based on their age. Those children whose age was below 9 were excluded because of their immaturity to understand and express the phenomenon under investigation.

1.9.2.3. Interviews with key actors

Among non-probability sampling techniques government experts/officials were selected based on purposive sampling technique. The goal of using purposive sampling was to select individuals who are likely to be information rich with respect to the thesis purposes.
Thus, the convenient place to collect the necessary data concerning the realization of the right to health of children in street situations in the study area was Women, Children and Youth Bureau of Jimma town and Jimma Town Health Bureau, respectively. The aim of these interviews was to examine how these state actors are implementing the obligation to ensure the right to health of children in street situations in the study area.

1.9.3. Secondary Data Sources

In this study, the author used secondary data from different sources such as books, research publications, journals articles, websites, and documents and reports from UN specialized agencies, government and non-government organizations as a well.

1.9.4 Sample size

A sample is the exact number of individuals selected from a population. Accordingly, it is recommended to use large sample size to be able to generalize the findings. However, the reason why the author limits the number of children who were participated on the research was just because of the time and budget constraint. Thus, this study has 42 informants, i.e. 40 children in street situations, 2 government officials/experts called, Coordinator for care and support for vulnerable, Jimma Town Health Bureau and expert on the rights and security of children, Women, Children and Youth Affairs Bureau, respectively.

1.9.5. Methods of Data Analysis

The data was gathered through qualitative data collection methods. During data collection, the interviewer used audio recorder upon the permission of interviewees; take a note to record expressions of participants that won’t be recorded by tape like facial expressions and gestures.

Then, it was summarized by using and categorizing thematically based on the specific objectives of the study. The researcher also prepared the data analysis by describing briefly each of the participants view, and by using direct quotes from the interviews. The local language transcripts was translated into English and analyzed through triangulation of various data sources to increase the validity and reliability of the findings of the study.

1.10. Limitations of the study

The main limitation of this thesis is the scope of the data collection. A larger sample, both in the number of interviews and geographical spread, would be preferable. However, both due to a set time frame and financial constraints a greater data collection was unfeasible for this thesis. Based on the observation of the author the existence and prevalence of the problem is visible. Unfortunately, there also be a difficulty in getting current statistics of children in street situations in the research area. There is no published research, report or any kind of related documents neither by the government nor by international or national non-governmental organization. An additional challenge to this thesis was a fear of developing infection of a pandemic disease called COVID 19. This affected the duration of the data collection from the subjects of the right holders and government official/expert on the issue.

1.11. Ethical issues

In accordance with the UNICEF Principles and Guidelines for Ethical Reporting, every child has to be carefully informed about the purpose of the interviews and how the information would be used.[37] Thus, informed consent was sought from the children. Therefore, children were adequately informed about the purpose of the interviews, what they will be used for, and they all will stay anonymous. The children were aware that they can terminate the interview at any time without providing any reasons as to why they wanted to stop. They were also informed that they do not have to respond to a question that made them feel uncomfortable in any way.

In order to ensure confidentiality; no recordings was taken during the interviews, nor photos that can identify the children. Confidentiality was an additional reason as to why group interviews were not be a suitable tool. In respect to the promise of confidentiality, as well as to avoid potential harm, informants were given pseudonyms in order to protect their privacy.

[37] UNICEF Procedure for ethical standards in research, 'evaluation, data collection and analysis' [2015], pp. 1-2.

1.12. Structure of the Study

The thesis is organized in five chapters. The first part is background of the study, literature review, and statement of the problem, objectives of the study, research questions, significance, and scope of the study, methodology, limitations and ethical considerations.

The second part examined the relevant international legal framework to determine the scope and content of the right, state parties' obligations and the different Committees' approach on the right to health of children in general and children in street situations in particular.

The third part of this examined the legal measures taken and its adequacy in light of international human rights legal instruments which Ethiopia has ratified to the full realization of the right to health of children in street situations.

Chapter four of this thesis examined the practical implementations of the right to health of children in street situations by the government of Ethiopia, with respect to the obligations stemming from the international legal framework, the extent of realization of the right to health of children in street situations and how children in street situations themselves experience deprivation of their rights. It further, examined challenges against the full realization of the right to health of children in street situation in Jimma Town, Ethiopia.

The last but not the least, it includes conclusions and possible recommendations as a result of the findings of the research.

CHAPTER TWO

THE RIGHT TO HEALTH UNDER INTERNATIONAL AND REGIONAL HUMAN RIGHTS LEGAL INSTRUMENTS

2.1. Introductions

The right to Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to live a life in dignity. The realization of the right to health may be pursued through different ways, such as the adoption of health policies, or the implementation of health programs/strategies developed by the World Health Organization (WHO), or the adoption of specific legal instruments.[38]

The human right to health is recognized in numerous international instruments, inter alia, article 25(1) of the Universal Declaration of Human Rights (UDHR), even though not binding on states affirms: *"Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services".* The ICESCR provides the most comprehensive article on the right to health in international human rights law. Pursuant to article 12 (1) of this Covenant, "*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health",* while article 12 (2) enumerates, by way of illustration, provide a lists of "*steps to be taken by the States parties ... to achieve the full realization of the right to health*". Children's right to health as defined in article 24 of the Convention on the Rights of the Child as an inclusive right, extending not only to timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services, but also to a right to develop to their full potential and live in conditions that enable them to attain the highest standard of health through the implementation of policies and programs that address the underlying determinants of health. A holistic approach to health places the realization of children's right to health within the broader framework of international human

[38] CESCR, General Comment No. 14, n 8, para 1.

rights obligations.[39] Additionally, African regional human rights instruments also recognize the right to health, such as, the African Charter on Human and Peoples' Rights (art. 16).

The health care is perceived as a means to serve the health and well-being of human beings, which is indispensable to exercise other human rights. By virtue of being a human being, all individuals are equally entitled to their corresponding inalienable human rights, including the right to health. The right to equal access to health care consists of a right to equal treatment in accessing health care and responds to the special needs of vulnerable and disadvantaged people, inter alia, children in street situations. As discrimination violates the principle of equality, the prohibition of discrimination seeks to ensure that all persons should enjoy and exercise their right to equal access to health care.

Thus, the aim of this Chapter is to outline the scope of the right to health and the state obligations under international and regional human rights law in respect to the right to health of children in street situations. Accordingly, each subchapter of this chapter will give a brief introduction to the instrument examined and will provide in depth analysis into each compliance mechanism's interpretation of the respective articles. This will be done by examining the adopted and available general comments by each compliance mechanism.

2.2 HUMAN RIGHTS ACCRUING TO CHILDREN IN STREET SITUATIONS

Children are endowed with human rights which are indivisible and interdependent. The CRC and the ACRWC are key documents in laying the foundation to the rights accruing to children. However, as human beings, children have a wide array of rights found in other international human rights instruments ratifying states are to observe. In the Serrano-Cruz Sisters v. El Salvador case,[40] Inter-American Court of Human Rights State's obligation "to take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

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[39] CRC, General comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)', Committee on the Rights of the Child, CRC/C/GC/15, 17 April 2013, para. 2.

[40] Serrano-Cruz Sisters v. El Salvador [2005] Inter-American Court of Human Rights Case of the Judgment of March 1, 2005, Para. 147. https://www.corteidh.or.cr/corteidh/docs/casos/articulos/seriec_120_ing.pdf, last accessed on 8, Feb 2020.

Child rights are set out in four main principles: right to life, survival and development; right to non-discrimination; the principle of the best interest of the child; and, the right to participation.[41] States are enjoined to respect, protect and fulfil these rights. International law also places an emphasis on the importance of the family as the central unit of society.[42] Parents are the primary caretakers of children. However, should the parents not be present, the state is obligated to fill this gap.[43] The state has the primary duty to realize the rights of vulnerable children.[44]This responsibility entails not only negative but also positive obligations.[45]States have recognized that children in vulnerable circumstances need special attention and action from their governments.[46] While children in street situations are not explicitly mentioned in the international instruments, the violation of rights and the challenges they face as a consequence of their presence on the streets, thus, they fall under the category of vulnerable children.[47] In the case of Villagran-Morales et al. v. Guatemala,[48] inter American Human Rights court emphasize the necessity of non-discrimination, special assistance for children deprived of their family environment, the guarantee of survival and development of the child, the right to an adequate standard of living, and the social rehabilitation of all children who are abandoned or exploited. It is clear to the Court that the acts perpetrated against children in street situations in this case, in which State agents were involved, violate these provisions.

[41] DM Chirwa, 'The merits and demerits of the African Charter on the Rights and Welfare of the Child' [2002] Vol.10 the Int'l J of Children's Rts, 157–177. https://www.deepdyve.com/lp/brill/the-merits-and-demerits-of-the-african-charter-on-the-rights-and-kuLxcMn0i4, last accessed 0n 8, Feb, 2020.
[42] CRC (n 5); The African Charter on the Rights and Welfare of the Child, Adopted in Addis Ababa, Ethiopia on 11 July 1990. Entered into force on 29 November, 1999. (Hereinafter called ACRWC).
[43] R Hodgkin & P Newell 'Children's right to life and maximum survival and development' [2007] in R Hodgkin et al (ed) Implementation handbook for the Convention on the Rights of the Child ,P. 31-247. (Hodgkin & Newell).
[44] CRC (n 5), art 19.
[45] Kids Report, 'Street Children Have Rights Too! 'Problems faced by street children globally and in the Philippines, and why their rights need protection' [2012] (Kids Report). https://files.kidsrights.org/wp-content/uploads/2019/08/15135134/KidsRights-Report-2012-Street-Children-Have-Rights-Too.pdf, last accessed on 7, Feb 2020.
[46] Guidelines for initial reports of state parties to the African Charter on the Rights and Welfare of the Child, 17 to 21 February 2003. Committee/ACRWC/2 II Rev 2 (2003) 3 Afr. Hum. Rts. L.J. 347. https://www.acerwc.africa/wp-content/uploads/2018/04/ACERWC-Guidelines-on-Initial-State-reports-English.pdf, accessed on 9, Feb 2020.
[47] UNICEF 'Excluded and invisible' (2006). https://www.unicef.org/media/84806/file/SOWC-2006.pdf, last accessed on 6, Feb 2020.
[48] Villagran-Morales et al. v. Guatemala [1999] Inter-American Court of Human Rights Case of the Judgment of November 19, 1999, para 196. https://www.corteidh.or.cr/docs/casos/articulos/seriec_63_ing.pdf, last accessed on 9, Feb 2020.

The right to life, survival and development is found in Article 6 of the CRC. It is a holistic right[49] which encompasses rights such as; protection from violence and exploitation,[50] the right to health, an adequate standard of living,[51] and development of the child's personality, mental and physical abilities to their fullest potential.[52] Children in street situations encounter violations of their rights in almost every sphere. They lack parental guidance and protection; they are not afforded suitable alternative care and consequently they live on the streets, resulting in failure to develop their potential. The lack of underlying determinants of the right to health, and the violence and exploitation[53] that they suffer show how little effort is put into realizing their rights. The right to food, shelter and clothing is in direct consonance with the right to health. However, it is one which is blatantly violated. Begging on the streets, sleeping in less than optimum conditions, and depending on the generosity of strangers to meet their basic needs does not render the fulfilment of their rights feasible.[54]

Any government that has ratified CESCR, CRC, ACRWC and CEDAW[55] is bound by those international instruments to create laws, policies, and to take steps intended to ensure the realization of the rights of the vulnerable child. Accordingly, the international and regional obligations of States towards this vulnerable group, i.e. children in street situations will be addressed in detail in the following sub-section.

2.3 The Right to Health under International Human Rights Instrument

2. 3.1 International Covenant on Economic Social and Cultural Rights (ICESCR)

The ICESCR[56] only contains economic, social and cultural rights, while its counterpart the ICCPR contains civil and political rights.[57] The ICESCR aims to ensure the protection of

[49] Hodgkin & Newell, n 42, P 83–94.
[50] CRC, n 19, arts 24, 27, 28, 29, 31.
[51] Ibid. arts 24, 27, 28, 29, 31.
[52] Ibid. art 29.
[53] Five Years On: A report from the NGO Advisory Council for follow-up to the UN Secretary- General's Study on Violence Against Children A global update on violence against children [2011] A report from the NGO Advisory Council for follow-up to the UN Secretary-General's Study on Violence Against Children https://resourcecentre.savethechildren.net/sites/default/files/documents/5085.pdf, last accessed on 8, Feb 2020.
[54] N Schimmel 'Freedom and Autonomy of Street Children' [2006] vol.14 Int'l J. Child. Rts, P. 211.
[55] UNGA Convention on the Elimination of All forms of Discrimination against Women (1979), U.N.T.S Vol. 1249, p13.
[56] The International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into Force 3 January 1976) (Hereinafter called ICESCR).
[57] The International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) (Hereinafter called ICCPR).

economic, social and cultural rights. It is the Committee on Economic, Social and Cultural Rights that monitor state parties' compliance with the ICESCR. The Committee is mandated to issue general comments on the interpretation of the Covenant.[58] States are expected to submit reports on the progress made in the implementation of the Covenant. Following this, the Committee issues concluding observations with recommendations on how to proceed with the implementation.[59]

2.3.2. Scope of the right to health under International Covenant on Economic Social and Cultural Rights

The right to health is to be afforded to all persons within the jurisdiction of the state party, and it is not solely about access to health care. The right is inclusive and therefore, it addresses socio-economic factors that can contribute to a healthy life.

In considering the normative content of article 12, the Committee highlights that the right to health does not mean the right to be healthy, but rather that it takes into account the individual' socioeconomic preconditions, and a State's available resources. The Committee emphasizes that the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions in order to achieve the highest attainable standard of health.[60] The Committee also underscores that the right to health is an inclusive right which not only obliges States parties to provide timely and appropriate health care, but also to address the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.[61]

The right to health in all its forms and at all levels contains the following interrelated and essential four components.[62]

(A) Availability

[58] Implementation of the International Covenant on Economic, Social and Cultural Rights, ECOSOC, E/RES/1985/17, 28 May 1985.

[59] ICESCR, n 56, art. 16.

[60] CESCR, General Comment No. 14, n 8, para. 8-9.

[61] Ibid. para. 11.

[62] CESCR, General Comment No. 14, n 8, para. 12.

This element oblige states to avail public health and health-care facilities, goods and services in sufficient quantity within a State. This includes the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, adequate numbers of health-related facilities and support services. Accordingly, an adequate supply of essential medicines for children in street situations should be available.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for healthcare services and goods, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services are affordable for all, including socially disadvantaged groups, inter alia, children in street situations.

(B) Accessibility

Health facilities, goods and services including underlying determinants of health have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions that has to be clear:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized section of the population, for instance, children in street situations, without discrimination of any of the prohibited grounds.

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, inter alia, children in street situations. Accessibility also implies that medical services and underlying determinates of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach.

Economic accessibility (affordability): Here, the principle is health facilities, goods and services must be affordable for all. Payment for healthcare goods and services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services are affordable for all, including socially disadvantaged groups like children in street situations.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues for all. Government has to give due regards during endemic

and epidemic disease occurs, especially, for vulnerable segment of population like children in street situations.

(C) Acceptability

Health facilities, goods and services should also respect medical ethics, and be gender-sensitive and culturally appropriate. In other words, it should be medically and culturally acceptable.

(D) Quality

Healthcare facilities, goods, and services must be of good quality, including scientifically and medically appropriate. This requires, inter alia, skilled medical and other personnel, scientifically approved and unexpired drugs, appropriate hospital equipment, safe and potable water, and adequate sanitation.

The minimum core content stemming from the right to health are an obligations that imposes state parties to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups'.[63] At first, the Committee on ESCR has used the term "minimum core" to give substance to the covenant's enumerated rights to water, food, health, housing and education.[64]The Committee has stated that without this minimum core content, the ICESCR would lose a lot of its '*raison d'être'*.[65]Besides, underlying factors that contribute to a healthy life are also included in this core content, i.e. 'access to the minimum essential food which is nutritionally adequate and safe, to ensure *freedom from hunger* to everyone … basic shelter, housing and sanitation, and an adequate supply of safe and potable water.'[66]

2.3.3. State Parties Obligations under International Covenant on Economic Social and Cultural Rights

Art. 2(1) of the ICESCR set out state obligations in regards to the Covenant and provides that:
Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of

[63] Ibid, para. 43.
[64] K. G.Young, 'The Minimum Core Obligation of Economic and Social Rights: A concept in Search of Content', [2008] Vol.33 YJIL, p.120.
https://lawdigitalcommons.bc.edu/cgi/viewcontent.cgi?article=1920&context=lsfp, last accessed on 8, Feb 2020.
[65] CESCR, General Comment No.3, n 16, para. 10.
[66] CESCR, General Comment No. 14, n 8, para. 43.

its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.[67]

This article sets out the obligation known as progressive realization. The notion recognizes that ESC-rights take time to fully realize, but still oblige state parties to work 'expeditiously and effectively' in realizing the rights. Both the duty of progressive realization and the duty to use the maximum of available resources require a prioritization of services and 'in times of resource constrains, the most vulnerable and disadvantaged members of society have to be prioritized'. In addition, the Committee has stressed the importance of the continuing state obligation to 'strive to ensure the widest possible enjoyment of the relevant rights under the prevailing circumstances'.[68] While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes on State parties various obligations which are of immediate effect. Accordingly, states parties have immediate obligations in relation to the right to health, such as, to ensure the right will be exercised without discrimination of any kind and the obligation to take steps towards the full realization right of everyone to the enjoyment of the highest attainable standard of physical and mental health. These steps have to be 'deliberate, concrete and targeted' towards the realization the rights therein.[69]

In addition to these concepts, the Committee has stated that states have minimum core obligations stemming from the articles of the ICESCR that have to be ensured as they are 'minimum essential levels of each of the rights is incumbent upon every State party'.[70] These are the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups, access to the minimum essential food which is nutritionally adequate and safe, [and] to ensure freedom from hunger to everyone, access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water, equitable distribution of all health facilities, goods and services, and to provide essential drugs and to adopt and implement a national public health strategy and plan of action.[71]

[67] ICESCR, n 56, art. 2(1).
[68] CESCR, General Comment No. 3, n 16, para. 9-11.
[69] CESCR, General Comment No. 14, n 8, para. 30.
[70] CESCR, General Comment No. 3, n 16, para. 10.
[71] CESCR, General Comment No. 14, n 8, para. 43.

The Committee has set out that a 'denial of access to health facilities … as a result of de jure or de facto discrimination' would amount to a violation of the obligation to respect the right to health.[72] Article 2(2) provides that the discrimination has to be on one of the prohibited grounds: 'race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[73] The Committee has stated that 'other status' a flexible provision intended to capture future scenarios of 'differential treatment that cannot be reasonably and objectively justified and are of a comparable nature to the expressly recognized grounds'.[74] Economic and social situation is mentioned as one example falling within the ambit of other grounds, and it is relevant for children in street situations. The Committee has provided that people living in poverty or those who are homeless risk being exposed to 'pervasive discrimination, stigmatization and negative stereotyping which can lead to the refusal of, or unequal access to, the same quality … health facilities, goods and services'.[75]Besides, the Committee places an obligation on states to provide 'necessary health insurance and health-care facilities' to those who does not have the necessary means.[76]

2.4. The Right to Health under International convention on the rights of the Child (CRC)

The CRC is legally binding and was the first instrument of its kind that included civil, political, economic, social and cultural rights for children. To date, it is the most widely ratified human rights convention. Currently, 196 countries have ratified the CRC. Ethiopia has been a state party since 1991.[77]

It is the Committee on the Rights of the Child that monitor the compliance of state parties on their obligations under the CRC. State parties are obliged to submit reports to the Committee on a regular basis. The first one is to be submitted within two years after ratification, and thereafter states need to submit reports every five years.[78] The Committee has a mandate to prepare general

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[72] Ibid. paras. 33-50.
[73] ICESCR, n 56, art. 2(2).
[74] CESCR, General Comment No. 20: Non-discrimination in Economic, Social and Cultural Rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), UN Committee on Economic, Social and Cultural Rights, E/C.12/GC/20, on 2 July 2009, para. 27.
[75] Ibid. para. 35.
[76] Ibid, paras. 19-20.
[77] State parties to CRC, https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en, last accessed on 12, August, 2020.
[78] CRC, n 5, art. 44.

comments based on the articles and provisions of the Convention with a view to promoting its further implementation and assisting States parties in fulfilling their reporting obligations.[79]

Children in street situations are not explicitly mentioned in the CRC. However, the closest reference might be found in the preamble: 'there are children living in exceptionally difficult conditions, and that such children need special consideration'.[80] In addition, while the Convention makes no explicit reference to them, all of its provisions are applicable to children in street situations. These children have been identified as particularly vulnerable.[81] One can argue that children in street situations do live in exceptionally difficult circumstances, and accordingly, it is possible to interpret that children in street situations should benefit from special consideration.

2.4.1 Scope of the right to health under International convention on the rights of the Child

The rights contained in the CRC are applicable to all children within the jurisdiction of the state party, and the rights have to be ensured in a non-discriminatory manner.

States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services.[82]

The CRC's General Comment No. 15 on the right to health clearly states that article 24 needs to be approached from a child-rights perspective, and that the right concerns all children under the age of 18. It is an inclusive right that also covers a 'right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health'. The right to health does not only regard freedom from sickness, but also 'a state of complete physical, mental and social well-being'. Children in 'disadvantaged situations' are to be in the Centre of efforts when implementing the right to health. Besides, states are advised to identify the underlying reasons of vulnerability of children and to address these through laws, policies, programs and services.

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[79] CRC, Rules of procedure', Committee on the Rights of the Child, CRC/C/4/Rev.4, on 18 March 2015, rule 77.

[80] CRC, n 5, preamble.

[81] CRC, General comment No. 21 on children in street situations, UN Committee on the Rights of the Child, CRC/C/GC/21, on 21 June, 2017, para. 2 and 28.

[82] CRC, n 5, art. 24 (1).

The Committee on the Rights of the Child has developed four criteria in evaluating state parties' performance and implementation of the right to health. These are availability, accessibility, acceptability and quality.[83] A principal duty is being placed on state parties to ensure that no child is deprived of access to health care. That also implies a duty to remove any barriers that stand in the way of such access, for instance financial.

Undeniably, child survival is inextricably linked to child development. The right to maximum survival and development are related in sense that survival is the beginning point that leads progresses of the child to optimum development. Children therefore have the right to survival under conditions that enable them to develop their full potential.[84]

States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures, inter alia, to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care.[85]General Comment No. 15 provides that state parties should, as a matter of priority, provide universal access to primary health care. The setting and content may vary in different state parties. However, robust funding, well-educated staff and suitable facilities are common denominators for all which could be a barrier for developing countries. States are also obliged to make essential medicines 'available, accessible and affordable'.[86]

2.4.2 State Parties Obligations under International Convention on the rights of the Child

Art. 4 of the CRC obliges state parties to ensure that all national legislation is in conformity with the Convention. In addition, the Committee has provided that it is essential that the principles and Provisions of the CRC can be 'directly applied and appropriately enforced'.[87] In accordance with article 4, state parties need to make sure that its legislation is in conformity with the CRC, and to implement the provisions within its respective jurisdictions. However, in order to

[83] CRC, General comment No. 15, n 39, para. 1,4,11, 112-116.
[84] M. Dutschke and K. Abrahams, 'Children's Right to Maximum Survival and Development, Children's Institute, University of Cape Town' [2006], p.1.
http://www.ci.uct.ac.za/sites/default/files/image_tool/images/367/Projects/Completed_Projects/Rights_in_brief_survival.pdf, last accessed on 9, Feb 2020.
[85] CRC, n 5, art. 24(2) (b).
[86] CRC, General comment No. 15, n 39, para. 37.
[87] CRC, General Comment No. 5 on General measures of implementation of the Convention on the Rights of the Child (arts. 4, 42 and 44, para. 6), Committee on the Rights of the Child, CRC/GC/2003/5, on 27 November 2003, para. 1.

effectively implement the provisions of the CRC, other measures are also important. However, the implementation of the right to health is subject to the availability of resources.[88]

Paragraph 4 of article 24 reflects, in part, the content of article 4 of the CRC, which provides that:

States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.[89]

The concept of progressive realization is present in the CRC, similar to the ICESCR. It is the consequence of 'a realistic acceptance that lack of resources like financial and other resources can hamper the full implementation of economic, social and cultural rights in some States'. However, the notion of progressive realization also includes an obligation on state parties to use, and demonstrate that they have used, the maximum available resources in the implementation of the CRC.[90] In addition, all state parties, irrespective of level of development, have to 'undertake targeted measures to move as expeditiously and effectively' towards the full realization of the rights of the CRC.

The obligations stemming from article 24 are multiple, these are, obligation to *respect* the freedoms and entitlements, to *protect* these rights from third parties or other threats, and to *fulfil* them 'through facilitation or direct provision'. In accordance with articles 4 and 24(4), state parties need to work effectively towards realizing the right to health while not taking any retrogressive measures. State parties also have minimum core obligations that need to be upheld: (i) Laws and policies have to be reviewed and amended to correlate with the Convention; (ii) Universal primary health care services need to be ensured, including access to 'care and treatment services, and essential drugs'; (ii) State parties need to address underlying factors of children's health; and (iv) Plans of Action need to be realized and have to be rights-based approaches.[91]

General Comment No. 4 on adolescent health and development provides two paragraphs that might relate to children in street situations. The first one stipulates that homeless adolescents shall be afforded special protection. Following this, policies need to be implemented in order to

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[88] ICESCR, n 56, art. 2(1).
[89] CRC, n 5, art. 24(4).
[90] CRC, General comment no. 5, n 87, para. 7.
[91] CRC, General comment No. 15, (n 39) para. 71, 72, 73, 115.

ensure their access to health care. The second provision provides an obligation for state parties to 'ensure that adolescents belonging to especially vulnerable groups are fully taken into account in the fulfilment of all aforementioned obligations'. However, the General Comment fails to define the age span of adolescents.[92]

2.5 The Right to Health under Regional Human Rights Law

2.5.1 The Right to Health under African Charter on Human and Peoples Rights

The African Charter on Human and Peoples' Rights (ACHPR) was adopted in 1981.[93] The ACHPR (African Charter) has been ratified by fifty-four (54) African Union (AU) Member States. The latest AU Member State to become a Party to the African Charter is the Republic of South Sudan, having ratified the Charter on 23 October 2013.[94] Ethiopia has been a state party since 1998.[95]

The Charter protects both civil and political rights; economic, social and cultural rights, as well as collective rights. State parties are to submit reports on the implementation of the Charter every two years. The African Commission on Human and People's Rights with the mandate to ensure the rights of the Charter, to interpret it and to give recommendations to state parties.[96]The Commission has, through resolutions, adopted a document known as the Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights.[97] The purpose of this principles and guidelines is to assist State Parties to comply with their obligations under the African Charter.

2.5.2 Scope of the right to health and State Parties Obligations under African Charter on Human and Peoples Rights

[92] CRC, General Comment No. 4 on Adolescent health and development in the context of the Convention on the Rights of the Child, Committee on the Rights of the Child, CRC/GC/2003/4, on 1 July 2003, paras. 1, 36, 39(h).
[93] ACHPR, n 10.
[94] List of state parties to African Charter, https://www.achpr.org/statepartiestotheafricancharter, last accessed on 5, September, 2020.
[95] Ibid.
[96] ACHPR, n 10, arts. 30, 45, 62.
[97] ACHPR, 'Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights' (Hereinafter called , ACHPR Principles and Guidelines on the Implementation of ESCR) https://www.achpr.org/public/Document/file/English/achpr_instr_guide_draft_esc_rights_eng.pdf, last accessed 5, September, 2020.

The very first article of the ACHPR provides a general obligation upon state parties to 'recognize the rights, duties and freedoms enshrined in the Charter and shall undertake to adopt legislative or other measures to give effect to them'.

The Commission has stated that the right to health does not only concern health care, but also 'underlying determinants of health'. The African Commission on Human and Peoples' Rights, similarly to the Committee on Economic, Social and Cultural Rights, has provided that the right to health consists of four elements**.** These are availability, adequacy, physical and economic accessibility and acceptability. Compared to the ICESCR notion of Availability, Accessibility and Acceptability and Quality, adequacy is added and quality is not mentioned.

In the same way as the ICESCR and CRC, the ACHPR also provides obligations on state parties to respect, protect and fulfil the rights of the Charter. The Committee states that when an individual cannot access ESC-rights by themselves, then it creates an obligation on state parties to ensure that these individuals may obtain these rights with satisfaction. The rights of vulnerable groups should be prioritized in all programs of social and economic developments, and due regards must be paid to vulnerable them in programs aimed at ensuring access to appropriate services and resources.

There are immediate obligations connected to the ESC-rights that are not subject to the notion of progressive realization. These are, *inter alia*, 'the obligation to take steps, the prohibition of retrogressive steps, minimum core obligations and the obligation to prevent discrimination in the enjoyment of economic, social and cultural rights'. State parties have an obligation to take 'concrete and targeted steps' towards the full realization of ESC-rights. Besides, essential needs of members of vulnerable and disadvantaged groups should be prioritized in all resource allocation processes.

Each of the rights contain minimum essential levels that states have an obligation to ensure. These minimum core obligations are both non-derogable and is not dependent upon available resources.[98]These essential levels constitute the 'minimum core content' of each right and the 'minimum core obligations' are those obligations necessary to satisfy these minimum essential levels.[99]

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[98] Principles and Guidelines on the Implementation of ESCR, n 97, paras. 3, 11-12, 61-63.

[99] Magdalena Sepulveda, 'The Nature of Obligations under the International Covenant on Economic, Social and Cultural Rights' [2003] Vo.18 School of Human Rights Research Series, P.366.

A definition of 'vulnerable and disadvantaged groups' has been provided and it reads to include people that have 'significant impediments to their enjoyment of economic, social and cultural rights'. The definition is followed by a non-exhaustive list that includes, children in street situations.

The Commission has provided details on how state parties are to realize the right to health for vulnerable and disadvantaged groups. State parties have to ensure that there is no 'discrimination in access to and use of the health system', as well as to 'ensure access to affordable health facilities, infrastructure, goods and services to all'. Regarding economic barriers to access of primary health care, the Commission has stated that state parties should introduce national health insurances and other mechanisms like fee waiver healthcare system so that individuals can be guaranteed such access. However, state parties are advised to adopt these 'where necessary', and the Committee fails to define the scope of the term.[100]

In realizing the right to health, the Commission has provided that state parties need to adopt national public health strategies and action plans with specific attention to primary health care, and that a target of 15% of annual budgets should be directed to the improvement of health sector. In addition, the national plans should adopt a human rights approach.[101]

2.6. The Right to Health under African Charter on the Rights and Welfare of Child

The ACRWC[102] has been ratified by 49 out of the 54 member states of the African Union. Ethiopia has ratified ACRWC in 2002.[103] The Preamble of the ACRWC recognizes that "the child occupies a unique and privileged position in the African society," "that the child should grow up in a family environment in an atmosphere of happiness, love and understanding," and acknowledges that the situation of African children "remains critical due to the unique factors of their socio-economic, cultural, traditional and developmental circumstances, natural disasters, armed conflicts, exploitation and hunger."[104]

The African Committee of Experts on the Rights and Welfare of the Child has the mandate of interpreting the provisions of the Charter and to provide principles to protect the rights of

[100] Principles and Guidelines on the Implementation of ESCR, n 97, para. 167(bb)
[101] Ibid, para. 167 (e) (f)-(n) (y).
[102] ACRWC, n 42.

[103] List of countries that have ratified ACRWC, https://www.acerwc.africa/ratifications-table/, last accessed on 30, July, 2020.
[104] ACRWC, n 42, Preamble par. 3, 4.

children. The Committee also oversees the implementation of the ACRWC and receives reports from state parties to which the Committee then issues recommendations.[105]

The Committee has not yet issued a general comment on the right to health. To date, the Committee has issued very limited number of General Comments, inter alia, General Comment No.1 on Article 30 deals with children of incarcerated and imprisoned parents and primary care givers[106] and General Comment No.2 that deals with the issue of birth registration, name and nationality, and prevention of statelessness are the major one so far.[107]

2.6.1 Scope of the right to health and State Parties Obligations under African Charter on the Rights and Welfare of Child

The ACRWC provides that a child is anyone below the age of 18, and that the rights of the Charter shall be afforded without discrimination on any of the prohibited grounds.[108] Furthermore, the rights and freedoms of the ACRWC shall be afforded to all children within the jurisdiction of the state party.[109]

Article 1 of the ACRWC provides a general obligation upon state parties. In a decision referring to an individual complaint against the Government of Uganda, the African Committee of Experts on the Rights and Welfare of the Child stated that 'this general obligation [stemming from article 1(1)] that States undertake is subject neither to progressive realization, nor to available resources'. Further, the Committee stated that 'effective implementation of laws with due diligence is part of States parties obligation under the Charter' and that 'the recognition of rights should be able to promote and improve the lived reality of children on the ground'.[110]

The Committee has provided that the right to health is to be implemented through the notion of progressive realization. However, state parties are to realize the right to health in an expedited manner, and are, thus, required to take 'immediate steps' and to use the 'maximum available resources', even if such resources are scarce. The Committee has further stated that discrimination regarding access to health care facilities or services, or a failure to provide 'basic

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[105] ACRWC, n 42, arts. 32, 42, 43.

[106] ACERWC, General Comment No. 1 on Children of Incarcerated and Imprisoned Parents and Primary Caregivers (Article 30 of the ACRWC), ACERWC/GC/01, 2013.

[107] ACERWC, General comment 2 on birth registration, name and nationality, and prevention of statelessness (article 6. of the ACRWC), ACERWC/GC/02, 2014.

[108] ACRWC, n 42, arts. 2-3.

[109] ACERWC, General comment No. 1, n 106, para 19.

[110] Michelo Hunsungule and Others (on Behalf of Children in Northern Uganda) v Uganda, [2013] Communication No. 1/2005, ACERWC, para. 37, 38.

healthcare services can amount to a violation' of article 14.[111] Additionally, the Committee has provided that state parties have an obligation to respect, protect and fulfil the rights of the ACRWC.[112] This is to be done in accordance with the obligations stemming from article 1 of ACRWC.

Concluding observations adopted by the African Committee of Experts on the Rights and Welfare of the Child in its CO to Ethiopia, the Committee is concerned that children in street situations are not duly taken into account. Therefore, Ethiopia was encouraged to improve the access to health care services in order to protect these children in a better way. Regrettably, no details were provided regarding appropriate measures.[113]The Committee provides that state parties need to make sure that these services are accessible for the whole population, and that medical facilities must be well-equipped.

State parties were urged to improve the situation of sanitation and housing, access to drinking water and to ensure the right to basic nutrition as these factors affect the healthy development of children.[114] Most importantly, Ethiopia was encouraged to implement laws and policies through training and capacity building of the executive arm of the government, increase budget on child rights issues and establish a functioning monitoring and evaluation mechanisms.[115]Furthermore, the committee encourages Ethiopia to appropriate measures to provide nutritious food for better survival, to increase accessibility of the healthcare services and goods to lower mortality and to protect "children on the street".[116]

Conclusion

This chapter has examined Human rights of children in street situations, scope of their specific right to health and state obligations to their implementation. Accordingly, it is clear that states

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[111] Michelo Hunsungule v Uganda, n 110, para. 72, 73.

[112] Institute for Human Rights and Development in Africa and the Open Society Justice Initiative (on Behalf of Children of Nubian Descent in Kenya) v Kenya, [2011] Decision: No 002/Com/002/2009, ACWRC, para. 58.

[113] Concluding Recommendation by the African Committee experts on the rights and welfare of the child (ACERWC) on the Federal Democratic Republic of Ethiopia's report on the status of Implementation of the African Charter on the Rights and Welfare of the Child, para. 16.

[114] Concluding Recommendations by the African Committee experts on the rights and welfare of the child (ACERWC) on the Liberia report on the status of Implementation of the African Charter on the Rights and Welfare of the Child, para 45; Concluding Recommendations by the African Committee experts on the rights and welfare of the child (ACERWC) on the Republic of South Africa on initial report on the status of Implementation of the African Charter on the Rights and Welfare of the Child, para. 45; see also ACRWC Concluding Recommendation, n 172, para.16.

[115] ACRWC, Concluding Recommendation for Ethiopia, n 113, para. 6.

[116] Ibid. 16.

have to ensure that legislation is in conformity with the conventions, and the implementation of laws has to be effective and able to create a real impact in the lives of children by improving their lives and promoting their rights. All children within the jurisdiction of the state party are to be afforded the rights contained in the conventions, which means that all of the obligations stemming from the right to health are relevant for children in street situations too. If state parties fail to provide basic health services and other underlying factors of the right to health to children including children in street situations, amounts to a violation.

State parties have a principal duty in ensuring that children are not deprived of the right to health, and to remove any barriers to such access. All children need to be ensured access to healthcare, facilities including health related goods and services with all underlying determinants of the right to health and lack of resources should not be a reason to not to realize this right to a child. Access to health care facilities, goods and services has to be provided without any ground of discrimination, and provides the necessity to pay particular attention to disadvantaged and vulnerable groups. Health care services have to be within both physical and financial reach for all children, and both these services and essential medicines should be made available, accessible and affordable with standard quality.

This thesis argues that children in street situations clearly fall within the ambit of 'most vulnerable situations', mainly due to them being outside the care of a parent or a guardian. Besides, the Committee on the Rights of the Child have made references to vulnerable groups implying that they need special attention. Hence, socio-economic factors need to be addressed in realizing the right to health. Measures that has to be taken are, *inter alia*, to ensure the availability of shelters or housing, and to provide food with nutrition, clothing and access to safe drinking water and sanitation. Regarding the right to health and its underlying determinants of the right to health, states have an immediate obligations, i.e. avoiding any ground of discrimination to exercise the right. Additionally, states have to take deliberate, concrete and targeted steps to the full realization of the highest attainable physical and mental health of these children. Accordingly, state parties need to use the maximum available resources when implementing the right to health and its underlying determinant of health.

CHAPTER THREE

THE RIGHT TO HEALTH OF CHILDREN IN STREET SITUATIONS UNDER ETHIOPIAN LEGAL FAMEWORK

3.1 Introduction

International human rights instruments impose binding legal obligations on those countries that ratified them. Ethiopia has ratified all of the four instruments examined in chapter two and has not made any reservations relevant for the purpose of this thesis. However, mere ratification is not an end. Consistent efforts are expected from states for implementation of international covenants.

When a State ratifies Conventions, assumes to implement the obligations provided under international human rights laws. Implementation is the process whereby State parties take action to ensure the realization of all rights recognized in the Convention for all in their jurisdiction. Accordingly, implementation of human rights refers to actual measures taken by states in order to enhance respect for human rights and also to prevent their violations. Standards of protection of human rights can truly be measured in light of effectiveness and adequacy of measures designed for their full realization. The duty of ratifying states to implement international human rights treaties domestically, as indicated above, is followed by obligations to respect, protect, promote, and fulfil such rights.[117]

The implementation of general socio-economic and cultural rights and specifically the right to health is largely depends upon economic capacity. Accordingly, Ethiopia is expected to take steps to the maximum of its available resources, with a view to achieving progressively and expeditiously to the full realization of the rights recognized in the Convention. The wording of Article 41 (4 & 5) of the FDRE Constitution acknowledge the nature of socio-economic rights as progressively realizable since it impose an obligation on the State to allocate its ever increasing resource for their realization. In addition, as a party to the ICESCR, Ethiopia has assumed the obligations to realize imposed on State parties' under this covenant these rights include the right to health. However, evaluating economic capacity of Ethiopia and the concept of progressive realization in the implementation of the right to health is utterly out of the scope of this thesis.

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[117] N.W. Orago, 'Limitation of Socio-Economic Rights in the 2010 Kenyan Constitution: A Proposal for the Adoption of a Proportionality Approach in the Judicial Adjudication of Socio-Economic Rights Disputes' [2013], 16 PELJ, P. 178.

Implementation of human rights standards requires their incorporation into domestic law, however, most conventions entitle states to decide on how to implement those standards. 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.[118] Nevertheless, it may be difficult to combat discrimination effectively in the absence of a sound legislation for necessary measures.[119]

Every county in the world is party to at least one human right treaty protecting the right to health of everyone including children.[120] This necessitates the implementation and giving effect to treaty obligations at domestic level. But to what extent states are adopting means of realization (complying) with their obligations is a question needs to be answered. Thus, this chapter examines the legal measures taken by Ethiopian government for the realization of the right to health of children in street situations in light of Ethiopia's obligation stemming from international human rights law. Here, the examination will be taken only from a legal point of view.

3.2. The Implementation of Children's Right to Health in Ethiopian Law

Ratification of an international human rights treaty is not an end in itself rather it is a means to an end. International human rights laws to be practically applicable structurally depend upon national laws and procedures for their domestic full implementation. Accordingly, implementation of human rights refers to actual measures taken by states in order to enhance respect for human rights and also to prevent their violations. Besides, domestic realization of international human rights covenants requires a cooperative and joint effort of all state organs.

The African Commission in its landmark Social and Economic Rights Action Centre (SERAC) case underscored that:

Internationally accepted ideas of the various obligations engendered by human rights indicate that all rights, both civil and political rights and social and economic generate at least four levels of duties for a state that undertakes to adhere to a rights regime, namely the duty to respect, protect, promote, and fulfil these rights. These obligations universally apply to all rights

[118] ACRWC, n 41, article 1.
[119] CESCR, General Comment No 3, n 16, p.3.
[120] S. Gruskin and L. Ferguson, 'Indicators of Human Rights and Public Health, Harvard School of Public Health, USA' [2009], p.2.

and entail a combination of negative and positive duties….Each layer of obligation is equally relevant to the rights in question.[121]

On the same talking, these obligations have got a place in some domestic legal systems through an explicit incorporation of them in the Constitution. The 1996 South African Constitution can be a good illustration to this due to the inclusion of an article that explicitly acknowledges these four State obligations of human rights.[122] However, unlike the international and regional human rights instruments as well as the South African Constitution, the FDRE Constitution under its Article 13 (1), which is the starting provision of the 'Fundamental Rights and Freedoms' included in the Constitution, imposes two type of duties on the part of the State organs both at the federal and regional level.[123] These obligations are 'the duty to respect and the duty to enforce'. This does not, however, mean that these are the only obligations imposed on the State regarding the 'Fundamental Rights and Freedoms' in general and socio-economic rights in particular under the FDRE Constitution. The obligation to respect, protect, promote and fulfill are one of the four categories of obligations assumed by State parties' under the provision of Article 2 (1) of the ICESCR. Accordingly, Ethiopia is a party to this covenant, thus, has these obligations in the implementation of the rights enshrined in the covenant. Both the entitlements and obligations found in the ICESCR are part and parcel of the substantive provisions of the Constitution as per the reading of the provision of Article 9 (4) of the FDRE Constitution. Hence, the obligations imposed on the State in the FDRE Constitution are not, thus, limited to the provisions of the Constitution but also to the provisions of international agreements ratified by Ethiopia including the ICESCR.[124]

The obligation to respect requires states to refrain from interfering directly or indirectly with the enjoyment of rights in question. At this level, human rights require governments to abstain from

[121] The Social and Economic Rights Action Centre (SERAC) and the Centre for Economic and Social Rights v Nigeria [2001] Comm. No. 155/96, 15th Annual Activity Report ACHPR, Para 44. (Hereinafter called SERAC).

[122] The constitution the Republic of South Africa, as adopted on 8 May 1996and amended on October 1996 by the constitutional Assembly, 1996, Section 7 (2). This section establishes that 'the state must respect, protect, promote and fulfil the rights enunciated in the Bills of Rights.

[123] FDRE constitution, n 19. Article 13 (1) states that:
All Federal and State legislative, executive and judicial organs at all levels shall have the responsibility and duty to respect and enforce the provisions of this Chapter.

[124] Amare Tesfaye, 'Justiciabilty of socio-economic rights in the Federal Republic of Ethiopia', [2010] A Thesis Submitted to the School of Graduate Studies of Addis Ababa University in Partial Fulfillment of the Requirements for the Masters of Law (LL.M) in Human Rights Law Stream, P.66- 67.

acting or refrain from deliberate infringement of those rights.[125] Thus, it entails negative duty on states since it requires in-action or non-interference. For example, Article 41 (6) places an obligation to pursue policies which aim to expand job opportunities for the unemployed and the poor and shall accordingly undertake programmes and public works projects. The acontrario reading of this provision is that, the government has the duty to abstain from arbitrary intervention through the adoption of policies or programs that closes job opportunity for the poor and the unemployed or by arbitrary firing those who are already employed.

The State is obliged to protect right-holders against other subjects by legislation and provision of effective remedies. This obligation requires the State to take measures to protect beneficiaries of the protected rights against political, economic and social interferences.[126] It also creates an obligation to ensure that third parties do not interfere with the right to health.[127] Accordingly, this duty compels the State to prevent third parties and government from infringing the socio-economic rights of individuals enshrined in either under international law or their Constitution. A good example for this can be found under Article 41 (3), which places a duty on the State to prevent third parties from interfering in the enjoyment of once right to equal access to publicly funded social services apparently, includes the right to health. The State should make sure that individuals are able to exercise their rights and freedoms, for example, by raising awareness, and even building infrastructures.[128] Thus, this requires the State to make the right-holders aware of what socio-economic rights do they have, what obligations do they assume in the exercise of their socio-economic rights and what should be done in case a violation of their socio-economic rights is occurred or likely to occur.

Obligation to Fulfill extends beyond states' non-interference and will require the state to take action. It requires states to adopt appropriate legislative, administrative, budgetary, judicial, and other measures towards the full realization of the rights.[129] Thus, states are required to take further positive steps to facilitate and provide what is necessary for the enjoyment of rights when

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[125] David Marcus, 'The Normative Development of Socio-economic Rights through Supranational Adjudication' [2006] Sanford J Int'l L, p.57-58.

[126] International Commission of Jurists, 'Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experience of Justiciability' [2008] HR and Rule of Law Series, No.2, p. 45.

[127] CESCR General Comment No. 14, n 8, paras. 33, 35.

[128] SERAC, n 122, Para 46.

[129] Elisabeth Koch: 'The justiciablity of Indivisible Rights' [2003] Nordic J Int'l L, Kluwer Law international, printed in Netherlands, p.9.

an individual or group is unable to realize the rights themselves.[130] In relation to the right to health, states are obliged to provide vaccinations, allocate sufficient resources in their national budget for health care and take steps to prevent the spread of infectious diseases, reduce infant mortality and promote the healthy development of infants and children. This duty includes, as in the instance of Article 41 (5), the allocation of resources for the realization of the socio-economic rights and the direct provision of basic needs when no other alternatives are available to the individuals.[131]

Generally, Socio-economic rights and specifically the right to health is as important as civil and political rights regarding the level of protection accorded to them and when it comes to children due to their vulnerability, special attention is important. Legislation that articulate their detail rights is the first step for the realization of right to health at grassroots level. Accordingly, this chapter only examines the legal measures taken by Ethiopian government and their adequacy for the implementation of the right to health of children, specifically, in street situations.

3.3. National Legal and Policy frameworks

International human rights standards and principles must be enshrined in national legislation as a first important step after ratification. Besides, existing national legislation must be harmonized with international treaty obligations. Legislations are necessary to define entitlements and access to services and benefits in areas such as health, education and housing. For instance, article 2 (1) of the International Covenant on Economic, Social and Cultural Rights underscores the importance of adopting domestic legislative measures to achieve the full realization of these rights. Conversely, failure to adopt legislation or adopting inadequate or insufficient legislation will most likely prevent international human rights obligations being met.

3.3.1 FDRE Constitution

With respect to children, the FDRE Constitution incorporates a specific article exclusively governing on their rights but does not, nevertheless, take an express provision of children's right to health or the underlining determinants of health, such as admission to food, safe drinking water, sanitation, and other living accommodations. As said, its provisions are so crude that it is

[130] A. Nolan et al. 'The Justiciablity of Social and Economic Rights: An Updated Appraisal' [2007] Center for Human Rights and Global Working Paper, NY School of Law, p.20.

[131] Rakeb Messele, 'Enforcement of Human Rights in Ethiopia, [2002] Research Sub-contracted by Action Professionals' Association for the People (APAP), p. 30-31.

difficult to identify the rights guaranteed and the extent of protection afforded to them.[132] Although, Ethiopia has acceded to international instruments of children's rights the Convention on the Rights of the Child (CRC) in 1991; the International Convention on Economic, Social, and Cultural Rights (ICESCR) in 1993; as well as regional instruments such as the African Charter on the Rights and Welfare of the Child (ACRWC) in 2002, FDRE constitution, mainly, article 36 fails to entrench children's right to health and their other socioeconomic rights including underlining determinants of health explicitly.[133]

Article 36 of FDRE constitution provides the right of children to live a life protected from violence, neglect, exploitation and abuse. In particular, the provision affirms the right of children to life and bans exploitative practices against children and their engagement in work which could be prejudicial to their health and well-being.[134] Children have the same rights as all other persons under the constitution, such as the right to life, information, equality, and non-discrimination. However again, none of these provisions expressly incorporate children's right to health and its underlining determinants of health.

There are no separate and specific provisions devoted to the right to health under FDRE constitution. As argued by Sisay the usage of the phrases like "publicly funded social services" allows us to read many of conventional economic and social rights in to art 41.[135] Accordingly, as per article 41(3), every Ethiopian national has the right to equal access to publicly funded social services, which apparently include health-related services. Pursuant to article 41(4) again, government has the obligation to allocate ever-increasing resources to provide to the public health services for the public at large. Besides, article 41(5) explicitly provides the obligation of the State to provide rehabilitation and assistance to children who are left without parent or guardian, it apparently embrace children in street situations. Children in street situations, just like any individuals, have the right to equal access to health related services which is provided in the Constitution. In addition they also have the right to equally enjoy the rights in particular the right to health which is contained under international and regional human right instruments to which Ethiopia is party.

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[132] Sisay Alemahu, 'The Constitutional Protection of Economic and Social Rights in the Federal Democratic Republic of Ethiopia' [2008] Vol. 22 JEL, p.139.
[133] FDRE constitution, n 19, article 36.
[134] Ibid. Article 36(1(a) and (e).
[135] Sisay Alemahu, n 132, p.139-140.

In addition, the Constitution states that fundamental rights and freedoms specified in the third chapter shall be interpreted in a manner conforming to principles of the Universal Declaration of Human Rights, International Covenants on Human Rights and International Instruments adopted by Ethiopia.[136] Thus, this provision impliedly allow the direct application of the right to health and the underlying determinants of health of children recognized under international human rights law which Ethiopia has ratified.

On the other hand, the FDRE Constitution under article 90 provides obligation on state to design policies that provide all Ethiopians access to public health. The obligation of the state extends to the extent the resources of the country permit and it is expected to design policies that aim to provide all Ethiopian access to public health, clean water, food and social security. Thus, all these elements have an impact on the right to health of children in street situations. However, it should also be noted that the contents of Article 90 are like Directive Principles of Public Policy protecting the right indirectly and cannot be invoked before courts of law. Despite the fact that the Constitution does not include the right to get medical service which is an important aspect of the right to health, however, we can argue that the right to housing, safe and potable water, food as a determinant factors for the full implementation of the right to health from the open-ended use in the constitution.[137]

The right of children in street situations to health cannot be materialized in the absence of the fulfillment of the underlying determinants of health. Underlying determinants of health are entitlements of the child which are preconditions for the achievement of the highest attainable standard of health. Besides, Article 44 of the constitution also states that “all Persons have the right to clean and healthy environment”, however, it fails to provide it as underlying determinants of highest attainable standard of health.

Rights of persons to food, health, education, to be free from torture, inhuman or degrading treatment and others are interrelated. The improvement of one right facilitates advancement of the others. Likewise, the deprivation of one right adversely affects the others. Most importantly, the right to life enunciated under Art 15 of the FDRE constitution will have a great assistance in the protection of the right to health through the notion of indivisibility and interdependence of human rights. Accordingly, there is a close interlink between the right life and dignity with that

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[136] FDRE constitution, n 19, article 13 (2).

[137] Sisay A, n 132, p. 140; See, FDRE constitutions, n 21, art. 41(4).

of the right to adequate standard of living that embody health, food, shelter and housing. Besides, under chapter three of the FDRE Constitution, a number of fundamental human rights, such as human dignity,[138] and freedom from discrimination,[139] is guaranteed. Apparently, all these rights are important in safeguarding the right to health and dignified life of children in street situations. Generally, under FDRE constitution there is no explicit provision that recognize the right to health and its underlying determinants of health of children in street situations. However, with all its flaws, it is impossible to argue that, the right to health is not protected under FDRE Constitution.

3.3.2. Public Health Proclamation No. 200/2000

Ethiopian Public health proclamation was enacted in 2000. This proclamation in its preamble, stresses the need for the active participation of society in the health sector and the attitudinal change of the society through primary health care approach that can solve most of the health problems of the country.[140] This legislation is an important step in carrying out the obligation to fulfill the right to health of all including vulnerable groups such as children in street situations.

The proclamation defines health as not only the absence of diseases but also the complete physical, mental, social well-being of an individual.[141] Accordingly, to achieve complete physical, mental, social well-being of children in street situations underlying determinants of health such as access to quality water and food has to be fulfilled. Unfortunately, in this proclamation underlying determinants are not stated in a manner that these determinants are crucial to the realization of the right to health.

The proclamation prohibit to prepare, import, distribute, or make available to consumers any food which is unhygienic, contaminated, unwholesome or mislabeled and does not meet the standards of food quality. Additionally, any food intended for human consumption shall meet the

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[138] FDRE Constitution, n 19, art. 14.
[139] Ibid. art. 25
[140] Public Health Proclamation No. 200/2000 , Federal Negarit Gazeta, 6th Year No. 28 Addis Ababa, 9th March 2000, the preamble states ―the active participation of the society in the health sector has become necessary for the implementation of the country's health policy; it is believed that the attitudinal change of the society through primary health care approach can solve most of the health problems of the country; the issuance of public health law is believed to be an important step for the promotion of the health of the society and for the creation of healthy environment for the future generation thereby enabling it assume its responsibility.
[141] Ibid. article, 2(5).

standards of food quality and should be labelled and preserved in accordingly healthy manner.[142] It prohibit to provide water "unless its quality is verified by the Health Authority". The Proclamation also provides that no person shall dispose of solid, liquid or any other waste in a manner which contaminates the environment.[143] Another core content of quality water is the safety of drinkable water and it is addressed in the same Proclamation.

Therefore, it can be deduced that the Public Health Proclamation addresses quality and safety, which are core elements of access to quality water and food. Furthermore, under article 14 of the same proclamation provides the requirement of authorization of appropriate authority to provide public bathing and pool services. The right to water clearly falls within the category of guarantees essential for securing an adequate standard of living.[144] However, this doesn't mean children in street situations explicitly has the right to access to quality water for drinking and sanitation and food to survive, which is the underlying determinants to their complete development of physical, mental and social well-being. Additionally, the proclamation doesn't provide the obligation of state to ensure and realize the right to health and its underlying determinants of health for all including children in street situations.

3.3.3. State of Emergency Proclamation Enacted to Counter and Control the Spread of COVID-19 and Mitigate Its Impact, Proclamation No. 3/2020 and its regulation

As per Article 93 of the Constitution, Ethiopia declared a State of emergency for the sake of containing the COVID-19 pandemic.[145] The state of emergency Proclamation is very short with a preamble and just 8 articles. The Preamble states the state of emergency is necessary since COVID-19 has become a global pandemic which cannot be controlled through regular law enforcement approaches. The hostile political, social and economic impacts of the pandemic and the need to mitigate the ensuing humanitarian crises, according to the Preamble, entail 'coordinated' decision making and implementation processes which in turn require the state of emergency. However, none of its provision regards the vulnerable section of societies, inter alia, children in street situations.

[142] Ibid. article 8 (1) (2).
[143] Ibid. Art 10-12.
[144] CESCR, General Comment No. 15, n 39, para.106.
[145] Federal Democratic Republic of Ethiopia, A State of Emergency Proclamation Enacted to Counter and Control the Spread of COVID-19 and Mitigate Its Impact, Proclamation 3/2020.

On the other hand, the UN High Commissioner for Human Rights cautioned states to make sure that their 'emergency responses to the coronavirus are proportionate, necessary and non-discriminatory'. The Commissioner further stated that emergency powers should not be used 'to target particular groups, minorities, or individuals nor should they "function as a cover for repressive action under the guise of protecting health". The commissioner also, encourage States to remain steadfast in maintaining a human rights-based approach to regulating this pandemic, in order to facilitate the emergence of healthy societies with rule of law and human rights protections,"[146]

The COVID-19 pandemic has risen to this level of threat in many countries. However, this does not necessarily mean that it justifies derogations from the right to information.[147] Numerous international statements have stressed, in general terms, the importance of access to information during the COVID-19 pandemic. The UN Secretary-General has noted the need for the "free flow of timely, accurate, factual information and disaggregated data", including to enable the scrutiny and critique of the effectiveness of government measures responding to the pandemic.[148]

The proclamation was enacted to take various measures to counter and mitigate the humanitarian, social, economic and political damage being caused by the pandemic. Accordingly, it doesn't clearly consider how to implement this law and regulation to protect socio-economic rights of vulnerable (children in street situations), inter alia, the right to health and its underlying factors and dissemination of health related information during this pandemic. Additionally, contrary to UN high commissioner for human rights recommendation, the proclamation imposes harsh penalty, which doesn't took into account the practical nature of children in street situations.

3.4. The Right to Health of Children in Street Situations under National Policies

The realization of children's right to health may be pursued through numerous ways of which the adoption of national health policies, strategies and plans that embraces children in street

[146] https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25722&LangID=E, last accessed on 1, November, 2020.

[147] UNESCO, 'the right to access to information in time of crisis: Access to Information – Saving Lives, Building Trust, Bringing Hope!' [2020] Issue brief in the UNESCO series: World Trends in Freedom of Expression and Media Development, https://en.unesco.org/sites/default/files/unesco_ati_iduai2020_english_sep_24.pdf, last accessed on 8, Feb, 2020.

[148] UN, 'COVID-19 and Human Rights: We are all in this together' [2020] https://unsdg.un.org/resources/covid-19-and-human-rights-we-are-all-together, last accessed on 8, Feb, 2020.

situations is one. Public policies, such as sectorial plans of action (for example, on housing, health or education), national poverty reduction strategies or development strategies, are also an important means of meeting obligations stemming from economic, social and cultural rights.

Health is the right of all persons and the duty of the State and is guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at universal and equal access to all actions and services for the promotion, protection and recovery of health. Accordingly, public policies translate the abstract text of treaties into context-driven specific measures to realize rights. Most of the time, they constitute the framework for putting economic, social and cultural rights into practice. Besides, they are also entry points for longer-term implementation strategies and for putting human rights at the Centre of decision-making.[149]

General Comment 14 requires States parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR) to develop a comprehensive home health plan encompassing human resources with an intent to assist them to realize their obligation of access to quality of health care to their population.[150] Accordingly, Ethiopian government have adopted several major policies which aim at ensuring that children are given opportunities, services and facilities to develop in a healthy manner.

3.4.1. National Health Policy 1993

A variety of theoretical justifications have been put forward to justify public health policies, inter alia, to pay greater attention to the persistence of health inequalities, to the role that a healthy population plays in economic and social development, and to achieve the goal of "health for all". These ideas, which were powerfully expressed in the Alma Ata Declaration[151]continue to inspire health sector reform efforts.

National Health Policy of Ethiopia was launched in 1993. The policy put in place key principles on which the health sector is founded, inter alia, democracy, and decentralization of governance, development of the preventive and promotive components of health care, development of an equitable and acceptable standard of health service system that will reach all segments of

[149] United Nations Human Rights office of high commissioner, Monitoring Economic, Social and Cultural Rights, P. 17.

[150] CESCR, General Comment No. 14, n 8 Para. 36.

[151] Declaration of Alma-Ata. In: International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. World Health Organization; 1978, www.who.int/publications/almaata_declaration_en.pdf, accessed on 11, September, 2020.

populations.[152] The policy underlined that health care services must primarily focus on health promotion and preventive care. It also highlighted the priority health issues to be addressed and strategies to be implemented. Accordingly, the general objective of this Health Policy is to improve the health and wellbeing of all Ethiopians, which indicate the basic principle of universal health coverage.

Universal Health Coverage has been defined as "all people receiving quality health services that meet their needs without exposing them to financial hardship in paying for them".[153] The priority health services referred to in this definition include promotive, preventive, curative, rehabilitative and palliative health services.[154] Defined in this way, the objectives of Universal Health Coverage ensures equitable access to quality and effectiveness of health services, and financial protection for all. Universal Health Coverage includes but is not limited to affordable access to healthcare services, it extends to public policies and actions taken outside the health sector to address the determinants of health.[155] The policy states that it is committed to equity and justice in health service distribution.[156] The policy also enshrines *"assurance of accessibility of health care for all segments of the population"* as one of its general policy areas and providing *"special assistance mechanisms for those who cannot afford to pay"* as one of its priority focuses. Children are the future generation, they should be cured, cared, and protected from different terrible and troubles that beyond their controls. Accordingly, children in street situation are one of the vulnerable segment of population who needs special attention. Unfortunately, in combined report by the government of Ethiopia to the African Commission on Human and Peoples' rights on the implementation of African charter on the human and Peoples rights, children in street situations are not explicitly provided in a very limited list of segments of population who need special attentions for their right to highest attainable health.[157]

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[152] Health Policy of the Transitional government of Ethiopia, 1993, preamble para. 8.

[153] World Health Organization, 'Universal health coverage: supporting country needs' [2013]. http://www.who.int/contracting/UHC_Country_Support.pdf, last accessed on 11, September, 2020.

[154] What is universal health coverage? In: Health financing for universal coverage [2016] (http://www.who.int/health_financing/universal_coverage_definition/en/), last accessed on 1, November, 2020.

[155] World Health Organization, 'Making fair choices on the path to universal health coverage' [2014] final report of the WHO Consultative Group on Equity and Universal Health Coverage, P. 3.

[156] Ethiopia Health policy, n 152, preamble.

[157] Federal Democratic Republic of Ethiopia, Combined report (Initial and fourth) to the African Commission on the African Charter on Human and Peoples' Rights, Implementation of the African Charter on Human and Peoples' Rights, Para. 203.

Ethiopian health policy gives an emphasis to control communicable, epidemics and diseases related to malnutrition and poor living condition, promotion of occupational health and safety, development of environmental health, rehabilitation of the health infrastructure and development of an appropriate health service management system with the special attention to children. Health policy cannot be considered in isolation from policies addressing food availability, acceptable living conditions and other prerequisites essential for health improvement, accordingly, this policy emphasizes the need for the development of effective inter-sectorality for a comprehensive betterment of life.[158]

Health policy of transitional government of Ethiopian has been played a tremendous role on setting a directive to different strategies and programs for the implementation of the right to health in the country so far. Accordingly, to implement this policy, the latest five-year health plan known as the Health Sector Transformation Plan (HSTP) was developed in August 2015. This plan was titled, 'Envisioning Ethiopia's Path to Universal Health Care through strengthening of Primary Health Care'. Therefore, the performance measures and targets of HSTP were based on the envisioning plan.

The plan sets ambitious goals to improve equity, coverage and utilization of essential health services, improve quality of health care, and enhance the implementation capacity of different components of the health sector. Generally, the plan reflects the overall desire of the Government of Ethiopia to have the highest possible level of health and quality of life for all its citizens, attained through providing and enhancing a comprehensive package of promotive, preventive, curative and rehabilitative health services of the highest possible quality in an equitable manner.[159] However, this plan has already lapsed and no other plan has been replace it yet.

3.4.2. National Children's Policy 2017

The Government of Ethiopia has formulated a comprehensive National Children's Policy in 2017 to sustain its commitment to respect, protect and fulfil children's rights and to enhance the healthy growth and personality development of children. It further emphasizes, prevention and

[158] Health Policy, n 152, Preamble.

[159] The Federal Democratic Republic of Ethiopia, 'Health Sector Transformation Plan (HSTP)', Ministry of Health, 2015/16 - 2019/20, adopted on [2015], P.69-71.

protection from socio-economic and political hardships and rehabilitation, care and support for children in difficult circumstances.[160]

The policy provide the principle of non- discrimination as its pillar principle. Accordingly, children shouldn't be discriminated to access healthcare facilities, goods and services and other underlying determinants of health for their complete development of mental, physical and social wellbeing because of their race, religion, and language, colour of skin, sex, ethnicity, and type of disability or by any other grounds. It gives a wide ground of protections for children, which apparently embraces children in street situations, by leaving the grounds of discrimination as an open ended which could literally include economic ground against the enjoyment of the right to health. This policy sets an obligation on government to take all appropriate measures to protect children from all forms of discrimination and neglect. It further provides the necessity of cooperation among stakeholders because the desired results in promoting and protecting children's rights were not achieved due to lack of coordination among the various actors.[161]

Among the major policy issues in this document is taking the necessary measures to ensure nutritional adequacy for the healthy mental and physical growth of children, ensuring equal access to medical service and immunization for children is equally provided. Even though, nothing is clearly and explicitly provided one may argue this policy issues includes children in street situations.

The entire life situations could expose children in street situations to a long lists of problems which has an impact on their health. To alleviate or eliminate this problem, if possible, expanding counselling centers that provide essential services for children in difficult circumstances and ensuring their accessibility is provided as one of a major policy issue. Besides, creating an enabling environment for children in difficult circumstances to have access to quality and timely social and economic services including healthcare is provided. Under this policy part of underlying determinants to the realization of the right to health is explicitly provided. Accordingly, creating favorable conditions for the construction and expansion of facilities of clean and safe water for drinking and sanitation, toilets and waste disposal in order to help children to maintain their personal and environmental hygiene are provided.[162] This policy was enacted to be implemented in a nationwide, nevertheless, its implementation could be vary

[160] National Children's Policy, n 20, pp. 1-2.
[161] Ibid. P. 10-14.
[162] Ibid. p. 17-19.

from place to place. Accordingly, its practical implementation in the study area will be analyzed in the next coming chapter.

3.4.3. National social Protection Policy 2012

Based on the core values of equity, solidarity and social justice, the ILO defines *social health protection* as a series of public or publicly organized and mandated private measures against economic loss caused by the reduction of productivity, reduction of earnings or the cost of necessary treatment that can result from ill health. However, it is up to national governments and institutions to put these values into practice.[163]

Promote social justice and equity – and make growth more efficient and equitable and ensure basic acceptable livelihood standards for all are the major rationale behind the need for social national protection policy.[164] National Social Protection Policy of Ethiopia was adopted in 2012 with the vision to see all Ethiopians enjoy social and economic wellbeing and social justice. It defines social protection as being a set of 'formal and informal interventions that aim to reduce social and economic risks, vulnerabilities and deprivations for all people and facilitates equitable growth'.[165]

Social protection is a central public policy component for countries addressing poverty, vulnerability and inequality. Children in street situations have the right to be treated as all other children. Social Protection improves the effectiveness and efficiency of investments in hygiene and health, education, and water thus, accelerating the attainment of the development goals of the country, especially for the most vulnerable members of society. Accordingly, establishing Ethiopia's Social Protection Policy framework is part and parcel of an integrated approach to the progressive realization of social and economic rights of citizens noted under article 41 of the constitution.

Social Protection policy was adopted with the intention of acknowledging social rights as defined in the constitution and reaffirms its intent to expand the progressive realization of those

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[163] Social Security Department International Labour Organization, 'Social Health Protection, An ILO strategy towards universal access to health care' [2007], P.3.

[164] Andy Norton et al. 'Social Protection Concepts and Approaches: Implication for Policy and Practice in International Development' [2001] Overseas Development Institute, P.24, https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/2999.pdf, last accessed on 9, Feb, 2020.

[165] The Federal Democratic Republic of Ethiopia (FDRE), 'National Social protection policy of Ethiopia', Ministry of Labour and Social Affairs, March [2012], P. 1 and 14.

rights according to the availability of resources. It indicates the necessity of strategy and action plan to be developed to implement it, in a gradual and sustained manner, to accelerate the realization of equitable social protection outcomes. The implementation of this policy mainly depends on pillar principles of inclusiveness, non-discrimination and accountability. Accordingly, Social protection measures are expected to be implemented in a manner to address social as well as economic vulnerabilities by protecting citizens against any grounds of discrimination and exclusion.

The policy admits provision of quality healthcare is key to building human capital which in turn improve productivity and economic growth and breaking intergenerational poverty. Financial protection is crucial to avoid health-related impoverishment. Financial protection includes the avoidance of out-of-pocket payments that reduce the affordability of services.[166] The extension of health services to all people is expected to address constraints to access, especially for the poor,[167] apparently embraces children in street situations. Explicit discrimination includes vagrancy laws and policies allowing street children to be detained for survival behaviors; implicit discrimination includes requiring birth certificates to access health care.[168] Discrimination based on any ground, including economic ground against the enjoyment of the right to health is prohibited under the examined four international human rights instruments that Ethiopia has ratified. Hence, to avoid discrimination against the right to health based on economic ground the National Social Protection Policy provides a fee-waiver schemes of basic healthcare services for vulnerable groups as an implementation strategy.

3.4.4. National Healthcare Financing Strategy of Ethiopia 2015-2035

The World Health Organization (WHO) defines health financing as the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system." It states that the "purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and

[166] National Social Protection, n 164, P.1, 13, 14.
[167] Ibid. P. 20.
[168] United Nations Human Rights office of High commissioner, 'Protection and promotion of the rights of children working and/or living on the street', P.16,

personal health care".[169]Thus, it is important for countries to develop policies for 'improving health financing mechanisms, designing adequate benefit packages including financial protection.'[170]

The state of healthcare financing in Ethiopia has over the years been characterized by low government spending.[171] Many health systems are distressed by overall resource constraints as well as low allocation of funds. Increasingly, policymakers in developing countries are basing decisions about financing and resource allocation on evidence about how much is spent on health, who pays, and who benefits from health spending.[172]

Ethiopian government developed and endorsed a health financing strategy in 1998 that directs resources for the health sector to be mobilized from different sources and permits government to provide health services through its health facilities by means of a cost-sharing arrangement with users. National Health Care Financing Strategy (2015-2035) is the revised version of Ethiopian Health Care Financing Strategy of 1998 which was developed and endorsed to increase resources for health, enhance efficiency in the use of available resources, improve the quality and coverage of health services, ensure equity and promote sustainability. This revision consists of ensuring universal health coverage through primary healthcare by the year 2035 as one of its prior goals. In pursuit of its general objectives, this Health Care Financing Strategy has set specific strategic objectives. One of these specific objectives is *"reducing out of pocket spending at the point of use".* "Strengthening the waiver system and insurance coverage of indigents population" has been mentioned as one of a strategic approaches used to meet the objective.

On its discussion of the third objective of enhancing equity and justice, the strategy directly identifies children in street situations as the prime beneficiaries of the waiver programs. It states, "Ethiopia will strengthen the current fee-waiver programs increasing its financing, improving its targeting and selection mechanisms. Federal Ministry of Health will work with and through other ministries to benefit and include special groups such as children in street situations with fee-waiver programs".[173]

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[169] World Health Organization, 'the World Health Report 2000 – health systems: improving performance' [2000], https://www.who.int/whr/2000/en/, last accessed, 2, September, 2020.

[170] National Social Protection, n 164, P.13.

[171] Richard G. Wamai, 'Reviewing Ethiopian's health system development' [2009], P. 282.

[172] Zelelew, Hailu, 'Health Care Financing Reform in Ethiopia: Improving Quality and Equity' [2012] Health Systems 20/20 USAID.

[173] National Health Care Financing Strategy [2015-2035], Ministry of health, Addis Ababa, Ethiopia, P. 10-13.

Ethiopia institutionalized mechanisms for providing services to the poor free of charge through a fee waiver system, as well as through free provision of selected public health services, through exemption, such as health education and treatment of tuberculosis patients, and through services targeting selected groups (e.g., immunization of children under the age of five). However, a strong need existed to systematize and standardize these services to be efficient and effective. For instance, reports indicates local authorities had been issuing and is still issuing fee-waiver certificates to the poor as verified through local social justice systems at the time of sickness.[174] This resulted in cumbersome procedures that caused delays in the poor's including children in street situations, ability to access healthcare facilities, goods and services. This will be delineated in relation to the practice in study area in the coming chapter.

3.4.5 Healthcare Financing Directive of Oromia Regional State 2015

The directive was adopted in 2015. The first purpose of this directive is to enable public health institutions in the region to generate and retain income in addition to allocated budget from government to this sector from an open ended sources of income inter alia, user fees and selling drugs. This income makes the public health institutions to increase human resource and fulfill health related facilities which finally allow them to deliver quality and accelerated health service to the public at large.[175] Additionally, this directive enables poor households, aged, person with disabilities, displaced persons because of natural disaster or man made to access public health service equally with the person who can afford for his/her health related costs. However, the directive sets a requirement of getting prior fee waiver certificate to access free healthcare services.[176]The directive provides basic principle of non- discrimination, thus, public health institutions has the obligation to ensure that fee waiver certificate holders are accessing medical care equally with the one who receive medical treatment from his/her out of pocket payment.[177] According to Article 44 of this directive the structure of government which has the power to provide fee waiver certificate to this vulnerable section of society for free healthcare service in a public health institutions are Woreda or Town administration, or Zonal employment and social affairs bureau or commission of protection and prevention of disaster.

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[174] Zelelew, n 172, P. 4.
[175] Oromia Regional State, 'Healthcare Financing Directive of Oromia Regional State' [2015], Article 5(1), 5(5).
[176] Ibid. Article 3(a).
[177] Ibid. Article 61(5).

In this directive article 46(3) among the exhaustive list of vulnerable section of society who can get fee-waiver certificate to access free healthcare services, children in street situation is explicitly provided. However, article 47 provides simple and clear requirement to acquire fee waiver health care service certificate to access free healthcare services in public health institutions. Accordingly, to get fee waiver certificate one has to be engage on small business like selling woods for the survival of his/her households, traditionally manufactured alcoholic beverage and person who engage on day to day labour work who cannot cover his/her personal cost other than cost of food for his/her daily survival. Additionally, aged persons and persons with disabilities are by default entitled to acquire fee waiver certificate without the provided prerequisite. The active duration of fee waiver certificate is only for a period of one year.[178] The reason why the directive limits the active duration of fee-waiver certificate is probably to encourage this vulnerable groups to be self-reliant. Accordingly, it has to be revised annually. Besides, without any legal justification, the directive limits the service for only four rounds annually and the person who access medical care beyond the allowed number of rounds by using this certificate is legally responsible. For the principle of four round access to healthcare annually, follow up appointment is provided as an exception.[179] Nevertheless, the directive provided no clue regarding what legal measures will be taken against the person who violate the principle of accessing four round free healthcare service annually.

Conclusion

In order to enhance the implementation of the ratified international human rights conventions state has the responsibility to enact laws and policies in conformity with the provisions of the Conventions. Accordingly, Ethiopia has the responsibility to recognize the right to health of children in its constitution and other legislations. Despite ratifying the four human rights instruments examined in this thesis, which all provide an obligation to provide a right to health and its underlying determinants in domestic legislations neither the Ethiopia Constitution, nor legislative acts or policies, contain explicit provisions that incorporate the right to health of children in street situations with the underlying determinant of health. However, as discussed above in detail, this doesn't mean the right to health of everyone including children are not recognized and protected in Ethiopia.

[178] Ibid. Article 53(6).
[179] Ibid. Article 57 (2).

States have to recognize the right to health in its Constitution, and give effect to the right through other legislative acts and policies which have tangible impact on implementation of the right at grass root level. Accordingly, as long as the national normative legal framework doesn't explicitly recognize the right to health thus, one cannot claim it as a right.

Ethiopia has several policies that positively impact on children in street situations right to health. These policies stem from implicit recognition of the constitutions and international human rights instruments that Ethiopia has undertaken to realize it at domestic level. Accordingly, the policies themselves can be seen as a commendable first step taken by the state to realize the right to health of children in street situations. However, merely addressing the right to health through political objectives and policies are not sufficient. In addition, the policies examined are inadequately or poorly reflecting the obligations that are connected to ensuring the right to health of children in street situations that should be mainstreamed in coherence with the ratified instruments. In addition, these policies are not legally binding, but are merely reflecting political objectives.

Generally, there is a crucial need for improvement in national normative framework governing the right to health of children in street situations. This has to begin with the explicit recognition of the right to health of children in street situations in a constitution and other legislations. Even though, recognition of international law under domestic legal framework is the very first obligation to be taken by every state parties it is necessary to institute practical measures that are realistic, targeted, concrete, deliberate, achievable, and have a monitoring mechanism that ensures the realization of those measures.

It has been suggested that children in 'exceptionally difficult situations', such as children in street situations, should be afforded 'special rights, or special consideration within the rights as provided by law. That is because the effect of the implementation of rights might not be the same for children in street situations as compared to children who live safely with their families. Although, this thesis agrees with this suggestion in theory, caution needs to be taken so that such measures do not run the risk of creating a pulling factor for the exacerbation street dwelling or poor parents encouraging their children to go live on the streets in order to be able to utilize such measures.

CHAPTER FOUR

THE PRACTICAL REALIZATION OF THE RIGHT TO HEALTH OF CHILDREN IN STREET SITUATIONS IN JIMMA TOWN, ETHIOPIA

4.1 Introduction

The Committee on the Rights of the Child has stated that children's views shall be heard and respected. This also includes matters related to the right to health, such as 'what services are needed, how and where they are best provided, and identifying the existence of discriminatory barriers to access healthcare services'.[180] Article 3 of the CRC stipulates that 'the best interests of the child shall be a primary consideration'.[181] This suggests that health care systems need to be aware of what is in the best interest of children, and that they need to adapt to 'meet the needs of children'.[182] The Committee has suggested that states have to take measures that even give children the opportunity to 'contribute their views and experiences to the planning and programming of services for their health and development'.[183]

It is hardly controversial to state that it is a challenge for states to fully implement the right to health. However, in light of the research conducted, this thesis fully agrees with the argument that health to health need to be 'implemented in a manner that recognizes children's special needs, circumstances and vulnerability and health of children is not compromised merely 'by gaps of lack of resources, or inadequacies in the social determinants of health such as, safe and adequate water for drink and sanitations, housing and food.[184]

Thus, the previous chapters have shown state obligations under international human rights laws that Ethiopia has ratified and legal measures taken in response to the obligations stemmed from the these international human rights at domestic level. Accordingly, the aim of this chapter is to assess the extent of practical realization of the right to health of children in street situations in the

[180] CRC, General Comment No. 12 on the right of the child to be heard', Committee on the Rights of the Child, CRC/C/GC/12, on 20 July 2009, para. 104.
[181] CRC, n 5, art. 3.
[182] Vandenhole et al. 'The convention on the right of child' [2015] Routledge International Handbook Children's Rights Studies, p. 219. file:///C:/Users/dell/Downloads/RoutledgeInternationalHBookofChildrensRights1st2.pdf, last accessed on 11, November, 2020.
[183] CRC, General Comment No. 12, n 180, para. 104.
[184] Vandelhole, n 182, p. 229.

study area, measures taken, their adequacy and challenges against the full realization of the right to health of children in street situations.

4.2. CAUSAL FACTORS TO CHILDREN BEING IN STREET SITUATIONS

In order to fully address the phenomenon of children in street situations, it's important to analyze the factors that cause children to be in these vulnerable circumstances. These causal factors have been divided into push and pull factors.[185]The 'pull' causes are the reasons a child left his/her home and entered the streets while the 'push' factors are the reasons that force a child to the streets.

Poverty is one of the most cited push causes that drive children from home and onto the street. However, poverty is not in itself a direct cause but the foundation that most of the other causes stem from. It is therefore, the consequences of poverty that cause children to leave their homes and seek a living somewhere else. Poverty characterized by a lack of food causes children to have no option but to fend for themselves in the streets.[186] In some poor families, children are sent to the streets by, or accompany their caregivers, to beg.[187]

Family breakdown is also one of the primary causes of the phenomenon of children in street situations. This breakdown can also be as a result of poverty.[188] In most African societies when a child loses his/her immediate family or there was turmoil that rendered living in the family difficult, the extended family and the clan stepped in to care for the child.[189] With urbanization and modernization, this sense of family and of community responsibility for children has disintegrated.[190]The phenomenon of children in street situations is further exacerbated with the many causes of death of caretakers: parents dying due to the HIV/AIDS epidemic,[191] and other

[185] OHCHR Report 19/35, (n 1).

[186] M Lemba 'Rapid Assessment of Street Children in Lusaka' [2002] Project Concern International Zambia & UNICEF, https://www.streetchildren.org/wp-content/uploads/2013/01/assessment-of-street-children-lusaka.pdf, last accessed on 7, Feb, 2020.

[187] Kids Report, (n 45).

[188] P M Correa 'Poverty as a violation of human rights: the case of street children in Guatemala and Brazil' [2013] vol.10. No 2. Brazil Journal of International Law.

[189] ADV Breda 'The Phenomenon and Concerns of Child-Headed Households in Africa' [2010] https://www.researchgate.net/publication/267800294_The_Phenomenon_and_Concerns_of_Child-Headed_Households_in_Africa, last accessed on, 7, Feb, 2020.

[190] M Pare 'Why Have Street Children Disappeared?' [2003-4] vol.11 Int'l J. Child. Rts. P.1.

[191] Bassuk and Friedman, 'Facts on Trauma and Homeless Children, National Child Traumatic Stress Network Homelessness and Extreme Poverty' [2005] https://www.nctsn.org/sites/default/files/resources/facts_on_trauma_and_homeless_children.pdf, last accessed on 7, Feb, 2020.

conflicts leaving the children orphaned and without any support from the extended family. Children who find themselves in these situations have limited options of survival and most find their only way to survive is to be on the streets.[192]

Domestic violence, [193]child abuse and neglect, natural disasters and harmful cultural practices[194] are some of other causal factors driving children to leave their homes and live on the streets. Children with disabilities are stigmatized and often chased away from their homes by the caregivers/parents who are not willing to care for them.[195] However, the underlying reason for children in street situations has been poor policies and efforts by governments to tackle root causes[196] and economic inequalities.[197]

Push factors and pull factors are intertwined and it is often difficult to identify which category is responsible for putting children in the streets. The pull factors are those that highlight the 'glamour' of the streets. Streets represent freedom, lack of supervision, big cities, opportunities, money and others. Children leave their homes in order to seek out and enjoy the sensation of the cities, following friends or under peer pressure[198] or even following siblings who have been in the streets and find it to be a better place than their home.[199] Despite this appeal, many children find the street life difficult; and are thus introduced to a life of violence and struggle.[200]

4.3. THE PRACTICAL REALIZATION OF THE RIGHT TO HEALTH OF CHILDREN IN STREET SITUATIONS IN JIMMA TOWN, ETHIOPIA AND THEIR ADEQUACY

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[192] UNICEF, Africa's orphaned Generations https://www.unicef.org/media/files/orphans.pdf, last accessed on 7, Feb, 2020.

[193] B Rwezaura 'The Value of a Child: Marginal Children and the Law in Contemporary Tanzania' [2000] vol.14 Int'l J.L. Pol'y & FAM, P. 326, https://www.un.org/en/africa/osaa/pdf/au/afr_charter_rights_welfare_child_africa_1990.pdf, last accessed on 9, Feb 2020.

[194] OHCHR Expert meeting on promoting and protecting the rights of children living and/or working on the street Summary report statement by Director, Human Rights Treaties Division, https://www.ohchr.org/Documents/Issues/Children/Study/OHCHRBrochureStreetChildren.pdf, last accessed on 8, Feb 2020.

[195] P A Kopoka 'the Problem of Street Children in Africa: An Ignored Tragedy' [2000]. Paper presented to an International Conference on Street Children and Street Children's Health in East Africa, http://bettercarenetwork.org/sites/default/files/attachments/The%20Problem%20of%20Street%20Children%20in%20Africa.pdf, last accessed on 8, Feb 2020.

[196] Ibid.

[197] Terre des Hommes, 'Children in Street Situations Sectoral policy' [2010] https://www.ohchr.org/Documents/Issues/Children/Study/TerreDesHommes.pdf, last accessed on 8, Feb 2020.

[198] M Lemba, (n 186).

[199] Rapid Situation Assessment Street Children Of Cairo & Alexandria, https://www.unicef.org/french/evaldatabase/files/EGY_2001_005.pdf, last accessed on 8, Feb 2020.

[200] P A Kopoka, (n 195).

The methodology of this chapter was elaborated in chapter one of this thesis. Accordingly, sample of forty children in street situations and two responsible government office experts, expert on the rights and security of children, Jimma Town Women's, children and Youth affairs and Coordinator on care and support for vulnerable, Jimma Town Health Bureau, Jimma, Ethiopia, respectively, were interviewed. Children in street situations interviewed were eleven girls and twenty nine boys. Most of the children were between 14-18 years of age,[201] and the youngest child was nine years old. Some children were not sure of their current age, but it could be determined by additional questions regarding schooling and different events in Ethiopia. Some children had only been on the streets for one or two years, while others had been on the streets for fourteen to fifteen years. Most children had been on the streets for 3-14 years. When the question of how long he had been on the streets was posed to Tomas**,** he responded, I cannot remember that far back I had spent half of my life on the streets.[202] Three of the children interviewed had been on the streets since they were two and four years old, respectively.

The majority of the children belong to the category of 'street living children': they sleep in public places and are not accompanied by their family members. Six children are so called street working children: they sleep at home, but spend their days in the street. None of the children interviewed belong to the category of children from street families. Three children fell outside the definitions of these three categories. Two of them spend their days on the streets and sleep at a friend's house during the nights and one child sleeps at his employer's house.

All four instruments examined have emphasized the importance of addressing socioeconomic factors that contribute to a healthy life, such as housing, food, safe drinking water and sanitation. Accordingly, this section examine the practical implementation of every underlying determinants of health that has a contribution on the realization of the right to health of children in street situations and their adequacy.

The finding show that most of the children sleep in public places. Some have permanent spots they go to every night, while others sleep anywhere. Some sleep on cardboard, some pile up a couple of tires to make a shelter and curl up inside them, covering themselves with a jacket. Other children mentioned sleeping in parking lots, on top of containers, some of them sleep adjacent to Jimma University main campus compound, some sleep in abandoned houses or on

[201] 27 children were in the age span of 9-14; 13 children were aged 15-18.

[202] Interview with Thomas, child in street situations, Jimma, Ethiopia, October 2020.

the verandas of different stores and shops. Yonas explained that he sniffs glue every night so that he will not feel the cold. 'The glue is like my cover or blanket'.[203]

Most children in street situations do not have extra cloth. Finding also revealed in most instances when children in street situations are given cloths they prefer to sell it to 'Quralios'[204] than using it for themselves. Almost all of them dress the same cloth. Besides, their cloths are very untidy and has got smell, one of the child called Ibsitu said that, *"I have no any other cloth other than this I always wear it. Last time an individual gave me T-shirt but I sold it with 35 birr and used the money to buy food to me and my friends. My friends also do the same when they are given cloth. Even when we wants to keep the extra cloth our friends will sell it as we have no place to hide or keep extra cloth"*

Some children work in order to be able to buy food, while others get food from passerby or friends. Many children receive food from hotels, tea houses or restaurants, but have to perform various duties in exchange for a meal. *I get food from a small tea houses, but in return I have to wash utensils, fetch water, serving as a messenger and mop floors and furniture.*[205] This is a common situation for these children, being exploited due to their vulnerability. Tomas and his friends normally looks for scrap early in the morning for their breakfast. Some days they cannot get enough and then they resort to digging for leftovers from hotels, restaurants, tea houses or they beg nearby or passerby individuals.[206] Many children spend their days searching for food in the garbage and in containers, and some beg for money on the streets. Many of them expressed that they often go hungry as they cannot get enough money to buy food. Some of them chew *khat* to stay awake and dim the hunger, and others sniff glue so that their thoughts of food decrease. When asked how he gets food and drinking water, a respondent called Abdi said, "It is pure luck. I beg passerby to buy me food"[207] Sometimes I am able to get food, and sometimes I am not. I drink water from small nearby cafes or tea houses, sometimes I sniff glue instead.[208] Most kids get water from different communal taps around town. Others drink rain water, buy bottled local water with 2ETB.[209] One child gets his drinking water from the local stream.[210]

[203] Interview with Yonas, child in street situations, Jimma, Ethiopia, October 2020.
[204] A small Business persons who buy and sell used materials such as, cloth, jerry can, metals, etc.
[205] Interview with Eyasu, child in street situations, Jimma, Ethiopia, October 2020.
[206] Interview with Thomas, child in street situations, Jimma, Ethiopia, October 2020.
[207] Interview with Abdi, child in street situations, Jimma, Ethiopia, October 2020.
[208] Interview with Abreham, child in street situations, Jimma, Ethiopia, October 2020.
[209] For your information 1USD IS equivalent 0.026ETB or 39ETB is equivalent to 1USD on 10, October, 2020.

Some children in street situations also rely on community pumps for water, however, many community pumps do not work, and in that case they resort to stream water.

Thus, the problem of drinking water and sanitation are among the main problems for children in street situations. They have to mainly beg to have an access to drinking water. Begging is commonly used by younger children and females in street situations. The majority wash their body and cloth at streams or rivers located in a distance place from where they usually stay. Most of them do not frequently wash their body and cloth. In addition, these children in street situations commonly use open fields to wash up.

Some children have friends that allow them to come by to wash up. Some wash up at a car wash, while others do work in exchange for some water to clean up. Half of the kids go to the river *Awetu* or Abba Hassen which is located about 20 and 15 minutes' walk away from the Jimma University main Campus.

Regarding the health condition of these children, most of the children had been sick within their stay on the street prior to the interview. Accordingly, the research reveal the condition of these children as follows: The finding reveal many of the children in street situations had been sick multiple times. Six of them had had malaria, typhus and typhoid one or more times, one had caught skin rashes, and some had been sick with the flu and/or colds. Many children complained of stomach pain after eating garbage and headaches, likely resulting from glue addiction.

Some children experience pain in their backs and joints due to working conditions and carrying heavy objects during the day to get money or food in exchange. A child called Tefera twisted a knee when falling into a ditch.[211] Many children had scars resulting from either cuts because of fights between themselves or falling out of wall of compounds while trying to get leftover food. Two boys called Derara and Abebe broke their hands, it was the second time for Abebe.[212] The extent to which they were able to receive treatment or medical assistance will be discussed later in this chapter.

Sometimes these children fight between themselves or between different groupings. One boy was beaten and lost one teeth, they call him Filfilu as his nick name (a name of Ethiopian well-known comedian who has no one front teeth) and one was stabbed in the head by another boy.

[210] It is a stream that most destitute section of society use it as a source of drinking water and at the same time to wash their cloths.

[211] Interview with Tefera, child in street situations, Jimma, Ethiopia, October 2020.

[212] Interview with Derara and Abebe, children in street situations, Jimma, Ethiopia, October 2020.

One boy was robbed of the money he had earned and got a 4cm estimated cut in the back of his neck. Some children mentioned being cut by glass or broken bottles, and one boy got stabbed in the upper arm by a surgery knife.

Many children testify to severe Kebele (The lowest administrative structure) militia brutality and abuse, both mental and physical. Many children testify that these militias often are drunk, which increases the risk of the children being harmed and abused. This type of abuse is often directed towards the older children. Tamirat was beaten by the Kebele militia in an effort to convince him to leave the streets and go home. He explained that, "Other people (in town) lie to Kebele militia and say that we have done bad things, like stealing, and then we are beaten by the Kebele militia".[213]One child noted, "They saw as a bad being and they suspects for every criminal act occurred around us".[214] Other children told stories about being woken by the police in the middle of the night and getting beaten and received cuts to their heads or any other places. Abdi shrugged his shoulders and said, "Only Allah has protected us".[215]

Out of the children that had been sick or hurt during their entire stay on the street, very limited number of them went to the hospital. Two of them were taken to the hospital while unconscious after being beaten on the head. The price of 250 and 400ETB,[216] respectively was paid by family members and "a compassionate stranger and doctors that saw the blood gushing from my head'.[217] One of the boys said, "If my mother had not paid I would not have survived".[218] The others that went to the hospital were either street working children whose parents paid for their treatment or a street living child that was lucky to receive treatment when he told the nurses and doctors that he lived on the streets. Some of street working children has a family, who engaged on different works like maidservant, cloth washing and simple business like selling fruits and vegetables in different small markets called Gulit. Accordingly, in time of emergency there is a condition when the family of street working children covers their medical costs. Thus, comparatively, this suggests that street working children access healthcare services to a higher degree compared to those children that belong in the category of street living children, because to get medical treatment they completely depend on the help of strangers or friends, if any.

[213] Interview with Tamirat, child in street situations, Jimma, Ethiopia, October 2020.
[214] Interview with Iman, child in street situations, Jimma, Ethiopia, October 2020.
[215] Interview with Abdi, child in street situations, Jimma, Ethiopia, October 2020.
[216] For the sake of comparison, it is the equivalent of about 6.14 and 10.25 US Dollars, respectively.
[217] Interview with Mahlet, child in street situations, Jimma, Ethiopia, October 2020.
[218] Interview with Robel, child in street situations, Jimma, Ethiopia, October 2020.

Some children went to local clinics and received pain killers, or bandages. Some had to pay and some were given it for free. In other cases, someone else paid. Children with different cuts could not get stitches without paying and therefore, because of some compassionate strangers they just received bandages and alcohol to stop the bleeding. In case of emergency some of them resorts to traditional wound care method, using a tree leaf called Mekanisa or Bisana to heal their wound. One child normally goes to a traditional doctor for small hand bone fracture.[219]

A clear majority of the children neither went to a hospital or clinic nor received any treatment. Surprisingly, one girl did not go because he believes he is resistant towards diseases.[220] The most frequent explanation as to why a child did not seek medical attention was money, i.e. related to the notion of economic accessibility. Some children went to pharmacy and bought either pills or pain killers from the money they had earned.

Most of them created their own cures by covering their wounds with local tree leaves called Mekanisa or Bisana as a substitute for medicines. In the words of Tariku, who broke his left leg, "I did not have the energy to walk hospital, (the hospital is 5-6 km away estimated distance from where he live), no one could help me to get to the hospital, and therefore, my friends brought me to a local traditional doctor to get massage for my broken leg."[221]

These are some of the comments on the economic accessibility that the children gave, "I do not have enough money to get treatment for scabies".[222] "They just see us as thieves".[223] "Even if I would go, I would not get help. I tried two times and was denied every time because I don't have enough money".[224] "I cannot get medicine either from hospital or clinic because I have no enough money."[225]

Only four of the children responded that it is possible to get health care treatment without money, but that only concerns pain killers like Paracetamol (A medicine ordered for pain killers) for our severe headache. One child received treatment free of charge, but that was due to the fact that she knew some of the people that were working in the hospital. She explained that she does not expect to be able to go there again.[226] One boy did not have to pay for treatment, but

[219] Interview with Firaol, child in street situations, Jimma, Ethiopia, October 2020.
[220] Interview with Jitu, child in street situations, Jimma, Ethiopia, October 2020.
[221] Interview with Abebe, child in street situations, Jimma, Ethiopia, October 2020.
[222] Interview with Elias, child in street situations, Jimma, Ethiopia, October 2020.
[223] Interview with Dinku, child in street situations, Jimma, Ethiopia, October 2020.
[224] Interview with Daniel, child in street situations, Jimma, Ethiopia, October 2020.
[225] Interview with Robel, child in street situations, Jimma, Ethiopia, October 2020.
[226] Interview with Merry, child in street situations, Jimma, Ethiopia, October 2020.

explained that it was a one-time thing. "They told me they could only help me once because they cannot keep helping. On the other day my friend got me to the clinic and I was only helped because I was unconscious."[227] The rest of the interviewed children explained that it is not possible to receive any treatment without payment, and several children stressed the importance of having someone that can help you. Thus, on their own, they cannot get the help they need.

All of the children interviewed do some type of work in order to get money for food, health care, medicines and so on. Most children spend their day looking for scrap and once they got it they left no friends behind, they eat together. Some of the children can make 30- 40ETB per day, most of them make about 15-25ETB, while some of the older boys can make up to 40-50ETB if they are lucky.[228] A normal, cheap lunch, in a restaurant or tea house serving local food, costs about 15-20ETB. It is possible to buy Ashambusa *and Koker* for only 5-10ETB from the nearby tea houses, but that will not provide all the nutrition needed.[229]Yonas, one of the older boys that has been on the streets the longest, described his situation in the following way:

"*I wake up at 6 am and start looking for scrap. It's all depend on luck. Sometimes the glue makes me forget that I have not taken food, and the glue makes me feel numb so that I do not feel so much starvation. The sad story behind all these story is, no one trusts me because they just see me as a street kid. I cannot get a job. I have been on the streets too long*".

Some children carry charcoal to café, tea house or restaurant owners and get 10ETB. Many children collect and remove garbage from private homes or cafe, some of them only receive 5-10ETB in return. One young boy carries 10 jerry cans of water for someone and is paid 20ETB for it. The jerry cans weigh is about 15-20 kilos each. Today he has shoulder and muscle pain resulting from that work.[230]

The finding revealed that children in street situations are victim of physical, verbal and sexual abuses. With regard to sexual abuse females were raped, forced kissing, touching private parts are the most common. Meanwhile, males were victim of attempt of penetration when sleeping by their friends and asking for same sex practice. One of the girls interviewed was forced into prostitution and is working every night. She explains that she has a hard time competing with others as she does not have enough money to spend on hygiene and clothes. In one night she can

[227] Interview with Disasa, child in street situations, Jimma, Ethiopia, October 2020.
[228] It is the equivalent of about 0.76-1.025, 0.38-0.64, 1.025-1.282US Dollars, respectively.
[229] Ashambusa or Koker is a kind of bread often served with rice or potato. Equivalent to 0.12-0.256USD.
[230] Interview with Gadebo, child in street situations, Jimma, Ethiopia, October 2020.

earn 150-200ETB after having 3-4 clients that often bargain. When she has paid the rent for the room she works in, she is left with 100 or sometimes only with 50, it is like a share with the room owner. Sometimes, my customers took me to their home and pay me 50-100. Sometimes they invite me dinner, alcohol and pay me nothing.[231] She said her challenge as follows: "*Unfortunately, all my customers are persons who engage on some kind of crimes, they sometimes beat me to death and leave me without paying me anything"*

Finding similarly reveal that physical and verbal abuse were common among both sex group. Accordingly, *a* respondent called Rahel said, "I was sleeping the place where we sleep on the floor without night cloth then I walk up from my sleep when unknown boy trying to undress my trouser then I shouted then my friends immediately came and asked why I was shouting and I told them what happened but the man insisted that he was doing it unconsciously in his dream and then yell at me and warned me not to disturb."

The finding showed that abused children in street situations hardly report to the police station when they are abused. They mostly abstain from reporting to the police in fear of the abuser at release that they tolerate and adjust themselves to the problem. One girl noted, "I don't want to report to the police because if did, for sure they will kill me."[232] Similarly, child girl said, we all choose to tolerate the situation we are in, it is actually better to be alive."[233]The other reason is that they have a fear that they will not be accepted and that police will not cooperate with them. As a result they deal with the problems by themselves.

Children's mental health may also suffer as a result of the pandemic. In Jimma town, Ethiopia, when the government announced the lockdown, it caused panic among most of the respondent children, some of them were started walking back to their villages, and many of them are over 15-45km away from Jimma Town. Surprisingly, an interview with one of the key informant revealed that they were forcefully deporting children in street situations to the nearest Woreda town and even to another Regional state called Southern Nation, Nationalities Region, most specifically to Tercha town, which is around 140km far away from Jimma town.[234] This act was done with the collaboration with Jimma town Police office and Jimma town administration.[235]

[231] Interview with Kidist, child in street situations, Jimma, Ethiopia, October, 2020.
[232] Interview with Hayat, child in street situations, Jimma, Ethiopia, October 2020.
[233] Interview with Lili, child in street situations, Jimma, Ethiopia, October 2020.
[234] Interview with Mr. Girma Zergaw, expert on the rights and security of children, Jimma Town Women's, children and Youth affairs, Jimma, Ethiopia, October 2020.
[235] Ibid.

However, the finding reveals some of the children in street situations were not comfortable to stay the town they were sent, accordingly, when things gradually becoming normal they came back to the street.

Many children in street situations are not protected against COVID 19 because they do not have access to appropriate health information. Most of these children do not have access to television or internet, which are the most common means of communication that government uses to share information and health education. In the study area, even when they do have access to information, they may not be able to understand it because it is not tailored to children, does not take into account low literacy levels. The finding with key informants reveal that, even though, there was a campaign to deliver health information regarding COVID 19 to the entire community of the town, unfortunately, none of them were not done specifically targeted to vulnerable groups including children in street situations.[236]

In the study area, Children in street situations are facing a multifaceted difficulties against accessing underlying determinants of their right to health, inter alia, Esak explained the obstacle that hinder them from accessing their right to health care as follows:

'*Either you need to a get a certificate or buy health insurance book that you have to bring every time you go to the clinic.*'[237] A boy who had fallen off a side walk stated that he needed to go to a local chairperson and receive a letter to present to the hospital and that was not possible because he don't have an ID-card that could show his membership to that Kebele administration.[238] One girl noted as follows: *"A friend took me there and got me a certificate without that friend I would not have received any treatment"*. Some children mentioned that they need to bring ID-card in order to receive treatment, but that they do not have such documentation nor do they have the possibilities to obtain them. One girl said, "*I'm living with fear. I do not have an ID-card. I do not know what would happen if I get sick.*"[239]

More than about half of the children have received some support and assistance during their time on the streets. A majority of them have been helped by a passerby. Even though, the role of NGOs to rehabilitate children in street situations and reunite them with their families, if possible,

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[236] Interview with Mr. Girma Zergaw, expert on the rights and security of children, Jimma Town Women's, children and Youth affairs, Jimma, Ethiopia, October 2020; Interview with Mr. Hafiz Hussien, Coordinator on care and support for vulnerable, Jimma Town Health Bureau, Jimma, Ethiopia, November, 2020 (Hereinafter called key informants).

[237] Interview with Meazi, child in street situations, Jimma, Ethiopia, October, 2020.

[238] Interview with Kasahun, child in street situations, Jimma, Ethiopia, October 2020.

[239] Interview with Iman, child in street situations, Jimma, Ethiopia, October, 2020.

or place them in foster care plays pivotal role, however, no NGOs were working specifically in the study area related to children in street situations while the researcher conducted this study. Most children have been helped by private persons, such as friends, passersby and pastors of local churches. Some by being given shelter or handouts of food. A couple of children also said they had received assistance, but referred to employment situations where they had to perform various duties in exchange for food, shelter or drinking water. One boy was taking care of cows in exchange for money, but considered it help rather than employment. The same applies for a boy who was washing utensils for a restaurant in exchange for some food. Unfortunately, none of the interviewed children had received any help or assistance from the government.

As part of follow-up questions, some children were asked what they would do for children in street situations if they were the prime Ministry of the country, and some children were asked what they think their government should do in order for children in street situations to feel safe when they fall sick or get hurt. These questions relate to the notion that children's views should be heard and respected. Reiterating what was explained in the introduction of this chapter, it is clear that this also include matters related to the right to health, such as what services are needed, how and where they are best provided, to identify discriminatory barriers against the realization of the right to health of them.

Many children responded that they think the government should provide the underlying determinants of health that positively contribute to their healthy growth including healthcare facilities, good and services free of charge for children in street situations. Most children agreed on their name called, "street child" which apparently lead them to be discriminate. One child noted word by word as follows; *"The government should eliminate the word street kids"*. We do not belong to the streets, we belong to families, although either they are far or poor. The name gives us a bad image when we go to either clinics, health centers or hospital and no one cares about us. Why is it that when we are sick, when we try to go to the clinic/hospital, why do they not care about us? Are we not human beings? Surprisingly, no one cares about us, we are living miserable and terrible life on the street. A respondent called Ibsa said, "As long as, we could not afford, the government should make sure that hospital facilities, including medical drugs do not demand money from children in street situations. They should make sure that the service delivery reaches everyone, including us and build free of charge health institutions." A respondent called Mohammed said, "Our right to healthcare services should be for free. If I were

the Prime Minister, I would facilitate health related things in public hospitals for children in street situations. And I would built hospital and hires physicians to treat children in street situations only".

A respondent called Betty said, "They should treat us equally and to avoid discrimination there should be a reserved services for us". A respondent called Abraham said, "The government should help children in street situations without harassing them". A respondent called Tamrat while indicating his interest for job opportunity he said, "In order to feel safe. I wish the government could get us jobs so that we could leave the streets, I guess job is the only way that make us self-reliant." A respondent called Daniel said, "The government should withdraw polices and Kebele militias that are harassing and hurting us." While re-emphasizing their condition a respondent called Kebede said, "The government should care and take care of us. Either Hospital guards or Kebele militia should not chase us away from the hospital and the town, respectively. They should treat us fairly, because we are human, too."

At the end of the interviews, the children were asked what they are dreaming about. These are children, just like any other children, but they have lived through events and seen things that no child should ever have to experience. Still, they have hopes and dreams for the future. Some of these children dream of becoming football players, others to become doctors, teachers, mechanics, engineers, soldiers and polices. A boy called Geremew dreams of going back to school, he used to be in the top of his class with very good grades. Another boy said he dreams of becoming a "business man".[240]

These goals are not unreachable and the dreams are not unrealistic, they can achieve it. It is possible to change the lives of children in street situations, unfortunately, as Ibsa explained the scenario they are in as follows: "*We are being treated badly and our voices have not been heard. No one considers us as a human beings. ... There is no one for us we are all alone.*"[241]

"If I am the prime Minister of Ethiopia, I would always come and make sure that they are doing their job well, monitor them. I would change the police and Kebele militia so that they cannot abuse their power. I would call all doctors and tell them how to treat people, doctors hold the lives of the people in their hands. Hospital staff should move around the streets and find out how

[240] Interview with Megersa, child in street situations, Jimma, Ethiopia, October 2020.
[241] Interview with Ibsa, child in street situations, Jimma, Ethiopia, October 2020.

the kids are doing."[242] "Most doctors brought us foods in the morning. They know who we are because most of us live around their homes. Thus, it's easy for them to understand our pains".[243]
The finding reveals that key informants personally have a knowledge about the situations and socio-economic conditions of these children in the town.[244] However, with the capacity of the office they are holding, they have no a detail knowledge about any of international human rights instruments that Ethiopia has ratified and undertake an obligation to realize it. While the right to health allows for progressive realization, in acknowledgement of the limits imposed by resource and other constraints, States have obligations of immediate effect, such as the guarantee that this right will be exercised without discrimination of any kind and that deliberate, concrete and targeted steps will be taken towards the right's full realization. However, the interview with both key informants reveal that no government budgets are allocated to implement and to take targeted, concrete and deliberate actions on the rights of the children in street situations in the town.[245] Accordingly, let alone the adequacy, both offices are not working or has took no measures to realize the right to health of children in street situations as their obligations and priority agenda. Again, the interview show these two key informants are fully aware of the growing number of children in street situations in Jimma Town, sadly, they have no mechanism, plan, program or means to identify the pulling and pushing factors, the socio-economic situations of these children and ultimately, to implement the constitutionally protected right to health and underlying determinants of health of children in street situations in the town.[246]

Finally, the examination of the practical implementation of the right to health indicate that it is clear that a majority of the children that took part in the interviews do not enjoy the right to health and its underlying determinant of health as it is stipulated in the examined instruments. Besides, let alone the adequacy of measures taken to realize the right to health of children in street situations in Jimma Town, Ethiopia, the finding boldly reveals that no measures has generally been taken to realize the right to health of children in street situations Jimma town, Ethiopia.

4.4. Challenges against the Realization of the Right to Health of Children in Street Situations in Jimma Town, Ethiopia

[242] Interview with Lemesa, child in street situations, Jimma, Ethiopia, October 2020.
[243] Interview with Faxuma, child in street situations, Jimma, Ethiopia, October 2020.
[244] Interview with key informants, n 236.
[245] Ibid.
[246] Ibid.

The interpretation of the right to health include the underlying determinants of health, that would mean states have obligations under the right to health to deal with the political, economic and health structure obstacles which may prevent the realization of the right to health of children in street situations. Interview with children in street situations reveal that there is little or no access to healthcare services because of a number of barriers. Thus, it's important to figure out challenges against the realization of the right o health of children in street situations in the study area. Accordingly, based on the overall analysis of the thesis and the information obtained from participants (Children in street situations) and key informants the following challenges against the realization of the right to health of children in street situations are identified.

1. Law related challenges

In Ethiopia under FDRE Constitution, the judiciary is vested with the power to consider rights matters, and the courts are guaranteed to do so free from interference or influence of any governmental body, government official, or any other source.[247] However, interpreting and applying the socioeconomic rights including the right to health of children in the constitution is arguably the most challenging task facing courts in Ethiopia on various grounds.

The right to health in the FDRE Constitution are formulated in crude and general wording with other socio- economic rights, which adds real challenges to the interpretation and implementation. Nevertheless, children's right to health, to access to food and safe drinking water, to adequate standard of living, and to other rights relating to the underlining determinants of the right to health have been explicitly recognized under the examined international human rights instruments. However, neither the FDRE constitution nor any specific legislation have a specific and explicit provision that deals with the right to health and its underlying determinants of the right to health of vulnerable, inter alia, children in street situations. The absence of explicit recognition might create ambiguity for the judges to enforce these rights when violated. On the other hand, to some extent policies discussed in chapter three tries to embrace and accommodate the right to health of children in street situations, however, these policies are not legally binding and one cannot bring a legal case based on it because it is mere political reflections and one cannot bring a legal case based on it. Overall, this manifests lack of compatibility between the domestic law with the relevant provisions of the, ICRC, ICESCR and ACRWC, ACHPR in the

[247] FDRE constitution, n 21, art, 78.

area of the right to health. As clearly highlighted in the decision of the African Commission in the case of *Purohit and Moore V Gambia*, when a state's legislation in the area of health care does not meet human rights treaties that such state has ratified or acceded, then the state is required to repeal its existing laws and replace it with a new legislative regime to ensure compatibility.[248]

Justiciability of the right to health by itself is yet an argumentative. Justiciability refers to the capability of rights to be enforced by a judicial or quasi-judicial organ and the existence of procedures to contest and redress violations.[249]Although, the debate over justiciability of socioeconomic rights seems to have been settled in many parts of the world, research shows this is not the case within the Ethiopian judiciary and among Ethiopian practitioners.[250] The non-inclusion of ESC rights particularly the right to health in the constitution debar the possibility of judicial efforts to give a remedy to the marginalized individuals or groups. The incorporation of such rights in a constitutions explicitly as enforceable rights adds legitimacy to judiciaries that aim to enforce them. Unfortunately, FDRE Constitution does not recognize the right to health explicitly as international human rights instruments that Ethiopia has ratified do.

Under chapter 10, the Ethiopian Constitution provides for 'National Policy Principles and Objectives' that guide any government organ in the implementation of constitutional provisions, other laws and public policies. These objectives, among others, require the government to promote self-rule and equality of the people, to formulate policies that ensure equal economic opportunities and benefits, and to adopt policies that aim at providing all Ethiopians access to public health and education, clean water, housing, food and social security to the extent the country's resources permit.[251] While the provisions of the constitution provide for individual and group entitlements, the policy objectives extend this protection by imposing the duty to adopt policies that ensure the enjoyment of rights by citizens. They may be used as tools that guide the interpretation of fundamental rights and freedoms. Policies should also be developed and implemented with due respect to fundamental rights. However, non-inclusion of the right to health explicitly in the constitution left the issue of justiciability of the right to health unresolved.

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[248] Purohit and moore v Gambia [2003] Communication No. 241/2001, AHRLR 96, ACHPR [2003].

[249] Sisay Alemahu Yeshanew, 'The justiciability of human rights in the Federal Democratic Republic of Ethiopia' [2008] AHRLJ, P. 274.

[250] Salma Yusuf, 'The rise of judicially enforced economic, social and cultural rights' [2012] SJSJ; 753-791.

[251] FDRE Constitution, n 19, art 85-89.

Thus, judicial measures are indispensable as a means of rights realization, however, justiciability still exists as a barrier to the realization of the right to health of children in street situations.

2. Lack of responsive government measures to implement the right to health of children in street situations in Jimma Town, Ethiopia

Through ratification of human rights treaties examined above, Ethiopia is required to give effect to the right to health at domestic level. More specifically, article 2 (1) of the International Covenant on Economic, Social and Cultural Rights underlines that States have the obligation to progressively achieve the full realization of the rights under the covenant, inter alia, the right to health. Not all aspects of the rights under the Covenant may be realized immediately, but at a minimum state must show that it is making every possible effort, within available resources, to better realize the right to health. While the concept of progressive realization applies to socio-economic and cultural rights under the Covenant, some obligations are of immediate effect, in particular the undertaking to guarantee that these rights are exercised on the basis of non-discrimination and the obligation to take steps towards the realization of the rights, including the right to health, which should be concrete, deliberate and targeted.

Accordingly, the ability to access healthcare facilities, goods and services without discrimination is one of an obvious requirement to be able to survive in good health. While no government can guarantee individual good health for everyone, every government does have obligations to allow people to enjoy the highest attainable standard of health they can, based on their individual conditions. While governments are not obligated to provide healthcare services that are beyond their scientific capacity or available resources, they are required to make all healthcare goods and services available to everyone, without discrimination. To do this, the first obligation that the government fails to do is to adopt and implement a clear *public health strategy and action plan* that requires state to realize progressively and to move forward towards achieving it. States make the excuse that fulfilment of the right to health is highly costly. But the author argues, to a large extent it involves no more than fair distribution of available resources in a more equitable manner and ensuring that children in street situations do not suffer adverse health effects from discrimination, mainly, economic discrimination. Even on a small health budget, for example, countries can design health systems to improve access to services for poor, vulnerable, including children in street situations. What is just required is the political commitment to take obligations seriously and to redistribute available resources accordingly.

Unfortunately, the finding with key informants reveals that neither government budgets are allocated nor program/plan adopted to reduce or eliminate the problem against the realization of the right to health and its underlying determinants of health including access to healthcare services and goods specifically targeted for children in street situations in nondiscriminatory way in the study area so far.[252]

Specifically, regarding the pandemic called COVID 19, fortunately, there was repeated health information movement in the town conducted by key informants to the public at large in the town. However, the health information delivered was not targeted and considered the socio-economic conditions and ability of understanding of children in street situations. It's apparent that when they told to self-isolate, children in street situations may not have a safe home to go to. When told to wash their hands frequently, they have no soap or clean water to do it with. And when instructions are given out over the radio, internet or in newspapers, most cannot read them and no access, thus, they remain uninformed of even basic information. They are unable to find the means to feed themselves. They are experiencing untold horrors, difficulties and experiencing grave human rights violations.

The right to health is inherent to the right to life. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to live a life in dignity. Everyone, regardless of their social or economic status, should have access to the healthcare they need.[253] Universal, affordable healthcare systems assist with combating the pandemic by ensuring access for everyone, without discrimination, to basic measures that contain the spread of the virus. This includes testing, care for the most vulnerable, apparently, includes children in street situations, intensive care and vaccination, when available, regardless of ability to pay. However, with the current condition of these children and less regards given to them by government, there is no or very little probability to happen in study area.

During a pandemic, preserving, protecting and promoting a child's right to health is, and must be, a priority. Every child needs to have access to adequate healthcare and health education to protect themselves and others from the virus, including children in street situations. However, the finding indicate that most of the study participants have low levels of knowledge on transmission

[252] Interview with key informants, n 236.

[253] UN, 'Human rights are critical – for the response and the recovery, COVID-19 and human rights: We are all in this together' [2020], P.7.

modes, prevention methods and practice of prevention of COVID-19. For instance, a respondent called Chala said, “I don’t even know how exactly the virus transmitted from person to person. Actually, I heard from my friends that the virus can spread from an infected person’s mouth or nose when they cough, sneeze, speak, sing or breathe heavily”.

Begging to survive on the streets had become increasingly tough for them, since the arrival of the new coronavirus. A participant called Biruk said, “As soon as the first case was registered, I was so worried because people started to avoid us, no one was there for us, we were all alone, we had nothing to eat, thus, we were starved, things were very complicated”. Another participant called Tariku said, “government or persons who knew us before, instead of giving us an information on how to protect ourselves and kits like face mask they all were ignoring us, as if we are not human being, I felt sad”. In this regard the finding with key informants reveal that the offices they are leading has no any budget allocated for the case of emergencies like COVID 19 pandemic, which could be specifically employed for vulnerable, like children in street situations or special supports from governments that can help them to distribute goods like facemasks and sanitizers, which are an important weapons to fight the virus.[254]

Many of the people most severely impacted by the crisis are those who already face enormous challenges in a daily struggle to survive. For more children in street situations, washing their hands regularly is not an option because they have inadequate access to water. Children in street situations who have inadequate, overcrowded housing, physical distancing is a nightmare. Poverty itself is an enormous risk factor, thus, children in street situations are, apparently, a destitute, and they even couldn’t afford to buy a single mask. During the first case was registered in Ethiopia the money that could bought a single mask can even cover a monthly cost of couple of children or more. A respondent called Tadesse said “We all sleep together, we cannot keep our distance as they said, we don’t have enough cloth to wear, thus, why would we kept our distance, and things are not easy here, sometimes, when things get worse, I even choose to die, I don’t really care about the disease called COVID 19”. They are not only at greater risk from the virus itself, they are most severely affected by the negative impacts of measures to control it.

[254] Interview with key informants, n 236.

Some respondent reveals that they were forced to leave the town.[255] The method was not based on consent of the children in street situations rather it was backed by police forces. They were not seen as human beings rather they were considered as a weapon to transmit the disease to the people of the town. Surprisingly, the key informants admitted this scenario, “We were trying to send them back to their homelands, because they were vulnerable and could transmit the disease to the people”.[256] Accordingly, the research reveal that, the measure taken was not child-friendly and didn’t take into account the human rights of them. Generally, in the study area, government lacks planned emergency management strategies /mechanism that could help the realization of the right to health of children in street situations based on human rights principles, which is a challenge that government has to address to make them more resilient.

3. Inaccessibility of the underlying determinants of health

As previously noted, General Comment 14 clarifies the obligation of states to ensure child-friendly health services, goods, and facilities are available, accessible, acceptable, and of high quality. The range of limitations in terms of availability of health-care facilities, goods, and services restricts the full realization of children’s right to healthcare.

Moreover, although ‘child malnutrition has declined, many Ethiopian children continue to go hungry’. Safe food is considered one of the underlying determinants of the right to health, but the rate of Ethiopia’s stunted children (caused by malnutrition) is above the average of other African countries, the average rate for African countries being 38% and that of Ethiopia’s is 58%.[257]

Pursuant to most respondent, the most common types of purchased food eaten by children in street situations are Ashambusa, koker, and fruits like Avocado, which represent typical cheap folk foods. When food cannot be purchased because of lack of money, they eat what they can find in the trash cans. Apparently, nutritional status is a key factor of children’s health, physical and emotional wellbeing, and in cognitive development. Children in street situations are at exceptional risk to a wide range of negative health outcomes and malnutrition. Apparently, consumption of tainted food, inadequate nutrients and repeated illnesses are the immediate

[255] Interview with, Thomas, Chala, Eyasu, Yonas, Abdi, Mohammed, Fuad and other six children in street situations, Jimma, Ethiopia, October, 2020.

[256] Interview with Mr. Girma Zergaw, n 234.

[257] The African Child Policy Forum (ACPF), ‘Africa’s Children and the Post-2015 Development Agenda’ [2014] Addis Ababa, Ethiopia.

causes of malnutrition among them. The respondent called Kiya said, “I sometime feels abdominal ache and diarrhea when I eat left over food and food that stay for long time in a garbage cans” Accordingly, the fact that they have no enough money to pay for food they may be forced to eat food that might have effect on their health. Children in street situations often employ different strategies to acquire food. Most of the respondents referred to begging, washing dishes in hotels and cafe, or having temporary jobs, if available. Others admitted that they steal food.

The accessibility of water for drink and sanitation both in quality and quantity are crucial for the wellbeing and the overall health of people in general and children in street situations in particular. Areas inhabited by them are less likely to have access to proper water and sanitation facilities. As a result most of the children in such areas beg water with poorer quality to drink and they use river or stream water to take shower. Lack of adequate sanitation and drink water drives them to use river water and low quality waters for drink. The respondent called Chala said, “Usually, we went to Abba Hassen and Boye River to take shower, sometimes, it result us to infect scabies, however, we don’t have an alternative to clean ourselves”. Accordingly, it’s clear that lacking this basic determinants of health exposes them to serious health risks.

Children’s health and overall well-being are deeply influenced by the quality of housing in which they live. Lack of adequate housing or homelessness tend to have a profound impact on children due to their specific needs, affecting their growth, development and enjoyment of a whole range of human rights, including the right to health and personal security. [258] Unfortunately, most respondents went back to their place or slums to sleep. They slept on road side, under the bridge, Verandas, in parking lots, and religious places. Among these locations, a higher concentration was observed in Veranda and road sides being exposed to weather of all season. Very small number of respondents live either with their friends. The respondent called Adugna said, “Getting veranda to sleep is very challenging for us especially on summer, we can`t sleep on street due to the rain and cold. As a result we are forced either to pay to or beg the other crews to get space on the veranda to sleep. Sometimes, the owner expel us from his veranda”. Furthermore, given the negative perception the society have on children in street situations they have to negotiate with the owners to sleep on veranda. Firaol said, “The crew thinks the verandas

[258] Office of the United Nations High Commissioner for Human Rights, UN Habitat, The right to adequate housing, Fact Sheet No. 21/Rev.1, P. 18.

where they sleep as their own territory and they consider new arrivals as a trespasser." Furthermore, the most important element of healthcare goods, medicine come at forefront. However, taking self-prescription medicines are common among children in street situations, they often consult each other when medical help is needed. Apparently, this may lead them to develop chronic diseases. Thus, lack of all these underlying determinants of health have a negative impact on the realization of the right to health of children in street situations in the study area.

4. Discrimination

States must respect and ensure the rights set forth in the Convention for each child within their jurisdiction without discrimination of any kind. However, discrimination is one of the prime causes of children ending up in street situations. The Committee interprets "other status" under article 2 of the Convention to include the street situation of a child or his or her parents and other family members.[259] International human rights law proscribes discrimination in access to healthcare and the underlying determinants of health, as well as to the means for their procurement, on any grounds. Human rights principles and standards, such as non-discrimination, availability, accessibility, acceptability, quality, accountability and universality, are essential foundations for the fair and equitable application of UHC[260] and are essential for guaranteeing coverage inclusive of and responsive to children in street situation's health needs. CRC Committee in its concluding observation to Ethiopia's report recommends, the elimination of de facto discrimination of all children and to ensure their full inclusion in all spheres of life, and particularly in education and health care.[261] It further recommends to ensure the incorporation of the principle of non-discrimination into all laws, policies and programs relating to children, particularly relating to education, healthcare.[262] However, various forms of discrimination continue to undermine the realization of the right to health of children in street situations. For example, they often face discrimination in access to general healthcare services within these services, which may deter them from seeking care in the first place. The following respondent confirmed this as follows.

[259] CRC, General comment 21, n 81, para 25.
[260] CESR, General comment No. 20, n 74, para 10.
[261] Committee on the Rights of the Child Concluding observations on the combined fourth and fifth periodic reports of Ethiopia, n 157, Para. 24 (c).
[262] Ibid, 32(a).

A respondent called Eyerus said*, "I have visited health center and hospital to get treatment two times. Occasionally, they admitted me to give treatment, however, the only treatment they gave me was just pain killer. On the other day, they failed to admit me saying that they would not provide me any treatment. In each occasion I saw other patients treated and got appropriate medicine but nothing in the case of mine, you know what the reason is? I have no enough money, thus, the principle is no money no services."*

Besides, the respondent called kiya said*, I don't think I have equal access to treatment either in hospitals and health centers like other patients. I made a visit to hospitals a couple of times. The maximum treatment which I got is injection and painkiller. But this injection and painkiller did nothing to my disease. Here is the point, other patients' access hospitals and health centers and they return home after getting appropriate health care service and goods but I went there and back without any appropriate healthcare service and goods, you know why I don't have enough money. Thus, can I say that other patients and I have equal access to healthcare? Obviously, not!*

On the other hand, the key respondents re-emphasizes what these children said, "No mechanisms are there which could allow individuals to access healthcare service and goods for free unless they got an insurance or a certificate given for a member of the concerned Kebele administrations to access healthcare services in public institutions either in hospital or health centers for free."[263] This issue will be discussed in detail in the coming section of this thesis. Accordingly, discrimination based on financial capacity are the main challenge that this children's are facing to access healthcare goods and services in the study area.

Basically, all human rights i.e. civil and political and socio-economic rights are interrelated, interdependent and indivisible as emphasized on different Human Rights instruments and FDRE constitution. This means that violating the right to health and right to equality and non-discrimination may often impair the enjoyment of other human rights. Hence, the realization of the right to health is important for the realization of other rights like the right to life, the right to work and the right to an adequate standard of living in particular because health is indispensable for the fulfillment of other human rights.

[263] Interview with key informants, n 236.

The Human Rights committee in its General Comment No.6, expresses the view that the protection of the right to life requires States Parties to adopt positive measures…." [264]The right to life should not be interpreted narrowly.[265]This indicates the right to life cannot be fully realized without undertaking some positive measures against problems detrimental to human health. Accordingly, the government is obliged to undertake measures against the challenges that hinder access to healthcare for the full realization of the right to life. The obligation to remove financial barriers to accessing health care is a core element of the right to health. The right to health requires government to provide healthcare to all people who need it including vulnerable, without discrimination, inter alia, discrimination on financial grounds.[266] However, failure to expressly providing it under national binding legal instruments and implementing it in practice is a clear violation of the right to health and ultimately the right to life of children in street situations.

5. Unaffordability of Payable Health Facilities and Challenges to use fee waiver healthcare services

Only very limited number of the children visited health facilities when they were sick. This access status of the children can be seen from two alternatives. Using the payable health services is the first alternative and accessing waiver health service is the second. The finding reveals that the physical availability and accessibility of hospitals, clinics and other health-related buildings in Jimma town are favorable. However, absolute majority of the children failed to visit health facilities on illness incidents for they could not afford the service fee, all the children that visited health facilities were supported by people around them. This indicates that financial ability chiefly influences the children's access to the facilities.

To give more emphasis, financial inability of the children to access the payable health services is a major barrier that hinder these children to access healthcare facilities, good and services. Regardless of the physical availability, easy accessibility and favorable health facility

[264] ICCPR, General Comment No. 6 on the Right to Life (Article 6), Adopted at the Sixteenth Session of the Human Rights Committee, on 30 April 1982, Para. 5.
[265] The preparatory work of the Convention indicate that the rights to life, survival and development under article 6 were understood as complementary and not mutually exclusive, and that the article poses positive obligations (E/CN.4/1988/28).
[266] Ooms G et al. 'Is universal health coverage the practical expression of the right to health care?' [2014] BMC Int Health Hum Rights, https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/1472-698X-14-3, accessed, 4, December, 2020; CESCR, General Comment No. 14, n 9, Para 12.

accommodative character, the children remained inaccessible to health care on their illness incidents. All the children stayed idle usually and engaged in menial jobs some times. They lived in absolute poverty and failed to cover the health service expense.

On the other hand, the finding with key informants revealed that they are not fully aware on the existence of the right to health of children in street situations, accordingly, they are not committed to protect the health right and underlying determinants of the right to health of these children.[267] Worst of all, with their extent of awareness to the right to health of children in street situations, due to non-existence of exclusive government budget allocated for this purpose, they are paying no attention to any of the entitlements of the children in street situations.

Most of the children had no clue on the right to access healthcare services and goods through fee waiver health service, meanwhile, they felt weak to claim for their right. For instance, the respondent called Eyasu said, "in case we went to kebele to get fee waiver healthcare certificate, unfortunately, none of the kebele works listen to us and we don't have the ability to question why we don't access any of the services that other population enjoy". This indicates that the children have to be empowered to be able to ask for their rights. Unfortunately, there was no advocacy group that works with the children either to empower them or advocate with/on behalf of the children so that the children could claim their healthcare access rights. Vulnerable children are unlikely to be able to bring claims for violations of their rights on their own behalf. Human rights NGOs could play tremendous role on creating awareness and capacity building to the right holders and respective government offices on children's right to health, respectively. Unfortunately, there are no Human rights NGOs are working specifically on the rights of children in street situations currently in Jimma town.

Indirect discrimination includes policies that result in exclusion from basic services, such as health and education, for example by requiring payment or the provision of identity documents.[268] Even if children in street situations are not disregarded from basic services, they might be isolated within such systems. The finding reveals the existence of fee waiver health service that is provided in Jimma town which is given by concerned Kebele administrations with the intention to help the economic inability of indigent people of the town. However, to get fee

[267] Interview with key informants, n 236.

[268] CRC, General comment 21, n 81, para 25.

waiver healthcare certificate one has to bring his/her Kebele membership ID card as basic requirement.

Unfortunately, absolute majority of children in street situations were inaccessible to the waiver health services. In the case of children in street situations, legal identity documents are significant barriers to equal access to health care. Accessing health services requires proof of identity, something many children in street situations are unable to do so, as they do not have the necessary documents. Due to their not being registered and able to meet law or bureaucratic requirements to receive the needed services for free, children in street situation are completely unprotected by the system.

The finding with key informant reveals that they are not giving them either ID cards that describe their membership to kebele administration or fee waiver healthcare certificate that could allow children in street situations to access healthcare goods and services for free.[269] Pursuant to an interview made with respondents (children in street situations), it's clear that most of them didn't stay in one places, they travel from one part of the town to another, thus, here the issue of children's sheltering arises. The key informants raises this issue as defense reason why they are not entertaining them equally with other destitute section of population.[270]

Thus, the children rarely visited the office to claim for the service. In the cases they claimed to use the service, they sometimes got the service at the good will of the officials. The criteria that the guideline of the fee waiver health service requires the beneficiaries to fulfill to use the waiver services are unlikely to be fulfilled by children in street situations. Accordingly, in Jimma town, Ethiopia, the human right of the children to access healthcare facilities, services and goods on illness incidents is hardly realized.

Conclusion

In their regular life, children in street situations are deprived of all basic needs. They live in street without shelter, on inadequate and unhealthy food, in a rag and dirty clothing, unhealthy water for their drink and sanitations and with no protector. All these conditions and their resultants contribute to the health conditions of the children to be severe. Apparently, for the

[269] Interview with Mr. Girma, n 234.
[270] Ibid.

sake of their life conditions, the children are highly vulnerable to contract diseases. Children in street situations respond in various ways when they get sick. They largely engage in sleeping off an illness, buying self-prescribed medicine from pharmacies and traditional way of self-treatment to recover from illnesses. If children visit public healthcare centers, they largely visit health facilities at the help of their friends and other surrounding people when their illnesses turn severe. Gravity of an illness, discrimination and stigma, non-fulfillment of indispensable underlying determinant of health with no government coping mechanism and mainly, their lack of economic affordability to healthcare facilities are making the situations of the children severe.

Basically, Ethiopian government is legally responsible to implement the right to health for children in street situations in case either the family or children are unable to do on themselves. Practically, in Jimma town Ethiopia, however, these legally recognized and protected rights of the children in street situations are not adequately secured and it remains undone for the children.

The children in street situations who have been interviewed are lacking all the rights a child should have. On the other hand, Ethiopia has undertaken to take measures to realize right to health and its underlying determinants of health to children in street situations. Sadly, in the study area they are totally ignored by government authority. Children lacking right to health leads to more poverty for them. Their future have limited chance to be improved, because they are not entitled to many options. Children in street situations in Jimma town do not have access or very limited access to the right to healthcare and all other underlying determinants of health. Lack of food, hygiene and basic shelter or housing of children in street situation are exposed to a higher risk of severe health and other socio-economic problems. Thus, according to the finding let alone the full realization of the right to health of children in street situations, there is a clear violation of the right to health and underlying determinants of health of children in street situations in Jimma town, Ethiopia.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

Conclusion

All four human rights instruments discussed above indicates the rights and special protections accrued to children in street situations, the notions of progressive realization, maximum use of available resources and minimum core obligations of states. The state obligations stemming from the minimum core content are more or less common for all of the instruments examined. Some of minimum core obligations to realize the right to health, at very least states have to ensure are: the need to amend or repeal legislation that is inconsistent with the instruments; to provide access to the minimum essential food, safe and potable water, basic shelter or housing, and sanitation; and to address underlying factors that affect children's health. It also includes the right of access to health facilities, goods and services on a nondiscriminatory basis. It also provide the necessity of special protections for vulnerable or marginalized groups, apparently include children in street situations.

The first indispensable obligation of State parties to realize the right to health is to recognize it through legislative and other policy measures. This is a common obligation of all four of the examined instruments. However, Ethiopia has not explicitly incorporated the right to health both in the Constitution and any other specific legislative acts. The right to health is only part of the National Objectives and Directive Principles of State Policy of which the issue of justiciability remains unclear. In addition, the policies examined do not fully, or they only poorly, reflect the obligations that are connected to ensuring the right to health that should be mainstreamed in coherence with the ratified instruments. In addition, these policies are not legally binding, but are merely political reflections.

The notion of progressive realization also includes that vulnerable and disadvantaged groups are to be prioritized. Consequently, children in street situations are among those who need to be prioritized in implementations that aim at the full realization of the right to health. It was shown that more than half of the children interviewed hadn't received any help or assistance, such as food, shelter, medical care or water. None of these children in the study area have received any government assistance.

Giving attention for children who live in hostile circumstances is an obligation of state parties and states shall play the principal duty to ensure the provision of necessary medical assistance and health care to all children including the children in street situations. Mainly, being the signatory of UNCRC, Ethiopia is responsible to protect, respect, promote and fulfill the health right of children in street situations that are enshrined in the convention.

FDRE Constitution enshrines rights that can protect the health and wellbeing of all Ethiopian citizens' regardless of their background, inter alia, every child has the right not to be subjected 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. Besides, all persons have the right to a clean and healthy environment. Accordingly, government shall endeavor to ensure that all Ethiopians live in a clean and healthy environment. Contrary to these constitutional rights, children in street situations are living on health-unfriendly basic stuffs: all their food, shelter, water, cloth are so hazardous to their health. Worst of all, no single effort that aims at improving the well-being of these children was underway in the study area. Accordingly, the rights, i.e. the right to health, equality and ultimately the right to life of the children, apparently includes children in street situations, that are enshrined in the supreme law of the land are violated.

Ensuring the health and wellbeing of all Ethiopians is among the general objective of the National Health Policy of Ethiopia. Accordingly, the policy is committed to the philosophies of equity and justice in providing health services. In Particular to children in street situations, the policy indicates that they are among the most neglected social segments that need special attention in health service provision. Practically however, most of children in street situations are not reached with the underlying determinants of health through the principles of human rights.

All of the instruments examined provide that the right to health shall be realized to everyone within the jurisdiction of state parties in a non-discriminatory basis. However, the finding in this thesis reveals, the variation of the law in theory and the practical implementation in the study area. Children in street situations do not have access to health care due to different barriers, of which discrimination because of economic background is the most prominent. Article 2 of CESCR has provided discrimination based the child's, parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or on 'other status' are proscribed. The phrase 'other status' encompasses a

person's economic and social situation. This applies to children in street situations as they often are both homeless, lack of parental care and live in poverty.

The National Health Care Financing Strategy of Ethiopia and Oromia healthcare financing directive indicates that the fees paid for health services have to take into account the social groups that are unable to afford the payment for the services. In promoting access to right to health the strategy states that, it is important to strengthen the waiver health service system through increasing funds for waiver and the number of people to be covered by the service. Notably, the strategy namely specifies that children in street situations are among the social groups that shall be the beneficiaries of waiver health service provision. However, most of the children are not accessible to waiver health care services that are promised in the strategy because of lack of legal identity documents. Thus, the rights of the children on paper and the actual reality on ground remained two different worlds implying that efforts have to be exerted to realize the rights of the children that are left on shelf.

A majority of the children, however, stated that they wanted medical attention when they are sick or hurt, but there is a *de facto* denial of healthcare goods and services because they simply do not have the means to afford them. Similarly, the CRC imposes a principal duty on state parties to ensure that no child is deprived of access to healthcare, consequently, state parties have to remove any barriers that hinder such access.

The realization of the right to health of children in street situations in Jimma Town is a clear illusion. Some children have or have had access to health care, but it has often been due to a parent, a compassionate stranger or luck – not due to an efficient government plan or policy that originates from national legislation and international human rights law. In addition, these children struggle to ensure food, shelter, water and sanitation for themselves. Although, the right to health might just be a dream at the moment, there is nothing to say that this cannot change and become realized for all of the children that live in different street situations in Ethiopia. What is needed is strong political will, not only to implement effective measures, but also to listen to the voices of the right holders themselves.

Recommendations

In light of the aforementioned conclusions the following recommendations are set out:

1. Merely addressing the right to health through policies are not sufficient, thus, Government of Ethiopia should separately and explicitly recognize the right to health of children under FDRE constitution unequivocal. Besides, clear and explicit recognition of the rights under domestic law is the first step to realize it into practice. Thus, government of Ethiopia should amend the existing FDRE constitution and legislations to recognize the right to health and underlying determinant of health clearly and explicitly.
2. The Committee on Economic, Social and Cultural Rights has underlined that States should, at a minimum, adopt a national policy and strategy to ensure the enjoyment of the right to health to all, based on human rights principles. Accordingly, policies should be adopted in a way that explicitly and clearly indicates the right to health of children in street situations and sufficient financial and human resources should be allocated for designing and implementing legislative and policy measures to ensure the realization of rights to health and to facilitate universal access to health care.
3. The government of Ethiopia should step up its efforts in guaranteeing the right to health for children in street situations as there are gaps in their protection in Jimma town, Ethiopia. This could be done by setting up rehabilitative centers that provide a holistic approach in addressing the underlying determinants of health of these children as well as assisting them in lifting themselves out of the situations they are in and ultimately, re-integrating them with their families.
4. Government should provide a sustainable capacity building and awareness in relation to international human rights instruments that Ethiopia has undertaken to realize the right to health of children to its officials in charge of this issues, experts, the right holders (children in street situations) and all stakeholders.
5. The finding reveals that several children interviewed in this thesis has been denied because of the circumstances they are in. In light of this, the Government of Ethiopia should take targeted, concrete and steps at least to ensure the minimum core obligations that no justification of whatsoever allowed to realize the right to health, inter alia, the right of access to health facilities, goods and services and underlying determinants of health on a non-discriminatory basis for children in street situations. Accordingly, to

eliminate all grounds of discrimination including economic barrier against the realization of the right to health of children in street situations by *de facto* equal access to primary healthcare facilities, goods and services and underlying determinants of health, mainly, by using affirmative action has to be ensured.

6. Children in street situations should be empowered, so their capacities can be used as an effective response against discrimination. This might include strengthening skills and knowledge, building self-acceptance, improving the socio-economic environment for their healthy change.
7. Civil society, including professional groups, NGOs, private societies, the media, the academic and research organizations should play key roles in addressing challenges against the realization of the right to health of children in street situations.
8. Taking steps to realize the right to health requires a variety of measures. As the most feasible measures to implement the right to health will apparently vary from State to State. However, the International Covenant on Economic, Social and Cultural Rights in article 2 (1) states that the full realization of the rights contained in the treaty must be realized through “all appropriate means”. The right to health cannot be realized without prior realization of its underlying determinants of health such as food, water, cloth, sanitations, housing, etc. Thus, government by considering the gravity of the problem, should allocate a sufficient budget and frame an overall action plan and program that can encompass underlying determinants of health such as food, water and sanitations, shelter, medical goods and services and health education, family reuniting mechanisms and other similar programs.
9. While the author maintains the importance of separate and explicit legal recognition of the right to health and proposes amendment of Article 36 of the constitution, in the absence of explicit children’s right to health and their other socioeconomic rights, the provisions dealing with the right to life and others and international human rights instruments that clearly and explicitly recognized the right to health of children that Ethiopia has ratified should be invoked to realize the right to health of children in street situations by way of temporal solution
10. In the context of a pandemic, where access to health care is more important than ever, governments should explore and immediately implement flexible solutions to remove any

barrier to accessing basic healthcare facilities, goods and services for free through accessible fee waiver system.

11. Access to health information are a human right that all individuals including children in street situations have. Accordingly, government should disseminate child-friendly broadcast, billboards placed everywhere and flyers of Covid-19 pandemic information in a language they can understand easily with the contents of, inter alia, what Covid-19 pandemic is, how the virus spreads and transmit to others, what the symptoms are, what cautions has to be taken and how they can protect themselves and what they should do and where to go in case they are infected.

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ANNEXES

Annex I

Questionnaire for Data Collection

Interview	No. Name:
Date:	Location:

Information prior to the interview

Introduce yourself and explain why you are in Jimma Town, Ethiopia.

Explain why you want to ask him/her some questions.

Explain what the answers will be used for.

Explain that he/she will be anonymous and that he/she can do not have to say anything he/she does not want to. Explain that we can stop the interview when he/she wants to. Ask again if it is okay to ask some questions.

1. Sex

☐ Female

☐ Male

2. Age

☐ 9-14

☐ 15-18

3. How long have you been on the streets?

____

4. Time spent on the streets

☐ Street living child (sleeping in public places, not accompanied by family)

☐ Street working child (sleep at home, but spend the days on the street)

☐ Child from street living family (living on the street with family)

☐ Other: ____

Everyday life: socioeconomic factors contributing to a healthy life

5. Where do you sleep at night?

____

____

6. How do you get food and drinking water?

____

____

7. Where do you go to wash up?

____

____

Health

8. Did you fall sick or get hurt during your stay on street?

☐ Yes

☐ No (continue with question 9)

8.1 How many times have you been sick or been hurt in your stay on the street?

____

8.2 What type of illness/injury did you get/incur?

____

____

8.3 Where did you go for help/treatment?

☐ Hospital

☐ Clinic

☐ did not go anywhere / did not get treatment

☐ Other: ____

Comment: ____

____

____

8.4 Did you have to pay for treatment? If yes, how much?

(Indicate what type of treatment it was)

☐ Yes

☐ No

____

____

8.5 Can you get treatment if you don't have any money?

☐ Yes

☐ No

Comments: ____

____

8.6 What do you do to get money?

____

____

____

8.7 What do you do to get treatment? (E.g paying money, getting fee waiver healthcare certificate, begging etc.)

____

____

____

(Question 9 only to be responded to if 'no' was indicated for question 8)

9. What will you do if you fall ill or get hurt? Where will you go?

☐ Hospital

☐ Clinic

☐ will not go anywhere

☐ Other: ____

Comment:

____

____

____

Support/Assistance

10. Have you received any help or assistance?

☐ Yes

☐ No

10.1 If yes, what type of assistance did you receive?

☐ Money

☐ Clothes

☐ Food

☐ Drinking water

☐ Shelter

☐ Healthcare treatment

☐ Medicines

☐ Other: ____

10.2 Who provided the assistance?

☐ Government (public sector)

☐ NGO, if any

☐ Other: ____

11. Have you ever get Covid-19 pandemic related health information? If any who gave you the information?

☐ Yes ☐ Government ☐ NGOs

☐ No

☐ Other____

12. If yes, how and from where did you receive information?

☐ Mass media

☐ Billboard

☐ Flyers

☐ Others: ____

At the end: It may be useful to ask children at the end of an interview how they have felt to talk about these issues. I will have time with them to either play with the child or talk about something pleasant at the end of an interview, so that they are not left focused on the issues I raised.

Annex II

Interview with a coordinator on care and support for vulnerable, Jimma Town administration Health Bureau

1. What appropriate measures have been taken by the government to ensure equal access of health services particularly to children?

2. In what way the health policy and strategy of the country gives concern to children in general and children in street situations in particular?

3. Taking in to account that children in street situations face different kinds of health problems, which efforts have been taken to improve delivery of health services to them?

4. Has any training been offered to children in street situations? What means have been undertaken to raise awareness of children in street situations? Has any health related education that addresses children in street situations been conducted by the bureau?

5. Has any research been conducted on the vulnerability of children in street situations to health problems and their access to health services?

6. Does the country's health policy and strategy have been fully accessible enough to meet children in street situation's needs on health services?

7. If not, what measures shall be undertaken to facilitate/ enhance the accessibility of health services?

8. What measures undertaken by the government to assist children in street situations in getting medical treatment with due regard to their available means?

9. Does the deployment of the budget system prioritize the delivery of health services to children? If so, in what way it addresses the issue of children in street situation in particular?

10. What progress registered in expanding the delivery of health services to children? And what problems faced in this regard?

Annex III

Interview with expert on the rights and security of children, Jimma Town Administration Women's, Children and youth Affairs Bureau

1. What are the listed duties and responsibilities of this sector with regard to children?

2. Until now, which activities/ projects have been undertaken by the bureau that addresses the issue of children?

3. Which supportive environment were designed and implemented to meet the needs of children in street situations particularly in areas of health? If so, in what way?

5. Has any research or baseline survey been conducted in the area of children in street situations? If yes, when and in what basis?

6. Are there any human rights awareness raising activity been conducted to children in street situation? If so, when and in what way?

7. On what basis the bureau undertakes its program and projects? Whether it is based on the rights of the child provided in the constitution and national legislations or international standards related to rights of the child or both?

8. What frameworks have been developed for the constructive engagement of NGOs working on the affairs of children in street situations?

9. Is any assistance given to stakeholders to enable their participation in such programmes? What schemes/ mechanisms/ have been established to monitor and evaluate their programs?

10. How the arrangement of the budget gives priority to the affairs of children?

11. Currently which programs are being implemented to practically ensure the realization of the rights of children? And what problems faced in this regard?