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The Right to Health for Children in Street Situations

Reality or Mere Illusion?



Author: Madeleine Ahlgren
Supervisor: Dr. Jennifer Sellin

Abstract

This thesis examines the international and the Ugandan legal frameworks regarding the right to health for children in street situations, with a specific focus on access to primary health care. It also examines what impact these frameworks have for children in street situations in Mbarara, Uganda. The thesis combines and complements classic legal research with empirical research, providing an original approach to the topic. The thesis argues that the respective compliance mechanisms of the international instruments examined should adopt General Comments on how state parties are to implement its obligations with regard to children in street situations in order to protect them in a sufficient and effective way. The examined practice shows that the compliance mechanisms either fail to address the situation of these children, or that it is addressed in an incoherent or inconsistent manner. The right to health is not explicitly incorporated in the Ugandan constitution, neither are there any other legislative acts that reflect its elements. Rather, it is merely addressed through political objectives and policies. Interviews with some of the right holders themselves show that the right to health for children in street situations in Mbarara mainly is an illusion. Some children have or had access to primary health care, but it has often been due to a parent, a compassionate stranger or luck – and not due to an efficient government plan or policy that originates from national legislation and international human rights law.

Key words: The Right to Health, Children in Street Situations, ICESCR, CRC, ACHPR, ACRWC, Uganda.

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List of Abbreviations

ACHPR	African Charter on Human and People's Rights
ACRWC	African Charter on the Rights and Welfare of the Child
CO	Concluding Observation
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisation
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICJ	International Court of Justice
NGO	Nongovernmental Organisation
NODPSP	National Objectives and Directive Principles of State Policy
OVC	Orphans and Other Vulnerable Children
UGX	Ugandan Shilling
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund

PART ONE

1 Introduction

1.1 The Situation of Children in Street Situations

It is not known how many children there are globally living in different street situations, but the number is estimated to be in the tens of millions.¹ One difficulty in assessing the number of children in street situations worldwide is due to various definitions of the term.² There is not one single definition of children in street situations: both terminology and the extent of the problem have been debated. However, the most commonly used definition is:

‘[a]ny 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’.³

Children in street situations are often referred to as street children. However, this thesis uses the term ‘children in street situations’ for two reasons. Firstly, it is the term used by the Committee on the Rights of the Child in their concluding observations.⁴ Secondly, and most important, many children interviewed in this thesis do not wish to be referred to as street children as it often has negative connotations.⁵

Children in street situations are not a homogeneous group and that has led to further categorization: street living children, street working children and children from street families. The first category refers to those children who sleep in public places and that are not accompanied by their families. The second refers to children who sleep at home, but spend their days in the streets. The third category refers to those children that live in the streets together with their families.⁶ For the purpose of this thesis the abovementioned definition will be used. The three categories will be used in the data collection in order to evaluate whether the enjoyment of the right to health is different depending on which of these categories the child belongs to.

¹ UNICEF, 2005, pp. 40-41.

² Thomas de Benitez, 2011, p. 7.

³ Plan International & Consortium for Street Children, 2011, p. 7.

⁴ See e.g.: CRC CO for Uruguay, 2015, paras. 67-68.

⁵ Interviews with children in street situations, Mbarara, Uganda, 2-6 April 2016.

⁶ Plan International & Consortium for Street Children, 2011, p. 7.

Children in street situations are one of the most vulnerable groups in our society, and they can be found in every country of the world. The human rights of children in street situations are often violated and basic rights, such as education and health care, have proven to be hard to provide as well as difficult to protect.⁷ Many children have been exposed to police brutality, been beaten up and even framed for crimes they did not commit as a result of corruption.⁸ The reasons as to why children end up on the streets are both multi-faceted and diverse. Some of these reasons are poverty, marginalisation, loss of parents, violence and abuse in the home, or the hope of starting a better life in the city.⁹

Children in street situations are deprived of many human rights and are often subjected to violence, discrimination and stigmatisation.¹⁰ Ensuring the right to health for children in street situations is essential, not only in itself, but also as it is ‘indispensable for the enjoyment of all ... other rights’.¹¹ Ensuring the human rights of children in street situations is also about striving for ‘social justice and human dignity’.¹²

1.2 Research Questions, Purpose and Outline

The thesis is structured in three parts that correspond to each of the research questions: (1) What are the state obligations under international human rights law regarding access to primary health care for children in street situations? (2) How is this framework and its subsequent obligations implemented in Uganda? (3) What impact do the frameworks have in real life for children in street situations, and are there gaps that need improvement?

The purpose of this thesis is threefold. The first is to examine the international legal framework regarding the protection of the right to health for children in street situations with a special focus on access to primary health care. Secondly, it is to examine the national legal framework of Uganda to see how it matches with the obligations stemming from international human rights law. And third, it is to examine what impact those legal frameworks have at a grassroots level by interviewing the right holders themselves.

⁷ UNICEF, 2005, pp. 40-41.

⁸ Interviews with children in street situations, Mbarara, Uganda, 2-6 April 2016.

⁹ Plan International & Consortium for Street Children, 2011, pp. 11-12.

¹⁰ Thomas de Benitez, 2011, p. 64.

¹¹ CRC/C/GC/15, ‘General comment No. 15 (2013) 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, 17 April 2013, para. 7.

¹² Vandenhoe, Desmet, Reynert & Lembrechts (eds.), 2015, p. 5.

This thesis is focused on the perspective and understanding of children as ‘active agents and subjects of rights’, rather than viewing children in street situations as victims, or delinquents.¹³ As agents of change, the voice of these children form an important basis of the subsequent research and analysis.

A lot of research has been carried out in the area of children in street situations and freedom from violence and abuse¹⁴, as well as juvenile justice.¹⁵ However, not a lot of research has been done in connection to the right to health, and there is a research gap in examining how the ‘application of international instruments ... protect and defend street children’s rights’.¹⁶ Further, contemporary publications tend to overlook the circumstances of children in street situations.¹⁷

The outline of the thesis is divided into three parts. The first part will examine the relevant legal framework to determine the scope of the right, state parties’ obligations and, by a comparative study, examine the different Committees’ approach to the right to health. The provisions will be compared in regards to content, what is provided, and an analysis will be made as to which instrument provides the most extensive and comprehensive protection of the right to health for children in street situations.

The second part is a case study that aims at examining the implementations by the government of Uganda, through legislation and policies, with respect to the obligations stemming from the international legal framework.

The third part will look at what impact the system has in practice. It aims at exploring to what extent children in street situations can access their right to primary health care. Qualitative interviews will be conducted with the right holders themselves to see how the legal framework has been transposed in real life. Have the norms been translated into reality, do children in street situations benefit from the right to health? What is there and what is lacking? The data collection and its subsequent analysis aims at providing normative content by defining gaps or suggesting

¹³ Thomas de Benitez, 2011, pp. 10-11.

¹⁴ See e.g. Human Rights Watch, “‘Where Do You Want Us to Go?’ Abuses against Street Children in Uganda’, 2014, https://www.hrw.org/sites/default/files/reports/uganda0714_forinsert_ForUpload.pdf, last consulted on 9 March 2016.

¹⁵ See e.g. Maria Wernham, *‘An Outside Chance: Street Children and Juvenile Justice – an International Perspective’*, Consortium for Street Children, London, 2004.

¹⁶ Thomas de Benitez, 2011, p. 57.

¹⁷ See e.g. Vandenhole, Desmet, Reynert & Lembrechts (eds.), 2015.

possible improvements as to how the right to health for children in street situations can be better protected.

A further aim of the third part is to complement the findings of the black letter methodology with ‘evidence-based human rights research’¹⁸ in order for the voices of the right holders themselves to be heard. As rights-based approaches continue to increase in use there is a growing need to examine how people themselves experience deprivation of their rights as well as to examine how duty-bearers respond.¹⁹

1.3 Methods, Material, Delimitations

This thesis examines the international legal framework regarding the right to health with a specific focus on access to primary health care for children in street situations. The first part of the thesis used a black letter methodology in order to establish the law *de lege lata*. In accordance with article 38 of the ICJ Statute, international conventions will be the material used when establishing the applicable law.²⁰ In addition, some preparatory works were used as supplementary means of interpretation.²¹

The Vienna Convention on the Law of Treaties provides that treaties ‘shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose’.²² Thus, the legal analysis in this thesis was carried out with this general rule as ‘the foundation of the interpretative process’.²³ None of the three aspects of interpretation are favoured over another, and the meaning of a word is not solely based on linguistics.²⁴ Rather, the article must be read ‘according to an overall logic’.²⁵ Gardiner provides that:

‘[i]t is the *treaty* that is to be interpreted; it is the *terms* whose ordinary meaning is to be the starting point, their context moderating selection of that meaning, and the process being further illuminated by the treaty’s object and purpose’.²⁶

¹⁸ Sano & Thelle, 2009, p. 91.

¹⁹ Ibid, p. 92.

²⁰ United Nations, ‘Statute of the International Court of Justice’ (18 April 1946), art. 38.

²¹ The Vienna Convention on the Law of Treaties (adopted 23 May 1969, entered into force 27 January 1980) 1155 UNTS 331 (VCLT), art. 32.

²² VCLT, art. 31.

²³ Corten & Klein (eds.), 2011, p. 807.

²⁴ Gardiner, 2008, p. 141.

²⁵ Corten & Klein (eds.), 2011, p. 807.

²⁶ Gardiner, 2008, p. 144.

Good faith is to be applied during the whole process of interpretation, and is not limited to the interpretation of specific words.²⁷ Good faith has been described as ‘the principle of effectiveness’,²⁸ and is linked to the concept of *pacta sunt servanda*.²⁹ The context consists of the text itself, the preamble, and, if any, annexes. The context can also include other agreements that have ‘bearing on the treaty’.³⁰ Article 31 is a compromise of textual, subjective and teleological interpretation, thus merging different means of interpretation with the aim of creating an interpretation that is ‘obvious (the ordinary meaning of terms), logical (*an acte clair*), and effective (a useful effect).’³¹

As a complement to the primary sources, doctrine, articles, UN documents and various reports of NGOs have been consulted as secondary sources. Further, this thesis compiles and analyses the practice of the treaty monitoring bodies that correspond to each treaty. Therefore, general comments will be used in examining and analysing the treaty monitoring bodies’ interpretation of the provisions related to the right to health. Concluding observations will be used in examining and analysing what the different Committees provide in regards of two aspects: (1) the normative content on access to primary health care, and (2) what is provided in regards to the right to health for children in street situations. All available concluding observations, 16 for the ACHPR and 11 for the ACRWC were examined. Regarding the ICESCR and the CRC, the concluding observations from 2012 to 2015 were examined, which amounts to a total of 70 COs for the CRC and 58 COs for the ICESCR.³²

The rationale for analysing the concluding observations is that they provide ‘guidance as to the normative interpretation of [the] treaty provisions as well as [they clarify] State obligations’.³³ It is also because the practice of UN Committees has proved to be of legal significance. In the case of *Ahmadou Sadio Diallo (Republic of Guinea v. Democratic Republic of Congo)*, the ICJ made some references that indicated the importance of what the UN Committees provide. The ICJ stated that, even though it is not compelled to interpret the treaty in the same way as the Committee, ‘great weight’ should be given to the interpretation made by it.³⁴ The reasons were, according to the ICJ, to attain both clarity and legal security and to keep the ‘essential

²⁷ Ibid, p. 148.

²⁸ Ibid.

²⁹ Ibid, p. 149.

³⁰ Corten & Klein (eds.), 2011, p. 808.

³¹ Ibid.

³² See bibliography for full list.

³³ Dabney Evans & Megan Price, 2009, p. 116.

³⁴ *Ahmadou Sadio Diallo (Republic of Guinea v. Democratic Republic of the Congo)*, Merits, Judgment, [2010] I.C.J. Reports, 639, 664.

consistency of international law'.³⁵ Further, the ICJ stated that it has to 'take due account of the interpretation of that instrument adopted by the independent bodies which have been specifically created [...] to monitor the sound application of the treaty in question'.³⁶ That great weight is given is an indication that, among other documents, the Concluding Observations and General Comments are of importance to ICJ when deciding a case.

The first part of this thesis is limited to four international legal instruments: the International Covenant on Economic, Social and Cultural Rights,³⁷ the Convention on the Rights of the Child,³⁸ the African Charter on Human and People's Rights,³⁹ and the African Charter on the Rights and Welfare of the Child.⁴⁰ These instruments were chosen as they are the most relevant in the context of children in street situations in Uganda.

The second part was conducted through a document review and an analysis of relevant legal acts and governmental policies to determine how the obligations stemming from the international treaties have been implemented in Uganda. The purpose of the review and analysis is to determine the extent to which the government of Uganda is fulfilling its obligations stemming from the international legal instruments examined in this thesis.⁴¹

The third part was conducted through a qualitative case study. The data was collected in Mbarara, Uganda, through semi-structured interviews with children in street situations. The aim and purpose of conducting these interviews was to get first-hand information from the right holders themselves, and thus provide normative content by defining gaps or suggesting possible improvements on the legal framework of the right to health.

It is imperative not to view children in street situations as 'helpless victims, nor to romanticize their lives'.⁴² Rather, they should be included in the conversation and, in accordance with the CRC, their views should be heard and respected.⁴³

³⁵ Ibid.

³⁶ Ibid.

³⁷ The International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR).

³⁸ The Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3 (CRC).

³⁹ The African Charter on Human and People's Rights (adopted June 27, 1981, entered into force 21 October 1986) (ACHPR).

⁴⁰ The African Charter on the Rights and Welfare of the Child (adopted July 1990, entered into force 29 November 1999) (ACRWC).

⁴¹ Stuttaford, 2009, p. 139.

⁴² Plan International & Consortium for Street Children, 2011, p. 15.

⁴³ CRC, art. 12.

In total, forty-two interviews were held. Forty-one children were interviewed in five different locations in Mbarara, Uganda. It is estimated that about one-hundred children are living in different street situations in Mbarara. The interviews took place from 2-6 April 2016. One young man that was interviewed had already turned 18. He had been living on the streets since he was only two years old, and had both valuable information and perspectives to provide that was of relevance for this thesis. Therefore, some of the information he shared is reflected in this thesis, but is not included in the statistical data.

The rationale for choosing Mbarara was that it was the most productive, practical and feasible alternative. The author had previously lived in the country and was therefore well-acquainted with the culture, and also had experience of working with children in street situations in Uganda. Further, the author had existing contacts with an NGO that could assist in data collection.

The interviews were semi-structured in that questions were prepared beforehand to be answered by all informants. However, the structure allowed for follow-up questions or additional comments made by informants that were important and relevant for the purpose of this thesis. The interviews sought both quantitative and qualitative information and therefore consisted of both open and closed questions.⁴⁴ Individual interviews were conducted, as opposed to the use of group discussions, as they are ‘good for revealing personal or unique experiences, which will add to the understanding of the range of experiences’.⁴⁵ Interviews were conducted in *Nyankole* with the assistance of social workers who are known to the children and who were able to translate the interviews into English.

Prior to the interviews, the children were informed that participation would 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 local NGOs. They were also encouraged to ask any questions they might have about the interviews and research.⁴⁶

The main limitation of the third part is the scope of the data collection. A larger sample, both in the number of conducted interviews and geographical spread, would have been preferred. However, both due to a set time frame and financial constraints a greater data collection was

⁴⁴ Save the Children, 2004, p. 64.

⁴⁵ UNICEF, 2014, p. 3.

⁴⁶ Save the Children, 2004, p. 34.

unfeasible for this thesis. The specific circumstances of children in street situations in the town of Mbarara cannot be used as a generalisation for children in street situations, neither across the country nor around the world. However, the data collection will provide an example, and is illustrative, of problems facing children in street situations with regards to their right to health and access to primary health care.

Ethical issues that were considered beforehand were informed consent, potential harm, confidentiality and compensation.⁴⁷ Normally, informed consent would be sought from the children's parents. In the context of this research, there were no parents or legal guardians to seek permission from. Therefore, and in accordance with the UNICEF Principles and Guidelines for Ethical Reporting, every child was carefully informed about the purpose of the interviews and how the information would be used.⁴⁸

Another issue considered was the use of consent forms. It has both advantages and disadvantages. For the purpose of this thesis, the conclusion was that the disadvantages weighed more heavily. That is for several reasons: not all of the participants could read or write, and the consent forms could appear to be a legal document. In addition, the consent forms could possibly create a feeling of being obliged to respond to each question.⁴⁹ Therefore, much time was instead spent on adequately informing the children about the purpose of the interviews, what they would be used for, and that the child would stay anonymous and so on. The children were also made aware that they could terminate the interview at any time without providing any reasons as to why they wanted to stop. They were also informed that they did not have to respond to a question that made them feel uncomfortable in any way.⁵⁰

In order to ensure confidentiality, no recordings were taken during the interviews, nor photos that could identify the children. Some children wanted their injuries and scars to be photographed as a form of evidence to the stories they were sharing. Some of them are included in chapter VII.⁵¹ Confidentiality was an additional reason as to why group interviews were not a suitable tool.⁵² Regarding potential harm, interviews were only conducted where there was no interference by non-participants and questions of a sensitive nature were not included.⁵³ In

⁴⁷ UNICEF, 2014, pp. 7-8.

⁴⁸ UNICEF, undated, pp. 1-2.

⁴⁹ Save the Children, 2004, p. 36.

⁵⁰ Ibid, p. 33.

⁵¹ Interviews with children in street situations, Mbarara, Uganda, 2-6 April 2016.

⁵² UNICEF, 2014, p. 8.

⁵³ Ibid.

respect to the promise of confidentiality, as well as to avoid potential harm, informants were given pseudonyms in order to protect their privacy.⁵⁴

The UNICEF Principles and Guidelines for Ethical Reporting, does not provide a specific policy on compensation for participating in interviews.⁵⁵ However, all the participating children received a hot meal and a beverage at different local restaurants as a simple thank you for contributing to the work of this thesis.

PART TWO – INTERNATIONAL LEGAL FRAMEWORK

The aim of this section is to outline the state obligations under international human rights law in respect to access to primary health care for children in street situations, as per the first research question. Each subsequent chapter of this section 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 and/or concluding observations by each compliance mechanism.

2 ICESCR – the Right to Health

The ICESCR entered into force 40 years ago.⁵⁶ It only contains economic, social and cultural rights, while its counterpart the ICCPR contains civil and political rights.⁵⁷ The ICESCR deals with 'entitlements and freedoms related to an adequate standard of living', such as economic participation, protection of workers, housing, food and education.⁵⁸ Currently, 164 countries have ratified the ICESCR. Uganda has been a state party since 21 January 1987.⁵⁹

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.⁶⁰ States are to submit reports on the progress made in the

⁵⁴ Human Rights Watch, 2014, p. 15.

⁵⁵ UNICEF, undated, pp. 1-3.

⁵⁶ The International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (ICESCR).

⁵⁷ The International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR).

⁵⁸ Coomans, 2009, pp. 293, 297.

⁵⁹ UN Treaty Collection, 'International Covenant on Economic, Social and Cultural Rights', https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV3&chapter=4&lang=en, last consulted on 24 May 2016.

⁶⁰ E/RES/1985/17, Implementation of the International Covenant on Economic, Social and Cultural Rights, ECOSOC, 28 May 1985.

implementation of the Covenant. Following this, the Committee issues concluding observations with recommendations on how to proceed with the implementation.⁶¹ The role of the Committee is threefold: (1) to provide and develop normative interpretation of the ICESCR; (2) to encourage state parties to develop mechanisms for accountability; (3) and to hold states accountable on an international level through state reporting.⁶²

2.1 Scope

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 also addresses socio-economic factors that can contribute to a healthy life, such as food, housing and sanitation.⁶³ It does not encompass a right to be healthy, but rather an entitlement to a system of health protection that is equal in opportunity.⁶⁴ Article 12 of the ICESCR provides that:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: ... (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.⁶⁵

The right to health, according to the Committee, contain four elements, known as the AAAQ, that are essential in implementation.⁶⁶ Functional facilities and services have to be made *available* in sufficient quantity. These have to be *accessible* without discrimination of any kind. The notion of accessibility contains four layers: non-discrimination, physical accessibility, economic accessibility and accessibility of information.⁶⁷ The first implies that health services and facilities need to be made accessible without ‘discrimination on any of the prohibited grounds’.⁶⁸ The key aspects of the second one are that health facilities need to be within a ‘safe physical reach’ for all, but it also concerns physical access to socioeconomic factors such as

⁶¹ ICESCR, art. 16.

⁶² Henry J. Steiner, Philip Alston & Ryan Goodman, 2008, p. 277.

⁶³ E/C.12/2000/4, ‘CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)’, UN Committee on Economic, Social and Cultural Rights, 11 August 2000, paras. 4, 11, 51.

⁶⁴ E/C.12/2000/4, 11 August 2000, para. 8.

⁶⁵ ICESCR, art. 12.

⁶⁶ E/C.12/2000/4, 11 August 2000, para. 12.

⁶⁷ Ibid.

⁶⁸ Ibid.

safe water and sanitation.⁶⁹ The third implies that services need to be affordable and based on the principle of equity. Finally, the fourth implies that there must be access to information regarding health care services. Health facilities and services need to be *acceptable* in regards to medical ethics. The Q stands for quality, and entails that the services have to be ‘scientifically and medically appropriate and of good quality’.⁷⁰

Article 12(2)(d) has been interpreted to require state parties to provide ‘equal and timely access to basic preventive, curative, rehabilitative health services and health education’. It also includes access to essential drugs.⁷¹

The minimum core content stemming from the right to health are for state parties 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’.⁷² The Committee has stated that without this minimum core content, the ICESCR would lose a lot of its ‘*raison d’être*’.⁷³ Further, underlying factors that contribute to a healthy life are also included in this core content: ‘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.’⁷⁴

2.2 State Parties Obligations

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 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.⁷⁵

This article sets out the obligation known as progressive realisation. The notion recognises that ESC-rights take time to fully realise, but still oblige state parties to work ‘expeditiously and

⁶⁹ Ibid.

⁷⁰ Ibid.

⁷¹ E/C.12/2000/4, 11 August 2000, para. 17.

⁷² Ibid, para. 43.

⁷³ E/1991/23, ‘CESCR General Comment No. 3: The Nature of States Parties’ Obligations (Art. 2, Para. 1, of the Covenant)’, 14 December 1990, para. 10.

⁷⁴ E/C.12/2000/4, 11 August 2000, para. 43.

⁷⁵ ICESCR, art. 2(1).

effectively' in realising the rights.⁷⁶ Progressive realisation is 'a means to an end [with] the ultimate goal of ... the full realisation' of the Covenant rights.⁷⁷ Both the duty of progressive realisation and the duty to use the maximum of available resources require a prioritisation of services and 'in times of resource constrains, the most vulnerable and disadvantaged members of society have to be prioritised'.⁷⁸ 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'.⁷⁹ Although the Covenant rights are to be fully realised through progressive realisation, there are obligations that have immediate effect.⁸⁰ These both to guarantee that the right to health is exercised without any discrimination, and to take steps in order to realise the right. These steps have to be 'deliberate, concrete and targeted' towards that realisation.⁸¹

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 [that] is incumbent upon every State party'.⁸² The minimum core obligations of the right to health are to ensure: (1) the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;⁸³ (2) 'access to the minimum essential food which is nutritionally adequate and safe, [and] to ensure freedom from hunger to everyone';⁸⁴ (3) 'access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water';⁸⁵ (4) 'equitable distribution of all health facilities, goods and services';⁸⁶ and to (5) 'provide essential drugs';⁸⁷ and to (6) 'adopt and implement a national public health strategy and plan of action'.⁸⁸

State parties have to *respect* the right to health by neither limiting, nor denying peoples equal access to health care. It also requires state parties not to interfere with the enjoyment of the right to health, neither directly, nor indirectly.⁸⁹ The obligation to *protect* implies that state parties

⁷⁶ E/1991/23, 14 December 1990, para. 9.

⁷⁷ Nolan & Dutschke, 2010, p. 282.

⁷⁸ Ibid.

⁷⁹ E/1991/23, 14 December 1990, para. 11.

⁸⁰ E/C.12/2000/4, 11 August 2000, para. 30.

⁸¹ Ibid.

⁸² E/1991/23, 14 December 1990, para. 10.

⁸³ E/C.12/2000/4, 11 August 2000, para. 43(a).

⁸⁴ Ibid, para. 43(b).

⁸⁵ Ibid, para. 43(c).

⁸⁶ Ibid, para. 43(e).

⁸⁷ Ibid, para. 43(d).

⁸⁸ Ibid, para. 43(f).

⁸⁹ E/C.12/2000/4, 11 August 2000, paras. 33-34.

need to ensure equal access through legislative measures, including for services that are provided by private actors. It also creates an obligation to ensure that third parties do not interfere with the right to health.⁹⁰ State parties also have an obligation to *fulfil* the right to health by giving it ‘sufficient recognition’ in its legal systems, by adopting national health policies, and by assisting individuals and communities to enjoy the right.⁹¹

The Committee has pointed 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 care.⁹² 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’.⁹³ 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’.⁹⁴ Economic and social situation is mentioned as one example falling within the ambit of other grounds,⁹⁵ 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 care’.⁹⁶

The Committee has also stressed the importance of ensuring equal access to health care and to include gender perspectives in policies. It places an obligation on states to provide ‘necessary health insurance and health-care facilities’ to those who does not have the necessary means.⁹⁷

This thesis has examined the 58 COs adopted by the Committee during 2012-2015 in order to establish the practice of the Committee in regards to the first research question. Only five of these COs explicitly mention children in street situations with regard to the right to health. Common for all five COs was the recommendation to either improve or provide access to health services for children in street situations.⁹⁸ Some countries were also advised to ensure access to

⁹⁰ Ibid, paras. 33, 35.

⁹¹ Ibid, paras. 36-37.

⁹² Ibid, para. 50.

⁹³ ICESCR, art. 2(2).

⁹⁴ E/C.12/GC/20, ‘*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, 2 July 2009, para. 27.

⁹⁵ E/C.12/GC/20, 2 July 2009, para. 35.

⁹⁶ Ibid.

⁹⁷ Ibid, paras. 19-20.

⁹⁸ ICESCR COs for: Islamic Republic of Iran, 2013, para. 19; Tanzania, 2012, p. 3; Ethiopia, 2012, para. 17; Peru, 2012, para. 16; Djibouti, 2013, para. 22.

shelter or housing,⁹⁹ and in addition, Peru was recommended to ensure ‘adequate nutrition’ for these children.¹⁰⁰

Nine of the COs mentioned children in street situations, but without any linkage to the right to health.¹⁰¹ In contrast, 44 of the 58 COs did not explicitly mention children in street situations,¹⁰² and 12 COs were silent on the normative content regarding access to primary health care.¹⁰³

Many of the COs contained general recommendations regarding access to primary health care that apply to everyone. The most frequent recommendation made was the need to ensure access to health services for everyone.¹⁰⁴ These services ‘should be accessible to everyone without discrimination’,¹⁰⁵ and special attention should be afforded to disadvantaged and/or marginalised groups.¹⁰⁶ In ensuring equal access to health care services, additional and more specific recommendations were given, such as ensuring sufficient human and/or financial resources,¹⁰⁷ increasing both availability and quality of health care services,¹⁰⁸ and addressing ‘economic, cultural and social barriers’ to equal access.¹⁰⁹

The Committee frequently addressed the issue of economic barriers to the enjoyment of primary health care services. States were, on several occasions, advised to guarantee de facto access to affordable health care.¹¹⁰ Mauretania was specifically advised to ‘devise health-care insurance schemes so as to ensure that payment for health-care services is affordable for all, and that poorer households are not disproportionately burdened by health expenses’.¹¹¹ A couple of countries were advised to eliminate informal fees,¹¹² and Norway was recommended to provide

⁹⁹ ICESCR COs for: Ethiopia, 2012, para. 17; Peru, 2012, para. 16; Djibouti, 2013, para. 22.

¹⁰⁰ ICESCR CO for Peru, 2012, para. 16.

¹⁰¹ ICESCR COs for: Bulgaria, 2012, para. 10; Mauretania 2012, para. 20; Albania, 2013, para. 24; Belgium, 2013, para. 17; El Salvador, 2014, para. 16; Serbia, 2014, para. 28; Burundi, 2015, paras. 41-42; Gambia, 2015, para. 22; Iraq, 2015, para. 44.

¹⁰² ICESCR COs for: New Zealand, 2012; Congo, 2013; Armenia, 2014; Paraguay, 2015. See para. 8 of Annex II for full list.

¹⁰³ ICESCR COs for: Bulgaria, 2012; Equatorial Guinea, 2012; Slovakia, 2012; Belarus, 2013; Belgium, 2013; Congo, 2013; Japan, 2013; Kuwait, 2013; Indonesia, 2014; Monaco, 2014; Portugal, 2014; Morocco, 2015.

¹⁰⁴ ICESCR COs for: Iceland, 2012, para. 17; Egypt, 2013, para. 21; Serbia, 2014, para. 33; Italy, 2015, para. 47. See para. 9 of Annex II for full list.

¹⁰⁵ ICESCR CO for Finland, 2014, para. 27.

¹⁰⁶ ICESCR CO for: Djibouti, 2013, para. 30; Gabon, 2013, para. 12; Lithuania, 2014, para. 21; Tajikistan, 2015, para. 30.

¹⁰⁷ ICESCR COs for: Austria, 2013, para. 21; El Salvador, 2014, para. 21; Greece, 2015, para. 36. See para. 10 of Annex II for full list.

¹⁰⁸ ICESCR COs for: Jamaica, 2013, para. 27; Burundi, 2015, para. 52; Guyana, 2015, para. 51; Paraguay, 2015, para. 28.

¹⁰⁹ ICESCR CO for Peru, 2012, para. 20.

¹¹⁰ ICESCR COs for: Austria, 2013, para. 21; Czech Republic, 2014, para. 15; China, 2014, para. 33; Ukraine, 2014, para. 19; Romania, 2014, para. 20.

¹¹¹ ICESCR CO for Mauretania, 2012, para. 25.

¹¹² ICESCR COs for: Armenia, 2013, para. 21; Romania, 2014, para. 20.

free health care to affected families due to a ‘high level of child poverty’ in parts of the society while the country itself had ‘general conditions of growing prosperity’.¹¹³

Socioeconomic factors that contribute to a healthy life were also addressed in several COs. The main recommendations concerned the need to improve access to ‘adequate sanitation facilities’,¹¹⁴ and ‘safe drinking water’.¹¹⁵ Safe drinking water needs to be affordable,¹¹⁶ as well as ‘available, accessible and of acceptable quality’.¹¹⁷ In addition, states need to ‘ensure access to improved sewage systems’,¹¹⁸ and ‘develop public sanitation and waste treatment services’.¹¹⁹

2.3 Conclusion

The right to health shall be afforded to all persons within the jurisdiction of the state party, thus the obligations stemming from the ICESCR are all relevant for children in street situations. State parties need to use the maximum available resources when implementing the ICESCR. However, an evaluation of the use of maximum available resources is outside the scope of this thesis.

The obligation stemming from article 2 of the ICESCR regarding the implementation of legislative measures will be further examined in chapter VI. One might argue that too much cannot be expected from a country that is ranked 163 on the Human Development Index.¹²⁰ However, the notion of progressive realization includes that vulnerable and disadvantaged members of society should be of priority, thus children in street situations need to be prioritized in implementations that aim at the full realisation of the right to health. In addition, the minimum core content of the right to health have to be implemented nonetheless.

The examinations of both general comments and concluding observations show that the children need to be afforded access to health care services without being discriminated against,

¹¹³ ICESCR CO for Norway, 2013, para. 14.

¹¹⁴ ICESCR COs for: Cameroon, 2012, para. 29; Islamic Republic of Iran, 2013, para. 23; Romania, 2014, para. 20; Uzbekistan, 2014, para. 25; Viet Nam, 2014, para. 31.

¹¹⁵ ICESCR COs for: Cameroon, 2012, para. 29; Islamic Republic of Iran, 2013, para. 23; Togo, 2013, para. 33; Romania, 2014, para. 20; Uzbekistan, 2014, para. 25.

¹¹⁶ ICESCR COs for: New Zealand, 2012, para. 23; Viet Nam, 2014, para. 31.

¹¹⁷ ICESCR CO for Djibouti, 2013, para. 28.

¹¹⁸ ICESCR COs for: New Zealand, 2012, para. 24; Togo, 2013, para. 33; Romania, 2014, para. 20.

¹¹⁹ ICESCR COs for: Cameroon, 2012, para. 29; Togo, 2013, para. 33.

¹²⁰ UNDP, ‘Human Development Reports: Uganda’, 2015, <http://hdr.undp.org/en/countries/profiles/UGA>, last consulted on 26 May 2016.

that the health care facilities need to be located within a safe distance, and that state parties also need to ensure socioeconomic factors that contribute to a healthy life. Regrettably, the practice of the Committee is not clear on how state parties are to remove economic barriers to achieve de facto equal access to health care services. There are a number of minimum core obligations that Uganda need to afford to children in street situations, and that therefore are relevant for the subsequent case study. First and foremost, essential primary health care and access to health facilities, goods and services need to be ensured these children on a non-discriminatory basis. They are also to have access to minimum essential food, sanitation, basic shelter, and be supplied with safe and potable water.

This section has examined state obligations that originates from the ICESCR as regards to access to primary health care for children in street situations. In the next section, the same examination will be applied to the CRC.

3 CRC – the Right to Health

The Convention on the Rights of the Child came into force 26 years ago.¹²¹ The CRC is legally binding and was the first instrument of its kind that included civil, political, economic, social and cultural rights for children. The CRC does not only reflect other international human rights instruments, but also introduces a strong ‘child-friendly focus in all obligations imposed’ on state parties.¹²² To date, it is the most widely ratified human rights convention. Currently, 196 countries have ratified the CRC. The United States has only signed but not ratified it. Uganda has been a state party since 17 August 1990.¹²³

It is the Committee on the Rights of the Child that monitor the compliance of state parties on their obligations under the CRC.¹²⁴ 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.¹²⁵ The Committee’s Rules of Procedure prescribe that the Committee can adopt General Comments.¹²⁶ The General Comments are

¹²¹ The Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3 (CRC).

¹²² Fottrell (ed.), 2000, pp. 1, 4-5.

¹²³ UN Treaty Collection, ‘Convention on the Rights of the Child’, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en, last consulted on 11 March 2016.

¹²⁴ CRC, art. 43.

¹²⁵ Ibid, art. 44.

¹²⁶ CRC/C/4/Rev.4, ‘Rules of procedure’, UN Committee on the Rights of the Child, 18 March 2015, rule 77.

supposed to promote implementation of the treaty and its optional protocols and help member states to fulfil their reporting obligations.¹²⁷

Children in street situations are not explicitly mentioned in the CRC. The closest reference might be found in the preamble: ‘there are children living in exceptionally difficult conditions, and that such children need special consideration’.¹²⁸ One can argue that children in street situations do live in exceptionally difficult situations, and accordingly, it is possible to interpret that children in street situations should benefit from special consideration.

3.1 Scope

The rights contained in the CRC are applicable to all children within the jurisdiction of the state party,¹²⁹ and the rights have to be ensured in a non-discriminatory manner.¹³⁰ A child is defined as someone below the age of 18, unless domestic law stipulates that majority is attained earlier.¹³¹ In regards to primary health care, the CRC provides a rather lengthy provision that will be examined in parts.

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 health care services.¹³²

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 18.¹³³ 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’.¹³⁴ The right to health does not only regard freedom from sickness, but also ‘a state of complete physical, mental and social well-being’.¹³⁵ Children in ‘disadvantaged situations’ are to be in the centre of efforts when implementing the right to health.¹³⁶ States are advised to identify the

¹²⁷ Ibid.

¹²⁸ CRC, preamble.

¹²⁹ CRC, art. 2.

¹³⁰ Ibid.

¹³¹ CRC, art. 1.

¹³² CRC, art. 24 (1).

¹³³ CRC/C/GC/15, ‘General comment No. 15 (2013) 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, 17 April 2013, para. 1.

¹³⁴ Ibid, para. 2.

¹³⁵ Ibid, para. 4.

¹³⁶ Ibid, para. 11.

underlying reasons of vulnerability of children and to address these through laws, policies, programs and services.¹³⁷

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.¹³⁸ The principle of non-discrimination has to be prevalent, and all children have to be ensured both *de jure* and *de facto* access. There must be functioning facilities and services that are adequate to serve all children within the state. These facilities have to be within a physical reach for all children. A child that cannot pay for medical services should not be denied it. Information on, *inter alia*, treatment options should be distributed in a language that the children understand. Health care services need to be acceptable in that they consider and respect children's needs and expectations. As regards to quality, 'services and facilities have to be medically and scientifically appropriate'.¹³⁹

Paragraph one of article 24 has been interpreted to encompass a right to access quality health services, and that they must be available and sufficient both in quality and quantity.¹⁴⁰ These services have to be 'within the physical and financial reach of all sections of the child population, and acceptable to all.'¹⁴¹ Primary health care provided should include care that is both preventative as well as focused on both nutrition and treatment of diseases.¹⁴² A principal duty is being placed on state parties to ensure that no child is deprived of access to primary health care. That also implies a duty to remove any barriers that stand in the way of such access, for instance financial or cultural ones.¹⁴³ This is highly relevant for children in street situations as they might not have the financial means to access primary health care.¹⁴⁴ However, it is not made clear how and to what extent these barriers should be removed.

During the drafting of the CRC, the working group discussed the issue of financial barriers. At the time, the representative of the Union of Soviet Socialist Republics proposed that a child should not be deprived of access to health care due to financial reasons. This was accepted and adopted by the working group, but later changed due to conflicting opinions about whether health care for children should be free of charge or not, and to what extent.¹⁴⁵ The result is that

¹³⁷ Ibid.

¹³⁸ CRC/C/GC/15, 17 April 2013, paras. 112-116.

¹³⁹ Ibid.

¹⁴⁰ Ibid, para. 25.

¹⁴¹ Ibid.

¹⁴² Ibid.

¹⁴³ Ibid, paras. 28-29.

¹⁴⁴ This will be further analysed in part IV.

¹⁴⁵ Detrick (ed.), 1992, pp. 346, 354, 357.

it is permissible to have fees for medical services, but that lack of money should not prevent a child from accessing such services.¹⁴⁶

States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: ... To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care.¹⁴⁷

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. States are also obliged to make essential medicines¹⁴⁸ ‘available, accessible and affordable’.¹⁴⁹

3.2 State Parties Obligations

Art. 4 of the CRC concern state obligations regarding implementation of the Convention and provides that:

States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.¹⁵⁰

The article 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’.¹⁵¹

Hammarberg argues that article 4 describes ‘obligations of conduct rather than of result’, and thus state efforts in implementing the Convention are essential.¹⁵² 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.¹⁵³ However, in order to effectively

¹⁴⁶ Eide & Barth Eide, 2006, p. 12.

¹⁴⁷ CRC, art. 24(2)(b).

¹⁴⁸ For details, see: The World Health Organization Model Lists of Essential Medicines, including the list for children. Available at <http://www.who.int/medicines/publications/essentialmedicines/en/>, last consulted on 12 March 2016.

¹⁴⁹ CRC/C/GC/15, 17 April 2013, para. 37.

¹⁵⁰ CRC, art. 4.

¹⁵¹ CRC/GC/2003/5, ‘General Comment No. 5 (2003)’, Committee on the Rights of the Child, 27 November 2003, para. 1.

¹⁵² Hammarberg, 1995, p. 298.

¹⁵³ Vandenhole, Desmet, Reynert & Lembrechts (eds.), 2015, p. 54.

implement the provisions of the CRC, other measures are needed too.¹⁵⁴ In addition, new legislation or amendments of existing acts need to both ‘follow a child rights approach’ as well as it cannot ‘lower the (minimum) standards of the CRC’.¹⁵⁵ Similarly to the ICESCR, the implementation of the right to health is subject to the availability of resources.¹⁵⁶

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.¹⁵⁷

The concept of progressive realisation is present in the CRC, similarly to the ICESCR, and it is the consequence of ‘a realistic acceptance that lack of resources - financial and other resources - can hamper the full implementation of economic, social and cultural rights in some States’.¹⁵⁸ However, the notion of progressive realisation 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.¹⁵⁹ In addition, all state parties, irrespective of level of development, have to ‘undertake targeted measures to move as expeditiously and effectively’ towards the full realisation of the rights of the CRC.¹⁶⁰

The obligations stemming from article 24 are multiple: to *respect* the freedoms and entitlements, to *protect* these from third parties or other threats, and to *fulfil* them ‘through facilitation or direct provision’.¹⁶¹ In accordance with articles 4 and 24(4), state parties need to work effectively towards realising the right to health while not taking any retrogressive measures. State parties also have minimum core obligations that need to be upheld: (1) Laws and policies have to be reviewed and amended to correlate with the Convention; (2) Universal primary health care services need to be ensured, including access to ‘care and treatment services, and essential drugs’; (3) State parties need to address underlying factors of children’s health; and (4) Plans of Action need to be realised and have rights-based approaches.¹⁶²

¹⁵⁴ Hammarberg, 1995, p. 298.

¹⁵⁵ Vandenhole, Desmet, Reynert & Lembrechts (eds.), 2015, p. 54.

¹⁵⁶ ICESCR, art. 2(1).

¹⁵⁷ CRC, art. 24(4).

¹⁵⁸ CRC/GC/2003/5, 27 November 2003, para. 7.

¹⁵⁹ Ibid.

¹⁶⁰ CRC/C/GC/15, 17 April 2013, para. 72.

¹⁶¹ Ibid, paras. 71, 73.

¹⁶² Ibid.

General Comment No. 15 does not make any explicit references to neither children in street situations, nor children without parents or legal guardians. It does state that special attention should be paid to certain groups where necessary. However, it does not outline what that attention would entail, nor does it provide descriptions or characteristics of the groups in mind.¹⁶³ This thesis argues that children in street situations are a group to which special attention should be afforded.

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 ensure their access to health care.¹⁶⁴ 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’.¹⁶⁵ However, the General Comment fails to define both the age span of adolescents, as well as ‘especially vulnerable groups’.¹⁶⁶

This thesis has examined the 70 COs adopted by the Committee during 2012-2015 in order to establish the practice of the Committee in regards to the first research question. 21 of the COs address the right to health specifically for children in street situations. The most recurring recommendation is that these children shall be provided with necessary protection and adequate health-care services.¹⁶⁷ Some COs add nutrition and shelter to this list,¹⁶⁸ and some mention access to substance abuse treatment.¹⁶⁹ Chile was recommended to implement measures in the health protection systems in order to guarantee children in street situations full respect for their right to health.¹⁷⁰ States have also been advised to ensure that children in street situations have access to health services,¹⁷¹ while in one case it was stated that these children are to be provided with adequate health services, not just have access to it.¹⁷² The Committee makes an interesting differentiation here, but further details as to what it entails are not given. It would have been a positive contribution if the Committee had explained the difference, if any, between ‘access’

¹⁶³ Ibid, para. 115.

¹⁶⁴ CRC/GC/2003/4, ‘General Comment No. 4 (2003) Adolescent health and development in the context of the Convention on the Rights of the Child’, Committee on the Rights of the Child, 1 July 2003, paras. 1, 36.

¹⁶⁵ Ibid, para. 39(h).

¹⁶⁶ Ibid.

¹⁶⁷ CRC COs for: Azerbaijan, 2012, para. 72; India, 2014, para. 84. See para. 4 of Annex II for full list.

¹⁶⁸ CRC COs for: Togo, 2012, para. 68; Indonesia, 2014, para. 74; Tanzania, 2015, para. 69. See para. 5 of Annex II for full list.

¹⁶⁹ CRC COs for: Timor-Leste, 2015, para. 59; Iraq, 2015, para. 83.

¹⁷⁰ CRC CO for Chile, 2015, para. 84(c).

¹⁷¹ CRC COs for: Albania, 2012, para. 81; Greece, 2012, paras. 53, 67; Turkey, 2012, para. 65; Uzbekistan, 2013, para. 52; Russian Federation, 2014, para. 66(b).

¹⁷² CRC CO for Uruguay, 2015, para. 68.

and being ‘provided with’. In addition, it would have been fruitful if the Committee had added details as to how states are to ensure this access.

Some socio-economic factors that contribute to a healthy life were also mentioned in regards to children in street situations, such as increasing the availability of suitable shelters,¹⁷³ or that they should ‘receive preferential access to subsidized State housing’.¹⁷⁴ A number of states were advised to ‘ensure that children in street situations are provided with adequate nutrition, clothing, housing, health care and educational opportunities, including vocational and life-skills training, in order to support their full development’.¹⁷⁵ Also regarding socio-economic factors, but for the situation of children in general, the Committee mentioned the importance of improving access to safe drinking water and/or sanitation.¹⁷⁶ In doing so, Tanzania was also recommended to ensure the ‘sustainability, availability, sufficiency and affordability to all, particularly children’.¹⁷⁷ Thailand was encouraged to ‘improve the nutrition of all children’, irrespective of their situation.¹⁷⁸

A majority of the COs did not provide normative content on the right to health specifically for children in street situations. Many did however provide normative content on access to primary health care regarding all children, which of course is of relevance for the purpose of this thesis. The main finding, and addressed in more than half of the COs, is that the Committee urges state parties to ensure that all children have equal access to, and quality of, primary health care.¹⁷⁹ In the CO to Australia it was further developed that, in ensuring this, special attention should be given to children in vulnerable situations¹⁸⁰ In a similar manner, Russia was recommended to ‘take measures to regularly assess the health conditions of children deprived of parental care and children in difficult situations in order to prevent irreparable damage to their health.’¹⁸¹ Many countries were encouraged to make sure that there are sufficient allocations of financial

¹⁷³ CRC CO for Brazil, 2015, para. 84.

¹⁷⁴ CRC CO for Algeria, 2012, para. 74.

¹⁷⁵ CRC COs for: Liberia, 2012, para. 79; Congo, 2014, para. 77; Jordan, 2014, para. 60; Morocco, 2014, para.67.

¹⁷⁶ CRC Cos for: Myanmar, 2012, para. 64(e); Yemen, 2014, para. 56; Dominican Republic, 2015, para. 50; Gambia, 2015, para. 61; Tanzania, 2015, para. 55; Timor-Leste, 2015, para. 47.

¹⁷⁷ CRC CO for Tanzania, 2015, para. 55.

¹⁷⁸ CRC CO for Thailand, 2012, para. 59.

¹⁷⁹ CRC COs for: Australia, 2012, para. 60; Slovenia, 2013, para. 53; Indonesia, 2014, para. 48; Colombia, 2015. See para. 6 of Annex II for full list.

¹⁸⁰ CRC CO for Australia, 2012, para. 60.

¹⁸¹ CRC CO for the Russian Federation, 2014, para. 52.

and human resources to the health sector.¹⁸² Sweden was urged to ensure that the right to health is guaranteed to children from marginalized or disadvantaged groups.¹⁸³

Economic accessibility is an element of the right to health that is of great importance for children in street situations as they often do not have the financial means to cover medical expenses.¹⁸⁴ The Committee has given a variety of recommendations to state parties in this area, such as ensuring that primary health care services are accessible and affordable, irrespectively of economic background,¹⁸⁵ or that children in the most vulnerable situations should be ensured free access to primary health care.¹⁸⁶ Portugal was recommended to ‘minimize the impact of financial restrictions in the area of health care, and ... that austerity measures ... should be evaluated on the basis of a child-rights impact assessment to ensure that such measures do not have a negative impact on child health and well-being’.¹⁸⁷ Other COs went further in its recommendations. Myanmar was encouraged to take steps in ensuring ‘free and equal access to primary health care in all areas of its territory’.¹⁸⁸ Similarly, Congo was recommended to ensure that ‘health care is provided free of charge’ for all children.¹⁸⁹ The Republic of Korea was recommended to ‘establish a system of public care facilities so that low-income families may have access to health systems at no cost’.¹⁹⁰ These examples can be compared to the CO given to India, where it was stated that there was a need to increase affordability of health care services.¹⁹¹ Some state parties that already provide health care services free of charge were recommended to eliminate any informal fees and/or to ensure that all children have access to such services without discrimination.¹⁹²

Seventeen of the COs were silent on the normative content on access to primary health care,¹⁹³ and 30 of the COs did not explicitly mention children in street situations.¹⁹⁴ The Committee often has a specific section devoted to these children, but sometimes fail to address the issue of

¹⁸² Algeria, 2012, para. 58; Lithuania, 2013, para. 40; Congo, 2014, para. 59; Iraq, 2015, para. 61. See para. 7 of Annex II for full list.

¹⁸³ CRC CO for Sweden, 2015, para. 42.

¹⁸⁴ Interviews with children in street situations, Mbarara, Uganda, 2-6 April 2016.

¹⁸⁵ CRC CO for Indonesia, 2014, para. 48.

¹⁸⁶ CRC CO for Guinea-Bissau, 2013, para. 53(d).

¹⁸⁷ CRC CO for Portugal, 2014, para. 48.

¹⁸⁸ CRC CO for Myanmar, 2012, para. 64(d).

¹⁸⁹ CRC CO for Congo, 2014, para. 65(a).

¹⁹⁰ CRC CO for the Republic of Korea, 2012, para. 54.

¹⁹¹ CRC CO for India, 2014, para. 64(a).

¹⁹² CRC COs for: Albania, 2013, para. 38; Uzbekistan, 2013, para. 52; Poland, 2015, para. 37.

¹⁹³ CRC COs for: Austria 2012; Malta, 2013; Saint Lucia, 2014; Turkmenistan, 2015. See para. 1 of Annex II for full list.

¹⁹⁴ CRC COs for: Australia, 2012; China, 2013; Portugal, 2014; Sweden, 2015. See para. 2 of Annex II for full list.

health in these recommendations.¹⁹⁵ For instance, the state of Iraq was recommended to ensure access to nutrition, clothing, housing, education, and to implement reintegration and recovery programs, but there was no mention of health care except for access to drug dependence treatment.¹⁹⁶ Similarly, although silent on the right to health, recommendations were made as to provide ‘adequate means of living in order to support [children in street situations] full development’.¹⁹⁷

3.3 Conclusion

This chapter has examined state obligations under the CRC regarding access to primary health care for children in street situations. All children within the jurisdiction of the state party are to be afforded the rights contained in the CRC, which means that all of the obligations stemming from the right to health are relevant for children in street situations too. Article 24 is to be approached from a child rights perspective, and similarly to the ICESCR, children in disadvantaged situations are to be at the centre of efforts in implementing the right to health. Thus, it can be argued that children in street situations are to be in the centre of efforts by state parties. State parties have been advised to address the root causes of vulnerability of children through, *inter alia*, laws and policies. This will be examined further in chapter VI.

State parties have a principal duty in ensuring that children are not deprived of access to primary health care, and to remove any barriers to such access. 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. Similarly to the ICESCR, state parties need to implement the provisions of the CRC through legislation, but with the additional requirement that the legislation should be based on a child rights approach.

All children need to be ensured access to health care, both *de jure* and *de facto*, and lack of resources should not be a reason to deny a child medical services. The recommendations made in regards to economic accessibility are various, ranging from affordable services to free access to health care services for children in the most vulnerable situations. One important question in this respect is how to differentiate between vulnerable situations and where to draw the line. This thesis argues that children in street situations clearly fall within the ambit of ‘most

¹⁹⁵ CRC COs for: Algeria, 2012, para. 73-74; Kuwait, 2013, para. 73; Poland, 2015, para. 49. See para. 3 of Annex II for full list.

¹⁹⁶ CRC CO for: Iraq, 2015, para. 83.

¹⁹⁷ CRC CO for: Gambia, 2015, para. 79.

vulnerable situations', mainly due to them being outside the care of a parent or a guardian. The Committee on the Rights of the Child have made references to vulnerable groups implying that they need special attention. However, it has not been outlined what those measures should or could be.

The Committee has specifically mentioned the right to health for children in street situations, providing that socioeconomic factors need to be addressed in realising the right to health. Such measures are, *inter alia*, to ensure the availability of shelters or subsidised housing, and to provide these children with nutrition, clothing and access to safe drinking water and sanitation.

The minimum core obligations that Uganda need to uphold are both to ensure that its legislation is in conformity with the CRC, but also to ensure access to primary health care and treatment services. In addition, underlying factors that have an impact on children's health need to be addressed, and there need to be plans of action in place that adopts a rights-based approach.

4 ACHPR – the Right to Health

The ACHPR was adopted in 1981,¹⁹⁸ and is a unique Charter in many ways. It has been ratified by 53 out of the 54 member states of the African Union. South Sudan has not yet signed or ratified the Charter. Uganda has been a state party since 1986.¹⁹⁹ The Charter protects both civil and political rights; economic, social and cultural rights, as well as collective rights.²⁰⁰ It was adopted at a time when the socio-economic situation was critical in many African countries. It would have then been illogical to adopt a Charter that would not address that very suffering, while providing for other human rights.²⁰¹ It differs from other international human rights treaties as it contains duties of individuals,²⁰² but also because it does not contain a provision on derogations in times of emergency.²⁰³ Instead, there are claw-back clauses that allow states to limit the rights in accordance with national law.²⁰⁴

¹⁹⁸ The African (Banjul) Charter on Human and Peoples Rights (adopted 27 June 1981, entered into force 21 October 1986) (ACHPR).

¹⁹⁹ African Commission on Human and Peoples' Rights, 'Ratification Table: African Charter on Human and Peoples' Rights', <http://www.achpr.org/instruments/achpr/ratification/>, last consulted on 23 April 2016.

²⁰⁰ Rehman, 2010, p. 310.

²⁰¹ Kabange Nkongolo, 2014, p. 492.

²⁰² ACHPR, arts. 27-29.

²⁰³ Article 19 v. Eritrea, Communications No. 275/03, 30 May 2007, African Commission on Human and Peoples' Rights, para. 87.

²⁰⁴ Rehman, 2010, p. 312.

State parties are to submit reports on the implementation of the Charter every two years. The African Commission on Human and People's Rights is a quasi-judicial body,²⁰⁵ with the mandate to ensure the rights of the Charter, to interpret it and to give recommendations to state parties.²⁰⁶ 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. It is a soft law instrument of importance for the work of the Commission.²⁰⁷

The Commission started issuing concluding observations in 2001.²⁰⁸ Since then, 20 concluding observations have been issued to 18 countries. Four of them are in French and will therefore not be considered in this thesis. 15 countries have not yet submitted any reports to the Commission. The remaining 21 state parties have submitted reports, but the corresponding COs have not been made available so far.²⁰⁹ Similarly to the COs of the ICESCR and the CRC, the COs adopted by the Committee are not legally binding *per se*.²¹⁰

4.1 Scope and State Parties Obligations

The very first article of the ACHPR provides a general obligation upon state parties to 'recognise the rights, duties and freedoms enshrined in the Charter and shall undertake to adopt legislative or other measures to give effect to them'.²¹¹

Article 16 of the ACHPR, is the right to health and provides that:

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.²¹²

²⁰⁵ Kabange Nkongolo, 2014, p. 498.

²⁰⁶ ACHPR, arts. 30, 45, 62.

²⁰⁷ Murray & Long, p. 59.

²⁰⁸ Steiner, Alston & Goodman, 2008, p. 1069.

²⁰⁹ African Commission on Human and Peoples' Rights, 'State Reports and Concluding Observations', <http://www.achpr.org/states/reports-and-concluding-observations/>, last consulted on 18 March.

[NB: Some of these reports were considered before 2001, which explains the lack of concluding observations. However, there are state reports that have been considered after 2001 where concluding observations have not yet been made available.]

²¹⁰ Murray & Long, 2015, p. 47.

²¹¹ ACHPR, art. 1.

²¹² Ibid, art. 16.

The Charter places ‘unequivocal obligations on states to direct resources towards the realisation’ of the right to health, but the scope of the right, as the ICESCR, is limited by the wording itself: best attainable standard,²¹³ which reflects the wording of the ICESCR.

The Commission has stated that the right to health does not only concern health care, but also ‘underlying determinants of health’.²¹⁴ These are ‘access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions’.²¹⁵ Thus, the Charter is similar to the ICESCR and the CRC, but with the addition of healthy occupational and environmental conditions.

The African Commission on Human and Peoples’ Rights, similarly to the Committee on Economic, Social and Cultural Rights,²¹⁶ has provided that the right to health consists of four elements. These are availability, adequacy, physical and economic accessibility and acceptability.²¹⁷ Compared to the ICESCR notion of AAAQ, adequacy is added and quality is not mentioned.²¹⁸

Availability refers to the ‘availability of rights’,²¹⁹ that is, states are obliged to make sure that the goods and services needed to enjoy the right ‘are practically available to the individual, regardless of how this is achieved’.²²⁰ Further, *adequacy* implies that the goods and services have to be sufficient to actually meet the requirements of the right.²²¹ The element of *physical and economic accessibility* requires special attention to vulnerable or disadvantaged groups. The goods and services have to be available to everyone. In order to ensure this for vulnerable or disadvantaged groups, special measures might be necessary. Economic accessibility is also included and described to imply that all people ‘should be able to acquire the specific requirements for the enjoyment of all economic, social and cultural rights without threatening

²¹³ Viljoen, 2008, p. 98.

²¹⁴ African Commission on Human and Peoples’ Rights, ‘*Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples’ Rights*’, http://www.achpr.org/files/instruments/economic-social-cultural/achpr_instr_guide_draft_esc_rights_eng.pdf last consulted on 27 May, paras. 61-63.

²¹⁵ Ibid.

²¹⁶ See chapter II.

²¹⁷ African Commission on Human and Peoples’ Rights, ‘*Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples’ Rights*’, http://www.achpr.org/files/instruments/economic-social-cultural/achpr_instr_guide_draft_esc_rights_eng.pdf last consulted on 27 May, para. 3.

²¹⁸ See section 2.1.

²¹⁹ African Commission on Human and Peoples’ Rights, ‘*Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples’ Rights*’, http://www.achpr.org/files/instruments/economic-social-cultural/achpr_instr_guide_draft_esc_rights_eng.pdf last consulted on 27 May, para. 3(a).

²²⁰ Ibid.

²²¹ Ibid, para. 3(b).

or compromising the enjoyment of other rights'.²²² Acceptability means that the right of the Charter are to be provided with respect for 'societal and cultural norms that are consistent with African and international human rights law'.²²³

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. State parties are to *respect* the rights by not 'interfering directly or indirectly' with the rights under the Charter.²²⁴ It also requires state parties to ensure that no branch of government or organs of the state violate the rights.²²⁵ The obligation to *protect* entails that state parties are to ensure that any type of non-state actor do not violate the rights of the Charter.²²⁶ The duty to fulfil the rights of the ACHPR requires states parties to take 'positive steps to advance the realisation of the rights'.²²⁷ These measures are to be 'comprehensive, co-ordinated, transparent, and contain clear goals, indicators and benchmarks for measuring progress'.²²⁸ Of particular interest of the purpose of this thesis is that 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.²²⁹

The ACHPR does not explicitly provide for the notion of progressive realisation. It has, however, been widely accepted within the interpretation of ESC-rights and frequently used within development aid.²³⁰ The notion has therefore been interpreted to be included in the Charter through articles 61 and 62.²³¹ This implies that the state parties have an obligation to take 'concrete and targeted steps' towards the full realisation of ESC-rights.²³²

There are immediate obligations connected to the ESC-rights that not subject to the notion of progressive realisation. These are, *inter alia*, 'the obligation to take steps, the prohibition of

²²² Ibid, para. 3(c).

²²³ Ibid, para. 3(d).

²²⁴ Ibid, para. 5.

²²⁵ Ibid, para. 6.

²²⁶ Ibid, para. 7.

²²⁷ Ibid, para. 10.

²²⁸ Ibid.

²²⁹ Ibid.

²³⁰ African Commission on Human and Peoples' Rights, '*Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights*', http://www.achpr.org/files/instruments/economic-social-cultural/achpr_instr_guide_draft_esc_rights_eng.pdf last consulted on 27 May, para. 11.

²³¹ ACHPR, arts. 61-62.

²³² African Commission on Human and Peoples' Rights, '*Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights*', http://www.achpr.org/files/instruments/economic-social-cultural/achpr_instr_guide_draft_esc_rights_eng.pdf, last consulted on 27 May, para. 14.

retrogressive steps, minimum core obligations and the obligation to prevent discrimination in the enjoyment of economic, social and cultural rights'.²³³

Each of the rights contain minimum essential levels that states have an obligation to ensure. These are known as minimum core obligations and the Committee has provided these imply that states have to ensure that 'no significant number of individuals is deprived of the essential elements of a particular right'.²³⁴ The minimum core obligations are both non-derogable and is not dependent upon available resources.²³⁵

The minimum core obligations in relation to the right to health are multiple. State parties are to provide a health care system that is accessible for everyone. Such access, including access to health-related goods and services, has to especially be ensured for disadvantaged and vulnerable groups and in light of the principle of non-discrimination.²³⁶ It is also to ensure 'essential drugs to all those who need them', guarantee universal immunisation, to provide information on health and to 'take measures to prevent, treat and control epidemic and endemic diseases'.²³⁷

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, *inter alia*, women children minorities, people living with terminal illnesses, victims of exploitation, refugees, and people working in the informal sector.²³⁸ As this list goes on, it may be questioned whether such definition serves its purpose since it covers a significant portion of the population in, for instance, Uganda. Another remarkable aspect of the list is that in enumerating groups of children that are particularly vulnerable, children in street situations are not mentioned. They do, of course, fall under the category of children, but it is still noteworthy that these groups of children were not specifically mentioned.

The Commission has provided details on how state parties are to realise 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'.²³⁹ Regarding economic

²³³ Ibid, para. 16.

²³⁴ Ibid, para. 17.

²³⁵ Ibid.

²³⁶ Ibid, para. 67.

²³⁷ Ibid, para. 67(a)-(e).

²³⁸ Ibid, para. 1(e).

²³⁹ African Commission on Human and Peoples' Rights, '*Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights*',

barriers to access of primary health care, the Commission has stated that state parties should introduce national health insurances 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.²⁴⁰

In realising 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 health sector. In addition, and similarly to the approach of the CRC, the national plans should adopt a human rights approach.²⁴¹

An examination of the 16 concluding observations that have been made available by the African Commission on Human and People’s Rights did not yield a lot of information that is of relevance for the purpose of this thesis. All of the COs were silent on children in street situations, or children in a nonfamily setting, with regards to the right to health.²⁴² Half of the COs were silent regarding primary health care and the normative content on the right to health.²⁴³

The most frequent recommendation made by the Committee is that state parties need to make sure that the health sector is allocated sufficient funds.²⁴⁴ Others were that state parties need to increase the population’s access to health care facilities;²⁴⁵ that facilities need to be provided in both urban and rural areas,²⁴⁶ and that they need to be adequately equipped.²⁴⁷

In two instances, the Committee recommended that children should have free access to anti-retroviral drugs.²⁴⁸ Further, Gabon was encouraged to provide free health care for children below the age of five.²⁴⁹ Some recommendations were of a more general nature, such as: the

http://www.achpr.org/files/instruments/economic-social-cultural/achpr_instr_guide_draft_esc_rights_eng.pdf
last consulted on 27 May, para. 67(y).

²⁴⁰ Ibid, para. 67(bb).

²⁴¹ Ibid, para. 67(f)-(n).

²⁴² ACHPR COs for: Angola, 2012; Botswana, 2010; Ethiopia, 2010; Gabon, 2014; Kenya, 2007; Liberia, 2015; Malawi, 2015; Mauritania, 2002; Mozambique, 2014; Niger, 2004; Nigeria, 2015; Sudan, 2012; Togo, 2002; Togo, 2012; Uganda, 2011; Uganda, 2015.

²⁴³ ACHPR COs for: Ethiopia, 2010; Liberia, 2015; Mauritania, 2002; Niger, 2004; Sudan, 2012; Togo, 2002; Uganda, 2011; Uganda, 2015.

²⁴⁴ ACHPR COs for: Angola, 2012, para 41; Mozambique, 2014; p. 13; Togo, 2012; para. 73; Uganda, 2015.

²⁴⁵ ACHPR CO for: Malawi, 2015, para. 130.

²⁴⁶ ACHPR COs for: Mozambique, 2014, p.13; Togo, 2012, para. 73.

²⁴⁷ ACHPR COs for: Malawi, 2015, para. 130; Togo, 2012, para. 73.

²⁴⁸ ACHPR COs for: Angola, 2012, para. 41; Ethiopia, 2010, para. 21.

²⁴⁹ ACHPR CO for: Gabon, 2014, para. 66.

need to adopt a comprehensive legal framework for health;²⁵⁰ to recognise economic, social and cultural rights in the constitution;²⁵¹ and to ‘take specific measures to cater for the needs of minority and vulnerable groups and promote and protect the rights of these groups’.²⁵²

4.3 Conclusion

This chapter has examined state obligations that originate from the ACHPR as regards to access to primary health care for children in street situations. The ACHPR takes a similar approach as the previously examined instruments as the right to health does not only regard health care, but also socioeconomic factors that contribute to a healthy life. The minimum core obligations include ensuring access to health care facilities and services without discrimination, and to pay particular attention to disadvantaged and vulnerable groups.

A non-exhaustive list of the definition for disadvantaged and vulnerable groups has been provided, but it is questionable whether it serves its purpose since it covers large portions of populations. State parties are to adopt national health insurances in order to remove economic barriers to the full enjoyment of the right to health, but only where necessary. Does this imply that states have such a wide discretion that the recommendation would not have a real impact in the lives of people that today do not have access to health care due to financial reasons?

Regrettably, the COs available rarely addressed the normative content of the right to health, and did not mention children in street situations with regards to their right to health. Although the Committee did mention that there is a need to take specific measures to address the needs of vulnerable groups, and to promote their rights, it is regrettable that the Committee did not provide specific examples of what those measures should or could entail.

5 ACRWC – the Right to Health

The ACRWC came into force 17 years ago and has been ratified by 45 out of the 54 member states of the African Union. Uganda has been a state party since 1994.²⁵³ The Charter was created as a reaction to the perception that African states were at the margin during the drafting

²⁵⁰ ACHPR CO for: Nigeria, 2015, para. 133.

²⁵¹ ACHPR CO for: Botswana, 2010, para. 53.

²⁵² ACHPR CO for: Togo, 2002, para. 26.

²⁵³ African Union, ‘ACRWC Ratifications Table’, <http://pages.au.int/acerwc/pages/acerwc-ratifications-table>, last consulted on 23 April 2016.

process of the CRC as only nine African states were part of the working group.²⁵⁴ It was also created to respond to the ‘economic, social, political, cultural and historical experience of African children’.²⁵⁵ The drafters of the ACRWC wanted to address issues that were not covered by the CRC, such as: prohibiting female genital mutilation and child marriages, as well as protecting both child refugees and internally displaced children.²⁵⁶

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 children.²⁵⁷ The Committee also oversees the implementation of the ACRWC and receives reports from state parties to which the Committee then issues recommendations.²⁵⁸ However, 18 concluding observations have been issued in response to reports from state parties. Seven of these concluding observations are only available in French and will therefore not be examined.²⁵⁹ The 11 COs that are available in English will be examined and analysed in the following section.²⁶⁰

The Committee has not yet issued a general comment on the right to health. Two general comments have been adopted so far. One deals with children of imprisoned parents and the other one is on name and nationality.²⁶¹

5.1 Scope and State Parties Obligations

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.²⁶² Further,

²⁵⁴ Viljoen, 2007, p. 261.

²⁵⁵ Kaime, 2009, p. 3.

²⁵⁶ Viljoen, 2007, p. 262.

²⁵⁷ The African Charter on the Rights and Welfare of the Child (adopted 11 July 1990, entered into force 29 November 1999) (ACRWC), arts. 32, 42.

²⁵⁸ Ibid, art. 43.

²⁵⁹ The concluding observations to Burkina Faso, Cameroon, Mali, Niger, Rwanda, Senegal and Togo are only available in French. See: African Committee of Experts on the Rights and Welfare of the Child, Concluding Observations, <http://www.acerwc.org/concluding-observations/>, last consulted on 16 March.

²⁶⁰ African Committee of Experts on the Rights and Welfare of the Child, Concluding Observations, <http://www.acerwc.org/concluding-observations/>, last consulted on 16 March.

²⁶¹ African Committee of Experts on the Rights and Welfare of the Child, ‘General Comments’, <http://www.acerwc.org/general-comments/>, last consulted on 16 March.

²⁶² ACRWC, arts. 2-3.

the rights and freedoms of the ACRWC shall be afforded to all children within the jurisdiction of the state party.²⁶³

The very first article of the ACRWC provides a general obligation upon state parties:

Member States of the Organization of African Unity Parties to the present Charter shall recognize the rights, freedoms and duties enshrined in this Charter and shall undertake to the necessary steps, in accordance with their Constitutional processes and with the provisions of the present Charter, to adopt such legislative or other measures as may be necessary to give effect to the provisions of this Charter.²⁶⁴

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’.²⁶⁵ 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’.²⁶⁶

The right to health shall, in accordance with article 3 of the Charter, be afforded without any discrimination to all children:

Every child shall be entitled to the enjoyment of the rights and freedoms recognized and guaranteed in this Charter irrespective of the child’s or his/her parents’ or legal guardians’ race, ethnic group, colour, sex, language, religion, political or other opinion, national and social origin, fortune, birth or other status.²⁶⁷

Article 3 is a non-autonomous provision that applies to all rights of the Charter and it can thus be applied in relation to the implementation of the right to health.²⁶⁸ The African Committee of

²⁶³ African Committee of Experts on the Rights and Welfare of the Child, ‘General Comment No. 1 (Article 30 of the African Charter on the Rights and Welfare of the Child) on “Children of Incarcerated and Imprisoned Parents and Primary Caregivers”’, 2013, <http://www.acerwc.org/?wpdmdl=8597>, last consulted on 16 March, para 19.

²⁶⁴ ACRWC, art. 1(1).

²⁶⁵ *Decision on the Communication Submitted by Michelo Hunsungule and Others (on Behalf of Children in Northern Uganda) against the Government of Uganda*, Communication No. 1/2005, 15-19 April 2013, African Committee of Experts on the Rights and Welfare of the Child, para. 37.

²⁶⁶ *Ibid.*, para. 38.

²⁶⁷ ACRWC, art. 3.

²⁶⁸ Kaime, 2009, p. 98.

Experts on the Rights and Welfare of the Child has provided that ‘the concept of discrimination encompasses any distinction, exclusion or preference’.²⁶⁹

In respect of primary health care, article 14 provides that:

1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.
2. States Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular shall take measures: ... (b) to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; ... (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology; ... (g) to integrate basic health service programmes in national development plans; ... (i) to ensure the meaningful participation of non-governmental organizations, local communities and the beneficiary population in the planning and management of a basic service programme for children; ... (j) to support through technical and financial means, the mobilization of local community resources in the development of primary health care for children.²⁷⁰

The Committee has provided that the right to health is to be implemented through the notion of progressive realisation. However, state parties are to realise 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.²⁷¹ The Committee has further stated that discrimination regarding access to health care facilities or services, or a failure to provide ‘basic health care services can [both] amount to a violation’ of article 14.²⁷²

The Committee has provided that state parties have an obligation to respect, protect and fulfil the rights of the ACRWC.²⁷³ This is to be done in accordance with the obligations stemming from article one.²⁷⁴ However, neither the adopted general comments, nor the decisions adopted outline details of what the notion of respect, protect, fulfil entail.

²⁶⁹ African Committee of Experts on the Rights and Welfare of the Child, ‘*General Comment No. 1 (Article 30 of the African Charter on the Rights and Welfare of the Child) on “Children of Incarcerated and Imprisoned Parents and Primary Caregivers”*’, 2013, <http://www.acerwc.org/?wpdmdl=8597>, last consulted on 16 March 2016, para. 19.

²⁷⁰ ACRWC, art. 14.

²⁷¹ *Decision on the Communication Submitted by Michelo Hunsungule and Others (on Behalf of Children in Northern Uganda) against the Government of Uganda*, Communication No. 1/2005, 15-19 April 2013, African Committee of Experts on the Rights and Welfare of the Child, para. 72.

²⁷² *Ibid*, para. 73.

²⁷³ *Decision on the Communication Submitted by the Institute for Human Rights and Development in Africa and the Open Society Justice Initiative (on Behalf of Children of Nubian Descent in Kenya) Against the Government of Kenya*, Communication No. Com/002/2009, 22 March 2011, African Committee of Experts on the Rights and Welfare of the Child, para. 58.

²⁷⁴ African Committee of Experts on the Rights and Welfare of the Child, ‘*General Comment on Article 6 of the African Charter on the Rights and Welfare of the Child: “Right to Birth Registration, Name and Nationality”*’,

An examination of the concluding observations adopted by the African Committee of Experts on the Rights and Welfare of the Child shows that children in street situations and the right to health are not always addressed. Only one out of the eleven examined COs specifically mention the right to health in connection to children in street situations. 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.²⁷⁵

A recurrent theme of the COs is the issue of access to health care services. 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.²⁷⁶

There seems to be different approaches to the notion of economic accessibility. Kenya was recommended to implement free of charge health care services for children below the age of five. Liberia was commended for doing just that, but also urged to make health care services free of charge for poor children.²⁷⁷ In the other COs examined, the economic accessibility was not mentioned. Perhaps the discrepancy between the recommendations to Kenya and Liberia is part of the notion of progressive realisation, and the fact that different countries have different economic situations. However, for children in street situations it would have been helpful if the Committee would have provided a definition of ‘poor children’.

Socioeconomic factors that contribute to a healthy life were also addressed by the Committee. State parties are 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.²⁷⁸

Some COs were silent on the issue of children in street situations,²⁷⁹ and some did not provide any normative content as to the interpretation of the right to health.²⁸⁰ However, state parties were encouraged to implement laws that ensure the substantive equality between children and

undated, http://www.acerwc.org/download/general_comment_article_6_name_and_nationality/?wpdmdl=8606, last consulted on 18 June, para. 11.

²⁷⁵ ACRWC CO for Ethiopia, para. 16.

²⁷⁶ ACRWC COs for: Ethiopia, para. 13; Guinea, para 31; Kenya, p. 3; Liberia, p. 10; South Africa, paras. 45-46; Tanzania, p. 8.

²⁷⁷ ACRWC COs for: Liberia, p. 8; Kenya, p. 5.

²⁷⁸ ACRWC COs for: Liberia, p. 8; Nigeria, para. 9; South Africa, paras. 45-46.

²⁷⁹ ACRWC COs for: Egypt, Guinea, Mozambique, Sudan & Uganda.

²⁸⁰ ACRWC COs for: Egypt, Sudan & Uganda.

children that are not in a family setting, nor belonging to marginalised groups.²⁸¹ The Committee urged Guinea to make sure that vulnerable groups had equal access to health care by giving them assistance. A further explanation as to which children belongs to vulnerable groups was not given.²⁸²

5.3 Conclusion

This chapter has examined state obligations that originate from the ACRWC regarding access to primary health care for children in street situations. It is clear that states have to ensure that legislation is in conformity with the ACRWC, and that 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.

The right to health has to be afforded to all children within the jurisdiction of the state parties, and discrimination in access to health care services might amount to a violation of article 14. If state parties fail to provide basic health services that would amount to a violation.

Only one of the examined concluding observations mentioned the right to health in connection to children in street situations, stating that these children need to be duly taken into account and afforded access to health care services. Economic accessibility was only mentioned in a couple of COs, providing different views on how to deal with the matter. It is possible that the discrepancy between the recommendations is due to the notion of progressive realisation, and the fact that different countries have different economic situations. However, for the purpose of this thesis it would have been a positive addition if the Committee would have provided a definition of poor children as the Committee stated that they should receive free health care. This thesis argues that children in street situations indeed should fall within a definition of poor children as they often live on far less than 1.25 US Dollar a day, which is the definition of extreme poverty.²⁸³ The children interviewed in this thesis, although only illustrative as they do not represent all children in street situations worldwide, live on 500 – 10 000 UGX per day.²⁸⁴

²⁸¹ ACRWC COs for: Ethiopia, para. 5; Mozambique, para. 13; South Africa, para. 21.

²⁸² ACRWC CO for Guinea, para. 14.

²⁸³ UNDP, *The Millennium Development Goals Report 2015*, 2015, http://www.undp.org/content/dam/undp/library/MDG/english/UNDP_MDG_Report_2015.pdf, last consulted on 28 May, p. 15.

²⁸⁴ The equivalent is about 0.14 – 2.97 US Dollars, as of 28 May 2016. Interviews with children in street situations, Mbarara, Uganda, 2-6 April 2016.

Other recommendations by the Committee stressed, similarly to the other instruments examined, the importance of addressing socioeconomic factors that contribute to a healthy life, such as ensuring access to sanitation and housing, drinking water and basic nutrition.

PART THREE – NATIONAL LEGAL FRAMEWORK

The aim of this section is to examine the extent to which the government of Uganda has implemented the obligations stemming from the international human rights instruments examined in the previous chapters of this thesis. This section thus aims at answering the second research question by examining relevant legislation and policies of the government of Uganda.

6 Implementations Made by the Government of Uganda

As shown in previous chapters, Uganda has ratified all of the four instruments examined and has not made any reservations relevant for the purpose of this thesis. Therefore, Uganda has an obligation to implement the state obligations that stem from those instruments in good faith.²⁸⁵

6.1 Constitution of the Republic of Uganda

The Constitution provides that a child is a person below the age of 18,²⁸⁶ and that it is the parents that bear both the right and the duty of caring for their children.²⁸⁷ It also stipulates that laws need to be in place to provide ‘special protection to orphans and other vulnerable children.’²⁸⁸ Under the heading of Rights of Children, it is provided that no child can be deprived of medical treatment. However, that is on grounds of their religion or beliefs. It is not a blanket provision stating that no child can be deprived of medical treatment.²⁸⁹

The Constitution does not explicitly reflect a right to health in one of its articles.²⁹⁰ It does however contain a codicil known as the National Objectives and Directive Principles of State Policy.²⁹¹ It provides, *inter alia*, that the ‘[s]tate shall endeavour to fulfil the fundamental rights of all Ugandans’ and to ensure ‘access to ... health services, clean and safe water ... decent shelter, adequate clothing, [and] food security’.²⁹² The NODPSP also provides that the state is

²⁸⁵ VCLT, art. 26.

²⁸⁶ Constitution of the Republic of Uganda, 1995, art. 257.

²⁸⁷ *Ibid*, art. 31(4).

²⁸⁸ *Ibid*, art. 34(7).

²⁸⁹ *Ibid*, art. 34(3).

²⁹⁰ Constitution of the Republic of Uganda, 1995; Mubangizi & Twinomugisha, 2010, p. 120.

²⁹¹ Le Roux-Kemp, 2016, p. 146.

²⁹² National Objectives and Directive Principles of State Policy, XIV(b).

to ‘take all practical measures to ensure the provision of basic medical services to the population’.²⁹³

The NODPSP has the purpose of guiding all state organs, non-state actors and citizens ‘in applying or interpreting the Constitution or any other law and in taking and implementing any policy decisions for the establishment and promotion of a just, free and democratic society’.²⁹⁴ However, it is debatable whether the NODPSP are justiciable since they themselves do not form part of the main body of the Constitution.²⁹⁵ The Constitution (Amendment) Act of 2005 introduced article 8A that reads:

‘Uganda shall be governed based on principles of national interest and common good enshrined in the national objectives and directive principles of state policy. ... Parliament shall make relevant laws for purposes of giving full effect to clause (1) of this article’²⁹⁶

This provision is said to ‘strengthen the application of the NODPSP’ and to have affirmed its legal status.²⁹⁷ That is because the new article is in the main body of the Constitution, and thus provides an ‘obligation on all organs and agencies of the state to be guided’ by the NODPSP.²⁹⁸

The Constitution provides a right to a clean and healthy environment,²⁹⁹ and explicitly provides for other economic, social and cultural rights, such as a right to education.³⁰⁰ It is also stated that ‘the rights, duties, declarations and guarantees relating to the fundamental and other human rights and freedoms specifically mentioned in this Chapter shall not be regarded as excluding others not specifically mentioned’.³⁰¹ The latter has been interpreted to legally recognise the right to health, including its possible enforcement in court. It is also possible to include the right to health through a ‘creative interpretation’ of other rights, such as the right to life, that are explicitly recognised in the Constitution.³⁰²

²⁹³ Ibid, XX.

²⁹⁴ Ibid, I(i).

²⁹⁵ Twinomugisha, 2015, p. 28.

²⁹⁶ The Constitution (Amendment) Act, 2005, para. 4.

²⁹⁷ Global Health Visions, ‘Country Case Study: Uganda. In-depth Landscape Analysis of Accountability for Maternal and Newborn Health in Uganda’, 2015, http://globalhealthvisions.com/Uganda_Country_Case_Study_MNH_Accountability.pdf, last consulted on 18 June 2016, p. 10

²⁹⁸ The Center for Health, Human Rights and Development (CEHURD), ‘Litigating Maternal Health Rights in Uganda: What Civil Society Groups must know’, September 2013, <http://www.cehurd.org/wp-content/uploads/downloads/2014/05/Litigating-maternal-health-sept-2013.pdf>, last consulted on 18 June 2016, p. 27.

²⁹⁹ Constitution of the Republic of Uganda, 1995, art. 39.

³⁰⁰ Ibid, art. 30.

³⁰¹ Ibid, art. 45.

³⁰² Mubangizi & Twinomugisha, 2010, p. 120.

Every citizen of Uganda has the duty to ‘protect children and vulnerable persons against any form of abuse, harassment or ill-treatment’.³⁰³ Further, children have a constitutional entitlement to ‘be protected from social or economic exploitation and shall not be employed in or required to perform work that is likely to be hazardous or to interfere with their education or to be harmful to their health or physical, mental, spiritual, moral or social development’³⁰⁴

6.2 Children Act

The Children Act was created to ‘reform and consolidate the law relating to children; to provide for the care, protection and maintenance of children; to provide for local authority support for children; to establish a family and children court; to make provision for children charged with offences and for other connected purposes’.³⁰⁵

The act provides that it is the duty of the parents, guardians or the one who has custody of a child to ensure that the child is provided with medical attention, clothing, shelter and adequate food.³⁰⁶ Thus, children that are without care, such as children in street situations, are left out of this provision. The chapter on guiding principles in the implementation of the Act provides that:

A child shall have the right ... to exercise, in addition to all the rights stated in this Schedule and this Act, all the rights set out in the United Nations Convention on the Rights of the Child and the Organisation for African Unity Charter on the Rights and Welfare of the African Child with appropriate modifications to suit the circumstances in Uganda, that are not specifically mentioned in this Act.³⁰⁷

The guiding principle thereby provides a reference to the right to health as contained in the CRC and the ACRWC.³⁰⁸ However, it is only a guiding principle and not a legal provision. In addition, it stipulates a blanket provision on ‘appropriate modifications’ that is not further explained or defined.

There is a provision of the Children Act that is relevant for children in street situations, as will be further demonstrated in chapter VII, which concerns harmful employment and reads:

³⁰³ Constitution of the Republic of Uganda, 1995, art. 17(c).

³⁰⁴ Ibid, art. 34(4).

³⁰⁵ Children Act, 1997, preamble.

³⁰⁶ Ibid, art. 5.

³⁰⁷ First Schedule, Guiding principles in the implementation of the Act, principle 4(c).

³⁰⁸ See chapters III & V of this thesis.

No child shall be employed or engaged in any activity that may be harmful to his or her health, education or mental, physical or moral development.³⁰⁹

In addition, article 10(6) provides that:

Each local government council shall provide assistance and accommodation for any child in need within its area of jurisdiction who appears to the committee to require assistance and accommodation as a result of his or her having been lost or abandoned or seeking refuge.³¹⁰

These two articles do not provide a right to health, but are relevant for socioeconomic factors that contribute to a healthy life. In conclusion, the Act does not provide a provision for the right to health as contained in the instruments examined in chapters II-V. Thus, the right to health has not been explicitly codified in either the Constitution, the Children act, nor in other domestic legislative acts.³¹¹ To date, there are no legislative acts that specifically concern the right to health and its elements.³¹² In addition, none of the examined instruments have been directly incorporated into Uganda's legal system. Rather, most issues concerning the right to health are covered by policies that are not legally binding.³¹³

6.3 Policies

As described in chapter II, the UN Committee on Economic, Social and Cultural rights has stressed the importance of adopting national health policies as part of the duty to fulfil the right to health. Similarly, as shown in chapter III, the Committee on the Rights of the Child has stated that states are to identify underlying reasons of vulnerability of children and to address these through laws and policies. Therefore, this section will examine some government policies to determine how they reflect the obligations stemming from the right to health, as described in chapters II-V. The policies are not legally binding.³¹⁴

6.3.1 National Strategic Programme Plan of Interventions for Orphans and other Vulnerable Children 2011/12—2015/16

The National Strategic Programme Plan of Interventions for Orphans and other Vulnerable Children (also known as the National OVC Policy), now at the final stages of implementation,

³⁰⁹ Children Act, 1997, art. 8.

³¹⁰ Ibid, art. 10(6).

³¹¹ See e.g.: The Health Service Commission Act, 2001 and the Public Health Act, 1935.

³¹² Twinomugisha, 2015, p. 34.

³¹³ Mubangizi & Twinomugisha, 2010, pp. 121-122, 129.

³¹⁴ Twinomugisha, 2015, p. 17.

was created in response to the high vulnerability among Ugandan children, a rate of 96%.³¹⁵ More than half of the Ugandan population are children. Thirty-one per cent of the whole population live under the poverty line and children make up 62% of that number.³¹⁶ The policy aims at targeting ‘51 percent of the children considered critically and/or moderately vulnerable’.³¹⁷

The National OVC Policy defines a vulnerable child as someone ‘who is suffering and/or is likely to suffer any form of abuse or deprivation and is therefore in need of care and protection’.³¹⁸ The mission and vision are described as ‘to provide a framework for the enjoyment of rights and fulfilment of responsibilities of the orphans and other vulnerable children’ where the goal is to have ‘[a] society where all orphans and other vulnerable children live to their full potential and their rights and aspirations are fulfilled’.³¹⁹

Children in street situations are mentioned as one of the groups belonging to the category of ‘critically vulnerable children’.³²⁰ One of the core objectives of the National OVC Policy is to ‘[e]xpand access to essential services for orphans and other vulnerable children, their caregivers and families/households’, with the outcome of, *inter alia*, increased access to and use of health services, safe water and sanitation, as well as an increased number of OVCs that live in ‘decent houses’.³²¹ Mentioned interventions include providing food aid to those children that are critically vulnerable.³²² Interventions related to ‘Health, Water, Sanitation and Shelter’ does not mention access to primary health care, but does provide strategies concerning socioeconomic factors that contribute to a healthy life. Those are, *inter alia*, the aims of installing safe water sources and advocating for these services to be free of charge for OVCs. Interventions also aim at providing ‘low cost, decent, durable and secure shelter’ for these children.³²³

Key actors in the implementation of the National OVC Policy are, *inter alia*, different government bodies, with the Ministry of Gender, Labour and Social Development as the leading actor, as well as faith-based and civil society organisations, the private sector and developing

³¹⁵ The Republic of Uganda, Ministry of Gender, Labour and Social Development Uganda, ‘*National Strategic Programme Plan of Interventions for Orphans and other Vulnerable Children 2011/12—2015/16*’, May 2011, http://www.unicef.org/uganda/Final_Printed_OVC_Strategic_Plan_Uganda_-NSPPI_2.pdf, last consulted 3 June 2016, p. xii.

³¹⁶ Ibid.

³¹⁷ Ibid.

³¹⁸ Ibid, p. xi.

³¹⁹ Ibid, p. xiv.

³²⁰ Ibid, p. 24.

³²¹ Ibid, p. 26.

³²² Ibid, p. 29.

³²³ Ibid, p. 31.

partners.³²⁴ The same actors are expected to contribute to the financial framework of the policy.³²⁵

The National OVC Policy partially reflects the minimum core obligations that stem from the examined instruments in chapters II-V, by providing the goal of increasing access to and use of health services, safe water, sanitation, and housing. However, there might still be economic barriers to such access. The Policy was adopted in 2011 and we shall see, in chapter VII, if the advocacy for services to be free of charge, and food aid, for OVCs has had an impact on the children interviewed in this thesis. The National OVC Policy fails to address some of the minimum core obligations, such as the principle of non-discrimination.

6.3.2 The Second National Health Policy

The Second National Health Policy was adopted in 2010 with the mission of providing ‘the highest possible level of health services to all people in Uganda through delivery of promotive, preventive, curative, palliative and rehabilitative health services at all levels’ and with the goal to ‘attain a good standard of health for all people in Uganda in order to promote healthy and productive lives’.³²⁶ The heading of social values describes the policy to have a client centred approach and that equity, meaning equal access to health services for those with the same health conditions, shall be ensured by the government.³²⁷ The government is also to ‘explore alternative, equitable and sustainable options for health financing’ and how to target vulnerable groups.³²⁸

The policy contains seven objectives, of which one is to ‘improve access to quality hospital services at all levels in both the public and private sectors’.³²⁹ This objective goes very much in line with one of the minimum core obligations stemming from the examined instruments. However, the strategies outlined to reach this objective are not very elaborate and does not address the barriers or obstacles that the Ugandan people might face when trying to access health care. Rather, the focus is on making hospitals semi-autonomous and to strengthen

³²⁴ Ibid, pp. 40-42.

³²⁵ Ibid, p. 46.

³²⁶ The Republic of Uganda, Ministry of Health, ‘The Second National Health Policy: Promoting People’s Health to Enhance Socio-Economic Development’, July 2010, http://www.unicef.org/uganda/The_Second_National_Health_Policy.pdf, last consulted 4 June, p. 11.

³²⁷ Ibid, p. 11.

³²⁸ Ibid, p. 13.

³²⁹ Ibid, p. 16.

management capacity, lower level facilities, the national referral system and the development of specialised hospitals.³³⁰

Another objective is the minimum health care package.³³¹ The aim of the package is to ensure free access to a number of health services that are affordable to the government.³³² The package consist of four clusters:

- (a) Health promotion, environmental health, disease prevention and community health initiatives, including epidemic and disaster preparedness and response (b) Maternal and Child Health; (c) Prevention, management and control of communicable diseases (d) Prevention, management and control of non-communicable diseases.³³³

In ensuring equal access to the minimum health package, affirmative action for, *inter alia*, vulnerable people is allowed.³³⁴ The goal is to ensure universal access to the package, especially for vulnerable people. It is then stated that, in order to realise this objective and goal, the government of Uganda shall prioritise interventions that are ‘effective, cost effective and affordable’, to ensure that the Ugandan people understand their right to health, to work on making people aware of health issues so as to bring about change in attitudes and behaviours, as well as strengthening both self-care and community health services.³³⁵

It is not clear whether the cluster on child health would apply to children in street situations, or at least not all of them. The policy neither defines nor outlines what child health would entail. However, the Health Sector Development Plan, which will be examined in the next section, defines child health to concern those children that are aged 29 days up until 5 years.³³⁶ One might assume that, since both the Second National Health Policy and the Health Sector Development Plan originate from the Ministry of Health, the same definition applies.

³³⁰ Ibid.

³³¹ Ibid.

³³² Ssenkooba, 2004, p. 1.

³³³ The Republic of Uganda, Ministry of Health, ‘The Second National Health Policy: Promoting People’s Health to Enhance Socio-Economic Development’, July 2010, http://www.unicef.org/uganda/The_Second_National_Health_Policy.pdf, last consulted 4 June, p. 16.

³³⁴ Ibid, p. 17.

³³⁵ Ibid, pp. 17-18.

³³⁶ The Republic of Uganda, Ministry of Health, ‘Health Sector Development Plan 2015/16 - 2019/20’, September 2015, <http://www.health.go.ug/download/file/fid/834>, last consulted 4 June 2016, p. 52.

6.3.3 Health Sector Development Plan 2015/16 - 2019/20

The Health Sector Development Plan was adopted in 2015 and will run for five years with the overarching goal of accelerating the ‘movement towards Universal Health Coverage (UHC) with essential health and related services needed for promotion of a healthy and productive life’.³³⁷ The ultimate goal of the UHC is to ‘ensure that all people receive essential and good quality health services they need without suffering financial hardship’.³³⁸

The Health Sector Development Plan has four specific objectives: (1) ‘to contribute to the production of a healthy human capital for wealth creation’; (2) ‘to address the key determinants of health’; (3) ‘to increase financial risk protection of households’, and (4) ‘to enhance health sector competitiveness in the region and globally’.³³⁹

The interventions relating to the first objective, and that are relevant for the purpose and scope of this thesis, are to establish ‘friendly corners at all levels of care’, to ensure that girls of a certain age are vaccinated against the Human Papilloma Virus, and to promote good nutrition and reproductive health in educational programs.³⁴⁰ An important question in this respect is how these interventions would reach children in street situations as they often do not attend any educational programs. The second objective aims at addressing socioeconomic factors that contribute to a healthy life, such as safe water, food, pollution and housing. However, none of the key interventions are aimed at actual access or provision, but rather the focus is on creating awareness among the population. The third objective focuses on making the financial processes of the health organisation efficient and transparent, rather than how to address economic barriers to access to health.³⁴¹ Finally, the last objective refers to competitiveness both in the region and globally, and is thus not relevant for the purpose of this thesis.³⁴²

Although the Health Sector Development Plan serves an important purpose and has ambitious goals, it is hard to see how it mainstreams the obligations stemming from the instruments examined in this thesis with regard to primary health care. The two first objectives can be important tools in ensuring the right to health for children in street situations, but the way the

³³⁷ Ibid, p. xiv.

³³⁸ Ibid.

³³⁹ Ibid, pp. 52, 57, 58, 60.

³⁴⁰ Ibid, p. 53.

³⁴¹ Ibid, pp. 57-58.

³⁴² Ibid, p. 60.

interventions are formulated it is hard to discern how they would ensure and implement at least the minimum core obligations.

6.4 Conclusion

Despite ratifying the four instruments examined in this thesis, which all provide a right to health, neither the Ugandan Constitution, nor the Children Act, or other legislative acts, contain explicit provisions that incorporate the right to health in domestic law. This is a specific requirement set out in all of the instruments examined, and thus Uganda is currently not fulfilling that obligation as a state party.

Uganda should, explicitly, recognise the right to health in its Constitution, and give effect to the right through other legislative acts. Merely addressing the right to health through political objectives and policies are not sufficient.³⁴³

In addition, the policies examined are inadequately or poorly reflecting the obligations that are connected to ensuring primary health care that should be mainstreamed in coherence with the ratified instruments. In addition, these policies are not legally binding, but are merely reflecting political obligations.

PART FOUR – THE FRAMEWORK IN PRACTICE

The aim of this section is to allow the voices of the right holders themselves to be heard. The previous chapters have shown what state obligations there are under international human rights law and to what extent these obligations have been implemented in Uganda. This section aims at answering the third, and final, research question and thus displaying, through empirical research, what impact this framework has on the lives of some of the right holders.

7 The Right to Health for Children in Street Situations in Uganda

7.1 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 if there are] discriminatory barriers to accessing services'.³⁴⁴ Article 3 of the CRC stipulates that 'the best interests of the child shall

³⁴³ Mubangizi & Twinomugisha, 2010, p. 134.

³⁴⁴ CRC/C/GC/12, 'General Comment No. 12 (2009) The right of the child to be heard', Committee on the Rights of the Child, 20 July 2009, para. 104.

be a primary consideration'.³⁴⁵ 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 individual children'.³⁴⁶ The Committee has suggested that states are to have measures in place that give children the opportunity to 'contribute their views and experiences to the planning and programming of services for their health and development'.³⁴⁷

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 written'.³⁴⁸ 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 with their families.³⁴⁹ Although this thesis agrees with this suggestion *in theory*, caution needs to be taken so that such rights or measures do not run the risk of poor parents encouraging their children to go live on the streets in order to be able to utilise such rights or measures.

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 care services need to be 'implemented in a manner that recognises children's special needs, circumstances and vulnerability'.³⁵⁰

7.2 Perspective of the Right Holders

The methodology of this chapter was elaborated on in chapter I of this thesis. Forty-one children in street situations were interviewed: three girls and thirty-eight boys. Most of the children were between 15-18 years of age,³⁵¹ and the youngest child was six 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 Uganda. For one child, it was not possible to determine his age. Some children had only been on the streets for one or two weeks, while others had been on the streets for fourteen years. Most children had been on the streets for 4-14 years. When the question of how long he had been on the streets was posed to Natukondo, ten years old, he

³⁴⁵ CRC, art. 3.

³⁴⁶ Vandenhole, Desmet, Reynert & Lembrechts (eds.), 2015, p. 219.

³⁴⁷ CRC/C/GC/12, 20 July 2009, para. 104.

³⁴⁸ Fottrell (ed.), 2000, p. 177.

³⁴⁹ Ibid.

³⁵⁰ Vandenhole, Desmet, Reynert & Lembrechts (eds.), 2015, p. 229.

³⁵¹ 25 children were in the age span of 15-18; 14 children were aged 10-14; and one child belonged to the group 5-10 years old.

responded: ‘I cannot remember that far back’. It turned out that he had spent half of his life on the streets.³⁵² 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.³⁵³ Four 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. One child sleeps in a small rented room during the night while working as a prostitute, and one child sleeps at his employer’s house.

All four instruments examined have emphasised the importance of addressing socioeconomic factors that contribute to a healthy life, such as housing, food, safe drinking water and sanitation. Most of the children sleep in public places. Some have permanent spots they go to every night, while others sleep anywhere. A larger group of children sleep ‘by the tires’, which is a stack of tires adjacent to a waste disposal site. 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, between sacks of charcoal, under trees and in bushes, in abandoned houses or on the verandas of different stores. Jonathan explained that he sniffs glue every night so that he will not feel the cold. ‘The glue is like my blanket’.³⁵⁴



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Some children work in order to be able to buy food, while others get food from well-wishers or friends and neighbours. Many children receive food from hotels or restaurants, but have to perform various duties in exchange for a meal. Tom gets food from a hotel, but in return he has to wash utensils, fetch water, start the cooking fires, and mop floors and furniture.³⁵⁵ This is a common situation for these children: being exploited due to their vulnerability. Natukondo normally looks for scrap early in the morning and then sells it in order to buy some food. Some days he cannot get enough and then he resorts to digging for leftovers from hotels.³⁵⁶

³⁵² Interview with ‘Natukondo’, Mbarara, Uganda, 5 April 2016.

³⁵³ See section 1.1.

³⁵⁴ Interview with ‘Jonathan’, Mbarara, Uganda, 6 April 2016.

³⁵⁵ Interview with ‘Tom’, Mbarara, Uganda, 5 April 2016.

³⁵⁶ Interview with ‘Natukondo’, Mbarara, Uganda, 2 April 2016.

Many children spend their days searching for food in the garbage and in containers, and some beg for food in the streets. Many of them expressed that they often go hungry as they cannot get enough money to buy food. Some of them chew *qat* to stay awake and dim the hunger, and others sniff glue so that their thoughts of



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food decrease. When asked how he gets food and drinking water, Demba responded: ‘It is pure luck. I clean garbage and collect peels of *matoke*³⁵⁷ to sell. Sometimes I am able to get food, and sometimes I am not. I do not take water, I sniff glue instead. It has been two days since I last had water. That was when it rained.’³⁵⁸ Most kids get water from different communal taps around town. However, it is not allowed to take that water, and it is neither clean nor boiled. Others drink rain water, buy bottled pot water or drink from the river *Katete*. One child gets his drinking water from the local sewage.³⁵⁹

Some children have friends that allow them to come by to wash up. Some use public bathrooms, where they pay 500 UGX in entrance fees.³⁶⁰ 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 *Katete*, which is located about 30 minutes’ walk from the city centre. However, the river is very rapid with strong currents, which has resulted in the deaths of several children.

Seventy-five per cent of the children had been sick or hurt within the six months prior to the interview. Many of them had been sick multiple times. Six of them had had malaria one or more



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times, one was infected by ringworms, one had caught skin infections, and some had been sick with the flu and/or colds. Many children complained of stomach pain after drinking rain water and headaches, likely resulting from glue addiction.

Some children experience pain in their backs and/or joints due to working conditions and carrying heavy objects during the day. One child twisted a knee when falling into a ditch and had troubles with a reoccurring swollen stomach. Many children had scars resulting from either cuts or falling out of trees. One child had been diagnosed with HIV. Two boys broke their legs, it was the second

³⁵⁷ Matoke is a green cooking banana.

³⁵⁸ Interview with ‘Demba’, Mbarara, Uganda, 2 April 2016.

³⁵⁹ This is a part of town where all of the urine, faeces and waste water is collected.

³⁶⁰ For the sake of comparison, it is the equivalent of about 0.14 US Dollars. (29 May 2016)

time for one of them, another child broke his wrist. 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 some teeth, and one was stabbed in the head by another boy. One boy was robbed of the money he had earned and got a 5 cm cut in the back of his head. Some children mentioned being cut by glass or broken bottles, and one boy got cut in the knee by a *panga*.³⁶¹ Two boys got into a fight while high on glue, which resulted in multiple cuts and stab wounds to the face, head and back.

Many children testify to severe police brutality and abuse, both mental and physical. One boy was, without provocation, shot with an arrow in the calf of his leg by a security guard. He ran away from the scene with the arrow still in his leg. Many children testify that police and/or security guards often are drunk while working, which increases the risk of the children being harmed. This type of abuse is often directed towards the older children. One boy was beaten by the police in an effort to convince him to leave the streets and go home. The same boy explained that: ‘Other people [in town] lie to the police and say that we have done bad things, like stealing, and then we are beaten by the police’.



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Stories were told, collaborated by different sources, about a boy who was wrongfully accused of a crime and killed in mob justice, by being stoned to death. Other children told stories about being woken by the police in the middle of the night and getting beaten or receiving cuts to their heads. Demba shrugged his shoulders and said: ‘Only God has protected us’.³⁶²

Out of the children that had been sick or hurt during the last six months, only 1/6 went to the hospital. Two of them were taken to the hospital while unconscious after being beaten or stabbed in the head. The price of 30 000 and 500 000 UGX³⁶³ respectively was paid by family members and ‘a compassionate stranger that saw the blood gushing from my head’.³⁶⁴ One of the boys said: ‘If my sisters had not paid – I would not have survived’.³⁶⁵ The others that went to the hospital were either street working children whose parents paid for their treatment or a

³⁶¹ A panga is a type of machete, a large hatchet-like knife.

³⁶² Interview with ‘Demba’, Mbarara, Uganda, 2 April 2016.

³⁶³ For the sake of comparison, it is the equivalent of about 8.9 – 148.5 US Dollars. (29 May 2016)

³⁶⁴ Interview with ‘Charles’, Mbarara, Uganda, 5 April 2016.

³⁶⁵ Interview with ‘Mugaba’, Mbarara, Uganda, 5 April 2016.

street living child that was lucky to receive treatment when he told the staff that he lived on the streets. This suggests that street working children enjoy the right to health to a higher degree compared to those children that belong in the category of street living children.

Some children went to local clinics and received band-aids, pain killers, or bandages. Some had to pay (5) and some were given it for free (7). In other cases, someone else paid (5). Children with different cuts could not get stitches without paying and therefore just received bandages to stop the bleeding. One child normally goes to a traditional doctor for smaller issues like headaches. He then receives pain killers in return for cleaning toilets.

A clear majority of the children neither went to a hospital or clinic nor received any treatment. One boy did not go because he believes he is resistant towards diseases, and it is very uncommon for his tribe to seek medical assistance. This was the only example of cultural barriers to accessing primary health care. 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 and bought either malaria pills or pain killers from the money they had earned. Others created their own cures by covering their wounds with grass, or mixing leaves and water to digest as a substitute for medicines.

One child explained that he used herbs because he fears to go to the hospital. He did not want to explain why he has those fears. A couple of children went to traditional doctors instead. In the words of Derrick, who broke his leg: 'I did not have the energy to walk there. No one could help me to get to the hospital, therefore I went to a traditional doctor.'³⁶⁶ A local NGO was contacted afterwards and was willing to pay for the treatment he had received, which amounted to 300 000 UGX.³⁶⁷ The child who has been infected with HIV cannot go and receive treatment due to costs associated with transportation. The HIV-treatment is free of charge, but there are other obstacles for the child to access the treatment. Ewan said: 'I cannot go anywhere. The hospital demands 15 000 UGX for pills and I do not have that'.³⁶⁸ Other children agreed and gave examples as to when they would have been obliged to pay sums ranging from 15 000 – 200 000 UGX,³⁶⁹ money that children in street situations simply do not have.



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³⁶⁶ Interview with 'Derrick', Mbarara, Uganda, 2 April 2016.

³⁶⁷ For the sake of comparison, it is the equivalent of about 89 US Dollars. (29 May 2016)

³⁶⁸ Interview with 'Ewan', Mbarara, Uganda, 2 April 2016.

³⁶⁹ For the sake of comparison, it is the equivalent of about 4.4 – 59.4 US Dollars. (29 May 2016)

These are some of the comments on the economic accessibility that the children gave: ‘I do not have enough money to get treatment for skin rashes’.³⁷⁰ ‘They just see us as thieves’.³⁷¹ ‘Even if I would go, I would not get help. I tried three times and was denied every time because I don’t have enough money’.³⁷² ‘I cannot get medicine [at the hospital or clinic] because I am not dressed well.’³⁷³

Only four of the children responded that it is possible to get health care treatment without money, but that only concerns pain killers. One child received treatment free of charge, but that was due to the fact that he knew some of the people that were working in the hospital. He explained that he does not expect to be able to go there again. One boy did not have to pay for treatment, but explained that it had been a one-time thing. ‘They told me they could only help me once – that they cannot keep helping. My friend got me to the clinic and I was only helped because I was unconscious.’³⁷⁴ The rest of the interviewed children explained that it is not possible to receive any treatment without money, and several children stressed the importance of having someone that can help you. 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 kids spend their day looking for scrap that they later sell to a scrap dealer. Some of the children can make 500 UGX per day, most of them make about 1000-2000 UGX, while some of the bigger boys can make up to 7000-10 000 UGX if they are lucky.³⁷⁵ A normal, cheap lunch, in a restaurant serving local food, costs about 4000-5000 UGX. It is possible to buy a *chapati* for only 500 UGX, but that will not provide all the nutrition needed.³⁷⁶

Jonathan, 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. I get 700 UGX per kilo, so I might get 8000 UGX in one day. That is enough. 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 when the police is beating me. 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’.

³⁷⁰ Interview with ‘Paul’, Mbarara, Uganda, 2 April 2016.

³⁷¹ Interview with ‘Mugaba’, Mbarara, Uganda, 5 April 2016.

³⁷² Interview with ‘Dan’, Mbarara, Uganda, 5 April 2016.

³⁷³ Interview with ‘Kamukama’, Mbarara, Uganda, 5 April 2016.

³⁷⁴ Interview with ‘Daniel’, Mbarara, Uganda, 4 April 2016.

³⁷⁵ It is the equivalent of about 0.14, 0.29-0.59 and 2.07-2.97 US Dollars. (30 May 2016)

³⁷⁶ A *chapati* is a type of bread often served with food. It resembles a soft tortilla bread.

Some children carry charcoal and get 1000 UGX for a day's work. Many children collect and remove garbage from private homes or hotels, some of them only receive 500 UGX in return. One young boy carries 10 jerry cans of water for someone and is paid 1000 UGX for it. The jerry cans weigh about 10-20 kilos each. Today he has shoulder and muscle pain resulting from that work.

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 earn 10 000 UGX after having 3-4 clients that often bargain. When she has paid the rent for the room she works in, she is left with 5000 UGX.³⁷⁷ Other children collect and sell peels of matoke, and some children do not have money at all since they cannot find any type of employment.

Lack of money is the main obstacle that hinder these children from accessing their right to primary health care. However, the children also face other difficulties. Victor explained that: 'You need to buy a book that you have to bring every time you go to the clinic. The book costs 600 UGX and I only make 700 UGX in one day.'³⁷⁸ A boy who had fallen off a bike stated that he needed to go to a local chairperson and receive a letter to present to the hospital. 'A friend took me there, without that friend I would not have received any treatment'. Some children mentioned that they need to bring id-cards in order to receive treatment, but that they do not have such documentation nor do they have the possibilities to obtain them. 'That is the fear I am living with. I do not have an id-card. I do not know what would happen if I get sick.'³⁷⁹

About half of the children have received some support and/or assistance during their time on the streets. A majority of them have been helped by a local NGO whose aim is to rehabilitate children in street situations and reunite them with their families, if possible, or place them in foster care. The NGO provides housing, clothes, drinking water, education, vocational training, counselling, and medical treatment when necessary. The children interviewed who have been part of this project have left it for different reasons. The main reason being that their drug addictions have been too strong and they have therefore not been able to cope and stay in the program.

³⁷⁷ Interview with 'Norah', Mbarara, Uganda, 4 April 2016.

The money she earns in one night is the equivalent of about 2.97 US Dollars. When rent is paid she is left with about 1.48 US Dollars. (30 May 2016)

³⁷⁸ Interview with 'Victor', Mbarara, Uganda, 5 April 2016.

³⁷⁹ Interview with 'Eric', Mbarara, Uganda, 2 April 2016.

Other children have been helped by private persons, such as friends and pastors of local churches. Some by being given shelter or handouts of food. A few children said that they had received help and assistance, but were actually referring to their mothers providing them with either food or clothes. 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 goats in exchange for money, but considered it help rather than employment. The same applies for a boy who was washing utensils for a hotel in exchange for some food. 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 president 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, [and if there are] discriminatory barriers to accessing services'.³⁸⁰

Many children responded that they think the government should provide health care and medicines free of charge for children in street situations, and that they should care for anyone who comes.

The government should eliminate the word street kids. We do not belong to the streets, we belong to families. The name gives us a bad image when we go to the hospital. ... The president is not the problem, but the political representatives from here do not shed light on the issues we face while being on the streets. ... Why is it that when we are sick, when we try to go to the hospital – why do they not care? Are we not human beings? That way, we have lost many friends from the street – because no one cares about us and our wellbeing. – 'Martin'

The government should make sure that hospital staff do not demand money from street children. They should make sure that the service delivery reaches everyone, and build free of charge hospitals. They should make sure that the police stop harming us. – 'Steven'

Our rights should be upheld and health care services should be for free. If I was the president, I would build a hospital only for street children. And I would set up vocational training. – 'Sadiki'

³⁸⁰ CRC/C/GC/12, 'General Comment No. 12 (2009) The right of the child to be heard', Committee on the Rights of the Child, 20 July 2009, para. 104.

In order to feel safe, they should care about us. I wish they would give medicine for free and build us shelters. – ‘Muhairwe’

There is no medicine in the hospital. They should change the way they are rendering the services and they should treat people equally. – ‘Sam’

Hospital staff should come and perform check-ups on us every month. They should care for us even if we do not have any money. – ‘Elliot’

They should treat us equally and there should be specialised services for us. – ‘Mugaba’

The government should help children in street situations without harassing them. – ‘Carl’

In order to feel safe, I wish the government would hire more doctors and nurses and that the police would not arrest us for being idle. I wish the government could get us jobs so that we could leave the streets. – ‘Dan’

The government should withdraw soldiers that are harassing us, soldiers that are hurting us. The hospital should care for me, because I am a Ugandan. – ‘Philip’

The government should take us to school. They should not chase us away from the hospital. They should treat us, because we are human. – ‘Kamukama’

At the end of the interviews, the children were asked what they are dreaming about and their faces lit up. 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 dream of becoming football players, others to become nurses, doctors, teachers, mechanics and engineers. One boy 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 ‘responsible man’.³⁸¹

These goals are not unreachable and the dreams are not unrealistic. It is possible to change the lives of children in street situations, but as Martin explained: ‘We are being treated badly and our voices have not been heard. Every time we try to make our voices heard, the government shut us down. ... There is no ambassador [for us].’³⁸²

It was suggested that the government should set up places for counselling and provide for job opportunities so that these children can lift themselves out of their situation in the streets.

If I was the president of Uganda, I would choose genuine people to be in the hospital. I would always come and make sure that they are doing their job well, monitor them. I would shut down private

³⁸¹ Interviews with children in street situations, Mbarara, Uganda, 2-6 April 2016.

³⁸² Interview with ‘Martin’, Mbarara, Uganda, 6 April 2016.

services so that services reach the poor. ... I would change the bosses regularly 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. ... I would give extra hours to doctors so that they could go and treat children on the streets. Hospital staff would move around the streets and find out how the kids are doing. They know who we are.

8 Conclusion

Some tens of millions of children around the world spend all or most of their time on the streets. These children belong to one of the most vulnerable groups in our society, and their human rights are often violated or not provided for. Many of these children have experienced violence, abuse, deprivation of food, housing and medical care, and have been subjected to discrimination and stigmatisation. This list could, sadly, go on. Ensuring the right to health for these children is essential, not only in itself but also because the enjoyment of the right to health is fundamental for the enjoyment of all other human rights.

This thesis endeavoured to examine the international and the Ugandan legal frameworks regarding the protection of the right to health for children in street situations, with a specific focus on access to primary health care. It also set out to examine what impact these frameworks have in real life for children in street situations in Mbarara, Uganda. A key strength of the present study was the combination of classic legal research through the black letter methodology, with empirical research through conducted interviews with the right holders themselves.

The generalisability of the results of this thesis is subject to certain limitations. For instance, the specific circumstances of children in street situations in the town of Mbarara cannot be used as a generalisation for children in street situations, neither across Uganda nor around the world. Notwithstanding these limitations, the study suggests that the findings of the research are illustrative of problems facing children in street situations with regards to their right to health and access to primary health care.

The main finding of this research is that it is clear that a majority of the children that took part in the interviews do not enjoy the right to health and access to primary health care as it is stipulated in the examined instruments.

The state obligations under international human rights law are quite similar if one compares the four instruments examined in this thesis. In regards of scope, they all provide that state parties

are to respect, protect and fulfil the right to health. According to its respective Committees, the ICESCR and the CRC both regard the right to health to consist of the four elements known as the AAAQ: availability, accessibility, acceptability and quality. The African Commission has provided, that for the ACHPR, a similar notion applies. The four elements of the right to health in the ACHPR are availability, adequacy, physical and economic accessibility and acceptability. The African Committee of Experts on the Rights and Welfare of the Child has not yet made clear if these four elements apply to the ACRWC as well.

All four instruments apply the notions of progressive realisation, maximum use of available resources and minimum core content. The state obligations stemming from the minimum core content are more or less common for all of the instruments examined. Some of these minimum core obligations are: the need to amend or implement legislation that is in conformity 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 non-discriminatory basis, especially for vulnerable or marginalized groups.

State parties have an obligation to recognise the right to health through legislative and other measures. This is a common obligation of all four of the examined instruments, and the African Committee of Experts on the Rights and Welfare of the Child, for instance, has stated that it is an obligation that does not depend upon the notion of progressive realisation. At the outset of this thesis one could have thought that the discussion would mainly concern how much can be required from a developing state when it comes to implementing the right to health. Thus the discussion would have mainly evolved around the notion of progressive realisation and the use of maximum available resources.

However, Uganda has not explicitly incorporated the right to health in neither the Constitution nor in any other legislative acts. The right to health is only part of the National Objectives and Directive Principles of State Policy of which the justiciability remains unclear. In addition, the policies examined do not fully, or they only poorly, reflect the obligations that are connected to ensuring primary health care that should be mainstreamed in coherence with the ratified instruments. In addition, these policies are not legally binding, but are merely reflecting political obligations. Therefore, the right to health should, explicitly, be incorporated in the Constitution and be given effect in other legislative acts too as merely addressing the right to health through political objectives and policies are not sufficient.

The notion of progressive realisation also includes that vulnerable and disadvantaged groups are to be prioritised. Consequently, children in street situations are among those who need to be prioritised in implementations that aim at the full realisation of the right to health. It was shown in chapter VII that only half of the children interviewed had received any help or assistance, such as food, shelter, medical care or water. However, none of these children have received any government assistance despite it forming part of the aims of the National Strategic Programme Plan of Interventions for Orphans and other Vulnerable Children. Thus it may be argued that these children, who belong to what the government themselves call critically vulnerable children, are not prioritised highly enough in government interventions.

Accordingly, the government of Uganda should step up its efforts in guaranteeing the right to health for children in street situations as there are gaps in their protection. This could be done by assigning a group of hospital staff to regularly perform check-ups on the local children that are living in different street situations, or to set up centres that provide a holistic approach in addressing the needs of these children and the root causes of why they end up on the streets, as well as assisting them in lifting themselves out of the situations they are in.

All of the instruments examined provide that the right to health shall be afforded to everyone within the jurisdiction of Uganda and on a non-discriminatory basis. The research in this thesis shows that this is not the case as the children do not have access to primary health care due to different barriers, of which the economic barrier is the most prominent, but also due to discrimination. The Committee on Economic, Social and Cultural Rights has provided that discrimination on 'other status' also encompasses a person's economic and social situation. This applies to children in street situations as they often are both homeless and live in poverty. Several children interviewed in this thesis gave examples of when they had tried to access primary health care but had been denied because of the circumstances they are in, and many gave stories of times when they had been exposed to stigmatisation and negative stereotyping. In light of this, the Government of Uganda should ensure *de facto* equal access to primary health care, perhaps by the use of affirmative action.

Discrimination is not the only barrier when these children try to access health care services: there are also cultural and economic barriers. The examined policies do not include how to address issues of economic, cultural and social barriers to equal access to health care services, although there is an obligation under international human rights law to do so. One child stated that he would not go to any medical clinic due to beliefs of his tribe, which is an example of a cultural barrier. A majority of the children, however, stated that they wanted medical attention

when they are sick or hurt, but that there is a *de facto* denial of primary health care services because they simply do not have the means to afford them or because they do not have a correct appearance.

The CRC imposes a principal duty on state parties to ensure that no child is deprived of access to primary health care, and consequently that state parties have to remove any barriers that hinder such access. For instance, the drafters of the CRC stated that lack of money should not prevent a child to access health care services. However, it is highly questionable whether the Committee on the Rights of the Child has maintained this approach – as it is not evident from the concluding observations of the last four years. In addition, the other instruments examined also provide that barriers to accessing primary health care should be removed, but it is rarely made clear how and to what extent that should be done. The compliance mechanisms often highlight the importance of affordability of both health care services and affordability of safe and potable water. This raises the question of what affordability is, how it is defined and where the line should be drawn. The examination of the practice of the compliance mechanisms has not been satisfactory to this end. On those occasions when these issues were addressed, it was only mentioned in a few concluding observations, which makes it difficult to draw any clear conclusion. Moreover, these findings must be interpreted with caution and cannot be extrapolated to all countries as the practice of the compliance mechanisms are not consistent.

Following this, one of the main conclusions of this thesis is that the different compliance mechanisms should adopt General Comments with a specific focus on children in street situations, so that their rights can be effectively upheld and protected. The examination of the concluding observations of the different compliance mechanisms show that the practice of addressing these children's right to health is either lacking, insufficient or inconsistent. There is a need for the compliance mechanisms to clearly outline what state parties have to do in order to respect, protect and fulfil the human rights of children in street situations. One concrete example is that there is a need to develop and provide authoritative interpretation on how and through which measures barriers in accessing primary health care should be removed. However, the need to adopt General Comments does not only regard the right to health, the topic of this thesis, but it regards all human rights. 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 with their families. Therefore, the compliance mechanisms should adopt general comments that provide authoritative interpretation of the different legal instruments on how to best protect these children.

The right to health for children in street situations in Mbarara is mainly an illusion. Some children have or have had access to primary 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 an illusion at the moment, there is nothing to say that this cannot change and become a reality for all of the children that live in different street situations in Uganda. 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.

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E/C.12/BIH/CO/2, '*Concluding observations on the second periodic report of Bosnia and Herzegovina*', Committee on Economic, Social and Cultural Rights, 16 December 2013.

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E/C.12/DJI/CO/1-2, '*Concluding observations on the initial and second periodic reports of Djibouti*', Committee on Economic, Social and Cultural Rights, 30 December 2013.

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E/C.12/CHN/CO/2, *'Concluding observations on the second periodic report of China, including Hong Kong, China, and Macao, China'*, Committee on Economic, Social and Cultural Rights, 16 July 2014.

E/C.12/CZE/CO/2, *'Concluding observations on the second periodic report of the Czech Republic'*, Committee on Economic, Social and Cultural Rights, 23 June 2014.

E/C.12/SLV/CO/3-5, *'Concluding observations on the combined third, fourth and fifth periodic reports of El Salvador'*, Committee on Economic, Social and Cultural Rights, 19 June 2014.

E/C.12/FIN/CO/6, *'Concluding observations on the sixth periodic report of Finland'*, Committee on Economic, Social and Cultural Rights, 17 December 2014.

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E/C.12/IDN/CO/1, *'Concluding observations on the initial report of Indonesia'*, Committee on Economic, Social and Cultural Rights, 19 June 2014.

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E/C.12/MNE/CO/1, *'Concluding observations on the initial report of Montenegro'*, Committee on Economic, Social and Cultural Rights, 15 December 2014.

E/C.12/NPL/CO/3, *'Concluding observations on the third periodic report of Nepal'*, Committee on Economic, Social and Cultural Rights, 12 December 2014.

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E/C.12/ROU/CO/3-5, *'Concluding observations on the combined third to fifth periodic reports of Romania'*, Committee on Economic, Social and Cultural Rights, 9 December 2014.

E/C.12/SRB/CO/2, *'Concluding observations on the second periodic report of Serbia'*, Committee on Economic, Social and Cultural Rights, 10 July 2014.

E/C.12/SVN/CO/2, *'Concluding observations on the second periodic report of Slovenia'*, Committee on Economic, Social and Cultural Rights, 15 December 2014.

E/C.12/UKR/CO/6, *'Concluding observations on the sixth periodic report of Ukraine'*, Committee on Economic, Social and Cultural Rights, 13 June 2014.

E/C.12/UZB/CO/2, *'Concluding observations on the second periodic report of Uzbekistan'*, Committee on Economic, Social and Cultural Rights, 13 June 2014.

E/C.12/VNM/CO/2-4, *'Concluding observations on the second to fourth periodic reports of Viet Nam'*, Committee on Economic, Social and Cultural Rights, 15 December 2014.

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E/C.12/GMB/CO/1, *'Concluding observations on the initial report of the Gambia'*, Committee on Economic, Social and Cultural Rights, 20 March 2015.

E/C.12/GRC/CO/2, *'Concluding observations on the second periodic report of Greece'*, Committee on Economic, Social and Cultural Rights, 27 October 2015.

E/C.12/GUY/CO/2-4, *'Concluding observations on the combined second to fourth periodic reports of Guyana'*, Committee on Economic, Social and Cultural Rights, 28 October 2015.

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E/C.12/ITA/CO/5, *'Concluding observations on the fifth periodic report of Italy'*, Committee on Economic, Social and Cultural Rights, 28 October 2015.

E/C.12/MAR/CO/4, *'Concluding observations on the fourth periodic report of Morocco'*, Committee on Economic, Social and Cultural Rights, 22 October 2015.

E/C.12/PRY/CO/4, *'Concluding observations on the fourth periodic report of Paraguay'*, Committee on Economic, Social and Cultural Rights, 20 March 2015.

E/C.12/SDN/CO/2, *'Concluding observations on the second periodic report of the Sudan'*, Committee on Economic, Social and Cultural Rights, 27 October 2015.

E/C.12/TJK/CO/2-3, *'Concluding observations on the combined second and third periodic reports of Tajikistan'*, Committee on Economic, Social and Cultural Rights, 25 March 2015.

Annex I – Questionnaire for Data Collection

Interview No.	Name:
Date:	Location:

Information prior to the interview

- Introduce yourself and explain why you are in Uganda.
- 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

- 5-9
- 10-14
- 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 in the past 6 months?

Yes

No (continue with question 9)

8.1 How many times have you been sick or been hurt in the past 6 months?

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

8.3 Where did you go for help/treatment?

- Hospital
- Clinic
- NGO
- 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 need to do to get treatment? (E.g walking distance, registering etc.)

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

9. What would you do if you fell ill or got hurt? Where would you go?

Hospital

Clinic

NGO

Would not go anywhere

Other: _____

Comment:

9.1 Would you have to pay for treatment?

Yes

No

9.2 What do you do to get money?

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

- Yes
- No
- Do not know

Comments: _____

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
- Health care treatment
- Medicines
- Other: _____
- N/A

10.2 Who provided the assistance?

- Government (public sector)
- NGO
- Other: _____
- N/A

[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. (Avoid potential harm) Make sure you allow time 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 you talked about with no time to adjust to the here and now.]

Annex II - Full References of Concluding Observations of the CRC and the ICESCR

The CRC

1. 17 of the COs were silent on normative content on access to primary health care.
Andorra, 2012; Austria 2012; Bosnia and Herzegovina, 2012; Canada, 2012; Cook Islands, 2012; Cyprus, 2012; Iceland 2012; Madagascar 2012; Seychelles, 2012; Turkey, 2012; Luxembourg, 2013; Malta, 2013; Holy See, 2014; Saint Lucia, 2014; Mauritius, 2015; Turkmenistan, 2015; United Arab Emirates, 2015.

2. 30 of the COs did not explicitly mention children in street situations.
Australia, 2012; Austria 2012; Canada, 2012; Cook Islands, 2012; Cyprus, 2012; Iceland 2012; Madagascar 2012; Republic of Korea, 2012; Seychelles, 2012; China, 2013; Guinea-Bissau, 2013; Guyana, 2013; Lithuania, 2013; Luxembourg, 2013; Malta, 2013; Monaco, 2013; Slovenia, 2013; Tuvalu, 2013; Croatia, 2014; Germany, 2014; Holy See, 2014; Hungary, 2014; Kyrgyzstan, 2014; Portugal, 2014; Saint Lucia, 2014; Yemen, 2014; Sweden, 2015; Switzerland, 2015; Turkmenistan, 2015; United Arab Emirates, 2015.

3. The Committee often has a specific section devoted to these children, but sometimes fail to address the issue of health in these recommendations.
Algeria, 2012, para. 73-74; Bosnia and Herzegovina, 2012, para. 71; Namibia, 2012, para. 70; Albania, 2013, para. 19; Guinea, 2013, para. 82; Kuwait, 2013, para. 73; Sao Tome and Principe, 2013, para. 59; Iraq, 2015, para. 83; Mauritius, 2015, para. 68; Poland, 2015, para. 49.

4. The most recurring recommendations are that these children shall be provided with necessary protection and adequate health-care services.
Azerbaijan, 2012, para. 72; Myanmar, 2012, para. 88(c); Syrian Arab Republic, 2012, para. 79; India, 2014, para. 84; Bangladesh, 2015, para. 77; Togo, 2012, para. 68; Fiji,

2014, para. 68; Indonesia, 2014, para. 74; Venezuela, 2014, para. 73; Colombia, 2015, para. 62; Jamaica, 2015, para. 61; Tanzania, 2015, para. 69.

5. Some COs add nutrition and shelter to this list. (*referring to para. 4 above*)

Togo, 2012, para. 68; Fiji, 2014, para. 68; Indonesia, 2014, para. 74; Venezuela, 2014, para. 73; Colombia, 2015, para. 62; Jamaica, 2015, para. 61; Tanzania, 2015, para. 69.

6. The main finding, and addressed in more than half of the COs, is that the Committee urges state parties to ensure that all children have equal access to, and quality of, primary health care.

Albania, 2012, para. 60; Algeria, 2012, para. 58; Australia, 2012, para. 60; Azerbaijan, 2012, para. 59; Liberia, 2012, para. 64; Namibia, 2012, para. 54; Syrian Arab Republic, 2012, para. 64; Togo, 2012, para. 54; Viet Nam, 2012, para. 58; Albania, 2013, para. 38; China, 2013, para. 63; Guinea, 2013, para. 66; Guinea-Bissau, 2013, para. 53; Guyana, 2013, para. 48; Kuwait, 2013, para. 58; Monaco, 2013, para. 38; Slovenia, 2013, para. 53; Tuvalu, 2013, para. 50; Congo, 2014, para. 59; Croatia, 2014, para. 45; Fiji, 2014, para. 42; Germany, 2014, para. 57; Hungary, 2014, para. 47; India, 2014, para. 64; Indonesia, 2014, para. 48; Jordan, 2014, para. 44; Kyrgyzstan, 2014, para. 48; Morocco, 2014, para. 55; Russian Federation, 2014, para. 52; Brazil, 2015, para. 54; Chile, 2015, para. 59; Colombia, 2015, para. 40; Gambia, 2015, para. 61; Jamaica, 2015, para. 45; Poland, 2015, para. 37; Switzerland, 2015, para. 57; Timor-Leste, 2015, para. 47; Uruguay, 2015, para. 46.

7. Many countries were encouraged to make sure that there are sufficient allocations of financial and human resources to the health sector.

Albania, 2012, para. 60; Algeria, 2012, para. 58; Guinea-Bissau, 2013, para. 53; Lithuania, 2013, para. 40; Sao Tome and Principe, 2013, para. 47; Uzbekistan, 2013, para. 52; Congo, 2014, para. 59; Croatia, 2014, para. 45; Indonesia, 2014, para. 48; Morocco, 2014, para. 55; Venezuela, 2014, para. 53; Yemen, 2014, para. 56; Bangladesh, 2015, para. 55; Dominican Republic, 2015, para. 50; Gambia, 2015, para.

61; Iraq, 2015, para. 61; Sweden, 2015, para. 42; Tanzania, 2015, para. 55; Timor-Leste, 2015, para. 47.

The ICESCR

8. 45 of the 58 COs did not explicitly mention children in street situations.

Cameroon, 2012; Ecuador, 2012; Equatorial Guinea, 2012; Iceland, 2012; New Zealand, 2012; Slovakia, 2012; Spain, 2012; Austria, 2012; Azerbaijan, 2013; Belarus, 2013; Bosnia and Herzegovina, 2013; Congo, 2013; Denmark, 2013; Egypt, 2013; Gabon, 2013; Jamaica, 2013; Japan, 2013; Kuwait, 2013; Norway, 2013; Rwanda, 2013; Togo, 2013; Armenia, 2014; China, 2014; Czech Republic, 2014; Finland, 2014; Guatemala, 2014; Indonesia, 2014; Lithuania, 2014; Monaco, 2014; Montenegro, 2014; Nepal, 2014; Portugal, 2014; Romania, 2014; Slovenia, 2014; Ukraine, 2014; Uzbekistan, 2014; Viet Nam, 2014; Burundi, 2015; Greece, 2015; Guyana, 2015; Italy, 2015; Morocco, 2015; Paraguay, 2015; Sudan, 2015; Tajikistan, 2015.

9. The most frequent recommendation made was the need to ensure access to health services for everyone.

Iceland, 2012, para. 17; Azerbaijan, 2013, para. 16; Bosnia and Herzegovina, 2013, paras. 10, 32; Denmark, 2013, para. 18; Egypt, 2013, para. 21; New Zealand, 2012, para. 24; Spain, 2012, para. 19; Norway, 2013, paras. 17, 21; Rwanda, 2013, para. 25; El Salvador, 2014, para. 21; Finland, 2014, para. 27; Guatemala, 2014, para. 22; Montenegro, 2014, para. 23; Serbia, 2014, para. 33; Slovenia, 2014, para. 24; Greece, 2015, para. 36; Italy, 2015, para. 47; Sudan, 2015, para. 52.

10. Ensuring sufficient human and/or financial resources

Albania, 2013, para. 32; Austria, 2013, para. 21; Djibouti, 2013, para. 30; Egypt, 2013, para. 21; Gabon, 2013, para. 28; Togo, 2013, para. 10; China, 2014, para. 33; El Salvador, 2014, para. 21; Guatemala, 2014, para. 22; Lithuania, 2014, para. 21; Montenegro, 2014, para. 23; Romania, 2014, para. 21; Serbia, 2014, para. 33; Ukraine, 2014, para. 19; Burundi, 2015, para. 52; Gambia, 2015, para. 27; Greece, 2015, para. 36; Iraq, 2015, para. 54; Paraguay, 2015, para. 28; Tajikistan, 2015, para. 30.