UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

A CRITICAL ANALYSIS OF THE POVERTY REDUCTION STRATEGIES AND THE RIGHT TO HEALTH FOR PEOPLE LIVING WITH HIV AND AIDS IN RWANDA

BY

WILLIAM NDENGEYINKA

STUDENT NUMBER 13225023

SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE MASTERS IN INTERNATIONAL HUMAN RIGHTS LAW AND HIV IN AFRICA

CENTRE FOR HUMAN RIGHTS

FACALTY OF LAW, UNIVERSITY OF PRETORIA

PREPARED UNDER THE SUPERVISION OF DR. CHARLES NGWENA

OCTOBER 2013

DECLARATION

I hereby declare that this dissertation, which I submit for the Master of Laws (LLM) degree at the University of Pretoria, is my own work and has not previously been submitted by me for a degree at another university. Both primary and secondary sources used have been duly acknowledged.

..... **.....**

WILLIAM NDENGEYINKA **Date**

ACKNOWLEDGEMENTS

First and foremost I would like to thank the Almighty God who helped me along the journey from the beginning up to the end.

I wish to acknowledge the much work put into this research by my supervisor, Dr. Charles Ngwena. His guidance, helpful suggestions and critical review of the manuscript made this work what it is.

I wish also to thank the HRDI family from Pretoria. Your financial support, advices, love, kindness and many other help you provided have made this work possible.

I appreciate the support provided by my colleagues whom we work together for the Great Lakes Initiative for Human Rights and Development (GLIHD). Many thank to Tom Mulisa, Vestine Umulisa, Steven Salim Gatari and Mr Mugenzi Asman.

My appreciations also go to my beloved family. My parents, brothers, sisters and all other family members without distinction who comforted and prayed for me when it was needed.

Also many people helped in writing this dissertation. I owe a particular dept to Tom Mulisa who guided me through out the whole programme. You have been close to me. Thank you. I thank Vedaste Bahati and his family who remained close to me both in times of sorrow and joy which alternated during this year. I also humbly say thanks to Dr. Adem from the centre for human right at the University of Pretoria who rescued me by helping in proofreading the second draft after my first draft work got lost due to the computer problems. You brought hope back to my heart. Last but not least, special thanks go to Landilani Banda for your considerable help. Your commitment in helping people will remain a souvenir in my heart.

THANK YOU!

ABBREVIATIONS AND ACRONYMS

ACHPR: African Charter on Human and Peoples' Rights

AIDS: Acquired Immune Deficiency Syndrome

ARV: Anti-retroviral

CCIs: Cross-Cutting Issues

CEDAW: Convention on the Elimination of All Forms of Discrimination against Women

CERD: Convention on the Elimination of All Forms of Racial Discrimination

CESCR: Covenant on Economic, Social and Cultural Rights

CRC: Convention on the Rights of the Child

EDPRS: Economic Development and Poverty Reduction Strategy

EICV: *Enquête Intégrale sur les Conditions de Vie des Ménages*

ESCR: Economic, Social and Cultural Rights

GoR: Government of Rwanda

HIV: Human Immunodeficiency Virus

IMF: International Monetary Fund

MINECOFIN: Ministry of Finance and Economic Planning

MLG: Ministry of Local Government

MoH: Ministry of Health

NCDs: Non-Communicable Diseases

OHCHR: Office of the High Commissioner for Human Rights

PLHIV: People Living with HIV

PRSP: Poverty Reduction Strategy Paper

RBA: Rights-Based Approach

RDHS: Rwanda Demographic and Health Survey

SAP: Structural Adjustment Programme

UDHR: Universal Declaration of the Human Rights

UN: United Nations

WB: World Bank

WHO: World Health Organisation

CONTENTS

CHAPTER ONE

1. BACKGROUND TO THE STUDY

Rwanda is a small, landlocked country in East Africa, bordering Burundi in the South, the Democratic Republic of Congo in the West, Tanzania in the East, and Uganda in the North.[1] The geographical location of Rwanda serves to lay a foundation for an understanding of the political economy of a landlocked country. Being landlocked, Rwanda needs to address poverty through trade with the neighbouring states and sustain its budget with local production and donor support.

The 1994 Genocide against Tutsi destroyed Rwanda's economic fabric and impoverished its population. Genocide did not only destroy the lives of the people but also property. While discussing the poverty levels in Rwanda, it is quite important to understand the socio-economic context and its genesis.

Forty per cent of the population in Rwanda lived in extreme poverty in the year 2000/2001.[2] Poverty levels fell to 36 per cent in year 2005/06 and 24 per cent in 2010/2011.[3] These statistics inform this research on whether the policies and methods employed in reducing poverty levels are inclusive enough to incorporate the most vulnerable especially people living with HIV and AIDS.

Rwanda is administratively divided into five provinces namely Northern Province, Southern Province, Eastern and Western Province and also the Kigali City.[4] The statistics show that levels of poverty vary from one province to another and from one period to another. Currently, three

---

[1] http://data.un.org/CountryProfile.aspx?crName=RWANDA (accessed 27 June 2013).
[2] The Rwandan Ministry of Finance and Economic Planning (MINECOFIN) 'The Third Integrated Household Living Conditions Survey (EICV3)' 2010-2011. http://www.minecofin.gov.rw (accessed 12 November 2012).
[3] As above (n 2).
[4] http://www.minaloc.gov.rw/index.php?id=492 (accessed 8 June 2013).

surveys have been done. The first was done in 2000/01, the second in 2005/06 and the third in 2010/11.[5]

The third integrated household living conditions and health survey (EICV3) has indicated a correlation between poverty level distribution with urban and rural settings.[6] The findings have indicated that the incidence of poverty is higher in urban areas than in rural areas. It is 22.1 per cent and 48.6 per cent in urban and rural areas respectively according to the 2010/11 survey.[7] The Urban capital city has lower levels of poverty compared to rural settings.[8]

It is quite important to relate the poverty levels and situation of people living with HIV and AIDS in Rwanda. During the genocide, systematic and planned rapes were used as integral tools of the genocide.[9] The Genocide of 1994 left more than 67 per cent of women who were raped infected with HIV.[10] It accelerated HIV transmission through sexual violence and rape. As a result, survivors of rape have been living under poverty, homelessness, and widowhood. This situation coupled with social exclusion and stigmatisation has rendered survivors of rape living with HIV vulnerable to poverty.

Some baseline statistics on HIV and AIDS conditions during the period under review depict that there has been essentially no change in Rwanda's

---

[5] MINECOFIN (n 2 above) 4.
[6] MINECOFIN (n 2 above) 5.
[7] As above.
[8] See results of surveys show that the poverty level was 22.7 per cent in 2000/01, 20.6 per cent in 2005/06 and 16.8 per cent in 2010/11 in the Kigali City. In the Southern Province results were 65.5 per cent, 66.7 per cent and 56.5 per cent respectively. In the Western Province results were 62.3 per cent, 60.4 per cent and 48.4 per cent respectively. In the Northern Province the results were 64.2 per cent, 60.5 per cent and 42.8 per cent respectively. In the Eastern Province the figures were 59.3 per cent, 52.1 per cent and 42.6 per cent respectively.
[9] P Akhavan 'The crime of genocide in the ICTR jurisprudence' (2005) 3 *Journal of International Criminal Justice* 989 http://jicj.oxfordjournals.org/content/3/4/989.abstract (accessed 27 June 3012); International Criminal Tribunal for Rwanda (ICTR), 'Jean Paul Akayesu Summary of the Judgement.' http://www.uniurb.it/scipol/pretelli/9%20Akayesu.pdf (accessed 18 November 2012).
[10] http://survivors-fund.org.uk/resources/rwandan-history/statistics/ (accessed 18 November 1012).

HIV prevalence since 2005.[11] According to the 2010 Rwanda Demographic and Health Survey (RDHS), HIV prevalence is 3.0 per cent for women and men aged 15–49, compared with 3.0 per cent in the 2005 RDHS.

Differences in numbers of infected people can be seen between male and female persons and between people in urban areas and in rural areas. The statistics show that the prevalence is 3.7 per cent for women, whereas it is 2.2 per cent for men.[12] HIV prevalence is three times as high in urban areas (7.1 per cent) than in rural areas (2.3 per cent). Kigali city has the highest HIV prevalence, where 7.3 per cent of adults aged 15–49 are HIV-positive. HIV estimates vary by age, with HIV prevalence highest among women aged 35–39 and men aged 40–44.[13] HIV prevalence is fairly uniform throughout the rest of Rwanda and ranges from 2.1 per cent to 2.5 per cent.[14]

The above statistics inform the statement of the problem of this research paper. The high level of poverty in Rwanda's rural settings and high level of infections among women present issues of both policy and legal considerations for Rwanda. The problem statement below interrogates the interconnections between poverty, HIV and AIDS and health.

1.2. Problem Statement

The 2010 Rwanda Demographic and Health Survey (RDHS) has shown that HIV prevalence was 3.0 per cent among people aged 15-49, and that 24 per cent of Rwandans were living in extreme poverty.[15]

It has been also argued that:

> Ill-health destroys livelihood, reduces worker productivity, lowers educational achievement, and limits opportunities—all of which can contribute to poverty. Conversely, poverty can diminish people's access to medical care, increase exposure

[11] Rwanda Demographic and Health Survey (RDHS), (2010) http://www.statistics.gov.rw/publications/demographic-and-health-survey-2010-final-report (accessed 27 June 2013).
[12] As above.
[13] RDHS (11 above) xxv.
[14] RDHS (as above)
[15] RDHS (n 11 above) xxv.

> to environmental risks, contribute to worst form of child labour, and cause malnutrition—all of which can predispose to ill-heath.[16]

This is a constant reminder that poverty, HIV and AIDS and health are interconnected and dwell in a similar environment. Those who are ill and sick cannot produce. In the long run, they cannot afford the basic essential medicines for treatment and cure.

In 2007, thirteen years after the 1994 Tutsi genocide, Rwanda put in place an Economic Development and Poverty reduction strategy (EDPRS 1) that was intended to cover the period from 2008 to 2013.[17] The Government's focus was in three major areas based on the country's priorities which were: Sustainable growth for jobs and exports, vision 2020 *Umurenge,*[18] and Good Governance.[19] This programme of EDPRS 1 is quite relevant to this research because there is need to evaluate the tools and mechanisms used by the Government of Rwanda (GoR) in approaching both poverty and health issues with emphasis to HIV and AIDS within the rural and poor populations in Rwanda.

On 7th February 2013, a second phase of EPDRS 2 was launched to complete the vision and intended objectives of EDPRS 1.[20] EDPRS 1 offered a vision of where Rwanda could be in 2012 and the role of the flagship programmes.[21] It also addressed the challenges of implementing the strategy, the monitoring and Evaluation. The analysis of this poverty reduction strategy is that it has been articulated in terms of human needs or just for development requirements. It can be deduced from the above

---

[16] P Hunt 'The UN Special Rapporteur on the Right to Heath: Key objectives, themes, and interventions' (2003-2004) 7 *Health and Human Rights* 1.
[17] Stated by James Musoni the former Rwandan Minister of Finance and Economic Planning in his forward of the newly adopted Economic Development and Poverty Reduction Strategy Paper which was implemented from 2008-2011.
[18] *Umurenge* means Sector which is one of Rwanda's administrative entities just below the district and this vision aims at an integrated rural development programme to eradicate extreme poverty and release the productive capacities of the poor.
[19] Rwandan Economic Development and Poverty Reduction Strategy (2008-2012).
[20] President of the Republic of Rwanda launched EDPRS 2 on 17th February 2013.
[21] They are means to prioritise actions by the Government of Rwanda (GoR), mobilise resources for development and improve policy implementation through more coordinated interventions across sectors (EDPRS1).

that EDPRS 1 was framed under the model of a needs based approach or rather a traditional development perspective.

Based on evaluating both EDPRS 1 and EDPRS 2 and analysing to what extent they provide for not only the poor but also those living with HIV and AIDS, this study seeks to pose some fundamental questions as indicated below.

1.3. Research Questions

The following main questions guide this study:

1. Is there a link between poverty and HIV and AIDS?
   a) What is a link between poverty and the right to health in particular?
   b) What is the peculiarity of the right to health, as it pertains to HIV and AIDS?
2. To what extent do Rwandan poverty reduction strategies respond to the problems suffered by poor people living with HIV and AIDS?
   a) What are the criteria for selection of beneficiaries of poverty reduction programmes and how do those criteria, if any, accommodate poor people living with HIV and AIDS?
   b) Should poor people living with HIV and AIDS be given priority over other poor people within the context of a given poverty reduction programmes?

In an attempt to provide a tentative solution to the above research questions, the hypothesis below argues for a human rights-based approach (RBA) that is holistic and sustainable in addressing the synergy between poverty, HIV/AIDS and health.

1.4. Hypothesis

Analysis of EDPRS 1 and 2 indicates the lack of some important aspects such as the process of identifying the poor and other most vulnerable groups. The two EDPRSs do not indicate how the national and international

human rights framework has been integrated in the policy and implementation.

This study presupposes that there is need to highlight the relevant human rights standards including fundamental principles of non-discrimination and people's effective participation.

The study advocates for a rights-based approach to development which contains specific human rights standards including the right to work, the right to food, adequate housing and the right to education.[22] A rights-based approach to development is one which considers human rights in a holistic way contrary to the traditional approach also called the needs-based approach which is based on the basic needs at the time.[23]

A rights-based approach describes situations not simply in terms of human needs, or of development requirements, but in terms of society's obligations to respond to the inalienable rights of individuals.[24] It empowers people themselves—especially vulnerable and the most marginalized—to participate in policy formulation and hold accountable those who have a duty to act.[25] It is concerned not just with civil and political rights, but also with economic, social and cultural rights.[26]

The difference between *needs-based* and *rights-based* approaches is also seen in the way each assesses the problem within the community. The former tends to deal with the problem in a generalized way.[27] It assesses the problem in a community as a whole. The latter puts into consideration the

---

[22] Office of the United Nations High Commissioner for Human Rights (OHCHR) *Principles and guidelines for human rights approach to development reduction strategies* (2006) http://www.ohchr.org/Documents/Publications/PovertyStrategiesen.pdf (accessed 27 June 2013).
[23] OHCHR *Frequently asked questions on a human rights-based approach to development cooperation* (2006) http://www.ohchr.org/Documents/Publications/FAQen.pdf (accessed 27 June 2013).
[24] E Filmer-Wilson 'The Rights-Based Approach to Development: The Right to Water' (2005) 23 *Netherlands Quarterly of Human Rights* 213.
[25] OHCHR (n 22 above) 7.
[26] EDPRS (n 19 above) par 27.
[27] A Lundström Sarelin 'Human Rights-Based Approaches to Development Cooperation, HIV/ AIDS, and Food Security' (2007) 29 *Human Rights Quarterly* 460.

specific vulnerable groups in the community.[28] It assesses the problems facing people in specific groups such as, women, indigenous peoples, and people living with HIV and AIDS.[29] It gives a contextual and tangible meaning to the specific rights of the people that are intended beneficiaries of rights.

For example, the right to health of people living with HIV and AIDS is not limited to the provision of the anti-retroviral (ARV) and some other health care services by the government. Instead it embraces a wider range of socio-economic factors that promote conditions in which people can lead a healthy life.[30] In addition, it extends to the underlying determinants of health, such as *food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.*[31]

The study contends that the realisation of the right to health has budgetary implications.[32] It requires financial resources from government for implementation as duty bearers. However, at this point, it is worth mentioning that finances are not the only factor that enables the realisation of this right.

There is need for a comprehensive document and with a clear implementation strategy that does not only offer development objectives but is also human rights friendly. It must be a human rights-based approach as opposed to traditional or needs-based.[33]

In responding to poverty, HIV/AIDS and health, any programme ought to explain the obligations of the government (*duty-bearer)* and the rights of the citizens (*right-holders*).[34] It ought to provide citizens with the knowledge and

---

[28] As above.
[29] EDPRS (19 above) 465.
[30] General Comment No 14.
[31] EDPRS (n 19 above) para 4.
[32] EDPRS (n 19 above) para 33.
[33] OHCHR *Human Rights, Health and Poverty Reduction Strategies* (2008). http://www.who.int/hhr/news/HRHPRS.pdf (accessed 27 June 2013).
[34] Filmer-Wilson (n 24 above) 217.

capacity to claim their rights from the government.[35] It should not only be perceived as a document that enables government to achieve its development objectives, but also as a document which contains a set of human rights standards which can be claimed and realised.[36]

1.5. Methodology

This study mainly used the desktop method of research. It involves the analysis of the Rwandan poverty reduction strategy papers and their programmes of implementation. In addition, a literature review of diverse scholarly works on the issues of development and human rights is analysed.

The research will consult literature that draws the relationship between poverty, HIV and AIDS and health. Literature on the two models of development has been consulted. These are the traditional or needs-based approach and a rights-based approach have been analysed below.

1.6. Literature Review

The literature review has analysed Rwanda's poverty reduction strategies and the normative principles underlying the right to health and poverty. The review has taken more emphasis on poverty and PLHIV. There is much scholarship on the interconnections between human rights, health, poverty and HIV and AIDS. Some scholars have analysed poverty reduction strategies using both a human rights-based approach and traditional approach in a number of countries but not in respect Rwanda. This research complements these works because Rwanda portrays a different socio-political background from the societies in covered.

The World Bank (WB) and the International Monetary Fund (IMF) have provided models for development and guidelines on poverty reduction strategies.[37] Even if poverty reduction strategy papers (PRSPs) are a creation of the WB and the IMF, the former has argued that there is no need

[35] As above.
[36] OHCHR n 21 above, (guideline 2).
[37] R Edward Kapindu 'Poverty Reduction Strategies and the Rights to Health and Housing: The Malawian and Ugandan Experience' (2006) 6 *Human Rights Reference Collection* 493.

for an explicit human right-based approach in PRSPs, as the goals of human rights and poverty reduction in PRSPs are the same.[38] This differs from this approach because it contends that a RBA to poverty reduction is more sustainable compared to the traditional approach.

Haugh and Ruan argue for a more thoroughly developed and explicit link between poverty reduction strategies and the rights-relevant policies and measurements.[39] For instance, this should inform Rwandan policy makers that EDPRS 1 and 2 should adopt the rights-based approach.

The UN Committee on Economic, Social and Cultural Rights (Committee on ESCR) is of the view that poverty is a multi-dimensional denial of human rights. Therefore, 'Anti-poverty policies are more likely to be effective, sustainable, inclusive, equitable and meaningful to those living in poverty if they are based upon international human rights'.[40]

Paul Hunt, the former UN Special Rapporteur on the Right to Health, echoed the views of the Committee on ESCR.[41] Linking poverty and the right to health he said:

> The right to health has a significant and constructive role to play in poverty reduction and related strategies. Policies based on national and international human rights are more likely to be effective, sustainable, inclusive, equitable, and meaningful for those living in poverty.[42]

This explanation lays the ground for the hypothesis of this study that is premised on the fact that a RBA to poverty is relevant in addressing poverty. When someone has ill-health, the individual cannot produce, and in the long run, would not be able to generate funds for sustainability.

The Office of the High Commissioner for Human Rights (OHCHR) and World Health Organisation (WHO), in discussing the right to health said:

---

[38] n 36 above, 499.
[39] As above.
[40] M Nowak 'A Human Rights Approach to Poverty' (2002) *Kluwer Law International* 15 21.
[41] n 15 above, 6.
[42] As above.

> It is generally recognized that HIV/AIDS raises human rights issues. Many human rights are relevant to HIV/AIDS, such as the right to freedom from discrimination, the right to life, equality before the law, the right to privacy and the right to the highest attainable standard of heath.[43]

It should be noted that the International Guidelines on HIV/AIDS and Human Rights extends the OHCHR and WHO's list by adding many other human rights.[44] On the issue of poverty, they clearly state that '[t]he links between the HIV/AIDS pandemic and poverty, stigma and discrimination, including that based on gender and sexual orientation, are widely acknowledged.'[45]

Joseph Collins and Bill Rau explain the relationship between poverty and HIV/AIDS as follows:

> Poverty is a factor in HIV transmission and exacerbating the impact of HIV/AIDS. The experience of HIV/AIDS by individuals, households and even communities that are poor can readily lead to an intensification of poverty and even push some non-poor into poverty. Thus HIV/AIDS can impoverish or further impoverish people in such a way as to intensify the epidemic itself.[46]

According to Alessandra Lundström Sarelin, 'In a human rights-based approach to HIV and AIDS, questions concerning what the state *is not doing* are as important as those concerning what the state *is doing'*. His view is that a generalized evaluation of the progress made for the whole population can be misleading. It is important to disaggregate and specifically monitor the situation of groups such as women living in poverty, indigenous peoples and HIV-positive people.[47] He continues arguing that '[i]n practice, *non-*

---

[43] OHCHR, WHO *The Right to Health, Fact Sheet No. 31* (2008) 20-21.
[44] OHCHR, UNAIDS *International Guidelines on HIV/AIDS and Human Rights* (2006) 80-81
[45] n 42 above, 21.
[46] J Collins & B Rau 'AIDS in the Context of Development' (2000) http://www.unrisd.org/unrisd/website/document.nsf/0/329e8acb59f4060580256b61004363fe/$FILE/collins.pdf (accessed 27 June 2013).
[47] n 26 above, 465.

discrimination implies a need to be aware of the individuals and groups who are most vulnerable in relation to the human rights goal."[48]

Although much literature has discussed poverty, HIV/AIDS and health, this study makes a difference by analysing poverty and human rights using national strategies for poverty reduction. Rwanda's poverty reduction strategies have been brought into perspective to analyse whether they embody human rights.

1.7. Outline of Chapters

Chapter one provides an introduction of the study, the research questions and methodology used in this study. Chapter two of the study discusses the link between poverty and human rights. In this chapter the meaning of the concept of poverty from a human rights perspective is explored. Chapter two also analyses the peculiarities of the right to health in relations to the HIV and AIDS health problems. The study analyses how the lack of each of the underlying determents of the right to health adversely impact on the life of poor people in general and on the life of poor PLHIV in particular.

The third chapter constitutes the core part of this study. It specifically analyses the Rwandan Government's interventions to reduce poverty incidence among vulnerable people. In this chapter, the study focuses on three major areas.

First, an attempt is made to respond to the following questions: to what extent do Rwandan poverty reduction strategies respond to the problems suffered by PLHIV? Second, what are the criteria for selection for who would be beneficiaries of the poverty reduction programmes? If any, how do they accommodate poor PLHIV? Finally, from an analytical result from the preceding questions, an attempt is made to draw an inference on the possibility and relevance of according a higher priority to the poor PLHIV over other beneficiaries of the Rwandan poverty reduction strategies and their programmes of implementation.

[48] n 26 above, 476.

Chapter four is a conclusion to the whole study. It includes a number of recommendations.

CHAPTER 2

2. LINK BETWEEN POVERTY, RIGHT TO HEALTH AND HIV/AIDS

2.1 Introduction

This chapter discusses the link between poverty, the right to health and HIV and AIDS. The concepts of poverty from a human rights perspective and link between poverty and the right to health are explored. This part also analyses the impact of poverty in the context of the right to health in relation to PLHIV. This chapter lays a normative understanding of the theories and how they relate in the context of poverty and HIV and AIDS.

2.2 Poverty from a Human Rights Perspective

2.2.1 Definition

Poverty has conventionally been defined in economic terms, focusing on individual and household, relative or absolute financial capacity.[49] This model of defining poverty tends to identify the poor as those who fall below a certain minimum income level commonly called the poverty line.[50]

Rwanda's third integrated household living conditions and health survey (EICV 3) states that 'the EICV household survey is designed to be able to measure poverty in *monetary terms*.[51] It also explains the *poverty line* as a level of household conception per adult below which a household is deemed to be poor.[52]

The Concise Oxford English Dictionary defines poverty as 'the state of not having and not being able to get the necessaries of life.'[53] This definition

---

[49] n 32 above, 6.

[50] n 36 above, 495.

[51] n 2 above 133.

[52] As above.

[53] The Concise Oxford English Dictionary as it was cited by JC Mubangizi 'Know your rights: exploring the connections between human rights and poverty reduction with specific reference to South Africa' (2005) 21 *South Africa Journal on Human Rights* 32.

illustrates that poverty means many things than the mere fact of being perceived as lack of command over resources.

In a human rights perspective, poverty is defined in a different way. First of all it rejects the idea of viewing poverty narrowly as a lack of adequate income.[54] These may include adequate nutrition, adequate health, adequate clothing and adequate housing. [55]

A comprehensive definition of poverty in human rights terms has been provided by the Committee on ESCR. It defines poverty as:

> A human condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights.[56]

This definition treats resources as one of the components of poverty but not the only component. From the definition of poverty as it was given by the Covenant on Economic, Social and Cultural Rights (CESCR), it is possible to define who is poor in human rights terms. Unlike in a conventional definition where a poor person is defined as someone who falls below a certain minimum income level, in a human rights language a poor person is one for whom a number of human rights remains unfulfilled.[57]

2.2.2 Background to the Concept of Poverty from a Human Rights Perspective

Governments and development agencies have been reluctant to recognise the relationship between development and human rights. The two concepts have been considered as separate and with diverging strategies and objectives.[58]

---

[54] n 36 above, 495.
[55] As above, 495.

[56] n 32 above, 6.
[57] n 21 above, para 7.
[58] E Filmer-Wilson 'The rights-based approach to development: the right to water' (2005) 23 *Netherlands Quarterly of Human Rights* 213.

In 1970s, development had nothing to do with human rights, but it had everything to do with industrialisation and economic growth.[59] During this period there was an idea that, what were called underdeveloped countries should be brought up to the economic standards of the industrialised countries.[60] It is during this same period that poverty simply meant lack of income.[61]

From the late 1970s, trends of linking human rights with development and poverty eradication started.[62] In 1981 the African Charter on Human and Peoples' Rights (ACHPR) was adopted.[63] This Charter has provided for the right to development and clearly imposes on the state parties the duty to individually or collectively exercise this right.[64] A few years later, in 1986, the UN declaration on the right to development was adopted and it is defined in the article one.[65] Article one defines development as follows:

> The right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to, and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized.[66]

The adoption of this declaration by UN was taken to be a formal recognition of the relationship between human rights and development at the international level.[67]

While at African and UN levels the right to development was being adopted, a new trend was emerging in the North. For instance, the Nordic states, Canada and the Netherlands were experiencing another trend of linking human rights and development. They have begun by applying policies of

---

[59] n 39 above, 17.
[60] As above.
[61] As above.
[62]As above.
[63] African Charter on Human and Peoples' Rights 'Eighteen assembly of head of states and government, June 1981, Nairobi, Kenya' (hereinafter referred to as the African Charter).
[64] Article 22 of the African Charter.
[65] www.un.org/documents/ga/res/41/a41r128.htm (accessed on 14 2013).

[66] Article 1 of the UN declaration on the right to development (1986).
[67] n 10 above, p 215.

human rights conditionality in their development cooperation.[68] According to this policy, donor countries reserved the right to reduce or even to discontinue development cooperation in response to gross and systematic human rights violations or the stagnation of democratisation in the recipient counties.[69] This policy came to be adopted by the European Union.[70]

The periods between the 1990s and 2000 focused on understanding poverty and its role in the framework of development policies.[71] There was a shift in policy by the international financial institutions (IMF and WB). The institutions started to change their attitude towards their approach to fight poverty.[72] In 1999, Poverty Reduction Strategies Papers (PRSPs) were introduced to replace Structural Adjustment Programmes (SAPs).[73] This was due to the devastating effects which SAPs had on human rights.[74] With the new policy (PRSPs), the WB had committed to fight poverty with passion and professionalism.[75] Hence, it had accepted that poverty is not only encompassing low income and consumption but also low achievement in education, health, nutrition and other areas of human development.[76]

Another important period is that commencing from 2000. As far as this study is concerned, this period is the last in series of periods which characterised the trend of linking human rights and development. The remarkable achievement in this respect was the adoption of the Principles and guidelines for a human rights approach to poverty reduction strategies in 2006 by the Committee on ESCR.[77] This publication was preceded by two other publications: *Draft guidelines on a human rights approach to poverty*

[68] n 57 above, 18.
[69] n 10 above, 18.
[70] As above.
[71] n 10 above, 19.
[72] As above, 19.
[73] n 10 above, 20.
[74] n 10 above, 18.
[75] World Development Report 2000/2001.
[76] n 10 above, 19.
[77] http://www.ohchr.org/Documents/Publications/PovertyStrategiesen.pdf (accessed 14 June 2013).

reduction strategies in 2002[78] and *human rights and poverty: a conceptual framework* in 2004.[79]

The three publications complement each other. They aim to contribute to UN endeavour to integrate human rights into development to combat poverty.[80] They provide policymakers and practitioners involved in the design and implementation of poverty reduction strategies with guidelines for the adoption of a human rights approach to poverty reduction.[81]

The above publications, which are guidelines and policies, may not have a legally binding character but they have nonetheless been used in practice by donor nations in their relationships with the donor-recipient nations.

2.3 Poverty and the Right to Health

2.3.1 The Right to Health

The human right to health is recognised in many international and regional instruments. However, it is also a fact that only few countries have recognised this right in their domestic legal frameworks.

The most authoritative definition is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health—often referred to as the right to health—is set out in article 12 of the CESCR.[82] The article defines and enumerates steps to be taken by states in order to fully realise this right. It reads as follows:

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. [83]

[78] http://www.refworld.org/cgi-bin/texis/vtx/rwmain?page=type&type=LEGALPOLICY&publisher=OHCHR&coi=&docid=3f8298544&skip=0 (accessed 14 June 2013).
[79] http://www.ohchr.org/Documents/Publications/PovertyReductionen.pdf (accessed 14 June 2013).
[80] n 21 above, para 2.
[81] As above.
[82]The International Covenant on Economic, Social and Cultural Rights (CESCR) was adopted by the United Nations General Assembly (UNGA) on 16 December 1966 http://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf (accessed 16 June 2013).
[83] Article 12 CESCR.

> 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:
>
> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
>
> (b) The improvement of all aspects of environmental and industrial hygiene;
>
> (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.

Given the right to health in CESCR was drafted in technical terms, the Committee on ESCR adopted the General Comment number 14 in order to clarify and operationalise the provisions of article 12 of CESCR.[84] It has interpreted this article by including some other rights as the underlying determinants of the right to heath.[85] This makes the right to health an inclusive right.[86]

Apart from being an inclusive right, the right to health also contains freedoms and entitlements.[87] Freedoms in the sense that it includes the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation.[88] It contains entitlements because it includes the right to a system of health protection which—on its side—provides equality of opportunity for people to enjoy the highest attainable level of health.[89]

[84] n 29 above.
[85] n 29 above, para 4.
[86] n 42 above, 3.
[87] n above, para 8.
[88] As above.
[89] n 29 above, para 8.

2.3.2 The Right to Health at International, Regional and National Levels

As far as this study is concerned, the international level means the UN level. The regional level is limited to the African region. National or domestic level limits itself on Rwandan legal and policy framework.

A. International Level

At the international level, the right to health has been widely recognised. For the first time, it was recognised in the Universal Declaration of Human Rights (UDHR).[90] It is provided in article 25(1).[91]

As it has been mentioned in the preceding section, the CESCR guarantees the right to health in its article 12(1).[92]

The International Convention on the Elimination of all Forms of Racial Discrimination (CERD) guarantees the right to health in its article 5(e) (iv).[93] The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), also guarantees the right to health in its article 12 and to a point in article 11(1) (f).[94] The Convention on the Rights of the Child (CRC) provides the right to health in its article 24.[95] Rwanda signed and ratified all the above mentioned international instruments.[96]

---

[90] Universal Declaration of Human Rights adopted by the UNGA on 10 December 1948, http://www.un.org/en/documents/udhr/index.shtml (accessed 17 June 2013).
[91] Article 25(1) of the UDHR.
[92] n 90 above, [Article 12(1)].
[93] International Convention on Elimination of all Forms of Racial Discrimination adopted on 21 December 1965 http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx (accessed on 17 June 2013).
[94] Convention on the Elimination of All Forms of Discrimination against Women adopted on 18 December 1979 http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm (accessed on 17 June 2013).
[95] Convention on the Rights of the Child adopted on 20 November 1989 http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx (accessed on 17 June 2013).
[96] http://www.bayefsky.com/pdf/rwanda_t1_ratifications.pdf (accessed 03 September 2013).

B. Regional Level

At the African level, the right to health is guaranteed in the African Charter on Human and Peoples' Rights.[97] The ACHPR seems to have adopted the definition of the right to health as it was defined by the CESCR. Article 16(1) of the Charter states that '[e]very individual shall have the right to enjoy the best attainable state of physical and mental health'.[98] However, the slight difference can be noticed in language used in both instruments. While article 12(1) of the CESCR starts by emphasising the recognition of the right to health by states, the ACHPR did the reverse by emphasising on the individual. The use of that language was a deliberate choice which aimed at empowering people. Hence, the study recommends the language used by the African Charter.[99]

The right to health is also guaranteed by the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. As the name of the protocol itself reveals this protocol emphasises on the right to health of women. It is provided in article 14.[100] The right is also provided by the African Charter on the Rights and Welfare of the Child under article 14.[101]

C. Domestic Level

At this level, the right to health ought to be analysed at first from the Rwandan Constitution. Two articles of the Constitution provide for the right to health, though—in the author's view—their provisions are not clear enough.

---

[97] n 62 above, article 2(1).
[98] As above.
[99] Emphasis by the Author.
[100] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa http://www.africa-union.org/root/au/Documents/Treaties/Text/Protocol%20on%20the%20Rights%20of%20Women.pdf (accessed on 17 June 2013).

[101] African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49 (1990), *entered into force* Nov. 29, 199, available at http://www1.umn.edu/humanrts/africa/afchild.htm (accessed 03 September 2013).

Article 41 provides that '[a]ll citizens have the right and duties relating to health. The State has the duty of mobilizing the population for activities aimed at promoting good health and to assist in the implementation of these activities.'[102] This division of responsibilities or even its shift from the state to the citizens which are seen in the wording of this article seems to be confusing mainly on the side of the state's obligations.

For example the use of the phrase like *the State has the duty of mobilizing the population for activities aimed at promoting good health and to assist in the implementation of these activities* seems not to be consistent with the obligations[103] to *respect, protect* and *fulfil* the right to health. Let it be a reminder that the right to health contains both *freedoms* and *entitlements*.[104]

The Constitution of the Republic of Rwanda also states that '[e]very citizen is entitled to a healthy and satisfying environment. Every person has the duty to protect, safeguard and promote the environment. The State shall protect the environment.'[105]

It is true that a healthy environment is an important component of the right to health. The CESCR mentions the improvement of all aspects of the environmental and industrial hygiene as an important obligation of a state for realisation of the right to health.[106] Considering the wording of the right to a healthy environment as provided for under the Rwandan Constitution, it is ambiguous to what extent the right to health may be justiciable under this Constitution. The constitutional provision is unclear as far as the obligations of the state are concerned. Instead the responsibilities on the side of the citizens seem to outweigh the state's responsibilities. The current wording of the right to health makes it difficult to be invoked before the courts of law.

---

[102] Rwandan Constitution of 4 June 2003 as revised up to date.
[103] These three obligations are discussed later in the study.
[104] n 29 above, para 8.
[105] n 99 above, Article 49.
[106] Article 12(2) (b) CESCR.

Furthermore, the Rwandan Constitution does not have the section concerning the directive principles of the state policy. If the situation would be otherwise, it would be argued that perhaps the duty of the state as mentioned in some provisions in the bill of rights are treated as the state directive principles. However, it is also important to mention that even where the directive principles of state policy have been incorporated in the constitutions, they are—in most of the cases—not enforceable by courts.[107]

2.3.3 Common Misconceptions about the Right to Health

There have been varying misconceptions on the definition of the right to health. The right to health has been confused with the state of being healthy.[108] It should be understood that the right to health is not the same as the right to be healthy.[109] It is impossible for the state to guarantee good health given that it is influenced by many factors outside the direct control of the state such as individual's biological make-up and socio-economic conditions.[110] However, it is possible for the state to guarantee the right to health since it is about the provision of goods, facilities and services—things which are to some extent within the control of the state.[111]

The right to health is not a merely programmatic goal to be attained progressively in the long term.[112] Instead there are some immediate obligations on the states that arise from it. For example, there should not be any reason for a state to not guarantee the right to health in a non-discriminatory manner.[113] Once this right is guaranteed it has to be realised on an equal basis.

A country's difficult financial situation is not a justification for not taking steps to realise the right to health.[114] Insufficient resources have been a pretext for many states to not fulfil their international obligations *vis-à-vis*

[107] Part IV of the Indian Constitution.
[108] n 42 above, 5.
[109] n 42 above, p 5.
[110] As above (n104).
[111] As above (n105).
[112] As above (n106).
[113] As above (n107).
[114] As above (n108).

the realisation of the economic, social and cultural rights, including the right to health. The concept of progressive realisation has been a shield in that respect. However, it should be clearly understood that the obligation of progressive realization, exists *independently* of any increase in resources. Above all, it requires effective use of resources available.[115]

2.3.4 Obligations of the State with respect to the Right to Health

A. General Legal Obligations

The general legal obligations are imbedded in the provisions of article 2 of the CESCR. They are common to all rights provided for by the convention. First, states parties have the obligation to *take steps* to realise the right to health. The convention simply imposes that obligation without explaining clearly what it means.[116] The CESCR, underlined that states should, at a minimum, adopt a national strategy to ensure to all the enjoyment of the right to health.[117]

The second general obligation is to *progressively realise* the right to health. It means that states parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the right to health.[118] It is also an implicit recognition that states have resource constraints and that it necessarily takes time to implement the treaty provisions.[119]

The third obligation is to guarantee the right to health *without discrimination* of any kind.[120] This obligation has to be fulfilled immediately.

---

[115] General Comment No 7 on the right to adequate housing (art. 11.1 of the Covenant): forced execution.
[116] Article 2(1) CESCR.
[117] n 29 above, para 53.
[118] n above, para 31.
[119] n 42 above, 23.
[120] Article 2(2) CESCR.

B. Specific Legal Obligations

Specific obligations are analysed through the obligations to *respect, protect* and *fulfil*.

The obligation to *respect* requires the states to refrain from interfering directly or indirectly with the right to health.[121] The factsheet no. 31 on the right to health and the General Comment No.14 give example on that respect.[122] The obligation for states to refrain from denying or limiting access to health-care services; from making unsafe drugs; from imposing discriminatory practices relating to women's health status and needs, just to name a few.[123]

The obligation to *protect* on its side requires states to prevent third parties from interfering with the right to health.[124] In order to fulfil this obligation states should among others adopt legislation or other measures to ensure that private actors conform with human rights standards when providing health care or other services; ensure that privatization does not constitute a threat to the availability, accessibility, acceptability and quality of health-care facilities, goods and services.[125]

The obligation to *fulfil* obliges states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measure to fully realise the right to health.[126] For example, states must adopt a national health policy or a national health plan covering the public and private sectors; ensure equal access for all to the underlying determinants of health, such as safe and nutritious food, sanitation and clean water.[127]

[121] n 42 above, 25.
[122] n 42 above, 26.
[123] As above.
[124] As above.
[125] n 42 above, 26.
[126] n 42 above, 27.
[127] As above.

C. Core Minimum Obligations

These are obligations aimed at ensuring the satisfaction of minimum essential levels of each of the rights under the Covenant.[128] With respect to the right to health the CESCR has mentioned the following as the core obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(b) to ensure access to the minimum essential food which is nutritionally adequate and safe;

(c) to ensure access to shelter, housing and sanitation and an adequate supply of safe drinking water;

(d) To provide essential drugs as from time to time defined under the WHO Action Programme on Essential Drugs;

(e) To ensure equitable distribution of all health facilities, goods and services;

(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population [129]

2.3.5 Application of the Right to Health to Specific Groups

The right to health is a right to be enjoyed by everyone and on a non-discriminatory basis. However, this does not mean that the non-fulfilment of the right to health will always have the same effects on everyone. Instead, the reality shows that some groups or individuals face specific hurdles in relation to the right to health.[130] These can result from biological or socio-economic factors, discrimination and stigma, or, generally, a combination of

[128] n 29 above, para 43.
[129] n 29 above, para 43.
[130] n 42 above, 11.

these.[131] Regarding these groups one may note children, women, persons with disabilities and persons living with HIV and AIDS.[132] The study focuses on the people living with HIV and AIDS.

It is recognised that HIV and AIDS raises many human rights issues. This is mainly due to the stigma and discrimination attached to HIV and AIDS.[133] Stigma and discrimination on their side are major causes of non-enjoyment of many human rights in general and the right health in particular.

For example, fear of being stigmatised may stop people from voluntarily seeking HIV and AIDS counselling and testing, which are vital to treatment and prevention.[134] In addition to that, one may not omit to mention that HIV and AIDS in itself can cause ill-health— which, in turn, can cause non-enjoyment of many other human rights.

2.3.6 Connection between Poverty and Right to Health

A. Poverty as a Consequence of Inadequacy in Realising the Right to Health: Emphasis on the Role of the State

The human right to health is an enabling right. It enables people to enjoy some other rights. A person free from diseases can work. It is the same for a child with a sound mind to easily follow lessons in class.[135] The right to health is made up of a combination of elements that can be divided into two categories: those related to *underlying determinants* and those related to *health care*.[136]

According to international human rights law, the obligations to prove elements that make up the right to health are primarily incumbent on the states. With regards to the connection between poverty and the right to health, the non-fulfilment of human rights would count as poverty when it

---

[131] As above.
[132] As above.
[133] P Hunt 'The UN Special Rapporteur on the Right to Heath: Key objectives, themes, and interventions' (2003-2004) 7 *Health and Human Rights* 1 13.
[134] n 128 above, 13.
[135] n 128 above, 6.
[136] OHCHR 'Human rights, health and poverty reduction strategies' (2008) 10.

meets certain conditions. First, the human rights involved must be those that correspond to the capabilities that are considered basic within a society.

Secondly, inadequate command over economic resources must play a role in the causal chain leading to the non-fulfilment of human rights.[137] This simply means that if the non-fulfilment of certain rights meets these two conditions, it can be said to have constitutive relevance to poverty. Consequently, the state's failure to fulfil its international obligations regarding the realisation of rights such as the right to food, education, housing and *health* can be a cause of poverty to its citizen.[138]

B. Poverty as a Corollary of Ignorance of the Right to Health by Citizens: Emphasis on the Role of the Citizens

In his speech as the Commissioner for human rights in the Council of Europe, Thomas Hammarberg once said:

> The best defence for human rights is that we all know what rights we have and how we can complain against injustices. Education about human rights is central to effective implementation of agreed international standards.[139]

This affirmation by Hammarberg, clearly explains the importance of human rights education in their realisation. In other words, one may say that the lower the level of human rights education is, the lower the level of human rights enjoyment will be.

In the poverty reduction strategies where the right to health ought to be a key component, the process of raising human rights awareness should also be incorporated. This will not only contribute to the expansion of people's

---

[137] P Hunt, M Nowak, S Osmani 'Human rights and poverty reduction strategies: A discussion paper of 28 February 2002 as cited by M Nowak 'A human rights approach to poverty' (2002) Kluwer Law International 26.
[138] n 21 above, (guideline 8).
[139] http://www.coe.int/t/dg4/nscentre/lisbonforum/LF09_ThomasHammarberg.pdf (Lisbon Forum 2009) (accessed 20 June 2013).

choices and capabilities but also to the empowerment of people to decide what this process should look like.[140]

People who do not know health as a human right are also ignorant of its determinants.[141] Consequently, they do not know that adequate nutrition, potable drinking water, housing, sanitation, healthy working environment, provision of health facilities, provision of essential drugs and many others are rights.[142]

It is impossible to claim a right which you do not know and as such, people who do not have *any* or *most* of the determinants of the right to health cannot claim them from the governments since most of them are vulnerable or poor.[143]

2.4 Poverty in the Context of Right to Health

2.4.1 Determinants of the Right to Health

On the one hand, the rights to food and nutrition, housing, safe and potable water, adequate sanitation and safe and healthy working environment should be equally enjoyed by everyone. On the other hand, the empirical evidence shows strong correlations between each of these rights and HIV and AIDS. This section analyses the impact that the non-fulfilment of each of them has or might have on lives of poor PLHIV.

A. Food and Nutrition

The right to food is guaranteed by the CESCR.[144] Article 11.1 provides for the right of everyone to an adequate standard of living for himself and his family, including *adequate food*, clothing and housing, and to the continuous improvement of living conditions. The second paragraph of the

[140] P Sob 'The implementation gap in the economic, social, and cultural rights field: a critical cross-examination of the agenda of the United Nations' (2007) 15 *African Year Book of International Law* 11.
[141] Emphasis by the author.
[142] Emphasis by the author.
[143] Emphasis by the author.
[144] Article 11, CESCR.

same article provides for the right to freedom from *hunger and malnutrition* as a fundamental one.

In the context of HIV and AIDS, the right to adequate food and nutrition becomes more relevant to PLHIV as it plays a crucial role in adherence to ARVs.[145] When PLHIV are involved in the process of identifying viable dietary alternatives or help to find options to manage food-drug interactions the adherence to the drug regime is increased.[146] The lack of this right may cause PLHIV to stop taking drugs. Hence, the study argues that the provision of ARVs only, is not sufficient for the PLHIV to enjoy the right to health.

B. Safe Water and Adequate Sanitation

Unlike many other rights that were said to be falling under the category of ESCR, the rights to water and adequate sanitation do not clearly appear in the CESCR. However, thanks to the Committee on ESCR the right to water has been given its meaning under articles 11(1) and 12(1) of the CESCR.[147] It means, under the right to food and the right to health respectively.

However, this right has been clearly provided for by the Convention on the Elimination of All Forms of Discrimination Against Women (1979)[148] and the Convention on the Rights of the Child (1989).[149]

While access to safe water and adequate sanitation is a human right for all, it is of crucial importance for PLHIV.[150] The combination of these rights

---

[145] B Twinomugisha 'Protection of the right to health care of women living with HIV/AIDS (WLA) in Uganda' (2007) http://dspace3.mak.ac.ug/xmlui/handle/10570/655 (accessed on 12 June 2012).
[146] A Vandenbogaerde 'The right to food in the context of HIV/AIDS' (2009) http://www.fao.org/docrep/016/ap551e/ap551e.pdf (accessed 21 June 2013).
[147] UN General Comment No. 15 (2002) on the right to water. http://www.unhchr.ch/tbs/doc.nsf/0/a5458d1d1bbd713fc1256cc400389e94/$FILE/G0340229.pdf (accessed 21 June 2013).
[148] Article 12 (2) (h) of the Convention on the Elimination of All Forms of Discrimination Against Women http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm (accessed 21 June 2013).
[149] Article 24 (2) (c) of the Convention on the Rights of the Child http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx (accessed 21 June 2013).
[150] M Wegelin-Schuringa & E Kamminga 'Water and sanitation in the context of HIV/AIDS: The right of access in resource-poor countries (2006) 9 *Health and Human Rights* 152.

helps infected people in resource-poor settings stay healthy and reduces the workload for caregivers and helps preserve human dignity.[151] Clean water is also needed for food preparation and good nutrition which can help to maintain and improve the nutritional status of a PLHIV and delay the progression from HIV to AIDS-related diseases.[152]

For HIV-positive breastfeeding mothers, there is 35 per cent chance that she will transmit the virus to her child if no preventive medication is taken. Of this, 33 per cent of transmissions occur through breast-feeding.[153] Among the alternatives to prevent this transmission is the use of baby formula instead of breast-feeding.[154] It is advisable that baby formula may be used only if a mother has access to clean drinking water.[155] This is due to the fact that the evidence has shown that during the first two months, a bottle-fed baby is nearly *six times* more likely to die from diarrhoea, respiratory, or other infections compared to a breast-fed child, mostly because contaminated water is used to mix the formula.[156]

The above rights demonstrate the linkages between HIV and AIDS and the rights to water and sanitation. It is important to acknowledge the relevance of these rights towards the enjoyment of the right to health by poor PLHIV.

C. Housing

The right to adequate housing has its basis in the article 11(1) of CESCR. It has been derived from the right to an adequate standard of living.[157] Most importantly, it is taken to be of central importance for the enjoyment of all ESCR.[158]

---

[151] n 145 above, 154.
[152] n 145above, 158.
[153] n 145 above, 160.
[154] n 145 above, 161.
[155] As above.
[156] As above.
[157] Article 11(1) CESCR
[158] General Comment No. 4 'The right to adequate housing' para 1 http://www.unhchr.ch/tbs/doc.nsf/0/469f4d91a9378221c12563ed0053547e (accessed 22 June 2013).

The right should not be understood as merely having a roof over one's head instead, as a combination of different things. These include adequate privacy, adequate security, adequate lighting and ventilation, adequate space, adequate basic infrastructure and adequate location with regard to work and basic facilities—all at reasonable cost.[159]

As the right to adequate housing, on the one hand, is the key for the enjoyment of the right to health, it is also the primary cause for non-enjoyment of that right for homeless and non-adequately housed people, on the other hand.[160]

Homeless and non-adequately housed PLHIV suffer a number of hardships regarding the enjoyment of the right to health. They, first of all need greater access to comprehensive health care, yet they have serious problems of lack of financial resources, health insurance coverage, address and many others.[161] Homeless and non-adequately housed poor PLHIV also may have difficulty adhering to prescribed HIV antiretroviral medication regimens.[162] This is due to the fact that these regimens can be complex and often involve restrictions on when and how the medications should be taken and stored. In addition, these medications can have side effects, such as recurring diarrhoea, that are especially problematic for homeless and non-adequately housed individuals.[163]

From all these examples and others that may be given, it is clear that PLHIV who are homeless or non-adequately housed face additional burdens not faced by other people either be HIV-positive or not. Hence, the study argues that housing is a structural intervention that has the potential to reduce

---

[159] n 153 above, para 7.
[160] Emphasis by the author.
[161] P Daniel Kidder et al; 'Health status, health care use, medication use, and medication adherence among homeless and housed people living with hiv/aids' (2007) 97*American Journal of Public Health* 2238.
[162] V Shubert & N Bernstine 'Moving from fact to policy: Housing is HIV prevention and health care' (2007) http://www.aidschicago.org/pdf/2008/housing_plan_MovingfromFact.pdf (accessed 22 June 2013).
[163] n 157 above, 2238.

HIV risk and improve health outcomes among homeless and non-adequately housed poor PLHIV.

D. Safe and Healthy Working Conditions

The right to safe and healthy working conditions is guaranteed to everyone by the CESCR.[164] WHO has defined the healthy workplace as one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of all workers and the sustainability of the workplace by considering the issues such as health and safety concerns in the physical work environment, just to name a few.[165]

People Living with HIV, in order to enjoy the right to health equally with their counterparts, who are not HIV-positive, need to be reasonably accommodated in the workplace. It means they need modification or adjustment to a job or to the workplace that is reasonably practicable and enables them to have access to, or participate or advance in employment.[166] As such, work should be organized in such a way as to accommodate the episodic nature of HIV and AIDS, as well as possible side effects of treatment.[167]

E. Healthy Environment

The right to an adequate environment is a well-recognized right, which although not explicitly stated in the CESCR. This right is implied as a prerequisite for many other rights, such as the right to food, the right to health and the right to life.[168]

---

[164] Article 7(b), CESCR.
[165] WHO healthy workplace framework and modal synthesis report http://www.who.int/occupational_health/healthy_workplaces_workshop_report.pdf (accessed 22 June 2013).
[166] Recommendation concerning HIV and AIDS and the world of work 2010 (No.200)http://www.ilo.org/public/english/region/eurpro/moscow/info/publ/wcms_142706.pdf (accessed June 2013).
[167] n 16 above, 6.
[168] The right to an adequate healthy environment http://www.escr-net.org/docs/i/401515 (accessed 22 June 2013).

The polluted environment and waste disposal affect people's lives especially those living with HIV and AIDS. This is due to the fact that both pollution and waste disposal have adverse effects on goods and services such as food, water, sanitation and hygiene services—which, in turn, severely affect PLHIV.[169]

2.5 Conclusion

There is a close nexus between poverty, HIV/AIDS, health and human rights. The underlying determinants of health lay the ground for a broader understanding of the right to health. In implementing the right to health, the state needs to do more than provide treatment and medicines to the people living with HIV and AIDS. The right necessitates the provision of clean water, food and nutrition and clean and healthy environment. These can only be assured in case those living and affected with HIV and AIDS have access to employment and other income generating activities. The rights holders and the duty bearers ought to know their rights and responsibilities respectively, in order to have them enforceable. A rights-based approach to development not only takes into account society's development but also ensures a holistic approach to human development.

[169] S Bolton & A Talman 'Interactions between HIV/AIDS and the environment' (2010) http://data.iucn.org/dbtw-wpd/edocs/2010-043.pdf (accessed 27 June 2013).

CHAPTER 3
RIGHT TO HEALTH FOR POOR PEOPLE LIVING WITH HIV/AIDS UNDER RWANDAN POVERTY REDUCTION STRATEGIES (EDPRS 1& 2)

3.1. Introduction

The present chapter constitutes the core part of the study. It focuses on an analysis of the Rwandan poverty reduction strategies which are known as Economic Development and Poverty Reduction Strategies (EDPRSs). Currently Rwanda has embarked to the second phase of these strategies. The first covered the period from 2008 to 2012.[170] The second covers the period from 2013 to 2018.[171]

Apart from this introduction which constitutes the first section, the chapter has four other main sections. The second section focuses on the contents of the Poverty Reduction Strategy Papers through the prism of international standards. Under this section the relevant principles and human rights standards are discussed. This serves as the point of reference during the analysis of the Rwandan EDPRSs.

The third section analyses the right to health *vis-à-vis* the Rwandan EDPRSs focusing on the positive aspects as well as potential weaknesses. The fourth section analyses HIV and AIDS under the two EDPRSs also focusing on the positive measures and shortcomings. It also discusses the potential significance of the poverty reduction programmes in addressing the concerns of the poor.

Finally, the chapter ends with a brief conclusion.

3.2. The Contents of Poverty Reduction Strategy Papers (PRSPs)

The Office of the United Nations High Commissioner for Human Rights has developed substantive guidelines for the integration of human rights in national poverty reduction strategies (Guidelines). The guidelines have three main chapters but this study focuses on two of them. This is because the

[170] n 19 above.
[171] The second Rwandan Economic Development and Poverty Reduction Strategy (2013-2018).

chapter concerning the rationale of a human rights approach—which is the chapter one of the guidelines—has been discussed in the first chapter of this study. Hence, the chapter containing basic principles[172] to be considered in the process of formulating any national PRSP and the chapter concerning human rights standards which have to be integrated in PRSP[173] have been discussed.

3.2.1. Basic Principles

In the PRSPs, principles such as identification of the poor, national and international human rights framework, equality and non-discrimination, participation, setting targets, benchmarks and priorities, monitoring and accountability, and international assistance and cooperation are of great importance.[174] The seven principles are all important but given the scope and length of this study, this paper discusses the first four.

A. Identification of the Poor

The guidelines mention the identification of the poor as the starting point of any strategy for poverty reduction.[175] They spell out two major steps in the process of this task.[176] The first step is to identify the attributes that are deemed to constitute poverty. These attributes may differ from one society to another according to the priority they have. But one may not ignore to mention the fact that the empirical observation suggests a common set of capabilities that can be considered basic in most societies. These are for example capabilities of being adequately nourished, avoiding preventable diseases and being adequately sheltered.[177]

The second step is to identify the population groups that possess these attributes. This consists in linking the already determined capabilities with the population groups that suffer from inadequate achievement of those

[172] n 22 above, pp 7-22.
[173] n 22 above, pp 23-49.
[174] n 22 above, pp 7-22.
[175] n 22 above, guideline 1.
[176] n 174 above.
[177] n 174 above.

basic capabilities.[178] Different methods might be used to reach this objective. But whatever method is used, the exercise to identify the poor should not be understood as aimed at coming up with the numbers of poor people in general, instead to ascertain who those people are and how poor they are.[179] In this exercise it is also crucial to identify those living in extreme poverty.

It is always possible to have people who are especially deprived and marginalized among those who are already identified as poor. These are population groups such as women, elderly, people with disability, those suffering from racial or religious discrimination and people living with HIV and AIDS.[180] The identification of these groups is crucial. It helps in resources allocation among members of those groups in case of resources scarcity. In other words, when resource constraints call for the setting of priorities, it is the entitlement of these groups that should receive prior attention.[181]

B. National and International Human Rights Framework

In a RBA, any poverty reduction strategy paper should be consistent with, and informed by the state's national and international human rights commitments. As the guidelines state, this will make the strategy more effective and ensure that some features of the strategy are not unlawful.[182] In this respect, the states should ensure that their human rights commitments are expressly referred to in their PRSPs.[183]

C. Participation

Participation is another principle which needs to come out clearly in any PRSP. It has its roots in the concept of country ownership by all stakeholders within the country. As far as this study is concerned the

[178] n 174 above.
[179] n 174 above.
[180] n 174 above.
[181] n 174 above.
[182] n 22 above, guideline 2.
[183] n 181 above.

participation means the ownership of the whole poverty reduction strategy by all citizens—including the poor. It starts from its definition, formulation, implementation, monitoring up to the supervision stage. The guidelines explain the concept of participation by dividing it into four stages: preference revelation; policy choice; implementation; and monitoring, assessment and accountability.[184]

Participation should be understood in a broad manner. For example, when it is seen in a RBA; participation is defined as a right itself and not as a mean to improve the government's programmes performance.[185] This helps to create obligations for the states and responsibility for development agencies to give participation a true meaning.[186]

Further, it is important to mention that, in the context of HIV, participation does not only mean the active involvement of PLHIV and affected communities in the agenda-setting and decision making within a development cooperation project.[187] It also means supporting efforts to challenge power hierarchies in these people's own communities and organisations, in order to achieve equal participation by all.[188] This is done mainly through the process of empowerment, which implies a participatory process that engages people in reflection, inquiry and action. In the context of this study the aim should not be just empowerment in general but empowerment in relation to the possibility to claim and realize their human rights.[189]

D. Equality and Non-discrimination

Equality and non-discrimination are twin principles which also have relevance in any poverty reduction strategy. Generally, the right to equality is understood as the means to guaranteeing that all persons are equal

[184] n 22 above, guideline 5.
[185] Lundström Sarelin (n 27 above) 477.
[186] As above.
[187] As above.
[188] As above.
[189] As above.

before the law.[190] This means that the law shall be formulated in general terms applicable to every individual and shall be enforced in an equal manner. The principle of non-discrimination on its side prohibits all prejudicial or unjust treatment of persons on grounds of race, colour, sex and health status, including HIV/AIDS just to name a few.[191]

With regard to people living in poverty, it is a fact that they are typically victims of discrimination based on different grounds as already mentioned. As the guidelines put it clearly, discrimination may cause poverty just as poverty causes discrimination.[192]

Having knowledge about this interconnection between poverty and discrimination one may affirm that the situation might be worse for poor people living with HIV/AIDS.[193] For them, they suffer double vulnerability to discriminatory practices. Vulnerability linked to poverty and that linked to HIV status. Hence, the study suggests that poverty reduction strategies should be formulated and implemented in a way that takes into consideration realities around poor people living with HIV/AIDS.

3.2.2. Specific Human Rights Standards

A human rights-based poverty reduction strategy should expressly incorporate human rights. Based on the understanding that human rights can be relevant to poverty in different ways, only rights with special significance in the context of poverty were highlighted in the guidelines.[194] The guidelines list eight core human rights that must be integrated in any human rights-based PRSP: right to work, right to adequate food, right to adequate housing, right to health, right to education, right to personal security and privacy, right of equal access to justice and political rights and freedoms.[195]

---

[190] n 90 above, article 7.
[191] n 22 above, guideline 3.
[192] n 22 above, guideline 3.
[193] Emphasis by the author.
[194] n 22 above, para 6.
[195] n 22 above, pp 23-49.

Given the focus of the study, only the relevance of incorporating the right to health in the poverty reduction strategy paper is examined.

A. Right to Health

The right to health is a core right which must clearly come out in any health component of a PRSP. This is because it has a crucial role to play in relation to poverty reduction.[196] During the development of a PRSP, it is crucial to make sure that its health component addresses deeply the causes of poverty and their impact on the health of the poor and vulnerable people.[197] In other words, the PRSP should have a closer look at how poverty is increasing the vulnerability of the poor to health-related problems, as well as exacerbating ill-health and whether poverty in itself is proving an impediment to the capacity of the poor to seek adequate health care services when needed.[198]

Different studies have established the linkages between health and poverty. Early in this study, it has been mentioned that ill health causes and contributes to poverty by destroying livelihoods, reducing worker productivity, lowering educational achievement and limiting opportunities.[199] It is both the cause and consequence of poverty. Good health on its side, contributes to create and sustain the capabilities that the poor need to escape from the poverty.[200] So, in the efforts to develop any PRSP it should be understood that good health is not just a result of development, but most importantly, it is a way to achieve that development.[201] At this point one may not ignore to mention that the enjoyment of the right to health is instrumental to securing other human rights.[202]

---

[196] n 22 above, pp 34-37.
[197] n 33 above, p 29.
[198] n 33 above, p 27.
[199] n 22 above, para 171.
[200] n 22 above, para 172.
[201] As above.
[202] n 22 above, para 173.

With regard to HIV/AIDS, incorporating health in a PRSP as a right is crucial. Poverty is a factor in the spread of HIV,[203] but it is also a barrier to the enjoyment of health by PLHIV because of lack of capabilities as it has already been mentioned. So, the identification of diseases such as HIV/AIDS, which have a particular impact on the poor and providing solutions in a rights-based approach, is crucial. It empowers poor people to know the obligations and duties of the governments and other development agencies and consequently claim and assert them in case of failure and inefficiency on the side of duty-bearers.

3.3. Right to Health under the EDPRSs

A. Under EDPRS 1

The EDPRS 1 recognised the importance of health in order for it to be implemented.[204] As the consequence, it has provided that the sectoral allocation of public expenditure was to be distributed to maintain momentum in social sectors including health.[205] It specifically, mentions that in the health sector, the objectives were to maximise preventative health measures and to build the capacity to have high quality and accessible health care services for the entire population in order to reduce malnutrition, infant and child mortality, and fertility, as well as to control communicable diseases.[206]

In order to achieve those objectives some measures were put into place. These include strengthening institutional capacity, increasing the quantity and quality of human resources, ensuring that health care is accessible to all the population, increasing geographical accessibility, increasing the availability and affordability of drugs, improving the quality of services in the control of diseases and encouraging the demand for such services.[207]

---

[203] n 33 above, p 27.
[204] EDPRS 1, p 8.
[205] As above.
[206] EDPRS 1, p 9.
[207] As above.

The EDPRS 1 also has established the link between improved health and higher income.[208] It stated that:

> Poverty and poor health are often linked in a vicious cycle. Poverty exposes households to greater health risks stemming from under nourishment, limited or no access to safe drinking water and basic sanitation, overcrowding, illiteracy, and an inability to access or utilise health care resources. Poor health reduces households' savings, constrains learning ability, lowers productivity, and leads to a low quality of life.[209]

With regard the implementation of the EDPRS health strategy, the EDPRS 1 has assigned roles to different stakeholders.[210] Two Ministries were at focal point: Ministry of Health (MoH) and Ministry in charge of local government (MLG).[211] Among tasks assigned to them were, to formulate policies, laws and decrees; mobilise resources and build capacity among others (on the side of MoH).[212] Local governments were responsible for ensuring that the health component of the EDPRS was effectively implemented.[213]

B. Under EDPRS 2

Apart from giving a summary of what has been achieved under the past poverty reduction strategy in the health sector, the EDPRS 2 specifically, promises to improve the quality of health care services.[214] This includes the management of hospitals, and expansion of the geographical and financial accessibility.[215] EDPRS 2 uses economic and social benefits as incentives for rural populations to move to formal settlements. Among social benefits the EDPRS 2 highlights the provision of schools, safe water, sanitation, and health centres just to name a few.[216]

[208] EDPRS 1, p 104.
[209] As above.
[210] EDPRS 1, p 126.
[211] As above.
[212] As above.
[213] As above.
[214] EDPRS 2, p 15.
[215] As above.
[216] EDPRS 2, p 59.

It recognises that water supply and sanitation play a critical role in preventive healthcare and socio-economic development in rural areas.[217] With regard to poor maternal, infant and child feeding, it observes that the effort to strengthen and scale up community based nutrition programmes and information campaigns across the country, will be a solution.[218]

The EDPRS 2 also has what it calls foundational issues.[219] Health is one of these issues.[220] These foundation issues enjoy priority in terms of allocation of funds. Health comes as number one priority for funding purposes.[221] It accounts for 31 per cent of total foundational issues costs. Education comes second with 29 per cent, transport with 10 per cent and others come after.[222] The EDPRS 2 seems to have given much attention to the health care component of the right to health.

3.3.1. Critique of measures instituted

A. Positive developments

It is significant that both the Rwanda EDPRSs recognise health as a key component in development efforts. They have included health across their different sections. They recognise the interconnection between health and poverty.

It is also significant to mention that the two EDPRSs recognise some of the essential elements of the right to health. They expressly mention water, sanitation and healthy environment as key factors for good health. This is in accordance with what is provided for by the Committee on ESCR under General Comment No 14. Under these strategies, especially EDPRS 2, health is among the foundational issues and is given priority over others. As the

[217] EDPRS 2, p 68.
[218] EDPRS 2, p 97.
[219] Foundational issues are on-going programmes that contribute directly to long-term development that are prerequisites for the existence of EDPRS 2. They provide the base for the realisation of the EDPRS 2 goals.
[220] EDPRS 2, p 128.
[221] EDPRS 2, p 68.
[222] EDPRS2, p 129.

result it is allocated more funds from the public expenditure. This is also in consonance with the provision of the CESCR.[223]

Another positive element is that, both strategies expressly mention the *accessibility* and *availability* of health care services. With regard to accessibility, both geographical and financial accessibility are set as objectives to be achieved. Regarding availability, it is provided that drugs will be available both in terms of quantity and quality. However, on this point one may not ignore to mention that *acceptability* has not been addressed.

Issues of increasing the number of medical personnel and their capacity building, assigning specific tasks to particular government institutions in order to facilitate implementation were also provided. These respond to the demand of the Committee on ESCR, where it suggests to the government to ensure the appropriate training of doctors and other medical personnel.[224]

B. Weaknesses

Though, the EDPRS 1 and 2 have registered some positive measures, they also have a number of weaknesses in relation to the right to health.

To begin with, the two EDPRS are not expressly founded on the norms and values set out in the international law of human rights. This contradicts what is provided by the guidelines. The guidelines provides that the essential idea underlying the adoption of a human rights approach to poverty reduction is that policies and institutions for poverty reduction should be based explicitly on the norms and values set out in international human rights law.[225] Nowhere in both EDPRSs was health referred to as a right. The language used is not imposing any obligations on the side of Government. Under both EDPRSs, health and its essential elements were mentioned as programmatic aspirations to achieve development, instead of being provided as policies which may be given legal effects in terms of rights.

[223] n 82 above, article 2(1).
[224] General Comment No 14 para 36.
[225] n 22 above, para 16.

The Rwandan EDPRS do not provide for basic principles which are recognised in the international standards as fundamental in any PRSP.[226] For example, the EDPRS 1 was found on three flagships namely: sustainable growth for jobs and exports, vision 2020 *Umurenge* and governance. The EDPRS 2 made a step by using the term *principles*. However, none of the basic principles mentioned above which were recommended as the international standards were included. Instead, it is based on principles such as *innovation, emerging priorities, inclusiveness and engagement, District-led development and sustainability*.[227] So, it is conspicuous that both EDPRS lack this important feature, which should have been basically the cornerstone. In other words both EDPRSs are not founded on the need or duty to respect and fulfil human rights and hence they don't have a human rights based approach.

Further, both EDPRS have referred to some elements which may fall under core minimum content of the right to health, if they were to be looked at in a human rights perspective. They make reference to concepts like water, sanitation, essential drugs and primary health care. But, the problem remains the same as the language used has nothing to do with human rights standards. For example, on the issue of housing, the EDPRS 2 acknowledges that the demand for housing is highest among low income earners, making up more than 90 per cent of the demand. But when it comes to solutions the use of a statement like 'mobilisation of large scale private investment in affordable housing and funding mechanisms to support the mortgage finance industry,' seems to contravene international human rights law standards. This makes the Government's obligations unclear. It should have said, for instance that every person is entitled to primary health care, adequate housing, or essential drugs. Based on this, the study argues that the Rwandan PRSPs fall short of the core minimum content of the right to health.

---

[226] Set of principles such as identification of poor, national and international human rights framework, equality and non-discrimination and some other are mentioned in the guidelines as principles that must appear in any poverty reduction strategy.
[227] EDPRS 2, p 31.

EDPRS 2 uses goods and services with direct impact to health as incentives for rural populations to move to formal settlements. Safe water, sanitation facilities and health centres are highlighted. It states that 'for individual households making settlement decisions, the economic and social benefits of living in a formal settlement must outweigh those of living in a scattered settlement.' This means that those living in formal settlement are more likely to access health care service than their counterparts who are not.

The study observes that such decisions can adversely affect the health of the poor who live in scattered settlements as they might not be able to afford the costs of resettlement. The situation might be worse for those infected with or affected by HIV/AIDS as they may be affected by long distance to access health services. Hence, the study submits that the effort that is put into activities aimed at providing those facilities should be the same as the effort aimed at identifying and helping poor and vulnerable people to get closer to health services, otherwise it might result in discrimination.

Finally, both EDPRS fail to propose the adoption of a legal document with binding force that recognises health as a right; distinguishes between the duty bearer and the right holder; and states the roles of each of them.

3.4. HIV and AIDS under the Rwandan EDPRSs

Both EDPRSs provides for HIV/AIDS and recognises it as a cross-cutting issue. However, the retrogression is noticed in the EDPRS 2 if you compare it with the EDPRS 1. The latter mainstreamed HIV almost in all its sections. It tackled the important areas that are useful to address problems related to HIV/AIDS. The former makes reference to HIV/AIDS only in one section concerning the prevention of HIV.

3.4.1. Critique of Measures Provided

A. Positive Developments

EDPRS 1

The EDPRS 1 has incorporated HIV/AIDS as a cross-cutting issue together with other issues such as gender, environment, social inclusion and youth.[228] This has given room for HIV to be discussed in depth throughout the whole EDPRS 1.

Firstly, it recognised the link between sustainable development and the different cross-cutting issues (CCIs)—HIV included.[229] In that regard, it has provided that CCIs should be included in all development sectors. This is in line with what is provided by the guidelines. The later includes among key features of a poverty reduction strategy to realise the right to health, the identification of diseases that have a particular impact on the poor.[230] The guidelines identify HIV as one of those diseases.[231]

It has also set some objectives aimed at reducing HIV incidence and mitigating negative attitudes towards HIV/AIDS. In that regard, the EDPRS 1 had set as its objectives to reduce HIV incidence among 15-24 year old men and women.[232] The rate for people tested for HIV was provided to rise from 65 per cent to 95 per cent.[233] The number of health centres with integrated VCT and PMTCT programmes had to be increased, while the proportion of women accessing PMTCT programmes had to be increased.[234] Also the increase in use of condoms as a means to prevent the spread of HIV was a concern under EDPRS 1.[235]

With regards to support, it was provided that different kinds of support were to be given to vulnerable people including those living with HIV. Among

[228] EDPRS 1, p 10.
[229] EDPRS 1, p 57.
[230] n 22 above p 42.
[231] As above.
[232] EDPRS 1, p 50.
[233] EDPRS 1, p 51.
[234] As above.
[235] EDPRS 1, p 57.

others, the EDPRS 1 highlighted the creation of legal aid programmes to improve access to justice for vulnerable people[236] and strengthen the provision of therapeutic and supplementary feeding services for malnourished children and PLHIV both at health facilities and community level.[237] Further, it stated that the HIV sector had to identify issues that adversely affect vulnerable groups and advocate for changes in areas pertinent to those infected and affected by HIV/AIDS.[238] Those areas included land rights, land tenure, participation in governance, and access to education, health and priority infrastructure such as shelter, water and sanitation.[239]

The EDPRS 1 has clearly mentioned the changes that should be made in sectors such as education, infrastructure and agriculture in order for them to contribute in the HIV response.

In the education sector, the school curriculum had to be revised to include new subjects which should promote positive attitudes towards issues such as gender equality, environment, population and HIV/AIDS.[240]

In the infrastructure sector, it provided for the development of an evidence-based action plan to ensure that a set of appropriate measures were in place, so that the delivery of the transport infrastructure and services contribute to the HIV/AIDS response. For example measures to prevent HIV/AIDS at rest areas along truck corridors were to be put into place. Furthermore, all tender contracts were required to have clauses addressing HIV/AIDS and had to allocate some percentage of the budget to HIV/AIDS.[241]

Finally, the agriculture sector was tasked to ensure access to food for the most disadvantaged and vulnerable rural households. To achieve this objective, it was provided to increase the production of key food crops

[236] EDPRS 1, p 92.
[237] EDPRS 1, p 107.
[238] EDPRS 1, p 109.
[239] As above.
[240] EDPRS 1, p 76.
[241] EDPRS 1, p 71.

coupled with the introduction of the special food security programmes. The latter had to address the specific needs of groups of people such as those living with HIV.[242]

EDPRS 2

As mentioned at the beginning of the present section, the EDPRS 2 seems to have not provided for HIV/AIDS as the EDPRS 1. The former provides for HIV/AIDS under its section on HIV/AIDS and non-communicable diseases (NCDs).

First, it commends the achievements that are already registered by Rwanda in fighting HIV and AIDS[243] and promises that the health sector will continue to contribute to the national efforts to halt the spread of HIV/AIDS. It mentions that this will be achieved through education of individuals and families about HIV/AIDS, provision of counselling, distribution of condoms, and making sure that all patients with HIV/AIDS receive and adhere to treatment and support. [244]

Finally, it provides that the key interventions will be regular sensitisation regarding HIV, voluntary counselling and testing, prevention of mother to child transmission and condom distribution.[245]

C. Shortcomings

Though, both Rwandan EDPRSs, specifically the EDPRS 1 have registered a number of positive measures, some shortcomings are also to be noted.

Firstly, it is important to note that both EDPRSs fail to state all their interventions in relation to HIV/AIDS as human rights. They were elaborated in a way that does not impose any obligations on the Government and does not give rise to just claims by citizens in case of non-compliance by the Government. As already mentioned, both EDPRSs provide for interventions such as provision of drugs, health care facilities, prevention

[242] EDPRS 1, p 76.
[243] EDPRS 2, p105.
[244] As above.
[245] As above.

and treatment of HIV/AIDS, use of condoms, HIV/AIDS education, just to name some. All of these fall under the meaning of article 12.2(c) and 12.2(d) of the CESCR and they are rights according to the Committee on ESCR under General Comments No 14.[246] So, the failure by both EDPRSs to recognise all these interventions as human rights is regarded as a contravention of the international human rights law standards.

Secondly, the lack of important principles such as *identification of the poor* and *equality and non-discrimination* is a major weakness to both EDPRSs in general but most especially when it comes to the issue about strategising for vulnerable and marginalised people. People in these groups suffer different human rights violations, stigma and discrimination being on top.[247] Thus, efforts should be made in the identification of the poor with special attention on the identification of those who are most vulnerable among them. The failure to do so may result in a PRSP being meaningless for the intended beneficiaries.

For example, the poor and marginalised people have less participation due to the lack of confidence.[248] This should inform governments about the possibility to adopt a suitable approach of bringing these groups on board in development activities. Hence, the study suggests that PRSPs must clearly address the issues of discrimination and stigma perpetuated against the poor and marginalised groups. Furthermore, the PRSPs should have an informed, transparent and participatory process of identifying the poor.[249] All in all, the whole process should be done in way that respects human dignity.

Though, EDPRS 2 shares the above mentioned weakness with the EDPRS 1, the former has some other weaknesses which are particular to it. The major weakness is the retrogression that is made in terms of strategising for PLHIV. The EDPRS 2 has almost left out all interventions which were

[246] General Comment No 14 para 16.
[247] OHCHR, Factsheet no 31 p 15.
[248] Filmer-Wilson (n 24 above) 225.
[249] Manfred Nowak (n 40 above) 29.

provided for PLHIV in the preceding EDPRS and where it provides for any intervention there are no details of how it could be implemented.

The Committee on ESCR does recognise the possibility of reviewing an existing strategy. However, the process by which the strategy and plan of action are reviewed, as well as their content, shall always give particular attention to all vulnerable or marginalized groups.[250] Hence, the study submits that this retrogression worsens the situation of the poor in general and of the poor PLHIV in particular, as it deeply compromises the enjoyment of their right to health.

3.5. Eligibility to Programmes Aimed at Reducing Poverty

Both EDPRSs failed to clearly provide for criteria for an individual or household to be eligible to any of the poverty reduction programmes. However, the EDPRS 1 provided for the responsibility of the Districts to make sure that any support provided reaches the most vulnerable.[251] This has led to the fact that different poverty reduction programmes have set their own criteria. The example that may be given is the 'one cow per poor family' programme.

One cow per poor family programme has two general criteria. First, the programme specifically focuses on homesteads that have less than 0.75 ha of land. Secondly, the programme is designed to focus on the area with high level of child malnutrition.[252] Apart from these land and malnutrition criteria, poor persons have, in addition, to fulfil the following conditions:

- They should not already own a cow;
- They should have controlled soil erosion on their land;
- They should have planted at least 20 acres of pasture;
- They should have constructed a shelter to house the animal;

[250] General Comment No 14 para 43(f).
[251] EDPRS 1, P 138.
[252] http://amis.minagri.gov.rw/category/livestock (accessed 28 August 2013).

- They should have mechanisms for water harvesting and conservation for the animal;

- They should have at least two pits near the homestead and shows good care for the environment;

- They should be growing and having a reasonable yield of one crop that is suitable for the particular area; and

- They should be of exemplary character and should participate in development and other activities related to good governance and poverty reduction.

Having read these criteria and knowing the poverty levels that exist in Rwanda,[253] one may not escape from questioning how these criteria might accommodate those who are really poor. It is clear that these criteria to be fulfilled need to be backed up with finances, yet a non negligible proportion of Rwandans are still in extreme poverty. Furthermore, the health component of these criteria is infinitesimal, and worse they have nothing to do with marginalised people including poor PLHIV. Hence, the study argues that if these criteria are maintained as they are, a large number of poor people might not be reached by the scheme and consequently, it will result in discrimination.

3.6. Conclusion

Poverty reduction strategy is crucial in order to achieve the full enjoyment of economic, social and cultural rights. However, this will be workable when the poverty reduction strategy is expressly based on the norms and values set out in international human rights law or briefly, when it adopts a HRBA. Furthermore, the poverty reduction strategy will need to clearly define who the duty-bearers are and who the rights-holders are and their respective responsibilities.

[253] It has already mentioned that 46.9 per cent of Rwandans are under poverty line whereas 24 per cent are living in extreme poverty.

The present chapter has demonstrated that both Rwandan EDPRSs have to some extent been able to address some issues with particular relevance to the health of the poor in general and of the poor PLHIV in particular. However, it has also noticed that both EDPRSs have a number of weaknesses.

They failed to expressly integrate basic human rights principles and standards as suggested by international human rights law. They fall short of addressing some essential elements of the right to health. They do not provide for the possibility to adopt a legal document with binding force with the view to recognise health as a human right and clearly identifying who the duty bearers and right holders are, as well as clearly highlighting their respective roles. Further, this chapter has noted that EDPRS 2 has retrogressed with respect to health of poor PLHIV.

CHAPTER 4

4. CONCLUSIONS AND RECOMMENDATIONS

4.1. Introduction

This chapter gives conclusions based on research findings in relation the research questions the study addresses. It then makes recommendations based on the conclusions**.**

4.2. Conclusions

This study was intended to critically analyse the Rwandan poverty reduction strategies in relation to the right to health for people living with HIV and AIDS. It was divided into four chapters based on the research questions. Chapter one was the background to the study and it also served as an introduction. The second chapter discussed the link between poverty, the right to health, and HIV/AIDS. It was crucial as it defined these concepts from a human rights perspective and laid the foundation for the third chapter. The latter was the core part of the study. It focused to the Rwandan poverty reduction strategies and analysed how they provide for health of the poor PLHIV. Drawing on international human rights standards regarding the formulation of poverty reduction strategies, both Rwandan EDPRSs were put to the test. Consequently, on the one hand, some positive developments were analysed but on the other hand, weaknesses were also highlighted. Finally, based on the discussions in the aforementioned chapters, this chapter presents the conclusions and recommendations.

A. HIV/AIDS Incidences and Poverty Levels

Firstly, the study found that there has been essentially no change in Rwanda's HIV prevalence since 2005. It remained 3.0 per cent for women and men aged 15–49.[254] However, the prevalence is higher among women than men. The situation is worse in groups of women such as widows and divorced women as the rates rise to 16.6 per cent. These findings question the effectiveness of the GoR's effort in the fight against HIV/AIDS but also

[254] n 11 above, p 27.

they should inform the Government about the increase in vulnerability among women.

The research has also found that poverty levels have been considerably decreasing since the adoption of the EDPRS 1. However, it is also important to mention that these levels are still high. This is explained by the fact that 44.9 per cent of Rwandans are still living under the poverty line while 24.1 per cent are living under extreme poverty.[255]

Furthermore, it is important to mention that both EDPRSs have to some extent recognised the link between health and poverty. In addition, both EDPRS recognised HIV/AIDS as a cross-cutting issue, though it was not given the same weight in both documents.

B. Rwandan Poverty Reduction Strategies and Right to Health

Firstly, the study found that both EDPRSs did not recognise health as a human right. This is mainly based on the fact that they did not clearly mention who the duty bearer is and who the claims holder is, as well as their respective roles in relation to the right to health. This has a great consequence that citizens found themselves in impossibility to claim anything under the provisions of these EDPRSs. Hence, the study argues that the enjoyment of the human right to health might be at stake. Further, the remedy might also be practically impossible given that the concept of accountability that was referred to in both EDPRSs might remain dead letters in real life of the citizens. The situation becomes worse given the fact that even the Rwandan Constitution does not recognise health as a justiciable right.

Also, none of the EDPRSs were explicitly based on the norms and values set out in international human rights law. They have instead adopted their own principles. This undermines the friendliness of the two EDPRSs to human rights. Based on that, the effectiveness and sustainability of the

[255] EDPRS 2, p 27.

interventions made in the efforts to reduce poverty in general and poverty among marginalised people in particular becomes questionable.

Further, this research found that the EDPRS 2 has retrogressively strategised with regards to health of PLHIV. While the EDPRS 1 had integrated HIV/AIDS almost across all its sections by addressing a number of important issues, the EDPRS 2 provides HIV/AIDS only in one section and without details. Hence, the study submits that this perceived deliberate choice might be regarded as a tactical or even strategic mistake on the side of the Government since it might result in an increase in new HIV infections.

C. Eligibility to Poverty Reduction Programmes

The research has established that none of the EDPRSs has set conditions for an individual or a household to benefit from any poverty reduction programmes. This led to the fact that any poverty reduction programme that is to be implemented in Rwanda has to set its own conditions. Most of these conditions have been criticised to be discriminatory, as it is extremely difficult for the poor to meet them. For example, the poor have to have money in order to prepare themselves to be given a cow under the programme known as 'one cow per poor family.'

4.3. Recommendations

This study has provided the analysis from a HRBA and as such a number of recommendations are proposed to the GoR. The latter are made in light of the research findings.

Firstly, the GoR should recognise health as a human right. In that regard, the provisions of article 41 of the Constitution should be amended in order to have the right stated in the language that obligates the Government and gives entitlements to the citizens. In other words, the right to health should be incorporated as a justiciable right.

Secondly, the human right to health should be understood in its broad meaning. It means, as the right which encompasses both elements

constituting health care and the underlying determinants of the right to health. Once health is understood in that sense, the Government's interventions will be human rights-motivated and not a mere fact to achieve a development objective. For example, setting up health centres, provision of clean and portable water, adequate sanitation and other essential elements of the right to health will not be regarded as incentives for citizens to move from scattered settlements to formal ones. They should rather be regarded as human rights to be enjoyed equally by citizens from both formal and scattered settlements.

Thirdly, the GoR should adopt a HRBA to poverty reduction strategy. This—in the Rwandan context—is justified by the fact that the existing levels of poverty and HIV incidences have their roots in the Rwandan history which for decades was characterised by discrimination and social exclusion. This history culminated in the 1994 genocide against Tutsis. The latter has not only destroyed the Rwandan economic fabric but also systematic rapes used during this genocide, have greatly contributed to increase HIV infections. Hence, the study recommends the HRBA as the one which focuses both on the *process* and the *outcome* of development. In addition, it does not only deal with the symptoms of poverty but most importantly with its underlying causes.

Fourthly, it is recommended for the next Rwandan poverty reduction strategy to have a clear process and just criteria to determine both the causes of poverty and the poor themselves. This should be an informed, transparent and participatory process. Further, the process should not compromise respect for human dignity. The existing criteria as has been adopted by some poverty reduction programmes should be revised as they were criticised to be discriminatory against the real poor.

Finally, the GoR should make sure that policies, rules and Government practice in relation to health in general and health of the poor PLHIV in particular are not retrogressive. The Committee on ESCR recognised that a strategy or other document relevant to health may be reviewed. However,

this should be done through the same process as the process of their adoption and it should always give particular attention to vulnerable and marginalized groups.[256]

[256] General Comments No 14 para 43 (f).

BIBLIOGRAPHY

Journal Articles

Akhavan, P 'The Crime of Genocide in the ICTR Jurisprudence' (2005) *1004 Journal of International Criminal Justice* 989

Daniel Kidder, P et al; 'Health status, health care use, medication use, and medication adherence among homeless and housed people living with hiv/aids' (2007) 97*American Journal of Public Health* 2238

Filmer-Wilson, E 'The rights-based approach to development: the right to water' (2005) 23 *Netherlands Quarterly of Human Rights* 213

Hunt, P 'Key Objectives, themes, and interventions' (2003-2004)*7 Health and Human Rights* 1

Hunt, P Nowak, M Osmani S 'Human rights and poverty reduction strategies: A discussion paper of 28 February 2002 as cited by M Nowak 'A human rights approach to poverty' (2002) *Kluwer Law International* 26

Kapindu, RE 'Poverty reduction strategies and the rights to health and housing: The Malawian and Ugandan experiences' (2006) 6 *African Human Rights Law Journal* 493

Lundström, SA 'A human rights-based approaches to development cooperation, HIV/ AIDS, and food security' (2007) 29 *Human Rights Quarterly* 460

Mubangizi JC 'Know your rights: exploring the rights and the connections between human rights and poverty reduction with specific reference to South Africa' (2005) 21 *South African Journal of Human Rights* 32

Nowak, M 'A human rights approach to poverty' (2002) *Human Rights in Development* 15

Sob, P 'The implementation gap in the economic, social, and cultural rights field: a critical cross-examination of the agenda of the United Nations' (2007) 15 *African Year Book of International Law* 11

Wegelin-Schuringa, M & Kamminga, E 'Water and sanitation in the context of HIV/AIDS: The right of access in resource-poor countries (2006) 9 *Health and Human Rights* 152

Papers and Reports

ICTR 'Jean Paul Akayesu Summary of the Judgement' (1998)

Collins, J & Rau, B 'AIDS in the context of development' (2000)

Frequently asked questions on a human rights-based approach to Development cooperation (2006) OHCHR

International Guidelines on HIV/AIDS and Human Rights (2006) OHCHR, UNAIDS

Principles and guidelines for human rights approach to development reduction strategies (2006) OHCHR

Twinomugisha, B 'Protection of the right to health care of women living with HIV/AIDS (WLA) in Uganda' (2007)

Human rights, health and poverty reduction strategies (2008) OHCHR

The Right to Health, Fact Sheet No. 31 (2008) OHCHR, WHO

Vandenbogaerde, A 'The right to food in the context of HIV/AIDS' (2009)

Bolton, S & Talman, A 'Interactions between HIV/AIDS and the environment' (2010)

WHO *Healthy workplace framework and modal synthesis report* (2010)

ILO Recommendation concerning HIV and AIDS and the world of work (2010)

UN, *Report of the Special Rapporteur on extreme poverty and human rights, Magdalena Sepúlveda Carmona,* 2013

International Human Rights Instruments

International Convention on Elimination of all Forms of Racial Discrimination, 2106 (XX), adopted 21 December 1965, entered into force 4 January 1969

International Convention on the Elimination of All Forms of Discrimination against Women, 34/180, adopted 18 December 1979, entered into force 3 September 1981

International Convention on the Rights of the Child, 44/25, adopted 20 November 1989, entered into force 2 September 1990

International Covenant on Economic, Social and Cultural Rights, 2200A (XXI), adopted 16 December 1966, entered into force 3 January 1976

Universal Declaration of Human Rights, 217 A (III), adopted 10 December 1948

General Comment No 15 on the right to water (2002)

General Comment No 4 on the right to adequate housing (1991)

General Comments No 14 on the right to the highest attainable standard of health (2000)

Regional Human Rights Instruments

African Charter on Human and Peoples' Rights, OAU Doc. CAB/LEG/67/3, adopted 1 June 1981, entered into force 21 October 1986

African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49, adopted 1 July 1990, entered into force 29 November 1999

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, AHG/Res.240 (XXXI), adopted 1 July 2003, entered into force 25 November 2005

Rwandan Legislation

Constitution of the republic of Rwanda (4 June 2003)

Country Reports and Statistical Documents

Rwanda Demographic and Health survey' (2010)

Rwanda Economic Development and Poverty Reduction Strategy (2013-2018)

Rwanda National strategic plan on HIV and AIDS (2009-2012)

Rwandan Economic Development and Poverty Reduction Strategy (2008-2012)

The Third Integrated Household Living Conditions Survey (2010/11)

Electronic Sources

AMIS Rwanda, 'A proposal to distribute cow to every poor family in Rwanda (2006)', http://amis.minagri.gov.rw (accessed 28 August 2013)

Council of Europe, 'Human rights education: fighting ignorance, encouraging tolerance', http://www.coe.int (accessed 20 June 2013)

OHCHR, 'Human rights and poverty reduction', http://www.ohchr.org (accessed 14 June 2013)

OHCHR, 'Principles and guidelines for a human rights approach to poverty reduction strategies', http://www.ohchr.org (accessed 14 June 2013)

OHCHR, 'Draft guidelines: a human rights approach to poverty reduction strategies', http://www.refworld.org (accessed 14 June 2013)

UN, 'The Universal Declaration of Human Rights', http://www.un.org (accessed 17 June 2013)

UN, 'Declaration on the Right to Development', http://www.un.org (accessed on 14 2013)