Legal and Policy Framework for the Realization of the Right to Health in Ethiopia: *The Case of Persons Living with Podoconiosis, Wolayta Zone Southern Ethiopia*

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### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACHPR</td>
<td>African Charter on Human and Peoples’ Rights</td>
</tr>
<tr>
<td>CEDAW</td>
<td>International Convention on the Elimination of All Forms of Discrimination Against Women</td>
</tr>
<tr>
<td>CERD</td>
<td>International Convention on the Elimination of All Forms of Racial Discrimination</td>
</tr>
<tr>
<td>CESCR</td>
<td>The United Nations Committee on Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>CRC</td>
<td>International Convention on the Right of Child</td>
</tr>
<tr>
<td>DPSP</td>
<td>National Policy Principles and Objectives</td>
</tr>
<tr>
<td>FDRE</td>
<td>Federal Democratic Republic of Ethiopia</td>
</tr>
<tr>
<td>HEWs</td>
<td>Health Extension Workers</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immune Virus/Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>HRC</td>
<td>The Human Rights Committee</td>
</tr>
<tr>
<td>HSDP</td>
<td>Health Sector Development Program</td>
</tr>
<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
</tr>
<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>MFTPA</td>
<td>Mossy Foot Treatment and Prevention Association</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
</tr>
<tr>
<td>---------</td>
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<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
</tr>
<tr>
<td>NTDs</td>
<td>Neglected Tropical Diseases</td>
</tr>
<tr>
<td>OAS</td>
<td>Organization of American States</td>
</tr>
<tr>
<td>SERAC</td>
<td>The Social and Economic Rights Action Centre</td>
</tr>
<tr>
<td>STH</td>
<td>Soil Transmitted Helminthiasis</td>
</tr>
<tr>
<td>TGE</td>
<td>Transitional Government of Ethiopia</td>
</tr>
<tr>
<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Abstract

Ethiopia has a significant number of people living with podoconiosis. Despite this, podoconiosis (endemic non-filarial elephantiasis) is one of the most neglected tropical diseases, and little is known of the socio-cultural impact of the disease in Ethiopia. In addition, the right to health of persons living with podoconiosis has been grossly neglected. Necessary healthcare and support services are frequently unavailable or inaccessible, while some human rights are denied within services where they do exist. This article explores the right to health as it relates to persons living with podoconiosis under international and regional human rights instruments, and issues affecting the realization of the right to health of persons living with podoconiosis in Ethiopia. It develops an analytical framework for the right to health, derived from General Comment 14 on the right to health of the United Nations Committee on Economic, Social and Cultural Rights; and it applies this framework in the context of persons living with podoconiosis. Although the Constitution of Ethiopia does not explicitly recognize the right to health, Ethiopia has ratified international and regional human rights instruments which guarantee the right to health as a fundamental human right. Arguing that policy and legislative initiatives are a prerequisite to the realization of the right to health for persons living with podoconiosis, the paper explores the major obstacles through human rights perspectives, (including unavailability of health care facilities, goods and service, inaccessibility, stigma and discrimination). The study does this in the first instance by analyzing the extent to which the legal and policy framework protects this right in Ethiopia, and delimits the scope, contours and content of the right, with a particular analysis of the situation of podoconiosis patients in Ethiopia. Furthermore, the paper identifies some of the non-guaranteed rights of these patients; for instance the right to health, right to work, right to education and right to form a family.

Key Words: The Right to Health, Podoconiosis, Human Rights Instruments, Realization
Chapter One

Introduction

1.1 Background of the Study
Wolayta Zone has a population of about 2.0 million with a natural population growth rate of 3%. The average family size is 8 to 10 persons per households. The infant mortality rate is 200/1000 live births. Over 95% of the population earns their living from subsistent farming, which makes the soil contact frequently. Wolayta Zone is one of the most densely populated areas in the country with average of 640 people Km\(^2\). The average land holding is said to be 0.4 ha/family. Famine, drought and epidemics of various communicable diseases repeatedly struck Wolayta.\(^1\) The elephantiasis patients’ survey conducted in the seven Woreda of Wolayta Zone in September 2005 showed that the prevalence of Podoconiosis exceeds 5.0%.\(^2\) Although there is a high number of an elephantiasis case in the area, there is no program set to meet this problem in the region.\(^3\)

Podoconiosis (endemic non-filarial elephantiasis) is a chronic disease characterized by the development of persistent swelling of plantar foot which progresses to the dorsum of the foot and encompasses lower leg slowly. It is non-infective disease, usually results from crystalline blockage of the lymphatic system of the limb, and almost always affects the lower limbs, especially the feet and rarely extends above knee. Most of the time when the disease advances it is accompanied by a number of acute episodes. Finally the disease may end up in a permanent feature of elephantiasis of varying degree.\(^4\)

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Podoconiosis (endemic non-filarial elephantiasis) has been recognized as a specific disease entity for over 1000 years and is widespread in tropical Africa, Central America and North India, yet it remains a neglected and under-researched condition.\(^5\)

From the time of the Roman Empire, travelers recorded anecdotes about people with progressive swelling of the feet. A more detailed reference to 'swollen legs' appears in the Tibetan translation of a fourth century revelation originally recorded in Sanskrit as the second book of Rgyud-Bzhi (the 'four tantras'). However, it was not until c.905 Persian physician Rhazes first distinguished elephantiasis 'of the Greeks' (lepromatous leprosy) from that 'of the Arabs' (most probably non-filarial elephantiasis).\(^6\)

In the 1770s, the adventurer James Bruce gave a graphic description of the elephantiasis he saw in Gondar, northern Ethiopia:

“the chief seat of this disease is from the bending of the knee downwards to the ankle; the leg is swelled to a great degree, becoming one size from bottom to top, and gathered into circular wrinkles...from between these circular divisions a great quantity of lymph constantly oozes. It should seem that the black colour of the skin, the thickness of the leg, its shapeless form and the rough tubercules or excrescences, very like those seen upon the elephant, gave the name to this disease...”

Bruce obtained permission from the emperor, Ras Mikhail, to treat a sufferer, using a range of regimes and medications, but beyond assuaging the patient's thirst with a constant supply of whey, no treatment (including hemlock, mercury and tar-water) appeared effective.\(^7\)

El Razi described the clinical feature of the disease as far as 10AD. In 1784 Handy named the disease ‘the glandular disease of the Barbados’ and he gave the idea that the disease could be lymphatic in origin. Later on in 1806 the work of Alder concluded that the disease is in the

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lymphatic vessel. The elephantiasis was explained by filariasis in 1878 but monographs in 1885 and 1886 identified that there are filarial and non-filarial types of elephantiasis.\(^8\)

Through the 18\(^{th}\) and 19\(^{th}\) centuries, the pathogenesis of elephantiasis was gradually elucidated through Hendy's study of the lymphatic system in affected people. Wucherer (in Brazil), Lewis (in India), Manson and Bancroft all recognized the role of filarial parasites in elephantiasis, and for a time it was concluded that all elephantiasis was filarial.\(^9\) Towards the end of the nineteenth century, the discrepancy between distribution of elephantiasis and distribution of filarial in North Africa, Central America and Europe prompted revision of this theory. For a time, streptococci were considered to be causative agents, but detailed description of patients in Guatemala (and persistently negative tests for filarial and streptococci) led Robles to infer that the elephantiasis he was seeing was an endemic condition closely associated with walking barefoot.\(^{10}\)

Progress in recognizing the international distribution of non-filarial elephantiasis came as Cohen suggested the use of the term 'idiopathic lymphoedema' in place of the local terms 'verrucosis lymphatica' in Kenya and 'mossy foot' in Ethiopia.\(^{11}\) The work of Oomen in the 1960s and Price in the 1970s was notable for distinguishing and concentrating on non-filarial elephantiasis. Price's extensive research on non-filarial elephantiasis helped him establish the term podoconiosis for non-filarial elephantiasis in Ethiopia (from the Greek for foot: Podos, and Dust: Konos) which has gained widespread acceptance.\(^{12}\)

The real cause of the disease was not identified till recently; Several studies done to find the cause of elephantiasis in Ethiopia have failed to show infectious cause, indicating the high probability of podoconosis studies confirmed that red clay soil of endemic area that is rich in fine

\(^9\) Davey et al, supra note 5, p.93.
\(^{10}\) Price, supra note 4, p. 118.
\(^{12}\) Davey et al, supra note 5, p. 96.
particles (mostly less than 10 micrometer) of silica and alunino-silicates play a significant role in the pathogenesis.\textsuperscript{13}

In Ethiopia the clay soil derived from volcanic rocks covers more than 200,000 km\textsuperscript{2} where more than 20.5 million people live and farm the fertile soil. These people are exposed for geochemical substances that cause the disease.\textsuperscript{14} Ethiopia is one of the countries in which podoconiosis is an important public health problem in endemic areas of red clay soil like Wolayta zone, where the prevalence of the condition exceeds 5\%.\textsuperscript{15}

Wolayta Zone, which is located in the Southern part of Ethiopia, has endowed with red clay fertile soil. The people who live in this area are the poorest groups usually cultivate the land using simple methods such as digging and weeding by hands. These direct and indirect contacts with soil lead to higher prevalence of podoconiosis patients in the area.\textsuperscript{16}

Health is not only essential for natural and normal development, but also necessary for the natural and normal functioning of the individual. Thus, irrespective of age, gender, socio-economic or ethnic background, an individual health is basic and essential asset.

The right to health is a fundamental part of our human rights and of our understanding of a life in dignity. Internationally, it was first articulated in the 1946 Constitution of the World Health Organization (WHO). Then, the 1948 Universal Declaration of Human Rights also incorporated health as part of the right to an adequate standard of living. The right to health was again recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights. Since then, other international and regional human rights treaties have recognized or referred to the right to health or to elements of it, such as the right to medical care. The right to health is relevant to all States: every State has ratified at least one international human rights treaty recognizing the right to health. Moreover, States have committed themselves to protecting this right through international human rights instruments, domestic laws and policies.

\textsuperscript{13} Price, supra note 3, p. 151.  
\textsuperscript{14} Desta K et al., supra note 2, p.218.  
\textsuperscript{15} Ibid.  
\textsuperscript{16} Price, supra note 3, p.152.
1.2 Statement of the Problem

In Ethiopia, where podoconiosis has been best described, prevalence is about 5% in areas of irritant soil.\(^{17}\) Podoconiosis is thus more common than HIV infection in these areas. About 11 million people (18% of the national population) live in endemic areas in Ethiopia, and between 500,000 and 1 million people are affected nationwide. Up to 64% of affected individuals are from the most economically active age-groups,\(^{18}\) and direct and productivity costs of podoconiosis in a group of 1.5 million inhabitants have been estimated at US$16 million a year.\(^{19}\)

Even though about 500,000 and 1 million people are affected nationwide and 11 million people are at risk in Ethiopia, there is no specific policies, programs or laws in the country which would recognize the full and equal enjoyment of fundamental rights including the right to health. In addition, persons with podoconiosis have long been neglected and marginalized by the state and society.

Furthermore, persons with podoconiosis face various challenges to the enjoyment of their right to health. For instance, persons with podoconiosis often have difficulties accessing health care, especially in rural areas, slums and suburban settings; they may not have access to affordable treatment through the public health system; women with podoconiosis may not receive gender-sensitive health services. Primary health services do not provide for podoconiosis patients and the skills of primary health clinicians are not sufficient to ensure detection and appropriate treatment of podoconiosis. Access to all types of health care for persons with podoconiosis is complicated by the stigma and discrimination they face. It should be recalled that States are obliged to provide access to health care on an equal basis. Such a situation is not only degrading, it is a violation of human rights under the international and regional human rights treaties to which Ethiopia is a party.


\(^{18}\) Ibid.

Research Questions:
The research answers the following questions:

➢ Does the Ethiopian law provide the realization of the right to health without any distinction?
➢ Does this extend to podoconiosis patients?
➢ Is there any health legislation which would recognize the right to health of podoconiosis patients?
➢ Why did policy makers ignorant about the right to health of Podoconiosis patients?
➢ What are some of non-guaranteed rights of podoconiosis patients?
➢ Is there any damage on podoconiosis patients as result of lacking of laws, policies and programs?
➢ What challenges and barriers podoconiosis patients commonly face in claiming their human rights?
➢ What are the existing barriers to realize the right to health of podoconiosis patients? What are the effects of these barriers on the health and quality of life of people with podoconiosis?

1.3. Objectives of the Study
The study has the following general and specific objectives.

1.3.1 General Objectives
The general objective of this study is to develop fundamental understanding of the human right to health of podoconiosis patients which is accorded under human rights law and to give rise awareness on the part of the community at large and any concerned body how to recognize and provide the realization of this right for podoconiosis patients.

1.3.2 Specific Objectives
The specific objectives of the study are:

➢ To analyze the human rights framework, at international, Regional and national level, with particular emphasis of the right to health of podoconiosis patient.
➢ To give an idea about the realization of the right to health of podoconiosis patients.
➢ To indicate the existing inequality and discrimination this is faced by podoconiosis patients on the right to health.
➢ Pinpoint the health problems and basic non-guaranteed rights of podoconiosis patients.
➢ Identify the challenges and barriers podoconiosis patients commonly face in claiming their human rights.
➢ Analysis of the intersection between Health Policy and Human Rights: access to health care, denial of health care, and discrimination against podoconiosis patients.

1.4 Significance of the Research
Podoconiosis is one of the ‘‘neglected tropical disease’’ to which little attention has been paid at both national and international health agenda.²⁰

Recently, the profile of the ‘‘neglected diseases’’ has been enhanced by a renewed interest by policymakers, including the new Director General of the World Health Organization.²¹ These diseases cause long-term morbidity, rather than high mortality, but have been overshadowed by higher-profile efforts to address malaria, tuberculosis, and HIV/AIDS.²² Recent studies show extensive and underestimated morbidity for the neglected diseases²³, totaling around 56 million cumulative disability-adjusted life years, which is more than for malaria and tuberculosis.²⁴

Although the disease is widely distributed in the Ethiopia and other countries, and has grave impacts on socio-economic development in addition to the patients’ right to have access to medical care and treatment, it is surprising that podoconiosis has got very little interest and is almost neglected in Ethiopia and other countries. The problem is less researched and less recognized by governmental and non-governmental organizations. Few resources have been made available for podoconiosis prevention and control, or research activities.

²³King C et al., 2005.
²⁴Hotez et al., 2006.
Therefore, this Study is expected to forward the following points.

- Give information to concerned body which has given little attention to the problem despite high prevalence in Ethiopia. The dissemination of information about podoconiosos, and the human rights of podoconiosis, is an important strategy for combating stigma and discrimination.
- Help the rehabilitation and welfare programs for podoconiosis patients by providing the challenges and barriers in the realization of the right to health of podoconiosis patients.
- Give insight into the health needs of podoconiosis patients.
- Suggest viable strategies to curb the health problem.
- To raise the awareness level of the community outside and inside endemic area. Podoconiosis patients do not exercise their rights properly due to lack of awareness about such rights, lack of knowledge about how to effectively assert their rights, and lack of confidence in asserting their rights.
- Assist health authorities, health professionals and non-governmental organizations to effectively promote and adequately protect the rights of podoconiosis patients.

1.5 Research Area and Scope

The study was conducted in Wolayta Zone which is located in Southern part of Ethiopia. It is located in Southern Nation, Nationality and People Regional State, covering a total area of 4541 sq. km. The scope of this Study was delimited only to podoconiosis patients in Wolayta Zone. Hence, conclusion reached only considers patients in the stated zone. This Study mainly deals with exploring the experiences around podoconiosis patients in claiming the realization of the right to health in Wolayta Zone.

Moreover, the Study is limited to the elaboration and evaluation of the treaties, laws and policies pertaining to the right to health. While the research addresses as much relevant laws and policies governing or affecting the right as possible, it does not claim to be exhaustive in the sense of dealing with all such instruments. In addition, the research is limited to laws and policies adopted by the federal government.
1.6 Research Methodology
Intensive analysis of the international and regional human rights instruments, FDRE Constitution of 1995 and policy consideration pertaining to the subject matter at hand.

This is a qualitative research and study conducted using semi-structured interview. The researcher employed an interview with podoconiosis patients, representatives of relevant governmental institutions and representatives of relevant NGO working on the podoconiosis patients.

1.7 Limitations of the Study
There are not adequate publications by different scholars on this particular subject matter except few works done by community health scholars. Especially on the case of Ethiopia, it was hardly possible to find any comprehensive study in this area and hence there was no choice other than relying on the few that are available on.

It was not possible to get the attention of some individuals in the Ministry of Health who could have given some more information for this research by way of interview as they claim to be extremely busy with their own work; and hence including the idea of few that were willing was the only option available to support the analysis of the legal and policy framework.

1.8 Organization of the Thesis
In brief, this study has attempted to explore whether the right to health of persons living with podoconiosis are realized in law and practice, with aim of assessing the experience around persons living with podoconiosis in claiming the right to health and the challenges and barriers these patients are facing as well as the remaining shortcoming in order to draw lessons learned aimed at informing key governmental and non governmental stakeholder for future interventions.

In doing so, the thesis aims in approaching the subject matter in the following sequences. The study has been divided in five chapters each of which has its own sections and sub sections.

Accordingly, the First chapter simply deals with general introduction to high light the statement of the problems, objectives of the study, scope as well as the significance of the study and related issues.
The Second chapter deals with a brief explanation of the meaning and background of podoconiosis. This chapter sheds light on the meaning, prevalence, socio-economic impact of podoconiosis and how it is neglected. In addition, it also discusses the link between neglected disease and the right to health.

Chapter Three renders a brief explanation of conceptual framework of the right to health under international and regional human rights instruments. This chapter under cover the human rights principles which enable persons living with podoconiosis to exercise their right to health in Ethiopia.

Chapter Four analyzes domestic law and policy on the right to health in particular on persons living with podoconiosis. It also deals the challenges and barriers that are facing persons living with podoconiosis in order to realize their right to health and some of the non-guaranteed rights. Chapter Five sets out brief conclusions and recommendations.
Chapter Two

Podoconiosis: Definition and Background

2.1 Description of the Disease
Podoconiosis (endemic non-filarial elephantiasis), from the Greek *podos* (of the feet) and *konion* (dust), is a non-infectious geochemical disease caused by exposure of barefoot to red-clay soil derived from volcanic rock. Not all histopathologists (doctors who study disease in human tissue) believe in the volcanic soil theory, but all of them agree that it’s not from some parasite, or filarial.

The disease process is one of progressive bilateral swelling of the lower legs (see Figure 1.1). It is found predominantly in bare-footed farmers who live in fertile volcanic highlands. When a person from a susceptible family absorbs soil-derived minerals such as silica and aluminosilicate particles through his or her feet, inflammation and thickening of tissues of the peripheral lymphatic system happens, with lymphatic obstruction, and fluid accumulation in the limbs. Patients present with moss-like over-growths of the feet and lower legs, and they may complain of burning sensations in one or both legs. If podoconiosis is left untreated it progresses gradually to a higher (more serious) ‘stage’, and the leg becomes very swollen, hence the term ‘elephantiasis’.

Figure 1.1 Lower legs of patient in his twenties, showing asymmetric nodular disease.

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26 Ibid.
27 Ibid.
28 Davey G et al, supra note 5, p. 92
Elephantiasis is a general term applied to the consequences of peripheral lymphedema, a condition in which blockage of the lymph system results in gross enlargement of limbs and other body parts. It can result from primary lymphatic disease (primary lymphedema can be hereditary, that is, an inherited disorder of the lymphatic system; or may follow developmental disorder of the lymphatics, in utero infection, or injury and/or delivery difficulties) or may be secondary to infection of physical trauma. With obstructed lymphatic channels, swelling eventually leads to rough corrugation, and a deep cracking of the skin and adjacent tissues. Thick, warty outgrowths increase rapidly in number until the surface of the leg or other body part resembles the rough hide of an elephant.

Lymphedema resulting from clay-derived silica and aluminosilicate is called non-filarial elephantiasis or podoconiosis, thus distinguishing it from the more common form of tropical elephantiasis caused by filarial parasites transmitted by mosquitoes. However, the name elephantiasis does not represent the pre-elephantiasic phase of silica-mediated lymphatic inflammation, so this longstanding condition was recently renamed podoconiosis – from the Greek podos (of the foot) and konion (dust).

2.2. Geographic Distribution and Prevalence
Podoconiosis is widely distributed in many parts of the world. It is found in highland areas of tropical Africa, Central America and North West India. It is found in African countries such as Uganda, Tanzania, Kenya, Equatorial Guinea, Cameroon, the Islands of Bioko, the Cape

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30 Ibid.
31 Ibid.
34 Davey G., supra note 20, p. 1176.
Verde Islands, Sao Tome & Principe\textsuperscript{39}, Rwanda, Burundi, Sudan and Ethiopia\textsuperscript{40}. Furthermore, in the Central American highlands in Mexico and Guatemala South to Ecuador and Brazil in South America\textsuperscript{41} the condition has been reported. In addition, on the north-east coast of South America in Suriname and French Guiana, the distinction between filarial and non-filarial elephantiasis has not been confirmed.\textsuperscript{42} Despite high prevalence of filarial elephantiasis in India, podoconiosis has been reported from northwest India, Sri Lanka and Indonesia.\textsuperscript{43} Many years ago, podoconiosis is thought to have existed in North Africa (Algeria, Tunisia, Morocco and the Canary Islands) and Europe (France, Ireland and Scotland), but it is no longer found in these areas,\textsuperscript{44} as result of use of footwear.

People who work barefoot particularly on red clay soils of volcanic areas are highly exposed to podoconiosis (see figure 1.2).\textsuperscript{45}

Figure 1.2 – a photo is taken when farmers working in the rich volcanic soil barefoot.

\textsuperscript{41} Price, supra note 8, p. 27.
\textsuperscript{42} Price, supra note 3, p.151-52.
\textsuperscript{43} Ibid.
\textsuperscript{44} Ruiz et al., supra note 39, p. 31-32.
\textsuperscript{45} Desta K et al, supra note 2, p. 217.
Studies have revealed that podoconiosis is common in areas affected by red clay soil derived from volcanic rocks, particularly basalt. Common features of affected areas are altitude over 1000m, annual rainfall above 1000mm, average temperatures of 20° C (which govern the type of soil produced), and soils of volcanic origin.\(^{46}\) The association between tropical red clay soil and the occurrence of podoconiosis has been tested and shown in the East African regions of Kenya, North Western Tanzania and Ethiopia, and in volcanic areas of Rwanda.\(^{47}\)

Podoconiosis has been known and highly prevalent in Ethiopia for a number of years (see Figure 1.2).\(^{48}\) According to the estimation the total number of cases per country is highest in Ethiopia, where up to 6% of the population is affected in endemic areas.\(^{49}\) Studies have shown that it is related to the distribution of red clay soil derived from volcanic rocks, particularly basalt.\(^{50}\)

Figure 1.3\(^{51}\)

\(^{46}\) Price, supra note 25, p. 291.
\(^{47}\) Crivelli, supra note 37, p. 193.
\(^{48}\) Ruiz et al, supra note 39, p. 30.
\(^{49}\) Davey G, supra note 20, p. 1176.
\(^{51}\) Supra note 1.
In Ethiopia the basalt area covers more than 200,000 km² which is approximately one-fifth of the land surface, and the fertility of the soil in such areas attracts an agricultural population of 20.5 million people.\(^{52}\)

An epidemiological study has been made in some parts of fertile areas of Ethiopia where podoconiosis is highly prevalent. Accordingly, early estimations demonstrated prevalence of 5.38\% in Wolayta Zone, Southern Ethiopia.\(^{53}\)

**Table 1. Prevalence of Podoconiosis in Wolayta Zone, by Woreda.**\(^{54}\)

<table>
<thead>
<tr>
<th>Woreda</th>
<th>Total population of Woreda</th>
<th>No. of patients in Woreda</th>
<th>Prevalence of the disease (%)</th>
<th>Weighted prevalence (%)</th>
<th>comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humbo</td>
<td>123,610</td>
<td>8,465</td>
<td>6.85</td>
<td>0.56</td>
<td></td>
</tr>
<tr>
<td>Offa</td>
<td>142,907</td>
<td>9,634</td>
<td>6.74</td>
<td>0.63</td>
<td></td>
</tr>
<tr>
<td>D/Woyde</td>
<td>192,201</td>
<td>11,806</td>
<td>6.14</td>
<td>0.80</td>
<td></td>
</tr>
<tr>
<td>S/Zuria</td>
<td>211,325</td>
<td>12,361</td>
<td>5.85</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>B/Sore</td>
<td>304,102</td>
<td>12,776</td>
<td>4.04</td>
<td>0.90</td>
<td></td>
</tr>
<tr>
<td>D/Gale</td>
<td>267,646</td>
<td>11,463</td>
<td>4.28</td>
<td>0.78</td>
<td></td>
</tr>
<tr>
<td>K/Koisha</td>
<td>180,503</td>
<td>11,960</td>
<td>6.63</td>
<td>0.78</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,424,094</strong></td>
<td><strong>78,465</strong></td>
<td><strong>5.8</strong></td>
<td><strong>5.46</strong></td>
<td></td>
</tr>
</tbody>
</table>


**Table 2. Prevalence of Podoconiosis by Age and Sex.**

<table>
<thead>
<tr>
<th>Age group (year)</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>Overall (%)</th>
<th>comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>13</td>
<td>28</td>
<td>41</td>
<td>0.05</td>
<td></td>
</tr>
<tr>
<td>6-15</td>
<td>2,698</td>
<td>2,574</td>
<td>5,272</td>
<td>6.72</td>
<td></td>
</tr>
<tr>
<td>16-20</td>
<td>6,020</td>
<td>5,978</td>
<td>11,998</td>
<td>15.30</td>
<td></td>
</tr>
<tr>
<td>21-30</td>
<td>8,635</td>
<td>8,263</td>
<td>16,898</td>
<td>21.53</td>
<td></td>
</tr>
<tr>
<td>31-45</td>
<td>10,586</td>
<td>10,462</td>
<td>21,048</td>
<td>26.82</td>
<td></td>
</tr>
<tr>
<td>46 and above</td>
<td>11,624</td>
<td>11,584</td>
<td>23,208</td>
<td>29.58</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>39,576</td>
<td>38,889</td>
<td>78,465</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

\(^{52}\) Ibid.


Further investigation in the village of Ocholo, located at 2000 m altitude in the mountains west of Lake Abaya, southern Ethiopia, elephantiasis was present in 5.1% of long-term residents, while in two resettlement schemes in Ilubabor, western Ethiopia, 9.1% of long-term residents were affected, and 5.2% of people resettled some 7—8 years previously.

More recent population-based surveys in northwest and southern Ethiopia, have documented prevalence of 6% and 5.4%, respectively. According to the investigation between 500,000 and 1 million people are affected nationwide and eleven million Ethiopians (18% of the population) are at risk through exposure to the irritant soil.

2.3 Clinical Features

2.3.1 Signs and Symptoms

Podoconiosis is usually observed in bare-footed people like farmers and other occupational groups such as gold miners and weavers who live in well defined tropical highland regions and have prolonged contact with volcanic soil. It occurs predominantly in rural areas, among people not using footwear and persons of the lowest social class. In addition, it affects both female and men equally, and while the majority of cases develop signs and symptoms in the second and third decades, individuals as young as 4 years old and as old as 60 may show early signs.

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58 Desta, K et al, supra note 2, p. 220.
59 Ibid.
60 Price, supra note 8, p. 58.
62 Ibid.
2.3.2 Diagnosis and Disease Progression
There are three stages in the natural history of podoconiosis: initial, progressive, and final.

In the initial phase (stage one and two), persistent swelling appears on the top of one foot, beginning near the first toe cleft; some patients complain of tenderness near the femoral lymph node (see figures 1.4 and 1.5).\(^63\)

The progressive stage (stage three and four) of podoconiosis is characterized by increased swelling and changes in the physical appearance of the foot and leg.\(^64\) At varying intervals from disease initiation, swelling progresses up the foot and lower leg; swelling can reach the knee within several months to several years, or it may never proceed to this level.\(^65\) Pruritus or “itchy foot” is initially localized to the base of the first or second toe; the itch then moves with the upper edge of swelling, thus reflecting progression of the disease up the leg.\(^66\) “Splayed toes” (in the shape of a spatula) and “block toes” (rigid attachments to the forefoot) are the physical consequences of severe edema of the toes; edema may be particularly evident in the second toe, and longitudinal skin markings (in contrast to normal lateral marks) may develop from the base of the cleft between the first and second toe (see figures 1.6 and 1.7).\(^67\)

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\(^{63}\) Birrie et al, supra note 56, p. 247.
\(^{64}\) Ibid.
\(^{65}\) Ibid.
\(^{66}\) Ibid.
\(^{67}\) Ibid.
In the final disease stage (stage five), elephantiasis becomes permanently established as a plate-like fibrotic mass of dermis and subcutaneous tissue firmly affixed to the deep fascia of the foot and leg. At this stage, damage is irreversible. The mass of the foot and leg vary from patient-to-patient, and the size of the limb generally determines the extent of the patient’s disability. Patients in this stage are confined by their disability to small areas in and around their home (see figure 1.8).

2.3.3. Differential Diagnosis
Filarial elephantiasis, leprotic lymphoedema and congenital or secondary damage to the lymphatic system are the most common differential diagnoses of podoconiosis in rural tropical settings.

68 Ibid.
Filarial elephantiasis is a tropical disease caused by long ‘hair-like’ tissue-dwelling nematodes such as *Wuchereria bancrofti*, *Brugia malayi* and *Brugia timori*, all of which are transmitted by mosquitoes. It affects about 120 million people worldwide. Its clinical features are filarial proliferation and the ensuing inflammation blocks lymphatic drainage, thus causing elephantiasis in various body parts – feet, legs, arms, scrotum, vulva, and breast. Infection is transmitted when microfilarial larvae circulating in the blood are transferred to other individuals by the bite of a vector mosquito.69 70 71

In the developing world, filarial elephantiasis is common, but it can be readily distinguished from podoconiosis by the differing natural histories of the diseases.72

Podoconiosis differs from filarial elephantiasis because its pathologic effects are restricted to the feet and legs. Also, podoconiosis cases are mostly limited to tropical highland regions where mosquitoes are absent, and the soil has specific disease-causing properties.73

According to different studies, in Ethiopia, the elephantiasis is predominantly non-filarial i.e podoconiosis. This is proved based on the evidence that the low hydrocele-to-elephantiasis ratio, the absence of filarial infection in humans and mosquitoes, the high altitude (1500 – 2200 meters above sea level) that hinders breeding of mosquitoes and contributes to formation of the soil in podoconiosis endemic areas, and the volcanic soil type in endemic areas.74 Various investigations conducted in 1935-1940 in different areas of Ethiopia such as Shewa, the then central province, and Harare province revealed no microfilaria in the peripheral blood taken.75 76

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69 Routh, supra note 29, p. 848.
72 Ibid.
73 Ibid.
75 Oomen, supra note 53, p. 239.
Similarly, for more than three decades, cases of filarial elephantiasis were not reported in mission hospitals of Wolaita Zone.\textsuperscript{77}

Other causes of peripheral edema include heart failure, nephritis, and cirrhosis of the liver. These conditions are characterized by equal bilateral swelling, while podoconiosis-associated swelling in usually asymmetrical.\textsuperscript{78,79}

Mostly in the developed world, elephantiasis verrucosa nostrum has been reported to occur as a consequence of lymphedema from congenital lymphatic abnormalities, or from secondary obstruction due to surgery, radiation, neoplastic blockage, obesity, or infection.\textsuperscript{80} Lymphedema secondary to infection is usually localized to limited areas, rather than the more progressive upward swelling from the foot to the leg that is characteristic of podoconiosis.\textsuperscript{81}

2.4. The Role of Environmental Factor in Podoconiosis

Some research has been done in Ethiopia and other parts of the world using analytical electron microscopy in combination with other techniques. A possible etiology of podoconiosis suggests that accumulation of inorganic materials of volcanic origin, particularly silicon and aluminum, either directly or together with other factors, is responsible for non-filarial elephantiasis of the lower legs.\textsuperscript{82}

Podoconiosis is associated with volcanic red clay soils. Warm temperatures and abundant rainfall facilitate the breakdown of alkalic basalt (lava) to form crystalline soil in tropical regions.\textsuperscript{83}

Podoconiosis may be caused by skin contact and dermal absorption of silica crystals and other soil constituents via the subdermal lymphatic system.\textsuperscript{84} The size of silica particles in the soil

\begin{footnotes}
\item[78] Destas et al, supra note 2, p.220.
\end{footnotes}
appears key to pathogenesis of the disease.\footnote{Ruiz et al, supra note 39, p. 32.} Silica (quartz) crystals are minute (between 0.2 and 2.0µm in diameter), which may facilitate their entry through the dermis of the foot.\footnote{Routh, supra note 29, p. 850.} The small size of the particles may also promote molding to the foot when moisture is present; clinging to the foot when dry; and difficulty in removing, especially where water is scarce (see figure 1.8).\footnote{Ruiz et al, supra note 39, p. 29.}

Figure 1.9\footnote{Supra note 1.}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure1.9.jpg}
\caption{Shards of volcanic ash – Scanning Electron Microscope; photo is 1/50th inch across}
\end{figure}

In Ethiopia, Kenya and Northwest Tanzania, podoconiosis occurs where soil originated from volcanic rocks, including basalt, at altitudes higher than 1500-2000 meters.\footnote{Price, supra note 25, p. 295.} Silicon, aluminum, and iron have been reported in podoconiosis biopsy samples, and the soil content of beryllium and zirconium (known to promote granuloma formation in lymphoid tissue) was reportedly twice as high in an endemic podoconiosis region of Ethiopia than in other areas (mineral analysis of soil collected in Ocholo village in Southwest of Ethiopia).\footnote{Frommel D, et al. "Podoconiosis in the Ethiopian Rift Valley. Role of Beryllium and Zirconium." Tropical and Geographical Medicine 45(4), (1993): 165-67.}

Podoconiosis in Equatorial Guinea is reported to arise from microcrystal of both black lava soil and red clay.\footnote{Corachan M, et al. "Podoconiosis in Equatorial Guinea. Report of Two Cases from Different Geological Environments." Tropical and Geographical Medicine 40(4), (1988): 359-64.} Podoconiosis also occurs in the areas of red clay soil in the north-west highlands
of Cameroon, in Central and Western Africa, where climatic, geological and soil characteristics were similar to those in East Africa.\(^92\)

The following are the common environmental features for high prevalence in all areas of tropical Africa: high altitude (> 1000 meters); high and seasonal rain fall (> 1000 mm annually); red clays which are very slippery when wet and very adherent if allowed to dry on the skin; the volcanic nature of the parent rock from which the soil developed; and the fact that the volcanism is of alkalic type.\(^93\)\(^94\)

2.5. Pathogenesis (causes) of Podoconiosis

Mineral particle induced inflammation on a background of genetic susceptibility is the most accepted cause of podoconiosis.\(^95\) As mentioned above, podoconiosis affects susceptible families of bare-footed farmers in well-defined fertile volcanic highland zone of Africa, Central and South America, and Indonesia.\(^96\) A genetic component is likely to contribute to the incidence of podoconiosis since the disease clusters in families.\(^97\) Candidate genes could explain differential susceptibility of individuals, by permissive or by protective factors. Differences may be due to properties of the skin, the lymphatic system, or to the host’s inflammatory response to the causative agent.\(^98\)\(^99\) This means not all individuals who are exposed to red clay soil develop podoconiosis. Accordingly, both genetic and environmental factors contribute to the pathogenesis of podoconiosis.\(^100\)

2.6. Socio-Economic Consequences of Podoconiosis

Podoconiosis causes immense social and financial consequence in endemic areas. Its public health and socioeconomic impact result from its incapacitating effects, which hinder people with podoconiosis from working, for instance from pursuing farming and other activities involving extensive walking. In addition, people with podoconiosis abandon agricultural work because the


\(^93\) Price, supra note 3, p. 152.

\(^94\) Price, supra note 4, p. 118.

\(^95\) Price, supra note 3, p. 151.

\(^96\) Price, supra note 25.

\(^97\) Ruiz et al, supra note 39, p. 30.

\(^98\) Davey et al., Supra note 5, p. 92.


\(^100\) Davey et al., Supra note 5, p. 95.
inflammation become severe as a result of gross deformity, swelling, repeated ulceration and secondary infection. The disease, although not fatal, causes progressive deformity and disability, and the presence of so many disabled adults in a largely subsistence economy represents a considerable drain on limited resource to provide food and shelter. In 2005, research conducted in Wolaita Zone, Southern Ethiopia, revealed that persons affected by podoconiosis lose 45% of total productive time, costing a single zone of 1.7 million inhabitants more than US$16m per year. Aside from indirect costs of podoconiosis due to lost productivity, there are also direct financial costs. A study of two subsistence farming villages in Southwestern Ethiopia revealed that at least half the population had evidence of skin disease, and patients were spending between 50% and 100% of their cash income for treatments; unfortunately, most of these so-called remedies proved ineffective.

In addition, podoconiosis is one of the most stigmatizing health problems in endemic areas. People with podoconiosis are subject to social stigma and discrimination, patients being excluded from school, denied participation in local meetings, churches and mosques, and barred from marriage with unaffected individual. Furthermore, not only patients suffer social prejudice but also their families suffer from various forms of stigma manifest during marital and social events, employment and schooling. The prevailing belief that podoconiosis runs in families makes families affected by podoconiosis targets of stigma. Social prejudice prevents marriage of young people with podoconiosis, primarily because they cannot work and support a family as the condition worsens. In some instances, siblings of the podoconiosis victim are considered less desirable as marriage partners because they come from susceptible families. An investigation conducted in Southern Ethiopia revealed that 93.4% of community respondents

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102 Desta K et al., supra note 2, p. 219.
103 Tekola et al., supra note 50, p. 1137.
106 Ibid.
107 Price, supra note 25.
108 Ruiz et al., supra note 39, p. 32.
have one or more misconceptions regarding the cause of podoconiosis. The majority of health professionals in Wolaita Zone also have misconceptions about the causes of podoconiosis, and stigmatizing attitude towards podoconiosis patients.

2.7. Prevention, Treatment and Control
Podoconiosis is entirely preventable and no longer exists in Scotland, France, the Cape Verde Islands and the Canary Islands since people have had access to shoes.

The most effective way to prevent the disease is to wear shoes from childhood to avoid contact with the irritant soil. Unfortunately, most patients in endemic areas are unable to afford the cost of durable shoes in different sizes for growing children, and may instead wear locally-made open sandals. For farmers who work on the fields, the moist clay soil can adhere to, and become embedded in standard footwear. For this reason, rubber boots provide better protection than shoes. In early onset disease, foot hygiene is very helpful to halt and reverse progress. It involves washing the feet with soap and water, use of antiseptic and emollients, and consistently wearing shoes and socks. Public healths programs can improve understanding of the risks of developing podoconiosis, teach individuals to recognize early signs, and encourage good hygiene and care for those who have already developed the condition. Such efforts can lessen the physical, emotional, and social tolls of this preventable disease.

Treatment of early stages of podoconiosis helps improve the quality of life of patients.

111 Ruiz et al., supra note 39, p. 30.
112 Ibid.
113 Desta K et al., supra note 2, p. 220.
114 Ruiz et al., supra note 39, p. 31.
Though not practiced in endemic areas, lymphatic drainage is also helpful. Elevation, compression bandages, and elastic stockings help in the advanced stages (see figure 1.10).

Figure 1.10 – (a photo is taken with permission before and after 4 months of treatment)

The other means of control, as a result of which the disease may regress partly, or totally, include the use of mechanized agricultural methods, a change of occupation from agriculture to one involving less contact with the soil and a change of residence to a non-endemic area. However, these solutions may not be feasible for many patients. Rehabilitation of patients and social-integration is critical to restore social values and improve productivity of patients.

2.8 Podoconiosis as a Neglected Disease and Disease of Poverty
Neglected diseases vary in the extent of the burden they impose, and in the availability and accessibility of appropriate treatments. There is no standard global definition of neglected diseases. However, WHO describes them as those diseases that “affect almost exclusively poor and powerless people living in rural parts of low-income countries”. The UN Special Rapporteur on the Right to Health notes that they are referred to as “poverty-related” diseases. People suffering from ill health are more likely to become impoverished, and the poor are more vulnerable to ill health, neglected diseases and associated disabilities. While they cause immense suffering and often life-long disabilities, these diseases rarely kill and therefore do not receive the attention and funding of high-mortality diseases, like AIDS, tuberculosis, and malaria. They are neglected in a second sense as well. Confined as they are to poor populations, all have

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119Price, supra note 60, p. 246.
traditionally suffered from a lack of incentives to develop drugs and vaccines for markets that cannot pay. Where expensive and effective drugs exist, demand fails because of inability to pay.\textsuperscript{122}

Moreover, the disabilities caused by most of these diseases are associated with great stigma. In addition to the physical and psychological suffering caused by neglected diseases, they also inflict an enormous economic burden on affected communities, which in turn contributes to the entrenched cycle of poverty and ill health for neglected populations.\textsuperscript{123}

People living in poverty have poorer access to the underlying determinants of the right to health such as adequate housing, water and health information and education. The marginalization of people living in poverty also means that their voices are less often heard in political processes.\textsuperscript{124}

Although neglected diseases are by no means homogeneous, it has been noted that many share the following common characteristics:\textsuperscript{125}

Firstly, they typically affect neglected populations - the poorest in the community, usually the most marginalized and those least able to demand services. These often include women, children and ethnic minorities, displaced people, as well as those living in remote areas with restricted access to services. Neglected diseases are a symptom of poverty and disadvantage.

Secondly, the introduction of basic public health measures, such as access to education, clean water and sanitation, as well as improved housing and nutrition, would significantly reduce the burden of a number of diseases.

Thirdly, where curative interventions exist, they have generally failed to reach populations early enough to prevent impairment.

Finally, the development of new tools - new diagnostics, drugs and vaccines - has been under-funded or neglected, largely because there has been little or no market incentive.

Consequently, there are clear links between neglected diseases and human rights:

\begin{itemize}
  \item \textsuperscript{122} Ibid.
  \item \textsuperscript{123} Ibid.
  \item \textsuperscript{124} Ibid.
  \item \textsuperscript{125} Ibid.
\end{itemize}
To begin with, neglected diseases are highly prevalent in low-income countries, in rural areas and settings where poverty is widespread. Guaranteeing the underlying determinants of the right to health is therefore key to reducing the incidence of neglected diseases. Subsequently, discrimination is both a cause and a consequence of neglected diseases. For example, discrimination may prevent persons affected by neglected diseases from seeking help and treatment in the first place.

In addition, essential drugs against neglected diseases are often unavailable or inadequate. Lastly, health interventions and research and development have long been inadequate and under funded (although the picture has changed in recent years, with more drug development projects under way).\textsuperscript{126} The obligation is on States to promote the development of new drugs, vaccines and diagnostic tools through research and development and through international cooperation.

\textsuperscript{126} Mary Moran et al. The New Landscape of Neglected Disease Drug Development (London School of Economics and Political Science and the Welcome Trust), 2005.
Chapter Three

The Right to Health in International Law

3.1. Legal Framework
The right to the highest attainable standard of health is a human right recognized in international and regional human rights laws. Among international human rights instruments the most explicit reference on the right to health is contained in the International Covenant on Economic, Social and Cultural Rights. Besides, instruments like International Convention on the Right of Child, Convention on the Elimination of All Forms of Racial Discrimination and Convention on the Elimination of All Forms of Discrimination against Women have rights related to health. In addition, the right to health is also included into regional human rights instruments like the African Charter on Human and Peoples’ Right, the European Social Charter and Additional Protocol of the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights. All of these human rights instruments define the content of the right to health and impose obligation on member states to assure health care services and promote and protect the health of its population. Furthermore, the role of United Nation Charter and WHO Constitution on development of the right to health is of significant value in mapping out the contour of the legal framework of the right to health.

3.1.1 International Instruments
The right to health has been recognized ever since the birth of the United Nations (UN) in 1945. The Charter of the UN urges state parties to respect rights to a higher standard of living and solutions to international health problems. 127

127 U.N. CHARTER, Article 55 provides as follows: with a view to the creation of conditions of stability and well being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote: a. higher standards of living, full employment, and conditions of economic and social progress and development; b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and c. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.
3.1.1.1 Constitution of the World Health Organization
The WHO Constitution was the first international legal document to mention the right to health. Defining "health" broadly as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," the WHO Constitution goes on to state that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."129

3.1.1.2 The Universal Declaration of Human Rights
The UDHR which was adopted in 1948 included a right to health and health care as a recognized international human right.130 The right to health enumerated under Article 25 enunciates: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."131 As a declaration, the UDHR does not impose specific obligations on state parties.132

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128 Constitution of the World Health Organization, preamble. July 22, 1946, 62 Stat. 6349, 14 U.N.T.S. 185, reprinted in 15 DEPT ST. BULL. 211 (Aug. 4, 1946). The preamble states that: ‘‘The enjoyment of the highest attainable standard of health is one of fundamental right of every human being without distinction of race, religion, political belief, economic or social condition. The health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states. The achievement of any states is the promotion and protection of health is a value to all.’’ In addition the preamble adopted a broad definition on the right to health and defining ‘‘health’’ broadly as ‘‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’’
129 Ibid.
131 Ibid.
Subsequently, the United Nations adopted two covenants to implement the UDHR: the International Covenant on Civil and Political Rights (ICCPR)\(^{133}\) and the International Covenant on Economic, Social and Cultural Rights (ICESCR).\(^{134}\)

3.1.1.3 The International Covenant on Economic, Social and Cultural Rights (ICESCR)

The ICESCR is the major U.N. treaty recognizing the international human right to health.\(^{135}\) According to Article 12 of ICESCR;

1. The States party to the present Covenant recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by States party 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.

This provision is wide and comprehensive, placing an obligation on state parties to ensure that they take active steps towards realizing the various aspect of the right to health.


3.1.1.4 International Covenant on Civil and Political Rights (ICCPR)
The ICCPR does not include a right to health, but it does include provisions which affect the right to health such as the right to life,\textsuperscript{136} to freedom from torture,\textsuperscript{137} to liberty and the security of the person,\textsuperscript{138} to humane treatment,\textsuperscript{139} to freedom of thought, conscience and religion,\textsuperscript{140} and to freedom “to seek, receive and impart information.”\textsuperscript{141} These rights help everyone attain health or enjoy the right to health, but the right to health is not contained within or bound by these rights. In the Vienna Declaration and Program of Action of 1993,\textsuperscript{142} it is reaffirmed that all human rights are universal, interdependent, interrelated and indivisible. The UN Human Rights Committee suggested that the right to life in article 6 of the ICCPR should not be given a narrow interpretation, but should be seen to affect other rights, such as the right to housing, food and medical care.\textsuperscript{143} Mann notes that nearly every article contained in human rights documents has the tendency to impact upon the enjoyment of the right to health.\textsuperscript{144}

3.1.1.5 Other Instruments
There are other international conventions which, though not part of the so-called “International Bill of Rights,” recognize a variety of rights related to health. Such treaties include the International Convention on the Rights of the Child (CRC),\textsuperscript{145} the International Convention on the Elimination of All Forms of Racial Discrimination

\textsuperscript{136} ICCPR, Art 6.
\textsuperscript{137} Id at art. 7.
\textsuperscript{138} Id at art. 9.
\textsuperscript{139} Id at art. 10.
\textsuperscript{140} Id at art. 18.
\textsuperscript{141} Id at art. 19.
\textsuperscript{143} "The right to life’ UN GAOR Human Rights Committee 37th session Supp No 40.

CRC is the most extensive in terms of provisions for child health care. Specifically, states parties must recognize "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" and that states parties shall "strive to ensure that no child is deprived of his or her right of access to such health care services." Care should include comprehensive preventive and health education services, "pre-natal and post-natal health care for mothers," and family planning education and services. Further, states must take measures to abolish "traditional practices prejudicial to the health of children." Finally, Article 23 establishes rights for the access to special care services for disabled children, including health care and other services free of charge, to preclude financial barriers to these services.

CERD contains provisions recognizing the right to health. Article 5(e)(iv) stipulates that states have an obligation to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone to equality before the law in the enjoyment of the right to ‘public health, medical care, social security and social services’.

Likewise, CEDAW obligates States to take all appropriate measures to eliminate discrimination in the field of health care in order to ensure, on the basis of equality between men and women, access to health care services, including those related to family planning. States parties have a further obligation to ensure to women appropriate services in connection with pregnancy.

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148Supra note 147.

149Id at art. 24(1).

150Id at art. 24(2).

151Id at art. 24(3).

152Id at art. 23.

153Id at art. 12(1).
confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and location.\(^{154}\)

The Convention on the Rights of Persons with Disabilities on its part requires States to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities, including their right to health, and to promote respect for their inherent dignity (art. 1). Article 25 further recognizes the “right to the enjoyment of the highest attainable standard of health without discrimination” for persons with disabilities and elaborates the measures States should take to ensure this right.

Numerous conferences and declarations, such as the International Conference on Primary Health Care (resulting in the Declaration of Alma-Ata\(^{155}\)), the United Nations Millennium Declaration and Millennium Development Goals,\(^{156}\) and the Declaration of Commitment on HIV/AIDS,\(^{157}\) have also helped clarify various aspects of public health relevant to the right to health and have reaffirmed commitments to its realization.

3.1.2 Regional Instruments
The African Charter guarantees a general right to ‘enjoy the best attainable state of physical and mental health’.\(^{158}\) It places an obligation on state parties to take the necessary measures ‘to protect the health of their people and to ensure that they receive medical attention when they are sick’.\(^{159}\) The African Charter on the Rights and the Welfare of the Child also recognizes health as a human right. In Article 14 (2), it lists measures to be undertaken by the state in the fulfillment of the right to health similar to those of the CRC cited above.

\(^{154}\) Id at art. 12(2).
\(^{155}\) Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, September 1978. Alma-Ata Declaration affirms the crucial role of primary health care, which addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly (art. VII). It stresses that access to primary health care is the key to attaining a level of health that will permit all individuals to lead a socially and economically productive life (art. V) and to contributing to the realization of the highest attainable standard of health.


\(^{159}\) Id at art. 14(2).
The European Convention and its Protocols do not include socio-economic rights, such as the right to health. However, the European Social Charter does contain a “right to the protection of health.”

The American Convention on Human Rights provide that the “State Parties undertake to adopt measures…. with a view to achieving progressively, by legislation or other appropriate means, the full realization of the rights implicit in the economic, social, educational, scientific, and cultural standards set forth in the Charter of the Organization of American States (“OAS”) as amended by the Protocol of Buenos Aires.”

The OAS Charter articulates a “right to material well-being,” and healthy working conditions.

In contrast, the Additional Protocol of the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights (Protocol of San Salvador) specifically provides for the right to health in Article 10.

Finally, at the domestic level, provisions on the right to health exist in about 115 national constitutions, though many of them are considered as directive principle and state policy.

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160 The single exception is the right to education in Protocol No. 1, art. 2. In addition, the European court of Human Rights has imposed affirmative duties on member states under article 11, the freedom of association, and article 8, the right to privacy.
161 European Social Charter, art. 11 provides that “the High Contracting Parties undertake… to take appropriate measures designed inter alia…..” to promote health through education and advice, to encourage “individual responsibility in matters of health… to prevent as far as possible” epidemics and other illnesses, and “to remove as far as possible the cause of ill-health. The European Charter does not define the right to health and it only requires the taking of “appropriate measures” for the “protection of health.” Moreover, the Charter strengthens the notion that the right to health is more than a right to medical care and includes in the fields which it touches the whole range of causes of ill health and focus on preventative measures and education as opposed to merely responding to medical or other health problems.
163 Charter of Organization of American States, art. 43(a) & (b), Apr. 30, 1948, 2 U.S.T. 2394, T.I.A.S. No. 2361; amended effective 1970, 21 U.S.T 607, T.I.A.S No. 6847. One could infer from these rights and the other social, economic and cultural rights, a general right to health as being implicit, and thus subject to the duty to take steps to achieve it progressively.
164 Pan-American Union, Final Act of the Ninth Conference of American States, Resolution XXX 38-45 (1948). Article 10 states: “Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well being.” Similar language in the 1948 American Declaration of the Rights and Duties of Man further reinforce the existence and importance of the right to health.
3.2 Content of the Right to Health
The United Nation Committee on International Covenant on Economic, Social and Cultural Right (ICESCR) – a treaty body which is responsible for the monitoring and implementation of ICESCR – has issued the General Comment 14 on May 15, 2000 which clarifies the content to the right to health.166 The General Comment 14 provides the authoritative interpretation of the right to health and addresses the content of the right to health and its implementation and enforcement. In addition, it describes individual remedies for victims of violations of the right and obligations assumed by states which are party to the Covenant.

While General Comment 14 refers to a range of health issues, it adopts a generic approach to the right to health. Health consists of many dimensions. Moreover, different groups have varying health needs. The generic analytical framework first identified in General Comment 14 and subsequently elaborated in the Special Rapporteur's reports needs to be applied to specific health specializations, such as persons with podoconiosis. This paper seeks to apply this framework in the contexts of persons with podoconiosis.

The General Comment 14 noted that the right to health is not the right to be healthy but it must be understood as the right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.167 Accordingly, the General Comment clarifies the content of the right to health in the following manner.

3.2.1 The Right to Health as Broad and an Inclusive Right
The right to health is closely related to and dependent on the realization of other human rights" and that reference to the "highest attainable standard of physical and mental health" extends "not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water housing, and adequate sanitation, and adequate supply of safe

167 General Comment 14, supra note 168, para 8.
food, nutrition healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.\textsuperscript{168}

### 3.2.2 Freedoms and Entitlement

The right to health contains both entitlements and freedoms, including freedom from discrimination. I give attention to nondiscrimination below.

Freedoms include the right to control one’s health and body, including sexual and reproductive health freedom, and the right to be free from interference, such as the right to be free from torture and other cruel, inhuman or degrading treatment or punishment, non-consensual medical treatment, research and experimentation.\textsuperscript{169}

The right to health includes an entitlement to a system of health protection, including healthcare and the underlying determinants of health, which provides equality of opportunity for people to enjoy the highest attainable standard of health, the right to prevention, treatment and control of diseases, access to essential medicines, maternal, child and reproductive health, equal and timely access to basic health services, the provision of health-related education and information, and participation of the population in health-related decision making at the national and community levels.\textsuperscript{170}

Podoconiosis patients have a right to a system of health protection which would enable them to enjoy the highest attainable level of health. The health protection system should provide equality of opportunity for everyone without any discrimination. Thus, persons with podoconiosis are entitled to a health protection system in equality of opportunity. Augmenting interventions to ensure equality of opportunity for the enjoyment of the right to health will require training of

\textsuperscript{168} Ibid, para 11.
\textsuperscript{169} Ibid, para 8.
\textsuperscript{170} Ibid.
adequate numbers of professionals in order to work toward the care and full integration of podoconiosis patients in the community. General practitioners and other primary care providers should be provided with essential healthcare and disability sensitization training to enable them to provide front-line healthcare to persons with podoconiosis.

Furthermore, persons with podoconiosis are entitled to prevention, treatment and control of the disease. Mostly, the disease affects people who do not use footwear, persons of the lowest social class and those in rural areas. Besides, the disease has three phases; initial, progressive and later. The disease may be totally prevented if widespread use of footwear is effective particularly in the first phase. This means, the disease is progressive from preventable stage to unpreventable and uncontrolled stage. Thus, patients should be provided with assistance to prevent and control the disease. In addition, persons with podoconiosis have equal right to get timely treatment in any hospitals and clinics and access to essential medicines. Moreover, patients have the right to be provided with information and education about the disease and participate in decision making at the national and community levels about their health.

3.2.3 Available, Accessible, Acceptable and Good Quality

3.2.3.1 Availability
Functioning public health and health-care facilities, goods and services must be available in sufficient quantity within a State. This includes adequate numbers of health-related facilities and support services, and adequate numbers of medical and other professionals trained to provide these services. For persons with podoconiosis an adequate supply of essential medicines should also be available.

3.2.3.2 Accessibility
It has four dimensions

Non-discrimination: health facilities, goods and services including support service must be accessible to all, especially the most vulnerable or marginalized section of the population, for instance podoconiosis patients, in law and in fact, without discrimination on any of the prohibited grounds. (See the section 3.3 on non-discrimination)
Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older person, persons with disabilities and persons with HIV/AIDS. Likewise, healthcare facilities, goods, and services, must be accessible physically and geographically—in other words, in safe physical and geographical reach of persons with podoconiosis. This has especially important implications for community-based care. Accessibility also implies that medical services and underlying determinates of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for person with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for healthcare services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups like podoconiosis patients. Equity demands that poorer households should not be disproportionately burdened with health expenses are compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues (for all, including persons with podoconiosis). However, accessibility to information should not impair the right to have personal health data treated with confidentiality.

3.2.3.3 Acceptability
The facilities, goods and services should also respect medical ethics, and be gender-sensitive and culturally appropriate. In other words, they should be medically and culturally acceptable.

3.2.3.4 Quality
Healthcare facilities, goods, and services must be of good quality, including scientifically and medically appropriate. This requires, inter alia, skilled medical and other personnel, scientifically approved and unexpired drugs, appropriate hospital equipment, safe and potable water, and adequate sanitation. In the context of persons with podoconiosis, this means that, for
example, health professionals should be provided with adequate healthcare training and other support services.

3.3 The Link between the Right to Health and Other Human Rights
The 1993 Vienna Declaration and Program of Action emphasize the fundamental interrelatedness of political and civil human rights and economic social and cultural human rights. The Vienna Declaration specifically provides:

All human rights are universal, indivisible, interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner on the same footing and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of states, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.

Human rights are interdependent, indivisible and interrelated. This means that violating the right to health may often impair the enjoyment of other human rights, such as the rights to education or work, and vice versa. The importance given to the “underlying determinants of health”, that is, the factors and conditions which protect and promote the right to health beyond health services, goods and facilities, shows that the right to health is dependent on, and contributes to, the realization of many other human rights. These include the rights to food, to water, to an adequate standard of living, to adequate housing, to freedom from discrimination, to privacy, to access to information, to participation, and the right to benefit from scientific progress and its applications, the prohibition against torture and the freedoms of association, assembly and movement.

The interdependence and interrelatedness of rights can be easily seen in the context of poverty. For people living in poverty, their health may be the only asset on which they can draw for the exercise of other economic and social rights, such as the right to work or the right to education.

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171 Vienna Declaration and Program of Action, 1993, supra note 144, part 1, art. 5.
172 Ibid.
173 Vienna Declaration and Program of Action, 1993, supra note 144, Part 1, paragraph 5, and CESCR General Comment No. 14, supra note 168, paragraph 3.
Physical health and mental health enable adults to work and children to learn, whereas ill health is a liability to the individuals themselves and to those who must care for them.

On the other hand, poor people are more vulnerable to ill health and poverty related diseases such as podoconiosis. Podoconiosis affects poor and powerless people living in remote rural areas. People suffering from podoconiosis cannot exercise their economic and social rights. This would impose not only psychological damage associated with stigma and discrimination but also economic burden as these people are more likely to be poorer. Conversely, podoconiosis patients’ right to health cannot be realized without realizing their other rights, the violations of which are at the root of poverty, such as the rights to work, food, housing and education, and the principle of non-discrimination.

3.4 The Principle of Non-discrimination and the Right to Health

The UN Committee on Economic, Social and Cultural Rights has published General Comment 20 which defines discrimination as “any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of [ICESCR] rights.”174 Thus, discrimination as prohibited under the ICESCR may be direct or indirect, in that a law or policy that appears neutral on its face can have a disproportionate impact upon certain groups.175

Discrimination is linked to the marginalization of specific population groups and is generally at the root of fundamental structural inequalities in society. This, in turn, may make these groups more vulnerable to poverty and ill health. Not surprisingly, traditionally discriminated and marginalized groups often bear a disproportionate share of health problems.176

Under International Human Rights Law, non-discrimination and equality are fundamental human rights principles and critical components of the right to health. The International Covenant on Economic, Social and Cultural Rights177 and the Convention on the Rights of the Child (art. 2

175 Ibid para 10.
177 ICESCR, supra note 135, art. 2.
(1) identify the following non-exhaustive grounds of discrimination: race, color, sex, language, religion, political or other opinion, national or social origin, property, disability, birth or other status. According to the Committee on Economic, Social and Cultural Rights, “other status” may include health status, disability, and sexual identity. In addition, the International Convention on the Elimination of All Forms of Racial Discrimination also stresses that States must prohibit and eliminate racial discrimination and guarantee the right of everyone to public health and medical care.\footnote{ICARD, supra note 148, art. 5.}

International human rights law proscribes discrimination in access to healthcare and the underlying determinants of health, as well as to the means for their procurement, on grounds including disability and health status.\footnote{General Comment 14, supra note 168, para 18-21.} Under international human rights law, States have an obligation to prohibit and eliminate discrimination on all grounds and ensure equality to all in relation to access to health care and the underlying determinants of health.

Non-discrimination and equality further imply that States must recognize and provide for the differences and specific needs of groups that generally face particular health challenges, such as higher mortality rates or vulnerability to specific diseases. The obligation to ensure nondiscrimination requires specific health standards to be applied to particular population groups, such as women, children or persons with disabilities or persons with podoconiosis.

Furthermore, the Committee on Economic, Social and Cultural Rights has made it clear that there is no justification for the lack of protection of vulnerable members of society, for instance podoconiosis patients, from health-related discrimination, be it in law or in fact. So even if hard, vulnerable members of society must be protected, for instance through the adoption of relatively low cost targeted programs.\footnote{General Comment 14, supra note 168, para. 18.}
3.5 Progressive Realization: Resource Constraints on the Right to Health

The international right to physical and mental health is subject to progressive realization and resource constraints.\(^\text{181}\) Put simply, all states are expected to be doing better in five years time than what they are doing today. And what is legally required of a developed state is a higher standard than what is legally required of a developing country.

The right to health requires that states take steps toward the “progressive realization” of the right to health.\(^\text{182}\) In accordance with the principle of progressive realization, recognized in Article 2 of the ICESCR, a state must take steps to operationalize the right to health only “to the maximum of its available resources, with a view to achieving progressively the full realization of the rights.”\(^\text{183}\) Referred to collectively as the “principle of progressive realization,” this principle acknowledges, in the case of the right to health, which states will undertake different health interventions based on their respective resources and consequently that states will enjoy vastly different standards of health.\(^\text{184}\)

Under the ICESCR’s conditional obligations under the right to health, states may justifiably differ in their actions based upon their respective political will, disease prevalence, and economic resources, so long as their compliance efforts “move as expeditiously and effectively as possible towards the full realization of Article 12.”\(^\text{185}\) Given these constraints, the right to health should be seen as inherently resource dependent.\(^\text{186}\)

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\(^{181}\) Article 2(1) of the ICESCR provides: “Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures”. The CESCR has elaborated on the meaning of the various components of this article in General Comment No 3 The Nature of States Parties’ Obligations (art 2(1) of the ICESCR) (5th session, 14 December 1990).

\(^{182}\) Ibid.

\(^{183}\) Ibid.

\(^{184}\) Matthew C.R. Craven, International Covenant on Economic, Social and Cultural Rights: A Perspective on Its Development 115 (1995) (“Given the variety of economic, social, and legal systems that exist among the States parties to the Covenant, and their different levels of development, it is natural that the approach of each State will vary according to the circumstances in which it finds itself.”).

\(^{185}\) General Comment 14, para 31.

The fact that the right to health is subject to progressive realization does not mean that no immediate obligations on States arise from it. In fact, States must make every possible effort, within available resources, to realize the right to health and to take steps in that direction without delay.\textsuperscript{187} Notwithstanding resource constraints, some obligations have an immediate effect, such as the undertaking to guarantee the right to health in a non-discriminatory manner, to develop specific legislation and plans of action, or other similar steps towards the full realization of this right, as is the case with any other human right.\textsuperscript{188} States have an obligation to refrain from taking and implementing ‘deliberately retrogressive measures’ resulting in the denial of existing rights. Otherwise, such measures would have to be justified fully by reference to all rights recognized in the Covenant in the context of the full use of the maximum available resources.\textsuperscript{189}

The CESCR has developed the concept of ‘minimum core obligations’ in order to ensure that economic, social and cultural rights are not interpreted as being entirely programmatic or ideals to be attained. The minimum core concept holds that each state party is obliged to satisfy, at the very least, minimum essential levels of each of the rights recognized under the Covenant.\textsuperscript{190} The concept is not intended to cripple under-resourced states. While recognizing that resource constraints are legitimate limitations on the realization of these rights, it requires that priority be given to the satisfaction of basic needs of people.\textsuperscript{191} This balance is struck by recognizing states pleading resource constrains as a defense to the failure to meet at least the minimum core obligations engendered by economic, social and cultural rights to demonstrate that every effort was made to use all resources that are at their disposal in an effort to satisfy, as a matter of priority, those obligations.\textsuperscript{192} According to the CESCR, the core obligations on states in respect of the right to health include to prepare a comprehensive, national plan for the development of the health system, ensure access to health-related services and facilities on a non-discriminatory basis, especially for disadvantaged individuals, communities and populations; this means, for

\textsuperscript{187} General Comment 3, para 9.
\textsuperscript{188} Ibid.
\textsuperscript{189} Ibid.
\textsuperscript{190} Ibid para 10.
example, that a state has a core obligation to establish effective outreach programs for those living in poverty, establish effective, transparent, accessible and independent mechanisms of accountability in relation to duties arising from the right to the highest attainable standard of health, provide essential drugs, as defined from time to time under WHO Action Program on Essential Drugs,\textsuperscript{193} and ensure the equitable distribution of health-related services and facilities e.g. a fair balance between rural and urban areas.\textsuperscript{194}

It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations above, which are non-derogable.\textsuperscript{195} The implication of this is that, although the state has a margin of discretion with regard to satisfaction of minimum essential levels of other aspect of the right to health on the grounds of resource constrains, such justification would be unacceptable under any circumstances with regard to non-derogable obligations.\textsuperscript{196}

Furthermore, the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (Maastricht Guidelines) stipulate that a state party violates the minimum essential level of the right to health if a significant number of its people are deprived of ‘essential primary health care’.\textsuperscript{197} As defined by the Alma-Alta Declaration, primary health care includes at least education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious disease; prevention and control of locally endemic disease; appropriate treatment of common disease and provision of essential drugs.\textsuperscript{198}

\begin{itemize}
\item \textsuperscript{193} Antiretroviral such as Nevirapine are included in the World Health Organization Model List of Essential Drugs (rev December 1999) s 6.4.2.
\item \textsuperscript{194} General Comment 14, supra note 168, paras 43(a), (d)-(e); 44(c).
\item \textsuperscript{195} General Comment 14, supra note 168, para 47.
\item \textsuperscript{196} Ibid.
\item \textsuperscript{197} Maastricht Guidelines para 9. The Guidelines were adopted in Maastricht, the Netherlands, on 22-26 January 1997.
\item \textsuperscript{198} Ibid para VII (3).
\end{itemize}
Moreover, since ICESCR went into effect in the 1970s, international policymakers and scholars have analyzed how ICESCR can be implemented effectively.\(^{199}\) An important milestone in this evolution is the enunciation of the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights by the U.N. Economic, Social and Cultural Committee.\(^{200}\) In addition to articulating the status of economic, social, and cultural rights as equal to political and civil rights and indispensable to the realization of these later rights,\(^{201}\) the Limburg Principles also articulated the meaning of the statement in ICESCR, Article 2(1) on the obligation to take steps toward "full realization of the rights" contained in the Covenant.\(^{202}\) Specifically, the Limburg Principles state that "legislative measures alone are not sufficient to fulfill the obligations of the Covenant"\(^{203}\) and that "states parties shall provide for effective remedies including, where appropriate, judicial remedies."\(^{204}\)

Above and beyond, there is a great deal that countries can do, even with very limited resources, toward the realization of the right to health. For example, even a country with limited resources can: include the recognition, care, and treatment (where appropriate) of non-filarial elephantiasis (podoconiosis) in training curricula of all health personnel; promote public campaigns against stigma and discrimination of persons with podoconiosis; support the formation of civil society groups; formulate modern policies and programs on podoconiosis and, as far as possible, extend community care; actively seek assistance and cooperation that benefits podoconiosis patients from donors and international organizations; and so on.


\(^{201}\) Ibid at 123-25.

\(^{202}\) ICESCR, supra note 135, art. 2(1).

\(^{203}\) Supra note 196 at 125.

\(^{204}\) Ibid.
3.6 Justiciability of the Right to Health

The right to health is categorized under socio-economic rights. One of the most important characteristics of socio-economic rights is that they require States to ‘take steps’ in order to ‘progressively’ achieve the realization of a social good ‘to the maximum of their available resources’. These limitations give rise to the question among some commentators and governments over the legal nature of the right to health. It has been asserted, for example, that socio-economic rights are merely “objectives to be attained rather than rights to be protected”. Others have argued that it is misleading to attach the label ‘rights’ to entitlements which can not be legally enforced and which lack justiciability. In addition, in the eyes of many Western commentators and governments socio-economic rights are considered at best as second class rights.

However, in 1993 the international community of States unambiguously reconfirmed that “all human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights in a fair and equal manner, on the same footing, and with the same emphasis.” The Vienna Declaration and Program of Action has created a new obligation on state parties on the scope and content of socio-economic rights including the right to health. In addition, at international level significant steps have been taken to subject the rights recognized in the ICESCR to a complaint procedure. As result, the Commission on Human Rights adopted a resolution on 22 April 2003 inviting Special Rapporteurs whose mandates deal with the realization of socio-economic rights to share views on an optional protocol to the ICESCR and to make recommendations to the working group on the said protocol at its next session.

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205 ICCPR, supra note 134, Art 2.
208 Supra note 138.
209 Para 15 of Resolution 2003/18 on ‘The Question of the Realization in All Countries of the Economic, Social and Cultural Rights Contained in the UDHR and the ICESCR, and Study of Special Problems which the Developing Countries Face in their Efforts to Achieve these Human Rights’.
The African Charter has become the first and only regional human rights instrument which includes both civil and political rights and the socio-economic rights. Under the African Charter socio-economic rights including the right to health are justifiable.\textsuperscript{210}

One of the best illustrations is SERAC (The Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v Nigeria)\textsuperscript{211} where the African Commission found violations of a range of socio-economic rights.

More importantly, socio-economic rights including the right to health have been increasingly recognized in most countries constitutions after 1989\textsuperscript{212} for instance the constitution of South Africa (1996)\textsuperscript{213}, the Indian Constitution (1950)\textsuperscript{214} and the constitution of Ecuador (1998)\textsuperscript{215}.

The right to health can also be protected under various other human rights such as the right to life and the right to quality. These rights are justiciable in international and domestic law.\textsuperscript{216} The Human Rights Committee (HRC), which monitors the ICCPR, has stated:

\begin{quote}
\textbf{210} Supra note 154 at art. 47; 55.\\
\textbf{211} The African Commission in \textit{The Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v Nigeria} Communication 55 of 1996 (SERAC).\\
\textbf{213} Constitution of South Africa (1996): Chapter II, Section 27: Health care, food, water and social security: “(1) Everyone has the right to have access to a. health-care services, including reproductive health care; b. sufficient food and water; […] (2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights. (3) No one may be refused emergency medical treatment.”\\
\textbf{214} Constitution of India (1950): Part IV, art. 47, articulates a duty of the State to raise the level of nutrition and the standard of living and to improve public health: “The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties…”\\
\textbf{215} Constitution of Ecuador (1998): Chapter IV: Economic, Social and Cultural Rights, art. 42: “The State guarantees the right to health, its promotion and protection, through the development of food security, the provision of drinking water and basic sanitation, the promotion of a healthy family, work and community environment, and the possibility of permanent and uninterrupted access to health services, in conformity with the principles of equity, universality, solidarity, quality and efficiency.”\\
\end{quote}
The expression ‘inherent right to life’ cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for State parties to take all possible measures to reduce infant morality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.\textsuperscript{217}

According to this construction, the right to health, impliedly, is protected through the right to life. The Indian Supreme Court affirmed such a construction in \textit{Samity v State of West Bengal}.\textsuperscript{218} According to the court:

\begin{quote}
Providing adequate medical facilities for the people is an essential part of the obligations undertaken by the Government in a welfare State.... Article 21 imposes an obligation on the State to safeguard the right to life to every person. Preservation of human life is thus of paramount importance... Failure on the part of a Government hospital to provide timely treatment to a person in need of such treatment results in a violation of his right to life guaranteed under Article 21.\textsuperscript{219}
\end{quote}

In addition, the right to health may also be covered under the right to equality and the non-discrimination clause. The principle of non-discrimination requires that differentiation among persons must not result in unfair treatment.\textsuperscript{220} For instance in \textit{Hendrika S Vos v The Netherlands}\textsuperscript{221} indirectly the link between issues relating to non-discrimination and access to health care services were noticeable.

Generally, the right to health is capable of judicial enforcement both directly and indirectly in international and domestic law.

\textsuperscript{217} UNHRC General Comment 6 on the right to life (16 July 1982) para 5.
\textsuperscript{218} AIR 1996 SC 2426, 2429.
\textsuperscript{219} Ibid.
\textsuperscript{220} Ibid.
\textsuperscript{221} Communication 218/1986, UN GAOR, HRC, 44\textsuperscript{th} Session, Supp No 40, 232, UN Doc A/44/40 (29 March 1989).
3.7 Obligations on States towards the Right to Health

States have the primary obligation to protect and promote human rights. Human rights obligations are defined and guaranteed by international customary law and international human rights treaties, creating binding obligations on the States that have ratified them to give effect to these rights.

3.7.1 General Obligations
All States which ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) have to give effect to the Covenant within the national jurisdiction. Especially, Article 2(1) of ICESCR clearly state that all member countries have an obligation to achieve the full realization of the rights which are included within the Covenant progressively. This is an implicit recognition that States have resource constraints and that it necessarily takes time to implement the treaty provisions.

Some components of socio-economic rights including to the right to health are subject to progressive realization. This means all aspect of the right may not be achieved fully within a short period of time because the rights demand availability of resources, but at a minimum States must show that they are making every possible effort, within available resources within a State as well as those available from the international community through international cooperation and assistance, as outlined in article 2 (1), to better protect and promote all rights under the Covenant.222

Parties to the Covenant, in addition to domestic obligation, have to require assistance from other States that are in a position to assist others to give effect to socio-economic rights including the right to health if a particular State is unable to on its own. Not only ICESCR underline the role of international assistance and cooperation but also the Charter of the United Nations, the Universal Declaration of Human Rights and the Convention on the Rights of the Child.223 States should thus have an active program of international assistance and cooperation and provide economic

222 CESCR General Comment Nº 3, para 6.
and technical assistance to enable other States to meet their obligations in relation to the right to health.\textsuperscript{224}

Even though Art. 2(1) ICESCR provides only for “achieving progressively the full realization of the rights” in the Covenant, the wording clearly imposes obligations to take immediate effect,\textsuperscript{225} most significantly the obligation to take steps to the maximum of a State Party’s available resources and, in Art. 2(2) ICESCR, the principle of non discrimination. The obligation to take steps means that State Parties have to establish a reasonable action program towards the full realization of the rights and to start its implementation within a reasonably short time.\textsuperscript{226} The action plan has to comply with the principle of non-discrimination, involve individuals and groups in the decision-making, be based on transparency and accountability.\textsuperscript{227} States have to employ all appropriate means to realize the right, including but not limited to legislative measures. In this regard, retrogressive measures are not permissible, unless a State can demonstrate that it has made every effort to use all resources at its disposal to meet its obligations. The condition leaves the choice of means to the states,\textsuperscript{228} but shows that the rights are relevant for all levels of state action, be it the drafting of health polices, the negotiation of trade agreements, the drafting of a law on social security or adjudication.

\textbf{3.7.2 Three Types of Obligations}
States have multifaceted obligations with respect to the right to health. These are the duty to respect, the duty to protect, and the duty to fulfill guarantees to the right to health.\textsuperscript{229}

\textbf{3.7.2.1 Obligation to Respect}
The duty to respect induces the state to refrain from interfering in the enjoyment of fundamental rights and to abstain from discriminatory practices, preventing and impairing access to human rights.\textsuperscript{230} According to Liebenberg the expression ‘preventing and impairing’ access is broad enough to include policies that result in denial of access to poor communities of the right, rather

\begin{itemize}
  \item \textsuperscript{224} Committee on Economic, Social and Cultural Rights, general comment N° 3 (1990) on the nature of States parties’ obligations and general comment N° 14, paras. 38–42.
  \item \textsuperscript{226} General Comment No. 3 paras 1,2; General Comment No. 14 para. 30.
  \item \textsuperscript{227} General Comment No. 14, supra note 168, paras. 54-56.
  \item \textsuperscript{228} General Comment No. 3 para 4.
  \item \textsuperscript{229} General Comment 14, supra note 168, para 33.
  \item \textsuperscript{230} \textit{Government of the Republic of South Africa v Grootboom} 2001 (1) SA 46 (CC) (Grootboom).
\end{itemize}
than simply an interference with the existing access to the right. The danger of discrimination is particularly high with respect to vulnerable groups, such as podoconiosis patients, HIV-positive patients, prisoners, minorities, asylum seekers, drug users, women and children. Any discrimination constitutes a violation of the obligation to respect. The duty of non-discrimination is strengthened by article 2 (2) ICESCR which bans “discrimination of any kind as to race, color, sex (...) or other status.”

Ethiopia has an obligation to prohibit discrimination and to ensure equality of opportunity for the enjoyment of the right to health by persons with podoconiosis under international law. For example, as well as being entitled to the same healthcare services as other members of society, the right to health gives rise to an entitlement of persons with podoconiosis to have access to, and to benefit from, those medical and/or social services that promote their independence and autonomy, prevent further disabilities, and support their social integration.

In addition, the obligation to respect requires States to refrain from interfering not only directly but also indirectly with enjoyment of the right to health. For example, States should refrain from denying or limiting access to health-care services; from marketing unsafe drugs; from imposing discriminatory practices relating to women’s health status and needs; from limiting access to contraceptives and other means of maintaining sexual and reproductive health; from withholding, censoring or misrepresenting health information; and from infringing on the right to privacy (e.g., of persons living with HIV/AIDS). Moreover, the State cannot take action which would directly injure health, and may require the state to prohibit torture and cruel punishment. In addition, this obligation may require the state to protect against the destruction of access to clean water or food for vulnerable population. For instance, states should also ensure that persons with podoconiosis in public institutions are not denied access to healthcare and related support services or to underlying determinants of health, including water and sanitation.

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233 General Comment 14, supra note 168, para 34.
234 Supra note 172 at 130 (quoting E/C12/1993 para. 8-10).
235 Ibid. (quoting E/C12/1993/Wp19, para.8).
3.7.2.2 Obligation to Protect

The obligation to protect requires State parties to prevent third parties from interfering with the right. General Comment No. 14 states that this obligation includes:

“inter alia, the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties.”\(^{236}\)

This obligation requires the state to take positive action to protect any acts of private actors which brings damage against citizens. Consequently, the state has the duty to ensure equal access to health care provided by third parties.\(^{237}\) Where the service is privatized, the state must ensure that the privatization ‘does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities’.\(^{238}\)

The duty to protect also requires that vulnerable groups be given special protection. For example, states should take measures to protect persons with podoconiosis from violence and other right-to-health-related abuses occurring in private healthcare or support services. In relation to people with disabilities the CESCR has stated:

The state discharges the duty to protect through ‘the creation and maintenance of an atmosphere or framework by an effective interplay of laws and regulations’ to enable individuals to freely realize their rights and freedoms.\(^{239}\) It has to establish ‘an effective regulatory system’ providing for ‘independent monitoring, genuine public participation and imposition of penalties for non-compliance’.\(^{240}\)

\(^{236}\) General Comment No. 14, supra note 168, para. 35.
\(^{237}\) Ibid at para 35.
\(^{238}\) Ibid.
\(^{239}\) SERAC para 46.
3.7.2.3 Obligation to Fulfill
The duty to fulfill includes the duty to promote.\(^{241}\) The latter enjoins the state to ensure that individuals are able to exercise their rights and freedoms through promoting tolerance and raising awareness.\(^{242}\) The duty to fulfill entails an obligation to facilitate the actual realization of the right. As part of discharging this obligation, the state must give sufficient recognition to the right to health in its domestic legal system.\(^{243}\) This requires states to recognize the right to health, including the right to health of persons with podoconiosis, in national political and legal systems, with a view to ensuring its implementation. States should adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures toward this end.\(^{244}\) For example, states should ensure that their population's right to the highest attainable standard of health and that the right to health of persons with podoconiosis are adequately reflected in their national health strategies, plans of action, and other relevant policies, such as national poverty reduction strategies and national budgets.\(^{245}\) States should also ensure that information about their human rights is made available to podoconiosis patients and their families, as well as medical personnel.\(^{246}\) Furthermore, the state has to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counseling and mental health services with due regard to equitable distribution throughout the country.\(^{247}\) In addition, this obligation requires the state to adopt positive measures that enable and assist individuals and communities to enjoy the right in question.\(^{248}\) Moreover, the duty to fulfil includes an obligation to provide the right when individuals or groups are unable to realize the right by their own means.\(^{249}\)

\(^{241}\) Ibid at para 25. The duty to fulfil entails the obligations to ‘facilitate, promote and provide’.
\(^{242}\) SERAC para 46.
\(^{243}\) General Comment 14, supra note 168, para 36.
\(^{244}\) Ibid.
\(^{245}\) Ibid.
\(^{246}\) Ibid.
\(^{247}\) Ibid.
\(^{248}\) Ibid
\(^{249}\) Ibid para 37.
Chapter Four

The Realization of the Right to Health of Persons Living with Podoconiosis in Ethiopia: Legal and Practical Problems

4.1 Background
The existence of podoconiosis in northern Ethiopia was first reported by the adventurer James Bruce in the 1970s. Subsequent reports listed northwest, southern, southwest and western part of Ethiopia as endemic areas of podoconiosis. Prevalence rates are high in areas of irritant red soil that covers approximately 18% of the surface area of Ethiopia. The prevalence rate in these areas is estimated at approximately 5%, translating to about 500,000 to 1 million affected persons, mostly affecting people between the ages of 4 and 60. In spite of this evidence that podoconiosis is a significant public health and socio-economic challenge in Ethiopia, it has been given little attention within Ethiopia. It is included in very few health professional curricula, and is largely ignored by health policy makers and is almost neglected in Ethiopia.

This neglect makes it impossible for proper action to be taken to address the disease. It must be admitted, though, that this inaction on the part of government is due mainly to lack of awareness. Coupled with this are the lack of reliable data, a lack of funding, the lack of participation by persons with podoconiosis and the inability of the legal system in the country to address the disease. All these factors have contributed to insufficient advocacy and awareness-raising. Consequently, some of the challenges faced by persons with podoconiosis as regards the realization of the right to health include stigma and discrimination, poor or no facilities in the health sector and the lack of a proper legal framework.

250 Davey et al., supra note 20, p. 1176.
251 Id.
252 Price, supra note 99, p. 78.
253 Id.
4.2 Legal and Policy Framework

4.2.1 FDRE Constitution

The right to health has been mentioned under FDRE Constitution of 1995. According to article 41(4), the State has the obligation to allocate ever-increasing resources to provide to the public health (health services for the public at large). As per article 41(3), every Ethiopian national has the right to equal access to publicly funded social services, which apparently include health-related services. It is also implicit in the obligation of the State to provide rehabilitation and assistance to the physically and mentally disabled, the aged, to children who are left without parent or guardian under article 41(5) that health services be provided to these groups of people.

Despite the fact that the Constitution does not include the right to get emergency medical service which is an important aspect of the right to health, one may add the right to housing, social security, safe and potable water, food etc… from the open-ended use in the constitution (... and other social services).²⁵⁴

Furthermore, the FDRE Constitution provides that all international agreements ratified by Ethiopia are an integral part of the law of the land.²⁵⁵ Accordingly, international treaties and conventions have to be ratified by the House of Peoples Representatives to become an integral part of the law of the land.²⁵⁶ In addition, the Constitution states that fundamental rights and freedoms specified in the third chapter shall be interpreted in a manner conforming to principles of the Universal Declaration of Human Rights, International Covenants on Human Rights and International Instruments adopted by Ethiopia.²⁵⁷

Ethiopia has ratified or accessed most of the international and regional human rights instruments which give recognition to the right to health. The most important ones are the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and, the Convention on the Rights of the Child (CRC). At a regional level, Ethiopia has ratified the African Charter on

²⁵⁵ FDRE Constitution, Art 9(4).
²⁵⁶ Id at art. 55(12).
²⁵⁷ Id at art. 13(2).
Human and Peoples’ Rights (ACHPR). Consequently, all the above international and regional
demand right instruments are an integral part of the law of the land.

Furthermore, chapter ten of the FDRE Constitution is devoted to National Policy Principles and
Objectives (DPSP). Accordingly, the Constitution obliges the State to design policies that
would provide all Ethiopian access to public health. This is one of the social objectives under
Article 90 of the Constitution. The obligation of the state extends to the extent the resources of
the country permit and it is expected to design policies that aim to provide all Ethiopian access to
public health, clean water, food and social security. Thus, as citizen all these elements have an
impact on the right to health of persons living with podoconiosis. However, it should also be
noted that the provisions of Article 90 are like Directive Principles of Public Policy protecting
right indirectly and cannot be invoked before courts of law.

In addition, under chapter three of the same Constitution, a number of fundamental human rights,
such as the right to life, human dignity, and freedom from discrimination, is guaranteed.
As mentioned earlier, all these rights are important in safeguarding the right to health for persons
living with podoconiosis.

Persons living with podoconiosis, just like any individuals, have the right to equal access to
health related services which is provided in the Constitution. They also have the right to equally
enjoy the rights in particular the right to health which is contained under international and
regional human right instruments to which Ethiopia is party. However, persons living with
podoconiosis have faced specific hurdles in relation to the right to health. These can result from
biological or socio-economic factors, discrimination and stigma, or, generally, a combination of
these. Considering health as a human right requires specific attention in particular those living in
vulnerable situations like podoconiosis patients in the society. Thus, States should adopt positive

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258 The Ethiopian Government had accessed ICESCR in 1993 and CRC in 1991 without reservation, ratified
CEDAW in 1981 with reservation to Art. 29(1) and ACHPR in 1998.
259 FDRE Constitution, Art 90.
260 Id.
261 Id at art. 15.
262 Id at art. 14.
263 Id at art. 25.
measures to ensure that individuals affected by podoconiosis are not discriminated against. For instance, they must disaggregate their health laws and policies and modify them to those most in need of assistance rather than passively allowing seemingly neutral laws and policies to benefit mainly the majority groups.

4.2.2 Public Health Proclamation No. 200/2000
In its preamble, the proclamation stresses the need for the active participation of society in the health sector and that the attitudinal change of the society through primary health care approach can solve most of the health problems of the country. Considering that the legislation has a stated contribution in the implementation of the country’s health policy, it is an important step in carrying out the obligation to fulfill the right to health including vulnerable groups such as persons living with podoconiosis.264

4.2.3 The Policy Framework (National Health Policy)
The National Health Policy of the Transitional Government of Ethiopia was launched in 1993. In its preamble the policy stresses the needs of the less privileged rural population which constitute the overwhelming majority of the population and the major productive force of the nation and reaffirms the interdependence, interrelatedness and association of health with other fundamental rights.

The National Health Policy underlines the importance of achieving universal access to a basic package of quality primary health care services to all people to decentralized, preventive, promotive and basic curative services.

The Government therefore accords health a prominent place in its order of priorities and is committed to the attainment of these goals utilizing all accessible internal and external resources. The major contributors to the burden of disease at all levels will be given the highest priority. These include HIV/AIDS, malaria, tuberculosis, leprosy blindness, child mortality and maternal

264 Proclamation no. 200/2000 preamble states “the active participation of the society in the health sector has become necessary for the implementation of the country's health policy; it is believed that the attitudinal change of the society through primary health care approach can solve most of the health problems of the country; the issuance of public health law is believed to be an important step for the promotion of the health of the society and for the creation of healthy environment for the future generation thereby enabling it assume its responsibility...”
mortality and onchocerciasis. These priority health problems shall be implemented through the Health Sector Development Program (HSDP).²⁶⁵

HSDP is the vehicle by which the National Health Policy articulated by the Transitional Government of Ethiopia (TGE) in 1993 is implemented. As such, the objectives and design of HSDP are entirely compatible with the policy which stresses the need to develop a comprehensive health service delivery system and the capacity for effective management in order to address the major problems of communicable disease, malnutrition, and the need for improved maternal and child health services.

HSDP was commenced in 1998 with the purpose of increasing the coverage and improving the quality of health services. The HSDP proposes long-term goals for the sector, and the means to attain them by way of a series of phased, medium-term plans.

The country follows a 20-year plan with a rolling five year program. It is broken down into four successive five-year plans and the first and second phase cover the period of 1997–2002, and 2002-2005. The 3rd was designed to cover from 2005/6 – 2009/10 which is under implementation.

4.3 Gaps in Domestic Law, Policy, Strategy and Plan Pertaining to the Right to Health of Persons Living with Podoconiosis

The right to health of vulnerable groups such as persons living with podoconiosis is recognized in numerous international instruments. The International Covenant on Economic, Social and Cultural Rights which provides the most comprehensive article on the right to health in the international human rights law recognizes the health needs of the vulnerable groups such as persons living with podoconiosis and explains through illustrations a number of steps to be taken by the State parties to achieve the full realization of the right to health of the general population and of vulnerable groups such as persons living with podoconiosis. The signatories of International Covenant on Economic, Social and Cultural Rights made an international commitment to protect, respect and fulfill the right to health of population of the respective nations as parties to the Covenant.

Ethiopia is party to a great number of these treaties and has made a strong international commitment to the international human right to health. By ratifying international human rights treaties that affirm the right to health, Ethiopia agrees to be accountable to the international community, as well as to the people living within its jurisdiction including persons living with podoconiosis, for the fulfillment of its obligations.

Furthermore, Ethiopia, under the international human rights treaty is required to adopt legislative measures and to employ all appropriate means to ensure that persons living with podoconiosis, can enjoy the rights conferred by the treaty. This means that international treaty provisions must be incorporated into the domestic legislation. Consequently, the 1995 Constitution of Ethiopia has made all international and regional human rights instruments which are ratified or accessed by State as integral law of the land. Thus, the right to health which is recognized under those instruments which Ethiopia ratified or acceded entitled every individual within its jurisdiction including by persons living with podoconiosis.

In addition, the FDRE Constitution enshrines socio-economic rights, though not expressly, providing for the right to health both in the Bill of Rights and in the National Policy Principles and Objectives. Article 41, entitled “Economic, Social and Cultural rights” provides the following:

That every Ethiopian national has the right to equal access to publicly funded social services and obliges the State to allocate ever-increasing resources to provide to the public health, education and other social services.

The FDRE Constitution entitles the enjoyment of publicly funded social services to all Ethiopian citizens on equal footing. Thus persons living with podoconiosis have the constitutionally guaranteed right to access to every social service provided by the State without discrimination based on their status.

Moreover, the FDRE Constitution under National Policy Principles and Objectives requires the government to develop policies that enable the enjoyment of rights by citizens. They are also used as tools that guide the interpretation of fundamental rights and freedoms of the FDRE
Constitution.\textsuperscript{266} In relation to social objective it is provided that \textit{to the extent the country’s resources permit polices shall aim to provide all Ethiopians access to public health and education, clean water, housing, food and social security.\textsuperscript{267}} Thus, the Ethiopian government is duty bound to adopt and implement such policies in all areas of economic and social rights.

Hence, Ethiopia has ratified a health sector policy in 1993. In the national health policy, primary health care service is designed to include preventive, promotive and basic curative and rehabilitative services. The main policy objective is to prevent the disease before it causes social and economic burden on vulnerable groups.

One key informant from Ministry of Health told this researcher that:\textsuperscript{268}

\begin{quote}
The 1993 national health policy of the country aims at strengthening a decentralized system as this system is the most appropriate to reach the vast majority of the rural populations which has limited access to basic health care services. The policy was designed to give the greatest importance to prevention, promotion and curative and rehabilitative services for all diseases which impose a socio-economic burden on the people. In addition, the policy deals with health in order of priority and gives much emphasis to the prevention of communicable and non-communicable diseases.
\end{quote}

According to this informant, the national health policy is inclusive and the primary health care service is intended to include the primary prevention of podoconiosis, and curative and rehabilitative services for persons living with podoconiosis.

However, the Ministry of Health subsequently launched a Health Sector Development Program (HSDP) for implementation of the national health policy over a period of twenty years. This program gives priority to prevention and control of HIV/AIDS, malaria, tuberculosis, leprosy, blindness, child mortality, maternal health and onchocerciasis.

One informant from Ministry of Health told that:\textsuperscript{269}

\begin{flushright}
\textsuperscript{266} FDRE Constitution, Art 85(1).
\textsuperscript{267} Id at art. 90(1).
\textsuperscript{268} Interview with \textit{Ato Sorsa Falitamo}, Officer, Public Relation Department, FDRE Ministry of Health, 26 Oct, 2010, Addis Ababa: Ethiopia.
\textsuperscript{269} Interview with \textit{Ato Hunegnaw Mekonnen}, Officer, Disease Promotion and Prevention Department, FDRE Ministry of Health, 27 Oct, 2010, Addis Ababa: Ethiopia.
\end{flushright}
The national health policy includes general policy objectives, priorities, strategies and goals. For the realization of this, the ministry developed the health sector development program (HSDP). The HSDP responds to a number of problems identified in the coverage and quality of health services. This program gives priority to the major contributors to the burden of disease like HIV/AIDS, malaria, tuberculosis, leprosy, blindness, child mortality, maternal health and onchocerciasis depending upon the available internal and external resources.

In addition, the Ministry of Health has issued a Draft National Plan on Integrated Neglected Tropical Diseases (NTDs) for the period of 2011-2015. According to the draft, Neglected Tropical Diseases (NTDs) are a group of diseases that include lymphatic filariasis, Onchocerciasis (river blindness), Schistosomiasis (bilharziasis), soil transmitted helminthiasis (STH), trachoma (blindness), Guinea worm (Dracunculiasis), Trypanosomiasis (sleeping sickness) and podoconiosis. Among NTDs the draft plan aims the control/elimination of the five targeted NTDs such as Onchocerciasis, LF, Schistosomiasis, STH and Trachoma based on preventive chemotherapy using safe and effective drugs.

Even though the draft plan on NTDs has recognized podoconiosis as one of NTDs in Ethiopia, and podoconiosis as one of the public health problems in the country, there is no national control program stating any target to prevent, treat and control the disease. The idea of formulating the National Master Plan on NTDs and including podoconiosis in the NTDs draft is encouraging; however, it is yet to see how far it would go regarding fighting podoconiosis in the country.

According to one informant from the Ministry of Health:

It is true that podoconiosis has got very little attention from the policy makers. This may be related to lack of reliable date on the prevalence rate and socio-economic impact of the disease in the country. I have been working in the NTDs for long time but I have not heard about podoconiosis. I know about elephantiasis because I took one course at undergraduate level but not about podoconiosis. Despite this the government has not totally ignored podoconiosis and persons living with podoconiosis though the disease is not directly included in the program, it has

271 Ibid.
272 Ibid.
273 Supra note 269.
included in the draft plan on NTDs. In addition, the health sector has introduced an innovative health service delivery system through the implementation of the health service extension program (HSEP) since 1997. The HSEP aims to train and deploy health extension workers (HEWs) in all the rural Kebeles who will be assigned to serve a population of 5000 with two HEWs including persons living with podoconiosis.

In spite of the fact that the health extension workers have been trained and deployed in all rural Kebeles of Wolayta Zone based on the plan of the Health Sector Development Program, they are delivering health service for those diseases which have already been given priority under the program. Hence, persons living with podoconiosis have not been the subject of the health service extension program for the following reasons. Firstly, the program was designed based on the Health Sector Development program and this program does not include the problem of podoconiosis. Secondly, the extension program has trained and deployed the workers only on the prioritized diseases; so that the workers do not have sufficient know-how how to deliver health services on podoconiosis and to persons living with podoconiosis.

This is confirmed by officers of diseases prevention and control of the health department of the Wolayta Zone.

One informant said:  

_The government has a health extension program which is planned to train and deploy health extension workers in all Kebeles in Wolayta Zone. These workers have been given short term training on the major communicable disease. Unfortunately, podoconiosis has not been the subject and the workers have not yet made any report to the health department about the socio-economic burden of the disease in the Zone because the training focuses on the diseases which are prioritized in the health sector development program._

Therefore, persons living with podoconiosis do not have a chance to get health services from extension workers. Consequently, most of the patients try whatever they think might treat their foot. Patients made every effort to use both traditional and modern means of treatment. Unfortunately, patients end up wasting time and scarce resources in spite of progressing pain and

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274 Interview made with Ato H/Giyorgis Abate, Coordinator, Disease Promotion and Prevention Department, Wolayta Zone Health Department, 10 Oct, 2010, Wolayta Sodo

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disability. Though the national health policy has designed the primary health care service to include preventive, promotive, curative and rehabilitative service, persons living with podoconiosis have been prevented from making informed early preventive measures and their choice for appropriate treatment because podoconiosis has not been the theme for Health Sector Development Program and control and elimination of integrated Neglected Tropical Disease in Ethiopia. Thus, the approach of the national health policy for persons living with podoconiosis is like “a gun without a bullet”.

One respondent who is living with podoconiosis described his feeling like this:

I am 35 years old. I was born in poor family who are living in very remote rural area. Farming is our livelihood. Since my childhood I made myself part of agricultural work. During farming I never used shoes so that I cut one of my legs many times. Through time my left leg developed a different feature than my right leg. First, I thought it was pneumonia but later I came to recognize that podoconiosis affected me. I did all I could to treat me but the result was nil. I always think if the government did something I would have been working like previous. I think it is the obligation of the government to prevent podoconiosis and provide treatment for persons living with podoconiosis. I believe I am the citizen of this country and my family pays tax to the government. Thus, the government has to fulfill any health care services and goods in order to enable me to treat this God damn disease just like malaria and HIV/AIDS patients.

The other respondent also expressed the following better ordeal of his life with podoconiosis:

Podoconiosis affected me a long time ago. During the time all my family and I could do was just to look what would happen next because my family was too poor to provide me treatment. After while my legs became bigger and bigger, which prevented me farming and sometimes walking. Now I am worthless for my family and my country. My family did nothing but the government has the obligation to prevent and provide me treatment. I am a human being just like others patients in the country. The government should do whatever things to prevent the disease. If I work I will help my family, me and the country.

In view of the fact that Ethiopia has become party to international and regional human rights instruments, it has an obligation to respect, protect and more importantly fulfill and promote the right to health towards persons living with podoconiosis. The right to the “highest attainable
“standard of health” takes into account differing levels of available resources. It acknowledges that countries, particularly developing countries, may have limited capacity to actually implement their obligations under the right to health and allows for flexibility in the manner and timing of implementation as befits each individual country. However, the CESCR obliges Ethiopia at least to implement the minimum obligation immediately through, for example, legislative, policy and regulatory measures towards persons living with podoconiosis. In spite of this fact, the right to health of persons living with podoconiosis has been violated which result from failure of the government at least to fulfill its minimum core obligation like failure to ensure the right of access to health facilities, goods and services, provide essential drugs, ensure equitable distribution of health facilities, goods and services, adopt a national health strategy and plan of action, take steps to prevent, treat and control endemic diseases (podoconiosis), provide health education and access to information regarding podoconiosis in the community who live in the endemic area of podoconiosis; and provide appropriate training for health personnel including education on podoconiosis and the right to health of persons living with podoconiosis.

4.4 Barriers to Implement the Right to Health of Persons Living with Podoconiosis
The interpretation of the right to health to include the underlying determinants of health would mean that countries have obligations under the right to health to deal with the political, economic and health structure obstacles which may prevent the realization of the right to health of person living with podoconiosis. Dealing with these obstacles is very clearly a part of fulfilling the right to health in respect of availability, accessibility, acceptability and quality provided under the General Comment 14. The main theme of the study under this section is therefore to discover barriers to exercising the right to health of persons living with podoconiosis to health care facilities, goods and services which are provided privately or publicly. Information on barriers to

276 General Comment 14, supra note 168, para 43.
277 Id, para 44.
278 Id, para 12.
treatment was obtained mainly from interviews held with focus group discussion participants and key informants.

4.4.1 Non-availability of Health Care Facilities and Trained Medical Professionals

According to the CESCR, functioning public health and health-care facilities, goods and services, as well as programs, have to be available in sufficient quantity within the State party.279 For instance, the availability criterion requires the presence of sufficient functioning public health and health-care facilities, goods and services, trained medical professionals and programs.

Persons living with podoconiosis are predominantly in areas where health facilities, goods and services are inadequate or essentially unavailable. Most of the patients have tried different mechanisms in order to get treatment. However, this effort has been hampered due to the non-availability of the health care facilities, good and services which is provided in their areas.

This is confirmed by the patients themselves in the following manner:

*It is 18 years since my foot started to trouble me. Now I am 40 years old and I have 3 children. I was a mother of 6 children. Three of my children died because of my ability to take care of them and feed them was not good. It was after I was pregnant with my sixth son that my body started to get swollen and show different kinds of uncommon signs especially my leg. I got tired, weak and I sweated very much without doing any hard work. My sixth son died right after birth. Different part of my body continued to get swollen and give pain. When things looked not normal to me, I went to a clinic in my area and the maximum treatment I got was an injection by a physician. At the moment, the pain in my body got better for a few hours and then started again. I continued to follow up with the injection when I felt more pain and weakness. The swelling of my body continued to make pus and bloody water. Something even worse started to happen. My foot started to make many other little toes around my toes. Terrible smell started to come out of my foot and make me uneasy.*

The other respondent also stated as follows:

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279 Id, para 3.
When I was 26 years of age, I came to figure out that podoconiosis affected me. From that moment onwards I started to look for any treatment options. I tried every traditional and modern medicine. I went to different places looking for holy water and went to different hospitals. But, no improvement was obtained. My foot was getting worse from time to time irrespective of my effort. Despite all the efforts the only thing I got was losing all I had. Thus I decided that I would never try another treatment.  

[42 year old male patient]

I have lived with podoconiosis for the last 17 years. Usually, I was farming, walking and doing any work barefooted. I came to know podoconiosis affected me when I was 20. I didn’t know the cause of the disease however I did my best to cure myself using different traditional medicines. Despite my effort my legs became bigger and bigger. Finally I decided to go to government health centers. Thus, I went to different hospitals and clinics however the response of health care providers was not more than pain killer. [47 year old male patient].

In addition, persons living with podoconiosis have been facing obstacles to the realization of their right to health through non-availability of medical professionals trained in the area of podoconiosis prevention and treatment. 

Although the disease is widespread and well known in Wolayta society, health professionals from different health facilities that render service to the community have misconceptions about the cause, prevention and treatment of podoconiosis. This reflects lack of awareness about the disease. All the health professionals who participated in a qualitative study believed that the disease was infectious and transmitted by a vector like that of filariasis. The word 'elephantiasis' was the name used by health professionals to indicate the disease. They were found to have mistaken the disease for filariasis, onchocerciasis, and schistosomiasis.280

One key informant from the government health center told this researcher that:281

I have been the health officer in Boditi health center for the last 2 years. Podoconiosis is one the major diseases in this area and it has huge socio-economic burden not only in this Woreda but also in the Zonal level. However, we didn’t list podoconiosis as the major disease because our main area of focus is the prevention

280 Yokob B, et al, supra note 110, p. 43.
281 Interview with Ato Sehale Sapa, Head, Boditi Health Center, 24 Sept, 2010, Boditi.
and treatment of malaria, HIV/AIDS, tuberculoses, child mortality and maternal health. Despite this, large numbers of persons affected by podoconiosis visits the health center every day. All we can do is to refer to Sodo Hospital because we do not have trained health care professional to provide health care facilities, good and services for patients affected by podoconiosis.

4.4.2 Inaccessibility

According to the CESCR, health facilities, goods and services must be accessible to persons living with podoconiosis, taking into account four overlapping dimensions.

Those dimensions are (1) non-discrimination;²⁸² (2) the provision of health facilities "within safe physical reach for persons living with podoconiosis including in rural areas";²⁸³ (3) economic accessibility or affordability, meaning that costs for health care services "whether privately or publicly provided, are affordable to all, including persons living with podoconiosis";²⁸⁴ and (4) "the right to seek, receive and impart information and ideas concerning health issues."²⁸⁵

Notwithstanding the stipulation of the General Comment 14, persons living with podoconiosis have been facing accessibility barriers to health care and an adequate standard of living. Health care facilities, goods and services are not physically accessible for persons living with podoconiosis because most of the governmental health centers are located in Wereda towns which patients in remote rural villages face difficulty of accessing. Remoteness of the location of clinic sites from the place of residence of patients, when coupled with their foot condition and lack of proper means of transport, can impede their access to treatment.

Some of the respondents’ described remoteness as barrier to visit the health centers in the following manner:

_There are villages where there is no public transport or even horse carriage service. The alternative to this is to walk on foot. But, to walk hours for a podoconiosis patient is challenging. Thus, some patients may refrain from visiting the health centers because of remoteness [a 45 year old male patient]._

²⁸² General Comment 14, supra note 168, para 3.
²⁸³ Id at para 3-4.
²⁸⁴ Id at para 4.
²⁸⁵ Id.
There are a number of patients, even in areas where there is public transport and horse carriage service, who never visited the health centers just because of lack of money. To walk on foot for two to three hours to arrive at the health centers is challenging for some patients [a 28 year old male patient].

I have been living with podoconiosis for the last 12 years. I visited traditional healers as well as government health centers when the disease was at initial stage. I didn’t get any solution and now I have very huge water bag legs. Today it is unthinkable to me to visit any health institution when I get sick. It takes two to three hours on foot to arrive health center. I was going there to get the treatment kits barefoot. My foot was developing wounds as a result of walking barefoot on stony road to health center. I then preferred not to go anywhere and stayed at home even if I am sick. [a 30 year old female patient].

The problem of distance becomes an important issue when it comes to older patients. As one respondent state:

I am 52 years old age and I have lived with podoconiosis for the last 24 years. I have faced difficulties in walking long distance. I tried to visit a health center which is about five to seven kilometers from my home. I remember that bad day, I made such a long walk to arrive the health center and I didn’t get anything. Finally, when I was coming to my home I fell down in the middle of the road. People gathered together, carried me and took me up to my home. I was completely unconscious when all that happens. From that day onwards I decided to remain at home. [a 52 year old female patient]

In addition, persons living with podoconiosis are facing barriers to exercise their right to health just because of lack of money. The General Comment 14 states that health facilities, goods and services must be economically accessible for poor section of the society like podoconiosis patient who cannot afford costs whether health care is provided privately or publicly. In the beginning, podoconiosis is the disease of poverty which affects in most cases marginalized poor people who live in remote rural areas. Thus, poverty is the main barrier which prevents persons living with podoconiosis from controlling the disease. If these patients are asked to pay a huge amount of money to get treatment, it will be putting the patients in more desperate situation.

All the respondents identified poverty as a major hindrance to access to and utilization of health care services provided privately and publicly. One respondent told this researcher,
My legs developed swelling and inflammation 7 years ago. My family did their best to treat me using traditional medicine but no changes. Through time my foot started to make many other little toes around my toes. The only chance to get back my foot was surgery. I went to Ottona hospital (government hospital in Wolayta Zone) but health care provider advised me to go to Soddo Christian hospital (private hospital in Wolayta Zone). That was a time I had lost my hope that is they told me to be ready to pay them four to six thousand birr. Forget about that huge amount of money it is difficult for me even to get two birr to pay for treatment costs. [a 29 year old male patient].

I failed to appear in the hospitals and clinics to get treatment because they asked me a lot of money with nil result. It is difficult to afford treatment expenses for patients like me. I was not only expected to cover treatment expenses but also transport expenses to reach hospitals and clinics because I am afraid of getting sick after walking on foot. Thus, I decided to remain at home. [a 16 year old female patient].

The other dimension in which persons living with podoconiosis have faced barriers to exercise the right to health is lack of information on the disease. The CESCR states that persons living with podoconiosis have the right to access information concerning health care facilities, goods and services. In addition, the national health policy was designed to include primary health care to include prevention, promotion, curative and rehabilitation service. Besides, the national health policy gives priority for education and information as the base to prevent a disease. Accordingly, information on health (and other) matters, including diagnosis and treatment, must be accessible to persons living with podoconiosis, to the parents of children living with podoconiosis and to the community at large who are living in podoconiosis-endemic areas. In spite of this, persons living with podoconiosis including children who are affected by podoconiosis have been denied this entitlement.

According to most pathological research findings, podoconiosis is a disease of individuals having frequent barefooted contact with red clay soils in volcanic areas. In addition recent studies have also confirmed genetic susceptibility to disease.

However, podoconiosis patients’ awareness of the cause of the disease and its early symptoms deviate from the cause of disease proved through pathological investigations. Either due to

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286 Price, supra note 101, p. 79.
information gap or lack of attention paid by policy makers, the pathology and preventability of podoconiosis is not widely known among members of podoconiosis endemic communities.\textsuperscript{288} Thus, awareness of patients and community members of the cause and prevention of the disease is biased to misconception of the disease.

Most podoconiosis patients this study dealt with wrongly perceived the cause of the disease. They perceived the disease as caused by snake bite, evil eye, injury by a sharp item, cold weather, stepping on frog and other dead animals. Such perceptions not only prevented the patients from making informed early preventive measures but also influenced their choice for appropriate treatment. Consequently, most of the patients in the study spent a great deal of time trying whatever they thought might treat their foot. The patients made every effort they could to get both traditional and modern means of treatment. Unfortunately, patients end up with a waste of time and scarce resources in spite of progressing pain and disability. Some of the respondents indicated their experiences in this regard as follows.

\textit{I had been strong worker and I spent most of my time farming. While farming I never used shoes and I didn’t like to put shoes on because I didn’t feel comfortable. In addition, I walked a long way barefooted. During all these ups and downs I got cut by sharp objects but I didn’t give attention. Accidentally my foot started growth. I thought it was snake bite but later it became podoconiosis. I didn’t know what podoconiosis is and how it comes until my foot started swelling and gave troubles. \textbf{[41 year-old male patient]}.}

\textit{I was 15 when podoconiosis affected me. Before that I was a trader and I sold fruits in the market. I had to buy first from the farmer and in order to do that I had to search home to home. When I made such an exhausting walk I never put shoes on. After while I came to recognize that one of my feet started to increase in size. I had no idea about the cause of enlargement of my foot. I thought it was simple - later it gave me trouble. I felt strong pain when I made long walk. \textbf{[27 year old female patient]}.}

\textit{I developed podoconiosis when I was 16. My parents did everything to treat me and they tried different traditional medicines. Despite this my legs became bigger and bigger. Nobody knows the reason for the disease. Even a single day my parents thought the reason for the disease was frequent contact with the soil. Even though}

\textsuperscript{288}Yokobe B, et al, supra note 110, p. 44.
they did their best to treat me, they did not allow me to put shoes on my feet. This is because they didn’t come to understand that podoconiosis arises from soil. [51 year old female patient].

Furthermore, some of the key informants from the community and site health workers in the Mossy Foot Treatment and Prevention Association (a national NGO working on treatment and prevention of podoconiosis in the Wolayta Zone) confirmed lack of information on health matter for persons living in the endemic area of podoconiosis in the following manner.

I was born here in Wolayta and lived here for the last 24 years. I have seen so many people who are suffering from ‘gede kita’ (local term for podoconiosis) in my area. These people have suffered a lot, for instance, they cannot make a long walk, farming and other activities. In addition discrimination and marginalization against the people are immense. I do not know the cause of the disease but I know ‘gede kita’ is one of the major health problems in the area than malaria, HIV/AIDS, tuberculoses and others. However, local government officials, health care providers and even church and community leaders keep silent about the disease and the patients. The amazing thing is that local radio station always has a program about malaria, HIV/AIDS and tuberculoses nothing about a disease for a minute. I always ask myself ‘why everybody opted silent about ‘gede kita’ and the patients? [36 year old male from the endemic area of podoconiosis]

I have served for the last 5 and half years in the Mossy Foot Treatment and Prevention Association in Boloso site as health care provider. During this period I came to understand that podoconiosis is one of the basic health problems in the area and it has caused a devastating impact on the life of the people. Most of the time the people in the area do their work barefooted and this frequent contact with the soil is the main reason for the cause of podoconiosis. However people do not know that such contact with the soil will expose them for the disease. The disease affects everyone, that is, children, adults and older people if footwear is not used for long time. As site health care provider it is my duty to inform about the disease to the surrounding government officials and health centers. I think government officials have known high prevalence of the disease in the area but nothing has done yet. Unfortunately, persons with podoconiosis are leading undignified life and some of them died either committing suicide or worse.

4.4.3 Stigma and Discrimination
International human rights law proscribes discrimination in access to healthcare and the underlying determinants of health, as well as to the means for their procurement, on grounds
including physical and mental disability and health status. Various forms of stigma and discrimination continue to undermine the realization of the right to health for persons living with podoconiosis. For example, they often face discrimination in access to general healthcare services or stigmatizing attitudes within these services, which may dissuade them from seeking care in the first place. The following respondent confirmed this as follows.

*I have visited health center and hospitals to get treatment two to three times. Occasionally, they admitted me to give treatment, however, the only treatment was advice that was referral to other health center or hospital or they gave me pain killer. On the other day, they failed to admit me saying that they would not provide me any treatment. I ask myself why I am treated differently. In each occasion I saw other patients treated and got appropriate medicine but nothing in the case of my disease. [33 year old female patient]*

*I don’t think I have equal access to treatment in hospitals and clinics like other patients. I made a visit to hospitals and clinics a couple of times. The maximum treatment which I got is injection. But this injection did nothing to my disease. Here is the point, other patients access hospitals and clinics and they return home after getting appropriate health care service and goods but I went there and back without any appropriate health care service and goods. Thus, can I say that other patients and I have equal access to health centers? [62 year old patient]*

In addition, stigma and discrimination within the community, schools, and workplaces can also act as a barrier to persons seeking social support, diagnosis, and treatment. Podoconiosis patients avoid appearance in public places to overcome the stigma they face in the community. One key informant from the government health center shares his experience as follows.

*I have worked in the Sodo Health Center as health officer for the last three years. During this period, I came to recognize that a very small number of persons living with podoconiosis visited the health center. I think the main reason is persons living with podoconiosis hide themselves even to the extent that they feel ashamed when they are observed by other people. As a result, some patients fear being identified as podoconiosis patients by appearing in health center.*

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289 General Comment 14, supra note 168, para 36.
290 Gebrehanna, supra note 105, p.23.
Moreover, one key informant, who is a social worker in the Mossy Foot Treatment and Prevention Association (a national NGO working on the treatment and prevention of podoconiosis in Wolayta Zone), shares his experience in the following manner.

*I am a social worker in the association and one of my duties is to make home-to-home visit. One day, I met with a boy who is living with podoconiosis but never attended any private or public health centers due to the unwillingness of his parents. I decided to find out why the parents prevented him from getting the treatment. I then asked the parents why they didn’t let their child at least visit government health centers. Their immediate response was that ‘there is nobody sick in our home’.* What I understood from their action is that they feared not to be identified as having a podoconiosis patient in their family [29 years old clinic site social worker]

As mentioned above, the role of stigma as a barrier to access to treatment is not a simple matter for persons living with podoconiosis.

### 4.5 Violation of Other Rights of Persons Living with Podoconiosis

All human rights i.e civil and political and socio-economic rights are interrelated, interdependent and indivisible as emphasized on the Vienna Declaration and Program of Actions. This means that violating the right to health and right to equality and non-discrimination as mentioned above may often impair the enjoyment of other human rights, such as the rights to education or work, and vice versa. Hence, the realization of the right to health is important for the realization of other rights like the right to life, the right to education, the right to work and the right to an adequate standard of living in particular because health is *sine qua non* for the fulfillment of other human rights.

#### 4.5.1 The Right to Dignified Life

The Human Rights committee in its General Comment No.6, expresses the view that the protection of the right to life requires States Parties to “adopt positive measures…..”\(^{292}\) This indicates the right to life cannot be fully realized without undertaking some positive measures against problems detrimental to human health. Accordingly, the government is obliged to undertake measures against health injuries like podoconiosis for the full realization of the right to life.

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\(^{292}\) General Comment No. 6, supra note 219.
Podoconiosis causes suffering from impaired health status. The disease does not directly cause death but complications arising when the disease advances are debilitating. Swollen legs and other parts frequently get infected and lymphatic obstruction limits movement.

Consequently, persons living with podoconiosis have been denied the ability to lead dignified life because the disease prevents more severely affected persons from pursuing farming and other activities, and most patients become beggars or less productive, and spend working time at home or in bed. In addition, the gross deformity, swelling, repeated ulceration and secondary infection make the swelling severe and decrease quality of life and results death because of starvation and infection.

One key informant who is a social worker in the Mossy Foot Treatment and Prevention Association told this researcher:

*I have seen some many podoconiosis patients who are bedridden in their shanty home. Some of the patients spend their time sitting around the fire. They cannot walk or work. They are totally ignored by their families, friends and close neighbor. Again I have met some many times that podoconiosis patient lost their life by committing suicide.*

This means persons living with podoconiosis have been denied the exercise of their right to live a dignified life which is guaranteed under human rights instruments and the Constitution because of the health injuries which makes their day to day life more of a struggle. One respondent shares her experience as follows.

*People could not approach me because of the stinky smell of my foot. I was isolated from my friends. I couldn’t go to school, church or market place. Some of my neighbors insult me and they don’t have any respect for me.* [14 year old female patient]

### 4.5.2 The Right to Education

The right to education is categorized under socio-economic rights. The International Covenant on Economic, Social, and Cultural Rights obliges member states to recognize the

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293 Desta et al, 2002; Fasil T., 2005; G/Hanna, 2005.
294 FDRE Constitution, Art. 15.
right to education of everyone. Violation of this right hampers the realization of other human right. Though everybody has the right to benefit from this right, persons living with podoconiosis have not been lucky because of the complications arising from the disease. Students with podoconiosis report that the disease interferes with their education. This was mainly due to the patient’s feeling that their fellow students rejected them (less friendly/isolated/no spontaneous invitation to join in group activities) and resulted in them not following classes regularly.

The severity and the frequent attacks of podoconiosis have an impact on the school performance of affected students. Students are obliged to miss classes and even to drop out of school for a year and more due to their illness. The reaction of other students in the classroom whenever patients have difficulties with their legs during attacks, which is mostly associated with bad smell, have contributed to the low performance of student and has caused some of the students to drop out of school.

One high school student who is a victim of podoconiosis put his physical disability in this way:

*I always wake up early in the morning to go to school so as to be on time but it takes me more than 3 hours to reach to my school. In contrary the healthy students from my neighborhood only take 30 -50 minutes to reach the same school. Always I arrive late for school and the teachers don’t let me in to the class. No one understands my problem. The students who come after me reach the school on time and laugh on me by saying he walks like ‘tortoise’. I am a useless person because you know I can’t even walk as sick people. Even I don’t have the privilege of sick person. My situation is the worst of all. You feel sick all the time.*

4.5.3 The Right to Work
This right is recognized under the International Covenant on Economic, Social and Cultural Rights and imposes an obligation on State Parties to recognize the enjoyment of just and favorable condition of work to ensure among other equal opportunity for everyone to be promoted in his employment to an appropriate higher level, subject to no considerations other
than those of seniority and competence.\textsuperscript{298} However, one can exercise this right only when in good health.

As mentioned above, podoconiosis affects very poor people who are living in rural areas and creates an addition burden on the people whose health may be the only asset on which they can draw to exercise the right to work. Consequently, podoconiosis patients face problems in integrating themselves in community activities because of physical disability, and this problem in turn leads to economic challenge. The patients had lower limbs affected and there was a significant association with difficulty in walking, standing for a long time, and using toilet, this in turn may lead to loss of job and inability to work. In other words, they cannot perform what they are supposed to perform at appropriate time and place compared to unaffected community members. Due to inability to walk long distance traders cannot trade. Farmers are unable to farm their land due to associated pain in their legs. This prevents them from becoming part of the educated labor force. Persons living with podoconiosis reported incapability to carry out their daily chores and loss of jobs due to the disease.

One farmer explained how the physical challenge due to the disease affected his work as follows:

\textit{I am destined to be poor because you know I am not capable of farming because of the physical difficulty associated with the disease. If you can’t farm and look after your land appropriately, your fate is to beg people for food. This is why I say I am destined to be poor. The acute attack of the disease lasts for a week and sometimes for two weeks. This time may be an appropriate time to seed or do some important activity related to farming. If you don’t sow in appropriate time what is your fate? \ldots begging, only begging. [53 year old male patient]}

Some podoconiosis patients are forced to quit their regular jobs due to consecutive absenteeism from work related to recurrent illness. Others are dismissed from their jobs due to prolonged absence pursuing treatment in hospitals and health centers. One in-depth interview informant describes the experience of job loss due to absenteeism from work as follows:

\textit{I was dismissed from my job when I was absent for three consecutive months while following treatment in the hospital. I was provided a dismissal letter, when I came back to the job after my stay in the hospital. I was working in the documentation center in}

\textsuperscript{298} ICESCR, Art. 7(c).
government office. I struggled for a number of years to get my job back, but I was unsuccessful. [59 year old male patient]

4.5.4 Marital, Personal and Family Right
The right to marry and found a family is recognized under international and regional human right instruments. Ethiopia is party to those human right instruments which give emphasis on the protection of this right. In addition, the FDRE Constitution included under chapter 3 which is fundamental right and freedom. Accordingly, article 34 states that men and women, without any distinction as to race, nation, nationality or religion, who have attained marriageable age as defined by law, have the right to marry and found a family.

Every individual including persons living with podoconiosis has the constitutionally guaranteed right to marry and found a family. Despite this, persons living with podoconiosis face difficulties in Wolayta during marriage arrangements. Due to the strong belief of the society that the disease is hereditary, willingness to marry podoconiosis patients is nil. The problem with marriage is not only limited to the patients themselves. It is also reflected in patients’ families. This is expressed by the way people dig into the family history for the evidence of podoconiosis before any marriage arrangement. In Wolayta community no matter healthy the individual is at the time of marriage the family history of podoconiosis matters more than anything.

A 27 year old girl explained how the disease is an obstacle to finding a partner in this way:

I am an appropriate age to marry, but still no one has proposed to me. My friends are married now. I know that I am a beautiful girl but this disease has created a major obstacle to my prospect of finding a husband.

One male patient also added by saying like this:

“Girls are not willing to marry individuals like me affected by the disease.”

The patients also have a high probability of undergoing divorce from their spouse after developing the disease. The unaffected partner does not want to continue living with the affected individual under the same roof. The experience of one woman explains this phenomenon best:

Gebrehanna, supra note 105, p. 28.
We were a happy family and we loved each other very much. But after I developed the disease everything changed, my husband was not happy with the situation. Before we make divorce he comes home very late. This is unusual behavior he showed after I developed the disease. Then from time to time our relationship became rough. Finally he told me that he didn’t want to live with me. Now he has got married to another girl and they are living together.

This shows persons living with podoconiosis not only face difficulty finding a marriage partner for themselves or their children, but are also likely to divorce. Many people believe persons affected with podoconiosis (including their family members) should not have a loving relationship, get married or have children, and some think the question of marriage relationship is disgusting.
Chapter Five

Conclusions and Recommendations

5.1 Conclusions
Persons living with podoconiosis have a right to health care, which includes available, accessible, acceptable, and good quality health care facilities, goods and services. This right is contained in various international and regional human rights instruments to which Ethiopia is party. Since Ethiopia has ratified numerous international human rights instruments that recognize the right to health as a fundamental right, the government must ensure that it respects, protects and fulfils this right. One of the ways of doing this is by guaranteeing access to treatment for all, particularly persons living with podoconiosis. Though the right under inquiry is not expressly recognized under the Bill of Rights in the 1995 Constitution, it can be protected through the application of norms contained in international and regional human rights instruments.

It is one thing to have a human right enshrined in a legal instrument, yet another to have it realized by the intended beneficiaries. Consequently, persons living with podoconiosis have been denied these benefits on various fronts. The Government has devoted no budgetary resources to podoconiosis and support services and has failed to develop adequate policies, programs, and laws. Hence, it is clear that the realization of the right to health of persons living with podoconiosis is not simple in Ethiopia. Many factors, including unavailability of health care facilities, goods and services, lack of trained medical personnel, inaccessibility of health care facilities, goods and services, stigma and discrimination associated with podoconiosis and a lack of an enabling environment, all exacerbate the problem of the realization of the right to health of persons living with podoconiosis in Ethiopia.

In addition, failure to include the disease in the national health agenda and lack of intervention programs through dissemination of information on prevention, treatment and control have played a significant role in the denial of the right to health and other human rights of persons living with podoconiosis. Persons living with podoconiosis have no treatment option in public or private health centers. Thus patients are forced into risky treatment choices. These treatment choices have debilitating health impacts on the patients. Podoconiosis patients commonly avoid activities and movements in these circumstances to reduce the incidence of recurrent illness. This in turn
increases poverty and threatens their resilience in stressful times like famine. It also results in a waste of scarce resources, deprives the chances of employment opportunities in labor intensive activities, and curtails their progress in education. Patients are overtly discriminated against in school situations by their teachers and classmates through denial of seats, offensive comments and insults. At funerals and weddings, patients are denied the roles of preparing food and appearing in front of strangers. Patients are also denied employment opportunities due to preconceived assumptions about their physical incapability.

The right to health may not be realizable unless an enabling environment, where the human rights of every citizen, including people affected by podoconiosis, are respected. Therefore, it is high time that the Ethiopian government enacts appropriate legislation to address the issue of stigma and discrimination associated with podoconiosis. Furthermore, training for health care providers, which emphasizes a respect for human rights, is essential to ensure that patients seeking treatment or information on podoconiosis are treated with respect and guaranteed of their rights.

The writer would like to emphasize that, unless the government introduces favorable policies, strategies and plans for podoconiosis and exhibits a political will to execute them, millions of people will continue to be affected by the disease.

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

- There is an urgent need to explicitly recognize the right to health of persons living with podoconiosis in the national health policy, strategy and plan that makes it unequivocal that the government is under an obligation to provide adequate, affordable and accessible health care facilities, goods and services for these persons.
- Podoconiosis prevention and control programs in Ethiopia are not integrated to the general health care service; therefore the Ministry of Health (MOH) should integrate it into health care service.
- In order to decrease the negative reaction of the wider community towards podoconiosis, the Ministry of Health or the regional health bureaus must plan health education to change behaviors and attitudes related to the disease. Any successful response to stigma
and discrimination needs to be based on a clear understanding of these phenomena and should be in line with available evidence. This includes being sure that people clearly understand what podoconiosis is, how it is (and is not) transmitted, how it is prevented, and how it is treated. It also means that people undertaking stigma reduction strategies or those targeted by them need to have a clear idea of what stigma and discrimination are, how they affect podoconiosis patients, and what can be done to counter them. Successful stigma reduction strategies need to be based on a clear and insightful appreciation of the specific local contexts and conditions and must build on lessons learned from past experience and from others.

- Persons living with podoconiosis should be empowered, so their capacities can be used as an effective response against stigma and discrimination. This might include strengthening skills and knowledge, building self-acceptance and social capital, improving the socio-political environment for healthy change, and enhancing elements of organizational skills development. Empowering patients includes helping them acquire advocacy and communication skills. It is a process that helps ensure that those directly affected by podoconiosis are integrally involved in decision making processes, as well as in planning and implementing diverse strategies.

- Awareness-creating programs about the disease must be disseminated through both print and mass media.

- Civil society, including professional groups, NGOs, private societies, the media, the academic and research organizations are expected to play key roles in addressing the health problems of podoconiosis patients.
Bibliography

Books/Articles


**Official Documents (International and Regional)**


National Law/Policy/Program/Plan


Internet Sources

Committee on Economic, Social, and Cultural Rights: General Comment 14, The Right to the Highest Attainable Standard of Health (21 session, 2000)


Interviews

Interview made with Ato H/Giyorgis Abate, Coordinator, Disease Promotion and Prevention Department, Wolayta Zone Health Department, 10 Oct, 2010, Wolayta Sodo.

Interview with Ato Meskele Ashine, Director, Mossy Foot Treatment and Prevention Association (MFTPA) 18 Oct, 2010, Wolayta Sodo.

Interview with Ato Sorsa Falitamo, Officer, Public Relation Department, FDRE Ministry of Health, 26 Oct, 2010, Addis Ababa: Ethiopia.

Interview with Ato Hunegnaw Mekonnen, Officer, Disease Promotion and Prevention Department, FDRE Ministry of Health, 27 Oct, 2010, Addis Ababa: Ethiopia.


Interview with Ato Sehale Sapa, Head, Boditi Health Center, 24 Sept, 2010, Boditi.
Appendix 1 - Interview Guide One: In-depth Interview Guide with

Persons Living with Podoconiosis

Thank him/her for agreeing to take part and explain who you are. Introduce why you do the interview.

1. Biography?
2. What do you know about the right to health?
   a) Do you know that the government has an obligation and you have the right to be prevented from podoconiosis?
   b) What were some of the factors that made it difficult for you to prevent problem?
   c) Do you know that the government has an obligation and you have the right to be treated from podoconiosis?
   d) What were some of the factors that made it difficult for you to get treatment for the disease?
3. Prevention
   a) Is there any attempt by local officials to supply goods and services that enable the people to protect themselves from podoconiosis?
   b) Is there any awareness program to the people in the locality by government officials regarding how to prevent podoconiosis?
4. What were your experiences around treatment availability?
   a) Where do you get most of your health care services?
   b) Is treatment for podoconiosis available in or near your village?
   c) Do you have health facilities, goods and services within safe physical reach?
   d) Do you have access to good quality medical services?
   e) Can you tell me any barriers and challenge you face to get treatment?
   f) What is your experience with health care providers with respect to treatment?
5. What have been your experiences of discrimination or stigma related to podoconiosis?
   a) Have there been any changes in your relationships, work environment, or friendships because of you or your family’s status? If so, please elaborate.
   b) Have you experienced any poor treatment at work, home, hospitals/clinics or in other public settings? If so, please explain.
   c) Do you think podoconiosis related stigma and discrimination differ for men and women? If so, how?
Appendix 2 - Interview Guide Two: In-depth Interview Guide with

Health Care Providers and the Community

Thank him/her for agreeing to take part and explain who you are. Introduce why you do the interview.

I. Community

1. Would you introduce yourself? Position/occupation?
2. What do you know about podoconiosis?
3. What is your attitude towards podoconiosis and the patients?
4. How does the community around here view people with podoconiosis?

II. Health Care Providers

1. Would you introduce yourself? Position/occupation?
2. What do you know about podoconiosis?
   a. Do you think that podoconiosis can be prevented, treated and controlled?
   b. How can you treat podoconiosis patients?
   c. Do you think that podoconiosis patient has equal health access as patients who do not have disease?
   d. Do patients frequently visit the heath centre?
3. Are there effective and adequate medicines that can be administered for the treatment of podoconiosis? Do you teach people on how to prevent podoconiosis? (for health care worker)
Appendix 3 - Interview Guide Three: In-depth Interview Guide with Mossy Foot Treatment and Prevention Association Workers

Thank him/her for agreeing to take part and explain who you are. Introduce why you do the interview.

1. Please let me know about yourself? Position/occupation?
2. Why do you think are policy makers ignorant despite large number of patients in Ethiopia?
3. What challenges and barriers podoconiosis patients commonly face?
4. What do you think can be done to decrease the challenges and barriers podoconiosis patients face?
Appendix 4 - Interview Guide Four: In-depth Interview Guide with

Ministry of Health Officers

Thank him/her for agreeing to take part and explain who you are. Introduce why you do the interview.

1. Would you introduce yourself? Position/occupation?
2. Have you ever heard about podoconiosis?
3. Do you think podoconiosis is a health problem?
4. Do you think that podoconiosis has been adequately recognized under the laws and policies?
5. Why do you think policy makers are ignorant about podoconiosis?
6. Do you think that podoconiosis patients in Ethiopia are facing difficulty in exercising their right to treatment and prevention?
7. The main health policy objective in Ethiopia is prevention of the disease. What do you think in terms of podoconiosis?
8. What is the government doing to fight podoconiosis in Ethiopia?