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Protection of the Right to Health of Internally Displaced Persons (IDPs) in Ethiopia: Access to Healthcare Services and Legal Redress for Health Injury

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Abstract

Recognizing 'health' as a human right, the World Health Organization (WHO) Constitution and other human rights instruments (UDHR and ICESCR) create a legal obligation on states to provide quality, accessible and acceptable public health care services to all citizens without discrimination based on race, ethnicity, gender, religion, legal status, political view, economic and social condition. Above all, it is recognized that the enjoyment of the "the highest attainable standard of health" is one of the fundamental rights of every human being. In line with this, States are required to take "legislative measures" for the progressive realization of the right to health within the limits of their available resources. In addition, international health laws impose legal obligations on States to protect their citizens from public health risks and injuries. Despite the stringent legal

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requirements at international level, many states fail to provide effective legal protection for the right to health of their citizens at domestic health systems. It is an international norm that vulnerable groups should get special protection of their human rights including the right to health. Thus, in light of the relevant international principles, this article strives to examine the legal protection of the right to health in Ethiopian health system taking the case of Internally Displaced Persons (IDPs) as an example. Besides, it briefly addresses the responsibility of the State in providing legal redress for health injuries.

Keywords: *health care services, human rights, health system, Internally Displace Persons (IDPs), health injury, and legal redress*

1. Introduction

The rights-based approach to health has been advocated by many human rights scholars, activists and institutions for the better implementation of the right to health in national health systems.[1] The right to health has been expressly provided in some international human rights instruments including the 1948 Universal Declaration of Human Rights (UDHR)[2], the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR)[3] and the 1946 Constitution of the World Health Organization (WHO).[4] These legal documents require the respective states to take legislative measures particularly to incorporate the right to health as part of socio-economic rights.[5] But none of those human rights documents give a clear definition

[1] Abegaz, Solomon Tekle. 2019. "A Human Rights-Based Approach to Maternal and Child Health in Ethiopia: Does it Matter to Promote Health Equities?" *IntechOpen*. Accessed April 11, 2020. doi:10.5772/intechopen.83513; Hunt, Paul. 2016. "Interpreting the International Right to Health in a Human Rights-Based Approach to Health." *Health and Human Rights Journal*. Accessed April 11, 2020. https://www.hhrjournal.org/2016/12/interpreting-the-international-right-to-health-in-a-human-rights-based-approach-to-health/; and Kinney, Eleanor D. 2016. "The International Human Right to health: What does this mean for our nation and world?" *Indiana Law Review* 34 (1457). Accessed April 12, 2020. https://mckinneylaw.iu.edu/ilr/pdf/vol34p1457.pdf.

[2] See article 25 (1) of the 1948 Universal Declaration of Human Rights (UDHR).

[3] Refer article 12(1) of International Covenant on Economic, Social and Cultural Rights (ICESCR) 1967.

[4] See the Preamble of the 1946 Constitution of World Health Organization (WHO). The Preamble provides that "The 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."

[5] See article 2(1) of the ICESCR, and the last paragraph of the Preamble of both UDHR and WHO Constitution.

of the right to health for any legal application. Despite the definitional gap, all the documents[6] underlie that every human being has the right to the enjoyment of the highest attainable standard of physical and mental health without any discrimination. It is stated that health as a human right does not mean the right to be healthy nor does it assert an unlimited right to be treated for every medical condition.[7] Rather, the right to health may be seen as having two constituents: a right to health care and a right to healthy living conditions.[8] The rights-based approach to health has two aspects: first, a clinical and curative perspective focusing on health care and health services, and second, a preventive perspective focusing on the social determinants of health including water, sanitation, nutrition, and health education.[9] As plainly provided in the preamble, the WHO Constitution (1946) envisages "…the highest attainable standard of health as a fundamental right of every human being."

[6] Refer Article 12 (1) of International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966, Article 25 of the Universal Declaration on Human Rights (UDHR) 1948, and the Preamble of World Health Organization (WHO) 1946.

[7] Special Rapporteur, Report of the Special Rapporteur on the Right to Health, E/CN.4/2006/48/Add. 1 (Dec. 22, 2005).

[8] Judith Asher, the Right To Health: A Resource Manual For NGOs, 2004 Int'l Health & Human Rts. Org. 17, Available at http://shr.aaas.org/pubs/rt_health/rt_health_manual.pdf.

[9] Hunt, Paul. 2016. "Interpreting the International Right to Health in a Human Rights-Based Approach to Health." *Health and Human Rights Journal.* Accessed April 11, 2020. https://www.hhrjournal.org/2016/12/interpreting-the-international-right-to-health-in-a-human-rights-based-approach-to-health/.

Understanding health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality.[10] While the term 'health' has been broadly defined in human rights documents, the 'right to health' lacks a precise definition. However, the right to health (Article 12 of ICESCR) was well described in General Comment 14 of the Committee on Economic, Social and Cultural Rights, a committee of Independent Experts[11], responsible for overseeing adherence to the Covenant. Accordingly, the right includes the following core components: first, availability, which refers to the need for a sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes for all. Availability can be measured through the analysis of disaggregated data to different and multiple stratifies including by age, sex, location and socio-economic status and qualitative surveys to understand coverage gaps and health workforce coverage. Accessibility, pertains to the requirement that health facilities, goods, and services must be accessible to everyone.

[10] Amare, G. 2016. "Right to Healthcare in Ethiopia: Then, Now and Tomorrow." Accessed April 16, 2020. http://aigaforum.com/article2016/right-to-health-care-part4.pdf.

[11] According to General Comment 14, health is a fundamental human right indispensable for the exercise of other human rights. Besides, the legal enforceability of the right to health is underlined. See the details at: https://www.refworld.org/pdfid/4538838d0.pdf.

Accessibility is the second most important component of the right to health. It has four overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability), and information accessibility. Assessing accessibility may require analysis of barriers: physical, financial or otherwise, that exist, and how they may affect the most vulnerable, and call for the establishment or application of clear norms and standards in both law and policy to address these barriers, as well as robust monitoring systems of health-related information and whether this information is reaching all populations. Thirdly, acceptability relates to respect for medical ethics, culturally appropriate, and sensitivity to gender. Acceptability requires that health facilities, goods, services and programmes are people-centered and cater for the specific needs of diverse population groups and in accordance with international standards of medical ethics for confidentiality and informed consent. Finally, the principle of quality requires that facilities, goods, and services must be scientifically and medically approved. Quality is a key component of Universal Health Coverage and includes the experience as well as the perception of health care. Quality health services should be safe[12],

[12] Safe health services avoid injuries to people for whom the care is intended.

effective[13], people-centered[14], timely[15], equitable[16], integrated[17], and efficient.[18]

A States' obligation to support the right to health including through the allocation of "maximum available resources" to progressively realize this goal is reviewed through various international human rights mechanisms such as the Universal Periodic Review or the Committee on Economic, Social and Cultural Rights.[19]In many cases, the right to health has been adopted into domestic laws or constitutionalized.[20] A rights-based approach to health requires that health policy and programmes must prioritize the needs of those furthest behind first towards greater equity, a principle that has been echoed in the recently adopted 2030 Agenda for Sustainable Development and

[13] Effective health services provide evidence-based healthcare services to those who need them.

[14] People-centered health services provide care that responds to individual preferences, needs and values.

[15] Timely health services reduce waiting times and sometimes harmful delays.

[16] Equitable health services provide care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status.

[17] Integrated health services provide care that makes available the full range of health services throughout the life course.

[18] Efficient health services maximize the benefit of available resources and avoiding waste.

[19] Refer article 16(1) of the ICESCR.

[20] Kinney, Eleanor D. 2016. "The International Human Right to health: What does this mean for our nation and world?" *Indiana Law Review* 34 (1457). Accessed April 12, 2020. https://mckinneylaw.iu.edu/ilr/pdf/vol34p1457.pdf.

Universal Health Coverage.[21] Policies should prioritize the health rights of vulnerable groups such as children, women, ethnic minorities, refugees, HIV/AIDS victims, and internally displaced people (IDPs) who need special and differential treatment in line with international human rights standards. Besides, recent developments calls for the right to health to be placed explicitly at the center of a rights-based approach and interpreted in accordance with public international law and international human rights law.[22] The right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status. Non-discrimination and equality[23] requires states to take steps to redress any discriminatory law, practice or policy.[24] Another feature of rights-based approaches is meaningful participation. Participation means ensuring that national stakeholders including non-state actors such as non-governmental organizations are meaningfully involved in all phases of programming: assessment, analysis, planning, implementation, monitoring and evaluation.

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[21] Transforming our World: The 2030 Agenda for Sustainable Development. UN General Assembly. 2015. 21 October. UN Doc. A/RES/70/1.

[22] Hunt, "Interpreting the International Right to Health," 5.

[23] The principle of non-discrimination seeks '…to guarantee that human rights are exercised without discrimination of any kind based on race, color, sex, language, religion, political, or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation'.

[24] Abegaz, "A Human Rights-Based Approach," 3.

In the area of public health, even though Ethiopia has reached a point where basic services are widely accessible to many rural communities[25], the country has poor health outcomes even by sub-Saharan Africa's standards characterized by many decades without a national health policy, poor legal infrastructure, weak healthcare system infrastructure and low government finance.[26]Irrespective of the multifarious challenges in building a stronger health system, Ethiopia has received international praise for its focus on developing primary health care services with a bottom-up approach that emphasized community engagement through volunteer community health workers, lower-level facilities with locally recruited health extension workers, and development of health centers and primary hospitals. In addition, the country has ambitious plans to advance toward universal health coverage through a primary health care approach, continuing to strengthen this system by expanding coverage, quality, and scope of services.[27]However, since more than 75% of the population in Ethiopia live in rural areas, up to 80% of the

[25] Downie, Richard. 2016. "Sustaining Improvements to Public Health in Ethiopia." Accessed April 5, 2020. https://csis-prod.s3.amazonaws.com/s3fs-public/legacy_files/files/publication/160226_Downie_SustainImprovementsEthiopia_Web.pdf.

[26] Wamai, Richard G. 2009. "Reviewing Ethiopia's Health System Development." *International Medical Community* 52 (4): 279–286. Accessed April 6, 2020. https://www.med.or.jp/english/journal/pdf/2009_04/279_286.pdf.

[27] Peter Berman, Carlyn Mann & Marie-Louise Ricculli. 2018. "Can Ethiopia Finance the Continued Development of Its Primary Health Care System If External Resources Decline?" *Health Systems & Reform* 4 (3): 227-238. Accessed April 6, 2020. doi:10.1080/23288604.2018.1448240.

people still use indigenous medicines for several reasons including the cultural acceptability of healers and local pharmacopeias, the relatively low cost of traditional medicines and difficult access to modern health facilities.[28]

Internally Displaced Persons (IDPs) are one of those vulnerable groups[29] identified by the UN who need special legal protection both at international and national levels. The UN has issued the Guiding principles on the protection of the rights of IDPs. In accordance with these principles, IDPs have the right to health and other basic services including the right to a standard of living adequate to maintain health and well-being. According to Principles 4 and 18 of the UN Guiding Principles on Internal Displacement 1998, IDPs are entitled to enjoy without discrimination, the same rights and freedoms under international and domestic law as do other persons in their country. Thus, this article focuses on how these rights are, or should be, implemented in Ethiopian domestic law and health system for the provision of

[28] Kebede Deribe Kassaye, Alemayehu Amberbir, Biniyam Getachew and Yunis Mussema. 2006. "A historical overview of traditional medicine practices and Policy in Ethiopia." *Ethiop.J.Health Dev.* 20 (2).

[29] According to the UN, the most vulnerable groups of people include Internally Displaced Persons (IDP´s), Stateless Persons, National Minorities, Indigenous Peoples, Migrant Workers, Disabled Persons, Elderly Persons, HIV Positive Persons and AIDS Victims, Roma/Gypsies/Sinti, and LGBTP (Lesbian, Gay, Bisexual and Transgender Persons). See the details at: http://www.humanrights.is/en/human-rights-education-project/human-rights-concepts-ideas-and-fora/the-human-rights-protection-of-vulnerable-groups.

essential health and other basic services to IDPs in several dimensions and various contexts. For the purpose of this article, the definition of health provided by WHO will be employed for any explanation or analysis. Accordingly, 'health' is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[30]

2. Brief Overview of the Ethiopian Health System

2.1 The Imperial Regime (Pre 1974)

Following the promulgation of the first Constitution in 1931, Emperor Haile Selassie took some administrative measures to modernize and integrate Ethiopian economic system to fit the world economy.[31] Accordingly, during 1931–34, Haile Selassie instituted projects for roads, schools, hospitals, communications, administration, and public services.[32]During the Italian occupation of Ethiopia (1936-1941), there were public health facilities in some cities administered by the Italians such as Addis Ababa and Jimma. However, the anti-epidemic and preventive medical programs developed by the Italian occupational forces

[30] See the preamble of Constitution of the World Health Organization (July 22, 1946).

[31] Kloos, Helmut. 1998. "Primary Health Care in Ethiopia: From Haile Sellassie to Meles Zenawi." *Northeast African Studies* (Michigan State University Press) 5 (1): pp. 83-113. http://www.jstor.org/stable/41931184 .

[32] Encyclopædia Britannica. 2020. *Ethiopia.* April 16. https://www.britannica.com/place/Ethiopia/Socialist-Ethiopia-1974-91.

during their stay in Ethiopia served only their own public health and political interest.[33]It was not available for Ethiopian people. After the Italians were ousted out of the country, the Ministry of Health was established in Ethiopia in 1947 by *Emperor Haile Selassie I* who intended Ethiopia to have a robust, Western-style health system, with indigenous doctors, administrators, and health officers. Instead, foreign officials consistently ignored the emperor's requests, preferring a "low-tech," preventative medical approach, asserting that this was more "appropriate" to Ethiopian needs, culture, and capacity.[34] Until 1974, the Imperial regime adopted series of Five-Year Plans with the aim of reaching less accessible rural areas with basic health services. The plans envisaged the expansion of a decentralized health services network integrating both preventive and curative health services. Accordingly, several health centers (one for 50,000 people) and health stations (one for every 5000 people) were established in rural areas. Despite the decentralization efforts, the plans failed to attain their objectives of making the hospital-based and urban-based system equitably accessible to all people.[35]

[33] Kloos, "Primary Health Care in Ethiopia," 86.

[34] Weis, Julianne. 2018. *LSE.* February 14. https://blogs.lse.ac.uk/africaatlse/2018/02/14/haile-selassie-and-his-quest-to-develop-a-westernised-medical-system-in-ethiopia/.

[35] Kloos, "Primary Health Care in Ethiopia," 90.

2.2 The Derg Regime (1974-1991)

For the first time in the constitutional history of the country, the right to health care was constitutionally protected in the 1987 Constitution of the Derg Regime.[36]The previous constitutions, the 1931 and the 1955 constitutions of the Imperial regime, had never mentioned anything related to the right to health and health care services. Unlike its precursors, the 1987 constitution expressly provides that all Ethiopians have the right to healthcare. The constitution does not merely state that all Ethiopians have the right to healthcare. Rather, it vests the state with the obligation to provide healthcare services by progressively expanding health institutions in the country.[37] The 1987 constitution provides for special healthcare services to Ethiopian women. Although the constitution states that women have equal rights[38] with men, it provides for differential treatment[39] (affirmative action), health services, suitable work conditions and adequate rest periods (maternal leaves) during pregnancy and maternity.[40]The constitution provides that all Ethiopians are equal before the law irrespective of nationality (ethnicity), sex, religion, occupation, social or other status.[41] Equality among Ethiopians was to be

[36] Refer Article 42(1) of the 1987 Constitution of the People's Democratic Republic of Ethiopia.

[37] Ibid., article 42(2)

[38] Ibid article 36(1)

[39] Ibid, article 36(2)

[40] Ibid, article 36(3)

[41] Ibid, article 35(1)

ensured through equal participation in political, economic, social and cultural affairs.[42] Thus, the 1987 seems to provide access to healthcare services for all Ethiopians without any discrimination. The government had the duty to take progressive measures[43] to provide healthcare services through establishing public health institutions throughout the country according to the administrative structure of the regime. Although there was no solidified health policy document, the Derg regime's health policy was rooted in the Alma Ata Declaration of 1978.[44]In line with this declaration, public health care must go beyond the provision of curative and even preventive medicine, such as health education, immunization and the promotion of environmental sanitation. It also includes the promotion of health as a component of political and socioeconomic development[45]. Immediately after assuming power, the Derg reorganized Ethiopia's fourteen provincial administrations and replaced all serving governors general. The fourteen provinces (teklay

[42] Ibid, article 35(2)

[43] Ibid, article 21

[44] According to the 1978 Alma Ata Declaration of "Health for All by the Year 2000", five PHC principles are implied, namely 1) equitable distribution of health services, 2) community participation in program planning and implementation, 3) emphasis on preventive services, 4) use of appropriate technology, and 5) a multi-sectoral approach recognizing that the requirements for good health cannot be met by the health sector alone but must include improvements in domestic water supply, sanitation, food security and economic status.

[45] Kloos, "Primary Health Care in Ethiopia," 101.

ghizats) were relabeled regions (kifle hagers) and were divided into 102 sub-regions (awrajas) and 556 districts (weredas). By 1981 the number of administrative divisions had increased to sixteen with the addition of Addis Ababa and Aseb. The restructuring was a major step toward dismantling feudal privilege and was an effort to decentralize the provision of public services including healthcare services to all the provinces. With the promulgation of the 1987 constitution the Derg regime, twenty-five administrative regions and five autonomous regions were created. The autonomous regions consisted of Eritrea (broken further into three sub-regions in the north, west, and south), Aseb, Tigray, Dire Dawa, and Ogaden. The change promised to alter significantly Ethiopia's traditional pattern of administrative organization which was highly centralized making the provision of public services highly inaccessible at grassroots level. Most health institutions were concentrated in urban centers prior to 1974 and were concerned with curative rather than preventive medicine. Starting in 1975, the regime embarked on the formulation of a new health policy emphasizing disease prevention and control, rural health services, and promotion of community involvement and self-reliance in health activities. In 1983 the government drew up a ten-year health perspective plan that was incorporated into the ten-year economic development plan launched in September 1984. The goal of this plan was the provision of health services to 80 percent of the population by 1993/94. The regime decentralized health care administration to

the local level in keeping with its objective of community involvement in health matters. Regional Ministry of Health offices gave assistance in technical matters, but peasant associations and kebeles had considerable autonomy in educating people on health matters and in constructing health facilities in outlying areas. Starting in 1981, a hierarchy of community health services, health stations, health centers, rural hospitals, regional hospitals, and central referral hospitals were supposed to provide health care. By the late 1980s, however, these facilities were available to only a small fraction of the country's population. Generally, the public health care service during the regime was characterized by limited budget, inaccessibility of services at lower administrative units (awrajas, woredas and kebeles), and small number of health professionals and institutions.[46]

2.3 The Post 1991 (Current Regime)

After the fall of the Derg regime in 1991, Ethiopia adopted the Transitional Period Charter. The Charter provided for the resettlement and rehabilitation of those people who had been uprooted (forcefully displaced) from their habitual residences due to the villagization and resettlement program of the Derg

[46] Kloos, "Primary Health Care in Ethiopia," 107.

regime.[47]The Charter made it its policy priority to provide relief and other humanitarian assistance to those segment of the community seriously affected by the civil war and drought in some parts of the country during the Derg regime. Thus, the charter acknowledged special legal protection of those vulnerable people in general and internally displaced persons in particular. As regards the provision of assistance and relief to internally displaced people, the charter gave autonomy to the concerned local governments (regional administrative units) of the country.[48]Ethiopia restructured its health system in 1993, in the same year the national health policy was issued. The health policy differs from that of the Derg primarily in that it incorporates elements of democratization, decentralization, inter-sectoral collaboration, collaboration with neighboring countries, and promotion of the participation of the private sector and non-government organizations (NGOs) in health care.[49] Ethiopian People's Revolutionary Democratic Front (EPRDF) started its move by formulating a health policy that aimed at expanding primary healthcare by promoting rural communities participation

[47] Article 14 of the Transitional Period Charter of Ethiopia (No.1) 1991, states that the policy shall give priority to the rehabilitation of those areas that have been severely affected by the war, prisoners of war ex-prisoners of war as well as those sections of the population that have been forcibly uprooted by the previous regime's policy of villagization and resettlement.

[48] Article 5 of the Charter states that local governments have the right to establish direct contact with relief organizations with respect to relief work.

[49] Kloos, "Primary Health Care in Ethiopia," 108.

and partnership.[50] Assurance of accessibility of health care for all segments of the population was one of the main policy goals[51]. EPRDF's health policy makes particular emphasis on prevention and promotion of primary healthcare. Under the umbrella of the health policy, the Ethiopian health sector adopts a seemingly innovative and rolling health program, namely, the Ethiopian Health Sector Development Program (HSDP). The HSDP has been introduced in recognition of the failure of essential health such as in terms of the challenges of reaching health care services and goods to the people at grassroots level, in particular to the underserved rural population. It was projected based on the concept and principles of comprehensive primary healthcare, which essentially includes healthcare for vulnerable people. Its target has been the expansion of essential health system inputs towards the achievement of the Millennium Development Goals (MDGs) then-now the Sustainable Development Goals (SDGs), an indication that its focus has not complied with the human rights obligations to health[52].In 2004, the Ethiopian government launched what has been called an innovative and groundbreaking solution to the country's public health challenges; the Health Extension Programme (HEP). Following the implementation of the HEP, Ethiopia has, according to the dominant narrative,

[50] Amare, "Right to Healthcare in Ethiopia," 5.

[51] See General Policy 6 of the Health Policy of Transitional Government of Ethiopia, September 1993.

[52] Abegaz, "A Human Rights-Based Approach," 8.

managed to improve access to and quality of primary health care for the most rural and underserved of its population.[53] Ethiopia's health service is structured into a three-tier system: primary, secondary and tertiary levels of care. The primary level of care includes primary hospitals, health centres (HCs) and health posts (HPs). The primary health care unit (PHCU) comprises five satellite HPs (the lowest-level health system facility, at village level) and a referral HC. This is the point where PHC is administered and primary services facilitated under the health service delivery structure. A primary hospital provides inpatient and ambulatory services to an average population of 100 000. A primary hospital provides emergency surgical services, and is a referral center for the HCs and a practical training center for nurses and other paramedical health professionals. A general hospital serves as a referral center for primary hospitals and as a training center for health officers, nurses and emergency surgeons. Similarly, a specialized hospital is a referral center for general hospitals.[54]

[53] Marit Tolo Østebø, Megan D Cogburn and Anjum Shams Mandani. 2018. "The silencing of political context in health research in Ethiopia: why it should be a concern." *Health Policy and Planning* (Oxford University Press in association with The London School of Hygiene and Tropical Medicine) 258–270. Accessed April 7, 2020. doi: 10.1093/heapol/czx150.

[54] PRIMASYS. 2017. "Primary health care systems (PRIMASYS)." *Case study from Ethiopia*. World Health Organization (WHO). Accessed April 16, 2020. https://www.who.int/alliance-hpsr/projects/alliancehpsr_ethiopiaabridgedprimasys.pdf.

3. The Causes and Consequences of IDPs in Ethiopia

3.1 The Causes of Internal Displacement

In line with the Guiding Principles, the Kampala Convention's Article 1 defines IDPs as "persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border".[55] Although there is no consensus on the root causes of internal displacement, the major causes of internal displacement are broadly categorized into five general grounds: armed conflicts (inter-state & intra-state war or civil wars); situations of generalized violence; gross violations of human rights; natural disasters (sudden impact, slow onset, and epidemic diseases); and man-made disasters (industrial or technological disasters and complex emergencies). Firstly, historically, inter-state wars[56] and civil war[57] had been the major causes of internal displacement in Ethiopia. Secondly, millions of people have been internally

[55] UNHCR Fact Sheet 2019 on the 2009 Kampala Convention on IDPs. See the details at: https://www.unhcr.org/5cd569877.pdf

[56] The 1976-78 Ethio-Somali War caused internal displacement in Ethiopian Ogaden region. Besides, in the wake of the 1998-2000 Ethio-Eritrean war, thousands of Ethiopians were displaced from the Ethio-Eritrean border areas.

[57] As a result of the protracted Civil war in Ethiopia from 1976 to 1991, thousands of people had been internally displaced particularly in the Tigray and Afar regions of Ethiopia.

displaced in Ethiopia due to political violence, inter-ethnic skirmishes, and inter-religious tensions. After the introduction of the current Ethno-lingual federal system as the administrative structure of the country, the number of internal displacement has significantly increased due to politically motivated inter-ethnic, inter-religious and communal conflicts in some administrative regions of the country. Thirdly, generalized violence are significantly causing internal displacement in Ethiopia. Some segment of the people are relatively marginalized by the government for political reasons. This indirect persecution places those internally displaced people in more vulnerable situation than even refugees.[58] While refuges can access public services either from the local government or the international humanitarian assistance, IDPs are usually deprived of such an access to assistance. The number of people newly displaced by conflict within the country rose from 296,000 in 2016 to 1.7 million in 2018.[59] This increase is mainly linked to the escalation of violence along ethnic lines. These episodes of violence have been taking place in a context of major shifts within the Ethiopian political system. Fourthly, gross and systematic human rights violations have caused a number of internal displacements in Ethiopia. The human rights violations occurred in the context of

[58] Lischer, Sarah Kenyon. 2009. "Causes and Consequences of Conflict-Induced Displacement." *Civil Wars* 9 (2): 142-155. Accessed March 15, 2020. doi:10.1080/13698240701207302.

[59] MSF. 2019. "Displacement and humanitarianresponse in Ethiopia: challenges and dilemmas in complex crises." Barcelona: MSF.

ethno-centric federalism and excessive politicization of ethnic identities and lack of law and order in the country.[60] Fifthly, population displacements and destruction of human lives and property also result from environmental factors, including the ravages of cyclones, tidal surges, hurricanes, floods, earthquakes, volcanic eruptions, pollution, droughts and famines.[61] In Ethiopia, the most consequential and recurrent natural disasters that have had significant impacts on people's lives and livelihoods are droughts, earthquakes, floods, human and livestock diseases, pestilence, wildfires, and landslides. Finally, huge development projects in many countries displace millions of people every year. Not only is development-induced displacement a widespread, and growing, phenomenon, but evidence suggests that while the beneficiaries of development are numerous, the costs are being borne disproportionately by the poorest and most marginalized populations. Ethiopia is carrying out massive developmental transformation in many sectors. Key among these projects is infrastructural projects such as dams, industries and industrial parks, railways, roads, and widespread urban renewal programmes, particularly in Addis Ababa. With the increased industrialization and urbanization projects, infrastructural and city renewal projects, such as land and identity related national

[60] Otunnu, Ogenga. 2002. "Population Displacements: Causes and Consequences." *Canada's Journal on Refugees* 1-4.

[61] Ibid

parks and dams, development-induced displacement is expected to rise. Thus, development-induced displacement may manifest itself in development projects, displacement, and livelihoods due to the following infrastructural development projects: road and rail transportation; hydroelectric and irrigation dams; urbanization projects (urban renewals, integrated urban master plans, and the relocations of persons); industrial parks; national parks; commercial agricultural farms and processing industries; state sponsored resettlement programmes.[62]

3.2 The Health Problems of IDPs

3.2.1 Scarcity of Food and Water

The impact of prolonged drought, nutritional insecurity and water scarcity are the main drivers of health risks in vulnerable societies. Forcibly dismantling people increases the risk of people falling into temporary or chronic malnutrition, defined as calorie-protein intake levels below the minimum required calories for normal growth and work. IDPs are very prone to high mortality due to hunger, malnutrition and even shortage of food and water; some empirical evidences underscore the potential impact that a displaced population might have on food security and health

[62] Mehari, Taddele Maru. 2017. "Causes, Dynamics, and Consequences of Internal Displacement in Ethiopia." *Working Paper FG 8: Division Global Issues.* Berlin: German Institute for International and Security Affairs, May.

status in an already fragile host population.[63] Since most IDPs in Ethiopia are farmers before their displacement, they will not be able to produce anything to survive, they are dependent only on human food aid from international or local sources. This condition makes them highly vulnerable to health risks.

3.2.2 Communicable Diseases

Most of the IDPs in Ethiopia live in a shantytown like shelters surrounded by garbage where personal hygiene and environmental cleanness is extremely limited.[64] Massive population displacement threatens to cause serious decline in health levels. Displacement-induced social stress and psychological trauma are sometimes accompanied by the outbreak of relocation related illnesses, particularly parasitic and vector-borne diseases such as malaria and schistosomiasis.[65] Unsafe water supply and improvised sewage systems increase

[63] Gilles Guerrier, Malaı¨ka Zounoun, Olimpia Delarosa, Isabelle Defourny, Michelo Lacharite, Vincent and Biagio Pedalino. 2009. "Malnutrition and Mortality Patterns among Internally Displaced and Non-Displaced Population Living in a Camp, a Village or a Town in Eastern Chad." *PLoS ONE* 4 (11). Accessed April 3, 2020. doi:10.1371/journal.pone.0008077.

[64] OCHA. 2020. *Ethiopia Humanitarian Needs Overview 2020 (January 2020).* January 9. https://reliefweb.int/report/ethiopia/ethiopia-humanitarian-needs-overview-2020-january-2020.

[65] Mesfin Araya, Wolde Tensai. 2007. "Postconflict internally displaced persons in Ethiopia: Mental distress and quality of life in relation to traumatic life events, coping strategy, social support, and living conditions." *Umea University Medical Dissertations.*

vulnerability to epidemics and chronic diarrhea, dysentery, and so on. The weakest segments of the demographic spectrum: infants, children, and the elderly are affected most strongly. There is extremely limited government intervention to control communicable diseases in IDP camps in Ethiopia as other parts of the world.[66] After COVID-19, government imposed internet and phone shut down due to violence in Ethiopia's western Oromia region, where there are thousands of IDPs, has extremely made it difficult for the IDPs to access information on how to protect themselves from the virus[67]. In addition to limiting information on COVID19, this inhibits communication among families, doctors, and their patients.

3.2.3 Sexual Violence and HIV/AIDS

According to the UN Guiding Principles, IDPs shall enjoy their civil and political as well as social, economic and cultural rights including the right to life and to protection against acts of violence

[66] Winifred Ekezie, Enemona Emmanuel Adaji, and Rachael L Murray. 2020. "Essential healthcare services provided to conflict-affected internally displaced populations in low and middle-income countries: A systematic review." *Health Promot Perspect* 10 (1): 24–37. Accessed May 31, 2020. doi:10.15171/hpp.2020.06.

[67] Refugees International. 2020. "COVID-19 and the Displaced: Addressing the Threat of the Novel Coronavirus in Humanitarian Emergencies." *Refugees International*. May 31. https://interagencystandingcommittee.org/system/files/2020-03/COVID-19%20and%20the%20Displaced%20-%20Refugees%20International%20-%20March%202020.pdf.

and torture, sexual and gender-based violence.[68] However, a number of people especially women are exposed to physical and sexual violence. They are highly exposed to sexually transmitted diseases including HIV/AIDS.[69]Thus, the displacement has put women, children and elderly people at risk such as family separation, sexual violence and labor abuse/exploitation. Furthermore, one study shows that violence against displaced women is a socially and psychologically harmful practice in communities affected by conflict in Ethiopia.[70] IDPs in Ethiopia reported rape, gang rape, abduction, imprisonment, forced testimony and physical, psychological and other sexual violence and forced / early marriage and pregnancy. These experiences were carried out by armed warriors (military or insurgents), unknown persons, community members, power people (religious leaders, employers), close partners and family members, and in some cases members of aid agencies.[71]Thus, evidences show that

[68] Refer Principle 11(2) (b) and Principle 19(2) of the UN Guiding Principles on Internal Displacement.

[69] Andrea L Wirtz, Nancy Glass, Kiemanh Pham and Saskia Loochkartt. 2014. "Gender-based violence in conflict and displacement: Qualitative findings from displaced women in Colombia." *Conflict and Health* 8 (1). Accessed June 15, 2020. doi:10.1186/1752-1505-8-10.

[70] Oluwakemi C. Amodu, Magdalena S. Richter and Bukola O. Salami. 2020. "A Scoping Review of the Health of Conflict-Induced Internally Displaced Women in Africa." *International Journal of Environmental Research and Public Health* 17 (1280): 1-21. doi:10.3390/ijerph17041280.

[71] A. L. Wirtz, N. Glass, K. Pham, N. Perrin, L. S. Rubenstein, , S. Singh and A. Vu. 2016. "Comprehensive development and testing of the ASIST-GBV, a screening tool for responding to gender-based violence among women in

internally displaced women and children are highly exposed to the risks of sexual abuses.

3.2.4 Limited Access to Health Services

Access to services remain limited, increasing the susceptibility of IDPs particularly women, children, the elderly, and the disabled to different protection risks.[72] IDPs live in poor tents, as shelters, usually far away from the city (urban) centers. Due to the poor road infrastructure and transportation problem, IDPs cannot access public health services in the needed time.[73] In many IDP cluster areas, there are extremely limited number of public clinics, health centers or health posts that provide health services to the indigent community. Even in those limited clinics, there is no adequate medicines, medical supplies and health workers (nurses, health officers, medical doctors, etc.). In addition, the lack of sustainable and dedicated health intervention compounded by weak *deyr* rains, increased numbers of IDPs unable to access basic sanitation, existing demand for emergency water trucking in health facilities further exacerbate the risk of opportunistic

humanitarian settings." *Conflict and Health* 10 (7): 1-14. Accessed June 13, 2020. doi:10.1186/s13031-016-0071-z.

[72] HCT. 2018. "Ethiopia: Humanitarian and Disaster Resilience Plan." *Joint Government and Humanitarian Partners' Document.* Addis Ababa: Humanitarian Country Team.

[73] "*Ethiopia Humanitarian Needs Overview 2020," OCHA, accessed January 9, 2020,* https://reliefweb.int/report/ethiopia/ethiopia-humanitarian-needs-overview-2020-january-2020.

disease outbreak notably acute watery diarrhea.[74] The Ministry of Health in collaboration with other partners has currently arranged an emergency mechanism to address this issue. The partners will continue to strengthen the capacity of the Ministry of Health in the emergency response, surveillance and prevention at facility and community level including through rapid response team deployment and emergency immunization. The intervention will help to provide more access to adequate medicines, medical supplies and essential public health services to reduce risk for vulnerable households and communities. Thus, the lack of security and limited access to basic healthcare services expanded the coping mechanisms of the affected populations and increased their vulnerability.[75]

4. The Legal Protection of the Right to Heath of IDPs

4.1 International Human Rights Instruments

The adoption of the Constitution of World Health Organization (WHO) in 1946 laid the foundation for the recognition of 'the

[74] Tull, Kerina. 2018. *Humanitarian interventions in Ethiopia responding to acute watery diarrhoea.* The K4D helpdesk. Accessed June 15, 2020. https://assets.publishing.service.gov.uk/media/5ab0e2cee5274a5e20ffe27a/260_Ethiopia_AWD_interventions.pdf.

[75] "*Ethiopia Humanitarian Needs Overview 2020."*

right to health' as an international norm at global level[76]. The constitution stated that the 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.[77] Furthermore, it provided a clear definition of health in a broader sense recognizing that health means something beyond the absence of disease. It encompassed the 'attainment by all peoples of the highest possible level of health' as its key objective.[78] To this end, the constitution vests states with the obligation of provide adequate health and social services for the realization of the highest attainable level of health for all their people.[79] After two years, in 1948, the Universal Declaration of Human Rights (UDHR) recognized 'health' as a human right. It stated that 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.[80] The

[76] Clift, Charles. 2013. "The Role of the World Health Organization in the International System." *Centre on Global Health Security Working Group Papers.* Accessed June 15, 2020. https://www.chathamhouse.org/sites/default/files/publications/research/2013-02-01-role-world-health-organization-international-system-clift.pdf.

[77] See the Preamble of the WHO Constitution.

[78] Refer Article 1 of the WHO Constitution 1946

[79] See the Preamble and Articles 61-65 of the WHO Constitution

[80] Refer Article 25(1) of the UDHR 1948

UDHR seems to have emphasized on what described the right to health instead of giving a mere definition to the term. The Declaration does not define the components of a right to health; however, it expresses that the right includes and transcends a mere medical care. Accordingly, it acknowledges that the right to health can only be attained through achieving an adequate standard of living (food, housing, medical care, social services, etc.) for all individuals. Besides, the declaration states that everyone is entitled to the right to equal protection before the law without any discrimination.[81] The declaration emphasizes on the equal protection of all persons before the law irrespective of their gender, religion, political views, socio-economic status, and other factors of discrimination. In 1966, the right to health was included in the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 of the ICESCR explicitly sets out a right to health and defines steps that states should take to "realize progressively" "to the maximum of its available resources" the "highest attainable standard of health," including "the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child"; "the improvement of all aspects of environmental and industrial hygiene"; "the prevention, treatment and control of epidemic, endemic, occupational and other diseases"; and "the creation of conditions which would assure to all medical service and medical attention in the event of

[81] See Article 7 of UDHR 1948

sickness."[82] The reference to a "highest attainable standard" of health, taken from the World Health Organization constitution, shows the reasonability standard states shall follow to provide adequate health services and create the conducive environment for the attainment of the highest possible degree of health to all people. That is, the state has a role to play in leveling the social playing field with respect to health. Along with the ICESCR, a wide array of international and regional treaties recognizes 'health' as a rights issue, and these reflect a broad consensus on the content of the norms. As it pertains to the protection of the health rights of IDPs, the UN Guiding Principles provide for the highest possible health care internally displaced persons shall get before, during and after displacement as the case may be. Before forceful displacement, for example, to the greatest practicable extent, the government authorities shall make sure that proper accommodation is provided to the displaced persons that such displacements are effected in satisfactory conditions of safety, nutrition, health and hygiene, and that members of the same family are not separated.[83]During and after displacement for any reason, IDPs have the right to be protected against forcible return to or resettlement in any place where their life, safety, liberty and/or health would be at risk.[84]In addition to this, the Guiding

[82] Refer Article 12(2) of International Covenant on Economic, Social and Cultural Rights 1966

[83] Refer Principle 7(2) of UN Guiding Principles on Internally Displaced Persons 1997 (the Guiding Principles)

[84] Ibid., Principle 15(d)

principles provide that special attention should be paid to the health needs of women, including access to female health care providers and services, such as reproductive health care, as well as appropriate counselling for victims of sexual and other abuses.[85] International health laws impose obligations on States to take public health safety measures to protect individuals or the community from public health risks and injuries.[86] In sum, a review of the international instruments and interpretive documents makes it clear that the right to health as it is enshrined in international law extends well beyond health care to include basic preconditions for health, such as potable water and adequate sanitation and nutrition.[87] Thus, under international law, there is a right not merely to health care but to the much broader concept of health.

4.2 Regional Human Rights Instruments

Since this article focuses on the health rights of IDPs in terms of access to health care services at domestic level, it is imperative to

[85] Ibid., Principle 19(2)

[86] Toebes, Brigit. 2016. "International health law: an emerging field of public international law." *Indian Journal of International Law* 55: 299–328. Accessed April 11, 2020. https://link.springer.com/article/10.1007/s40901-016-0020-9.

[87] Yamin, Alicia Ely. 2005. "The Right to Health Under International Law and Its Relevance to the United States." *American Journal of Public Health* 95 (7). Accessed April 11, 2020. doi:10.2105/AJPH.2004.055111.

place the study in the general context of regional legal protection before exploring the matter at national level. Several human rights instruments in Africa recognize the right to health. The African Charter on Human and People's Rights (1981) provides that every citizen has the right of equal access to public services (including health care services) of his country.[88] More specifically, the charter states that every individual shall have the right to enjoy the best attainable state of physical and mental health and that states shall take all the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.[89]Besides, the charter provides for the special protection of women, children, the aged and disabled people without any discrimination in line with other international legal instruments.[90]The 2003 Protocol to the African Charter on Human and Peoples' Rights of Women in Africa (the Maputo Protocol) provides specific heath rights to women in Africa. It poses positive duty on states to ensure the right to health of women particularly the promotion of the sexual and reproductive health. The protocol emphasizes that states shall take all measures to provide adequate, affordable and accessible health services to women.[91] According to this protocol, internally displaced women have the right to special protection by the government against all

[88] Article 13(2) of the African Charter on Human and People's Rights 1981

[89] Article 16 of the of the African Charter on Human and People's Rights 1981

[90] Article 18 of the Charter

[91] See Article 14 of the 2003 Protocol to the African Charter on Human and Peoples' Rights of Women in Africa.

forms of violence, rape and other forms of sexual exploitation particularly in the context of displacement due to an armed conflict.[92]The other human rights document worth mentioning here is the 1990 African Charter on the Rights and Welfare of the Child. According to this Charter, every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.[93]Thus, state parties to the Charter undertake to pursue the full implementation of this right and in particular taking measures to provide primary health care services and medical assistance, nutrition, drinking water, and environmental sanitation. Internally displaced children, whether through natural disaster, internal armed conflicts, civil strife, and breakdown of economic and social order or howsoever caused, have the right to receive humanitarian assistance including health care services.[94] Finally, to give legal effect to the rights of internally displaced persons that are recognized by several internal legal instruments, the African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa (Kampala Convention) was adopted in 2009. In cases of armed conflict, the Convention requires that parties to the conflict shall not deny internally displaced persons the right to live in satisfactory conditions of

[92] Refer Article 11(3) of the Maputo Protocol

[93] Article 14 of the 1990 African Charter on the Rights and Welfare of the Child

[94] Article 23(4) of the 1990 African Charter on the Rights and Welfare of the Child

dignity, security, sanitation, food, water, and health and shelter.[95] In any case of internal displacement, states are required to provide internally displaced persons, to the fullest extent practicable and with the least possible delay, with adequate humanitarian assistance, which shall include food, water, shelter, medical care and other health services, sanitation, education, and any other necessary social services, and where appropriate, extend such assistance to local and host communities. Specially, states are to take special measures to protect and provide for the reproductive and sexual health of internally displaced women as well as appropriate psycho-social support for victims of sexual and other related abuses.[96]

4.3 National Legislation

States, the primary duty holders under public international law, have certain legal obligations to enhance the health of their population.[97] Based on the right to health, they have the duty to realize the highest attainable standard of health of all individuals residing on their territory (and potentially beyond). States' responsibility towards the provision, protection and fulfillment of the right to health emanates from various internal human rights instruments and documents mentioned above. In this section, it

[95] Article 7(5) (c) of the Kampala Convention
[96] Article 9(2) of the Kampala Convention
[97] Toebes, "International health law," 306.

is imperative to explore the legal protection of the right to health and access to healthcare services in Ethiopia with particular focus on IDPs. According to international law, Ethiopia has the duty to adopt legislative measures for the realization of the right to health at national level. As member to the WHO, she is under duty to mainstream 'health' as a human right into healthcare programmes and policies on national level by looking at underlying determinants of health as part of a comprehensive approach to health and human rights.[98]This means that the country is duty bound to establish a national public health strategy and plan of action through a properly functioning health system[99] The FDRE Constitution provides that the State has the obligation to allocate an ever increasing resources to provide to the public health of every citizen.[100] Besides, all persons have the constitutional right to a clean and healthy environment.[101] To the extent the country's resources permit, government policies are required to provide all Ethiopians access to public health, clean water, housing, food and social security.[102]It is also a constitutionally stated objective of the government to ensure that all Ethiopians live in a clean and

[98] WHO. 2017. *World Health Organization*. December 29. Accessed April 10, 2020. https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health.

[99] Toebes, "International health law," 308.

[100] Refer Article 41 (4) of the Federal Democratic Republic of Ethiopia (FDRE) Constitution.

[101] Refer Article 44(1) of FDRE Constitution.

[102] Refer Article 90(1) of the FDRE Constitution.

healthy environment.[103] In addition to the general health-related provisions, the Constitution dedicate a specific provision entirely dealing with the rights of women due to their vulnerability. It states that women have the right "to prevent harm arising from pregnancy and childbirth and in order to safeguard their health, women have the right of access to family planning education, information and capacity". Similarly, article 35(1) of the constitution guarantees the right to equality of women with men and further provides for the obligations of the state to eliminate the influences of harmful customs, laws, customs, and practices that oppress or cause bodily or mental harm to women. However, none of these provisions adequately mention women's right to access to health care and the underlining determinants of health other than the ones mentioned under Article 35(9) of the FDRE Constitution. This particular sub-article provides for women's right of access to family planning, education, information, and capacity. With respect to children, article 36 of the FDRE Constitution equally incorporates a specific article exclusively governing on the rights of the child but it does not, nevertheless, expressly provide for children's right to health or the underlining determinants of health, such as admission to food, safe drinking water, sanitation, and living accommodations. Although Ethiopia has acceded to international instruments of children's rights the Convention on the Rights of the Child (CRC) in 1991; the

[103] Refer Article 92(1) of the FDRE Constitution.

International Convention on Economic, Social, and Cultural Rights (ICESCR) in 1993; as well as regional instruments such as the African Charter on the Rights and Welfare of the Child (ACRWC) in 2002, the constitution fails to provide children's right of access to healthcare and their other socioeconomic rights explicitly. However, children's right to life and the best interests of the child are recognized in the constitution. Besides, women and children have the same rights as all other persons under the constitution such as the right to life, information, equality, and nondiscrimination. However again, none of these provisions adequately incorporate children's right to access to health care and the underlining determinants of health. It is arguably true that the right to health is not explicitly recognized in Ethiopian Constitution. Overall, this manifests lack of compatibility between the domestic law with the relevant provisions of the ICESCR and African Charter on the Rights and Welfare of the Child in the area of health care. When a state's legislation in the area of healthcare does not meet human rights treaties that such state has ratified or acceded, then the state is required to repeal its existing laws and replace it with a new legislative regime to ensure compatibility. Even though the constitutional recognition of the right to health of children, women and all other vulnerable groups is indispensably important for the realization of the right, the author holds that legislative actions are more important than

the general provisions of the constitution which are too elusive to give any legal enforcement.

In line with international health law, states have the legal duty to establish effective health system by adopting working legal framework of health laws at domestic level.[104] The domestic health system should be established in such a way that it can effectively address the health problems of citizens both in normal days and in times of national or international health crisis (emergency). The national health laws should expressly provide for the detailed health rights of citizens and pose the duty on the state to provide, protect and fulfill the right to health as part of its duty in the enforcement of human rights. Health infrastructure includes not only the physical structures of public health agencies, clinics and hospitals and the human resources to operate them, but also countries' legal infrastructure, i.e. the laws and policies that empower, obligate and limit government and private action concerning health[105]. In an effort to build a strong national health system, the Ethiopian government has taken some legislative measures with a view to enforce health policies, programs and plans at all levels of governance in the country. In addition to constitutionally recognizing the right to health in an elusive

[104] Toebes, "International health law," 320.

[105] Géraldine Marks-Sultan, Feng-jen Tsai , Evan Anderson , Florian Kastler , Dominique Sprumont, & Scott Burris. 2016. "National public health law: a role for WHO in capacity-building and promoting transparency." *Bulletin of the World Health Organization*, May 3: 34-539. Accessed April 10, 2020. doi:http://dx.doi.org/10.2471/BLT.15.164749.

manner, the country has enacted some health-related legislation to establish health institutions at various levels, to provide public health services, to protect public health dangers, and to regulate medicines and pharmaceuticals. In the domain of public health delivery, two institutions play the central role in Ethiopia: the Ministry of Health and the Ethiopian Public Health Institute. These are the primary government organs that are entrusted with the general administration of public health-related issues. In addition to these institutions, other private health institutions such as hospitals, clinics, drug stores and pharmacies are also engaged in the provision and promotion of public health services in the country. However, Ethiopia does not have a clear legal infrastructure that enables effective health care service delivery and that prescribes the accountability ground in case of violation of the right to health of citizens of the country. According to the applicable health laws in Ethiopia, the public health authorities issue legal regulations and directives to protect the public from common public health problems such as communicable diseases rather than to provide health care services to the individual citizens. The Ethiopian government believes that the attitudinal change of the society through primary health care approach can solve most of the health problems of the country.[106] Proclamation No.200/2000 of the Federal Democratic Republic of Ethiopia

[106] Refer the Preamble of Public Health Proclamation No. 200/2000 of the Federal Democratic Republic of Ethiopia (FDRE)

gives the legal authority to the Ministry of Health to investigate and act on public health dangers, to control food quality, to control the quality of water, to control occupational health and the use of machines, to regulate waste handling and disposal, to control the availability of public toilet facilities, to control communicable diseases, and to protect clean environment for the public. If the ministry, for example, fails to take any of these actions, the people cannot take legal action to claim their legal rights as the proclamation does not provide the procedures for government accountability. Council of Ministers Regulation No.301/2013 establishes the Ethiopian Public health Institute with a view to foster public health services in Ethiopia. The institute conducts a 'health system research'[107] with the aim of disseminating knowledge especially on nutrition researches. Besides, it identifies public health risks and emergencies, and establishes laboratories for testing services. The Revised Federal Family Code of Ethiopia tacitly recognizes the right to health of the minor (child). Accordingly, the guardian of the child is under legal duty to watch over and to pay for the medical treatment of the child in case of sickness.[108] In addition, by virtue of Proclamation No.1112/2019 (Food and Medicine Administration

[107] According to the Regulation, "Health system research" means a problem solving study undertaken on health service delivery, medical equipment and drug supply, human resource training and deployment, budget allocation and utilization, health information and management system and health sector policy and governance.

[108] Refer Article 257 of the Federal Negarit Gazetta Extra Ordinary Issue No. 1/2000, The Revised Family Code Proclamation No. 213/2000

Proclamation), Ethiopia has adopted a national legal framework for the coordinated food, medicine, medical devices, cosmetics, and tobacco products regulatory system. The overarching purpose of the system is to protect the public health side effects of the unregulated use of poor quality food, medicine, cosmetics and tobacco. There are several acts of individuals, groups or even corporate persons which are criminalized with the intention of protecting public health in general. The acts are categorized as crimes against public health. Thus, spreading of human diseases, spreading of animal diseases, propagation of an agricultural or forest parasite, contamination of water, contamination of pastureland, environmental pollution, mismanagement of hazardous wastes and other materials, acts contrary to environmental impact assessment, infringement of preventive and protective public health measures, and creation of distress and famine are criminally punishable acts in Ethiopia.[109] Therefore, it is visible that the existing health-related legislation in Ethiopia focus more on the protection of public health risks than the provision and fulfilment of public healthcare services as 'human right' for the people base on the rights-based approach. Besides, the laws do not provide for any differential treatment of vulnerable groups in general IDPs in particular. Currently, the

[109] Refer Articles 514-529 of the Criminal Code of the Federal Democratic Republic of Ethiopia.

legal framework in Ethiopia does not give any room for the protection of the special healthcare needs of IDPs.

5. The Institutional Protection of the Right to Health of IDPs

5.1 Protection by Governmental Institutions

The Federal Ministry of Health (FMOH) and regional health bureaus (RHBs) are the main actors in the delivery of humanitarian health services through permanent and temporary health facilities and Health Extension Workers (HEWs) network. Besides, the Ethiopian Public Health Institute (EPHI) supports the FMOH by conducting public health related researches, by identifying health emergency situations, and equipping and by staffing public health laboratories throughout the country.[110] The Ministry of Health is responsible for major policies and guidelines, provision of policy and technical guidance, and coordination of donor support. Currently, there are nine constituent regional states in the Federal Democratic Republic of Ethiopia. Each of these regions have their own sub administrative units known as zones, woredas and kebeles. Thus, Regional Health Bureaus (at regional level), Zonal Health Departments (at zonal level), Woreda Health Offices (at Woreda level) and Kebele Health Posts (at kebele level) are the major government offices

[110] Refer Article 5 of Ethiopian Public Health Institute Establishment Council of Ministers Regulation No. 301/2013

responsible for the administration of healthcare services in Ethiopia. At all administrative levels, there are public hospitals, clinics, health centers, health posts, and pharmacies (drug stores) organized to serve the community. However, these institutions are not equally accessible to internally displaced persons with other parts of the community at least for two reasons. In the first place, IDPs live in secluded camps far away from such institutions. Secondly, the provision of healthcare services requires the IDPs to have their kebele identity cards.[111] Thus, since it is almost impossible for the IDPs to go back to their villages (kebeles) to access such healthcare services, they just suffer from the consequences sickness in their camps where there is hardly any health service.

5.2 Protection by Nongovernmental Organizations

In addition to the regular governmental organs, several domestic and international organizations are engaged in the provision, promotion and fulfilment of health care services to Ethiopians in general and IDPs in particular. In the UN system, there are a number of intergovernmental agencies as well as offices that could potentially deal with the problem of internal displacement.

[111] "*Ethiopia Humanitarian Needs Overview 2020," OCHA, accessed January 9, 2020,* https://reliefweb.int/report/ethiopia/ethiopia-humanitarian-needs-overview-2020-january-2020.

Some have the power to serve IDPs, refugees and immigrants; others have duties such as human rights protection, humanitarian aid provision and development intervention. Some function as reporters and advocates; others are operational organizations with field personnel worldwide. This discussion focuses on the institutions and offices involved in the protection and / or support of IDPs. Firstly, United Nations High Commission for Refugees (UNHCR) has an interest in the protection and welfare of persons who have been displaced by persecution, situations of general violence, conflict or massive violations of human rights, because of their similarity to refugees in terms of the causes and consequences of their displacement and their humanitarian needs.[112] Secondly, UNICEF is the other UN specialized agency which devotes special attention to the protection of the world's most vulnerable and disadvantaged children: "victims of war, disasters, extreme poverty, all forms of violence and exploitation, and those with disabilities." It focuses on "indigenous children, children belonging to minorities and vulnerable groups, are disproportionately disadvantaged in many countries due to all forms of discrimination."[113] Thirdly, in terms of policy implications, World Food Programme (WFP) has committed

[112] UNHCR. 2000. "Internally Displaced Persons: The Role of the United Nations High Commissioner for Refugees." *Position Paper*. United Nations High Commissioner for Refugees (UNHCR), March 6.

[113] Mickey Chopra, Alyssa Sharkey, Nita Dalmiya, David Anthony, Nancy Binkin. 2012. "Strategies to improve health coverage and narrow the equity gap in child survival, health, and nutrition." *The Lancet* 380 (9850): 1331–1340. Accessed May 30, 2020. doi:10.1016/S0140-6736(12)61423-8.

itself to greater collaboration and inter-agency coordination at the inter-agency and national levels to enhance assistance and protection for IDPs and address food and security among those populations.[114] Fourthly, as regards shelter building, UN-Habitat also provides technical assistance to countries and cities in the areas of urban governance, housing, environmental management, disaster mitigation, post-conflict rehabilitation, urban safety, water management and poverty reduction.[115] Fifthly, IOM has been actively engaged worldwide in helping persons displaced by conflict to return and resettle by providing transport and reintegration assistance.[116]Sixthly, in post-conflict situations in many countries, UNDP in particular has become increasingly involved in programs involving the resettlement and reintegration of internally displaced populations. Its role with IDPs also extends to emergency situations, where the Resident Representative normally serves as the Resident Coordinator of the entire UN system.[117] Finally, ICRC performs a variety of

[114] Pantuliano, Sara. 2007. "From food aid to livelihoods support: rethinking the role of WFP in eastern Sudan." *Disasters* 1 (s1): 77-90. Accessed May 30, 2020. doi:10.1111/j.1467-7717.2007.00350.x .

[115] Guaralda, Luisa Bravo & Mirko. 2017. "Our commitment to implement contents related to public space included in the New Urban Agenda adopted at the UN Habitat III conference." *The Journal of Public Space* 2 (1). Accessed May 31, 2020. doi:10.5204/jps.v2i1.44.

[116] Pécoud, Antoine. 2017. "What do we know about the International Organization for Migration?" *Journal of Ethnic and Migration Studies*. Accessed May 31, 2020. doi:10.1080/1369183X.2017.1354028.

[117] United Nations. 2009. *Achieving the Global Public Health Agenda: Dialogue at the Economic and Social Council* . New York: United Nations.

tasks, which include providing protection and assistance to civilian populations, conducting health-related activities, visiting prisoners of war and security detainees, and restoring contact between family members separated by war.[118]

6. The Legal Redress for Health Injury

This section will briefly discuss the available legal redress for health injury in Ethiopia. The discussion will focus on investigating the level of State liability for health injury and the availability of compensatory schemes in the Ethiopian law. The legal liability of medical professionals (health institutions) and the legal rights of patients (clients) for compensation in cases of harms or injuries resulting from violations of health rules, professional fault, professional negligence, professional malpractice, and other forms of medical errors shall be clearly defined and provided by law for ensuring ethical administration of healthcare and for restituting victims of medical trespasses.[119]

[118] Kellenberger, Jakob. 2009. "The ICRC's response to internal displacement: strengths, challenges and constraints." *International Review of the Red Cross* 91 (875): 675-690. Accessed May 31, 2020. doi::10.1017/S1816383109990324.

[119] Biruk L Wamisho, Mesafint Abeje, Yeweyenhareg Feleke ,Abiy Hiruy, Yeneneh Getachew. 2015. "Analysis of medical malpractice clams and measures proposed by the Health Professionals Ethics Federal Committee of Ethiopia: review of the three years proceedings." *Ethiopian Medical Journal* 53 (1): 1-7.

Thus, it is imperative to briefly overview the Ethiopian legal system on this topic. However, while the Ethiopian law provides a room for compensation for health injuries, it does not clearly state the perfect or strict liability of the State in compensating the victims. Health injury can be defined as any physical or psychological harm inflicted to an individual by the commission or omission of an act such as medical malpractice, professional negligence, unsafe work environment, environmental pollution, and other similar acts. The Ethiopian law stipulates three forms of liability in cases of health injury: disciplinary measures, civil liability and criminal liability. There are laws that guide the delivery of healthcare services in an ethical manner. In cases of violations of such ethical standards, the professionals will be held liable for disciplinary measures. The disciplinary measures do not exclude the professional in default from being held liable both for civil and criminal liability for the same issue. Thus, the party that inflicts such health injury is accountable for disciplinary and criminal measures. The Health Professionals Ethics committee, which was established at National level under Regulation number 76/1994, has been examining complaints related to medical errors due to negligence.[120]The committee investigates ethical complaints against health professionals to take disciplinary measures in cases of violations. This, however, does not prevent the victim from resorting to the court for legal redress. Thus, any

[120] Ibid

victim in Ethiopia can go to courts and file legal suits against any health worker who inflicted the medical error. The court uses information generated by the Ethics Committee, among other sources of information, to decide whether there were any sustained medical errors due to negligence. This is currently substituted by Regulation number 99/2006. Accordingly, a new Health Professionals Ethics Committee was established under the recent regulation.

As regards civil liability, health injuries that ensue from medical malpractice, professional negligence and medical errors are governed by contractual or extra-contractual liability laws in Ethiopia. The Ethiopian legal system provides for the personal and institutional liability for medical harms (health injuries) incurred by patients at public or private medical institutions. Medical error is an act of omission or commission in planning or execution that contributes or could contribute to an unintended result.[121] The civil liability of medical (health) professionals and health institutions for indemnifying the injuries and death of their patients (clients) emanates from both contractual and tortious liabilities. According to the provisions articles 2647 and 2651 of the Civil Code, medical professionals and hospitals (health institutions) are legally liable for compensating their victims based on the medical contracts they sign with their clients (patients). As per article 2647(1) of the Civil Code, the physician

[121] Ibid

(health professional) is liable only if he/she commits a medical fault. Medical fault is defined as the commission or omission of any act detrimental to the patient.[122] Even though the law provides for the liability of the medical professional, the legal duty to pay compensation is the vicarious liability of the institution the medical professional is employed. Thus, the law provides that the medical institution shall be civilly liable for the damage caused to a sick person by the fault of the physician or auxiliary staff which it employs.[123] The other source of liability of medical professionals emanates from extra-contractual liability. According to the Ethiopian law of extra-contractual liability, medical professionals who are employed by the state institutions as civil servants are personally liable to make good any damage they cause, by their fault, to other persons (clients) even though they do not have any contractual relationships with their clients.[124] If the fault is a professional fault, the victim may claim compensation from the State provided that the State can subsequently claim the amount from the employee at fault.[125]Professional fault is defined in the law as a fault committed by the professional in good faith while discharging his/her work under the scope of his/her duties and when the act is

[122] Article 2647(2) of the Civil Code of the Empire of Ethiopia 1960.

[123] Ibid, article 2651

[124] Ibid, article 2126 (1)

[125] Ibid, article 2126 (2)

done in the interest of the State.[126] Both public and private health institutions can be held liable for the fault of their employed health professionals, their legal representatives or agents, or their paid workers when they incur liability in the discharge of their duties.[127] The law establishes the employer's liability for the employee's liability in the discharge of his/her duties.[128] A medical professional shall be liable for his/her professional negligence when he/she is guilty of imprudence and negligence constituting definite ignorance of his/her duties. The negligence is determined based on scientific facts or the accepted rules of the practice of the medical profession.[129] Medical error and malpractice investigation requests are alarmingly increasing in Ethiopia. But, medical errors are not just the result of human error, but also the result of the systems in which humans work and interact. Thus, any improvement in reducing medical errors must come from looking at the systems and processes as a whole, not just at the individual level.[130] In most parts of the world, a primary objective of litigation is compensation. But in order to obtain compensation, the patient must prove negligence and also that the

[126] Ibid, article 2127(1)

[127] Ibid, article 2129

[128] Ibid, article 2130

[129] Ibid, article 2031(2)

[130] Biruk L Wamisho, Mesafint Abeje Tiruneh, Lidiya Enkubahiry Teklemariam. 2019. "Surgical And Medical Error Claims In Ethiopia: Trends Observed From 125 Decisions Made By The Federal Ethics Committee For Health Professionals Ethics Review." *Dove Press journal: Medicolegal and Bioethics* 9: 23-31.

particular negligence concerned caused the harm that is to be compensated. However, causation may be too difficult to prove.[131] When a patient is harmed by a medical error the highest priority is timely and free provision of the healthcare needed to minimize that harm.[132]An acknowledgement of the fact that something has gone wrong, an empathic apology and an explanation are all essential, and should be given early and readily. This requirement has been called 'open disclosure' and is becoming enshrined in the policies of institutions and legislation of many countries. Appropriate compensation should be provided as of right, and should include the costs of any healthcare and rehabilitation and any loss of earning capacity arising from the accident (health injury). Ideally, compensation should not be linked to the need to prove fault (as it is in litigation). An appropriate analysis of why things went wrong and a concerted effort to correct any failure in the system and minimize the likelihood of a recurrence is essential.[133] In Ethiopia, if the relationship between the patient and the medical institutions is formed through contract, the liability of the medical institution for

[131] Merry, Alan F. 2009. "How does the law recognize and deal with medical errors?" *Journal of the Royal Society of Medicine* 265–271. doi:10.1258/jrsm.2009.09k029.

[132] STA Law Firm. 2018. *United Arab Emirates: Medical Negligence Claims And Liability In Gulf Countries: A Critical Analysis.* November 15. https://www.mondaq.com/healthcare/754908/medical-negligence-claims-and-liability-in-gulf-countries-a-critical-analysis.

[133] Merry, "How does the law recognize and deal with medical errors?",270.

injuries sustained by its patients is limited to faults committed by physicians or auxiliary staffs which the institution employs. This implies that medical institutions are not going to be liable for the fault of independent contractor or non-employee physicians even if the injury occur within the confines of the institution. As such, in the existing legal framework, medical institutions in Ethiopia can use contractual arrangements to insulate themselves from liability for acts of medical malpractice or negligence committed up on its premises.[134] Some writers argue that the liability for health injury (medical harm) health injury should not be imputed only to the medical professionals; rather, the liability shall be imputed to the system they conduct their professional duty.[135] Most of medical professionals in Ethiopia provide medical services in hospitals where there is no adequate technological infrastructure, extremely limited medical equipment, and limited professional staffing. Thus, some alleged medical errors ultimately turn out to be system errors.

In addition to the disciplinary and the civil liability measures, the Ethiopian law prescribes criminal penalties on medical

[134] Simachew, Habtamu. 2011. "Liability Of Medical Institutions In Ethiopia: Injuries Caused By Independent Contractors And Non-Employee Physicians." *A Thesis Submitted To Addis Ababa University, The School Of Graduate Studies, School Of Law In Partial Fulfillment Of The Requirements For The Degree Of Master Of Laws (LL.M) In Business Law*. Addis Ababa University, October.

[135] Abera, Belay. 2019. *Ethiopia: Medical Mistakes, Avoidable With Employment of Technology.* https://allafrica.com/stories/201901090584.html.

malpractices and professional negligence. Any medical error done in the exercise of a professional duty is liable to punishment when it is not in accordance with the accepted practice of the profession and the doer commits grave professional fault.[136] Any medical or health professional who refuses to provide professional services in a case of serious need, whether from indifference, selfishness, cupidity, hatred or contempt or any other similar motive, is to be fined or imprisoned.[137]. Besides, providing medical services beyond one's qualifications and the legal license[138] to provide such services is prohibited and punishable at law.[139] The criminal law prescribes that compensation shall be paid by the offender to the victim in case of any health injuries to the victim.[140]

Concerning health injuries that result from unsafe occupational environment, the Ethiopian labor and employment law governs the situation. According to the Occupational Safety and Health Convention of 1981, employers have the overall responsibility of ensuring that all practicable preventive and protective measures are taken to minimize occupational risks (heath injuries). Work-

[136] The contrary reading of article 69 of the FDRE Criminal Code

[137] Ibid., 537(1)

[138] According to article 33 of Proclamation No.661/2009, no person shall practice as a health professional without having obtained a professional practice license issued by the appropriate organ.

[139] Refer article 535 (1) of the FDRE Criminal Code

[140] Refer article 101 & article 553 (2) of the Criminal Code.

related injury is one of the most important health issues that workers have to deal with nowadays in Ethiopia.[141]The Ethiopian labor law provides for measures guaranteeing occupational safety and health[142], policies and compensation for victims of occupational accidents and diseases; responsibilities and rights of organizations (employers) and individuals in respect of occupational safety and health and state management for it.[143]According to the Ethiopian Labor Law, the employer is liable for compensating for health injuries resulting from occupational diseases.[144]In addition to this, health insurance is usually used as a means to redress occupational health risks or injuries. Health insurance is a type of insurance coverage that pays for medical, surgical, and sometimes dental expenses incurred by the insured.[145] Health insurance can reimburse the insured for

[141] Abera Kumie, Tadesse Amera , Kiros Berhane , Jonathan Samet , Nuvjote Hundal, Fitsum G/Michael , Frank Gilliland. 2016. "Occupational Health and Safety in Ethiopia: A Review of Situational Analysis and Needs Assessment." *Ethiop J Health Dev.* 30 (1 Spec Iss): 17-27. Accessed May 30, 2020. https://pubmed.ncbi.nlm.nih.gov/28867918/.

[142] According to article 92 of the labor proclamation, employer shall take the necessary measure to safe guard adequately the health and safety of the workers in terms of complying with safety and health requirements; informing and instructing the workers; providing protective equipment, clothing and other materials; ensuring that the working environment is safe; implementing instructions by competent authority, and etc.

[143] Tilahun, Ashenafi. 2020. *Examining Workers Rights, Occupational Safety Measures and Benefits amid Covid-19 Under Ethiopian Labour Law.* April 7. https://www.abyssinialaw.com/blog-posts/itemlist/user/8618-ashenafitilahun.

[144] Refer article 98 of the Labor Proclamation No. 1156/2019.

[145] Kagan, Julia. 2019. *Health Insurance.* October 23. https://www.investopedia.com/terms/h/healthinsurance.asp.

expenses incurred from illness or injury, or pay the care provider directly. It is often included in employer benefit packages as a means of enticing quality employees, with premiums partially covered by the employer but often also deducted from employee paychecks.

As regards those health injuries that are caused by environmental pollution, the Ethiopian environmental laws apply. The FDRE Constitution provides for the right to clean environment for all citizens. Accordingly, the Ethiopian Environmental Protection Authority is established to protect the environment from pollution that causes harm to the health of the society. Environmental pollution will inevitably produce a variety of adverse effects on human health. Therefore, estimating health economic losses caused by air pollution can not only help people and governments to have a more accurate understanding of environmental governance costs, but also provide a scientific basis and reference for developing schemes and policies for sustainable development of health in the future.[146] The Polluter Pays Principle (PPP) is often applied as a liability and compensation mechanism which can also act as an incentive for potential polluters to implement whatever measures deemed necessary to prevent potential

[146] Hui, Chen Yu and Sun. 2016. "Research on Value Assessment and Compensation for Health Hazards of Urban Air Pollution-A Case Study of Urumqi." *Brazilian Archives of Biology and Technology* 59. Accessed May 30, 2020. doi:http://dx.doi.org/10.1590/1678-4324-2016160503.

pollution, comply with regulations, and avoid additional costs.[147] Thus, any person who pollutes the environment is liable to restore it or to pay compensation.[148] Any person who sustains health injury due to such pollution can bring a legal claim against the polluter for compensation before the competent court based on the general rules of extra-contractual liability. In sum, the Ethiopian legal system does not provide the strict liability of the State to compensate health injuries (medical harms) occurring to citizens by acts attributable to the government or government employees in the context of healthcare services.

7. Conclusion

Adopting a rights-based approach in the healthcare system of a country plays an instrumental role in providing equitable access to healthcare for all segments of the society without any discrimination. States have the duty to establish the legal infrastructure for protecting, providing and fulfilling healthcare as a human right. Thus, not only should states provide equal access to healthcare, but also put in place a legal redress for any violations of healthcare services and restitution of the resultant medical harm or health injury. However, as it has been examined

[147] Clear Seas. 2017. *Clear Seas Centre for Responsible Marine Shipping*. August 23. https://clearseas.org/en/blog/polluter-pays-principle/.

[148] Refer article 17(c) of the Proclamation No. 300/2002 Environmental Pollution Control Proclamation.

in this article, the internally displaced persons in Ethiopia are facing challenges to receive the minimum standard of healthcare let alone attaining the highest attainable standard of health due to the insufficiency of healthcare services. At policy level, Ethiopia has developed a health system that aspires to provide accessible, acceptable, available and quality healthcare services to all people without any discrimination. However, many IDPs in the country still suffer from health problems including malnutrition (scarcity of food and water), sexual and gender based violence, communicable diseases (malaria, diarrhea, dysentery, etc.), and extremely limited health services. The legal infrastructure that underpins the Ethiopian health system fails to properly address the needs of IDPs as regards their health rights and protection from public health risks and injuries. Therefore, based on the available literature, this article suggests that a right-based approach should be adopted to address the health equity gaps in Ethiopia. In other words, the Ethiopian health system should follow a rights-based approach to make health services equitably accessible to all vulnerable groups, including IDPs in the country.

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