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ADDIS ABABA UNIVERSITY  
SCHOOL OF GRADUATE STUDIES  
SCHOOL OF LAW AND GOVERNANCE  
CENTER FOR HUMAN RIGHTS

THE RIGHT TO ACCESS HEALTH CARE FOR ELDERLY PEOPLE:  
THE CASE OF ADDIS ABABA, GULELE SUB-CITY

BY: HANA ABADI

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**THE RIGHT TO ACCESS HEALTH CARE FOR ELDERLY PEOPLE:  
THE CASE OF ADDIS ABABA, GULELE SUB-CITY**

**A Thesis Submitted to the School of Graduate Studies  
Addis Ababa University  
In Partial Fulfillment for the Requirements of  
Degree of Master of Arts in Human Rights**

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## **DECLARATION**

This thesis is my original work, has not been presented for a degree in any other university or institute and all sources of materials used for the thesis are duly acknowledged.

Name:

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## ACRONYMS

CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSA	Central Statistics Agency
FDRE	Federal Democratic Republic of Ethiopia
I	Interviewee
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICRMW	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families
MoLSA	Ministry of Labour and Social Affairs
MoH	Ministry of Health
TGE	Transitional Government of Ethiopia
NCPOP	National Center for the Protection of Older People
UDHR	Universal Declaration on Human Rights
UN	United Nations
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
WHO	World Health Organization

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## **Abstract**

Elderly people's population is growing faster all over the world. Elderly people, in Ethiopia, are one of the vulnerable groups in the society due to physical change, health disorder and financial constraint. The increase in population together with their increased vulnerability is an alarming call for policy action and service provision for the elderly. Elderly need special care and support from all parts of the society. Elderly people also want to access basic service. However, the human rights of elderly people to access basic services are neglected. The objective of this study is, therefore, to assess the right to access health care of elderly people in Addis Ababa, Gulele Sub-city. The study used a qualitative research methodology and employed different data collection tools to collect the necessary data from ten key informants, two FGDs and different officials. Relevant international, regional and national human rights instruments that address issues on elderly, in general, and their right to access health care are explored. The findings of the study reveal that the right to access health care of elderly is jeopardized. The poor access to health care is the result of unavailability, inaccessibility, lack of acceptance and poor quality of the health care service. Though it is not strong, the roles of government and NGOs are addressed. And finally, the research draws conclusions and recommendations.

**Key Words:** Elderly People, Health care, Access, Human rights

# Chapter One

## Background to the Study

### 1.1. Introduction

Societies have different perceptions, positive and negative, towards elderly. The usual trend in Ethiopia is that the community at large shows much respect to the elderly. Due to such positions they have in the community they are entrusted to be mediators in conflict and they are also known for their knowledge of history and stories. On the other hand, elderly people are viewed as weak and helpless parts of the society.

The number of elderly is rapidly increasing in the 21<sup>st</sup> century. Worldwide, the proportion of elderly people is predicted to double from 10 percent in the year 2000 to 20 percent in 2050 (WHO, 2011). Some of the reasons for the rise in number of elderly are the improvements that are observed in health care, hygiene, water supply, and the control of infectious diseases also decreased the rate of death (HelpAge, 2000 as quoted in HelpAge, 2010)

Elderlyhood is a normal process of life that comes at the latest age. However, it makes elderly people vulnerable members of the society and exposes them to diseases or disability that limits their daily activities (Hutton D., 2008). Health status is an important factor that has a significant impact on the quality of life of elderly people. Nevertheless, elderly people in Ethiopia are being denied their right to access health care.

Health care systems are not planned taking into account the health care need of the elderly people. All together, the current health care services are not age-friendly (Williams, J., 2011). The denial to access health care results in violation of their right to access health care which has a direct implication on their right to health and other human rights of the elderly. Therefore, the focus of this research will be to assess the accessibility of health care services for elderly people in Addis Ababa, Gulele Sub-city.

## 1.2. Statement of the Problem

Elderly people undergo a number of social, economic and political problems. Some of the major one's include diseases, psychological disorder, weak status and exclusion from their contribution in the society, poverty and poor access to basic needs (Zastrow, C., 1996 as cited in Getachew, G., 2007).

Mostly elderly are not capable of saving money that can be used when they are needy. Unlike the most of the developed countries, only few developing countries have social security or pension schemes for elderly (HelpAge, 2013).

A research conducted by HelpAge International (2010) in African countries identified that the major barriers to elderly people's access to health care services are allocation of low budget to their health systems, over-load on the health care facilities and professionals, poor supply of medicines and physical inaccessibility of facilities. Affordability of the health care services and goods together with the absence professionals trained in geriatrics and chronic diseases<sup>1</sup> and the fact that elderly are not getting priorities at service giving facilities are the other major barriers faced by the elderly (HelpAge, 2010).

A national survey conducted by HelpAge International (2013) on "*The State of Health and Ageing in Ethiopia*" reported that about 75 per cent of the elderly respondents who participated in the survey are suffering from at least one chronic disease and 23 per cent of them were not taking treatment because they do not have enough money and they have mobility problems to go to health facilities. They also do not have trust on the health care service (HelpAge, 2013).

Similar to other parts of the country, the priority concerns for poor older people in Addis Ababa are identified to be food, shelter, health, clothing, psychological support and others (HelpAge, 2010). All these other concerns such as food, shelter, psychological support, and others have a very significant impact on the health of elderly people. This is because where there is no adequate food, hygiene, and shelter; we cannot have healthy people.

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<sup>1</sup> Chronic Disease is a long-lasting condition that can be controlled but not cured. Some of the examples of these diseases are heart attacks, stroke, cancer, diabetes, Alzheimer, asthma and epilepsy (International Encyclopedia of Marriage and Family, 2003).

There is a major gap of academic research in Ethiopia, on the human right, in general, and health care and other issues of elderly in particular. However, there are researches conducted by few researchers. Fasil Nigussie (2010) explored the effect of institutional care on the life of older people. Fasil conducted the study in one governmental institutional care center. He described the social, psychological, spiritual, economic, health, and service aspects of life in institutional care center. The research was conducted for a Master's Degree from the Social Works discipline. He used a qualitative research methodology.

Getachew Negash (2007) focused on assessing the living situations, major problems and survival mechanisms of older persons living in Lideta Sub-city in Addis Ababa. From the Social Works discipline perspective, he explored the informal social support that elderly people get from their families, friends and relatives based on their tangible and emotional needs. This research was conducted through a qualitative methodology.

Setegn Ali (2010) from the Social Works discipline explores the community based care system of the Awramba community for older persons through a qualitative research methodology. The finding of the study revealed that older persons in Awramba were receiving a wide range of services from the community.

Kifle Mengesha (2002) call attention to old age and social change in rural areas. The study was carried out among the Amhara of Ensaro. The Social Anthropology study by Kifle describes the life of older persons in the context of local, social, cultural and economic frameworks. This study was also conducted through a qualitative method.

These studies attempted to show the socio-economic and other status of the elderly. But they did not give emphasis on the access to health care needs of the elderly. All the researches are conducted mainly from a social aspect. None of the studies conducted addressed the problems of elderly people in Addis Ababa, Gulele Sub-city from the human rights perspectives. This study, therefore, is expected to fill these gaps by assessing the access to health care issues of elderly from the human rights perspective.

### **1.3. Objectives of the Study**

#### **1.3.1. General Objective**

The general objective of this study is to assess the recognition and implementation of the right to access health care for elderly people.

#### **1.3.2. Specific Objectives**

Exploring the international, regional and national human rights instruments on themes related to elderly and health care;

Assessing the availability, accessibility, acceptability and quality of health care service in Gulele Sub-city;

Identifying gaps between existing health care services and actual needs;

Analyzing the existing and planned health care service and assistance programmes by the government and others; and

Understand the coping mechanisms of the elderly people.

### **1.4. Research Questions**

The major research questions used in the study are:

What are the international, regional and national human rights instruments on elderly and health care?

Are there special health care provisions for the elderly at national level and/or at Addis Ababa, Gulele Sub-city?

Are the health care services available and accessible, acceptable and of good quality for elderly in Gulele Sub-city?

What are the gaps between existing health care services and the services elderly need?

What are the measures taken and the future plans of the government and Non-Government Organizations to curb the problems to access health care?

What are the coping measures of the elderly?

### **1.5. Significance of the Study**

This research will have the significance to fill the knowledge gaps identified above on the study of the right to access health care for elderly people. It will also initiate further researches to be conducted on the rights of elderly people. It will have the significance to raise awareness and to advocate for the human rights of elderly people, specifically, their right to access to health care. Advocating their right to access health care and the special needs of elderly people is very important to get decision makers (i.e. policymakers), implementing organs, the society and others concerned to recognize and respond appropriately. The study will also initiate both government and Non-Government Organizations in designing advocacy works, to create forums, and seek the collaboration efforts of stakeholders.

### **1.6. Research Methodology**

The right to access to health care for elderly is assessed qualitatively. Qualitative research is said to have a direct relevance to human rights studies because it is the voice of the ‘marginalized’, the poor, those ignored by the society and so on (Scott, W., 2009; Steve, J., 1984 as cited in Yitayew, A., et al). Qualitative research emphasizes on understanding about social life. To better understand the life of the informants, qualitative researches make use of words than numbers for analysis of data (Michael, Q. et al, 2007).

Qualitative method is selected because it strongly fits to a study like this, which helps to recognize a certain research problem from the perspectives of the community itself (Mack, N. et al, 2005). Qualitative methodologies are also preferred to studies that aim to address people’s experiences of health needs and access to health care (Michael, Q., et al 2007).

Both primary and secondary sources of data are used in the study. The primary sources of data are collected through in-depth interview, focus group discussions (FGDs) and observation. While the secondary sources of data are collected through on desk review.

### **1.6.1. In-depth Interview**

The in-depth interview is an effective method that allows people to express their personal feelings, views and experiences (Mack, N., et al, 2011). A semi-structured in-depth interview guide was developed for the study. Semi-structured interviews involve open-ended questions, which give both the interviewer and interviewee the opportunities to discuss some topics in detailed manner. It allows the interviewer to encourage the interviewee, to help understand and respond the questions in situations where the interviewee has difficulty replying a question or give short and not clear response (Hancock, B., 1998).

Interviews with elderly were conducted to find out if there is special health care provision for the elderly, the physical accessibility, affordability, acceptability and the quality of the services; and to learn about the different coping mechanisms used by the elderly.

The researcher interviewed elderly that were selected using purposive sampling. Only those individuals above the age of 60 were selected for the purpose of this research. In order to make it representative, the researcher considered the variables such as gender, employment status (income) and marital status. Interviews were conducted with ten elderly respondents. The number of elderly respondents in the research is composed of equal number of both male and female. Identification of the elderly interviewees is attached under Appendix A.

Taking into account the age, the health and physical conditions of the key informants, the researcher tried to make the interview as brief as possible. Each interview lasted for the average of Forty-five minutes.

Some of the interviewee thought the researcher is using the data for personal purposes. Some also thought the researcher will be solving their problems, while some said even if they share their situations there will not be any change. But after clarifying the purpose of the research all interviewees agreed to be interviewed and were free.

Representatives of most relevant government sector offices/institutions and NGO, namely, the Ministry of Labour and Social Affairs (MoLSA), the Gulele Sub-city Labour and Social Affairs Office , the Ministry of Health (MoH), Gulele Sub-city Health Office , Gulele Health Center and

Eneredada Elderly Peoples Association (an NGO) were interviewed using semi-structured checklists developed to guide the interviews.

The interviews with these institutions allowed address the research objectives on: exploring the international, regional and national human rights instruments on elderly and health care; examining if there is a special health care provision for the elderly; if health care service is available and physically accessible; and if it is acceptable and of good quality. It also allow to identify gaps between existing health care services and actual needs; and to analyze existing and planned health care service programmes by the government and NGOs.

### **1.6.2. Focus Group Discussion (FGD)**

FGD is conducted in order to substantiate, to confirm and cross check the findings from the individual interviews. Two FGDs were conducted with groups of elderly. Each group consisted of five participants. The participants of the FGDs were selected based on the age requirement, 60 and above; and consisted of equal number of male and female. The participants that are different from the Interviewees were selected with the help of the sub-city administration. The FGDs was held after the completion of the individual interviews with elderly respondents. The FGDs took the average of fifty-five minutes.

### **1.6.3. Observation**

The interview was conducted in home setting for the in-person interviews with the elderly. This made possible for the researcher to observe their health condition, physical mobility and living condition. It also helped to observe the distance of the health care facilities from their home settings. The observation at the Gulele Health Center and Eneredada Elder People Associations also contributed in witnessing the health care provision and other facilities for the elderly.

### **1.6.4. Secondary Sources of Data**

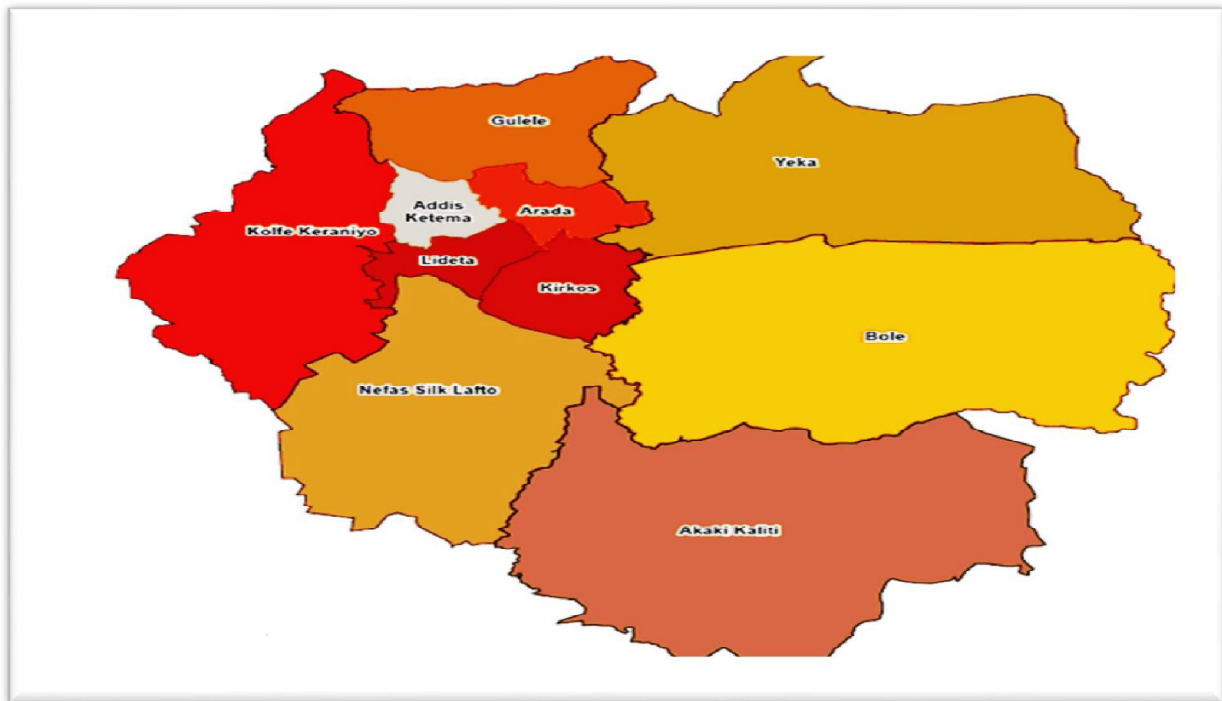
Secondary Sources of Data were used mainly to explore the international, regional and national human rights instruments on elderly and health care; and to support the other research question. Relevant academic writings, i.e., books, journal articles; and nonacademic literature were reviewed and embodied in the different parts of the study.

## 1.7. Description of the Study Area

Addis Ababa, the capital city of Ethiopia, is the largest city of the country. Established in 1887 by emperor Menilik II, Addis Ababa is the principal political, economic, cultural and historical city of the country. The city is divided into ten sub-cities. The sub-cities are divided into *Woreda's* (CSA, 2011, as cited in Bureau of Finance and Economic Development, 2013). The number of elderly in Addis Ababa is 139,423 (68,483 male and 70,940 female) (CSA, 2007).

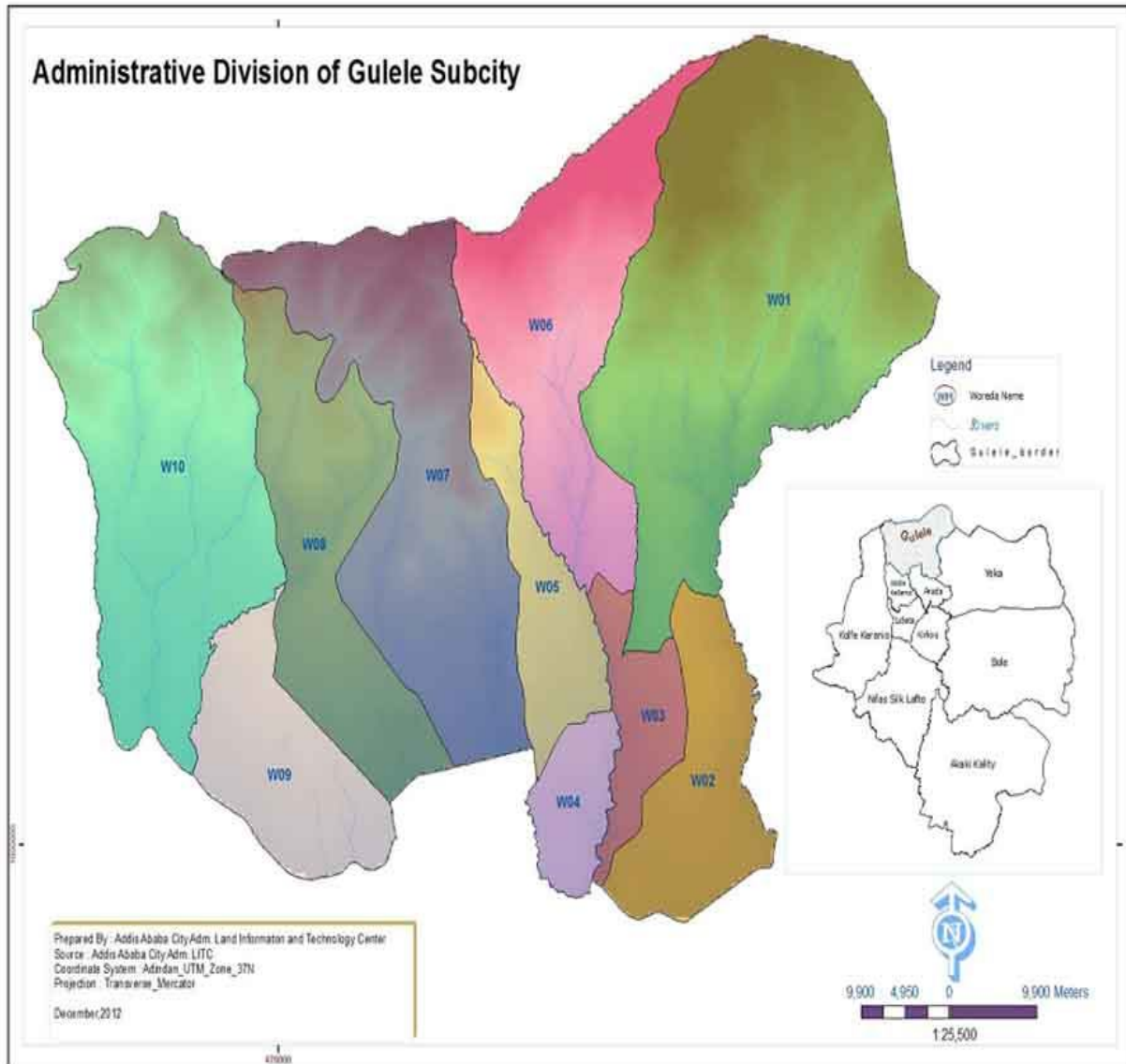
Gulele sub-city is one of the sub-cities of Addis Ababa. The sub-city is bordered by Oromia regional state in the North, Kolfe Keranio sub-city in the West, Yeka in the East and Arada and Addis Ketema sub-cities in the south. Gulele has a total population of 297,818. The number of elderly in Gulele sub-city is 15, 513 (7,617 male and 7,896 female) (CSA, 2007).

**Figure 1: Administrative Map of Addis Ababa**



**Source:** Bureau of Finance and Economic Development, 2013

**Figure 2: Map of Gulele Sub-city**



**Source:** Addis Ababa City Administration Integrated Land Information Center, 2012

### **1.8. Scope and Limitations of the Study**

The scope of this study is limited to the human rights issues of elderly people related with access to health care in Addis Ababa, Gulele Sub-city. The small sample size may create potential limitations for the outcome of the study. The research sample does not fully represent all the elderly in Addis Ababa, Ethiopia. Elderly people from the sample area were included in the research. The elderly included in the interviews and focus group discussions were urban. There

was no representation by rural older persons. Time and resource constraints limited the scope of the research.

The researcher encountered problems in getting a comprehensive data about the situation of the elderly and the health care provisions. Searching literatures on elderly people in Ethiopia was a challenge. However, the researcher, as much as possible, tried to access literatures and data on elderly people in Ethiopia, Addis Ababa and Gulele Sub-city.

## **1.9. Ethical Considerations**

The researcher first obtained an official letter from the Center for Human Rights, School of Law and Governance at Addis Ababa University indicating the name of the researcher, the title of the research and requesting for cooperation of the concerned bodies. Most of the respondents have consented for their name to be identified in the research, some asked for privacy. Therefore, the researcher exposes only names of those who gave their consent. The interviews are conducted at the convenience of the respondents, mostly in the morning session.

## **1.10. Organization of the Thesis**

The study is organized in five chapters. Chapter one introduces the study, discusses the objectives and the research questions. It presents the significance of the study, description about the research site, methodology, scope and limitations of the study and the ethical consideration. Chapter two presents the conceptual frameworks and discusses the concepts elderly, health and the right to access health care. Furthermore, this chapter includes review of literatures including the major international, regional and national human rights instruments on elderly and health care. Chapter three evaluates the access to health care of the elderly people in Addis Ababa, Gulele sub-city from four perspectives i.e., availability, accessibility, acceptance and quality. It also discusses the coping mechanisms of the elderly. Chapter four then deal with the role of government and its obligation; and also that of non-government organizations in enhancing the elderly's access to health care. Finally, Chapter Five comprises the conclusion and some recommendations.

## **Chapter Two**

### **Conceptual Framework and Review of Related Literature**

#### **2.1. Conceptual Framework**

##### **2.1.1. The Concept of Elderly**

The term ‘elderly’ has different meanings; and the concepts vary from society to society. It is mainly related to chronological age, functional and retirement age (Africa Regional Development Centre, 2001). Chronological age defines age according to the number of years a person has lived. The United Nations uses 60 years and above to refer to older people (UNFPA, 2012). The definition also gained acceptance in Ethiopian context as it matches with the country's official retirement age (MoLSA, 2011).

In many countries, especially in rural areas, older people do not know their exact age because births were not registered until recently. In situations where age is not known people make a guess based on memorable events, i.e. times of war or severe food shortage occurred or in reference to the age of others in their area (Africa Regional Development Centre, 2001).

There are other definitions of elderly that go beyond chronological age. Being old as a social construct is commonly related to a change of social roles and activities, i.e., becoming a grandparent, someone who has grey hair, and in the case of women, who can no longer have children or someone who became a pensioner. Older persons themselves describe old age as a point at which functional, mental and physical capacity is weakening and people are more exposed to disease or disabilities (UNFPA, 2012).

Chronological age provides appropriate means of describing a population group but it is very limited as it does not reflect the perception of ageing within a specific social or cultural situation. Therefore, it is necessary to determine the cultural based meanings of age and use them together with the UN definition of age (Africa Regional Development Centre, 2001). However, for the purpose of this study the chronological age definition given by the UN which is 60 years and above; and that gains recognition by Ethiopia will be used to refer to elderly people.

Societal perceptions of ageing and older people are often based on traditions and stereotypes (Musaiger & D'Souza, 2009 as cited in NCPOP, 2009). A study carried out on the stereotypes of older people have identified positive, neutral and negative elements in people's perceptions on ageing and older people (Robinson, et al. 2008 as cited in NCPOP, 2009).

NCPOP under its review pointed out that:

*Older people are sometimes perceived in a positive light, as active members of the community, loyal, sociable, and warm. However, negative perceptions tended to predominate. For example, older people were stereotyped as having poor health with diminishing mental ability, unattractive, sexless, negative personality traits, unhappy, lonely and excluded from society (NCPOP, 2009).*

While the neutral one's have the perceptions both positive and negative. Though there are similarities, societal attitudes towards elderly differ from society to society from culture to culture. In Ethiopia, older people traditionally enjoy respect, and support among the diverse cultural groups. They are also recognized for their wealth of experience and for their important roles as teachers of moral values, leaders of religious institutions, traditional medicine experts, and traditional birth attendance expertise, for their role as chairpersons of social courts and community affairs, mediators of conflicts, literacy skill educators and marriage counselors and mediators (HelpAge, 2009).

On the contrary, ageing and older people are also perceived negatively in other social settings. The Amharic word *shimagile* (old man) or *arogit* (old woman) may imply physically weak persons, easily susceptible to diseases, persons who could have little or no involvement in certain kinds of work, persons who need and deserve to be supported and so on (HelpAge, 2013).

Community's perceptions or insights on older people can have its own impact on the elderly in different situations, i.e., in employment, education, and health facilities, and in the overall treatment of older people (NCPOP, 2009).

One of the negative opinions towards elderly is the view that elderly suffer from poor health. Many elderly live with health conditions. It is pronounced by WHO that old age is followed by disease and disability for many elderly people (WHO, 2001).

### 2.1.2. The Concept of Health

There is lack of consensus concerning the concept of health among scholars and health care professionals. Health is used in many different contexts to refer to different aspects of life. Webster's Dictionary defines health as:

*“The state of being hale, sound, or whole, in body, mind, or soul; especially, the state of being free from physical disease or pain (Webster's Dictionary, 1913).”*

Formerly, health was conceptualized as the absence of disease, but the concept has progressed and advanced through a number of different stages. In 1948, the World Health Organization declared that:

*“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO Constitution, 1948).”*

WHO gave a broad definition to health. The public health expert Gina B. (2011) tried to show the weakness of the definition stating:

*“A complete state of well-being appears too idealistic. In this view can anyone be healthy? If someone was to be in a complete state of well-being what would they be like?”*

It is also inquired by numerous existing scholars as to what the WHO mean by the terms “complete”, “physical”, and “mental”? It is also questioned as to what the WHO aspired when it uses “social” and “well-being” to define “health”? The meanings of “disease” and “infirmity” as used in the WHO's definition are also disputed. It is indicated that these terms need to be appropriately addressed in order to gain a comprehensive image of health (Ananth, M., 2008).

Many other modern-day scholars on the other hand improve, complement; or abandon or accepted the definition provided by the WHO and came up with their own theories of health. Consequently, the following two schools of thought have developed to the concept of health:

#### 1. Health as a Natural Concept

Naturalists contend that the concept of health is a value-free concept. Michael Ruse describes the naturalist perspective as follows:

*The naturalist approach attempts initially to approach matters in a no value-laden fashion. In particular, the notion of disease, the concept of disease, is defined without respect to the implications for the bearer whether they be good or bad, happiness generating or otherwise, or anything else of this emotive nature. Essentially, a healthy state is taken to be one of proper functioning. A diseased state is taken to be one that, in some sense, interferes with this proper functioning (Michael, R., et al, 1997 as cited in Ananth, M., 2008).*

Hence, naturalists discard that values are part of the concept of health, saying that health basically involves only the functional activities of organisms and their parts.

## 2. Health as a Normative Concept

Normativists, on the other hand, argue that the concept of health is value-laden. According to this school of thought, health is described in two ways. First and for most they state that since science itself is prejudiced with values. As a result, medical scientists cannot conceptualize health without integrating values. The other description by normativists is that cultural and/or social environment influence diagnosis and treatment of patients which on the other hand impact the scope of the concept of health (Ananth M., 2008). Talcott Parsons defends this normativist position from a social context perspective as follows:

*Health may be defined as the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized. It is thus define with reference to the individual's participation in the social system. It is also defined as relative to his "status" in the society, i.e. to differentiated type of role and corresponding task structure, e.g., by sex or age, and by level of education which he has attained and the like (Talcott P., 1987 as cited in Ananth M., 2008).*

While WHO further explain the concept of health as:

*The extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the object of living; it is a*

*positive concept emphasizing social and personal resources, as well as physical capabilities (WHO, 1984).*

The tensions between the two concepts of health in which normativists comprise societal concerns and insist that norms are unavoidable parts of the concept of health on the one hand; and the naturalists claim that limit the scope of medicine to the condition of the human body distinguished from the body, on the other hand, are barriers observed in identifying accepted concepts of health (Ananth, M., 2008). Therefore, for the purpose of this study the definitions and explanations given by the WHO will be used.

### **2.1.3. The Right to Access Health Care**

The United Nations Committee of Economic, Cultural and Social Rights proclaim the right to access health care as a key aspect of the right to health. According to the Committee's General Comment No 14, the right to health includes the right to health care that is timely and appropriate. OHCHR & WHO (2008) explain the human right to health care to mean that all services, goods and facilities must be available, accessible, and acceptable and of good quality, where and when needed.

From a patient's perspective, it is required to be provided with best quality and at the lowest cost or at no cost through a public health care system. While from a physician's perspective, access to health care means that all service are provided according to the needs of all patients (Value in Health, 2011).

The concepts availability, accessibility, acceptance and quality will be used throughout the study as concepts comprising the right to access health care.

## **2.2. Review of Related Literature**

### **2.2.1. The Elderly Population**

The number of people aged 60 and above is rapidly increasing in the 21st century. Globally, the percentage of older people is projected to double from 10 per cent in 2000 to 20 percent in 2050. The rising life expectancy within the older population itself is increasing the number and proportion of people at a very old age (people aged 85 or older) who constitute 8 percent of the world's 65 and over population where 12 percent is in more developed countries and 6 percent in

less developed countries (WHO, 2011).

Aging is not an issue that only concerns the developed countries. HelpAge discusses that:

*The myth that older people do not exist in the underdeveloped world because life expectancy is low is contradicted by the statistics. Even the world poorest countries, those who survive the disease of infancy and childhood have a very good chance of living to be grandparents. This means that the numbers of older people in developing countries will more than double over the next quarter century, reaching 850 million by 2025, 12 percent of their total population. By 2050, the proportion will be 20 percent (HelpAge International, 2000 as quoted in HelpAge, 2010).*

In Ethiopia, it is estimated that the number of elderly people is about 5 per cent or 5.2 million of the overall population. The number of elderly is likely to rise to 10 percent by the year 2050 (HelpAge, 2012).

The factors behind increase in number of older population are also identified as follows:

*“The rapid growth in the number of older people is creating an unprecedented global demographic revolution. During this century, improvements in hygiene and water supply and control of infectious diseases have reduced the risks of premature death.... (HelpAge International, 2000 as quoted in HelpAge, 2010).”*

The increase in number of older population is also a result of progress in the health care and technology, improvement in deterrence and eradicating of infectious diseases, and enriched nutrition, hygiene and sanitation (WHO, 2004 as cited in HelpAge, 2013).

The rise in the number of older people increases the burden of providing social services, including health care services, on duty bearers who may be forced to leave much of the needs of these groups of people unaddressed (HelpAge, 2013).

### **2.2.2. Livelihood of the Elderly**

Older people, especially in developing countries, are a very vulnerable group of the society exposed to hardship, malnutrition, poverty and old age related diseases (WHO, 2004). In these

countries, the major problems related with old age are poor diet, ill health and inadequate housing, which are all made worse by poverty.

Once an older person resigns from the work, families will lose income that was earned earlier. Meanwhile, to sustain his or her standard of living, the older person not only needs financial support, but potentially additional supports as costs relating to deteriorating health increase (Charles K., 2013).

For different reasons, grand parenting is a social role that is played by many elderly people. Even if this could be a good opportunity for the children, it can have the effect of ignoring the elderly's financial, physical and/or emotional needs (NACHC, 2008). In parts of sub-Saharan Africa, an older person or couple lives with at least one grandchild without middle-generation family members, and this has become increasingly common because of high mortality from HIV/AIDS. For example, in Zambia 30 percent of older women take care of such households (WHO, 2011).

Family members can have a very helpful or hurtful role in the life of elderly people. In situations where the capacity of an elderly person is in problem, family members may or may not be available and interested to help them with financial, medical or other supports. It is highly expected that older people who lack capacity will not be in a position to have a legal guardian, which makes it very hard for them to guarantee that living provisions, medical care, financial management or other needs are addressed properly. In other situations, family members or others may inappropriately use their power to access to the finances of elderly people (NACHC, 2008).

The relationship between health and housing is also difficult for many older people. The relationship between housing and health do not necessarily mean there is a causal relationship, i.e., that poor health is always associated with poor housing or vice versa. Although it is understandable that poor housing can contribute to different health conditions and problems as good housing may help to limit the consequences or existence of other conditions and problems (Institute of Public Care, 2012).

Housing plays several crucial roles for older adults: it serves as shelter, a place of family relations and shared memories, and a location for supports and services if disability occurs. But housing is also an important financial asset, and its costs are a significant portion of most

household budgets. The availability of housing that is safe, affordable, and appropriate for people of all ages and incomes is an essential part of a livable community (Rodney H., 2011). Older people spend between 70 and 90 per cent of their time in their home, thus a warm, secure environment that meets individual requirements is crucial (ODPM, 2006, cited in Rita D., 2007).

Intra and inter-generational ties and ties between neighbors and the community are fundamental aspects for the adjustment of old age. The good and strong relationships will help them to leading their last phase of life in peace and security (Kifle, M., 2002).

Living arrangements, such as living alone or homelessness are also related with various health issues (NACHC, 2008). In the past, living alone in older age often was equated with social isolation or family abandonment. However, research on the other hand show that in many cultural settings older people prefer to be in their own homes and communities, even if that results in living alone (WHO, 2011). But older people who live alone are possibly not to benefit from the goods and services that could be available in a larger family and the risk of falling into poverty in older age may increase as family size decreases. On the other hand, older people are also a resource for the rest of the family, and their absence may create an additional problem for other and younger members of the family (WHO, 2011).

In 2010, a survey conducted by HelpAge International across 32 countries show that 72 per cent of older people say their income does not pay for basic services such as water, electricity, health care, food and decent housing (Williams, J., 2011).

Research shows that the existence or absence of social protection in old age has significant impact on the lives of the elderly people. Where a formal social protection system is not available, older persons will have difficult choices. The first one is to be dependent on family and other assistance networks, while the other one is to face it alone and make sacrifices in terms of welfare (Charles, K., 2013).

In most developing countries, formal systems of income security for elderly are very limited or non-existent. In practice, eligibility to income security is limited to a small number of retired workers who have been employed in the formal sector, such as former employees of government

and large scale public organizations, or within private enterprise (Amanda, H., 1999 as cited in Getachew, G., 2007).

In Ethiopia, the majority of older persons are involved in the informal and tiresome types of works. The incomes they earn from these jobs do not enable them to meet their basic needs. They are forced to keep working in these informal jobs until they are very sick or die; because they have no access to social security (MOLSA, 2011). Similarly, the World Bank estimates that over 70% of the world's older population relies on informal systems of security. This percentage is highest among the older population in the developing countries (Amanda, H., 1999 as cited in Getachew, G., 2007).

The key findings of the assessment carried out by HelpAge International (2010) on “*The Vulnerability and Living Conditions of Older People in Addis Ababa*” reported that among the older people who were part of the survey: 78 per cent of all older people surveyed have a chronic health problem and 36 per cent of all people surveyed do not know about the free government health service for poor people; more than 88 per cent of the homeless older people and 66 per cent of those living at home do not have enough to eat and 79 per cent of all older people surveyed eat only once or twice a day. While 79 per cent of homeless older people get water by begging; 93 percent of all older people surveyed do not have access to bath or shower and 71 per cent of homeless older people use rivers or drains for washing and 29 per cent do not wash.

### **2.2.3. Health and Aging**

The World Health Organization assert that normal ageing is not a disease, but in due course leads to structural and functional decline and involves increased vulnerability to diseases due to intrinsic and extrinsic factors (HelpAge, 2013).

WHO tried to show the difference between the *ageing process* and the *process of ageing*. The *ageing process* or ‘normal ageing’ is the universal biological changes that occur with age and are unaffected by disease and environmental influences. This implies that all age related changes do not necessarily have adverse medical effects. Whereas the *process of ageing* is highly influenced by the effects of environmental, lifestyle and disease states; and these in either ways are associated to or change with ageing but are not as a result of ageing itself (WHO, 2001).

The World Health Day in 1999 celebrated old age and “*active ageing*”, and WHO called for the elderly to be viewed as active citizens with a positive contribution to make rather than as a burden. The active-ageing concept, promoted by WHO, encourages the process of growing older without growing old through the maintenance of physical, social, and spiritual activities throughout a lifetime.

For many people, especially in developing countries, old age is come with chronic illness and disability. This is the result of lives lived in poverty, with little or no access to adequate health care (WHO, 2001). By 2030, non-communicable diseases are estimated to account for more than one-half of the disease burden in low-income countries and more than three-fourths in middle-income countries. Infectious and parasitic diseases will account for 30 percent and 10 percent, respectively, in low and middle-income countries. Among the 60 and over population, non-communicable diseases already account for more than 87 percent of the burden in low, middle, and high-income countries (WHO, 2011).

In developing countries, where there are no adequate resources to meet the health service needs of the general population, governments find it very difficult to meet the special needs of older people. In these countries, primary health care remains largely focused on other groups, such as mothers and young children, rather than older people and on treating communicable and infectious diseases rather than non-communicable diseases (HelpAge, 2013). This is also the same in Ethiopia in which the health policy does not identify non-communicable diseases as a priority focus although these diseases account for the most common health problems of older people (HelpAge, 2009).

#### **2.2.4. Available, Accessible, Acceptable and Quality Health Care for Elderly**

As discussed above, the human rights to health care means that all services, goods and facilities must be available, accessible, acceptable and of good quality. Availability indicates that an effective public health care facilities, goods and services must be available in sufficient quantity within a state (OHCHR & WHO, 2008). This means adequate health care infrastructure such as hospitals, community health facilities, trained health care professionals; goods like drugs, and equipment; and services such as primary care, mental health must be available in all geographical areas and to all communities (NESRI, 2009).

The concept accessible indicates that health care must be universal, guaranteed for all on an equitable basis. Health care must be physically accessible meaning in safe reach for all parts of the population, including children, adolescents, older persons, persons with disabilities and other vulnerable groups. It also needs to be financially accessible and on the basis of non-discrimination. Accessibility also indicates the right to seek, receive and impart health related information in an accessible format for all, including persons with disabilities, but does not prejudice the right to have personal health data treated confidentially (NESRI, 2009).

Acceptability on the other hand indicates that the facilities, goods and services should be gender sensitive and culturally appropriate; and they must respect medical ethics. They should also be responsive to needs based on age, language, and different ways of life and abilities (NESRI, 2009). In other words, they should be medically and culturally acceptable.

Good quality also refers that health care must be scientifically and medically appropriate and of good quality. This specifically requires trained health professionals, scientifically approved and unexpired drugs and hospital equipment, adequate sanitation and safe drinking water (OHCHR & WHO, 2008). And all health care must be provided in a timely, safe, and patient-centered manner.

In 2010, a survey conducted by Help age International across 32 countries show that 63 per cent of older people said they found it difficult to access health care when they needed it (Williams, J., 2011). Many older people cannot access health services because of the cost and time of travel to access health care and health insurance being usually available to those who are in better living standard and to those in formal sector employment.

The fact that primary health care remains mainly focused on other groups, such as mothers and young children rather than older people; and the attention given to chronic conditions such as stroke, heart disease and cancer that account for a higher share of older people's mortality than infectious diseases being very small and remain to get a lower priority in global and in many national health policy agendas are serious barriers to access health care services (Williams, J., 2011). Long waiting times and lack of information about free services can also be a barrier to access (Sleap, B., 2011).

## **2.2.5. Human Rights Instruments on the Rights of Elderly People**

### **2.2.5.1. International Human Rights Instruments on Elderly People**

Human rights are universal and they apply to all human beings everywhere without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Charter of the United Nations under its article 55, request for member states of the United Nations to promote higher standards of living for all people, social and economic progress, international cooperation on social issues including health and education and universal respect for human rights regardless of individual background or characteristics (UN, 1945).

#### **2.2.5.1.1. Binding Instruments**

- a. The Universal Declaration of Human Rights (UDHR):** UDHR is a binding customary law. UDHR is very important to elderly people because it guarantees the right to adequate standard of living which includes the right to health care and the right to security that are basic to elderly. Article 25(1) of this declaration put it as follows:

*“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 (UDHR, 1948).”*

- b. The International Convention on Economic Social and Cultural Rights (ICESCR):** ICESCR under its Articles 6 and 7 addresses specific rights for older people related with work. The Convention also obliges states parties to recognize the right of everyone to social security, including social insurance. The right to social insurance which includes pension rights is very important to the rights of elderly. The ICESCR also deals with adequate standard of living and education.

In terms of ensuring the right to access health care for elderly people, article 12 sub article 1 and sub 2(d) of the ICESCR require state parties to recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. It also stipulates the necessary

steps that should be taken to achieve the full realization of the right to the highest attainable standard of physical and mental health which includes the creation of conditions which would guarantee to all medical service and medical attention in the event of sickness.

- c. **The International Convention on Civil and Political Right (ICCPR):** ICCPR is also essential for the respect, protection and promotion of the rights of elderly people. Regardless of the fact that human rights are universal, there are number of treaties that specifically deal with the rights of some groups. But there are no treaties that are meant to distinctively deal with problems of elderly people, while few of the instruments raise issues of age.
- d. **The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW):** CEDAW under Article 11(1(e)) refers to women in old age in relation to the equal rights of women and men to social security and paid leave. It indicates that state parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure equality of men and women. These are the right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave (CEDAW, 1979).

In relation to access to health care that is also applicable to older women, Article 12 of CEDAW stipulates that states parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning (CEDAW, 1979).

- e. **The Convention on the Protection of the Rights of Migrant Workers and the Members of their Families (ICMW):** ICMW under its article 7 includes age as one of the prohibited grounds of discrimination (ICMW, 1990).
- f. **The Convention on the Rights of Persons with Disabilities (CRPD):** CRPD provides important protection for older persons. The CRPD in its Preamble, raised about the problems of different forms of discriminations faced by persons with disabilities especially on the basis of age. Although all older persons do not have disabilities, many

of its articles can be utilized by older persons seeking human rights protection (CRPD, 2006).

The CRPD obliges states to combat stereotypes and prejudices relating to persons with disabilities, including those based on age. Article 25(b) of the CRPD on the right to health services, and in Article 28(2)(b) on the right to access to social protection and poverty reduction programs has referred elderly. Article 13(1) refers to age appropriate accommodations on access to justice. Article 16(2) mentions that states shall provide age sensitive assistance and support to ensure freedom from exploitation, violence and abuse. Elderly people could also benefit from the articles on accessibility, independent living, and personal mobility and on habitation.

**g. The Convention relating to the Status of Refugees:** It establishes that states shall treat refugees lawfully abiding in their territory with the same respect for rights as other nationals including providing for a refugee's social security in the event of sickness, disability or old age. The UN High Commissioner for Refugees also promulgated a policy on older refugees in 2000 (UNHCR, 2000).

The rights of older persons are protected very generally in the Bill of Rights and are also found scattered in some international human rights instruments. There is no international human rights instrument that provides comprehensive and binding protection for the rights of elderly people

#### **2.2.5.1.2. Soft Law Instruments**

The international community under the shade of the United Nations took a number of steps towards the improvement of the lives of older persons through soft law protections. Though they are not binding, the Committee's of the different human rights instruments also played a significant role in coming up with recommendations and declarations that help to interpret the existing instruments in consideration of the elderly.

##### **a. Committee of ICESCR**

Although the ICESCR does not clearly refer to older persons, the Committee on Economic, Social and Cultural Rights (CESCR) gave comment on the economic, social and cultural rights of older persons under its General Comment No. 6. In the General Comment, the Committee calls on states parties, to pay particular attention to older women as they have often not engaged

in a remunerated activity entitling them to an old-age pension; to institute measures to prevent discrimination on grounds of age in employment and occupation; to take appropriate measures to establish general regimes of compulsory old-age insurance; and to establish social services to support the whole family when there are elderly people at home and assist elderly persons living alone or elderly couples wishing to remain at home. Although age is not specified as a prohibited ground for discrimination in the Convention, the Comment stipulated that the term ‘other status’ could be interpreted as applying to age (CESCR, 1995).

The Committee of ICESCR in its General Comment 14 also interprets the right to health. According to the General Comment, the right to health includes a wide range of socio-economic factors that promote conditions in which people can lead a healthy life that extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation and a healthy environment. In addition, the right to health includes the right to control one’s health and body as well as the right to be free from interference, for example, from non-consensual medical treatment. It also includes the right to health care that is timely and appropriate. Equal access to health care requires States to guarantee access to health care facilities to individuals without sufficient means, as well as to prevent any discrimination in health care provision (CESCR, 2000). This interpretation given by ICESCR Committee on the right to health is helpful in terms of declaring the right to access health care as a key aspect of the right to health.

Under its General Comment No. 19, the Committee on ICESCR also gave its interpretation on the right to social security. The General Comment identified the fundamental elements of the right to social security to include availability, old age, adequacy of any provision, and accessibility of any scheme. It also indicated that social protection programmes must pay full respect to the principle of human dignity and states must take into consideration the especial needs of women, part time and casual workers, home workers and those active in the informal economy. General Comment 19 also recommend for noncontributory schemes to those who are outside the arrangement of contributory pensions and a system of compulsory old age insurance. It is also stated that states are expected to establish a flexible retirement age that takes account of occupation and working abilities of older people together with encouraging states to guarantee survivors’ and orphans’ benefits. In addition the Comment obliges states to ensure that existing

programmes are non-discriminatory and promote gender equality; to develop a plan of action for more comprehensive coverage which includes seeking international assistance if required; and to monitor the impact of programmes to ensure the delivery of the service (CESCR, 2008).

This interpretation by the Committee helps consider elderly people in the informal sector while talking about social security. And specially, as most elderly women in developing countries make their livelihood working in their homes and engaged in informal or part time works, this Comment is very significant to ensure their social security rights.

**In** 2009, this same Committee passed a General Comment No. 20 dealing with Non-discrimination in economic, social and cultural rights. It states that age is a prohibited ground of discrimination in several contexts. The CESCR emphasizes the need to address discrimination against older persons in finding work, in professional training, and against those living in poverty with unequal access to pensions because of their place of residency (CESCR, 2009).

#### **b. Committee of CEDAW**

The Committee to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), in its decision 26/III of 2002, acknowledged that the Convention is an important tool for addressing the specific issue of the human rights of older women (CEDAW, 2002).

The General recommendation no. 25 on temporary special measures also recognizes that age is one of the grounds on which women may suffer multiple forms of discrimination. The Committee also recognized the need for statistical data, disaggregated by age and sex, in order to better assess the situation of older women.

The Committee on CEDAW being aware of the number of forms of discrimination faced by older women in 2008 adopted a General Recommendation on older women and protection of their human rights. The recommendation explores the relationship between the articles of the Convention and ageing. It recognize the multiple forms of discrimination that women face in their old age, outlines the content of the obligations to be assumed by States parties with regard to ageing with dignity and older women's rights, and includes policy recommendations intended at mainstreaming the responses to the concerns of older women into national strategies,

development initiatives and positive action so that older women can fully engage in the public without discrimination and on an equal basis (CEDAW, 2008).

The General Recommendation also gives guidance to State parties on the inclusion of the situation of older women in their reports on the implementation of the Convention. The Committee gave number of recommendation on issue of health and recommends that States parties should adopt a comprehensive health care policy aimed at protecting the health needs of older women.

The Committee's 1999 General Recommendation No. 24 on women and health recommends that the health care policy should ensure affordable and accessible health care to all older women through, the elimination of user fees, training of health workers in geriatric illnesses, provision of medicine to treat age-related chronic and non-communicable diseases, long term health and social care, including care that allows for independent living and palliative care. Long term care provisions are said to include interventions promoting behavioral and lifestyle changes to delay the onset of health problems, such as healthy nutritional practices and an active lifestyle, and affordable access to health care services, including screening for and treatment of diseases, in particular those most prevalent among older women. Health policies must also ensure that health care provided to older women, including those with disabilities, is based on the free and informed consent of the person concerned.

The Committee also recommends that States parties should adopt special programmes tailored to the physical, mental, emotional and health needs of older women, with special focus on women belonging to minorities and women with disabilities, as well as women tasked with caring for grandchildren and other young family dependents due to the migration of young adults, and women caring for family members living with or affected by HIV/AIDS (CEDAW, 2008).

On the other hand, the 1993 Declaration on the Elimination of Violence against Women also focuses on violence against women as both a violation of their rights and as an obstacle to achieving equality. It review the types of violence often committed against women and brings special attention to groups of women that are particularly vulnerable, including elderly women (UNGA, 1993).

- c. **The International Labour Organisation (ILO):** ILO adopted different recommendations that refer elderly people. The Recommendation on older workers states that older workers must enjoy equality of opportunity and treatment with other workers without age discrimination, including access to housing, social services and health institutions, particularly when this access is related to occupational activity or employment (ILO, 1980).
- d. **Vienna International Plan of Action on Ageing (VIPAA):** The World Assembly on Ageing adopted the VIPAA in 1982. This was the first UN human rights instrument on ageing. It was endorsed by UNGA Resolution 37/51. The Plan promotes international cooperation to strengthen the capacities of states to contend with the ageing of populations and to address the developmental potential and dependency needs of older persons.

It addresses research, training and education and makes recommendations in areas of: education; health and nutrition; family; protection of elderly consumers; income security and employment; housing and environment; and social welfare. Its recommendations included avoiding the segregation of the elderly, making available home-based care for elderly persons; rejecting stereotypical concepts in government policies and recognizing the value of old age (UNGA, 1982).

- e. **United Nations Principles for Older Persons:** In 1991, the UN General Assembly adopted the United Nations Principles for Older Persons through resolution 46/91. It encourages governments to incorporate the following principles into their national programmes, these are: independence, participation, care, selffulfilment and dignity of elderly persons. It also keeps explaining as to what is meant by each principle. The principle independence includes access to adequate food, water, shelter, clothing and health care, as well as the opportunity for remunerated work and access to education and training. While the participation principle aims for older persons to actively participate in the formulation and implementation of policies that affect their wellbeing and to share their knowledge with younger generations. It also provides that elderly should have the right to form movements and associations (UNGA,1991).

The principle of care emphasise that the elderly should benefit from family and health care and that when residing in care or treatment facilities their human rights and fundamental freedoms shall be respected. Self-fulfilment as one of the principles for older persons entails that educational, cultural, spiritual and recreational resources should be available for older persons to be able to pursue opportunities for the full development of their potential. The last principle from the United Nations Principles for Older Persons is dignity which aim for the elderly to live in dignity and security and be free of exploitation and physical or mental abuse; to be treated fairly, regardless of age, gender, racial or ethnic background, disability, financial situation or any other status; and be valued independently of their economic contribution (UNGA,1991).

- f. **Proclamation on Ageing:** In 1992, a Proclamation on Ageing was adopted by the General Assembly, after ten years following the first World Assembly on Ageing. Recognizing the need for a practical strategy on ageing, it urges the international community to promote the implementation of the International Plan of Action on Ageing; and to disseminate widely the United Nations Principles for Older Persons among other things.

It also urges the support of national initiatives on ageing in the context of national cultures and conditions, so that appropriate national policies and programmes for the elderly are considered as part of overall development strategies; policies which enhance the role of government, the voluntary sector and private groups are expanded and supported; and governmental and non-governmental organizations collaborate in the development of primary health care, health promotion and self-help programmes for the elderly (UNGA,1992).

The General Assembly also proclaimed the year 1999 as the International Year of Older Persons on this same Proclamation on ageing to follow up on the International Plan of Action and the Principles for Older Persons.

- g. **Political Declaration and Madrid International Plan of Action on Ageing:** It was adopted by the Second World Assembly on Ageing in 2002. The Second International Plan of Action on Ageing settes out goals, objectives and commitments. These are the full realisation of all human rights and fundamental freedoms of all older persons; the achievement of secure ageing; empowerment of older persons; provision of opportunities

for individual development; ensuring the full enjoyment of all human rights, and the elimination of all forms of violence and discrimination against older persons; gender equality among older persons; recognition of the importance of families; provision of health care, support and social protection for older persons; and recognition of the situation of ageing indigenous persons (UNGA, 2002).

The Second International Plan of Action on Ageing also identified recommendations for action that guide policy formulation and implementation. These are: older persons and development; advancing health and wellbeing into old age; and ensuring enabling and supportive environments. The UN Commission for Social Development is responsible for follow-up and appraisal of the implementation of the 2002 International Plan of Action on Ageing. The Commission is to integrate the different dimensions of population ageing as contained in the Plan of Action (UNGA, 2002).

In general, compared to binding international human rights instruments, the international soft law documents of the human rights of elderly people are inclusive and comes up with sets of principles, declarations, action plans, and comments on how to interpret the protection and gaps under the already established human rights instruments with regards to older persons. These soft law documents are helpful in a way that they serve as guides for state action in setting standards and influencing domestic policies.

Nevertheless, all these documents are not legally binding and in effect, do not impose legally binding obligations. Therefore, because of the non-binding nature of these soft law human rights protection instruments, implementation is weak, and above all states do not succeed in incorporating these international standards into their domestic policies.

#### **2.2.5.1.3. Arguments for and against a Convention on the Rights of Elderly**

There are many international treaties and conventions that give broad human rights protection that apply to all human beings. These instruments are also applicable to older persons. The Madrid International Plan of Action on Ageing and General Comment No.6 on the ICESCR are the most important soft law protections as they guide and influence the application of law and made a significant role in protection of older people. However, many NGOs together with some

UN member states argue that these soft law protection instruments fail to provide clear support and are easily subject to ageist interpretation (Marthe, F., Simon, B., 2012).

The Open-Ended Working Group on Ageing was established by the General Assembly by resolution 65/182 on 2010. The working group will consider the existing international framework of the human rights of older persons and identify possible gaps and how best to address them, including by considering, as appropriate, the feasibility of further instruments and measures (UNOEWG, 2011).

Arguments in favour of a convention explicitly aimed at older people include that older people experience specific forms of rights violation based on their age. Just like other social and economic circumstances, the vulnerability of older persons to poverty, discrimination, abuse, marginalisation and exploitation is common across cultures and borders.

The Open-ended Working Group on Ageing has identified four types of gaps. There is a normative gap that exists where constant acts and circumstances depriving a person of their dignity are not provided for in existing human rights law. Such a gap requires a more comprehensive instrument that can frame the rights of the affected group more clearly, even when existing instruments already provide some protection. According to the 2009 report by the Human Rights Council Advisory Committee, there is a normative gap in the existing human rights framework because age is not listed explicitly as a reason for discrimination. Just as women and children have been recognised as distinct groups who require specific care in human rights law, the case can be made that older persons too should be recognised as a distinct group who deserve special attention (Marthe, F., Simon, B., 2012).

An implementation gap exists where the rights and obligations are contained within law, but are not wholly translated into national law and practice. The weak implementation could arise from lack of political will to start or maintain the necessary procedures; prioritize issue, lack of resources; a lack of visibility of the issue in international or national dialogue for action; or a lack of technical understanding in how to implement procedures to fulfill obligations.

A monitoring gap exists where no independent body or mechanism is obliged to ensure States comply with their obligations. It is difficult to determine the member states' commitment to

furthering the rights of older persons, especially on a global scale. A 2011 study undertaken for the United Nations Population Fund and HelpAge International discovered that monitoring bodies rarely asked the member states to include older persons in their reporting, and that the work of special rapporteurs and independent experts who examine rights in geographic areas failed to consider the rights of older persons as a specific category (UNFPA, et al, 2011 as cited in Marthe, F., Simon, B., 2012).

An information gap exists where substantive discussions on the rights of older people are made invisible by a lack of disaggregated data and statistics. This prevents an accurate picture of the current situation from being drawn and impacts on the duties of experts and monitoring bodies to draw conclusions and make targeted, specific recommendations (HelpAge, 2012).

Those who argue for a separate convention on the rights of elderly argue that in terms of combating ageism and age discrimination, a convention would help to reduce age discrimination and ageism; oblige ratifying states to adopt nondiscriminatory laws; draw attention to the multiple discriminations that older people experience; provide the basis for advocacy, public awareness and education on the rights of older people; strengthen societies' responses to the challenges of demographic change and improve intergenerational solidarity.

A convention would also help older people live lives of dignity; change the view of older people from recipients of charity to individuals with knowledge, power and experience. Increased respect for older people will improve relationships between different generations and make societies more cohesive. Most importantly, a convention clarify responsibilities through providing the necessary, legally binding protection of older people's rights under international law; provide clarity on what older people's rights are and the minimum standards and actions necessary to protect them; make visible the responsibilities of States and other actors towards older people; complement and raise the profile of MIPAA and the UN Principles for Older Persons; strengthen the implementation of existing international law by making the rights of older people more explicit.

A convention would on the other hand improve accountability as it obliges states to provide a report which is an accountability mechanism for States' actions towards older people; provide a system of redress for the violation of the rights of older people; encourage ongoing dialogue

among UN Member States, civil society organisations, NGOs, the private sector and older people themselves, through the monitoring of its implementation.

Those who argue for a convention also explain that the very significance of having a convention is that it provides a framework to guide policy decision making; encourage the collection of age disaggregated data to inform policy decisions; promote age sensitive programmes; help governments allocate resources more fairly; encourage greater development aid for programmes benefiting older people ; lead to the training of health care personnel, employees, the judiciary and others involved in older people's issues; guide the private sector in how it can protect older people's rights.

On the contrary there are groups who argue against a separate convention for elderly people. First, they argue saying the entire human rights regime is based on the idea of the universality of rights. According to those who argue against a new convention, the rights of older persons are therefore sufficiently covered in existing international law (Frederic, M., 2011).

The soft law protection for older persons is strong under the existing international instruments. The UN Principles for Older Persons, the Proclamation on Ageing and the MIPAA and its Political Declaration provide enough protection. The focus of advocates of the rights of older persons ought to be on better implementation and respect for present conventions, treaties, principles and declarations (Frederic, M., 2011).

Drafting a convention is also costly and lengthy process. There are limits to the enforceability of international conventions, the accountability system is weak and there are no effective sanctions. The system that handles complaints and monitors the implementation of existing treaties is already under too much stress. UN member states are already obliged to submit many reports to UN monitoring committees and to deal with complaints and many are reluctant to commit to even further obligations.

### **2.2.5.2. Regional Human Rights Instruments on Elderly People**

At the regional level there are few references to elderly people.

#### **A. African Union**

The African Charter on Human and Peoples' Rights under its article 16 and 18 recognizes the basic, specific right of elderly persons to special measures of protection and security according to their needs, both physical and moral (ACHPR, 1981).

AU's endorsed Social Policy Framework and Plan of Action on Ageing by Heads of States in 2002. A Draft Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa is drafted by the Working Group on Older Persons and People with Disabilities in Africa, of the African Commission on Human and People's Rights. The Working Group is elaborating a Draft Protocol on the Rights of Older Persons which was most recently submitted to the 50th Ordinary Session of the African Commission (ACHPR, 2013).

#### **B. European Union**

European Social Charter (ESC) forwards the need for a system of social security and medical care and these rights are relevant to elderly people (ESC, 1961 as revised in 1996). There are also recommendations passed by the European Commission (CoF) on different issues concerning elderly. Recommendation No. 22 on the screening and surveillance of elderly persons suggests that all health care professionals involved with these tasks should receive training in geriatric medicine and gerontology (CoE, 1987). In 1994, Recommendation No. 1254 on the medical and welfare rights of the elderly: ethics and policies was issued (CoE, 1994). The Additional Protocol to the European Social Charter states that every elderly person is entitled to social protection. It provides that elderly people should have access to suitable housing and access to health care (CoE, 1998). Subsequent to the United Nations declaration of the year 1999 the "International Year of Older Persons" Recommendation No. 1428 on the future of senior citizens: protection, participation and promotion was developed (CoE, 1999).

In 2000, the Council comes up with the Charter of Fundamental Rights of the European Union that recognizes and respects the rights of the elderly to live a life of dignity and independence and to participate in social and cultural life. The Charter also entitled everyone to preventative

health care and medical treatment as provided for by national law (CoE, 2000). In February 2014, the Committee of Ministers adopted Recommendation No. 2 to member States on the promotion of human rights of older persons (CoE, 2014).

### **C. Organization of American States**

The 1948 American Declaration of the Rights and Duties of Man (ADRDM) states that all people have the right to be able to maintain their standard of health within the resources of the community or state. It also states that in times of old age, one is entitled to social security in order to maintain an adequate standard of living (ADRDM, 1948).

The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights states that elderly are entitled to social security in order to maintain an adequate standard of living (OAS, 1988). In 2012, the Organization of American States has prepared a draft convention on the human rights of older persons and it is still under negotiation (OAS, 2014).

### **D. League of Arab States**

The Cairo Declaration on Human Rights in Islam (CDHRI) addresses the issues of security and the means of providing basic needs that are essential concerns of elderly persons. The declaration recognizes that everyone has the right to health and medical care within the capability of each state; and the right to live in security (CDHRI, 1990).

The Arab Charter on Human Rights (ACHR) also establishes that every citizen of States in the League has the right to comprehensive social security. The charter recognizes that member states will also provide care for the aged (ACHR, 1994).

#### **2.2.5.3. Ethiopia's Human Rights Instruments on Elderly People**

National human rights instruments are important as it is the direct tool to ensure the protection and promotion of human rights of elderly people. The Federal Democratic Republic of Ethiopia Constitution, under its Article 9, provides that international agreements ratified by Ethiopia are an integral part of the law of the land. Furthermore, it notes that the third Chapter which is a human rights chapter must be interpreted in a manner conforming to the principles of the UDHR, international covenants on human rights and international instruments adopted by Ethiopia.

- a. **The FDRE Constitution:** The Constitution under its Art.41 (5) recognizes the rights of older people and stipulates that “the state shall, with available means, allocate resources to provide rehabilitation and assistance to the physically and the mentally disabled, the aged, and the children who are left without parents or guardian” (FDRE Constitution, 1995).
- b. **The Growth and Transformation Plan (GTP):** The GTP with the main goal of promoting the economic and social development of the country gives emphasis to elderly people under its social welfare program. Its main strategic direction is protecting the rights of and creating opportunities for participation of elderly people so that they contribute fully to the development process as well as to political, economic and social activities (MoFED, 2010).

The annual reports made by the Ministry of Finance and Economic Development state all together the number of beneficiaries for both disabled and elderly people and sometimes specific when it comes to persons with disability. But none of the reports show what has been specifically done in terms of protecting the rights of elderly and ensuring their participation.

Ethiopia has different policies that deal with social and other problems in the society. The Ministry of Labour and Social Affairs is one of the government executive organs that take the major responsibility in realizing the welfare of the society, including the elderly people. The Ministry of Labour and Social Affairs and other Ministries comes up with different laws, policies and action plans addressing and touching up on issues of the elderly.

- c. **The Developmental Social Welfare Policy (DSWP):** DSWP was promulgated in 1996 by replacing the 1994 National Social Policy. The DSWP took the first step in the country’s social welfare to deal with children, youth, women, elderly people and disabled people and the inherent social problems that are challenging them. The policy has the objectives to maintain developmental, preventive and rehabilitative welfare services (MoLSA, 1996).

As one of the social welfare concern of the country, the DSWP mentions the needs of elderly people. It acknowledges the great role played by elderly people in sharing their knowledge and lived experiences. Their social roles in counseling and mediating conflicts are also given recognition (MoLSA, 1996).

The DSWP advocates that arranging proper social and cultural environment for the participation of older people is very important. The policy stresses that strengthening the family is a basic system for ensuring the security and welfare of older people. It encourages the promotion of appropriate social security and assistance for older people that do not have any material and psychological support in their communities. The policy seeks for the enactment and enforcement of social security programmes to guarantee wellbeing of older people.

The policy recommends the creation of follow-up mechanisms to ensure that services aimed at ensuring the security and wellbeing of older people are inclusive. The policy also encourages and supports non-governmental organisations, voluntary associations and community action groups to establish services to assist and support older people. Community participation, partnership and coordination, research and capacity building are the strategies that are identified in order to accelerate the implementation of the DSWP (MoLSA, 1996).

In one way, the policy is appreciated for being inclusive. While on the other hand it is criticized for not giving the required value for existing and coming forward social and health issues like the impacts of HIV and AIDS on elderly people (HelpAge, 2009). The officials from MoLSA stated that the policy did not fully accomplish its objectives. The implementation is weak because of the poor collaboration between the concerned stakeholders, together with lack of the necessary budget. The fact that the policy is not integrated to community level is also another reason.

The policy's ability to address all citizens through its program is found to be minimal. And in addition, it does not have the appropriate system that encourages multi-facial relationship and collaboration between stakeholders. In order to make it updated with the current national and global situation, the DSWP is under revision with a draft Social Protection Policy. While DSWP focuses on service or welfare only, the draft Social Protection Policy comes with legal aspects, social safety net programmes and pension scheme.

**d. The National Plan of Action on Older People (NPAOP) (2007-2016):** NPAOP is one of the most significant frameworks that recognize the rights of elderly people in the country. It was developed in line with the UN Principles for Older persons, the Madrid International Plan of Action on Aging and the AU Policy Framework and Plan of Action.

Moreover, other government policies and strategies such as the Developmental Social Welfare Policy, Population Policy, Education and Training Policy, Health Policy, Women Policy, MDGs, the PASDEP and HIV/AIDS Strategy were taken into consideration in the course of developing the Plan of Action and given due attention in the implementation process (HelpAge, 2010).

It was necessitated by the rapid growth of number of elderly people and the number elderly who need support and assistance is increasing. The Action Plan was also required because of the need to implement the Madrid International Plan of Action on Aging and because of the need to have a focal body at national and regional level in order to coordinate the activities of different governmental and non- governmental bodies working on issues of elderly (MoLSA, 2007).

The objectives of the action plan are to: expand and strengthen services for older people based on community participation; encourage the participation of older people to make use of their rich experience in bringing about development; give attention to the rights and needs of older persons to make them part of the country's development plans and poverty reduction strategies; and identify issues related to older people and work on them by listing specific objectives and activities (MoLSA, 2006).

It also has the objectives to coordinate concerned government and non-government organizations in order to make them contribute their share in realising the objectives of the programme and facilitate conditions to solicit support from abroad through promoting the issues of older people of Ethiopia at the national and international level (MoLSA, 2006).

The National Plan of Action has identified key issues and activities. These are: health and well being, family and community care, the rights of older people, housing and living environment, social security, education and training, employment and income generation, poverty reduction, HIV/AIDS, gender and older people, food and nutrition, emergencies, protection of life and property as important strategic areas to advance the lives of older people. All these issues have objectives and detailed key activities (MoLSA, 2006).

The action plans' issue on health and wellbeing comes up with the objectives to enjoy an active and healthy ageing by expanding health education and disease prevention; strengthen basic health care services and facilities; and enabling older persons suffering from multiple diseases

and permanent injury receive long term treatment and care. While, the action plans' issue on rights of elderly has the objectives to properly understand rights of older persons; and enabling older persons exercise their rights (MoLSA, 2006).

Research, data collection, advocacy and awareness raising, implementation capacity, coordination, monitoring and evaluation are the major implementation strategies of the action plan (MoLSA, 2007). The officials explained that Ministry of Labour and Social Affairs developed an implementation manual for the National Plan of Action. The manual identified basic activities and the stakeholders that could work together with the Ministry.

The officials also said that a number of meetings were arranged with different stakeholder in order for them to take into consideration the needs of older people in their activities. A national implementation forum composed of different Ministry offices and agencies is established. Action plan implementation committees are also established at regional level.

The National Plan of Action is a very important mainstreaming tool to allow the Ministry to work in collaboration with other stakeholders. But on the other hand, the Ministry does not have the legal power to enforce the action plan by obliging the other stakeholders; therefore, the implementation is loss.

The implementation of the National Plan of Action requires the mainstreaming of the activities and the allocating the required budget government and non-government bodies government entities. And above all need strong enforcing and monitoring mechanisms.

NPAOP is left with one year of implementation. The Ministry noted that it is necessary to make amendments on the action plan for better performance following the problems observed during implementation as well as involve other key stakeholders which were not part of the initiative. For instance, it was necessary to involve the office of Ombudsman and the Ethiopian Human Rights Commission as it was vital for us to address the human rights issues of the older persons.

- e. **The Pension Scheme:** It was launched in Ethiopia by legal decree of 46/1961. The decree aimed at supporting government employees and their direct dependents in the time of their retirement, in cases of chronic health problems or permanent disability. The decree was amended by proclamation 209/63 and proclamation 5/1975. These

amendment proclamations were significant for the reason that they incorporated employees of government owned public enterprises and profit making organizations to the pension scheme (HelpAge, 2009).

In 2011, the Public Servants' Pension Proclamation No. 714/2011 was issued repealing the Pension Proclamation No. 345/2003. The pension scheme provides coverage for retirees, survivors, and incapacity and employment injury payment benefits. The beneficiary survivors could include children under 18, widows or dependent parents of a main breadwinner. The pension scheme also has the arrangement to continue giving the survivors or direct dependents of retired government employees after the death of the regular pensioners. Surviving widows and widowers are also entitled to pension payments as long as they have not re-married and surviving children continue to receive payments until they reach the age of 18.

The pension scheme was criticized for excluding private employees, self-employed and the unemployed. Now, the government introduced pension scheme for private organizations employees through Private Organization Employees' Pension Proclamation No. 715/2011. The employer and the employee contribute 11% and 7% of the salary of the employee, respectively. The coming in to effect of this proclamation is a significant move to be able to address a large number of people; and gives protection to elderly people who have been enrolled in private organizations.

But still, the self-employed and the unemployed sections of the society are not covered in the pension schemes. This makes a number of self-employed and the unemployed elderly people vulnerable to financial problems at old age.

**f. The National Health Policy:** It was issued in 1993. The general Policy stands are: democratization and decentralisation of the health system; development of preventive and promotive components of the health service; developing an equitable and acceptable standard of health service within given resource limitations to reach all segments of the population; ensuring the accessibility of health care to the entire population; development of needs-based capacity building initiatives; provision of health care for the population on a scheme of payment according to ability with special assistance mechanisms for those who cannot afford

to pay; and promotion of the participation of the private sector and non-governmental organizations in health care (TGE, 1993).

The health problems of elderly people are directly and indirectly addressed by this policy. The fact that the policy recognized the need to provide equitable and acceptable health care service for all parts of the country and specially providing support to those who cannot afford the medical expenses is very important for elderly people.

The policy indicates that emphasis shall be given to the control of communicable diseases, epidemics and diseases related to malnutrition and poor living conditions. And appropriate support shall be given to the curative and rehabilitative components of health including mental health. This is also a very important point to ensure health care of elderly people but the policy gives more emphasis to communicable diseases, while not giving attention to the common health problems of elderly people which are non-communicable diseases.

The policy indicates that community based and task-oriented training shall be given to the health professional. If health care needs of elderly are identified as areas that need special training, this shows that there is a possibility for the professionals to get trainings. Accordingly, this helps the health care professionals to enhance their capacity in treating elderly clients and it also helps the elderly who have difficulty going to health care centers to get treatments in their places or without going too far.

The policy identified priority areas that need special attention to their health needs. These are: the family particularly women and children, most neglected regions and section of the population including the majority of the rural population, pastoralists, the urban poor and national minorities, and victims of manmade and natural disasters. Elderly people could benefit from these expressions as they can be grouped in the neglected sections of the population. But elderly people are not in clear terms considered as parts of the society that need special health care attention. This arises from not understanding and not taking into consideration the health status and health care needs of elderly people.

On the other hand, this policy under its strategies state that inter-sectoral collaboration shall be given emphasis especially in the development of community based facilities for the care of the

physically and mentally disabled, the abandoned, street children and the aged. The aged are recognized when it comes to working in collaboration among stakeholders while they are ignored or are not made priority as vulnerable groups of the society that need special attention.

One of the strategies of the policy is to update existing public health laws and regulations and to develop new rules and regulations in order to help the implementation of the policy and addressing new health issues. Among the different measures, the government took the courage to achieve universal health care coverage through cost sharing between beneficiaries and government in the health sector. And among the existing sustainable health care financing mechanisms which enhance equitable access to improved health services through cross-subsidization, social health insurance is chosen which is beneficial to elderly people.

The government issued the Social Health Insurance Proclamation No. 690/2010. The objective of the social health insurance scheme is to provide quality and sustainable universal health care coverage to the beneficiary through pooling of risks and reducing financial barriers at the point of service delivery. The health insurance is mandatory to government employees, pensioners and private employees (Social Health Insurance Proclamation, 2010).

The proclamation requires that the beneficiaries should contribute 3 percent of their salary. But pensioners are excluded from contributing and government will cover their payment. The health insurance program will also cover families of the beneficiaries. In order for employees and pensioners to be beneficiaries of the social health insurance, they should be members of the scheme. The insurance scheme is administered by the Ethiopian health insurance agency (Social Health Insurance Proclamation, 2010). The Social Health Insurance arrangement is very supportive; and gives hope to elderly people especially to pensioners who cannot afford to cover their health care expenses through their pension income.

The National HIV/AIDS Policy was promulgated in 1998. It has the aim of providing an enabling environment for the prevention and control of HIV/AIDS in Ethiopia. Its targets are: establishing effective HIV/AIDS prevention and control strategies in order to limit the spread of the epidemic; promoting proper institutional, home and community based health care and psychosocial support for people living with HIV/AIDS, orphans and serving dependents, safeguarding the human rights of people living with HIV/AIDS and avoid discrimination against

them; and empowering women, youth and other vulnerable groups to take action to protect themselves against HIV/AIDS (National HIV/AIDS Policy, 1998).

HIV/AIDS affects all parts of the society including elderly people. Elderly people are affected by the virus in different ways. Even if elderly people are supposed to be cared at this time if their life, they have the responsibility to take care of their families especially their children who are victims of the virus. Because of lack of awareness as to how to protect themselves, elderly people are highly vulnerable to the virus. And they are also forced to look after their orphaned grandchildren together with their economical, psychological and social problems.

Even if the policy might have the possibility to cover elderly people through the vulnerable groups' category, the fact that the National HIV/AIDS policy does not specifically identify elderly people as priority while it specifically mentions women, children and youth as its priority target groups show that the impact of HIV/AIDS over elderly people is underestimated.

The right to access health care for elderly people is not properly recognized under the national human rights framework. The existing documents do not consider the current living situations of the elderly, and they are soundless that they do not show the urgency of the matter and invite for action. The framework is not strong enough to adequately protect the rights of elderly.

The researcher tried to find more literatures written on the rights of elderly people in Ethiopia but there were very few. This is also one gap identified by the research.

## **Chapter Three**

### **Access to Health Care for Elderly People in Addis Ababa, Gulele Sub-city**

This chapter addresses the central questions of the study specifically in relation to examining the availability of health care, the accessibility, the acceptance and quality of the health care provided for the elderly in the study area. This part also gives response to the research questions as to the provision of a special health care service for elderly people and their coping mechanisms.

The elderly people who participated in this study suffered from a number of diseases. The diseases related with eye, heart, nerve, ear, respiratory, asthma, joints of their hands & legs and gastric are among the prevailing ones. They believe that they are exposed to these diseases because of their aging, and from lack of having good access to health care services.

The United Nations Committee on Economic, Cultural and Social Rights assert that the right to access health care is an important feature of the right to health (ICESCR, 2000). The human rights to health care means that all services, goods and facilities must be available, accessible, acceptable and of good quality (OHCHR & WHO, 2008). The human rights principles: universality, equity, transparency, accountability and participation also apply to the right to health care. This research reveals that the elderly people are suffering from multifaceted challenges. The experiences of the elderly people will be examined one by one from the perspectives of the four related concepts: availability, accessibility, acceptability and good quality.

#### **3.1. Availability of Health Care**

The availability of health care is all about the availability of the necessary health care infrastructure, goods, and services. These infrastructures must be available in all geographic areas and to all. Therefore, the availability of health care refers to the existence of such health care infrastructures in a given area (NHeLP, 2008).

Reports show that in Addis Ababa there are 42 hospitals (36 private and 6 gov't), 53 Health Centers (all gov't), 700 health clinics from low to higher (all Private), 235 drug store, 293 pharmacies and 2 health posts both government and private owns. The data shows that the lion share belongs to the private health sector (Bureau of Finance and Economic Development, 2013).

In order to make the health service accessible to the population 50 health centers became operational. The city administration also spent over 550 million Birr for the construction and expansion of the health facilities. Gulele Sub-City has two Federal hospitals (Saint Paul and Saint Petros), one higher clinic, three health centers, six health posts and about 28 private clinics (ACB, 2009 as cited in Ephrem, S., 2010).

In Addis Ababa, the ratio of the overall population per hospitals is 1:65,196; clinics 1: 7,627; health posts 1:72,236; health centers 1: 76,062 and pharmacies 1:62,233. While in Gulele sub-city, the ratio of population per hospitals is 1:133,691, clinics 1:11,625, health posts 1: 53,476; health centers 1: 53,476 and pharmacies is 1:267,381 (CSA, 2007).

The Census indicates that the number of hospitals, clinics and pharmacy in Gulele sub-city is the least in number compared to the other sub-cities. In 2012/13, the Ministry of Health under its Annual Performance Report announced that the number of Health Centers in Addis Ababa raised its number to 62 (MoH, 2013). But the report does not show the distribution of these facilities throughout the sub-cities.

General Comment No. 14 issued by CESR in 2000, examined the right to health based on the availability of health care facilities, goods, services and programs. OHCHR & WHO also explain availability of health care facilities as referring to provision of adequate health care infrastructure such as hospitals, community health facilities, trained health care professionals and so on (OHCHR & WHO, 2008). Accordingly, the availability of health care to elderly people refers to the existence of hospitals and trained health care professionals, the provision of drugs and equipment that have the potential to address the health care needs of elderly people.

According to the Political Declaration and Madrid International Plan of Action on Ageing (2002), health care services need to comprise of the basic facilities to meet the special needs of the older population. One of the objectives of the National Plan of Action on Older Persons

(NPAOP) that was planned to be implemented between 1998 and 2007 is strengthening basic health care services and facilities. However, the Action Plan does not address as to what these services and facilities are. Rather, the Implementation Manual prepared by MoLSA for the implementation of the NPAOP indicates that facilities such as geriatric ward will be provided for elderly clients. According to the Implementation Manual that is meant to mainstream the action plan across different stakeholders, medical and health related responsibilities are assigned to the Ministry of Health under the supervision of the Ministry of Labor and Social Affairs.

All the interviewed elderly notified that there are no special geriatric hospitals, centers and/or geriatric wards that are meant to give medical services to elderly. They all stressed the fact that the health care professionals that treat them are not specialists on geriatrics.

I<sub>1</sub>, elderly man aged 70, said:

*“I have visited different hospitals and health centers but I have never been to and never heard of such special hospitals or special wards that exclusively give health care services to elderly people. Or maybe I don’t really know if there is one.”*

The availability of the necessary health care goods are also the necessary inputs to ensure the availability of health care for elderly people. Among these health care goods, geriatric medicines and medical equipments are found.

The NPAOP had the objectives to increase the supply of geriatrics medicines and medical equipment in quantity and quality (MoLSA, 2006). But the research reveals that the elderly are not getting these services because there are no such provisions at a national level. All the elderly responded that they use all the health care services together with the other patients as there are no special provisions for them. Both FGD 1 and 2 also confirm that there are no specialized hospitals or provision of special facilities meant exclusively for the health care of elderly people.

### **3.2. Accessibility of Health Care**

Health care must be physically and financially accessible for all sections of the society, including elderly and other vulnerable groups. Accessibility also indicates the right to seek, receive and pass on health related information in an accessible manner for all (NESRI, 2009).

Access to care should also be universal and protect everyone's health on an equitable basis. Facilities, goods, and services must be affordable and widespread for all and accessible where and when needed (NHeLP, 2008).

### **3.2.1. Physical Accessibility**

Physical accessibility refers to the geographic distance of the facilities. This research found out that in Ethiopia, specifically in Addis Ababa, there are no special health care provisions available to elderly people. Therefore, elderly are forced to use the existing facilities. Altogether, the availability of the existing facilities does not guarantee the accessibility of the health care for the elderly. Most of the facilities are not physically accessible for the elderly.

The distribution of services and the medical workforces differ from hospitals to hospitals. The health care professionals may not be able to provide the types of services required by many elderly clients. In such circumstances the patients are referred to hospitals providing such services. I<sub>2</sub> elderly man aged 87 said:

*“I do not get the medical treatment I need from the nearby available health facility. So, mostly I visit the centers just to get referral letters to other specialized hospitals.”*

I<sub>3</sub> elderly woman aged 60 also states that it is not easy for her to get health care services in the nearby facilities for serious health issues. As most of the elderly need special medical treatments, they all complained about visiting more than one health centers (private and government) that are found in places away from their homes, looking for medical specialist.

Physical accessibility of the health care facilities is very important factor for a person to ensure his/her access to the facilities. Because of the physical inaccessibility the elderly are exposed to extra cost of medication and transportation. They may not also have the ability or the courage to go and visit other health care facilities. Above all, the facts that they do not get the services in nearby health centers make them loose hope.

But then I<sub>6</sub>, elderly woman aged 67 stated that:

*“Compared to the earlier times, I can say that the health center is found near our village. It is only when I am referred to other hospitals for special treatment that I visit far health facilities.”*

The other problem is the fact that they need to wait for longer appointments. Furthermore, most of the elderly have emphasized that making appointments are complicated for them.

I<sub>4</sub> elderly woman aged 75 said:

*“I cannot visit a health center, identify which medication I need and make appointments to see a doctor, by myself. If I don’t have any one by my side it is difficult for me to do things alone.”*

The participants from the two FGDs being positive about the efforts to make health centers accessible to the society at local level, raise that this is not adequate compared to the necessities of the elderly who need specialized care without going so far from their locality.

Except for primary health care services, most of the elderly are not able to access the treatments they most needed from the health centers. The hospitals are not proportionally situated throughout the different sub-cities in Addis Ababa. And specialists are not equally distributed in all the hospitals. Therefore, either through direct visit or referrals, elderly people are forced to travel to some other public or private facilities that are found in a distance places.

Researches also identified that physical barriers to access health care and distance related barriers are one of the major limitations that plays role to the poor access to health care services of elderly people (HelpAge, 2010). Most elderly people also have limitations to access health care services because of the cost and time of travel to the health care facilities (Williams, 2011).

The physical inaccessibility of the health care facilities result in additional costs of transportation. It is observed in the city that getting transportation is difficult for all, which is worse to elderly. They are forced to use private transports, which tend to be expensive for the elderly who in most cases live in destitute conditions. Together with the physical accessibility, the availability of the means of transportation when needed and the affordability are some of the major outstanding challenges they are confronted with.

I<sub>2</sub> said he and most elderly have difficulty in moving from one place to another and pointed out that they often have hard time in accessing the available services:

*“Because I have heart attack and visual impairment, I cannot even walk from the door of my house to the main road. But I have to go and see a doctor. I try to reach the taxi with my legs shaking and my breath taken away. This is because if I do not go to the health centers with the help of other people, there is no one, no health professional to visit me back in my home.”*

The researcher also observed that this old man cannot go anywhere without the support of others.

I<sub>9</sub> elderly man aged 67, pointing out the problem with those who are not able to go to health centers added that:

*“Health care professionals that visit weak elderly people who cannot visit health centers for different reasons should be available just like the health care professional who make a home to home visit to help mothers and children.”*

The Council of Minister Regulation No. 299/2013 on Food, Medicine and Health Care Administration and Control, under its Article 51(2) clearly point out that medical services could be provided at the patients' home.

Though this is stipulated in the laws, none of the interviewees and respondents from the different offices mentioned that elderly who have limitation of moving benefited from this provision. The participants from the two FGDs, therefore, claim that there should be a means in which health professionals visit and treat weak elderly people at their home.

### **3.2.2. Affordability/ Economic Accessibility**

Health facilities, goods and services must be affordable for all. Payment for health care services has to be based on the principle of equity to guarantee that these services, comprising underprivileged parts of the society, are affordable for all. Equity stress that those who are financially weak should not be unreasonably burdened with health care expenses as compared to richer households (ICESCR, 2000).

Most elderly are said to be among the destitute part of the society and are financially weak. Facts show that older people normally fall into the severe poverty and they cannot afford basic health care, social services or housing (MoLSA, 2009).

Financial power and affordability of services and goods are very important in order to ensure access to health care. The expense for the health care services, i.e., diagnosis, laboratory, medicine and in-patient care have to be based on the principle of equity and whether privately or publicly provided, guarantee these services are affordable for all, including socially disadvantaged groups (Aytenuw, D., 2013). But, the costs related with health care are expensive and unaffordable for many of the elderly people.

Visiting private health centers is expensive for most of the elderly except for those who get support from their children and relatives. I<sub>5</sub>, elderly women aged 65 said:

*“I believe that I could get a better medication at private health centers but I cannot visit them because I cannot afford the costs.”*

Both the interviewees and the respondents from the FGDs also stress that both the government and the private health centers send them to other private laboratories that are very expensive. All the respondents reveal that they are very frustrated about their being repeatedly referred to other facilities.

Together with this, all the elderly raised the fact that they cannot afford the cost of the medicines. Pharmaceutical costs are also economic barriers to access health care. All the elderly said except for some types of medicines that are provided by the health facilities for free or cheaper price, they cannot afford to buy the medicines especially those that are prescribed to chronic diseases.

Although all parts of the society with lower income suffer from being able to afford the expenses of health care services, the case of elderly is more prevalent. This is because elderly face difficulty to earn income as a result of quieting their jobs for different reasons such as loss of physical strength, mobility, loss of vision, suffering from chronic diseases, and so on (HelpAge and Cordaid, 2011).

Most of the elderly respondents stated that they have been working until they got physical weak. Research shows that the existence or absence of social security in old age has significant impact

on the lives of the elderly people. Ethiopia does not have old age pension. The only social security provision in Ethiopia is the pension scheme, which non-government employees do not benefit from. Recently, employees of private organizations are made beneficiaries of the pension scheme. But, self-employed and the unemployed sections of the society are not covered in the pension schemes. This makes a number of elderly people vulnerable to financial problems at old age.

There are about half a million elderly people that are beneficiaries of the pension scheme (Fasil, N., 2010). However, it cannot cover their basic needs. I<sub>7</sub> elderly man aged 72, stated that he receives pension but the payment is insufficient (i.e., less than 300 Birr) to cover all his financial needs including health care needs. Therefore, all the interviewees and the participants from the FGDs identified the need for regular economic and social supports.

The National Health Policy underlines the provision of free health care to those who cannot afford to pay. Similarly, giving special attention to enable poor elderly receive free medical services through policy supported measures is one of the key objectives of the National Action Plan. But there is no special free health care service provision to elderly that let go the requirement for the provision of certificate proving their poverty status.

For a person to get free health care service, he/she should bring a certificate proving that person's poverty status from the local *Kebele*. Both the interview and the FGDs reveal that because of the processes in the *Kebele's* and elderly's physical inability to visit the offices when needed. The elderly are tired and not interested to frequently seek for the certificates. This directly inhibits them from benefiting from the free health care service provided.

#### **4.2.3. Access to Information**

The Madrid International Plan of Action on Ageing (MIPAA) states that there should be equality of opportunity throughout life with respect to continuing education and training. Access to information on health and health care issues is also a factor to insure access to health care. Information accessibility includes the right to seek, receive and impart information and ideas concerning health issues (ICESCR, 2000).

One of the objectives of the NPAOP on education and training is to enable older people to live properly by providing them access to education and training. Similarly, the Health Policy stipulates that health education shall be strengthened generally and for specific target populations through the mass media, community leaders, religious and cultural leaders, professional associations, schools and other social organizations for shaping attitudes of responsibility for self-care in health and assurance of safe environment; encouraging the awareness and development of health promotive life-styles and attention to personal hygiene and healthy environment; and enhancing awareness of common communicable and nutritional diseases and the means for their prevention (TGE, 1993).

The health education also aims at enhancing attitudes of participation in community health development; identifying and discouraging harmful traditional practices while encouraging their beneficial aspects; discouraging the acquisition of harmful habits such as cigarette smoking, alcohol consumption, drug abuse and irresponsible sexual behavior; and creating awareness in the population about the rational use of drugs.

Regulation No. 299/2013 under its Article 50 clearly stipulates that:

*“Any health institution shall have the obligation to provide health education and current information to clients.”*

But, it is found out through this study that elderly people’s access to training is very insignificant, especially on health care. With regards to getting trainings and education on health issues, the opinions of the respondents differ. Most of the interviewees and participants from the FGDs said that they do not get trainings on health issues in general, and specifically trainings that concern elderly people’s health. While some of the interviewees and participants from the FGDs mention that, together with the other parts of the community, they received trainings in relation to personal and environmental hygiene which help them maintain their health.

Till recently, awareness creating programs on HIV/AIDS did not consider elderly people because it was wrongly understood that the virus only affects the youth and the real fact was ignored by the responsible organs. The gap appeared because elderly people are not given proper attention in the health system. And because of lack of awareness elderly people are highly vulnerable to and are victims of HIV/AIDS.

### 3.3. Acceptability

Acceptability of health care services and goods is one of the factors that show accessibility of health care. The acceptance of the health care provided for the elderly is also addressed in this study. Acceptability refers to the shared understanding between the attitudes and beliefs of the users and the provider (Brigette, K. et al, 2007). Health care institutions and providers must respect dignity, provide culturally appropriate care, follow medical ethics and protect patients' rights (NESRI, 2009).

The participants from the FGDs support most of the interviewees claims that they are directly or indirectly told that most of the diseases originate as a result of aging. And this understanding or approaches of the health professionals make them loose hope in the health care system and increase their dissatisfaction.

During the research, the researcher learned about the dissatisfaction from the elderly side, on the one hand; and the existence of common understanding from the service givers that aging expose elderly to diseases, on the other hand. This result the current approaches of the health professionals towards the health of elderly people that do not take into consideration mental and physical wellbeing of the elderly clients.

But on the other hand, all the interviewees and participants of the FGDs assert that they are treated with respect by the health care providers and the other staff members of the medical institutions. And all said they never faced or noticed discrimination.

Over all it is observed that the elderly clients do not know or understand what the medical professionals' ethics are and they don't know their rights towards access to health care.

Except for few participants in the FGDs, the other interviewees stated that they never participated in elderly associations and on meetings arranged by the government. I<sub>2</sub> said:

*“I have never been to such meeting because I never received invitation. And I don't know what the associations are doing on our behalf. I don't see them bring any change to our life. Even if I am invited I don't think I will be going because I will not make a difference.”*

While I<sub>5</sub><sup>2</sup> said:

*“I know that there are some meetings in which elderly people are invited. But even if I want to go I can’t. One is because I have a mentally-ill son I need to take care of and the other is that I have a very bad, non-stop coughing that don’t allow me to stay on such gatherings for even few minutes. So, I prefer staying at my home.”*

I<sub>10</sub>, woman aged 64 added that:

*“The meetings I tried to attend deal with the issues of the society in general. I have never come across a meeting that is meant to deal with issues of elderly. We just attend the meetings, listen to what they say and get back to our home.”*

### **3.4. Good Quality**

Health care must be medically appropriate and of good quality and provided in a timely, continuous and patient centered manner (NESRI, 2008).

The research reveals that chronic diseases are common among the elderly people. This implies that they need timely, regular and continues treatment. But in fact elderly people are not getting timely, regular and continuous health care services. Long waiting times are the challenges faced by the elderly people in access to health care.

The National Action Plan has the objective to facilitate conditions for older persons to be given priority in getting medical services at a specially arranged schedule in hospitals and other health institutions. I<sub>8</sub>, elderly man aged 74 said:

*“We do not get priority at the health institutions. According to the orders of the card, we wait till our turn is up. Especially in hospitals, we could spend half a day or even a whole day waiting for our turn. If it gets worst, we can be given appointments for as long as a week or so. ”*

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<sup>2</sup> The woman had a bad cough with disturbing sounds. She even had difficulty in conducting the interview.

Discussing if they are getting a timely and regular health care service, one of the participants of FGD 1 also added that:

*“It is difficult for us elderly to get health care by the time we need it. One of the reasons is that the health centers do not work the whole week. The nearby health centers do not give service on weekends except for emergency matters. Therefore, when we need regular treatment on the weekends, either we have to visit other hospitals, mostly the private one. Or we are required to wait till the center is open on Monday”*

The long times that are spent waiting to visit health care professionals are barriers to ensure access (Sleap, B., 2011). This is a challenge for the elderly people to get health care service on a timely manner.

### **3.5. Elderly’s Coping Mechanisms**

Both the interview and the group discussions reveal that elderly people are suffering from health and other age related problems. Their health situation together with their aging makes them dependent on others. General Comment 19 recommend for noncontributory schemes to those who are outside the arrangement of contributory pensions and a system of compulsory old age insurance (CESCR, 2008).

In our country, the available pension scheme (i.e., arranged for public servants and recently for private employees) provides coverage for retirees, survivors, and incapacity and employment injury payment benefits. This arrangement excludes those that used to run their own business and those who do not work at all.

In situations where a formal social protection system is not available, elderly people will be forced to make challenging choices. Where situations allow them, they primarily choose to depend on family and other support mechanisms, while their other option is to face it on their own (Charles, K., 2013).

The national survey conducted by HelpAge International (2013) on *“The State of Health and Ageing in Ethiopia”* reported that among the elderly respondents who are dependent on other people’s support, 82 per cent were dependent on their children, while about 6 per cent and 5.24

per cent of them were dependent on their sons' or daughters'-in-law and on their grandchildren, respectively. The other 1.4 per cent was reported to depend on their neighbors or on the communities.

The report also shows that though the dependency of elderly on their neighbors and the communities is minor, it indicates the existence of the value of sharing among the community. It is further indicated in other studies that extended family is essential to give maintenance and create interaction with elderly people that has the potential to mitigate the lack of health care services (Brigette, K., et al, 2007).

The researcher realised that children are the main supporters of the elderly people. They provide them with shelter, food and clothing; and cover their medical expenses. Kifle, under his research emphasis that intra and inter-generational ties and ties between neighbors and the community are very important relationships especially at old age. He added that such affiliations will help them live in harmony and under protection (Kifle, M., 2002).

Except for I<sub>7</sub> who said he receives pension and I<sub>8</sub> who gets support from one local NGO, all the elderly under this research responded that they get support from their children and their relatives. I<sub>4</sub> pointed out that she would have been in a difficult situation had it not been for the support of her children and the other family members. She said she feels safe because she got her families on her side when she is in need.

*“I have my kids and my daughter-in-law that takes care of me when I am in need.  
If I had no children and the other family members, no one would take care of me.  
I would have been left over on bed.”*

Most of the elderly said that they are not getting the assistance they need in a sufficient manner. The participants from the FGDs, those who get support from their children said one of the reasons elderly are not getting enough support is that their children's income is very low and therefore, cannot fulfill what they need specially on health care. The other is that their children started their own families and are having difficulty to support two households.

Except for I<sub>3</sub>, none of the elderly participants are engaged in any activity that could earn them income. I<sub>2</sub> said:

*“I was Shemane<sup>3</sup>. I used to earn my own income from my own business. But now, I am very old that I cannot work anymore. So, I am dependent on my children.”*

Findings of MOLSA show that because of the fact that there is no access to social security to the elderly, elderly are obliged to retain in their informal works till they seriously got ill (MOLSA, 2011). By the time elderly people resign from their work, both the elderly themselves and their families’ loss their income. Therefore, elderly people need financial support for their living to fulfill their basic needs. But, elderly also need additional financial support as a result of their increasing vulnerability to diseases (Charles, K., 2013).

The above discussed barriers related with accessibility, availability, acceptance and quality of health care provision hinder the right to access health care of elderly people. As a result, the elderly are forced to take different measures and make decisions. From the interviewee and the FGD, the researcher understood that the elderly people tend to use traditional medicines, holy water and *emnet* (holy soil) as a coping mechanism to the problems they are facing.

One of the elderly women I<sub>3</sub>, let alone affording her medical expenses, she got a problem leading her life. She lives alone with no support from any one. Therefore, she is forced to keep working for survival. She said:

*“I sell vegetables and charcoal at gultit<sup>4</sup>. The income I earn from this cannot cover my medical expenses and all the things I need, including food and clothing.”*

It is commonly observed that elderly people in Ethiopia are forced to keep working at their times of rest because the social security or the pension scheme do not make all elderly beneficiary.

The elderly seem to lose courage to go to health centers unless they badly suffer from the disease and/ or are forced by their families or neighbors. I<sub>3</sub> expresses that:

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<sup>3</sup> *Shemane* is the Amharic term to weaver.

<sup>4</sup> *gultit* is an Amharic term for small local market areas for vegetables, usually found on the side of streets.

*“I usually use traditional medicines and holy water when I feel sick. I can find traditional medicines and holy water anytime I want them with no cost to both, or cheaper expense to traditional medicines or treatments.”*

Poverty is also identified as one obstacle to secure old age (John, 2003 as cited in Fasil N., 2010). Hutton David under its study on elderly stated that:

*Older people’s health may also be compromised by poor diet and nutrition. A study in central Ethiopia found that 67% of older people were malnourished; a third of these were severely malnourished. Malnutrition’s causes may include poverty, responsibility for supporting grandchildren, living alone or age-related disabilities such as immobility, blindness and/or loss of teeth. During emergencies, older people’s vulnerability to hunger is often heightened by inaccessible food distribution points, difficult-to-digest foods, inability to prepare foods and many older people’s tendency share scarce food rations with family members (Hutton, D., 2008).*

World Health Organization reports also show that elderly people, especially in developing countries, are vulnerable group of the society that face severe hardships among which is poor diet (WHO, 2004). I<sub>10</sub> stated that:

*“I am not observing any improvement on my health situation. In order to take the medicines prescribed, we need to eat properly; otherwise it is causing us another disease. Therefore, I prefer not to take these medicines and to use tsebel and traditional medicines.”*

A national survey conducted by HelpAge International (2013) also stipulated that one of the major reasons for the elderly not to regularly visit the health centers and not taking medical treatment is the lack of trust in the health care service (Help age, 2013).

Similar to the other interviewed elderly people, one of the elderly respondents I<sub>5</sub> stated that:

*“I am tired of spending money on a medication that brings no change. My children take me to church to apply tsebel and eminet when we loss hope on the medication.”*

Lack of information about available services can also be a barrier and adversely affect elderly people's access (Sleap, 2011). This implies that the provision of basic information on the available services and facilities could help ease and better serve elderly people in process of their access to the services.

But, most of the elderly stated that they received no support from others including; government, NGOs, community and others. One of the elderly woman, I<sub>4</sub> said she does not know about the provision of support by other organs; and if others are getting support. While on the other hand, I<sub>8</sub> stated that he himself receives support from one local NGO. Most of the elderly do not have enough information regarding the different forms of support being provided by different organs.

## Chapter Four

# The Role of Government and NGOs in Enhancing the Elderly's Access to Health Care

Government and NGOs have their own role in promoting, protecting and fulfilling the rights of elderly people. These organs also have the responsibility to ensure accessibility, availability, acceptance and quality of health care for elderly people. This part of the study will try to analyze existing health care programmes and services that have impact on the right to access health care of elderly. It will also identify gaps between existing programmes and actual needs and analyze planned health care service and assistance programmes by the government and NGOs.

### 4.1. The Role of Government

Governments need to incorporate the principles of independence, participation, care, self-fulfilment and dignity of elderly persons into their national programmes (UNGA, 1991). In order to make elderly part of one's development strategies and plans, the Proclamation on Ageing demand policy makers for the provision of national initiatives on ageing. Basically, the proclamation aim for policies which boost the role of government and non-governmental organizations to work together in the progress of primary health care, health promotion and self-help programmes for the elderly (UNGA,1992).

The principle of *independence*, one of the UN Principles stipulate that indepedece could be viewed from the perspective of access to basic need and health care to the elderly. Inorder for elderly to excersise their right to access health care, elderly need special provision of services i.e., specialized hospitals/wards, geriatric medicines, trained professionals and so on.

However, Ato Isayas from the MoH revealed the non-existence of special hospitals and/or wards that are meant to treat elderly on special manner. It is explained that a holistic health care service is provided by the government directly through regular facilities, and indirectly by delegation. The Ministry has limitations in accessing all parts of the society for every health care need. The Ministry together with giving medical services in the public health facilities supports

professional associations and NGOs. The official said that even if the system did not come up with a special health care provision to the elderly it recognizes and supports NGOs like the Macedonians Humanitarian Association<sup>5</sup> through budget and other assistances.

The Ministry also signs Memorandum of Understanding with volunteering medical professionals teams that come from abroad to give medical service to patients, among which elderly are beneficiary. For instance, there are teams that repeatedly visited Ethiopian elderly and make surgery, especially on eyes. The ministry and other Ethiopian health care professionals assist the teams through provision of facility and other supports. Furthermore, he mentioned that the Ministry is planning to establish wards for special care of elderly people.

The governments' health care priority is on the prevention of diseases. The official from MoH said:

*“The health care needs of elderly mostly arise from chronic diseases and not from communicable diseases. Till recently, chronic diseases were not that prevalent over the country, so were not given much attention.”*

According to the official, the overall number of medical specialists on chronic diseases in the country is very small compared to the needs.

The Ministry did not so far conduct any research on the health status and health care needs of elderly. Accordingly, it is expected that the MoH does not and will not be able to understand the health status and health care needs of elderly unless it carries out studies or refers to the studies conducted by other organs.

In order to address those who cannot physically access and/or who do not visit the health facilities for different reasons at local level, the government launched the Health Extension

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<sup>5</sup> The Macedonians Humanitarian Association (MHA) is an indigenous non-governmental, non-profit and independent organization, founded on January 2010. The purpose of MHA is to support elderly people and people with disabilities who otherwise have no means of survival by providing them with shelter, clothing, food, and other basic services. The organization is an Ethiopian Resident Charity under the legal supervision of the Ethiopian Federal Government Charities and Societies Agency and headquartered in Addis Ababa, Ethiopia (MHA, 2012).

Program (HEP) in 2003; and inter into operation between 2004 and 2005 (Hailom, B., 2011). The HEP is a community based strategy that facilitates to deliver preventive and primitive services and find solutions at community level. The program was expected to help reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases. The program realizes the participation of the community in the process of creating awareness, behavioral change, and community organization and mobilization. In addition, it moved forward the service of health care facilities by filling the gaps and creating a link between the community and health care facilities by using Health Extension Workers (HEW) (MoH, 2014).

In terms of ensuring primary health care need of the society, the role of HEW is significant. The official from the MoH pointed out that:

*“The main targets of these HEW are mothers and children. But still, as they are visiting the whole family, there is this chance that members of the families who are elderly could get the services provided through the HEW.”*

The other principle of the UN Principle, the principle of *care*, indicates the fact that elderly people should be beneficiaries from family and health care provisions (UNGA, 1991). However, the role of HEW is insignificant when it comes to elderly people. In addition, there is no community based health care program that addresses the health care needs of elderly people. This is because elderly people are not identified as part of the society that need special health care provision.

Except for mothers and children, there is no practical arrangement to address the rest of the society who cannot access health care services. The other part of the society including elderly people can access the basic services only if they physically visit the facilities.

Though the elderly did not directly refer to HEW, they reflect that there is a need to make available health care programs in which health professionals make a home to home visit and give treatment to weak elderly people at their convenience.

In terms of finance, the government finances the health care service through provision of exempted service and fee waiver. In the exempted service, the government covers the cost of expensive treatments and medicines such as HIV, Malaria, and Tuberculosis. These are very

expensive treatments that cannot be afforded by individuals. Therefore, the government provides these services for free. The government also provides free service to maternal and newborn health services.

While fee waiver scheme is a mechanism through which citizens who can present evidence documenting their inability to pay for their medical expenses are entitled to free health care service, and any authority that provide waiver certificate is supposed to cover costs incurred for the service provided.

Regardless of the discouraging processes to get the certificate that proves the status of the elderly as poor, some of the elderly respondents stated that government is promoting for them to properly use the provision of free health care. They can obtain the certificate only if they apply and prove their condition. Though it is not meant to separately address the destitute elderly people, there is a possibility in which they can benefit from the free health care service provided by the government for all the poor parts of the society.

The respondent from the MoH reply that, as much as possible, especially painkillers and antibiotic are made available to most clients for free. And, added that treatments for HIV/AIDS, Malaria, and Tuberculosis are made available for free for any parts of the society regardless of their financial capacity. While on the other hand, clients' especially poor elderly suffer from the inaccessibility and expensiveness of the medicines that are prescribed for their treatment.

To address the financial barrier and ensure a more equitable financing mechanism, the government of Ethiopia adopted community based health insurance for the informal sector, and social health insurance for the formal sector including pensioners. A pilot project is started in some parts of the country (i.e., the Amhara Regional State) but then it will enter into operation throughout the country in a while.

MoLSA has programs through which poor older persons who are leading their families at a subsistence level are financially subsidized at a monthly basis. But due to budget constraints the majorities are not included in the program.

Similarly, Ato Dagachew from the Office of Labour and Social Affairs of Gulele sub-city said that their office has got plans to identify destitute elderly people that need help and provide them

support on different aspects i.e., them with food, clothing, consultation and other assistances including access to health care. Yet, he disclosed that there are no measures that are taken to work in collaboration with the health office of the sub-city. But, it is stated that the Office has included the need to work together with the Health Office in their annual plan.

The respondent from the Health Office of Gulele Sub-city, in general, responded that there are no arrangements to separately ensure access to health care of elderly people. It is rather claimed by this officer that in situations where they need information on elderly people, they cannot get full-fledged information on the number and status of elderly people in the sub-city. The other gap that is identified by this research is the lack of proper documentation of updated data on the status of elderly people.

The UN Principles for Older Persons also promotes the principles of *independence*, which includes the provision of education and training (UNGA, 1991). However, the Official from MoH explained that they never had plans on giving training or providing education for elderly on health related issues or for others on health care issues of elderly. Likewise, the respondent from the Health Office of Gulele Sub-city pointed out that they never identified elderly people as target groups who need training and education on health.

Mr. Damitew from MoLSA and the Mr. Dagnachew from Labour and Social Affairs Office of Gulele Sub-city stipulated that it cannot be said trainings are given in manner that could address majority of the elderly group. They said the only way they can pass their messages to the elderly is when they have meetings through their associations and at times of celebrating elderly's day. Once a while, awareness creating programs and trainings are arranged on HIV/AIDS, hygiene and self-care issues.

They said their training arrangements made their focus on organizing the elderly in small scale cooperatives and on income generating activities. They understand that elderly people lack access to adequate information on health related issues. They also underline that they did not so far tried to reach those who are not able to come to the meeting which they said should be given attention in the future.

According to NPAOP, elderly people need to get proper respect so that they can lead a healthy and happy life. Explaining if health professionals respect dignity of elderly clients and follow

medical ethics, the respondent from the MoH pointed out that, there are medical professional's ethical standards in which all health professionals are expected to strictly comply with. In addition, there are patient grievances handling committees in each health care facility that receive and investigate complaint over service delivery, including ethical issues. In situations where ethical standards are found to be violated, they will be held accountable and corrective measures will be taken. But, they pointed out that, so far, they never received reports of ethical issues that go against the medical ethics and disrespect the dignity of elderly people.

Elderly people should be made active participants in the formulation and implementation of policies that directly affect their welfare (UNGA, 1991). In terms of ensuring transparency, accountability and participation of their stakeholders, which they call the public wing, the government health care facilities conduct four meeting in a year. The society also participates through Community Conferences. It is observed by the researcher that there are also suggestion boxes in every health facility that give users the chance to communicate their concerns. In addition, customer satisfaction surveys which give insight on the satisfaction level of the clients are conducted. But these processes and arrangements do not show if elderly people have the awareness and the access to participate on such events and communicate their dissatisfaction.

The official from MoLSA stated that elderly associations are one of the members of the public wing forum. Elderly people participate through their associations when plans are prepared and performance reports are presented. However, these arrangements do not make sure the participation of a large number of elderly. The Labour and Social Affairs Office of Gulele Sub-city had included the plan to organize annual meeting for the elderly association of the sub-city under its annual plan.

On the provision of culturally appropriate care, the official from MoH first made a point on the culture of the people towards using the accessible health care facility. He said:

*Even if it is improving these days, the culture of going or visiting health centers in our society specially the elderly ones is very poor. This is because they tend to religious and traditional treatments. Most of them visit to the medical centers after they got weak which complicates the health care service and result in dissatisfaction of the clients. Had they*

*visited the health centers in earlier stage, they could have got a medication on time, minimizing the level of suffering.*

But on the other hand, both the respondents from the MoH and the health center assert that they respect and value the culture of the society in using other health care options other than the formal health care services. There is lack of awareness among the society as to the fact that, where appropriate, they can use both the medication provided by the formal health care system and the traditional and religious ones at the same time.

Furthermore, they assert that there is both lack of awareness and training from the health care professionals side in positively viewing and promoting the use of traditional and religious treatments alone or together with the medicines or treatments prescribed by the health care facilities.

Explaining the relationship between ageing and health, the respondent from the health center said:

*“Aging gives rise to the level of vulnerability of the elderly people towards diseases especially to the chronic ones.”*

The official from the Health Center said that in the process of giving health care services, some people are given priority according to the severity of the pain and weakness of the patient that include elderly. But from the researchers’ observation, unlike some service giving institutions, there are no notices posted in the health center to give priority to elderly people. The researcher also observed that the buildings in the health institution did not take into consideration weak elderly people who have limitation in using the buildings.

Accessing health care in a regular and continues manner depends on the availability and affordability of the health care, on the existence of home based care, on the awareness of the elderly themselves, and so on. Replying if the health care services provided are off appropriate and good quality, the respondent from the MoH stipulated that:

*It cannot be said that the health care services provided are of good quality, and the services are timely and patient centered. The quality of the health care provision should be seen from the countries overall economic status. With all the efforts to ensure access*

*to health care to all parts of the society, we still have a lot of way to go with delivering quality service. Most of the medical instruments are outdated, so are on the process of being changed and replaced with latest equipment's.*

It is also noted that the Health Sector Development program IV that will be implemented for the next five years will focus on quality. Building specialized hospitals and expansion works on the existing facilities are the next targets to be achieved. It is believed by the researcher that through this quality infrastructure, the special health care needs of elderly will be taken into consideration and be addressed.

The MoLSA, in a very informal and general manner, tried to come up with elderly care givers service standard to ensure health care, food and psychological supports are given with quality standards, and to control the application.

In terms of ensuring the availability of trained health professionals, which is one criterion for assuring quality, the NPAOP had a plan to develop a curriculum aimed at increasing the number of professionals in the field of ageing to deal effectively with health problems of older persons.

Let alone increasing the number of professionals in the field of ageing, the respondents from the MoH, MoLSA and the Health Center assert that there is no one single health care professional or informal care giver that specialized on health problems of elderly. Even short trainings are not given or arranged to the health professionals, to informal care givers and social workers in relation to health care issues of elderly.

The official from MoLSA said that even if the social workers in the Ministry did not get such special training on elderly, they are expected to have the awareness on the situation of elderly as vulnerable groups from their educational background.

If there are no professionals in the field of ageing, there is no doubt that the access to health care issues of elderly will not be dealt with properly. As chronic diseases are becoming common among the society and especially with elderly, the respondent from MoH said the Ministry will plan to conduct need assessment. And, depending on the extent of the need, specialists will be trained in the future. There is no doubt that it is necessary to train health care professionals, informal care givers and social workers, at least with short trainings.

The respondent from MoLSA stated that the government provides institutional care centers for homeless and helpless elderly people. These are Kaliti Institutional Care Center for the Elderly (Addis Ababa), Beteselehome Home for the Aged (Debre Libanos) and Abrha Bahta Home for the Aged (Harari). These institutions provide them with shelter, food, clothing, health care services and recreational facilities.

In order to solve these deep rooted and interrelated problems of elderly people, MoLSA is working on a project to build the first Model Elderly Center in the country, in Addis Ababa, Yeka Sub-city. It aims at giving a holistic service where different facilities are provided.

The center will have its own clinic that gives free health care service for those who are financially weak. Elderly health care professional will also get the opportunity to be employed. Above all this clinic will work on identifying the diseases that are prevalent over elderly people and will prepare the list of geriatric medicines. It aims at providing both traditional and modern health care service. It also will collect data on health status and issues of elderly. It will also be an institution that will strongly suggest for the establishment of specialized geriatric hospitals, geriatric posts and wards at all level.

The principle of self-fulfilment from the UN Principles for Older Persons claims that educational, cultural, spiritual and recreational resources should be available for older persons. These resources will help them get the chance to the full development of their potential. But the respondent from MoLSA indicated that most families and support centers donot realize non-material needs of elderly people. He said:

*Families and supporter after providing them with their food and clothing let them be idel. Specially families make them keepers of their homes. This expose them to stress. There are a number of elderly who have a great deal of knowledge and life experience. They want to share it and they need to entertain.*

In order to solve these and other concerns, the center will have meeting hall, Gymnasium, cafeteria with indoor games and training rooms on income generating activities. It also will have guest houses to give services to elderly people who come from the different parts of the country for different reasons. The beneficiaries of this center will be elderly people who are pensioners from all over the country. The Ministry took over the site from the Addis Ababa City

Administration and is working on the design of the building. The project is meant to commence by the end of the budget year. This center will serve as a model to other Regional States to establish such elderly centers.

It is also emphasized by the respondent from MoLSA that donors do not often support elderly in their policies. The funds that are available from the fund raisers are mainly spent on communicable diseases and for child and maternal care. Therefore, associations and project working on elderly people lack funds.

But this does not relieve the government from the responsibility of allocating a proper budget to ensure the implementation of all the promising plans on the papers. Not fulfilling the entire obligation results in violation of the rights of elderly people in the country. The government also has the obligation to supervise the activities of NGO's that are operating in support and care of elderly, and the government should assist them in their operation.

These government organs operate in collaboration with other government and local and foreign non-government organizations. But the research reveals that these government organs do not have or arrange regular meeting or workshops to discuss with the stakeholder on current issues and future activities. Some of the NGOs that work with the government offices are HelpAge International, Macedonian Humanitarian Association, Eneledada Elder People Association Yewedekutene Enanisa and Kibre Aregawuyan Migbare Senay Dirijit.

#### **4.1.1. State Obligations**

A State has four human rights obligation towards its people. These are the obligation to respect, to protect, to promote and to fulfill which also apply to the right to access health care. The obligation to respect obliges States to refrain from interfering directly or indirectly with the enjoyment of the right to access health care. The obligation to protect requires States to safeguard and take measures against others who interfere with the right to access health care. The obligation to fulfill entails States to take appropriate legislative, administrative, budgetary, judicial, promotional and other measures to the realization of the right to access health care (UNHCHR, 1993).

Legislative measures are one of the fundamental actions that should be taken by a government in the effort to ensure the right to access health care. The Second International Plan of Action on Ageing urge that policy formulation and implementation are very important factors to advance health and welfare of elderly. It is clearly stipulated in the Madrid International Plan of Action that:

*The growing need for care and treatment of an ageing population requires adequate policies. The absence of such policies can cause major cost increases. Policies that promote lifelong health, including health promotion and disease prevention, assistive technology, rehabilitative care, when indicated, mental health services, promotion of healthy lifestyles and supportive environments, can reduce disability levels associated with old age and effect budgetary savings.*

Ethiopia is a party to the core UN and regional human rights instruments. Ethiopia was also participant in the first world assembly on ageing, which was held in Vienna, Australia in 1982. Ethiopia gave recognition and participates on the International Day of Older Persons, which the UN introduced. The Ethiopia also participated on the expert meetings to develop the OAU Policy Framework and Plan of Action on Ageing, in South Africa 2002.

The right of elderly people is recognized under the FDRE Constitution. The Constitution clearly specifies that the state have the responsibility to provide rehabilitation and assistance to the aged with available means by allocating proper resources (FDRE Constitution, 1995). The Constitution also provides that the Chapter that deals with fundamental rights and freedoms should be interpreted in a manner conforming to the principles of the UDHR, international covenants on human rights and international instruments adopted by Ethiopia.

Accordingly, all the international instruments adopted by Ethiopia equally apply to elderly people. Though the human rights instruments that specifically deal with elderly people are not binding instruments, the Ethiopian government showed its compliance by utilizing these non-binding instruments as a benchmark to enact the National Plan of Action on Older People.

The right to access health care for the elderly is jeopardized because of the non-existence of binding legislation on rights of elderly. In Ethiopia, there is no any binding legislation that exclusively deals with issues of elderly. However, there exist the Public Servants' Pension

Proclamation No. 714/2011 and Private Organization Employees Pension Proclamation No. 715/2011, through which the pension schemes provide coverage for elderly retirees, survivors, and incapacity and employment injury payment benefits. Nevertheless, the self-employed and the unemployed sections of the society are not covered in the pension schemes. This makes a number of self-employed and the unemployed elderly people vulnerable to financial problems at old age.

The major policy measure taken by the government that addresses the rights of elderly people in the country is the National Plan of Action on Older People (2007-2016) which was developed in line with the UN Principles for Older persons, the Madrid International Plan of Action on Aging and the AU Policy Framework and Plan of Action. Though, the Action Plan and its implementation manual cannot be said to have a legislative value.

The non-existence of legislative framework obviously results in not protecting, promoting and fulfilling the human rights of elderly people. This is because the introduction of set of norms and standards for the access to health care of elderly people will at least help in ensuring protection and promotion of elderly people's right. The lack of specific policy causes problems on prioritization and maximization of scarce public resources and support systems in the provision of the best possible care for elderly people.

The absence of any legally prescribed mechanisms on the standards of geriatric care gives a freedom to health facilities and caregivers to act with feelings of empathy and not logically in the process of giving health care. In the absence of any law on geriatric care, there is no guarantee for the elderly to be treated with the standards of human rights.

The development of a comprehensive community based elderly health care service that is ensures access to health care of elderly people; and integrating it into the general health care service could have been advanced by a comprehensive elderly policy. A policy framework could have a direct impact on the respect, protection, promotion and fulfillment of the human rights of elderly people.

The general recommendation adopted by the Committee on CEDAW, on older women and protection of their human rights also gives guidance to State parties on the inclusion of the situation of older women in their reports on the implementation of the Convention. Among other

things, the Committee gave number of recommendation on issue of health and recommends that States parties should adopt a comprehensive health care policy aimed at protecting the health needs of older women. The National Plan of Action conform the need to provide special health care for elderly women, which is not practical so far.

The Health Policy of Ethiopia also clearly stipulate that the policy should ensure affordable and accessible health care to all older women through, the elimination of user fees, training of health workers in geriatric illnesses, provision of medicine to treat age-related chronic and non-communicable diseases, long term health and social care, including care that allows for independent living. But no action or measure is taken to comply with these obligations. This is therefore a failure to fulfill one's obligation towards health care services for elderly women.

From the administrative measures aspect, MoLSA, the responsible organ to supervise and support the implementation of the Action Plan, does not have authority or power over the other government institutions and NGOs so as to comply with its duties. The fact that the state organs or agencies are not given direct obligation by binding legislation compromise the respect for the human rights standards of elderly people. Consequently, the plans to come up with facilities, i.e., hospitals, health centers or wards, geriatric medicines, and trained professionals to ensure the availability of health care for elderly people are left in paper and their implementation is very loose.

There are no specialized hospitals or even wards for geriatric care; and there no physicians or informal care givers who specialize on geriatrics or at least took short trainings which has a huge impact on the rights to access health care of elderly people. This is clear human rights issue. In order to protect and fulfill the right to access health care of elderly people the recognition and inclusion of geriatric care in training curricula for all health professionals is very important.

Budgetary actions by a state are also part of the State's obligation to fulfill the right to access to health care. The fact that budgets are not allocated for geriatric care shows a substantial gap between the high demand for geriatric care and the fact that the demand is not recognized. This also shows the concern given to geriatric care services compared to child and maternal care is minimal. The non-existence of budget allocated for geriatric care in fact limits the expansion of facilities for geriatric care and the development of the human resources.

The Committee on ICESR emphasis that, in contrast with richer parts of the society, particularly poor households should not be unreasonably imposed with expensive health expenses. Most elderly are among the marginalized parts of the society who cannot afford to pay for their basic needs.

The fact that elderly people have poor access to health care because they cannot afford the medical expenses could indicate that the state did not comply with its obligation to practically provide a pension scheme and social security program to ensure and enable that all elderly people who are in need are in the position to fulfill their basic needs.

The right to social security or social protection is a universal human right that is acknowledged by major international and regional instruments. States should ensure the right to social security through allocation of adequate budget. Social security is a very important human right especially at old age (Charles, K., 2013). Social protection arrangements allow states to realize their obligations at the minimum to ensure the economic, social and cultural rights. Social pensions also support the economic needs of a society specially the needy ones.

General Comment 19 of the Committee on ICESCR, request for non-contributory pension schemes to those who are not covered in the contributory pension's arrangement (CESCR, 2008). This interpretation by the Committee helps to consider elderly people in the informal sector. And specially, as most elderly women in developing countries, including ours, make their living working in their homes and engaged in informal or part time works, this Comment is very significant to ensure their social security rights.

The State has an obligation to provide services for the health needs of its people but it is clear that access to health care for elderly people is poor. Equal access to health care requires States to guarantee access to health care facilities to individuals without sufficient means, as well as to prevent any discrimination in health care provision (CESCR, 2000). The findings of this research show that elderly people are not in a position to access health care services on an equal basis with other persons. This could amount to discrimination among elderly people based on age (CESCR, 2009). Promoting the rights and welfare of elderly is also another obligation of the government. However, the measures taken in terms of promoting welfare of elderly is very minimal.

In general, the researcher observed that this research helped in showing the gaps and motivating the different officials to further assess the needs of elderly; and to take further actions to guarantee access to health care need of elderly and realize the human rights of elderly people.

However, even if the government is the first responsible organ to fulfill these obligations, other private organs should also take their share. Therefore, the MoLSA is preparing a draft on Corporate Social Responsibility through which private organization will be expected to participate in enhancing the life of their surrounding society. The document is said to be open for discussion among stakeholders.

## **4.2. The Role of NGOs**

The government has a primary significant role in protecting the rights of elderly, in general, and particularly, in guaranteeing their right to access to health care. Similarly, NGOs and Civil Society Organizations are also expected to be engaged in supporting vulnerable groups like elderly people. But NGOs and civil society organizations are not considerably taking part in providing health care services for elderly people. For the purpose of this study, the researcher identified one NGO named Eneredada Elder People Association that support destitute elderly people.

Eneredada Elder People Association is an Ethiopian resident charity association which was established in 1997 G.C with the objective of making destitute and needy elders and their family members, self-supporting and self-respected citizens.

It operates in Gulele, Arada and Addis Ketema sub-cities. It provides support for needy and destitute elderly people who have no family support with basic need items like food supply, clothing, day care services, recreational service, psycho-social support, medical and income generation activity. It secure its fund from international and local donors, fund raising programs, sales of goods produced by the elderly and the use of recycling of different used materials, and now planning to expand its operational intervention areas to additional sub cities in Addis Ababa.

The Eneredada identify and select the elderly by contacting the *kebele* administration and by conducting home-to-home visit. Sometimes, the elderly themselves go to the association to seek

for support. They have four types of support programs. These are cash transfer, Group Income Generating Activities (IGA), Ration and Individual IGA. The cash transfer program permanently provides money to some elderly.

Through the Group IGA, the association provides them with capital both cash and/ or machines i.e., bread and *enjera* baking machines. And in collaboration with the local *kebeles* and *woredas*, it facilitates the provision of working place to the group of elderly. A total of eighty two elderly (73 women and 9 men) are beneficiaries of the Group IGA.

The Individual IGA program similarly provides individual elderly a capital to start their own business, so that they can change theirs and their families' life. This program covers one hundred and three (92 women and 11 men) elderly. Each are given a maximum of 4000 Birr as initial capital to start their business.

The Ration program supports the destitute elderly through kind, i.e., flour, soup, food oil, clothes. They also cover the cost of the rent of their house and repair their houses, and cover their medical expense. These elderly are served with lunch three days a week in the center. In addition, clothes are distributed to the elders and their grandchildren on a quarterly basis and during selected holidays. This program benefits Fifty (35 women and 15 men) elderly. While, the Cash Transfer Program address twenty elderly (15 women and 5 men) in which each receive 400 Birr.

The number of women who get support from the Association outnumber that of men, but the representative of the Associations' communicate that they do not have a program or intention to give priority and special support to women.

The Association's major sources of fund are HelpAge International, Ethiopia Aid and CEDA. Different Embassies also support them with finance and give them used materials i.e., electronics, computer and so on. And the Association sells them through auctions. There are also individual members who pay monthly fee starting from Ten (10) Birr to any amount they can afford.

In addition, in order not to make the elderly feel like they are dependent, the elders engage in spinning, weaving and produce traditional garments, prepare spices "*Balitina*" and mats. The

products will be sold and used as an income to them. The researcher also observed and visited the activities and products of the elderly. Volunteers in the Association also organize bazaars for income generating.

The association believes that together with their poverty status and due to aging, elderly are exposed to different types of health problems. Therefore, helping elderly to have access to health services is found to be very important. Accordingly, the association has first aid clinic where voluntary nurses give services. The elderly permanently get medical tests every two month. In situations where they need higher treatment the association through referral send them to Saint Joseph Charity Center where they can get a better medical service.

Saint Joseph Charity Center is a center that supports the association by covering the cost of medication up to 3,000 birr per person. And still even if they get the examination for free, they need to cover the cost of the prescribed medicines, which is very costly for the elderly. Off all the elderly who get support from the association only few are capable of going and access the services provided in the association. The rest have difficulty in moving from one place to another. Therefore, the voluntaries and the other elderly members of the association who are capable of taking care of others are given trainings on how to take care of the elderly. Then, they take home visit and bath the elderly, clean their house and cook for them.

Eneredada arranges trainings on hygiene and the health issues of the elderly to the elderly themselves every Friday at the Center. The trainings address healthy nutrition that is appropriate with aging. The respondent from this association indicated that there is a gap in providing information about elderly health status especially when it comes to HIV/AIDS. She said all the data received on HIV/AIDS only show the status of the age group that is found below the age of 49 (forty nine).

It is said that in order to fill this gap, the association repeatedly gave trainings on HIV/AIDS and on how to treat their family that are carriers of HIV/AIDS. It is found out that these days; because their awareness is rising, they are voluntarily going through tests to know their status. There were members of the association who formerly do not express themselves as carries of the virus in fear of discrimination. But now, they are expressing themselves and are taking their

medicines properly. The association also provides brochures to create awareness on HIV/AIDS and elderly.

But, Eneredada Elder People Association stated that the nurses that voluntarily serve in the association do not have trainings on geriatrics. And, the trainings that are given for the informal caregivers are general trainings on how to take care of elderly are very insignificant compared to the need.

The association is working together with Embassy's, Charity centers, Labour and Social Affairs Office, Health Office, Women and Children Affairs Office and Small Scale Cooperative Associations. They said they have regular meeting with their stakeholders every three months. By working with the local government offices, the association said it enabled the HIV/AIDS carrier elderly people who used to have problems in accessing medicines have easy access.

NGOs are playing a great role in the society. However, not all elderly are lucky enough to get the various supports they need from the NGOs. This is because very few NGOs are working on the issues of elderly. While the major problem is financial constraint, the lack of awareness on the need to support elderly in an organized manner is another problem.

# Chapter Five

## Conclusion and Recommendations

### 5.1. Conclusion

Human rights are universal and they apply to all human beings without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. There are number of international and regional human rights instruments that are meant for respecting, protecting and fulfilling human rights.

However, no binding human rights instrument is developed to protect the rights of elderly people (Marthe, F., Simon, B., 2012). The absence of such protection through the international human rights regime results in the violations of their human rights and dignity. But this does not mean that the other human rights protection instruments do not apply to the elderly people. All international instruments do apply to elderly people.

Though there are no specific binding instruments, the international community came up with non-binding human rights instruments that acknowledge the special needs of elderly people as it has been presented under chapter two above. Similarly, regional human rights systems also adopted additional human rights protections.

The adoption of the Vienna International Plan of Action on Ageing (VIPAA), the first UN human rights instrument on ageing is significant to the recognition and protection of the rights of elderly people. The UN General Assembly also adopted the United Nations Principles for Older Persons, a Proclamation on Ageing, and the Second International Plan of Action on Ageing.

These and other international instruments came up with sets of principles, measures, and comments on how to interpret the protection and fill gaps under the already established human rights instruments with regards to elderly. These instruments serve as guides for state action in setting standards and influencing domestic policies. However, all these documents are not legally binding and consequently, do not impose legally binding obligations. The non-binding nature of these human rights protection instruments on the other hand results in poor implementation.

In this research, the research questions that are raised dealt with understanding: the existing international, regional and national human rights instruments on elderly and on access to health care for the elderly; the existence of a special health care provision for the elderly; the availability, accessibility, acceptability and quality health care; elderly's coping measures, the gaps between existing health care programmes and services and actual needs, and existing measures taken and the future plans of the government and NGO's; and the implications of access to health care on the other human rights of elderly and the state obligations.

Ethiopia as signatory to the core UN human rights instruments and the African human rights instruments took national measures to comply with the international instruments. The National Plan of Action on Older People is one of the most significant frameworks that recognize the rights of elderly people in the country. There are also other national policies and programs that directly or indirectly have impact on the respect of the rights of elderly people.

Despite the provision of these policy measures by the government, the lack of neither any special law nor a special policy on elderly people exposed them to the violation of their rights. Though NPAOP is enacted, MoLSA does not have full-fledged power to enforce and control its implementation in collaboration with other government and non-government organizations.

Among other rights, the right to access health care is a right that is under threat and has significant implication on human rights of elderly people. Elderly people are vulnerable groups of the society that are exposed to diseases. Regardless of the fact that the number of elderly population is increasing and elderly are suffering from chronic diseases, the health care system mainly focused on other groups, i.e., mothers and young children rather than elderly people.

In addition, the attention given to chronic conditions such as stroke, diabetes, asthma and epilepsy and others that are prevalent on elderly people is very minimal. The fact that these points are ignored and are not given emphasis at national health policy arrangements are barriers for the elderly to access health care.

It is true that a State has the obligation to provide highest attainable standard of living. And it is supposed to be realized progressively depending on the economic level of a country. But, the amount of budget allocated to entertain issues of elderly people is very insignificant. And when it

comes to health care, there is no budget allocated to address the health care issues of elderly people. The fact that budgets are not allocated for geriatric care shows that the special health care needs of elderly is not recognized. This in fact limited the provision of facilities for geriatric care and the development of the human resources.

Though it is stated in the NPAOP, this research reveals that there are no special health care centers and/or wards for the care of elderly people. This is a clear indication of the non-fulfillment of access to health care for elderly people. Let alone the provision of special centers and wards, the existing health care facilities are not physically accessible and financially affordable for elderly people.

There is an arrangement in which poor individuals can get examinations and some medicines for free at the public health care institutions in situations where they can prove their economic status on a regular basis. Though they are benefiting from this arrangement, the system did not take into account the ability of the elderly to repeatedly visit *Kebele's* and acquire the certificate of status. Because they are tired of the process, usually they chose not use the free services.

Surveys indicate that, in Ethiopia, about 75 per cent of elderly people are suffering from at least one chronic disease (HelpAge, 2013). This research also find out that all the elderly who participated in this research are suffering from one and more diseases. The health status of the elderly is aggravated from the insufficiency of health care services.

As most of the elderly suffer from chronic diseases, mostly, they don't get the health care service they needed badly at the nearby health centers. Therefore, they are repeatedly sent to other far hospitals by referral. They are also required to bring laboratory examinations from other private laboratories. The elderly cannot also afford the prices of most of the prescribed medicines. Though the government is required to work on training health care professionals on geriatric care and provide them with geriatric medicines, there are no such provisions. This is the indicator of poor quality health care provision for elderly people.

Because of the limited number of specialists and the load at public health facilities, elderly are forced to visit private health centers that are very expensive and not economically accessible to the elderly people. Elderly people face financial limitations. One is because they are not capable

of working and earn income; and the other is because the government and other are not properly addressing the economic needs of the elderly.

The formal social security system is very weak because most elderly are excluded from the only social security arrangement which is pension. The pension scheme only addresses those who were engaged in the formal working environment. The self-employed and the unemployed parts of the society are excluded from the pension schemes. This exposed most of self-employed and unemployed elderly people to be vulnerable to financial problems.

Though it is not that strong, the only support they can rely on, both financially and psychologically, is the support they get from their family members. The government is not seriously handling the issues of elderly. There are limitations in identifying their problems and act accordingly. Similarly, NGOs give focus to only few vulnerable groups in the society i.e., women and children. The numbers of organizations that work on supporting elderly are very few.

Elderly people are not being made active participants in the formulation implementation and evaluation of policies and plans. The elderly cannot also be said to have information on health and health care issues especially at old age. The research also reveals that there are also limitations of capacity and awareness from the health professionals' side. There are no specialists on geriatric care and they not even get trainings on health issues of elderly people.

There are no researches conducted by all the responsible organs and this is one of the reasons the government and other organs are not giving proper attention. The researcher believe that the reason that elderly are not getting proper consideration because of the mentality that the health care issues of the elderly arise from their old age and there is no relevance in investing resources on these groups of people.

The elderly are frustrated with the health care system because they cannot easily access health care facilities and they cannot afford the expenses. They see no progress in their health status. Therefore, the elderly opt to use religious and traditional medicines and treatments as coping mechanisms. And, they do not visit health centers unless they seriously suffer from the diseases.

According to the Office of the United Nations High Commissioner for Human Rights, the right to health contains entitlements such as the right to a system of health protection providing

equality of opportunity for everyone to enjoy the highest attainable level of health; the right to prevention, treatment and control of diseases; access to essential medicines; and equal and timely access to basic health services. It also includes the provision of health-related education and information; and the participation of the population in health-related decision making at the national and community levels (UNHCHR, 1993). This implies that these groups of entitlements that should have been enjoyed or entertained by elderly people are also neglected as a result of the violations on the right to access health care.

Human rights are interdependent, indivisible and interrelated (Vienna Declaration and Programme of Action, 1993). As a result, access to health care that is the essential element of the right to health contributes to the realization of other human rights. These could include the right to an adequate standard of living, the right to freedom from discrimination, the right to access information the right to participation and the right to benefit from scientific progress and its applications (UNHCHR, 1993).

Non-discrimination and equality are also basic human rights principles that have link to the right to health. Based on the interpretation by the Committee on ICESCR on the term “other status” under ICESCR list of grounds of discrimination, States have an obligation to ensure equality to all on access to health care and to prohibit and eliminate discrimination on all grounds. The principles non-discrimination and equality also infer that States must recognize and make available for the different and specific needs of groups that generally face particular health challenges, i.e., vulnerability to specific diseases. In addition, it is required that specific health standards need to be applied to particular population groups (UNHCHR, 1993). The fact that specific health standards are not applies on elderly; the fact that their special needs are not recognized as vulnerable groups, indicate that elderly people’s rights to equality and freedom from discrimination are ignored.

A States’ failure to provide access to health care results in the violation of the rights of elderly people. This is a violation of the obligations undertaken under the international and regional human rights instruments i.e., International Convention on Economic Social and Cultural Rights and African Charter on Human and People’s Right, which Ethiopia acceded.

In conclusion, though the government recognizes the rights of elderly people, the research reveals that the right to access health care for elderly is not given proper response by the policy makers and the health care system of the country. The government needs to react in order to ensure its duty of respect, protect, promote and fulfill the rights of elderly. Besides, the implementation of the existing policies and plans towards elderly is very poor. This places elderly people that are vulnerable parts of the society in a destitute situation. Therefore, the government needs to be responsive to the actual needs elderly people in addition to adopting policies and laws to fully realize the rights of the elderly people. The research community, too, did not sufficiently study the overall and health care needs of elderly.

## **5.2. Recommendations**

International human rights instruments recognize the rights of elderly and impose obligations to respect, protect, promote and fulfill all human rights including the right to access health care of elderly people. In order to realize the right to access health care of elderly people, health care should be made available, accessible, affordable, and acceptable with good quality. To realize the right to access health care for the elderly:

- Elderly policy that enables them exercises their right needs to be introduced in order to ensure proper implementation. All responsible organs need to be made responsible for implementing and mainstreaming NPAOP and other policy instruments. And MoLSA should actively coordinate the activities of others.
- The revised social security scheme should come up with non-contributory pension scheme to include unemployed or those who never served at government, NGOs or military. The amount of payments also needs to consider the living cost of the society.
- The health insurance arrangement should also be revised in a way that benefits a large number of the society including elderly people.
- The concerned government organs (i.e., the House of Peoples Representatives, Council of Ministers, MoLSA, MoH, and others) should allocate adequate budget for health care provision of elderly people.
- A comprehensive and updated data on the health care need of elderly need be developed and made available to stakeholders.

- The government and different stakeholders should work together to come up with geriatric hospitals or at least have geriatric wards in the hospitals or health care facilities. Geriatric medicines and medical equipment should also be made available with quantity and quality. Both long and short term trainings should also be arranged for medical personnel's.
- Health care facilities should take into consideration the special health care needs of elderly and provide them with geriatric treatments and medicines which will ensure delivery of quality service to elderly.
- Health facilities need to give elderly priorities. In addition, they need to arrange them special schedules. They should also make sure that their building and other facilities can easily be used by all elderly people.
- In order to ensure that cost of medication do not impede access to health care government and other health care providers need to reduce the cost of their services and take all other necessary measures to those who cannot afford to pay.
- For elderly to properly exploit the free health care service provided, the local administrations should make simpler the procedures for elderly to get the certificate to receive free health care. Or where appropriate its better if the government provides age identification cards that easily enable them access health care for free, without the need to repeatedly acquire a poverty certificate.
- Mobile health care services should be made available. The health care providers should also arrange professionals who give on-site services. This will enable address elderly people who cannot easily visit the facilities. The health programs i.e., Health Extension Program, need to consider the exceptional characteristics of elderly and provide services and trainings accordingly.
- The government and other stakeholders need to advocate human rights of elderly and create awareness to the elderly, health professionals, informal care givers, families and other parts of the society.
- Elderly people need to be made active participants on matters impact them.
- The government should support and encourage NGOs, fundraisers, investors, families, individuals and others who are engaged in elderly related activities to work in collaboration with each other and share experience.

- The government and other researchers also need to conduct researches on elderly to show their status and raise their human rights issues.

## Bibliography

Addis Ababa City Administration Integrated Land Information Center, 2012, Available at <http://www.ilic.gov.et/index.php/en/subcities/gulele> last visited April 26, 2015

Addis Ababa Communication Bureau, 2009, *Addis Ababa from 1991-2008/2009*, Ethiopia

African Charter on Human and Peoples' Rights (ACHPR), 1981, Organization of African Unity

African Charter on Human and Peoples' Rights (ACHPR), 2013, *Draft Protocol on the Rights of Older Persons*, African Union

Africa Regional Development Centre and HelpAge International, 2001, *Addressing the Nutritional needs of older people in emergency situations in Africa: ideas for action*, HelpAge International

Amanda, Heslop, 1999, *Aging and Development, Social Development Working Paper No. 3*, HelpAge International

Ananth, M., 2008, *In Defense of an Evolutionary Concept of Health: Nature, Norms, and Human Biology*, England, Ashgate

Aytenew, Debebe, 2010, *The Rights of Persons with Mental Disabilities to Access Mental Health Care and Their Human Rights Conditions in Psychiatric Facilities in Ethiopia*, LLB, School of Law and Governance, Addis Ababa University, unpublished

Brigitte, Krieg, Diane J. F. Martz, Lisa McCallum, 2007, *Access to Health Services for Elderly Metis Women in Buffalo Narrows, Saskatchewan, Canada*, Prairie Women's Health Centre of Excellence, August 2007

Bureau of Finance and Economic Development, 2013, *Socio-Economic Profile of Addis Ababa*

*For the Year 2004 E.C/2011/12G.C*, Bureau of Finance and Economic Development, City Government of Addis Ababa, May 2013

Charles, Knox-Vydmanov, 2013, *Pensions for all elderly people*, Paul Springett/Linear

CSA, 2007, *Population and Housing Census Report*, Addis Ababa, Ethiopia

CSA, 2011, *Survey Population Study*, Addis Ababa, Ethiopia

Ephrem, Setegn, 2010, *The Role of Micro and Small enterprises in Poverty Alleviation in Gulele Sub city, Addis Ababa, Ethiopia*, MA, Business Administration, Addis Ababa University, unpublished

European Commission, 1996, *European Social Charter*, European Commission

European Commission, 1987, *Recommendation No. 22 on the screening and surveillance of elderly persons*, European Commission

European Commission, 1994, *Recommendation No. 1254 on the medical and welfare rights of the elderly: ethics and policies*, European Commission

European Commission, 1998, *Additional Protocol to the European Social Charter*, European Commission

European Commission, 1999, *Recommendation No. 1428 on the future of senior citizens: protection, participation and promotion*, European Commission

European Commission, 2000, *Charter of Fundamental Rights of the European Union*, European Commission

Fasil, Nigussie, 2010, *Exploring the Effects of Institutional Care on the Life of Older Persons (A Case study on Kaliti Institutional Care Center for the Elderly)*, MA, Social Works, Addis Ababa University, unpublished

FDRE, 1995, *the Proclamation of the Constitution of FDRE, Proc. No. 1, Neg. Gaz. Year 1, no. 1*

FDRE, 2013, *Council of Minister Regulation No. 299/2013 on Food, Medicine and Health Care Administration and Control*, 20<sup>th</sup> year No. 11, Addis Ababa, January 2014

Frederic, Megret, 2011, *the human rights of older persons: a growing challenge*, Human Rights Law Review, Volume 11, Issue 1, 37-66, Oxford University Press

- Getachew, Negash, 2007, *the elderly and informal social support: The case of elderly in Lideta sub-city*, MA, Social Works, Addis Ababa University, unpublished
- Gina, Boamah, 2011, *Concepts and Dimensions of Health and Health Beliefs*, Public health, UK
- Global Alliance for the Rights of Older People, 2013, Available at <http://www.rightsalliance.org/index.php/about-us/who-we-are> last visited April 24, 2015
- Hailom, Banteyerga, 2011, *Ethiopia's Health Extension Program: Improving Health through Community Involvement*, MEDICC Review, Vol. 13, No 3, July 2011
- Hancock, Beverley, 1998, *an Introduction to Qualitative Research*, Trent Focus
- HelpAge International, 2009, *an assessment of the inclusion of older people in the key national policies of Ethiopia*, Addis Ababa, Ethiopia
- HelpAge International, 2012, *an Introduction to HelpAge International in Ethiopia: A brief guide to who we are and what we do*, Addis Ababa, Ethiopia
- HelpAge International, 2013, *the State of Health and Ageing in Ethiopia: A Survey of Health Needs and Challenges of Service Provisions*, Ethiopia
- HelpAge International, 2010, *the Vulnerability and Living Conditions of Older People in Addis Ababa: Assessment Report*, Addis Ababa, Ethiopia
- HelpAge International, 2010, *the Living Condition and Vulnerability of Poor Urban Older People in Addis Ababa: Assessment Report*, Addis Ababa, March 2010
- HelpAge International and Cordaid, 2011, *a study of older people's livelihoods in Ethiopia*, January 2007
- Hutton, David, 2008, *Older People in Emergencies: Considerations for Action and Policy Development*, Geneva, World Health Organization
- Icelandic Human Rights Centre, 2013, Available at <http://www.humanrights.is/the-human-rights-project/humanrightscasesandmaterials/humanrightskonceptsideasandfora/Undirflokkur/elderlypersons/> last visited April 27, 2015

Imogen, Lyons, 2009, *Public Perceptions of Older People and Ageing: A literature review, Review 1*, National Centre for the protection of Older People

Institute of Public Care, 2012, *Briefing Paper 2: Health, Wellbeing, and the Older People Housing Agenda*, London, Housing Learning & Improvement Network, Available at [http://ipc.brookes.ac.uk/publications/pdf/HWB\\_and\\_the\\_Older\\_People\\_Housing\\_Agenda.pdf](http://ipc.brookes.ac.uk/publications/pdf/HWB_and_the_Older_People_Housing_Agenda.pdf) last visited on April 27, 2015

International Encyclopedia of Marriage and Family, 2003, *Chronic Illness*, Available at <http://www.encyclopedia.com/doc/1G2-3406900077.html> last visited April 26, 2015

International Labour Organization (ILO), 1980, *Recommendation on Older Workers*, ILO

John, Vincent, 2003, *Old Age*, London, Taylor & Francis e-library

Kifle, Mengesha, 2002, *Old Age and Social Change: an Anthropological Study of the Lives of the Elderly Among the Amhara of Ensar*, MA, Social Anthropology, Addis Ababa University, unpublished

Macedonians Humanitarian Association (MHA), 2012, *About Us*, Available at <http://mekedonia.blogspot.com/2012/06/about-us.html> last visited April 26, 2015

Mack, Natasha, et al, 2005, *Qualitative Research Methods: A Data Collector's Field Guide*, Family Health International

Marthe, Fredvang, Simon, Biggs, 2012, *The rights of older persons: Protection and gaps under human rights law*, Brotherhood of St Laurence and University of Melbourne Centre for Public Policy

Michael, Ruse, James, M. Humber and Robert, F. Almeder (eds), 1997, *What is Disease? Defining Disease: The Question of Sexual Orientation*, Totowa

Michael, Quinn Patton, Michael, Cochran, 2007, *A Guide to Using Qualitative Research Methodology*, UK, Michael Quinn Patton and Michael Cochran, 2002

Miller Jaclyn M., 2010, *International Human Rights and the Elderly*, Marquette Elder's Advisor,

Vol. 11: Issue 2, Article 6, 343-365

Ministry of Finance and Economic Development (MoFED), 2010, *Growth and Transformation Plan*, Ethiopia

Ministry of Labour and Social Affairs (MoLSA), 1996, *Developmental Social Welfare Policy*, Ethiopia

Ministry of Labour and Social Affairs (MoLSA), 2011 *General Situation of the Elderly*, Available at [\\_http://www.molsa.gov.et/English/SWD/Pages/SituationofElderly.aspx](http://www.molsa.gov.et/English/SWD/Pages/SituationofElderly.aspx) last visited April 28, 2015

Ministry of Labour and Social Affairs (MoLSA), 2006, *National Plan of Action on Older Persons (1998-2007 e.c)*, Addis Ababa

Ministry of Labour and Social Affairs (MoLSA), 2011, *Social Security for Older Person*, MOLSA Available at [www.molsa.gov.et/English/SWDPages/SocialSecurity.aspx](http://www.molsa.gov.et/English/SWDPages/SocialSecurity.aspx) last visited April 28, 2015

Murphy, Maggie, 2012, *International Human Rights Law and Older People: Gaps, Fragments and Loopholes*, HelpAge International

Musaiger, A.O. & D'Souza, R., 2009, *Role of age and gender in the perception of aging: A community-based survey in Kuwait*, Archives of Gerontology & Geriatrics, 48(1)

Natasha, Mack, et al, 2011, *Qualitative Research Methods: A Data Collector's Field Guide*, Family Health International, 2005

National Association of Community Health Center (NACHC), 2008, *A guide to address unique challenges of caring for elderly people with disabilities, Frailty, and Other Special Needs*, National Economic and Social Rights, US, Available at <http://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care> last visited April 27, 2015

National Center for the Protection of Older People (NCPOP), 2009, *Public Perceptions of Older People and Aging: A Literature Review*, Review 1, November 2009

National Policy Consensus Center, 2004, *Improving Health Care Access: Finding Solutions in a*

*Time of Crisis, Collaborative Problem Solving for States and Communities*, NPCC, November 2004

Office of the Deputy Prime Minister (ODPM), 2006, *A sure start to later life: ending inequalities for older people*, London, Crown

Office of the United Nations High Commissioner for Human Rights, 1993, *the Right to Health, Fact Sheet No. 31*, Switzerland, Office of the United Nations High Commissioner for Human Rights and World Health Organization

Organization of American States, 1948, *American Declaration of the Rights and Duties of Man*, Organization of American States

Organization of American States, 1969, *American Convention on Human Rights*, Organization of American States

Organization of American States, 1988, *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights*, Organization of American States

Organization of American States, 1994, *Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women*, Organization of American States

Public Servants' Pension Proclamation, 2011, *Proclamation No. 714/2011*, Ethiopia

Rita, Diaz, 2007, *Factsheet: Older people and housing*, Shelter, London, Available at [http://england.shelter.org.uk/\\_\\_data/assets/pdf\\_file/0013/41440/factsheet\\_older\\_people\\_and\\_housing\\_may\\_2007.pdf](http://england.shelter.org.uk/__data/assets/pdf_file/0013/41440/factsheet_older_people_and_housing_may_2007.pdf) last visited April 27, 2015

Robinson, T., Gustafson B. & Popovich, M., 2008, *Perceptions of negative stereotypes of older people in magazine advertisements: Comparing the perceptions of older adults and college students*, *Ageing & Society*, 28(2)

Rodney, Harrell, 2011, *Insight on the Issues 53; Housing for Older Adults: The Impacts of the Recession*, Washington, DC, AARP Public Policy Institute

Setegn, Ali, 2010, *Community based care system of Awramba towards older persons*, MA, Social Works, Addis Ababa University, unpublished

Scott, W. Vanderstoep and Deirdre, D. Johnson, 2009, *Research Methods for Everyday Life: Blending Qualitative and Quantitative Approaches*, Jossey-Bass

Sleap, Bridget, 2011, *the right to health in old age: unavailable, inaccessible and unacceptable*, HelpAge International

Social Health Insurance Proclamation, 2010, *Proclamation No. 690/2010*, Ethiopia

Steven, J. Taylor and Robert, Bogdan, 1984, *Introduction to Qualitative Research Methods: The Search for Meaning*, 2<sup>nd</sup> ed., A Wiley-Interscience Publication

Talcott, Parson, 1981, *Concepts of Health and Disease: Interdisciplinary Perspectives*, in Arthur L. Caplan, H. Tristram Engelhardt, Jr., and James J. McCartney (eds), *Definitions of Health and Illness in the Light of American Values and Social Structure*, London

TGE, 1993, *Health Policy*, Transitional Government of Ethiopia

UN Committee on Convention on the Elimination of All Forms of Discrimination against Women, 1999, *General Recommendation No. 24 on women and health*, United Nations

UN Committee on Convention on the Elimination of All Forms of Discrimination against Women, 2008, *General recommendation on Older Women and Protection of their Human Rights*, United Nations

UN Committee on Economic, Social and Cultural Rights, 1995, *General Comment No. 6, the Economic, Social and Cultural Rights of Older Persons*, United Nations

UN Committee on Economic, Social and Cultural Rights, 2000, *General Comment No. 14 on the Right to Health*, United Nations

UN Committee on Economic, Social and Cultural Rights, 2008, *General Comment No. 19: The right to social security (Art. 9 of the Covenant)*, 4 February 2008, E/C. 12/GC/19, United Nations

UN General Assembly, 1948, *Universal Declaration of Human Rights*, United Nations

UN General Assembly, 1959, *Declaration of the Rights of the Child*, United Nations

UN General Assembly, 1966, *International Covenant on Civil and Political Rights*, United Nations

UN General Assembly, 1966, *International Covenant on Economic, Social and Cultural Rights*, United Nations

UN General Assembly, 1979, *Convention on the Elimination of All Forms of Discrimination Against Women*, United Nations

UN General Assembly, 1989, *Convention on the Rights of the Child*, United Nations

UN General Assembly, 1990, *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*, United Nations

UN General Assembly, 1991, United Nations Principles for Older Persons: Resolution 46/91, United Nations

UN General Assembly, 1992, *Proclamation on Ageing*, United Nations

UN General Assembly, 2002, *Madrid International Plan of Action*, United Nations

UN General Assembly, 2008, *Convention on the Rights of Persons with Disabilities*, United Nations

UN High Commissioner for Refugees, 2000, *Policy on Older Refugees*, United Nations

United Nations Population Fund, 2012, *Ageing in the Twenty-First Century: A Celebration and A Challenge*, United Nations Population Fund (UNFPA), New York, HelpAge International,

United Nations Open-Ended Working Group on Ageing (UNOEWG), 2011, United Nations Open-Ended Working Group on Ageing, Available at <http://social.un.org/ageing-working-group> last visited April 27, 2015

United Nations Population Fund (UNFPA) & HelpAge International, 2011, *Overview of available policies and legislation, data and research, and institutional arrangements relating to*

*older persons: progress since Madrid*, New York, United Nations Population Fund & HelpAge International

Value in Health, 2011, *Is Equity of Access to Health Care Achievable in Latin America?*, Available at [www.elsevier.com/locate/jval](http://www.elsevier.com/locate/jval) last visited on April 27, 2015

Vienna Declaration and Programme of Action, 1993, World Conference on Human Rights

Webster's Dictionary, 1913, Available at <http://machaut.uchicago.edu/cgi-bin/WEBSTER.sh?WORD=health> last visited April 27, 2015

Williams, Jennifer, 2011, *Insights on Ageing: a survey report*, HelpAge International

WHO, 1948, *the Constitution of the World Health Organization*, World Health Organization

WHO, 2001, *Men Ageing and Health: Achieving health across the life span*, Geneva, World Health Organization

WHO, 2004, *Health of the Elderly in South East Asia: A Profile Regional Office for South East Asia*, World Health Organization

WHO, 2011, *Global Health and Aging*, World Health Organization

Yitayew, Alemayehu and Wondmagegn, Tadesse, 2013, *Human Rights Research: A Practical Guidebook on Methodology and Methods*, Center for Human Rights, Addis Ababa University

Zastrow, C., 1996, *Social Problems: Issues and Solutions*, Chicago, Nelson-Hall Publishers

## Appendixes

### Appendix A

#### Identification of the interviewees

##### Individual Interviewees

1. Name: Ato. Eshetu  
Sex: Male  
Age: 70  
Marital Status: Widower  
Children: 4  
Income: no income  
Currently living with: children
  
2. Name: Ato Nigatu  
Sex: Male  
Age: 87  
Marital Status: Married  
Children: 3  
Income: no income  
Currently living with: wife and children
  
3. Name: W/ro Emebet  
Sex: Female  
Age: 60  
Marital Status: Widow  
Children: 1  
Income: From daily work  
Currently living with: Alone
  
4. Name: W/ro Fikadenesh  
Sex: Female

Age: 75  
Marital Status: Married  
Children: 5  
Income: no income  
Currently living with: Children

**5. Name: W/ro Asazineu**

Sex: Female  
Age: 65  
Marital Status: Divorced  
Children: 3  
Income: no income  
Currently living with: children

**6. Name: W/ro Alem**

Sex: Female  
Age: 67  
Marital Status: Widow  
Children: 2  
Income: no income  
Currently living with: Children

**7. Name: Ato Getahun**

Sex: Male  
Age: 72  
Marital Status: Married  
Children: none  
Income: Pensioner  
Currently living with: Wife and Relative

**8. Name: Ato Asamineu**

Sex: Male  
Age: 74  
Marital Status: Widower

Children: 3

Income: Support from NGO

Currently living with: Relative

**9.** Name: Ato Girma

Sex: Male

Age: 67

Marital Status: Married

Children: 6

Income: none

Currently living with: Children

**10.** Name: W/ro Bayush

Sex: Female

Age: 64

Marital Status: Widow

Children: 5

Income: no income

Currently living with: Children

## **Appendix B**

**Addis Ababa University**  
**Center for Human Rights**  
**Research Questionnaire for the Elderly**

The purpose of this research is to assess the right to access health care for elderly people. Therefore, the purpose of this questionnaire is to gather data that will be used as an input for the research. The information you are going to provide will be confidential and are used only for the purpose of this research. Therefore, I kindly request you to give sincere responses.

You can stop giving response to any question you don't want to answer or cease the interview anytime you want.

### **Personal Information**

Name:

Sex:

Age:

Marital Status:

Children:

Income:

Currently living with:

1. How is your health?
2. Do you have any impairment that affects your daily activity?
  - If yes, what type of impairment?
3. Do you have any chronic disease?
  - If yes, what type of diseases?
4. Do you get any care and support from your family/relatives or others when you get sick?
  - If yes, what types of support?
5. Do you get information/education on the prevention and treatment of different health problems; specifically on old age related health problems?

- If yes, what were the means and media of communication? What was the scope? Was it helpful in anyway?
6. Do you often visit health care centers?
  7. Are there factors that discourage older people from visiting health facilities?
    - If yes, what are they?
  8. What are the challenges for you to get health care service?
  9. Which health facility do you often attend (Public, Private, NGO, Traditional, religious or other)?
  10. Are the health care centers physical accessible for you?
  11. How do you travel to health care centers?
  12. Do you get adequate and ongoing health care service on time?
  13. Who covers your health care expenses?
  14. If you cover your health care expenses by yourself, is it affordable?
  15. Do you know about the free health service that the government provides to poor people?
 

Have you ever accessed free health service that the government provides to poor people?

    - If not, what was the reason?
  16. What kind of service do you get for free?
  17. Are you treated by health professional that specialized on elderly issue?
  18. How do the health professionals treat you? Do you experience discrimination in getting health care service?
  19. Are there care and humanitarian support services provided to elderly people by others; other than your family/relatives i.e. government, NGOs, religious institutions and community in your area?
    - If yes, what type of support?
  20. What are your coping mechanisms (Traditional, community and religious)?
  21. What is the implication of access to health care on the other activities in your life?
  22. Are there organizations that work on the rights of elderly people and support you to organize?
  23. Do you play role in identifying your problems and solutions in program designing in your area?
    - If no, why not?

24. Are you satisfied with the health care services provided to you?
  - If no, why not? How do you communicate your dissatisfaction?
25. What do you think should be improved in the future in order to facilitate elderly people's right to access health care?

## **Appendix C**

### **Interview Question for Ministry of Health/ Health Bureau of Gulele sub-city**

1. Is there policy and strategy or any other legal instrument in relation to the right to access health care of elderly people?
  - If yes, what are the health care issues of elderly people that are addressed in the instruments?
  - If not what is your plan on this issue in the future?
2. Do you have guidelines and standards of health care services for elderly people?
  - If so, describe the scope and coverage of the guidelines, standards/norms
  - If not, what is the reason?
3. Are there programs promoting healthy ageing?
  - If so, describe the scope and coverage
  - If not, what is the reason?
4. Do you undertake research projects identifying risk factors at older age?
  - If so, please describe the scope and coverage of such programs.
  - If you do not have, what is the reason?
5. Are there training and education programs in promoting health and managing diseases for elderly?
  - If so, indicate their scope and coverage
  - If not, what is the reason?
6. Do you have community-based programs for health services especially on elderly?
  - If so, describe the scope and coverage of such programs
  - If you do not have, what is the reason?
7. Are there health care facilities age-friendly/ with specialized care for older clients?
  - If so, describe the scope and coverage

- If not, what is the reason?
8. Are there health care professionals trained in areas of geriatrics?
    - If so, indicate their number, adequacy to the need
    - If not, what is the reason?
  9. Do you have programs developed with the involvement of older people?
    - If so, describe the scope and coverage
    - If not, what is the reason?
  10. Does your office held discussions on the health problems of elderly with the responsible body?
    - If yes, what was the result of the meeting to solve the elderly people's health problems?
  11. What are between existing health care programmes and services, access and actual needs?
  12. What are the existing measures taken, the gaps and the future plans of the Office to curb the problems to access health care?
  13. What are the measures that should be taken to help realize the rights of elderly people to access health care?

## **Appendix D**

### **Interview Questions for Ministry of Labour and Social Affairs/ Labor and Social Affairs Bureau Gulele sub-city**

1. Does your office have estimated data on the number of elderly population in the country/city/sub-city?
  - If yes, how many are they?
2. Is there policy and strategy or any other legal instrument in relation to the right of elderly people, in general; and the right of elderly people to access health care?
  - If yes, what are the health care issues of elderly people that are addressed in the instruments?
  - If not, what is your plan on this issue in the future?
3. Do you have guidelines and standards of health care and rehabilitation services for elderly people?
  - If so, describe the scope and coverage
  - If not, what is the reason?

4. Are there programs promoting healthy ageing?
  - If so, describe the scope and coverage
  - If not, what is the reason?
14. Do you undertake research projects identifying risk factors at older age?
  - If so, please describe the scope and coverage of such programs.
  - If you do not have, what is the reason?
15. Are there training and education programs in promoting health and managing diseases for elderly?
  - If so, indicate their scope and coverage
  - If not, what is the reason?
16. Do you have community-based programs for health services specially on elderly?
  - If so, describe the scope and coverage of such programs
  - If you do not have, what is the reason?
17. Are there health care facilities age-friendly/ with specialized care for older clients?
  - If so, describe the scope and coverage
  - If not, what is the reason?
5. Are there social care professionals, informal caregivers with training in the care of elderly?
  - If so, indicate their number, adequacy to the need
  - If not, what is the reason?
6. Does your office held discussions on the health problems of elderly with the responsible body?
  - If yes, what was the result of the meeting to solve the elderly people's health problems?
7. Who is the responsible body to facilitate the right to access health care?
8. Did you consider the health care of elderly people during developing your annual plan?
9. What are the existing measures taken, existing health care programmes and services and the future plans of the government to curb the problems to access health care?
10. What are the measures that should be taken to help realize the rights of elderly people to access health care?

## **Appendix D**

### **Interview Question for Health Center**

1. How are the health care issues of elderly addressed in your institution?
2. Are elderly people getting adequate health care service?
  - If no, why not?
3. Are there health care facilities with specialized care for older clients/ age-friendly?
  - If so, describe the scope and coverage
  - If not, what is the reason?
4. Are there health care professionals trained in geriatrics care?
  - If so, indicate their number in geriatric care at present and the adequacy to the need
  - If not, what is the reason?
5. How do you address elderly people who cannot visit the health center?
6. What are the gaps between existing health care programmes and services and actual needs?
7. What are the existing measures taken and the future plans of your institution to curb the problems to access health care?
8. What are the measures that should be taken to help realize the rights of elderly people to access health care?

## **Appendix F**

### **Guideline for Focus Group Discussion**

#### **Discussion Rules**

- Each person can reflect its view based on the points raised in the discussion.
  - We must listen others when they speak and respect their opinion.
1. How do you see the status of health of elderly people?
  2. What are the diseases that are prevalent on elderly people?
  3. Do you get any care and support from your family/relatives and others?
  4. Do you get information/education on health issues specifically on old age related health problems?

5. What are the challenges faced by elderly to get health care service?
6. Do you use the free health service that the government provides to poor people?
7. Are you treated by health professional that specialized on elderly care?
8. How do the health professionals treat you?
9. Do elderly people play role in identifying their problems and solutions in program designing?
10. What are your coping mechanisms?
11. Are you satisfied with the health care services provided to you?
12. What do you think should be improved in the future in order to realize elderly people's right to access health care?