

## **The Law and Ethics of Coronavirus Disease (Covid-19) in Kenya**

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### **Abstract**

*The COVID-19 pandemic is a public health emergency that raises many ethical and legal issues. Of significance is that the pandemic requires emergency public health measures to be put in place by the government significantly disrupting the lives of many. Governments should however remember that emergency public health measures must be legally sound in accordance with their right to health obligations under international law, national constitution and legislation. Suffice to note, the international community has an obligation to assist and cooperate with each other towards fighting the disease. The health providers who are currently at the forefront in fighting the pandemic are being faced with numerous challenges especially in developing countries due to lack of adequate resources. This however should not be an excuse for violating ethical principles put in place including respecting the confidentiality, privacy, and autonomy of the patients. Lastly, the community has a role to play in making sure that they follow lawful orders and guidelines put in place including social distancing, washing hands and staying at home. (Key words: coronavirus/COVID-19; right to health; public health; Kenya; law and ethics)*

### **1. Introduction**

On 30 January 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a public health emergency of international concern.<sup>1</sup> Coronavirus disease (COVID-19) is a respiratory disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pathogen. Coronaviruses (HCoV) were long considered “inconsequential pathogens,” as they cause the “common cold” in otherwise healthy people.<sup>2</sup> Most of the coronaviruses “are endemic globally and account for 10% to 30% of upper respiratory tract infections in adults.”<sup>3</sup> The onset of SARS (Severe Acute Respiratory Syndrome) in 2002, and MERS (Middle East Respiratory Syndrome) in 2012 shattered the myth of coronaviruses as inconsequential pathogens, and brought the reality that coronaviruses are a pandemic threat. COVID-19 is a highly contagious disease<sup>4</sup> that is transmitted quite efficiently, albeit clumsily.<sup>5</sup>

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<sup>1</sup> World Health Organization ‘Statement of the Second Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus (2019-nCoV)’ (30 January 2020), <[https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))> (accessed 23 March 2020).

<sup>2</sup> Catharine I. Paules Hilary D. Marston, and Anthony S. Fauci, ‘Coronavirus Infections—More Than Just the Common Cold’ (23 January 2020), <doi:10.1001/jama.2020.0757 > accessed 19 March 2020.

<sup>3</sup> Ibid

<sup>4</sup> Wendy E. Parmet and Michael S. Sinha, ‘Covid-19— The Law and Limits of Quarantine,’ (18 March 2020) <DOI: 10.1056/NEJMp2004211> visited 19 March 2020

<sup>5</sup> Bill Gates, ‘Responding to Covid-19 — A Once-in-a-Century Pandemic?’ (28 February 2020) <DOI: 10.1056/NEJMp2003762> accessed 19 March 2020

The first COVID-19 case in Kenya was reported on 12 March 2020 after a Kenyan citizen returned back into the country on 5 March 2020.<sup>6</sup> The numbers have risen steadily since then, prompting the government to announce various emergency public health measures.<sup>7</sup> A range of stringent emergency public health measures continue to be imposed by the government all in an effort to curb the spread of the COVID-19 virus pandemic, starting with the imposition of a 7pm to 5am curfew, which has been ruthlessly enforced by the police amidst claims of numerous police brutality and human rights violations.<sup>8</sup>

In other countries, very extreme public health measures have been taken which include national lockdowns as is the case in India, Italy, France, United Kingdom, South Africa among others.<sup>9</sup> As the cases continue to rise, Kenya may also be forced to impose a national lockdown unless the virus is contained, which option is looking increasingly unlikely.

The County Governments have also responded to the COVID-19 pandemic by announcing a raft of emergency public health measures including closure of markets, restaurants and other social places.<sup>10</sup> According to the Constitution of Kenya, health is a devolved function and county governments are expected to play an important role in dealing with the current pandemic including the provision of the needed health services and health personnel.<sup>11</sup>

According to the WHO, the strategy to control the current pandemic should have the following objectives:<sup>12</sup>

- a) Interrupt human-to-human transmission including reducing secondary infections among close contacts and health care workers, preventing transmission amplification events, and preventing further international spread;
- b) Identify, isolate and care for patients early, including providing optimized care for infected patients;
- c) Identify and reduce transmission from the animal source;
- d) Address crucial unknowns regarding clinical severity, extent of transmission and infection, treatment options, and accelerate the development of diagnostics, therapeutics and vaccines;
- e) Communicate critical risk and event information to all communities and counter misinformation;
- f) Minimize social and economic impact through multisectoral partnerships.

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<sup>6</sup>Ministry of Health, 'First Case of Coronavirus Disease Confirmed in Kenya' (13 March 2020), <<http://www.health.go.ke/first-case-of-coronavirus-disease-confirmed-in-kenya/>> (accessed 23 March 2020).

<sup>7</sup>Nasibo Kabale, 'Coronavirus: Kenya takes bold steps after cases rise to three' (*Daily Nation*, 15 March 2020) <<https://www.nation.co.ke/news/Coronavirus-Kenya-confirms-2-more-cases/1056-5492028-4817d7z/index.html>> accessed 19 March 2020.

<sup>8</sup>'Chaos, teargas as Kenyans rush home to beat curfew' (*The East African*, 27 March 2020), <<https://www.theeastafrican.co.ke/news/ea/Chaos--teargas-as-Kenyans-rush-home-to-beat-curfew/4552908-5506712-fbc1sx/index.html>> (accessed 31 March 2020).

<sup>9</sup>Emily Czachor, 'Which Countries are on Nationwide Lockdown Because of Coronavirus?' (*Newsweek*, 24 March 2020), <<https://www.newsweek.com/which-countries-are-nationwide-lockdown-because-coronavirus-1494017>> (accessed 23 March 2020).

<sup>10</sup>'How counties are responding to COVID-19' (*The Star*, 18 March 2020) <<https://www.the-star.co.ke/news/2020-03-18-how-counties-are-responding-to-covid-19/>> accessed 30 March 2020.

<sup>11</sup> Constitution of Kenya, 2010, Schedule Four.

<sup>12</sup>World Health Organization, 'Coronavirus Disease 2019 (COVID-19) Situation Report -58' (18 March 2020), <[https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200318-sitrep-58-covid-19.pdf?sfvrsn=20876712\\_2](https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200318-sitrep-58-covid-19.pdf?sfvrsn=20876712_2)> (accessed 23 March 2020).

The COVID-19 virus pandemic is indeed a game changer, and has brought with it many challenges in the public health sector. The pandemic has also revived the discourse concerning the necessity of respecting human rights in implementing measures taken by governments during public health emergencies.<sup>13</sup> Of particular concern is that the measures taken by the government during public health emergencies are extraordinary and may sometimes go beyond the ‘normal use’ of government power or authority.<sup>14</sup> What is clear is that all public health measures should be ethically and legally grounded.<sup>15</sup> Governments must negotiate the delicate balance between the prevention and control of risk and damage to public health and the respect for human rights enshrined in many international instruments and national constitutions.<sup>16</sup> The WHO has not yet issued ‘any substantive guidance on how countries can take public health measures that achieve health protection while respecting human rights.’<sup>17</sup> Consequently, governments have been able to assert that they are doing what is necessary or effective.<sup>18</sup> It appears as though respect for human rights is an afterthought during this pandemic.<sup>19</sup>

This paper examines the health law and ethics in the context of COVID-19 pandemic response measures and proposes guidelines that are ethically and legally grounded. The structure of this article is as follows. The first part addresses the international legal framework for dealing with public health pandemics. The second part addresses the ethical and legal issues arising from the COVID-19 pandemic. The third part discusses the right to health obligations of the government in the context of public health emergencies. The fourth part looks at the responsibility of patients and communities in responding to the present pandemic. The fifth part expounds on the issue of health professionals and the ethics of prevention, treatment and care. Drawing from the preceding parts of this paper, the penultimate part lays out some guidelines on ethical and legal issues that could aid in balancing the many competing interests and values that are presented by the COVID-19 pandemic. The last part is the conclusion.

## **2. The International Legal Framework for dealing with Public Health Pandemics**

The most prominent international legal framework for dealing with public health emergencies is the International Health Regulations (2005) (IHR). The IHR are a regulatory framework ‘to manage and prevent public health risks from arising from the international spread of disease, while avoiding unnecessary interference with international traffic and trade.’<sup>20</sup> They are ‘a legally binding set of regulations adopted under the auspices of the WHO, focusing on global surveillance for communicable diseases.’<sup>21</sup> Article 2 of the IHR set out their purpose as to ‘prevent, protect against, control and provide public health response to

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<sup>13</sup>Paula Lobato de Faria & Joao V. Cordeiro ‘Public Health: Current and Emergent Legal and Ethical Issues in a Nutshell’ in Yann Joly & Bartha Maria Knoppers (eds) *Routledge Handbook of Medical Law and Ethics* (Routledge New York 2015) 371.

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid, 371-2.

<sup>17</sup>Alicia Ely Yamin & Roojin Habibi, ‘Human Rights and Coronavirus: What’s at Stake for Truth, Trust, and Democracy?’ (*Health and Human Rights Journal*, 1 March 2020), <<https://www.hhrjournal.org/2020/03/human-rights-and-coronavirus-whats-at-stake-for-truth-trust-and-democracy/>> (accessed 23 March 2020).

<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

<sup>20</sup>World Health Organization, International Health Regulations (2005), adopted by the Fifty Eighth World Health Assembly on 23<sup>rd</sup> May 2005 – Resolution WHA 58.3. They entered into force on 15<sup>th</sup> June 2007.

<sup>21</sup>V. K. Agarwal, ‘Pandemic Response and International Health Regulations’ (2007) 63(4) *Med J Armed Forces India* 366

the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.”

The IHR were first adopted by the World Health Assembly in 1969,<sup>22</sup> following the 1951 International Sanitary Regulations (ISR). The 1969 Regulations covered six diseases that were subject to quarantine, but subsequent revisions reduced the number to three (yellow fever, the plague and cholera). The 2005 revision replaced the previous adoption of a list approach to quarantine diseases with an open ended approach to the reporting of new and emergent diseases which pose an international risk, such as COVID–19.

The IHR place the WHO as the focal point of providing transnational health governance leadership on the formulation and implementation of a legal and ethical normative frameworks dealing with global responses to Public Health Emergencies of International Concern (PHEIC). The WHO is responsible under the regulations for raising awareness, information sharing, coordinating national responses and measures, providing and mobilizing assistance as well as organizing technical meetings to discuss solutions to these public health emergencies.

The IHR impose various obligations on Member States. State parties are required to designate or establish national focal points within their respective jurisdictions for the implementation of health measures that are set out under the IHR.<sup>23</sup> They are also to develop capacities to detect, notify and report events in accordance with the set out and prescribed procedures and processes in the IHR.<sup>24</sup> Each state party shall assess events within their territories using the decision instrument set out in the IHR, and communicate to the WHO timely, accurate and sufficiently detailed public health information.<sup>25</sup> If the Member State has evidence of an unexpected or unusual public health event within its territory, which may constitute a public health emergency of international concern, it shall provide to the WHO all the necessary information.<sup>26</sup>

Apart from placing obligations on member states on surveillance, notification and reporting of PHEIC, the IHR provide an opportunity and avenue for examining the interface between public health and public security, as questions are raised on the restrictive measures that governments put in place in a bid to curb the spread of the disease. As Burci puts it:

These restrictive measures have raised questions about the extent of national emergency powers and the relevance of human rights considerations to ensure a measure of due process,

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<sup>22</sup> These were amended in 1973 and 1981

<sup>23</sup> Article 4, IHR 2005

<sup>24</sup> Article 5, IHR 2005; see also Nirmal Kandel, *et. al.* ‘Health Security Capacities in the Context of COVID -19 outbreak: An Analysis of International Health Regulations Annual Report Data from 182 Countries,’ [2020] (395) (10229) *The Lancet* 1047 where five indices were developed to check capacity of countries: Prevent, Detect, Respond, Enable, Function.

<sup>25</sup> Article 6, IHR 2005

<sup>26</sup> Article 7, IHR 2005

proportionality of measures to the actual risk as well as to generate domestic and international accountability.<sup>27</sup>

The challenges of implementing the IHR are felt in different ways. Firstly, the approach of the WHO Director General (DG) in declaring COVID-19 a public health emergency of international concern and the recommendations given therein have been criticized as being very “soft.” The DG acts in accordance with recommendations given by an Emergency Committee that is constituted with every event, and as such, there is no permanent emergency committee. Therefore, no common approach is adopted. Common principles have not been formulated. Each event attracts its own experts who form different opinion. The WHO has declared 6 pandemics from 2009 to 2020. Each has had its own approach which weakens the implementation of the IHR.

Secondly, the deliberations of the Emergency Committee are done in private, raising issues of the legitimacy and transparency of the measures that they come up with. This approach of conducting deliberations is also in danger of politicization. Other inadequacies of the IHR include, the lack of a global coordinated support for the regulations, the challenge of implementation for developing countries, the ease with which countries can easily put in measures that violate human rights, the interpretation of what constitutes a public health emergency of international concern, the lack of a global fund for pandemic support, as well as a lack of formal mechanism for ensuring compliance with the IHR. The approach of the WHO is that states will comply with these regulations on a voluntary basis.

In light of these challenges to the recognition and implementation of the IHR as a legally binding instrument, there is need for other measures to enable the compliance by member states with obligations for public health emergency surveillance, assessment, reporting and response. There are proposals to use the UN Security Council mechanisms where public health emergencies are seen as an extreme security threat. On the other hand, international cooperation and assistance would be seen as a good compromise where states comply with their obligations and undertakings under international instruments, such as the United Nations Charter,<sup>28</sup> International Covenant on Economic, Social and Cultural Rights (ICESCR),<sup>29</sup> and the Sustainable Development Goals, particularly Goal 3 on health. The ICESCR in particular provides that:<sup>30</sup>

Each State party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights.

The socioeconomic right that is of concern and is relevant here is the right to the highest attainable standard of health. Certain principles are relevant in considering the provision of international assistance; transparency and accountability, non – discrimination and participation. There is the argument for the

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<sup>27</sup>Gian Luca Burci, ‘The Outbreak of COVID 19 Coronavirus: Are the International Health Regulations Fit for Purpose?’ (27 February 2020), < <https://www.ejiltalk.org/the-outbreak-of-covid-19-coronavirus-are-the-international-health-regulations-fit-for-purpose/>> accessed 19 March 2020

<sup>28</sup> UN Charter, Articles 55 and 56

<sup>29</sup> ICESCR, Article 2(1)

<sup>30</sup> Ibid

Optional Protocol to the ICESCR to be used as an enforcement mechanism for the obligation to assist and cooperate.<sup>31</sup>

The current COVID -19 Pandemic has raised serious concerns as to whether the obligation to assist and cooperate can be effectively met, with many developed countries facing their own challenges in dealing with the outbreak. Developing countries thus have to rely on their own resources, or assistance from well-wishers and philanthropists. The recently concluded Virtual G20 Summit has been criticised as being vague with empty promises being given.<sup>32</sup> The International Executive Director of Oxfam has stated in this regard that:<sup>33</sup>

...we need those with broader shoulders to bear most of the cost. The G20 as a group of the richest countries can give billions of dollars in support to developing countries. The richest people and corporations – through greater taxation – can help pay for this.

The kind of assistance that would be needed is emergency funding, vaccine collaboration and financial reform for example increasing multilateral bank contributions to assist in strengthening the international health systems, particularly for the poorer nations.<sup>34</sup> International assistance and cooperation remains a challenge, particularly with respect to economic assistance. Blame shifting has already begun, with a lawsuit filed against China, seeking to have it bear the cost of the pandemic.<sup>35</sup> The fact that countries have different political, social and cultural norms and practices, may pose challenges to a common approach to international assistance.<sup>36</sup>

The cooperation within research and scientific fields may yield better fruits at the moment, allowing scientists, virologists and immunologists to work round the clock to develop diagnostic kits, vaccines and treatments for the COVID -19 disease. In addition, the Bretton Woods institutions should be prepared to play a bigger role in helping poor countries overcome the economic burden of the current and future

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<sup>31</sup>Magdalena Sepulveda Carmona, 'The Obligations of International Assistance and Cooperation under the International Covenant on Economic, Social and Cultural Rights: A Possible Entry Point to a Human Rights Based Approach to the Millennium Development Goal 8' (2009) 13(1) *The International Journal of Human Rights* 86

<sup>32</sup>Jake Johnson, "'World Leaders Seem in Denial": Demands for Radical Global Action on Coronavirus as Virtual G20 Summit Ends With Vague Promises', (*Common Dreams*, 26 March 2020) <<https://www.commondreams.org/news/2020/03/26/world-leaders-seem-denial-demands-radical-global-action-coronavirus-virtual-g20>> accessed 28th March 2020

<sup>33</sup>Oxfam International, 'Never in Our Lifetimes Has There Been a Call for Compassion Like This' (26 March 2020) <<https://medium.com/@Oxfam/never-in-our-lifetimes-has-there-been-a-call-for-compassion-like-this-26505a473b4f>> accessed 28th March 2020

<sup>34</sup>Global Fund, 'Global Fund Issues New Guidance in Response to COVID-19' 4 March 2020, <<https://www.theglobalfund.org/en/news/2020-03-04-global-fund-issues-new-guidance-in-response-to-covid-19/>> accessed 26<sup>th</sup> March 2020. The Global Fund asking states to rechannel their grants for Malaria, HIV and TB to the fight against the Coronavirus

<sup>35</sup>Anwasha Madhukalya, '\$20 trillion lawsuit against China! US group says coronavirus is bioweapon,' (2 April 2020) <<https://www.businesstoday.in/current/world/usd-20-trillion-lawsuit-against-china-us-group-says-coronavirus-bioweapon/story/399071.html>> accessed 28th March 2020

<sup>36</sup>Chen Dongxiao, Zhang Haibing 'International Cooperation for the Coronavirus Combat: Results, Lessons and Way Ahead,' (Shanghai Institute for International Studies, March 2020) <[https://www.fmprc.gov.cn/mfa\\_eng/topics\\_665678/kjgzbdffyq/P020200310355462655277.pdf](https://www.fmprc.gov.cn/mfa_eng/topics_665678/kjgzbdffyq/P020200310355462655277.pdf)> accessed 28 March 2020

pandemics. International assistance and cooperation is the silver-bullet in the context of COVID-19 pandemic.

### **3. Ethical and Legal Issues Arising from the COVID – 19 Pandemic in Kenya**

The COVID–19 disease has raised global panic and has led to desperate, and in many cases, extreme measures being put in place by governments in order to curb the spread of the disease. On March 11th, 2020, the WHO declared that the outbreak of COVID – 19 a global pandemic, required aggressive and urgent steps by governments to curb the spread of the disease.<sup>37</sup>

The measures that are being taken by states beg the question as to whether, in adopting measures to deal with citizens and those suspected of having the disease or who already have been diagnosed with the disease, there is room for the rule of law, and medical and public health ethics. Has the state of global public health emergency rendered ethical and legal considerations useless? Is there time and mental space to consider the law and ethics? These questions are particularly pertinent from a developing country perspective, where preventative measures taken to curb the spread of the disease will likely infringe on the rights and freedoms of citizens, and will cause unprecedented economic and social damage.

To answer this question, we need to consider the ethical and legal dilemmas and issues that states like Kenya are facing, and what frameworks need to be put in place to deal with these issues and dilemmas. This section maps out the ethical and legal considerations that need to be considered by Kenya, in light of its constitutional obligation to ensure that its citizens enjoy the highest attainable standard of health. The major question is: what is the place of health law and ethics in the face of pandemics? What is clear is that a country preparedness for a pandemic such as what has been presented by COVID – 19, means more than just infrastructural and resource based preparedness. It also means preparedness to deal with the moral, ethical and legal issues that are bound to arise.

#### **3.1 Ethical Issues and Dilemmas in the Context of COVID-19 Pandemic**

##### ***3.1.1 Allocation and Utilisation of Scarce Resources***

A pandemic such as COVID – 19 tests the ability of many countries to allocate, distribute and utilise their scarce healthcare resources in a manner that is equitable and respectful of the dignity and human rights of patients. This conversation is not new however, as there have been other epidemics that have tested this issue – SARS, H1N1, Ebola, etc

The questions raised are in the context of scarce resources are the following: who is to be given priority in testing and treatment? Who will be given priority in vaccination? Who is to get admitted and who is to be treated from home? Who would receive life-saving treatment, if available? The high rates of infection amongst the populace imply that there needs to be rationing and rationalisation of the available scarce resources. If the statistics from other countries that have been hardest hit by COVID – 19 are anything to go by, there is a very real risk that there will be a crisis of resources if the number of those exposed and

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<sup>37</sup>World Health Organization Regional Office for Europe, ‘WHO announces COVID-19 outbreak a pandemic’ (12 March 2020)

<<http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/news/news/2020/3/who-announces-covid-19-outbreak-a-pandemic>> accessed 28<sup>th</sup> March 2020

infected rise. Resource allocation decisions therefore, will essentially determine who lives and who dies. These decisions are also being faced in the developed world where health care systems are more advanced than those of Kenya. For example, Italy, which is the hardest hit country in terms of COVID–19 deaths, has had to develop guidelines on the criteria that nurses and doctors will use in allocating their scarce resources among those who need intensive care. The principle used is utilitarianism, where factors such as age, the presence of comorbidities and those with the highest chances of benefiting from intensive care, are taken into account.<sup>38</sup>

What resources are currently available in Kenya? Already, there is a scarcity of supplies, commodities, equipment, medication and health personnel. Are there enough testing kits? What is the bed capacity? Are there enough ICU units?<sup>39</sup> Is there preparedness at the county level? Can samples be collected and stored safely? Can patients be transported to testing facilities from the counties in good time? Are there enough health personnel? What happens to patients with other conditions? Policy and decision makers should urgently provide advice on how to allocate the available scarce resources, both at the national and county levels. This advice must necessarily be influenced by ethical considerations in order to be justifiable amongst the citizens. Choices have to be made. A good example is that on the 24<sup>th</sup> of March 2020, over 60 cancer patients who were admitted at the Kenyatta National Hospital had their treatment suspended and were sent home. The hospital is to come up with a rationing policy on who gets radiotherapy treatment.<sup>40</sup> The rationing of the scarce resources requires choosing among patients. In Italy, doctors had to withhold treatment from the elderly who are more sick and unlikely to recover, and divert resources towards younger patients who are likely to recover.<sup>41</sup> This is a utilitarian approach of making choices rather than the egalitarian approach which is favoured by human rights advocates. Patients are not treated the same. Patients who are vulnerable such as those who are living with disabilities, or those living with HIV, or those with other underlying conditions, or with suppressed or compromised immune systems such as those with Cancers, would also have to face the same kind of rationing decisions based on utility. This utilitarian approach to decision making may cause injustices, including the practice of profiling based on age, disability, ethnicity, etc. All these grounds are prohibited grounds of discrimination in the Constitution of Kenya.<sup>42</sup>

It is therefore incumbent on the government, through the Ministry of Health, to come up with guidelines which will be acceptable and accepted by the public on how to ration and rationalise the existing scarce resources. These guidelines would have to produce the best results, and be justifiable on the basis of transparency and justice.

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<sup>38</sup>Marco Vergano, et al ‘Clinical Ethics Recommendations for the Allocation of Intensive Care Treatments in Exceptional, Resource – Limited Circumstances’ (SAARTI, 16<sup>th</sup> March 2020)

<sup>39</sup>Betty Njeru, ‘Covid-19: List of Counties with ICU beds,’ *The East African Standard* (Nairobi, 28th Mar 2020) <<https://www.standardmedia.co.ke/article/2001366028/covid-19-number-of-icu-beds-in-kenya>> accessed 30th March 2020

<sup>40</sup>John Muchangi, ‘Kenyatta Hospital Stops Cancer Treatment over Corona virus,’ *The Star* (Nairobi, 24<sup>th</sup> March 2020)

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<sup>41</sup> Ibid

<sup>42</sup> Constitution of Kenya, Article 27(4)



### 3.1.2 Veracity, Information Sharing, Publicity and Public Engagement

Transparent sharing of information vis a vis public security and the protection of the public from alarm is a challenge that would be faced by the government in Kenya. Transparency and openness are important in the fight against pandemics. They inform the health seeking behaviours of citizens, and their preventative and protective behaviours. Truth telling and transparency on the part of a government promotes public trust in the administrative processes of that government.<sup>43</sup> This trust in governments will likely lead to better responses to governmental directives given to curb the spread of an epidemic.

During the SARS and the MERS epidemics, there was clear reluctance on the part of the Chinese government to give information. The current COVID-19 pandemic seems to have evoked the same kind of reluctance on the part of the Chinese government. The Chinese government prioritised secrecy above what they perceived to be alarmism. Indeed, the whistle blowing doctor, together with other healthcare workers who raised the alarm about the Wuhan Pneumonia, were criminalised and following, the doctor died from the disease.<sup>44</sup> The information that the government chose to share when the disease was noticed in December 2019 was that it was not transferrable amongst humans, and that it was not an epidemic.<sup>45</sup> In essence, the severity of the disease was downplayed. This information contributed to the spread of the disease beyond Wuhan in China, to other countries in the world. Outside China, in the USA, the prioritisation of economic and public relations over openness and transparency concerning the disease, is likely to have contributed to its rapid spread. In Kenya, a Kenya Airways employee was suspended from employment after he shared a video on social media, showing a passenger plane from China landing at the Jomo Kenyatta International Airport in February 2020. The plane had 239 passengers of Chinese descent on board.<sup>46</sup> The video revealed serious gaps in the screening process of passengers for COVID-19 at the airport.

O'Malley, Rainford and Thompson<sup>47</sup> have noted that the challenges that undermine transparency in times of epidemics are three fold. Firstly, there is a reluctance to announce health threats until their nature and source have been scientifically confirmed. Secondly, there is also a reluctance to acknowledge health threats

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<sup>43</sup>World Health Organization, 'Managing Epidemics: Key facts about major deadly diseases,' (2018) <<https://www.who.int/emergencies/diseases/managing-epidemics-interactive.pdf>> accessed 1st April 2020; see also Human Rights Watch, 'Human Rights Dimensions of COVID-19 Response,' (19 March 2020) <[https://www.hrw.org/news/2020/03/19/human-rights-dimensions-covid-19-response#\\_Toc35446579](https://www.hrw.org/news/2020/03/19/human-rights-dimensions-covid-19-response#_Toc35446579)> accessed 1<sup>st</sup> April 2020

<sup>44</sup> Helen Davidson, Chinese inquiry exonerates coronavirus whistleblower doctor, *The Guardian* (Hong Kong, 20 March 2020) < <https://www.theguardian.com/world/2020/mar/20/chinese-inquiry-exonerates-coronavirus-whistleblower-doctor-li-wenliang>> accessed 2<sup>nd</sup> April 2020

<sup>45</sup> BBC, 'Coronavirus: China admits "shortcomings and deficiencies"' (4 February 2020) <<https://www.bbc.com/news/world-asia-china-51362336>> accessed 29th March 2020; see also Chris Buckley and Steven Lee Myers, 'As New Coronavirus Spread, China's Old Habits Delayed Fight,' *New York Times*, (New York, 1 February 2020) <<https://www.nytimes.com/2020/02/01/world/asia/china-coronavirus.html>> accessed 30th March 2020

<sup>46</sup> The Employment and Labour Relations Court has blocked the pending arrest of Mr Gire Ali and ordered his reinstatement.

<sup>47</sup> P. O'Malley, J. Rainford and A. Thompson, 'Transparency during Public Health Emergencies: From Rhetoric to Reality,' [2009] 87 Bulletin of the World Health Organization 614 - 618 <<http://dx.doi.org/10.2471/BLT.08.056689>> accessed 6 April 2020.

that have a potential to cause social, economic and political damage. Finally, information is usually very strictly controlled among those who have it.

The announcement of the first COVID – 19 case in Kenya, raised a public alarm with many people rushing to supermarkets to stock up on basic supplies. Despite the Presidential directive for suppliers not to hike their prices, many small traders across the counties were still able to hike their prices and make a profit from the panic buying of Kenyans.<sup>48</sup> Actual statistics that have come to the knowledge of public officials should be reported, even though they may reveal weaknesses in the healthcare structures and systems, the social and behavioural preventative measures adopted, and the implementation measures. The quality of the information also matters. It should be factual and accurate and reflect the actual state of affairs. Fortunately, risk communication is a core component within the implementation framework under the IHR. The right to information is not only a stand-alone right within the Constitution of Kenya, it is also an essential component of the right to health.<sup>49</sup> Perhaps it is with this in mind that the Law Society of Kenya, two doctors and an NGO petitioned the High Court to summon the Cabinet Secretary (CS) of Health to present a report on the plans that the government has made for surveillance, control and response to the COVID-19 pandemic and Kenya's preparedness. Justice Weldon Korir refused to summon the CS, demonstrating the deference that the judiciary has towards the Executive when it comes to matters dealing with information, policy and decision making during times of a public health emergency. The Honourable Judge stated:

I decline to summon the CS...We must all appreciate that we are now at war with an enemy unknown to man...Although what the petitioners are trying to achieve through this case is also important in the fight against the virus, I do not find it reasonable to call a soldier or a general at the war front to come to court and present a report which can be prepared and filed by his staff.<sup>50</sup>

In spite of this deference, an interdict should then have been granted where a timeline is given for the submission of this report so that Kenyans are aware of the measures that the government is taking in response to this pandemic.

### **3.1.3 The Ethics of Confidentiality during Pandemics**

Confidentiality and privacy should be viewed from both the clinical perspective (between doctor and patient) and from a public health perspective. The sensitivity of health data, no doubt, should be subject to greater protection than normal data. However, during a pandemic or an epidemic, serious questions are raised about privacy and confidentiality and whether they should still be respected. Maintaining confidentiality and privacy of patients promotes their human dignity. From a utilitarian point of view, protecting confidentiality and privacy promotes health seeking behaviours of patients, as they have trust

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<sup>48</sup> Business Today, 'Coronavirus no Excuse for Cooking Gas Price Hikes,' (27 March 2020)

<<https://businesstoday.co.ke/coronavirus-cooking-gas-price-hikes-kenya-illegal-epa-covid-19/>> accessed 30 March 2020; see also Collins Omulo, Uhuru warns traders against hiking prices, *The Daily Nation* (Nairobi, 18 March 2020) <<https://www.nation.co.ke/business/Uhuru-warns-traders-against-hiking-prices/996-5495452-992p4wz/index.html>> accessed 30 March 2020

<sup>49</sup> Article 35(1) of the Constitution of Kenya 2010

<sup>50</sup> Bernice Mbugua, 'COVID-19: Court declines to summon health CS,' *The People Daily*, (Nairobi, March 19th, 2020) <<https://www.pd.co.ke/news/national/covid-19-court-declines-to-summon-health-cs-29093/>> accessed 5 April 2020

and confidence that their health information will not be shared to others who do not have a legitimate interest in receiving that information.<sup>51</sup> The question of who has a legitimate interest to receive information or to know who is suffering from the disease is a pertinent one in a public health emergency. This is because, information may be needed for tracing, screening and testing purposes particularly when there has been exposure, whether deliberately or inadvertently, to a person who has tested positive for COVID-19. In some jurisdictions such as the US, during the polio epidemic, the names of people who had polio were published.

The balancing act is in the maintenance of the human rights of the individual to privacy, protection from stigmatisation and the protection of the vulnerable and already marginalized groups, and in the protection of community and public health. Needless to say, the right to confidentiality and privacy is not an absolute right and there are exceptions to its protection.

The Health Act 2017 provides for user information confidentiality, unless it is disclosed by order of the court or informed consent for health research and policy planning purposes and non – disclosure of the information represents a serious threat to public health.<sup>52</sup> The Public Health Act similarly contains provisions for the Notification of Infectious Diseases.<sup>53</sup> Data protection and disclosure may also be viewed from a national security point of view, where certain information is needed for the promotion of public security concerns. Indeed, COVID-19 raises serious issues on the interface and interrelationship between national health and national security. The criminalisation of those who do not self – isolate or self – quarantine after being exposed or being found positive for the virus, demonstrates this interface well. The government recently issued a statement that the National Police Service as well as the Administration apparatus would be deployed to implement its directives. The stigma attached to identification as a potentially exposed person, may cause people to go into hiding and not go for testing. A framework which recognises the rights of the human being more than the threat of the disease should be formulated. There should be a balancing act where the human rights of the individual should be protected hand in hand with public health.

### ***3.1.4 The ethics of autonomy vis a vis communitarianism***

The principlism approach of ethicists such as Beauchamp and Childress emphasizes that medical principles and ethics like autonomy are the cornerstone of healthcare practice and policy. Autonomy denotes the concept of self-determination, and this in turn will influence a number of things. First, whether a person will voluntarily submit for testing when they have been exposed or when they begin to exhibit symptoms. Second, whether after testing they will want to be treated. Third, can a person have the freedom to be treated from home? In other words, can they refuse to be admitted in a health facility choosing instead to be an outpatient? Can a patient refuse treatment for a potentially deadly and highly infectious disease? Whilst movement may be restricted as a result of the quarantine requirements, can patients be forced to take medication? Can patient autonomy still be respect in a public health emergency?

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<sup>51</sup>C. Jones, 'The Utilitarian Argument for Patient Confidentiality: A Pilot Study of Patients' Views,' (2003) 29 *Journal of Medical Ethics* 348

<sup>52</sup> Health Act 2017, section 11(1) and (2)(c)

<sup>53</sup> Public Health Act (Cap 242, Laws of Kenya) Parts III and IV of the Act; see also *W. v. Egdell* (1990) 1 All ER 835; See also UN Commission on Human Rights, 'The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights,' 28 September 1984, E/CN.4/1985/4, <<https://www.refworld.org/docid/4672bc122.html>> accessed 6 April 2020.

Public health regulations may restrict the rights of the individual who is infectious. But these restrictions are not without limit. In *Daniel Ng'etich & 2 Others v. Attorney General & Others*<sup>54</sup> the court reiterated that the restriction of freedom was in the community interest, and is not to punish the patient and remove their dignity. It declared that the petitioners' confinement in prison was against the intentions of the Public Health Act. This case suggests that restrictions on autonomy (particularly the freedom of movement), can and should be done in a manner that still respects the dignity of the patient or person affected. This principle can be applied during the current COVID-19 crisis.<sup>55</sup>

Whereas restriction of movement can be done without the patient's consent, the question remains as to whether treatment can be done without their consent. The Health Act 2017 suggests that even if a patient (who is also referred to as a "user") has the right to informed consent before treatment is administered; there are exceptions to this general rule. One exception is where "the failure to treat the user, or a group of people which includes the user, will result in a serious risk to public health."<sup>56</sup> Therefore, legally, and perhaps ethically, a patient can be treated without their express or implied consent, without going into the complex arguments as to whether they have the mental capacity to consent to treatment or not.

#### **4. The Right to Health Obligations of the Government in the Context of Public Health Emergencies**

##### **4.1 General Obligations of the Government under Human Rights Law**

The state has a general obligation to respect, protect and fulfil human rights.<sup>57</sup> According to Langford and King, the typology is useful to reaffirm the emerging consensus that civil and political rights, as well as the economic, social and cultural rights are similar and attract the same duties from the state, namely, 'respect (refrain from impeding), protect (ensure others do not impede), and fulfil (actually provide) the conditions necessary for realizing human rights.'<sup>58</sup> The government therefore has to ensure that the right to health is not only respected but also protected and fulfilled including in relation to public health emergencies. Failure to do so will lead to violations and may expose the government to right to health litigation.

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<sup>54</sup> (2016) eKLR

<sup>55</sup> Angela Oketch, 'Covid-19: Uproar over extension of quarantine period,' *The Daily Nation* (Nairobi, 5 April 2020) <<https://www.nation.co.ke/news/Covid-19--Uproar-over-extension-of-quarantine-period--/1056-5514482-4d92ra/index.html>> accessed 5 April 2020 – the extension of the mandatory quarantine period by another 14 days for foreigners and Kenyans who came into the country raises issues about the dignity with which they are being handled. The danger of being infected when one is not positive, the frustrations of no contact with family and the concern about who will bear the costs of the extended quarantine period, are all issues to think about in the public health regulations regarding COVID -19.

<sup>56</sup> Health Act 2017, Section 9(1)(e)

<sup>57</sup> United Nations Committee on Economic, Social and Cultural Rights, 'General Comment No. 12, Right to Adequate Food' (Twentieth Session, 1999), U.N. Doc. E/C.12/1999/5 (1999) para. 5.

<sup>58</sup> Malcolm Langford and Jeff A. King, 'Committee on Economic, Social and Cultural Rights: Past, Present and Future' in Malcolm Langford (ed) *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (Cambridge University Press 2008) 484.

#### 4.2 The Right to Health Obligations

The General Comment No. 14,<sup>59</sup> which is an elaboration of the Article 12 of the ICESCR on the right to health, provides the most useful guidance in the context of right to health and specifically public health emergencies. ICESCR Article 12.2 (c) deals with the right to prevention, treatment and control of diseases. The issue of control of diseases is usually more nuanced during public health emergencies than prevention and treatment. In this regard, General Comment No 14 provides that the control of diseases refers to

States' individual and joint efforts to, *inter alia*, make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunization programmes and other strategies for infectious disease control.

From the above, the government in line with the right to health obligations can take measures such as providing relevant technologies, surveillance and collection of data, and immunization. However, the list is not exhaustive as the government may also pursue 'other strategies for infectious disease control.' Challenges arise when governments sometimes take drastic measures that may be illegal or in contravention of human rights.

Legislation on public health and other public health regulations, guidelines and policies impose restrictions to arbitrariness of governmental measures, and perhaps ensure compliance with the right to health requirements. In Kenya, Part IV of the Public Health Act on prevention and suppression of infectious diseases, provides for, *inter alia*, removal to hospital of infected persons and isolation of persons who have been exposed to infection.<sup>60</sup> This issue arose in the case of *Daniele Ng'etich & 2 Others v Attorney General & 3 Others*<sup>61</sup> where the High Court determined that arresting and detaining TB patients in prisons for failing to adhere to TB medication courses was unconstitutional in Kenya.<sup>62</sup> It therefore appears that even isolation of persons who have been exposed to infection must be conducted in a manner that respects human rights. Isolating people in prison is according to this case, not permissible. It may also be plausible to suggest that quarantining passengers entering the country in a dirty hotel without basic amenities as was recently the case in Gambia may also be found to be unacceptable.<sup>63</sup>

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<sup>59</sup> United Nations Committee on Economic, Social and Cultural Rights, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12),' UN Doc E/C.12/2000/4, 11 August 2000, <<https://www.refworld.org/pdfid/4538838d0.pdf>>, accessed on 25 March 2020.

<sup>60</sup> See Public Health Act, Sections 26 and 27.

<sup>61</sup> (2016) eKLR.

<sup>62</sup> Allan Maleche & Nerima Were, 'Petition 329: A Legal Challenge to the Involuntary Confinement of TB Patients in Kenyan Prisons' (*Health and Human Rights Journal*, 21 June 2016), <<https://www.hhrjournal.org/2016/06/petition-329-a-legal-challenge-to-the-involuntary-confinement-of-tb-patients-in-kenyan-prisons/>> (accessed 25 March 2020).

<sup>63</sup> Freedom Newspaper, 'Breaking News: Quarantined Gambia Experience Passengers Flee from the Golden Beach Hotel after Breaking the Hotel Gate!' (*Freedom Newspaper*, 18 March 2020) <<https://www.freedomnewspaper.com/2020/03/18/breaking-news-quarantined-gambia-experience-passengers-flee-from-the-golden-beach-hotel-after-breaking-the-hotel-door/>> (accessed 26 March 2020).

Kenya also has in place a national infection prevention and control guidelines for health care services in Kenya which outlines the measures that may be taken to control pandemics.<sup>64</sup> The guidelines aims at ensuring standard practices and activities in preventing, identifying, monitoring and control of infections by among others: using scientifically sound measures for preventing and controlling infections; monitoring health care practices; surveillance of infection in health care facilities; reporting infection prevention and control (IPC) activities; providing adequate infrastructure, such as sinks and ventilation and appropriate supplies and equipment; educating and training staff about IPC principles; educating patients, families and members of the community in disease causation, prevention, and control; effectively managing IPC programmes; and, periodically evaluating IPC policies and guidelines. Following these guidelines to the letter will therefore assist the state to comply with its right to health obligations in the context of COVID-19 pandemic. More guidelines however should be developed to deal with COVID-19 and related diseases specifically to be fully compliant with the right to health.

#### **4.3 Provision of Relevant Technologies and Other Personal Protective Equipment**

The government has an obligation to make available relevant technologies to deal with the virus. In Italy, there is a reported case involving a group of volunteers using 3D printer to create unofficial copies of a patented valve for life-saving coronavirus treatments without authorization from the patent owner.<sup>65</sup> The government should ensure that these volunteers are not exposed to legal suits which will in turn interfere with the supply of needed technology and therefore lead to loss of lives. Government should also make available personal protective equipment (PPEs) such as masks and protective clothings. In Kakamega, it was reported that nurses and doctors had flee the hospital when they encountered a patient with symptoms of COVID-19 because they did not have PPEs to handle the patient.<sup>66</sup>

A similar case can be made in relation to medicines and vaccines of COVID-19 when they are discovered. In light of the COVID-19 experience, it is argued that there should be no overreliance henceforth on private sector to provide the medicine that is required and instead proposed system should prioritize public health needs in the wake of industry failure.<sup>67</sup>

#### **4.4 Health-related education, access to information and public participation**

Transparency, access to information and public participation is also important in dealing with a pandemic crisis as has already been discussed. Some individuals have deliberately disobeyed measures imposed by the government in dealing with COVID-19. In Gauteng, South Africa, the health department was forced to

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<sup>64</sup> Ministry of Public Health and Sanitation, *National Infection Prevention and Control Guidelines for Health Care Services in Kenya* (Nairobi, December 2010), <[http://www.ashcott.com/images/IPC\\_GUIDELINES.pdf](http://www.ashcott.com/images/IPC_GUIDELINES.pdf)> (accessed 26 March 2020).

<sup>65</sup> Jay Peters, 'Volunteers produce 3D-printed valves for life-saving coronavirus treatments' (*The Verge*, 17 March 2020), <<https://www.theverge.com/2020/3/17/21184308/coronavirus-italy-medical-3d-print-valves-treatments>> accessed 26 March 2020.

<sup>66</sup> Racheal Nyaguthie, 'Kakamega: Doctors flee from patient with coronavirus-like symptoms' (*Tuko*, 18 March 2020), <<https://www.tuko.co.ke/346799-kakamega-doctors-flee-patient-coronavirus-symptoms.html>> accessed 26 March 2020.

<sup>67</sup> Zain Rizvi, 'Blind Spot: How the COVID-19 Outbreak Shows the Limits of Pharma's Monopoly Model' (19 February 2020), <<https://www.citizen.org/article/blind-spot/>> accessed on 31 March 2020.

obtain a court order to quarantine a family that had tested positive.<sup>68</sup> In Kenya, a patient who was in isolation left the hospital and was later confirmed to have tested positive of the virus.<sup>69</sup> Another case involved a Deputy Governor who failed to quarantine himself as advised by the government and attended official functions upon returning from a foreign trip, and subsequently exposed many people to infection.<sup>70</sup> Ignorance, lack of access to information, and public participation can be reasons for a failure to obey or implement government measures. Indeed, the right to health extends to among others ‘access to health-related information’ and ‘participation of the population in all health-related decision-making at the community, national and international levels.’<sup>71</sup>

The government should further understand that<sup>72</sup>

We are not passive targets either of an oncoming virus, or of governmental programs. Governments must be able to provide adequate and transparent justification for the measures being taken (and those not taken) to contain the virus and protect public health. And contrary to views that people’s active participation would slow down command-and-control decisions regarding the virus, every experience with past outbreaks, everywhere in the world demonstrates that the agency and meaningful (not tokenistic) engagement of individuals and communities is essential for effectively managing the spread of disease.

The government therefore needs the people to be part of the solution as much as possible. The General Comment No 14 in fact sanctions a participatory and transparent process of implementing a national public health strategy and plan as replicated below:<sup>73</sup>

To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised as well as their content, shall give particular attention to all vulnerable or marginalized groups.

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<sup>68</sup>Ntaagae Seleka, ‘Coronavirus: Gauteng health tracks down family that refused to be quarantined after testing positive’ (*News24*, 17 March 2020), <<https://m.news24.com/SouthAfrica/News/coronavirus-gauteng-health-tracks-down-family-that-refused-to-be-quarantined-after-testing-positive-20200317>> accessed 29 March 2020.

<sup>69</sup>Noni Ileri, ‘Coronavirus: Woman who escaped Mbagathi isolation ward tests positive’ (*Kenyans*, 18 March 2020) <<https://www.kenyans.co.ke/news/50976-coronavirus-woman-who-escaped-mbagathi-isolation-ward-tests-positive>> accessed 29 March 2020.

<sup>70</sup>Benard Sanga, Patrick Beja, Weldon Kipkemoi and Cyrus Ombati, ‘How reckless Kilifi Deputy Governor Gideon Saburi put you and I in Coronavirus danger,’ (*The Standard*, 23 March 2020) <<https://www.standardmedia.co.ke/article/2001365251/covid-19-agents-of-death>> accessed 30 March 2020.

<sup>71</sup>CESCR General Comment No. 14, para. 11(n 59 above).

<sup>72</sup>Alicia Ely Yamin & Roojin Habibi, *supra* note 17.

<sup>73</sup>CESCR General Comment No. 14 (n59 above), para. 43(f).

## **5. Responsibility of Patients and Communities in Relation to Public Health Pandemics**

The COVID-19 pandemic,<sup>74</sup> raises interesting and intriguing questions about the responsibility of patients and communities in responding to pandemics generally, and the COVID-19 in particular. From a public health legal-ethical and policy perspective, critical questions include: what responsibilities, if any does a supposed or actual patient have to himself or herself, family and associates, and the general population? Do these include self-disclosure of status, self-reporting, self-isolation or self-quarantine, self-restraint in social and commercial interaction, social distancing, and the like? At whose cost are these responsibilities? Could there be penalties for breach of these responsibilities? Are such responsibilities enforceable legally against the patient? Moreover, does the community in which the actual or supposed patient(s) exist have reciprocal responsibilities and what would they be? Could they possibly include care and concern, reporting, prevention of contagion and spread, mitigating loss and providing support to affected individuals and families, and other proactive community action? How should community responsibility be enforced? Overall, which legal, ethical and policy frameworks govern patient and community responsibility in case of pandemics or major public health emergencies, and are they adequate in the COVID-19 pandemic?

A few preliminary comments are in order. First, the COVID-19 pandemic is highly unusual in its scale and reach. It is global, has spread so fast and is afflicting so many people, communities and nations simultaneously. Not since the 1918 post World War 1 “Spanish flu” has the world experienced anything like this. If anything, there has never been such a global pandemic and public health crisis, and COVID-19 is therefore unprecedented. It is both nobody’s and everyone’s disease and problem. Patient and community responses are therefore not well understood and developed. Academic and scientific literature and knowledge, including on legal-ethical and policy aspects, on COVID-19 is neither abundant nor conclusive. Second, the actual and potential impacts of the COVID-19 pandemic are only at the formative and evolutionary stages, it may take months or years to properly size up the impacts. However, it is clear that the most dramatic impacts would include high mortality rates and widespread disease burden, global and national lock downs, and debilitating socio-economic and other knock-on consequences of global scale. Clearly millions of jobs and livelihoods are at stake, as are entire national and regional economies. These unprecedented negative impacts would arguably make it difficult to prescribe or even predict patient and community responses to the pandemic at this stage.

Third, even assuming full understanding of scientific and technical aspects of COVID-19 and its full impact, there are legal-ethical and policy dilemmas about prescribing or predicting the appropriate patient and community responsibilities in the face of a global pandemic in which they bear no primary responsibility and where they are largely and primarily victims thereof. It would arguably amount to a double jeopardy situation where the victims of a global pandemic are required to bear consequences at law and to have penalties or sanctions imposed or enforced against them.

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<sup>74</sup> The new corona virus which causes an illness known as COVID-19 has spread to more than 150 countries and territories since it was first identified in the Chinese city of Wuhan in December.



## 5.1 Patient and Community Responsibilities

There are no codes of conduct which define duties and responsibilities for patients and communities in times of pandemics, unlike healthcare professionals or health care workers and entities.<sup>75</sup> However, patients and communities in the context of COVID-19 are expected to regularly and thoroughly wash hands with soap or alcohol based sanitizers, create social distance with others, especially those who are coughing or sneezing, avoid to touch their faces, noses, eyes or mouth, avoid hugs, and to stay at home or self-quarantine especially if feeling unwell.

It appears that as the COVID-19 pandemic evolves, some of the key responsibilities of the patient include self-quarantine, self-isolation and self-disclosure. A person who has travelled to or from places where the outbreak has occurred, especially across international boundaries, is duty bound to self-quarantine for a period up to 14 days.<sup>76</sup> In Kenya the legal primary basis for this requirement is the Public Health Act.<sup>77</sup> Apparently, there are legal consequences or penalties for breach of the requirement for self-quarantine. The following case illustrates this point: a Deputy Governor of a coastal county in Kenya was forced to a government institution for quarantine after a public furore for apparently refusing to self-quarantine after travelling back into Kenya from Germany. He tested positive for COVID-19 and the government placed him in quarantine and treatment. He was thereafter charged with committing an offence under the Public Health Act. The Deputy Governor came into contact with numerous people at the county offices, in burials, social and entertainment places, and in his other movements, and these included police officers, political leaders and government officials.<sup>78</sup> Some of the affected people developed symptomatic complications and were admitted to testing and treatment while many went into self-quarantine.<sup>79</sup>

On its part, the Government of Kenya embarked on a plan to quarantine all passengers arriving at the Jomo Kenyatta International Airport on international flights following revelations that most of the confirmed cases were imported into the country through the international airport. The Government announced that henceforth all international flights would be suspended to stem the tide of infections, and that either the passengers would be quarantined at designated hotels at their cost or at government health or residential

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<sup>75</sup>D. Orentlicher, 'The Physician's Duty to Treat during Pandemics,' [2018] 108 *AJPH* 1459, C. Ruderman *et al.*, 'On Pandemics and the duty to care: whose duty? Who cares?' [2006] 7 *BMC Med Ethics* <<https://doi.org/10.1186/1472-6939-7-5>> accessed 6 April 2020, H. Mahm *et al.*, 'Ethics, Pandemics and the Duty to Treat' [2008] 8 *The American Journal of Bioethics* 4, DOI: <10.1080/15265160802317974> accessed 6 April 2020, A. K. Simonds and D. K. Sokol, 'Lives on the Line? Ethics and Practicalities of Duty of Care in Pandemics,' [2009] 34 *European Respiratory Journal* 303, DOI: <10.1183/09031936.00041609> accessed 6 April 2020

<sup>76</sup>China imposed near total lockdown of its corona virus epicentre Wuhan province; most European countries and notably Italy, Spain, France and United Kingdom, as well as Australia, New Zealand, Unites States and Canada, imposed near lockdown guidelines; India, United Arab Emirates, and most African states have blends of lockdown, curfew and other strict control measures

<sup>77</sup>The Public Health Act, the primary legislation applicable to matters of public health crises, authorizes public health authorities, particularly the Minister of Health, to take various actions during public health crises, including declaring an infectious disease a "notifiable infectious disease" or a "formidable epidemic, endemic or infectious disease," and taking the necessary prevention and suppression measures to fight the disease. Specific powers accorded to health authorities for the purpose of prevention and suppression of an infectious disease include search, seizure, and detention powers; the power to designate any place as a quarantine area, including ships and aircraft; and the power to restrict or ban immigration into the country.

<sup>78</sup> *Ibid*, p 3

<sup>79</sup> *Ibid*

facilities.<sup>80</sup> This decision has been criticized as hasty, without adequate preparations and without taking into account the passengers' welfare.<sup>81</sup> The mandatory quarantine and the attendant inconveniences to passengers, including young students is understandable. Government had apparently noted that the voluntary self-quarantine, which had relied on the goodwill of individuals, did not guarantee compliance. It is well established under Kenyan law that the government may confine people against their will if those individuals present a danger to themselves or others, even if the person or persons are confined has not committed an offence. Under the Public Health Act, an individual who is forcefully quarantined does have a right to be released from that quarantine but also has a right to demand some sort of adjudicative process to determine whether the quarantine is justified. The Act states that person can be placed in a place of isolation and detained until, in the opinion of the medical officer of health he or she is free from infection or is able to be discharged without danger to public health. Penalties for breach of self-quarantine or isolation include a maximum fine of KES. 30,000/- or imprisonment for a period of up to three years or both.

The above case scenarios highlight issues of law, ethics and public policy in respect of public health emergencies. First, should a public health crisis such as the COVID-19 be the basis of abrogation of civil rights, including movement and association, and especially of those who are directly afflicted as patients or even as communities? Why should a person or communities suffer both the disease and legal liabilities for failing to self-quarantine, or such other "breach"? Is it not the case that a patient's first duty is to themselves, rather than to the community or undisclosed public? Is it the duty of the individual patient or even international airline passenger to submit themselves to testing for the disease, or does this duty belong to public health authorities to undertake structured and targeted testing and management of cases.

Second, where a public health pandemic such as COVID-19 occurs, who should bear the cost of testing, treatment and quarantine or isolation? In our view, public health authorities should bear the primary burden of the financial and logistical costs especially for the poor and vulnerable groups. It would be unfair and unconscionable to demand, as authorities in Kenya have done, that all patients or arriving passengers on international flights, and by extension their families and communities, should pay for themselves in mandatory quarantine in government designated hotels or other accommodation facilities. After all quarantine measures are ordinarily designed to benefit the wider public as opposed to the individual patient or arriving passenger. Public health law and policy should be aligned accordingly.

Third, the communities have a responsibility to observe all directives legally issued by the government including those relating to curfew and/or national lockdown. These directives are usually enforced by the police or law enforcement agencies and it would be in the best interest of the community to observe them to avoid conflict. Contingency plans however should be put in place to deal with arising issues on a regular basis.

Finally, while it is important that the rights and responsibilities of health care professionals and entities be clarified and settled, especially during pandemics such as COVID-19, it is also important to address the duties and responsibilities of patients and communities.

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<sup>80</sup> Ibid

<sup>81</sup> Ibid

## 6. Health professionals and the ethics of prevention, treatment and care

Ethical dilemmas are common stay encounters amongst health professional in their daily practice.<sup>82</sup> Ethical dilemma encounters and the corresponding challenges posed in decision making for health professionals are exacerbated during pandemics due to among others, the stresses that pandemics place of health systems. As the pipeline of COVID-19 patients in need of critical care and the number of health professionals who are becoming infected in the process of providing care to patients in many countries demonstrate, pandemics are not only likely to overrun the best of the health systems available (in Lombardy, Italy for example) but also present ethical challenges to health providers at unprecedented scale. Hospitals and associations of health professionals are re-writing guidelines on who gets care amid COVID-19 surge in many countries including developed ones.<sup>83</sup> Movement and transfer of health professionals from one jurisdiction to support another in need during times of pandemics suggest that the principles of ethics in the prevention of outbreaks, treatment and care of patients that apply to health professionals are universal.<sup>84</sup> In any event, the Hippocratic Oath, itself an oath of ethics is universal. It is therefore necessary to examine the ethics of prevention, treatment and care, how these principles get tested in pandemics and whether any legislative measure could exist to aid in the application of these principles.

It is broadly accepted that there are four basic principles of healthcare ethics that health professionals must follow in order to ensure optimal patient safety.<sup>85</sup> These are autonomy, beneficence, non-maleficence and, justice. Each of these principles is put into practice differently by each health professional depending on the circumstances and the patient case they face. In this section, these guiding principles are explored in brief, and the challenges that obtain in pandemic situations such as that presented by COVID-19. Further, a survey of the legal instruments that are available particularly in the Kenyan context to provide support to these ethical principles is made.

As an ethical principle, autonomy refers to the ability of a patient to retain control over his or her body. A health professional must determine the wishes of the patient in order to protect his or her autonomy.<sup>86</sup> The relationship between a patient and a health professional is based on trust, as the patient relies on the expertise of the professional.<sup>87</sup> Autonomy forms the basis of the doctrine of informed consent.<sup>88</sup> In healthcare setting, informed consent requires that patients must be informed of the medical interventions they are to be subjected to and must consent to it. A patient's refusal to treatment forms part of this rubric.

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<sup>82</sup>D. Gracia, 'The Intellectual Basis of Bioethics in Southern European Countries,' [1993] 7 *Bioethics* 97

<sup>83</sup>Sacha Pfeiffer, 'U.S. Hospitals Prepare Guidelines For Who Gets Care Amid Coronavirus Surge,' (21 March 2020), <<https://www.npr.org/2020/03/21/819645036/u-s-hospitals-prepare-guidelines-for-who-gets-care-amid-coronavirus-surge>> accessed on 23rd March 2020.

<sup>84</sup>'Cuban doctors travel to Italy to help fight Covid-19,' (*MR Online*, 23 March 2020), <<https://mronline.org/2020/03/23/cuban-doctors-travel-to-italy-to-help-fight-covid-19/>> accessed on 23rd March 2020.

<sup>85</sup>T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics*, (Fourth Edition, Oxford University Press 1994).

<sup>86</sup>Erlanger Medical Ethics Orientation Manual, 2000, <<http://www.utcomchatt.org/docs/biomedethics.pdf>> on 23rd March 2020.

<sup>87</sup>Helen Senderovich, 'The Ethical Responsibility of Health Care Providers to Provide Treatment to Smokers,' (2015) 23 *Annals of Long-Term Care: Clinical Care and Aging* 37.

<sup>88</sup>Jonathan Breslin, Susan MacRae, Jennifer Bell & Peter Singer, 'Top 10 Health Care Ethics Challenges Facing the Public: Views of Toronto Bioethicists,' (2005), 6 *BMC Medical Ethics* E5, DOI: <10.1186/1472-6939-6-5> (accessed 23 March 2020).

An extension of the autonomy strand is that where a patient is not capable due to the illness to give consent, then this responsibility is delegated to the next of kin. The contagious nature of COVID-19 tests this principle as patient isolation is part of the treatment protocol. As such where medical procedures have to be made and the patient is not capable of giving consent, the next of kin can only give consent based not on their own assessment of the condition of the patient, but rather on the explanation given by the health professional. Furthermore, given that there is no cure yet for COVID-19, and health care systems do get overwhelmed such that opportunities for second medical opinions may not be available, the consent giver even where it is the patient, has to exclusively rely on the opinion of the health professional.

The beneficence and non-maleficence principles are related. Beneficence requires a health professional to do all they can to benefit a patient, with all recommended procedures and treatments intended to achieve the best outcome to a patient. Non-maleficence on the other hand is about a health professional's decision concerning a patient "doing no harm" to another individual or society even if such a decision may benefit the patient.<sup>89</sup> These two principles are centered around patient interest with beneficence being a positive requirement and non-maleficence requires restraint from action that may damage a patient's interest.<sup>90</sup> The distinction between the two principles lies in the character of the avoidance of positive harm and the demand for positive benefit.<sup>91</sup> Doing nothing may constitute non-maleficence or a violation of the principle of beneficence depending on the circumstances.

The principles of beneficence and non-maleficence operate all other things being equal. Presumably then, a health professional will do all they can to benefit a patient when all the health commodities and products necessary to enable the professional execute the medical protocols necessary are available. Being a contagion, treatment of COVID-19 patients demands a lot from a health system: from personal protection equipment (PPEs) for the health professionals, ICU beds and ventilators for the patients. Cases have been reported in China, Spain and Italy of high incidences of health professional infections courtesy of unavailability of PPEs in health systems suggesting health professional putting their lives at risk in the quest to do all they can to benefit a patient. Unavailability of adequate numbers of ventilators in hospitals is compromising COVID-19 patient care<sup>92</sup> and as such the health professional has to make life and death decisions which in some circumstances may be seen to be a violation of the principle of non-maleficence, e.g., which patient to put on a ventilator and which one not to.

Justice, as a principle of healthcare ethics, demands that medical goods and services including benefits and burdens of care be distributed fairly across society.<sup>93</sup> Thus, two patients with the same medical need ought to be in general, treated equally.<sup>94</sup> Criteria such as race, citizenship, and celebrity status are not permitted to play a role in organ allocation listing decisions.<sup>95</sup> Furthermore, it is also argued that excluding patients

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<sup>89</sup> Beauchamp and Childress, *Supra* note 87.

<sup>90</sup> Erlanger Medical Ethics Orientation Manual, 2000, *supra* note 88

<sup>91</sup> *Ibid*

<sup>92</sup> Noah Higgins-Dunn and William Feuer, 'Gov. Cuomo says New York needs ventilators now, help from GM and Ford "does us no good"' <<https://www.cnbc.com/2020/03/24/gov-cuomo-says-new-york-needs-ventilators-now-help-from-gm-ford-does-us-no-good.html>>, accessed 23 March 2020.

<sup>93</sup> Erlanger Medical Ethics Orientation Manual, 2000, *supra* note 88

<sup>94</sup> Beauchamp and Childress, *supra* note 87.

<sup>95</sup> Nikhil A. Patel, 'Health and Social Justice: The Role of Today's Physician,' [2015] 17 *AMA J Ethics* 894 doi: <10.1001/journalofethics.2015.17.10.fred1-1510> accessed 6 April 2020.

based on ability to pay may lead to erosion of public trust in a health system.<sup>96</sup> Ultimately, justice in the context of healthcare ethics requires that some groups should not succumb to death and disease disproportionately while advantages protect others, due to disparities in health care provision among the population (Patel, 2015). Obviously, this responsibility runs beyond the scope of a health professional, notwithstanding being at the penultimate end of attainment of social justice with regard to healthcare. COVID-19 has exposed the soft underbelly of what were hitherto considered to be strong health systems. In the US for example, claims have been made that National Basketball Association (NBA) players got ahead of the line for COVID-19 tests and high-profile citizens were tested despite being asymptomatic.<sup>97</sup> Incidences of diversion or blockade of material shipments to countries ostensibly based on trade rules, and the idea to direct supplies to those in need rather than those with the ability to pay have been reported.<sup>98</sup> While these examples are only indicative, it is apparent that parity and equality of access to health care will remain tested in the course of prevention, treatment and care of COVID-19 patients.

Does the law come in aid in any way to complement the ethical principles in place especially in a country such as Kenya? The Constitution, by providing for the right to health as a social economic right (article 43), must be seen as forming a solid foundation for supplementary application of these ethical principles. While health law in Kenya is still at infancy courtesy of a myriad factors- weak health research and development capacity, poor health delivery infrastructure, fragmentation in hierarchy of health care to name a few, a number of legislation further cement these ethical principles into Kenya's health system and provide a basis for decision making in treatment of pandemics. For example, the Consumer Protection Act<sup>99</sup> provides legislative basis for furtherance of the autonomy principle, which is not only grounded in the constitutional provisions but also in the Medical Practitioners and Dentists Act.<sup>100</sup> The Public Health Act<sup>101</sup> and the Occupational Safety and Health Act<sup>102</sup> provide for the occupational and hygienic conditions for places, such as where health professionals work, should meet. A health professional therefore in trying to provide the best care possible to a patient must bear in mind that legislation requires that in the first place, the professional must be properly equipped for personal safety. The dilemma whether a specific medical procedure should be undertaken, i.e. that the health professional should do nothing because PPEs are not available is not foreseen by the law. Finally, Article 27 of the Constitution is broadly expressive on equality and freedom from non-discrimination. Equality in enjoyment of all rights and fundamental freedoms is guaranteed. Discrimination on all grounds is chastised. As such it behooves the State to ensure that healthcare services are accessible in an equal and non-discriminatory manner. This is particularly critical with COVID-19, a disease whose mode of transmission is disobedient to economic and social status and is overwhelming health systems in unprecedented manner. Finally, the Code of Professional Conduct and

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<sup>96</sup> Aaron Wightman and Douglas Diekema, Should an Undocumented Immigrant Receive a Heart Transplant? [2015] 17 *AMA J Ethics* 909, doi: <10.1001/journalofethics.2015.17.10.peer1-1510> accessed 6 April 2020.

<sup>97</sup> Juliet Eilperin and Ben Golliver, 'VIPs go to the head of the line for coronavirus tests,' *Washington Post*, (Washington, DC, 19 March 2020) <<https://www.washingtonpost.com/health/2020/03/19/nba-players-celebrities-coronavirus-test-access/>> accessed on 23<sup>rd</sup> March 2020.

<sup>98</sup> Jan Dahinten and Matthias Wabl, 'Germany Faces Backlash From Neighbors Over Mask Export Ban,' *Bloomberg*, (New York, 9 March 2020) <<https://www.bloomberg.com/news/articles/2020-03-09/germany-faces-backlash-from-neighbors-over-mask-export-ban>> accessed on 24<sup>th</sup> March 2020.

<sup>99</sup> No. 46 of 2012

<sup>100</sup> Cap. 253.

<sup>101</sup> Cap. 242.

<sup>102</sup> No. 15 of 2007.

Discipline promulgated by the Medical Practitioners and Dentists Board fortifies the ethical principles of medical ethics and gives them a force of law.

### **7. Guidelines on ethical and legal issues presented by the COVID 19 pandemic**

Effective responses to COVID-19 will require that a delicate balance be struck between the many competing interests and values that the pandemic has thrown up for Kenya. It is proposed that Kenya's interventions be structured around respect, protection, promotion and fulfilment of human rights. A rights-based approach increases the likelihood that COVID-19 measures are less likely to be inordinately burdensome to certain individuals or groups and that the inherent dignity of all is held paramount. A rights-based approach also lessens the specter of discrimination both in the context of allocation of health related goods, facilities and services and in the removal of stigma that may be directed against those perceived to be afflicted by COVID-19. While the Constitution may provide general principles, there are specific ethical and legal guidelines that should be at the forefront of measures taken to deal with COVID-19.

#### **7.1 Equitable allocation of health goods, facilities and services and underlying determinants of health**

Government must prioritise its resource allocation so that no section of the population is unable to access and utilize health resources such as hospitals, personnel, medicines and other relevant primary health needs. As such, both National and County Governments must ensure that facilities are erected or improved and made accessible to the population in an equitable manner. Facilities must have the relevant health personnel in sufficient numbers and who must be properly equipped. In the long run, the Government must assess the state of underlying determinants of health such food, sanitation, water and shelter with a view to establishing how shortages can be ameliorated so as to improve the general health of the population. This means that investment in preventive health care must also be enhanced.

#### **7.2 Confidentiality, privacy and human dignity**

The virulent nature of COVID-19 and the public danger it poses must not be excuses to undermine the very core of rights that define a human being. In all instances, confidentiality must be promoted and health information that should be held private should remain so. Disclosure must be absolutely justified and be within the bounds of the Constitution. Disclosure only meant to expose patients or their family is a violation because it will likely be followed by stigmatization and discrimination. Known patients must be accorded full dignity and be treated as patients and not threats. If information is required for public purposes such stating morbidity and mortality, such information must be verified. Sensationalised reporting or opinions should be discouraged.

#### **7.3 Public health responsibilities for members of the public**

The risk that COVID-19 represents requires that members of the public be responsible for slowing down and eliminating the spread of the pandemic. Personal hygiene measures such as washing hands at regular intervals must be taken seriously. Directives and or recommendations such as social distancing must be adhered to. Citizens must respect self-isolation and self-reporting measures imposed or recommended by the Government. Moreover, citizens must ultimately realise that the right to health does not entail the right to be healthy meaning that many steps for health are self-driven. Citizens also have the responsibility to look out for their neighbours. While they must be vigilant on the risks posed by infected neighbours, they must not violate the rights of others in the guise of vigilance. They must not spread false and alarmist

information because this is not only dangerous but it also diverts resources which would otherwise be spent more efficiently.

#### **7.4 Health professionals and the ethics of prevention, treatment and care**

Because, health professionals are in the front line in the fight against COVID-19, they are at a higher risk of infection than the general population. They must be properly trained and equipped. The Government must provide not only personal protective equipment, but also other tools (such as testing kits) that enable health professionals provide effective care for patients. Properly equipped healthcare workers will have no excuse to refuse to attend to persons suspected of being COVID-19 positive (or patients). Refusal to render care where no risk is posed to the carer must attract appropriate sanctions as contemplated under law.

#### **7.5 Public participation and responsibility**

COVID-19 is a communal threat that requires concerted responses. Infection of one individual may mean infection of all. Therefore, communities in Kenya, regardless of how constituted should be encouraged to take part in the formulation and implementation of measures meant to temper the spread of COVID-19. The ethics of public participation in decision-making inherent in the Constitution must be tailored to enable the community be part of the solution.

#### **7.6 Restriction of rights such as freedom of movement and freedom of association**

Increasingly, the Government is having to impose restrictions on certain individual rights as a way of stemming the spread of COVID-19. It may be necessary that the freedom of movement and the freedom of association be limited as a response to the pandemic. In such situation, it is important that the limitations be done in full compliance with Constitutional clauses on limitation of rights, that is to say, the limitation must be specified in law in addition to it being necessary in an open and democratic society. Enforcement of the restrictions must also comply with the law and be reasonable. Arbitrary arrests and beating of citizens must not be allowed and where it so happens appropriate sanctions ought to be imposed.

#### **7.7 Access to justice**

Since responses to COVID-19 are likely to be extra-ordinary, there is increased potential of official overreach. It is important that courts and other institutions are available to provide an opportunity for redress of possible government excesses. While court operations can be structured around the public health concerns, tools that enable citizens to seek justice need not be placed completely out of reach.

#### **7.8 International responsibility**

COVID-19 having been declared an international pandemic, the international community must work together to rid the world of COVID 19 by providing resources to improve access to health goods, facilities and services. Global health organisations must allocate available resources equitably and pay special regard to countries that are especially vulnerable.

### **8. Conclusion**

COVID-19 is a pandemic of international concern. The WHO relying on international instruments public health pandemics such as the IHR has been coordinating efforts to deal with COVID-19 at the international level. The crisis will be handled if international cooperation and assistance is also emphasized. The virus has hit many countries including Kenya. As expected, the authorities have declared various emergency

public health measures whose challenges are addressed in this paper. The main question addressed how to protect public health in a legally and ethically sound manner. There is a need to put in place proper guidelines to manage available resources, and this should not be based on utilitarian but egalitarian understanding of the crisis especially in the context of developing countries where resources to fight the virus are constrained. It also appears that criminalizing self-quarantine may achieve poor outcomes since many people will hide as opposed to presenting themselves for testing as a result of stigma. Individual autonomy is also usually restricted in the interest of public health and isolation and treatment may be made without consent of the patient. The authorities however should be prepared to bear the primary economic burden of all the public health measures put in place including cost of quarantine where necessary. In the context of extreme measures such as curfews and national lockdowns, contingency measures should be put in place to deal with emerging situations on a case by case basis. Lastly, there should be developed a comprehensive guideline covering the rights, duties and/or responsibilities of the government, health professionals, (international) community, and patients. The existence of such a guideline in the country will help achieve right to health ends than is currently being realized.



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