

## Ensuring Healthy Lives and Well-being for All Kenyans

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### *Abstract*

*Sustainable Development Goal (SDG) 3 of the United Nations 2030 Agenda on Sustainable Development obligates State Parties to work towards ensuring healthy lives and well-being of people of all ages in their territories by the year 2030. The Corona Virus Disease Pandemic (COVID-19) has drawn the attention of all countries to the status of their health system, mostly by exposing the weaknesses. This ranges from the inadequate health facilities, shortage of health workers and even the limited financial investment in emergency treatment requirements. The results have been devastating on most countries' economies. Kenya has not been left behind as it has had to mainly rely on grants and loans from foreign sources to meet its public health obligations and needs. This paper highlights these challenges in line with Sustainable Development Goal 3 (SDG 3) which requires all states to put in place measures geared towards ensuring healthy lives and the general well-being of their citizens. The paper also offers some recommendations in line with the same.*

### **1. Introduction**

The Corona Virus Disease Pandemic (COVID-19) has exposed and brought to the attention of the whole world just how important health and well-being of the population is. Indeed, the fact that COVID-19 has affected all sectors of the global economy is evidence enough that human health and well-being form the backbone of the global economy. It has become clear that no matter how much governments invest in other areas of the economy, if the health sector is ailing, then all the other efforts come to naught. Indeed, it has been argued that 'health care is not only a problem of healthcare but also a problem of a profound social nature, making it an integral part of all the social and economic development conditions'.<sup>1</sup>

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While Kenya has been investing and making efforts towards guaranteeing the realisation of the right to health care and well-being for all, there are still a lot of challenges facing the health sector. This paper discusses some of the main challenges and offers recommendations on what the country can do in its efforts towards realisation of Sustainable Development Goal (SDG) 3 on ensuring healthy lives and well-being of all its citizens.<sup>2</sup> SDG 3 spells out the

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<sup>1</sup> Tomaziu-Todosia M, 'The Importance of Public Health Policies in the Social-Economic Development of Romania' (2019) 10 *Postmodern Openings* 162.

<sup>2</sup> SDG 3 seeks to "ensure healthy lives and promote well-being for all at all ages". The Health targets for SDG 3 include: By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births; By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births; By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases; By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being; Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol; By 2020, halve the number of global deaths and injuries from road traffic accidents; By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes; Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all; By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination; 3.a Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate; 3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all; 3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States; and 3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks.

(‘WHO | Sustainable Development Goal 3: Health’ (WHO))

specific targets and end goals that countries should aspire to achieve. Notably, SDG 3 outlines targets that touch on various aspects of right to health for all groups of people, including men, women and children and their group-specific health needs.

## 2. Right to Health: Definition and Scope

The 1946 Constitution of the World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The preamble further states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”<sup>3</sup>

The *CESCR General Comment No. 14 on The Right to the Highest Attainable Standard of Health*<sup>4</sup>, defines the right to health as a; “... a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.”<sup>5</sup>

Arguably, the right to health is conditioned by the health system and the socio-economic factors, which are reflected in the health of the population.<sup>6</sup> Notably, socioeconomic status underlies three major determinants of health: health care, environmental exposure, and health behaviour.<sup>7</sup>

The World Health Organization's Commission has defined the Social Determinants of Health, that is, the factors apart from medical care that can be

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<http://www.who.int/topics/sustainable-development-goals/targets/en/> accessed 16 December 2020).

<sup>3</sup> Preamble, *Constitution of the World Health Organization*, Basic Documents, Forty-fifth edition, Supplement, October 2006, pp.1-18.

<sup>4</sup> UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

<sup>5</sup> *Ibid.*, para. 1.

<sup>6</sup> Tomaziu-Todosia M, ‘The Importance of Public Health Policies in the Social-Economic Development of Romania’ (2019) 10 *Postmodern Openings* 162.

<sup>7</sup> Nancy E Adler and Katherine Newman, ‘Socioeconomic Disparities in Health: Pathways and Policies’ (2002) 21 *Health Affairs* 60.

influenced by social policies and shape health in powerful ways, as “the conditions in which people are born, grow, live, work and age” and “the fundamental drivers of these conditions”.<sup>8</sup> Related to this is the fact that ‘health-related behaviours are strongly shaped by social factors, including income, education, and employment’.<sup>9</sup>

The scope, content and nature of State obligations under Article 12 of the ICESCR have been expounded by the *Committee on Economic, Social and Cultural Rights (CESCR)* under the *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*.

The *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*<sup>10</sup> acknowledges that ‘the right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement, all of which and other rights and freedoms address integral components of the right to health.’<sup>11</sup>

It has been observed that while it is difficult to pinpoint exactly what the right to health entails, there are specific elements that constitute the core content of the right to health and these include: a) access to maternal and child health care, including family planning; b) immunisation against the major infectious diseases; c) appropriate treatment of common diseases and injuries; d) essential drugs; e) adequate supply of safe water and basic sanitation; and f) freedom from serious environmental health threats. In addition to the scope of core content, a number of guidelines constitute the framework of the right to health: a) availability of health services; b) financial, geographic and cultural

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<sup>8</sup> Paula Braveman and Laura Gottlieb, ‘The Social Determinants of Health: It’s Time to Consider the Causes of the Causes’ (2014) 129 *Public Health Reports* 19.

<sup>9</sup> *Ibid.*

<sup>10</sup> UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

<sup>11</sup> *Ibid.*, para. 3.

accessibility of health services; c) quality of health services; and d) equality in access to available health services.<sup>12</sup>

In addition to the foregoing, the right to health is also considered to be part of the broader right to an adequate standard of living.<sup>13</sup> Under Article 25(1) of the 1948 Universal Declaration of Human Rights, ‘everyone has the right to a standard of living adequate for the health and well-being of himself and his family’ and this includes the following elements: a) food; b) clothing; c) housing; d) medical care; and e) necessary social services.<sup>14</sup> These elements are also all captured under Article 43 of the Constitution of Kenya 2010 on socio-economic rights.

It is therefore evident that the right to health is not a standalone right but instead it is intertwined with many other rights.

### **3. Right to Health: International and National Legal Frameworks**

#### **3.1. Right to Health and International Law**

The *Universal Declaration of Human Rights*<sup>15</sup> guarantees that ‘everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control’.<sup>16</sup> In addition, ‘motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection’.<sup>17</sup>

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<sup>12</sup> ‘The Right to Health’ (*Icelandic Human Rights Centre*)

<<https://www.humanrights.is/en/human-rights-education-project/human-rights-concepts-ideas-and-fora/substantive-human-rights/the-right-to-health>> accessed 16 December 2020.

<sup>13</sup> *Ibid.*

<sup>14</sup> *Ibid.*

<sup>15</sup> UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III).

<sup>16</sup> *Ibid.*, Article 25(1).

<sup>17</sup> *Ibid.*, Article 25(2).

The *International Covenant on Economic, Social and Cultural Rights*<sup>18</sup> is one of the main international human rights instrument laying basis for a comprehensive recognition of the right to health. It guarantees that ‘the States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.<sup>19</sup> In addition, ‘the steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and the creation of conditions which would assure to all medical service and medical attention in the event of sickness.’<sup>20</sup>

The *Convention on the Elimination of All Forms of Discrimination against Women*<sup>21</sup> captures the State Parties’ concern that in situations of poverty women have the least access to food, *health*, education, training and opportunities for employment and other needs.<sup>22</sup> The Convention requires State Parties to take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women, *inter alia*: access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.<sup>23</sup> In addition, States Parties are to take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular,

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<sup>18</sup> UN General Assembly, *International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights and Optional Protocol to the International Covenant on Civil and Political Rights*, 16 December 1966, A/RES/2200.

<sup>19</sup> *International Covenant on Economic, Social and Cultural Rights, International Covenant on Civil and Political Rights and Optional Protocol to the International Covenant on Civil and Political Rights*, Article 12(1).

<sup>20</sup> *Ibid* Article 12(2).

<sup>21</sup> UN General Assembly, *Convention on the Elimination of All Forms of Discrimination against Women*, 18 December 1979, A/RES/34/180.

<sup>22</sup> *Ibid*, Preamble.

<sup>23</sup> *Ibid*, Article 10 (h).

*inter alia*: the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.<sup>24</sup>

Besides the foregoing, the Convention states 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.<sup>25</sup> Notwithstanding the provisions of paragraph I of this article, States Parties are also obligated to ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.<sup>26</sup>

The State Parties to this Convention are supposed to ensure that these rights extend to all women including those in the rural areas by ensuring that they have, *inter alia*, access to adequate health care facilities, including information, counselling and services in family planning.<sup>27</sup>

The *Convention on the Rights of the Child*<sup>28</sup> requires that States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform to the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.<sup>29</sup> Under the Convention, States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall thus strive to ensure that no child is deprived of his or her right of access to such health care services.<sup>30</sup> In line with this, States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: to diminish infant and child

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<sup>24</sup> *Ibid*, Article 11(f).

<sup>25</sup> *Ibid*, Article 12(1).

<sup>26</sup> *Ibid*, Article 12(2).

<sup>27</sup> *Ibid*, Article 14.

<sup>28</sup> UN Commission on Human Rights, *Convention on the Rights of the Child*, 7 March 1990, E/CN.4/RES/1990/74.

<sup>29</sup> *Ibid*, Article 3(3).

<sup>30</sup> *Ibid*, Article 24(1).

mortality; to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; to combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution; to ensure appropriate pre-natal and post-natal health care for mothers; to ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; and to develop preventive health care, guidance for parents and family planning education and services.<sup>31</sup>

The *African Charter on Human and Peoples' Rights*<sup>32</sup> guarantees that 'every individual shall have the right to enjoy the best attainable state of physical and mental health'.<sup>33</sup> In addition, States Parties to the Charter are obligated to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.<sup>34</sup>

Notably the foregoing international and regional legal instruments spell out the state obligations relating to the realization of the right to health which obligations relate to: the obligations to *respect*, *protect* and *fulfil*. Under the *General Comment No. 14 on the right to health*:

The *obligation to fulfil* contains *obligations to facilitate, provide and promote*. The *obligation to respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The *obligation to protect* requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the *obligation to fulfil* requires States to adopt appropriate

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<sup>31</sup> Ibid, Article 24(2).

<sup>32</sup> Organization of African Unity (OAU), *African Charter on Human and Peoples' Rights ("Banjul Charter")*, 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982).

<sup>33</sup> Ibid, Article 16(1).

<sup>34</sup> Ibid, Article 16(2).

legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.<sup>35</sup>

These obligations are in turn captured under the domestic laws of state parties and are supposed to define the content of legal and institutional frameworks. Notably, the right to health is not to be understood as a right to be healthy but it contains both freedoms and entitlements.<sup>36</sup> The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. On the other hand, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.<sup>37</sup>

### **3.2. Right to Health under the Domestic Law in Kenya: Legal and Institutional Framework**

Notably, Article 2 (5) and (6) of the Constitution of Kenya make any treaty or convention ratified by Kenya, part of the laws applicable to Kenya.<sup>38</sup> Thus, in addition to the legal instruments discussed under this section, the international ones discussed in the foregoing section are also applicable in Kenya in so far as the same have been ratified accordingly.

The Constitution of Kenya 2010 has numerous provisions that capture not only the various elements of the right to health/health care services but also guarantees this right for all groups of persons.<sup>39</sup>

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<sup>35</sup> UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, para. 33.

<sup>36</sup> UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, para. 8.

<sup>37</sup> UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, para. 8.

<sup>38</sup> See also Treaty making and Ratification Act, No. 45 of 2012, Laws of Kenya.

<sup>39</sup> Section 26 of the Bill of Rights provides for the fundamental right to life.

Article 27(1) and (2) of the Constitution of Kenya states that every person is equal before the law and has a right to equal protection, equal benefit and equal enjoyment of all rights and fundamental freedoms. (4) The State shall not

The Constitution guarantees that ‘every person has the right— to the highest attainable standard of health, which includes the right to health care services,

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discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth.

Article 43 (1) (a) of the Constitution provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.

Article 43 (2) also provides that a person shall not be denied emergency medical treatment.

#### Article 46. Consumer rights

(1) Consumers have the right—

(a) to goods and services of reasonable quality;

(c) to the protection of their health, safety, and economic interests;

#### Article 53. Children

(1) Every child has the right—

(c) to basic nutrition, shelter and health care;

(d) to be protected from abuse, neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment, and hazardous or exploitative labour;

#### 56. Minorities and marginalised groups

The State shall put in place affirmative action programmes designed to ensure that minorities and marginalised groups—e) have reasonable access to water, health services and infrastructure.

#### 57. Older members of society

The State shall take measures to ensure the rights of older persons—

(d) to receive reasonable care and assistance from their family and the State.

#### 204. Equalisation Fund

(2) The national government shall use the Equalisation Fund only to provide basic services including water, roads, health facilities and electricity to marginalised areas to the extent necessary to bring the quality of those services in those areas to the level generally enjoyed by the rest of the nation, so far as possible.

including reproductive health care.<sup>40</sup> Article 43(2) thereof also provides that a person shall not be denied emergency medical treatment.<sup>41</sup>

The state of health is closely the state of the environment and as such, Article 42 of the Constitution guarantees that ‘every person has the right to a clean and healthy environment, which includes the right to have the environment protected for the benefit of present and future generations through legislative and other measures, particularly those contemplated in Article 69; and to have obligations relating to the environment fulfilled under Article 70.’<sup>42</sup>

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<sup>40</sup> Constitution of Kenya 2010, Article 43(1).

<sup>41</sup> Ibid, Article 43(2). Art 42: See also Article 26. Right to life

*(1) Every person has the right to life.*

*(2) The life of a person begins at conception.*

*(3) A person shall not be deprived of life intentionally, except to the extent authorised by this Constitution or other written law.*

*(4) Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.*

<sup>42</sup> In *Kiluwa Limited & another v Commissioner of Lands & 3 others* [2015] eKLR, Constitutional Petition 8 of 2012, the Court stated as follows:

*137. The right to a clean and healthy environment, guaranteed under 42 of the Constitution includes the right to have the environment protected for the benefit of the present and future generations not only through legislative and other measures, and particularly those measures contemplated in Article 69 to ensure inter alia sustainable exploitation, utilization, management and conservation of the environment and natural resources and ensure the equitable sharing of the accruing benefits.*

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*142. On the question of the right to clean and healthy environment, though Article 43 of the Constitution guarantees that right, it would not be remiss for this court to refer to the much earlier law, the Environment Management and Control Act No. 8 of 1999 (EMCA) which came into force on 14th January, 2000 (as amended by Acts of that name Nos. 6 of 2006, No. 17 of 2006, and No. 5 of 2007), had in section 3(1) thereof, declared that every person in Kenya is entitled to a clean and healthy environment, and has the duty to safeguard and enhance the environment. That right is granted constitutional sanctity in Article 42 of the constitution, that every person has the right to a clean and healthy environment and this includes –*

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(a) *the right to have the environment protected for the benefit of present and future generations through legislative and other measures, particularly, those contemplated in Article 69, and*

(b) *to have the obligations relating to the environment fulfilled under Article 70.*

143. *Under section 3(2) of EMCA, the entitlement to a clean and healthy environment under section 3(1) includes the access by any person in Kenya to the various public elements or segments of the environment for recreational, educational, health, spiritual and cultural purposes. Section 3(4) gives capacity or standing to any person to bring an action notwithstanding that such a person cannot show that the Defendant's act or omission has caused or is likely to cause him any personal injury provided that such action—*

(a) *is not frivolous or vexatious, or*

(b) *is not an abuse of the court process.*

144. *An action seeking any orders on protection of the environment, may include orders to -*

(1) *prevent, discontinue any act or omission deleterious to the environment;*

(2) *to compel any public officer to take measures to prevent or discontinue any act or omission deleterious to the environment.*

145. *In granting any of the above orders, the court will be guided by the following principles –*

(1) *the principle of public participation in the development of policies, plans and processes for the management of the environment;*

(2) *the cultural and social principles traditionally applied by any community in Kenya for the management of the environment or natural resources in so far as the same are relevant and are not repugnant to justice and morality or inconsistent with any written law;*

(3) *the principles of international co-operation on the management of environmental resources shared by two or more states;*

(4) *the polluter pays principle; and*

(5) *the precautionary principle.*

This connection has been affirmed in various courts, locally and internationally.<sup>43</sup> In the case of *Peter.K.Waweru vs R*<sup>44</sup>, the High Court of Kenya affirmed that indeed, the right to life and right to clean and healthy environment are connected, in the following words:

***“it is quite evident from perusing the most important international instruments on the environment that the word life and the environment are inseparable and the word “life” means much more than keeping body and soul together.”***

The UN Conference on the Human Environment 1972, that is the Seminal Stockholm Declaration noted that the environment was “*essential to ... the enjoyment of basic human rights – even the right to life itself.*” Principle 1 asserts that:

*“Man has the fundamental right to freedom, equality and adequate conditions of life; in an environment of a quality that permits a life of dignity and well-being.”*<sup>45</sup>

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<sup>43</sup> Peter K. Waweru v Republic [2006] eKLR, Mis.Civl Appli.No. 118 OF 2004; In Ms. Shehla Zia v. WAPDA, PLD 1994 SC 693 Justice SALEEM AKHTAR (Supreme Court of Pakistan) held as follows:

*“The Constitution guarantees dignity of man and also right to “life” under Article 9 and if both are read together, question will arise whether a person can be said to have dignity of man if his right to life is below bare necessity line without proper food, clothing shelter education, healthcare, clean atmosphere and unpolluted environment.”*

<sup>44</sup> Peter K. Waweru v Republic [2006] eKLR, Mis.Civl Appli.No. 118 OF 2004.

<sup>45</sup> As quoted in Peter K. Waweru v Republic [2006] eKLR, Mis.Civl Appli.No. 118 OF 2004.

In *Mohamed Ali Baadi and others v Attorney General & 11 others* [2018] eKLR<sup>46</sup>, the High Court of Kenya stated as follows:

109. *In addition to the above, one of the issues implicated in this Petition is what is now generally recognized minimum requirements for existence of environmental democracy, namely, "the tripartite of the so-called access rights in environmental matters, namely, (a) access to information, (b) participation in decision-making, and (c) access to justice."*[53] *These three access rights have the common denominator that they empower individuals to have a meaningful voice in decisions that affect them and their development. The Constitution of Kenya and Environmental Law recognizes these three access rights.*

110. *As pointed out later in this judgment, the above rights are also intertwined in that achievement and application of each impact on realization of the others. For instance, access to information ensures that all persons who choose to participate in environmental decision-making are equipped with the necessary, or at least, basic facts about quality of their environment and their legitimate expectation on the same.*

111. *Thus, violation of rights to a clean and healthy environment can easily lead to the violation of other rights in the Bill of Rights such as the right to life. Yet, the determination of violations or threats of violation of any rights in the Bill of Rights undoubtedly falls within the province of this Court.*

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277. *Article 70 of the Constitution confers standing upon a person who alleges violation of rights to a clean and healthy*

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<sup>46</sup> Mohamed Ali Baadi and others v Attorney General & 11 others [2018] eKLR, Petition 22 of 2012.

*environment. This means that “the environmental right is sufficiently comprehensive and all-encompassing to provide ‘everyone’ with the possibility of seeking judicial recourse in the event that any of several potential aspects related to the right or guarantee derived there from is infringed.” From the foregoing, it is clear that protection of the environment has now become an urgent responsibility to which our legal system responds to inadequately. It is undisputed that environmental protection in Kenya has constitutional protection.*

The right to clean and healthy environment is thus recognised under the laws of Kenya as an integral part of the right to health and general well-being for all people.<sup>47</sup>

The Health Act, 2017<sup>48</sup> was enacted to establish a unified health system, to coordinate the inter-relationship between the national government and county government health systems, to provide for regulation of health care service and health care service providers, health products and health technologies and for connected purposes.<sup>49</sup> The objects of the Act are to—establish a national health system which encompasses public and private institutions and providers of health services at the national and county levels and facilitate in a progressive and equitable manner, the highest attainable standard of health services; protect, respect, promote and fulfill the health rights of all persons in Kenya to the progressive realization of their right to the highest attainable standard of health, including reproductive health care and the right to emergency medical treatment; protect, respect, promote and fulfill the rights of children to basic nutrition and health care services contemplated in Articles 43(1) (c) and 53(1) (c) of the Constitution; protect, respect, promote and fulfill the rights of vulnerable groups as defined in Article 21 of the Constitution in all matters regarding health; and recognize the role of health regulatory bodies

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<sup>47</sup> See Muigua, K., "Reconceptualising the Right to Clean and Healthy Environment in Kenya." (2015).

<sup>48</sup> Health Act, No. 21 of 2017, Laws of Kenya.

<sup>49</sup> Ibid, Preamble.

established under any written law and to distinguish their regulatory role from the policy making function of the national government.<sup>50</sup>

The Health Act, 2017 guarantees that it is a fundamental duty of the State to observe, respect, protect, promote and fulfill the right to the highest attainable standard of health including reproductive health care and emergency medical treatment by inter alia—developing policies, laws and other measures necessary to protect, promote, improve and maintain the health and well-being of every person; ensuring the prioritization and adequate investment in research for health to promote technology and innovation in health care delivery; ensuring the realization of the health related rights and interests of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalized communities and members of particular ethnic, religious or cultural communities; ensuring the provision of a health service package at all levels of the health care system, which shall include services addressing promotion, prevention, curative, palliative and rehabilitation, as well as physical and financial access to health care; and ensuring adequate investment in research for health to promote technology and innovation in health care delivery.<sup>51</sup>

The Health Act also guarantees that every person has the right to the highest attainable standard of health which shall include progressive access for provision of promotive, preventive, curative, palliative and rehabilitative services.<sup>52</sup> In addition, every person shall have the right to be treated with dignity, respect and have their privacy respected in accordance with the Constitution and this Act.<sup>53</sup>

The other relevant national legal instruments include: Public Health Act Cap 242<sup>54</sup>; Public Health Officers (Training Registration and Licensing) Act of

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<sup>50</sup> Health Act, 2017, sec. 3.

<sup>51</sup> Health Act, 2017, sec. 4.

<sup>52</sup> Health Act, 2017, sec. 5(1).

<sup>53</sup> Health Act, 2017, sec. 5(2).

<sup>54</sup> An Act of Parliament to make provision for securing and maintaining health.

2013<sup>55</sup>; Kenya Health Sector Referral Implementation Guidelines 2014<sup>56</sup>; Kenya Health Sector Referral Strategy 2014-2018; Kenya Health Policy 2012-2030<sup>57</sup>; and Kenya National Patients' Right Charter 2013<sup>58</sup>.

While Kenya's healthcare system is made up of several systems: public, private and faith-based or NGO, it is estimated that about 48% are public and operate under the Ministry of Health, 41% are in the private sector, 8% are faith-based health services, and 3% are run by NGOs.<sup>59</sup>

In a bid to implement Sustainable Development Goal 3 on Good Health and Well-being, the institutional stakeholders working together in Kenya include but are not limited to: Ministry of Health (MOH); Ministry of labour;

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<sup>55</sup> An Act of Parliament to make provision for the training, registration and licensing of public health officers and public health technicians, to regulate their practice, to provide for the establishment, powers and functions of the Public Health Officers and Public Health Technicians Council and for connected purposes.

<sup>56</sup> The goal of the referral guidelines is to guide the effective management of referral services to ensure continuity of care and effective management of the health needs of the population of Kenya (para. 1.4.1); The referral guidelines have the following objectives: Increase the use of services at lower levels of the health care system; Reduce self-referral to the higher levels of care; Develop service providers' capacity to offer services and appropriately refer at each level of the health care system; Improve the health system's ability to transfer clients, client parameters, specimens and expertise between the different levels of the health care system; Improve supportive supervision, thereby ensuring up-to-date management practices in use across the country; Improve referral performance monitoring and coordination; Improve preparedness and response to emergencies and disasters; Improve counter referral and referral feedback information system and strengthen out-reach systems for provision of referral health services to marginalized and vulnerable populations; Provide quality emergency health services at the point of need, regardless of ability to pay.

<sup>57</sup> The Kenya Health Policy 2012–2030 has defined the approach to strengthen comprehensive service delivery in the country. It emphasises the elaboration of service delivery solutions across the six levels of care from the community health services (level 1), primary care services (levels 2 and 3), county health services (levels 4 and 5), and the national referral services (level 6).

<sup>58</sup> The patient's rights charter explains the rights of patients and how patients can register complaints or compliments about any health professional or facility.

<sup>59</sup> Mohiddin A and Temmerman M, 'COVID-19 Exposes Weaknesses in Kenya's Healthcare System. And What Can Be Done' (*The Conversation*)

<<http://theconversation.com/covid-19-exposes-weaknesses-in-kenyas-healthcare-system-and-what-can-be-done-143356>> accessed 15 December 2020.

Government of Kenya (GOK); Council of Governors (COG); Ministry of Education; Elizabeth Glaser Pediatric AIDS Foundation (EGPAF); and National Social Security Fund (NSSF).<sup>60</sup>

#### **4. The State of Health Sector in Kenya: Challenges and Successes**

In 2018, the Government of Kenya launched the national Universal Health Coverage pilot programme in a controlled population in four counties namely: Kisumu County, because it leads in the high number of infectious diseases like HIV/AIDS and tuberculosis; Machakos County hospital visits are mostly because of accidents and injuries; Nyeri County which is leading in cases of non-communicable diseases, particularly diabetes; and Isiolo County which was ideally meant to assess how the package will work among the nomadic population.<sup>61</sup>

The Government of Kenya has made some progress and key reforms towards achieving Universal Health Care, and these include: free maternity services in all public health facilities since 2013; free primary health care in all public primary healthcare facilities – about 3,300 facilities; major programme to equip major public hospitals across the country with modern diagnostic equipment (94 facilities) where contracts have already been signed up with suppliers; a National Referral Strategy has been developed and piloted; health insurance subsidies through NHIF targeting disadvantaged groups continues to be implemented; provision of infrastructure and equipment to health facilities across county governments (new wards, ambulances, additional health workers); among other initiatives.<sup>62</sup>

It is however worth pointing that despite this, the Kenyan population is struggling with financing medical care and it is estimated that about 20% of

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<sup>60</sup> ‘Sustainable Development Goal 3: Good Health and Well-Being | United Nations in Kenya’ <<https://kenya.un.org/en/sdgs/3>> accessed 14 December 2020.

<sup>61</sup> ‘County Governments at the Centre of Achieving Universal Health Care | Kenya Vision 2030’ <<https://vision2030.go.ke/county-governments-at-the-centre-of-achieving-universal-health-care/>> accessed 15 December 2020.

<sup>62</sup> ‘Beyond The Conference – Kenya’s Progress towards Affordable and Accessible Health Care | Kenya Vision 2030’ <<https://vision2030.go.ke/beyond-the-conference-kenyas-progress-towards-affordable-and-accessible-health-care/>> accessed 16 December 2020.

Kenyans have some form of health insurance coverage, including national health insurance, but this varies by region, with 41% of residents in Nairobi having cover, while under 3% have cover in marginalised rural areas such as Wajir and West Pokot.<sup>63</sup>

While the Government of Kenya, both at national and devolved levels of governance, has been making efforts to achieve the right to health for the people of Kenya, there are a lot of challenges that have been identified as still affecting the sector. According to a Report published by the National Commission on Human Rights in 2017 focusing on a Case Study of Kisumu County on realization of the right to health, there has been progress in the realization of the right to health, but significant gaps still exist, which include: concerns about poor services or the total lack of some aspects of health services in the country. In addition, the ability of the county governments to ensure the realization of the right to health has also been questioned by some stakeholders, including medical practitioners and members of the public.<sup>64</sup> The complaints range from underequipped public facilities; inability of the infrastructure in place to contain the growing population of residents; inadequate human resource in comparison to persons seeking medical treatment, thereby limiting the ability of residents to access quality and affordable health care services, among others.<sup>65</sup>

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<sup>63</sup> Mohiddin A and Temmerman M, 'COVID-19 Exposes Weaknesses in Kenya's Healthcare System. And What Can Be Done' (*The Conversation*) <<http://theconversation.com/covid-19-exposes-weaknesses-in-kenyas-healthcare-system-and-what-can-be-done-143356>> accessed 15 December 2020; Dutta, A., T. Maina, M. Ginivan, and S. Koseki. 2018. Kenya Health Financing System Assessment, 2018: Time to Pick the Best Path. Washington, DC: Palladium, Health Policy Plus

<[http://www.healthpolicyplus.com/ns/pubs/11323-](http://www.healthpolicyplus.com/ns/pubs/11323-11587_KenyaHealthFinancingSystemAssessment.pdf)

[11587\\_KenyaHealthFinancingSystemAssessment.pdf](http://www.healthpolicyplus.com/ns/pubs/11323-11587_KenyaHealthFinancingSystemAssessment.pdf)> accessed 15 December 2020.

<sup>64</sup> Kenya National Commission on Human Rights, *The Right to Health: A Case Study of Kisumu County*, 2017

<<https://www.knchr.org/Portals/0/EcosocReports/Report%20on%20the%20Right%20to%20Health%20in%20Kisumu%20County.pdf?ver=2018-02-19-123045-547>> accessed 14 December 2020.

<sup>65</sup> Kenya National Commission on Human Rights, *The Right to Health: A Case Study of Kisumu County*, 2017.

Kenyans wake up every other day to threats of strikes by medical staff ranging from doctors to nurses in public health facilities. The strikes are attributable to limited career opportunities, insufficient workforce, and low remuneration thus increasing the risk of the health care staff migrating from their countries but also within countries such as from public hospitals to private ones.<sup>66</sup> This is despite the fact health care staff are crucial for health service delivery and the provision of quality care to patients.<sup>67</sup>

## 5. Ensuring Healthy Lives and Well-being for All Kenyans

The *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health* affirms that the realization of the right to health may be pursued through numerous, complementary approaches, such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments.<sup>68</sup> This section outlines some recommendations that can help Kenya get closer to ensuring that all its citizens enjoy healthy lives and general well-being.

### 5.1 Addressing the Socioeconomic Factors that Affect Right to Health in Kenya: Way Forward

As already pointed out, the health status of any population is not independent of the socioeconomic status of the group of people in question. Studies, although some contentious, have established a relation between health and other factors such as poverty, income and education, among others.<sup>69</sup> It is

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<sup>66</sup> Goetz K and others, 'Working Atmosphere and Job Satisfaction of Health Care Staff in Kenya: An Exploratory Study' (*BioMed Research International*, 4 October 2015) <<https://www.hindawi.com/journals/bmri/2015/256205/>> accessed 15 December 2020; Waithaka D and others, 'Prolonged Health Worker Strikes in Kenya- Perspectives and Experiences of Frontline Health Managers and Local Communities in Kilifi County' (2020) 19 *International Journal for Equity in Health* 23.

<sup>67</sup> Goetz K and others, 'Working Atmosphere and Job Satisfaction of Health Care Staff in Kenya: An Exploratory Study' (*BioMed Research International*, 4 October 2015) <<https://www.hindawi.com/journals/bmri/2015/256205/>> accessed 15 December 2020.

<sup>68</sup> UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, para. 1.

<sup>69</sup> See Paula Braveman and Laura Gottlieb, 'The Social Determinants of Health: It's Time to Consider the Causes of the Causes' (2014) 129 *Public Health Reports* 19.

however acknowledged that these factors do not work in isolation even in their influence on health-genetics also may play a role in an individual's vulnerability or resilience to socioeconomic adversity: different individuals' biological responses to the same socio-environmental trigger can vary markedly according to specific genetic polymorphisms.<sup>70</sup>

Studies carried out on socio-economic inequality and inequity in use of health care services in Kenya have established that:

*‘there is significant inequality and inequity in the use of all types of care services favouring richer population groups, with particularly pronounced levels for preventive and inpatient care services. These are driven primarily by differences in living standards and educational achievement, while the region of residence is a key driver for inequality in preventive care use only. Pro-rich inequalities are particularly pronounced for care provided in privately owned facilities, while public providers serve a much larger share of individuals from lower socio-economic groups’.*<sup>71</sup>

There are also other studies which support the fact that individuals from poorer households show lower propensity to seek care in health facilities (as opposed to relying on traditional healers or self-treating with medicines bought directly from pharmacies) when facing health problems and illness and the quality of service providers is lower in poorer areas.<sup>72</sup>

There is a need for the Government to continually address abject poverty that afflicts huge parts of the Kenyan population. This is because it has been argued that children growing up in socioeconomically disadvantaged neighborhoods face greater direct physical challenges to health status and health-promoting

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<sup>70</sup> Paula Braveman and Laura Gottlieb, ‘The Social Determinants of Health: It’s Time to Consider the Causes of the Causes’ (2014) 129 Public Health Reports 19.

<sup>71</sup> Ilinca S and others, ‘Socio-Economic Inequality and Inequity in Use of Health Care Services in Kenya: Evidence from the Fourth Kenya Household Health Expenditure and Utilization Survey’ (2019) 18 International Journal for Equity in Health 196.

<sup>72</sup> Ilinca S and others, ‘Socio-Economic Inequality and Inequity in Use of Health Care Services in Kenya: Evidence from the Fourth Kenya Household Health Expenditure and Utilization Survey’ (2019) 18 International Journal for Equity in Health 196.

behaviours; they also often experience emotional and psychological stressors, such as family conflict and instability arising from chronically inadequate resources.<sup>73</sup> It is worth pointing out that the realization of these socio-economic factors is also closely related to the realization of the right to dignity as guaranteed under Article 28 of the Constitution which provides that; *“Every person has an inherent dignity and the right to have that dignity respected and protected.*

*Article 19 of the Constitution of Kenya is categorical that ‘the Bill of Rights is an integral part of Kenya’s democratic state and is the framework for social, economic and cultural policies’.*<sup>74</sup> *In addition, it provides that ‘the purpose of recognising and protecting human rights and fundamental freedoms is to preserve the dignity of individuals and communities and to promote social justice and the realisation of the potential of all human beings’.*<sup>75</sup>

## **5.2 Multisectoral Approach and Collaboration among Different Stakeholders**

While continued investment on improving the health sector in the country is a commendable move, ‘in order to achieve equity in health and access to care, such efforts must be paralleled by multi-sectoral approaches to address all key drivers of inequity: persistent poverty, disparities in living standards and educational achievement, as well as regional differences in availability and accessibility of care’.<sup>76</sup>

Under the current Constitution of Kenya, primary health care provision is a shared responsibility between the national and county governments.<sup>77</sup> It has been argued that while the pilot implementation of UHC in four counties in Kenya has demonstrated better impact on the health outcome and greater accessibility while building Resilient and Sustainable Health system that can

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<sup>73</sup> See Paula Braveman and Laura Gottlieb, ‘The Social Determinants of Health: It’s Time to Consider the Causes of the Causes’ (2014) 129 Public Health Reports 19.

<sup>74</sup> Constitution of Kenya 2010, Article 19 (1).

<sup>75</sup> Constitution of Kenya 2010, Article 19 (2).

<sup>76</sup> Ilinca S and others, ‘Socio-Economic Inequality and Inequity in Use of Health Care Services in Kenya: Evidence from the Fourth Kenya Household Health Expenditure and Utilization Survey’ (2019) 18 International Journal for Equity in Health 196.

<sup>77</sup> Constitution of Kenya 2010, Fourth Schedule.

respond to unforeseen shocks, the success of UHC in Kenya will require more than executive or national-level goodwill; with health as a devolved function, each of the 47 counties must put in systems and resources to ensure its success.<sup>78</sup>

The county governors ought to prioritize delivery of a better healthcare system to citizens through a deliberate cohesive approach to UHC between the central government and the counties in order to achieve desired outputs within a short time.<sup>79</sup>

The collaboration should however go beyond provision of healthcare services to tackling the challenges that hinder enjoyment of the right to health care by all, such as persistent poverty, disparities in living standards and educational achievement, as well as regional differences in availability and accessibility of care'. There must be better coordination between the government, private and faith or NGO institutions especially in relation to specialist care and other empowerment programmes.<sup>80</sup>

### **5.3 Strict Regulation of Private Health Care Providers**

Due to socio-economic inequalities, the private sector primarily serves wealthier individuals, whereas those from poorer households more commonly rely on public care providers or use lower standard, often unlicensed, private care facilities.<sup>81</sup>

Reports from as recent as the year 2019 indicated that as at March 2019, at least 7,900 health facilities in Nairobi County were not registered or licensed

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<sup>78</sup> 'COVID-19: Lessons from the Losses' (*Inter Press Service*, 7 September 2020) <<http://www.ipsnews.net/2020/09/covid-19-lessons-losses/>> accessed 15 December 2020.

<sup>79</sup> *Ibid.*

<sup>80</sup> Mohiddin A and Temmerman M, 'COVID-19 Exposes Weaknesses in Kenya's Healthcare System. And What Can Be Done' (*The Conversation*) <<http://theconversation.com/covid-19-exposes-weaknesses-in-kenyas-healthcare-system-and-what-can-be-done-143356>> accessed 15 December 2020.

<sup>81</sup> Ilinca S and others, 'Socio-Economic Inequality and Inequity in Use of Health Care Services in Kenya: Evidence from the Fourth Kenya Household Health Expenditure and Utilization Survey' (2019) 18 *International Journal for Equity in Health* 196.

and were therefore operating illegally.<sup>82</sup> These numbers would grow astronomically if a study were to document the whole country. It also follows that a huge number of the poor sections of the general population has either suffered loss or obtained substandard medical attention.

There is a need for the relevant Regulatory boards such as the Kenya Medical Practitioners and Dentists Board, the Nursing Council, the Clinical Officers Council, Laboratory Board, Radiation Board and the Pharmacy and Poisons Board to crack the whip and weed out all these illegal facilities in a bid to protect the health and well-being of the Kenyan populace.

#### **5.4 Affordable and Sustainable Health Insurance Cover in Kenya**

COVID-19 disease pandemic has exposed the challenges of health care financing in the country, especially with the National Health Insurance Fund (NHIF) declining to fund treatment for its members who contract the disease, with the exception of civil servants, police and prisons service.<sup>83</sup> Notably, even the private insurers declined to cover the cost of treating COVID-19 cases thus complicating the problem further.<sup>84</sup>

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<sup>82</sup> Omulo C, 'Kenya: 7,900 Clinics Operating Illegally in Nairobi, Committee Reports' (*allAfrica.com*, 11 April 2019) <<https://allafrica.com/stories/201904110184.html>> accessed 15 December 2020; <https://www.the-star.co.ke/authors/maureen-kinyanjui>, '7,964 Health Facilities in Nairobi Are Illegal' (*The Star*) <<https://www.the-star.co.ke/counties/nairobi/2019-04-11-7964-health-facilities-in-nairobi-are-illegal/>> accessed 15 December 2020; Thiong'o J, '90pc of Nairobi Clinics Do Not Have Licenses - Standard Health' (*Health*) <<https://www.standardmedia.co.ke/health/article/2001320591/90pc-of-nairobi-clinics-do-not-have-licenses>> accessed 15 December 2020.

<sup>83</sup> pm EM on 18 N 2020-12:52, 'NHIF to Only Cover Covid-19 Costs for Govt Workers' (*Kenyans.co.ke*) <<https://www.kenyans.co.ke/news/59265-nhif-only-cover-covid-19-costs-govt-workers>> accessed 15 December 2020; Thiong'o J, 'Over 100,000 Nairobi County Staff Risk Losing NHIF Cover' (*The Standard*) <<https://www.standardmedia.co.ke/business/article/2001369484/over-100-000-nairobi-county-staff-risk-losing-nhif-cover>> accessed 15 December 2020.

<sup>84</sup> am EM on 15 N 2020-9:07, 'Father's Agony as Family Billed 750K After 4 Days' (*Kenyans.co.ke*) <<https://www.kenyans.co.ke/news/59153-crisis-nhif-private-insurers-refuse-settle-covid-19-bills>> accessed 15 December 2020.

NHIF is the primary provider of health insurance in Kenya and the primary vehicle through which Kenya intends to expand insurance coverage.<sup>85</sup> It is one of the most common employment based health financing scheme in the country. While the NHIF has been expanding in coverage areas and the target population,<sup>86</sup> the failure or inability to cover COVID-19 cases has demonstrated all the more the urgent need for the Universal Health Coverage (UHC) for all.<sup>87</sup> Recent studies have concluded that ‘Through its focus on increasing affordability of care for all Kenyans, the newly launched universal health coverage scheme represents a crucial step towards reducing disparities in health care utilization’.<sup>88</sup>

The country’s development blueprint, Vision 2030 and the Presidency’s Big Four Agenda all have 100% Universal Health Coverage (UHC) as one of the main pillars, a commendable step.<sup>89</sup> The 100% Universal Health Coverage (UHC) aims to: actualize 100% cost subsidy on essential health services and reduce medical out-of-pocket expenses by 54% as a percentage of household expenditure.<sup>90</sup> The Government has been distributing World Class medical equipment to all counties, introduced a free maternity health program and expanded National Hospital Insurance Fund.<sup>91</sup>

There is a need for financial investment and political goodwill towards ensuring that the UHC is realised for all Kenyans to benefit, both rich and poor. UHC might be more stable than the employment based health financing

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<sup>85</sup> Dutta, A., T. Maina, M. Ginivan, and S. Koseki. 2018. Kenya Health Financing System Assessment, 2018: Time to Pick the Best Path. Washington, DC: Palladium, Health Policy Plus, 60; see also National Hospital Insurance Act of 1966.

<sup>86</sup> ‘President’s Delivery Unit - Flagship Projects - NHIF Expansion’ <<https://www.delivery.go.ke/flagship/nhif>> accessed 15 December 2020.

<sup>87</sup> ‘COVID-19: Lessons from the Losses’ (*Inter Press Service*, 7 September 2020) <<http://www.ipsnews.net/2020/09/covid-19-lessons-losses/>> accessed 15 December 2020.

<sup>88</sup> Ilinca S and others, ‘Socio-Economic Inequality and Inequity in Use of Health Care Services in Kenya: Evidence from the Fourth Kenya Household Health Expenditure and Utilization Survey’ (2019) 18 *International Journal for Equity in Health* 196.

<sup>89</sup> ‘The Big 4 - Empowering the Nation’ <<https://big4.delivery.go.ke/>> accessed 15 December 2020.

<sup>90</sup> *Ibid.*

<sup>91</sup> ‘President’s Delivery Unit - Flagship Projects’ <<https://www.delivery.go.ke/flagship>> accessed 15 December 2020.

as a source of health revenue, because employment based health financing is unstable, fragmented, and inequitable, particularly during economic crises as evidenced during the covid-19 pandemic where many people lost access to employment linked healthcare because of a job loss in the family.<sup>92</sup>

While employment based health financing remains an important source of revenue, especially for low and middle income countries that need to mobilise additional domestic resources, it has been suggested that universal healthcare entitlements, mandatory inclusion in national schemes, general tax contributions for resource pooling, and a move away from voluntary or contributory schemes that are linked to benefits entitlements are recommended.<sup>93</sup>

Notably, the realization of UHC in Kenya will only be achieved if the Government of Kenya will increase its budget allocation towards health and lead solid health system strengthening initiatives – as for example the NHIF reform – to increase efficiency, effectiveness and accountability within the health sector.<sup>94</sup>

Medical care should however also be made generally affordable. In *Pharmaceutical Society of South Africa v. Tshabalala-Msimang*, South African High Court held that ‘access to health care services required services to be both physically accessible and affordable, and acknowledged that prohibitive pricing of medicines may amount to a denial of access.’<sup>95</sup>

## **5.5 Improved Working Conditions for Health workers in Kenya**

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<sup>92</sup> Vijayasingham L and others, ‘Employment Based Health Financing Does Not Support Gender Equity in Universal Health Coverage’ (2020) 371 *BMJ* m3384.

<sup>93</sup> *Ibid.*

<sup>94</sup> ‘NHIF Reform Critical to Affordable Health For All in Kenya’ (*Inter Press Service*, 27 March 2019) <<http://www.ipsnews.net/2019/03/nhif-reform-critical-affordable-health-kenya/>> accessed 16 December 2020; cf. Okungu V, Chuma J and McIntyre D, ‘The Cost of Free Health Care for All Kenyans: Assessing the Financial Sustainability of Contributory and Non-Contributory Financing Mechanisms’ (2017) 16 *International Journal for Equity in Health* 39.

<sup>95</sup> *Pharmaceutical Society of South Africa v. Tshabalala-Msimang* 2005 (3) SA 23 8 (SCA) paras 42, 53, 77.

Job satisfaction and working atmosphere are considered to be important for optimal health care delivery.<sup>96</sup> In the face of frequent strikes by health workers in Kenya, there is a need for the national government and the county governments to work closely with all the stakeholders and health workers' unions' leaders to address the challenges of limited career opportunities, insufficient workforce, and low remuneration in order to curb the risk of the health care staff migrating to other countries as well as also within countries such as from public hospitals to private ones. This should be done as part of ensuring that Kenyans are guaranteed access to health care services and well-being.<sup>97</sup>

Even as the national and county governments continually invest in health infrastructure and facilities under the UHC programmes, there is a need for the investment in infrastructure to be done simultaneously with that in human capital, competent and well-trained personnel to handle the equipment and patients in these facilities.<sup>98</sup>

Even as the Government of the Republic of Kenya continue to hire foreign doctors and in particular doctors from Cuba to work in Kenyan public medical facilities, there is need for capacity building within the local medical health workers.<sup>99</sup>

## **5.6 Use of Technology in Health care Provision: Telemedicine**

Telemedicine has been taking root in Kenya, especially with the outbreak of the COVID-19 pandemic. The World Health Organisation observes that Information and Communication Technologies (ICTs) have great potential to

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<sup>96</sup> Goetz K and others, 'Working Atmosphere and Job Satisfaction of Health Care Staff in Kenya: An Exploratory Study' (*BioMed Research International*, 4 October 2015) <<https://www.hindawi.com/journals/bmri/2015/256205/>> accessed 15 December 2020.

<sup>97</sup> Waithaka D and others, 'Prolonged Health Worker Strikes in Kenya- Perspectives and Experiences of Frontline Health Managers and Local Communities in Kilifi County' (2020) 19 *International Journal for Equity in Health* 23.

<sup>98</sup> 'COVID-19: Lessons from the Losses' (*Inter Press Service*, 7 September 2020) <<http://www.ipsnews.net/2020/09/covid-19-lessons-losses/>> accessed 15 December 2020.

<sup>99</sup> Cf. Samuel Nduati & 3 others v Cabinet Secretary Ministry of Health & 9 others [2018] eKLR, Petition 42 & 46 of 2018 (Consolidated).

address some of the challenges faced by both developed and developing countries in providing accessible, cost-effective, high-quality health care services through the use of telemedicine. Telemedicine uses ICTs to overcome geographical barriers, and increase access to health care services. This is particularly beneficial for rural and underserved communities in developing countries – groups that traditionally suffer from lack of access to health care.<sup>100</sup> The World Health Organization uses the following broad description of the term ‘telemedicine’:

*“The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities”.*<sup>101</sup>

Notably, telemedicine is an open and constantly evolving science, as it incorporates new advancements in technology and responds and adapts to the changing health needs and contexts of societies.<sup>102</sup>

Telemedicine episodes may be classified on the basis of: (1) the interaction between the client and the expert (i.e. real-time or prerecorded), and (2) the type of information being transmitted (for example, text, audio, video).<sup>103</sup>

In Kenya, a large portion of the population is unable to have face-to-face consults with medical providers and as a result, much of the care is triaged through community health workers and nurses and only those patients deemed to be in critical need of hospital services are transferred to see a medical

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<sup>100</sup> Seewon Ryu, ‘Telemedicine: Opportunities and Developments in Member States: Report on the Second Global Survey on EHealth 2009 (Global Observatory for EHealth Series, Volume 2)’ (2012) 18 *Healthcare Informatics Research* 153, 8.

<sup>101</sup> *Ibid.*, 9.

<sup>102</sup> *Ibid.*

<sup>103</sup> Craig J and Patterson V, ‘Introduction to the Practice of Telemedicine’ (2005) 11 *Journal of telemedicine and telecare* 3.

provider.<sup>104</sup> This situation is made worse by the fact that there is a shortage of approximately 50% of the needed health care workforce to meet the needs of the population in Africa.<sup>105</sup> Telemedicine and other telehealth services are thus meant to address the very limited access to face-to-face medical consults and high medical cost which can consequently see a reduction in poverty, improved health and well-being, improved education, and economic growth.<sup>106</sup>

In places such as Lamu County, where residents face extremely limited access to healthcare, the residents have now access to care-at-a-distance through the telemedicine project initiated by Huawei, Safaricom and local partners, which allows local healthcare workers and patients to remotely consult with specialists in towns and cities.<sup>107</sup> There is a scarcity of licensed doctors and specialists in Lamu, and telemedicine is expected to transform medical care for low-income families in the region by reducing travel time and expenses; and 50% more patients will attend referrals each year, leading to significantly better patient outcomes.<sup>108</sup>

The Philips Foundation, a registered charity and platform for the worldwide societal activities of Royal Philips, has also since introduced mobile

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<sup>104</sup> ‘Telehealth, MHealth, Mobile Medical Care, Telehealth Technology’, (*Village HopeCore International*, 6 September 2018)

<<https://www.villagehopecore.org/telehealth-in-rural-kenya/>> accessed 16 December 2020.

<sup>105</sup> Ibid.

<sup>106</sup> Ibid; See also Holmes K and others, ‘Pilot Results of a Telemedicine Social Franchise in Rural Kenya: Evidence of Sustainable Livelihood Creation’ (2014) 78 *Procedia Engineering* 200; ‘Profit-Making Idea: The Time for Telemedicine Has Arrived in Kenya’ (*How We Made It In Africa*, 31 July 2020)

<<https://www.howwemadeitinafrica.com/profit-making-idea-the-time-for-telemedicine-has-arrived-in-kenya/69458/>> accessed 16 December 2020;

‘Telemedicine Takes Root in Kenya amid COVID-19 Infection Fears - Xinhua | English.News.Cn’

<[http://www.xinhuanet.com/english/africa/2020-05/12/c\\_139050942.htm](http://www.xinhuanet.com/english/africa/2020-05/12/c_139050942.htm)> accessed 16 December 2020.

<sup>107</sup> ‘Making Remote Healthcare a Reality in Kenya’ (*huawei*)

<<https://www.huawei.com/en/industry-insights/outlook/mobile-broadband/wireless-for-sustainability/cases/making-remote-healthcare-a-reality-in-kenya>> accessed 16 December 2020.

<sup>108</sup> Ibid.

ultrasound technology, meant to improve maternal and child health, where ways will be explored to use mobile ultrasound technology at primary care level, performed by midwives and supported by remote experts through telehealth, to enhance availability of affordable services in the underserved communities and remote areas of Kenya.<sup>109</sup>

While telemedicine is no longer new in Kenya<sup>110</sup>, there is a need for the regulators to continually review the regulatory framework that will not only promote its growth and development, but also to ensure that those who use it are either held or benefit from the same standards of professional care as those under the traditional forms of medical care and data protection.<sup>111</sup> Notably, the Health Act, 2017 defines “e-Health” to mean the combined use of electronic communication and information technology in the health Sector including telemedicine.<sup>112</sup>

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<sup>109</sup> ‘Philips Foundation Announces Projects in Kenya’ (*Philips*)

<<https://www.philips.co.ke/a-w/about/news/archive/standart/news/press/2019/20190307-philips-foundation-announces-projects-in-kenya.html>> accessed 16 December 2020.

<sup>110</sup> ‘Tele-Health Providers in Kenya – Kenya Healthcare Federation’

<[https://khf.co.ke/covid19\\_khf-news/tele-health-providers-in-kenya/](https://khf.co.ke/covid19_khf-news/tele-health-providers-in-kenya/)> accessed 16 December 2020; ‘Kenya Launches Telemedicine Initiative for the Poor’ (*Sub-Saharan Africa*)

<<https://www.scidev.net/sub-saharan-africa/news/kenya-launches-telemedicine-initiative-poor/>> accessed 16 December 2020; CORRESPONDENT, ‘Smart Applications Partners with Rural Private Hospitals Associations’ (*Capital Business*, 22 October 2020) <<https://www.capitalfm.co.ke/business/2020/10/smart-applications-partners-with-rural-private-hospitals-associations/>> accessed 16 December 2020; Sue Anderson, ‘Telemedicine In Kenya: Big Idea Creating Access To Healthcare’ (*MATTER*, 25 September 2020)

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<sup>111</sup> Rangasamy M and others, ‘Role of Telemedicine in Health Care System: A Review’ “Role of telemedicine in health care system: a review,” *Int J Recent Adv Pharma Res* 2 (2011): 1-10; ‘The Emerging Practice of Telemedicine and the Law: Kenya’s Stance’ (*Centre for Intellectual Property and Information Technology law*, 20 August 2020) <<https://cipit.strathmore.edu/the-emerging-practice-of-telemedicine-and-the-law-kenyas-stance/>> accessed 16 December 2020.

<sup>112</sup> Sec. 2, Health Act, 2017.

Telemedicine and telehealth services can indeed supplement the investment in physical infrastructure in provision of health care services.<sup>113</sup>

### **5.7 Investment in Advanced medical technologies: The Viability of Medical Tourism**

A working health system is not only capable of ensuring that the citizens enjoy healthy lives and well-being, but is also capable of earning some extra income for the government through what is now commonly known as ‘medical tourism’, defined as the travel of people to a place other than where they normally reside for the purpose of obtaining medical treatment in that country.<sup>114</sup> India has emerged as one of the countries that have heavily invested in medical tourism. Medical tourism is a multi-billion dollar industry that has been heavily promoted by governments and the medical and tourism industries for the potential mutual benefits.<sup>115</sup> India takes pride in being uniquely placed by virtue of its skilled manpower, common language, diverse medical conditions that doctors deal with, the volume of patients, and a large nonresident Indian population overseas.<sup>116</sup> They have also invested in

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<sup>113</sup> ‘Telemedicine Takes Root in Kenya amid COVID-19 Infection Fears - Xinhua | English.News.Cn’

<[http://www.xinhuanet.com/english/africa/2020-05/12/c\\_139050942.htm](http://www.xinhuanet.com/english/africa/2020-05/12/c_139050942.htm)> accessed 16 December 2020; ‘Africa Can Improve Future Health Systems Resilience by Complementing Gaps in Physical Infrastructure with Digital Health Solutions | African Arguments’ <<http://africanarguments.org/2020/11/africa-can-improve-future-health-systems-resilience-by-complementing-gaps-in-physical-infrastructure-with-digital-health-solutions/>> accessed 16 December 2020.

<sup>114</sup> ‘India’s Medical Tourism Gets Africans’ Attention’ (*Africa Renewal*, 25 November 2016)

<<https://www.un.org/africarenewal/magazine/december-2016-march-2017/india%E2%80%99s-medical-tourism-gets-africans%E2%80%99-attention>> accessed 15 December 2020; ‘Medical Tourism and The Value Of Technology In Medicine - Electronic Health Reporter’

<<https://electronichealthreporter.com/medical-tourism-and-the-value-of-technology-in-medicine/>> accessed 16 December 2020; Manickam R and others, ‘Emerging Trends and Future Prospects of Medical Tourism in India’ (2015) 7 *Journal of Pharmaceutical Sciences and Research* 248.

<sup>115</sup> ‘Medical Tourism in India: Winners and Losers | Indian Journal of Medical Ethics’ <<https://ijme.in/articles/medical-tourism-in-india-winners-and-losers/?galley=html>> accessed 15 December 2020.

<sup>116</sup> Gupta V and Das P, ‘Medical Tourism in India’ (2012) 32 *Clinics in Laboratory Medicine* 321; ‘Why Medical Tourism Is Booming In India | The Dope Why Medical Tourism Is Booming In India’ (*The Dope*, 25 February 2020)

provision of dedicated services to alleviate the anxiety of foreign patients which include translation, currency conversion, travel, visa, post treatment care system, and accommodation of patient relatives during and after treatment.<sup>117</sup> In 2019, India was ranked as the third most preferred destination for medical tourism, with the industry set to reach \$9 billion in valuation in 2020, although the projection might have since been affected by the COVID-19 pandemic.<sup>118</sup>

Notably, South Africa has also been making medical advances, and in addition to shorter travel times than India, South Africa advertises the added allure of safaris and spas.<sup>119</sup> As Kenya pursues the dream of UHC as a key delivery under Vision 2030 and the Big Four Agenda, the government and all the relevant stakeholders in the health care sector should consider following in the footsteps of India and South Africa. In India, while the private sector has always been prominent as a source of medical care, since 1991 neoliberal government policies supporting the private sector have created conditions for its rapid growth.<sup>120</sup> This may, therefore, take a while to achieve, but continuous investment in infrastructure and the medical personnel will see to it that we finally get there. While the country may not yet benefit from patients from outside the continent, it may first target patients from the region and the African continent in general. Medical tourism, however, should not be pursued at the expense of the poor in the country: the Government should ensure that

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<<https://thedope.news/why-medical-tourism-is-booming-in-india/>> accessed 16 December 2020.

<sup>117</sup> Ibid.

<sup>118</sup> Biswas D, 'In Dire Straits: India's Medical Tourism Companies Find No Business amid COVID-19' (*YourStory.com*, 24 June 2020)

<<https://yourstory.com/2020/06/coronavirus-medical-tourism-industry-lockdown-business>> accessed 15 December 2020; CNN MS, 'India Wants to Make Medical Tourism a \$9 Billion Industry by 2020' (*CNN*)

<<https://www.cnn.com/2019/02/13/health/india-medical-tourism-industry-intl/index.html>> accessed 16 December 2020.

<sup>119</sup> 'India's Medical Tourism Gets Africans' Attention' (*Africa Renewal*, 25 November 2016)

<<https://www.un.org/africarenewal/magazine/december-2016-march-2017/india%E2%80%99s-medical-tourism-gets-africans%E2%80%99-attention>> accessed 15 December 2020.

<sup>120</sup> 'Medical Tourism in India: Winners and Losers | Indian Journal of Medical Ethics' <<https://ijme.in/articles/medical-tourism-in-india-winners-and-losers/?galley=html>> accessed 15 December 2020.

the general populace in the country can access health care services before it seeks to extend the same to the foreigners. Kenya should consider going the Cuban way where, Cuba, which has been a pioneer in medical tourism for almost four decades, has hospitals for Cuban residents and others for foreigners and diplomats. Both kinds are run by the government and Cubans receive free healthcare for life while tourists have to pay for it.<sup>121</sup> In addition, the Cuban government has developed medical tourism to generate income which is then reinvested into the country's medical sector to benefit its country's citizens.<sup>122</sup>

## **6 Conclusion**

The right to health is not an isolated right as demonstrated in this paper. It not only forms the basis for the realisation and enjoyment of other rights but it also requires the implementation and protection of other human rights for its full enjoyment. While Kenya has made commendable steps towards ensuring that its citizens enjoy healthy lives and general well-being, there is still a lot that requires to be done. This calls for multisectoral approach and cooperation between stakeholders to ensure that the same is realised. Any nation that seeks to develop must first invest in the health of its people. A healthy population is a wealthy population.<sup>123</sup> Ensuring Healthy Lives and Well-being for all Kenyans is a vital Sustainable Development goal that should be attained at the earliest.

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<sup>121</sup> Ibid.

<sup>122</sup> Ibid; Network eHealth, 'Medical Tourism in Puducherry, an Under-Exploited Potential - EHealth Magazine' <<https://ehealth.eletsonline.com/2018/07/medical-tourism-in-puducherry-an-under-exploited-potential/>> accessed 15 December 2020; Hernández Nariño A, 'Cuban Medical Tourism: Strategies to Make It More Competitive' (2008).

<sup>123</sup> 'The Health and Wealth of Nations' (*ResearchGate*) <[https://www.researchgate.net/publication/238827665\\_The\\_Health\\_and\\_Wealth\\_of\\_Nations](https://www.researchgate.net/publication/238827665_The_Health_and_Wealth_of_Nations)> accessed 16 December 2020; '(PDF) Population Health and Economic Growth in Sub-Saharan Africa: A Panel Cointegration Analysis' (*ResearchGate*) <[https://www.researchgate.net/publication/343281582\\_Population\\_health\\_and\\_economic\\_growth\\_in\\_sub-Saharan\\_Africa\\_A\\_Panel\\_Cointegration\\_Analysis](https://www.researchgate.net/publication/343281582_Population_health_and_economic_growth_in_sub-Saharan_Africa_A_Panel_Cointegration_Analysis)> accessed 16 December 2020; Baum F, 'Wealth and Health: The Need for More Strategic Public Health Research' (2005) 59 *Journal of Epidemiology & Community Health* 542.

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