COMPENDIUM ON THE RIGHT TO HEALTH

Emerging and Comparative Jurisprudence on the Right to Health

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ICJ Kenya House, Off Silanga Road, Karen,
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Email: info@icj-kenya.org
Website: https://icj-kenya.org
Facebook: @ICJ.Kenya
Twitter: @ICJKenya

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ICJ KENYA COMPENDIUM ON THE RIGHT TO HEALTH

Papers on Emerging Issues and Comparative Jurisprudence on the Right to Health

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To contribute to the realisation of the Right to Health, ICJ Kenya has utilised innovative approaches in developing its knowledge products to effectively involve and include all relevant stakeholders in the health sector to address policy, legal gaps, and challenges that impede access to healthcare services in Kenya.

This compendium is among the series of knowledge products under our Right to Health project. It analyses various emerging issues and comparative jurisprudence on the right to health in diverse countries. The compendium offers a resource for comparison and experience sharing for Kenya's health governance and lessons for Kenya as she works on the realisation of the highest standard of healthcare. It focuses on Kenya, India, Rwanda, Italy, and Uganda.

ICJ Kenya is profoundly grateful to Rossella De Falco, Ph.D., Shweta Marathe, Marion Muringe Ogeto, Valentine Nyokabi Njogu, Busingye Louis, Derrick Kimani, Anthony Masake, Miracle Okoth Mideyi and Geoffrey Odhiambo for being contributors to this compendium. We also wish to thank Maurice Oduor, the consultant who provided technical and editorial expertise to the compendium.

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Elsy Sainna
Executive Director
ICJ Kenya.

LIST ABBREVIATIONS

AGYW	Adolescent Girls and Young Women
AU	African Union
ACHPR	African Charter of Human and Peoples' Rights
APHRC	African Population and Health Research Center
ATI	Access to Information
CBHI	Community-Based Health Insurance
CEA	Clinical Establishment Act
CESCR	Committee on Economic, Social and Cultural Rights
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CEFROHT	Center for Food and Adequate Living Rights
CEHURD	Center for Health, Human Rights and Development
CEPI	Coalition for Epidemic Preparedness Innovations
CFREU	Charter of Fundamental Rights of the European Union
CHW	Community Health Worker(s)
CPA	Consumer Protection Act
CRC	Committee on the Rights of the Child
CRPWD	Convention on the Rights of Persons with Disabilities
EAHRC	East African Health Research Commission
EOC	Equal Opportunities Commission
FIDA	Federation of Women Lawyers (Kenya)
GI-ESCR	Global Initiative for Economic, Social and Cultural Rights
GP	General Practioner(s)
HEAPI	Health Equity and Policy Initiative
HIS	Health Information System
HSDP	Health Sector Development Plan
ISER	Initiative for Social and Economic Rights
JTFC	Joint Task Force Committee

KELIN	Kenya Legal & Ethical Issues Network on HIV and AIDS
KNCHR	Kenya National Commission on Human Rights
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
KEPH	Kenya Essential Package for Health
MCI	Medical Council of India
mhGAP-IG	Mental Health Gap Action Programme Intervention Guide
MoHFW	Ministry of Health and Family Welfare
NABH	National Accreditation Board for Hospitals
NEPRCC	National Epidemic Preparedness and Response Coordination Committee
NERC	National Emergency Response Committee
NDP	National Development Plan
NHRC	National Human Rights Commission
NHS	National Health System
PPE	Personal Protective Equipment
PRC	Patients' Rights Charter/Charter of Patient Rights
PRIME	Programme for Improving Mental Health Care
RBC	Rwanda Biomedical Center
SGBV	Sexual and Gender-Based Violence
SMC	State Medical Councils
SRHR	Sexual and Reproductive Health and Rights
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Care
UHRC	Uganda Human Rights Commission
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organisation

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EXECUTIVE SUMMARY

This publication is a compendium on the right to health, titled "Emerging and Comparative Jurisprudence on the Right to Health," with perspectives from diverse contributors. The compendium features eight papers exploring various aspects of the right to health and offers valuable insights into the challenges and opportunities in achieving this fundamental human right. With a focus on interdisciplinary approaches, the contributors shed light on the legal, social, and economic dimensions of the right to health and offer a comprehensive and multidimensional exploration of the right to health.

The contributors combine their expertise in law, social sciences, economics, gender studies, and technology to provide a holistic understanding of the challenges and opportunities in promoting and realising the right to health. This publication is a valuable resource for academia, policymakers, healthcare practitioners, researchers, and advocates working towards ensuring health equity and universal access to quality healthcare services for all individuals.

The first paper, authored by Marion Ogeto, delves into the issue of reproductive health and the lack of safe abortion services for survivors of sexual violence in Kenya. It analyses international human rights instruments and the State's responsibility to fulfil the right to abortion in Kenya as a health issue. It also underscores the barriers to accessing safe abortion services for survivors of sexual violence while accentuating some crucial jurisprudence from the courts.

In the second paper, Miracle Okoth and Geoffrey Ochieng present an overview of the mental healthcare regime in Kenya to appraise whether the existing legal and policy frameworks are enough. By assessing the provisions of the celebrated Mental Health (Amendment) Act, 2022, which is seen to breathe new life into managing mental health in the country, the authors further explore how regional and international laws come to the rescue and the best practices globally. It concludes that beyond the legal and policy frameworks and to enhance the mental health system in Kenya, it is essential to prioritise resource allocation and investment in mental health services.

Nyokabi Njogu and Marion Ogeto examine the public right to know and the interlinkage between the right of access to information and the right to health, especially in the wake of the Covid-19 pandemic as the third paper. They explore the need for proactive disclosure of information by the State during a health pandemic and underpin that unjustifiable limitation of access to information

could likely have consequences on exercising other rights. They posit that while the Executive and the Judiciary, as crucial arms of the government, have not robustly applied and interpreted the right to access information during the pandemic, there is hope that the courts could settle the content of the right to information during pandemics in the pending litigation.

The fourth paper, authored by Anthony Masake, focuses on Uganda's law and governance structures. The author succinctly dissects the international, regional, and national laws on the right to health and Uganda's health governance structures, focusing on the progress, gaps, and opportunities. He also delves into the governance determinants as indicators of the right to health by looking at the judicial—jurisprudential track record and quasi-judicial mechanisms, NDP and health policies, and the achieving the pertinent elements of the right to health. The author notes that while Uganda has made positive steps towards achieving the highest attainable healthcare standard, significant gaps still require attention from the government. He concludes by positing that public health facilities also need to address the staffing gaps to scale up healthcare access and regulate private hospitals and pharmacies to ensure that they do not unduly profit from their patients and clients at all times, particularly during a pandemic.

The fifth paper, authored by Rosella De Falco, addresses the lessons for protecting the right to health during health pandemics and looks at the position in Italy. The author explores the UHC experience in Italy while assessing the international and regional human rights norms in the Italian context. The paper concludes that there is a need for the different cadres of government to use their available resources to realise the right to health through well-coordinated public healthcare systems resilient to shocks such as public health emergencies. Further, it is not enough to regulate and monitor commercial healthcare providers. All public policies leading to structural changes in health care must be assessed against their potential human rights impacts.

In the sixth paper, Shweta Marathe explores the insights from the Covid-19 pandemic experiences with private hospitals in India. The author postulates that while the privatisation of hospitals in India has led to improved infrastructure and services, affordability and accessibility remain significant concerns. Further, although the Patients' Rights Charter (PRC) has been adopted, it still falls short in implementation. Though the state government involved private hospitals and steered them through rate capping on Covid-19 treatment to deal with the pandemic crisis, private hospitals managed to circumvent Covid-19 specific measures due to the absence of a larger and legally

backed accountability framework. The author concludes that there is a need to move from adoption to effective implementation of patient rights, augmented by strengthening grievance redressal mechanisms and bringing social accountability and regulatory mechanisms to private hospitals.

The seventh paper, by Derrick Kimani, explores the implications of Covid-19 on the right to health in Kenya and issues a government scorecard. The author examines the responses by the Government of Kenya to the spread of Covid-19 and the implications of those responses on the right to health. While assessing the government's performance on these obligations, the paper also considers the jurisprudence that emerged from the High Court when some government measures were challenged. In sum, the author notes that the jurisprudence emanating from the Kenyan Courts about implementing the right to health in Kenya during the Covid-19 pandemic casts a light on the fragility of her public health care system.

Busingye Louis explores the public health governance and pandemic response strategies in Rwanda in the eighth and final paper of the compendium. The author articulates the UHC's localisation in Rwanda and explores how the State managed Covid-19 through service delivery, partnerships, and capacity building of health workers. The paper also assesses the use of technology and how Rwanda was among the first countries to achieve vast covid-19 vaccination. The author concludes that Covid-19 presented an opportunity to evaluate the many intersections of health governance in advancing equitable, accessible, and quality health services.

CLAIMING SPACE FOR ADOLESCENT GIRLS AND YOUNG WOMEN'S REPRODUCTIVE HEALTH RIGHTS: LACK OF SAFE ABORTION SERVICES FOR SURVIVORS OF SEXUAL VIOLENCE IN KENYA

Marion Muringe Ogeto*

1. Introduction

Studies have shown that adolescent girls and young women (AGYW) are at a higher risk of being subjected to sexual violence.[1] The World Health Organisation (WHO) estimated that despite young age being a probable factor in victimisation, AGYW who possess low education levels and come from 'underprivileged' backgrounds are further likely to experience sexual violence.[2] Moreover, the Covid-19 pandemic exacerbated AGYW's risk of being subjected to sexual and gender based violence.[3] In 2020, over 152,000 adolescent girls became pregnant during the three-month lockdown in Kenya, and reports indicated a spike in violence cases.[4] The high rate of teenage pregnancies was attributed to sexual violence and exploitation, among other reasons. Many pregnant girls were likely to resort to unsafe abortions at the hands of quacks, thus increasing the likelihood of dying due to complications.[5]

Sexual violence directly impacts AGYW's reproductive health rights due to the consequences such as the increased risk of contraceptive non-use, unwanted pregnancies (some being vested on children not physically mature enough to bear children), unsafe abortions, sexually transmitted infections and low birth weight babies.[6] The African Union (AU) has also noted that apart from the potential physical injuries in the short and long term, the unavailability or refusal of access to

* LLB Strathmore University, Advocate of the High Court of Kenya and a Program Associate at KELIN.

[1] African Population and Health Research Center, "Coping with Unintended Pregnancies: Narratives from Adolescents in Nairobi Slums", (accessed on 5th June, 2022) online at: https://www.popcouncil.org/uploads/pdfs/2014STEPUP_APHRC-ResearchReport.pdf.

[2] *Ibid.*

[3] African Population and Health Research Center, *Coping with Unintended Pregnancies: Narratives from Adolescents in Nairobi Slums*, 2014

[4] Human Rights Watch, "I Had Nowhere to Go: Violence Against Women and Girls During the Covid-19 Pandemic in Kenya" (accessed on 23rd March, 2022) online at: https://www.hrw.org/sites/default/files/media_2021/12/kenya0921_web.pdf

[5] Centre for Reproductive Rights, "In Harm's Way: The Impact of Kenya's Restrictive Abortion Laws," (accessed 8th April 2022) https://reproductiverights.org/in-harms-way-the-impact-of-kenyas-restrictive-abortion-law/, 13.

[6] *C.K. (A Child) & 11 Others v. Commissioner of Police/Inspector-General of the National Police Service & 2 Others*, [2012] eKLR.

safe abortion services is often the cause of mental suffering, which can be exacerbated by the disability or precarious socio-economic status of women.[7] Forcing women to keep a pregnancy resulting from sexual assault constitutes additional trauma affecting physical and mental health.[8]

Through General Comment No. 4 on adolescent health and development, the Committee on the Rights of the Child (CRC) noted that State parties have not given sufficient attention to the specific concerns of adolescents and the youth as rights holders and to promoting their health and development.[9] Given that AGYW are more at risk of sexual violence, the mandate rests on the State to ensure their right to health is fulfilled, including the right to safe abortion. This paper thus aims to show that there is still a lack of safe abortion services for survivors of sexual violence in Kenya, despite the availability of legal and policy frameworks on reproductive health. The paper analyses how due to the high rate of violence cases among adolescent girls and young women during the pandemic, there is a need to revisit the discussion on access to safe abortion services.

The paper thus analyses the responsibility to promote, protect, fulfil and respect reproductive health and rights, including the right to access safe abortion for survivors. It then proceeds to analyse the barriers preventing accessibility of safe abortion services in Kenya and how the same was further metastasized during the pandemic by examining the legislative framework, the impact of religious and cultural views on the same, and addresses whether State bodies under the national and county governments have enabled a safe environment for survivors to access safe abortion services.

2. State Responsibility to Fulfil the Right to Abortion in Kenya as a Health Right

The Constitution raises a fundamental duty on the State and all its organs to observe, respect, protect, promote and fulfil the rights and fundamental freedoms in the Bill of Rights.[10] The obligation to fulfil raises a positive responsibility on the State to develop mechanisms to ensure the actualisation of the rights. It goes hand in hand with the promotion of fundamental rights and

[7] AfCmHPR, General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14.2 (a) and (c) of the Protocol to the African Charter on Human and Peoples Rights of Women in Africa.
[8] *Ibid.*
[9] UNCRC, *General comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, 1.
[10] *Constitution of Kenya*, (2010) Article 21 (1).

freedoms.[11] The obligation to respect is a negative obligation barring the State and state actors from interfering with fundamental rights and freedoms. The obligation to protect calls upon the State to guard against rights violations by third parties.[12] Additionally, this obligation generally contains the responsibility of the state to create an atmosphere where citizens may be able to enjoy their fundamental rights and freedoms.[13]

Article 43 provides that every person has the right to the *highest* attainable standard of health, including reproductive health care. The *highest attainable standard of health* is a product of the international human rights law framework, which Kenya has adopted and must uphold by dint of Articles 2(5) and 2(6) of the Constitution. The normative content of the right further includes essential elements—availability, accessibility, acceptability and quality health services and products.[14]

From the Protocol to the African Charter of Human and Peoples Rights (ACHPR) on Women's Rights (Maputo Protocol),[15] States have a duty to provide safe abortion services to survivors of sexual violence as a component of the right to health. Where adolescents are involved, the "evolving capacities" principle can be applied to render services that promote the health and development of adolescents.[16] This principle promotes the notion that as children continue to develop and enhance their competencies, there is a need for the State to moderate the absolute need for protection and enable them to start taking responsibility for decisions affecting their lives. That includes providing adequate information and parental support to facilitate the development of a relationship of trust and confidence in issues regarding, for example, sexuality and sexual

[11] *Social and Economic Rights Action Centre (SERAC) and Another v Nigeria (Merits)* (2001) African Commission Human and People's Rights Communication No 155/96, 47.
[12] *Ibid*, 46.
[13] *Ibid.*
[14] *Ibid.*
[15] African Union, Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 11 July 2003; Communication No: 0012/Com/001/2019 Decision No 002/2022, *Legal and Human Rights Centre and Centre for Reproductive Rights (on behalf of Tanzanian girls) v United Republic of Tanzania,* para 78: the African Committee on the Rights and Welfare of the Child note that the Maputo Protocol's scope includes girls, therefore adolescent girls are equally guaranteed protection of reproductive health and rights as stipulated under Article 14 of the Protocol.
[16] CRC, General comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child, 1 July 2003, 5.

behavior, discussing risky lifestyles openly and finding acceptable solutions that respect the adolescent's rights.[17]

The CRC has explicitly recognised the importance of safe abortion services for adolescents in certain circumstances.[18] Similarly, the Human Rights Committee has addressed the issue of the provision of safe abortion for children facing health risks and survivors of sexual violence.[19]

The right to safe abortion services for AGYW, as a reproductive health right, must be available, accessible, affordable, acceptable and of the highest quality. The normative content of availability provides that proper public health and health care facilities, goods and services, and programs must be available in sufficient quantity within the State.[20] Accessibility provides that the services ought to be accessible to everyone without discrimination. The element further includes economic accessibility. Quality health care entails generally medically appropriate services, skilled medical personnel, appropriate medication and equipment.[21]

Moreover, States must meet AGYW's other rights to fully recognise reproductive rights due to the indivisibility, interconnectedness and interdependence of human rights and fundamental freedoms.[22] Reproductive rights are linked to the right to life due to the mortality rates, the right to access information, the right to freedom from torture and freedom from discrimination, to name just a few.

2.1. Role of the National Government in Ensuring Accessibility of Safe Abortion Services

In embracing State responsibility as a means to fulfil the right to reproductive health under Article 43, the Constitution mandates the Legislature to enact legislation and regulations on the right to health. It is further required to review the existing laws to ensure the Constitution's values and principles are fully integrated. Section 68 of the Health Act No. 21 of 2017[23] provides for the development of the National health system to include adolescent and youth sexual and

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[17] *Supra* at note 16.
[18] CRC General Comment No. 15, 53-54.
[19] *K.L. v. Peru*, (2005) United Nations Human Rights Committee, Comm No. 1153/2003, para 6.3-6.5.
[20] CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August, 2000, 12.
[21] KELIN, "Monitoring the Implementation of the Right to Health under the Constitution of Kenya," (accessed 9th July, 2022), http://kelinkenya.org/wp-content/uploads/2016/11/FINAL-TRAINING-MANUAL-NOV-2016.pdf , 2016, 11.
[22] CESCR, General Comment No. 22, Right to Sexual and Reproductive Health, 2 May, 2016, 12-23.
[23] *Health Act 2017*, s. 68.

reproductive health. Further, the Children's Act 2022 embraces a progressive application by promoting the evolving capacities principle, in line with the best interest of the child, which can be used to promote the reproductive health and rights of adolescents.[24] Additionally, it promotes Article 53 of the Constitution, which reinforces the recognition of the best interest of the child.[25]

The Executive, through the Ministry of Health, on the other hand, is fully mandated with the implementation of legal and policy underpinnings. It developed the Standards and Guidelines for Prevention of Mortality and Morbidity from Unsafe Abortions. However, the statistics show these guidelines are yet to be implemented fully.[26] Furthermore, the Executive has failed to fulfil and promote survivors' rights to access safe abortion by failing to take a policy stance that actively recognises safe abortion as a reproductive health right and, in certain instances, developing policies that limit the right to safe abortion.

The Ministry of Health launched a Reproductive Health Policy on 6 July 2022. The stakeholders in the health sector have heavily criticised it for its retrogressive provisions on reproductive health and rights, such as creating a requirement that before providing abortion services, the practitioner ought to ensure the highest attainable standard of health for the unborn child as well as the mother.[27] The Clause presumably creates an impossible situation whereby health practitioners would have to balance the rights of both. This also exacerbates the existing fear and stigma among health care providers in dispensing abortion services, even for survivors of sexual violence.

Moreover, the Ministry of Health withdrew the Guidelines on Safe Abortion in 2013,[28] only one year after its adoption. Yet, the standards recognised the need for survivors of sexual violence to access safe abortion. The Standards and Guidelines were eventually reinstated following a High

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[24] *The Children's Act*, 2022, s. 8 notes that the best of interest of the child shall take primary consideration. Further s 8 (2) provides that the best interest of the child shall be calculated to safeguard and promote the rights and welfare of the child and conserve and promote the welfare of the child. The provision proceeds to note that in any matters affecting a child, the child shall be accorded an opportunity to express their opinion, and that opinion shall be taken into account in appropriate cases, having regard to the child's age and degree of maturity.

[25] *The Constitution of Kenya* (2010), Article 53 (2).

[26] Ministry of Health, "STANDARDS and GUIDELINES for reducing morbidity & mortality from unsafe abortion in Kenya," (accessed 10th September,2022) https://www.safeabortionwomensright.org/wp-content/uploads/2018/02/Standards-Guidelines-for-the-Reduction-of-Morbidity-and-Mortality-from-Unsafe-Abortion.pdf.

[27] Reproductive Health Policy, Clause 3.4.1, p 23; 'Civil Society Groups Want Reproductive Health Policy Delayed,' (accessed 10th September, 2022), https://nation.africa/kenya/news/civil-society-groups-want-reproductive-health-policy-delayed-again-3869654.

[28] *Federation of Women Lawyers (FIDA – Kenya) & 3 others v Attorney General & 2 others; East Africa Center for Law & Justice & 6 others (Interested Party) & Women's Link Worldwide & 2 others (Amicus Curiae),* [2019] eKLR

Court decision (which shall be further discussed below) that demonstrated the withdrawal led to a violation of rights.[29]

Among the core minimums, the State is also mandated to put timelines for implementing the right to health, formulate strategies and policies combating the main issues, make funds available to ensure implementation and establish a grievance mechanism.[30] The Legislature and the Executive have clearly fallen short of the minimum obligations, and there is no grievance mechanism—the only resort for the citizen is to institute a Public Interest suit seeking declaratory orders.

2.2. Role of County Governments in Ensuring Accessibility of Safe Abortion Services

Under the new constitutional dispensation, essential health service delivery is assigned to county governments.[31] Many counties have resorted to developing county specific legislation on maternal, newborn and child health care. However, some have limited access to abortion services only to emergency cases but have failed to include services for survivors of sexual violence.[32]

Funding under the health care system correspondingly plays a crucial role in ensuring the implementation of the health policy. Financing health care is within the purview of the national and county governments. Given that Kenya is a signatory to the Abuja Declaration, there is a requirement to invest at least 15% of the country's annual budget in health. At the county level, access to reproductive health care, including abortion services, is wanting due to the lack of adequate funding.[33] The situation was made dire during the Covid-19 pandemic, as shall be buttressed below.

In Kenya, the State spends an average of 7.4 hours of health care personnel time on treating a woman from complications of unsafe abortions.[34] Financially, in 2012, the treatment of unsafe abortion complications cost the public health system a total of Kshs 432.7 million; in 2016, it was

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[29] *Supra* at note 28.
[30] CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), para 43.
[31] Constitution of Kenya 2010, Fourth Schedule.
[32] *Kilifi County Maternal, Newborn and Child Health Act,* Act No. 23 of 2016.
[33] Health Policy Plus "Is Kenya Allocating Enough Funds for Health care?" (accessed 20th September, 2022) http://www.healthpolicyplus.com/ns/pubs/18441-18879_KenyaNCBABrief.pdf.
[34] Ministry of Health, "The Costs of Treating Unsafe Abortion Complications in Public Health Facilities in Kenya," (accessed 10th August, 2022), https://aphrc.org/post/publications/costs-treating-unsafe-abortion-complications-public-health-facilities-kenya.

estimated to reach 533 million.[35] This causes a significant drain on the health system, yet the time and money can be directed to deal with the cause of the problem altogether.

In the next segment, the paper addresses what services are to be provided to survivors of sexual violence and how the right to quality abortion services is crucial in the wake of Kenya's health care system's challenges.

3. Provision of Reproductive Health Services to Survivors of Sexual Violence

States must provide the victims of sexual violence with medical services to mitigate and/or remedy the consequences of the violence they have suffered.[36] These services must include, but not be limited to, treatment provided by gynecologists, proctologists, and urologists for potential injuries suffered, especially to treat infections and other sexually transmitted infections (STIs), including HIV; access to pregnancy tests, contraception (including emergency contraception that prevents conception), medical abortions, post-abortion care, and psychological support.[37] States must not require victims to have lodged a complaint or reported the violence to the police before these services are provided.[38]

Domestic legislation and policies provide that persons affected by sexual and gender-based violence (SGBV) must be accorded the highest attainable standard of health. *The Sexual Offences Act 2006* provides for the prevention and protection of all persons from harm from unlawful sexual acts and access to justice and psychosocial support.

The Victim Protection Act 2014 further provides the rights of survivors and permits any person dealing with a victim to secure their urgent medical treatment.[39] The same is provided under the *National Framework toward Response and Prevention of Gender Based Violence in Kenya*.[40]

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[35] *Supra* at note 34.
[36] Ministry of Health, Kenya National Guidelines on Management of Sexual Violence in Kenya,2014, xi.
[37] *Ibid*.
[38] ACHPR Guidelines on Combatting Sexual Violence and its Consequences; *See*: Doctors without Borders, Untreated Violence: The Need for Patient-Centred Care for Survivors of Sexual Violence in the Platinum Mining Belt (2016).
[39] *The Victim Protection Act,* s. 11 (2) (c).
[40] National Framework toward Response and Prevention of Gender Based Violence in Kenya, Guiding Principles, 2014, p. 13.

Moreover, the policy stipulates that the Ministry of Health is responsible for delivering quality services for SGBV survivors/victims.[41]

3.1. Barriers to Accessing Safe Abortion Services for Survivors of Sexual Violence in Kenya

While Kenya has a strong foundation of legal and policy underpinnings on health care, including the decentralisation of health care services, there are still identifiable obstacles to accessing safe abortion for survivors of sexual violence.

3.1.1. Lack of Availability, Accessibility and Quality of Abortion Services in Kenya

Access to emergency health care following sexual violence is crucial. In Kenya, survivors are not in a position to guarantee access to emergency treatment after the attack, given most sexual violence survivors either do not access health care, access it late, or do not complete treatment.[42] This is further promoted by consistent stock outs in pharmacies and shipment delays, which prevent girls from reliably accessing the medicine.[43] Moreover, the lack of access to emergency contraception is further aggravated by the absence of information on what steps are to be undertaken to get treatment. Conversely, where one is aware, many survivors opt not to report the cases due to the stigma and discrimination that follows the reporting. Therefore, the availability of safe abortion services cannot be overlooked.

The pandemic created complications regarding access to health care services and products, even for survivors. Generally, pandemics affect the availability of routine health care to individuals and societies having a low income and not having regular physicals.[44] Previous pandemics resulted in decreased access to services for family planning, curettage, prenatal and postnatal care, gender

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[41] *Supra* at note 40, page 19.

[42] Anne Gatuguta *et al*, "Missed treatment opportunities and barriers to comprehensive treatment for sexual violence survivors in Kenya: a mixed methods study" (2018) 18 *BMC Public Health*, 769,(accessed 30th March, 2022) https://doi.org/10.1186/s12889-018-5681-5.

[43] CEDAW Committee, Concluding Observations: Kenya, para. 37, U.N. Doc. CEDAW/C/KEN/CO/7 (2011); International Consortium for Emergency Contraception. Counting What Counts: Tracking Access to Emergency Contraception Kenya. New York; 2013 (accessed 29th March, 2022) https://www.cecinfo.org/wp-content/uploads/2013/05/ICEC-Kenya-Fact-Sheet-2013.pdf; Ooms, G.I., Kibira, D., Reed, T. et al, 'Access to sexual and reproductive health commodities in East and Southern Africa: a cross-country comparison of availability, affordability and stock-outs in Kenya, Tanzania, Uganda and Zambia,' *BMC Public Health 20, 1053, 2020 (*accessed 29th March, 2022) https://doi.org/10.1186/s12889-020-09155-w.

[44] Derya Kaya Senol, Filiz Pollat, "Effects of the pandemic on women's reproductive health protective attitudes: a Turkish sample,"(2022)19 *Reproductive Health* (accessed 31st March, 2022) https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-022-01412-y, March 2022.

based violence, mental health care, increased morbidity and mortality due to unwanted pregnancies, sexually transmitted infections and pregnancy related complications.[45] Owing to the government's modified health policies during pandemics, reproductive health services can be delayed and disregarded, and women of reproductive age may experience some difficulties.[46]

In Kenya, the pandemic similarly impacted access to reproductive health care, including emergency contraception and abortion services. For example, a report demonstrated DKT International, one of the world's largest providers of contraception and safe abortion products and services, ran extremely low on its stock of medical abortion pills for its Kenya program when thousands of packs got stuck at the New Delhi airport for nearly six weeks due to air cargo delays.[47]

Further, the African Population and Health Research Center (APHRC) demonstrated recently that shortages of reproductive health commodities in Kenya were prevalent in public and private facilities occasioned by the pandemic. According to a survey by APHRC, an average of 2.8% of the respondents could not receive SGBV related services from health care facilities.[48] Additionally, 72% of the facilities reported a lack of medical abortion medications during the survey.[49] The study highlighted other barriers that prevented women and adolescent girls from accessing reproductive health services, such as restricted movements, closure of health facilities due to Covid-19, long distance to access facilities and health facilities being too harsh to provide the service to avoid contracting Covid-19. [50] Fear of contracting the virus at health facilities was also a factor.

Also, the case of the *Federation of Women Lawyers (FIDA – Kenya) & 3 others v Attorney General & 2 others*[51] demonstrates that there was a challenge concerning the availability of emergency care, including abortion rights, even before the pandemic. The matter was a constitutional petition where a 14 year old girl, JMM, succumbed to injuries from an unsafe abortion after being sexually abused. The Petitioner argued that the *Ministry of Health National Guidelines on the Management*

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[45] *Supra* at note 44.
[46] *Ibid.*
[47] Neha Wadekar, "The Coronavirus Is Cutting Off Africa's Abortion Access," (accessed 31st June, 2022) https://foreignpolicy.com/2020/05/04/coronavirus-africa-abortion-access/, May, 2020.
[48] African Population and Health Research Center, "Impact of the Covid-19 Pandemic on Sexual and Reproductive Health Services in Burkina Faso, Ethiopia, Kenya, Malawi and Uganda,"(accessed 30th June 2022) https://aphrc.org/wp-content/uploads/2022/05/APHRC-COVID-Report-PRINT.pdf.
[49] *Ibid.*
[50] *Ibid.*
[51] *Federation of Women Lawyers (Fida – Kenya) & 3 others v Attorney General & 2 others; East Africa Center for Law & Justice & 6 others (Interested Party) & Women's Link Worldwide & 2 others (Amicus Curiae)* [2019] eKLR

of Sexual Violence in Kenya, 2nd Edition, 2009 (2009 National Guidelines), made pursuant to section 35 (3) of the Sexual Offences Act, allowed termination of pregnancy as an option in cases of pregnancy occurring as a result of rape. However, there is no clarity on how it could be accessed. The Petitioner also argued that the withdrawal of the *2012 Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya (2012 Standards and Guidelines)* and *the National Training Curriculum for the Management of Unintended, Risky and Unplanned Pregnancies (the Training Curriculum)* undermined the right to safe abortion.

The court considered the Ministry of Health, APHRC, Ipas and Guttmacher Institute report launched in 2013, providing that the missing link in reducing maternal mortality has been the absence of technical and policy guidelines for preventing and managing unsafe abortions to the extent allowed by the Kenyan law.[52] Therefore, the court took cognizance of the main issue, being how young girls and women would resort to unsafe abortions and thus either succumb to the injuries or suffer from disabilities as a result of the unsafe procedure.

3.1.2. Ambiguity of Provisions Limiting the Accessibility of Safe Abortion Services

Access to safe and legal abortions is crucial to reproductive health rights. However, it remains a very contentious issue. In Kenya, the Penal Code generally prohibits the performance of unlawful abortion. Further, it stipulates that a person will not be held criminally responsible for performing an abortion if done to preserve the woman's life.[53] The Constitution offers a more expansive interpretation regarding abortion by providing that it is not permitted unless, in the opinion of a trained health professional, there is a need for emergency treatment or the life or health of the mother is in danger, or if permitted by any other written law.[54]

The effect of Kenya's religious and cultural background, as read together with the 'blanket ban' on abortion and the exceptions under the Penal Code and the Constitution, raises ambiguity over abortion laws in Kenya. Furthermore, the failure by the Ministry of Health to specifically provide for the right to safe abortion under its national policies, and subsequent actions by the Ministry that arbitrarily limit the right to safe abortion (such as withdrawal of the guidelines as well as the

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[52] *Supra* at note 51, para 314.
[53] *The Penal Code, Cap 63 Laws of Kenya*, Section 158-160, 228, 240, Centre for Reproductive Rights 'In Harm's Way: The Impact of Kenya's Restrictive Abortion Laws,' 2010, 13 (accessed 18 July, 2022) https://www.reproductiverights.org/story/in-harms-way-the-impact-of-kenyas-restrictive-abortion-law.
[54] *The Constitution of Kenya* (2010), Article 26 (4) .

conflicting provisions of the Reproductive Health Policy 2022), have contributed significantly to lack of access to safe abortion services for all AGYW including survivors of violence.

There is an alarmingly high level of stigma associated with abortion, thereby rendering women and girls crippled with fear at the thought of anyone becoming aware that they procured or sought to procure the service. Decisions to procure abortions by younger and married women are highly stigmatised, with men being the biggest culprits propagating the stigma.[55] Women seeking abortion services cite stigma, isolation and shame as major hindrances to seeking the services at health facilities. The stigmatisation is also a motivation towards seeking services from untrained providers. [56] The Kenya Medical Association also noted that there is fear and stigma among medical practitioners characterised by cultural and religious views that young women should not be permitted to procure an abortion.[57]

The ambiguity in the provision of legal abortion services has further led to the prosecution of medical practitioners even when provided in line with the law. This is evident in the ill-famed case of *Republic v Dr. Nyamu and others,*[58] where medical practitioners were arrested and wrongfully charged with murder in connection with alleged illegal abortions. In another case, *Republic v. Jackson Tali*, the trial court found Tali, a registered health worker operating a clinic, guilty of murder and sentenced him to death after a young woman with pregnancy complications died in his care.[59] The trial court convicted Tali despite the lack of any form of medical or forensic evidence to prove that the deceased had undergone an abortion or that Tali had performed the abortion unlawfully, outside the exceptions in section 240 of the penal code.[60] The case shows the threats to medical practitioners providing the abortion service, even within the confines of the law. The Court of Appeal overturned the case for failure to establish the burden of proof.

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[55] Kenya Medical Association, "Chief Conspirators in Unsafe Abortion and Maternal Deaths in Kenya," https://kma.co.ke/images/CHIEF_CONSPIRATORS_IN_UNSAFE_ABORTION_AND_MATERNAL_DEATHS_IN_KENYA.pdf.
[56] *Ibid.*
[57] *Ibid.*
[58] *Republic v John Nyamu & 2 others,* [2005] eKLR.
[59] *Jackson Namunya Tali v. Republic*, Criminal Appeal No. 173 of 2016, judgment delivered October 19, 2017; see "A Decade of Existence: Tracking Implementation of Article 26 (4) of the Constitution of Kenya (2010)," June 2020, https://reproductiverights.org/sites/default/files/documents/A-Decade-of-Existence-Kenya_0.pdf.
[60] *Ibid.*

The effect of the threats to medical practitioners is seen in the medical environment where there is an alarm about providing safe, legal abortion services even to survivors of sexual violence. The Center for Reproductive Rights also noted that between 2010 and 2019, 29 cases were filed in criminal courts, with charges relating to the provisions of the penal code that prohibit abortion and related acts.[61] This further impedes medical practitioners from providing post-abortal care as a matter of life and death. It is evidenced by the recent decision where a doctor was prosecuted in Malindi for providing post-abortal care to a minor who had procured an abortion.[62] Civil society actors pursued the case through a constitutional petition when the prosecutor refused to drop the charges.

4. Conclusion and Recommendations

The Covid-19 pandemic exposed the existing loopholes in the health system, key among them being the vacuum as regards availability and accessibility of critical reproductive health services to adolescents and young women. The pandemic further led to spark an increase in cases of sexual and gender-based violence, especially among AGYW leading to alarming numbers of teenage pregnancies. As the African Union noted, SGBV gravely impacts the victim's physical and mental well-being. The situation worsens when the victim is forced to carry a pregnancy to term as a result of the rape. Therefore, we can no longer turn a blind eye to the need for safe abortion services, especially for survivors of sexual violence.

The Legislature and the Executive have fallen short of fulfilling the reproductive rights of AGYW, especially abortion services. There is a lack of a clear policy stance as regards the provision of safe abortion services, yet the Constitution explicitly permits abortion in certain instances. However, due to the high rate of stigma, ambiguous and inconsistent laws (at the county and national level), and lack of available and accessible services, even survivors of sexual violence cannot access the service.

Thus, it is time for the national and county government to ensure policies conform with the Constitution to allow abortion services for survivors of violence. Further, there is a need for

[61] *Supra* at note *59*.
[62] *PAK & Salim Mohamed v Attorney General & 3 Others*, Petition E009 of 2020 [2022] KEHC 262 (KLR).

continuous sensitisation among medical practitioners and law enforcement agencies to understand the legal parameters regarding the provision of abortion services in Kenya.

Certain events repeatedly trigger debates and discussions surrounding pregnant adolescents; however, the topic gets buried after a while leading to more adolescent girls dying without finding proper solutions. It is time to create a better future for adolescent girls in Kenya and, subsequently, in Africa by claiming the space for their reproductive rights.

AN APPRAISAL OF THE MENTAL HEALTHCARE REGIME IN KENYA: ARE WE THERE YET?

Miracle Okoth Okumu Mudeyi[*] and Geoffrey O. Ochieng[**]

1. Introduction

The advent of the Covid-19 pandemic in late 2019 exacerbated the historical neglect of dignified mental healthcare in Kenya's context. Our country's protracted neglect and glaring underinvestment in mental healthcare have been exposed. Moreover, the pandemic quickly spread through the world, and thus, the necessity to devise several measures to mitigate the effects. This resulted in the closure of schools, workplaces and non-essential services. Additionally, it led to the issuance of 'stay at home' orders, curfews and lockdowns. Subsequently, the impact of physical and mental isolation on the mental health of Kenyans was disastrously coupled with emotional regulation and the unavailability of professional support.

1.1. The Current State of Mental Healthcare in Kenya

In general, Kenya and Africa need to rethink mental health care in education, policy, and practice to maximise the benefits of both traditional and biomedical approaches.[1] In mental health, stakeholder views are essential in informing the planning, delivery, and evaluation of interventions. Important factors such as a clear therapeutic framework, evidence base, and socio-cultural adaptation must be developed to sustain such interventions to be persistent.[2] Despite prevalent mental disorders in Kenya today, it is glaringly shameless that only 500 special mental health workers serve Kenya's 50 million-plus population.[3]

Reforming mental health in Kenya is not only a medical matter but an issue of justice and freedom - it's about honouring those psychiatrised and maltreated by the colonial system. It is about

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[*] The author is a finalist law student at the University of Nairobi and the 2022 CB Madan Student Prize recipient.
[**] LLB (Moi University), works with the Kenya Commission of the International Commission of Jurists (ICJ Kenya) as a programme officer under the Economic Justice Programme.
[1] Mohamed Ibrahim, "Mental Health in Kenya: Not Yet Uhuru - Repositoriocdpd.net:8080" (The Critical Institute, 2017), http://repositoriocdpd.net:8080/handle/123456789/1503.
[2] Elijah Marangu et al., "Mental Healthcare in Kenya: Exploring Optimal Conditions for Capacity Building," African Journal of Primary Health Care & Amp; Family Medicine 6, no. 1 (October 2014), https://doi.org/10.4102/phcfm.v6i1.682.
[3] Joy Muhia et al., "A Human Rights Assessment of a Large Mental Hospital in Kenya," *Pan African Medical Journal* 40 (December 3, 2021): pp. 2-7, https://doi.org/10.11604/pamj.2021.40.199.30470.

decolonising mental health.[4] In breaking through the chokehold of mental health disorders, machine learning methods can be used to predict individuals' mental health status according to a set of data analysed by the Busara Center.[5]

1.2. The State of Mental Health Literacy and Awareness in Kenya

The Covid-19 pandemic exerted undue pressure on public mental health in Kenya. In a cross-sectional survey carried out during the pendency of the Corona Virus between August and November 2020 among health care workers at three major hospitals, it was discovered that such workers directly involved with the treatment of patients with Covid-19 reported higher rates of mental health symptoms and thus a dire need of mitigating strategies.[6]

Mental health literacy can be described as the knowledge about mental health disorders associated with their recognition, management and prevention.[7] It is a seemingly emerging concept, hence why it is little known. The high prevalence rates of mental health disorders are a fundamental concern for public health professionals because of the many consequences for individuals and their families and the socioeconomic burden on the Kenyan national economy. In the Kenyan context, many people with mental health disorders lack access to professional assistance or help. Seeking prompt, professional support has been shown to promote early interventions and results and improve long-term outcomes.[8]

Mental health literacy is a crucial factor, especially during a pandemic. Many people struggle to access, understand, appraise and utilise the information that is supposed to improve their mental health. Mental literacy is vital for purposes of policy impact and the development of numerous

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[4] Mohamed Ibrahim, "Mental Health in Kenya: Not Yet Uhuru - Repositoriocdpd.net:8080" (The Critical Institute, 2017), http://repositoriocdpd.net:8080/handle/123456789/1503.
[5] Yarah E Alharahsheh and Malak A Abdullah, "Predicting Individuals Mental Health Status in Kenya Using Machine Learning Methods," IEEE Xplore, 2021, https://ieeexplore.ieee.org/abstract/document/9464608/.
[6] Jasmit Shah et al., "Mental Health Disorders among Healthcare Workers during the Covid-19 Pandemic: A Cross-Sectional Survey from Three Major Hospitals in Kenya," BMJ Open (British Medical Journal Publishing Group, June 1, 2021), https://bmjopen.bmj.com/content/11/6/e050316.abstract
[7] Adrian Furnham and Viren Swami, "Mental Health Literacy: A Review of What It Is and Why It Matters," International Perspectives in Psychology 7, no. 4 (2018): pp. 240-257, https://doi.org/10.1037/ipp0000094.
[8] Ziyan Xu et al., "Effectiveness of Interventions to Promote Help-Seeking for Mental Health Problems: Systematic Review and Meta-Analysis," *Psychological Medicine* 48, no. 16 (January 2018): pp. 2658-2667, https://doi.org/10.1017/s0033291718001265.

interventions.[9] Kenya's cultural context has a massive influence on the conceptions of mental health disorders and, thus, the need for experts and scholars to understand it. Deprived mental health literacy remains an exigent public concern because it influences the public's decision-making about their mental health. There is a sharp divide in opinions on the best treatment methods for mental health disorders in developing countries.[10]

It is thus a clarion call to all stakeholders—academics, health practitioners, and civil society organisations- to lead in designing and evaluating interventions that will go a long way in promoting mental health literacy among the general public (*wanjiku*). This will subsequently result in improved rates of persons seeking help, treatment, and medication for mental health disorders.

1.3. The Constitutional Framework for Achieving a Proper Mental Health Regime

In its preamble, the Constitution of Kenya 2010 recognises the aspirations of all Kenyans for a government based on indispensable values of human rights, equality, freedom, democracy, social justice, and the rule of law. Persons with mental health conditions should therefore enjoy all rights and freedoms equally with other individuals.[11]

Article 43(1) (a) provides that every person has the right to the highest attainable standards of health, which includes the right to health care services.[12] Additionally, Article 28 of the Constitution of Kenya 2010 explicates that every person has inherent dignity and the right to have that dignity respected and protected. It thus includes persons with mental health illnesses and disabilities.[13]

Article 29(f) of the Constitution of Kenya further lays out that every person has a right to freedom and security of the person which includes the right not to be treated in a cruel, inhuman, or degrading manner.[14] Furthermore, Article 260 defines disability to include any physical, sensory, mental, psychological, or other impairment, condition, or illness that has or is perceived by

[9] Anthony F. Jorm, "Why We Need the Concept of 'Mental Health Literacy,'" Health Communication 30, no. 12 (2015): pp. 1166-1168, doi:10.1080/10410236.2015.1037423.
[10] M.C. Angermeyer, A. Holzinger, and H. Matschinger, "Mental Health Literacy and Attitude towards People with Mental Illness: A Trend Analysis Based on Population Surveys in the Eastern Part of Germany," European Psychiatry 24, no. 4 (2009): pp. 225-232, doi:10.1016/j.eurpsy.2008.06.010.
[11] Constitution of Kenya, 2010, Preamble.
[12] Constitution of Kenya, 2010, Article 43(1)(a)
[13] Constitution of Kenya, 2010, Article 28
[14] Constitution of Kenya, 2010, Article 29(f)

significant sectors of the community to have a substantial or long-term effect on an individual's ability to carry out ordinary day-to-day activities.[15]

The rights of persons with disabilities have been sheltered under Article 54 of the Constitution of Kenya, 2010, which guarantees that persons with disabilities are entitled to be treated with dignity and respect and to be addressed in a manner that is not demeaning.[16] Moreover, Article 27(4) clarifies that the State shall not discriminate directly or indirectly against a person on any ground, including disability. The applicability of the aforementioned section is also helpful to private citizens.[17]

The Government of Kenya, under Article 21 of the Constitution, is obliged to take measures, including the setting of standards to achieve the progressive realisation of the right guaranteed under Article 43 of the Constitution without lowering the standard set thereto but set standards that must be reasonable and which may result in effective implementation of Article 43 and 46 as regards the right to health.

2. The Current Statutory and Policy Framework; Is it Adequate?

The Health Act, 2017 defines a disease as any physical or mental condition that causes pain, dysfunction, distress, social problems, or death to the person afflicted or similar problems for those in contact with the person.[18] Additionally, before the enactment of the Mental Health (Amendment) Act, 2022, Section 2 of the Mental Health Act[19] defined a person suffering from mental health as a person who is so suffering under this Act and includes a person diagnosed as a psychopathic person with mental illness and a person suffering from mental impairment due to alcohol or substance abuse.

Section 73 of the Health Act[20] stipulates that there shall be established by an Act of Parliament, Mental health legislation to—protect the rights of any individual suffering from any mental disorder or condition; ensure the custody of such persons and the management of their estates as necessary; establish, manage and control mental hospitals having sufficient capacity to serve all

[15] Constitution of Kenya, 2010, Article 260.
[16] Constitution of Kenya ,2010, Article 54
[17] Constitution of Kenya, 2010, Article 27(4).
[18] *The Health Act 2017*, s. 2.
[19] Cap 248, Laws of Kenya.
[20] *The Health Act, 2017*.

parts of the country at the national and county levels; advance the implementation of other measures introduced by specific legislation in the field of mental health, and to ensure research is conducted to identify the factors associated with mental health. The legislation under this provision must consider international best practices and current norms and standards in mental health. Section 104 calls for the recognition and incorporation of e-health as a mode of health delivery.[21] According to the Act, e-health is the combined use of electronic communication and information technology in the health sector, including telemedicine.[22] E-health is especially significant in the field of mental health.

2.1. In the Purview of the Reformed Law (The Mental Health (Amendment) Act, 2022); Breathing new life

In breathing life to Article 43(1) (a) of the Constitution and Section 73 of the Health Act of 2017, there were calls to expedite the enactment of the Mental Health (Amendment) Act, 2022. This Act aims to respond comprehensively to the shortcomings of the Mental Health Act of 1989. It provides a framework to promote the mental health and wellbeing of all persons, including reducing the incidences of mental illness,[23] coordinating the prevention of mental illness, access to mental health care, treatment and rehabilitation services of persons with mental illness,[24] reducing the impact of mental illness, including the effects of stigma on individuals, family and the community,[25] promoting the recovery from mental illness and enhancing rehabilitation and integration of person with mental illness into the community.[26] It finally seeks to ensure that the rights of a person with mental illness are protected and safeguarded.[27] The Act proposes to bring mental health services and the welfare of mentally ill people in Kenya to an equivalence set by international standards.

The Mental Health (Amendment) Act, 2022 has set guidelines to ensure that mental health services are affordable and accessible to all *Wanjiku*.[28] It mandates national and county governments to determine and coordinate the implementation of policies to ensure mental healthcare provision in

[21] *Supra* at note 20, s. 104
[22] *Ibid*, s. 2
[23] *The Mental Health (Amendment) Act, 2022* s. 2A (a)
[24] *Ibid*, s. 2A (b)
[25] *Ibid*, s. 2A(c)
[26] *Ibid*, s. 2A(d)
[27] *Ibid*, s. 2A (e)
[28] *Ibid*, s. 2B.

health facilities at the community, primary, secondary and tertiary levels.[29] It ensures decentralisation and devolution of mental health services to reach every county and persons distant from major towns like Nairobi and Mombasa. The Act guides national and county governments in promoting community mental health by providing appropriate resources, facilities, services, personnel and programmes.[30] This allows *Wanjiku* with mental illness to access services at the community level; it also includes the development of outpatient services for persons with mental illness and clinics in health centres and general hospitals all over the country.[31]

Additionally, the Mental Health Act (principal Act) set forth guidelines for establishing mental health regulating bodies – the Kenya Board on Mental Health[32] at the national level and the County mental health councils to be established in each county.[33] The respective bodies will be responsible for regulating mental health services, including advising the government, establishing and inspecting mental health facilities, and investigating any matters related to mental health services or programmes.

2.2. Mental Health Implications of Covid-19 in Kenya

The Covid-19 pandemic had a tremendous impact on mental health in Kenya, exacerbating existing issues and creating new ones. Individuals' mental health suffered due to fear, uncertaint y, and social isolation. The pandemic disrupted daily routines, causing stress and anxiety. According to a study published in the International Journal of Environmental Research and Public Health, there was a considerable rise in anxiety and depression symptoms among Kenyan adults during the pandemic compared to pre-pandemic levels.[34]

The Ministry of Health, in its February 2021 Report titled, *'Readiness for Covid-19 Response and Continuity of Essential Health Services in Health Facilities and Communities'*[35] found that the only

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[29] *Supra* at note 23, sections 2C and 2D.
[30] *Ibid.*
[31] *Ibid.*
[32] *Mental Health Act*, 1989, s. 4.
[33] *Supra* at note 28, s. 2E.
[34] International Journal of Environmental Research and Public Health: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7798125/
[35] Ministry of Health, Kenya, 'Readiness For Covid-19 Response And Continuity Of Essential Health Services In Health Facilities And Communities' available at https://www.health.go.ke/wp-content/uploads/2022/01/Readiness-for-COVID-19-Response-and-Continuity-of-Essential-Health-Services-in-Health-Facilities-April-2021.pdf accessed 3 May 2022.

service that saw an increase in utilisation was mental health, with 23% of the health facilities assessed indicating this increase and perhaps reflecting the effects of Covid-19 on mental health.

On the community perceptions towards continuity of essential health services in the presence of Covid-19, at least 65% of the informants believed that the community had unmet needs for mental health services during the Covid-19 pandemic.[36] On the availability of medical supplies for treating mentally ill patients, *carbamazepine*, the tracer drug, was missing in about a third of the facilities assessed.[37]

In sum, there was no specific mental health response strategy for the Covid-19 response. There was an unmet need for psychological first aid in the community. While guidelines for managing mental health conditions during the Covid-19 pandemic were prepared, implementation remained a major challenge due to an under-resourced mental health system. Further, there was no established mental health surveillance system, limiting the ability to form evidence-based interventions.[38]

2.3. Public Mental Health Education during the Covid-19 Pandemic by the National Emergency Response Committee (NERC)[39]

The Ministry of Health undertook public mental health education during the Covid-19 Pandemic. The pandemic was found to affect the mental health of individuals negatively in different ways. [40] Fear of the virus was associated with the experience of intense pain. Further, prolonged distress could lead to anxiety disorders and depression, and physical isolation of individuals, families or communities exposed to Covid-19 was an additional risk for psychosocial problems.

Social problems emerged, such as the breakdown of community support systems and stigma against the vulnerable and the ill. There was a drastic decline in income generation within communities as a consequence of travel and work restrictions, loss of family and community

[36] *Supra* at note 35, page vii.
[37] *Ibid*, page vii.
[38] Jaguga, F., Kwobah, E. Mental health response to the Covid-19 pandemic in Kenya: a review. *Int J Ment Health Syst* 14, 68 (2020). https://doi.org/10.1186/s13033-020-00400-8
[39] Public Mental Health Education during the Covid-19 Available at http://www.kenyalaw.org/kl/fileadmin/pdfdownloads/Public-Mental-Health-education-during-COVID-19-Pandemic%20.pdf
[40] *Ibid*.

members and the collapse of the business. Furthermore, persons with pre-existing mental conditions faced relapses and, sometimes, failed to find adequate care, including medication.[41]

The National Response Emergency Committee set out an array of ways of remaining mentally healthy during the pendency of the pandemic. They included; establishing and maintaining a daily routine with periods of rest, shunning the consumption of alcohol and drugs as a coping mechanism, and minimising the consumption of news that causes anxiety. Further measures included protecting oneself and being supportive of others, appreciating the role of health workers during the pandemic, practising good self-care through adequate rest, a nutritious diet and regular exercise.[42]

The Ministry advised persons with existing mental illnesses to keep taking their medication, utilise teleconsultations or alternative care during the pandemic, and often call their loved ones in case of a crisis.

2.4. Kenya Health Policy 2014-2030[43]

The policy gives direction to ensure significant improvement in the overall status of health in Kenya in line with the Constitution of Kenya, the country's long-term development agenda, Vision 2030 and global commitments. It demonstrates the health sector's commitment, under the government's stewardship, to ensure that the country attains the highest possible standards of health in a manner responsive to the population's needs.[44]

Further, the policy contains six objectives. It aims to eliminate communicable conditions; halt and reverse the rising burden of non-communicable conditions and mental disorders; reduce the burden of violence and injuries; provide essential health care; minimise exposure to health risk factors; and strengthen collaboration with the private sector and other health-related sectors.

Policy objective two (2) proposes to halt and reverse the rising burden of non-communicable diseases and mental disorders and aims to achieve that through the employment of various strategies, including the promotion of universal access to interventions addressing priority non-

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[41] *Supra* at note 40.
[42] *Ibid.*
[43] Government of Kenya, Ministry of Health, 2014, Kenya Health Policy 2014-2030, available at https://www.ncikenya.or.ke/documents/kenya-health-policy.pdf
[44] *Ibid.*

communicable conditions and mental disorders in the country.[45] It also seeks to strengthen the integrated surveillance system to monitor trends in mental disorders, including risk factors, to inform policy and planning.[46]

2.5 The Kenya Mental Health Policy 2015-2030[47]

The development of the Kenya Mental Health Policy was informed by the need to reform the mental health systems in Kenya. This policy seeks to address the following: To align the mental health services with the Constitution of Kenya and with the National and Global health agenda, to address the mental health systemic challenges and emerging trends and mitigate the burden of mental disorders, to integrate the mental health services within the Kenya Essential Package for Health (KEPH), to promote, respect and observe the rights of persons with mental disorders under national and international laws.[48]

Most importantly, the policy highlights why mental health should be understood; Mental health is a crucial determinant of overall health and socioeconomic development. It influences individual and community outcomes such as healthier lifestyles, better physical health, improved recovery from illness, fewer limitations in daily living, higher education attainment, greater productivity, employment and earnings, better relationships with adults and with children, more social cohesion and engagement and improved quality of life. This policy also highlights the determinants of mental health and mental disorders, the burden and prevalence of mental disorders globally and locally and the challenges facing mental health care and service delivery in Kenya. It also provides policy directions on preventing, managing and controlling mental disorders.[49]

The vision of the policy is *'A Nation where mental health is valued and promoted, mental disorders prevented and persons affected by mental disorders are treated without stigmatisation and discrimination,'* while its goal is to attain the highest standard of mental health. The policy's objectives are to strengthen mental health systems, strengthen effective leadership and governance for mental health, and ensure access to comprehensive, integrated and high quality, promotive,

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[45] *Supra* at note 43, page 32
[46] *Ibid.*
[47] Government of Kenya, Ministry of Health, 2015 Kenya Mental Health Policy 2015-2030, available at https://mental.health.go.ke/download/kenya-mental-health-policy-2015-2030/
[48] *Ibid*
[49] *Ibid.*

preventive, curative and rehabilitative mental healthcare services at all levels of health care. It further aims to implement strategies for promoting mental health, preventing mental health disorders and substance use disorders.

Further, the policy instrument employs several strategies aimed at promoting mental health well-being which include: developing a Mental Health Plan to operationalise the Mental Health Policy, reviewing and revising the Mental Health Legislation, developing guidelines and standards on Promotion, Prevention, Care, Treatment and Rehabilitation of persons with mental, neurological and substance use disorders.[50]

The other strategies include; Integration of mental health into the Health Information System (HIS), investing in the mental health system for health financing, leadership, health products and technologies, health information and research, human resource, service delivery and infrastructure and developing monitoring and evaluation frameworks for mental health services.[51]

The policy decries barriers to increased access to effective mental health services, which include the absence of mental health from the public health agenda and the implications of funding, the current organisation of mental health services, lack of integration within primary care, inadequate human resources for mental health and lack of public mental health leadership.[52]

2.6 The Kenya Mental Health Action Plan 2021-2025[53]

The Action plan was instituted at the height of the Covid-19 pandemic, which caused enormous significant health, socioeconomic and psychological impacts on the population, hence the need for critical mental health and psychological support strategies and measures. It aims to operationalise mental health policy's four main objectives: to strengthen effective leadership and governance for mental health; ensure access to comprehensive, integrated and high-quality mental health care services at all levels of healthcare; implement promotive and preventive mental health strategies and strengthen mental health systems.[54]

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[50] *Supra* at note 47.
[51] *Ibid.*
[52] *Ibid*, page 32.
[53] Government of Kenya, Ministry of Health, 2021 *The Kenya Mental Health Action Plan 2021-2025* https://mental.health.go.ke/download/kenya-mental-health-action-plan-2021-2025/
[54] *Ibid*, page 6.

Additionally, the Action plan provides a framework for national and county governments and stakeholders to implement the Mental Health Policy through strategic objectives with specified priority targets and indicators. One key target is to have national and county governments annual mental health plans with increased budget allocation for mental health (Promotive, preventive, curative and rehabilitative) 100% (by 2022/23). [55] Laudably, target 1.3 advocates for an audit of Acts of Parliament that have an impact on mental health and revision of the Mental Health Act 100% (By the year 2022/2023). This was achieved by enacting the Mental Health (Amendment) Act, 2022.

3. Judicial Pronouncements in the Wake of Covid-19

A court can fashion new remedies to protect fundamental rights, enlarge old remedies, and invent new ones if that is what it takes or is necessary in an appropriate case to secure and vindicate the rights breached. This was set out in *Republic Ex Parte Chudasama v The Chief Magistrates Court and Another*.[56] Ultimately the court is the defender and guarantor of constitutional rights.

In the case of *Mathew Okwanda v Minister of Health and Medical Services & 3 others,*[57] the court stated that it must be recalled that the right guaranteed under Article 43(1)(a) is premised on the establishment of a "standard" which standard must be judged holistically. Within the confines of the criminal justice system, judges increasingly recognise the rights to health and especially towards ameliorating the rights of offenders with mental disorders. In constitutionalising the right to health in the case of *Hassan Hussein Yusuf v Republic,*[58] the High Court held that the detention of sick or mentally unstable persons instead of a health facility was unconstitutional, the detention order was set aside, and the suspect was escorted to a medical facility with the capacity to re-evaluate his mental condition, this was also the position of Justice Mrima in another case.[59]

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[55] *Supra* at note 53, target 1.1, page 23.
[56] *Ex Parte Chudasama v The Chief Magistrates Court and Another* [2008] 2 EA 311.
[57] *Mathew Okwanda v Minister of Health and Medical Services & 3 others* [2013] eKLR.
[58] *Hassan Hussein Yusuf v Republic* [2016] eKLR.
[59] See *Kimaru and 17 Others v AG and Another* [2022] eKLR.

4. Regional and International Law Framework to the Rescue?

The Constitution of Kenya 2010 recognises any treaty instrument or convention ratified in Kenya as part of the laws of Kenya.[60] Furthermore, domestic law must be consistent with international law.[61] Invisible impairments, such as mental health, are increasingly recognised by the international community as one of the most overlooked yet critical development concerns in meeting internationally agreed development goals.[62]

The economic cost of mental health issues is enormous, whereas a minimal investment in mental health can help individuals live happier lives. Poverty, a lack of education, gender inequality, bad health, violence, and other global concerns all contribute to poor mental health. It limits people's ability to work productively, reach their full potential, and contribute to their community.[63] Investing in people with mental health conditions can improve development outcomes.

The World Health Organization has called for the integration of mental health into primary caregiving for good reasons: the burden of mental health is great, mental and physical health problems are interwoven, the treatment gap for mental disorders is enormous, and primary care for mental health enhances access, primary care for mental health promotes respect for human rights, primary care for mental health is affordable and cost-effective and that primary care for mental health generates good health outcomes.[64]

The Preamble of the Charter of the United Nations states that human dignity is a value that the members of the United Nations strive to achieve[65]. The principle of dignity is also captured in

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[60] Constitution of Kenya, 2010, Article 2(6).
[61] See E Rosenthal and C Sundram, 'The Role of International Human Rights in National Mental Health Legislation' (Geneva: WHO, 2004). Copes available at http://www.who.int/mental_health/policy/international_hr_in_national_mhlegislation.pdf (accessed 30 April 2022); World Health Organisation, WHO Resource Book on Mental Health, Human Rights and Legislation (Geneva: WHO, 2005). Copies in English and French available at http://www.who.int/mental_health/policy/legislation/policy/en/ (accessed 30 April 2022)
[62] 'Mental Health and Development | United Nations Enable' (Un.org, 2010) http://www.un.org/development/desa/disabilities/issues/mental-health-and-development.html accessed 30 April 2022.
[63] 'Mental Health and Development | United Nations Enable' (Un.org, 2010) http://www.un.org/development/desa/disabilities/issues/mental-health-and-development.html accessed 30 April 2022.
[64] https://www.who.int/mental_health/po;licy/Integrating%20MH%20into%20primary%20care-%20final%20low-res%20140908.pdf accessed 30 April 2022.
[65] The words are part of the second paragraph of the Preamble, which reads in full as follows:" to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men And women and of nations large and small."

several other international instruments, including the Universal Declaration of Human Rights[66], the International Covenant on Civil and Political Rights[67], and the International Covenant on Economic, Social and Cultural Rights.[68]

The African Charter on Human and Peoples' Rights grants every individual the right to enjoy the best attainable physical and mental health state. Consequently, State parties to this charter are obligated to take necessary measures to protect their people's health and ensure that they receive medical attention when sick.[69] The charter provides that 'Every individual shall have the right to the highest attainable standard of physical and mental health.'[70]

The Convention on the Rights of Persons with Disabilities[71], which was acceded to by Kenya in May 2008, obligates States to recognise that persons with disabilities have the right to enjoy the highest attainable standard of health without discrimination based on disability. Kenya, as a State party, is obligated to provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes.[72]

Kenya is further charged with ensuring that those health services are needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimise and prevent further disabilities, including among children and older persons.[73] Kenya is supposed to provide these health services as close as possible to people's communities, including in rural areas.[74]

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[66] The preamble to the Universal Declaration proposes that human rights and dignity are self-evident, the "Highest aspiration of the common people," and "the foundation of freedom, justice and peace." "Social progress and better standards of life in larger freedom," including the prevention of "barbarous acts which have outraged the conscience of mankind," and, broadly speaking, individual and collective well-being, are Considered to depend upon the "promotion of universal respect for and observance of human rights.
[67] Article 10 provides that "all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.
[68] Article 1 (3) states that "education shall be directed to the full development of the human personality and The sense of its dignity.
[69] The African Charter on Human and People's Rights, 1987, Article 16.
[70] *Ibid*, Article 16(1)
[71] UN General Assembly, Convention on the Rights of Persons with Disabilities: resolution / adopted by the General Assembly, 24 January 2007, A/RES/61/106, available at: https://www.refworld.org/docid/45f973632.html [accessed 10 May 2022]
[72] *Ibid*, Article 25(a)
[73] *Ibid*, Article 25(b)
[74] *Ibid*, Article 25(c)

Additionally, health professionals should provide care of the same quality to persons with disabilities equally to others, including based on free and informed consent by, among other things, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care.[75]

State parties are supposed to prohibit discrimination against persons with disabilities in the provision of health insurance and life insurance where such insurance is permitted by national law, which shall be provided fairly and reasonably.[76] Kenya must prevent discriminatory denial of health care, health services, food, and fluids based on disability.[77]

The principles for the protection of persons with mental illness and the improvement of mental healthcare make provisions that every person with mental illness shall have the right to exercise all civil, political, economic, social and cultural rights recognised in the UDHR, ICCPR, ICESCR, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.[78]

An overview of the World Health Organization's Comprehensive Global Mental Health Action Plan 2013–2020[79] proposes a global vision and some core principles, including universal access and equity in mental health, the promotion of human rights, the application of evidence-based practise adoption of a life-course approach, the adoption of a multisectoral approach and the empowerment of people with mental disorders. This action plan was developed in response to the growing burden of mental health disorders and the challenges that health systems worldwide face to respond to the needs of people with mental health problems. Kenya adopted the action plan in May 2013, and its vision is;

A world in which mental health is valued, promoted, and protected, mental health disorders are prevented and individuals affected by these disorders are able to exercise the full range of human rights and access high-quality, culturally-appropriate health and social care in a timely way to

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[75] *Supra* at note 71, Article 25 (d)
[76] *Ibid*, Article 25(e)
[77] *Ibid*, Article 25(f)
[78] United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, 1991, Principle 5.
[79] 'Comprehensive Mental Health Action Plan 2013-2030' (Who.int, 2013) https://www.who.int/publications/i/item/9789240031029 accessed 1 May 2022.

promote recovery, all to attain the highest possible level of health and participate fully in society and at work free from stigmatisation and discrimination.[80]

The objectives of this action plan are to strengthen effective leadership and governance for mental health, to provide comprehensive, integrated and responsive mental health and social care services in community-based settings, to implement strategies for the promotion and prevention of mental health issues and finally, to strengthen information systems, evidence and research for mental health.[81]

4.1. International Best Practices for Achieving a Proper Mental Health Regime

Best practices are health practices, methods, interventions, procedures, or techniques based on high-quality evidence to obtain improved patient and health outcomes. The need for implementing best practices is to improve individual patients' health outcomes and overall healthcare quality and strengthen the health system at large.[82] For successful healthcare outcomes, the tenet of best practices involves the cost of healthcare, clinical, patient education and healthcare provider education and experience.[83]

In the sphere of mental health, WHO's Mental Health Gap Action Programme Intervention Guide (mhGAP-IG)[84] was developed and launched to aid the training of non-specialists to deliver care and thus bridge the gap in the treatment of mental, neurological and substance use disorders in low and middle-income countries. Its use in pre-service training has improved knowledge and skills to manage mental health conditions.[85] It has been used for in-service training to build the capacity of non-specialised healthcare providers to assess and manage priority mental, neurological and

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[80] 'Comprehensive Mental Health Action Plan 2013-2030' (Who.int, 2013) https://www.who.int/publications/i/item/9789240031029 accessed 1 May 2022.
[81] "Comprehensive Mental Health Action Plan 2013-2030," World Health Organization (World Health Organization, September 21, 2021), https://www.who.int/publications-detail-redirect/9789240031029.
[82] Wilma Ten Ham-Baloyi, Karin Minnie, and Christa van der Walt, "Improving Healthcare: A Guide to Roll-out Best Practices," African health sciences (Makerere Medical School, September 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7751558/.
[83] Araya R;Alvarado R;Minoletti A; "Chile: An Ongoing Mental Health Revolution," Lancet (London, England) (U.S. National Library of Medicine), accessed May 16, 2022, https://pubmed.ncbi.nlm.nih.gov/19699997/.
[84] China Mills and Kimberly Lacroix, "Reflections on Doing Training for the World Health Organization's Mental Health Gap Action Program Intervention Guide (MHGAP-IG)," *International Journal of Mental Health* 48, no. 4 (February 2019): pp. 309-322, https://doi.org/10.1080/00207411.2019.1683681.
[85] Roxanne Keynejad, Jessica Spagnolo, and Graham Thornicroft, "Who Mental Health Gap Action Programme (Mhgap) Intervention Guide: Updated Systematic Review on Evidence and Impact," *Evidence Based Mental Health* 24, no. 3 (2021): pp. 124-130, https://doi.org/10.1136/ebmental-2021-300254.

substance disorders in more than a hundred countries. In Kenya, it is already in the pilot stage in Kilifi County.[86]

The Programme for Improving Mental Health Care (PRIME) is another best practice for mental health and originates from the United Kingdom.[87] Stakeholder analysis is an essential tool in health policy and systems research and, as such, reduces the knowledge gap between research and policy, subsequently improving health system outcomes.[88] The research programme was tried and tested in Ethiopia, India, Nepal, South Africa and Uganda, which delivered evidence-based psychosocial and pharmacological interventions in a way that was integrated into primary healthcare systems and sensitive to local needs. It ensured high-quality care while utilising a task-sharing approach. General primary care workers were employed to deliver mental healthcare, thus ensuring continuous quality improvement in challenging low-resource settings.[89]

5. Conclusion

Kenya's legal and policy framework for mental health has come a long way in recent years. The Mental Health Act of 1989 was a critical step in acknowledging the importance of mental health and creating a legal foundation for its promotion and protection. Furthermore, the Mental Health (Amendment) Act, 2022, reinforced the legal framework by providing measures to protect the rights of people suffering from mental illnesses.

The policy framework has also evolved with the introduction of the Mental Health Policy 2015-2030. This policy promotes mental health, prevents mental disorders, and ensures access to high-quality treatments. It emphasises the integration of mental health into primary care and the community and the involvement of diverse stakeholders in mental health service delivery.

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[86] Mary A. Bitta et al., "Contextualizing and Pilot Testing the Mental Health Gap Action Programme Intervention Guide (MHGAP-IG) to Primary Healthcare Workers in Kilifi, Kenya," *Global Mental Health* 7 (2020), https://doi.org/10.1017/gmh.2020.6.

[87] Erica Breuer et al., "Using Workshops to Develop Theories of Change in Five Low and Middle Income Countries: Lessons from the Programme for Improving Mental Health Care (Prime)," *International Journal of Mental Health Systems* 8, no. 1 (2014), https://doi.org/10.1186/1752-4458-8-15.

[88] Amit Makan et al., "Stakeholder Analysis of the Programme for Improving Mental Health Care (Prime): Baseline Findings," *International Journal of Mental Health Systems* 9, no. 1 (August 2015), https://doi.org/10.1186/s13033-015-0020-z.

[89] Crick Lund, "Improving Quality of Mental Health Care in Low-Resource Settings: Lessons from Prime," *World Psychiatry* 17, no. 1 (2018): pp. 47-48, https://doi.org/10.1002/wps.20489.

While these legal and policy developments are commendable, several challenges still need to be addressed. One of the most significant challenges is the lack of implementation and enforcement of existing laws and policies. Many mental health facilities in Kenya continue to face inadequate funding, staffing, and infrastructure, which hinders the delivery of effective and accessible mental health services. Furthermore, mental health stigma remains a barrier to seeking help and support. Public awareness campaigns and educational initiatives are crucial in challenging these stigmas and promoting a more understanding and compassionate society.

Beyond the legal and policy frameworks and to enhance the mental health system in Kenya, it is essential to prioritise resource allocation and investment in mental health services. This includes increasing funding for mental health facilities, training healthcare professionals in mental health care, and integrating mental health services into primary healthcare settings. Additionally, partnerships between the government, non-governmental organisations, and international agencies can play a vital role in supporting mental health initiatives and programs.

THE PUBLIC'S RIGHT TO KNOW: INCORPORATING ACCESS TO INFORMATION IN RESPONSES AGAINST COVID-19 IN KENYA

Nyokabi Njogu[*] and Marion Muringe Ogeto[**]

1. Introduction

Access to information is a fundamental right that enables the realisation of all human rights and freedoms, including the right to life, health and education. The promulgation of the Constitution in 2010 marked the liberalisation of human rights, including access to information protected under Article 35. Access to information is further safeguarded in international human rights instruments, including the International Convention on Civil and Political Rights (ICCPR).[1] The Constitution recognises the stark importance of access to information by enhancing its protection through the national values and principles of governance, which include transparency and accountability, to the explicit requirement for the State's obligation to ensure access to information by citizens through the regular and periodic publication of anything relevant to the public.[2]

Under international human rights law, each State has a prime responsibility and duty to protect, fulfil and respect all human rights and fundamental freedoms by, *inter alia*, adopting such steps as may be necessary to create all conditions essential in the social, economic, political and other fields, as well as the legal guarantees required to ensure that all persons under its jurisdiction, individually and in association with others, can enjoy all those rights and freedoms in practice. [3]

The measures to ensure the protection of members of the public, adopted by the transformative and rights-based Constitution and the Access to Information (ATI) Act 2016, were put to the test in the wake of the Covid-19 pandemic. In 2020, the government failed to proactively publish information that was crucial in enabling those within Kenya to enjoy their constitutionally guaranteed rights even as the State put in measures to control the spread of the virus. Moreover, it failed to respond to various requests for access to life and health saving information by members

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[*] LLM (CEU); LLB (CUEA). Advocate of the High Court of Kenya and Legal Counsel at KELIN.
[**] LLB Strathmore University, Advocate of the High Court of Kenya and a Program Associate at KELIN.
[1] International Covenant on Civil and Political Rights (ICCPR), Article 19, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171, available at: https://www.refworld.org/docid/3ae6b3aa0.html
[2] The Constitution of Kenya 2010, Article 35.
[3] UNGA, (8 March 1999) "Declaration on the Right and Responsibility of Individuals, Groups and Organs of the Society to Promote and Protect Universally Recognised Human Rights and Fundamental Freedoms," 53/144.

of the public as well as different stakeholders who were in dire need of information on how the State was handling the pandemic. This affected the citizen's right to access health care to the highest attainable standard and only served to undermine the response to the pandemic and violate the right to health, which has one of the core determinants as the right to access information.

This paper will analyse the failure of the State to provide information by scrutinising the intersecting links between the Covid-19 pandemic, the right to health and the right to access information in Kenya. First, the paper assesses the nature of the right to access information in Kenya by looking at the historical development of the same in comparison to the element of the right under the new constitutional dispensation. Secondly, the paper addresses how courts have recognised that access to information contributes to the accessibility and availability of quality health care in the context of the pandemic.

2. Nature of the Right to Access Information

Within the ambit of access to information, Article 35 of the Constitution provides that the State has an obligation to publicise important information to the nation. Article 35 (1) (a) of the Constitution grants a citizen the right to seek and have information from a State or State organ. This is further buttressed under Section 8 of the Access to Information Act which States that one may apply to access information. States are under a positive obligation to disclose on a *proactive basis* key *emergency-related health*, budgetary, policy-making, procurement, economic, benefits-related and other information.[4] Moreover, The UN Committee on Economic, Social and Cultural Rights has called on States to provide "access to information concerning the main health problems in the community, including methods of preventing and controlling them" as part of the core obligation to protect the right to health.[5]

The ATI Act provides parameters regarding response to requests for access to information. Section 8 of the Act specifically provides that anyone can make an application to access information in writing, and the officer is mandated to respond to the same. State actors are mandated to respond to requests for information within 21 days; however, when it concerns the person's life or liberty,

[4] *Access to Information (ATI) Act, 2016*, s. 8.
[5] Committee on Social Economic Rights, General Comment No. 14, 2000.

the information must be provided within 48 hours.[6] Responding to requests for information is not only a legal obligation but also a constitutional one. If the State actor(s) do not want to disclose information, they carry the burden of proving that the information is not of public concern or, if it is of public concern, that the information has been specifically exempted by law.[7] Moreover, citizens do not need to show any legal or special interest to establish their right to information.[8]

Section 5 of the ATI Act provides guidelines for the public disclosure of information by public entities. The provision embraces an intersectional and progressive approach by mandating State actors to take into consideration while disseminating information, the need to reach persons with disabilities, cost, the local language, the most effective method of communication in that local area, and ensuring the information is easily accessible and available free or at cost considering the medium used.[9] Secondly, the State is responsible for responding substantially to requests for information within a reasonable time. Article 35 (1) (a) of the Constitution stipulates that every citizen has a right to information. That provision binds State actors to disclose information sought per section 4 of the ATI Act.

International human rights law on access to information calls for States to abide by the principle of maximum disclosure.[10] In that regard, full disclosure of information should be the norm, and restrictions and exceptions to access information should only apply in minimal circumstances.[11] Further, the format for disclosure is key, given that citizens ought to be able to access the same without any strain. Information should be released routinely, i.e., proactive disclosure, and in a manner that is understandable and accessible in "medium, format and language."[12] The Human Rights Committee has also noted that the States parties should make every effort to ensure easy, prompt, effective and practical access to such information.[13]

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[6] *ATI Act*, s. 9.
[7] *Legaski v Civil Service Commission*, G.R. No. 72119. May 29, 1987.
[8] *Ibid.*
[9] *ATI Act*, s. 5(2).
[10] *Trusted Society of Human Rights Alliance & 3 Others v Judicial Service Commission* [2016] eKLR.
[11] *Ibid.*
[12] Inter-American Commission on Human Rights, Model Inter-American Law on Access to Public Information (2010), preamble, available at: https://www.oas.org/dil/AG-RES_2607-2010_eng.pdf; and African Commission on Human and Peoples' Rights, Model Law on Access to Information for Africa (2012), sections 8(2)(ii) and 66(3), available at: http://www.achpr.org/files/instruments/access-information/achpr_instr_model_law_access_to_information_2012_eng.pdf.
[13] Human Rights Committee, General Comment 34: Article 19 Freedoms of Opinion and Expression, 12 September, 2011.

2.1. Format for Proactive Disclosure of Information

The State is mandated to ensure the information is shared in a manner that will be accessible and available. As the Inter-American Commission of Human and Peoples' Rights noted, the information must be shared in a way that is understandable and accessible in *medium, format* and *language*.[14] Subsequently, they note that merely publishing information on websites is insufficient amidst a health emergency, including a pandemic.

As explained above, the ATI Act uses a progressive and intersectional approach with respect to the proactive disclosure of information. State actors are mandated to ensure that the information provided is accessible to persons with disabilities and other vulnerable and marginalised persons who may not be able to access information easily. The provisions of the Act with regard to the procedure set out have been found to be in conformity with the Constitution in *Margaret Kisingo Muga & 21 others v County Government of Mombasa & 2 others [2020] eKLR* and *Commission for Human Rights and Justice v Khandwalla & 3 others [2021] eKLR* with the court finding that the framework provided in the Access to Information Act ought to be complied with before parties approach the courts for enforcement of their rights under Article 35 of the Constitution.

Despite the legal framework for exercising the right to information, the State has exhibited a blatant disregard for its obligations, forcing public spirited persons to approach courts to interpret the State's obligation to ensure the right to health and access to life and health saving information.

3. Interdependence of Human Rights: Relation between Access to Information and Right to Health

The Constitution recognises that every person has a right to the highest attainable standard of health.[15] The right to health also finds expression under the Health Act.[16] The *highest attainable standard of health* is a product of the international human rights law framework, which Kenya has adopted, thus, must uphold by dint of Articles 2(5) and 2(6) of the Constitution. The normative content of the right further includes essential elements: availability, in that proper public health and health care facilities, goods and services, and programs have to be available in sufficient

[14] *Supra* at note 13.
[15] The Constitution of Kenya, 2010, Art. 43(2)(a).
[16] *The Health Act, 2017*, s. 5(1).

quantity within the State party.[17] Further, the highest standard of health must be accessible to everyone without discrimination. Accessibility relates to economic accessibility ensuring that the services, whether privately or publicly provided, are affordable for all in line with the principle of equity. Quality health care is also a component of health, which generally entails medically appropriate services, skilled medical personnel, appropriate medication and equipment, safe and potable water, adequate sanitation, clean and healthy environment, among other things.[18]

All human rights are universal, indivisible, interdependent and interrelated.[19] In this regard, violation of one right would ultimately lead to violation of other rights. The Committee on Economic, Social and Cultural Rights noted that the right to health is closely related to and dependent upon the realization of other rights, including access to information.[20] The Committee accordingly interprets the right to health as an inclusive right extending to timely and appropriate health care and the underlying determinants of health, such as access to health-related education and information.[21]

The World Health Organization has further provided that a well-functioning health information system ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.[22] Health information has been regarded as crucial with respect to ensuring the protection of one's life, given it enables individuals and communities to promote their own health, participate effectively, claim quality services, monitor progressive realization, expose corruption, hold those responsible to account, and so on.[23] The UN Special Rapporteur on the right to the highest attainable standard of health further noted that the requirement of transparency applies to all those working in health-related

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[17] CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August, 2000, 12.
[18] KELIN, "Monitoring the Implementation of the Right to Health under the Constitution of Kenya," 2016, (accessed on 28 July, 2020).
http://kelinkenya.org/wp-content/uploads/2016/11/FINAL-TRAINING-MANUAL-NOV-2016.pdf on
[19] Vienna Declaration and Programme of Actions, 25th June 1993, para 5.
[20] General Comment No. 14, UN Doc E/C.12 /2000/4 Para 3.
[21] *Ibid.*
[22] World Health Organisation,2007, "Everybody's Business: Strengthening Health Systems to Improve Health Outcomes," (accessed on 24 April 2022) http://who.int/healthsystems/strategy/everybodys_business.pdf.
[23] UN Human Rights Council,31 January 2008, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, Paul Hunt, A/HRC/7/11, https://www.refworld.org/docid/47ce6ddd2.html.

sectors, including States, international organizations, public-private partnerships, business enterprises and civil society organizations.[24]

4. Access to Information during a Health Pandemic

The urgency of accessibility to information is heightened during a pandemic. The Aarhus Convention explicitly stipulates that in the event of any imminent threat to human health or the environment, all information that could enable the public to take measures to prevent or mitigate harm arising from the threat and is held by a public authority is disseminated immediately and without delay to members of the public who may be affected.[25] Therefore, the State is obligated to implement maximum disclosure of information during a health emergency, such as Covid-19. Some key types of information that should be released proactively during a public health crisis include information about: the progression of the disease, broken down as granularly as possible; steps governments are taking to protect individuals and how to maximise the effectiveness of those steps; decision-making around responding to the crisis; allocation of emergency funding; procurement of emergency equipment; the allocation of grants; and how to access government programmes and benefits introduced in response to the pandemic.[26] The disclosure of this information is significant from an accountability perspective, given the momentous decisions governments are likely to make during a crisis.[27]

4.1. Proactive Disclosure of information during the Pandemic: A Lost Opportunity to Compel the State to Provide Life Saving Information

WHO declared Covid-19 a pandemic on 11 March 2020.[28] Two days later, on 13 March 2020, the first Kenyan case was confirmed. Subsequently, the State developed a series of protection measures to slow down the spread of the virus. These measures included the banning of any gatherings, reducing the number of passengers in public transport, suspension of all international

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[24] *Supra* at note 23.
[25] Convention on Access to Information, Public Participation in Decision-Making and Access to Justice in Environmental Matters, adopted 25 June 1998, in force 30 October 2001.
[26] *Trusted Society of Human Rights Alliance & 3 Others v Judicial Service Commission* [2016] eKLR.
[27] UNESCO,2020, The Right to Information in Times of Crisis, CI-2020/WTR/4.
[28] World Health Organization, "COVID Disease COVID-19 Pandemic", (accessed 14th April, 2022) https://www.who.int/emergencies/diseases/novel-coronavirus-2019?adgroupsurvey={adgroupsurvey}&gclid=CjwKCAiAmuKbBhA2EiwAxQnt72gB2ImMzhQmbqlCB5I_SQMeJtkuhO0aZx2rTmNYIUocGvgXoZyBBBoCGR0QAvD_BwE, .

passenger flights, mandatory quarantine and isolation of individuals who were suspected of having come into contact with the virus or who tested positive for the virus, as well as an immediate nationwide curfew.[29] Subsequent regulations were imposed under the Public Health Act. The Cabinet Secretary for Health published the Public Health (Prevention, Control and Suppression of Covid-19) Rules, 2020 and the Public Health (Covid-19 Restriction of Movement of Persons and Related Measures) Rules 2020, which were to provide a framework through which the Ministry of Health could declare places for quarantine and isolation, to declare places infected areas within the meaning of section 36 of the Public Health Act. The manner in which the curfew orders and the enforcement of the regulations were implemented violated the right to health and the right to access health information, thereby sparking various cases at the High Court of Kenya.

Decisions from the court on the provision of access to information in Kenya have been non-progressive. In *Law Society of Kenya v Hillary Mutyambai Inspector General National Police Service & 4 others,*[30] the Petitioners challenged the validity and propriety of curfew orders imposed after the emergence of Covid-19 in Kenya. They sought various orders, including requiring the Cabinet Secretary for Health to issue information and guidelines in response to the pandemic. Specifically, the Petitioners asked the court to order the Ministry of Health to provide information on the resources being used to finance the response, the working conditions of workers who were providing essential health services, and how communities can participate in efforts to reduce health risks. They also sought orders that the information sought be disseminated by a neutral SMS platform and tailored to meet all underserved populations, such as persons with disabilities, including prioritizing information and the communication needs of children and adolescents and publishing the requested information in newspapers of national circulation, the website of the Ministry of Health and in a manner that is easily accessible. They also sought that the Ministry provides information and guidelines for pregnant women to enable them to access health care services during the curfew period.

In its judgement, the court found that the curfew order met the constitutional and statutory requirements. The Court then considered the other prayers sought by the Petitioners, specifically

[29] Public Order (State Curfew) Order 2020 (Legal Notice No 36 of 2020).
[30] *Law Society of Kenya v Hillary Mutyambai Inspector General National Police Service & 4 others; Kenya National Commission on Human Rights & 3 others* (Interested Parties) [2020] eKLR.

with respect to the guidelines that were sought by the petitioners and the interested party on ensuring the optimization of slowing the spread of Covid-19 and also ensuring that vulnerable and marginalised communities had easy access to health and health care services. The court found that since the implementation of the curfew order remained in the purview of the National Police Service, there was no need for any special guidelines. The court further refused to make any orders concerning the procurements done by the State as it prepared to address the pandemic, asserting that the Petitioners had to follow the applicable law in seeking access to such information. However, the court appreciated the vital role that the media played in providing information and in keeping members of the public aware of the actions of the State's response to the pandemic.

In that decision, the court failed to consider the effect of the curfew order, how it would be carried out, and how members of the public could access other healthcare services. In particular, the orders sought by the 2nd Interested party, which were intended to ensure that the curfew order was implemented in a humane way as regards the provision of essential health care services for pregnant women, children and adolescents, were to advance and protect the rights under Articles 26, 28, 43(1)(a) and (2), and 53(2) of the Constitution.[31] Further, the court failed to consider that the role of addressing the pandemic lay with the Cabinet Secretary, Ministry of Health and not the National Police Service. By deferring to the latter, the court took the view that the responses to Covid-19 had a national security angle rather than matters to do with health. The court, therefore, failed to determine the core issue before it, which was whether the State is obliged to proactively provide information on access to essential health services, particularly for vulnerable groups, even as it takes measures to address the pandemic.

The court took similarly restricted views on access to information in *Margaret Kisingo Muga & 21 others v County Government of Mombasa & 2 others [2020] eKLR* and in *Commission for Human Rights and Justice v Khandwalla & 3 others [2021] eKLR* where the court limited the right to access information. These petitions were based on concerns the petitioners had about setting up isolation centres and access to medical facilities designated as isolation facilities. [For context, it is important to discuss the kind of information the Petitioners had requested, from whom it was requested, and how their requests were dealt with, prompting the filing of the petitions]. In both of these decisions, the court stated that where there has been no compliance with the provisions of

[31] *Law Society of Kenya v Attorney General & Another* [2020] eKLR at paragraph 76.

the Access to Information Act, then the court cannot step in. In the *Commission for Human Rights and Justice v Khandwalla* decision, the court did not address itself to the fact that a written request for information had been made to the respondents, but there had been no response forthcoming. Since the Petitioners' rights to access medical facilities during the pandemic were threatened, the information needed was urgent, thus falling under the ambit of life-threatening information. This prompted the Petitioners to move to court to vindicate their right to information. The latter point is one of the issues the court has been asked to consider in *Erick Okioma & 12 Others v Mutahi Kagwe, Cabinet Secretary for Health & 8 Others Petition No 218 of 2020,* which is presently pending before the High Court in Nairobi.

5. Affirming the People's Right to Know: The State's Duty to Disclosure and Education

Availability of information ensures that members of the public are informed of the actions of the State in a way that enables them to participate in Government-led responses to the pandemic and also so that they can actively enjoy other constitutionally guaranteed rights. In the context of a global health pandemic, the State is obliged to fulfil the right to access information because the rights to life, health and liberty of members of the public are at stake. By ensuring access to information, the State will likely get public buy-in on the measures it is implementing, even if they limit certain other rights. Such cooperation and participation may just be needed to suppress the spread of pandemics successfully.

Public bodies are obligated to ensure the disclosure of information in their possession so that members of the public enjoy it as a right. Any limitations must meet the standards prescribed under Article 24 of the Constitution as read together with the Access to Information Act and the Siracusa Principles. The State's duty on public disclosure also requires a broad definition of the term "information" so that when courts are called upon to determine alleged violations, they must ensure that they construe the right to information in a manner that ensures the most exhaustive interpretation possible.[32] In the context of a pandemic, information ought to be provided *proactively*, particularly where it is intended to safeguard the lives of the public. Where it is

[32] *Trusted Society of Human Rights Alliance & 3 Others v Judicial Service Commission,* [2016] eKLR adopting with approval *The Public's Right to Know: Principles on Freedom of Information Legislation –Article 19 at page 2.*

requested, then it must be provided without undue delay. The availability of information on the pandemic ensures that the public is adequately capacitated to make choices and also enhances public interest, accountability and trust.[33] It must be strictly justified where confidentiality or other exceptions, such as national security, are claimed. That was the issue before the Administrative Tribunal of Cundinamarca in Colombia, where the International Institute of Anti-Corruption Studies (Instituto Internacional de Estudios Anticorrupción) had sued the National Unit for Disaster Risk Management (Unidad Nacional de Gestión del Riesgo de Desastres) for the failure to provide information on State actions taken to address the pandemic.[34] The State handed over some of the information but refused to hand over certain information regarding contracts for the acquisition of vaccines, claiming that those contracts were confidential.

In its determination, the Tribunal held that access to Covid-19 vaccines as well as ensuring an effective immunisation process, is a public good. It noted that the right to access information is governed by the principle of maximum disclosure, meaning that the starting point is that all information held by public authorities should be publicly available. This availability can only be limited in strict circumstances, spelt out in the law. It must be subject to strict interpretation with regard to proportionality and reasonableness and in line with the international human rights standards under the Siracusa Principles. Concerning the duty to disclose the contents of a contract, the Tribunal stated that while the negotiations before the execution of the contract may be subject to confidentiality, the contract itself cannot be confidential. The contractual agreement must be made publicly available to enable public oversight in the management of the pandemic. Moreover, the tribunal stated that confidentiality clauses in the vaccination contracts undermine public good because they undermine the ability of the State to engage with other bodies to ensure a rapid response to the pandemic. It further held that the aggravating circumstances of the pandemic increased the obligation to ensure the application of human rights stands on access to public information and measures being taken to respond to the pandemic because they would foster increased transparency and accountability, as well as trust in the Covid-19 vaccine, and with that, access to health.[35]

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[33] UNESCO,2020, The Right to Information in Times of Crisis, CI-2020/WTR/4.
[34] 2021-05-081 R1 (Recurso de insistencia).
[35] The full text of the ruling in Spanish is available here. For a summary published by the International Commission of Jurists (ICJ) please see /https://www.icj.org/wp-content/uploads/2021/08/Final-Colombia-Case-Summary-27-July-2021.pdf.

Related to the duty of maximum disclosure is the duty to ensure that members of the public are educated about the measures that the State is taking and how these measures are likely to affect the exercise of other rights. In the words of the African Commission on Human and People's Rights, as regards the pandemic, members of the public should receive factual, regular and comprehensive information based on science, which will ensure that there is no misinformation or myths about the spread of the virus.[36] As the virus continued to spread, the State took further measures to curb its impact. In Kenya, these included the rollout of vaccination programmes to ensure that as many people as possible are vaccinated.

These were, however, accompanied by various cases challenging State actors' actions during the pandemic. The Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) was invited by the High Court of Kenya at Nairobi[37] to put in an amicus brief providing information on the importance of public education in ensuring a successful vaccination campaign and has provided information on a rights based approach which demonstrates that States are under a positive obligation to disclose on a *proactive basis* key *emergency-related health*, budgetary, policy-making, procurement, economic, benefits-related and other information. Moreover, the UN Committee on Economic, Social and Cultural Rights has called on States to provide "*access to information concerning the main health problems in the community, including methods of preventing and controlling them" as part of the core obligation to protect the right to health*."[38]

6. Conclusion

Over and above being a fundamental right on its own, the right to information is an essential component of the right to health. Any unjustifiable limitation of access to information will likely have consequences on exercising other rights. The provision of information during a pandemic demonstrates a culture of respect to the right to health. It is also critical to the success of any mitigating measures imposed by the State. Unfortunately, Kenya's executive and judiciary have

[36]African Commission on Human and Peoples' Right ,2020, "African Commission on Human and Peoples' Rights Press Statement on human rights based effective response to the novel COVID-19 virus in Africa."(accessed on 15 April 2022) online at https://www.achpr.org/pressrelease/detail?id=483

[37] *Winfred Clarkson Otieno Ochieng & 13 Others v The Cabinet Secretary, Ministry of Health & 9 others* Constitutional Petition No E500 of 2021 (consolidated with Petition Nos E505 of 2021, E518 of 2021, E520 of 2021 and E27 of 2021), which is presently pending before the High Court of Kenya at Nairobi.

[38] Committee on Economic, Social and Cultural Rights,11 August 2000, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), para. 44.

not been very robust in applying and interpreting the right to access information during the pandemic. However, the courts still have an opportunity to settle the content of the right to information during pandemic times in pending litigation.

UNPACKING THE RIGHT TO HEALTH IN UGANDA: THE LAW, GOVERNANCE STRUCTURES AND THE COVID-19 RESPONSE

Anthony Masake*

1. Introduction

The right to health is a fundamental human right that is well established under international, regional and national human rights law. While it is not often defined, the right to health includes the realisation of underlying determinants of health, such as availability and access to basic medical services, access to clean and safe water, access to adequate food and nutrition and access to a clean and healthy environment.

The Committee on Economic, Social and Cultural Rights ("CESCR") General Comment number 14[1] provides a detailed interpretation of the right to the highest attainable standard of health. Other General Comments provide interpretative guidance on the determinants of health. For instance, CESCR General Comment number 12 provides guidance on the right to adequate food; CESCR General Comment number 15 provides guidance on the right to water; CESCR General Comment number 20 guides on the right to non-discrimination, social and cultural rights; and CESCR General Comment number 22 provides guidance on the right to sexual and reproductive health.

The General Comments accentuate the duty of States to take specific positive action to respect, protect and fulfil the right to health. This includes positively engaging their financial and human resources. Therefore, the realisation of the right to health is subject to the principles of progressive realisation and maximum available resources—in other words, States must take steps to realise the right to health gradually and continuously over time, and they must not take any retrogressive action.[2] At the bare minimum, States must observe minimum core obligations set out in the General Comments.

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* Anthony Masake, Program Officer, Chapter Four Uganda. Plot 2 Wampewo Close, Kololo, Kampala, Uganda. Email: masakeonline@gmail.com

[1] CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, UN Doc. E/C12/2000/4 (2000), (accessed 22 June 2022) online at: https://www.refworld.org/pdfid/4538838d0.pdf

[2] 1966. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) art. 2(1).

During a pandemic, the State has specific obligations related to containing the spread of the virus by testing persons for the presence of the disease, tracing their contacts, quarantining suspected cases and treating confirmed cases. The State must also ensure that those who fall sick have access to hospital care.[3] The realisation of the above State obligations requires the governments to put in place progressive legal and policy frameworks and continuously invest resources to realise the right to health. This paper interrogates the health governance structure in Uganda and assesses the country's response to the Covid-19 pandemic. The author appraised the applicable legal and policy framework, trends in jurisprudence and conducted a literature review to determine the status of the health governance structures and situate the country's response to the Covid-19 pandemic.

2. International, Regional and National Laws on the Right to Health

Uganda's International, regional, and national laws affirm the right to health. Internationally, Uganda is bound by treaties like the Universal Declaration of Human Rights. Regionally, the African Charter on Human and Peoples' Rights applies and nationally, the Ugandan Constitution guarantees the right to health for its citizens.

2.1. Application of International Human Rights Law in Uganda

Uganda is a common law country.[4] The supreme law of the land is the 1995 Constitution of the Republic of Uganda (hereinafter referred to as the Constitution). The Constitution recognises the importance of international treaties to which Uganda is a party. Article 287 provides that any international agreements, treaties and conventions to which Uganda was a State party before the coming into force of the Constitution shall not be affected by the coming into force of the Constitution.[5] Other future treaties are required to be ratified in accordance with the Ratification of Treaties Act (Cap 204) and then domesticated by an Act of the Parliament of

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[3] Montel L, Kapilashrami A *et al, The Right to Health in Times of Pandemic: What Can We Learn from the UK's Response to the COVID-19 Outbreak?* Health Human Rights. 2020 Dec; 22(2):227-241. PMID: 33390709; PMCID: PMC7762905, (accessed 1 July 2022) online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7762905/

[4] Uganda attained her independence from Britain on 9 October 1962.

[5] In the landmark case of *Attorney General v Susan Kigula & 417 Others*, Constitutional Appeal 03 of 2006, Supreme Court of Uganda, the Court observed that: "[t]the framers of the Constitution were aware of the various United Nations instruments, particularly those to which Uganda is a party. That is why article 287 provided for the continuation of treaties and conventions to which Uganda is a party." (accessed 20 June 2022) online at: https://ulii.org/ug/judgement/supreme-court-uganda/2009/6

Uganda. Under the foreign policy objectives, Uganda's 1995 Constitution guarantees that Uganda shall ensure 'respect for international law and treaty obligations.'[6]

However, as a dualist country, international law does not operate automatically. The law does not strictly require the courts and administrative bodies to have regard to applicable current norms of public international law in interpreting the Constitution.[7] International law is not explicitly recognised as a source of law under section 14(2) of the Judicature Act (Cap 13), which provides the framework for exercising the courts' powers in the administration of the law. In the event of a conflict between the Constitution and international law, Article 2(2) commands that the Constitution prevails to the extent of the inconsistency.

Despite the above limitations, Ugandan courts have demonstrated regard for international law as an aid to constitutional interpretation.[8] The dominant view in courts appears to be that the Bill of Rights had been modelled upon various international conventions and that it is only logical to have regard to the jurisprudence of international tribunals interpreting provisions similar to those of the Uganda Constitution.[9]

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[6] Objective XXVIII(i)(b) of National Objectives and Directives of State Policy of the 1995 Constitution.
[7] See Articles 132 and 137 of the 1995 Constitution on Supreme Court and the Constitutional Court. For further reading on international human rights law in interpreting constitutional rights, see link: https://www.ahrlj.up.ac.za/mujuzi-jd-2009-2
[8] Some of the cases where the courts have considered international law: *Major General David Tinyefuza v Attorney General* (Constitutional Petition 1 of 1996) [1997] UGCC 3 (25 April 1997), (accessed 20 June 2022) online at: https://ulii.org/ug/judgement/constitutional-court-uganda/1997/3; *Charles Onyango Obbo and Anor v Attorney General*, Constitutional Appeal No 2 of 2002, ILDC 166; [2004] UGSC 1, 11 February 2004. (accessed 20 June 2022) online at: https://ulii.org/ug/judgement/supreme-court-uganda/2004/81; *Muwanga Kivumbi v Attorney General* (Constitutional Petition No 9 of 2005) [2008] UGCC 4 (27 May 2008), (accessed 20 June 2022) online at: https://ulii.org/ug/judgement/constitutional-court-uganda/2008/34; *Col (rtd.) Dr. Besigye Kiiza v Museveni Yoweri Kaguta and Electoral Commission* (Election Petition No. 1 of 2001) [2001] UGSC 3 (21 April 2001), (accessed 20 June 2022) online at: https://old.ulii.org/ug/judgement/supreme-court/2001/3; and *Victor Juliet Mukasa & Yvonne Oyo v The Attorney General*, High Court Miscellaneous Cause 247 of 2006, (2008) AHRLR 248 UGHC 2008, (accessed 20 June 2022) online at: https://www.icj.org/sogicasebook/mukasa-and-oyo-v-attorney-general-high-court-of-uganda-at-kampala-22-december-2008/
[9] M. Killander, *International law and domestic human rights litigation in Africa,* (Pretoria University Law Press, 2010). See chapter on the *"The application of international law in the Ugandan judicial system: A critical enquiry"* by Busingye Kabumba at Pg. 96, (accessed 20 June 2022) online at: https://www.academia.edu/928630/Chapter_in_International_law_and_domestic_human_rights_litigation_in_Africa?email_work_card=view-paper

2.2. International Human Rights Law Standards on the Right to Health

Uganda has an obligation to respect international law and treaty obligations, which establish and recognise the right to health. Prominently under customary international law, Uganda, as a member State of the UN, has an obligation to respect the Universal Declaration of Human Rights ("UDHR").[10] Uganda has further ratified a significant number of international human rights instruments that recognise the right to health, including the International Covenant on Economic, Social and Cultural Rights ("ICESCR"),[11] the Convention on the Elimination of All Forms of Discrimination against Women ("CEDAW"),[12] the Convention on the Rights of Persons with Disabilities ("CRPD"),[13] and the Convention on the Rights of the Child ("CRC").[14]

The UDHR recognises and establishes the foundation for the right to health under several Articles. For example, Article 25(1) affirms: "Everyone has the right to a standard of living adequate for the health of himself and his family, including food, clothing, housing and medical care and necessary social services". Article 25(2) further provides for the special care and assistance for mothers, including the protection of all children. Article 27(1) provides for the right to freely participate in and share in scientific advancement and its benefits, including advancements in traditional and biomedical health services.

The ICESCR provides the most comprehensive Articles on the right to the highest attainable standard of physical and mental health. Several Articles require the State to take specific actions to realise the right to health. For instance, Article 11(1) provides for the right to an adequate standard of living, including adequate food, clothing and housing, and their continuous improvement. Article 11(2) establishes freedom from hunger and requires the States to take action to improve food production, conservation and distribution. The CESCR

[10] UDHR, (accessed 10 June 2022) online at: https://www.un.org/sites/un2.un.org/files/2021/03/udhr.pdf
[11] ICESCR, (accessed 10 June 2022) online at: https://www.ohchr.org/sites/default/files/cescr.pdf
[12] CEDAW, (accessed 10 June 2022) online at: https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/cedaw.pdf
[13] CRPD, (accessed 10 June 2022) online at: https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf
[14] CRC, (accessed 10 June 2022) online at: https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/crc.pdf

General Comments[15] further provide for the substantive issues on implementing the Covenant, for instance, on the "political question doctrine".[16]

On 22 July 1985, Uganda became a member State to the CEDAW following the ratification of the Convention.[17] The ratification placed an obligation on Uganda to take specific actions to protect and ensure that women access the highest attainable standard of physical and mental health. These include ensuring that employed women have access to healthy and safe working conditions and paid maternity leave, protection from discrimination against women on the grounds of maternity, ensuring equal access to appropriate health services, including family planning and adequate nutrition during pregnancy and postnatal care, and ensuring that women in rural areas have access to adequate healthcare, family planning and healthy living conditions.[18]

On 17 August 1990, the government of Uganda ratified the CRC, committing itself to paying special attention to the rights of children.[19] The Convention establishes the primary considerations that must be taken in the best interest of a child, requires States to ensure the maximum development and survival of every child, requires States to ensure that each child enjoys the highest attainable standards of health and access to healthcare facilities for treatment and rehabilitation and sets a duty for the States to fully implement measures to diminish infant and child mortality and combat disease and malnutrition.[20]

2.3. Regional Human Rights Law on the Right to Health

Uganda has further committed to regional human rights instruments, both at the continental and the East African levels. At the continental level, Uganda ratified the African Charter on Human and Peoples' Rights ("ACHPR")[21] on 27 March 1986. Article 16 of the Charter affirms that "Every individual shall have the right to enjoy the best attainable state of physical and

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[15] CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (ICESCR Art. 12), (accessed 10 June 2022) online at: https://www.refworld.org/pdfid/4538838d0.pdf
[16] General Comment No. 9, paragraph 10, (accessed 11 June 2022) online at: https://www.refworld.org/docid/47a7079d6.html
[17] UN Treaty Body Database, (accessed 13 November 2022) online at: https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=182&Lang=EN
[18] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), (accessed 13 November 2022) online at: https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/cedaw.pdf
[19] UN Treaty Body Database, (accessed 13 November 2022) online at: https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=182&Lang=EN
[20] Convention on the Rights of the Child, (accessed 13 November 2022) online at: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child
[21] Banjul Charter, (accessed 11 June 2022) online at: https://www.achpr.org/legalinstruments/detail?id=49

mental health." State parties are further required to "take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."

To cater for minority and marginalised groups and enable enforcement of the human rights principles set out in the Charter, four protocols to the ACHPR – including the protocol to the ACHPR on the Rights of Women in Africa (Maputo Protocol)[22] and the Establishment of an African Court on Human and Peoples' Rights[23] – have been established.

At the East African level, Uganda is committed to the Treaty for the Establishment of the East African Community ("EAC Treaty"),[24] which urges partner States under Article 118 to undertake joint action towards the prevention and control of communicable and non-communicable diseases and to control pandemics and epidemics of communicable and vector-borne diseases, promote the management of health delivery systems, develop a common drug policy, promote the development of good nutritional standards and the popularisation of indigenous foods, and harmonise national health policies and regulations to achieve quality health within the community. The East African Partner States have since established the East African Health Research Commission ("EAHRC"),[25] a mechanism established under Article 118 of the Treaty to advise the States on all matters of health and health-related research and findings.

2.4. National Law Standards on the Right to Health

The Constitution of the Republic of Uganda, 1995 (the "Constitution") is the supreme law of Uganda.[26] The Constitution does not provide for the right to health in its operational Articles. However, it protects the right to health within several Articles under the Bill of Rights in Chapter Four. Some of the Articles that protect core underlying determinants of health include Article 39, which guarantees the right to a clean and healthy environment and Article 40 (1)(a),

[22] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, (accessed 13 November 2022) online at: https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WG/ProtocolontheRightsofWomen.pdf

[23] Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights, (accessed 13 November 2022) online at: http://www.african-court.org/wpafc/wp-content/uploads/2020/10/2-PROTOCOL-TO-THE-AFRICAN-CHARTER-ON-HUMAN-AND-PEOPLES-RIGHTS-ON-THE-ESTABLISHMENT-OF-AN-AFRICAN-COURT-ON-HUMAN-AND-PEOPLES-RIGHTS.pdf

[24] EAC Treaty, (accessed 11 June 2022) online at: https://www.eacj.org/?page_id=33

[25] For more reading about the EAHRC mechanism, see link, (accessed 12 June 2022) online at: https://www.eahealth.org/about-eahrc

[26] Article 2(1) states that "This Constitution is the supreme law of Uganda and shall have binding force on all authorities and persons throughout Uganda," (accessed 10 June 2022) online at: https://ulii.org/akn/ug/act/statute/1995/constitution/eng%402018-01-05

which guarantees the right of persons to work under satisfactory, safe and healthy conditions. On the rights of children, Article 34 (3) provides that no child shall be deprived by any person of medical treatment or any other social benefits by reason of religious or other beliefs. Children are also protected from social or economic exploitation that harms their health or physical or mental development.

Under the National Objectives and Directive Principles of State Policy, the 1995 Constitution further provides for objectives and principles that are crucial for the underlying determinants of the right to health to guide all organs and agencies of the State and citizens in applying or interpreting the Constitution. For instance, Objectives XX and XXI oblige the State to take all practical measures to ensure the provision of basic medical services to the population and to promote access to clean and safe water. Objective XXII further requires the State to take appropriate steps to encourage people to grow and store adequate food, establish national food reserves, and encourage and promote proper nutrition through mass education and other appropriate means to build a healthy State. Objective XXVII obligates the State to take all possible measures to prevent or minimise damage and destruction to land, air and water resources to guarantee the right to a clean environment.

In implementing the constitutional provisions outlined above, the Constitution requires under Article 21 that equality and freedom from discrimination shall be guaranteed. This means that women, persons with disabilities, persons with albinism, refugees, and other minority and marginalised groups shall not be discriminated against in the enjoyment of the right to health. Further, Article 33 (1) specifically provides that women shall be accorded full and equal dignity of the person with men. Any laws, culture, customs or traditions concerning the right to health or any other human rights that are against the dignity, welfare or interest of women or which undermine their status are prohibited.

Uganda further has the Public Health Act (Chapter 281),[27] which was enacted to consolidate the law regarding the preservation of public health in Uganda. The law was passed in October 1935 and amended in December 2000 and September 2020. During the Covid-19 pandemic, the law was instrumental in providing the legal framework for preventing and suppressing infectious diseases through the issuance of Statutory Instruments. The said Statutory Instruments will be discussed further in this paper.

[27] Public Health Act (Chapter 281) [Laws of Uganda], (accessed 12 June 2022) online at: https://ulii.org/akn/ug/act/ord/1935/13/eng%402000-12-31

3. Health Governance Structures: Progress, Gaps and Opportunities

Governance in health is a salient cross-cutting theme that involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability. According to the World Health Organisation ("WHO"), leadership/governance is one of the six building blocks in the WHO Health System Framework.[28] The other blocks include health care financing, health workforce, medical products and technologies, information and research, and service delivery. Studies indicate that this health system framework is instrumental in strengthening the overall health systems and uses a catalyst for achieving global health targets, unlike other health system strategies, which are disease specific.[29] This section presents an assessment of Uganda's health governance structures along the two pillars of rules-based indicators and outcome-based indicators on the right to health.

3.1. Rules-Based Indicators on the Right to Health: Governance Determinants

Uganda has an elaborate governance structure in place to guide the realisation of the highest attainable level of the right to health. In addition to the legal framework presented above, this section focuses on the significant jurisprudence from the courts of law on the right to health. It reflects on the quasi-judicial mechanisms, national policies, and development plans on the right to health.

3.1.1. Judicial mechanisms: Analysis of court decisions on the right to health

Under Article 50 (1), the Constitution permits anyone who claims that a fundamental right, including the right to health, has been infringed or threatened to apply to a competent court for redress.[30] Cases can also be filed in court to enforce the right to health in individual cases, whether in criminal cases or civil cases where an aggrieved party seeks compensation for damages suffered in relation to obligations that arise from the right to health.

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[28] World Health Organisation, *Monitoring the building blocks of health systems: A handbook of indicators and their measurement strategies,* (2010), (accessed 13 June 2022) online at: https://apps.who.int/iris/bitstream/handle/10665/258734/9789241564052-eng.pdf

[29] Manyazewal, T. *Using the World Health Organisation health system building blocks through survey of healthcare professionals to determine the performance of public healthcare facilities*, Arch Public Health 75, 50 (2017), (accessed 15 June 2022) online at: https://archpublichealth.biomedcentral.com/articles/10.1186/s13690-017-0221-9

[30] The Parliament of Uganda has since enacted the Human Rights (Enforcement) Act, 2019 to give effect to the Article of the Constitution.

In an effort to use the courts to make inroads on the right to health, several strategic cases have been litigated in the courts of law, leading to progressive decisions.[31] The landmark case of *Center for Health, Human Rights and Development (CEHURD) & 3 Others v Attorney General*[32] set key precedents on the justiciability of the right to health, the concept of minimum core obligations on the right to health, the question of measuring progressive realisation for maternal health care in Uganda, and finally dealing with the 'political question' doctrine. In the constitutional petition, the petitioners sought declarations to the effect that failure to provide basic, indispensable maternal health commodities in government health facilities, failure to hire an adequate human resource for maternal health and the imprudent and unethical behaviour of some health workers towards expectant mothers were inconsistent with the Constitution and are therefore a violation of the right to health.

At the commencement of the hearing, the Attorney General of Uganda raised a preliminary objection based on the political question doctrine.[33] The Attorney General argued that by adjudicating the matter, the Constitutional Court would interfere with the political discretion, which is a preserve of the Executive and the Legislature.[34] In its ruling, the Court upheld the Attorney General's preliminary objection and dismissed the petition, noting that:

> *Much as it may be true that the government has not allocated enough resources to the health sector, particularly maternal healthcare services, this court is ... reluctant to determine the questions raised in this petition. The Executive has the political and legal responsibility to determine, formulate and implement policies of government... This court has no power to determine or enforce its jurisdiction on matters that require*

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[31] EQUINET Discussion Paper 118. *Comparative review: Implementation of constitutional provisions on the right to healthcare in Kenya and Uganda,* (EQUINET, 2021), (accessed 4 July 2022) online at: https://www.equinetafrica.org/sites/default/files/uploads/documents/EQ%20Diss%20118%20Const%202019.pdf

[32] *Center for Health, Human Rights & Development (CEHURD) and 3 Others v Attorney General,* Constitutional Petition No. 16 of 2011. Constitutional Court of Uganda. Judgement delivered on August 19, 2020, (accessed 16 June 2022) online at: https://ulii.org/ug/judgement/constitutional-court-uganda/2020/12

[33] The Black's Law Dictionary, 9th Edition at page 1277 defines political question to mean "a question that Court will not consider because it involves the exercise of discretionary power by the executive or legislative branch of government – Also termed as non-justiciable question."

[34] *A Political Question? Reflecting on the Constitutional Court's ruling in the maternal mortality case (CEHURD & Others v Attorney General of Uganda).* Initiative for Social and Economic Rights (ISER), (accessed 16 June 2022) online at: https://www.iser-uganda.org/images/downloads/ISER_Commentary_maternal_mortality_case.pdf

analysis of the health sector government policies and review of some of the provisions of these policies and their implementation.[35]

The petitioners challenged the decision in the Supreme Court. In a unanimous decision, the Supreme Court ordered the Constitutional Court to hear the petition on its merits before determining if it raises a political question. The Supreme Court guided on the application of the political question doctrine in Uganda:

> *[T]he political question doctrine has limited application in Uganda's current Constitutional order and only extends to shield both the Executive arm of Government as well [as] Parliament from judicial scrutiny where either institution is properly exercising its mandate, duly vested in it by the Constitution.*[36]

Further to the above, the Chief Justice emphasised that separation of powers is not absolute and that the Constitutional Court would need to consider whether the government had taken "all practical measures to ensure basic medical services" as required under Objective XX of the Constitution.

The Constitutional Court proceeded to hear the petition on its merits and delivered judgement on 19 August 2020.[37] In the lead judgement delivered by Hon. Justice Cheborion Barishaki JCC, the Court found that the government's omission to adequately provide basic maternal health care services in public health facilities violates the right to health and rights of women and is inconsistent and in contravention with and in contravention of the Constitution. To remedy the situation, the Court directed the government to "prioritise and provide sufficient funds in the national budget for maternal health care" and further directed the Minister of Health to "ensure that all the staff who provide maternal health care services in Uganda are fully trained, and all health centres are equipped within the next two financial years (2020/2021

[35] *Center for Health, Human Rights & Development (CEHURD) and 3 Others v Attorney General. Constitutional Petition No. 16 of 2011.* Ruling delivered on October 30, 2015, (accessed 17 June 2022) online at: https://www.escr-net.org/caselaw/2015/centre-health-human-rights-and-development-3-others-v-attorney-general-2015

[36] *Centre for Health, Human Rights and Development (CEHURD) and 3 Others v The Attorney General.* Constitutional Appeal No. 01 of 2013, Supreme Court of Uganda, (accessed 20 June 2022) online at: https://ulii.org/ug/judgement/supreme-court-uganda/2015/69

[37] *Center for Health, Human Rights & Development (CEHURD) and 3 Others v Attorney General,* Constitutional Petition No. 16 of 2011, Constitutional Court of Uganda, Judgement delivered on August 19, 2020, (accessed 20 June 2022) online at: https://ulii.org/ug/judgement/constitutional-court-uganda/2020/12

and 2021/2022)." The Court further awarded general and exemplary damages to two petitioners for the loss and torture suffered as a result of acts and omissions of the medical personnel at Mityana Hospital and Arua Regional Referral Hospital.

In the case of *Centre for Health, Human Rights and Development & Ors vs Nakaseke Local Government*,[38] the plaintiffs contended that the deceased, who had an obstructed labour condition, did not receive the appropriate medical care because the assigned doctor on duty was absent from the hospital. The High Court of Uganda held that the death of the expectant mother and her baby was caused by negligence at the medical facility and that it amounted to a failure to protect women as required by Article 33 of the 1995 Constitution of Uganda.

The rights of persons with mental disabilities in the criminal justice system have also been litigated in courts of law. In the case of the *Centre for Health, Human Rights and Development (CEHURD) and Anor v The Attorney General,*[39] the petitioners contended that Section 82(6) of the Trial on Indictments Act is discriminatory and Section 130 of the Penal Code Act is unconstitutional in so far as it refers to persons with mental disabilities as idiots and imbeciles and as such subjecting them to inhuman and degrading treatment contrary to Articles 24 and 35 of the Constitution. On 30 October 2015, the Constitutional Court directed the government to "review the status of persons with mental disabilities so that they are removed from jails and prisons and are instead taken for care and treatment in appropriate places" and "review and amend the [law] to provide clarity on how people with mental disabilities amounting to insanity should be handled through the criminal justice system in accordance with and in compliance with the Constitution…"

3.1.2. Quasi-judicial Mechanisms: Analysis of Establishment and Mandate

The Constitution further provides for quasi-judicial mechanisms to monitor the government's compliance with the right to health. These include the Uganda Human Rights Commission ("UHRC") and the Equal Opportunities Commission ("EOC"). One of the core functions of the UHRC, as provided under Article 52(1) of the Constitution, includes the duty to investigate, at its own initiative or on a complaint made by any person or group of persons, against the violation of any human rights, including the right to health. The UHRC further has the mandate

[38] Civil Suit 111 of 2012, High Court of Uganda.
[39] *Center for Health, Human Rights and Development (CEHURD) and Anor v The Attorney General.* Constitutional Petition No. 64 of 2011, Constitutional Court of Uganda, (accessed 20 June 2022) online at: https://ulii.org/ug/judgement/constitutional-court-uganda/2015/14

to monitor the government's compliance with international treaty and convention obligations on human rights, including the right to health. The EOC has similar powers with a specific focus on discriminatory practices or any other acts or omissions that undermine the enjoyment of equal opportunities, including in the access of determinants of the right to health. Uganda further has a Ugandan Medical and Dental Practitioners Council, a body mandated to look into cases of alleged professional misconduct of medical and dental professionals in the country.

3.1.3. National development plans, health policies and systems

Over the years, Uganda has developed several development plans, policies and systems to guide health system governance in line with Uganda's medium-term strategic direction, development priorities and implementation strategies as set out in the National Development Plan ("NDP"). Currently, Uganda is implementing the NDP III 2020/21 – 2024/25,[40] which is guided by the Uganda Vision 2040. The Plans are developed to contribute to Uganda's competitiveness, wealth creation and employment, and inclusive growth through a healthy and productive population.

Uganda has also adopted plans on the right to health. For instance, in 2015, the Health Sector Development Plan 2015/16-2019/20 was adopted to outline broad health sector development priorities, including strengthening health sector governance; disease prevention, mitigation and control; rehabilitation; palliative care services; health infrastructure development; and health education, promotion and control. In the same year, the second Health Sector Development Plan ("HSDP") 2015/16 – 2019/20, as part of the Plans aimed at achieving Uganda Vision 2040 of a healthy and productive population, was launched to accelerate the movement towards universal health coverage with essential health and related services needed for the promotion of a healthy and productive life.[41]

Uganda has also adopted several policies on the right to health. For instance, the National Health Policy II 2010-2020 was launched to build on the successes of the first National Health Policy, 2010[42] by strengthening health systems in line with decentralisation, reconceptualising

[40] National Planning Authority (Uganda). Third National Development Plan (NDP III) 2020/21 – 2024/25, (accessed 16 June 2022) online at: http://www.npa.go.ug/wp-content/uploads/2020/08/NDPIII-Finale_Compressed.pdf

[41] Ministry of Health, *The Health Sector Development Plan 2015/16 – 2019/20*, (accessed 16 June 2022) online at: http://extwprlegs1.fao.org/docs/pdf/uga179615.pdf

[42] Ministry of Health, *Second National Health Policy, 2010,* (accessed 16 June 2022) online at: http://library.health.go.ug/publications/policy-documents/second-national-health-policy-2010

and organising supervision and monitoring of health systems at all levels and taking steps to address the human resource crisis.

Regarding patients' rights, Uganda has made efforts to ensure they access quality healthcare. In November 2021, the Ministry of Health launched the Patient Rights and Responsibilities Charter 2019 to enhance community participation and empower individuals to take responsibility for their health to improve accountability and the quality of health services. This builds on the 2009 Patients' Charter[43] and the 2021 Ministry of Health Client Charter.[44] Despite this, patients' rights remain a contentious issue in Uganda. In 2019, the Health Minister, Dr Ruth Jane Aceng, was quoted by the media noting, "creating patients' rights by law is detrimental to the health services."[45]

3.1.4. Health Care Provision Governance

The ownership of health facilities in Uganda is diverse. According to the Ministry of Health, there are 6,937 health facilities in Uganda, comprising public and private health facilities. Out of these, 45.16 per cent (3,133 health facilities) are government owned / public, 14.44 per cent (1,002 health facilities) are private and owned by the not-for-profit, 40.29 per cent (2,795 health facilities) are private-for-profit, while 0.10 per cent (7 health facilities) are community-owned.[46]

The government provides financial support to the health sector, which funds public health facilities. However, over the years, the allocations have been below the April 2001 commitment made by Uganda and other African nations at the *Abuja Declaration,*[47] which requires the government to allocate "at least 15%" of the annual budget to the improvement of the health sector. The trend continues to deteriorate amidst a rise in population growth and refugee influx. For example, according to the UNICEF (National Budget Framework FY 2020/21), [48] in the

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[43] Ministry of Health, *Patients' Charter (2009),* (accessed 17 June 2022) online at: http://library.health.go.ug/publications/quality-assurance-quality-improvement/patients-charter

[44] Ministry of Health, *Ministry of Health Client Charter (July 2021),* (accessed 17 June 2022) online at: http://library.health.go.ug/sites/default/files/resources/MoH%20Client%20Chater%20July%202021.pdf

[45] Daily Monitor, "*Patient's rights law is not necessary – Dr Aceng*," (December 05, 2019), (accessed 18 June 2022) online at: https://www.monitor.co.ug/uganda/news/national/patient-s-rights-law-is-not-necessary-dr-aceng-1862950

[46] Ministry of Health. *Hospitals,* (accessed 17 June 2022) online at: https://www.health.go.ug/hospitals/

[47] *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (*24-27 April 2001), (accessed 15 June 2022) online at: https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf

[48] UNICEF, *The National Budget Framework FY 2020/21: Budget Brief No. 2020/3 (Source: National BFP FY 2020/21 – 2024/25)*, (accessed 20 June 2022) online at: https://www.unicef.org/esa/media/5961/file/UNICEF-Uganda-2020-2021-Health-Budget-Brief.pdf

Financial Year (FY) 2009/10, the total budgetary allocation to the health sector was at 9.6 per cent, it dropped to 8.7 per cent in FY 2014/15, and it dropped further to 7.9 per cent in the FY 2019/20.[49] During the 2020/21 FY, the allocation to the health sector dropped again to 5.1 per cent. Donors and development partners continue to invest heavily in the health sector. In the FY 2018/19, for example, donor contributions amounted to approximately 76 per cent of the total health sector resource envelope, excluding private contributions. This signifies that Uganda's health sector remains largely donor dependent. This trend raises concerns about the commitment of the State to invest in the right to health and sustainability.[50]

3.2. Outcome-Based Indicators on the Right to Health

3.2.1 Accessibility and Affordability of Hospitals and Health Centres

Uganda has taken several steps to close the accessibility gap in regard to the right to healthcare. According to the *NDP III*, access and utilisation of health services have significantly increased. By 2018, 75 per cent of the population lived within a five-kilometre radius of a health facility. The national health infrastructure network has also improved over the years, with more focus on decentralisation. The health facilities are classified into seven levels based on the services they provide and the geographical area that they serve, that is, Health Centre I, Health Centre II (3,610 centres), Health Centre III (1,250 centres), Health Centre IV (194 centres), General District Hospital (147 hospitals), Regional Referral Hospital (19 hospitals) and the National Referral Hospital (4 hospitals).[51]

Uganda also has five specialised hospitals: the Mulago Super Specialised Hospital, Mulago Women and Neonatal Specialised hospital (with 320 bed capacity), Regional Paediatric Surgical Hospital Entebbe, Uganda Heart Institute and the Uganda Cancer Institute.[52] This government health infrastructure is supplemented by private and community health facilities – hospitals, clinics and pharmacies – providing much-needed services. This has increased access to and utilisation of health services.

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[49] *Supra* at note 48.
[50] World Health Organisation (WHO), *Uganda: Country cooperation strategy at a glance (May 2018)*, (accessed 20 June 2022) online at: https://apps.who.int/iris/bitstream/handle/10665/136975/ccsbrief_uga_en.pdf
[51] National Planning Authority (Uganda). Third National Development Plan (NDP III) 2020/21 – 2024/25, (accessed 16 June 2022) online at: http://www.npa.go.ug/wp-content/uploads/2020/08/NDPIII-Finale_Compressed.pdf
[52] Ministry of Health. *Hospitals, supra.*

The affordability of healthcare services, however, still remains an issue of concern. While the services at public health facilities are supposed to be free of charge, reports of demands for payment for the services are commonplace. This frustrates the ability of patients to access healthcare services freely. In private facilities, the costs for consultation and other healthcare services are generally prohibitive for many people. As a result, while private facilities are available, not all Ugandans can afford them.

3.2.2. Availability of Health Care Workers at Health Facilities

Despite efforts made by the Ugandan government, its development partners and the private sector to improve the availability of healthcare workers, a shortage still persists at the health facilities.[53] According to WHO,[54] a country needs at least 4.45 professional health workers (doctors, midwives and nurses) for every 1,000 inhabitants. This formula means that Uganda should have 167,765 professional health workers. By 2019, Uganda had only 27,761 professional health workers. If we are to include the allied health professional cadres, namely clinical officers, laboratory staff, theatre staff, orthopaedic officers, dental officers, pharmacy staff, radiographers, anaesthetic officers and dispensers, the number will rise to approximately 39,000 (that would represent one health worker for every 1,000 inhabitants) – which is still way below the WHO target. On the distribution of health workers, the vacancy rates are generally higher in health facilities in rural areas despite Uganda's population being predominantly rural.[55]

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[53] World Health Organisation (2016), Health workforce requirements for universal health coverage and the Sustainable Development Goals, (accessed 13 November 2022) online at: https://apps.who.int/iris/bitstream/handle/10665/250330/9789241511407-eng.pdf

[54] *Ibid.*

[55] Wemos Health Limited, *Country Report Uganda: Uganda's human resources for health – paradoxes and dilemmas,* Pg. 11 – 12, (accessed 20 June 2022) online at: https://www.wemos.nl/wp-content/uploads/2019/11/Wemos_Country-report-Uganda-2019_Ugandas-Human-resources-for-health_Paradoxes-and-dilemmas.pdf

4. Pandemic Profiteering? Reflections on Uganda's Response to the Covid-19 Pandemic

4.1. The Advent of the Covid-19 Pandemic in Uganda and the Emergency Restrictions

The Corona Virus Disease 2019 (Covid-19) started in China in late 2019 and quickly spread across the world, ravaging thousands of communities and claiming lives. On 18 March 2020, before reporting its first case, Uganda moved to impose the first emergency measures through presidential directives – all persons travelling into the country from 'high risk' countries were required to undergo institutional quarantine, and those from 'low risk' countries to self-isolate at home for 14 days.

On 21 March 2020, Uganda registered its first case of Covid-19, and the president issued further declarations.[56] To clothe the declarations of President Yoweri Museveni, the Minister in charge of Health invoked her powers under Sections 10, 11 and 27 of the Public Health Act, Cap 281, to issue emergency Rules and Orders through Statutory Declarations. The first Rule was the Public Health (Notification of Covid-19) Order, 2020,[57] which declared Covid-19 a notifiable disease. This paved the way for the minister to impose further measures reserved for preventing and suppressing infectious diseases under the law.

4.2. Impact of the Covid-19 Emergency Restrictions on the Right to Health

Quarantines

The use of quarantines as a public health measure to control the spread of an infectious disease is well documented. It involves restricting the movement of individuals suspected to have been exposed to an infectious individual for observation for some time, whether or not they are showing any symptoms. It is an unpleasant experience due to physical isolation from family and loved ones. It triggers fear and resentment and fear of death, among others.

In a 2021 study[58] to explore the experiences of persons in Covid-19 institutional quarantine in Uganda, the findings revealed at least 2,661 individuals were subjected to institutional

[56] Anadolu Agency, *Uganda confirms first case of COVID-19,* (accessed 13 November 2022) online at: https://www.aa.com.tr/en/africa/uganda-confirms-first-case-of-covid-19/1774578
[57] ULII, Public Health (Notification of COVID-19) Order, 2020 (Statutory Instrument 45 of 2020), (accessed 13 November 2022) online at: https://ulii.org/akn/ug/act/si/2020/45/eng%402020-03-17
[58] Ndejjo *et al.* BMC Public Health (2021) 21:482, (accessed 23 June 2022) online at: https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-021-10519-z.pdf

quarantine in several facilities such as hotels, university hostels and schools across major towns in central Uganda. Several concerns, including holding people in "non-conducive facilities with inadequate provisions and poor compliance with disease prevention and control measures, having to pay for quarantine costs, poor communication from authorities and extension of the (arbitrary) quarantine period" were also reported. At a personal level, the report revealed that people in quarantine struggled with "poor attitudes towards quarantine, fears of infection and stigma, boredom and poor coping mechanisms, the lack of access to health care and unnecessary post-quarantine follow ups."[59]

Restrictions of movement

Amidst a sharp rise in Covid-19 cases and the number of deaths, the Ugandan government suspended public and private transport, cross-border restrictions and imposed night curfews.[60] The restrictions lasted for several months during 2020 and 2021. These emergency measures resulted in severe travel restrictions that negatively impacted access to healthcare services and other underlying determinants of the right to health. For instance, during the 3-month lockdown, the number of antenatal attendances, immunisation clinic attendance, attendances for prevention of mother-to-child transmission of HIV, number of children treated for pneumonia and malaria, and other critical maternal, child and neonatal health services significantly decreased. In contrast, the number of women treated for high blood pressure, eclampsia and pre-eclampsia, adverse pregnancy outcomes, neonatal unit admissions, neonatal deaths and abortions increased immediately post-lockdown.[61]

The Covid-19 lockdown further impacted the rights of girls in vulnerable communities. A spike in teenage pregnancies in 2020 and 2021 was registered. For instance, among the refugee population, the lockdown denied girls and young women a safe space resulting in a 22.5 per cent increase in teenage pregnancies in refugee settlements.[62] At the national level, 354,736

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[59] *Supra* at note 58.
[60] Anadolu Agency. *Uganda declares curfew to curb spread of COVID-19,* (accessed 13 November 2022) online at: https://ulii.org/akn/ug/act/si/2020/45/eng%402020-03-17
[61] Burt JF, Ouma J, Lubyayi L, *et al. Indirect effects of COVID-19 on maternal, neonatal, child, sexual and reproductive health services in Kampala, Uganda.* BMJ Global Health, 2021; 6:e006102, (accessed 4 July 2022) online at: https://gh.bmj.com/content/6/8/e006102
[62] War Child. *Refugee girls report 'torture' of early pregnancy due to Covid school closures*, (accessed 1 July 2022) online at: https://www.warchildholland.org/news/early-pregnancy-due-to-covid-school-closures/

teenage pregnancies were registered in 2020, and in the first six months of 2021, 196,499 cases were reported.[63]

The travel restrictions further condemned many to starvation. Due to the abrupt nature of the first 3-month lockdown, thousands of people and their families were trapped within cities and urban centres.[64] Most urban dwellers survive on their daily or monthly earnings. The abrupt suspension of public and private transport meant they would not travel to their homes in the countryside, where survival may have been better. Although the government distributed food relief in an attempt to alleviate the situation, it was far too little too late. In the *Center for Food and adequate Living Rights (CEFROHT) v Attorney General,*[65] the applicant organisation brought an action arguing that the respondent's failure and omission to issue guidance on the access to and availability of food during the Covid-19 pandemic was a violation of and a threat to the Constitution. On 4 June 2020, the High Court in Kampala held that "there are other systems that the government has put in place and is working on" to ensure food availability.

4.3. Pandemic Profiteering? Exorbitant Cost of COVID-19 Treatment

At the peak of the Covid-19 pandemic in Uganda, hospitals significantly raised treatment costs to prohibitive amounts, as reported by the Center for Health, Human Rights and Development (CEHURD)[66] in a statement and analysed in detail in an article by the *Opinio Juris*.[67] A day in the Intensive Care Unit (ICU) at a private hospital in Kampala would cost a Covid-19 patient between 2,000,000 Uganda Shillings (about $530) to 10,000,000 Uganda Shillings (about $2,600) per day, depending on the hospital. Covid-19 patients with moderate symptoms paid between 1,500,000 Uganda Shillings (about $400) to 5,000,000 Uganda Shillings (about

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[63] UNICEF, *Addressing teenage pregnancy during the COVID-19 pandemic,* (accessed 1 July 2022) online at: https://uganda.unfpa.org/en/news/addressing-teenage-pregnancy-during-covid-19-pandemic

[64] Alliance for Science, *Uganda's 'urban poor' fear dying of hunger during COVID-19 lockdown,* (accessed 4 July 2022) online at: https://allianceforscience.cornell.edu/blog/2020/04/ugandas-urban-poor-fear-dying-of-hunger-during-covid-19-lockdown/

[65] *Center for Food and Adequate Living Rights (CEFROHT) v Attorney General* (Miscellaneous Cause 75 of 2020) [2020] UGHCCD 157, (accessed 4 July 2022) online at: https://www.cehurd.org/publications/download-info/court-order-on-regulation-of-covid-19-treatment-costs/

[66] CEHURD, *Regulate the rates hospitals are charging for management and treatment of Covid-19,* (accessed 28 June 2022) online at: https://www.cehurd.org/regulate-the-rates-hospitals-are-charging-for-management-and-treatment-of-covid-19/

[67] Opinio Juris, "The poor person is meant to die": Uganda's failing health system in the context of COVID-19, (accessed 13 November 2022) online at: https://opiniojuris.org/2021/08/17/the-poor-person-is-meant-to-die-ugandas-failing-health-system-in-the-context-of-covid-19/

$1,300) per day.[68] These daily rates are significantly compounded if the patient requires treatment over a few days.

In one of the cases, which is well documented, a hospital in Kampala demanded a deposit of 40,000,000 Uganda Shillings (about $10,600) before a Covid-19 patient would be admitted, and then 47,000,000 Uganda Shillings (about $12,500) on the night before she died, and an additional 40,000,000 Uganda Shillings (about $10,600) before the hospital would release her body.[69] That is 127,000,000 Uganda Shillings (about $33,900) in medical costs. The family had to engage a lawyer, a specialist doctor and a banker to negotiate with the hospital, and eventually, they had to pay 100,000,000 Uganda Shillings (about $28,000).[70]

In an effort to push back, the *Mulumba Moses and the Center for Health, Human Rights and Development (CEHURD)* and the *Health Equity and Policy Initiative (HEAPI)*[71] filed two separate strategic cases in court to challenge the government's omission or failure to regulate rates and pricing of medical services provided by private health facilities to guarantee the elements of availability, accessibility and affordabili ty of the right to healthcare, especially in a pandemic. In the *Mulumba Moses case*,[72] a consent judgement was entered on 8 July 2021, wherein the High Court in Kampala ordered the government to intervene and make regulations for reasonable fees for hospital management and treatment of Covid-19 patients.

5. Conclusion

This paper establishes that the right to health is well grounded in Uganda's legal and policy framework. There are also adequate legal provisions to guide the government on necessary legal and policy actions in case of health crises, such as the Covid-19 pandemic. Uganda has also taken several positive strides towards the realisation of the highest attainable level of health. However, despite the positive trends, there still remain significant gaps that require attention from the political class and the technical staff. For the political leaders in the Parliament of Uganda and other local urban councils, there is a need for increased resource

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[68] *Supra* at note 67.
[69] Global Press Journal, *COVID patients saddled with steep bills at private hospitals,* (accessed 28 June 2022) online at: https://globalpressjournal.com/africa/uganda/covid-patients-saddled-steep-bills-private-hospitals/
[70] *Ibid.*
[71] 'Notice of Motion' in the *Health Equity and Policy Initiative (HEAPI) v Hon. Dr. Jane Ruth Aceng Ocero, Minister of Health and the Attorney General of Uganda,* Miscellaneous Cause No. 24 of 2021, (accessed on 13 November 2022) online at: https://www.dropbox.com/s/sdpjxwwym7rgywh/HEAPI%20MC%20NO.%20024-2021.pdf?dl=0
[72] CEHURD, *Court order on regulation of Covid-19 treatment costs,* (accessed 4 July 2022) online at: https://www.cehurd.org/publications/download-info/court-order-on-regulation-of-covid-19-treatment-costs/

allocation to the sectors that impact access to the critical determinants of the right to health, such as the right to adequate food, right to water, freedom from discrimination and the right to sexual and reproductive health. There is also a need to address the staffing gaps at public health facilities to scale up healthcare access for all and regulate private hospitals and pharmacies to ensure that they do not unduly profit from their patients and clients at all times, particularly during a pandemic. The coverage of public health facilities that are authorised to have doctors should also be scaled up. The health facilities should be equipped with functioning laboratories for the early detection of health conditions for appropriate management. Finally, the courts of law should continuously play the critical role of adjudicating matters of the right to health in a timely and progressive manner to ensure that governance determinants are responsive to the challenges of the day.

THE COVID-19 PANDEMIC IN ITALY: WHAT LESSONS FOR THE PROTECTION OF THE RIGHT TO HEALTH AT TIMES OF PUBLIC HEALTH EMERGENCY?

Rosella De Falco*

1. Introduction

On 31 December 2019, the first case of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was reported in Wuhan, China.[1] From then, the virus causing the novel coronavirus disease (Covid-19) spread rapidly across the world, straining healthcare systems in both developed and developing countries. On 11 March 2020, the World Health Organisation (WHO) declared the Covid-19 outbreak a global pandemic.[2]

Figure 1: COVID-19 Mortality Rates, Italy

Source: Italian Institute for Health data, available here at page 21.

In Europe, the first Covid-19 positive patient was found in Codogno hospital, Northern Italy, on 21 February 2020.[3] Only one month later, Italy became one of the most affected countries worldwide,[4] with more than 400,000 confirmed cases and 36,000 Covid-attributed deaths as of mid-October

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* Programme Officer on the Right to Health at the Global Initiative for Economic, Social and Cultural Rights; PhD *cum Laude* and Doctor Europaeus in Human Rights at the University of Padova, Human Rights Center, Italy; LL.M. in Economic, Social and Cultural Rights *with distinction* at the University of Essex, School of Law, UK; M.A. in International Affairst at the Johns Hopkins University, School of Advanced International Studies

[1] European Centre for Disease Prevention and Control (ECED) "Covid-19" (accessed 19 January 2022) online at: https://www.ecdc.europa.eu/en/covid-19-pandemic.

[2] World Health Organization (WHO), "WHO Director-General's opening remarks at the media briefing on Covid-19-11 March 2020" (accessed 11 March 2020) online at: https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

[3] Milano Today, "Milano, primi casi di coronavirus accertati in Lombardia: 38enne ricoverato a Codogno" *Milano Today* (21 February 2020, accessed 6 April 2022) online at: https://www.milanotoday.it/attualita/coronavirus-codogno.html.

[4] Chirag Modi *et al.* "Estimating Covid-19 mortality in Italy early in the Covid-19 pandemic" (2021) 12 *Nature Communications* 2729.

2020.[5] The pandemic severely hit Northern regions in Italy, while the South was less impacted, as Figure 1 shows.[6]

On 30 January 2020, the Italian central government declared a state of emergency.[7] This was followed by a nationwide lockdown on 9 March 2020, enforcing severe movement restrictions on Italy's 60 million people.[8] In the same month, the central government issued a series of urgent measures and guidelines for pandemic response.[9]

Within these broad guidelines, the 20 regions that compose Italy chose different health policy approaches to handle the public health emergency.[10] This has been possible because the Italian Republic has a decentralised healthcare system, where regions retain considerable administrative, fiscal and legislative autonomy in healthcare services management.[11] Given the variety of local responses to Covid-19, the Italian case study offers lessons on how different public health policies influence the protection of the right to health in the context of pandemic preparedness and response.

Over the past two years, international and Italian academic literature has reflected extensively on the link between different pandemic responses and Covid-19 health outcomes. This chapter will summarise the findings of such scientific and medical literature. Then, applying a human rights framework, this chapter will reflect on the implications of enjoying the right to health, particularly the right to universal healthcare services, in Italy. The conclusions draw lessons from the Italian experience that might also be applied to other contexts.

The chapter is divided as foll ows. First, it introduces the framework for the right to health in

[5] Johns Hopkins Coronavirus Resource Center, "Covid-19 Map" (accessed 25 April 2022) online at: https://coronavirus.jhu.edu/map.html.
[6] Istituto Superiore di Sanità, *Case fatality rate of SARS-CoV-2 infection at regional level and across different phases of the epidemic in Italy. Version of January 20, 2021,* (2021) Report ISS Covid-19 n. 1/2021 (in Italian).
[7] Delibera del Consiglio dei Ministri of 31 January 2020.
[8] Jason Horowitz, "Italy Announces Restrictions Over Entire Country in Attempt to Halt Coronavirus", *The New York Times* (9 March 2020, accessed 26 April 2022) online at: https://www.nytimes.com/2020/03/09/world/europe/italy-lockdown-coronavirus.html.
[9] *Decree-law "Disposizioni urgenti per potenziamento del Servizio sanitario nazionale in relazione all'emergenza Covid-19"* No 14 of 9 March 2020; *Decree-Law "Misure di potenziamento del Servizio sanitario nazionale e di sostegno economico per famiglie, lavoratori e imprese connesse all'emergenza epidemiologica da Covid-19"* No. 18 of 17 March 2020.
[10] Andrea Crisanti & Antonio Cassone, "In one Italian town, we showed mass testing could eradicate the coronavirus", *The Guardian* (March 2020).
[11] Franca Maino, "La Regionalizzazione Della Sanità Italiana Negli Anni Novanta", (1999) 4 *Il politico* 64 at p. 583.

Italy at national, European and international levels. Furthermore, it presents a historical overview of the development of the universal healthcare system in Italy. Then, the chapter unpacks the different regional responses to Covid-19 in Italy, focusing mainly on Veneto, Lombardy and Emilia-Romagna, three regions that registered higher infection rates in the first stages of the pandemic, but also rapidly mentioning the situation in other areas as a way of reference. The aim of such investigation is to understand which elements of these health policies worked better from a right-to-health perspective. Special attention is given to the role of pre-existing characteristics of health systems to determine the policy choices at times of crisis. Finally, the different health policy choices during Covid-19 are analysed considering Italy's obligations under international human rights law in the context of the right to health, drawing lessons for other countries.

This chapter is based on secondary data collected through a variety of sources. First, a literature review of peer-reviewed academic articles, preprints, institutional reports, civil society reports, and policy briefs was conducted. Only documents published between March 2020 and April 2022 in both English and Italian languages were included. Preprints were included too. Second, official statistics were analysed, including those from the Italian Ministry of Health and the WHO Global Observatory. Results were triangulated to draw lessons from a human rights perspective.

2. From Privilege to Fundamental Right: The Development of Universal Healthcare in Italy

The Italian Constitution (the Constitution), drafted in 1946 and entered into force in 1948, was the first step toward recognising health as a fundamental human right rather than a privilege or a matter of charity in the country. The Constitution's Article 32 protects health as "a fundamental right of the individual" as well as a "collective interest," guaranteeing "free medical care to the indigent."[12] Article 38 of the Constitution further warrants that: "workers shall be entitled to adequate insurance for their needs in case of an accident, illness, disability, old age, and involuntary unemployment."[13]

[12] *Constitution of the Italian Republic* (drafted in 1946, entered into force in 1948), art. 32 [hereinafter Italian Constitution].
[13] *Italian Constitution*, art. 38.

A second important step towards universal healthcare was the establishment of the Ministry of Health in 1958.[14] This was followed by Law 132 of 1968,[15] which integrated hospital care among the public services provided by the state. This hospital reform was fundamental for the development of hospitals as public institutions understood as fundamental for the protection of individual and public health under the direct responsibility of the state.

However, the milestone in the universal healthcare journey came only in 1978, with the establishment of the Italian National Health System (*Servizio Sanitario Nazionale*) (hereinafter Italian NHS),[16] which is still in place today. The Italian NHS is financed through general taxation and provides healthcare services free of charge at the point of use. Based on the principle of solidarity, universality and financial protection from healthcare costs, the system translates into automatic universal access to healthcare services for all citizens, foreign residents and migrants holding residence permits. Access to the Italian NHS also includes a family doctor for each adult and a paediatrician for every child, free of charge. The package of benefits provided by such public healthcare system is very large, ranging from inpatient to outpatient services for both physical and mental health conditions. This includes, for instance, public health promotion, prevention, family medicine, general and specialised treatments in hospitals and clinics, emergency care (including ambulance services), as well as rehabilitation and long-term residential care.[17]

The Italian healthcare system is similar in many ways[18] to the British National Health System (NHS), which was adopted in the United Kingdom in 1948.[19] Implemented based on a report written by the economist William Beveridge,[20] the British healthcare system is often referred to as the Beveridge model. When the Italian healthcare system was conceived, the other main healthcare model was mandatory social health insurance schemes, referred to as Bismarck, instituted in Germany for the first time in 1883.[21] Today, the Bismarck and the Beveridge

[14] *Law "Costituzione del Ministero della Sanità"* No. 296 of 1958.
[15] *Law "Enti Ospedalieri e Assistenza Ospedaliera"* No. 132 of 1968 of 1968.
[16] *Law "Istituzione del Servizio Sanitario Nationale"* No. 833 of 1978.
[17] For more information on healthcare in Italy, see: WHO Europe, "*Italy*" (accessed 25 April 2022) online at: https://www.euro.who.int/en/countries/italy.
[18] Garattini, et al. "The Italian NHS at regional level: same in theory, different in practice" (2022) *Eur J Health Econ* 23, 1–5.
[19] *National Health Service Act* of 1948.
[20] Philp Musgrove, "Health Insurance: The Influence of the Beveridge Report", (2000) *Bulletin of the World Health Organization* 78, at p. 845.
[21] Gerhard Bosch, "The German welfare state: from an inclusive to an exclusive Bismarckian model." In *The European Social Model in Crisis*, pp. 175-229. Edward Elgar Publishing, 2015.

models are still the two main typologies of pre-pooled financing schemes for healthcare services, with other countries adopting one or the other, even with some important variations.[22] Health systems inspired by the NHS have been adopted in Australia, New Zealand, Canada, Spain and Greece, for instance, whereas healthcare systems similar to the Bismarck model have been implemented in Belgium, France and Austria.[23]

Even though medical services provided by the Italian NHS are free of charge at the point of use, in 1989, co-payments were introduced into the financing structure of the healthcare system.[24] These co-payments are generally low and only applicable to a restricted number of services specified by the Ministry of Health.[25] In 1998, Law 124 disciplined further exemptions from co-payments based on household income, health status and age.[26]

3. International and Regional Human Rights Norms in the Italian Context

Beyond national provisions, Italy also recognises the right to health as a human right in international law. Italy is a party to the *International Covenant on Economic, Social and Cultural Rights* (ICESCR, 1966, ratified by Italy in 1978), whose Article 12 obliges States, *inter alia*, to take steps towards "the prevention, treatment and control of epidemic, endemic, occupational and other diseases."[27] Italy has, thus, a legal obligation to respect, protect and fulfil the right to health by ensuring quality healthcare services for all to the maximum of its capacities and available resources as per Article 2 of the ICESCR.[28] Importantly, non-discrimination and equality are essential to the exercise and enjoyment of economic, social and cultural rights, including the right to health. States must ensure *de jure* and *de facto* equality between everyone by eliminating barriers to enjoying the right to health.[29]

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[22] Katharina Böhm et al., *Classifying OECD healthcare systems: a deductive approach* (2012) 165 *TranState Working Papers*.
[23] *Ibid*.
[24] *Decree-Law* No. 382 of 1989; *Law* No. 537 of 1992.
[25] Italian Ministry of Health, "Esenzioni dal Ticket" (accessed 23 April 2022) online at: https://www.salute.gov.it/portale/esenzioni/dettaglioContenutiEsenzioni.jsp?area=esenzioni&id=4674&lingua=italiano&menu=vuoto.
[26] *Law* No. 124 of 1998.
[27] *International Covenant on Economic, Social and Cultural Rights* (ICESCR) (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3.
[28] ICESCR, Art. 2.
[29] CESCR, "General Comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights" (2 July 2009) E/C.12/GC/20.

The right to health, while not being a right to be healthy, is a right to those elements that influence health under the State's control.[30] The Committee on Economic, Social and Cultural Rights (CESCR, hereinafter the Committee) has interpreted the right to health as encompassing access to the underlying determinants of health,[31] including but not limited to food, water, housing and information.[32] Likewise, healthcare services are essential for realising the right to health. The Committee has underlined that such healthcare services must be available, accessible, acceptable and of good quality.[33] *Availability* refers to the existence of healthcare facilities and essential medicines in proper quantity and of acceptable quality; *accessibility* is composed both of physical accessibility and economic accessibility, non-discrimination and information accessibility; *acceptabili*ty translates into the public duty to guarantee medical ethics in all treatments, and *quality*, which means that all medical treatment has to be in line with medical standards. Recent literature has also clarified these standards in the context of mental health services.[34] Quality healthcare requires, for example, that services are provided through skilled medical personnel, scientifically approved and unexpired pharmaceuticals and hospital equipment, and adequate sanitation. Italy is also obliged to strictly monitor and regulate private actors in healthcare.[35] This means that clear normative requirements have to be in place on the involvement of private actors in healthcare, followed by strict implementation.

At the European level, Italy is a party to the *Charter of Fundamental Rights of the European Union (CFREU)*. Article 52 protects the right to health by providing as follows:

> Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.[36]

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[30] Paul Hunt, "The Human Right to the Highest Attainable Standard of Health: New Opportunities and Challenges," (2006) 7 *Transactions of the Royal Society of Tropical Medicine and Hygi ene* 100, at p. 603.
[31] Audrey Chapman, "The Social Determinants of Health, Health Equity, and Human Rights," (2010) 2 *Health and Human Rights* 12, at p. 17.
[32] CESCR, "General Comment No. 14, The right to the highest attainable standard of health (Article 12 of the Covenant)" (11 August 2000) E/C.12/2000/4.
[33] *Ibid.*
[34] Paul Hunt & Judith Mesquita, "Mental Disabilities and the Human Right to the Highest Attainable Standard of Health" (2006) *Human Rights Quarterly* 28 at p. 332.
[35] UN Human Rights Council, "Protect, respect and remedy: a framework for business and human rights: report of the Special Representative of the Secretary-General on the Issue of Human Rights and Transnational Corporations and Other Business Enterprises, John Ruggie" (7 April 2008) A/HRC/8/5.
[36] European Union, *Charter of Fundamental Rights of the European Union*, 26 October 2012, 2012/C 326/02.

Italy is also a member of the *European Social Charter* (1961, revised in 1966), which relates to healthcare in several articles, including Article 3 on health and safety at work, Articles 7 and 17 on the health of children and young adults, Article 8 and 17 on maternal health and Article 11 on public health.[37] Other international norms relevant when analysing Italy's obligations include Article 24 of the Convention on the Rights of the Child (CRC),[38] Articles 10(h), 11.1(f), 11.2, 12 and 14.2(b) of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),[39] and Article 25 of the Convention on the Rights of Persons with Disabilities (CRPWD).[40]

4. The National Healthcare System in Italy: A Decentralised Model

This part will explore how the Italian NHS progressively shifted from a relatively centralised model, as initially conceived, to a strongly decentralised healthcare system. In the first period after the Italian NHS was established (1978–1992), the governance of the Italian public healthcare system was shared between the central state, regions and local governments. The reforms of 1992-1993[41] and subsequent legislation introduced considerable administrative autonomy in healthcare management to regions. Amendments to Title V of the Constitution further reinforced the regionalisation of the Italian NHS.[42]

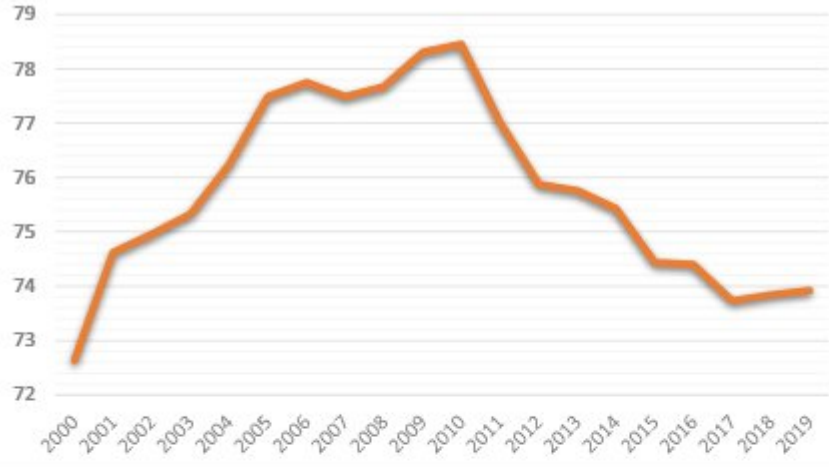
Currently, the central state is now responsible for collecting and allocating healthcare funds. Since 2001, the Ministry of Health is also in charge of establishing the essential package of benefits that must always be publicly provided in all regions. These core levels are referred to as "essential levels of assistance" (*Livelli Essenziali di Assistenza* – LEAs) and normally include a wide array of preventative, curative and rehabilitative services as well as public health promotion.[43] Once the central government allocates the budget necessary for realising the essential levels of assistance, regions are responsible for healthcare delivery and public

[37] Italy ratified the 1961 European Social Charter on 22/10/1965 and the Revised Social Charter on 5/07/1999, accepting 97 out of 98 paragraphs.
[38] UN General Assembly, *Convention on the Rights of the Child*, (20 November 1989), United Nations, Treaty Series, vol. 1577, p. 3.
[39] UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, (18 December 1979), United Nations, Treaty Series, vol. 1249, p. 13.
[40] UN General Assembly, *Convention on the Rights of Persons with Disabilities: resolution/adopted by the General Assembly*, (24 January 2007), A/RES/61/106.
[41] *Decree-Law* No. 502 of 1992; *Decree-Law* No. 517 of 1993.
[42] *Italian Constitution*, Title V, art. 117.
[43] *DPCM Decree "Definizione dei livelli essenziali di assistenza"* of 2001.

health.[44] Within this framework, regions are responsible for the local administration of healthcare delivery through local health authorities and public health policies.[45]

Finally, to better understand the Italian context, it is noteworthy that budget cuts in the aftermath of the 2008's economic crisis weakened the public healthcare system, with negative consequences on equal access to healthcare services[46] and health outcomes, including mental health.[47] As shown in Figure 2, after a decade of positive growth, government health expenditure as a share of overall health spending decreased sharply after 2010, when budget cuts started in most European countries impacted by the global financial crisis: from 78.5% in 2010 to 74% in 2019. Over the same period, out-of-pocket payments, which are payments made by users at the point of using the services, increased from 20% to 23% of overall spending over the same period, signalling a gradual, yet concerning, shift in the healthcare financing burden from the public onto the individual in less than 10 years.

Figure 2: Government health expenditure (% Current Health Expenditure)



Source: World Health Organization Global Health Expenditure database available at: apps.who.int/nha/database.

[44] Stefano Neri, "Crisis, 'The Italian National Health Service after the Economic Crisis: From Decentralization to Differentiated Federalism", (2019), *e-cadernos CES.*
[45] Stefano Neri, "The evolution of regional health services and the new governance of the NHS in Italy" in: Douglas Angus & Zoe Boutsioli (eds) *Health Studies: Economic, Management and Policy* (Athens: Atier 2011) at p. 269.
[46] Rossella De Falco, "Access to Healthcare and the Global Financial Crisis in Italy: A Human Rights Perspective," *E-Cadernos CES* 31 (2019), https://doi.org/10.4000/eces.4452.
[47] Roberto De Vogli, Maria Diletta Buio and Rossella De Falco, "Effects of the Covid-19 Pandemic on Health Inequalities and Mental Health: Effective Public Policies", (2021), 6 *Epidemiologia e Prevenzione* 45, at p. 588.

5. Comparing Different Responses to Covid-19 Across Italian Regions: Hospital-Centric Versus Community-Oriented Strategies

Two main approaches can be identified to how regional health systems handled the pandemic in Italy. On the one hand, most regional administrations framed the pandemic as an intensive care emergency,[48] concentrating efforts on the hospitalisation of acute cases requiring intensive medical care, such as mechanical ventilation, while focusing less on testing and tracking Covid-19 cases. By contrast, a few regions responded to the pandemic as an emergency that had to be proactively managed in communities, including large-scale testing, tracking and monitoring of Covid-19 cases, home diagnosis and care, and prevention.[49] These two approaches will respectively be labelled *hospital-centric* and *community-oriented*. Some regions also combined elements of the two approaches.[50] Importantly, several administrations also changed strategy as the pandemic unfolded, attempting to imitate successful strategies.[51]

Increasingly, international academic literature confirms that the community-oriented approach correlates with reduced Covid-19 deaths, morbidity and infection rates, resulting in an efficient pandemic response.[52] The strength of this approach lies in the synergic integration between outpatient and inpatient medical care, especially family medicine, home diagnosis and care, emergency services and acute hospital care. By contrast, the narrower approach focused on treating acute cases in hospitals is being increasingly associated with poorer Covid-19 health outcomes and higher infection rates, with overall negative consequences for health protection.[53]

In Italy, the archetype of the community-oriented approach was applied in the Veneto region.[54] The Veneto administration was able to enact a proactive testing strategy, which allowed

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[48] Federico Toth, "How the Health Services of Emilia-Romagna, Lombardy and Veneto Handled the Covid-19 Emergency", (2021), 2 *Contemporary Italian Politics* 13 at p. 226.
[49] Mattia Casula, Andrea Terlizzi & Federico Toth, "I Servizi Sanitari Regionali Alla Prova Del Covid-19," (2020) 3 *Rivista Italiana Di Politiche Pubbliche* 15 (2020) at p. 307.
[50] Americo Cicchetti & Eugenio Di Brino (eds) *Analisi dei modelli organizzativi di risposta al Covid-19: Focus su Lombardia, Veneto, Emilia-Romagna, Piemonte, Lazio e Marche* (Milano: Università Cattolica del Sacro Cuore 2020).
[51] Gianluca Busilacchi & Federico Toth, "Il Servizio sanitario nazionale alla prova della pandemia. Cosa abbiamo appreso?" (2021) *Italian Journal of Social Policy* 2.
[52] Tadele Girum et al., "Global Strategies and Effectiveness for Covid-19 Prevention through Contact Tracing, Screening, Quarantine, and Isolation: A Systematic Review", (2021), 1 *Tropical Medicine and Health* 48 at p. 91.
[53] Roberto De Vogli, Maria Diletta Buio & Rossella De Falco, "Effects of the Covid-19 Pandemic on Health Inequalities and Mental Health", (2022), 6 *Epidemiologia & Prevenzione* 45, at p. 588.
[54] Gary Pisano et al., "Lessons from Italy's Response to Coronavirus" *Harvard Business Review* 2020. Available online: https://hbr.org/2020/03/lessons-from-italys-response-to-coronavirus (accessed on 04 April 2022).

identifying Covid-19 cases early before they would overcrowd hospitals in large numbers.[55] Advised by a small group of experts, and partly against official national and WHO guidelines, the Veneto region approved a policy of 'active surveillance' wh ich involved testing both symptomatic and asymptomatic cases.[56] This strategy soon proved very effective in extinguishing the outbreak and was praised by the international scientific community.[57]

This approach was possible due to a series of farsighted policy decisions taken at the time of and before the pandemic in the Veneto region.[58] In the years before the pandemic, Veneto had invested heavily in general practitioners (GP) services, including a large network of GP surgeries and preventative medicine.[59] GPs' surgeries made a fundamental contribution to the large-scale testing and tracing implemented.[60] Furthermore, Veneto also had incentivised using open-circuit machines to process reagents for testing in laboratories and hospitals.[61] Open-circuit machines can be used with generic reagents rather than being bound to the reagent of a specific manufacturer. When there were shortages of reagents on the international markets during the pandemic, this proved to be a key advantage.[62]

As a result of this winning strategy, on 30 April, 4.7% of the overall population in the Veneto region was tested, above the national average of 2.1%. When possible, samples were collected at the patients' homes and then brought for testing in local laboratories.[63] Veneto also implemented proactive contact tracing, meaning that once a positive case was found, all the close contacts were tested as well.[64] This approach was soon imitated by Emilia-Romagna and Tuscany, situated in North-Central Italy, with similar positive outcomes.[65]

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[55] Michele Usuelli, "The Lombardy Region of Italy Launches the First Investigative Covid-19 Commission", (2022) *The 10262 Lancet* 396 at p. e86.
[56] Italian National Institute of Health, *Documento relativo ai criteri per sottoporre soggetti clinicamente asintomatici alla ricerca d'infezione da SARS-CoV-2 attraverso tampone rino-faringeo e test diagnostico*, (26 February 2020), report of the Italian National Institute of Health.
[57] Enrico Lavezzo et al., "Suppression of a SARS-CoV-2 Outbreak in the Italian Municipality of Vo'", (2020) 7821 *Nature* 584 at p. 425.
[58] Federico Toth, "How the Health Services of Emilia-Romagna, Lombardy and Veneto Handled the Covid-19 Emergency" (2021) 2 *Contemporary Italian Politics* 13.
[59] *Ibid.*
[60] *Ibid.*
[61] *Ibid.*
[62] Elisabetta Burba, "Perché in Veneto non c'è carenza di reagenti" *Panorama* (14 Mary 2022, accessed 26 April 2022) available online at: https://www.panorama.it/news/cronaca/tamponi-veneto-reagenti
[63] Giacomo Mugnai & Claudio Bilato, "Covid-19 in Italy: Lesson from the Veneto Region", (2020), *European Journal of Internal Medicine* 77 at p. 161.
[64] Miqdad Asaria et al., "How a Universal Health System Reduces Inequalities: Lessons from England", (2016) 7 *Journal of Epidemiology and Community Health* 70 at p. 637.
[65] Federico Toth (2021) at note 55.

By contrast, the ineffective nature of the hospital-centric approach was exemplified by the pandemic response in Lombardy, a wealthy Northern Italian region, which responded to the emergency by relying on its large hospital network. As a result, only 43.5% of patients were treated at home, compared to 74.9% in Veneto. Likewise, between 1 March and 28 April 2020, Veneto tested 7% of the population, while only 4% were tested in Lombardy. In July 2020, a total of 21.6 tests per positive case were performed in the Veneto against 5.5 in Lombardy.[66] The wait-and-see strategy centred on treating acute cases in hospitals was ineffective in curbing the spread of infection. One month after the first case was detected, Lombardy had already experienced 114,800 cases and 16,994 deaths, which accounted for one-third of all Covid-19 cases and half of all Covid-19 deaths in Italy.[67] As infected patients flocked to hospitals, and with a lack of Personal Protective Equipment (PPE), 12,000 health workers were infected, and 76 health workers died as of September 2020.[68] As of April 2020, Lombardy had the highest Covid-19 case fatality ratio - the proportion of people diagnosed with a disease that die from it[69] - in Italy. At 5.7%, Lombardy's case fatality rate more than doubled the national fatality rate, which was 2.4% and that of the neighbouring Veneto, standing at 3.0%.[70] Lombardy also registered 14% of infections among frontline healthcare workers, in contrast to only 4% in the neighbouring region of Veneto.[71]

The contrasts between the two approaches have been recorded by several studies as well. The health policy adopted in Veneto was associated with better health outcomes in comparison to Lombardy, especially among frontline healthcare workers.[72] Another study suggests that the more regions reacted to a community-oriented approach, the better the outcomes in terms of morbidity, infection and death rates.[73] Veneto's epidemiological strategy, especially e xploring

[66] Giacomo Mugnai et al. (2022) supra at note 60.
[67] Italian Ministry of Health, "Covid-19 – Situazione in Italia" (accessed 24 April 2022) available online at: https://www.salute.gov.it/portale/nuovocoronavirus/dettaglioContenutiNuovoCoronavirus.jsp?area=nuovoCoronavirus&id=5351&lingua=italiano&menu=vuoto..
[68] ANSA, "In Lombardia 12mila medici e sanitari positivi, 76 morti" *Ansa* (09 September 2022, accessed 22 April 2022) available online at: https://www.ansa.it/lombardia/notizie/2020/09/09/in-lombardia-12mila-medici-e-sanitari-positivi-76-morti_09beece1-8adc-4972-b05f-b1eb503a2c92.html.
[69] Rebecca Harrington, "Case fatality rate" *Encyclopedia Britannica* (accessed 25 April 2022). Available online at: https://www.britannica.com/science/case-fatality-rate.
[70] Istituto Superiore di Sanità (2021) *supra* at note 6.
[71] Nancy Binkin et al., "Protecting Our Health Care Workers While Protecting Our Communities during the Covid-19 Pandemic: A Comparison of Approaches and Early Outcomes in Two Italian Regions" (2020), *Public and Global Health* (preprint).
[72] *Ibid.*
[73] Fabrizio Pecoraro et al., "Analysis of the Different Approaches Adopted in the Italian Regions to Care for Patients Affected by Covid-19" 3 *Int. J. Environ. Res. Public Health* 18 at p. 848.

the case study of the municipality of Vo', was also praised. [74] Similar highlights demonstrated that the case of Veneto could be a positive example for the world.[75]

Boccia et al., explain that a lower hospitalisation rate, as it happened in those regions that treated patients at home as much as possible, may have contributed to limiting the spread of the virus in healthcare settings where there is a higher concentration of more fragile patients and healthcare workers, with overall beneficial effects for population's health. [76] According to the authors, this further reinforces the argument that the community-oriented management model effectively controls the outbreaks of infectious diseases such as Covid-19.

6. Health Systems Characteristics and Pandemic Preparedness

As the health policy strategy adopted to contain the virus can be so determinant in saving lives at times of Covid-19, it is fundamental to understand why policymakers implemented one or the other and which factors were constraining their choices when the pandemic hit. A recent academic study explains that the Italian regional health systems responded to the pandemic coherently with their pre-existing characteristics, including both strengths and weaknesses.[77] At the empirical level, this would be in line with the theory of *path dependence*, one of the most popular theories in social sciences, which posits that policymakers are constrained by past events or decisions in their later policy choices.[78]

Notably, Lombardy responded to the pandemic by relying on its large hospital network precisely because it prioritised the growth of hospital care and hospital care excellence in the previous years.[79] By contrast, Lombardy had a relatively weak outpatient care system. Therefore, it could not implement the community-oriented approaches, focused on diagnosis and care at home as well as testing and tracking, as seen in Veneto, Tuscany and Emilia-Romagna.

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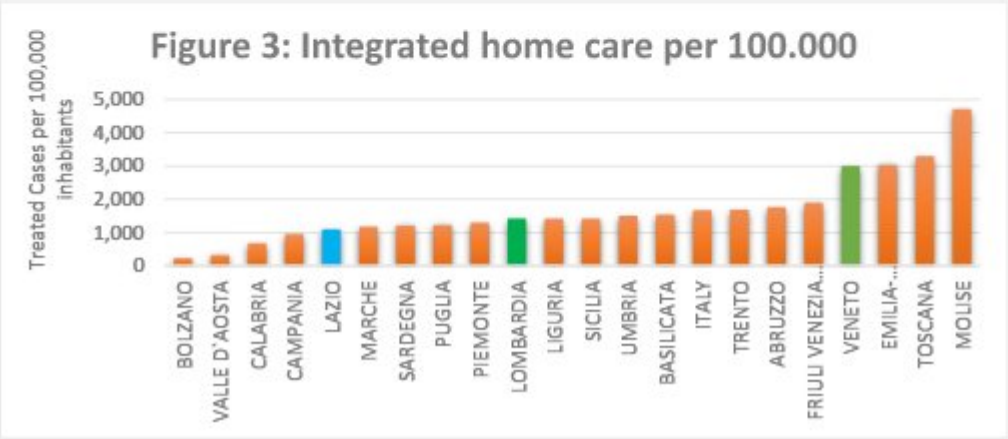
[74] Enrico Lavezzo et al. (2020) *supra* at note 54.
[75] Giacomo Mugnai et al. (2022) supra at note 60.
[76] Stefania Boccia et al. "What Other Countries Can Learn From Italy During the Covid-19 Pandemic", (2020), 7 *JAMA internal medicine* 180 at p. 927.
[77] Casula et al. (2020), *supra* at note 48.
[78] Paul Pierson, "Increasing Returns, Path Dependence, and the Study of Politics," (2000), 2 *American Political Science Review* 94 at p. 251.
[79] Casula et al. (2021) *supra* at note 48.

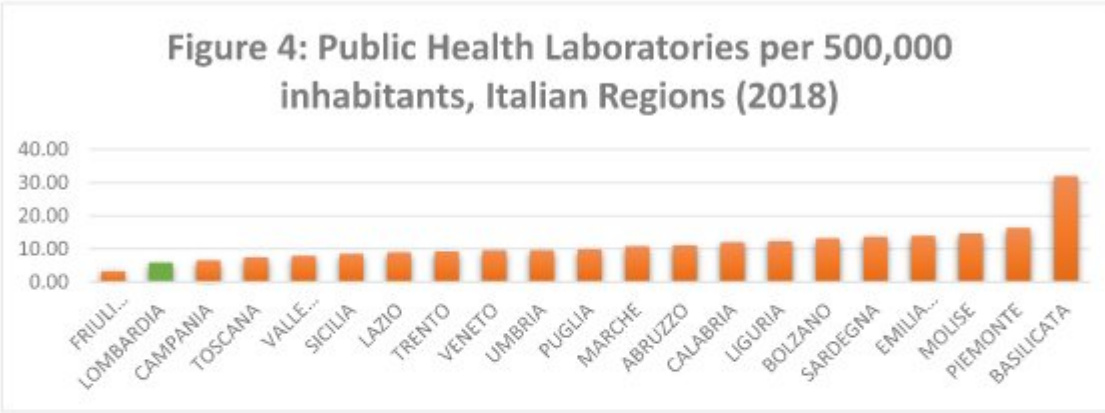
This perspective is in line with available official statistics. Figure 3 shows that Lombardy and Lazio (which applied a similar hospital-centric strategy) have very low scores on the indicator of integrated home care, whereas Veneto, Emilia-Romagna and Toscana are above Italy's average. As home care allowed individuals to get assistance without having to move, it was effective in the cases of those people who were chronically ill or disabled. It also limited the chances of the spread of the virus.



Source: Italian Ministry of Health, "Annuario Statistico del Servizio Sanitario Nazionale 2018" (2018).

A similar trend is observed in the distribution of public laboratories, which proved to be fundamental in analysing the virus during the pandemic. As Figure 4 shows, Lombardy has only five public laboratories per 500,000 inhabitants, against the 10 of Veneto or 14 or Emilia-Romagna, which were able to respond more effectively to the pandemic.[80] Similar trends are observed looking at preventative care, with Veneto and Emilia-Romagna having approximately two public departments of prevention for 1 million inhabitants, compared to less than one for every 1 million inhabitants in Lombardy.[81] Lombardy is also one of the Italian regions with fewer family doctors per inhabitant, with 1.4 adults per family doctor, against 1.3 in Veneto and Emilia-Romagna or 1.2 in Tuscany.[82]

[80] Italian Ministry of Health, *Annuario Statistico del Servizio Sanitario Nazionale 2018* (2018).
[81] *Ibid.*
[82] *Ibid.*



Source: Italian Ministry of Health, 'Annuario Statistico del Servizio Sanitario Nazionale 2018' (2018)

7. Market Models in Healthcare: The Impact on Healthcare Governance

The previous section showed how pre-existing characteristics of regional health systems played a role in shaping the response to the pandemic. The question that arises is why regions developed such different healthcare systems. A factor that deserves special attention is the influence of private sector involvement in healthcare. Together with decentralisation, the early 90s' reforms, in tandem with the health service market trends elsewhere, also enabled greater private sector participation in healthcare provision.[83] In 1992, a national law introduced the system of '*accreditatamento*' in healthcare, a form of market-based private sector contracting.[84] With this mechanism, the regional authorities were allowed to set criteria for private healthcare facilities to be eligible for public funding.

The growth of private healthcare providers has not been the same throughout the country. It has been more notable in certain regions, such as Lombardy[85] or Lazio, than in others, such as Veneto or Emilia-Romagna, reflecting different policy choices between regions.[86] Lombardy

[83] Federico Toth, "Healthcare Policies over the Last 20 Years: Reforms and Counter-Reforms," (2009) 1 *Health Policy* 95 at p. 20.
[84] Osservatorio di diritto sanitario (OASI), *Rapporto dell'Osservatorio sulle Aziende e sul Sistema sanitario Italiano, Sulla "natura" giuridica dell'accreditamento sanitario* (2018) Cergas Bocconi. (accessed 24 April 2021) available online at: https://www.cergas.unibocconi.eu/sites/default/files/files/4_OASI2020.pdf?CVID=nopRtrC&MOD=AJPERES.
[85] Julian Le Grand, "Quasi-Markets and Social Policy", (1991), 408 *The Economic Journal* 101 at p. 1256; Elenka Brenna, "Quasi-market and Cost-containment in Beveridge Systems: The Lombardy Model of Italy", (2011), 2-3 *Health Policy* 103 at p. 209.
[86] Federico Toth, "How Health Care Regionalisation in Italy Is Widening the North-South Gap," (2014) *Health Economic Policy & Law* 9 at p. 231.

started to deregulate its health system[87] since the Formigoni Law of 1997,[88] allowing private providers to freely choose which services to deliver and to compete with public facilities for public funds.[89] This approach contrasts with the system in Veneto, where healthcare services are strictly administered and controlled by the regional government.[90] After regional autonomy was granted, Veneto did not implement the same marketisation reforms as in Lombardy, focusing more on public governance, promoting a general approach of collaboration and coordination between providers rather than free-market competition.[91] This led to a completely different health system organisation in the different regions. For instance, in 2019, the private healthcare sector in Lombardy represented 41% of the total publicly funded health care services; it was 42% in Lazio.[92] Contrastingly, in regions with better outcomes, that number stood at 30% in Veneto and 29% in Emilia-Romagna.[93]

A Global Initiative for Economic, Social and Cultural Rights (GI-ESCR) report reflected on the correlation between a poorer pandemic response in Lombardy and higher private sector participation in healthcare.[94] By comparing the case of Lombardy to the neighbouring region of Veneto, which registered the first cases in the same month but fared significantly better in terms of health outcomes, the report underlines that Lombardy's weak health-policy response to the pandemic was likely due to the inherent effects of market models in healthcare management. According to the report, for-profit incentives risk leading to an oversupply of medical services that are highly remunerative, such as highly specialised hospital care or long-term residential elderly care, at the expense of prevention, emergency treatment and acute

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[87] Stefano Neri, *La regolazione dei sistemi sanitari in Italia e in Gran Bretagna* (Milan: FrancoAngeli 2006); Emanuele Pavolini, "Governance regionali: modelli e stime di performance", (2008), 3 *La Rivista delle Politiche Sociali* at p. 149; Cristiano Gori (ed.), *Il welfare delle riforme? Le politiche lombarde tra norme ed attuazione* (Maggioli Editore: Sant'Arcangelo di Romangna 2018).
[88] *Regional Law* No. 31 of 1997.
[89] Casula et al. (2020) *supra* at note 48.
[90] *Ibid.*
[91] Camilla Costa, *L'evoluzione dei sistemi sanitari regionali. Un'analisi degli assetti di governance e degli ambiti territoriali in veneto; Toscana; Lombardia ed Emilia-Romagna*(2016) Report Istituto di Ricerche Economiche e Sociali Veneto (IRES).
[92] OASI (2020) *supra* at note 82, p. 148.
[93] *Ibid.*
[94] The Global Initiative for Economic, Social and Cultural Rights (GI-ESCR), "Italy's Experience during Covid-19: the Limits of Privatisation in Healthcare", (2 June 2021, accessed 23 April 2022), available online at: https://www.gi-escr.org/publications/policy-brief-italys-experience-during-covid-19-and-the-limits-of-privatisation-in-healthcare.

care.[95] This disadvantaged Lombardy when it came to protecting the population's health during times of pandemic.

8. Conclusions: The Human Rights Implications of Health Policy Choices

Under WHO's international health regulations,[96] a legally binding treaty that Italy ratified in 2007, the country must develop, strengthen and maintain the capacity to respond to public health emergencies promptly and effectively (Article 13.1) and detect, assess and report on public health risks (Article 5.1).[97] Likewise, Article 12 of the ICESCR requires States to progressively build coordinated universal public health systems for 'the prevention, treatment and control of epidemic, endemic, occupational and other diseases, using its maximum available resources, as per Article 2 of the ICESCR.[98] Therefore, Italy has legally-binding obligations to use its maximum available resources to build healthcare systems that respect, protect and fulfil the right to health, including responding to pandemics like Covid-19.

Such government obligations extend to all levels and branches.[99] The Italian national, regional and local governments must use their available resources to realise the right to health through well-coordinated public healthcare systems resilient to shocks such as public health emergencies. Decades of public policy choices taken by the regional government in Lombardy have undermined the overall health system's resilience to pandemics, with consequences on the enjoyment of the right to health. Such policies have encouraged higher commercial sector participation in healthcare provision as well as the adoption of several market-based mechanisms in healthcare governance, including competition amongst providers.[100]

This led to a negative consequence on the capacity of the regional health system to respond to epidemics. The sectors of family medicines, prevention, home care and acute care, while being

[95] Maria Elena Sartor, "Sanità lombarda: domande in cerca di risposta", (2019), *Salute Internazionale (*accessed 25 April 2022*)* available online at: https://www.saluteinternazionale.info/2019/07/sanita-lombarda-domande-in-cerca-di-risposta/.
[96] WHO, International Health Regulations (adopted in 2005, entered into force in 2007), Internet version, 2016, (accessed 23 April 2022) available online at: https://apps.who.int/iris/bitstream/handle/10665/246107/9789241580496-eng.pdf;jsessionid=571A416D79BA24BE767C1B1A23389728?sequence=1.
[97] *Ibid.*
[98] ICESCR, *supra* at note 24.
[99] United Nations OHCHR, *Cities, local and regional governments and human rights* (website) https://www.ohchr.org/en/about-us/what-we-do/partnership/local-governments.
[100] Sartor, *supra* at note 95.

foundational for the enjoyment of everyone's right to health, have been relatively underdeveloped even in comparison to regions in Italy with less economic resources than Lombardy.[101] During Covid-19, such underdevelopment of preventative care, family medicine, acute care and home care led in Lombardy contributed to the region weak response to Covid-19. By contrast, the neighbouring Veneto region effectively used its strong network of primary health care services and family doctors to control the spread of the virus.

To avoid this problem, the national, regional and local governments always have to implement *ex-ante* and *post-facto* human rights impact assessments of public policies in healthcare. It is not enough to regulate and monitor commercial healthcare providers. All public policies leading to structural changes in health care must be assessed against their potential human rights impacts. If higher competition between providers and higher involvement of commercial actors in healthcare provision, for instance, undermines the capacity of the system to respond to pandemics, this has to be treated as a human rights problem.[102]

This concerning trend does not apply only to Italy. Human rights treaty bodies increasingly recognise that private actors' involvement in healthcare posits several risks to the enjoyment of the right to health.[103] For example, the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW) has urged State Parties to: 'monitor the privatisation of health care and its impact on the health of poor women and provide such information in its next periodic report.'[104]

As a final remark, this analysis also shows that human rights experts working on the right to health cannot refrain from questioning public health policies from a human rights perspective, including using a systemic perspective and scanning organisational aspects, such as what

[101] GI-ESCR, *supra* at note 94.
[102] The Global Initiative for Economic, Social and Cultural Rights (GI-ESCR), "Submission to the UN Committee on Economic, Social and Cultural Rights (CESCR) for the review of the sixth periodic report by Italy: For-profit actors' involvement in healthcare during the Covid-19 pandemic and its impact on the right to health in Italy" (August 2022) available online at: https://www.gi-escr.org/latest-news/gi-escr-submitted-a-report-to-the-un-committee-on-economic-social-and-cultural-rights-on-the-impact-of-private-actors-on-the-right-to-health-in-italy-during-covid-19.
[103] The Global Initiative for Economic, Social and Cultural Rights (GI-ESCR), "Compendium of United Nations Human Rights Treaty Bodies' Statements on Private Actors in Healthcare" (2021, accessed 23 April 2022) available online at: https://www.gi-escr.org/publications/compendium-of-united-nations-human-rights-treaty-bodies-statements-on-private-actors-in-healthcare. .
[104] CEDAW, "Concluding observations on the combined second and third reports of India" (2 February 2007) CEDAW/C/ IND/2-3.

services are being prioritised, to whom they are targeted and for what reasons. It is fundamental that human rights champions routinely analyse the health policy and norms against human rights obligations of states, including demanding detailed human rights impact assessments. It is not enough, for instance, to call for higher spending on healthcare services. Human rights theory and practice should scrutinise which services such money is being spent and assess such policy decisions against human rights obligations.

As the case study of Italy testifies, to protect populations' health from current and future epidemics, it is fundamental to have strong public healthcare services that have enough quality services for the whole population that cover a full range of services, including prevention, family medicine and outpatient medical care. Italy and other countries can build even stronger public healthcare services starting from the lessons learnt in this pandemic. This is a long-term journey that has to start now to protect populations' health and increase equality in access to healthcare services in the future.

FROM ADOPTION TO IMPLEMENTATION OF PATIENTS' RIGHTS IN INDIA: INSIGHTS FROM THE COVID-19 PANDEMIC EXPERIENCES WITH PRIVATE HOSPITALS

Shweta Marathe*

1. Introduction

"The only way to do the human rights thing is to do the right thing medically. So, I can't show you how health care is a basic human right. But what I can argue is that no one should have to die of a disease that is treatable"-Paul Farmer.

As expressed in Farmer's quote, just as health rights are vital to ensure that quality healthcare is available, accessible, and affordable to everyone, patients' rights are essential to safeguard their interests while receiving healthcare services. The discourse on achieving health rights is not new. But, the Covid-19 pandemic has accentuated this agenda and underscored the importance of patients' rights, given the numerous complaints, including denial of care and excessive charging for health care in private hospitals during the pandemic.[1] Due to a weak patients' rights protection system, infringements became much more prevalent during the pandemic. Three factors were key: an under-resourced public health system, a weakly regulated and highly commercialised private health sector and dysfunctional grievance redressal mechanisms for patients.

The pandemic severely strained health systems worldwide, with an unprecedented increase in demand for health services since the first wave was announced in March 2020. While the second wave was more damaging, India had the world's Second-Worst Covid-19 pandemic.[2]

* Institutional affiliation- SATHI, Address- Aman E Terrace, Lane Number 20, Chandralok Nagari, Dahanukar Colony, Kothrud, Pune, Maharashtra 411038 Phone No. +91 20 25473565
Author's email- shweta@sathicehat.org

[1] In this paper, the term private hospitals refer to a range of private clinical establishments, including small clinics, maternity homes, corporate hospitals, and charitable trust hospitals, given the heterogeneity of private healthcare providers.

[2] Perrigo B. Officially, India Has the World's Second-Worst COVID-19 Outbreak. Unofficially, It's Almost Certainly the Worst. *Time*, April 14, 2021. https://time.com/5954416/india-covid-second-wave/

So far, according to officially reported data, there have been 5.21 lakh Covid-19 deaths in India,[3] but even these high figures are widely contested as an underestimation.[4]

While the public health system has weakened over the years from decades of neglect, the private sector has burgeoned with the increasing policy-level push for privatisation. The data of India's public and private sectors show obvious inequity in the distribution of health services, with most services concentrated in the private sector.[5] Currently, the public sector in India has 25,778 hospitals and 713,986 beds, while the private sector has an estimated 43,487 hospitals with 1,185,242 beds.[6] Due to the shortage of infrastructure, many patients during the pandemic were denied free health care in the public health system. As a result, both the middle class and the poor sections of society were compelled to seek costly healthcare from private hospitals.

In response to the spike in Covid-19 cases, various Indian states requisitioned the private sector to increase their capacity. Due to complaints of overcharging for Covid-19 treatment by private hospitals, some federal governments imposed a rate regulation. However, in the absence of a larger framework for the regulation of the private sector and for adopting health care as a fundamental right, the implementation of the states' Covid-19 specific regulatory measures largely faltered, allowing many private hospitals to seek profits, with severe consequences for patients and their rights.

This paper aims to critically examine government regulatory measures with the private sector during the Covid-19 pandemic, focusing on the implementation of the adopted patients' rights in Maharashtra state, India. While it is noted that patients' rights violations were prevalent in both public and private hospitals during the pandemic, this paper focuses on private hospitals for three reasons: a. private hospitals took on a significant proportion of the Covid-19 caseload in India due to their prominent presence. b. innumerable reports on widespread treatment denials, heavy deposits and excessive billing from private hospitals. c. the absence of a legally

[3] Government of India. Ministry of Health and Family Welfare, (accessed on 30 March 2022) online at: https://www.mohfw.gov.in

[4] Covid-19 Excess Mortality Collaborators (2022). Estimating excess mortality due to the Covid-19 pandemic: a systematic analysis of Covid-19-related mortality, 2020–21. *The lancet*.p.1

[5] Kapoor Gitanjali et al. *State-wise estimates of current hospital beds, intensive care unit (ICU) beds and ventilators in India: Are we prepared for a surge in Covid-19 hospitalisations?* (2020). Washington D. C. and New Delhi.

[6] *Ibid.*

backed accountability framework as well as ineffective grievance redressal mechanisms for complaints concerning private hospitals.

The paper delves into the implementation of the charter of patients' rights during the pandemic by providing an analytical overview of the following four areas:

- First, a brief background of India's differential private healthcare sector and the rationale and perspective related to the need to adopt patient rights in India.
- Second, the government's Covid-19 specific regulatory measures over the private sector and the private sector's response to these measures.
- Third, patients' rights violations experienced by patients during the pandemic in Maharashtra state.
- Forth, the current status of grievance redressal mechanisms and regulatory legislation in India and lessons learnt from the pandemic.

2. A Brief Background to the Private Health Sector in India

The private sector dominates India's plural health system, which has expanded in recent decades. Nearly 70% of all patients in India are treated in the private sector. According to the 75th National Sample Survey Office conducted in 2017 – 2018, 58% of all inpatients are hospitalised in private hospitals;[7] 90% of all allopathic doctors[8] and around 80% of nurses are engaged in private health care. The unaffordable costs of privatised healthcare in India are estimated to push 55 million people into poverty yearly. The average price of healthcare in India has tripled between 2005 and 2015 due to unregulated private healthcare expenditure.[9]

In the last few decades, India has become a favourable destination for private investment companies. Foreign investment in the hospital sector in India increased from merely Rs 31 crore in 2001– 02 to Rs 3995 crore in 2013–14, an over one hundred-fold increase in little more than a decade.[10] The overall healthcare market in India was estimated to be $100 billion in

[7] National Sample Survey Organization (NSSO), NSO, MoSPI (2020). Health in India. Report No. 586 on Social Consumption of Health Survey (NSSO 75th Round, 2017- 18.

[8] Chethankumar. (2018, Dec25). Healthcare for poor: only 1 in 10 doctors join government hospitals. *Times of India.*

[9] Sundararaman T. Falling Sick, Paying the Price (2015). *Economic & Political Weekly*, Vol. 50, Issue No. 33. P. 41

[10] Hooda, S.K. Foreign Investment in Hospital Sector in India: Trends, Pattern and Issues. (2015) Working Paper No. 181, Institute for Studies in Industrial Development, New Delhi

2015 and was projected to grow to $280 billion by 2020, with an annual growth rate of 22.9%.[11] As the policy environment favours foreign investments in health care, national policies have fiercely encouraged privatisation by increasing private sector investment and engagement in delivering health care services in the country. While promoting privatisation, the government has tended to overlook the ramifications of the commercialisation of healthcare, which result in irrational care, malpractices, overcharging, and many other ills.[12]

The need for private health sector regulation does not seem to get adequate policy attention. The Union Ministry passed the Clinical Establishment Act (CEA) in 2010; however, it has been experiencing a regulatory stalemate for nearly a decade now in most states.[13] A recent report by NITI Aayog in 2020[14] (National Institution for Transforming India; a public policy think tank of the government of India) on investment opportunities for the private sector strongly endorses privatisation, but it neither mentions the perils of the private sector nor highlights the need for its regulation.

3. Adoption of Patients' Rights Charter in India

3.1. Rationale and Perspective for Patients' Rights

In 1981, the World Medical Association adopted the first declaration on patient rights.[15] Since then, there has been growing consensus at the international level that all patients have some fundamental rights and that patient rights are human rights. Physicians', health care providers', and the State's obligations to the patient have shaped the Patients' Rights Charter (PRC) in various contexts. Knowledge asymmetry and power relations between patients and healthcare providers make it even more essential to ensure that patients are entitled to specific amounts of protection from physicians, health care providers, and the State.[16] The right to health means everyone should have access to the health services they need, when and where they need them, without suffering financial hardship. No one should get sick and die just because they

[11] Sectoral Report Healthcare," India Brand Equity Foundation, (2017). accessed on 5 March 2018 https://www.ibef.org/industry/healthcare-india.aspx

[12] Marathe S. Regulation for profit private healthcare sector India: whose voices are being heard? (2020). SHAPES featured article series. International Health Policies.

[13] Shukla Abhay et al. Analysing regulation of private healthcare in India, (2021). *Oxfam, India*.

[14] NITI Aayog. Investment opportunities in healthcare, (2021). Government of India. Government of India.

[15] WMA Declaration of Lisbon 1981, 2015 (last version) accessed at 11 March 2022. online on: http://www.wma.net/en/30publications/10policies/l4/

[16] Bloom Gerry Et al. 'Markets, Information Asymmetry and Health Care: Towards New Social Contracts', (2017) Social Science & Medicine 66.10: 2076–87

are poor or cannot access the health services they need. The government is primarily responsible for ensuring everyone's right to health. "The right to the highest attainable standard of health" implies a clear set of legal obligations on States to ensure appropriate conditions for the enjoyment of health for all people without discrimination. A patient's right, however, is more than a set of entitlements. It is also a regulatory tool for the interaction between hospitals and patients and for health care delivery.

The current human rights framework does not explicitly address the for-profit private health sector and infringement of patients' rights, which may be the reason for limited discourse on the responsibility of private hospitals in advancing the right to health.[17] Currently, in India, State regulation of the private sector is nearly non-existent, and self-regulation appears to have largely failed. In such a situation, it becomes difficult for people to ask for basic entitlements like standard rates, information on schemes or treatment, medical records etc. Making such complaints or approaching grievance redressal in the context of private hospitals is far more challenging than in public hospitals. Additionally, existing grievance redressal mechanisms suffer from elite capture and lack a pro-people approach in their functioning, in the context of private hospitals.[18] Given the dominant presence of the private sector in many countries, its commercialised practices, and its serious consequences for patients, the rights of patients must be protected with a legal tool. As such, the right to health care will be inadequate without commensurate rights for patients and users of the public and private health sectors.

3.2. Adoption of Patients' Rights Charter

The National Human Rights Commission (NHRC) adopted India's Charter of Patients' Rights in 2019.[19] The process was galvanised after the NHRC and People's Health Movement – India had collaboratively organised a public hearing on the Right to Health Care in January 2016. During the hearing, the NHRC did not hear cases related to private hospitals, citing its lack of legal jurisdiction over the private medical sector; however, the Commission took serious note of the failure of the medical councils, lack of regulatory framework for private

[17] COPASAH. *Ensuring patients' rights as a core strategy for demanding social accountability of the private healthcare sector.* 2019. COPASAH Thematic Hub on Accountability of Private Medical Sector. P. 1
[18] A. Shukla Abhay et al. Making private health care accountable: Mobilising civil society and ethical doctors in India. (2018) IDS Bulletin, 49 (2), p. 141
[19] National Human Rights Commission. PRC. (accessed on 30 March 2022). Online on https://nhrc.nic.in/document/charter-patient-rights

hospitals, and the absence of a grievance redressal mechanism for patients.[20] Subsequently, the NHRC adopted a PRC, which applies to all public and private hospitals. This charter draws upon various legal provisions related to patients' rights, which are scattered across different legal documents, e.g. The Constitution of India, Article 21, Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002, The Consumer Protection Act 1986; Drugs and Cosmetic Act 1940, Clinical Establishment Act 2010 and rules and standards framed therein; various judgments given by Hon'ble Supreme Court of India and decisions of the National Consumer Disputes Redressal Commission. In August 2018, the Ministry of Health and Family Welfare (MoHFW) released India's first Patients' Rights Charter (PRC) with recommendations from the NHRC.[21] The MoHFW urged state governments to adopt the PRC through a letter in June 2019. Maharashtra adopted it during the pandemic in November of 2021 and is reportedly the first state to do so.

Although the adoption of the PRC in India is significant, without its effective implementation, it has limited value, and the pandemic sharply exposed PRC's still pending implementation. While private hospitals' significant contribution to combating Covid-19 care is undeniable, their widespread regressive practices during the humanitarian crisis, with severe implications for patients' rights, also cannot be ignored. Therefore, it is relevant to bring to light the status of patients' rights during the pandemic while understanding the efficacy of the government's regulatory measures.

4. Government Measures in Response to the Covid-19 Pandemic

In the initial phases of the Covid-19 pandemic in March 2020, public health responses were essentially (with some notable exceptions) biosecurity-focused, authoritarian, command-control over populations in some countries, and laissez-faire responses leaving people to make individual choices in others.[22] However, some countries or local settings,[23] including many states in India, charted paths outside the conventional public health system governance network. This section examines the government's response to health rights related challenges

[20]Shukla Abhay et al. Making private health care accountable: Mobilising civil society and ethical doctors in India, (2018). *IDS Bulletin*, 49 (2) (2018), pp. 1-16

[21]Singh & Associates. India: Ministry of Health Releases First Patient's Charter In the Country 22 October 2018. https://www.mondaq.com/india/healthcare/747800/ministry-of-health-releases-first-patients-charter-in-the-country.

22 Bhaduri, S. D. (2020). The criticality of community engagement. The Hindu. https://www.thehindu.com/opinion/lead/the-criticality-of-community-engagement/article31264494.ece

[23] Clark, D., Hellowell, Mark., and O'Hanlon B. All hands-on deck: mobilising the private sector for the Covid-19 response (2020). UHC2030.

posed by the pandemic at two levels: (1) the NHRC issuing an advisory on the right to health, and (2) engaging with and steering private hospitals to ensure the provision of Covid-19 care for people.

4.1 Advisory on the Right to Health

Keeping in view the situation in the country due to the Covid-19 pandemic and the urgency of redressal issues related to human rights violations like denial of the right to access to healthcare etc., the NHRC issued an advisory on the Right to Health[24] and expected states to follow it, to protect the human rights of patients, and the public in general, by ensuring that they had access to the necessary healthcare. This advisory also mentioned a specific clause on display and observance of the PRC in each health facility, whether public or private.

4.2 Engaging with Private Hospitals

Given the limited capacity of the public health system, different state governments engaged with non-state actors to deliver health interventions during the Covid-19 epidemic. The state governments had expanded their governance strategy with two key actors: civil society and private health care. Regarding the private sector, several states took unconventional steps to increase states' capacity and meet public health exigencies by requisitioning private hospitals as designated Covid-19 treatment centres, taking over private hospitals, and issuing orders to private hospitals to reserve 20%-80% of beds for Covid-19 patients.

Initially, many small to medium-sized private hospitals closed down or were reluctant to provide care for Covid-19 patients. Conversely, corporate hospitals[25] and corporate diagnostic chains pursued profit maximisation, charging exorbitantly for Covid-19 treatment and tests.[26] In response to many patients' complaints about private hospitals, concerning the denial of treatment, overcharging etc., around fifteen Indian states took an exemplary decision to regulate rates of Covid-19 treatment in private hospitals.[27] This decision stands out against the

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[24]National Human Rights Commission. Advisory on the right to health in the context of Covid-19. Accessed at 31 March 2022. Online at: https://nhrc.nic.in/reportsrecommendations/human-rights-advisory-right-health-view-second-wave-covid-1pandemic.

[25] Nathanael, NM. *Profiteering during a pandemic.* The Hindu. (2020, April 30).

[26] Torgalkar V. *Covid-19: Maharashtra Pvt Hospitals Charge Exorbitantly from Patients Despite State Govt.* Newsclick. *(26* May 2020).

[27] Bhuyan, A. *Exorbitant' Covid-19 Treatment Prices Slashed as State Governments Step Up* Indiaspend. (2020, Aug 4). https://www.indiaspend.com/exorbitant-covid-19-treatment-prices-slashed-as-state-governments-step-up/

backdrop of lax state regulation of the private sector, bringing this much-contested issue back to the fore. This was done by invoking the Disaster Management Act of 2005 and the Epidemic Disease Act of 1897, and in a way, enforcing the public obligations of private healthcare providers to ensure private hospitals mandatorily treated Covid-19 patients.

In short, even without the adoption of health rights in India, the government was forced to take responsibility for people's health and provide Covid-19 care. Moreover, the government was obliged to regulate commercialised private hospitals, as they could no longer be left to their ways and were required to fulfil important public obligations.

5. Response of Private Hospitals to Government Regulatory Measures

Although the government's pandemic-specific directives were welcome, private hospitals did not fully align due to the lack of a broader accountability framework. Despite state orders, patients' hardship while seeking healthcare continued in terms of overcharging and denial of care to Covid-19 positive patients by private hospitals.

The state-imposed decision of rate regulation on Covid-19 treatment was met with resistance by many private providers and their associations. Some doctors expressed that the government decided rates of Covid-19 treatment were not viable and could severely impact the cash flow, especially as 50%-80% of the sector's costs are fixed. [28]

As a result, many private hospitals continued to indulge in exploitative and unethical practices, including excessive charging, non-transparency in treatment and billing, not informing patients about rate regulation and public schemes, demanding hefty advances and denying admission without advance payment etc.[29] Such practices were a manifestation of widespread commercialisation, business-driven strategies, and weak regulatory mechanisms, indicating how the profit motives of private hospitals prevail over their public obligations even in a time of crisis.

[28] Financial express. *Covid-19 may affect free cash flows of health sector*. (2020, April 10).
[29] The times of India. *Maharashtra: Covid patients' kin complain of inflated hospital bills, lack of subsidised treatment*. (6 Feb 2021).

6. Patient Rights Violations in Private Hospitals During the Covid-19 Pandemic

As mentioned before, violation of health rights or patients' rights is not a new phenomenon in India. However, it came to the fore during the pandemic. Innumerable patients had to face the double whammy of the pandemic as they were faced with the disease and the choice between ill-equipped government hospitals and expensive, non-transparent private hospitals. Many families were burdened with the loss of loved ones, and their misery was further compounded by running into debt due to heavy bills charged in private hospitals.

The violations of patients' rights are drawn from three sources of information: (1) findings from a survey conducted in September 2021 by two large voluntary networks[30] in Maharashtra state, which collected data from families of 2579 patients who had undergone treatment for Covid-19 in various hospitals across Maharashtra, and who had encountered excessive billing; (2) The a compendium[31] titled '*Patients' Voices during the Pandemic: Stories and Analysis of Rights Violations and Overchargi ng by Private Hospitals*.' It compiles 23 testimonies from patients or their kin from October to December 2020, documenting price gouging by private hospitals in Maharashtra, demonstrating the blatant disregard of government price capping by hospitals and the total inadequacy of regulatory bodies to enforce them; and (3) the most expansive source is media reports[32,33,34,35,36,37] from various Indian states.

There are 17 rights included in India's PRC, of which the following patients' rights were frequently violated during the pandemic.

- *Right to emergency medical care*

[30] Shantha S. *Maharashtra Survey Finds Private Hospitals Routinely Overcharged Covid-19 Patients*. The wire Oct 2021.

[31] Marathe S, Bhalerao S, Pawar K, Kakade D and Shukla A (March 2022). Patients' voices during the pandemic: Stories and analysis of rights violations and overcharging by private hospitals. Compendium. SATHI, Pune.

[32] Ghosh S. *Private hospitals charging hefty fees, claim kin of Covid-19 patients.* The Indian express. (26 May 2020).

[33] The Tribune. *Hospitals making Covid afflicted to pay through their nose.* (24 May 2021)

[34] Singh S. *Surviving Covid 19, A Fire 2 Hospitals and a struggling system: A patient speaks*. Wire. (16 June 2020)

[35] Shah A. *Delhi Private hospitals flout government rates, make hay out of Covid-19 crisis*. Federal. (20 July 2020)

[36] Banerjee S. Bengaluru Private Hospitals Violate Govt Rules; Charge Exorbitant Prices for Covid-19 Tests. Rublicworld.com. (May 2021)

[37] Businessline. *West Bengal caps Covid-19 treatment costs at private hospitals. (26 June2020)*

- *Right to information*
- *Right to records and reports*
- *Right to informed consent*
- *Right to safety and quality as per standards*
- *Right to transparency in rates and care*
- *Right to be discharged, right to receive the body of a deceased person from the hospitals*
- *Right to human dignity*
- *Right to be heard and seek redressal*

Despite the rate regulation by various Indian states, most private hospitals defied government rate regulations and overcharged the patients. According to the survey in Maharashtra,[38] out of the total sample of 2579 patients, 75% of patients had experienced overcharging, compared to the official rates, which should have been charged as per regulations. Besides excessive charging, private hospitals continued to refuse admission without advance payment, ripping patients off with unnecessary treatment, denying health insurance coverage, detaining dead bodies unless bills were settled, and so on, violating patients' fundamental rights.

The right to emergency medical care clause states that '*such care must be initiated without demanding advance payment, and the patient's primary consideration should be provided irrespective of paying capacity. The hospital management must ensure the provision of such emergency care through its doctors and staff, rendered promptly without compromising the quality and safety of the patient*s'. Some hospitals advised patients to step in only if they could pay the fat deposit. Patients with cashless private insurance were also required to pay a deposit. Although a few state governments issued a notice that private hospitals would be penalised if deposits were collected for admission, they continued to charge patients for deposits. Patients were charged hefty advance payments ranging from Rs. 30,000 to 4 lakhs, and failure to pay it led to the denial of healthcare. Such denials in a crisis violate not just the right to emergency care as part of the patients' rights but also human rights.

According to the charter, '*every patient has a right to adequate, relevant information about the nature, cause of illness, provisional or confirmed diagnosis, proposed investigations and*

[38] Shantha S. *Maharashtra Survey Finds Private Hospitals Routinely Overcharged Covid Patients*. The wire Oct 2021

management, and possible complications. This information should be explained at their level of understanding in a language known to them. The treating physician must ensure that this information is provided in simple and intelligible language to the patient to be communicated personally by the physician or using their qualified assistants'. However, it was observed that patients were often faced with an information deficit, as many hospitals failed to inform patients or their next of kin regarding the line of treatment, relevant health schemes of the government, or state orders on rate capping for Covid-19 treatment.

Most of the patients' relatives complained of not receiving accurate information about the line of treatment and timely updates on the condition of patients. Lack of transparency in medicine, investigations, and billing was also prevalent. Additionally, the procedure of consent-taking was also neglected in some cases. While consent for medical procedures was primarily obtained from relatives, in most instances, the signature on the consent form was taken in a hurry without informing them about the government notification of rate capping on Covid-19 treatment.

The rights to obtain medical records, all bills, to be discharged and to receive the body of a deceased person from the hospitals were also denied. In the case of some patients, hospitals conducted Covid-19 tests but never shared test reports with them or did not inform them about the positive test results. Many patients never received medical reports, diagnostic test reports, or discharge summaries after medical discharge. In some cases, discharge or handing over the deceased patient's body was withheld unless the entire bill was paid, constituting an infringement of patients' rights and a reflection of inhuman treatment at private hospitals.

The right to safety and quality care according to standards is another fundamental right expected to be realised by hospitals. As per the charter, '*Patients have a right to receive quality health care according to currently accepted standards, norms and standard guidelines as per National Accreditation Board for Hospitals (NABH) or similar.'* Private hospitals are widely perceived to be of good quality with better infrastructure and facilities than public hospitals. It is believed that even though patients have to pay more in a private hospital, suitable treatment is assured. However, after several patient complaints regarding private hospitals' safety and quality of medical care, this assumption needs to be re-examined.

As the charter states, '*the hospital management must ensure that its staff upholds the human dignity of every patient in all situations*.' Hospital staff's rude and disrespectful behaviour was

a common issue that undermined patient dignity. In some cases, during the entire episode of hospitalisation, doctors interacted with patients to only convey bill amounts. Such instances are not just concerned with patients' rights but also affect the doctor-patient trust relationship. While the medical fraternity is highly revered and placed on a high pedestal by society, such experiences as gaps in doctor-patient communication, callous attitude, rude behaviour toward patients and relatives, etc., would have a detrimental effect on the doctor-patient relationship.

With respect to the right to be heard and seek redressal, the situation appears to be grim for patients. In light of many complaints of overcharging by private hospitals, the Maharashtra state government formed committees for grievance redressal in some cities to address patients' grievances. However, most people lacked information about where to seek justice. The government fell short in publicising such critical information widely. In general, the lack of public awareness of such spaces for grievance redressal seems to be another bottleneck.

7. Current Status of Grievance Redressal for Patients and Accountability of the Private Sector

7.1. A Poor State of the Grievance Redressal Mechanisms

The issue of where to seek justice is not confined to the pandemic but has existed for decades. The implementation of patients' rights is incomplete without effective, patient-friendly and accessible mechanisms for grievance redressal. Given the nature and status of current grievance redressal mechanisms, ordinary patients have no effective means to ensure redressal except through a prolonged, gruelling process with few tools at their disposal. Even then, outcomes often turn out in favour of the doctors. Although the Consumer Protection Act (CPA) 1986 is an essential law that can cover grievance redressal of patients, this option is riddled with limitations because it considers patients as consumers and health care as a service, thus departing drastically from the understanding of health care as a human right. Though violations of patients' rights are wide-ranging, medical negligence is the only thing that has been legally articulated so far, that too in its narrowest sense, viz. 'deficiency' of service under the CPA. [39]

Besides CPA, State Medical Councils (SMC) are the State's most crucial quasi-judicial body for patient redressal in medical negligence and violation of patients' rights. The SMC determines whether a complaint is relevant or not. If the patient is not satisfied with the decision

[39] Pinto P et al. Politics of Evidence and Right to Health Care in India. (2018). *Arch Health Sci;* 1(1): 102.

of the SMC, they can apply to the Medical Council of India (MCI). Cases deemed genuine with valid documentation are then submitted to a ten-member executive committee, which takes the final call. The Committee decides if the doctor is guilty of misconduct, and the appropriate penalty, such as suspension of license (permanent/temporary), warning etc., is declared. Seven hundred cases were pending with the SMC till 2019 (100-125 complaints per year),[40] which depicts the poor functioning of this body.

Along with massive delays in proceeding with the cases, the functioning of SMCs appears biased as cases are heard by a disciplinary committee consisting of only medical professionals.[41] Thus, the committee members tend to lean favourably toward the doctors. Anecdotal reports suggest that complainants' experience of SMC hearings is unfriendly and even downright hostile. Also, there is no system to help patient victims with hearings – no patient advocates. Overall, the current medico-legal ecosystem is ineffective for protecting patient rights, as it remains dominated and influenced by the interests of powerful lobbies of medical professionals, lacks multi-stakeholder bodies for grievance redressal of patients, is commercially propelled and generally unregulated, and is not held accountable to the medical profession.

7.2. Regulation and Accountability of the Private Sector

Regarding accountability of the private sector, indeed, the enactment of the Clinical Establishment Act (CEA) in India is a milestone. The Act is essential for regulating private hospitals and bolstering the implementation of the PRC. The parliament passed the CEA in 2010 to introduce quality standards and control the cost of healthcare in private healthcare facilities across India. However, only 11 states and six union territories have adopted it in over a decade. CEA 2010 is a legal instrument for regulating private hospitals.[42] However, a lack of support from state governments and stiff resistance from medical professional groups have slowed its adoption and implementation. It may be relevant to examine if state regulatory orders and patient rights were better complied with in states that have already adopted CEA compared to states that have not yet adopted it.

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[40] Shelar J. T*wo years on, negligence case comes up for first hearing.* The Hindu (20 May 2019)
[41] Pinto P et al. Politics of Evidence and Right to Health Care in India. (2018). *Arch Health Sci;* 1(1): 102.
[42]Shukla Abhay et al. Analysing regulation of private healthcare in India, (2021). *Oxfam, India.*

8. Learning from the Pandemic

The pandemic has made us realise the importance of protecting patient rights and the need to follow through with the PRC like never before. It revealed that even where the PRC has been adopted, it still falls short in implementation. Though the state government involved private hospitals and steered them through rate capping on Covid-19 treatment to deal with the pandemic crisis, private hospitals managed to circumvent Covid-19 specific measures due to the absence of a larger and legally backed accountability framework. NHRC advisories on health rights also remained largely neglected as the right to health care is probably not formally recognised in India as a fundamental right. Consequently, despite the adoption of PRC by the union ministry, many profit-driven private hospitals violated it.

As a way forward, it is essential to build a discourse for promoting patients' rights, advocate for improving the implementation of PRC, generate public awareness related to PRC, and build an effective grievance redressal mechanism for ensuring justice for people, using evidence from people's experiences with private hospitals during the pandemic. Unless these steps are taken, ensuring patients' rights will remain half-done. Also, the accountability framework for the private sector must be devised to tackle the deeper issue of inadequately regulated private hospitals. Such a framework will help enforce patient rights implementation; further, the PRC can potentially galvanise the process for adopting health rights. Adopting and implementing existing CEA by various Indian states may also foster the implementation of the PRC. As indicated through peer reports, some Indian states, such as Rajasthan,[43] Kerala and Tamil Nadu, have already initiated the process for health rights.

In conclusion, there is a need to move from adoption to effective implementation of patient rights, augmented by strengthening grievance redressal mechanisms and bringing social accountability and regulatory mechanisms to private hospitals. This is imperative for the effective engagement of the private healthcare sector in achieving Universal Health Care (UHC) and ultimately assuring the right to health services that are equitable and affordable. Overall, it is essential to build a discourse and advocacy for a conducive policy environment among policymakers, government officials, medical practitioners, and civil

[43]Rajasthan Assembly refers Right to Health Bill to select committee https://www.business-standard.com/article/current-affairs/rajasthan-assembly-refers-right-to-health-bill-to-select-committee-122092400023_1.html accessed on 19 October 2022

society organisations that acknowledge patients' rights and support endeavours to promote, protect, and fulfil health rights.

IMPLICATIONS OF COVID-19 ON THE RIGHT TO HEALTH IN KENYA: GOVERNMENT'S SCORECARD

Derrick Kimani*

1.0 Introduction

The right to health is a fundamental human right and has been recognised as a prerequisite for enjoying the other rights and fundamental freedoms in the Bill of rights.[1] Put differently, the right to health is a foundation of the other rights in the Bill of rights.[2] This right is provided under Article 43(1) of the Constitution of Kenya 2010 and also finds a basis in applicable regional and international law. Article 16 of the African Charter on Human and Peoples' Rights (The Banjul Charter) proclaims that "every individual shall have the right to enjoy the best attainable state of physical and mental health." In addition, the Banjul Charter requires State parties to "…take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick." Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) provides that "The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

Although the Constitution does not define what this right entails, the United Nations (UN) Committee on Economic, Social and Cultural Rights in General Comment No. 14 on the right to the highest attainable standard of health defined the right to include the deliverables related to health such as hospitals, medicines, equipment and also the other factors that help citizens to maintain healthy bodies such as food, water, shelter, clean environment. Further, the right has been said to entail four (4) elements, i.e., Availability, Accessibility, Acceptability and Quality.[3] Article 21 of the Constitution of Kenya imposes on the State the obligation to observe, respect, protect, promote and fulfil the rights in the Bill of rights. Therefore, realising the right to health would entail obligations on the State to prevent, treat and control endemics.

* LLM, International Humanitarian Law and International Human Rights Law, Geneva Academy; LLB, Moi University.

[1] *MMM v Permanent Secretary, Ministry of Education & 2 others [2013] eKLR* Paragraphs 14-20 and the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (Principles 8, 21-24).

[2] *Ibid.*

[3] General Comment No. 14, Para 12.

Additionally, General Comment No 14 provides in Paragraph 37 that "State parties are also obliged to fulfil (provide) a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realise that right themselves by the means at their disposal."

This paper examines the responses by the Government of Kenya to the spread of Covid-19 and the implications of those responses on the right to health. While assessing the government's performance on these obligations, this paper will also consider the jurisprudence that emerged from the High Court when some government measures were challenged. Some of the measures discussed in the paper are the curfew order, the contingency plan, quarantine, provision of protective gear to healthcare providers and vaccination. The author will also highlight some court decisions during the pandemic.[4]

1.1. The Kenya Government's Anti-Covid-19 Measures and Their Implications

1.1.1. Curfew

In Kenya, from 3 January 2020 to 24 August 2022, there were 338,061 confirmed cases of Covid-19, with 5,673 deaths reported to WHO.[5] This deadly virus tested the limits of the Kenyan healthcare system. Upon discovering the first Covid-19 case in Kenya, the government introduced various measures to control the virus's spread.[6] It enforced restrictions on movement (curfew orders) using the Public Order Act and established health rules under the Public Health Act.[7] The Curfew Order restricted population movement between 1900 and 0400 hours, and the Health Rules stipulated regulations relating to issues such as social-distancing

[4] *Okiya Omtatah Okoiti & 2 others v Cabinet Secretary, Ministry of Health & 2 others*; *Kenya National Commission on Human Rights (Interested Party) [2020] eKLR*; *Law Society of Kenya v Hillary Mutyambai Inspector General National Police Service & 4 others*; *Kenya National Commission on Human Rights & 3 others (Interested Parties) [2020] eKLR* and *Law Society of Kenya & 7 others v Cabinet Secretary for Health & 8 others*; *China Southern Co. Airline Ltd (Interested Party) [2020] eKLR*.

[5] WHO Health Emergency Dashboard, https://covid19.who.int/region/afro/country/ke (accessed 24.08.2022)

[6] Republic of Kenya Ministry of Health, FIRST CASE OF CORONAVIRUS DISEASE CONFIRMED IN KENYA, https://www.health.go.ke/first-case-of-coronavirus-disease-confirmed-in-kenya/#:~:text=Port%20Health%20Services-,FIRST%20CASE%20OF%20CORONAVIRUS%20DISEASE%20CONFIRMED%20IN%20KENYA,in%20China%20in%20December%202019., (accessed 24.08.2022)

[7] Republic of Kenya, Kenya Public Order Act; Republic of Kenya, Kenya Public Health Act, No 21.

requirements and the disposal of bodies of people who died or were suspected of having died of Covid-19 complications.[8]

The constitutionality of the Curfew Order[9] was, however, shortly after challenged in court on the grounds that it was 'illegal, illegitimate and unproportionate' and 'blanket in scope and indefinite in length.'[10] It was also argued that the curfew did not demonstrate what legitimate public health or other interest it sought to achieve.[11] The fact that the State did not declare a State of Emergency under Article 58 of the Constitution was also raised as an issue.[12] The Court upheld the legality of the Curfew and found that the Curfew Order's purpose of restricting contact between persons to slow the spread of Covid-19 was legitimate.[13]

As a State Party to the Constitution of WHO, Kenya is bound by this document, whose objective is the attainment by all people of the highest possible level of health. The WHO has the following functions relevant to the present measure, to act as the directing and coordinating authority on international health work; to stimulate and advance work to eradicate epidemic, endemic and other diseases, to public conventions, agreements and regulations and to make recommendations concerning international health matters.[14]

Article 21(a) and 22 of the WHO Constitution empowers the World Health Assembly (WHA) to adopt regulations designed to prevent the international spread of disease. Once adopted by the Health Assembly, the regulations enter into force for all WHO members states that do not affirmatively opt out of them within a specified time. Having been a dopted by the 58th World Health Assembly on 23 May 2005, the International Health Regulations (2005) entered into force on 15 June 2007.

The purpose and scope of the health regulations are "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are

[8] Legal Notice 36 of 2020, Public Order (State Curfew) Order; Public Health (Prevention, Control and Suppression of Covid-19) Rules of 2020; Public Health (Restriction of Movement of Persons and Related Measures) Rules.
[9] The Public Order (State Curfew) Order, 2020.
[10] *Law Society of Kenya v Hillary Mutyambai Inspector General National Police Service & 4 Others; Kenya National Commission on Human Rights & 3 Others (Interested Parties) [2020] EKLR*, para 127
[11] *Ibid*, paras 11-14.
[12] *Ibid*, para 14.
[13] *Ibid*, para 132. The Court initially found that the Curfew Order failed to comply with the Public Order Act in that it initially failed to indicate the authority or person to grant written permit for persons who for good reason cannot remain indoors during the curfew hours; but this was later amended to comply with the Public Order Act
[14] Constitution of the World Health Organisation, Article 2.

commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."[15]

While the curfew was upheld, the learned judge was keen to note that the main problem with the Curfew Order was not the order itself but the manner in which it had been implemented.[16] Police officers abused their power and used excessive force when implementing Covid-19 directives, resulting in massive human rights violations. For instance, the Kenya National Commission on Human Rights (KNCHR) noted the use of force was against the standards set out in Section 61 (2) and the sixth schedule of the National Police Service Act advisory issued by special procedure mandate holders[17] calling on law enforcement agencies against use of arbitrary deprivation of life and use of torture and inhuman and degrading treatment. Further, the mandate holders recognised that breaking curfew or restriction of movement could not justify the use of force by the police.[18]

The President issued a public apology for the excessive use of force by the police officers. Additionally, the Cabinet Secretary in charge of the Ministry of Interior and Coordination of National Government and the Inspector General undertook to hold the concerned officers accountable. Nevertheless, KNHCR continued to receive complaints of brutality and human rights violations.[19]

However, there was some good news—the six officers implicated in the brutal killings of Emmanuel Mutura and Benson Ndwiga were found and charged with the brothers' murders. On 1 August 2021, at Kianjokoma Center, the brothers were taken into custody for breaking the 10:00 PM to 4:00 AM curfew.[20]

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[15] The International Health Regulations (2005), Article 2.
[16] *Supra*, note 10 para 143.
[17] Special Rapporteurs and Independent Experts 2020.
[18] The *Law Society of Kenya v Hillary Mutyambai* case.
[19] Kenya National Commission on Human Rights, PAIN AND PANDEMIC Unmasking the State of Human Rights in Kenya in Containment of the Covid-19 Pandemic, https://www.knchr.org/Portals/0/Reports/KNCHR-Pain-and-Pandemic_Final%20Report.pdf?ver=2020-12-10-091017-467, (accessed 24.08.2022).
[20] Susan Kendi, Police officers involved in the death of Kianjokoma brothers to remain in custody, ICJ Kenya 17 August 2021, https://icj-kenya.org/news/police-officers-involved-in-the-death-of-kianjokoma-brothers-to-remain-in-custody/, (accessed 25.08.2022).

1.1.2. Contingency Plan

According to the WHO, contingency planning relies on the identification and monitoring of risks and capabilities to plan and implement measures that respond to the identified risks.[21] It is a model for handling emergencies.

The petitioners in the matter of *Law Society of Kenya & 7 others v Cabinet Secretary for Health & 8 others; China Southern Co. Airline Ltd* (Interested Party) [2020] sought an order of the court requiring the respondents to prepare a contingency plan and present it to court for scrutiny. The court was moved, and it granted conservatory orders in the form of a structural interdict compelling respondents to prepare and present a contingency plan on 28 February 2020.

Pursuant to the Protection of Rights and Fundamental Freedoms Practice and Procedure Rules (2013),[22] the respondents brought an application on 8 April 2020 asking the court to stay the implementation of the Conservatory Order issued in the form of structural interdict compelling the Cabinet Secretary for Health to prepare and present to the Court for scrutiny, a contingency plan on prevention, surveillance, control and response systems to coronavirus (Covid-19) outbreak in Kenya.

While upholding the order, the court directed that the contingency plan to be developed ought to comply with the WHO Guidelines on contingency planning as "identification and regular monitoring of risks, vulnerabilities and capacities (to) inform the planning and implementation of measures to mitigate the risks and preparedness to respond."

The Guidelines indicate the rationale for contingency planning in protecting public health as follows:

> "The goal of the WHO Health Emergencies Programme is to help countries coordinate international action to prevent, prepare for, detect, rapidly respond to, and recover from outbreaks and emergencies to reduce the mortality and morbidity of affected populations…. Understanding the risk that threatens people's health, planning to mitigate the impact, and preparing to respond can significantly save lives and preserve health and well-being. Thus, all WHO offices need to undertake, along with

[21] World Health Organisation, *WHO guidance for contingency planning*. Available at https://apps.who.int/iris/bitstream/handle/10665/260554/WHO-WHE-CPI-2018.13-eng.pdf.
[22] Legal Notice No. 117

governments, other UN agencies and partners, or alone if needed, regular strategic risks analysis and monitoring, and related contingency planning."

The contingency planning Guidelines outline the following steps:

a. Risk analysis
b. Risk mitigation
c. Preparedness actions
d. Contingency plan
e. Develop action plan
f. Testing and monitoring

Article 22(1)[23] requires "competent authorities" like the Kenyan Ministry of Health to have an effective contingency arrangement to deal with an unexpected public health event. Failure to do so would be a blatant and wanton disregard for the obligations under International Law.

The Court also issued an order preventing the Kenyan Government from letting into the country by air, sea and land any persons from China and or any other WHO-designated hot-spot country that is adversely affected by the Covid-19 outbreak, pending the hearing and determination of the Application.

Moreover, the court compelled the State to trace, account, re-examine, confine and quarantine in a Kenya Defence Forces (KDF) facility and or a specially guarded medical facility, all the 239 passengers that they let into the country 239 aboard a Chinese flight CZ 6043, which landed at Jomo Kenyatta International Airport (JKIA) on 26 February 2020 at 7:29 AM, until they were duly certified to be free from Covid-19, pending the hearing and determination of this matter.

1.1.3. Quarantine

Quarantine is the process of separating and restricting the movement of those people that have been exposed to contagious infections to determine if they fall sick.[24] In the matter of *Okiya Omtatah Okoiti & 2 others v Cabinet Secretary, Ministry of Health & 2 others; Kenya National Commission on Human Rights* (Interested Party) [2020] eKLR, the legality of self-sponsored compulsory quarantine was the subject. The 1st Petitioner and the Interested Party urged that Section 27 of the Public Health Act had been violated by the Respondents. They contended

[23] International Health Regulations, 2005.
[24] Centers for Disease Control and Prevention, *Quarantine and isolation* (2020). Available https://www.cdc.gov/quarantine/index.html.

that according to the Act, a person can only be isolated based on the opinion of a medical officer accompanied by an order of a magistrate and that the costs associated with the isolation were to be borne by the local authority of the district (the State) where the isolated person is found. Further, they contended that the quarantined persons were required to pay for their upkeep contrary to the law, which requires the State to foot their bills. A good number of individuals also had their period of compulsory quarantine extended unprocedurally and unfairly.

The court found that quarantining persons without an order from a magistrate and at their own cost violated Section 27 of the Public Health Act. With respect to a refund of the money paid for their upkeep, the court held that the prayer was neither pleaded nor proved. Thus, it proceeded to decline the prayer.

1.1.4. Provision of Protective Gear to Health Care Workers

Providing personal protective equipment (PPE) – masks, gloves, or overalls/gowns - to health care providers ensures the protection of their rights. This includes the 'right to life,' protected by Article 26 of the Kenyan Constitution and Article 6 of the International Covenant on Civil and Political Rights (ICCPR). The Constitution and ICCPR impose positive obligations on the State to take steps to protect the lives of those within their jurisdictions. Article 6 ICCPR requires States to undertake reasonable positive measures which do not impose on them impossible or disproportionate burdens in response to foreseeable threats to life[25]

A report by Human Rights Watch found that Kenyan authorities did not provide PPE to all health workers in time to prevent the spread of Covid-19 infections among them.[26] Doctors, nurses, and laboratory experts said that by the time the government finally made supplies available, around June in many parts of the country and July in others, only nurses and doctors in isolation wards received the equipment, mainly gowns, gloves and masks, which were of inferior quality. In an interview, one doctor said that healthcare workers were given one overall

[25] Communication No. 1862/2009, Peiris v Sri Lanka, Views adopted on 26 Oct. 2011, para. 7.2; African Commission on Human And Peoples' Rights Principles and Guidelines on The Implementation of Economic, Social and Cultural Rights In The African Charter On Human And Peoples' Rights, Right to Health, paras 60-67, https://www.achpr.org/public/Document/file/English/achpr_instr_guide_draft_esc_rights_eng.pdf, (accessed 24.08.2022).

[26] Human Rights Watch, *Kenya: Pandemic Health Workers Lack Protection* (2021). Available at https://www.hrw.org/news/2021/10/21/kenya-pandemic-health-workers-lack-protection.

and one mask to use for the whole day while one gown should be used per incident and masks are supposed to be changed regularly."[27]

1.1.5. Vaccination Against Covid-19

On 21 November 2021, Kenya's Cabinet Secretary for Health, Mutahi Kagwe, announced that authorities would require anyone seeking government services to provide proof of full Covid-19 vaccination. The affected services included: public transportation, education, immigration, hospitals, and prison visitation. Proof of vaccination would also be mandatory for entering national parks, hotels, and restaurants.[28]

At the time of the press release, only approximately 8.8% of Kenyans were fully vaccinated.[29] The directive that all persons be vaccinated by 21 December 2021 would deny over 24 Million Kenyans government services as well as the freedom of association and assembly. It would further infringe on the freedom of movement and access to justice, among other violations. Human Rights Watch (HRW) urged that the proposed measures should be amended to avoid "undermining basic rights"[30] HRW contended that the directive was discriminatory and that the government should have employed reasonable measures to protect its citizens. On 14 December 2021, Justice Anthony Mrima temporarily suspended the vaccination directive pending the determination of the matter filed by businessman Enock Aura.

In issuing the directive, it could be argued that the government relied on its positive obligations under the Constitution and international instruments to take measures that ensure the protection of life. More specifically, it buttressed the obligation of States to put in place effective public health policies for combating serious and contagious diseases and to protect the life and physical integrity of those within their jurisdiction. Therefore, it was imperative for the

[27] Kenya: Pandemic Health Workers Lack Protection, Ensure Safety During Covid-19; Address Plight of Frontline Workers

[28] Brief No. 605A - National Emergency Response Committee Press Release on Covid–19, https://www.health.go.ke/wp-content/uploads/2021/11/Press-Statement-on-Covid-19-21st-November-2021.pdf, (accessed 24.08.2022)

[29] *Winfred Clarkson Otieno Ochieng & 12 others v Cabinet Secretary, Ministry of Health & 9 other s ; Shanice Wanjiku & another (Interested Parties); Kenya Legal & Ethical Issues Network on HIV & AIDS (Kelin)(Intended Amicus Curiae) [2022] eKLR*, para 8, http://kenyalaw.org/caselaw/cases/view/230706/, (accessed 25.08.2022)

[30] Human Rights Watch, Kenya: Vaccine Requirements Violate Rights, Global Support, Holistic Approach Urgent to Drive Up Vaccine Access, 13 December 2021, https://www.hrw.org/news/2021/12/13/kenya-vaccine-requirements-violate-rights (accessed 25.08.2022)

government to undertake measures that protected citizens from contracting the infectious Covid-19.[31]

At the time of the release of the vaccination directive, public and media attention had shifted away from disease prevention to vaccine safety.[32] This had the potential to distort the perception of reality and generate vaccine misinformation, resulting in decreasing vaccination rates and the possible spiking of infection rates. Vaccine hesitancy was recognised as a serious global problem. Making vaccination compulsory was thus a natural response, in that it was projected to improve national vaccination coverage. Other African States were resorting to that mandatory approach. Vaccines were provided free of charge by the State. As of 2 July 2022, 18,535,975 vaccine doses had been administered.[33]

2.0 Conclusion

The jurisprudence emanating from the Kenyan Courts with regard to the implementation of the right to health in Kenya during the Covid-19 pandemic casts a light on the fragility of her public health care system. Additionally, the enforcement of the government's pandemic containment measures and guidelines was accompanied by human rights violations by State agencies as they enforced the measures adopted across the country. Top on the list of human rights violators were security agencies that brutalised citizens, some of whom succumbed in the process.

[31]David Thomas, Kenya urged to amend compulsory Covid vaccine rules, 14 December 2021, https://african.business/2021/12/technology-information/kenya-urged-to-amend-compulsory-covid-vaccine-rules/, (accessed 25.08.2022)
[32] Antonio Coco and Talita de Souza Dias Prevent, Respond, Cooperate States' Due Diligence Duties vis-à-vis the covid-19 Pandemic, Journal of International Humanitarian Legal Studies 11 (2020) 218-236.
[33]WHO Health Emergency Dashboard at https://covid19.who.int/region/afro/country/ke (accessed 25.08.2022).

PUBLIC HEALTH GOVERNANCE AND PANDEMIC RESPONSE STRATEGIES IN RWANDA

Busingye Louis*

1. Introduction

When the constitution backs social rights, they become legitimate claims against the State since they require State action for their realisation. Rwanda's legal and policy frameworks provide for these legitimate claims in health. This has been vital in shaping the country's public health set up as we know it today by addressing many public health concerns. The right to good health is a constitutional guarantee embedded under the Bill of Rights: "All Rwandans have the right to good health."[1] This guarantee, however, comes with specific obligations and responsibilities that complement it. For instance, the State has a constitutional obligation to mobilise the population for activities to promote good health and assist them in realising those activities. On the other hand, citizens also have the onus of participating in initiatives that enable good health.[2]

When these two articles[3] are analysed homogeneously, the right to health is a 'normative benefit right', and the State is duty bound to guarantee the enactment of specific laws and regulations to protect the right. Further, another lens specifies the social rights aspect of the right to health as a public affair that is an absolute responsibility for all Rwandan citizens in the context of Article 45. In a practical sense, the right to health is related to and impacts all members of society. It has a 'normality of publicness' and cannot exclude the benefits of some members. The protective capacity that the constitution offers, or any other subsidiary legislation for that matter, is of the essence in guaranteeing the right.

For the right to health to function effectively as a fundamental social right, it must have a legal basis offering public benefit with the intent that it reflects the highest attainable standards of health care. The State uses different information to shape and influence law making. Such influence is seen in the response and control mechanisms with strengthening pandemic

* The Author is a Human Rights Lawyer, LLM International Human Rights Law – Lancaster University He is also the National Program Officer Human Rights and Democracy at the Embassy of Sweden in Kigali Rwanda. The views represented in this piece do not reflect the opinions of his employer but are facts collected through previously published researched material.

[1] Article 21, Constitution of the Republic of Rwanda 2003 amended in 2015

[2] *Article 45 of the Constitution makes provisions for Promotion of activities aimed at good health.*

[3] *Ibid*, note 1 and 2.

prevention, preparedness and response in Rwanda. This was best exemplified during the most recent Covid-19 pandemic, where the government's approaches to prevention took various forms guided by the need to preserve the right to good health for all Rwandans. Medical interventions, such as vaccines, behavioural modification, engineering controls to prevent harmful exposures, and political, legal and policy initiatives had the central aim of keeping people healthy to avoid contracting the disease and avert death.

This chapter addresses the key themes of the compendium: the right to health and public health emergencies, in this case, Covid-19.

1.1. A General Context

Rwanda, an East African nation of more than 12 million people, has close to 83% of its population living in rural areas. Whereas societal healing and conflict management strategies characterise the post conflict country as an aftermath of the 1994 Genocide against the Tutsi, the country has made significant advancements in healthcare and economic development over the last 20 years. It has emerged as a leader in providing health care in the East African region. The entitlement to good health is embedded in the Constitution of the Republic of Rwanda.[4] From this guarantee, the fundamental human right to the enjoyment of the highest attainable standard of physical and mental health is legislatively provided for, thus offering binding normative guidance for the healthcare system in the country. This spells out an underlying requirement that health goods, services, and facilities are of standard quality, available in adequate numbers, and accessible on a financial, geographical, and non-discriminatory basis.

Rwanda's Universal Health Coverage framework, a mutual health insurance plan commonly referred to as *Mutuelle de Santé*, is one of the most extensive community-based health insurance schemes operated in Sub-Saharan Africa, covering over ninety per cent of the population.[5] The *Mutuelle de Santé* has addressed the two fundamental objectives of health insurance in a low income setting. These are; the increase of access to health care and the aim of reducing the burden of catastrophic health spending, particularly for vulnerable groups.

It is widely acknowledged that Rwanda's community-based health insurance scheme greatly inspired the nation's pandemic preparedness and response structures. Modelled by the World Health Organization's dimensions embodying the concept of Universal Health Coverage, i.e.,

[4] *Supra*, note 2.

[5] Agnes Binagwaho, Renate Hartwig, Denyse Ingeri, and Andrew Makaka. *Mutual Health Insurance and the Contribution to Improvements in Child Health in Rwanda, (June 1st, 2012)*

equity in access to health, dimensions - those who need the services should get them, not just those who can pay for them; quality of health services - expounding on the standard of health which is good enough to improve the health of those receiving services; and financial-risk protection – the expectation that universal coverage brings the hope of better health and protection from poverty for the multitudes, especially those in the most vulnerable situations.[6]

The government made unprecedented efforts to ensure that vaccination rollout strategies targeted those who needed the jab as a priority and received it first. The Ministry of Health and other subsidiary bodies, such as the Rwanda Biomedical Centre, were prompt in guaranteeing that vaccine deployment was of a scale that was akin to those in developed nations with much more established infrastructure. In a bid to ensure fast and steady access to vaccines, there were end-to-end logistics necessary for a population-wide vaccination. Given the circumstances, such as the urgent need to re-open the economy fully and prevent transmission of the virus, a highly complex endeavour by any standard, the response was best exemplified by a rollout that require a vastly coordinated and sustained effort among the diverse actors involved. This was also complimented by strategic and tailored delivery structures enabled by digital technology and data systems that were instrumental in relaying real-time information pertaining to the rollout.

1.2. Assessing and Mitigating Risks

There would have been dire consequences had the country failed or been ill-equipped to implement mass vaccinations. For example, an inadequate cold chain would have led to vaccine spoilage. An ill-trained health and support workforce would have translated to an uninformed public and vaccine wastage. The unintended expiration of vaccines would have ultimately resulted in financial loss from the investment in those doses. The inability to efficiently deliver vaccines to the population would have exasperated the spread, causing needless excess morbidity and death. It could also mean segmenting lower-coverage countries from the global economy, leading to substantial economic losses and exacerbating global inequities. Bearing in mind that every new transmission presented the virus with an opportunity to mutate - the longer the virus was allowed to spread, the more likely a mutation would have occurred. A lot was at stake, and a multifaceted, prompt and efficient approach was conceived.

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[6] Médard Nyandekwe, Manassé Nzayirambaho and Jean Baptiste Kakoma, "*Universal health coverage in Rwanda: dream or reality.*" (March 2014), The Pan African medical journal vol. 17 232. 27

The National Epidemic Preparedness and Response Coordination Committee (NEPRCC), Covid-19 Joint Task Force Committee (JTFC), as well as several health-focused national and international organisations from the onset were spurred by a risk analysis that placed into perspective worst case scenarios in line with the looming catastrophe that the pandemic presented. As the country anticipated the arrival of lifesaving vaccines, the Scientific Advisory Group and National Task Force for Covid-19 Vaccination regularly met to establish a rollout strategy, identify gaps and mitigate risks in the delivery chain, and make critical decisions. From these decisions, activities were organised across ministries, regional and local authorities. The committee regularly reported on the strategies' planning and delivery status to the head of State.[7]

The Government of Rwanda took the initiative to ensure swift coordination within its institutions and equally allied itself with private and non-governmental actors. These partnerships were crucial in addressing the needs and mitigating the risks of the Covid-19 pandemic. There were collaborations with strategic entities such as medical-supply manufacturers, healthcare professionals, logistical companies, technology providers and the media as part of the key private sector stakeholders. National and International Non-governmental stakeholders were also instrumental in guaranteeing efficient rollout. Further, multilateral partners such as the World Health Organisation, the African Union, several local civil society groups, and religious institutions were pivotal in raising mass awareness and contributing to strategy.[8]

The government of Rwanda planned to vaccinate at least 60 per cent of its population within two years from the outbreak of the pandemic. By 2022, 26,106,436 doses had been administered, with 8,962,371 people receiving all three doses. That represents 72.4% of the entire eligible population being fully vaccinated.[9] This success rate can be attributed to establishing a prioritisation list that provided vaccines to those at the highest risk first—Frontline healthcare workers, the elderly and people with underlying chronic conditions. According to this prioritisation, the government conducted a mass, rapid national screening process to calculate how many vaccines would be needed in each community. In recognition that village leaders would have the most up-to-date information on community members and

[7] Hitimana et al. Covid-19 Rwanda response updates. *Rw. Public Health Bul. 2020; 2(2): 18-23.*
[8] *Ibid*
[9] U.S. Support Contributed to 70 percent Covid-19 Vaccination in Rwanda. Available at https://rw.usembassy.gov/u-s-support-contributed-to-70-percent-covid-19-vaccination-in-rwanda/ Accessed on November 11th 2022

household structures in more remote village settings, a cross-government operation was undertaken to survey communities and collect this information from local leaders for two months. With updated population demographics and up-to-date non-communicable disease screening, the government of Rwanda could accurately procure and allocate vaccine supply. Vaccines were pushed from the central stock warehouse to all 50 district hospitals and cascaded to more than 500 health centres based on this allocation.

1.3. Digital monitoring

The mitigation strategies included inculcating digital solutions to Covid-19 response mechanisms. Rwanda was one of the first countries in Africa to receive vaccines against Covid-19. It was noted that even before the first doses arrived, the country was one of the first in the continent to develop a vaccine management system that would help them oversee the logistics of vaccine distribution using an Electronic Immunization Registry that was used to capture and maintain patient-level vaccination information, plus a custom application that was used to generate digital vaccine certificates.[10] To date, the RBC-C19 is the official Covid-19 test and vaccination status application for Rwanda's national health implementation agency, Rwanda Biomedical Center (RBC), under the Ministry of Health, where real-time data is relayed to both the service providers being the health practitioners as well as the right holders being the Rwandan citizens. [11]

[10] Francis, J.N.P., Mugabo, L. Rwanda Galvanizes Healthcare Readiness, Citizen Support, and Technology to Flatten the Coronavirus Curve in the Land of a Thousand Hills. Springer (2022). In: Shultz, II, C.J., Rahtz, D.R., Sirgy, M.J. (eds) Community, Economy and COVID-19. Community Quality-of-Life and Well-Being.
[11] Rwanda Biomedical Centre, Vaccinating Portal RBC-Covid19 Vaccination Portal (moh.gov.rw)

2. The Country's Trajectory, *"The Rwanda We Want" – A 2050 Vision with Health at the Centre*

The country's vision 2050 articulates a long-term strategic direction for "the Rwanda we want" – a thirty-year logical outline to ensure high living standards for all Rwandans.[12] An enabling pathway to achieving this ambition is the pillar of universal access to quality health care as a building block to improving the quality of life. Through this strategy, Rwanda aims to sustain significant achievements in the health sector, including attaining indicator 3.3 of the 2030 development framework, Sustainable development goal 3 geared towards ending pandemics, epidemics other communicable diseases.[13]

Access to quality health for all Rwandan citizens is fundamental to offering a comprehensive healthcare system. This is reflected by an existing impetus for Universal Health Coverage in the country, one that Rwanda has championed over the years and has seen tremendous success in improving the quality of care for non-communicable diseases and commonplace screening for preventable forms of cancer, like cervical cancer. Expanding upon the Community based Health Insurance Scheme (CBHI), the model has vastly improved the quality of services offered, which aims to limit the exclusion of the most marginalised population segments from health services.

2.1. A Focus on Public Health Emergencies and Pandemics

The Covid-19 pandemic disrupted the country's economy and severely hampered the socio-economic fabric of the entire nation. However, through the recurrent outbreaks of Ebola within the regions bordering Rwanda over the past two decades, the government has been adequately prepared to establish a robust surveillance and outbreak system, develop preparedness capacity and strengthen the national health system to prevent and control epidemics and other public health emergencies and threats.[14] The country is recurrently under red alert due to the Ebola outbreak in Uganda and the Democratic Republic of Congo. Rwanda has established mechanisms to prevent its spread into the country. Additionally, a detailed National Preparedness Plan is in place, including training health workers in early detection and response,

[12] Ministry of Finance and Economic Planning, Goal Number 2, Rwanda's Vision 2050, (2020)
Also emphasized by Then Minister Claver GATETE , Ministry of Finance and Economic Planning, during the National Umusyikirano Dialogue (16th December 2016)

[13] Target set under WHO available at https://www.who.int/data/gho/data/themes/topics/sdg-target-3_3-communicable-diseases

[14] Nyamusore J. et al. The Rwanda National Ebola Preparedness Exercise and Response Strategies. *Rw. Public Health Bul. 2019; 1(2): 6-10*

educating communities about Ebola, vaccinating health workers in high-risk areas, equipping health facilities, and conducting simulation exercises to maintain a high level of readiness. It includes screening for Ebola symptoms at points of entry, which has been ongoing since the beginning of the outbreak. For instance, Rwandan immigration authorities set up an Ebola prevention booth at the Gatuna border crossing with Uganda. Anyone who crosses the border is invited to have their temperature taken. If they have symptoms, they are placed in a quarantine room before being transported to the hospital for further monitoring and treatment.[15]

As the Covid-19 pandemic ravaged the entire globe, severely dilapidating healthcare systems, especially in the northern hemisphere, it was widely assumed that Africa could not withstand the onslaught. On the contrary, Rwanda, like many other African countries, efficiently limited the spread of the virus. [16] While vaccine readiness was essential in combating Covid-19, most Western countries leveraged their economic powers to secure enough doses for their populations. It was a potentially huge risk that left African countries with the option of securing and receiving Covid-19 vaccines through COVAX (the Covid-19 Vaccines Global Access initiative, co-led by GAVI, the WHO and CEPI) and others.[17] Among the few countries, Rwanda was an exemplar in controlling the pandemic and conducting a successful vaccine rollout during the first quarter of 2021. Getting the correct information and data was vital in vaccine distribution and allocation to combat the effects of the pandemic at its peak.[18]

2.2. Sexual and Reproductive Health

The Committee on Economic, Social and Cultural Rights (CESCR) and the Committee on the Elimination of Discrimination against Women (CEDAW) have both clearly indicated the need for States to respect, protect and fulfil rights related to women's sexual and reproductive health.[19] As a public health issue, sexual and reproductive health and rights captured considerable attention during the Covid-19 pandemic.

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[15] Africa News, Rwanda sets up Ebola prevention booth at border with Uganda, (30-10-2022)
[16] H. Andersen, "Vaccinating Africa: What Governments Can Learn from Rwanda's Effective Rollout. Tony Blair Global Institute for Health
[17] Vaccine hoarding will prolong COVID warns WHO, as agency mulls early Omicron data Vaccine hoarding will prolong COVID warns WHO, as agency mulls early Omicron data | | 1UN News December 2021
[18] Gavi, Rolling out COVID-19 vaccines in Rwanda, (12 April 2021)
[19] Sexual and reproductive health and rights. Available at https://www.ohchr.org/en/women/sexual-and-reproductive-health-and-rights

The pandemic significantly impacted health systems' capacity to deliver essential health services. While the country's healthcare provision was being stretched by the increased demand for care of Covid-19 patients, all other health related services, including sexual reproductive health services, needed to be equally considered and catered for. Despite the lockdown, the demand for Sexual and Reproductive Health and Rights (SRHR) services skyrocketed among women and young girls. Emergency contraception, access to abortion in the case of unwanted and unintended pregnancies, post-abortion care and family planning, were among the most demanded services.[20]

Several multilateral agencies and international non-governmental organisations (INGOs) stepped in to address these emergent issues. For instance, the United Nations Population Fund (UNFPA) through the One UN was very timely in supporting the National Covid-19 Preparedness and Response Plan with a focus on the continuity of sexual and reproductive health services, including the protection of the health workforce, addressing gender-based violence, and ensuring the supply of modern contraceptives and other reproductive health commodities. UNFPA assisted national efforts to keep health systems functioning to maintain the provision of sexual and reproductive health and rights information and services. This support was seen in several forms—the UNFPA contributed to the National Plans' capacity building of health providers in infection prevention and control, epidemiological surveillance, risk communication and community engagement.

Further, UNFPA, together with Health Development Partners in Rwanda, coordinated in supporting the Government of Rwanda by co-chairing an SRHR sub-group of partners committed to ensuring that women and girls, especially pregnant and lactating women, continue to have timely access to safe and quality health care, including sexual and reproductive health care during the pandemic – thereby ensuring continuity of SRHR services, which were equally essential. [21]

Worth mentioning is the progress that the country has made in guaranteeing safe abortion, which is a right legally provided for by the Ministerial Order of 2019 regulating safe abortion.[22] Article 3 of the Ministerial Order underscores the conditions to be satisfied for a medical doctor to perform an abortion. Particular grounds can satisfy the threshold. According to the Order,

[20] Rights & Choices for Sexual and Reproductive Health even during COVID-19. Available at https://rwanda.unfpa.org/en/news/rights-choices-sexual-and-reproductive-health-even-during-covid-19

[21] *Ibid.*

[22] Ministerial Order No.002/MoH/2019 of 8 April 2019.

abortion can only be allowed if the pregnant person is a child; the person requesting abortion became pregnant as a result of rape; the pregnancy was after being subjected to forced marriage, as a result of incest committed with a person to the second degree of kinship and the pregnancy puts at risk the health of the pregnant person or the foetus.[23]

2.3. Universal Health Coverage

The World Health Organisation defines Universal Health Coverage (UHC) as a means by which all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need. It must be of sufficient quality while ensuring that the benefits do not expose the user to financial hardship.[24] As a global agenda, UHC focuses on financial risk protection, access to quality essential healthcare services and safe, effective, quality and affordable essential medicines and vaccines for all.[25]

Mutuelle de santé (mutual health insurance), Rwanda's largest insurance scheme, caters for the healthcare service needs of approximately 88 per cent of Rwanda's 12 million people.[26] It is a community-based health insurance program established in 1999 by the Government of Rwanda as a vital component of the national health strategy for universal health care. This medical scheme promotes comprehensive primary health care, social protection, and sustainable financing. An overarching goal of *Mutuelles* is alleviating poverty and achieving sustainable development for all. It recognises that health depends not only on having access to medical services and a means of paying for these services but also on understanding the links between social factors, the environment, natural disasters, and other similarly intricate issues that concern the public. [27]

Two primary goals of universal coverage that Mutuelle's strategy has clearly outlined are ensuring access to care for those in need; and providing financial risk protection by lowering catastrophic out-of-pocket health spending. Studies have shown that devastating health spending pushes households into poverty in developed and developing countries.[28] Despite

[23] Supra, note 23, Article 3, determining conditions to be satisfied for a medical doctor to perform an abortion.
[24] World Health Organisation, Universal health coverage - UHC, (1st April 2021)
[25] UN Sustainable Development Goal target 3.8, Agenda 2030
[26] Dr Agnes Binagwaho MD et al, Rwanda 20 years on: investing in life, The Lancet Volume 384, Issue 9940, 26 July–1 August 2014, Pages 371-375
[27] Dorothy E. Logie, Michael Rowson, Felix Ndagije, Innovations in Rwanda's health system: looking to the future, Lancet, Volume 372, Issue 9634, 19–25 July 2008, Pages 256-261
[28] Towards Universal Health Coverage: An Evaluation of Rwanda *Mutuelles* in Its First Eight Years; Chunling Lu, Brian Chin, Jiwon Lee Lewandowski, Paulin Basinga, Lisa R. Hirschhorn, Kenneth Hill, Megan Murray, Agnes Binagwaho, Published: June 18, 2012

limited resources, the Government of Rwanda has been implementing *Mutuelles* to provide affordable essential services to the uninsured, especially child and maternal care. Rwanda is the only country in sub-Saharan Africa where community-based health programs cover more than 90% of the population. [29]

The goal of universal health coverage is for the health sector to offer quality products and services that consider the needs of all people, including poor and marginalised populations, and make these affordable, accessible and sustainable. This success is determined by the collective nature of the efforts of the people of Rwanda and its entities.

However, the Covid-19 pandemic had devastating effects and presented a bottleneck to Rwanda's health insurance coverage. Less than half of Rwandans who use *Mutuelle de Santé* managed to pay their fees for the fiscal year of 2020 - 2021. This was because of the Covid-19 pandemic that had entirely eroded people's incomes. According to figures from Rwanda Social Security Board (RSSB), only 44 per cent of the subscribers to the community-based health insurance had paid their premiums for that year,[30] exacerbating the devastating effects of the pandemic on Rwanda's health system's fabric and the enjoyment of the right to health.

3. Service delivery, Capacity, Partnerships

3.1. Community Health Workers

Rwanda's Community Health Workers (CHWs) program emerged in 1995 after years of instability that degraded health infrastructure and outcomes. Today, Rwanda maintains a workforce of nearly 45,000 workers who provide maternal check-ins and age-appropriate health assessments, among others. These workers are recognised as key drivers of achieving the country's developmental agenda. Community Health Workers are a mitigating factor to the medical professional-to-population ratio. The doctor-per-population ratio stands at one doctor to approximately 8,919 citizens.[31] Community Health Workers are elected based on merit through a community-centred participatory process during the monthly Communal work (*Umuganda*).[32]

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[29] Mamadou Selly Ly, Oumar Bassoum, Adama Faye, Universal health insurance in Africa: a narrative review of the literature on institutional models, *BMJ Global Health* 2022;7:e 008219.

[30] *Bertrand Byishimo,* Rwanda: Less Than Half Have Paid Mutuelle De Santé Premium, New Times Rwanda, 8 July 2021

[31] Ministry of Health, 10-year Government program: National Strategy for Health Professions Development (2020 – 2030)

[32] Rwanda Elects Fourth Community Health Worker. Available at https://www.moh.gov.rw/news-detail/rwanda-elects-fourth-community-health-worker

3.2. Implementation

During the Covid-19 pandemic, extended lockdowns, local and international travel restrictions, and the increased demand on the health system, community health workers were called upon to respond to an increased need for community-based healthcare. Concurrently, community health workers were tasked to respond to new pandemic related emergencies.

A notable best practice in Rwanda was leveraging information technology (IT) to complement traditional contact tracing methods by community health workers. It was beneficial in mitigating the challenges faced by an increased workload in order to maintain efficiency. Specifically, Rwandan community health workers were trained in using cell phones in data collection to augment contact tracing efforts.[33] This was a significant achievement for the country where IT solutions were integrated into Covid 19 responses.

Community health workers were crucial in demystifying misconceptions that came with the pandemic, specifically societal stigma, which was registered as an early challenge during the pandemic. CHWs participated in sensitisation campaigns in collaboration with public and private authorities to minimise the impact of the misconceptions. Operation 'Save a Neighbour' was another homegrown solution where community health workers were seen to be central in the response mechanism adapted to combat the pandemic. That model strengthened the support system around community health workers assigned to care for Covid-19 patients. The initiative trained CHWs and guaranteed them the support of doctors.[34]

3.3. Impact of Community Health Workers

Rwanda remains a country with one of the highest vaccination rates in the continent and the lowest fatality rate due to the Covid-19 pandemic. Much of the response was built on the country's existing community health system, which ensures access to essential healthcare provision and advice at the village level across the country through a network of health facilities.

Rwanda Minister of Health Dr. Ngamije attested to the success and claimed that "Having trained people who can give practical advice at a community level helped prevent the healthcare

[33] Niyigena A, I, Barnhart DA, *et al*. Rwanda's community health workers at the front line: a mixed-method study on perceived needs and challenges for community-based healthcare delivery during COVID-19 pandemic. *BMJ Open (*2022;12)

[34] World Health Organisation, How home-based care eased Rwanda's COVID-19 response (*19 April 2022)*

system from being overwhelmed with minor or asymptomatic cases, which allowed resources to be concentrated on serious cases,"[35]

3.4. Addressing Vaccine Inequity

When Covid-19 vaccines were first developed and approved in 2020, wealthy nations amassed most of the world's vaccine supply leaving African countries to scramble for whatever few doses were left.[36] Northern hemisphere nations then blamed Africa for its low vaccination rates and implemented discriminatory measures such as travel bans and restrictions.[37] Rwanda saw the potential to fill this gap by forging a partnership with BioNTech. This made the country one of the two African countries where the production and distribution of Covid-19 vaccines would be readily welcome. Rwanda hopes to build on that progress by becoming a centre for vaccine production in Africa. BioNTech's choice of Rwanda and Senegal as manufacturing and distribution centres represents the most serious effort to address the stark global inequalities in vaccine access.[38]

3.5. Drones – An Innovative Strategy

The public-private partnership between the Government of Rwanda and Zipline Technology also played a role in bridging the technological gap in the public health sector through innovative strategies that have significantly impacted the well-being of Rwandan citizens, especially those living in rural areas. Using drones operated by Zipline enabled the efficient delivery of medical supplies and blood in areas with inadequate road infrastructure.[39]

Drawing from the innovative lesson, the Government of Rwanda applied similar strategies using drones to urge compliance with preventive measures against Covid-19, especially in densely populated, inaccessible, and high-risk zones where citizens were seen not adhering to the precautionary measures. The lack of compliance was because community awareness teams

[35] African Business, Rwanda aims to forge vaccine production hub in BioNTech deal (11 March 2022). https://african.business/2022/03/energy-resources/rwanda-aims-to-forge-vaccine-production-hub-in-biontech-deal

[36] Christian Aid, Vaccine inequity down to rich countries' selfish policies, (28 March 2022). https://www.christianaid.org.uk/news/vaccine-inequity-down-rich-countries-policies

[37] Al Jazeera Opinion, 'The colonial undertones of Omicron travel bans', (6 Dec 2021). https://www.aljazeera.com/opinions/2021/12/6/the-colonial-roots-of-western-responses-to-omicron

[38] Rwanda Development Board, IFC, Government of Rwanda Partner to Develop Vaccine Manufacturing Capacity in Rwanda (September 3, 2021). https://rdb.rw/ifc-government-of-rwanda-partner-to-develop-vaccine-manufacturing-capacity-in-rwanda

[39] World Health Organisation, Drones take Rwanda's national blood service to new heights. https://www.who.int/news-room/feature-stories/detail/drones-take-rwandas-national-blood-service-to-new-heights

could not access the areas. Therefore, drones equipped with cameras were deployed to complement efforts by mass media, community health workers and other community leaders. The recorded footage allowed local authorities to closely monitor areas needing intervention or evacuation that generally take longer to identify and organise.[40]

4. Conclusion

Rwanda's developmental trajectory has seen the nation grow in leaps and bounds in socio-economic transformation strategies that are relevant to the contemporary needs of its citizens and match the global developmental agenda on the same. With health and the right to health being the centre of the discussion, Covid-19 presented an opportunity to assess the many intersections of health governance in advancing equitable, accessible and quality health services. The country has led on several fronts through innovative and community led initiatives that speak of the successes of 'The Rwanda we want' in mitigating and eventually defeating the pandemic. It has also set the tone for dealing with future or recurrent health pandemics. Rwanda's approaches can serve as best practices in many ways than one. Naturally, there is no such thing as a one-size-fits-all approach, especially when contexts are different, hence the approach to managing the pandemic. However, given the circumstances and the history attached to the country, lessons can be drawn from the pandemic management.

[40] World Health Organisation, Rwanda: Drones for community awareness and nation-wide measures in COVID-19 response, 20th July 2020. https://www.who.int/news-room/feature-stories/detail/rwanda-drones-for-community-awareness-and-nation-wide-measures-in-covid-19-response

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China Mills and Kimberly Lacroix, "Reflections on Doing Training for the World Health Organization's Mental Health Gap Action Program Intervention Guide (MHGAP-IG)," *International Journal of Mental Health* 48, no. 4 (February 2019): pp. 309-322, https://doi.org/10.1080/00207411.2019.1683681.

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THE KENYAN SECTION OF THE INTERNATIONAL COMMISSION OF JURISTS
ICJ KENYA HOUSE, OFF SILANGA ROAD, KAREN
P.O. BOX 59743-00200, NAIROBI, KENYA
OFFICE TEL: +254-20-2084836/8 | +254 720 491549
MOBILE PHONE: +254 726 687295

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