

A REVIEW OF THE LEGAL AND POLICY FRAMEWORKS ON THE RIGHT TO HEALTH IN KENYA



*Unpacking Health Rights for Accountability to
Facilitate Access to Health Services in Kenya*

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TABLE OF CONTENTS

LIST OF TABLES	5
LIST OF FIGURES	5
ACRONYMS	6
ACKNOWLEDGEMENT	8
EXECUTIVE SUMMARY	9
CHAPTER ONE: INTRODUCTION AND BACKGROUND.....	15
1.1 Introduction	15
1.2 Rationale for the Review	16
1.3 Scope and Objectives of the Review	16
1.3.1 Purpose of the study.....	16
1.3.2 Objective of the review	17
1.4 Study methodology	17
1.5 Study limitations	18
CHAPTER TWO: THE RIGHT TO HEALTH AND ITS NORMATIVE CONTENT	19
2.1 What is the Right to Health?.....	19
2.2 The Right to Highest Attainable Standards of Health	21
2.3 Progressive Realization of the Right to Health	22
2.4 Human Rights-Based Approach to Health	24
CHAPTER THREE: SITUATION ANALYSIS.....	25
3.1 Population and Demographic Trends	25
3.2 Health Profile and Epidemiological Trends.....	26
3.2.1 The disease burden and epidemiological trends	26
3.2.2 Health status	27
3.2.3 Nutrition status	30
3.2.4 Social determinants of health.....	31
3.3 Access to Health Care Services	31
3.4 Healthcare Financing	33
CHAPTER FOUR: LEGAL, POLICY AND HEALTH SYSTEM FRAMEWORK FOR THE RIGHT TO HEALTH.....	36
4.1 Global and Regional Normative and Policy Framework for the Right to Health	36
4.2 The Constitutional Framework for the Right to Health.....	41
4.2.1 Gaps and challenges in implementation	45
4.3 The Policy and Legal Framework for the Right to Health	45

4.3.1 Policy framework for the right to health.....	46
4.3.2 The legal framework	47
4.3.3 The gaps and implementation challenges of the policy and legal frameworks	50
4.4 Judicial Enforcement and the Emerging Jurisprudence on the Right to Health in Kenya	55
4.4.1 Gaps and challenges.....	66
4.5 Health System and Intergovernmental Framework for Health Service Delivery.....	67
4.5.1 Gaps and challenges.....	71

CHAPTER FIVE: ASSESSMENT OF THE CHALLENGES AND GAPS INHIBITING ENJOYMENT OF THE RIGHT TO HEALTH IN KENYA 72

5.1 Assessment of the Challenges and Gaps Inhibiting the Full enjoyment of the Right to Health ..	72
5.1.1 Availability	73
5.1.2 Accessibility	74
5.1.3 Acceptability	75
5.1.4 Quality	77
5.2 Right to Health in the Context of Health Emergencies	78
5.3 Disclosure of Information and the Right to Health	80
5.4 Factors that Inhibit Enjoyment of the Right to Health	81

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS 85

6.1 Conclusion	85
6.2 Recommendations	85

REFERENCES 90

Annex 1	97
Annex 2	98

LIST OF TABLES

Table 1: International and regional instruments relevant to the right to health	38
Table 2: Summary of the main Constitutional provisions that have implications for the right to health	43
Table 3: Summary of existing laws from the old constitutional order that need to be aligned to the Constitution of Kenya	51
Table 4: Summary of laws that may need to be reviewed to be properly aligned with the current constitutional dispensation	53
Table 5: Summary of executive orders that violate the principles set out in the Constitution of Kenya hence inhibit smooth service delivery in health	55
Table 6: Assignment and distribution of health sector functions under the Fourth Schedule of the Constitution of Kenya 2010	68

LIST OF FIGURES

Figure 1: Pre- and post-devolution budget allocations to health	34
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ACRONYMS

AAAQ	Availability, Accessibility, Acceptability, Quality
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ASAL	Arid and Semi-Arid Land
CAJ	Commission on Administrative Justice
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CERD	International Convention on the Elimination of All Forms of Racial Discrimination
CESCR	Committee on Economic, Social and Cultural Rights
CHUs	Community Health Units
CoG	Council of Governors
CoK	Constitution of Kenya
COVID	Coronavirus Disease
CRA	Commission on Revenue Allocation
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSOs	Civil Society Organizations
DANIDA	Danish International Development Agency
EMC	Emergency Medical Care
EQUINET	Equity in Health in East and Southern Africa
FGM	Female Genital Mutilation
FY	Financial Year
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GPW	General Programme of Work
HIS	Health information System
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
ICESCR	International Covenant on Economic Social and Cultural Rights
ICJ KENYA	International Commission of Jurists Kenya
ICPD	International Conference on Population and Development
ICU	Intensive Care Unit
IDPs	Internally Displaced Persons
IGME	Inter-Agency Group for Child Mortality Estimation
iHRIS	Integrated Human Resources Information System
KDHS	Kenya Demographic and Health Survey

KEMSA	Kenya Medical Supplies Authority
KHHEUS	Kenya Household Health Expenditure and Utilization Survey
KHHFA	Kenya Harmonized Health Facility Assessment
KHIS	Kenya Health Information System
KII	Key Informant Interview
KMPDB	Kenya Medical Practitioners and Dentists Board
KNCHR	Kenya National Commission on Human Rights
KNH	Kenyatta National Hospital
KNPHI	Kenya National Public Health Institute
KUTRH	Kenyatta University Teaching and Referral Hospital
LMIC	Low and Middle- Income Countries
LMIS	Logistical Management Systems
mCPR	modern Contraceptive Prevalence Rate
MMEIG	Maternal Mortality Inter-agency working Group
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
NACADA	National Authority for the Campaign against Alcohol and Drug Abuse
NACC	National Aids Control Council
NCD	Non-Communicable Disease
NEMA	National Environment Management Authority
NGEC	National Gender and Equality Commission
NHA	National Health Accounts
NHIF	National Health Insurance Fund
PMA	Performance Monitoring for Action
PPE	Personal Protective Equipment
PWD	People with Disability
SDG	Sustainable Development Goals
SDH	Social Determinants of Health
TB	Tuberculosis
TFR	Total Fertility Rate
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization

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The Kenyan Section of the International Commission of Jurists (ICJ Kenya), under its 2021 – 2024 strategic plan, aims to promote the respect and enjoyment of Economic, Social, and Cultural Rights (ECOSOC) with a specific focus on the Right to Health. ECOSOC rights are central to ICJ Kenya’s strategic objective under our Economic Justice result area.

To contribute to the realisation of the Right to Health, ICJ Kenya has utilized 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 publication is among the series of knowledge products under our Right to Health project. It underscores how strengthening legislative and policy reforms and interventions is essential to improve access to health services at the national and county level in Kenya. An enabling legal and policy framework for health is vital to realizing the right to health as enshrined in the Constitution of Kenya 2010. Furthermore, advancing the right to health requires commitment and action from duty bearers and right holders. This publication will guide ICJ Kenya stakeholder engagements on the right to health and how best to improve health service delivery in Kenya through legislative and policy reforms and interventions.

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EXECUTIVE SUMMARY

1. INTRODUCTION

The Constitution of Kenya guarantees every person the right to the highest attainable standard of health, which constitutes the right to healthcare services, including reproductive healthcare and emergency medical treatment. To this end, the Kenyan government endeavours to enhance the population's health status by increasing equitable access to quality health care. Additionally, Kenya strives to attain the Sustainable Development Goal of Universal Health Coverage by 2030.

For Kenya to realize its long-term development goals, robust policy and legal frameworks are a prerequisite to help clarify the goals and chart an implementation path with accountability. Yet despite putting in place numerous policy and legislative frameworks on the right to health, Kenya still has a long way to go to fully realize the attainment of the right to health for all. Ultimately, this study aimed to review existing legal and policy frameworks related to the right to health, identify the challenges and gaps that inhibit the enjoyment of the right to health, and develop comprehensive recommendations to address current challenges within the health sector.

2. METHODOLOGY

The study employed a highly participatory and consultative approach through Key Informant Interviews (KIIs), round tables and focused group discussions (FGDs) with specific stakeholders in the health sector, including policymakers, civil society actors, and key development partners. The discussions were geared towards; improving legislative and policy reforms that enhance the right to health; institutional systems strengthening at the national and county levels; enhancing awareness on the right to health; equipping stakeholders to better engage with emerging issues relating to the right to health; and improving delivery and access to health services for all Kenyans.

3. THE POLICY AND LEGAL CONTEXT

Kenya has evolved a supportive legal, policy and institutional environment for the right to health. The constitutional recognition of the right to health makes it an entitlement to every person and an obligation upon the State to make every possible effort to protect, fulfil and promote the right to health for better health and well-being for all. The entrenchment of the right to health has thus become a high normative standard which impacts health policy and provides an enabling environment for its implementation and enforcement.

Kenya is a party to several international and regional conventions, treaties and declarations that enumerate the State's duty to realize the right to health. These include, but are not limited to: the International Covenant on Economic, Social and Cultural Rights; the Convention on the Rights of the Child; the Convention on the Elimination of All Forms of Discrimination Against Women; the Convention on the Rights of Persons with Disabilities; the International Convention on the Elimination of All Forms of Racial Discrimination; and the Program of Action of the International Conference on Population and Development.

Kenya has adopted global commitments to health, including; Sustainable Development Goals three, which aims to ensure healthy lives and promote well-being for all ages by reducing the burden of priority diseases, reducing mortality, ensuring universal access to sexual and reproductive health care services and achieving Universal Health Coverage. The World Health Organisation (WHO) constitution states that: "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." The African Charter on Human and People's Rights (also called the Banjul Charter) Article 16 states that every individual shall have the right to enjoy the best attainable physical and mental health. The African Charter on the Rights and Welfare of the Child Article 14 states that every child shall have the right to enjoy the best attainable physical, mental and spiritual health. The Convention on the Rights of Persons with Disabilities Article 24 requires States Parties to recognize that persons with disabilities have the right to enjoy the highest attainable standard of health without discrimination.

At the national level, the Constitution of Kenya provides the overarching policy and legal framework to ensure a comprehensive rights-based approach to health services delivery. It guarantees the right to health under Article 43(1)(a), while the Fourth Schedule distributes health service functions between the National Government and County Governments. The policy and legal framework for the right to health is provided mainly through the Kenya Vision 2030, the Kenya Health Policy (2014-2030), the Health Act No. 21 of 2017 and the Public Health Act Cap 242.

Hence, Kenya is a party to many global and regional treaties on the right to health and has put numerous policy and legal frameworks in place. However, it has been established that there are growing inequities in access to healthcare services in Kenya, with most of the Sustainable Development Goals health targets off-track to being achieved by 2030. In addition, Kenya has also not taken adequate financing measures to pursue the full implementation of the right to health. It has also been established that despite the Fourth Schedule to the Constitution of Kenya assigning functions to the National Government and Counties, the National Government still controls the largest proportion of the health sector resources. The budget allocations to the Ministry of Health are increasing despite the devolution of most health functions to County Governments.

4. KEY FINDINGS

A. Assessment of the challenges and gaps inhibiting the full enjoyment of the right to health

Overall, the study revealed that while the current policy and legal frameworks for the right to health are robust, the standards adopted by the State as enforceable obligations are not clarified and operationalized as public health measures at national and county levels. The circumstances created inhibit accountability measures towards ensuring full enjoyment of the right to health as guaranteed under Article 43 of the Constitution of Kenya. Consequently, the right to health currently enacted under national, regional, and international laws and policies is not being promoted or protected. In its place, the country continues to grapple with systemic and structural issues inhibiting the right to health. The full enjoyment of the right to health encompasses four critical elements according to the Committee of Economic, Social, and Cultural Rights in its General Comment 14. These elements are accessibility, availability, acceptability, and quality and constitute the AAAQ framework used to analyze findings in Kenya's case.

Availability: While the study indicates that the number of health facilities has more than doubled in the last two decades, only 33 of the 47 County Governments have attained the WHO target on health facility density. Hence the availability of health facilities has remained highly inadequate and inequitable. Where health facilities exist, there are challenges in health service readiness and a poor health workforce density of 15.6 per 10,000 population. Other challenges and gaps witnessed are inadequate supply and frequent stock-outs of medicines and commodities associated with inadequate health facility capacity to plan and forecast and weak procurement processes that are often lengthy and marred with corruption; substandard health facilities and infrastructure; inadequate investment in promotive and preventive health care including community and home-based health care services.

Accessibility: This refers to the ability of a health system to ensure that healthcare services, including emergency medical care, are available to all without discrimination. The findings indicated that overt and covert discriminatory practices are common within the health system inhibiting access to and the full enjoyment of the right to health by members of marginalized, vulnerable, and disadvantaged groups, including women and girls, among other key populations. Manifestation of discrimination resulted from limited access to education and other economic opportunities; prohibitive health care costs; weak public health system; geographical barriers; ineffective referral systems; and inadequate regulation of public and private health service providers. The lack of a comprehensive social health insurance scheme against the backdrop of the privatization of health services has effectively led to the exclusion of millions of Kenyans from accessing quality healthcare services and remains a significant threat to the goal of Universal Health Coverage by 2030.

Acceptability: The findings also indicated that some healthcare service providers' negative attitudes and reception discouraged communities from seeking services from the formal system

and only visiting health facilities as a last resort. This is primarily due to the ill-treatment of patients in health facilities and the feeling among patients that they are not respected and that their views are not taken seriously by medical practitioners. Health services in Kenya are also perceived to be discriminative on the basis of gender, age, and disability. Services in many facilities are offered without considering the needs and preferences of women and girls, adolescents and youth, boys, and girls. Gender-based discrimination that marginalizes women and girls typically puts them at a disadvantage with limited access to health care, including sexual and reproductive health rights, which includes safe motherhood, newborn care, abortion care, family planning, prevention and management of sexually transmitted infections, including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) prevention and management of infertility, and prevention and management of cancers of the reproductive system. Other reported challenges that undermine the acceptability of persons with a disability regarding accessing healthcare services included a lack of responsiveness to their unique circumstances, provider failure to provide accommodations, and inadequate communication.

Quality: The study indicated that the quality of healthcare services in Kenya is affected by the inadequate number of skilled medical personnel, lack of drugs, commodities, and equipment in health facilities, lack of safe and potable water, and poor sanitation, among others. Some of the systematic challenges found were, among others, inadequate and poor maintenance of health infrastructure and facilities; inadequate room for installing medical equipment; lack of electricity, water and other amenities; inadequate ambulance facilities for referral of emergency cases; poor adherence to medical ethics and code of practice by health professionals; inadequate skilled personnel; poor-quality medical products and technologies due to lack of adherence to the procurement laws and corruption; and weak regulation.

B. Health system and intergovernmental framework for health service delivery

The most significant feature of the Constitution of Kenya is the introduction of a devolved system of government consisting of the National Government and 47 County Governments. The governments at the national and county levels are “distinct and interdependent” and are required to undertake their relations through “consultation and cooperation” (Article 6). To a large extent, the powers and functions relating to health, including the implementation of the right to health guaranteed under Article 43 (1) (a) and (2), are concurrent and shared between the two levels of government. However, the health system faces several challenges that negatively affect access to quality healthcare services and realising the right to health. These include weak intergovernmental relations and inter-sectoral coordination within the health system and weak systems for monitoring the implementation and violation of the right to health and for holding duty bearers accountable.

C. Right to health in the context of health emergencies

While the State must prepare adequately for health emergencies and ensure sufficient material and human resources to provide emergency health care at any one time, the Coronavirus Disease (COVID-19) pandemic response revealed the unpreparedness of the health system to respond to health emergencies effectively. Despite citing human rights principles and prioritizing strengthening the health system, the government failed to equip the facilities and train health personnel with skills to tackle the pandemic. The government also failed to adequately equip health facilities and healthcare workers with Personal Protective Equipment (PPEs). The national COVID-19 response also revealed the lack of a clear strategy for addressing healthcare inequalities, disproportionately affecting key vulnerable groups such as elderly persons, children, women, persons with disabilities, people living in deprived areas, and crowded households. The failure of the government to tackle these vulnerabilities and to make specific provisions for vulnerable groups exposed these groups to a violation of their right to health.

D. Disclosure of information and the right to health

The findings indicated a massive gap in information management due to the weaknesses of the health laws and policies in setting clear guidelines for privacy. Sharing data through the Health Information System (HIS) to manage patient records for better effective service delivery remains challenging. Medics face impediments in their efforts towards adequate provision of services due to a lack of timely and insufficient information. Further, within the HIS, data from the private sector is missing due to non-compliance with reporting by private facilities and weak enforcement mechanisms by the Ministry of Health at the national level and County Governments. Moreover, the lack of clear policy and legal framework for privacy protection on health records and cross-sharing of patient history across facilities during case management was untenable.

E. Factors inhibiting the enjoyment of the right to health

The study identified several factors that inhibit the right to health in Kenya, including policy and legal obstacles, health system-related obstacles, health financing bottlenecks, and poor management of human resources for health.

5. KEY RECOMMENDATIONS

Ultimately, the study found that the right to health, as currently enacted under national and international laws and policies, is far from being enjoyed by most of the population due to various sociocultural, economic, policy, legal, systemic, and structural challenges. The study recommends the following to address these challenges:

- i. Improve legislative and policy reforms and interventions and concurrent health functions that enable the full enjoyment of the right to health, especially for the vulnerable, marginalized, and disadvantaged in society;
- ii. Improve access to quality healthcare services through capacity development and technical assistance to counties, promotion of inclusivity in service delivery at all levels, and instituting regulatory mechanisms that promote the quality of healthcare services;
- iii. Strengthen the health system and institutional environment for the right to health;
- iv. Strengthen the right to health during health emergencies and humanitarian situations;
- v. Enhance awareness and understanding of the right to health and citizens' capacity to claim their rights through deliberate programs and initiatives in conjunction with civil society actors to engage with citizens fully; and
- vi. Ensure sustainable health sector financing through regulation, advocacy, costing of health functions, donor coordination, and other policy and legal measures for sustainable healthcare delivery.

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Introduction

The right to health in Kenya has evolved from when the content of the right was not defined in the Constitution, specific policies or legislation. Before the 2010 Constitution, the Public Health Act was the primary legislative framework on health and focused on controlling infectious and communicable diseases. The Constitution of Kenya 2010 brought a significant shift on the right to health. Firstly, the right to the highest attainable standard of health is among the social, economic, and cultural rights entrenched under Article 43 of the Constitution. Further, Articles 2(5) and 2(6) of the Constitution of Kenya provide for the application of the general rules of international law and any treaty or convention ratified by Kenya as part of the laws of Kenya, which elevates the status and application of international treaty obligations related to health. Secondly, the Constitution of Kenya devolves the health function with a clear allocation of responsibilities between the National Government and County Governments under the Fourth Schedule.

Beyond the Constitution of Kenya and the international conventions and treaties, Kenya has enacted the Health Act 2017 and developed various policies that guide the priorities in the health sector. These include the Kenya Health Policy (2014- 2030) as the overarching policy, implemented through five-year strategic plans.¹ The government is implementing the Universal Health Coverage (UHC) program to support the realisation of the right to health. The UHC program goal is to ensure that all persons in Kenya can use the essential services they need for their health and well-being through a single unified benefit package without the risk of financial catastrophe by 2022.²

It is against this background that ICJ Kenya commissioned this study to review existing legal and policy frameworks to identify policy and legal gaps and challenges that inhibit access to healthcare services and the right to health and make proposals for improving the legislative and policy environment, health service delivery and institutional systems at the national and county levels in Kenya.

¹ Available at <https://www.health.go.ke/resources/policies/> (accessed 23.04.2022).

² The UHC Policy Brief, available at <https://www.health.go.ke/wp-content/uploads/2019/01/UHC-QI-Policy-Brief.pdf> (accessed 23.04.2022)

1.2 Rationale for the Review

Despite numerous policy and legislative frameworks on the right to health in Kenya, attaining the right to health remains a major challenge for most Kenyans. According to the United Nations High Commissioner for Human Rights, millions of people are routinely excluded from health coverage due to a combination of factors, including the commodification of health care, the underfunding of the health sector, poor prioritization, discrimination, and poverty.³

The UHC program that is meant to solve the cost challenge in the health sector has been slow, further exacerbated by the COVID-19 pandemic. Due to the outbreak of the COVID-19 pandemic, there was a sudden rise in the requirement for isolation beds, Intensive Care Units (ICU), and other lifesaving facilities. Simultaneously, the economic implications of the COVID-19 pandemic have put more Kenyans at risk of being pushed into poverty by catastrophic healthcare costs arising from COVID-19 treatment.

The devolution of health services has also had significant transitional challenges, including health staff management characterized by frequent strikes, poor cooperation, and coordination between both levels of government demonstrated by inconsistencies on issues, and frequent delays in the transfer of funds, to mention a few.⁴ Against this background, ICJ Kenya sought to review existing legal and policy frameworks, identify gaps and make recommendations for improving the legislative and policy environment for achieving the right to health; health service delivery, awareness of the right to health; and stakeholders' engagement in right to health advocacy.

1.3 Scope and Objectives of the Review

This qualitative study involved desk study, roundtables, and a validation forum with select stakeholders, including key development partners, civil society actors, community health volunteers, and policymakers drawn from the national and county levels. The review focused on existing legal and policy frameworks that inhibit access to healthcare services and the right to health.

1.3.1 Purpose of the study

The purpose of the study was to review existing legal and policy frameworks that inhibit access to health rights and develop comprehensive recommendations to address current challenges in the sector towards:

- a) Improving legislative and policy reforms that enhance the right to health;

³ *Economic, Social and Cultural Rights Report of the United Nations High Commissioner for Human Rights*, available at <https://undocs.org/E/2019/52> (accessed on 8.12.2022)

⁴ Leah Kimathi, 'Challenges of the Devolved Health Sector in Kenya: Teething Problems or Systemic Contradictions', *Africa Development*, Volume XLII, No. 1, 2017, pp. 55-77

- b) Institutional systems strengthening at the national and county levels;
- c) Enhancing awareness on the right to health;
- d) Equipping various stakeholders to better engage with emerging issues relating to the right to health;
- e) Improving delivery and access to health services for all Kenyans.

1.3.2 Objective of the review

The review's broad objective was to audit the existing legal and policy frameworks related to the right to health to identify gaps and recommend reforms and intervention areas.

The specific objectives of the review were to:

1. Review existing legal and policy frameworks that inhibit access to health rights.
2. Interrogate the gaps in intergovernmental relations in light of the challenges witnessed in coordinating the National Government and County Governments in health governance as a devolved function.
3. Interrogate the relationship between disclosure of information and the realization of the right to health within the devolved governance system, drawing comparisons between counties where best practices have emerged vis-a-vis counties facing more challenges.
4. Review regional and global trends and human rights normative frameworks to inform Kenya's right to health discourse, particularly during the pandemic.

1.4 Study methodology

To meet the objectives of the study, a broadly qualitative design was adopted involving literature review, evidence synthesis and policy analysis techniques, key informant interviews, focused group discussions, stakeholder workshops, and roundtable approaches. The study respondents were purposively selected from diverse stakeholder groups such as National Government and County Government officials, civil society organizations, community health volunteers, and development partners involved in matters related to the right to health and the provision of health services in Kenya. In selecting the respondents, due consideration was given to their experience, exposure and knowledge in the right to health matters. Such persons were deemed capable of providing the required information based on the review objectives as key informants, round table, and focus group participants.

1.4.1 Data collection methods

To meet the objectives of the study, both primary and secondary data were collected through the following methods:

- a. Literature review: This process involved a critical analysis of relevant literature, including policy and legal documents, reports, case studies, journal articles, books, and other secondary information from various secondary sources, including databases/ knowledge platforms and published and grey materials.
- a. Key informant interviews (KIIs): The key informant interviews targeted a cross-section of purposively selected key persons at the national and county levels with relevant knowledge, experience, and insight on the subject matter of the study. Key informant interview guides were developed and administered according to the category of the key person or stakeholder targeted. Most key informant interviews were conducted virtually using Microsoft Teams and Zoom software.
- a. Stakeholder discussion roundtables: The study collected vital information from key persons through stakeholder roundtable forums. The discussions centred on the existing legal and policy frameworks, key gaps and challenges, and recommendations to improve the policy and legal frameworks for health rights in Kenya. The methods deployed during the stakeholder roundtables and validation workshops included brainstorming, group work, discussions, and plenary presentations.

Various data collection tools were developed and administered to collect the data, including key informant interview guides and roundtable discussion guides.

1.4.2 Data analysis

Qualitative data analysis methods were employed to collate and analyze data gathered from secondary sources, key informant interviews, and roundtable discussions. The data was organized, summarized, and categorized according to source, themes, and objectives of the review. At the interpretation stage, the data from various sources was triangulated and the review's findings were collated into a comprehensive report presented to the key stakeholders for review and validation.

1.5 Study limitations

The major limitation was the inadequate resources availed for the study, which resulted in a significant reduction in the county coverage and delayed decision on the methodological approach, and the execution of the study. This was mitigated by adopting stakeholder round table discussions approach and virtual key informant interviews, selecting a few stakeholders for the key informant interviews and roundtable forums and maximizing on secondary sources of data.

CHAPTER TWO

THE RIGHT TO HEALTH AND ITS NORMATIVE CONTENT

The World Health Organization's (WHO) Constitution 1946⁵ defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” The enjoyment of the highest attainable standard of health is thus one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

2.1 What is the Right to Health?

The right to health is one of a set of internationally agreed human rights standards. Human rights are universal and inalienable. They apply equally, to all people, everywhere, without distinction. Human rights standards – to food, health, education, to be free from torture, and inhuman or degrading treatment – are also interrelated. The improvement of one right facilitates the advancement of others. Likewise, the deprivation of one right adversely affects others.⁶

Understanding health as a human right creates a legal obligation on the State to ensure access to timely, acceptable, and affordable health care of appropriate quality.⁷ The Committee on Economic, Social and Cultural Rights (CESCR) interprets the right to health (Article 12.1 of the International Covenant on Economic, Social and Cultural Rights) as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health and gender equality.⁸ A further important aspect is the population's participation in all health-related decision-making at the community, national and international levels. The right to health is hence inseparable or ‘indivisible’ from other human rights, such as food, housing, work, education, information, and participation.

5 The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (Off. Rec. Wld Hlth Org., 2, 100), and entered into force on 7 April 1948. Amendments adopted by the Twenty-sixth, Twenty-ninth, Thirty-ninth and Fifty-first World Health Assemblies (resolutions WHA26.37, WHA29.38, WHA39.6 and WHA51.23) came into force on 3 February 1977, 20 January 1984, 11 July 1994 and 15 September 2005 respectively and are incorporated in the present text.

6 WHO (2017), Human rights and health, 29 December 2017. <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> Accessed on 4th March 2022.

7 WHO (2017), Human rights and health, 29 December 2017. <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> Accessed on 4th March 2022.

8 Committee On Economic, Social and Cultural Rights (CESCR) General Comment No. 14 (2000): The Right to the Highest Attainable Standard of Health (Art. 12), Committee On Economic, Social and Cultural Rights (CESCR), Twenty-second session Geneva, 25 April-12 May 2000

The right to health is not to be understood as a right to be healthy. Like all other human rights, the right to health includes freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.⁹

As defined in General Comment 14 of the CESCR, the right to health (Article 12) consists of four core components, including quality; availability of public health and healthcare facilities, goods and services in sufficient quantity; acceptability; and physical, social, cultural and economic accessibility of public health and health care facilities, goods and services, as well as programmes to everyone without discrimination.¹⁰

The State, therefore, must respect, promote, protect, and fulfil the right of every person to health. The State's obligation to progressively realise the right to health includes allocating "maximum available resources" to provide adequate healthcare services and social measures, including promoting and protecting health for all. This is reviewed through various international human rights mechanisms, such as the Universal Periodic Review or the Committee on Economic, Social and Cultural Rights. In Kenya, the right to health has been adopted into the Constitution under Article 43 and related provisions. Box 1 below outlines the key obligations under the Committee on Economic, Social and Cultural Rights General Comment 14.

⁹ WHO (2017), *Human rights and health*, 29 December 2017. <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> Accessed on 4th March 2022; Committee On Economic, Social and Cultural Rights (CESCR) General Comment No. 14 (2000): *The Right to the Highest Attainable Standard of Health (Art. 12)*, Committee On Economic, Social and Cultural Rights (CESCR), Twenty-second session Geneva, 25 April-12 May 2000

¹⁰ Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14 (2000): *The Right to the Highest Attainable Standard of Health (Art. 12)*, CESCR Twenty-second session Geneva, 25 April-12 May 2000.

Box 1: Key Obligations from General Comment 14 on the Right to Health

Core minimum obligations

- ✓ *To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;*
- ✓ *To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;*
- ✓ *To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;*
- ✓ *To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;*
- ✓ *To ensure equitable distribution of all health facilities, goods and services;*
- ✓ *To adopt and implement a national public health strategy and plan of action on the basis of epidemiological evidence, addressing the health concerns of the whole population*

Obligations of comparable priority

- ✓ *To ensure reproductive, maternal and child health care;*
- ✓ *To provide immunization against the major infectious diseases occurring in the community;*
- ✓ *To take measures to prevent, treat and control epidemic and endemic diseases;*
- ✓ *To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;*
- ✓ *To provide appropriate training for health personnel, including education on health and human rights.*

Source: Committee on Economic Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, UN Doc. E/C12/2000/4 (2000), paras. 43–44.

2.2 The Right to Highest Attainable Standards of Health

The WHO Constitution envisages the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.¹¹ The Kenyan Constitution Article 43 (1) (a) guarantees every person the right to the highest attainable standard of health, which includes

¹¹ WHO (2017), *Human rights and health*, 29 December 2017. <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> Accessed on 4th March 2022.

the right to health care services, including reproductive health care. The notion of “the highest attainable standard of health” under Article 12.1 of the International Covenant on Economic, Social and Cultural Rights and the Constitution of Kenya take into account both the individual’s biological and socio-economic preconditions and the State’s available resources. In this regard, the highest attainable standard of health implies a clear set of legal obligations on the State to ensure appropriate conditions for the enjoyment of the right to health.¹² This includes a variety of healthcare facilities, goods, services, and conditions necessary for realising the highest attainable standard of health for all people without discrimination.

2.3 Progressive Realization of the Right to Health

The International Covenant on Economic, Social and Cultural Rights (Art. 2 (1) requires each State Party to take steps, individually and through international assistance and cooperation, to achieve progressively the full realization of the economic, social and cultural rights recognized in the Covenant by all appropriate means, including particularly the adoption of legislative measures. In Kenya, the Constitution under Article 21 (2) obligates the State to take legislative, policy and other measures, including setting standards, to progressively realise the economic, social and cultural rights guaranteed under Article 43.

The concept of “progressive realization” describes a central aspect of States’ obligations under international human rights treaties to take appropriate measures towards fully realising the economic, social and cultural rights, including the right to health to the maximum of their available resources.¹³ The reference to “available resources” recognizes that the realization of the right to health can be hampered by a lack of resources and can be achieved only over time. Because each country faces different resource limits, the progressive realization of a human right to health, including health care, must consider those different limits.

Due to reasonable resource limits, not everything can be done for everyone in need, which means that the progressive realization of the right to health cannot deduce that a specific intervention is an entitlement of that right unless the intervention is part of an array of services to which all must have access according to a fair process.¹⁴ A lack or insufficiency of resources cannot justify inaction or indefinite postponement of measures to implement the rights. The State must

¹² Committee On Economic, Social and Cultural Rights (CESCR) General Comment No. 14 (2000): *The Right to the Highest Attainable Standard of Health (Art. 12)*, Committee On Economic, Social and Cultural Rights (CESCR), Twenty-second session Geneva, 25 April-12 May 2000

¹³ Office of the United Nations High Commissioner for Human Rights (2008), *Frequently Asked Questions on Economic, Social and Cultural Rights Fact Sheet No. 33*, December 2008–8,820

¹⁴ Norman Daniels, Sofia Charvel, Adriane H. Gelpi, Thalia Porteny & Julian Urrutia (2015) *Role of the Courts in the Progressive Realization of the Right to Health: Between the Threat and the Promise of Judicialization in Mexico*, *Health Systems & Reform*, 1:3, 229-234, DOI: 10.1080/23288604.2014.1002705

demonstrate that they are making every effort to ensure the full enjoyment of the rights, even when resources are scarce.¹⁵ The Constitution of Kenya Article 20 (5) provides that in applying any economic, social and cultural rights guaranteed under Article 43 if the State claims that it does not have the resources to implement the right, a court, tribunal, or other authority shall be guided by the following principles—

- a. it is the responsibility of the State to show that the resources are not available;
- b. in allocating resources, the State shall give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals; and
- c. the court, tribunal or other authority may not interfere with a decision by a State organ concerning the allocation of available resources solely on the basis that it would have reached a different conclusion.

Irrespective of the available resources, the State should, as a priority, ensure that everyone has access to, at the very least, minimum levels or standards of health and healthcare services and target programmes to protect the poor, the marginalized and the disadvantaged. No matter what level of resources the State has at its disposal, progressive realization requires that the government takes immediate steps towards fulfilling the right to health. Similarly, regardless of resource capacity, the State should not allow the existing gains in realising health rights to deteriorate unless there are strong justifications for a retrogressive measure. This means the elimination of discrimination and improvements in the legal and juridical systems must be acted upon.¹⁶ The State's compliance with its obligation to take appropriate measures to ensure progressive realisation should hence be assessed in the light of the resources—financial and others—made available for that purpose. This requires that clear performance indicators and targets are set on what constitutes the progressive realization of the right to health or health care to ensure tracking and monitoring of progress.¹⁷

¹⁵ Office of the United Nations High Commissioner for Human Rights (2008), *Frequently Asked Questions on Economic, Social and Cultural Rights Fact Sheet No. 33, December 2008–8,820*

¹⁶ WHO (2017), *Human rights and health*, 29 December 2017. <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> Accessed on 4th March 2022

¹⁷ Norman Daniels, Sofia Charvel, Adriane H. Gelpi, Thalia Porteny & Julian Urrutia (2015) *Role of the Courts in the Progressive Realization of the Right to Health: Between the Threat and the Promise of Judicialization in Mexico, Health Systems & Reform*, 1:3, 229-234, DOI: 10.1080/23288604.2014.1002705

2.4 Human Rights-Based Approach to Health

A human rights-based approach to health provides a set of clear principles for setting and evaluating health policy and service delivery, targeting discriminatory practices and systemic bottlenecks at the heart of inequitable health outcomes.¹⁸ A rights-based approach to health requires that health policy and programmes prioritize the needs of those furthest behind first towards greater equity. In pursuing a rights-based approach, health policy, strategies, and programmes should be designed explicitly to improve the enjoyment of all people to the right to health, focusing on the poor, the marginalized, the vulnerable and the disadvantaged.

The core principles and standards of a rights-based approach include: Accountability, where the State and other duty-bearers are answerable for the observance of the right to health; Equality and non-discrimination in distributing and providing resources and health services. Non-discrimination and equality are key measures required to address the social determinants affecting the enjoyment of the right to health; and meaningful participation of all stakeholders – including non-state actors such as non-governmental organizations to ensure ownership and control over health and development processes in all phases of the programming cycle: assessment, analysis, planning, implementation, monitoring, and evaluation.

¹⁸ WHO (2017), *Human rights and health*, 29 December 2017. <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> Accessed on 4th March 2022

CHAPTER THREE

SITUATION ANALYSIS

Kenya is a lower-middle-income (LMIC) country with the largest economy in East and Central Africa. Kenya's Gross Domestic Product (GDP) growth rate has been above five per cent for most of the last decade. The percentage of persons living below the poverty line in Kenya declined from 55.5 per cent in 2000 and 46.8 per cent in 2005/2006 to 36.1 per cent in 2015/2016.¹⁹ However, the absolute number of persons living below the poverty line in Kenya increased due to the impact of COVID-19. The World Bank Review published in November 2020 revealed that the COVID-19 pandemic might have increased poverty by four percentage points, thus increasing the number of poor people by approximately two million.²⁰ Literacy levels reached 78.1 per cent, although age and geographical distribution inequalities persist. Gender disparities remain significant; with the Gender Inequality Index, the measure of disparity on health, empowerment and labour market stood at 0.618 and ranked 130 out of 146 countries worldwide in 2012.²¹ Security concerns persist in some areas of the country, making it difficult for communities to access and use existing services. Gender-based crimes also continue with reported rape and defilement cases on the rise.

3.1 Population and Demographic Trends

The 2019 Kenya Population and Housing Census enumerated 47.5 million people in the country with 12.2 million households.²² Between 2009 and 2019, Kenya's population grew at 2.3 per cent annually, down from 2.9 per cent between 1999 and 2009. The population is currently estimated at 53,771,296 people. In 2015, the fertility rate in Kenya was 4.32, with a crude birth rate of 34.9 per 1,000 population.²³ While the country has experienced a substantial decline in fertility rate, reaching a Total Fertility Rate (TFR) of 3.4 in 2019 from a high of 7.9 in the 1970s, the country's population is projected to reach about 59 million by 2030 at an annual growth rate of 2.2 per cent.²⁴ The country's average household size is four people. Kenya has a young population, with about 73 per cent of the populace below 30 years of age and have an average life expectancy of 66 years as of 2019.

19 The World Bank data, Kenya, 2020. <https://data.worldbank.org/country/kenya>; The World Bank, Kenya Economic Update: Policy Options to Advance the Big 4 Unleashing Kenya's Private Sector to Drive Inclusive Growth and Accelerate Poverty Reduction. Edition 17. 2018. <http://documents1.worldbank.org/curated/en/327691523276540220/pdf/125056-WP-P162368-PUBLICKenyaEconomicUpdateFINAL.pdf>

20 Ibid

21 UNDP, Human Development Report, 2013

22 Kenya National Bureau of Statistics (KNBS), 2019 Kenya Population and Housing Census Volume I: Population by County and Sub-County. 2019;

23 UNICEF, 2015

24 National Council for Population and Development, Kenya National Population Policy for Sustainable Development Draft 2021

3.2 Health Profile and Epidemiological Trends

There has been a general improvement in the health profile of Kenya over the past two decades. Life expectancy at birth increased from a low of 50 years in 2000²⁵ to 60 years in 2009 and 66 years in 2019²⁶. Despite the general improvement in the country's health profile, Kenya still faces several health challenges. These include high maternal – newborn-child mortality and a high burden of communicable and non-communicable diseases such as HIV/AIDS, tuberculosis, upper respiratory tract infections, hypertension, diabetes, cancers and malnutrition.

3.2.1 The disease burden and epidemiological trends

Kenya is facing a triple burden of diseases from neonatal diseases (a threat to infants under one year old and are usually vaccine-preventable), communicable diseases (spread through contact with infected agents or carriers), and non-communicable diseases (lifestyle and environmental illnesses). Kenya is also undergoing an epidemiological transition marked by a decline in morbidity and mortality due to communicable conditions and an increase in the burden of non-communicable diseases (NCDs), which include diseases such as diabetes, cancers, cardiovascular diseases and chronic respiratory infections. According to the surveillance of NCD risk factors (STEPS)²⁷ survey 2015, NCDs accounted for over 55 per cent of hospital deaths in Kenya, while more than 50 per cent of all hospital admissions were due to NCDs.²⁸

WHO STEPwise approach to chronic disease risk factor surveillance (STEPS) with modification to suit the Kenyan situation. The approach was a sequential process consisting of three 'steps' of gathering information: Step 1 - Interviews on demographic information and selected major health risk behaviours. Step 2 - Anthropometric measurements on Blood Pressure and heart rate, height, weight, waist and hip circumference. Step 3 - Biochemical measurements of fasting blood glucose, triglyceride, and cholesterol levels.

The SDGs aim to reduce NCD mortality by one-third from the 2015 level by 2030. According to the Global Burden of Disease (GBD) 2019 estimates, NCD mortality rate was 372.9 per 1,000 population in 2015. The national target for mortality attributed to NCDs is 261 per 100,000 population²⁹ by 2030, using the GBD 2019 as a baseline. Mortality attributed to NCDs in Kenya

25 Kenya Demographic and Health Survey 2003. 8 WHO 2010 World Health Statistics.

26 WHO 2016, Kenya key Indicators <https://apps.who.int/gho/data/node.cco.ki-KEN?lang=en>

27 The WHO STEPwise approach is a sequential process consisting of three 'steps' of information gathering as follows: Step 1 Interviews on demographic information and selected major health risk behaviors; Step 2 Anthropometric measurements on Blood Pressure and heart rate, height, weight, waist and hip circumference; and Step 3 Biochemical measurements of fasting blood glucose, triglyceride, and cholesterol levels.

28 Dr. Kiarie Helen, Dr. Gatheca Gladwell, Ngichio Calestus and Dr. Elizabeth Wangia (2019), Policy Brief Lifestyle Diseases – An Increasing Cause of Health Loss, MOH, <https://www.health.go.ke/wp-content/uploads/2019/01/Revised-Non-Communicable-Disease-Policy-Brief.pdf>

29 Institute of Health Metrics and Evaluation. [Online] 2020. [Cited: 12 15, 2020.] <http://ghdx.healthdata.org/gbd-results-tool>

reduced by 4 per cent to 356.5 per 100,000 population. The average annualized rate of decline in Kenya between 2015 and 2019 was 1.1 per cent, which is insufficient to achieve the target of reducing mortality attributed to NCDs by one-third. Mortality attributed to NCDs is, therefore, off-track. Globally, NCDs accounted for 71 per cent of all global deaths and 85 per cent of premature deaths in Lower and Middle- Income Countries in 2015.³⁰ The average annualized rate of decline in NCD mortality globally slowed down from 1.6 per cent between 2000 and 2010 to -1.1 per cent between 2010 and 2016.³¹ HIV and AIDS remain the most frequent cause of death in Kenya. For example, in 2019, with a rate of almost 104 deaths per 100,000, Kenya was the fourth country worldwide with the highest number of AIDS-related deaths.³² Neonatal diseases and communicable, maternal and nutritional diseases account for 63 per cent of deaths in the country, whereas NCDs account for 27 per cent and injuries for ten per cent.³³

The COVID-19 pandemic is feared to have disrupted progress in many SDGs, reversing gains made over the years in reducing the burden of diseases due to its social, economic and health effects. Most COVID-19 infections have been experienced by the age group of 30 to 39 years, with more deaths experienced in the age groups of 60 years and above.

3.2.2 Health status

The Constitution of Kenya Article 43 (1)(a) and (2) guarantee the right of every person to the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare and emergency medical treatment. The Government of Kenya has endeavoured to enhance the population's health status by increasing equitable access to quality health care. Like most countries worldwide, Kenya strives to attain the SDG of UHC by 2030. SDG three aims to ensure healthy lives and promote well-being for all ages by reducing the burden of priority diseases, reducing mortality and achieving UHC. UHC aims to ensure that no one is left behind and that the entire population has access to quality healthcare services at a cost that does not lead them to financial hardship.³⁴ To this end, the Government of Kenya made UHC one of its main development priorities, thus bringing Kenya closer to the goal of UHC.³⁵ While there is evidence of improvements in indicators for specific age groups, particularly those related to adult, infant, and child health, some indicators are off track, especially those

30 GBD 2015 Risk Factors Collaborators. *Global, regional, and national comparative risk assessment of 79 behavioural, environmental and occupational, and metabolic risks or clusters of risks, 1990–2015: a systematic analysis for the Global Burden of Disease Study (GBD) 2015*. *Lancet*, 2016; 388(10053):1659–1724

31 Kenya - the Global burden of disease health-related SDGs dashboard; Africa – the Atlas of Africa Health Statistics 2018; Global – World Health Statistics 2019

32 Statista 2021, <https://www.statista.com/statistics/1221721/main-causes-of-deaths-in-kenya/> 4 Feb 2021

33 Beth Waruguru Hinga (2021), *The Terrible Three: Easing The Triple Burden of Disease in Kenya* on March 2, 2021 <https://www.borgenmagazine.com/triple-burden-of-disease/>

34 United Nations (UN), *Goal 3: Ensure healthy lives and promote well-being for all at all ages*. Accessed in August, 2020.

35 Ministry of Health, “President Uhuru launches Universal Health Coverage Pilot Program Nairobi”. 2018. <https://www.health.go.ke/president-uhuru-launches-universal-health-coverage-pilot-program-nairobi-kenyadecember-13-2018/>

related to neonatal and maternal health. According to World Bank estimates, life expectancy at birth in Kenya, which was 64.8 years in 2015, increased to 66.3 years in 2018. Life expectancy at birth has remained higher among females than males throughout the period.

For children, SDG 3.2 targets to reduce the global neonatal and under-five mortality rates to 12 and 25 per 1,000 live births, respectively, by 2030. The neonatal mortality rate in Kenya in 2019 was 21 per 1,000 live births, lower than that in the African region (27 per 1,000 live births) but higher than the global level of 18 deaths per 1,000.³⁶ Some leading causes of neonatal deaths are preterm complications (12 per cent), Asphyxia (9 per cent) and Sepsis among other complications such as antepartum haemorrhage, eclampsia, and abnormal presentation and prematurity, which are purely preventable and treatable.

According to the 2022 Kenya Demographic and Health Survey (KDHS), under-five mortality and neonatal mortality stood at 41 and 21 deaths per 1,000 live births, respectively.³⁷ The UN Inter-Agency Group for Child Mortality Estimation (IGME) estimates that the under-five mortality rate in Kenya reduced from 49.6 per 1000 live births in 2015 to 43.2 in 2019 and classified Kenya as on track to achieving the SDG target.³⁸ Infant mortality (before age one) is estimated at 35.1 per 1,000 live births (KDHS 2022 estimates it at 32 per 1,000 live births). Fifty-six per cent of infant deaths in Kenya occur during the first month of life, while estimates indicate that 29 deaths per 1000 live births occur in the first week of life. Most (99 per cent) of the children who die during the first four weeks of life reside in the poorer parts of the country, especially the informal dwellings and Arid and Semi-Arid Land (ASAL) areas. More deaths occur among male children than female children during their first year of life (44 deaths and 37 deaths per 1,000 live births, respectively).³⁹ According to data from the Kenya Health Information System (KHIS), the proportion of children fully vaccinated in one year in Kenya was 91 per cent in 2019. The coverage of the pentavalent vaccine was higher than 90 per cent throughout the period.⁴⁰ The country is on track to achieving the SDG 3.b target on access to immunization.⁴¹

As to maternal mortality, SDG 3.1 targets to reduce the global Maternal Mortality Ratio (MMR) to less than 70 deaths and countries with a high maternal mortality burden to less than 140 deaths per 100,000 live births by 2030. Modelled estimates by the Maternal Mortality Inter-

36 Ministry of Health (2020), *Kenya Progress Report on Health and Health-related SDGs*, WHO, December, 2020

37 Ministry of Health (2019), *Kenya Harmonized Health Facility Assessment Report*. Nairobi, Kenya: s.n., 2019.

38 Ministry of Health (2020), *Kenya Progress Report on Health and Health-related SDGs*, WHO, December, 2020

39 National Council for Population and Development, *Kenya National Population Policy for Sustainable Development Draft 2021*

40 Ministry of Health (2020), *Kenya Progress Report on Health and Health-related SDGs*, WHO, December, 2020

41 Ministry of Health (2020), *Kenya Progress Report on Health and Health-related SDGs*, WHO, December, 2020

Agency Working Group (MMEIG) indicate a reduction in Kenya's MMR from 353 in 2015 to 342 per 100,000 live births in 2017, with massive regional disparities. However, the annual rate of decline in MMR (3.3 per cent) was inadequate to achieve the target of 140 per 100,000 by 2030.⁴² This is partly attributable to the shortage of professional midwives in many counties in Kenya and the continued practice of harmful cultural practices such as Female Genital Mutilation (FGM). Most maternal deaths are due to causes directly related to pregnancy and childbirth, unsafe abortion and obstetric complications such as severe bleeding, infection, hypertensive disorders, and obstructed labour. Others are due to causes such as malaria, diabetes, hepatitis, and anaemia, aggravated by pregnancy.⁴³

Skilled attendance at birth is one of the key strategies for reducing maternal mortality. SDG 3.1 targets 90 per cent of births conducted by skilled attendants. In Kenya, the proportion of pregnant women who had skilled attendance at birth increased from 69.1 per cent in 2015 to 80.6 per cent in 2019.⁴⁴ Between 2014 and 2019, 81 per cent of births were attended by skilled health personnel globally. Therefore, Kenya is on track towards achieving SDG 3.1, which targets 90 per cent of births conducted by skilled attendants.⁴⁵ Among women aged 15 to 49, 51 per cent received a postnatal check-up in the first two days after their last live birth. While nine in ten mothers report seeing a skilled provider at least once for Antenatal Care (ANC), only 58 per cent of women have four or more antenatal visits.⁴⁶ The WHO recommends at least four ANC visits during a woman's pregnancy.

SDG 3.7 aims to have universal access to sexual and reproductive healthcare, including family planning. According to the Performance Monitoring for Action (PMA) 2020 report, the modern contraceptive prevalence rate (mCPR) for all women reduced from 46 per cent in 2015 to 43 per cent in 2019.⁴⁷ The mCPR was higher in married women than in unmarried sexually active women. The mCPR among married women dropped from 62 per cent in 2015 to 56 per cent in 2019. The mCPR is, therefore, off-track towards attaining the SDG goal of universal access to modern contraceptives.⁴⁸

42 Maternal Mortality Estimation Inter-Agency Group (MMEIG), *Maternal Mortality in 2000-2017*. [Online] 2018. [Cited: 12 15, 2020.] https://www.who.int/gho/maternal_health/countries/ken.pdf?ua=1f.

43 WHO (2012). *Maternal and child health: Kenya*

44 Kenya baseline and 2019 – KHIS; *Global - World Health Statistics Report 2019*

45 Ministry of Health (2020), *Kenya Progress Report on Health and Health-related SDGs*, WHO, December, 2020

46 KDHS (2022). *Kenya Demographic and Health Survey*

47 International Center for Reproductive Health, *Performance Monitoring for Action (PMA) 2020, Determinants of Modern Contraceptive Use Among Sexually Active Men in Kenya*. <https://www.icrhk.org/performance-monitoring-for-action-pma-kenya-2/>

48 Ministry of Health (2020), *Kenya Progress Report on Health and Health-related SDGs*, WHO, December, 2020

3.2.3 Nutrition status

Despite the efforts to promote exclusive breastfeeding and proper child nutrition, there has been modest progress in reducing wasting and stunting in children under five years. Acute nutrition deficiencies have been recorded, including underweight indicators in children under five years. Additionally, acute and chronically undernourished children are seen more in urban areas than in rural areas of the country.

According to KDHS 2022, 18 per cent of children under five years in Kenya were stunted. Estimates from the Global Burden of Disease (GBD) 2019 indicated stunting among children under five years in Kenya reduced from 19 per cent in 2015 to 18 per cent in 2019, thus nearly meeting the SDG target. The Kenya Nutrition Survey 2017-2019 from 12 high-burden selected counties, found a 22.6 per cent prevalence of stunting in 2019, while the prevalence of wasting was 23.4 per cent. The prevalence of stunting was above the national target in 43 per cent (20) of the counties, including Wajir (32 per cent), West Pokot (29 per cent), Mandera (28 per cent), Kitui (23 per cent) and Kilifi (23 per cent) which had the highest rates. The national prevalence of wasting was 3.9 per cent in 2015, which did not reduce throughout the period. The prevalence of wasting among children under five years in 2019 was highest in Marsabit (10 per cent), Tana River (seven per cent), Isiolo (seven per cent), Kisumu (seven per cent) and Baringo counties (seven per cent). The prevalence of overweight among the same group increased from 4.1 per cent in 2015 to 4.9 per cent in 2019. The nutrition status of women has also stagnated. Over 12 per cent of adult women are stunted with an unacceptably low Body Mass Index (BMI). Undernutrition is higher among women ages 15–19 years and in rural areas of the country, whereas obesity is more prevalent in urban areas.

According to the 2021 Global Nutrition Report, Kenya is ‘on course’ to meet four global nutrition targets. These include the low birth weight target, with 11.5 per cent of infants having low weight at birth; exclusive breastfeeding target, with 61.4 per cent of infants aged zero to five months exclusively breastfed; stunting, with 26.2 per cent of children under five years of age affected, which is lower than the average for the Africa region (30.7 per cent); wasting, with 4.2 per cent of children under five years of age affected, which is lower than the average for the Africa region (six per cent); and overweight children under five years of age estimated at 4.1 per cent. However, Kenya has shown limited progress towards achieving the diet-related NCD targets and no progress towards achieving the target for obesity, with an estimated 13.4 per cent of adult (aged 18 years and over) women and 3.6 per cent of adult men living with obesity.⁴⁹ The high burden of malnutrition in Kenya, however, remains a threat to achieving the SDG health and health-related targets and a clear indication of inadequate realization of human rights.⁵⁰

⁴⁹ Global Nutrition Report 2021, Kenya Country Nutrition Profile - The burden of malnutrition at a glance <https://globalnutritionreport.org/resources/nutrition-profiles/africa/eastern-africa/kenya/>

⁵⁰ Ministry of Health (2020), Kenya Progress Report on Health and Health-related SDGs, WHO, December,

3.2.4 Social determinants of health

The Social Determinants of Health (SDH) are the non-medical factors that influence health equity and outcomes. They are the living conditions of people, including the wider set of forces, economic policies and systems, development agendas, social norms, social policies and political systems that shape and influence the conditions of daily life.⁵¹ The key health determinants include unemployment and job security, income and social protection, work conditions, the literacy levels of women, nutrition and food security, alcohol and substance abuse; access to safe water and adequate sanitation, proper housing, basic amenities and environment, roads and infrastructure, structural conflicts, discrimination and gender-related determinants among others. Women's literacy level strongly correlates with a child's health and survival. Although there has been an increase in women's literacy levels in Kenya, which peaked to 85.6 per cent in 2013, progress towards improved child nutrition has stagnated.

Many communicable diseases result from unhealthy living conditions and lack of access to clean and safe water and sanitation. Further, they are the second leading risk factor and contributors to high morbidity burden (DALY) and mortality (deaths) in Kenya.⁵² For instance, more than half of the population is at risk of diseases and death due to poor water, sanitation and hygiene. Poor personal hygiene, inadequate sanitation practices and unsafe drinking water cause over 75 per cent of the country's disease burden. Among children, diarrhoea diseases and intestinal worm infestation contribute to a high disease burden and mortality, with diarrhoea contributing to at least 40 per cent of deaths among children under five children.⁵³ In addition, about 35 per cent of children in Kenya suffer from moderate to severe stunting, which has been linked to poor sanitation, particularly open defecation.⁵⁴

3.3 Access to Health Care Services

The Constitution of Kenya Article 43 guarantees every person the right to the highest attainable standards of health, which includes the right to healthcare services, including reproductive healthcare and emergency medical treatment. Further, the Constitution of Kenya devolves the provision of healthcare services to County Governments and the National Government. The National Government functions include national health policy, national referral health facilities and laboratories, capacity building and technical assistance to counties, investment and financing, regulation, quality assurance and standards, monitoring and evaluation,

2020

51 WHO, *Social Health Determinants of Health*, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

52 WHO 2009, *Global Health Risks Global Health Risks, WHO Mortality and burden of disease attributable to selected major risks*.

53 MOH 2012, *Report of the Global Hand washing Day in Kenya, 2012*

54 UNICEF 2013, *The State of the World's Children (SOWC): Children with Disabilities*, UNICEF, New York, May 2013

education, port health and national healthcare agencies and infectious disease control programs. The County Governments are responsible for managing county health facilities, ambulance services, promotion of primary health care, disease surveillance and response, public health and sanitation, disaster management, veterinary services and waste disposal. Regulation and management of human resources for health and professions at national and county levels is conducted within the norms and standards set by the National Government in accordance with the relevant legislation and policies.

Over the last two decades, the number of health facilities to serve Kenya's growing population has more than doubled from 4,421 health facilities in 2001⁵⁵ to the present 10,466 health facilities.⁵⁶ According to the Kenya Harmonized Health Facility Assessment (KHHFA) report 2018, the health facility density in Kenya was 2.2 per 10,000 population, well above the WHO recommendation (2 per 10,000 population), with 70 per cent (33) of the counties having attained the WHO target on health facility density.⁵⁷ The general health service readiness as a proxy of the coverage of essential services declined from 63 per cent in 2015 to 57.2 per cent in 2019 and is off-track.⁵⁸

While the WHO recommends the optimal core health workforce density of 23 per 10,000 population, the Kenya Health Facility Assessment Report 2018 showed Kenya's core health workforce density as 15.6 per 10,000 population, falling short of the WHO target. However, data from the Kenya Integrated Human Resources Information System (iHRIS) indicated that the core health workforce density increased marginally from 15.4 in the 2017/2018 financial year to 16.6 in the 2018/2019 financial year. In relation to health emergency preparedness, the country is off-track on the International Health Regulations (IHR) core capacity and emergency preparedness. Kenya's IHR core capacity index dropped from 58 per cent (level 3 preparedness) in 2018⁵⁹ to 44 per cent (level 2 preparedness) in 2019.⁶⁰

Overall, the right to health is undermined by several factors including rapid population growth rate, including a large young and dependent population; large proportion of the population living in absolute poverty estimated at 36.1 per cent; gender inequality; climate change, variability and vulnerability; regional disparities in the distribution of health facilities; inequitable access to quality health care by the poor and 'hard-to-reach' communities; inadequate essential drugs, equipment, medical and non-medical supplies; substandard facilities and infrastructure including poor sanitation, water supply and electricity; inadequate investment in primary and community health services and weak referral systems; inadequate preparedness to handle emergencies;

55 Mulaki A. et al. 2019. http://www.healthpolicyplus.com/ns/pubs/11328-11600_KenyaHSARreport.pdf

56 Dr. Richard Muga, Dr. Paul Kizito, Mr. Michael Mbayah, Dr. Terry Gakuruh, *Overview of the Health System in Kenya*, <https://dhsprogram.com/pubs/pdf/spa8/02chapter2.pdf>

57 Ministry of Health. *Kenya Harmonized Health Facility Assessment Report*. Nairobi, Kenya: s.n., 2019

58 Ministry of Health (2020), *Kenya Progress Report on Health and Health-related SDGs*, WHO, December, 2020

59 2017 Joint External Assessment report

60 2019 International Health Regulations (IHR) States Parties Self-Assessment Annual Reporting (SPAR)

weak systems to ensure continuity of patient care; inadequate budgetary allocation and insufficient government expenditure on healthcare function within the county health systems; weak stakeholder and intergovernmental coordination systems; inadequate staffing and critical shortage of essential health workforce; lack of advanced healthcare technology and innovations; and weak monitoring, evaluation and social accountability systems among others.

The COVID-19 pandemic has further put pressure on the health system's capacity to deliver quality healthcare especially to the most vulnerable populations, thereby reversing the gains realized towards universal health coverage. This has exposed the gaps in the health system, particularly the underdeveloped community and primary health care system.⁶¹

3.4 Healthcare Financing

Health financing relates to mobilizing, allocating, managing and utilizing financial resources to ensure quality health services and related health programmes. The primary responsibility of providing the funding required for healthcare services as a government function under the Fourth Schedule and a human right guaranteed under Article 43 of the Constitution of Kenya lies with the State at the national and county levels of government. The Constitution of Kenya under Articles 187, 175, 20 and 21 provides clear guidance on the matching of functions and revenue sharing between the National Government and County Governments; and the allocation of adequate resources to ensure the widest possible enjoyment of the right to health while giving priority to the needs of vulnerable and marginalized groups within society. The key health funds sources include monies appropriated by Parliament and County Assemblies, conditional and unconditional grants, donor funding/transfers (on-budget and off-budget), private sector financing and out-of-pocket financing. Following the devolution of health services implemented in the 2013/2014 financial year, the two levels of government share the allocation of funding to health. Because of the transfer of most of the health service delivery functions to County Governments, the bulk of the financing to health should ideally go to County Governments. However, many health sector resources remain at the national level, with the Ministry of Health continuing to perform some health functions that have been devolved to County Governments.

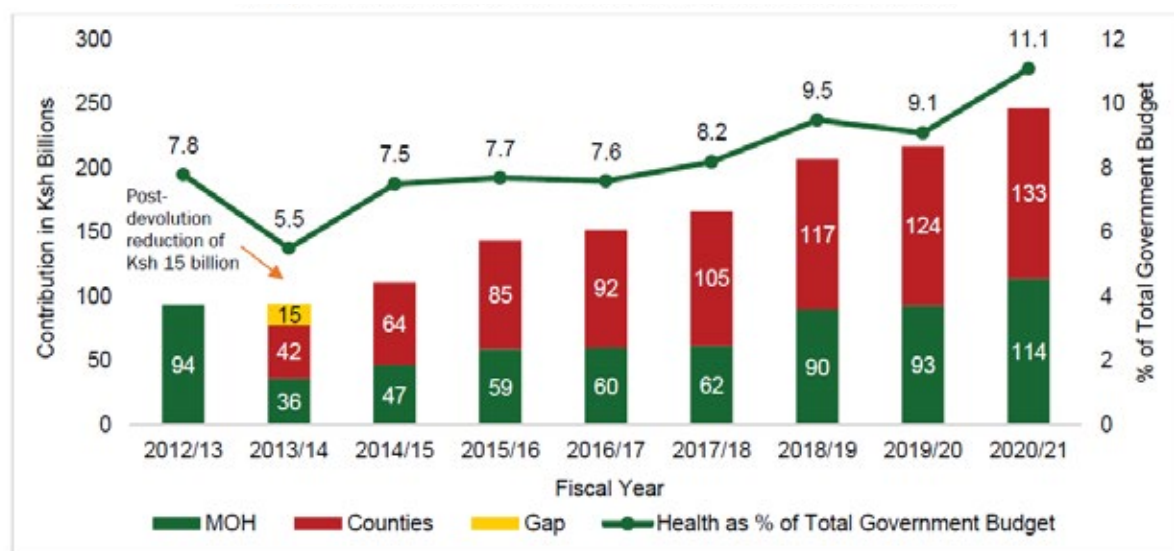
The African Union countries, under Abuja Declaration in 2001, committed to allocating 15 per cent of their budgets to health. While the proportion of the combined discretionary public budget allocated to health has been increasing from about 7 per cent within the 2014/15 to 2016/17 financial years to 9.2 per cent in the 2018/2019 financial year, it is still highly inadequate. It falls below the government target of at least 10 per cent by 2022 and the Abuja declaration target of 15 per cent.⁶² The amount of money allocated to health services by County Governments has

⁶¹ Eunice Pallangyo, Mary Grace Nakate, Rose Maina, and Valerie Fleming, (2020), *The impact of covid-19 on midwives' practice in Kenya, Uganda and Tanzania: A reflective account*, Midwifery. 2020 Oct; 89: 102775.

⁶² MOH (2020), *National and County Health Budget Analysis FY 2018/19*

also grown steadily from Kenya shillings 85 billion in the 2015/2016 financial year to Kenya shillings 117 billion in the 2018/2019 financial year. According to the National Health Accounts (NHA) 2015/16 financial year, the proportion of total government spending on health increased from 6.7 per cent in the 2015/2016 financial year to 8.3 per cent in the 2018/2019 financial year.⁶³

Figure 1: Pre- and post-devolution budget allocations to health



Sources: Republic of Kenya, 2012/13–2020/21; Republic of Kenya, 2013/14–2020/21

Source: Ministry of Health, National and County Health Budget Analysis FY 2018/2019. Nairobi, Kenya: s.n., 2020

The Constitution of Kenya assigns most health service delivery functions (from level one to level five) to County Governments. Still, most of the health budget expenditure remains with the National Government, which is only responsible for level six referral hospitals, training and capacity building, and health policy.

According to Article 216 of the Constitution of Kenya, the principal function of the Commission on Revenue Allocation (CRA) is to make recommendations concerning the basis for equitable sharing of revenue between the National Government and County Governments and among Counties. The two Houses of Parliament approve these recommendations and ultimately decide on the modalities of revenue sharing. In some cases, Parliament excludes certain criteria recommended to them by CRA. For instance, in the third-generation formula approved by Parliament in September 2020, despite CRA's advice, Parliament excluded two critical parameters: incentives for County Governments to adhere to fiscal responsibility (fiscal prudence); and capacity to raise their own revenue (fiscal effort). The vertical transfers of funds, which influence what is available to be shared by the 47 County Governments, thus depend on the goodwill of Parliament. In this regard, once Parliament adopts a formula and allocates to both government levels, the decision is final.

63 Ministry of Health. National and County Health Budget Analysis FY 2018/2019. Nairobi, Kenya: s.n., 2020

As part of the health services parameter, CRA makes recommendations for allocations based on two criteria: health expenditure and health outcome measures. Health expenditure criteria entails determining the demand for services at health facilities based on bed density, human resources for health (HRH) needs, immunization needs, and disease burden. On the other hand, health outcome measures criteria entail existing expenditure levels and the state of health in the population in relation to maternal mortality rates, neonatal mortality rates, skilled birth, contraceptive use, child immunization, and life expectancy, among others. Interestingly, the health index that determines the horizontal allocation of healthcare funds to Counties weighted healthcare at 17 per cent of the total County Government budgets, which from the face value is in line with the Abuja Declaration commitment of at least 15 per cent of total budget allocation to health. However, in computing the total allocation to Counties, the schedule does not include level one of the healthcare system (community health services) nor the equitable vertical share of health sector resources. This results in disproportionately high health sector resources remaining at the national level compared to the 47 County Governments responsible for the largest proportion of health services provision. The failure to recognize level one also severely negates the delivery of healthcare services at the community level, which is the most fundamental and critical part of the primary healthcare system. Ultimately, evidence-based costing of healthcare functions assigned to both levels of government as per the Fourth Schedule of the Constitution of Kenya remains a challenge hence inhibiting the attainment of the right to health.

Much of the National Government and County Government budget allocations go to recurrent expenditures, with minimal allocations to development expenditures. Donors contribute almost 60 per cent of the Ministry of Health development budget, with much of the funding allocated to HIV, reproductive health, immunisation, and health systems support. The average share of County Governments' health budget allocation for recurrent expenditure has remained high, estimated at 79 per cent, which is higher than the recommended 70 per cent threshold, with the proportion of County Government budget allocation to health differing from county to county over the years. The expectation is that each County Government should allocate at least 35 per cent of its budget to health services for optimal service delivery. However, most County Governments are still far from achieving the target, with 30 Counties allocating less than 30 per cent of their budgets to health in the 2018/2019 financial year.⁶⁴

The proportion of households spending more than ten per cent of all their total household expenditure or 40 per cent of their non-food expenditures on health remains high despite the substantial progress made in health financing. The Kenya Household Health Expenditure and Utilization Survey (KHHEUS) 2018 reported that the total Out Of Pocket (OOP) expenditure increased by 90 per cent between 2013 (62.1 billion) and 2018 (118.2 billion), with 78 per cent of OOP in 2018 attributed to spending on outpatient services.⁶⁵ However, there was a decline in the number of households spending over ten per cent of all their total household expenditure on health from 12.7 per cent in 2013 to eight per cent in 2018.⁶⁶

⁶⁴ Ministry of Health (2020), *Kenya Progress Report on Health and Health-related SDGs*, WHO, December, 2020; Ministry of Health. *Kenya Health Sector Monitoring and Evaluation Plan*. Nairobi, Kenya: s.n., 2019

⁶⁵ Ministry of Health. *National and County Health Budget Analysis FY 2018/2019*. Nairobi, Kenya: s.n., 2020.

⁶⁶ Ministry of Health (2020), *Kenya Progress Report on Health and Health-related SDGs*, WHO, December, 2020

CHAPTER FOUR

LEGAL, POLICY AND HEALTH SYSTEM FRAMEWORK FOR THE RIGHT TO HEALTH

Broadly, Kenya has evolved a supportive legal, policy and institutional environment for realising the right to health. The constitutional recognition of the right to health makes it an entitlement to every person and an obligation upon the State to make every possible effort to protect, fulfil and promote the right to health for better health and well-being.⁶⁷ The entrenchment of the right to health has thus become a high normative standard which impacts health policy and provides an enabling environment for its implementation and enforcement.

4.1 Global and Regional Normative and Policy Framework for the Right to Health

The right to health is a fundamental human right recognized under international human rights law. The Constitution of Kenya Article 2(6) provides that any treaty or convention ratified by Kenya shall form part of the Law of Kenya.⁶⁸ In this respect, Kenya is bound by several global and regional international treaty documents that enumerate the duty of the State to realize the right to health.

At the global level, several international conventions, treaties and declarations enumerate the right to health in its various aspects. These include but are not limited to International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention on the Rights of the Child (CRC); the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); the Convention on the Rights of Persons with Disabilities (CRPD); Program of Action of ICPD (1994); and the Sustainable Development Goals (SDGs).

SDG 3 sets out the global agenda for health. SDG 3 aims to ensure healthy lives and promote well-being for all ages by reducing the burden of priority diseases, reducing mortality, ensuring universal access to sexual and reproductive health care services and achieving UHC. UHC seeks to ensure access to health services by protecting vulnerable populations from catastrophic health expenditures and promoting equity. The SDGs further emphasize environmental determinants of health by tracking the proportion of all deaths attributed to environmental issues such as air pollution, poor sanitation, exposure to radiation and other environment-related causes. SDG 5

67 Kavanagh M, 'Constitutionalizing health: Rights, democracy and political economy of health policy' Publicly Accessible Penn Dissertations, 2863 (2017) -<<https://repository.upenn.edu/cgi/viewcontent.cgi?article=4649&context=edissertations>> on 23 March 2020.
68 Republic of Kenya (2010), *The Constitution Kenya 2010*

focuses on gender equality and women's empowerment. Specifically, SDG target 5.6 seeks to ensure universal access to sexual and reproductive health and reproductive rights agreed upon under the Program of Action of the International Conference on Population and Development.

The WHO developed a medium-term plan, the Thirteenth General Programme of Work (GPW 13) for 2019-2023, focusing on measurable impacts on people's health at the country level. GPW 13 has three bold targets (Triple Billion): one billion more people accessing UHC, one billion more people protected from health emergencies and one billion more people enjoying good health and well-being (WHO, 2019).⁶⁹ The World Health Assembly (WHA) in May 2019 approved 46 indicators for measuring the Triple Billion targets (39 SDG and seven non-SDG indicators).

At the regional level, the key instruments include The African Charter on Human and People's Rights (also called the Banjul Charter); the African Charter on the Rights and Welfare of the Child; the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol); the African Union Agenda 2063; and the Ministerial Commitment on Comprehensive Sexuality Education and Sexual Reproductive Health Services for Adolescents and Young People in Eastern and Southern Africa (ESA, 2013) among others.

The African Charter on Human and People's Rights recognizes the right of every individual to "enjoy the best attainable state of physical and mental health". It also urges States to "take necessary measures to protect the health of their people and to ensure that they receive medical attention when sick".

The Protocol to the African Charter on Human and People's Rights on the Right of Women in Africa and the African Charter on the Rights and Welfare of the Child recognize the right to health of women and children, respectively. Table 1 below provides a snapshot of the international and regional instruments relevant to the right to health.

⁶⁹ World Health Organization (2019), *The Thirteenth General Programme of Work, 2019–2023*, WHO/PRP/18.1, Approved by the Seventy-first WHA in Resolution WHA71.1 on 25 May 2018.

Table 1: International and regional instruments relevant to the right to health

Instrument	Provisions relevant to the right to health
World Health Organization (WHO) Constitution of 1946	The right to health was first articulated in the WHO Constitution, which states that: “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition.” The preamble of the Constitution defines health as: “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”
Universal Declaration of Human Rights of 1948 (UDHR)	The Declaration sets forth a standard under which the right to adequate health can be understood. Article 25 states, “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services.”
International Covenant on Economic, Social and Cultural Rights of 1966 (ICESCR)	<p>The most comprehensive statement of the right to health is Article 12 of the ICESCR. Article 12 states: The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:</p> <ul style="list-style-type: none"><i>(a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;</i><i>(b) The improvement of all aspects of environmental and industrial hygiene;</i><i>(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;</i><i>(d) The creation of conditions which would assure all medical service and medical attention in the event of sickness ...</i>
Convention on the Elimination of All Forms of Discrimination against Women of 1979 (CEDAW)	<p>This Convention reaffirms the universal protection of the right to adequate health and details the special protections and considerations due to women. Article 12 of the Convention specifically concerns women’s health. It states as follows:</p> <ul style="list-style-type: none">a) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care to ensure, on the basis of equality of men and women, access to health care services, including those related to family planning.b) Notwithstanding the provisions of Paragraph 1 of this Article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary and adequate nutrition during pregnancy and lactation. Kenya ratified the convention in 1984.

Convention on the Rights of the Child of 1989 (CRC)	<p>Article 24 of the CRC identifies specific aspects of the right to health as it applies to children and their development. It states:</p> <p>1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.</p>
Convention on the Rights of Persons with Disabilities of 2006 (CRPD)	<p>The CRPD contains this right in Article 25:</p> <p>“States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to gender-sensitive health services, including health-related rehabilitation. In particular, States Parties shall:</p> <ol style="list-style-type: none"> 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; Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons; Provide these health services as close as possible to people’s own communities, including in rural areas;
Convention on the Rights of Persons with Disabilities of 2006 (CRPD)	<ol style="list-style-type: none"> Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, 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; 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 in a fair and reasonable manner; Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability”.
African Charter on Human and Peoples’ Rights of 1981 (ACPHR)	<p>Article 16 states that every individual shall have the right to enjoy the best attainable state of physical and mental health. States Parties to the present Charter shall take the necessary measures to protect their people’s health and ensure that they receive medical attention when they are sick.</p>

<p>African Charter on the Rights and Welfare of the Child of 1990</p>	<p>Article 14 states:</p> <ol style="list-style-type: none"> 1. Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health. 2. States Parties to the present Charter shall undertake to pursue the full implementation of this right and in particular, shall take measures: <ol style="list-style-type: none"> a) To reduce infant and child mortality rate; b) To ensure the provision of necessary medical assistance and health care to all children with an emphasis on the development of primary health care; c) To ensure the provision of adequate nutrition and safe drinking water; d) To combat disease and malnutrition, including within the framework of primary health care, through inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution; e) To ensure appropriate health care for expectant and nursing f) mothers; g) To develop preventive health care, guidance for parents and family planning education and services. h) To ensure appropriate pre-natal and post-natal health care for mothers;
<p>African Charter on the Rights and Welfare of the Child of 1990</p>	<ol style="list-style-type: none"> a) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; a) To ensure the meaningful participation of nongovernmental organizations, local communities and the beneficiary population in the planning and management of a basic service programme for children; a) To support through technical and financial means the mobilization of local community resources in developing primary health care for children.

<p>Protocol to the African Charter on Human and People's Rights on the Rights of Women (Maputo Protocol) - Not fully ratified by Kenya</p>	<p>Article 14 on Health and Reproductive Rights states:</p> <ol style="list-style-type: none"> 1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes: <ol style="list-style-type: none"> a) The right to control their fertility; b) The right to decide whether to have children, the number of children and the spacing of children; c) The right to choose any method of contraception; d) The right to self-protection and to be protected against sexually transmitted infections, including HIV/ e) AIDS; f) The right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices; g) The right to have family planning education. 2. States Parties shall take all appropriate measures to: <ol style="list-style-type: none"> a) Provide adequate, affordable and accessible health services, including information, education and communication programmes to women, especially those in rural areas; b) Establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breastfeeding; c) Protect women's reproductive rights by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.
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Despite Kenya's various international and regional commitments to the right to health, there remain large and growing inequities in access to health care, with most SDGs' health targets off-track to achieve by 2030.⁷⁰ Kenya has not taken adequate financing measures to pursue the full implementation of the right to health.

4.2 The Constitutional Framework for the Right to Health

The Constitution of Kenya provides the overarching legal framework to ensure a comprehensive rights-based approach to health services delivery. Article 43 (1)(a) states that "every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care." Article 43(2) provides further that a person shall

⁷⁰ WHO. *Health Inequities in the African Region of the World Health Organization: Magnitudes, Trends and Sources*. World Health Organization, Regional Office for Africa, Brazzaville, Congo, 2010.

not be denied emergency medical treatment. Article 26(4) on the right to life permits abortion where 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. Article 46 (1) and (3) on consumer rights provide that consumers have the right to goods and services of reasonable quality; to the information necessary for them to gain full benefit from goods and services; to the protection of their health, safety, and economic interests; and to compensation for loss or injury arising from defects in goods or services.

With respect to implementing the right to health guaranteed under Article 43, the Constitution of Kenya Article 21(2) provides that the State shall take legislative, policy and other measures, including the setting of standards, to achieve the progressive realization of the rights guaranteed therein. The Constitution of Kenya also emphasizes the right of access to quality health services by all, including children, persons with disabilities, minority and marginalized groups, and the elderly. In this regard, Article 21(3) provides that all State organs and public officers have the duty to address the needs of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalised communities, and members of particular ethnic, religious or cultural communities. Article 20(5) (b) the Constitution of Kenya further states that “in allocating resources, the State shall give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals.”

The Fourth Schedule of the Constitution of Kenya distributes health service functions between the National Government and Counties. Further, the Constitution of Kenya outlines the values and principles that all State organs and officers are expected to employ to deliver services. Therefore, the health sector must implement the principles in Articles 10 and 232, Chapters 6 and 12 of the Constitution of Kenya, among others, and establish the framework necessary to support their implementation. Table 2 below summarizes the main constitutional provisions relevant to the right to health in Kenya.

Table 2: Summary of the main Constitutional provisions that have implications for the right to health

Articles of the Constitution of Kenya 2010	Content
1	Provides for and recognizes that all sovereign power belongs to the people of Kenya, which shall be exercised directly or indirectly at the national and county level according to the Constitution.
6	Provides for the division of Kenya into Counties (47) and includes the nature of the two levels of government as distinct entities. Requires national state organs to ensure reasonable access to their services in all parts of the Republic in so far as they are appropriate.

10	Outlines principles such as equality, equity, fair treatment, human dignity, inclusiveness, protection of marginalized, non-discrimination and human rights as key ingredients of the Constitution of Kenya.
19	Provides that the Bill of Rights is an integral part of Kenya's democratic state and is the framework for social, economic and cultural policies and provides for an overall purpose that being to preserve the dignity of individuals and communities and to promote social justice and the realisation of the potential of all human beings.
20	20 (5) (a) Responsibility of the State to show resources are unavailable. 20 (5) (b) In allocating resources, the State will give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals
21	Duty of the State and State organs to provide for and take policy, legislative and other measures, including setting standards for the progressive realisation of rights under Article 43, including addressing the needs of vulnerable groups within society and the international obligations regarding those rights.
26	Right to life: Life begins at conception; abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment or the life or health of the mother is in danger, or if permitted by any other written law.
42	Provides the right to a clean and healthy environment
43	Every person has the right— 1. To the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare; 2. To reasonable standards of sanitation; 3. To be free from hunger and have adequate food of acceptable quality; 4. To clean and safe water in adequate quantities. 5. A person shall not be denied emergency medical treatment.
32	Provides for the freedom of conscience, religion, belief, and opinion.
46	Consumers have the right to protection of their health, safety, and economic interests.
53–57	Rights of special groups: 1. Children have the right to basic nutrition and healthcare. 2. People with disabilities have the right to reasonable access to health facilities, materials, and devices. 3. Youth have the right to relevant education and protection from harmful cultural practices and exploitation. 4. Minority and marginalised groups have the right to reasonable health services.

174	<p>Objects and principles of devolved government</p> <p>These principles and objectives include: promoting democracy, enhancing national unity, giving the people the powers of self-governance while recognizing the right of communities to manage their own affairs, protecting minorities and marginalized communities, decentralizing services and ensuring equitable development of the country.</p>
175	175 (b) County Governments shall have reliable sources of revenue to enable them to govern and deliver services effectively.
176	County Governments will decentralise their functions and the provision of services to the extent that it is efficient and practicable
183	Provides for the general powers of the County Government, including functions of County Executive Committees, implementation of national legislation and policy where required, implementation of County policy and legislation, and managing and administering the County and its executive departments.
189–191	Cooperation between National Government and County Governments, support to County Governments, and conflict of laws between different levels of government
183	Provides for the general powers of the County Government, including implementing national legislation and policy where required, implementing County policy and legislation, and managing and administering the County and its executive departments.
185	The legislative authority of County Assemblies includes making laws that are necessary for the effective performance of the powers and functions of the county government under the Fourth Schedule; exercising oversight over the County Executive; approving plans and policies for the management of county resources and the development and management of county infrastructure and institutions
186	Functions and powers of National Government and County Governments set out in the Fourth Schedule, including exclusive, concurrent and residual powers and functions.
187	Transfer of functions and powers between levels of government
220	States that legislation shall provide guidelines for National Government and County Governments level budgets and development plans and that there shall be a timetable and process for the development of the same.
232	Outlays values and principles that underpin the performance of the public service. These values echo the national values and principles captured in Article 10 of the Constitution and apply to all state organs at both levels of government and all State corporations.

235	Staffing of county governments: Within the framework of uniform norms and standards prescribed by an Act of Parliament for establishing and abolishing offices, appointment, confirmation and disciplining staff except for teachers
Fourth Schedule	National Government: health policy; national referral health facilities; capacity building and technical assistance to counties; County health services: County health facilities and pharmacies; ambulance services; promotion of primary healthcare; licensing and control of undertakings that sell food in public places; veterinary services; cemeteries, funeral parlours, and crematoria; refuse removal, refuse dumps, and solid waste. County governments to ensure and coordinate the participation of communities and locations in governance and service delivery at the local level.

Source: Ministry of Health, Kenya Health Policy 2014 - 2030

4.2.1 Gaps and challenges in implementation

The National Government still controls the largest proportion of the health sector resources. The budget allocations to the Ministry of Health are increasing despite the devolution of most health functions to County Governments. Instead the National Government appears to continue to undertake a number of health functions that are reserved for County Governments such as primary health care; procurement of medical supplies; implementation of donor funded programs such as HIV, Tuberculosis (TB), Malaria, reproductive health, immunization services; receiving and handling money from donors, for example, Global Fund meant for service delivery in the health sector; infrastructure development, procurement, and maintenance of medical equipment at County health facilities; hiring of staff for the County health facilities on short term contracts; inspection and licensing of medical premises including reporting; licensing of waste management services by National Environment Management Authority (NEMA); provision of lower level services in select counties through satellite hospitals model for example Kenyatta National Hospital (KNH) running satellite hospitals in Othaya – Mwai Kibaki Teaching and Referral Hospital and Mama Margaret Kenyatta Hospital in Nairobi and Kenyatta University Teaching and Referral Hospital (KUTRH) running a satellite hospital in Gatundu among others.

4.3 The Policy and Legal Framework for the Right to Health

The Constitution of Kenya Article 21(2) and (4) require the State to take necessary legislative, policy and other measures, including the setting of standards, to achieve the progressive realization of the rights guaranteed under Article 43; and to enact and implement legislation to fulfil its international obligations in respect to human rights and fundamental freedoms.

4.3.1 Policy framework for the right to health

Kenya has broadly evolved a supportive policy environment for the right to health since the promulgation of the Constitution in 2010. These include the Kenya Vision 2030, Kenya Health Policy (2014-2030), the National Reproductive Health Policy (2022), National Adolescent Sexual and Reproductive Health Policy, 2015 (under review), Sessional Paper No. 3 on Population Policy for National Development (2012), the Kenya Community Health Policy 2020-2030,⁷¹ the Kenya Primary Health Care Strategic Framework (2019 – 2024), the Menstrual Hygiene Policy (2019 – 2030), the Kenya Environmental Sanitation and Hygiene Policy (KESHP) 2016 – 2030 and the Kenya School Health Policy (2018) among others.

The Kenya Vision 2030, under the social pillar, seeks to improve the overall livelihoods of Kenyans by providing an efficient, integrated and high-quality affordable healthcare system.

The Kenya Health Policy 2014 – 2030, in line with the country’s long-term development agenda, the Kenya Vision 2030, the Constitution of Kenya and its global (human rights) commitments, employs a human rights-based approach to health care delivery. It integrates the norms and principles of human rights. It embraces the principles of social inclusion and protection of the rights of the marginalized and vulnerable groups, including children, persons with disabilities, youth, minorities, the marginalized and older members of society. The Kenya Health Policy 2014 – 2030 goal is to ensure universal coverage of critical essential services packages that positively contribute to the progressive realisation of the right to the highest attainable health and health care services standards. The main objectives of the policy are the elimination of communicable diseases, halting and reversing the rising burden on non-communicable diseases and mental disorders, reducing the burden of violence and injuries, providing essential healthcare, minimizing exposure to risk factors for health conditions and strengthening inter-sectoral collaborations towards improving population health in Kenya. The goal of UHC is to ensure that every citizen has access to the best possible health care at the most affordable price, including enhancing healthcare programmes for mothers and children. Under the Kenya Health Policy 2014- 2030, the government is committed to ensuring “people are able to have a satisfying and safe sex life and that they can reproduce and possess the freedom to decide if, when, and how often to do so.”

The Kenya Emergency Medical Care Policy of 2021 provides a framework for mainstreaming emergency medical care as a key component of UHC. Before the policy, there were no established ambulance standards or standard operating procedures for emergency departments. In addition, emergency medical care guidelines for prehospital and in-hospital care were not defined (MoH, 2021). However, in reality, there are many instances where Kenyans are still denied emergency medical treatment due to the inability of individuals to pay or provide proof

⁷¹ Ministry of Health, Kenya Community Health Policy 2020 - 20

of insurance coverage to be attended to in a hospital. While the Health Act 2017 establishes the Emergency Medical Treatment Fund, it is yet to be operationalized in terms of funding, administration and utilization in line with the Emergency Medical Care Policy.

The Kenya Community Health Policy (2020-2030),⁷² in line with the global health commitments, the Kenya Vision 2030, the Constitution of Kenya 2010, the Kenya Health Policy (2014 -2030), and the country's universal health coverage agenda aims to empower individuals, families and communities to attain the highest possible standard of health through the provision of high-quality community health services.

The Kenya Primary Health Care Strategic Framework (2019 – 2024),⁷³ in line with the Kenya Health Policy Framework (2014 -2030), provides guidelines for designing and implementing programmes to strengthen the primary health care system and services in Kenya. The strategy envisages the transformation of the health service delivery team by functionally linking all Community Health Units (CHUs) to primary health facilities and introducing multi-disciplinary teams focusing on promotive and preventive health services. The strategy aims to reduce the burden of health needs by ensuring universal access to comprehensive health services, preventing disease and the underlying social determinants of ill health and promoting health and wellness.

The Kenya Health Financing Strategy 2020–2030⁷⁴ aligns with the Kenya Health Policy (2014-2030) that defines the health financing orientation that the country requires to ensure adequate financial resources are available to meet the country's policy commitments, including Kenya Vision 2030 and the SDGs and constitutional obligations of ensuring access to highest attainable standards of health. The specific objectives are: (a) to mobilize resources required to provide the essential high-quality health services that the people of Kenya need; (b) to maximize efficiency and value for money in the management and utilization of available health resources; and (c) to ensure equity in the mobilization and allocation of health funds to guarantee fairness in use.

4.3.2 The legal framework

The legal framework of health in Kenya includes the Health Act No. 21 of 2017, the Public Health Act CAP.242, Nutritionists and Dieticians Act CAP. 253B, Sexual Offences Act 2006, Children Act 2022, the Penal Code, Prohibition of FGM Act (2011), Person with Disability Act (2003), HIV and AIDS Prevention and Control Act (No. 3 of 2006, County Government Act (No. 17 of 2012), Public Finance Management Act (No. 18 of 2012), Kenya Medical Supplies Authority Act No. 20 of 2013, National Authority for Campaign Against Alcohol and Drug Abuse Act 14 of 2013, the Basic Education Act No. 14 of 2013 and the Science, Technology and Innovation Act No. 28 of 2013, among others.

⁷² Ministry of Health, Kenya Community Health Policy 2020 - 2030

⁷³ Ministry of Health, Kenya Primary Health Care Strategic Framework 2019-2024

⁷⁴ Ministry of Health, Kenya Health Financing Strategy 2020–2030

The Health Act 2017 establishes a unified health system encompassing public and private institutions and providers of health services at the national and county levels. It coordinates the inter-governmental relationship between the National Government and County Government health systems. It provides for the regulation of health care services, health care service providers and health technologies.

The Health Act 2017 section 3 (b), (c), (d) reiterates the constitutional standard of the right to health. The objectives of the Act are to protect, respect, promote and fulfil the health rights of all persons in Kenya to the progressive realization of their right to the highest attainable standard of health, including reproductive health care and the right to emergency medical treatment. The Act seeks to protect, respect, promote and fulfil the rights of children to basic nutrition and health care services contemplated in Articles 43 (1) (c) and 53 (1) (c) of the Constitution of Kenya. Further, the Act seeks to protect, respect, promote and fulfil the rights of vulnerable groups as defined in Article 21 of the Constitution of Kenya in all matters regarding health. Additionally, the Act defines emergency medical treatment as the “necessary immediate health care that must be administered to prevent death or worsening of a medical situation. In addition, the definition of health services contained in the Act also includes emergency health services. Therefore, the Health Act 2017 aligns with the constitutional provision that no person shall be denied emergency medical treatment in Kenya.

The Health Act, 2017 section 4 adopts a human rights-based-approach for the realisation of the right to health⁷⁵ and delineates the obligation of the State to observe, respect, protect, promote and fulfil the right to the highest attainable standard of health, including reproductive health care and emergency medical treatment. This is to be achieved by developing necessary policies, laws and other measures; ensuring the prioritization and adequate investment in research, technology and innovation in health care delivery; ensuring the realization of the health-related rights and interests of vulnerable groups within society; and ensuring physical and financial access to health care including the provision of a health service package addressing promotion, prevention, curative, palliative and rehabilitation at all levels of the health care system.

The Health Act, 2017, section 5 sets out the standard for the realization of the right of every person to the highest attainable standard of health. It includes progressive access to promotive, preventive, curative, palliative and rehabilitative services; the right to be treated with dignity, respect and privacy respected; the provision of free and compulsory vaccination for children under five years of age and maternity care. Sections 6, 7 and 8 of the Act focus on the right to reproductive health care, emergency treatment and health information. Although the Act does not define quality, its definition of healthcare services implies an understanding of quality

⁷⁵ Hunt P, 'Interpreting the international right to health in a human rights-based approach to health' 18 (2) *Health and Human Rights Journal*, 2016, 109–130.

in healthcare.⁷⁶ Further, the Act defines healthcare services as “the prevention, promotion, management or alleviation of disease, illness, injury, and other physical and mental impairments in individuals, delivered by healthcare professionals through the healthcare system’s routine health services, or its emergency health services.”⁷⁷ Section 6 (3) of the Act obligates the State to ensure the provision of health care in legally recognized health facilities by trained health professionals and to provide enabling environment consisting of the minimum human resource, infrastructure, commodities and supplies as defined in the norms and standards.

Section 3 (e) of the Health Act 2017 recognizes the role of health regulatory bodies established under any written law to ensure the realisation of the right to the highest attainable health and healthcare services standards. To this end, the Act tasks regulatory bodies to hold accountable health professionals to ensure quality in their service provision. The regulatory bodies are, therefore, responsible under Section 15 (j) (l) to develop training and institutions providing education to meet service delivery needs;⁷⁸ and ensure compliance with professional standards on the registration; and licensing of individuals in the healthcare sector.⁷⁹

Furthermore, the Health Act, 2017 Section 45 establishes the Kenya Health Professions Oversight Authority.⁸⁰ The mandate of the Kenya Health Professions Oversight Authority is to maintain a register of all health professionals; receive and facilitate the resolution of complaints from patients, aggrieved parties and regulatory bodies; and ensure the necessary standards for health professionals are not compromised.⁸¹ Section 62 establishes a single regulatory body for health products and health technologies⁸² to license health products and technologies, license manufacturers and distributors, conduct testing and inspection of manufacturing and distribution facilities and conduct clinical trials.⁸³ Further, Section 66 sets standards for the sale of medicine, vaccine or other health product or technology to members of the public.

The National Health Insurance Fund Act, 1998 (as amended in 2022) provides for the establishment of the National Health Insurance Fund (NHIF Fund), the National Health Insurance Fund Management Board (NHIF Board), and mechanisms of contributions to and the payment of benefits out of the NHIF Fund. Section 3 of the NHIF Act provides that the NHIF Fund consists of monies that the National Assembly may appropriate for indigent and vulnerable persons. Section 5(1) (g) of the NHIF Act provides that one of the objects of the Board is to facilitate the attainment of universal health coverage with respect to health insurance. Section 15 (1B) of the NHIF Act makes the National Government liable as a contributor to the NHIF

76 Ouma S, ‘A review of the Health Act 2017 from an access, quality & cost paradigm’, *KELIN Workshop On Article 43(1): Strategic Litigation and Discourse on the Right to Health*, Limuru, 29 September 2017, 17 -<https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3047970>- on 23 March 2020.

77 Section 15 (j), *Health Act (Act No 21 of 2017)*.

78 Section 15 (j), *Health Act (Act No 21 of 2017)*.

79 Section 15 (l), *Health Act (Act No 21 of 2017)*.

80 Section 45, *Health Act (Act No 21 of 2017)*.

81 Section 48, *Health Act (Act No 21 of 2017)*.

82 Section 62, *Health Act (Act No 21 of 2017)*.

83 Section 63, *Health Act (Act No 21 of 2017)*.

Fund on behalf of the indigent and vulnerable persons identified by the relevant government body. The NHIF Act defines “indigent” as a person who is poor and needy to the extent that the person cannot meet the basic necessities of life. It defines a vulnerable person as one who needs special care, support or protection, including orphans and vulnerable children, widows or widowers, a person with a disability, elderly persons or indigent due to a risk of abuse or neglect and who has been identified as such by the relevant government body. The NHIF Act makes contributions mandatory for citizens aged 18 years and above, except those listed as dependents.

4.3.3 The gaps and implementation challenges of the policy and legal frameworks

While the Kenya Health Policy 2014-2030 and the Health Act 2017, read together with the Constitution of Kenya Article 43 (1) and the Fourth Schedule, provide an enabling framework for realising the right to health, their implementation remains challenging. The main areas of concern include:

- a. The implementation of the right to reproductive health, especially for adolescents and young people, including the incongruence between the right to reproductive health care services and the application of the Penal Code;
- b. Access to emergency medical services, especially by the poor, indigent and vulnerable populations;
- c. The access to health information and HIS for reporting on progress in the realization of the right to health and national and county indicators;
- d. Provision of adequate health financing to ensure appropriate and sustainable funding for universal health coverage and to reduce catastrophic health expenditures;
- e. Inter-governmental coordination and cooperation in the implementation of concurrent functions;
- f. Human resources for health;
- g. Regulation of health care services;
- h. Access to affordable and quality health products and technologies;
- i. Public and environmental health;
- j. Ensuring accountable health sector governance and leadership.

Further, County Governments also have a duty under Articles 21(3) and 20(5) (b) of the Constitution of Kenya to address the needs of vulnerable groups within society and to give priority when allocating resources to ensure the widest possible enjoyment of the right health having regard to prevailing circumstances, including the vulnerability of particular groups or individuals. However, the NHIF Act excludes, as one of the NHIF Funds sources, monies from the County Governments as may be appropriated by the County Assemblies for indigent and vulnerable persons. The NHIF Act also exempts County Governments from liability as

a contributor to the NHIF Fund on behalf of indigent and vulnerable persons. This is despite some County Governments having contractual agreements with NHIF to cover sections of their population, i.e., civil servants, the elderly, and persons with disabilities. By design, the NHIF should be established as an inter-government agency rather than a National Government agency.

There has not been a comprehensive review of the policy and legal frameworks and their alignment for attaining the right to health. Some legislations, such as the Public Health Act, are not fully aligned with the Constitution of Kenya 2010 since they were premised on the old constitutional order. While the government of Kenya may have revised some policies and legislations after the promulgation of the Constitution in 2010, several still require comprehensive review and alignment or repeal.

Table 3: Summary of existing laws from the old constitutional order that need to be aligned to the Constitution of Kenya

Existing laws from old constitutional order			
Law	Year enacted	Purpose of the law	Gaps
Public Health Act (CAP 242)	1921 and minimally revised in 2012	Established structures that enabled the implementation of public health services. It is concerned with the protection of public health. It sets rules in relation to food hygiene and protection, keeping and handling of food animals, protection of public water supplies, prevention and destruction of mosquitos and the abatement of nuisances, including nuisances arising from sewerage.	It needs an overhaul to conform to the provisions of the Constitution of Kenya.

Pharmacy and Poisons Act (CAP 244)	1957 and minimally revised in 2012	Regulation of pharmacy as a profession as well as the production, quality control and distribution of pharmaceuticals and poisons.	It is misaligned to the current constitutional provisions.
State Corporations Act (CAP 446)	1986 and minimally revised in 2015	Established for control and regulation of state corporations	It is misaligned to the current constitutional provisions.
National Health Insurance Fund (NHIF Act)	1998 and amended in 2021	Provides the legal framework for the management of Kenya's largest public health insurer	It does not take devolution into account and the various functions of two levels of government. It has not protected the interests of the majority who utilize public hospitals due to a bias by the NHIF for private hospital reimbursements. Hence social and economic justice does not obtain.
Narcotic Drugs and Psychotropic Substances Act	1994 and amended in 2019	Domiciled within the Ministry of Interior, it is meant to control the trafficking, distribution and use of proscribed narcotic drugs and psychotropic substances.	It focuses only on the trafficking and illegal possession of narcotics and psychotropic substances but does not speak to the role of other government agencies, ministries, departments or devolved units.
HIV and AIDS Policy	2009	Domiciled in the Ministry Of Gender, Children and Social Development, it provides the guiding framework for preventing the spread of and managing those infected with HIV and AIDS at the workplace at national and county levels.	It is misaligned to the current constitutional provisions.

Source: Council of Governors, Ministry of Health and Intergovernmental Relations Technical Committee presentation on "County Perspectives and Challenges in the Implementation of the Health Function and Unbundling of the Health Function," during a Consultative Workshop on the Review of Policies and Legislation on the Right to Health.

There is another category of laws passed after the promulgation of the Constitution of Kenya in 2010 that impede the right to health contrary to the constitutional provisions. Both health practitioners and some policymakers have deemed them deficient to the extent that they may not be properly aligned with the Constitution of Kenya.

Table 4: Summary of laws that may need to be reviewed to be properly aligned with the current constitutional dispensation

Law/ policy	Year enacted	Implications	Gaps
Health Act	2017	□ It is the main legislation concerned with providing the right to the highest attainable standard of health in line with the constitution.	□ The Act and its attendant instruments do not define what the highest attainable standard of health means.
The Kenya Medical Supplies Authority (KEMSA) Act	2013	□ Establishes KEMSA, which is charged with delivering drugs and equipment to health facilities nationwide.	□ Prohibits County Governments from procuring medical supplies and equipment from suppliers other than KEMSA, creating a monopoly. □ The Council of Governors attests that corruption allegations at the institution and bureaucracy have caused supply hitches, hampering efficient service delivery in Counties.
National Authority for the Campaign Against Alcohol and Drug Abuse Act	2012	□ It creates NACADA, a body charged with instituting campaigns and promoting education and advocacy against alcohol and drug abuse.	□ It, however, does not unpack the functions of the County and National Governments.

Counsellors and Psychologists Act	2015	☐ Provides for counsellors and psychologists' training, registration, licensing, and practice.	☐ However, it is not aligned to the devolved system of government and does not provide for intergovernmental linkage.
Clinical Officers (Training, Registration and Licensing) Act	2017	☐ It is meant to provide a legal framework for the training, regulation and licensing of the professional cadre of clinical officers.	☐ The devolved system of government is not factored in the coordination of functions between national and county governments.

Source: Council of Governors, Ministry of Health, Intergovernmental Relations Technical Committee presentation on "County Perspectives and Challenges in the Implementation of the Health Function and Unbundling of the Health Function," during a consultative workshop on the review of policies and legislation on the right to health.

Several Presidential Executive Orders also directly contravene the Constitution of Kenya and the spirit of devolution. These have become issues of contention, with some attracting legal challenges in court.

Table 5 below highlights some of the Executive orders.

Table 5: Summary of executive orders that violate the principles set out in the Constitution of Kenya hence inhibit smooth service delivery in health

Executive Orders that impede on collegiate delivery of health under devolution		
Executive order	Year published	Implications
Executive Order establishing the National Blood Transfusion and Tissue Transplant Authority	August 1, 2022	<ul style="list-style-type: none"> The body is centralized and intended to take charge of blood transfusion and tissue transplant as part of healthcare delivery. It is based on the Health Policy 2014- 2030 interpretation, which Council of Governors contests. It runs counter to the spirit of devolution and the principles of cooperative government and mutual respect.
Executive Order establishing the Kenya National Public Health Institute	2021	<ul style="list-style-type: none"> KNPHI to be a body established for health promotion through service delivery in public health. Intrudes into the functions of Counties and refers to unreviewed old legislations i.e. Public Health Act.

Executive Order transforming the National Aids Control Council (NACC) to the Syndemic Diseases Control Council	August 5, 2022	<ul style="list-style-type: none"> The AIDS control body now takes up a larger mandate to include other diseases such as Malaria, Leprosy and others. Duplication of functions is created as the body performs similar functions as County Government health departments.
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Source: Council of Governors, Ministry of Health, Intergovernmental Relations Technical Committee presentation on “County Perspectives and Challenges in the Implementation of the Health Function and Unbundling of the Health Function,” during a consultative workshop on the review of policies and legislation on the right to health.

4.4 Judicial Enforcement and the Emerging Jurisprudence on the Right to Health in Kenya

The Constitution of Kenya Article 20 (1) states that “the Bill of Rights applies to all laws and binds all State organs and all persons.” Article 43 (1) (a) and (2) guarantees every person the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care and emergency medical treatment. To ensure the realization of the rights guaranteed under Article 43, Article 20 (5) (a) and (b) require the State to make available adequate resources giving priority to ensuring the widest possible enjoyment of the rights having regard to prevailing circumstances, including the vulnerability of particular groups or individuals.

The Constitution of Kenya Articles 23 and 165 grant the High Court of Kenya the jurisdiction to determine applications for the redress of a denial, violation or infringement of or a threat to a right or fundamental freedom in the Bill of Rights including the right to health. Article 22 gives every person the right to institute court proceedings claiming their rights have been denied, violated, infringed, or threatened. The person includes a person acting in their interest; a person acting on behalf of another person who cannot act in their name; a person acting as a member of, or in the interest of, a group or class of persons; a person acting in public interest; or an association acting in the interest of one or more of its members. Article 20 (3) (b) requires the court to adopt the interpretation that most favours the enforcement of a right or fundamental freedom and the Chief Justice is required under Article 22 (3) to make rules for the court proceedings in respect of the claims that certain right(s) has been denied, violated or infringed, or is threatened. The High Court may therefore declare rights, issue an injunction to stop the violation of rights, and declare the invalidity of any law, policy, or other instruments that facilitate the denials, violations, and infringements that threaten the right to health. The High Court may also issue an order of compensation in some instances.

The Kenya National Commission on Human Rights (KNCHR), the National Gender and Equality Commission (NGEC) and the Commission on Administrative Justice (CAJ) play different roles in providing oversight on matters relating to human rights and monitoring the implementation of human rights and administrative Justice in Kenya. The Kenya National Human Rights and Equality Commission, under Article 59 (2) (e) and (f) of the Constitution of Kenya, is given the

power to, among other things, receive and investigate complaints about alleged abuses of human rights and take steps to secure appropriate redress where human rights have been violated; and on its own initiative or on the basis of complaints, to investigate or research a matter in respect of human rights, and make recommendations to improve the functioning of State organs. The National Gender and Equality Commission is particularly mandated under its statute to work with other relevant institutions to develop standards for implementing policies for the progressive realization of the economic and social rights specified in Article 43 of the Constitution of Kenya and other written laws.

Until the promulgation of the Constitution of Kenya in 2010, the social and economic rights entrenched in Article 43 were not justiciable and the courts were barely confronted with the question of the right to health. The advent of the Constitution of Kenya in 2010 has thus seen the jurisprudence on the right to health developing, with several cases instituted on claims of violation or infringement on the right to health. These claims have allowed the Judiciary to interpret the Constitution of Kenya and give meaning to the right to health as guaranteed in the Bill of Rights.

Below are highlights of some relevant cases relating to the right to health under the Constitution of Kenya 2010.

*PAO and others v Attorney General (Petition 409 of 2009)*⁸⁴

This was the first case on the right to health determined under the Constitution of Kenya 2010. The PAO case challenged the constitutionality of Sections 2, 32 and 34 of the Anti-Counterfeit Act, 2008, which it was argued were likely to adversely affect access to affordable medicines, especially generic anti-retroviral medication for persons living with HIV which adversely affected their rights to life, human dignity and health.

Claim: The Petitioners averred that the Act adopted a broad definition of counterfeit goods encompassing generic medication and gave the police wide powers to confiscate such medication. This would substantially increase the cost of HIV medication, making it unaffordable to the more vulnerable people relying on generic medication.

Finding: Considering the normative framework of the right to health, the Court found that: Section 2 of the Anti-Counterfeit Act could be read to include generic medication and was likely to adversely affect the manufacture, distribution and sale of generic drugs; and that unavailability of essential lifesaving medicines would have adverse consequences to the right to health, dignity and life of the Petitioners.

Significance of the case: The importance of this case is its finding that the right to health in-

⁸⁴ *High Court of Kenya (2012) 'Petition 409 of 2009, P.A.O and 2 others Vs Attorney General,' High Court of Kenya, Nairobi*

cludes access to affordable medicines and that rights are indivisible and interrelated. The Court held that: *“In my view, the right to health, life and human dignity are inextricably bound. There can be no argument that without health, the right to life is in jeopardy, and where one has an illness that is as debilitating as HIV/AIDS is now generally recognised as being, one’s inherent dignity as a human being with the sense of self-worth and ability to take care of oneself is compromised”* (High Court of Kenya, 2012:15).

*Kenya Society of the Mentally Handicapped (KSMH) v Attorney General and Others (Petition No. 155A of 2011)*⁸⁵

This case touched on the inadequacy of Kenya’s policy framework regarding persons living with mental disability and their ability to realize their fundamental rights.

Claim: The Petitioner sought a declaration that the rights of persons with mental disabilities had been violated due to their unequal treatment and that a sound legal framework addressing the needs of persons with mental disabilities, including their health, needed to be established. The Petitioner argued that *“there is entrenched stigma and discrimination against people with mental, intellectual and psychosocial disabilities; and low level of awareness on their rights to inclusive health services together with informed habilitation and rehabilitation services, in line with the Kenya Constitution 2010 and the UN Convention on the Rights of Persons with Disabilities”* (High Court of Kenya, 2012:2).

Finding: While the Court found that persons with mental disabilities face many challenges, the Court held that the Petition was inadequate for it to conduct the necessary inquiry based on the facts and evidence before it.

Significance: This case illustrates the importance of proper and adequate presentation in public interest cases, given that seeking to enforce fundamental rights does not immunize one from the rules of procedure.

*Okwanda v Minister of Health and Medical Services and 3 Others (Petition 94 of 2012)*⁸⁶

An elderly man, Michael Okwanda, who suffered from diabetes mellitus and lacked the financial means to manage his illness due to the cost of care, filed this case.

Claim: The Petitioner sought a declaration that he was entitled to several rights, including the highest standard of health as guaranteed by Article 43 of the Constitution and Article 11 of IC-ESCR (High Court of Kenya, 2013).

⁸⁵ High Court of Kenya (2012) ‘Petition No 155A of 2011, Kenya Society of the Mentally Handicapped (KSMH) v Attorney General and Others,’ High Court of Kenya, Constitutional and Human Rights Division, Nairobi

⁸⁶ High Court of Kenya (2013) ‘Petition 94 of 2012, Mathew Okwanda v Minister of Health and Medical Services and 3 others,’ High Court of Kenya, Constitutional and Human Rights Division, Nairobi.

Finding: The Court emphasised the importance of socio-economic rights in ameliorating the conditions of poor and vulnerable individuals and populations living in the margins of society. The Court stated that the failure to address the issues of poverty, ignorance, unemployment and disease would undermine the foundation of the Constitution of Kenya. The Court stated, *“On the basis of the material before the court, I find that at least the Government Hospitals provide healthcare to the petitioner at a cost. Whether the form of healthcare provided in these circumstances meets the minimum core obligation or the highest standard is not one that was the subject of evidence and argument before me. The prohibitive costs involved in accessing the treatment and whether such treatment should be free, bearing in mind the necessity to progressively realize these rights, were not explored in the depositions. Therefore, there is no basis upon which I can find one way or the other”* (High Court of Kenya, 2013:6).

Significance: While the Court affirmed that all Kenyans should access the right to health, it found that no violation of the right to health had been proven. This finding was more or less similar to the Court finding in the case of *Kenya Society of the Mentally Handicapped (KSMH) v Attorney General and Others*.

*Luco Njagi and 21 Others v The Ministry of Health and 2 others (Petition No. 218 of 2013)*⁸⁷

The Petitioners, all persons suffering from renal failure, brought this petition to compel the Ministry of Health to cover the cost of renal dialysis in private facilities. The Kenyatta National Hospital (KNH), where the Petitioners accessed treatment, was not adequately equipped to address the Petitioners’ needs. The Court in this case, was called to decide on the realization of the right to health for individual citizens as against the resources available in the Country.

Claim: The Petitioners argued that due to the congestion of the dialysis machines at KNH, they were forced to pay for similar services at a private hospital for about Kshs 178,000 as compared to the subsidised fees offered by KNH of Kshs 5,000. This was contended to violate the right to health as guaranteed in the Constitution.

Finding: The Court found that the State is primarily obligated to ensure the highest attainable health. However, the Court concluded that the State had not failed to meet its obligation in this case. Looking at the provisions of (Article 20(5)), the Court found that the State had shown that it had met its obligation within the resources available. The Court stated: *“In the case before me, the petitioners all suffer from chronic renal failure, and as they aver, need dialysis two or three times a week. They ask the court to intervene and ask that the state subsidize their treatment at private institutions. In making this demand, they ask the court to interfere with matters of policy which, as the Constitution enjoins in Article 20(5), should be left to the State, as the court is not suited, and does not have the requisite information, to enable it decide as to the best use of scarce resources in the health sector vis a vis other equally critical, sectors”* (High

⁸⁷ High Court of Kenya (2015) ‘Petition No 218 of 2013, Luco Njagi and 21 others v Ministry of Health and 2 others,’ High Court of Kenya, Constitutional and Human Rights Division Nairobi

Court of Kenya, 2015:15).

Significance: The case demonstrates the difficulty in enforcing and litigating on the right to health since the implementation of the socio-economic rights guaranteed under Article 43 of the Constitution are limited by the economic situation within the country and the available resources. Therefore, even in a case such as this, where the health and lives of persons are clearly under threat due to their inability to access healthcare, this may not violate their right to health.

*W.J and another v Astarikoh Henry Amkoah and 9 others (Petition No. 331 of 2011)*⁸⁸

This petition was brought against a teacher accused of defilement. The case's background is that the deputy head teacher defiled both the petitioners' who were minors. This case illustrates how the right to health interacts with other rights, particularly the convergence between the right to health, reproductive health and sexual violence.

Finding: In its determination, the Court considered the right to health of the petitioners in terms of physical well-being and psychological health, which could be severely impacted by sexual violence. The Court held that: *"I agree with the petitioners and the interested parties, as well as the Amicus Curiae, that the consequences of sexual violence against minors are severe: they can affect their physical and emotional well-being, and expose them to the risk of contracting sexually transmitted illnesses, thus affecting their right to health. In addition, the fact that their psychological well-being was affected clearly violates their right to health, which is defined as including the highest attainable standard of physical and mental well-being"* (High Court of Kenya, 2015:20).

Significance: The W.J case illustrates the Judiciary's interpretation of the right to health and assertion that the Court will not look at rights in isolation and is willing to infer a number of violations from one act.

*KELIN and three others v The Cabinet Secretary for the Ministry of Health and Others (Petition No. 250 of 2015)*⁸⁹

This case came up against the backdrop of President Uhuru Kenyatta's directive in February 2015 to the County Commissioners to work with County Directors of Education and Medical Services to collect up-to-date data and prepare a report on all school going children who are living with HIV, information on their guardians, number of expectant mothers who are living with

⁸⁸ High Court of Kenya (2015) 'Petition No 331 of 2011, *W.J and another v Astarikoh Henry Amkoah and 9 others*, ' High Court of Kenya, Constitutional and Human Rights Division, Nairobi

⁸⁹ High Court of Kenya (2016) 'Petition No 250 of 2015, *Kenya Legal and Ethical Network on HIV & AIDS (KELIN) & 3 others v Cabinet Secretary Ministry of Health & 4 others*, High Court of Kenya, Constitutional and Human Rights Division, Nairobi

HIV and number of breastfeeding mothers living with HIV. Implementing this directive was deemed to have threatened the fundamental human rights of persons living with HIV (PLHIV) in Kenya.

Claim: The Petitioners argued that the data collection was to be done in a prescribed data matrix that would directly link the targeted persons with their HIV status, thus putting them at risk of being stigmatised and discriminated against. There was a further risk of compulsory testing to acquire the data, violating their right to privacy and disclosure of information. The Petition focused on several rights, including the rights to health, privacy, equality, dignity, free from cruel, inhumane and degrading treatment and the principle of the best interests of a child.

Finding: While the Petition focused on several rights, the Court limited itself to the right to privacy and the best interest of the child principle. The Court held that: *“I have already found that disclosure of the results of HIV tests of an individual and the providing of any information that directly identifies a person to whom HIV test relates, violates the confidentiality of the medical records as stipulated under Section 20 of the [HIV and AIDS Prevention and Control Act, 2006]. That is all that can be said of the matter because the directive intended to put specific measures and strategies to target the affected persons to guarantee their right to health services. The focus of the directive per se and its implementation was on granting that right instead of taking it away. In the event, I do not see how the right to health was violated as alleged”* (High Court of Kenya, 2016:45).

Significance: The Court found no link between an infringement of privacy and an ability to enjoy the highest attainable standard of health. This judgment was contrary to previous findings of the Court in the W.J. Case that found that the right to health is inextricably linked to other rights⁹⁰ and failed to consider the adverse consequences a violation of the right to privacy can have on seeking health services particularly for persons living with HIV.

*Maimuna Awour and another v The Attorney General and Others (Petition No. 562 of 2012)*⁹¹

This case was about two women detained in Pumwani Maternity Hospital for their inability to pay maternity fees in 2012. The Petitioners, represented by the Centre for Reproductive Rights, were detained in deplorable conditions (the second petitioner was forced to sleep on the floor for 7 days) until it was possible for their spouses and family to raise enough money to pay for their fees and they were discharged.

Claim: This case touched on several issues, including unlawful detention, the right to health, dignity, liberty, and freedom from cruel, inhumane and degrading treatment.

⁹⁰ High Court of Kenya (2015) ‘Petition No 331 of 2011, W.J and another v Astarikoh Henry Amkoah and 9 others,’ High Court of Kenya, Constitutional and Human Rights Division, Nairobi

⁹¹ High Court of Kenya (2016) ‘Petition No 562 of 2012, Maimuna Awuor (MA) & Another v Honourable Attorney General & 4 others,’ High Court of Kenya, Constitutional and Human Rights Division Nairobi

Finding: On the right to health, the Court was guided by the CESC and held that “*In this regard, ICESCR requires state parties to ensure that health services are available, accessible, acceptable, and of good quality. It interprets availability to encompass ...not only...timely and appropriate health care but also...the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related ... information.....Accessibility requires non-discriminatory access to health facilities, goods and services, ...especially [for] the population’s most vulnerable or marginalised sections. In addition, accessibility also requires that health services be available and free from discrimination; they must be physically accessible; and they must also be economically accessible, that is, affordable*” (High Court of Kenya, 2016:23).

Significance: This case is unique because it unpacked the right to health, finding that health services must be available, accessible, acceptable and of good quality (AAAQ), and it held that accessibility speaks to more than physical accessibility; prohibitive costs would render health services inaccessible. Secondly, it awarded damages for the violation of fundamental rights.

*Jesca Moraa (on behalf of the late Alex Madaga Matini) and Kenyatta National Hospital and Coptic Hospital (The Kenya Medical Practitioners and Dentists Board, Professional Conduct Committee Case No, 2 of 2016)*⁹².

This case related to professional misconduct brought before the Professional Conduct Committee (PCC) of the Kenya Medical Practitioners and Dentists Board (KMPDB) Professional Conduct Committee, 2016. While it was not argued in a court, it illustrates the interpretation of the right to emergency treatment as guaranteed in Article 43(2) of the Constitution. Alex Madaga was involved in a road accident as a result of which he needed intensive care. He later died due to a delay in accessing the required care. The delay resulted from a refusal by various hospitals to admit Alex for the needed care over a period of 2 days. Before he died, Alex Madaga was taken to five hospitals: PCEA Kikuyu, which examined him and stabilised him but did not have an intensive care unit (ICU); the Nairobi Women’s Hospital and Ladnan Hospital, which both indicated that they were unable to admit him because they had no space in their ICUs; and finally, KNH and Coptic Hospital where he was neither examined nor admitted.

Claim: Alex Madaga’s counsel argued that KNH refused and failed to grant Alex emergency treatment in contravention of Article 43(2) of the Constitution.

Finding: The Professional Conduct Committee (PCC) found that KNH was not liable for failing to provide Alex Madaga with emergency treatment because ICU care did not amount to

⁹² Professional Conduct Committee (2016) ‘Professional conduct committee Case No, 2 of 2016, Jesca Moraa on behalf of the late Alex Maaga Matini Vs Kenyatta National Hospital and Another,’ The Medical Practitioners and Dentists Board, Kenya

emergency treatment. The PCC found that Alex Madaga had received emergency treatment at PCEA Kikuyu hospital.

Significance: While this complaint did not lead to a finding that Article 43(2) was violated, it did highlight various challenges in the health sector regarding emergency cases which led the PCC to direct that KMPDB develop and disseminate policies and guidelines for referral of emergency cases.

*AIDS Law Project v Attorney General and 3 others*⁹³

This case focused on the interaction between the right to health and interrelated rights such as privacy and criminal law. The case was centred on Section 24 of the HIV and AIDS Prevention and Control Act, 2006, which criminalised HIV transmission under prescribed circumstances.

Finding: While this case touched on the negative aspects of criminalisation of transmission, particularly stigma and discrimination on persons living with HIV, the Court's finding was grounded on the vagueness and over-broadness of Section 24, which the Court rendered unconstitutional. The Court held that: "...it is impossible to state with certainty and precision how the targets of the section are expected to conduct themselves and in respect of whom. Are, for example, children ...sexual contact... in relation to their mothers and if so, how is the disclosure supposed to take place between the mother and the child? As drafted, section 24 of the Act is so broad that it could be interpreted to apply to women who expose or transmit HIV to a child during pregnancy, delivery or breastfeeding. Such overbroad legislation is to be deprecated, and the spirit of the Constitution and its principles frowns upon such overbroad enactments (High Court of Kenya, 2015:14).

Significance: Without explicitly stating so, the case touched on the interaction between the right to health and criminal law. The Court took cognizance of the adverse effects of stigma and discrimination on people living with HIV and how a provision obliging them to disclose their status could worsen such stigma. The Court also considered that such vague and overbroad legislation could negatively impact public health because stigma may lead to a reluctance to approach medical facilities for preventative or curative measures.

*JOO (also known as JM) v. Attorney General and 6 others (Petition No. 5 of 2014)*⁹⁴

JOO (J.M.) sought maternal health care at the Bungoma County Referral Hospital. In line with the President of Kenya's 2013 Presidential Directive that public health facilities were expected to provide free maternal health care, J.M. was told to pay for medicine to induce her labor.

⁹³ High Court of Kenya (2015) 'Petition No 97 of 2010, Aids Law Project v Attorney General & 3 others,' High Court of Kenya, Civil Division, Nairobi

⁹⁴ JOO (also known as JM) v. Attorney General and 6 others Petition No. 5 of 2014 [2018] eKLR

But after her labor was induced, she was ordered to walk to the delivery room when her labor pains started. She followed the directive, found the delivery beds occupied, and began to return to the labor ward, when she fainted. While unconscious, she delivered her baby. She awoke to nurses shouting at her, hitting her, and commanding her to return to the delivery room to deliver her placenta. Without her knowledge, the clip was filmed by a fellow patient, and it was later picked up by journalists and shown on the national news. J.M. only realized the extent of her mistreatment when she saw the video after the incident.

Claim: J.M. brought the case against county and national authorities, challenging the disrespectful and abusive treatment she received and demanding that the government address the infrastructure challenges of the healthcare system in Kenya. She claimed the verbal and physical mistreatment, disrespect to her dignity, and government failure to guarantee adequate maternal care violated her constitutional rights and rights under the African Charter on Human and Peoples' Rights and several other international human rights treaties, including ICESCR and CEDAW.

Finding: Although the Attorney General and national Cabinet Secretary for Health maintained that the Ministry of Health had executed its mandate to set standards and policies for health care, and the hospital and County Government claim that J.M. had not followed the correct grievance procedure and that internal investigations absolved the nurses of mistreatment, the Court found that the hospital's treatment of J.M. violated several rights under the Kenyan Constitution and international law. The Court observed that the Bungoma hospital did not have space or personnel to adequately attend to J.M. and other women who needed maternal care. Given these standards, the hospital's inadequacies; lack of equipment, basic supplies, and drugs; and low quality of care violated J.M.'s right to health. The Court also found that the government violated J.M.'s constitutional and international right to dignity and to freedom from cruel, inhuman, and degrading treatment because she was forced to give birth on the floor in an open area where other patients could film her, and because the nurses verbally and physically abused her in cruel and demeaning ways. The Court further made explicit the link between the violation of J.M.'s right to health and national policy. In this regard, the Court reasoned that the government failed to develop and implement effective policies and dedicate the mandated maximum available resources to achieve quality maternal health care. In particular, the Court found the authorities *"have not devoted adequate resources to healthcare services, have not put in place effective measures to implement, monitor and provide minimum acceptable standards of healthcare."* The Court ordered that J.M. be given a formal apology from the nurses, the County health secretary, and the hospital and be awarded damages.

Significance: The case built on *Millicent Awuor (Maimuna) and Margaret Anyoso Oliele V AG and others*, in which the Court found gender and socioeconomic discrimination—as well as cruel, inhuman, and degrading treatment—of two women detained after childbirth for failure to pay medical fees. This case sets a precedent that women must be provided quality maternal

care and that government failure to implement policies can be directly tied to violating citizens' rights to healthcare and dignity. Because the video of J.M.'s abuse was shown on national television, her case has drawn more attention to the crisis of institutional negligence in maternal health care in Kenya. The case demonstrated the desperate situation in public health facilities, including overcrowding, precarious conditions, and a lack of supplies, which drives up rates of infant and maternal mortality and puts substantial pressure on staff to get patients in and out quickly, which may influence unethical practices. This case may help address such systemic issues by drawing attention to the responsibilities of policymakers that flow from constitutional and international human rights law.

*Okiaya Omtatah Okiita, Muslims for Human Rights (Muhuri) and George Bush vs. Cabinet Secretary for Health & 2 Others (Consolidated Petitions Nos. 140 of 2020, 128 of 2020 and 28 of 2020)*⁹⁵

This case was instituted against the backdrop of the government's measures to contain the spread of the Covid-19 pandemic in Kenya and the claim that the decision to quarantine members of the public at various facilities and forcing them to pay for their upkeep was contrary to Section 27 of the Public Health Act and that the National and County governments failed to ensure that persons who were undergoing isolation and quarantine were provided with the highest attainable health care and accessible and hygiene friendly housing.

Claim: The consolidated case claimed that the Government's actions on compulsory/forceful isolation quarantine blatantly disregarded Section 27 of the Public Health Act; that the failure of the Government to strictly adhere to Section 27 of the Public Health Act strictly put previously uninfected people in isolation facilities at risk of getting infected from fellow, infected detainees in breach of Article 43(1)(a) of the Constitution, Section 4(a) and 5(1) and (2) of the Health Act; that contrary to the express provisions of Section 27 of the Public Health Act, 1921 Cap 242 Laws of Kenya, the Cabinet Secretary forced persons in compulsory quarantine at the Government designated quarantine and/or isolation centres to pay for their upkeep, medical, accommodation and general expenses incurred yet the law requires the State to foot their bills; that the said isolation centres were in poor degradable conditions and lacked sufficient number of beds, food and other essential basic human needs required by the standards of health contrary to the constitutional provisions; and that the Cabinet Secretary declined to acknowledge the sanctity of life and denied the poor Kenyans the right to medical services.

Finding: In its determination, the Court found that the decision to quarantine members of the public at various facilities without an order of the magistrate and forcing them to pay for their upkeep was contrary to Section 27 of the Public Health Act and unconstitutional. The Court,

⁹⁵ *High Court (2020), the Consolidated Petitions Nos. 140 of 2020, 128 of 2020 and 28 of 2020, Okiaya Omtatah Okiita, Muslims for Human Rights (Muhuri) and George Bush vs. Cabinet Secretary for Health & 2 Others, High Court of Kenya, Constitutional and Human Rights Division Nairobi*

however, declined to order the government to refund in full the money to each person who it quarantined and was forced to pay for their upkeep on the account that such prayer was not particularized, specifically pleaded and strictly proved and that the County Governments who were required to make payments had not been joined as parties.

Significance: This case stated the duty of the government to bear the costs related to medical, accommodation and general upkeep of persons in compulsory quarantine while at the Government designated quarantine and/or isolation centres as provided in the law. While the Court appeared to affirm the right to the highest attainable standard of health care guaranteed under Article 43(1) (a) and that the standard care must be judged holistically, any claim for refund or compensation in the event of violation or infringement of the rights the affected persons must be specifically pleaded and strictly proved being a claim for special damages. The responsible or impugned parties required to refund or pay special damages must be enjoined in such pleadings as respondents or interested parties.

Other cases, while not explicitly referring to the right to health, are relevant to adjudicating the right to health in Kenya. These include the case of *Daniel Ng'etich and others v The Attorney General and Others*.⁹⁶ This case was filed by KELIN and two persons infected with tuberculosis. The Petitioners brought to the fore the tension between public health considerations and individual liberties with the court indicating the necessity of finding a balance between public health and individual liberties in that the State cannot unjustifiably limit the rights of individuals as a public health measure (Maleche and Were, 2016).⁹⁷

In the case of *AAA v Registered Trustees (Aga Khan University Hospital Nairobi)*⁹⁸. Although this case centred on the principles of negligence to determine a duty of care and breach of said duty, the court found the respondent liable for failing to provide contraceptive services, which resulted in a child being born and a violation of the right to reproductive health which includes the right to choose if to have a child, when to have a child and how to space your children (UNFPA, 2016).⁹⁹

The *Law Society v Cabinet Secretary for Health & Another* case¹⁰⁰ challenged the legality of the Public Health (COVID-19 Restriction of Movement of Persons and Related Measures) Rules,

96 High Court of Kenya (2016) 'Petition No 329 of 2014, Daniel Ng'etich & 2 others v Attorney General & 3 others,' High Court of Kenya, Constitutional and Human Rights Division Nairobi

97 Maleche A and Were N (2016) Petition 329 'A Legal Challenge on the Involuntary Confinement of TB Patients in Kenyan Prisons' Health and Human Rights Journal, 18(1).

98 High Court of Kenya (2015c) 'Civil Case No 3 of 2013, AAA v Registered Trustees – (Aga Khan University Hospital, Nairobi),' High Court of Kenya, Civil Division, Nairobi

99 United Nations Population Fund (UNFPA) (2016) 'ICPD Beyond 2014 High-Level Global Commitments', UNFPA

100 High Court of Kenya (2020), Petition No. 132 of 2020, Law Society of Kenya v Attorney General & another; National Commission for Human Rights & another (Interested Parties), Constitutional and Human Rights Division Nairobi [2020] eKLR

2020 and the legal notices thereunder. The petitioner alleged that the impugned Regulation was discriminatory to the poor/needy/vulnerable persons in the society on account of their failure to provide for means by which the poor/needy/vulnerable persons would acquire face masks spelt out in Regulation 6 (1) (b), thus violating their socio-economic rights, including their right to health under Article 43 of the Constitution of Kenya. The court declined to accede to the declarations sought, finding that publishing the Regulation and Rules was not aimed at disadvantaging any person but at protecting everyone equally from the threat of COVID-19. The court found that such law should embrace the provisions of Article 43 of the Constitution of Kenya and ensure every person has the right to the highest attainable standard of health, which should include the right to health care services, especially the older members of the society, poor and vulnerable. The court argued that by allowing the reliefs sought, Kenyans would be exposed to unnecessary health risks and death in worst-case scenarios. The measures and steps undertaken under the Public Health (Prevention, Control and Suppression of COVID-19) Regulations, 2020, should therefore be supported for the good of all Kenyan people.

4.4.1 Gaps and challenges

Despite the entrenchment of the right to health as a guaranteed human right under the Bill of Rights of the Constitution of Kenya and the Judiciary's significant efforts to develop robust jurisprudence on the right to health, several challenges remain in the judicial enforcement of the right. These include the normative interpretation of the right to health; the appropriate remedy when the right to health has been infringed, violated or threatened; and how to monitor the implementation of the right.¹⁰¹ In addition, the cases on the right to health have illustrated not only the difficulties in litigating the cases, particularly with regard to proving a violation has occurred but also the resource constraints and their effect on the realization or enjoyment of the right to health (KELIN 2018).¹⁰² The cases have also demonstrated that violations or lack of attention to the right to health and related human rights contribute to denial of dignity and exacerbate poor health, including mental and physical health outcomes and discrimination in delivering quality healthcare services (WHO, 2017).¹⁰³

101 Mbicha, Evans Ayiema (2014), *Judicial Enforcement of the Right to Health under the New Constitution of Kenya, A Thesis Submitted in Partial Fulfilment of the Requirements for the Masters of Laws (LLM) Degree of the University of Nairobi*, October 2014.

102 Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) (2018), *Mapping the constitutional provisions on the right to health and the mechanisms for implementation in Kenya: A case study report*, KELIN, Regional Network for Equity in Health in East and Southern Africa (EQUINET), December 2018, Kenya

103 WHO (2017), *Fact Sheet on Human rights and health*, 29 December 2017. <https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health> Accessed on 4th March 2022

4.5 Health System and Intergovernmental Framework for Health Service Delivery

The most significant feature of the Constitution of Kenya is the introduction of a devolved system of government consisting of the National Government and 47 County Governments. The governments at the national and county levels are “distinct and interdependent” and are expected to undertake their relations through “consultation and cooperation” (Article 6). The distinctiveness of both levels of government are determined by the functions assigned to each level of government under the Fourth Schedule of the Constitution of Kenya. In line with Article 186 of the Constitution of Kenya 2010, the health functions are broadly classified as exclusive, concurrent and residual functions. However, to a large extent, the powers and functions relating to health including the implementation of the right to health guaranteed under Article 43 (1) (a) and (2) is shared between both levels of government. To this end, Article 21 tasks the State at both the national and county level with a duty of taking legislative, policy and other measures to achieve the progressive realization of economic and social rights, including the right to health guaranteed under Article 43 of the Constitution of Kenya.

Under the Fourth Schedule of the Constitution of Kenya, the National Government is assigned the responsibility for national health policy, national referral health facilities, disaster management, port and international health, capacity building and technical assistance to the counties, public investment, regulation, quality assurance and standards, and national healthcare agencies, infectious disease control programs, national statistics and data on population, education policy, university and tertiary education and research institutions among others. Article 6 (3) of the Constitution of Kenya requires national state organs to ensure reasonable access to their services in all parts of the Republic in so far as they are appropriate to do so having regard to the nature of the service. County Governments are responsible for county health services, including county health facilities and pharmacies, ambulance services, and promotion of primary health care, among others. Regulation and management of human resources for health at national and county levels is conducted within the norms and standards set by the National Government in accordance with the relevant legislation and policies. Table 6 below shows the assignment and distribution of health sector functions between the National Government and County Governments under the Fourth Schedule of the Constitution of Kenya.

Table 6: Assignment and distribution of health sector functions under the Fourth Schedule of the Constitution of Kenya 2010

Functions of County Government and National Government (Fourth Schedule) in Health	
Constitution of Kenya Fourth Schedule Part I	Constitution of Kenya Fourth Schedule Part II
<ul style="list-style-type: none"> 1. Foreign affairs and foreign policy 11. National statistics and data on the population 14. Consumer protection 16. Universities, tertiary educational institutions and other institutions of research and higher learning 21. General principles of land planning and the coordination of planning by the counties. 23. National referral health facilities. 28. Health Policy. 32. Capacity building and technical assistance to counties 33. Public Investment 	<ul style="list-style-type: none"> 2. County health services, including, in particular— <ul style="list-style-type: none"> (a) county health facilities and pharmacies; (b) ambulance services; (c) promotion of primary health care; (d) licensing and control of undertakings that sell food to the public; (e) veterinary services (excluding regulation of the profession); (f) cemeteries, funeral parlours and crematoria; and (g) refuse removal, refuse dumps and solid waste disposal. 3. Control of air pollution, noise pollution and other public nuisances 8. County planning and development, including statistics 11. County public works and services, including— <ul style="list-style-type: none"> (a) stormwater management systems in built-up areas; and (b) water and sanitation services. 12. Firefighting services and disaster management. 13. Control of drugs and pornography. 14. Coordination of community participation in governance at the local level

Exclusive Functions of State and County Departments of Health	
National	County: County health services including
<ul style="list-style-type: none"> • KNH • Moi Teaching and Referral Hospital (MT&RH) • Kenyatta University Teaching and Referral Hospital • Kenya Medical Training College (KMTC) • KEMSA • National Hospital Insurance Fund (NHIF) • National Quality Control Laboratory (NQCL) • National Blood Transfusion Services • Pharmacy and Poisons Board • National Public Health Laboratory • Government Chemist • Radiation Protection Board • Kenya Medical Research Institute (KEMRI) • Mathari Mental Hospital • Spinal injury Hospital 	<ul style="list-style-type: none"> • County health facilities and services • Primary and community health services • Environmental health services • Communicable Disease Control • Nutrition • Family Planning Maternal and Child Health • Health Education • Health Informative System • Food Control Administrative Services • Vector Borne Disease Control • Communicable Disease Control and Management • County health Planning • Water and sanitation services • Rural Health Training and Demonstration Centres
Concurrent functions between national and county governments in health	
National	County
<ul style="list-style-type: none"> • Resource mobilization • Quarantine administration • Disaster preparedness • Emergencies/outbreaks • Partnerships (Public and Private), including intergovernmental relations • Planning and budgeting • Legislation • Procurement of health products and technologies • Disease prevention & control (policy & coordination) • Monitoring and Evaluation • HIS • Health financing (Policy & regulation) • HRH management and development 	<ul style="list-style-type: none"> • Resource mobilization • Quarantine administration • Disaster preparedness • Emergencies/outbreaks • Partnerships (Public and Private), including inter-governmental relations • Planning and budgeting • Legislation • Procurement of health products and technologies • Disease prevention & control • Monitoring and Evaluation • HIS • Health financing (implementation) • HRH management and development

Residual functions (National level)	
Residual functions	<ul style="list-style-type: none"> • Regulation of Health Products & Technologies • Regulation, setting norms and standards • Regulation of Health Professionals & Services (Boards & Councils) • Port health services • International health relations and diplomacy • International Health Regulations (IHR) • Regulation of medical training (tertiary & middle level) • Health Research • Food Safety Policy & Regulation • Regulation of the health professions

The First Schedule to the Health Act 2017 outlines the technical classification of levels of health service delivery in Kenya. These include - Level 1: Community Health Services; Level 2: Dispensary/Clinic; Level 3: Health Centre; Level 4: Primary Hospital; Level 5: Secondary Hospital; and Level 6: Tertiary Hospital. The first five levels (Levels 1-5) are managed within the county health system, while the National Government manages the sixth level within the national health system. The patients may move from one level to the next within the health service delivery system using a referral letter.

Health services in Kenya are provided by government facilities across the six levels of service, faith-based health facilities and private health facilities. Private medical practitioners also directly provide services to a relatively small population through clinics. The National Government, in consultation with stakeholders, is expected to define essential health services package and delivery system, taking into account the six lifecycle cohorts for which services are to be provided, as follows (a) pregnancy and the newborn child (up to 28 days of age); (b) early childhood (28 days to 5 years); (c) late childhood (6 to 12 years); (d) adolescence and youth (13 to 24 years); (e) adulthood (25 to 59 years); and elderly (60 years and over).

Since health functions and concerns, including pandemics and other public health issues, go beyond the boundaries of a single County Government or require cross-county and often require National Government intervention and action, intergovernmental mechanisms and responses are imperative. Thus, given the interdependence of the health functions, the Constitution of Kenya under Articles 6 and 189 place a duty on the two levels of government to consult and cooperate to ensure a harmonious and coordinated delivery of health services in the country. The governments at either level can cooperate by assisting, supporting, consulting and, as

appropriate, implementing the legislation of the other level of government; liaising with the government at the other level to exchange information, coordinate policies and administration and enhance capacity; and co-operating in the performance of functions and exercise of powers and, for that purpose, may set up joint committees and joint authorities; and setting up mechanisms for resolving intergovernmental disputes. The Intergovernmental Relations Act 2012 provides for the establishment of structures to facilitate intergovernmental relations. These structures include the Summit, the Council of Governors, the Sectoral Intergovernmental Forums and the Intergovernmental Technical Committee.

Intergovernmental cooperation for better service delivery in the health sector may take different forms, including facilitation of a particular health service to many needy people across all the counties, adjacent counties sharing a facility or facilities or equipment and costs for the benefit of the residents of all the counties; and joint purchase drugs and commodities as a cost-effective measure among others. This, however, must be conducted in a manner that respects the functional and institutional integrity of government at the other level and respects the constitutional status and institutions of government within the county level.

4.5.1 Gaps and challenges

Kenya's health system faces several challenges that negatively affect access to quality of healthcare services and the realization of the right to health. These include inequitable access to quality health care, including skilled care for the poor and 'hard-to-reach' communities; inadequate essential drugs, equipment, medical supplies and infrastructure; inadequate investment in community health programs and services; inadequate preparedness to handle health emergencies, including pandemics; weak systems to ensure continuity of patient care; inadequate budgetary allocation and insufficient government expenditure on preventive and promotive health services; weak intergovernmental and inter-sectoral coordination within the health system; critical shortage of health care personnel; inadequate use of e-health and innovations; and weak systems for monitoring the implementation and violation of the right to health and for holding duty bearers accountable.

CHAPTER FIVE

ASSESSMENT OF THE CHALLENGES AND GAPS INHIBITING ENJOYMENT OF THE RIGHT TO HEALTH IN KENYA

The purpose of this study was to review existing legal and policy frameworks related to the right to health and identify the challenges and gaps that inhibit the enjoyment of the right to health. This chapter assesses the challenges and gaps inhibiting equitable access to and full enjoyment of the right to highest attainable standards of health and health care services in Kenya.

5.1 Assessment of the Challenges and Gaps Inhibiting the Full enjoyment of the Right to Health

One of the major dimensions of the right to health is the right to access health services and the protection of public health.¹⁰⁴ This implies the obligation of the State not only to provide timely and appropriate health care but also to address the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.¹⁰⁵

In Kenya, Articles 42 and 43 of the Constitution guarantee every person the right to a clean and healthy environment, the highest attainable standards of health, including the right to healthcare services and reproductive healthcare, emergency medical treatment as well as the right to accessible and adequate housing, and reasonable standards of sanitation, adequate food of acceptable quality, clean and safe water in adequate quantities, education and social security. According to the Committee on Economic, Social and Cultural Rights in its General Comment 14, full enjoyment of the right to health comprises four essential elements: availability, accessibility, acceptability and quality (AAAQ).

This section presents the findings on the challenges and gaps in ensuring equitable access to health care services and the full enjoyment of the right to health within the AAAQ framework. Equitable access to healthcare services requires that every person is able to receive healthcare services that improve their health at a cost that does not portend catastrophic financial burden and that no one is left behind due to their economic and social circumstances, including the poor, vulnerable, marginalized and disadvantaged

104 Eide WB and Kracht U (eds) (2005), *Food and Human Rights in Development: Legal and Institutional Dimensions and Selected Topics (Volume 1, Intersentia 2005)*

105 Committee on Economic, Social and Cultural Rights (CESCR) General Comment 14 Para 11.

5.1.1 Availability

The availability element of the right to health implies that healthcare facilities, goods, services and programmes are made available in sufficient quantities within safe physical reach. These include the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential medicines.¹⁰⁶

While over the last two decades, the number of health facilities has more than doubled from 4,421 health facilities in 2001¹⁰⁷ to 9,064 health facilities in 2020,¹⁰⁸ and 70 per cent (33) of the counties have attained the WHO target on health facility density,¹⁰⁹ availability of health services remains highly inadequate and inequitable. The general health service readiness as a proxy of the coverage of essential services and health emergency preparedness are off-track.¹¹⁰ The country's core health workforce density at 15.6 per 10,000 population falls short of the WHO target of 23 per 10,000 population. The implication is that there are inadequate functional health facilities in Kenya to enable full enjoyment of the right to the highest attainable standards of health and health care services within safe physical reach, for example, at least five Kilometres radius for all citizens.

Asked about the challenges and gaps in making health care services available for all, the respondents interviewed cited several factors. These included: inadequate number of functional health facilities; regional disparities in the distribution of health facilities, especially in marginalized and remote areas and informal urban settlements; inadequate supply and frequent stock-outs of medicines and commodities associated with inadequate health facility capacity to plan and forecast and weak procurement processes that are often lengthy and marred with corruption; substandard health facilities and infrastructure; inadequate investment in promotive and preventive health care including community and home-based health care services; inadequate health system preparedness for health emergencies; weak referral systems; inadequate staffing and a critical shortage of essential health workforce; inadequate use of healthcare technology and innovations; and inadequate government expenditure on healthcare function within the county health systems. The respondents pointed out that even where health facilities may be available, a major hindrance to access to healthcare services is the shortage of healthcare workers and poor work environment, especially in public facilities.

The other challenges of making health care services available to all that the respondents identified included: rapid population growth rate; poor economic performance; high unemployment rates; high poverty levels; prohibitive cost of health care, and the inability of the majority of the

¹⁰⁶ Mbazira C, (2009) *Litigating Socio-Economic Rights in South Africa: A choice between Corrective and Distributive Justice* (Pretoria University Law Press 2009)

¹⁰⁷ Mulaki A. et al. 2019. http://www.healthpolicyplus.com/ns/pubs/11328-11600_KenyaHSARreport.pdf

¹⁰⁸ Kenya Gazette (2020), *Categorization of Health Facilities, the Medical Practitioners and Dentists Council*, Vol. CXXII — No. 24, Gazette Notice No. 786 4th February, 2020, Nairobi,

¹⁰⁹ Ministry of Health. *Kenya Harmonized Health Facility Assessment Report*. Nairobi, Kenya: s.n., 2019

¹¹⁰ Ministry of Health (2020), *Kenya Progress Report on Health and Health-related SDGs*, WHO, December, 2020

population to afford essential medical care; low health insurance coverage; gender inequality; environmental pollution; cultural and religious beliefs and practices; inadequate water supply and poor sanitation; poor roads and low electricity connectivity.

5.1.2 Accessibility

Accessibility to health services is determined by the ability of a health system to ensure that healthcare services are available to all without discrimination.¹¹¹ Accessibility has four overlapping dimensions: non-discrimination; physical accessibility; economic accessibility; and information accessibility. These dimensions imply that: health care services, including emergency medical care, are accessible to all without discrimination on any grounds and that the State must recognize and provide for the specific needs of groups that generally face particular health challenges or vulnerability to specific diseases or conditions; health care services are available within safe physical reach of all sections of the population, especially vulnerable or marginalized groups, such as minorities, women, children, adolescents, older persons and persons with disabilities; health care services whether privately or publicly provided, are affordable for all based on the principle of equity; and that information and ideas concerning health are accessible to all without impairing the right to have personal health data treated with confidentiality¹¹².

The respondents noted that healthcare services are inaccessible to the vast majority of the population due to several factors, including limited access to education and other economic opportunities; prohibitive healthcare costs; weak public health system; geographical barriers; ineffective referral systems; and ineffective regulation of public and private health service providers. It was pointed out that the lack of a comprehensive social health insurance scheme against the backdrop of the privatization of health services has led to the exclusion of millions of Kenyans from accessing quality health care services and remains a major threat to the attainment of the goal of universal health coverage by 2030. Much of health spending consists of out-of-pocket household payments that typically expose people to risks of catastrophic expenditures and impoverishment.¹¹³ Lack of access to information and education and awareness of the right to health also significantly limits the population's ability to access available healthcare services, claim their health rights and hold duty bearers accountable.

Both overt and covert discriminatory practices are common within the health system inhibiting access to and the full enjoyment of the right to health by members of marginalized, vulnerable and disadvantaged groups, including women and girls, orphans, street children, the elderly,

111 Mbazira C, (2009) *Litigating Socio-Economic Rights in South Africa: A choice between Corrective and Distributive Justice* (Pretoria University Law Press 2009)

112 *Committee On Economic, Social and Cultural Rights (CESCR) General Comment No. 14 (2000): The Right to the Highest Attainable Standard of Health (Art. 12)*, Committee On Economic, Social and Cultural Rights (CESCR), Twenty-second session Geneva, 25 April-12 May 2000

113 WHO: *The World Health Report 2010: Health Systems Financing – the Path to Universal Coverage*. World Health Organization, Geneva; 2010.

prisoners, migrants, refugees, internally displaced persons (IDPs), people with disabilities, commercial sex workers and other key populations. As a result, these population subgroups suffer poor health and quality of life because their specific healthcare needs are often overlooked, resulting in underfunding services and programmes targeted at them. Inadequate consideration of gender and age-responsive healthcare needs and gender-based discrimination limit women's and adolescents' access to healthcare services and enjoyment of their sexual and reproductive health rights.¹¹⁴

5.1.3 Acceptability

Acceptability implies that all health care services are culturally appropriate, sensitive to gender and life-cycle requirements and respectful of medical ethics and confidentiality of the health status of those concerned.¹¹⁵ Social acceptability in particular, refers to “the patient's assessment of the suitability, adequacy or effectiveness of care and treatment.”¹¹⁶ The content, context and quality of care received may thus affect acceptability and the recipients' likelihood to utilize the services, adhere to treatment recommendations and benefit from improved health outcomes. On the other hand, if the services are not delivered according to the defined or expected standards, the overall effectiveness and acceptability of the health service interventions will be affected.^{117 118}

The availability of health care services does not mean that they are equally acceptable and accessible to the recipients. Broadly, many factors influence and affect the right to health acceptability criteria. These include the need for services by specific populations; socio-economic, demographic and cultural factors such as poverty, geographic area of residence, race and ethnicity, sex, age, language, and disability status; responsiveness and appropriateness of the health care intervention to the local health problems; suitability of health care services to individual or population needs; effectiveness in managing the health problem; and the ability to access care—including whether the health care services are available, timely and convenient, and affordable.¹¹⁹

114 *General Comment No. 14 (2000) on the right to health adopted by the Committee on Economic, Social and Cultural Rights, states that reproductive health means that women and men have the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right to access appropriate health-care services that will, for example enable women to go through pregnancy and childbirth.*

115 *General Comment 14 para 12(c).*

116 Stanisewska S, Crowe S, Badenoch D, Edwards C, Savage J, Norman W. *The PRIME project: developing a patient evidence base.* *Health Expect.* 2010;13(3):312–22.

117 Diepeveen S, Ling T, Suhrcke M, Roland M, Marteau TM. *Public acceptability of government intervention to change health-related behaviours: a systematic review and narrative synthesis.* *BMC Public Health.* 2013;13(1):756.

118 Borrelli B, Sepinwall D, Ernst D, Bellg AJ, Czajkowski S, Breger R, DeFrancesco C, Levesque C, Sharp DL, Ogedegbe G. *A new tool to assess treatment fidelity and evaluation of treatment fidelity across 10 years of health behavior research.* *J Consult Clin Psychol.* 2005;73(5):852

119 Sidani S, Epstein DR, Bootzin RR, Moritz P, Miranda J. *Assessment of preferences for treatment: validation of a measure.* *Res Nurs Health.* 2009;32(4):419.

The respondents identified several factors hindering the acceptability element of the right to health, including the poor attitude of health workers towards patients, lack of trust between healthcare service providers and service-seekers; lack of respect of medical ethics and sensitivity to the patient's needs and privacy and social/community/religious norms; gender sensitivity; discrimination and stigmatization according to disease condition; lack of adequate information on the available services at different levels; lack of adolescent and youth-friendly services; inadequate health facilities and infrastructure; inadequate health workforce; lack of reliable medical supplies and commodities; and poor quality water and sanitary conditions in health facilities.

The respondents observed that due to negative attitudes, unfriendly and disrespectful treatment by the healthcare service providers both in public and private sectors, communities and patients have lost trust in the formal health system and are increasingly seeking alternative forms of care, and in some cases, visit health facilities as a last resort. This is mostly due to the ill-treatment of patients in health facilities and the feeling among patients that they are not respected and that their views are not taken seriously by medical practitioners. This contributes to them losing trust and having a negative perception of the services provided and tends to hinder their utilization of the available services.

Health services are also seen by many to be discriminative based on gender, age and disability. Services in many facilities are not offered with due consideration of the needs and preferences of women, adolescents and youth. Gender-based discrimination that marginalizes women and girls typically puts them at a disadvantage with limited access to health care, including sexual and reproductive health rights, which include safe motherhood and newborn care, abortion care, family planning, prevention and management of sexually transmitted infections, including HIV and AIDS, prevention and management of infertility, and prevention and management of cancers of the reproductive system. The respondents also reported cases of HPV vaccine being administered to girls in primary schools without their parents' consent, raising serious ethical concerns. Discrimination in the health system is also seen to emanate from the negative experiences of patients based on their disease condition, which amounts to stigmatization. In this case, it was reported by some respondents that patients are sometimes identified by their disease condition as opposed to their real identity.

For persons with disabilities who are often poorer and have worse overall health status, many factors hinder their access to needed health care, including provider discrimination and negative attitudes, lack of responsiveness to their unique circumstances, provider failure to provide accommodations, and inadequate communication with providers.

5.1.4 Quality

According to WHO, quality health care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. Quality health care entails effectiveness – providing evidence-based healthcare services to those who need them; Safety – avoiding harm to people for whom the care is intended; and People-centeredness – providing care that responds to individual preferences, needs and values.¹²⁰ Quality healthcare includes such characteristics as availability, accessibility, affordability, acceptability, appropriateness, competency, timeliness, privacy, confidentiality, attentiveness, caring, responsiveness, accountability, accuracy, reliability, comprehensiveness, continuity, equity, amenities, and facilities.¹²¹

The quality imperative for the right to health implies that apart from being culturally acceptable, healthcare services must also be scientifically and medically appropriate and of good quality.¹²² To realize the benefits of quality health care, health services must be timely; equitable, leaving no one behind; integrated, making available the full range of health services throughout the life course; and efficient, maximizing the benefit of available resources and avoiding waste.¹²³ Ensuring quality of care requires, inter alia, skilled medical personnel, availability of scientifically proven and efficacious drugs, commodities and equipment, appropriate health facilities and infrastructure, safe and potable water, and adequate sanitation.¹²⁴

Delivering quality healthcare services, however, remains one of the major challenges facing the health system in Kenya. Many socio-demographic, healthcare provider and health system factors influence and affect the delivery of quality healthcare and achieving the quality element of the right to health. The socio-demographic factors include education, attitudes and behaviours; information, education and knowledge; participation and involvement; and provider knowledge, technical skills, attitudes and job satisfaction. The key organisational factors influencing provider motivation and job satisfaction include pay, working environment, managerial leadership, organisational policies, co-workers, recognition, job security, job identity, and chances for promotion and career advancement. The key health system factors that influence and affect quality healthcare include the referral system from the primary healthcare level to the secondary and tertiary level; the cost of health care; availability of resources and inputs including material human and financial resources; effective management and planning; supportive policy, legal and regulatory environment; cooperation and teamwork among healthcare providers; cooperation between the recipients or patients and the healthcare providers among others.¹²⁵

120 WHO (2020) *Quality of health care*, 20 July 2020. https://www.who.int/health-topics/quality-of-care#tab=tab_1

121 Mosadeghrad AM. *A conceptual framework for quality of care*. *Mat Soc. Med.* 2012;24:251–61. doi: 10.5455/msm.2012.24.251-261

122 *General Comment 14 para 12 (d)*.

123 WHO (2020) *Quality of health care*, 20 July 2020. https://www.who.int/health-topics/quality-of-care#tab=tab_1

124 Mbazira C, (2009) *Litigating Socio-Economic Rights in South Africa: A choice between Corrective and Distributive Justice* (Pretoria University Law Press 2009) (n 14).

125 Ali Mohammad Mosadeghrad (2014), *Factors influencing healthcare service quality*, *International*

The respondents linked poor quality healthcare to the inadequate and poor maintenance of health infrastructure and facilities; inadequate room for installing medical equipment, lack of electricity, water and other amenities; inadequate ambulance facilities for referral of emergency cases; poor adherence to medical ethics and code of practice by health professionals; inadequate skilled personnel; poor-quality medical products and technologies due to lack of adherence to the procurement laws and corruption; and weak regulation. The respondents also identified poor sanitation and hygiene and lack of reliable, clean and safe water supply as major concerns for most health facilities. The respondents noted that inadequate resource allocation and poor management drove the poor state of facilities. Due to the perception of poor-quality health care services in health facilities, increasing cases of alternative medicine use were reported. The respondents also raised concerns regarding the referral system ranging from unnecessary referrals being made, expensive referral processes for poor Kenyans, poor referral process and lack of adequate training for effective referral, especially at the primary health level.

5.2 Right to Health in the Context of Health Emergencies

The Committee on Economic, Social and Cultural Rights' General Comment 14 requires states to take measures to prevent, treat, and control epidemic and endemic diseases and encourages the creation of a system of emergency medical care in cases of accidents, pandemics, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergencies. This points to the duty of the State to prepare adequately for health emergencies and to ensure the availability of sufficient material and human resources to provide emergency health care at any one time. The binding 2005 International Health Regulations and the non-binding 2011 Pandemic Influenza Preparedness Framework are also key international instruments that apply to all WHO member states regarding preparing for infectious disease outbreaks.¹²⁶

The Health Act, 2017 section 69 (a), (g), (h) provides for the formulation of national strategic and operation policies that provide for measures including ensuring and promoting the provision of quarantine, especially in ports, borders and frontiers health services; public education; and promoting the public health and the prevention, limitation or suppression of preventable diseases including communicable and non-communicable diseases within Kenya. The Public Health Act provides for the prevention and guarding against the introduction of infectious disease into Kenya from outside; promoting public health and the prevention, limitation or suppression of infectious, communicable or preventable disease within Kenya; promoting and carrying out investigations in connection with the prevention or treatment of human diseases; and preparing and publishing reports or other information relative to the public health.

Journal of Health Policy and Management, 2014 July; Vol. 3(2): 77–89. doi: 10.15171/ijhpm.2014.65
126 Chandan J. S., Taylor J., Bradbury-Jones C. et al. "COVID-19: A public health approach to manage domestic violence is needed," *Lancet Public Health*. 2020;5(6)

While through the COVID-19 pandemic, the government of Kenya demonstrated decisiveness in response to and managing the public health emergency with an impact on the right to health, the onset of the pandemic revealed the unpreparedness of the health system to respond to such health emergencies effectively. It also revealed the inadequacy of the international public health instruments, such as the International Health Regulations on their own, to adequately protect the right of every person to health during pandemics. They do not propose a rights-based approach to managing public health emergencies despite referring to human rights principles. Therefore, they are insufficient to protect the right to health during pandemics.¹²⁷

Despite the government prioritizing strengthening the healthcare system's capacity and maintaining the functionality of secondary and tertiary services in response to COVID-19, it failed to adequately equip the health facilities and health care workers with PPE. The lack of appropriate training for health personnel and poor working conditions for healthcare workers exacerbated the situation. The national COVID-19 response also revealed the lack of a clear strategy for addressing inequalities in accessing health care which disproportionately affect key vulnerable groups such as elderly persons, children, women, persons with disabilities, people living in deprived areas and crowded households. The failure of the government to tackle these vulnerabilities and to make specific provisions for vulnerable groups exposed these groups to a violation of their right to health. The public health emergency response must explicitly address vulnerable groups to ensure universal access to health services and facilities during health emergencies.

The respondents pointed out that the country is generally ill-prepared to deal with health emergencies such as the COVID-19 pandemic due to a lack of essential equipment, untrained personnel, vaccines, medicines and health facilities to manage high volumes of patients in dire need of emergency care. In addition, the respondents identified the following factors as inhibitors to the right to health in the context of health emergencies: social inequalities where the rich were better prepared to deal with the effects of lockdowns and quarantine measures while the poor did not enjoy the same privileges and therefore more likely to report suffering and neglect; poor management of the pandemic by both the National Government and County Governments with no clear strategies deployed to effectively manage testing, treatment or communication to deal with misinformation; the developed countries hoarding of COVID-19 vaccine - in the early stages of the pandemic when vaccines were finally produced, it took a long time for vaccines to be brought into the country and distributed to all the counties. Much of the developed world had surpluses in vaccines. In contrast, the developing and underdeveloped countries had huge deficits and could not develop PPEs and vaccines locally. This hampered the process of effectively dealing with the pandemic.

127 Lisa Montel, Anuj Kapilashrami, Michel P. Coleman and Claudia Allemani (2020), *The Right to Health in Times of Pandemic: What Can We Learn from the UK's Response to the COVID-19 Outbreak? Health and Human Rights*, Harvard University Press & François-Xavier Bagnoud Center for Health and Human Rights.

5.3 Disclosure of Information and the Right to Health

Access to and disclosure of information is central to realising the right to health. The Constitution of Kenya Article 35 (1) and (3) provide that every citizen has the right to access information held by the state and another person required to exercise and protect any right. It further requires the State to publish and publicise any important information to the public. Article 33 (1) (a) and (b) provides that every person has the right to freedom of expression, including freedom to seek, receive or impart information or ideas. Article 46 (1) provides for the rights of consumers to the information necessary to gain full benefit from goods and services. The Access to Information Act No. 31 of 2016 gives effect to Article 35 of the Constitution of Kenya.

The Health Act No. 21 of 2017 under sections 8, 9, 10, 12, 13 and 14 make extensive provisions on the responsibility for health information requiring health care providers to provide information to users in a language that the user understands and in a manner which takes into account the user's level of literacy; healthcare providers to seek patient's informed consent in provision of services unless the patient is unable to give informed consent and such consent is given by a person mandated by the patient or other person authorized to give such consent in terms of any law or court order; county governments to disseminate appropriate, adequate and comprehensive information on the health functions for which they are responsible being cognizant of the provisions of Article 35(1)(b) of the Constitution of Kenya; users in the absence of any observable incapacity, to supply the healthcare providers with accurate information pertaining to his or her health status; and the right to file a complaint about the manner in which a user was treated at a health facility and to have the complaint investigated appropriately. Other relevant legislations include:

- a. The County Government Act, 2012 outlines the principles of citizen participation in county governance, including timely access to information, data, documents, and other information relevant or related to policy formulation and implementation and the requirement of each county to provide clear input, output and outcome performance indicators, including the percentage of households with access to basic services contemplated under Article 43 of the Bill of Rights of the Constitution;
- b. The Public Finance and Management Act, 2012 provides for the general nature of the documents that the public may access and various national and local media through which a county government or any of its entities may publish and publicize documents or information relevant to the budget process;
- c. The Public Procurement and Disposal Act 2015 requires procuring entities to avail procurement records after closure of proceedings publicly, publicise notice of intention to enter into a contract on websites and public notice boards and publish and publicise all contract awards; and

- d. The Data Protection Act No. 24 of 2019 gives effect to Articles 31(c) and (d) of the Constitution of Kenya and makes provision for the regulation of the processing of personal data and the rights of data subjects and obligations of data controllers and processors.

Despite the elaborate legal provisions on the access to and disclosure of information critical for the full enjoyment of the right to health, stakeholders noted a huge gap in the disclosure of information due to the weaknesses in the enforcement of the laws and lack of clear guidelines. Patient information is sometimes not handled with the confidentiality it deserves, as reported by stakeholders leading to the failure of the health facilities to build confidence among members of the public. For instance, cases of ostracization were reported especially in relation to HIV and AIDS and other medical conditions. Stigmatization is a major concern in the community for the affected patients.

Another major challenge that was cited was the poor management of health information. Stakeholders noted a gap in Kenya's Health Information System (HIS) management. They noted that failure to share data impeded on the effective provision of services due to a lack of sufficient information promptly. The study respondents observed that data from the private sector is often missing within the HIS due to non-compliance of reporting by private facilities coupled with weak enforcement mechanisms by the Ministry of Health at national and county levels.

An opportunity is also missed within the health system where patient information sharing in health facilities is not practiced. For instance, a health facility that diagnosed a patient in Marsabit should be able to confidentially avail information to a hospital in Mombasa where the patient seeks care to ensure efficient service delivery. However, this is not the case in Kenya, as each health facility manages patient historical data independently. Effective management of electronic medical information is key under a framework of clearly established confidentiality and privacy policy guidelines to prevent abuse of patient information.

5.4 Factors that Inhibit Enjoyment of the Right to Health

The respondents recognized that Kenya has evolved a robust legal and policy framework for the pursuit of the right to health since the promulgation of the Constitution of Kenya in 2010. Despite the progress, the respondents identified several policy and legal obstacles to the realization of the right to health. These include:

- a. Lack of adequate national and county legal and policy instrument to meaningfully give effect the right to health guaranteed under Article 43(1)(a) and (2);

- b. Lack of intergovernmental mechanism(s) to ensure equitable access to health care services and referral between and among counties and national government;
- c. Lack of national tariff policy for healthcare services leading to prohibitive medical costs with healthcare services tariffs that do not match the costs of providing the services;
- d. Lack of affirmative action and social health insurance policy and legislation to protect and cushion the vulnerable and marginalized groups and indigent individuals from the risks of catastrophic expenditures;
- e. Lack of national health financing policy and guidelines on budget allocations for the implementation of Articles 43 (1)(a) and (2), 21(3) and 20(5)(a) and the Fourth Schedule of the Constitution;
- f. Lack of national policy on implementation and management of concurrent health functions, including implementation of the health rights between the National Government and County Governments;
- g. Lack of policy guidelines on the progressive realization of the right to health stated under Article 21(2) of the Constitution of Kenya and the UN CESCR General Comment No. 3 of 1990.

The health system-related obstacles to the realization of the right to health include:

- a. Weak regulation and monitoring of private healthcare services. The growth of private health providers has been encouraged by public policies that have supported private sector engagement in healthcare over the last few decades, which have not been accompanied by sufficient regulation and monitoring of private healthcare actors, thus contributing to a proliferation of poorly established private clinics, nursing homes and laboratories. While a legal framework for the regulation and monitoring of private healthcare providers exists, it has not been sufficiently implemented in practice. The weak regulation of the private healthcare providers has undermined the right to health as it has brought about inequalities in the availability, accessibility, affordability, acceptability and quality of healthcare facilities and providers, making dependants on healthcare services consumers rather than rights holders. Low-income households have to rely on underfunded public healthcare facilities or low-cost private healthcare facilities that offer substandard medical services, thus impeding their enjoyment of the right to healthcare.¹²⁸
- b. Lack of clear strategy for scaling up and sustainability of Universal Health Coverage pilot program;
- c. Inadequate healthcare workforce in health facilities contrary to norms and standards;

¹²⁸ *African Commission on Human and Peoples' Rights (2022), General Comment 7: State obligations under the African Charter on Human and Peoples' Rights in the context of private provision of social services, Adopted during the 72th Ordinary Session of the African Commission on Human and Peoples' Rights on 28 July 2022 in Banjul, The Gambia.*

- d. Inefficient utilization of the available human resources within the national and devolved health system;
- e. Weak supply-chain management systems for medical commodities, consumables, equipment and technologies. The respondents further pointed out that stockouts in health facilities across the country remain a significant challenge in delivering health services in Kenya. This was attributed mainly to the monopoly of KEMSA, which is the sole entity that procures and distributes medical supplies to all public health facilities at national and county levels;
- f. Lack of formal recognition and integration of the community health system as a critical part of the health system.
- g. Ineffective emergency and referral system

Further, the respondents indicated that health system management in Kenya is not optimal since some of the challenges in the sector are attributed to the lack of coordination and cooperation within the devolved health system between the national and county governments. The vertical governance arrangements between the national and county governments with limited mechanisms and opportunities for intergovernmental cooperation and coordination in the health sector remain a major impediment to ensuring effective working relationships and synergy in health service delivery and governance.

With respect to health financing, the respondents raised several concerns, including:

- a. Frequent delays in disbursement of equitable share and conditional grants¹²⁹ or additional allocations¹³⁰ by the National Treasury to County Governments. Whenever the funds disbursement delay, County Governments struggle to fund their operations, including meeting the cost of managing healthcare since the equitable share revenue forms the bulk of resources that devolved units use to plan and execute their functions;
- b. Inadequate fiscal decentralization and accountability in the management of revenues from health facilities; and
- c. Lack of fiscal decentralization within County Governments, the controlling fiscal powers centralized at the County Treasuries limiting the ability of departments such as health and health facilities to offer quality healthcare services. The health funds are also not ring-fenced in most County Governments. In some cases, the monies allocated for health are misappropriated or reallocated to other functions within the county system.

¹²⁹ *The County Governments Grants Act, 2021, Kenya Gazette Supplement No. 108 (Senate Bills No. 35) defines “conditional allocations” as additional resources allocated to county governments from revenue raised nationally or in the form of loans and grants from development partners.*

¹³⁰ *The County Governments Additional Allocations Act, 2022, Kenya Gazette Supplement No. 74 (Acts No. 17) for the 2021/2022 financial year defines “additional allocations” as additional resources allocated to county governments from the National Government’s share of revenue or in the form of loans and grants from development partners.*

Despite the National Health Insurance Fund Act being touted as the major financing instrument for achieving UHC, it still has not sufficiently addressed some of the critical issues that relate to social inclusion. For instance, respondents observed that the health benefits package provided in regulations does not cover some diseases and therefore is not beneficial to the affected Kenyans who need insurance. In addition, while 70 per cent of Kenyans seek health services at public health facilities, data from NHIF reportedly indicates that only 30 per cent of reimbursement payments are made to public health facilities. Curiously, NHIF pays the bigger 70 per cent portion of reimbursements to private health facilities.

In relation to the health workforce, some of the key concerns raised included:

- a. Delayed salaries;
- b. Lack of merit in recruitment and promotion of health workers;
- c. Assigning intern duties without proper supervision;
- d. Shortage of staff leading to overworked personnel;
- e. Lack of recognition and remuneration of community health volunteers as a critical part of the primary health care workforce. Community health volunteers are given some stipend in some counties while others don't pay them by dint of them being "volunteers"; and
- f. Poor attitude of some health workers, negligence, absenteeism.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

The Constitution of Kenya guarantees the right to health and clearly defines the State's obligations to promote, protect, respect and fulfil the right to health. While there is a growing jurisprudence on the right to health in Kenya under the Constitution, the courts have emphasised the State's available resources rather than the minimum content approach when adjudicating cases on claims of violation of the right to health. Thus, despite the significant efforts towards giving effect to the right to health, many challenges and structural barriers that inhibit access to healthcare services and the full enjoyment of the right remain. These include personnel, health service provider, health system and structural challenges and barriers. While the current policy and legal framework for the right to health is robust, the standards of the State's obligations are not clarified and operationalized as public health measures at the National and County levels of government to ensure full enjoyment of the right to health as guaranteed under the Constitution of Kenya. Consequently, the right to health, as currently enacted under national and international laws and policies, is insufficient to protect every person's right to the highest attainable health standards and address the systemic and structural issues inhibiting the right to health.

6.2 Recommendations

6.1 Improve legislative and policy reforms and interventions that enhance the right to health

- 1) There is a need for a comprehensive review of national and county legislations and policies to assess their consistency with human rights norms, standards, and principles and the capacity of institutional mechanisms put in place to ensure the implementation and enforcement of the right to health as guaranteed in the Constitution of Kenya and attendant legislation.
- 2) There is a need to define the minimum essential elements of the right to health to include equitable access to, and distribution of, health facilities and services, reproductive health, maternal and child health services; access to health-related education and information and; the availability of appropriately trained health personnel; and sufficient budgetary allocations for health care provision to ensure universal health coverage.
- 3) There is a need for national policy guidelines and roadmap on the progressive realization of the right to health in line with Article 21(2) of the Constitution of Kenya

and the UN CESCR General Comment No. 3 of 1990.

- 4) There is need to systematically integrate gender and human rights-based approaches to the development of health sector policies and strategies at national and county levels to reduce gender and social inequities in health.
- 5) There is need to advocate for fast-tracking the enactment of the Reproductive Health Bill 2019 and the National Community Health Services Bill 2019 into law.
- 6) There is a need to review the concurrent function relating to HIS (data collection, collation, analysis, and reporting, supportive supervision, patient and health facility, records, and inventories) and associated investments in technology such as digital platforms - Electronic Medical Records Systems, Logistical Management Information Systems (LMIS). Further, the associated funding should be shared equitably and the component for County Governments should be transferred directly to counties.

6.2 Improving access to quality healthcare services

- 1) There is a need for a national capacity development and technical assistance strategy for County Governments to ensure effective health system management and delivery of quality health services.
- 2) There is a need to fully operationalize the newly amended National Health Insurance Fund Act into a comprehensive national social health insurance scheme to ensure all Kenyans have access to the highest attainable standard of health care services guaranteed under Article 43 of the Constitution of Kenya. Develop tools and guidelines to identify and protect the vulnerable and indigent groups who cannot afford insurance premiums under NHIF from discrimination and exclusion in accessing quality healthcare services.
- 3) There is a need to incorporate considerations for persons with disabilities in all the designs of health facilities, infrastructure, and provision of services. This should include capacity building for policymakers and healthcare providers on disability inclusion. Ultimately, all health facilities should be able to provide sign language interpretation, have essential health information in braille or appropriate format and ensure knowledge transfer on health matters for people with disabilities (PWDs).
- 4) There is a need to strengthen the capacities of regulatory authorities to ensure the quality health care services and safety and efficacy of medicines, health products and technologies. The funding for health products and technologies (pharma and non-pharma) supply chain functions, including those supported by development partners, need to be reviewed and shared in line with the functional responsibility of each level of government.

6.3 Strengthening the health system and institutional environment for the right to health

- 1) There is a need for a national policy on the implementation, coordination, joint action and management of concurrent health functions, including the right to health.
- 2) The Council of Governors and the Ministry of Health need to collaborate to ensure full operationalization of the Health Sector Inter-Governmental Consultative Forum and other health sector intergovernmental coordination mechanisms established under the Health Act, 2017 for mutual consultation, coordination and collaboration between the National Government and County Governments on all matters related to health including the implementation of the right to health and health service delivery.
- 3) There is a need to strengthen mechanisms for multi-sectoral stakeholder and intergovernmental collaboration, cooperation and coordination at the National Government and County Government levels and between all relevant County Government and National Government Ministries Departments and Agencies, Parliament and County Assemblies Committees, national human rights institutions, development partners and civil society to address issues of marginalization, stigma, and discrimination and the factors that inhibit the enjoyment of the right to health for all and specific health care needs of vulnerable and marginalized populations.
- 4) There is a need to establish a Health Service Commission as an independent constitutional commission for the effective management of human resources for health, including the recruitment posting, promotion and remuneration of all health workers within a standardized framework for the national government and all the 47 county government health systems.
- 5) There is a need to establish and strengthen the national and county capacity to effectively monitor and track the right to health at all levels.
- 6) There is a need to strengthen community-based capacity in participatory planning, monitoring and social accountability for effective participation in planning, monitoring and tracking of the right to health.
- 7) There is a need to strengthen the public healthcare system's capacity to provide quality health services and ensure sufficient resources are mobilised, allocated and spent in an accountable, effective, efficient, equitable, participatory, transparent and sustainable manner.

6.4 Strengthening the right to health during health emergencies and humanitarian situations

- 1) There is a need to develop and implement regulations on the right to emergency medical treatment to operationalize the Kenya Emergency Medical Care Policy 2020 – 2030.

- 2) There is a need to develop policy guidelines to be followed in response to health emergencies such as COVID-19 to guard against decisions and actions that endanger the human right to health while responding to health crises.
- 3) There is a need to develop national policy guidelines on a rights-based approach to managing public health emergencies and protecting human rights and the right to health during emergencies such as pandemics, epidemics, disasters and other humanitarian situations.
- 4) There is a need to establish a national healthcare system capacity-strengthening strategy and program on health emergency preparedness and management. The strategy should take into account the needs of vulnerable groups such as elderly persons, children, women, persons with disabilities, and people living in deprived areas and crowded households during health emergencies.

6.5 Enhancing awareness and understanding of the right to health

- 1) There is a need to establish a national program to increase public awareness and understanding of the right to health and social, religious and cultural practices that inhibit the realization of the right to health, including sexual reproductive health, throughout the country. National human rights institutions, civil society and the general public, should actively implement and monitor the right to health awareness and education programs.
- 2) Both National Government and County Governments and agencies should promote and create safe spaces for citizens to actively and meaningfully participate in legislation, policymaking, and decision-making related to the right to health and the provision of health care services. Such efforts should be coupled with civic education to enable meaningful public participation.
- 3) There is a need to promote and deepen the role of CSOs in public interest litigation and thought leadership to encourage more people to approach the courts and claim and safeguard their health rights when such are threatened, violated or infringed upon. Public interest litigation training should be offered to the civil society organizations, Judiciary and the national human rights commission in partnership with Judiciary Training Institute.
- 4) There is a need to develop Information Education and Communication (IEC) materials on the right to health and to package targeted information for diverse audiences such as the public and decision-makers.

6.6 Financing for sustainable healthcare delivery

- 1) There is a need to develop national health financing regulations and policy guidelines on budget allocations for the implementation of the right to health and health functions enshrined under Articles 43 (1)(a) and (2), 21(3) and 20(5)(a) and the Fourth Schedule of the Constitution of Kenya.

- 2) There is a need to advocate for increased budgetary allocation for health by both the National Government and County Governments in accordance with the Abuja declaration commitment of at least 15 per cent of the budget allocated to health by the year 2030 through progressive budgetary scale-up in successive financial years in favour of the sector.
- 3) There is a need to fully cost the realization of the right to health under Article 43 (1) (a) and (2) and the health functions under the Fourth Schedule of the Constitution of Kenya based on the principle of resources must follow and match functions as provided under Article 187(2) of the Constitution of Kenya.
- 4) There is a need to advocate for each County Government to establish county health services funds through enabling county legislation to safeguard and ring-fence revenues generated from various sources and funds appropriated by County Assemblies to deliver health services.
- 5) Enhance donor coordination for effective and efficient investment in the implementation of the right to health at the national and county levels and with CSOs.
- 6) Ensure timely disbursement of conditional grants or additional resources for health allocated to County Governments from revenue raised nationally or in the form of loans and grants from development partners as per the applicable annual County Governments Conditional Grants or County Governments Additional Allocations Act as the case may be.
- 7) Promote strategic dialogue with the private sector on health financing, taking into account the obligation of the State under General Comment 7 of the African Commission on Human and Peoples' Rights to effectively regulate any private provision of social services to ensure that these actors prioritise the public interest rather than private or commercial interests.¹³¹
- 8) Ensure the implementation of the Kenya Health Financing Strategy 2020–2030¹³² and the domestication of the same at the county level to increase investment and public spending in health throughout the country. This will help rationalize health expenditure, improve aid effectiveness and ensure the provision of adequate safety-net mechanisms for the poor and vulnerable as the country works towards achieving universal health coverage and the right of every person to highest attainable standards of health, as enshrined in the Constitution of Kenya.

¹³¹ *African Commission on Human and Peoples' Rights (2022), General Comment 7: State obligations under the African Charter on Human and Peoples' Rights in the context of private provision of social services, Adopted during the 72th Ordinary Session of the African Commission on Human and Peoples' Rights on 28 July 2022 in Banjul, The Gambia.*

¹³² *Ministry of Health, Kenya Health Financing Strategy 2020–2030*

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Annex 1

List of Participants In The ICJ Review of Right to Health Meetings.

NO	ORGANIZATION
1.	Economic & Social Rights Centre- Hakijamii
2.	White Ribbon Alliance Kenya
3.	Non-Communicable Disease Alliance Kenya
4.	Amnesty International Kenya
5.	SRHR-Alliance
6.	World Vision Kenya
7.	HIVOS East Africa
8.	PHM-K
9.	Tunawiri
10.	Umande Trust
11.	Social Justice Center Working Group
12.	Usalama Reforms Forum
13.	HERAF
16.	Kariobangi Paralegal Networks
17.	Kenya National Commission on Human Right (KNCHR)
18.	Law Society of Kenya (LSK)
19.	East Africa Center for Human Rights (EACH Rights)
20.	Global Initiative- Economic & Social Rights Centre (GI-ESCR)
21.	Centre for Reproductive Rights (CRR)
22.	Transparency International Kenya
23.	Council of Governors (CoG)
24.	Youth Alive Kenya
25.	Intergovernmental Relations Technical Committee (IGRTC)
26.	Commission on Revenue Allocation (CRA)
27.	Kituo cha Sheria
28.	Amref Health in Africa Kenya
29.	Ministry of Health (MOH)
30.	Open Society Initiative for Eastern Africa (OSIEA)
31.	Health NGOs Network (HENNET)
32.	Diakonia
33.	World Bank Kenya Office
34.	Danish International Development Agency (Danida)
35.	Community Health Volunteers – Nairobi, Nyeri, Narok, Mombasa, Machakos, Kiambu, Isiolo, Kakamega, Kisumu

Annex 2

Assessment Framework for the Review Legal and Policy Frameworks that Inhibit the Right to Health in Kenya

1. PURPOSE OF THE STUDY

To contribute to –

- a) Improving legislative and policy reforms that enhance the right to health;
- b) Improving health service delivery through institutional systems strengthening at the national and county levels; and
- c) Enhancing awareness on the right to health.

2. BROAD OBJECTIVE OF THE REVIEW

The broad objective is to review the existing legal and policy frameworks related to the right to health in order to identify gaps and recommend reforms and/ or intervention areas.

3. SPECIFIC OBJECTIVES OF THE REVIEW

The specific objectives of the assignment are to:

1. Review existing legal and policy frameworks that inhibit access to health rights
2. Review regional and global trends and human rights normative frameworks to inform Kenya's right to health discourse, particularly during the pandemic.
3. Interrogate the gaps in intergovernmental relations in light of the challenges witnessed in coordinating the national and county governments in health governance as a devolved function
4. Interrogate the relationship between disclosure of information and the realization of the right to health within the devolved governance system, drawing comparisons between counties where best practices have emerged vis-a-vis counties facing more challenges.

5. PURPOSE OF THE STAKEHOLDER DISCUSSION ROUNDTABLE

The broad purpose of the stakeholders' discussion roundtables is to::

1. Discuss and identify policy and legal gaps in accessing rights to health and universal health coverage in Kenya.
2. Discuss and identify the key factors inhibiting access to and realization of the right to health for all.
3. Make recommendations or proposals for reforms and/ or intervention areas.

ASSESSMENT FRAMEWORK

Assessment area of focus	Assessment questions (Identification of key challenges, gaps and issues)
1. Health Situation and Profile	Identify the key health problems and challenges in Kenya
	➤ What are the key determinants of health and health rights?
2. Health Right (Article 43 (1) (a) (2)) - right to highest attainable standard of:	➤ What does the right to health mean in Kenya?
	➤ In your view, to what extent has Kenya achieved the right to health for every person?
	➤ What are the key obstacles to realizing the right to? <ul style="list-style-type: none"> i. Health ii. Health care services iii. Reproductive health care service iv. Emergency medical treatment
	➤ What are the imperatives for achieving the right to health?
3. Enforcement of right to health Article 22	In your view are the health rights guaranteed under article 43 1A (2) effectively enforced? <i>If YES/NO: Give reasons</i>
	What are some of the key obstacles to effective enforcement of the right to health?
	➤ Are the following institutions effective in playing their roles in enforcing the right to health as required by law? <ul style="list-style-type: none"> <input type="checkbox"/> Judiciary <input type="checkbox"/> Office of Director of Public Prosecutions <input type="checkbox"/> National Police Service <input type="checkbox"/> The Kenya National Commission on Human Rights <input type="checkbox"/> National Gender and Equality Commission <input type="checkbox"/> Commission on Administrative Justice <input type="checkbox"/> National Government <input type="checkbox"/> County Governments <input type="checkbox"/> Parliament (National Assembly and Senate) <input type="checkbox"/> County Legislative Assemblies <input type="checkbox"/> Citizens (rights holders)
	➤ What should they do differently to ensure effective enforcement of the right to health?

4. Legal and policy framework (Article 21 (2))	➤ In your view are the existing legal and policy framework adequate to achieve the right to health? <i>If YES/NO: Give reasons</i>
	➤ In your view has the State at county and national levels taken adequate legislative and policy measures to ensure the realization of right to health as guaranteed under Art 43? <i>If YES/NO: Give reasons</i>
	➤ What are the strengths, weaknesses, opportunities and threats of the existing policy and legal framework for the realization of the right to health?
	➤ In your view, are there clearly defined standards for the realization of right to health at national and county level? <i>If YES/NO: Give reasons</i>
5. Health System	➤ What are the key health system bottlenecks to achieving the right to health at the following levels? <ul style="list-style-type: none"> i. National ii. County iii. Community iv. Health Facility
	➤ What are the key gaps/challenges in intergovernmental relationships between county and national governments in achieving the right to health?
6. Health human resource for health	➤ What are the key human resources for health challenges for the realization of right to health at the following levels; <ul style="list-style-type: none"> i. National ii. County iii. Health facility and iv. community

7. Access to healthcare services	➤ To what extent is Kenya achieving its goal for achieving universal health coverage by 2030? <i>If Kenya is off track, what are the reasons?</i>
	i. What are the key factors affecting access to health care in relation to the following?
	➤ In your view what are the factors that inhibit/ affect the enjoyment of the right to highest attainable standards to health and health care services by the following groups: <ul style="list-style-type: none"> i. Women of the reproductive age ii. Children iii. Adolescents and young people iv. PWDs v. The Elderly vi. Marginalized communities e.g. pastoralists vii. Minorities viii. Rural areas ix. Urban informal settlements
	➤ What are the factors inhibiting/affecting the right to health in the context of health emergencies e.g. (epidemics, pandemics) disease outbreak and humanitarian situations/disasters?
8. Health Financing (Art 20 (5))	➤ What are the key health financing gaps and challenges for realization of right to health in Kenya?
	➤ In your view, are the provisions of art 20, (5) being adequately enforced/applied to ensure realization of right to health?
9. Information and health right (Article 35)	➤ In your view, what is the relationship between disclosure of information and realization of right to health?
	➤ In your view, to what extent has disclosure of information policy within the health sector affected realization of right to health?

10. Monitoring and tracking of realization of right to health	<p>➤ Is there a functional national and county level information, monitoring and tracking system for the right to health?</p> <p><i>If yes, how effective is the system?</i></p>
	<p>➤ What are the factors affecting functionality of the monitoring and tracking system?</p>
	<p>➤ What are the key challenges and gaps in monitoring and tracking of right to health?</p>
	<p>➤ Does the system have clearly articulated/stated performance indicators and benchmarks for monitoring and tracking the right to health?</p>
	<p>➤ How effective is the monitoring and tracking system (if at all) in generating evidence/information at national, county and community levels for the following:</p> <ul style="list-style-type: none"> i. rights based planning for health? ii. rights based resource allocation for health iii. learning and sharing of best practices
	<p>➤ What are the challenges and gaps in ensuring effective monitoring and tracking of the right to health at national and county levels</p>
General observations and comments	



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