

**Mapping the constitutional provisions on the
right to health and the mechanisms for
implementation in Kenya**

Case study report

**Kenya Legal and Ethical Issues Network
on HIV and AIDS (KELIN)**



In the

**Regional Network for Equity in Health
in East and Southern Africa (EQUINET)**



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Executive summary

This case study is produced by the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN), working with Charles Dulo as a contributor, in the theme work on health rights and law of the Regional Network for Equity in Health in East and Southern Africa (EQUINET). This Paper's objective is to answer the question, "What difference have constitutional rights to health made in practice and what have been the issues affecting the capacity to claim and deliver on the rights in Kenya?" It is a follow up on the results of work on the right to health that highlighted a need to do further studies in countries that do not have expressed provision on the rights to health.

It is a desk review of literature that explores the historical background on the right to health before the current constitution that was promulgated in 2010. This is followed by a review of the legislative framework after 2010 and jurisprudence on the right health, and concludes by highlighting key challenges in the realization of the right to health in Kenya.

Kenya's health policy after independence in 1963 was founded on the Sessional Paper No. 10 on African Socialism and its Application to Kenya of 1965, which emphasised the elimination of disease, poverty, and illiteracy. The major policy goal was universal health coverage. Major shift in health services was however seen in 1994 under the first Kenya health policy framework and this guided the health sector until 2010. Unfortunately, this shift did not necessarily translate into better health services.

The constitutions before the current did not have specific provisions on the right to health but the 1969 supreme law for example, did allow for the State to limit or exclude the rights of individual citizens for public health reasons. Even without the specific provisions, specific enactments were made to ensure access to health for the people of Kenya. In addition, the state ratified a number of international human rights instruments that advance the right to health but that constitution was silent on the process of ratification although later, the country adopted dualism. Unfortunately, this practice of domesticating international law was ad hoc, with no clarity on what treaties were binding on the state – a consequence of the lack of provisions on domestication in the constitution.

The 2010 constitution was the first in the country to explicitly mention the right to the highest attainable standard of health, in the Bill of Rights. This constitution also turned Kenya into a monist state through a provision that allows for general rules of international law forming part of the law of Kenya. It upholds the principles of human rights and expounds the role of state including taking legislative, policy and other measures, including the setting of standards, to achieve the progressive realization of the rights. The constitution further provides for decentralisation of the public decision-making processes to the 47 county governments, giving them autonomy over provision of county health services. The national or central government oversees the national referral health facilities.

Following the promulgation of the new constitution which is explicit on the right to health, a Kenya Health policy 2014 – 2030 was formulated to advance a human rights based approach in health care delivery. During this policy period a basic minimum health and expandable package, Kenya Essential Health Package (KEPH), will be provided to all Kenyans. Other health systems investments will be strengthened to ensure progressive realization of rights to health in the country. This policy was developed in line with the country's long-term development agenda, Vision 2030, the Constitution of Kenya 2010 and its global (Human Rights) commitments. It demonstrates the health sector's commitment, under the government's stewardship, to ensuring that the country attains

the highest possible standard of health, in a manner responsive to the needs of the population.

The 2010 constitution further advances the justiciability of social-economic rights including the right to health. Case law has provided the judiciary with an opportunity to interpret the Constitution and give meaning to the fundamental rights guaranteed in the Bill of Rights. The cases highlighted in this case study directly impact on the right to health. Some however, are not primarily on the right to health but may have an impact on its realization because of ancillary considerations.

Some of the key challenges to realizing the right to health include the limited knowledge and capacity on devolution of powers to county governments, a factor which complicates accountability. Other challenges include constricted budget allocations to health; limited understanding of progressive realisation of rights; stringent processes preferred by development partners which slow down the implementation of projects; and limited community participation.

1. Introduction

The Regional network for Equity in Health in East and Southern Africa (EQUINET) through the Center for Health, Human Rights and Development (CEHURD), with support from International Development Research Centre (IDRC) Canada, commissioned this comparative mapping of the constitutional provisions on the right to health in Kenya as case study. This paper's objective is to answer the question "What difference have constitutional rights to health made in practice and what have been the issues affecting the capacity to claim and deliver on the rights in Kenya?"

In answering the primary question, we begin by briefly exploring the historical background of the right to health pre-2010, the legislative framework of the right to health in Kenya post 2010, the jurisprudence on the right to health and, finally, some of the challenges in realizing the right to health.

2. The right to health in Kenya 1963-2010

2.1. Background

Kenya's health policy after independence in 1963 was founded on the country's landmark post-colonial nation-building and socio-economic development blueprint, the Sessional Paper No. 10 on African Socialism and its Application to Kenya of 1965, which emphasised the elimination of disease, poverty, and illiteracy (Wamai, 2009). On this basis universal health care was a major policy goal with the government abolishing user fees implemented by the colonial government funding health services through general tax up until 1988 (Wamai, 2009). A number of reasons were provided for introducing user fees including poor economic performance, inadequate financial resources and declining budgets (Chuma and Vincent, 2011). The health sector in this period was centralised with funding being derived from the general tax and distributed through the Ministry of Health.

The major shift in health services came in 1994 and this guided the health sector until 2010. The Kenya Health Policy Framework had the underlying vision for health development and reform to provide for quality healthcare that is affordable and accessible to all (Wamai, 2009). The implementation strategy for health policy has been devised in a series of two five-year National Health Sector Strategic Plan. However, the shift did not translate to better health care services (Government of Kenya, 2003).

2.2. Social determinants of health in Kenya

Social determinants of health are those conditions that people are born into; grow up, live, work and age in, that have an influence on their health status (Chapman, 2010). According to the World Health Organisation (WHO), the conditions of daily life and underlying structural determinants that shape them, work together to constitute the social determinants of health (Solar and Irwin, 2010). These are discussed in this section however; it is noteworthy that this will still be applicable after 2010. The Commission on Social determinants of health has identified three elements in the framework on the social determinants of health.

- a. The first element is the socio-economic and political context, which refers to the spectrum of factors in society that cannot be directly measured at the individual level. These may include factors such as governance, macroeconomic policies, social policies such as the labor market, housing and land. Translated within a Kenyan context, these include factors such as the implications of our devolved system of governance and how that impacts the ability to access health care. Land is also a very contentious issue in Kenya and politics around it permeates all spheres of life. In this context it is important to consider the impact of the access or lack thereof, on health. This relates for example to access to housing, and thus water and sanitation, which are all determinants of the effective

realization of the right to health. Also included are public policies affecting areas such as education and medical care. Culture and societal values are also a composite element of the socio-economic and political context. Epidemiological conditions, especially in the case of major epidemics such as HIV and AIDS which may have an influence on certain social structures and thus affect people's ability to access health services (Solar and Irwin, 2010).

- b. The second element is structural determinants and socioeconomic position. Structural determinants refer specifically to the interplay between the socioeconomic-political contexts, structural mechanisms generating social stratification and the resulting socioeconomic position of individuals. Two major variables are used to determine socioeconomic position in health, social stratification and social class, with stratification referring to the social hierarchies in which individuals or groups can be arranged along a ranked order of some attribute and class referring to relations of ownership or control over productive resources. These are influenced by factors such as social class, gender, ethnicity, education, occupation or income. These factors are particularly relevant in a Kenyan context where one's ability to access quality health care is linked to one's social position which is invariably linked to one's class. These are further exacerbated by issues such as gender due to the patriarchal nature of the Kenyan society: ethnicity due to the highly tribal nature of our politics. Kenya is therefore a stratified society very much divided along the basis of class, race and gender which all have an impact on one's ability to access health services effectively (Solar and Irwin, 2010).
- c. The final element is intermediary determinants, which are the factors through which structural determinants operate. The main categories of these determinants are material circumstances, psychosocial circumstances, behavioural and/or biological factors and the health system itself. Material circumstances relate to one's physical environment such as housing, consumption potential and the physical working environment (Solar and Irwin, 2010).

Differentiated material circumstances are the factors with the greatest impact and depending on the quality, these circumstances may provide resources for health but also pose certain health risks depending on context. Psychosocial circumstances are influenced by the difference in exposure to experiences and life situations that are perceived as threatening, frightening and difficult for coping in the everyday (Solar and Irwin, 2010). This partly explains the long-term pattern of social inequalities in health. Behavioural and biological factors include smoking, diet, alcohol consumption and lack of physical exercise, which again can be either health protecting and enhancing (like exercise) or health damaging (cigarette smoking and obesity); in between biological factors we are including genetics factors, as well as from the perspective of social determinants of health, age and sex distribution. The role of the health system itself as a determinant becomes particularly relevant with respect to access that incorporates differences in exposure and vulnerability. On the other hand, differences in access to health care certainly do not fully account for the social patterning of health outcomes (Solar and Irwin, 2010).

It is very clear from the above that there are several factors that may influence a person's ability to access health. The WHO has been key in highlighting the main categories of social determinants that may impact the ability to access health services in Kenya. What follows is a discussion of these determinants operationalised through a highlight of the main challenges that face the realisation of the right to health in Kenya.

2.3. Constitutional and legislative framework

The Constitution of Kenya, 1969 made no specific provision on the right to health (Republic of Kenya, 1969). Much like that in many African countries colonised by Britain it

made no reference to socio-economic rights and did not contain a robust Bill of Rights (Munene, 2002).

While no specific provision was made for the right to health the 1969 Constitution did allow for the State to limit or exclude the rights of individual citizens for public health reasons (Mulumba et al, 2011). Section 72, is an example of this, providing that that one's property can be possessed by the State in the interests of public safety or public health. This limitation or exclusion also affected the right to freedom of expression, freedom of assembly and freedom of movement (Republic of Kenya, 1969).

Despite the silence on the Constitution, there were several legislative enactments that governed access to health services in Kenya. The main Act in this respect is the Public Health Act, which guarantees the public's right to health including the prevention and suppression of infectious and communicable diseases (Republic of Kenya, 1921). During that time, it also guided local authorities on matters affecting public health amongst others. Section 13 provided for the general duties of health authorities and stated that:

It shall be the duty of every health authority to take all lawful, necessary and, under its special circumstances, reasonably practicable measures for preventing the occurrence or dealing with any outbreak or prevalence of any infectious, communicable or preventable disease, to safeguard and promote the public health and to exercise the powers and perform the duties in respect of the public health conferred or imposed on it by this Act or any other law.(Govt of Kenya, 1921:14)

Other legislative enactments include The Nurses Act (Republic of Kenya, 1983), the Clinical Officers (Training, Registration and Licensing) Act (Republic of Kenya, 1988) and The Children's Act (Republic of Kenya, 2010a). The challenge with these specific legislative enactments is that they were limited in their scope. Apart from the Public Health Act which went into some detail in highlighting states responsibilities with respect to public health, none of the other enactments highlighted which health services the government should provide and the measures through which these obligations were to be realized.

The HIV and AIDS Prevention and Control Act, offers the most comprehensive definition of a health care service, within the Kenyan legislative framework (Republic of Kenya, 2006).

According to the Act, Health care service rendered to a person means:

(a) The physical or mental examination of that person; (b) The treatment or prevention of any physical or mental defect, illness or deficiency and the giving of advice in relation to that defect, illness or deficiency; (c) The performing of any surgical or other invasive procedure; (d) The giving of advice in relation to treatment of any condition arising out of a pregnancy; (e) The prescribing, dispensing, supplying or applying of any medicine, appliance or apparatus in relation to any defect, illness or pregnancy; (f) X-ray, laboratory and other investigative and diagnostic procedures; (g) Physiotherapy, speech therapy, occupational therapy and other types and variations of similar rehabilitative treatment; (h) Nursing or midwifery in health institutions and other places where nursing and midwifery services may be rendered, including home-based nursing and midwifery services by duly qualified registered and experienced nurses and midwives; (i) The supply of accommodation in any institution established or registered in terms of any law as a health institution or any other institution or place where surgical or other medical procedures are performed, provided that such accommodation is necessitated by any physical or mental defect, illness, deficiency or a pregnancy; (j) The provision of pre-test or post-test counseling services (Republic of Kenya, 2006:6).

The object and purpose of the Act is to promote public awareness about the causes, modes of transmission, consequences, means of prevention and control of HIV and AIDS

and to extend to every person suspected or known to be infected with HIV and AIDS full protection of their human rights and civil liberties. This is to be done through prohibiting compulsory HIV testing save as provided in this Act, guaranteeing the right to privacy of the individual, outlawing discrimination in all its forms and subtleties against persons with or persons perceived or suspected of having HIV and AIDS and ensuring the provision of basic health care and social services for persons infected with HIV and AIDS. The objects of the Act also include the promotion of utmost safety and universal precautions in practices and procedures that carry the risk of HIV transmission and to positively address and seek to eradicate conditions that aggravate the spread of HIV infection (Republic of Kenya, 2006).

The Act specifically prohibits discriminatory acts and policies in the workplace (Section 31), in schools (Section 32), on travel and habitation (Section 33). No person shall be denied the right to seek an elective or other public office on the grounds of their HIV status (Section 34) and may not be excluded from credit and insurance services (Section 35). The Act also places an obligation on the government to, amongst other things, engage in HIV and AIDS education and information in institutions of learning and the work place and secures its position as a health care service.

According to section 19 (Republic of Kenya, 2006):

(1) Every health institution, whether public or private, and every health management organisation or medical insurance provider shall facilitate access to health care services to persons with HIV without discrimination on the basis of HIV status.

(2) The Government shall, to the maximum of its available resources, take the steps necessary to ensure the access to essential health care services, including the access to essential medicines at affordable prices by persons with HIV or AIDS and those exposed to the risk of HIV infection.

The Constitution of the Republic of Kenya, 2010 was passed by a popular vote and provided a drastic breakaway from the 1969 Constitution through its Bill of Rights. Article 43(1) (a) of the 2010 constitution recognises socio-economic rights including the right to the highest attainable standard of health as a key Constitutional principle (Republic of Kenya, 2010b).

2.4. International treaty obligations

Kenya's obligations under international law are tabulated below and while most of these treaties were ratified prior to 2010 their significance became more apparent after the promulgation of the Constitution, 2010. The Constitution, 1969 was silent on the process of treaty ratification but over time a practice of dualism emerged in the country (Mwagiru, 2014). The power to negotiate and execute treaties was exercised by the executive and treaties became part of the country's law after domestication through the passage of legislation (Kenya National Commission on Human Rights, 2011).

While Kenya operated, as a dualist state, the practice was not founded in the Constitution and was mostly ad hoc it was not always apparent what treaties were binding on the State and if domestication was the only way in which a treaty could be binding. An example of domestication of international obligations is the Children's Act, which was enacted to give effect to the principles in the Convention of the Rights of the Child and the African Charter on the Rights and Welfare of the Child (Republic of Kenya, 2010a). An instance in which treaty law was considered without domestication was a decision by the Court of Appeal in *Rono v Rono* (Kenya Court of Appeal, 2005) where the Court guided by the Bangalore Principles on the Domestic Application of International Human Rights Norms held that:

. . . the current thinking on the common law theory is that both international customary law and treaty law can be applied by State courts where there is no conflict with existing State law, even in the absence of implementing legislation. (Kenya Court of Appeal, 2005:16)

Therefore, while Kenya had ratified a number of treaties that provided for the right to health prior to 2010 the State's obligations under these treaties in the absence of domestication is unclear because of the silence in the previous Constitution. Thus, while it is accepted that these treaties imposed obligations on the State this became more apparent after the 2010 Constitution and it is thus more appropriate to discuss these obligations later in this document.

2.5. Policy framework

As mentioned above Kenya shifted from a socialist lean towards health whereby all user fees were abolished guided by Sessional Paper No. 10 on African Socialism, which was characterised by centralisation of systems and frameworks (Mboya, 1969). The shift came in 1994 with the Kenya Health Policy Framework (KHPF), which had 6 strategic imperatives (Republic of Kenya, 1994).

These included:

1. Ensure equitable allocation of GOK resources to reduce disparities in health status;
2. Increase cost-effectiveness and efficiency of resource allocation and use;
3. Manage population growth;
4. Enhance the regulatory role of the government in health care provision;
5. Create an enabling environment for increased private sector and community involvement in service provision and financing; and
6. Increase and diversify per capita financial flows to the health sector.

The second and fifth strategic objectives are particularly telling because it is evidence of the shift from a socialist approach to health to one with more capitalist leanings that sought to open up the space for private sector, which was comprised of for-profit facilities.

The Kenya Health Policy Framework was operationalised through the Kenya Health Policy Implementation framework that developed initiatives to address the following constraints seen in the health sector including decline in health sector expenditure, inefficient utilisation of resources, centralised decision-making, inequitable management information systems, outdated health laws, inadequate management skills at the district level, worsening poverty levels, increasing burden of disease, and rapid population growth (Republic of Kenya, 1994). Further two 5-year plans were devised to translate the policy objectives into implementable programmes, these are: the National Health Sector Strategic Plan 1999-2004 (HSSP I) (Government of Kenya, 1999) and the Health Sector Strategic Plan 2005-2010 (HSSP II) (Republic of Kenya, 2005).

Notably, as early as 1994 the centralisation of the health system was seen as a barrier to an efficient and effective health sector. Decentralisation was therefore advanced as a key management strategy in addressing the challenges noted in the health sector in Kenya (Republic of Kenya, 1994). One of the findings in the external evaluation of HSSP I indicated that absence of a legislative framework for decentralisation was a barrier to adoption of the approach (NCAPD et al., 2005).

2.6. Health systems and structures

A health system has been defined as “the combination of resources, organisation, financing and management that culminate in the delivery of health services to the population” (World Bank, 2007). The WHO refined this definition as “all activities whose primary purpose is to promote, restore and maintain health” (World Bank, 2007). Therefore health systems can be understood to mean the health infrastructure, health financing, health utilisation, management and organisation of health. The following discussion will be focused on health infrastructure and health financing in Kenya before 2010.

a. Health infrastructure

Kenya's health infrastructure was a hierarchical/pyramidal comprising five levels: national teaching hospitals, provincial hospitals, district and sub-district hospitals, health centers and dispensaries. At the apex of this was Kenyatta National Hospital and village dispensaries were at the lowest level (Wamai, 2009).

Kenya was divided into eight provinces that were further divided into districts. Under the decentralisation strategy decided in 1994 districts formed the central pillars of the public health system. In 2007 data was indicative that there were over 5,000 health facilities across Kenya being operated broadly by three owners: the government, non-governmental organisations and private business. The government only accounted for 41% of the health facilities, however this comprised most of the hospitals, health care facilities and dispensaries while the private sector accounted for a large majority of clinics and nursing homes (Wamai, 2009).

Under this system there was an uneven distribution of facilities in the provinces with some provinces being worse off and under-resourced. For instance in 2006 Central Province had twice the number of facilities per population than some of the worst off provinces, Western and Nyanza (Chuma and Vincent, 2011). This was also indicated in the accessibility of these health facilities with Nairobi and Central provinces having the shortest distances to health care facilities due to the relatively smaller sizes of these provinces (Chuma and Vincent, 2011). This highlights just some of the challenges faced in terms of health infrastructure prior to 2010, specifically uneven distribution of facilities, unequal access to facilities and a significant amount of facilities being within the private sector.

b. Healthcare financing

Between 1965 and 1988 health care was financed through the general tax with recipients of care accessing services without the need of payment. However, in 1988 the Kenyan government yielded to pressure from the World Bank and International Monetary Fund to introduce user fees and other major reforms in the health sector (WHO, 2006) User fees were introduced for both inpatient and outpatient services at health facilities to address severe budgetary constraints within the government and were to subsidise other contributions to health financing (WHO, 2006). There was some push and pull around this with the user fees being scrapped due to internal pressure and reinstated due to pressure from development partners.

The introduction of the user fees only represented one aspect of the health system financing with the government seeking to rely on health insurance as a mode of financing to reduce out of pocket costs for persons who utilise health services (WHO, 2006). The National Health Insurance Fund (NHIF) was established in 1966 through Sessional Paper No. 10 of 1965, however in its initial stages it was only compulsory for workers in the formal sector (WHO, 2006). The NHIF is the main type of health insurance in Kenya, however it must be noted that uptake of health insurance was relatively low with about 10% of Kenyans being covered by both mandatory and voluntary insurance schemes (Amu et al., 2018).

NHIF in Kenya went through massive restructuring and reform since its inception as it was initially set to offer health insurance coverage to formal sector employees only (Chuma and Vincent, 2011). In 1972 the NHIF Act was amended to incorporate voluntary membership although this was only implemented in practice in 2005 (Chuma and Vincent, 2011). However, despite these amendments uptake in insurance remained relatively low with most Kenyans seeking to utilise health care facilities being subject to out of pocket fees to subsidise the general tax funding.

3. The right to health in Kenya post-2010

3.1. The Constitution of Kenya, 2010

The Constitution is the supreme law of the land and all persons and all state organs at all levels of government are bound by the contents therein (Article 2(1) (Republic of Kenya, 2010b). It provides in Article 2(5) that the general rules of international law shall form part of the law of Kenya. Chapter 4 of the Constitution provides for the Bill of Rights, an integral part of the democratic state and the framework for the realization of social, economic and cultural policies (Article 19(1)). According to Article 20, the Bill of Rights is applicable to all law and binds all state organs and persons. Further every person shall enjoy the rights and freedoms captured therein, to the greatest extent consistent with the nature or the right or fundamental freedom (Republic of Kenya, 2010b).

The right to health in the Kenyan Constitution 2010 is guaranteed under Article 43 (1)(a), which states “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 not be denied emergency medical treatment (Republic of Kenya, 2010b).

This provision is however subject to Article 20(5) which states that:

... 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 propriety 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 (Republic of Kenya, 2010b:19)*

With respect to the implementation of Article 43 the Constitution provides in Article 21(2) 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. Article 21(3) provides further 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. Also relevant is Article 26(4) on the right to life which prohibits abortion except for where a trained health professional has confirmed the need for emergency treatment, or the life/health of the mother is in danger or if permitted by any other written law.

With respect to the realization of the right to health for children, Article 53(1)(c) and (d) provides that:

Every child has the right to basic nutrition, shelter and health care; [and] to be protected from abuse, neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment, and hazardous or exploitative labour (Republic of Kenya, 2010b:35)

The right to health services is also impacted by Article 46 (1) and (3) of the Constitution on consumer rights which provides that:

(1) 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...

(3) This article applies to goods and services offered by public entities or private persons (Republic of Kenya, 2010b:36)

One of the main pillars of the new constitutional dispensation is the process of devolution which refers to decentralisation of the public decision-making processes. There are two levels of governments: one is National and Forty-seven (47) are County governments. Under the new dispensation health is one of the functions that have been devolved and its implementation will fall under the County Government (The Fourth Schedule of the Constitution of Kenya, 2010). The county and national levels of government are distinct and interdependent and will conduct business on the basis of consultation and cooperation (KELIN Kenya, 2016).

Part 2, Article 2 highlights, the distribution of functions between the national and county governments. National health referral facilities fall within the ambit of the national government and the county government is responsible for county health services including in particular:

(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 (Republic of Kenya, 2010b:174).

3.2. Legislative enactments

Alongside the Constitutional provisions above, there are also key legislative enactments adopted after the Constitution of 2010 relating to health. These include the Kenya Medical Supplies Authority Act (Republic of Kenya, 2013a), which was enacted to make provisions for the establishment of the Kenya Medical Supplies Authority and for connected purposes. The National Authority for Campaign against Alcohol and Drug Abuse Act (Republic of Kenya, 2013b) was enacted to establish an institutional framework for the control of alcohol and drug abuse and for the formulation and implementation of policy thereto and for connected purposes. It established the Board for the National Authority for Campaign against Alcohol and Drug Abuse and highlights its functions, and other administrative provisions.

The Science, Technology and Innovation Act was enacted to facilitate the promotion, co-ordination and regulation of the progress of science, technology and innovation of the country (Republic of Kenya, 2013c). It also assigns priority to the development of science, technology and innovation and entrenches science, technology and innovation into the national production system and for connected purposes. The Public Health Officers (Training, Registration and Licensing) Act was enacted to make provision for the training, registration and licensing of public health officers and public health technicians (Republic of Kenya, 2013d). Public health in this context includes environmental health and a public health officer is defined as person who has undergone the prescribed course of training in an approved institution and holds a diploma, higher diploma or degree in environmental health.

There are current efforts to consolidate the laws on public health into one health law that will create better clarity on enforcement and hopefully enforce greater certainty on the enforcement of constitutional guarantees on the right to health (and other fundamental rights). The following are to be adopted to give effect to the provisions of the Constitution and the various international law obligations it imposes on the Government of Kenya.

- a) At the time of writing the paper, the Health Bill of 2016 was set to be the most comprehensive legislative enactment on the right to health once adopted. According to Section 5, every person has the right to the highest attainable standard of health which shall include progressive access for provision of primitive, preventive, curative, palliative and rehabilitative services (Republic of Kenya, 2016). It is further provided that every person shall have the right to be treated with dignity, respect and have their privacy respected in accordance with the Constitution and this Act. "The specific rights and duties that shall be provided for in this Act, once adopted include,

reproductive health rights (article 6), emergency treatment (Article 7), health information (article 8), consent related to the access of various health services (article 9), information dissemination by the government (article 10) and confidentiality (Article 11). It provides in section 12, the rights and duties of health care providers, which will include amongst others the right not to be unfairly discriminated against on account of their health and the right to a safe working environment that minimizes the risk of disease transmission and injury or damage to the health care personnel or to their clients, family or property. Duties of health care workers will include, amongst others, to provide health care, conscientiously and to the best of their knowledge within their scope of practice and ability, to every person entrusted to their care or seeking their support (Republic of Kenya, 2016). The authors note that this Bill has since been passed as an Act.

- b) The Reproductive Health Care Bill, 2014 if adopted would provide for the recognition of reproductive rights; to set the standards of reproductive health; provide for the right to make decisions regarding reproduction free from discrimination, coercion and violence; and for connected purposes. If passed, this Bill will regulate access to contraceptives and family planning services, gestational surrogacy, safe motherhood including antenatal care services and information and treatment on HIV/AIDS, termination of pregnancy. It also clearly indicates what would constitute a health facility and provides for confidentiality in reproductive health. Also provided for is child health care and reproductive health of adolescents. The Bill also contemplates a reproductive and child health care board and tribunal (Republic of Kenya, 2014).

3.3. International treaty obligations in light of the Kenyan Constitution

Article 2(6) of the Constitution 2010 provides that any treaty or convention ratified by Kenya shall form part of the Law of Kenya (Republic of Kenya, 2010b). In this respect, Kenya is bound by several global and regional international treaty documents that enumerate the states duty to realize the right to health. At the global level, the right to health in its various facets is enumerated in several international agreements including but not limited to the Universal Declaration on Human Rights in Article 25 (UN, 1948), Article 5 (e) (iv) of the International Convention on the Elimination on all forms of Racial Discrimination (UN, 1965) , the International Covenant on Economic, Social and Cultural Rights (ICESCR, 2015), the Convention on the elimination of all forms of Discrimination against Women (UN, 1979), the Convention on the Rights of the Child (UN, 1990) and the Convention on the Rights of Persons with Disabilities (UN, 2007). See *Appendix 1* for tabled summary of the state's obligations under various treaties.

Periodically, the Bodies for these international Human Rights treaties issue general comments or recommendations to enumerate the states various duties with respect to the realization of the rights articulated in these treaties. The UN Committee for the implementation of the Covenant on Economic, Social and Cultural Rights issued General Comment No. 14 which addresses substantive issues arising in the implementation of Article 12 on the right to health (CESCR, 2000). This General Comment expands the definition of the right to health to include a set of freedoms and entitlements that accommodate the individual's biological and social conditions, as well as available state resources, which may preclude a right to be healthy. The General Comment acknowledges that *the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health* (UN CESCR, 2000:4). In this respect, the General Comment holds that the specific steps towards realizing the right to health enumerated in Article 12 are non-exhaustive. The General Comment also makes reference to the question of health equity, a concept not addressed in the initial International Covenant. It notes that: *The Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement* (UN CESCR, 2000:18). Moreover, responsibility for addressing discrimination and its effects with regards to health is delegated to the State. The

document provides that: *States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services* (UN CESCR, 2000:19). Additional emphasis is placed upon non-discrimination on the basis of gender, age, disability, or membership in indigenous communities.

Pursuant to Article 12 of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), The Committee issued General Recommendation No. 24 (CEDAW, 1999), expounding on the provisions of this Article. Taking recognition of the other treaty documents that also adopt provisions on the right to health, this General Recommendation places an obligation on state parties to adopt necessary measures to ensure women realize this right. This includes ensuring access to contraceptives and other family planning measures. It also highlights measures related to HIV/AIDS management and access to other reproductive health issues. It also draws a distinction between the needs of women and adolescent girls with respect to access to health services.

There was a general acceptance that global international treaties were blind to the nuances expressed in an African context. In this respect the African Human Rights system has adopted several treaties, which also include in their scope a duty on the state to realize the right to health. The state is therefore bound under the African Charter on Human and Peoples' Rights (OAU, 1982), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa also called the Maputo protocol (AU, 2003) and the African Charter on the Rights and Welfare of the Child (OAU, 1990). The African system is unique in that it goes further than other documents in articulating for example access to reproductive health as an integral part of the realization of women's rights in Africa. This includes access to HIV services and Family planning information.

In the same manner as global human rights bodies have, the African Commission on Human and Peoples' rights as the main implementing body of various human rights in the region, has adopted general comments to enumerate states responsibilities in the realization of human rights. General Comments on Article 14 (1) focus on sexual and reproductive health rights, while the General Comment under Article 14 (2) spell out the obligations of the state (AU, 2012). Article 14(2)c obligates the state to ensure access to safe medical abortion in events of rape, incest, defilement or to save maternal or fetal life (AU, 2014). It is a contentious document given Kenya's explicit exclusion of abortion, save for within certain contexts. This General Comment requires states to remove any existing impediments women may face in accessing health care and services for women, including ideological and belief-based barriers. These Comments also provide that according to Article 14(2) (a), a state is required to develop a national health plan with comprehensive (sexual and reproductive) health services alongside guidelines and standards that are consistent with those established by the WHO and the committees responsible for the realization thereof.

3.4. Mechanisms and capacities for realising health rights in policy

The Kenya Health Policy 2014 – 2030 gives direction on how to ensure improvement in the overall status of health in Kenya. The policy aims to attain the right to health as outlined in the Constitution of Kenya 2010 (Republic of Kenya, 2014). To attain this, the policy seeks to employ a human rights based approach in health care delivery. This means that the policy will integrate human rights norms and principles in the design, implementation, monitoring, and evaluation of health interventions and programmes. These include human dignity, attention to the needs and rights of vulnerable groups, and an emphasis on ensuring that health systems are made accessible to all. During this policy period a basic minimum health and expandable package, Kenya Essential Health Package (KEPH), detailing what every person is entitled to will be defined and provided

to all Kenyans. Other health systems investments will be strengthened to ensure progressive realization of rights to health across the country (Republic of Kenya, 2014).

This policy was developed in line with the country's long-term development agenda, Vision 2030, the Constitution of Kenya 2010 and its global (Human Rights) commitments. It demonstrates the health sector's commitment, under the government's stewardship, to ensuring that the country attains the highest possible standard of health, in a manner responsive to the needs of the population. The aim is to achieve this through supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Kenyans and is designed to focus on primary health care (Republic of Kenya, 2014).

This policy is designed to be comprehensive, balanced and coherent and focuses on two health obligations: the progressive realization of the right to health and the contribution to development as defined in Kenya's Vision 2030 (Republic of Kenya, 2007). It focuses on ensuring equity, people centeredness and participatory approach, efficiency, a multi-sectoral approach and social accountability in the delivery of health care services. The policy embraces the principles of protection of rights and fundamental freedoms to specific groups of persons, including the right to health of children, persons with disabilities, youth, minorities, the marginalized and the older members of the society, in accordance with the Constitution (Republic of Kenya, 2014).

The policy focuses on six objectives, and seven orientations to attain the government's goals in health (Kenya's Vision 2030). The objectives are to:

- a. Eliminate communicable conditions;
- b. Halt and reverse the rising burden of non-communicable conditions;
- c. Reduce the burden of violence and injuries;
- d. Provide essential health care;
- e. Minimise exposure to health risk factors; and
- f. Strengthen collaboration with other sectors that have an impact on health.

It takes into account the functional responsibilities between the two levels of government (county and national) with respective accountability, reporting and management lines. It proposes a comprehensive and innovative approach to harness and synergize health services delivery at all levels by engaging all actors, signaling a radical departure from past approaches in addressing the health agenda. There is therefore a need to raise awareness and ensure that the objectives of this policy are understood and fully owned by the various stakeholders and implementing partners (Republic of Kenya, 2014).

The policy was developed through a participatory process involving stakeholders in health including government ministries, departments, and agencies, clients, counties, constitutional bodies, development partners (multi-sectoral and bilateral) and implementing partners (faith-based, private sector and civil society). The detailed strategies, specific programmes and packages will be elaborated in subsequent five-year strategic and investment plans.

The policy also aims to attain universal coverage of critical services that positively contribute to the realisation of the policy goal. The successful implementation of this policy will be dependent upon the collaborative efforts and synergies of all the stakeholders and actors through establishment of an effective partnership framework. This includes the development of a Health Sector 5-year Strategic Plan, multi-year National and County Health Sectoral Plans and Annual Work Plans. The policy implementation process will adopt a multi-sectoral approach, involving different stakeholders- consumers (individuals, Households, communities), non-state actors (CSOs, FBOs/NGOs, private sector, and development partners), and state actors (government ministries and agencies) at the national and county levels (Republic of Kenya, 2014).

4. The role of the courts in realising the right to health

The court's role in the realization of the right to health did not begin to take shape until the 2010 Constitution was promulgated and socio-economic rights became justiciable. Before this, the Courts were barely confronted with the question of the right to health. One case of *J.A.O v Homepark Caterers Ltd and 2 others* (High Court of Kenya, 2004), which was adjudicated on before the 2010 Constitution. This case was focused on procedural aspects and was eventually settled out of Court but it is important because of the Court's treatment of HIV as grounds for discrimination under the previous Constitution. While the Court did not make a finding on discrimination, because the case was centered on a procedural question, whether or not the plaintiff had raised a reasonable cause of action in her pleadings. While making a finding that the pleadings disclosed a reasonable cause of action the Court held that:

Where the treatment of HIV/AIDS patients by doctors, hospitals employers and others has been put under legal scrutiny with a view to molding attitudes and public policy such that the same would be free of discriminatory practices (High Court of Kenya, 2004:7).

This case did not proceed and was settled out of Court once the procedural aspects were decided, it is therefore unclear what position the Court would have taken if the case had proceeded to hearing on the merits. However, the framing of the issues was limited to aspects of discrimination and had this been discussed under a different constitutional framework health and privacy may have played a more prominent role.

Since the advent of the Constitution, 2010 the jurisprudence on the right to health has been developing. Case law has provided the judiciary with an opportunity to interpret the Constitution and give meaning to the fundamental rights guaranteed in the Bill of Rights. Below is a discussion of key cases where the right to health has been explored highlighting the finding and the thinking of the judiciary around these rights. The cases have been chosen primarily because of their engagement with the right to health directly however, we also considered cases which though not primarily decided on the right to health may have an impact on its realization because of ancillary considerations (*Satrose Ayuma and 11 others v Registered Trustees of the Kenya Railways Staff Retirement Benefits Scheme and 3 others* Petition No. 65 of 2010; *Mitu-Bell Welfare Society v Attorney General and 2 others* Petition No. 164 of 2011).

a. PAO and others v Attorney General (Petition 409 of 2009)

This was the first case on the right to health determined under the Constitution 2010 (High Court of Kenya, 2009). 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 (High Court of Kenya, 2012a).

The Petitioners' case was grounded on the reasoning that the Act adopted a broad definition of counterfeit goods that encompassed generic medication and gave the police wide powers to confiscate such medication. This would have the effect of substantially increasing the cost of HIV medication, making them unaffordable to the more vulnerable persons on society that rely on generic medication. Having considered 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. The Court found that unavailability of essential lifesaving medicines would have adverse consequences to the right to health, dignity and life.

The importance of the PAO case is not only its finding on the right to health but its interpretation finding that a component of the right to health is the access to affordable medicines. A further significant aspect of this case was the finding that rights are indivisible and interrelated when 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, 2012a:15)

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

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 (High Court of Kenya, 2012b). The Petitioner was seeking a declaration that the rights of persons with mental disability had been violated due to their unequal treatment and that a sound legal framework addressing the needs of persons with mental disability including their health needs is 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, 2012b:2).

This case was unfortunately inadequately presented and while the Court found that persons with mental disability do face a number of challenges the Court held that the petition was inadequate for it to conduct the necessary inquiry based on the facts and evidence before it (High Court of Kenya, 2012b).” This case is an illustration of the significance of proper and adequate presentation in public interest cases given that seeking to enforce fundamental rights does not immunise you to the rules of procedure.

c. Okwanda v Minister of Health and Medical Services and 3 Others (Petition 94 of 2012)

An elderly man, Michael Okwanda, who was suffering from diabetes mellitus and lacked the financial means to manage his illness due to the cost of care, filed this matter. The Petitioner sought a declaration that he was entitled to a number of rights including the highest standard of health of health as guaranteed by Article 43 of the Constitution and Article 11 of the ICESCR (High Court of Kenya, 2013). The Court in the Okwanda case placed emphasis on the importance of socio-economic rights in amelioration of the conditions of poor and vulnerable individuals and populations that live 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 (High Court of Kenya, 2013).

In coming to a determination that Court had to be satisfied that the Petitioner had made a case that the State had failed in its duty and the Court found that there was no evidence placed before it to reach that conclusion. The Court stated that:

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 issue of 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 was not explored in the depositions and therefore there is no basis upon which I can make a finding one way or the other (High Court of Kenya, 2013:6).

The Okwanda case took a similar turn as the *Kenya Society of the Mentally Handicapped* case with the Court affirming that the right to health should be accessed by all Kenyans but finding that in the case before it a violation had not been proven.

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

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 (Kenyatta), where the Petitioners accessed treatment was not adequately equipped to address the needs of the Petitioners (High Court of Kenya, 2015a). The Petitioners argued that due to the congestion of the dialysis machines at Kenyatta 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 Kenyatta of Kshs 5,000 This it was contended was a violation of the right to health as guaranteed in the Constitution.

The Court in this case was called to make a determination on the realization of the right to health for individual citizens as against the resources that are available in the Country. The Court found that the State has the primary obligation in ensuring the highest attainable of health. However, the Court came to the conclusion that in this case the State had not failed to meet its obligation finding that:

In the case now 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 their treatment be subsidised by the state at private institutions. In making this demand, they ask the court to interfere with matters of policy which, as the Constitution enjoins at 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 make a determination as to the best use of scarce resources in the health sector vis a vis other equally critical, sectors” (High Court of Kenya, 2015a:15).

The Court looking at the provisions of (Article 20(5) found that the State had shown that it had met its obligation within the resources available. This case perhaps exemplifies the difficulty in both enforcing and litigating on socio-economic rights. Socio-economic rights are not illimitable and are subject to the economic situation within the country and such information is usually within the knowledge of the State and not the public. Therefore, even in a case such as this when the lives of persons are likely to be lost by their inability to access healthcare, this may not result in a violation of their right to health.

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

This case is an illustration of how the right to health interacts with other rights particularly the convergence between the right to health, reproductive health and sexual violence. The background of the case is that the petitioners both minors were defiled by the deputy head teacher (High Court of Kenya, 2015b).

This petition was brought against the teacher accused of defilement, the School, the Teachers Service Commission and the Attorney General on behalf of the State. The Court's finding illustrated a broader understanding of the right to health in Kenya as it was 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 is a clear violation of their right to health, which is defined as including the highest attainable standard of physical and mental well-being (High Court of Kenya, 2015b:20).

While the Court did not explicitly mention the WHO definition of health: "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (Huber, 2011)", it is apparent that the Court did not limit itself to the physical well-being of Petitioners but also considered their psychological health which could be severely impacted on by sexual violence.

The W.J case is an illustration of the judiciary's understanding of the right to health and also it is an assertion that the Court will not look at rights in isolation and is willing to infer a number of violations from one act.

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

In February 2015, the President of Kenya, Uhuru Kenyatta, issued a directive whose implementation posed a threat to fundamental human rights of persons living with HIV (PLHIV) in Kenya. In the directive, the president ordered 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 HIV and number of breastfeeding mothers living with HIV (Uhuru HIV List).

This data was to be collected in a prescribed data matrix that would directly link the above mentioned persons with their HIV status thus putting them at a risk of being stigmatised and discriminated against. There was further risk of compulsory testing in order to acquire the data, which would in turn violate right to privacy and disclosure of information.

While the Constitutional Petition filed was focused on a number of rights including the rights to health, privacy, equality dignity, be free from cruel, inhumane and degrading treatment and the principle of the best interest of the child. The Court limited itself to a finding on the right to privacy and the best interest of the child principle (High Court of Kenya, 2016a).

Having made a finding that the directive violated the right to privacy 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 intention of the directive was to put in place specific measures and strategies" to target the affected persons with a view to ensuring that their right to health services was guaranteed. The directive per se and its implementation was therefore in fact focused towards granting that right as opposed to taking it away. In the event, I do not see how the right to health was violated as alleged (High Court of Kenya, 2016a:45).

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 that the right to health is inextricably linked to other rights (High Court of Kenya, 2012a) 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.

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

In 2012 two women were detained in Pumwani Maternity Hospital for their inability to pay maternity fees. 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 (High Court of Kenya, 2016b).

This case touched on a number of issues: unlawful detention, the right to health, dignity, liberty and to be free from cruel, inhumane and degrading treatment. On the right to health the Court was guided by the Committee on Economic Social and Cultural Right (CESCR) and held that:

In this regard, the CESCR states that 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 most vulnerable or marginalised sections of the population. 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 they must be affordable (High Court of Kenya, 2016b:23).

This case is unique for two reasons 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 (High Court of Kenya, 2015b).

h. Jesca Moraa (on behalf of the late Alex Madaga Matini) and Kenyatta National Hospital and Coptic Hospital

This is a case of professional misconduct that was brought before Professional Conduct Committee of the Kenya Medical Practitioners and Dentists Board (Professional Conduct Committee, 2016). While it was not argued in a court, it is an illustration of 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 delay in accessing the needed care. The delay resulted from 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. This hospital however, recommended that he be taken to a facility with an intensive care unit (ICU) as it did not have one. He also visited 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. Finally, he was taken to both Kenyatta National Hospital (KNH) and Coptic Hospital where he was neither examined nor admitted.

Alex Madaga's counsel argued that Kenyatta National Hospital refused and failed to grant Alex emergency treatment in contravention of Article 43(2) of the Constitution. The Professional Conduct Committee (PCC) found that KNH was not liable for the failure to provide Alex Madaga with emergency treatment because ICU care did not amount to emergency treatment. The PCC found that Alex Madaga had received emergency treatment at PCEA Kikuyu hospital.

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 Kenya Medical Practitioners and Dentists Board develop and disseminate policies and guidelines for referral of emergency cases.

i. Other Cases

There are other cases, which while not explicitly referring to the right to health do touch on health issues and can serve as guidance in seeking to understand adjudication on the right to health in Kenya. The case of *Daniel Ng'etich and others v The Attorney General and Others* (High Court of Kenya, 2016c) was brought by KELIN and two persons who

had been infected with tuberculosis. It demonstrates the tension between public health considerations and individual liberties. While the Court did not make a finding on the right to health it did indicate that there has to be a necessary balance between public health and individual liberties in that the State cannot as a public health measure unjustifiably limit the rights of individuals (Maleche and Were, 2016). Limitation of rights should be within a framework that is respectful of a democratic society guided by the Bill of Rights and the values of the Constitution.

Another case of interest is *AAA v Registered Trustees (Aga Khan University Hospital Nairobi)* (High Court of Kenya, 2015c) where the Court found the Respondent liable for failing to provide contraceptive services, which resulted in a child being born. While this case was centered on the law of torts (the principles of negligence were utilised in determining a duty of care and breach of said duty) it may have been an opportunity to discuss the right to reproductive health as guaranteed in Article 43(1) and the Maputo Protocol. Wrongful birth cases touch on more than negligence but are also 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)

The interaction between the right to health and the interrelated rights such as privacy and criminal law was discussed in *AIDS Law Project v Attorney General and 3 others* (High Court of Kenya, 2015d). This case was centered on Section 24 of the HIV and AIDS Prevention and Control Act that criminalised HIV transmission under prescribed circumstances (Republic of Kenya, 2006). While this case touched the negative aspects of criminalisation of transmission particularly stigma and discrimination on persons living with HIV, the finding was grounded on the vagueness and over broadness of Section 24 which the Court rendered unconstitutional (High Court of Kenya, 2015d). The Court focused on the meaning of sexual contact in the provision holding 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 contacts... in relation to their mothers and if so how is the disclosure supposed to take place between the mother and the child? Section 24 of the Act as drafted 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 are to be deprecated and the spirit of the Constitution and its principles frowns upon such overbroad enactments (High Court of Kenya, 2015d:14).

The AIDS Law Project case without explicitly ever stating so, touched on the interaction between the right to health and criminal law. The Court took cognizance of the negative 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 took into account that such over broad legislation could have a negative impact on public health because stigma may lead to a reluctance to approach medical facilities for preventative or curative measures (Cortez and Others vs. Salvador Case 12.249, 20 March 2009). The Court in the end reached the conclusion that the Section was unconstitutional because it failed to meet one of the principles of rule of law: legality – which requires that laws a certain, and in this case the law was not (High Court of Kenya, 2015).

Other significant cases are those that have been decided on some of the social determinants of health, in particular, the courts have been engaged with right to housing is *Satrose Ayuma and 11 Others v Registered Trustees of the Kenya Railways Staff Recruitment*.

Key lessons learned from judicial determination on the right to health in Kenya

- a) The judiciary has played a significant role in developing robust jurisprudence pertaining to the right to health.

- b) These cases have given content to the right to health significantly, *PAO and others v Attorney General*.
- c) These cases have been illustrative of the difficulties in litigating socio-economic cases, particularly with regard to proving a violation has occurred.
- d) The cases have been illustrative of the resource constraints within Kenya and its effect on the right to health.

5. Challenges faced in realising the right to health

While the Constitution and the legislative framework has provided mechanisms for the realisation of the right to health this paper identifies a number of challenges that have an impact on the realisation of this right.

5.1. Governance and the impact of devolution

Prior to 2010, the health System in Kenya was centralised and after the 2010 Constitution there was a clear division of roles. The National Government is charged with National Referral Hospitals and Health Facilities and County Governments are charged with county health services including— county health facilities and pharmacies; ambulance services; promotion of primary health care; licensing and control of undertakings that sell food to the public; veterinary services (excluding regulation of the profession); cemeteries, funeral parlours and crematoria amongst others (Republic of Kenya, 2010b). Notably the bulk of functions relating to health are now within the mandate of Counties.

The journey to devolution has been a difficult one and almost 7 years after the Constitution was passed, the national government continues to display a lack of appreciation for this function. Further, there is little knowledge on devolution, which makes it difficult to hold the State accountable for its various shortcomings. Prompted by this awareness, of a gap in knowledge around devolution, KELIN developed a resource material to support civil society to monitor the implementation of the right to health under the Constitution of Kenya (KELIN Kenya, 2016). This was launched and followed with trainings for civil society that work with health to ensure they understand health as a devolved function and how to monitor it.

Other challenges to devolution include significant capacity gaps within county political and management structures (Williamson and Mulaki, 2015). When resources were devolved, few countries possessed the administrative capability to absorb the available funding or plan for its use (Williamson and Mulaki, 2015).

This gap exacerbated the challenges faced with respect to misfeasance in the public sector. This has an impact, not only on the economy and polity of the nation, but also has a noted impact in the provision of certain services, not limited, but including health care services (Mills, 2012). Corruption results in a reduction of available resources for health, reduces the quality, equity and efficiency of health care services. It also results in a reduction of the volume of these services while increasing the cost of providing these services; it ultimately has a negative impact on the population's level of health as it discourages people from using such health services (Kenya Anti-Corruption Commission, 2010).

According to the Global Corruption Report (2006), Kenya's health care system lacked accountability mechanisms allowing abuse and misappropriation of funds. Some identified areas of vulnerability include: construction and rehabilitation of health facilities, purchase of equipment and supplies including drugs, distribution and use of drugs and supplies in service delivery, regulation of quality in products, services, facilities and professionals, and medical research and provisions of services by frontline health workers. According to this report, the money lost through these areas is monumental and

addressing such vulnerabilities would allow funds to be directed to health care improvement and general poverty reduction programmes in Kenya. It is thus necessary to formulate effective prevention programmes to address this issue (Transparency International, 2006).

The most common forms of irregularity in public health facilities include unjustified absence among medical staff, mismanagement of procurement, theft of drugs or equipment, unauthorised use of equipment, facilities or supplies and unauthorised billing of patients (Kenya Anti-Corruption Commission, 2010). With respect to health care delivery systems, lack of accountability and transparency in management, management and control of health facilities, inadequate access to information (Kenya Anti-Corruption Commission, 2010). These work cumulatively to affect the quality of health care in Kenya.

Never-the-less, there are some instances that highlight the potential benefit of an effective county government with respect to health. Siaya County, which has for the longest time had the highest prevalence of malaria in Kenya, managed to lower the rate to 20% from 42%. Through the combined efforts of the National government and civil society, the competency of the county government to provide primary health care was fully realised through this programme. Community health workers have also been commended in this instance due to their sensitisation efforts.

5.2. Budgeting for health

According to the Kenya National Health Accounts for 2009/2010 (USAID, 2015), there have been significant gains over the past decade in the Total Health Expenditure, which has increased by 44% from Ksh82.2 billion in 2001/2002 to Ksh122.9 billion in 2009/2010. The Total Health Expenditure per capita has also increased from Ksh 2,636 in 2001/2002 to Ksh3,203 in 2009/2010. Although the per capita health expenditure has increased it is still significantly low and falls short of the amount needed to provide an essential package of services for all Kenyans (Muigai, 2012). Government health expenditure in Kenya declined from 8% in 2001/2002 to 4.6% in 2009/2010 This is a far cry from the Abuja Declaration (April 2011) where African heads of state committed to allocate 15% of their national budgets to health as well as mobilise resources for improved access to HIV medications, vaccine research and prevention programmes (Muigai, 2012).

In the 2013/2014 financial year, Kshs.34.7 billion was set aside for the National Government compared to Kshs.55.1 billion in the previous financial year. This difference was attributed to the devolution of health services and sharing of management of facilities between the national and County Governments. Although it has been reported in the media that Kshs.60 billion was allocated by counties, which would bring the total allocation to Kshs.95 billion, or 5.7 % of the total national budget. This is well below the target agreed to under the Abuja declaration (Nesoba, 2014).

In the 2014/15 financial year the ministry of health received Sh47.4 billion, constituting 4% of the national budget, compared to 3.4 per cent in the previous year. The combined budget allocations (national and county) increased from an estimated 5.5 % of the national budget in 2013/14 to 7.5 % in 2014/15 (Muchangi, 2016). There was a further increase in the budget for 2016/2017 financial year, with the Ministry of Health receiving Sh60.269 billion, compared to Sh59 billion in the previous budget year. Of the Sh60 billion, Sh29.090 billion would go to recurrent expenditure and Sh31.179 to development expenditure. Sh4.298 billion will go to the free maternity program while Sh4.5 billion would cater for medical equipment for 98 hospitals. Sh8.8 billion would go to Kenyatta National Hospital, Sh4.8 billion will to the Moi Teaching and Referral Hospital and Sh1.7 billion to the Kenya Medical Research Institute. A further Sh2.747 billion would cater for the allowances of intern doctors, nurses and clinical officers. Sh1.394 billion was earmarked for the universal health care coverage in addition to Sh900 million allocated

for free primary health care. Sh500 million would go towards social health protection for the old and physically disabled and Sh500 million will go towards establishing clinics in low income and hard to reach areas. Whether these allocations were effected as provided is yet to be seen and although this marks an increase in the allocation to health it is once again below the percentage that states agreed to under the Abuja declaration (Muchangi, 2016).

The discussion above focuses on trends in budgeting for health in Kenya however, this would be incomplete without a discussion on the impact of devolution on budgeting for health. The Constitution in Chapter 12 on public finance provides that county governments will receive at least fifteen per cent of the most recently audited accounts approved by parliament to enable them deliver on their mandates (Republic of Kenya, 2010b). Counties in which marginalised communities exist may receive additional equalisation funds comprising one half per cent (0.5%) of all the revenue collected by national government calculated from the most recently audited accounts approved by the national assembly - Article 204(1) read with Article 204(3) (Republic of Kenya, 2010b). The equalisation fund seeks to address inequities that may exist between counties because of historical injustices (Oduor, 2014). In addition to this County governments are able to raise revenues through rates charged on property, entertainment tax and charges imposed for services delivered within the County. Further counties may receive grants or transfers from the national government and also have the leeway to borrow funds from private lenders however; this has to be guaranteed by the National Government (Oduor, 2014).

In addition to the Constitution the normative framework for county budgeting includes the County Governments Act, 2012 which required counties to develop plans including: Five-year County Integrated Development Plan (CIDP), ten year programme based county sectoral plan as component parts of the CIDP, county spatial plans and cities and urban areas plans (Republic of Kenya, 2012a). These plans are the basis for all budgeting and spending in the county and funds shall not be appropriated outside of a planning framework developed by the County Executive Committee and approved by the County Assembly (Republic of Kenya, 2012a).

The second significant legislation is the Public Finance Management Act, 2012 which makes it a requirement that county governments prepare an integrated development plan that includes strategic priorities for the medium-term, that reflect the county government's priorities and plans, a description of how the county government is responding to changes in the financial and economic environment; and programmes to be delivered (Republic of Kenya, 2012b). Finally, is the Intergovernmental Relations Act, 2012 which provides a framework for the relationship between county and national governments (Republic of Kenya, 2012c).

Within the agreed framework Counties have relative autonomy to manage their budgets however; the Public Finance Management Act does pose some restrictions on counties which are as follows:

- a. a county government's actual expenditure on development shall be at least 30 per cent;
- b. a county government's recurrent expenditure shall not exceed the government's total revenue;
- c. the county government's expenditure on wages and benefits for its public officers shall not exceed a percentage of the county government's total revenue as prescribed by the County Executive member for finance in regulations and approved by the County Assembly; and
- d. The government's borrowings shall be used only for the purpose of financing development expenditure and not for recurrent expenditure (Republic of Kenya, 2012b)

The National and County Government Health Budget Analysis indicates that in the year 2016/17 county governments increased their budget allocations for health to 25.2% of the total budgets (an estimated Kshs.92 Billion) from the previous years 23.4% (an estimated 85 Billion). While the increased expenditure is indicative of goodwill from counties to provide for health services it remains a concern that the National Government, through the Ministry of Health, is allocated Kshs.60 Billion despite the fact that its functions have been significantly reduced. As discussed above the mandate of the national government is limited to the development of national health policy and the administration of national referral hospital yet they maintain a relatively bloated budget. The recent doctors' strike may be seen as a failure by the government to consider the negative effects of inadequate budgeting for health. According to Human Rights Watch, massive corruption in health care resulted in the deterioration of the health care system in Kenya forcing doctors to down their tools demanding that amongst other things increase in salary and improved working conditions. This would only be realised through an effective and comprehensive budget for health devolved at a county level. Transparent and effective accountability in the disbursement and use of funds for health may then realise marked improvements in the health sector (HRW, 2017).

5.3. The meaning of the term progressive realisation

Article 21(2) states that: (2) The State shall take legislative, policy and other measures, including the setting of standards, to achieve the progressive realisation of the rights guaranteed under Article 43(Republic of Kenya, 2010b). The right to health is guaranteed under Article 43(1) (a) and this therefore begs the question: What is progressive realisation? How does one define it? How is it quantified? And how then should one hold the state accountable?

The Committee on Economic, Social and Cultural Rights (CESCR) in General Comment No. 3 (UN CESCR, 1990) defines the Nature of the State Parties' Obligations as follows:

*The concept of progressive realisation constitutes a recognition of the fact that full realisation of all economic, social and cultural rights will generally not be able to be achieved in a short period of time. . . Nevertheless, the fact that realisation over time, or in other words progressively, is foreseen under the Covenant should not be misinterpreted as depriving the obligation of all meaningful content. It is on the one hand a necessary flexibility device, reflecting the realities of the real world and the difficulties involved for any country in ensuring full realisation of economic, social and cultural rights. On the other hand, the phrase must be read in the light of the overall objective, indeed the *raison d'être*, of the Covenant, which is to establish clear obligations for States parties in respect of the full realisation of the rights in question. It thus imposes an obligation to move as expeditiously and effectively as possible towards that goal. Moreover, any deliberately retrogressive measures in that regard would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources (UN CESCR, 1990:9).*

The Constitution recognises that with limited resources some rights may not be immediately achieved in their entirety. However, that should not be interpreted in a manner that leads to the deprivation of the right. This has been recognised by the CESCR and the high court of Kenya. In *Mitubell Welfare Society vs. The Attorney General & 2 Others* Petition No. 164 of 2011, which held that:

The argument that social and economic rights cannot be claimed at this point two years after the promulgation of the Constitution ignores the fact that no provisions of the Constitution is intended to wait until the state feels it is ready to meet its constitutional obligations. Article 21 and 43 require that there should be progressive realisation of socio- economic rights, implying that the state must be

seen to be taking steps, towards realisation of these rights.” (High Court of Kenya, 2013:12).

The challenge does not lie in understanding that the steps must be taken; it lies in quantifying whether or not the steps taken are adequate. The Constitution went a step further in Article 20(5)(a) providing that: *In applying any right 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— it is the responsibility of the State to show that the resources are not available* (Republic of Kenya, 2010b:19). Therefore, the burden of proof is on the state to provide evidence that resources are not available to provide the right to health.

5.4. Development partners

There is a general recognition of and respect for the Constitution of the Republic of Kenya by developmental partners. In a statement released in the Standard Newspaper, developmental partners stated that they were proud to support Kenya in the continued expansion of the economy and increased trade and investment and the creation of more jobs (Standard Media, 2013). They recognised the Constitution of the Republic of Kenya as a progressive document offering clear direction towards the attainment of a well-balanced society with the necessary checks and balances to ensure that this goal is realised (Standard Media, 2013). Progress thus far was noted and appreciated, alongside the central role of devolution, as a unique opportunity to establish a democratic and efficient structure closer to the people. Devolution was also recognised as a means of ensuring more effective service delivery and distribution of resources. This would, however, take some time through effective capacity building, political will and public buy-in. Development partners committed to continued support of these processes as envisioned by the Constitution, including assistance with the preservation of coherence between national and county governments (Standard Media, 2013).

A set of principles agreed upon in Busan, South Korea, 2011 focused on the need to rework development assistance architecture to involve as many stakeholders as possible in the determination of how best different streams of financing for development can address to socio-economic needs of emerging and developing countries across the globe (Busan Partnership, 2011). In February 2014, Development Initiatives Africa Hub conducted a study to evaluate the extent to which the principles agreed on in Busan were working to enhance effective development co-operation in Kenya. This study found that while the Government of Kenya has introduced systems to ensure that resources are administered prudently, they remain weak and vulnerable to corruption. The stringent processes preferred by some development partners also had an impact, and slowed down the effective implementation of projects and concessions leading to a low absorption of developmental finances. It was also noted that there is an emerging trend of active alienation of civil society organisations alongside a shrinking of democratic space that has a negative impact for effective development cooperation (Development Initiatives, 2014).

Devolution was noted as an opportunity for the flow of resources to the lowest levels of service delivery thus posing potential for better impact. However, the fact that sub-national entities are unable to directly negotiate for grants with development partners may pose a challenge with respect to coordination of development assistance. There is also the potential challenge of donors favouring certain projects, geographical areas or sectors to the disadvantage of national policies. There is also a noted shift by donors to bilateralism driven mainly by commercial interest, rather than a genuine drive for socio-economic development as was previously emphasised by traditional partners (Development Initiatives, 2014).

5.5. The role of the community and participation

Despite a broad consensus that communities should be actively involved in improving their own health, evidence for the effect of community participation on specific health outcomes is limited (Marston et al, 2013).

Community members make a significant contribution to community health. The Kenya community health strategy rolled out in 2006 provides a plan to expand community access to health care across the country. Within this strategy the district health management team, now called sub-county health management team, is responsible for the coordination of community services. There is a focal person tasked with the supervision, planning and monitoring of community health-related activities (McCollum et al., 2016).

Community health services at a sub-county level are centered on community units consisting of 5000 people including 50 volunteer community health workers responsible for 20 households each. The strategy lays out their roles and responsibilities which include disease prevention and control to reduce morbidity, mortality and disability; provision of family health services to expand family planning, maternal, child and youth services; and promotion of environmental hygiene and sanitation. They may also be involved in a range of other tasks including home-based care, observed treatment and some curative tasks dependent on location (McCollum et al., 2016).

There is a general appreciation of the community health strategy however certain factors hinder its effective implementation. These include high attrition, lack of accountability for voluntary community health workers and lack of funds for salaries of community health workers. There is also a high workload for voluntary and salaried community health workers combined to hinder the effective realization of the community health strategy in Kenya.

A mapping exercise of Community Health Units in certain regions of Kenya highlights that the necessary areas for change include the provision of adequate travel resources, an even distribution of community health services, and equalised standards in the provision of community health services. There was also a noted gap in knowledge about the community health strategy and its proposed revisions that needs to be addressed. Any revisions to the community health strategy must involve the provision of home-based HIV testing and counseling (McCollum et al., 2016).

6. Conclusion

The right to health is guaranteed under the Constitution of Kenya and this has opened up the space for rights holders because the Constitution has clearly defined the obligations of the State in providing for this. While this has seen a shift, particularly in the jurisprudence of Kenya, it has not been without its challenges. The Courts have shown their willingness to advance the Bill of Rights and its realisation, but the operational framework for realizing this right has been hampered with an inability or unwillingness by the national and county governments to ensure that this right is realised.

There are several factors that may influence a person's ability to access effective health care in Kenya, including but not limited to certain structural barriers, e.g. our policy and legislative framework and socioeconomic factors such as class and age. In Kenya particularly, the challenges that hinder the effective realisation of the right to health include a lack of understanding of our governance structures and the resulting obligations, alongside a lack of understanding of the constitutional obligation to realise this right progressively. There are some instances where effective devolution and careful management of funds has resulted in a marked improvement in the provision of county health services, such as in Siaya. These should be applauded and replicated as good examples for others to follow.

7. Recommendations

A number of challenges have been highlighted with the realisation of the right to health post 2010 and the following recommendations are suggested:

There is a need to internalise devolution for its effective implementation. Siaya County was cited, and such can be used as best practices, but this is only one project in one area. Both national and county governments, as duty bearers, have to delineate their roles and respect the constitutional dispensation with each playing its constitutionally mandated role. This will need political will at both levels of government to make devolution work.

Health financing remains a contentious subject, with the Kenyan government continuously failing to meet its commitment in terms of the Abuja Declaration. The Constitution does provide the public with greater opportunity to engage in the process of decision-making at both county and national level. Therefore, it is recommended that organisations that have expertise in budget making engage with organisations that work on health as well as the public to demystify the budget making process and foster greater awareness of these processes. This may ensure greater participation in the process and develop a framework for accountability to the public at the budget making stage.

Public and community participation in decision making remains key to ensuring that the country has a framework of accountability for realizing the right to health. A number of counties are already developing legislation around public participation guided by the County Public Participation Guidelines developed by the Ministry of Devolution (Country Public Participation Guidelines, 2016). Such efforts are in the right direction and must be coupled with civic education to enable meaningful participation by communities that are empowered and knowledgeable of their civic duty.

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Acronyms

AAAQ	Available, Accessible, Acceptable, and of Good Quality
ACHPR	African Commission on Human and Peoples' Rights
CESCR	Committee on Economic, Social, and Cultural Rights
CIPD	Country Integrated Development Plan
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of People with Disabilities
CRR	Center for Reproductive Rights
EQUINET	Regional Network for Equity in Health in East and South Africa
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HSSP I	Health Sector Strategy Plan I, 2004
HSSP II	Health Sector Strategic Plan II, 2005-2010
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social, and Cultural Rights
ICU	Intensive Care Unit
IMF	International Monetary Fund
KELIN	Kenya Legal and Ethical Issues Network on HIV and AIDS
KHPF	Kenya Health Policy Framework
KSMH	Kenya Society for the Mentally Handicapped
KNH	Kenyatta National Hospital
MOH	Ministry of Health
NHIF	National Health Insurance Fund
PCC	Professional Conduct Committee
PCEA	Presbyterian Church of East Africa
PLHIV	People Living with Human Immunodeficiency Virus
UDHR	Universal Declaration of Human Rights
WHO	World Health Organization

Appendix 1: International legal obligations for the realisation of the right to health

Treaty document	Provision related to health
Universal Declaration on Human Rights	Article 25(1): Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.
International Convention on the Elimination of Racial Discrimination	Article 5 (e) (iv): States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of Economic, social and cultural rights, in particular: The right to public health, medical care, social security and social services ...
International Covenant on Economic Social and Cultural Rights	Article 12: "1. The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness."
Convention on the elimination of all forms of Discrimination against Women	Article 12: 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. 2. 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, as well as adequate nutrition during pregnancy and lactation."
Convention on the Rights of the Child	Article 24:"Parties recognise 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 shall strive to ensure that no child is deprived of his or her right of access to such health care services." The following measures are to be adopted by states in the realisation of the rights above: a) To diminish infant and child mortality; b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; c) 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; d) To ensure appropriate pre-natal and post-natal health care for mothers; e) 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; f) To develop preventive health care, guidance for parents and family planning education and services.
Convention on the Rights of Persons with Disabilities	Article 25: States Parties recognise 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 health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall: (a) 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; (b) Provide those health services needed by persons with disabilities specifically because of

Treaty document	Provision related to health
	<p>their disabilities, including early identification and intervention as appropriate, and services designed to minimise and prevent further disabilities, including among children and older persons; (c) Provide these health services as close as possible to people's own communities, including in rural areas; (d) 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; (e) 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; (f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.</p>
African Charter on Human and Peoples Rights	<p>Article 16: "Every individual shall have the right to enjoy the best attainable state of physical and mental health." "State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."</p>
Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women	<p>Article 14"1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes: 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/AIDS; e) 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.</p> <p>2. States Parties shall take all appropriate measures to: 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 breast-feeding; c) protect the reproductive rights of women by authorizing 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."</p>
African Charter on the Rights and Welfare of the Child	<p>Article 14: 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: (a) to reduce infant and child mortality rate; (b) to ensure the provision of necessary medical assistance and health care to all children with 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 within the framework of primary health care through the application of appropriate technology; (e) to ensure appropriate health care for expectant and nursing mothers; (f) to develop preventive health care and family life education and provision of service; (g) to integrate basic health service programmes in national development plans (h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of domestic and other accidents; (i) to ensure the meaningful participation of non-governmental organisations, local communities and the beneficiary population in the planning and management of a basic service programme for children; (j) to support through technical and financial means, the mobilisation of local community resources in the development of primary health care for children.</p>

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity-oriented interventions. EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Promoting public health law and health rights
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET from the following institutions:

TARSC, Zimbabwe; CWGH, Zimbabwe; University of Cape Town (UCT), South Africa; CEHURD Uganda; University of Limpopo, South Africa; SEATINI, Zimbabwe; REACH Trust Malawi; Ministry of Health Mozambique; Ifakara Health Institute, Tanzania; Kenya Health Equity Network; Malawi Health Equity Network, SATUCC and NEAPACOH

For further information on EQUINET please contact the secretariat:
Training and Research Support Centre (TARSC)
Box CY651, Causeway, Harare, Zimbabwe Tel + 263 4 705108/708835
Email: admin@equinetafrica.org
Website: www.equinetafrica.org