



The Global Initiative
for Economic, Social and Cultural Rights



Patients or customers?

**The impact of commercialised
healthcare on the right to
health in Kenya during the
COVID-19 pandemic**

The Global Initiative for Economic,
Social and Cultural Rights

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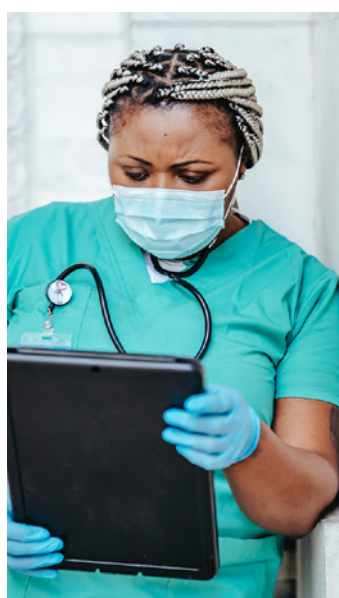


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Executive summary

In Kenya, the right to health is legally well-protected.¹ According to the law, the East African State, which as of 2020 has a population of 53.77 million, must provide quality and timely healthcare services to everyone, without discrimination.² However, there is a wide gap between norms and reality. Health services are limited: while the World Health Organisation (WHO) recommends a minimum of 21.7 doctors and 228 nurses per 100,000 people,³ Kenya has only 16 doctors per 100,000 and 167 nurses per 100,000 as of 2018.⁴ In 2018, an official survey found that none of the country's health facilities had all essential medicines, and that only a small fraction (12%) had all items needed for infection prevention.⁵



This is perhaps not surprising, as healthcare services are starved of resources: domestic spending on health was as low as 9% of the national budget in 2020,⁶ far below the target of 15% to which the African Union States committed to in the Abuja Declaration.⁷ Looking at health spending as a share of national income, Kenya's general government spending on health in 2018 accounted for only 2.17% of its gross domestic product (GDP).⁸

The scarce medical resources are also unevenly distributed. Across the 47 counties of Kenya, acute socio-economic health inequalities exist in accessing medical services,⁹ including reproductive and maternal healthcare,¹⁰

1. Constitution of Kenya (2010); African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) (1982) 21 ILM 58 (African Charter).

2. International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) Art. 12.

3. WHO, *Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals* (2016) <<https://apps.who.int/iris/bitstream/handle/10665/250330/9789241511407-eng.pdf>> accessed 14 March 2022.

4. World Bank, *World Bank Databank* (2022) <https://data.worldbank.org/indicator/SH.MED.NUMW.P3?locations=KE> accessed 10 January 2022.

5. Ministry of Health, *The Kenya Harmonized Health Facility Assessment (KHFA) 2018-2019* (2020) <https://www.health.go.ke/wp-content/uploads/2020/01/KHFA-2018-19-Popular-version-report-Final-.pdf> accessed 03 January 2022.

6. Republic of Kenya. 2013/14—2019/20. County Budget Estimates. Nairobi, Kenya: Republic of Kenya; see also: Health Policy Plus, 'Is Kenya allocating enough funds for healthcare?' (February 2021) <http://www.healthpolicyplus.com/ns/pubs/18441-18879_KenyaNC-BABrief.pdf> accessed 10 January 2022.

7. WHO, *The Abuja Declaration: Ten Years On* (2011) <https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1> accessed 14 March 2022.

8. WHO, *Global Health Expenditure Database* (2022) <https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS?locations=NG-KE-ZA-CI-ZG> accessed 21 January 2022.

9. Julius Korir, Jacob Omolo and Charles C Nzai, 'An Empirical Analysis of the Effect of Poverty on Health Care Utilization in Kenya' (2018) 14 *European Scientific Journal*.

10. Emily Catherine Keats and others, 'Assessment of Inequalities in Coverage of Essential Reproductive, Maternal, Newborn, Child, and Adolescent Health Interventions in Kenya' (2018) 1 *JAMA Network Open* e185152; Jennifer Yourkavitch and others, 'Using Geographical Analysis to Identify Child Health Inequality in Sub-Saharan Africa' (2018) 13 *PLOS ONE* e0201870.

prevention and immunisation,¹¹ and urgent care.¹² Beyond economic inequality, spatial factors are also an obstacle to accessing quality healthcare: high-end medical services are concentrated in the wealthy areas of cities, at the expense of those living in rural and marginalised urban areas.¹³

The array of challenges have many causes. Increasingly, civil society and academic research are demonstrating that commercialisation of healthcare - that is the proliferation of market logic and mechanisms, including competition and performance incentives to gain private benefits - within the healthcare system is among the most prominent impediments to the progressive realisation of the right to health in Kenya.¹⁴ Private health actors have been present in the country since its independence, and it is important to acknowledge that private actors are diverse, including a significant share of non-profit actors that play a positive role in filling some of the gaps left by insufficient public healthcare provision. However, for-profit providers have considerably increased their activities in relatively recent times. Between 2013-2021, the share of health establishments that are for-profit in Kenya grew from 33% to 43% in less than 10 years.¹⁵

This has not happened by chance. It is the result of political choices. The Kenya Health Policy 2014-2030 frames strengthening the role of the private sector as both a financier and a provider as one of its core objectives, including through tax exemptions and the development of an enabling legal framework for private-public partnerships.¹⁶ International development actors have also contributed to higher private health sector involvement, investing in private-sector-led healthcare projects across a wide range of medical services.¹⁷

This report assesses whether the commercialisation of healthcare in Kenya has undermined the realisation of the right to health, particularly in the context of the COVID-19 pandemic. The focus is on individuals living in poverty in urban informal settlements.

11. Carine Van Malderen and others, 'Decomposing Kenyan Socio-Economic Inequalities in Skilled Birth Attendance and Measles Immunization' (2013) 12 International Journal for Equity in Health 3.

12. WP O'Meara and others, 'Heterogeneity in Health Seeking Behaviour for Treatment, Prevention and Urgent Care in Four Districts in Western Kenya' (2014) 128 Public Health 993.

13. Nirali M Chakraborty and others, 'Assessing Provision and Equity in Low- and Middle-Income Country Health Markets: A Study from Kenya' (2017) Oakland CA: Metrics for Management <http://m4mgmt.org/wp-content/uploads/2018/07/PEM-Report.pdf> accessed 30 November 2021.

14. Economic and Social Rights Centre – Hakijami and the Centre for Human Rights and Global Justice, 'Wrong Prescriptions: the Impact of Privatising Healthcare in Kenya' (17 November 2021) https://chrgi.org/wp-content/uploads/2021/11/Report_Wrong-Prescription_Eng_.pdf accessed 13 January 2022; People's Health Movement (PHM) and Regional Network for Equity in Health in East and Southern Africa (EQUINET), 'Report of the East and Southern Africa Regional People's Health University' (2021) <<https://www.equinet africa.org/sites/default/files/uploads/documents/ESA%20RPHU%20Report%202021.pdf>> accessed 14 January 2022; UNISON <https://gala.gre.ac.uk/id/eprint/16416/7/16416%20LETHBRIDGE_Unhealthy_Development_2016.pdf> accessed 14 January 2022.

15. Data from 2013 are from the following official report: Ministry of Health, Kenya Service Availability Readiness Assessment Mapping (SARAM) Report, <http://guidelines.health.go.ke:8000/media/Kenya_Saram_Report.pdf> page 12.

16. Ministry of Health, 'Kenya Health Policy 2014-2030' (2014) <http://publications.universalhealth2030.org/uploads/kenya_health_policy_2014_to_2030.pdf> accessed 09 November 2021.

17. BEAMExchange, 'PSP4H: Private Sector Innovation Programme for Health' (June 2016) <https://beamexchange.org/practice/programme-index/112/> accessed 14 January 2022.

This is a population that has a high risk of suffering the worst effects of the current pandemic. Living where social distancing and adherence to hygiene routines are nearly impossible, financially deprived individuals have higher odds of contracting infective diseases, including the COVID-19 virus. Likewise, due to pre-existing comorbidities that are frequent in their communities, such as respiratory problems, those living in informal settlements are also more prone to suffer the worst health consequences from the virus.

To undertake this research, we conducted 47 individual interviews and three focus group discussions in three of Nairobi's largest informal settlements: Dandora, Mathare and Mukuru Kwa Njenga. We conducted such data collection over a three-month period, from September to November 2021.

Using a human rights framework to assess private sector involvement in healthcare, the report identifies four ways through which the commercialisation of healthcare impacts on the right to the highest standard of health of Kenyans, especially those from a disadvantaged socio-economic background, amidst the COVID-19 crisis.



First, decades of commercialisation have resulted in a lack of public healthcare services. Currently, Kenya lacks the necessary medical resources to respond effectively to both the current pandemic and to future ones. Kenya is remarkably short on medical resources that are vital to identify COVID-19 cases, such as reagents for testing, and to treat COVID-19, such as ventilators and acute care hospital beds.

Second, commercialisation is exacerbating inequalities in access to healthcare services. First-class looking private health facilities are largely inaccessible to low-income individuals, who instead rely on the limited availability of public medical facilities or low-cost private health services offering substandard medical services.¹⁸ The COVID-19 pandemic has cast into stark relief these inequalities, with the worst-off facing the highest difficulties in accessing COVID-19 testing and treatments, as well as other medical services, during the public health crisis.

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

Third, the public policies that have encouraged higher private sector engagement in healthcare over the last few decades have not been accompanied by sufficient regulation and monitoring of private healthcare actors, which has contributed to a proliferation of ramshackle private clinics, nursing homes and laboratories. While a legal framework for the regulation and monitoring of private healthcare providers exists, it has not been sufficiently implemented in practice. As a result, the private health sector is fragmented and plagued by episodes of negligence, malpractice and other forms of lack of adherence to scientific protocols and medical ethics.

Fourth, partly because of insufficient regulation and monitoring several private health facilities in marginalised areas are unsafe and offer substandard medical services. These facilities, often unlicensed, often employ unqualified doctors and chemists or sell expired drugs.¹⁹ Registered private facilities also have challenges, including episodes of misdiagnosis, unnecessary treatments or misrepresentation of medical qualifications.²⁰ The chaos created by the COVID-19 pandemic seems to be a breeding ground for these practices in the for-profit health sector as demonstrated in this report. Health workers and community leaders we interviewed reiterated that they prefer to refer patients to the nearest public facility available as the quality is perceived as better; however, as it has been already noted, public health services are limited.

These four findings demonstrate that, in a system that has experienced a rapid increase of commercial private sector participation in healthcare, access to quality healthcare depends on one's position in society, including relative access to wealth, employment, education, transportation and information. Those occupying the higher echelons of society can enjoy quality healthcare as a luxury by paying for it or travelling abroad. However, entrusting healthcare to commercial actors, private interests and the market logic is a loss for everyone. Private health providers are less likely to operate where there is less opportunity for revenue, such as in rural areas.²¹ By the same token, for-profit health providers will be less likely to deliver services that do not generate high returns but are essential for protecting populations' health, like prevention, family medicine and emergency care. Healthcare systems based on commercial drivers are in this way less resilient to shocks such as epidemics and prioritise short-term profits over public health goals, undermining the realisation of the right to health.

19. David I Muthaka and others, A Review of the Regulatory Framework for Private Healthcare Services in Kenya (2004) https://pdf.usaid.gov/pdf_docs/pnads076.pdf accessed 14 March 2022.

20. Ibid.

21. World Bank and Government of Kenya, Health Service Delivery Indicator Survey 2018 Report 83-84.

Policy recommendations

We urge the government of Kenya to:



Increase government funding to health to at least 15% of the national budget to expand the availability of quality, well-coordinated public healthcare services

Kenya is among the African Union States that pledged in the 2001 Abuja Declaration to raise the proportion of government funding for health to at least 15% of the overall national budget.²² However, Kenya is far below that target. Domestic public spending on health was at 9% of general government expenditure in 2018 (figure 2).²³ Increasing the public spending on health would also be in line with Kenya's obligation to allocate its maximum available resources to ensure that everyone has access to universal, public healthcare services, in accordance with the African Charter on Human and Peoples' Rights and the other international human rights treaties that Kenya has ratified.



Ensure that all healthcare providers are strictly monitored and regulated at the national, county and local levels

The legal framework on private actors' regulation is well-developed, yet it is not accompanied by sufficient implementation in practice. However, the study confirms that, in practice, the quality of private healthcare provision is sometimes very low and not in line with medical or human rights standards. The national and county governments should coordinate efforts to ensure that all health care providers in the country comply with regulatory requirements as established in the national and international legal framework.

22. WHO, The Abuja Declaration: Ten Years On (2011) <https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1> accessed 25 October 2021.

23. Republic of Kenya. 2013/14—2019/20. County Budget Estimates. Nairobi, Kenya: Republic of Kenya; see also: Health Policy Plus, 'Is Kenya allocating enough funds for healthcare' (February 2021) <http://www.healthpolicyplus.com/ns/pubs/18441-18879_KenyaNCBAbrief.pdf> accessed 10 January 2022.



Take concrete steps to ensure universal access to health insurance

As this report highlights, participation in the National Health Insurance Fund is extremely low. Marginalised populations face financial and information barriers that often prevent them from accessing the scheme. It is thus particularly important to take proactive steps, through adequate public health policies, to address cost or information as a barrier to access healthcare insurance or any other form of pre-pooled scheme.



Promote the development of a stronger public health-care system accessible to all

As this report demonstrates, market mechanisms in health-care fail to adequately fill the gaps left by a weak public sector. Rather than promoting market-based solutions that have dangerous impacts on the realisation of the right to health, Kenya should invest in a strong public universal healthcare system that is democratically managed, funded and delivered by non-commercial actors, and reinforce the public health-care sector's capacity. This would be in accordance with Kenya's obligation to prevent, respond to and detect pandemics and to provide universal healthcare services, including during public health crises.

I. Introduction

Since the first case of COVID-19 was recorded in Kenya on 12 March 2020, the country's health system has been struggling to cope with the pandemic. This situation was to have been expected: even before the pandemic struck, Kenya lacked essential medical resources to adequately respond to a public health crisis involving infective diseases. According to the latest data available, in 2018, just 12% of Kenya's health facilities had the items necessary to prevent infections, such as gloves and disinfectants, and only 23% of hospitals offered mechanical ventilation.²⁴ Thus, when the pandemic happened, hospital beds quickly filled up, and health workers lacked adequate protection from infection.²⁵ Kenya had only 256 ventilators for a population of nearly 54 million in 2020²⁶ and 518 intensive care hospital beds per 100,000 inhabitants.²⁷ By 2021, there was still a shortage of oxygen and reagents for COVID-19 testing.²⁸

As at January 2022, only 8% of the population had been fully vaccinated against COVID-19.²⁹ Several medical services are also being compromised due to the limited health resources being diverted to respond to the COVID-19 emergency. For instance, malaria prevention activities, tuberculosis contact tracing, cancer screening and human papillomavirus vaccinations have all been disrupted or reduced due to the pandemic.³⁰ Marginalised groups, such as sex workers, have disproportionately been exposed to the collateral damage of the pandemic in terms of access to other healthcare services.³¹

Amidst this emergency, some are suffering more than others. Inequalities are both geographical and economic. Geographically, most of the intensive care units to treat COVID-19 cases are concentrated in cities, while 72% of the Kenyan population lives in rural areas.³² For instance, the Kakuma refugee camp, in Kenya's northwest, is a nine-hour drive away from the nearest intensive hospital care unit, and the camp clinic lacks adequate equipment to treat COVID-19 cases.³³

24. Ibid. p. 59.

25. Human Rights Watch, 'Kenya: Pandemic Health Workers Lack Protection' (Human Rights Watch 21 October 2021) <<https://www.hrw.org/news/2021/10/21/kenya-pandemic-health-workers-lack-protection>> accessed 07 January 2022.

26. Edwine W Barasa, Paul O Ouma and Emelda A Okiro, 'Assessing the Hospital Surge Capacity of the Kenyan Health System in the Face of the COVID-19 Pandemic' (2020) 15 PLOS ONE e0236308.

27. Katharine Houreld and others 'Understanding COVID-19: Virus exposes gaping holes in Africa's health system' (Reuters Graphics 7 May 2021) <<https://graphics.reuters.com/HEALTH-CORONAVIRUS/AFRICA/yzdpqxqbdvx/>> accessed 14 March 2022.

28. Joseph Akwiri and Maggie Fick, 'In Kenya, COVID-19's Rural Spread Strains Creaky Healthcare' (Reuters 07 December 2021) <<https://www.reuters.com/article/us-health-coronavirus-kenya-idUSKBN28H0J0>> accessed 14 March 2022.

29. Our World in Data, Share of the Population has been Fully Vaccinated against COVID-19 (January 2022) <<https://ourworldindata.org/coronavirus/country/kenya>> accessed 7 January 2022.

30. Edwine Barasa and others, 'Indirect Health Effects of the COVID-19 Pandemic in Kenya: A Mixed Methods Assessment' (2021) 21 BMC Health Services Research 740.

31. Susan Gichuna and others, 'Access to Healthcare in a Time of COVID-19: Sex Workers in Crisis in Nairobi, Kenya' (2020) 15 Global Public Health 1430.

32. World Bank, Rural population (%) Kenya <<https://data.worldbank.org/indicator/SPRUR.TOTL.ZS?locations=KE>> accessed 5 November 2021.

33. Joseph Akwiri and Maggie Fick, 'In Kenya, COVID-19's Rural Spread Strains Creaky Healthcare' (Reuters 7 December 2021) ac-



Economically, those from low socio-economic backgrounds risk huge hospital bills that might push them into debt or lead to exclusion from healthcare.³⁴ This was true before the pandemic, and is now even worse, for both COVID-19 and other medical services. For instance, evidence shows that a COVID-19 test can cost up to 10,825 Kenyan shillings (approximately 94.28 USD),³⁵ a prohibitive cost for the 36% of the Kenyan population that lives below the national poverty line, or on less than 2 USD a day.³⁶ Even though cheaper and even free tests are administered at some public and private facilities, there is limited dissemination of information about where to receive free testing services.³⁷

The challenges Kenya is facing have many causes. Increasingly, civil society and academic research are demonstrating that the commercialisation of healthcare - that is the proliferation of market logic and mechanisms such as competition and performance incentives to gain private benefits within the healthcare system - is one of the most prominent impediments to the progressive realisation of the right to the highest attainable standard of health in the country.³⁸

cessed 14 March 2022.

34. Paola Salari and others, 'The Catastrophic and Impoverishing Effects of Out-of-Pocket Healthcare Payments in Kenya, 2018' (2019) 4 *BMJ Global Health* e001809.

35. Polet Njeri Ouma, Abednego Nzyuko Masai and Israel Nyaburi Nyadera, 'Health Coverage and What Kenya Can Learn from the COVID-19 Pandemic' (2020) 10 *Journal of Global Health* 020362.

36. World Bank, Global Poverty Working Group (2022) <https://data.worldbank.org/indicator/SI.POV.NAHC?locations=KE> accessed 20 January 2022.

37. Nirmala Ravishankar and Edwine Barasa, 'Now and forever: removing financial barriers to health services in Kenya' Social Health Protection Network <https://p4h.world/en/now-and-forever-removing-financial-barriers-health-services-kenya> (accessed 28 March 2022).

38. Economic and Social Rights Centre – Hakijami and the Centre for Human Rights and Global Justice, 'Wrong Prescriptions: the Impact of Privatising Healthcare in Kenya' (17 November 2021) https://chrgi.org/wp-content/uploads/2021/11/Report_Wrong-Prescription_Eng_.pdf accessed 13 January 2022; People's Health Movement (PHM) and Regional Network for Equity in Health in East

What is privatisation and commercialisation in healthcare?

For the purposes of this report, we define privatisation in healthcare as the growth of the share of private sector involvement in healthcare, or the adoption of private-sector practices in the health sector. This might take several forms. Increased private sector involvement in the ownership, financing, management, governance or provision of healthcare services can all be deemed as privatisation in healthcare. Examples of privatisation are selling public assets to private actors or the governance and administration of healthcare services being shifted from the public into the private sphere, including through public-private partnerships. Privatisation is thus an umbrella term that might cause or encompass one or more of the following:

- Commercialisation: the progressive spread of market mechanisms in health, such as competition and performance incentives, to gain private benefits
- Marketisation: enabling state enterprises to operate as market-oriented firms
- Financialisation: the increasing influence of financial motives and financial markets in health, such as private investment in health-related bonds.

The last few decades have seen increasing privatisation in healthcare across the world. This raises several challenges in terms of the realisation of the right to health, as United Nations Human Rights monitoring bodies, as well as human rights organisations and scholars, are increasingly recognising.

Source:

- GI-ESCR, 'Compendium on United Nations Human Rights Treaty Bodies' Statements on Private Actors in Healthcare' (June 2021) <<https://www.gi-escr.org/publications/compendium-of-united-nations-human-rights-treaty-bodies-statements-on-private-actors-in-healthcare>> accessed 14 March 2022.
- GI-ESCR, 'Italy's experience during COVID-19 and the limits of privatisation in healthcare' (2 June 2021) <<https://www.gi-escr.org/publications/policy-brief-italys-experience-during-covid-19-and-the-limits-of-privatisation-in-healthcare>> accessed 16 March 2022.
- Audrey Chapman, 'The Impact of Reliance on Private Sector Health Services on the Right to Health' (2014) 16 Health Hum Rights 122.
- Antenor Hallo de Wolf and Brigit Toebes, 'Assessing Private Sector Involvement in Health Care and Universal Health Coverage in Light of the Right to Health' (2016) 18 Health and Human Rights 79.

These concerns are not exclusive to Kenya. Comparative research on low- and middle-income countries highlights the potential public health impacts of private sector engagement in healthcare. In 2012, a systematic review³⁹ showed that private sector providers more frequently violated medical standards of practice and their use was associated with poorer outcomes and inequalities, even if private health facilities presented reduced waiting times in comparison to the public healthcare sector.⁴⁰ According to the same study, private healthcare providers were less efficient than public providers, partly due

and Southern Africa (EQUINET), 'Report of the East and Southern Africa Regional People's Health University' (2021) <<https://www.equinet africa.org/sites/default/files/uploads/documents/ESA%20RPHU%20Report%202021.pdf>> accessed 14 January 2022; UNISON <https://gala.gre.ac.uk/id/eprint/16416/7/16416%20LETHBRIDGE_Unhealthy_Development_2016.pdf> accessed 14 January 2022.

39. Sanjay Basu and others, 'Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review' (2012) 9 PLoS Medicine e1001244.

40. Ibid.

to private health providers' incentives for unnecessary testing and treatments.⁴¹ Interestingly, when the definition of a private sector included unlicensed and uncertified providers, most patients appear to access private healthcare provision. However, when only licensed providers were included, most people accessed public healthcare.⁴²

In 2021, a systematic review of an international news database found that the private health sector has not been resilient to the shock of the pandemic in many low- and middle-income countries and that profit motives have generated inefficiencies.⁴³ According to this review, in low- and middle-income countries, private health providers filtered patients based on the ability to pay, and some closed down due to business failure amidst the pandemic.⁴⁴

This report verifies and expands previous findings through a case study analysis of the impacts of the COVID-19 pandemic in urban informal settlements in the context of a largely privatised healthcare system.

Private health actors have been present in Kenya since its independence, however in recent years for-profit providers have increased their activities considerably. Between 2013 and 2021, the share of health establishments that are for-profit in Kenya grew from 33% to 43% of the total in less than 10 years.⁴⁵

This report explores the link between commercialisation in healthcare and the enjoyment of the right to health, especially as it concerns the right to healthcare services, through a review of the impacts of the COVID-19 pandemic on people living in urban informal settlements. People living in informal settlements are exposed to the worst consequences of the COVID-19 pandemic. They tend to live in unhealthy conditions, residing in overcrowded and unsafe houses, while water is often contaminated by sewage.⁴⁶ This makes social distancing difficult, and handwashing and sanitation routines nearly impossible – both of which are essential for COVID-19 prevention. In Nairobi's informal settlements, people are also more exposed to the health risks of COVID-19 due to pre-existing morbidities, such as respiratory diseases.⁴⁷ They also face relatively higher barriers in accessing healthcare, such as socio-economic, geographical, information, and technology barriers, which make them even more at risk of suffering from the collateral damages of the COVID-19 pandemic on the availability of other medical services.⁴⁸

41. Ibid.

42. Ibid.

43. David Williams O, Yung KC and Grépin KA, 'The Failure of Private Health Services: COVID-19 Induced Crises in Low- and Middle-Income Country (LMIC) Health Systems' (2021) 16 *Global Public Health* 1320.

44. Mark Hellowell and others, 'COVID-19 and the Collapse of the Private Health Sector: A Threat to Countries. Response Efforts and the Future of Health Systems Strengthening' (27 May 2020) Health Systems Collaborative <<https://hsgovcollab.org/en/blog/covid-19-and-collapse-private-health-sector-threat-countries-response-efforts-and-future>> accessed 14 March 2022.

45. Data from 2013 are from the following official report: Ministry of Health, Kenya Service Availability Readiness Assessment Mapping (SARAM) Report, <http://guidelines.health.go.ke:8000/media/Kenya_Saram_Report.pdf> page 12.

46. Henry Owino, 'Into Their Own Hands: Kibera, Kenya's Largest Slum, Tames COVID-19' (Pulitzer Center 7 July 2020) <<https://pulitzercenter.org/stories/their-own-hands-kibera-kenyas-largest-slum-tames-covid-19>> accessed 14 March 2022.

47. Clare Bamba and others, 'The COVID-19 Pandemic and Health Inequalities' (2020) 74 *J Epidemiol Community Health* 964.

48. Peter O Otieno and others, 'Access to Primary Healthcare Services and Associated Factors in Urban Slums in Nairobi-Kenya' (2020)

Methodology

This report is based on primary data as well as a literature review and a systematic review of news articles. To select participants, a mix of purposive and snowball sampling was used. Field notes and pictures were also gathered. A trained human rights researcher and consultant conducted interviews and focus groups with individuals, health workers, community leaders, activists and hospital owners in three of the largest urban informal urban settlements in Nairobi: Dandora, Mathare and Mukuru Kwa Njenga. Semi-structured interviews were conducted based on a set of guiding questions with a total of 47 individual interviews and three focus groups in each of the three settlements over three months (September–November 2021).

All interviews were audio-recorded, transcribed and translated where applicable from Swahili to English by three professional transcribers. Transcriptions were encoded by two human rights researchers and then analysed thematically with the free version of the qualitative software QDA Miner Lite. The software QGIS was also used to analyse data on health facilities in one of the settlements. All participants signed an informed consent form. Interviews are anonymous. Where names are used, they are pseudonyms to protect the privacy of participants.

The news and literature review on COVID-19 in Kenya was realised with the support of a team of three graduate human rights students in the context of a project at the Human Rights Clinic of Miami University. The timespan set for the search went from March 2021 to November 2021, including monitoring of daily updates on the constantly evolving situation. For academic literature, the following databases were searched: PubMed, Hein Online, Google Scholar, Scopus and Web of Science. For news, Google News and Twitter were searched. Further information was retrieved through a manual search of major newspapers and official governmental websites in Kenya. Criteria for inclusion were that the article was in English, related to only Kenya and included information on privatisation/commercialisation. Articles related to COVID-19 were first identified by searching with keywords such as 'coronavirus', 'COVID-19', 'ventilator', 'mask', 'pandemic', 'oxygen'. Synonyms and different spellings were included. Articles were then manually searched using keywords such as 'private' and 'commercial'. A full list with details on keywords is available [here](#). Finally, GI-ESCR, with the support of Miami University Human Rights Clinic, also conducted document analysis of official norms, policies and standards on the right to healthcare services, including regulation and monitoring of private health providers.



Description: A focus group conducted for this study, Mathare, Nairobi.

II. Context: the right to health, healthcare services and commercialisation in Kenya

The right to health is recognised in Kenya's constitution, as well as in the human rights treaties to which Kenya is a party. Kenya also has a relatively well-developed legal framework for the regulation of private health providers.

1. The normative framework on the right to health

The 2010 Constitution of Kenya provides that 'every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive health care' and that 'no one shall be denied emergency medical treatment'.⁴⁹ The Constitution also includes a right to accessible and adequate housing, reasonable standards of sanitation and clean and safe water, which are crucial social determinants of the right to health, in particular in the context of the pandemic.⁵⁰ The Constitution requires the State to take affirmative action to ensure that minorities and marginalised groups have reasonable access to healthcare services.⁵¹

The 2017 Health Act reaffirms Kenya's duty to 'protect, respect, promote, and fulfil the health rights of all persons'.⁵² Additionally, the 2017 Health Act recognises the government's obligations to provide comprehensive health information⁵³ and to 'develop health policies, laws and administrative procedures and programmes [...] for the progressive realisation of the highest attainable standards of health'.⁵⁴ It also states that 'the public and private health services and facilities shall complement each other in the provision of comprehensive and accessible health care to the people'.⁵⁵

The right to health is also enshrined in the international treaties to which Kenya is a party, such as the African Charter on Human and Peoples' Rights (ratified in 1992).⁵⁶ The African Charter prescribes that 'States Parties shall take the necessary measures to protect their people's health and ensure that they receive medical attention when they

49. Constitution of Kenya (2010), article 43 (1)(a) and (2).

50. Ibid., article 43 (1) (b, c).

51. Ibid., articles 53 - 57.

52. Kenya Health Act (2017) Part I, section 3.

53. Ibid., at Part I, section 4; Part II.

54. Ibid., 15 (1) (a).

55. Ibid., section 88, para (2).

56. African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) (1982) 21 ILM 58 (African Charter).

are sick'.⁵⁷ In 2019 and 2020, the African Commission on Human and Peoples' Rights, which monitors the implementation of the African Charter, issued two landmark resolutions addressing the role of private actors in health and education. The 2019 resolution⁵⁸ affirms that the African States are 'the duty bearers for the protection and fulfilment of economic, social and cultural rights, in particular the rights to health and education without discrimination, for which quality public services are essential'.⁵⁹ This resolution also expresses concerns regarding multilateral donors and international institutions putting 'pressure on States Parties to privatise or facilitate access to private actors in their health and education sectors'⁶⁰ in disregard of States' obligations. The African Commission also calls on States to 'consider carefully the risks for the realisation of economic, social and cultural rights of public-private partnerships and ensure that any potential arrangements for public-private partnerships are in accordance with their substantive, procedural and operational human rights obligations'.⁶¹ The 2020 resolution calls for the development of norms on States' obligations to regulate private actors involved in the provision of social services.⁶²

Kenya has also ratified the African Charter on the Rights and Welfare of the Child. Article 14 commits States 'to ensure the provision of necessary medical assistance and healthcare to all children with an emphasis on the development of primary health-care'.⁶³ Kenya is also a party to the International Covenant on Economic, Social and Cultural Rights (ICESCR)⁶⁴ which protects the right of everyone to the highest attainable standard of physical and mental health (Article 14).⁶⁵ Kenya has signed up to the other major international human rights treaties that also indirectly guarantee the right to health, including the International Covenant on Civil and Political Rights, the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of Persons with Disabilities.

The right to health requires that everyone has access to quality healthcare services without discrimination on any grounds. States must ensure that all health facilities, staff and goods are of high quality and culturally acceptable. States should take af-

57. Ibid., article 16.

58. African Commission on Human and Peoples' Rights, 'Resolution on States' Obligation to Regulate Private Actors Involved in the Provision of Health and Education Services' (2019) Res. 420 (LXIV) <https://www.achpr.org/sessions/resolutions?id=444> accessed 14 March 2022.

59. Ibid.

60. Ibid.

61. Ibid.

62. African Commission on Human and Peoples' Rights, 'Resolution on the Need to Develop Norms on States' Obligations to Regulate Private Actors Involved in the Provision of Social Services' (2020) Res. 434 (EXT.OS/XXVI1) <<https://www.achpr.org/sessions/resolutions?id=465>> accessed 31 January 2022.

63. African Charter on the Rights and Welfare of the Child (adopted 11 July 1990, entered into force 29 November 1999) OAU Doc. CAB/LEG/24.9/49 (1990).

64. International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) Art. 12

65. CESCR, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)' (11 August 2000) E/C.12/2000/4.



firmative steps to remove geographical, socio-economic and other barriers to access healthcare while also monitoring and regulating private health actors involved in healthcare. The right to health also includes a right to the underlying determinants of health, including access to food, water and housing.

Under international human rights law, States have specific obligations in the context of a pandemic. Article 12 of the ICESCR requires States to progressively build coordinated universal health systems for 'the prevention, treatment and control of epidemic, endemic, occupational and other diseases'.⁶⁶ The United Nations Committee on Economic, Social and Cultural Rights (CESCR), the body in charge of monitoring and interpreting the ICESCR, recently affirmed in a statement on the COVID-19 pandemic that States must adopt appropriate regulatory measures to ensure that healthcare resources in 'both the public and the private sectors are mobilised and shared among the whole population to ensure a comprehensive, coordinated health-care response to the crisis'.⁶⁷

In addition, the World Health Organisation (WHO) International Health Regulations, which were ratified in Kenya in 2007, urge States to detect, assess and respond to public health emergencies.⁶⁸

66. ICESCR (28).

67. CESCR 'Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social, and Cultural Rights' (17 April 2020) E/C.12/2020/1.

68. WHO, International Health Regulations (adopted by the 58th World Health Assembly in 2005 through Resolution WHA58.3).

The human rights framework on the right to health has increasingly addressed the involvement of private actors in healthcare delivery (Box 2). United Nations human rights treaty bodies have been progressively reflecting on the human rights implications of private sector involvement in healthcare, calling on States to assess the impact of any privatisation plans on the right to health, to prevent any negative impact on marginalised groups, and to monitor and regulate private healthcare providers.⁶⁹

Towards a human rights framework to assess private actors' involvement in healthcare

The report 'Private actors in health services: towards a human rights impact assessment framework', published in 2019 by the Global Initiative for Economic, Social and Cultural Rights, the Initiative for Social and Economic Rights, and the University of Essex provides a first review of the existing standards on the right to health in the context of private actors' involvement. Building on an analysis of the jurisprudence, it lists the main human rights obligations with regard to the right to health, including the following State obligations:

- to protect the right to health when a third party is involved;
- to ensure that any private involvement in healthcare does not undermine the accessibility, availability, acceptability and quality of healthcare;
- to assess privatisation plans to ensure that they do not interfere with the fulfilment of the right to health at the maximum of their available resources;
- to ensure that healthcare privatisation does not reduce the level of the enjoyment of the right previously granted;
- to strictly regulate and monitor private healthcare actors. In particular, when private actors provide services in areas where the public sector has traditionally been strong, they should be 'subject to strict regulations that impose on them so-called 'public services obligations': (...) private healthcare providers should be prohibited from denying access to affordable and adequate services, treatments or information.'

It is against this framework that the present analysis is conducted.

Source:

- CESCR, 'General Comment No. 24: State obligations under the ICESCR in the context of business activities' (10 August 2017) E/C.12/GC/24.

2. The healthcare system

A healthcare system consists of all the organisations, institutions, resources and people whose primary purpose is to improve health,⁷⁰ including core inpatient and outpatient

69. GI-ESCR, 'Compendium on United Nations Human Rights Treaty Bodies' Statements on Private Actors in Healthcare' (June 2021) <<https://www.gi-escr.org/publications/compendium-of-united-nations-human-rights-treaty-bodies-statements-on-private-actors-in-healthcare>> accessed 08 November 2021.

70. WHO, Official Website (2021) <http://www.who.int/healthsystems/about/en/> accessed 14 March 2022.

medical services, public health promotion and preventative care. The Kenya healthcare system is organised into six hierarchical levels, according to the types of medical care provided (i.e. from less to more specialised treatments).⁷¹ The lowest are community services (level 1); then there are dispensaries, health centres and clinics, including maternity and nursing homes (level 2-3); followed by sub-county hospitals (level 4); then county-referral hospitals (level 5); and finally national referral hospitals (level 6). Under the 2010 Kenyan Constitution, the Ministry of Health is in charge of formulating health policies at the national level, while county governments are responsible for



healthcare delivery.⁷² The 2017 National Health Act establishes a unified health system and formalised collaboration between the national and county governments.⁷³ The 2017 Health Act also states that the Ministry of Health is responsible for providing a 'framework for examining means of optimising usage of private health services as a result of relieving the burden carried by the publicly financed system'.⁷⁴

3. The growing commercialisation and privatisation of the healthcare system in Kenya

According to the official statistics of the Ministry of Health, private actors (in their diversity) own more than half (54%) of the health establishments in Kenya (Figure 1).⁷⁵ Figure 1 shows the distribution of health facilities by owner category: public, non-governmental organisations, faith-based institutions and 'private practice' (which is a category including private practitioners such as doctors opening their own clinic or private companies). The category of 'private practice' covers the largest share of health providers (43% of the total), and a significant share is owned by actors that are likely to be non-profit, with 3% and 8% of the total facilities owned by non-governmental institutions and faith-based associations respectively. The remaining 46% are publicly owned.

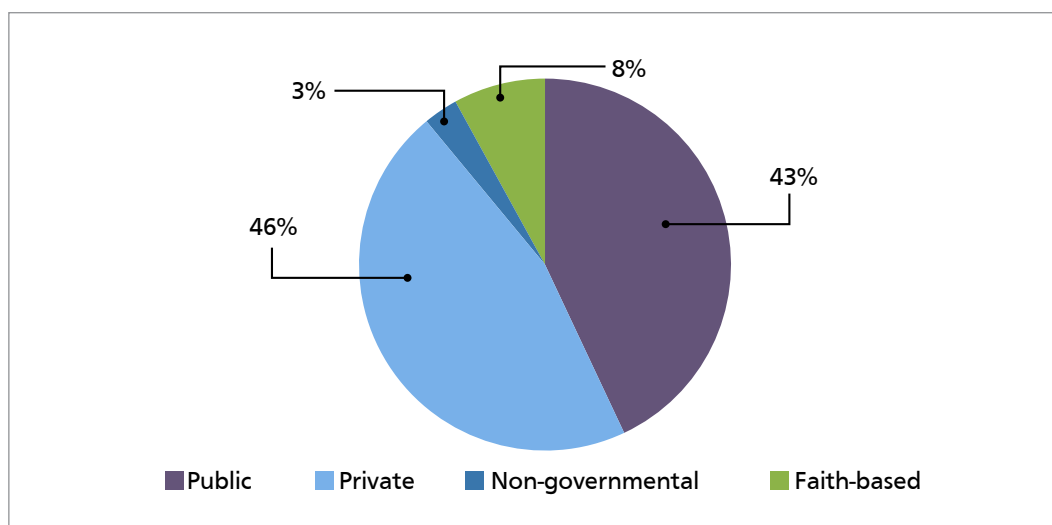
71. WHO, Primary health care systems (PRIMASYS): case study from Kenya, abridged version (2017) https://www.who.int/alliance-hpsr/projects/alliancehpsr_kenyaabridgedprimasys.pdf accessed 14 March 2022.

72. Constitution of Kenya, Fourth Schedule.

73. Health Act, 2017.

74. Health Act 2017, Section 86, Para (2) (b).

75. Ministry of Kenya, Health Facility List, <http://kmhfl.health.go.ke/#/facility_filter> accessed 14 March 2022.

Figure 1: Health facilities in Kenya by owner (2021)

Source: Ministry of Kenya, Health Facility List, available at: http://kmhfl.health.go.ke/#/facility_filter accessed 14 March 2022.

The for-profit share of health providers has grown rapidly over the past decade, increasing from 33% to 43% of the total between 2013 and 2021.⁷⁶ The growing private sector engagement in healthcare is in line with the Kenya Health Policy 2014-2030 which lists the creation of ‘an enabling environment for increased private sector and community involvement in health services, provision and finances’⁷⁷ among its core objectives.

During COVID-19, the government also continued to actively support private engagement in healthcare provision during the pandemic.⁷⁸ In 2020, the Ministry of Health launched a new strategy on public-private collaboration in health services delivery.⁷⁹ In July 2021, the Kenyan government signed an agreement with Italy’s largest private hospital group for the construction of new hospitals and telemedicine development.⁸⁰ The government also included 43 private laboratories⁸¹ in the list of designated labo-

76. Data from 2013 are from the following official report: Ministry of Health, Kenya Service Availability Readiness Assessment Mapping (SARAM) Report, <http://guidelines.health.go.ke:8000/media/Kenya_Saram_Report.pdf> page 12; also see: Economic and Social Rights Centre – Hakijami and the Centre for Human Rights and Global Justice, ‘Wrong Prescriptions: the Impact of Privatising Healthcare in Kenya’ (17 November 2021) https://chrgj.org/wp-content/uploads/2021/11/Report_Wrong-Prescription_Eng_.pdf accessed 13 January 2022, p. 12.

77. Ministry of Health, ‘Kenya Health Policy 2014-2030’ (2014) <http://publications.universalhealth2030.org/uploads/kenya_health_policy_2014_to_2030.pdf> accessed 14 March 2022.

78. Kenya Ministry of Health, ‘Government and Private Sector explore ways to build on the gains made on Universal Health Coverage’ (5 November 2021) <<https://www.health.go.ke/government-and-private-sector-explore-ways-to-build-on-the-gains-made-on-universal-health-coverage/>> accessed 21 March 2022.

79. Kenya Ministry of Health, The Kenya Health Public-Private Collaboration Strategy (2020) <<https://www.health.go.ke/wp-content/uploads/2021/11/The-Kenya-Health-Public-Private-Collaboration-Strategy-2020.pdf>> accessed 21 March 2022.

80. GlobalNewsWire, ‘Gruppo San Donato, Italy’s leading private hospital group, and Kenya sign an agreement to strengthen the East African’s local health care’ (19 July 2021) <<https://www.globenewswire.com/en/news-release/2021/07/19/2264986/0/en/Gruppo-San-Donato-Italy-s-leading-private-hospital-group-and-Kenya-sign-an-agreement-to-strengthen-the-East-African-s-local-health-care.html>> accessed 13 January 2022.

81. Kenya Ministry of Health, List of Authorised Laboratories (2022) <<https://khf.co.ke/wp-content/uploads/2021/08/LIST-OF-RT-PCR->

ratories for COVID-19 testing, which then provided them on a fee-for-service basis.⁸²

The individuals we interviewed in Nairobi's informal settlements exemplify what the commercialisation of healthcare services looks like in practice in the Kenyan context. John, who lives in Dandora, explained: *'I recently went to a public hospital, but the laboratory was not operational, so I had to visit a private one where I was tested and then I paid'*.⁸³ Jim, similarly, shared that: *'The public facilities are okay. The only problem in these hospitals is that there are insufficient drugs. Mostly, you are prescribed medicines to buy from the private chemists outside'*.⁸⁴

[COVID-19-LABS.pdf](#)> (accessed 21 March 2022).

82. Health Systems Governance, New country case studies available! Private sector engagement, COVID-19 in Rwanda and Kenya (24 August 2020) <<https://hsgovcollab.org/en/news/new-country-case-studies-available-private-sector-engagement-covid-19-rwanda-and-kenya>> accessed 21 March 2022.

83. Interview with a man living in Dandora, Nairobi, Kenya (conducted on 16 October 2021).

84. Interview with a man living in Dandora, Nairobi, Kenya (conducted on 15 October 2021).

III. How the commercialisation of healthcare is preventing enjoyment of the right to health in Kenya during the pandemic

The research highlighted four main challenges that have undermined the enjoyment of healthcare services in the context of the COVID-19 pandemic: (1) insufficient public medical services (2) socio-economic barriers in accessing medical services; (3) insufficient regulation and monitoring of private health care providers; and (4) unsafe and low-quality private health facilities, in particular in informal settlements. Each of these challenges is fuelled or exacerbated by the commercialisation of healthcare services.

1. Insufficient public medical services

According to the ICESCR, everyone has a right to healthcare services that are available in sufficient quantity and quality.

States must use the maximum of their available resources to ensure a minimum core level of care services for all. United Nations human rights monitoring bodies have increasingly reiterated that States are required, as a matter of human rights law, to directly provide public health services or ensure their provision by a public body. The United Nations Committee on Economic, Social and Cultural Rights and the Committee on the Rights of the Child have both called on specific States to provide public services and public healthcare.

Source:

- Art. 12 ICESCR, CESCR, 'General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant)' (11 August 2000) E/C.12/2000/4, para. 32.
- GI-ESCR, 'States' Human Rights Obligations regarding Public Services: The United Nations' Framework' (19 October 2020) <<https://www.gi-escr.org/publications/states-human-rights-obligations-regarding-public-services-the-united-nations-normative-framework>> accessed 15 March 2022.
- GI-ESCR, 'Compendium of United Nations Human Rights Treaty Bodies' Statements on Private Actors in Healthcare' (June 2021) <<https://www.gi-escr.org/publications/compendium-of-united-nations-human-rights-treaty-bodies-statements-on-private-actors-in-healthcare>> accessed 09 February 2022.

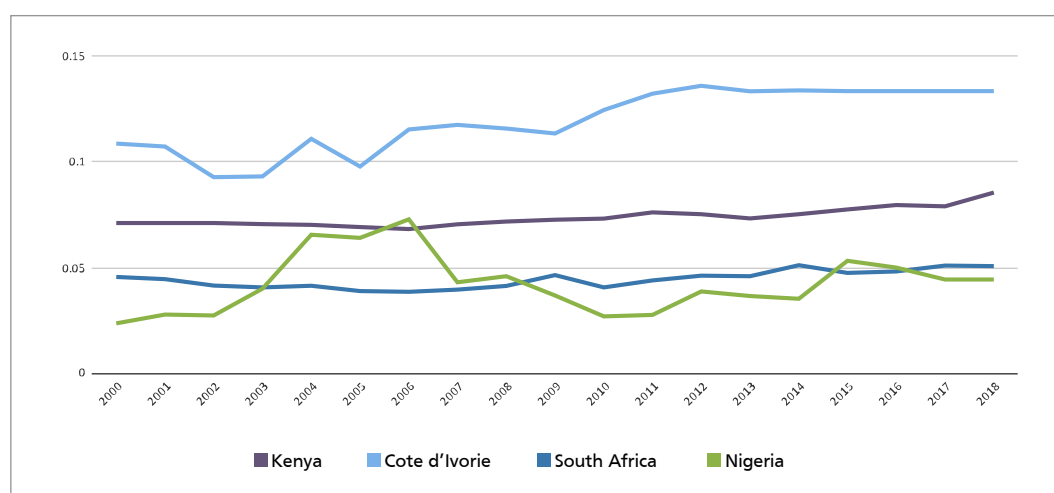
Kenya currently does not have sufficient medical facilities, staff and goods to fulfil the right to health for all. While the WHO recommends a minimum of 21.7 doctors and 228 nurses per 100,000 people,⁸⁵ As at 2018, Kenya had only 16 doctors per 100,000

85. WHO, 'Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals' (2016) <<https://apps.who.int/iris/bitstream/handle/10665/250330/9789241511407-eng.pdf>> accessed 11 November 2021.

and 167 nurses per 100,000, including staff working in both public and private facilities.⁸⁶ In 2018, the Kenya Harmonised Health Facility Assessment found that none of the health facilities had all essential medicines and that only a small fraction (12%) had all items needed for infection prevention.⁸⁷

A potential explanation for the lack of resources is low public funding for healthcare. Domestic public spending on health was 9% of general government expenditure in 2018 (figure 2),⁸⁸ far below the target of 15% which the African Union States agreed to in the Abuja Declaration.⁸⁹ General government spending on health represented only 2.17% of GDP as at 2018, lower than a number of other countries in the region such as South Africa (4.46%) or Botswana (4.53%) (though higher than countries such as Nigeria (0.57% of GDP) or Côte d'Ivoire (1.2%), and also slightly higher than Sub-Saharan Africa's average more broadly (1.9% of GDP)⁹⁰).

Figure 2: Healthcare spending as a share of total government spending (%) over 2000-2018, selected comparable African countries



Source: Source: [WHO Global Health Observatory data](https://data.who.int/global-health-observatory/data), available for download [here](https://data.who.int/global-health-observatory/data) (accessed 18 January 2022).

This lack of available healthcare facilities, goods and services has been visible in the country's inadequate response to COVID-19. The WHO estimates that around 14% of COVID-19 patients require hospitalisation, including oxygen support, and that 5% require a ventilator.⁹¹ However, according to media reports, there are just 297 ventilators available in Kenya, against the estimated 4,511 that would be needed in the country

86. World Bank, World Bank Databank (2022) <https://data.worldbank.org/indicator/SH.MED.NUMW.P3?locations=KE> accessed 10 January 2022.

87. Ministry of Health, The Kenya Harmonized Health Facility Assessment (KHFA) 2018-2019 (2020) <https://www.health.go.ke/wp-content/uploads/2020/01/KHFA-2018-19-Popular-version-report-Final-.pdf> accessed 03 January 2022.

88. WHO Global Health Expenditure Database, Domestic general government health expenditure (% of general government expenditure) (2022) <<https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS>> accessed 29 January 2022.

89. WHO, 'The Abuja Declaration: Ten Years On' (2011) <https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1> accessed 25 October 2021.

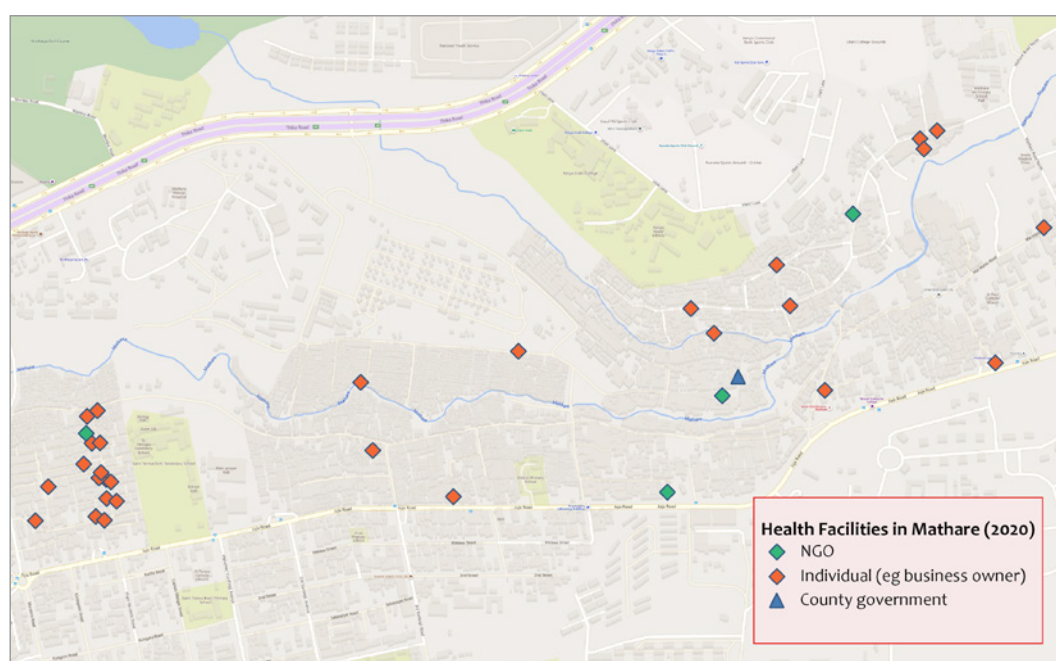
90. Ibid.

91. Ibid.

during a peak in the pandemic.⁹² Kenya also only has 518 intensive care beds available for the entire population, many of which are already in use by patients with other conditions.⁹³ These few resources are mostly only accessible to those who can pay for services in for-profit health facilities. For instance, in Nairobi, according to 2020 data, almost 50% of all intensive care beds are in private for-profit hospitals, compared to 35% in public hospitals, and 15% in non-profit ones.⁹⁴

Interviewees in Nairobi's informal settlements described the lived experience of lacking available medical services. The insufficient provision takes many forms and causes different struggles at the point of access. According to a 2020 report by UN-Habitat, Mathare informal settlement hosts 200,000 people.⁹⁵ Figure 3 shows 2020 data collected by UN-Habitat and highlights how privately-owned health facilities are predominant in the settlement.⁹⁶ It should be noted that, since 2020, from data collected in our interviews it appears that new public health facilities have been built in Mathare, although data on this was not readily available at the time of publication.

Figure 3: Health Facilities in the urban Informal Settlement of Mathare (2020)



Source: UN-Habitat Data (2020), available [here](#). Map made by the authors of this report (GI-ESCR) using the software QGIS.

92. Ibid.

93. Katharine Houreld and others 'Understanding COVID-19: Virus exposes gaping holes in Africa's health system' (Reuters Graphics 7 May 2021) <<https://graphics.reuters.com/HEALTH-CORONAVIRUS/AFRICA/yzdpqobdvx/>> accessed 14 March 2022.

94. Data can be downloaded at this address: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7371160/> accessed 14 January 2022. Data were provided by the Kenya Healthcare Federation Survey (2020) to researchers for the following article: Edwine W Barasa, Paul O Ouma and Emelda A Okiro, 'Assessing the Hospital Surge Capacity of the Kenyan Health System in the Face of the COVID-19 Pandemic' (2020) 15 PLOS ONE e0236308.

95. United Nations Habitat, The case of Mathare (June 2020) <https://unhabitat.org/sites/default/files/2021/08/the_case_of_mathare_final.pdf> accessed 15 March 2022.

96. The civil society organisation Map Kibera also collected data on private health facilities (only) in Mathare's informal settlement. Such data can be viewed at the following link: http://umap.openstreetmap.fr/en/map/mathare-health-facilities_726092#15/-1.2600/36.8745

As a result, people often have to wait for a long time when they need to access public healthcare. This is also common across the other two settlements we visited. Clara, a woman we interviewed in Mukuru, described that: *'Before consulting a doctor you have to wait on the long queue with a card. The patient might even die while at the queue.'*⁹⁷ In Mathare, a woman reported that overcrowded facilities and long queues might lead to foregoing medical care altogether: *'You might go to the hospital at ten or eleven, you are told it is full, there is no space (...) it forces you to just go back home, because you cannot afford these private [facilities].'*⁹⁸

Even when people are able to access public health centres, they often face challenges related to the lack of available material, such as screening and diagnostic services for testing, which is essential to complete most medical treatments. The existing facilities often do not have sufficient staff, diagnostic services and drugs to guarantee medical attention to everyone. For instance, Eugene, a community health mobiliser in Dandora, told us that:

*There are not enough personnel in the facilities. It can happen that there are one or two doctors, two clinicians who are supposed to deal with the entire number of patients (...) the pharmacy has no drugs, or you are told it doesn't have the medicine that you want, or the lab doesn't have maybe the reagents, which are needed to test for whatever thing you want to test. So, you find that most people just visit the hospital for the clinical advice then when you need the testing you have to go outside to get that then you come back in.'*⁹⁹

To complicate matters further, many of the available facilities have short working hours or do not operate at night, exacerbating the scarcity of medical services available. Janet, a woman living in Dandora, indicated that, to her knowledge, public health centres: *'operate until four o'clock in the evening but beyond that, there are no services available (...) they do not operate on weekends.'*¹⁰⁰

Respondents also highlighted challenges in accessing specialised treatments, including those that address some common diseases. In Dandora, for example, because of the presence of a dumpsite, the residents suffer from respiratory issues including asthma. Eye allergies are also very common because of the smoke from the fires used to burn the rubbish in the dumpsite. The largest health centre in the area is a public facility that does not have the capacity to treat any of the above issues, according to

97. Interview with a man living in Mukuru, focus group, Mukuru, Nairobi, Kenya (conducted on 16 October 2021).

98. Interview with a woman living in Dandora, Nairobi, Kenya (conducted on 15 October 2021).

99. Interview with a community health mobiliser, Dandora, Nairobi (conducted on 16 October 2021).

100. Interview with a woman living in Dandora, Nairobi (conducted on 16 October 2021).



Description: Dumpsite in Dandora, Nairobi.

respondents. Teresa, who lives in Dandora explained that, despite respiratory problems and eye allergies being very common in the community, the nearby public health centres do not have the necessary equipment to deal with such conditions: *'We are always told to go and buy elsewhere, and, in most cases, we don't have the money so we just go back home and pray'*.¹⁰¹

Several respondents indicated that the COVID-19 pandemic has exacerbated these pre-existing challenges. The existing shortages of medical services has increased further since the outbreak of COVID-19, as a lot of resources have been diverted to handle the pandemic. The healthcare workers that we interviewed highlighted that public health facilities have been overwhelmed by COVID-19 cases. A health worker at a public health facility described the situation as follows: *'During the COVID-19 pandemic (...) people were turning up in huge numbers (...) so we were overwhelmed.'*¹⁰²

From the perspective of patients, the COVID-19 context has also led to a reduction in available hospital beds for all. This emerged as a recurrent theme across all three focus groups we conducted in the three settlements. In the words of Margaret, a woman we interviewed in Mathare: *'During the pandemic, it was difficult (...) it was a challenge just getting space and a bed in a public hospital (...)'*¹⁰³

Other respondents described the lack of facilities treating COVID-19. When asked whether he knew if he could receive COVID-19 treatment nearby, Johnstone a man living in Mathare, indicated:

*'No, no, COVID-19 treatment was in those big, big hospitals, here at Mathare we don't have those big hospitals.'*¹⁰⁴ In Dandora, Eugene told us: *'I do not think there was any facility here which was declared that you could go there for COVID-19 related treatment. There wasn't any. Maybe people were being referred to Mama Lucy, but not within this area.'*¹⁰⁵

Individuals living in informal settlements also face geographical barriers in reaching medical services. A woman suffering from epilepsy in Dandora, for instance, explained that she faces barriers reaching the clinic where she goes for medical treatments:

101. Interview with woman living in Dandora, Nairobi (conducted on 15 October 2021).

102. Interview with a nurse working at a public health facility, Mukuru, Nairobi (conducted on 30 October 2021).

103. Interview with a woman living in Mathare, Nairobi (focus group conducted on 10 October 2021).

104. Interview with a man living in Mathare, Nairobi (focus group conducted on 10 October 2021).

105. Interview with a woman living in Dandora, Nairobi (conducted on 16 October 2021).

*When public transportation is not available or I don't have money, I have to walk. At times this would force I don't go. Because I am in pain, shaking, and I also would risk falling.*¹⁰⁶

Lack of access to COVID-19 testing has been another obstacle for individuals seeking medical care in the context of COVID-19. A human rights lawyer and expert we interviewed further explained that: *'At first, testing was mostly delegated to private facilities. The cost for a test was between 40 and 60 USD. For the most part, this cost is completely out of reach for the lower socioeconomic classes.'*¹⁰⁷ She added that this was problematic because it had indirect effects on accessing a wide range of health-care services: *'most private facilities required COVID-19 testing prior to accessing other services unrelated to COVID-19 (i.e. pregnancy screenings).'*¹⁰⁸ As a community health volunteer living in Mukuru shared: *'During COVID-19, it was very different. You could not be attended to if you were not examined. COVID-19 test is a must. I don't know where I can do it here.'*¹⁰⁹

The positive impact of public healthcare services on the right to health

Despite being underfunded, public healthcare services in Kenya have had important positive impacts for the right to health.

The public healthcare system has achieved landmark results in removing financial barriers to access medical services. While user fees were introduced in 1989, the Kenyan government was able to progressively remove or reduce them in public health facilities. In 2004, the Kenyan Ministry of Health removed user fees in primary health services replacing them with registration charges of 10 to 20 Kenyan shillings (0.08 to 0.17 USD approximately in 2004). According to a medical study, this policy had direct positive effects in increasing access to antenatal care at the population level. In 2013, the Minister of Health in Kenya abolished user fees in all public health centres and dispensaries (levels 2-3). Moreover, the government introduced free maternity services in all public health facilities from primary to tertiary care. A peer-reviewed study found that the policy has had positive access on low-income women's access to healthcare, with women being significantly more likely to deliver in public health facilities rather than private ones. A survey conducted across nine urban informal settlements in Nairobi found that 61% of respondents took their child when sick to a public healthcare facility rather than a private one.

While the individuals we interviewed highlighted that public healthcare services are not enough from a quantitative perspective, they were generally satisfied in terms of their quality and financial accessibility. Respondents in the three communities frequently

106. Interview with a woman living in Dandora, Nairobi (conducted on 9 October 2021).

107. Interview with human rights lawyer and expert based in Nairobi (conducted online on 20 February 2022).

108. Ibid.

109. Interview with community health volunteer, Dandora (conducted on 9 October 2021).

reported positive experience in public health facilities. While the main problem of such public health facilities remains short working hours and lack of medical resources, respondents are generally satisfied with the quality of medical treatment. For instance, a resident in Dandora indicated that he was able to easily obtain the COVID-19 vaccine at a public health facility: 'I have been vaccinated with the first dose at Forty-One (i.e. a public hospital) and they did not ask for anything (...) I will receive the second one on Monday.' Others described the positive experience in accessing free medicines at public facilities: 'At Dandora Forty-One (...) drugs there are free'. In Mukuru, a woman told us: 'At public hospital, they do communicate properly with the language that you are conversant with, they normally ask questions before starting treatment.' These findings suggest that the main challenges regarding public healthcare services is that they are insufficient in number, and are understaffed and under-resourced, but they are of good quality and can be a powerful tool in realising the right to health.

It is therefore commendable that at the peak of the COVID-19 pandemic, the Nairobi Metropolitan Services recognised the strain on the healthcare system in Nairobi and commissioned the construction of 24 additional public levels 2 and 3 health facilities around Nairobi, including in Mathare and Mukuru kwa Njenga, most of which have been constructed and equipped. These will go a long way in addressing the challenges with availability of healthcare services.

Source:

- Ministry of Health, 2018 *Household Health Expenditure and Utilization Survey* (2018) pp. 27, 42.
- The New Humanitarian, 'Free medical care in public health centres' (July 2004)
- <<https://www.thenewhumanitarian.org/report/50327/kenya-free-medical-care-public-health-centres>> accessed 25 February 2022.
- Mardieh L Dennis and others, 'Examining User Fee Reductions in Public Primary Healthcare Facilities in Kenya, 1997–2012: Effects on the Use and Content of Antenatal Care' (2020) 19 *International Journal for Equity in Health* 35.
- Lisa M Calhoun and others, 'The Effect of the Removal of User Fees for Delivery at Public Health Facilities on Institutional Delivery in Urban Kenya' (2018) 22 *Maternal and Child Health Journal* 409.
- Samuel Kirichu, 'Integrated Health and Nutrition Baseline Survey in the Nairobi Slums' (2014) <<http://www.nutrition-health.or.ke/wp-content/uploads/Downloads/Nairobi%20Slums%20MNCH%20KPC%20Final%20Report.pdf>> accessed 30 December 2021.
- Interview with a man living in Dandora, Nairobi (conducted on 15 October 2021).
- Interview with a man living in Dandora, Nairobi (conducted on 15 October 2021).
- Interview with a man living in Mukuru, Nairobi (conducted on 19 October 2021).
- Ouma Oluga, *Improving access to healthcare in Nairobi County* (2021) <<https://youtu.be/rx9E99SdU0k>> accessed 15 March 2022.

2. Barriers in accessing healthcare services

Everyone has a right to access quality healthcare services, regardless of their socio-economic condition, disability, gender, age, or any other status.

Non-discrimination and equality are fundamental components of international human rights law and essential to the exercise and enjoyment of economic, social and cultural rights, such as the right to health. States must ensure equality between everyone, in form and substance, by eliminating policy and practical barriers to enjoying the right to health. United Nations treaty bodies have highlighted how privatisation in healthcare can undermine equal access to healthcare, urging States not to implement privatisa-

tion when it may result in higher health inequalities impacting marginalised groups. For instance, in relation to women, the Committee on the Elimination of All Forms of Discrimination against Women has urged State Parties to: 'monitor the privatization of health care and its impact on the health of poor women and provide such information in its next periodic report'.

Source:

- CESCR, 'General Comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)' (2 July 2009) E/C.12/GC/20.
- CESCR, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the Covenant)' (11 August 2000) E/C.12/2000/4.
- GI-ESCR, 'Compendium of United Nations Human Rights Treaty Bodies' Statements on Private Actors in Healthcare' (June 2021) <<https://www.gi-escr.org/publications/compendium-of-united-nations-human-rights-treaty-bodies-statements-on-private-actors-in-healthcare>> accessed 25 February 2022.
- CEDAW, 'Concluding observations on the combined second and third reports of India' (2 February 2007) CEDAW/C/IND/2-3.

Discriminatory access to healthcare is widespread in the country, both within and across social groups and on a variety of grounds. Several studies have corroborated the existence of acute socio-economic inequalities across a range of medical services, including reproductive and maternal healthcare,¹¹⁰ prevention and immunisation,¹¹¹ urgent care,¹¹² as well as healthcare utilisation in general.¹¹³ For instance, one study found that across counties, higher poverty levels are associated with higher perceived unmet needs for medical care due to lack of money and high costs.¹¹⁴

The study found that higher education levels, good self-rated health, enrolment in insurance, and relative higher wealth made it less likely that people would forego healthcare due to cost.¹¹⁵ Self-reported unmet needs for healthcare is an indicator often used in official surveys, including in Kenya, to measure whether some barriers in accessing healthcare services, such as distance, cost or information, result in individuals not being able to obtain such medical services.¹¹⁶ Specific marginalised groups are particularly exposed to difficulties in accessing healthcare, such as children with disabilities¹¹⁷ and women.¹¹⁸

110. Emily Catherine Keats and others, 'Assessment of Inequalities in Coverage of Essential Reproductive, Maternal, Newborn, Child, and Adolescent Health Interventions in Kenya' (2018) 1 JAMA Network Open e185152; Jennifer Yourkavitch and others, 'Using Geographical Analysis to Identify Child Health Inequality in Sub-Saharan Africa' (2018) 13 PLOS ONE e0201870.

111. Carine Van Malderen and others, 'Decomposing Kenyan Socio-Economic Inequalities in Skilled Birth Attendance and Measles Immunization' (2013) 12 International Journal for Equity in Health 3.

112. WP O'Meara and others, 'Heterogeneity in Health Seeking Behaviour for Treatment, Prevention and Urgent Care in Four Districts in Western Kenya' (2014) 128 Public Health 993.

113. Julius Korir, Jacob Omolo and Charles C Nzai, 'An Empirical Analysis of the Effect of Poverty on Health Care Utilization in Kenya' (2018) 14 European Scientific Journal.

114. Purity Njagi, Jelena Arsenijevic and Wim Groot, 'Cost-Related Unmet Need for Healthcare Services in Kenya' (2020) 20 BMC Health Services Research 322.

115. Ibid.

116. For information on what self-reported medical needs for healthcare are see: WHO, Metadata Registry (2022) <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/855> accessed 03 March 2022.

117. Molalign B Adugna and others, 'Barriers and Facilitators to Healthcare Access for Children with Disabilities in Low and Middle Income Sub-Saharan African Countries: A Scoping Review' (2020) 20 BMC Health Services Research 15.

118. Carine Van Malderen and others, 'Decomposing Kenyan Socio-Economic Inequalities in Skilled Birth Attendance and Measles Immunization' (2013) 12 International Journal for Equity in Health 3; Jackline Oluoch-Aridi and others, 'COVID-19 Effect on Access to Maternal Health Services in Kenya' (2020) 1 Frontiers in Global Women's Health 599267.

This section of the report shows that several and interconnected barriers to the enjoyment of the right to healthcare exist in Kenya. These barriers are the result of existing social and economic inequalities. This can result, in practice, in discrimination in accessing healthcare services based on relative wealth and income, education level, employment status or access to information. These barriers might also interact, causing the risk of intersectional discrimination.

The following paragraphs explain the different barriers in accessing healthcare we identified, how they interact with pre-existing social and economic inequalities, and how they might ultimately result in potential discrimination in accessing medical services. Each paragraph is dedicated to a different problem that interacts with pre-existing socio-economic status and creates a barrier to accessing healthcare.

The first paragraph focuses on how financial barriers in access to medical services, such as user fees, the cost of medicines and upfront cash payments, can make individuals decide to forego medical care or enter medical debt. The second paragraph focuses on how information and financial barriers prevent many living in urban informal settlements from accessing healthcare insurance. The third paragraph unpacks how COVID-19 has further exacerbated these pre-existing trends.

Finally, the box at the end of the section explores how the engagement of the private sector in healthcare, especially for-profit actors, interacts with existing socio-economic inequalities and exacerbates the barriers in healthcare access, potentially resulting in higher discrimination.

a. Financial barriers in accessing medical services

All individuals living in informal settlements in our study came from a low socio-economic background and were either unemployed or in informal employment. All of them highlighted financial barriers in accessing healthcare services. Financial barriers can take the form of user fees for medical services, cost of medicines or upfront cash payment. For instance, Janet, a respondent from Mukuru, explained how diagnostic services are too expensive for her to access them:

*There was a time I went to Mukuru Health Centre and they told me that I required some laboratory tests that they didn't have so I had to go to Mama Lucy (a level 4 public hospital). At Mama Lucy they asked for 2,000 shillings (about 17.42 USD) which I did not have. I told the doctor that I was going for the money at home, and I never returned.*¹¹⁹

119. Interview with a woman living in Mukuru, Nairobi (conducted on 20 October 2021).

Likewise, according to Clara, living in Mathare:

*You are required to go to an outside facility so that you can be tested and it's very expensive, a single test can cost as much as 500 or 700 shillings (i.e. about 4.35 or 6.10 USD). There are no X-rays and people are having hard times since there is no money, so you are forced to stay home while you are sick. In public hospitals, there are no facilities and medication while private hospitals charge a lot of money that we don't have.*¹²⁰

Across the three settlements, several respondents highlighted that the cost of medicines complicated access to healthcare. Even what might seem like a small cost can prevent people facing financial hurdles from accessing necessary medicines, with negative health consequences:

*They prescribed five drugs type which cost 250 shillings each (about 2.18 USD). My husband didn't have enough money, so he bought it for five days. I have finished taking the drugs, but still, I'm not feeling well, I think it is because I did not take the full dose.*¹²¹

Finally, upfront cash payment for healthcare, which are widespread in Kenya, can endanger the lives of those seeking medical attention, especially in cases of emergency. A tragic example of this is narrated by Tracy who witnessed a man who had been stabbed bleed to death outside a private clinic after the clinic refused to admit him because neither he nor the people who had rushed him to the hospital were able to raise the required 'consultation fees':

*So, when they took him there (the private clinic), on arrival at the gate those doctors asked his girlfriend whether she had any consultation fee to pay first, so that they can open the gate for her. They didn't have any money. They told the doctors '(...) just help us, at least he would feel better. When morning comes, we shall see how to sort you out.' They (the doctors) refused. So, they stayed there trying to see how they will be helped, calling an ambulance to come help, but in that period he died like that.*¹²²

This lack of financially accessible healthcare services, goods and drugs has led to some choosing to forego healthcare. As Valerie, living in Mukuru, explained: 'When you don't have money, you just survive'.¹²³

120. Interview with a woman living in Mathare, Nairobi (conducted on 8 October 2021).

121. Interview with a man living in Dandora, Nairobi (conducted on 15 October 2021).

122. Interview with a woman living in Mathare urban informal settlement, Nairobi (conducted on 9 October 2021).

123. Interview with a woman living in Mukuru, Nairobi (focus group conducted on 20 October 2021).

b. Financial and information barriers in accessing healthcare insurance

Socio-economic status and employment status also create inequalities in accessing healthcare insurance, which in turn worsens inequalities in healthcare access. In 2018, only 19% of Kenya's population had any form of healthcare insurance.¹²⁴ This low percentage is concerning as enrolling in insurance schemes can prevent medical debt and catastrophic health spending. A 2019 study estimated that, between 2013 and 2018, the number of people pushed into poverty as a result of out-of-pocket healthcare spending more than doubled.¹²⁵ Difficulties in accessing healthcare insurance emerge as a cross-cutting theme that exacerbates other challenges.

Although respondents in our study were aware of health insurance plans, specifically the National Health Insurance Fund (NHIF), many were unable to pay the monthly rate: *'I have not registered because I don't have money and I don't have a job.'*¹²⁶ Others registered but they expressed difficulties in paying every month due to lack of stable income:

*Yes, I use it (NHIF). Though, at times, I'm unable to pay for the card because as you can see, I do not have a steady source of income. The children need to be fed; I also need to eat. The children are still studying, and they also need to be clothed. All that is a challenge. It's just hustling.*¹²⁷

Beyond cost, another barrier individuals face when trying to access healthcare insurance is accessing information regarding either the application process or the role of insurance. For instance, a woman in Dandora explained that she only understood the role of the social health insurance scheme after her baby fell sick: *'I had not applied. After my child being sick that's when I came to realise the importance of having it.'*¹²⁸ Another woman from Dandora reported: *'I know what NHIF is, but I do not know the process to enrol.'*¹²⁹

c. Barriers in accessing healthcare services amidst the COVID-19 pandemic

Socio-economic status has also been a potential ground of discrimination when accessing healthcare services in the context of the COVID-19 pandemic. A woman living in Dandora with chronic illnesses (HIV and diabetes), explained how after testing positive for COVID-19 she was not able to get free medical care due to lack of ventilators

124. Ministry of Health, Kenya Household Health Expenditure and Utilization Survey (2018) <<https://globalinitiativeescr.sharepoint.com/b/g/EfNiZR8V5BhEpMA6uaKbLa0BGA-o67LrhYh4dnQUTOGsKg?e=a11HB1>> accessed 09 February 2022, p. 55.

125. Salari Paola and others, 'The Catastrophic and Impoverishing Effects of Out-of-Pocket Healthcare Payments in Kenya, 2018' (2019) 4 BMJ Global Health e001809.

126. Interview with a woman living in Mukuru, Nairobi (conducted on 20 October 2021).

127. Interview with a man living in Dandora, Nairobi (conducted on 15 October 2021).

128. Interview with a woman living in Dandora, Nairobi (conducted on 20 October 2021).

129. Interview with a woman living in Dandora, Nairobi, (conducted on 20 October 2021).

at public health facilities and had to obtain care at an expensive private hospital:

I tested positive for Coronavirus, and they directed me to a public hospital, yet they had no ventilation machine. My children and husband took me to a private hospital. In seven days, we have spent about 300,000 shillings (about 2,612.85 USD). We put our title deed as security (for payment).¹³⁰

However, because she and her family are having trouble clearing the hospital bill, the hospital may sell their land to settle the bill: *'Our land will be sold because we have a hospital bill of 300,000 shillings (about 2,612.85 USD).'*¹³¹

Similarly, although Kenya began administering the AstraZeneca vaccine free of charge in March 2021 at public and selected private facilities,¹³² newspapers reported that some people were able to skip the line through personal connections or bribes as high as 100,000 shillings (about 870.95 USD).¹³³ According to news reports, the Health Cabinet Secretary, Mutahi Kagwe, declared that queue-jumping is more frequent in private health facilities.¹³⁴ Meanwhile, those trying to access the vaccines through the normal procedure experienced delays and vaccine shortages.¹³⁵

d. How commercial motives worsen barriers in accessing healthcare services

The inequalities in accessing healthcare are driven by policies and practices in both the public and private system, but commercialisation often plays a prominent role in creating and accelerating systemic discrimination and segregation.

A 2019 quantitative analysis found that the private sector in Kenya mainly serves the richest segment of the population, while public services deliver medical care to a much wider share of individuals from a low socio-economic background.¹³⁶ This reflects the fact that formal, high-end private healthcare facilities are concentrated in wealthy urban areas and target upper-income patients,¹³⁷ while public services are generally more spatially widespread and include completely free services at public centres and dispensaries (i.e. facilities of level 2-3 in Kenya's health system, as explained in Section II, para 3).

130. Interview with a woman living in Dandora, Nairobi (conducted on 15 October 2021).

131. Ibid.

132. Max Bearak, 'They have another door: Kenya's vaccine rollout exposes rich-poor divide' (Washington Post 3 April 2021), <<https://www.washingtonpost.com/world/2021/04/03/kenya-vaccine-inequality/>> accessed 09 November 2021.

133. Olivia Sher, 'COVID-19 vaccine access in Kenya illustrates dire global inequity' (Physicians for Human Rights 14 June 2021) <<https://phr.org/our-work/resources/covid-19-vaccine-access-in-kenya-illustrates-dire-global-inequity/>> accessed 30 December 2021.

134. Magdaline Saya, 'Vaccine Scandal: Rogue staff selling COVID-19 jabs' (The Star 23 March 2021) <<https://www.the-star.co.ke/news/2021-03-23-vaccine-scandal-rogue-staff-selling-covid-19-jabs/>> accessed 08 November 2021.

135. Ibid.

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

137. Kenya Institute for Public Policy Analysis, 'A review of the Regulatory Framework for Private Healthcare Services in Kenya' https://pdf.usaid.gov/pdf_docs/pnads076.pdf accessed 30 December 2021.

Likewise, where public institutions apply user fees (in level 4 and above facilities), these are lower than those charged by private institutions. A study found that, across a wide range of non-communicable diseases treatments, private health facilities charge higher fees than public facilities for the same service, as shown in Table 1.¹³⁸

Table 1: Average user fees for medical treatment in private and public facilities

Medical Treatment	Public (in USD)	Private (in USD)
Annual hypertension medication	26 - 234	418 to 987
Stroke admissions	1,874	16,711
Dialysis for chronic kidney disease	5,338	11,024

Source: findings adapted from Sujha Subramanian and others, (2018) 'Cost and Affordability of Non-Communicable Disease Screening, Diagnosis and Treatment in Kenya: Patient Payments in the Private and Public Sectors' PLOS ONE.

During COVID-19, the cost of COVID testing at private laboratories designated by the government is another example of how commercial motives might not facilitate access to healthcare. Private laboratories have been testing on a fee-for-service basis at costs largely inaccessible for most Kenyans. For instance, the Lancet private facility cost approximately 40 USD for business staff and \$80 for individuals, while the Nairobi and Aga Khan private hospitals charge 130 USD per test.¹³⁹

3. Insufficient regulation and monitoring of private health care providers

States have an obligation to monitor and regulate private health providers

Under human rights law, States have an obligation to protect everyone's right to health when non-state actors provide medical services or are involved in other forms of activities related to healthcare. This means that States must enact clear and implement regulation and monitoring frameworks to ensure the realisation of the right to health.

138. Sujha Subramanian and others, 'Cost and Affordability of Non-Communicable Disease Screening, Diagnosis and Treatment in Kenya: Patient Payments in the Private and Public Sectors' (2018) 13 PLOS ONE e0190113.

139. Health Systems Governance, Private sector engagement in the COVID-19 response: Kenya country experience (24 August 2020) <<https://hsgovcollab.org/en/node/4511>> accessed 21 March 2022, p. 3.

Source:

- UN Human Rights Council, 'Protect, respect and remedy: a framework for business and human rights: report of the Special Representative of the Secretary-General on the Issue of Human Rights and Transnational Corporations and Other Business Enterprises, John Ruggie' (7 April 2008) A/HRC/8/5.

Under the 2017 Health Act,¹⁴⁰ the Ministry of Health is responsible for the regulation, monitoring and inspection of all health facilities, including private ones. Specifically, the Health Act establishes the Kenya Health Professions Oversight Authority¹⁴¹ as the main body responsible for the regulation of all healthcare facilities, in coordination with the Cabinet Secretary of the Ministry of Health and a wide range of pre-existing professional regulatory bodies, such as the Nursing Council of Kenya, the Clinical Officers Authority and the Medical Practitioners and Dentists Board.¹⁴²

The 2017 Health Act also specifies that private facilities and professionals must obtain a license, meeting certain standards to operate. The Kenya Ministry of Health has developed clear guidelines on the accreditation procedure in the Kenyan health system. At the time of writing, the most recent and comprehensive policy document outlining such framework is the 2020 Quality of Care Certification Manual,¹⁴³ which specifies how to conduct the registration, licensing, accreditation and inspection of health facilities and providers as well as clarifying the responsibilities of the different regulatory bodies.

Kenya thus has a comprehensive legal and policy framework for the regulation and monitoring of healthcare providers. There is, however, a significant implementation gap that has been documented in academic, civil society, and institutional research. According to research, there is in Kenya a large informal healthcare sector offering both traditional medicine and modern medicine.¹⁴⁴ The widespread proliferation of unlicensed private clinics and laboratories is problematic due to the high incidence of these providers using expired drugs and reagents, or employing unqualified and untrained health staff.¹⁴⁵ Even in registered private facilities, there are challenges, such as numerous instances of medical malpractice and negligence or staff misrepresenting their qualifications.¹⁴⁶ Corruption in licensing practices complicates matters even further.¹⁴⁷ These problems become particularly acute in marginalised areas and when services are being used by individuals from a disadvantaged socio-economic background.¹⁴⁸

140. Health Act (2017) <http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/HealthActNo.21of2017.pdf> accessed 31 December 2021.

141. Ibid., 45.

142. Ibid., 60, para (2).

143. Kenya Ministry of Health, Quality of Care Certification Manual for the Kenyan Health Sector (2020) <<https://www.health.go.ke/wp-content/uploads/2021/10/Quality-of-Care-Certification-Manual-for-the-Kenya-Health-Sector-March-2020.pdf>> accessed 24 January 2022.

144. David I Muthaka and others, A Review of the Regulatory Framework for Private Healthcare Services in Kenya (2004) https://pdf.usaid.gov/pdf_docs/pnads076.pdf accessed 31 December 2021.

145. Ibid.

146. Ibid.

147. Ibid.

148. Tomo Takasugi and ACK Lee, 'Why Do Community Health Workers Volunteer? A Qualitative Study in Kenya' (2012) 126 Public



Description: Children sitting outside a pharmacy in Mukuru, Nairobi.

The COVID-19 pandemic has made visible the need for increased regulation and monitoring of private health facilities. For instance, there have been several reported cases of private laboratories issuing fake COVID-19 tests. In January 2022, the Ministry of Health found that two accredited private laboratories (Checkup Medical and Meditest) were issuing fake COVID-19 tests for travellers and banned such private facilities from further conducting tests.¹⁴⁹ Likewise, in July 2020, officials closed

the laboratory of Lang'ata Hospital, a privately owned facility in Nairobi, over allegations that it was issuing counterfeit COVID-19 tests using expired reagents while charging patients 6,600 shillings (57.48 USD).¹⁵⁰ This practise is so widespread that Dubai issued a flight ban on travellers flying from Kenya due to the many fake COVID-19 tests found.¹⁵¹ Similar incidents also occurred in treating COVID-19 cases: there have been several cases of private hospitals overcharging patients suspected of being infected with COVID-19, such as by selling a pair of gloves at 8,000 shillings (69.68 USD).¹⁵²

The interviews conducted reinforce the evidence of a large, fragmented and unregulated private health sector in Kenya, especially in marginalised areas. All respondents confirmed the existence of unlicensed private clinics and pharmacies in urban informal settlements. They reported ramshackle private health facilities that employ unqualified health personnel, misdiagnose patients, engage in unnecessary treatments, sell expired medicines or lack appropriate cleaning services and decent infrastructure. Joseph, in Dandora, shared the case of a misdiagnosis that led to death:

*We have had cases where people have been diagnosed with something, then maybe they have been injected by someone, then they die. So, those questions arise whether he was injected by a real doctor and before you can find out [...] that person has run away.*¹⁵³

Clara, a community health mobiliser in Mathare, further confirmed that there are many

health 839.

149. Mashirima Kapombe, 'Ministry Of Health Suspends Two COVID-19 Testing Labs Due To Fake Results' (Citizen Digital 11 January 2022) <<https://citizen.digital/news/ministry-of-health-suspends-two-covid-19-testing-labs-due-to-fake-results-n290092>> accessed 12 January 2022.

150. Hilary Kimuyu, 'Kenya: Lang'ata Hospital Hit By COVID-19 Tests Scandal' (All Africa 9 July 2020)

<https://allafrica.com/stories/202007100086.html> accessed 12 January 2022.

151. Bonface Otieno, 'Fake Covid Tests behind Dubai Kenya Flight Ban' (Business Daily Africa 06 January 2022) <https://www.business-dailyafrica.com/bd/economy/fake-covid-tests-behind-dubai-kenya-flight-ban-3673478> accessed 12 January 2022.

152. Joseph Muraya, 'Private Hospitals Warned against Overcharging Patients on COVID-19' (Capital FM 6 April 2020) <https://www.capitalfm.co.ke/news/2020/04/private-hospitals-warned-against-overcharging-patients-on-covid-19/> accessed 12 January 2022.

153. Focus group, Dandora, Nairobi, (conducted on 16 October 2021).

health facilities operating without a license in the community:

*I think that half of the facilities in Mathare are operating illegally, without a license. Or you find that somebody is operating with a certificate of the brother. Or you find that somebody is attending a patient when he is drunk, under the influence of alcohol. These persons are endangering our lives.*¹⁵⁴

A respondent in Mathare also highlighted: ‘At some point you find that there is mistreatment or wrong prescriptions because the doctor there is drunk all the time’.¹⁵⁵

When patients have been mistreated, it is not easy to seek justice and remedies. John highlighted an instance of a private health centre disappearing after a botched abortion procedure: ‘there was a case of a woman dying after an abortion (at a private health centre). The place was closed down immediately when the news popped up (...). The entire place was painted over, the name was erased’.¹⁵⁶

This situation requires increased monitoring of private health facilities, including in marginalised urban areas, as a community health worker in Dandora clarified:

*Health facilities should be regularly assessed because a lot of private institutions are coming up in our informal settlements, and they are not regulated, they don’t have qualifications, they are not registered (...) and when the quality assurance is passing by (...) they are being alerted by other abusive health institutions that are in the area: “they have passed here, they are coming there, have you closed?”*¹⁵⁷



Description: Private medical clinic in Mathare, Nairobi.

154. Interview with community mobiliser, Mathare, Nairobi (conducted on 9 October 2021).

155. Interview with a man living in Mathare, Nairobi (conducted on 10 October 2021).

156. Interview with community mobiliser, Dandora, Nairobi (conducted on 19 January 2022).

157. Interview with a community health worker, Dandora, Nairobi (conducted on 16 October 2021).

4. Unsafe and low-quality private health facilities, particularly those in urban informal settlements

Everyone has a right to high-quality healthcare services

The right to the highest attainable standard of physical and mental health includes access to healthcare that is scientifically and medically appropriate and of good quality. Quality healthcare requires, among other factors, services that are provided through skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

Source:

- CESCR, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health' (adopted on 11 August 2020) E/C.12/2000/4.

The policy and legal framework surrounding quality healthcare is well-developed in Kenya. In 2018, the Ministry of Health issued official guidelines on quality in healthcare, detailing a list of standards and a checklist to monitor progress to be used for self-assessment in all health facilities, including private ones. Recommendations include ensuring the participation of patients in their care decisions and care processes



Description: A low-cost private health clinic in Mathare, Nairobi.

and the employment of skilled and trained professionals. The guidelines also recommend measures to ensure safe delivery for maternal care, including by discharging babies within 24 hours of delivery regardless of the ability to pay.¹⁵⁸

High quality healthcare can be accessed in Kenya mostly in high-end, expensive private hospitals or by travelling abroad. By contrast, in marginalised parts of the city, such as informal settlements, several private healthcare providers offer sub-standard and unsafe medical services. For instance, a study described how women in deprived areas prefer to use private healthcare services for contraception services due to long queues at public facilities. However, the women interviewed in the study were more confident of the medical quality and technical expertise of public facilities, while

158. Kenya Ministry of Health, Core Standards for Quality Healthcare - Kenya Quality Model for Health (2018) <https://www.health.go.ke/wp-content/uploads/2021/10/KQMH-Quality-Standards-Final-Booklet_March-2018.pdf> accessed 31 December 2021.

they showed concerns over private providers prioritising profits over safe medical practice.¹⁵⁹

Many of the respondents expressed a lack of trust in the quality of private health facilities regarding various dimensions of quality. Regarding healthcare personnel, respondents highlighted the lack of qualification of many working in private facilities. According to Geoffrey, *'a lot of people are just in the health sector business without qualification; we wonder whether these people are real doctors or fake ones'*.¹⁶⁰

Lack of quality can also mean lack of referral of the patients to an adequate medical specialist or higher-level health facility. Clara explained how dangerous this practice can be:

*I had taken my child to a private hospital when he was five months old. The child had chest problems and he was coughing a lot. The doctor gave me some drugs and we went back home. (...) A friend of mine insisted that I should take the child to a major hospital. When I took the child there, the doctor was like: "Did you want to kill your child?" He said that the child was suffering from pneumonia and if I had hesitated to take him to the hospital, the child would have died. We were admitted there for about two weeks, while he was put on the ventilator machine, and by the end he was fine.*¹⁶¹

In the Dandora focus group, it emerged that in some instances private health facilities diagnose patients without prior examination. Akinyi described:

*Most of the private hospitals are only concerned with money, but not the type of disease that the patients have. Most private hospitals usually tell most patients that they are suffering from typhoid, yet they have not examined the patients, and their charges are high. There is a doctor at Phase 3, who always tells his patients that they are suffering from typhoid, and they are being put on [a drip]. I remember one Saturday, when I went there, he told me that I was suffering from typhoid. When your health condition advances that is the time they will refer you to a major hospital like Kenyatta.*¹⁶²

Almasi, a community health volunteer in Dandora, reported that she is concerned with the quality of private hospitals and prefers to direct patients to public hospitals:

159. 'Why Do Women Choose Private over Public Facilities for Family Planning Services? A Qualitative Study of Post-Partum Women in an Informal Urban Settlement in Kenya | SpringerLink' <<https://link.springer.com/article/10.1186/s12913-015-0997-7>> accessed 31 December 2021.

160. Interview with a man living in Dandora, Dandora, Nairobi (conducted on 15 October 2021).

161. Interview with a woman living in Dandora, focus group in Dandora, Nairobi (conducted on 16 October 2021).

162. Focus group in Dandora, Nairobi (conducted on 16 October 2021).

*There are many challenges in private hospitals. Doctors in a private hospital are not honest with their patients. They cannot refer their patients to a major hospital, that's the reason you find that the death rate has increased. I had taken a child to a private hospital, but later he died. I was told that the child was suffering from typhoid and he was very weak and he died some days later. That's the reason we do recommend patients to go to a public hospital even though you will be prescribed some drugs to buy.*¹⁶³

In this context, it is important to note that there are also private health providers offering good quality medical services. This is typically the case of some non-profit facilities, such as those owned by NGOs. Respondents in our study seemed to perceive a difference between for-profit and non-profit business in their experience as patients, with non-profit facilities being described as generally accessible and often of good quality. A respondent from Mathare explained this:

*Now if it is here at Shofco (i.e. a non-profit health facility), especially during the day, you can come talk with the social workers, they can assist you. If you cannot pay completely, they know how you will access that medical care, they will help you. But now if it is private (i.e. for-profit), it is hard, it is hard since I think private has nothing to do with social work.*¹⁶⁴



Description: Waiting room in Shofco, a non-profit healthcare facility in Mathare, Nairobi.

163. Interview with a community health worker, Dandora, Nairobi (conducted on 16 October 2021).

164. Interview with a woman living in Mathare, Nairobi (conducted on 16 October 2021).



Description: Private chemist in Mathare, Nairobi.

IV. Conclusions

In Kenya, the healthcare system is increasingly organised as a market rather than as a public service, with health increasingly viewed as a commodity rather than a right. In such a system, access to quality healthcare services largely depends on one's financial means, level of education, access to transportation and access to information, creating discrimination in the enjoyment of the right to health.

Despite the government's efforts to expand access to healthcare, the public healthcare system is still grappling with significant challenges, partly because of inadequate budgetary allocation. The government has allocated only 9% of its budget to health in 2018,¹⁶⁵ which is below the 15% threshold to which the African Union member States committed to in the Abuja Declaration.¹⁶⁶

In this context, this report has highlighted four ways through which the commercialisation of healthcare services impacted on individuals living in urban informal settlements during the COVID-19 pandemic.

First, there are insufficient public medical services as a result of decades of commercialisation in healthcare. The gap left by underinvestment in universal public healthcare services is not filled by private healthcare provision. The formal, high-end, for-profit health sector in Kenya mainly serves the richest segment of the population while individuals living in urban informal settlements are forced to rely on low-quality and unsafe commercial healthcare services.



In this context, non-profit private healthcare services often play a positive role in easing inequality in access to healthcare. Nonetheless, even non-profit healthcare actors cannot substitute a strong, reliable public healthcare system aimed at realising the right to health.

During COVID-19, the human rights implications of insufficient public healthcare services have been even more evident. Limited

165. Republic of Kenya. 2013/14—2019/20. County Budget Estimates. Nairobi, Kenya: Republic of Kenya; see also: Health Policy Plus, 'Is Kenya allocating enough funds for healthcare' (February 2021) <http://www.healthpolicyplus.com/ns/pubs/18441-18879_KenyaNCBABrief.pdf> accessed 10 January 2022.

166. WHO, The Abuja Declaration: Ten Years On (2011) <https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1> accessed 14 March 2022.

resources in the healthcare system have hampered efforts to prevent, control and respond to the pandemic, and the few resources available have also been concentrated in wealthy areas and accessible only to those in the highest socio-economic quintiles.

Second, marginalised populations face multiple interconnected barriers in accessing quality medical services, and such barriers were more evident during COVID-19. In practice, this leads to discrimination in access to medical services on the basis of the ability to pay, access to information, place of residence and education level.

Respondents in our report highlighted financial barriers due to excessive user fees for medical services, cost of medicines or upfront cash payment. Many respondents signalled that they lacked knowledge about how to enrol in the national social health insurance scheme, or that they were not informed about its benefits. Others signalled that, while they were aware of the benefits of the scheme, they lacked a stable source of income to pay for it.

In the context of the pandemic, marginalised populations have faced financial and transportation barriers in accessing COVID-19 testing, which has in turn impacted on their ability to access other forms of medical care for which a COVID-19 test is required. There was also lack of information on where COVID-19 treatment and testing could be obtained.

Third, the encouragement of private sector engagement in healthcare has not been accompanied by adequate monitoring in practice. This is despite the well-established legal framework on monitoring and regulation of healthcare providers. This lack of regulation has contributed to the proliferation of makeshift private clinics, nursing homes and laboratories, especially in marginalised areas. These facilities are often unlicensed and might even employ untrained doctors and chemists.¹⁶⁷ There are also problems in registered private facilities, including misdiagnosis, unnecessary treatments or misrepresentation of medical qualifications.¹⁶⁸

Fourth, partly because of insufficient regulation and monitoring, there are a number of private health providers offering unsafe and low-quality medical services, including lack of referral to adequate specialists, misdiagnosis, and unnecessary treatments as well as the use of expired reagents and drugs. Health workers and community leaders reiterated that they prefer to refer patients to the nearest public facility available as the quality is often perceived as better.

167. David I Muthaka and others, A Review of the Regulatory Framework for Private Healthcare Services in Kenya (2004) https://pdf.usaid.gov/pdf_docs/pnads076.pdf accessed 31 December 2021.

168. Ibid.

The disruption caused by the COVID-19 pandemic has made these practices even more frequent in the for-profit health sector. Private health facilities have been implicated in scandals regarding the issuing of counterfeit COVID-19 tests,¹⁶⁹ the use of expired reagents, and the overcharging of suspected COVID-19 patients for protective gear.¹⁷⁰

Overall, in a system that is increasingly organised as a free market due to the high level of private sector participation in healthcare, access to quality healthcare depends on one's position in society. However, entrusting healthcare to commercial actors, private interests and market logic is a loss for everyone. Private health providers are less likely to operate where there is less opportunity for revenue, like rural areas.¹⁷¹ By the same token, for-profit health providers will be less likely to deliver services that do not generate high returns but are essential for protecting populations' health, like prevention, family medicine and emergency care. Healthcare systems based on commercial drivers are therefore less resilient to shocks, such as epidemics, and prioritise short-term profits over public health goals, undermining the realisation of the right to health and universal healthcare services.

Rather than fuelling this self-defeating market approach, Kenya should invest its maximum available resources on coordinated, public healthcare services that prioritise public health and human rights.

169. Bonface Otieno, 'Fake Covid Tests behind Dubai Kenya Flight Ban' (Business Daily Africa 6 January 2022) <https://www.business-dailyafrica.com/bd/economy/fake-covid-tests-behind-dubai-kenya-flight-ban-3673478> accessed 12 January 2022.

170. Joseph Muraya, 'Private Hospitals Warned against Overcharging Patients on COVID-19' (Capital FM 6 April 2020) <https://www.capitalfm.co.ke/news/2020/04/private-hospitals-warned-against-overcharging-patients-on-covid-19/> accessed 12 January 2022.

171. World Bank and Government of Kenya, Health Service Delivery Indicator Survey 2018 Report pp. 83-84.

V. Policy recommendations

From the findings of this report, we urge the government of Kenya to:



Increase government funding to health to at least 15% of the national budget to expand the availability of quality, well-coordinated public healthcare services

Kenya is among the African Union States that pledged to raise the proportion of government funding for health to at least 15% of the overall national budget in the 2001 Abuja Declaration.¹⁷² However, Kenya is far below that target. Domestic public spending on health was at 9% of general government expenditure in 2018.¹⁷³ To increase the public spending on health would also be in line with Kenya's obligation to allocate its maximum available resources to ensure that everyone has access to universal, public healthcare services, which is set out in the African Charter on Human and Peoples' Rights and the other international human rights treaties that Kenya has ratified.



Ensure that all healthcare providers are strictly monitored and regulated at the national, county and local levels

The legal framework on private actors' regulation is well-developed. However, research confirms that, in practice, the quality of private healthcare provision is sometimes very low and not in line with medical nor human rights standards. The national and county governments should coordinate efforts to ensure that all health care providers in the country, both public and private, comply with regulatory requirements as established in the national and international legal framework.

172. WHO, The Abuja Declaration: Ten Years On (2011) <https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1> accessed 25 October 2021.

173. Republic of Kenya. 2013/14—2019/20. County Budget Estimates. Nairobi, Kenya: Republic of Kenya; see also: Health Policy Plus, 'Is Kenya allocating enough funds for healthcare' (February 2021) <http://www.healthpolicyplus.com/ns/pubs/18441-18879_KenyaNCBAbrief.pdf> accessed 10 January 2022.



Take concrete steps to ensure universal access to health insurance

This report has highlighted that participation in the National Health Insurance Fund is extremely low. Marginalised populations face financial and information barriers that often prevent them from accessing the scheme. It is thus particularly important to take proactive steps, through adequate public health policies, to address cost or information as a barrier to access healthcare insurance or any other form of pre-pooled scheme.



Promote the development of a stronger public healthcare system accessible to all

This report has demonstrated that market mechanisms in healthcare fail to adequately fill the gaps left by a weak public sector. Rather than promoting market-based solutions that have dangerous impacts on the realisation of the right to health, Kenya should invest in a strong public universal healthcare system that is democratically managed, funded, and delivered by non-commercial actors, and reinforce the public healthcare sector's capacity.



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