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COURSE: GPR 699: RESEARCH THESIS

ASSESSING KENYA'S COMPLIANCE WITH THE INTERNATIONAL REGULATORY FRAMEWORK FOR THE PROTECTION OF REFUGEES: *A RIGHT TO HEALTH PERSPECTIVE*

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REG: G62/34960/2019

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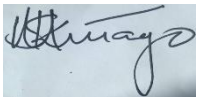
DECLARATION

I, KINAGO SAADA MOHAMMED, do hereby declare that this Research Thesis is my original work submitted in partial fulfillment for the award of a Degree in Master of Laws (LL.M) at the University of Nairobi, School of Law, and has not been submitted or is pending submission in any other University. Moreover, references made to texts, articles, papers, journals, and other pertinent materials, have been fully acknowledged.

Signed:  **Date:** 19TH November, 2021

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Supervisor's approval

Signed: ……. **Date:** 21ST November 2021

DR. WYNE KENNETH MUTUMA

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DEDICATION

To the hundreds of thousands of refugees and asylum-seekers suffering internally, this is specially dedicated to your silent cries. Know that we hear you.

My utmost respect and appreciation go to the United Nations High Commissioner for Refugees, UN partnered agencies without forgetting both local and foreign stakeholders for their undying efforts in ensuring that a great percentage of refugees currently secure access to quality and affordable health care. You have spearheaded efforts directed at the realization of medical needs for the world's most deprived communities and instilled a sense of contention and hope for better days in the hearts of millions of children globally, and for that alone, I applaud you.

Optimistic that this work will contribute to the conformity and consciousness of its constitutionally protected right, this writing is dedicated to the Government of Kenya. We can do better! We have the means and potential, all we need is the will. Together we can join efforts and not only fulfill our international law obligations as a state, but we can also transform the lives of these medically deprived victims into ones that reflect their unique contributions to society.

Lastly, I dedicate this work to God Almighty. You alone are able!

ACKNOWLEDGEMENT

I wish to express my earnest gratitude and indebtedness to my supervisor for his exceptionally dedicated mentorship during my writing of this thesis. If today this piece of work is considered solid, I owe it all to him. To Dr. Wyne Kenneth Mutuma, for believing in me even when I doubted myself, for your unrelenting and thought-provoking guidance, and for the countless times you triggered my potentials: Thank you!

I especially recognize the efforts of, and give special thanks to my Public International Law lecturers for the knowledge they have imparted throughout the LL.M program. The diverse and distinct, yet interrelated knowledge of International Law you conveyed through lectures and discussions has inspired and guided my comprehension and literature of this entire study. This research paper reflects realities and viewpoints as instilled through your constant enlightenment and commitment to educate. I salute you all!

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3. The Refugee Act No. 13 of 2006 [Revised 2012].

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2. African Union, *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 11 July (2003)*
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4. UN Committee on Economic, Social and Cultural Rights '*General Comment No. 14' on the highest attainable standard of health* (11 August, 2000) UN Doc E/C.12/2000/4
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12. The New York Declaration on Refugees and Migrants (adopted 3 October 2006 UNGA Res A/RES/71/1)
13. The Ottawa Charter for Health Promotion (adopted on 21 November 1986 1st WHO Conference on Health Promotion) (Ottawa Charter)

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LIST OF ABBREVIATIONS AND ACRONYMS

ANC Antenatal Care

AJS Acute Jaundice Syndrome

CEDAW Convention on Elimination of all Forms of Discrimination against Women

CRC Convention on the Rights of the Child

CESCR Committee on Economic, Social and Cultural Rights

EXCOM Executive Committee

ECHR	European Convention on the Protection of Human Rights and Fundamental Freedoms
ECOSOC	Convention on Economic, Social and Cultural Rights
EWARS	Early Warning, Alert, and Response System
EWARN	Early Warning, Alert and Response Network
GoK	Government of Kenya
ICCPR	International Covenant on Civil and Political Rights
ICRC	International Committee of the Red Cross
IERS	Interactive Electronic Reporting System
ILO	International Labor Organization
IOM	International Organization for Migration
IRO	International Refugee Organization
I T	Information Technology
LGBTI	Lesbians, Gays, Bisexuals, Transsexuals and Intersex
NYDRM	New York Declaration on Refugees and Migrants
MHPSS	Mental and Psychological Support
MoH	Ministry of Health

OAU	Organization of African Unity
OHCHR	Office of the High Commissioner for Human Rights
PLW	Pregnant and Lactating Women
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post Natal Care
REMEDI	Refugee Medical Insurance
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNPFA	United Nations Population Fund
WFP	World Food Programme
WHO	World Health Organization

ABSTRACT

The intrinsic prerogative to "the highest attainable standard of health" is anchored in international legal texts and serves [or rather is presumed to serve] as the cornerstone of any country's practical consideration of 'healthcare' and protection of fundamental human rights. The setting of this ultimate human entitlement is construed to function in a progressive, yet practical, efficient and sustainable manner. Furthermore, at the heart of this inalienable entitlement lies an effective and inclusive health system – one that promotes equitable and indiscriminate access to health care facilities and encompasses an adequate supply and availability of medical resources, including a fulfilled or advancing commitment to its underlying determinants. Yet in Kenya, the refugee health system is collapsing with little to no initiatives targeted at its improvement, giving rise to a humanitarian health issue. By encompassing the Bill of Rights, and in particular Article 43 in its Constitution, 2010, Kenya confirms its commitment to the international human rights duty to indiscriminately respect, protect, promote and fulfill the fundamental right to health of its entire population. With its initial articulation being the World Health Organization's Constitution, seconded by international legal instruments it has acceded to and ratified, Kenya, guided by its commitment to achieving Universal Health Coverage grounded on the Limburg principles undertakes the responsibility of progressively securing equitable public health access, for all.

This study is inspired by the apprehension that despite Kenya's accession and adoption of the 1951 Refugee Convention, International Humanitarian laws and Human Rights instruments pledging upon the indispensable right to health, including embracing one of the most advanced and spirited Constitutions of its time, scrutiny of its realistic implementation reveals the state's failure to adequately and efficiently respond to refugee health concerns. This paper, therefore, the extent of

divergence and convergence that exists in Kenya's obedience to the facilitation of health care access envisaged in legal texts, resonating with its international law-grounded refugee 'protection' mandate. Driven by this notion, this research thesis consequently advances three focal arguments. The first contention is that regardless of the numerous provisions that exist concerning safeguarding refugees' entitlement to *the highest attainable standard of health*, the Government of Kenya fails to actively and adequately react to the populations' medical demands; secondly, this creates a public health dilemma between the international community's pressure on the execution of state responsibility and the global agenda for the achievement of Universal Health Coverage; and thirdly, that progressive accomplishments undertaken through comprehensive initiatives is a potential structure to bridge the long-standing gap between the law in the books and the law as lived, for a pragmatic realization, hence securing compliance.

Establishing that refugees are entitled to equal protection of their fundamental rights as host states' nationals, this study relies on the human rights theory, with the consent-based theory asserting that indeed Kenya is bound in obedience to the extent of that which it freely consents to. This paper is purely doctrinal. It seeks to compare and contrast health care access as an entitlement depicted in refugee and human rights legal provisions and the law "on the ground". This study demonstrates that whereas Kenya has proved quite welcoming to persecution survivors, its protection capacity does not fully extend to appreciating their central rights – especially health. Whereas the notion of "protection" is expressly construed as obliging member states' grant of safe asylum to refuge-seekers, the same is implied in the context of their universal rights. In this study, I postulate that the law in the text can be in accord with the "living reality" if collaborative and dedicated health equity approaches can be framed, practically implemented, and maintained as per the United

Nations General Assembly Resolutions on Health, Ottawa Charter provisions and the New York Declaration Refugees and Migrants. This research paper considers that while the law technically determines and regulates member states' responsibility, several other factors reflect and justify the host country's inability to comply. I however contend that Kenya's financial incapacity to *fully* conform should not end at that; the Government ought to create a means to secure progress fulfillment: an imperative for the achievement of refugee health equity and a culturally-primed reform to its morally oppressive health system.

CHAPTER ONE

INTRODUCTION

"*If access to health is considered a human right, who is human enough to have that right?*"[1]

1.1 Introduction to Refugees Right to Health

This study involves examining Kenya's compliance to the international legal and institutional refugee frameworks in response to the protection and implementation of the fundamental right to health. The Refugee Convention defines a refugee to be any person who:

> "Owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, religion, country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it, member of a particular social group or political opinion, is outside the country of his nationality, and is unable or owing to such fear, is unwilling to avail himself of the protection of that".[2]

He is distinguished from an ordinary migrant with the main feature being that the former, upon fleeing his native land, in bad terms with the government of the territory in which he used to reside before seeking asylum, thus becoming a refugee. In essence, the refugee must be against the government, or rather, the government must be against him, to such an extent that life in his

[1] Paul Farmer's Quote on Pinterest, 2005.
[2] Convention Relating to the Status of Refugees (adopted 28 July 1951, entered into force 22 April 1954) 189 UNTS 137 (Refugee Convention) Art. 1 (A)

previous territory is impossible or intolerable.[3] Accordingly, a refugee is usually without the *de facto* or *de jure* protection of his homeland's government and therefore tends to become stateless.[4] He is viewed as an involuntary immigrant, a victim left with no choice but to seek refuge in foreign lands.[5] As a result of wars, torture, violence, human rights violations, and fear of being persecuted with no aid from his government, a person may be forced to flee to seek refuge in another country. At this point, however, since the government in their country of origin can no longer protect them, by application of international law, the international community takes charge. The host state, Kenya in this case, acts in its international law capacity to ensure that all fundamental human rights, including access to quality medical care as provided for in the Constitution of the World Health Organization, are not curtailed.

Noting that human rights have no boundaries, the protection of refugees' rights in third states includes the protection of their entitlement to access healthcare services. The right for every single individual to access medical aid is an ancient one having been earlier expounded by Aristotle.[6] The Universal Declaration of Human Rights (UDHR),[7] while affirming individuals' entitlement to medical care, identifies an adequate standard of living, including food, and housing as encompassing healthcare access.[8] P.A.O and 2 others v Attorney General found that the prerogative to health enshrined in the constitution, 2010, is inalienable, and includes access to

[3] Ditchburn. Robert W., 'The Refugee Problem'(1939) *An Irish Quarterly Review*, vol. 28(110) pp. 275-292 <www.jstor.org/stable/30097719> accessed March 12, 2020,
[4] *Ibid*.
[5] *See* e.g. The Shorter Oxford English Dictionary (3rd ed., 1997)
[6] Ram-Tiktin Efrat, 'The Right to Health Care as a Right to Basic Human Functional Capabilities: Ethical Theory and Moral Practice' (2012) vol. 15(3) 337-351 <http://www.jstor.org/stable/23254293> accessed May 25, 2021
[7] Article 2 provides that, "Everyone is entitled to all the rights and freedoms set forth in this Declaration […] no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or under any other limitation of sovereignty."
[8] Universal Declaration of Human Rights (adopted 10 December 1948 UNGA Res 217A(III) (UDHR) Art. 25 (1)

affordable medical resources, and essential medicines.[9] However, unlike in the provision of food and shelter, the Kenyan government and international community at large, to ensure equitable access to medical aid for refugees, with particular emphasis on mental and specialized care, have done the bare minimum. Nonetheless, with the continuing influx of refugees being noticed across the globe, there is an urgent need for host Governments to address the refugee health care *crisis* as a matter of priority. Health, as defined by the Health Act, 2017, includes an overall state of physical, mental, and social well-being and not merely the absence of disease or infirmity.[10] The dramatic movement of refugees, though not a risk factor on its own, is likely to expose them to huge health hazards with both physical and psychological complications.

Undeterred by the diversified laws governing refugee status and protection, Kenya's refugee residents face several problems including access to healthcare facilities, physical and sexual abuse, as well as violence, compared to the local communities. In most common law countries, there is minimum to no distinction at all between nationals and aliens in matters of accessibility to public health, as refugees enjoy the same rights and freedoms. Nevertheless, for a country like Kenya, however much has been done with regard to legislative enforcements to promote the protection of human rights, and to secure equal treatment and access to healthcare services, intentional discrimination of refugees persists. With social and psychological factors added to this equation, refugees are many a time indigent; they exist within strenuous environments and are frequently viewed as the hopeless unprotected "man without papers"[11] despite the establishment of international instruments serving as their guardians. These factors have greatly contributed to the

[9] P.A.O and two others v Attorney General [2012] eKLR.
[10] Kenya: THE HEALTH ACT No. 21 of 2017, Sec. 2
[11] Weiss, Paul, 'The International Protection of Refugees' (2012) *The American Journal of International Law* vol. 48(2), pp, 193-9 <www.jstor.org/stable/2194371> accessed 3 June, 2021

need for an action by the Kenyan Government to assess what is the suitable move to ensure first-rate protection of refugees' universally guaranteed entitlement: their access to health care assistance.[12]

Further, while Kenya's move to restrict illegal immigration and movements of large numbers of people into its territory is a legitimate means of maintaining state sovereignty, an infringement of their right to health is not. International law, backed by the nine (9) core International Human Rights instruments, maintains that all persons [including refugees and asylum-seekers] ought to be dealt with in obedience to human standards, with their safety and general well-being prioritized. As a matter of fact, the 2016 New York Declaration on Refugees and Migrants[13] insists that, despite treatment of refugees being regulated by distinct legal frameworks, they have similar entitlements, and are equally deserving of protection. Kenya has adopted a range of international instruments, including policies that serve to guarantee and promote universal enjoyment of this right, particularly the International Covenant on Economic, Social, and Cultural Rights (ICESCR).[14] This paper, therefore, noting that access to health includes the availability and affordability of medical resources,[15] attempts to assess Kenya's conformity to the current regulatory framework governing refugees' right to access health care, displaying its weaknesses and proposing recommendations targeting the protection and promotion of equitable access to medical assistance.

[12] Constitution of the World Health Organization, (adopted 17 November 1947, entered into force 7 April 1948) UN Doc A/RES/131, preamble.
[13] The New York Declaration on Refugees and Migrants (adopted 3 October 2006 UNGA Res A/RES/71/1)
[14] General Assembly (UNGA) Res 2200A (XXI) (16 December 1966)
[15] Pharmaceutical Society of South Africa v. Tshabalala-Msimang 2005 (3) SA 23 8 (SCA)
paras 42 and 53

1.2 Background of the Study

For decades, Kenya has been increasingly confronted with massive refugee flows from differing points around Africa, with a larger fraction of its population comprising of individuals from Somalia and South Sudan – their persecution plight being mainly as a result of civil wars, aggression, ethnic and religious struggles, including violation of human rights and political persecution. Nevertheless, some strongly believe that the global refugee problem currently in existence is entirely an economic one, insisting that, it is due to the political and economic constraints caused by war, and by failure to adapt the organization of production and distribution of the changing situation immediately after the war.[16] Undeniably, migration has been a vital element of globalization, with the periodical movement of people becoming progressively complex. The growing number of refugees and asylum-seekers the world continues to witness gives no hope for a permanent and suitable resolution to this predicament. The main agenda surrounding the adoption of the 1951 Convention[17] – finding durable solutions to their plight – has therefore not been met, yet. However, while migration is definitely inevitable and an enduring solution is far from a reality, Kenya's duty as a refugee host state, to uphold and protect individual fundamental human rights, remains.

Protection of refugees and asylum-seekers, being the primary obligation for all signatories to the 1951 Convention on the Status of Refugees, has significantly deteriorated over the last decades despite being considered a mandate of the international community from the time when the first

[16]Ditchburn, Robert W, 'The Refugee Problem' (1939) *An Irish Quarterly Review* vol. 28(110), pp. 275-292 <www.jstor.org/stable/30097719> accessed 15 March 2020
[17] *See* supra note 2

organizational agreements were drafted under the League of Nations.[18] Furthermore, since the provision of health is not *specifically* highlighted in both international, regional, and national legal refugee instrument(s), the notion of "protection" may be controversially construed by states hosting refugees within their territories. Certainly, despite not having a precise definition as to what Kenya's duty to "protect" entails, the sense of protection is however clear. It is undeniably presumed to include all individual human rights, with particular emphasis to their general well-being as interpreted in the lens of the objectives and purposes of international, regional, and national Refugee instruments, along with International Human Rights laws. Nevertheless, the Refugee Agency imposes a little substantive limitation on how the protection function necessitates:[19] its mandate being essentially limited to the protection of refugees' rights.

UNHCR-Kenya, assisted by local and international NGOs has carried out its mandate by identifying refugees, issuing travel documents, along with advocating for more precise guidelines for their handling,[20] including facilitating access to public health care services but, this is merely in support of the Kenyan Government and does not withdraw it of its obligations. Notwithstanding this, however, refugee health problems continue with no hope of its total extinction, with refugees in Kenya persistently facing barriers to access, and unavailability of quality medical care resources. Albeit the preamble of WHO's Constitution[21] guaranteeing every individual the right to health, including admittance to urgent medical assistance, Article 23[22] of the Refugee Convention clearly

[18] Goodwin-Gill and Guy S 'Refugees: Challenges to Protection'(2001) *The International Migration Review* vol. 35(1), pp. 130-142 <www.jstor.org/stable/2676055> accessed March 15, 2020

[19] According to the Office of the United Nations High Commissioner for Refugees (UNHCR) statute, the High Commissioner's obligation is entirely non-political and humanitarian, and relates only to groups and categories of refugees. Its mandate is therefore limited to the protection of refugees' rights.

[20] Kennedy, David, 'International Refugee Protection' (1986) *Johns Hopkins University Press* vol. 8(1) pp. 16

[21] Constitution of the World Health Organization, (adopted 17 November 1947, entered into force 7 April 1948) UN Doc A/RES/131, Art. 1

[22] *See* supra note 2

stipulates an obligation to refugee host states: the duty to provide public relief assistance similar to that afforded to its nationals. This can be interpreted to mean that Kenya, being a signatory to the Convention, owes an indispensable duty of ensuring refugees lawfully within its jurisdiction can access quality healthcare assistance – at whatever level – as its host population. The barriers, including restrictions based on documentation and legal status, cultural differences, illiteracy, corruption, and financial incapacity that impede an equitable realization of medical care services are therefore to be dealt with in a manner that guarantees equal enjoyment of refugees fundamental health rights.

Prior to resettlement, refugees in Kenya often live in camps, alongside a restricted availability of healthcare resources, inadequate food and clean water, and particularly little to no regard for proper standards of sanitation, and hygiene. These resettlement areas, namely the Dadaab complex, Kalobeyei settlement, and Kakuma Refugee camp which are meant to support refugees' self-determination through rendering improved livelihood opportunities and enhancing public service delivery, are nothing more than hubs for diseases and health deteriorations, with congestion, and poor hygienic environments defining its aura. The common protection challenges being the failure of parliamentarians to respond to refugee emergencies, protecting the refugee women and most especially children, and their lack of efforts to seek practical solutions to the preexisting refugee healthcare concerns, along with making provision for, and encouraging access to quality standards of health care services, are ignored. Sadly, refugees' unmet health care protection threshold by Kenya proves that they continue to face "persecution" even in their country of refuge, adding to their psychological torture and trauma. Undoubtedly, refugee protection is not centered on the initial mandate of UNCHR, which ended with a successful re-assimilation of refugees into the

national regime. Protection, unquestionable extends to the sufferings encountered by refugees while in asylum.

Looking back over the years, there has always been supporting for refugee asylum within the international community especially by third world states like Kenya, but the level of support and protection of their human rights and fundamental freedoms, particularly with regard to health, varies considerably. The right to health stems primarily, though not absolutely, from Article 12 of the International Covenant on Economic, Social and Cultural Rights[23] and binds ratifying states to the responsibility of promoting and protecting "the right of everyone to the *highest attainable standard* of physical and mental health". The UN Committee on Economic, Social and Cultural Rights[24] further provides that health is a fundamental human right indispensable for the exercise of other human rights, adding that every person is entitled to the enjoyment of health conducive to living a life in dignity."[25] Moreover, relying on the preamble of the 1946 WHO Constitution, an express obligation is created upon states – a duty that should not merely be grounded on text. These simple, yet significant wordings create a direct obligation: a responsibility Kenya willfully undertakes, through its unambiguous concession, to guarantee its populations an excellent state of health, with equitable access to the "highest attainable standard" of services similar to that of its citizens.

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

[24] The Committee on Economic, Social and Cultural Rights (CESCR) is made up of 18 independent experts charged with the duty to oversee member states' application of the International Covenant on Economic, Social and Cultural Rights.

[25] The Committee on the Economic, Social and Cultural Rights General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000, E/C.12/2000/4

International Human Rights Conventions impose an obligation on Kenya to indiscriminately respect, protect, promote and fulfill individuals' fundamental human rights within its jurisdiction, irrespective of nationality. The presumption made by the 1951 Refugee Convention and several other humanitarian laws, that the burden of flow and protection of refugees will be shared equitably between states within the international sphere, has failed miserably. The burden of refugees is particularly shouldered on economically weak states,[26] with more refugee assistance being granted by developing states with relatively no help from the developed. For refugee host states like Kenya, despite displaying great willingness to welcome refugees into their territories, the poor living conditions in the resettlement camps are a factor that deteriorates their well-being. Furthermore, insufficient medical resources are reserved for the thousands of residents crowded in camps.

Essentially, the international refugee healthcare experience is generally unsatisfactory, particularly due to Kenya's weak health system. While those in camps may be said to have partially secured medical care access through humanitarian partners' assistance stationed within camps, this is not the case for the tens of thousands who are left to fend for themselves in urban centers. Critically, despite the 2010 Constitution guaranteeing individuals' entitlement to health,[27] refugees, even those duly registered continue to encounter unique obstacles in accessing health-related services. With health care being regarded as a necessity of life and universally acknowledged as unchallengeable; its implementation on refugees has remained a sham despite Kenya avowing compliance through ratification.

[26] Musarat-Akram, Susan, 'The World Refugee Regime in Crisis; *A Failure to Fulfill the Burden-Sharing and Humanitarian Requirements of the 1951 Refugee Convention Proceedings of the Annual Meeting*'(1999) (*American Society of International Law*) vol. 93 pp. 213-216 <www.jstor.org/stable/25659295> accessed May 15, 2020
[27] *See* Article 43 (1) (a) of the Constitution of Kenya, 2010.

The situation is further threatened by the Governments' unwillingness to allow refugees into its territory attributing this to a compromise to their national security. Whereas many maintain that we owe the refuge-seeker the bare minimum and the supposed "failed asylum-seeker" nothing at all,[28] including healthcare access, Kenya, despite being a signatory to the 1951 Convention and its 1967 Protocol and therefore bound to its provisions, is reluctant in providing quality medical care to its refugee population. Additionally, however, whereas various global mechanisms, such as the Global Compact on Refugees and The 10-Point Plan[29] understand the urgency to enhance international cooperation in light of refugee human rights violations, practical implementation remains a dilemma.

The SDG Agenda that Kenya claims to adhere to is grounded on leaving no individual behind, come 2030. However, this pledge has not changed the game concerning its health system in meeting refugees' health demands. Simply providing asylum within its territorial boundaries is inadequate as per the legal realm of "protection" and the interpretation of the term technically advances to a sense of security for their indispensable rights – which is not merely a legal ground, but a moral and humanitarian responsibility. Further, it should be noted that the right to health, being universally recognized by international law cannot be dispensed with on grounds of documentation. Whereas other rights – to some extent – may be restricted with minimal effect to an individual, what is central to their well-being cannot be curtailed, irrespective of their legitimacy before the eyes of the host government.

[28]Stevens, Dallal, 'Asylum Seekers and the Right to Access Healthcare' (2010) *The Northern Ireland legal quarterly* vol.61(4),pp.367<https://www.researchgate.net/publication/228135021_Asylum_Seekers_and_the_Right_to_Access_Health_Care/citation/download> accessed on 14 May, 2020

[29]UNHCR 'Refugee Protection and Mixed Migration; The 10-Point Plan in Action' (2007) <https://www.unhcr.org/50a4c2b09.pdf>

Though human rights activists, Civil Society Organizations, and even scholars have made significant advancements in promoting and procuring the realization of this right, execution by Kenya with regard to its refugee populations has remained unsatisfactory. There is therefore a dire need for a realistic implementation and practical enforcement of suitable measures for equitable and progressive protection of refugees' health care needs.[30] Taking note of the Refugee Convention, International Human Rights, and Humanitarian Law provisions sustaining Kenya as a sovereign state that has voluntarily assumed responsibility, the idea behind the protection, and promotion of health implies Kenya's obligation to refrain from jeopardizing, compromising, or interfering with access to healthcare services.

1.3 Statement of the Problem

Generally, member states are tasked with the responsibility to protect persons, both in the sense of security, and guaranteeing healthcare access within and outside their geographical jurisdictions, irrespective of their nationality; legally registered or not. However, Kenya has failed in its obligation to secure adequate and quality healthcare access for its refugee populace, both in camp, and urban residents. The prolonged and frustrating Refugee Status Determination (RSD) processes – currently taking up to a decade to be finalized – further limit access to the available medical services for the unregistered population. Without documentation, UNHCR-Kenya says, both adults and children cannot get access to healthcare systems and support.[31] Inarguably, not everyone

[30] *See* Mitu-Bell Welfare Society v Attorney General & 2 others, the term 'Progressive realization' implies that the state must immediately begin taking necessary steps to gradually secure the realization of rights, being a constitutional obligation of every state.

[31] UNHCR-Kenya, 'Registration and Documentation' (2019) <https://www.unhcr.org/ke/registration> accessed 15 May, 2020

seeking asylum is entitled to its grant save for those defined under the 1951 Convention, however by virtue of being human, such are all the same qualified for protection of their fundamental human right to health.[32] As demand for a comprehensive refugee health system continues to grow, rather than devising a resolution for individual refugees, solutions need to be obtained to deal with the entire refugee population, collectively.

The focus still rests on Kenya's legal and moral obligation to endorse and safeguard both health care, and human rights. The living conditions refugees are subjected to; with limited access to necessities, indicates that for this particular community, even the reputed minimum health approaches as introduced by the UN Committee on Economic, Social, and Cultural Rights – a progressive realization of the right to access health services, including medication[33] – undoubtedly remains a promise with no hope of fulfillment. It is safe to say that, while the right to "the highest attainable standard of health" is contained in the Constitution of the World Health Organization (WHO), including various legally binding international agreements, the level of fulfillment from one refugee host state to another is conspicuously disproportionate. The current frameworks prove ineffective in securing Kenya's *practical* implementation of its health care protection directive, precisely since, despite major reforms and even incorporation of legal provisions into its national laws, the Kenyan Government still fails to fully comply with the international norms in not only protecting but prioritizing refugees' access to equitable and quality medical care, dragging forward the refugee "healthcare *crisis*".

[32] CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), Para 1 provides that, "Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity".
[33] Amrei, Müller, 'The Minimum Core Approach to the Right to Health; Progress and Remaining Challenges' (2017) Tra*nscript Verlag, Bielefeld* pp. 55-7 <http://www.jstor.org/stable/j.ctv1fxf7w.5> accessed 15 August 2020.

1.4 Research Questions

To realize its objectives, this study pursues to react to the following questions.

1. Do the current refugee frameworks provide for the protection of refugees' health care entitlements?
2. What are the health complications facing Kenya's refugee population and the barriers impeding their access to health care services?
3. What strategies can Kenya implement to encourage refugees' access to health care assistance?
4. What recommendations may be applied to progressively secure the realization of equitable and quality health care for refugees in Kenya?

1.5 Research Objectives

This study seeks:

1. To investigate whether the existing regulatory frameworks cater for the protection of refugees' health care rights.
2. To discuss the health concerns facing refugees in Kenya and the factors impeding their utilization of healthcare resources.
3. To investigate the strategies to remedy Kenya's refugee health care dilemma.
4. To recommend appropriate measures and solutions to facilitate health equity for Kenya's refugee populace.

1.6 Hypotheses

In my analysis, I posit that:

1. The divergence that exists between the protection of refugees' right to access healthcare services in theory and practice in Kenya's resettlement regions is partly attributed to the absence of *specific* binding refugee legal provisions, both at the national and regional levels.

2. The shortcomings and operational gaps encountered by refugees directly accredit their impeded access to the available health care resources.

1.7 Theoretical Framework

Any well-structured legal assignment is centrally steered by certain basic assumptions that incline towards a concept or set of concepts. A theoretical framework, in this case, provides insight for handling, analyzing, and interpreting data. For this particular study, I employ the human rights theory and the compliance-based theory.

1.7.1 Human Rights Theory

The doctrine of human rights rests upon a moral concept that identifies and demands certain minimal fundamental rights as prerequisite to every human being, inspiring the enactment of soft law and legally binding instruments. To *John Locke*, the primary, if not the sole purpose for the

existence of authority in a sovereign state is to protect individuals' inherent rights.[34] He contends that the duty to foster respect for and protection of human rights is what forms the basis of a government. Similarly, to the 18th Century's moral philosopher, *Immanuel Kant*, individual human rights are not subject to any superior political being but rather, are grounded on human dignity, equality, and reasoning.[35] Refugees are therefore inherently entitled to the protection of their fundamental human rights and freedoms. Human rights values exist to ensure that the dignity of all individuals is equally preserved. The universal and inalienable nature of human rights acknowledges that all individuals are at liberty, with the same entitlements and dignity.[36]

The concept focuses on a number of Conventions that fall within the refugee protection scope, such as the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR). This theory recognizes the right pertinent to the objective of my study: the protection of refugees' health care entitlement.[37] Essentially, toward determining and understanding the rights and freedoms owed to refugees, hence demanding protection by the Kenyan government, human rights law must be invoked. The rationale is that refugee protection encompasses principles embodied in human rights and humanitarian law.[38] Based on the largely established human rights norms, refugees are entitled to the protection of their health needs irrespective of whether or not they left their countries of origin.

[34] Donnelly, Jack, 'Human Rights as Natural Rights. Human Rights Quarterly' (1982) vol. 4(3) pp. 391-8 doi:10.2307/762225 <www.jstor.org/stable/762225> accessed 25 May, 2021
[35] Bayefsky, Rachel, 'Dignity, Honour, and Human Rights: Kant's Perspective, Political Theory'(2013) vol. 41(6) pp. 809-12 <http://www.jstor.org/stable/24571373> accessed July 25, 2021
[36] *See* supra note 7
[37] Helton, A.L 'Refugees and Human Rights. In Defense of the Alien' (1992) vol. 15 pp. 143-148 <www.jstor.org/stable/23143127> accessed April 8, 2020
[38] *Ibid*, pp. 145

This theory supports my study since it supplements the entitlement to refugees' health care protection by Kenya, thus aiding in filling the apparent gaps in the legal frameworks. I have particularly utilized this theory because, "the right to the highest attainable standard of health"[39] implies a well-defined legal duty gleaned from the principles of Human Rights obligation on Kenya, to guarantee and provide suitable conditions for access to health services for all, without discrimination based on religion, ethnicity, nationality or any other status. This theory facilitates the understanding that health care access is a right engraved under international customary law and irrespective of its existence in refugee frameworks, indiscriminately applies to everyone, notwithstanding their legal status. Most importantly, however, I project its relevance in an attempt to bring out the complementary relationship between the preexisting refugee protection instruments and Kenya's compliance, vis-à-vis the binding nature of human rights.

1.7.2 Compliance-Based Theory

It is commonly believed that International Law is paramount and affects how states behave which is, in effect, the relevance of the law. Notably, however, compliance is one of the most central questions under this regulation. Without understanding the nexus between International law and states' actions, valuable policy guidance regarding International law may not be provided.[40] The theory is relevant to the protection of refugees' healthcare rights as it suggests that since Kenya, through ratification, voluntarily submits to Refugee and International Human Rights Conventions, and must therefore ensure realistic adherence to the same. This as a result will guarantee its

[39] UN Committee on Economic, Social and Cultural Rights 'General Comment No. 14' on the highest attainable standard of health (11 August, 2000) UN Doc E/C.12/2000/4, para 1-3
[40] Guzman, Andrew T. 'A Compliance-Based Theory of International Law' (2002) *California Law Review* vol. 90(6), pp. 1823-27.

compliance to the regulatory frameworks in place for refugee protection. Likewise, it is presumed that States are rational and inherently selfish, and are very much aware of the influence International law has on their behavior.[41] A model of consent, therefore, requires machinery through which states that violate a covenant are sanctioned, in an effort to create a system whereby international law is respected.[42] This theory claims that through ratification of an international agreement, a state indemnifies its status – necessitating the need for appropriate mechanisms that punish nations for their defiance of international law. With regards to the international law doctrine of *pacta sunt servanda* [agreements must be kept], this notion emphasizes the need for states to secure compliance of their obligations upon ratification of international agreements, as a means to avoid grave consequences on their international standing and potential arrangements.

This concept suits my study in the sense that international human rights laws and Conventions are enacted, and unanimously ratified to safeguard and protect individuals, including refugees' right to health. Regardless of this, however, hundreds of thousands of Kenya's camp and urban refugees often lack access to quality health services, along with financial security for their medical needs. Kenya's healthcare support system for refugees in resettlement regions countrywide remains a dilemma, surrounded by the inadequacy of medical aid, despite the existence of provisions binding the state. Further, since the Republic of Kenya voluntarily ratified the core Human Rights Conventions, the 1969 Organization of African Unity Convention, in addition to the 1951 Refugee Convention and its 1967 Protocol, it willingly undertakes the responsibility to assure utmost

[41] *See* supra note 37.
[42] *Ibid.*

compliance to its provisions by upholding the global recommendations on refugee rights.[43] With its incorporation of Article 2(5) and (6) of the Constitution, adopting a monist view of the international instruments it pledges adherence to, in this case with regard to treaties and conventions in support of Article 43(1), Kenya undertakes to be held accountable for any breach, notwithstanding wounding its reputation before the international community.

1.8 Literature Review

The review of the literature relating to my study focuses on writings by different authors and scholars based on the law concerning refugees and their prerogative to health. It elaborates the correlation between the black letter law and its practical application. It is however important to note that there are very few texts that address refugees' right to health – particularly on host states' dispensation of services. Most of the scholarly articles rather address health as a human right ascribed under the International Covenant on Economic, Social and Cultural Rights, and various other International Human Rights Laws.

1.8.1 Substantiating Refugee Health as a Human Right

Numerous steps have been undertaken to reiterate that health is a fundamental right, including provisions in the Constitution of Kenya. Nevertheless, in this study, I argue that even the supreme law of the land has failed in its legislative effort to safeguard the health rights of refugees within its jurisdiction. Article 43(1) (a) of the Constitution, 2010, in categorizing health as a socio-

[43] Masuku, Sikanyiso, and Sizo Nkala 'Patterns of the refugee cycle in Africa: A hazardous cycle with no end in sight?' (2018) *Journal of African Union Studies* vol. 7(3), pp. 90 <https://www.jstor.org/stable/26890366> accessed June 15, 2021

economic entitlement, is to the effect that every individual reserves access to *the highest attainable standard of health*, which incorporates equitable access to reproductive health care, with a linked emphasis on access to emergency treatment.[44] Adopting a monist system, the mother law goes further to affirm the general international law guidelines as forming part of Kenyan law, and that an agreement duly consented to shall form part of its law.[45] In this study, I argue that the constitutional provisions with respect to the universal nature of the right to health, originally incorporated in the preamble of the WHO Constitution apply to all persons including refugees, to the extent consistent with it.

Andra le Roux-Kemp[46] notes that an indispensable international obligation lies with every state, including Kenya, to ensure a pragmatic fulfillment of fundamental rights and freedoms contained in the Bill of Rights. Le Roux further contends that the essence of what health necessitates is based on who the rights-holders are, the method of its enforcement, and its direct effect on the lives of its beneficiaries, which is fully dependent on the particular understanding and exposition of health as a prerogative. The author argues that it is relatively difficult for a state to guarantee absolute health rights to its entire population, and what is possible to achieve is the creation of opportunities for communities' realization of their potential, either through facilitating medical care access, and or guaranteeing the availability of its social determinants.

[44] Kenya: The Constitution of Kenya [Kenya], 27 August 2010, Article 43(2)
[45] *Ibid*, Article 2(5) and (6)
[46] Le Roux-Kemp, Andra 'The Enforceability of Health Rights in Kenya; An African Constitutional Evaluation' (2019) *African Journal of International and Comparative Law* Vol. 27 pp. 126-129 <https://www.researchgate.net/publication/330858640_The_Enforceability_of_Health_Rights_in_Kenya_An_African_Constitutional_Evaluation> accessed 12 June, 2021

My paper hails the 2010 Kenya Constitution as one of the most transformative and progressive constitutions in the current era of modern democracy and agrees with the author contending that the government's failure remains with the implementation of the right to health, particularly for refugees. This study shall adopt Roux-Kemp's arguments in analyzing Kenya's obligation and promising legal texts under its domestic system, apropos to the implementation of health – a legal and moral right that has remained elusive for thousands of refugees residing in Kenya. My arguments concerning, the author's assertion – Kenya's impossibility to secure utmost fulfillment of health prerogatives – will be led by the minimum core approach reiterated by the UN Committee on Economic, Social, and Cultural Rights, all through noting that Kenya is a middle-income country low on finances. My study will reveal that whereas ICESCR advocates for a progressive realization of rights by states, the Kenyan Government with regard to the facilitation of refugees' health rights has undertaken significantly few improvements on health care and the system's general infrastructure. I argue that since the camps were first established, Kenya has exerted minimum efforts in promoting access to specialized care, as well as eradicating the gaps and challenges barring their access.

In an analysis of its healthcare protection directive titled "Access to Health",[47] the UN Refugee Agency identifies health as a central right for all, including refugees, and further emphasizes their entitlement to access services similar to that of the host state's population, as articulated by the 1951 Refugee Convention. The Agency raises various issues relevant to its mandate regarding the protection and facilitation of refugees' health rights. For instance, with its strategy steered towards achieving global health equity, and its commitment to the Sustainable Development Goals,

[47] UNHCR, 'Access to Health' (2021) para. 3-7 <https://www.unhcr.org/access-to-healthcare.html> accessed on 12 June, 2021

UNHCR advocates for, and prioritizes the inclusion of refugees into the national health systems, as a means to benefit the refugee population, as well as host communities. Concurring with the UN Refugee Agency, *Dallal Stevens*[48] identifies 'protection' as the main rationale for the existence of refugee policy. In his writing, he addresses what exactly is meant by "protection".

He analyses the definition of "protection" in the 1951 Convention, against the provisions of the UNHCR Statute, contending that the starting point to understanding the meaning of protection, is to examine the legal instruments containing it. The author agrees with the principle established in the *Hovarth case,*[49] that the 1951 Convention is grounded on "enabling the person who has lost the benefit of protection against persecution in his own country." Stevens further acknowledges the evolvement of the universal protection function from being based on consular and diplomatic relationships, to safeguarding refugees' basic rights and freedoms. The article further examines the International Bill of Rights, with particular regard to its universality principle and the fact that human rights, including medical care access, are inalienable, irrespective of nationality. In effect, he maintains that even refugees deserve, and are entitled to equal rights as host communities. In my analysis, I reflect Steven's arguments in reasoning that the right to access healthcare for refugees falls within the protection definition of the 1969 OAU Convention, the 1951 Convention, and its 1967 Protocol, including the 2006 Kenya Refugee Act. In this study, I contend that Kenya's obligation with regard to the "protection" of refugees includes guarding them in every aspect necessary to secure the realization of their fundamental rights.

[48] Stevens, Dallal 'What Do We Mean by Protection?' *International Journal on Minority and Group Rights*'(2013) vol. 20(2), pp. 237 <www.jstor.org/stable/24675883> accessed 5 April, 2020
[49] Horvath v. Secretary of State for the Home Department [2001] 1 AC 489

Further, *Heiner B., Sabine K., Martina S.,* & *Andreas F*[50] acknowledge the fact that health is a central right that suffers a lot of contention despite being guaranteed through legally enforceable obligations. The quad contends that the right to health requires a respectful attitude towards the patients seeking its enjoyment in the sense that health facilities and equipment should be adequate and appropriate, based on cultural sensitivity and medical ethics, to secure the utmost fulfillment of this right. The authors' views reflect that of my study grounded on the fact that Kenya's refugee health facilities are underequipped, and below the minimum international standards – a disparity that proves the state's noncompliance to its international law obligations – risking the lives of hundreds of thousands of refugees. In *Michael Krennerich's* "*The Human Right to Health"*,[51] the author's argument is similar to that of Andra le Roux-Kemp[52] holding that, states are the guardians of individuals' rights and it is the same state that is obligated under international law to refrain from violations, and protect individuals against the interference of their rights.[53] Krennerich maintains that safeguarding the right to health, as well as ensuring proper living conditions with access to appropriate healthcare, is a duty that lies upon the hosting state.

He treks on to feature the nexus between International Human Rights instruments and their incorporation of the right to health, noting that the provisions do not provide for persons of specific nationality but rather the global population as a whole. Through his texts, he reasonably acknowledges that, before the right to health can be appreciated, its social determinants must first

[50] Sabine, Klotz (eds.) et al., 'Healthcare as a Human Rights Issue, Normative Profile, Conflicts and Implementation' (2017) *Transcript Verlag* vol. 4 pp. 96-99 <https://library.oapen.org/bitstream/id/54d73f52-5427-4cb9-8a01-93d1c16c6042/646439.pdf> accessed on 12 June, 2021

[51]Krennerich, Michael, 'The Human Right to Health: Fundamentals of a Complex Right' (2017) *Transcript Verlag* <http://www.jstor.org/stable/j.ctv1fxf7w.4> accessed 17 June 2021

[52] *See* supra note 43

[53] In Kenya Society for the Mentally Handicapped v Attorney General and Others, the court found that the responsibility to secure protection of the fundamental right to health lies with the state.

be adequately met. In this paper, I argue that in line with Krennerich's view that, despite international agreements featuring the entitlement to health – comprehensively seeking to secure health rights for all categories of persons, there is a distinct variance with respect to how the health needs of refugees are fully met. The mere fact that although Kenya's national laws are in favor of protection and realization of health care entitlements, its practical implementation with respect to the unhealthy conditions hundreds of thousands of refugees are subjected to is a gap that consequently intensifies the country's refugee healthcare dilemma. This paper argues that the approach to attain complete fulfillment of quality health, based on the achievement of its social determinants, is a valid one that would on its own, considerably improve the general wellbeing of Kenya's refugee population.

Bolliger .L & *Aro .A*[54] examine the refugee disaster as a result of the millions of refugees who fled to Europe, particularly focusing on their right to access medical care. They both argue that the medical code of ethics is highly breached in countries hosting larger fractions of refugees. The authors focus on the medical code of ethics in emphasizing the protection of health as a universal human entitlement. They identify health as a fundamental right recognized by diverse international instruments, including the Universal Declaration of Human Rights [UDHR], the International Covenant on Economic, Social and Cultural Rights [ICESCR], and as initially, the constitution of the World Health Organization [WHO]. While emphasizing the right to access quality medical services, Bolliger and Aro insist that the failure of States to protect refugees' rights is particularly ascribed to their lack of awareness thereof. In their writing, the authors place absolute focus on the infringement of refugees' health rights, and the need for urgent improvements to accord them the

[54] Bollinger Larissa and Aro Arja R., 'Europe's Refugee Crisis and the Human Right of Access to Health Care: A Public Health Challenge from an Ethical Perspective' (2018) *Harvard Public Health Review* vol. 20 pp. 1-4.

desired protection. In this research paper, I argue along the lines of the authors' views contending that population outreach and the high illiteracy levels in Kenya's refugee system are among the gaps impeding equitable access to health care, hence necessitating the Government's immediate intervention.

1.8.2 Refugee Health Risks and Access Complications

Kristina .M, Lorin .D & Nassim .A [55] together with *Divito, B., Payton, C., Shanfeld, G., Altshuler, M., & Scott, K* [56] examine the challenges encountered by refugees in their utilization of medical care services, contending that the lack of qualified translators greatly attributes to their failure to access suitable health care assistance. They note that the refugee camps perpetuated by violence, diseases, and deplorable conditions, further disseminate the environment the refuge-seekers fled; a contention that the authors share with my writing. Similar to the arguments captured by my study, the authors observe that refugees have a greater possibility of suffering from mental disorders, and for medical professionals to administer the appropriate assistance, there is a need to first understand their medical history, and adopt a culturally-sensitive health care approach. My paper argues that, whereas less attention is afforded to refugees' health needs, mental and psychological assistance falls short of Kenya's concern, and with the minimum available assistance, various impediments to its access remain unresolved.

[55]Kristina M. Adams et al., 'Healthcare challenges from the developing world; Post-immigration refugee medicine' (2004) *BMJ: British Medical Journal* vol. 328(7455) pp. 1548-1552 <www.jstor.org/stable/41708113> accessed 18 May, 2020

[56]DiVito, Brittany et al., 'A Collaborative Approach to Promoting Continuing Care for Refugees; Philadelphia's Strategies and Lessons Learned' (2016) *Harvard Public Health Review* vol. 9, pp. 3-7 <https://www.jstor.org/stable/48503135> accessed 29 June, 2021

In their writing, *Divito, B., Payton, C., Shanfeld, G., Altshuler, M., and Scott, K* reason that the delay and consequent failure to access medical care by refugees is partly attributed to language barriers, lack of a screening system, and navigation through the foreign healthcare system. However, as will be further expounded through my study, the authors have ignored the fact that the international community is partly to blame for refugees' failure to access health care aid based on their ignorance of the notion of responsibility and burden sharing, advocated for in the 2016 New York Declaration. The authors are silent on the remedies that can be taken into consideration by refugee host states to permanently resolve this healthcare predicament – an angle that this paper will extensively deliberate on.

The trio, *Kanyiva M., Blessing M., & Alice S.*,[57] observe that undocumented refugees residing in Kenya's urban settings find themselves ineligible for healthcare assistance, with humanitarian agencies basing their concentration on camp residents. The authors note that health issues, including hypertension, significantly rise with the duration of refugees' stay in camps, as compared to their arrival, with only a selected few gaining access to specialized treatment. The three further stress that refugees are living in leaky and unhygienic rooms, with inadequate availability of clean water and proper hygiene. They turn the focus to the extent of hostilities faced by urban refugees in Kenya. The writers assert that refugees relying on informal trading to make a living find themselves harassed by officials and host communities. Based on the observations made in their writing, I argue that the deplorable living conditions and hostilities subjected to refugees are detrimental to their wellbeing. On this view, my study perceives a gap that Kenya as a signatory to the 1951 Refugee Convention, its 1967 Protocol and International and Regional Human Rights

[57] Kanyiva, Muindi *et al*., 'Dismantling Barriers to Health and Wellbeing for Nairobi's Refugees' (2019) *IIED Briefing Papers* pp. 1-3 <https://pubs.iied.org/17714iied> Accessed on 12 June, 2021

instruments, including UNHCR as a fully mandated refugee protection institution, has failed to bridge, extending the negative impact on refugees' health status.

This paper argues that, despite being guided by the commitment to fulfill its obligations as set out in the African Charter on Human and Peoples' Rights, Kenya's efforts to secure health care access for refugees within its jurisdiction, are strained in several instances. *Paul Odongo*[58] reiterates that humanitarian assistance in the camps constituting the Dadaab refugee complex has considerably declined. The author echoes the cries of refugees in Dagahaley camp who have lived within for over three decades, with inadequate access to food and specialized medical care, adding that for the manual works the refugees are engaged in, the remuneration is 'nothing short of an assault to human dignity.

Odongo notes that the conditions of the camp, which the residents insist have been made difficult as a means of compelling their repatriation, have gravely affected the refugees' mental and psychological well-being, with cases of suicide attempts, trauma, and depression piercing through the camps. In my writing, I argue in line with Odongo's views that the Kenyan government, working closely with the international community should take urgent action to foster refugee integration as a means to secure their basic needs, and specialized medical aid. The absence of practical implementation of policies that favor refugee integration and inclusion by Kenya, as a means to secure health services utilization is a clear gap, and grounds for reform are vitally necessary, towards the realization of the Global Compact on Refugees' commitments.

[58] Paul, Odongo, 'Shut Out and Forgotten: Refugees in Dadaab Appeal for Dignity' (2019) <https://www.msf.org/forgotten-refugees-kenya-dadaab-camps-appeal-dignity> accessed 12 June, 2021

Similarly, *Sikanyiso Masuku* & *Sizo Nkala*[59] contend that despite their financial incapacity, the African continent is overwhelmed through hosting over a third of the global refugee populaces, forcing host states to utilize their little resources to safeguard the needs of those they welcome. Citing relevant international and regional legislations, the duo notes that, despite the global recognition of refugees' entitlement to health, the main reason why African states do not adhere to international human rights and humanitarian laws, is accredited to their misinterpretation of the 1967 Protocol, which settles that state parties are only bound by the 1951 Convention. As my study will later reflect the authors' observations, I contend that African refugee host states like Kenya typically rely on food supply and medical aid, including the construction of healthcare facilities from civil society organizations and humanitarian partners such as UN agencies, who have *de facto* assumed the role of host countries, with little to no efforts from the obligated states.

In investigating the current conditions of the Dadaab refugee complex, my study argues that the refugee resettlement areas, despite being initially established to temporarily host refuge seekers, for three decades now, refugees live indefinitely in the deplorable surroundings, without any improvements to its infrastructure or living conditions, presenting a myriad of risks to their welfare. The authors in their analysis argue that the persisting appalling conditions of refugee camps in Africa are attributed to underfunding by the host governments who lack respect for, and adherence to international laws. Agreeing with the authors' arguments, the last Section of this study argues that an empowerment program should be adopted by Kenya in an attempt to enable

[59] Masuku, Sikanyiso, and Sizo Nkala, 'Patterns of the Refugee Cycle in Africa: A Hazardous Cycle with No End in Sight?' (2018) Journal of African Union Studies vol. 7(3) pp. 89–92 <https://www.jstor.org/stable/26890366> accessed 13 June, 2021

refugees' management, while at the same time reducing the burden of its health system, fostering the achievement of sustainable peace for the refugee communities.

According to *Cathryn Lamb* and *Mitchell Smith*,[60] there are adverse refugee medical needs that arise from conflict, including persecution plight, and need specialized care. They note that language is by far the main barrier to healthcare access, with misinterpretations resulting in misdiagnosis, forcing medical officers to turn away refugees in need of medical assistance. As depicted through the next chapters of my study, the duo also identifies lack of awareness on medical services availability, financial constraints, and mistrust of medical personnel as barriers impeding most refugees' access to quality medical care, especially for traumatized victims of persecution and torture from authorities.

The pair argues that failure to access quality medical care aid is not owed to refugee patients entirely, and that host governments' health systems play a huge role in this health care catastrophe. Adopting the writers' opinions, my study argues that many refugee patients in Kenya's resettlement areas lack access to quality and specialized medical treatment since such aid is unavailable within the remote areas where camps are situated. Cathryn and Mitchell contend that the failure of health systems to administer appropriate medical aid is relatively accredited to health officers' incompetence in adopting treatment that is accommodative of victims of persecution. From this understanding, this paper argues that the absence of culturally sensitive treatment,

[60] Cathryn, Finney Lamb and Mitchell, Smith (2014) 'Problems Refugee Face When Accessing Health Services' *NSW Refugee Health Service* vol. 13(7), pp. 161-2 <https://www.phrp.com.au/wp-content/uploads/2014/10/NB02065.pdf> accessed on 11 June, 2021

coupled with high levels of discrimination of the marginalized, Kenya's health system is likely to prompt less access to healthcare services by refugees.

1.9 Justification of the Study

Despite refugee laws and policies being grounded on resolving the refugee *crisis*, and securing fulfillment of basic human entitlements, decades later and violations still endure. Evidently, at present, refugees from multiple countries across the globe no longer seek asylum merely as a result of war, but for various other reasons. The escalation of refugees, and the upsurge of reasons why the number of refugees keeps on increasing exhibit the need to look into and evaluate the current conventions, protocols, other multi-lateral treaties, as well as municipal laws, to enhance effective protection of refugee rights. This particular class of immigrants generally encounters many life-altering complications in their migration journeys towards asylum. Despite their great contribution in stimulating the global economy, refugees, particularly those in low-income countries like Kenya, are exposed to inhumane living conditions, with insufficient availability of food, clean water, and health assistance: issues that pressingly require intervention to prevent lifelong consequences that would impede their potential.

Kenya does not give health care the priority it requires. Refugees under its jurisdiction face various problems in accessing not only physical, but also mental, and psychological care. The notion of 'protection' emphasized in international refugee legislation is disregarded in this particular East African region, thus affecting refugees' utilization of healthcare resources. The Kenyan Government has rather mainly focused on providing minimum access to shelter and food, with little to no regard for the populations' internal sufferings. The state's commitment to achieving

universal health coverage in line with its SDG agenda target 3.8 [achievement of global health equity, financial security, including access to quality and inexpensive health services, medications, and vaccinations] concerning its refugee population, is far from reality. This paper scrutinizes refugees' dilemma in gaining access to appropriate medical care vis-à-vis Kenya's obligations as contained in the preexisting regulatory frameworks for their protection, thereby recommending practical resolutions.

1.10 Methodology

Like much legal research has for decades been dominated, this study was exclusively doctrinal. The methodology employed in this paper was secondary research that was based on conducting library investigation of books, articles, online journals, legislation, reports, websites, etc. The distinct information gathered from these sources was compared and contrasted to give validity and credibility to the research. The study took a descriptive approach to the refugee health care situation in Kenya. Despite not adopting a comparative technique, this study has relied on countries with better lessons and rather positive experiences in realizing refugees' health care needs, to highlight the line of divergence surrounding Kenya's compliance capacity.

1.11 Limitations of the Study

Particularly, this research paper seeks to examine Kenya's compliance with the preexisting refugee frameworks in the context of its obligation to protect and promote refugees' access to health care. The data analyzed by this study relies upon secondary research methods. Since it is a purely legal study, the objective will focus on how the applicable legislations, both international, regional and national, including institutional frameworks, and UN policy guidelines have proved ineffective in

practically securing Kenya's compliance in providing the "highest attainable standards of health" for the refugee communities hosted. The study will pursue to investigate the gaps and challenges impeding refugees' utilization of health care resources, and further recommend strategies that target an absolute and pragmatic diagnosis.

Whereas a considerable number of refugees have relocated to urban centers, this research paper *mainly* concerns those residing in the north-east [Dadaab complex] and north-west [Kakuma camp and Kalobeyei integrated settlement] parts of Kenya. Since this study is doctrinal, it does not provide, nor does it represent the full picture of all the general health complications and access barriers facing the refugee communities in Kenya. Nevertheless, most if not all refugees in third-world countries are likely to face similar dilemmas in the fight for their physical, mental, and social well-being. Noting the impossibility of reviewing all UN General Assembly Resolutions and Civil Society Organizations, this study will adopt a few for illustrative purposes.

1.12 Chapter Breakdown

The flow of this study will be based on five (5) correlated sections as deliberated below.

Chapter 1: Introduction

This chapter embarks on introducing the research topic. It proceeded to set out the tone and rationale of the study by explaining the nature of the setback. Here, I explained the theoretical basis of my study and recognized the relevant literature. I have gone ahead to predict the outcome of the study by hypothesizing that a discrepancy exists between Kenya's implementation of refugees' right to health in theory and realistically.

Chapter 2: The Frameworks for Refugee Protection – *A Healthcare Evaluation*

This chapter will venture into discussing the refugee regulatory frameworks in light of their protection of refugees' health rights. It will advance to identify the international, regional and municipal frameworks binding Kenya to its obligation to protect refugees' healthcare entitlements. Further, the chapter will consider the correlation between non-refugee instruments, i.e. international human rights instruments, and international humanitarian laws in respect of securing refugee health protection. The UNHCR as the core institution tasked with the mandate of protecting refugees will be looked at in this section.

Chapter 3: Impediments to Health Care Access

In this chapter, I will proceed to analyze the refugee health complications highlighting the gaps and challenges restricting their access to medical care and services. I will further my discussion by scrutinizing the various problems asylum-seekers grapple with in the face of persecution and later analyze the different categories of health problems and obstacles they encounter in resettlement areas. This section resolves to deliberate on the various barriers restricting refugees' access to the available health care assistance, including examining how the COVID-19 pandemic has negatively influenced healthcare rights for Kenya's refugee camp residents.

Chapter 4: Strategies Targeted at Remedying the Refugee Health Care Dilemma

In this section, I will look into the strategies, which, if implemented by the Government's relevant sectors, including local and international actors will remedy refugees' health access problems. I

commence the discussion with an analysis of the legislative interventions that, if successfully enacted and practically executed, universal access to top-notch healthcare services can be attained, towards the achievement of SDG '3'. I will further proceed to review the social interventions, noting that health determinants are critical to the general well-being of individuals, and securing the protection of refugees' healthcare entitlements, primarily targeting its availability, while suggesting necessary reforms, and crucial advances. With lack of funds being a commonly identified barrier to health care access, particularly for developing host states, I will discuss the initiatives to remedy the refugee financial problem, including examining inclusion and integration as structural interventions aimed at culminating the refugee healthcare dilemma.

Chapter 5: Summary of Findings, Recommendations, and Conclusion on the Facilitation of Refugee Health Equity

In the ultimate section of this research paper, I proceed to test the hypotheses as presumed and later proved throughout this study. I will further advance to give a summary, conclusion and based on the findings, offer recommendations aligned with the object and purpose of the analysis.

1.13 Conclusion

This first chapter has introduced the paper. I stated the background of the study, the research questions, and the aims, including the hypotheses. The section investigated the nature of the problem to be assessed by the end of this proposition. Some of the works of literature to be reviewed in this discourse have been indicated and their relevance to the study identified. Chapter two discusses the governing frameworks in place subject to the protection of refugees, assessing their relevance to Kenya's health care protection obligation.

CHAPTER TWO

THE FRAMEWORKS FOR REFUGEE PROTECTION: *A HEALTH CARE EVALUATION*

2.1 Introduction

This chapter examines the regulatory frameworks surrounding the protection of the entitlement to health care by refugees, particularly the instruments adopted by Kenya. This quest is based on the Universal Declaration of Human Rights provision that human rights are universal, inalienable – and are entitled to every human being, irrespective of where they are,[61] including the protection owed to refugees by the international community. Today, multitudes of refugee adults and children around the world lack access to medical care simply because they cannot afford it. Despite the existence of various provisions promoting this right legally binding upon refugee host states, access to health benefits remains a luxury in several (if not all) refugee host jurisdictions. Refugees' right to access healthcare assistance in Kenya is often curtailed, merely because they are outside the territories of their countries of origin, and cannot, therefore, demand its utilization.

As the world continues to witness a tremendous upsurge in the number of immigrants, ensuring that refugees gain access to health care services must be prioritized. Kenya has ratified international legal instruments to ensure respect for, including the promotion, protection, and implementation of individuals' health, terming it a "fundamental human right" established by international law. This however is not the case, precisely on the implementation aspect of it, as a large fraction of its refugee population still struggles to procure primary medical care. There are

[61] Universal Declaration of Human Rights (adopted 10 December 1948 UNGA Res 217A(III) (UDHR), Art. 2

various legal instruments approved by numerous states to enforce the implementation of every individual's entitlement to health. Kenya, for instance, has among others, adopted the 1966 International Covenant on Economic, Social and Cultural Rights, 1948 UN Universal Declaration of Human Rights (UDHR), Convention on the Rights of Persons with Disabilities, 2008, including the Constitution of the World Health Organization (WHO), 1946.

The Constitution, 2010, provides that, the general rules of international law shall form part of the law of Kenya, and that any treaty or convention ratified by it, shall constitute its law.[62] This entails that, just like any of its municipal laws, Kenya being a sovereign state is legally bound and must therefore seek to implement the provisions of any international legal instrument it voluntarily accedes to. As the provision in the 2010 Constitution that maintains access to the maximum available quality of health as a central socioeconomic right,[63] the WHO Constitution makes the same assertion, defining health to constitute "...a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."[64] Additionally, health being listed under the Constitution's Bill of Rights, including other municipal laws across the globe as constituting a dominant prerogative, same however seems to exclude refugees in its interpretation.

This chapter, therefore, seeks to examine the legal and institutional frameworks for the protection of refugees, with particular emphasis on access to health care services, and their relevance to Kenya's refugee protection cause. This section is divided into seven (7) parts: part one looks into the international legal frameworks governing refugee protection, citing the 1951 Convention and

[62] *See* supra note 38, Article 2(5) (6).
[63] *Ibid*, Article 43 (1) (a).
[64] Constitution of the World Health Organization, (adopted 17 November 1947, entered into force 7 April 1948) UN Doc A/RES/131, preamble, para 1

its 1967 Protocol as the only legally binding instruments under International Refugee Law. The second part discusses the regional frameworks for refugee protection binding Kenya, essentially, the 1969 OAU Convention Governing the Specific Aspects of Refugee Problems in Africa. Further, part three will look into the national laws that governments, within their respective jurisdictions adopt for the implementation of international refugee laws, in the context of this particular study, the 2006 Kenya Refugee Act.

Part four will proceed to discuss the international legal frameworks not exclusively defined as to form part of refugee law (non-refugee agreements), but which Kenya has ratified, and may therefore be invoked to justify its compliance with respect to the protection of refugees' [and all persecution survivors for that matter] entitlement to quality health care. The fifth part of this Chapter will dive into an analysis of the institutional frameworks governing refugees' health care, citing the World Health Organization (WHO) as the primary institution targeting global public health equity. Since it is relatively impossible to evaluate all refugee healthcare rights-related instruments within the diverse international law angles, I have selected a few International Human Rights and Humanitarian Law instruments for this purpose. The final part will undertake to discuss a number of Civil Society Organizations, highlighting their advances in procuring health care access for Kenya's refugee population.

2.2 The International Legal Frameworks

2.2.1 The 1951 United Nations Convention Relating to the Status of Refugees

In defining a refugee, Article 1(A) (2) of the Refugee Convention[65] posits that, "any person who is outside his country of citizenship, and due to a well-founded fear of being persecuted either on grounds of race, religion, nationality, is unable or unwilling to return to it or seek its protection", is considered a refugee. Essentially, it seeks to protect only safety seekers with a genuine fear of persecution based on grounds identified in its statutory definition. This implication, read along with Article 33, which obliges states not to return an asylum-seeker to where there is a danger of persecution, [the principle of non-refoulement] to some extent, creates a legal obligation to states regarding the treatment of asylum seekers by the international community.

However, some may argue that the Convention's definition of a "refugee" is inadequate since there are other reasonable grounds for *refugeehood* that the agreement fails to acknowledge. The author cites the incident of a Somali woman who was denied asylum in Uganda since her situation is not represented by the Convention's definition of a 'refugee'. *Laura Ferracioli*[66] argues that, despite not being acknowledged by the Convention, the woman's basis to flee Somalia, a failed state with no form of humanitarian and health care assistance leading to its citizens' starvation and deterioration of their well-being, is a basis that warrants inclusion in the refugee definition, hence an entitlement of protection. Further, Article 23 of the Refugee Convention maintains the obligation for member states to secure equitable access to public relief for the refugee population

[65] Convention Relating to the Status of Refugees (adopted 28 July 1951, entered into force 22 April 1954) 189 UNTS 137 (Refugee Convention), Art. 1(A) (2)
[66] Ferracioli, Laura, 'The Appeal and Danger of a New Refugee Convention: Social Theory and Practice' (2014) vol. 40(1) pp. 123-125<www.jstor.org/stable/24332266> accessed 15 May, 2020

legally residing within their territories. This implies that Kenya, as a signatory to the Convention is bound to ensure that the refugee communities it hosts are not deprived of the same standards of medical assistance as that it affords to its nationals. The statute essentially recognizes, although in a broad context, the health care entitlements of refugees as constituting an absolute human entitlement.

2.2.2 The 1967 Protocol Relating to the Status of Refugees

This piece of legislation was adopted to modify the 1951 Refugee Convention, complement it, and serve to bridge the protection gap for persons who did not fall within its scope. In effect, it was intended to confront the refugee occurrences that necessitated the adoption of the Convention in 1951,[67] with its significant achievement being the elimination of both time and territorial restrictions contained in the Convention. As generally misconceived, however, the Refugee Protocol is, though to some extent intertwined and said to be read alongside it,[68] entirely independent of the 1951 Convention. Undersigned states to the 1951 Convention are also legally bound to the 1967 Protocol without necessarily acceding to it.[69] Meaning that the 1951 Refugee Convention applies universally to all States who have ratified the Protocol[70] i.e. Kenya. These protection rights, along with providing refugees with legal status, including adhering to the principle of non-refoulement.[71] The 1967 Protocol is however silent on the protection of refugees'

[67] Ira L. Frank 'Effect of the 1967 United Nations Protocol on the Status of Refugees in the United States; The International Lawyer' (1977) vol. 11(2), pp. 291-4 <www.jstor.org/stable/40705096> accessed May 14, 2020
[68] Protocol Relating to the Status of Refugees (adopted 31 January 1967, entered into force 4 October 1967) 606 UNTS 267 (Protocol)
[69] *Ibid*. Art. 1
[70] For instance, the United States of America only adopted the Protocol and not the Convention but will still be constrained to handle refugees according to the required international standards
[71] *See* supra note 60, art. 33

health care entitlement, although such may be implied through its provision of Article 1 (1),[72] linking it to the generalized Article 23[73] of the 1951 Refugee Convention.

2.3 Regional Frameworks

2.3.1 The 1969 Organization of African Unity (OAU) Convention Governing the Specific Aspects of Refugee Problems in Africa

The need for a framework that seeks to provide amicable solutions to the refugee crisis, and a sense of security for refugees' fundamental rights were not only appreciated through embracing the 1967 Refugee Protocol, but also the 1969 OAU Convention.[74] Currently, the OAU Convention is the sole legally enforceable regional agreement central to refugee protection within the continent of Africa. The Convention, being a regional complement to the 1951 Refugee Convention, has adopted its definition, but widened its scope to include classifications of persons not recognized by the international instrument, like those eligible for grant of refugee status.

Notably, unlike the 1951 Refugee Convention and its 1967 Protocol, the OAU Convention is set more on humanitarian grounds by providing a larger scope to include asylum for those in desperate need.[75] Rooted on the essence of African *brotherhood*, the OAU Convention encourages the sharing of the refugee burden amongst African member states to prevent overwhelming a country unable to take in more refugees into its territory:[76] a position not suggested by the 1951

[72] *See* supra note 66, Art. 1 (1) provides that, "The States Parties to the present Protocol undertake to apply articles 2 to 34 inclusive of the Convention to refugees as hereinafter defined."
[73] *Ibid*. Ar.t 23 provides that, "The Contracting States shall accord to refugees lawfully staying in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals."
[74] Organization of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa (adopted 10 September 1969, entered into force 20 June 1974) 1001 U.N.T.S. 45 (OAU Convention)
[75] *Ibid*, Art. 2
[76] *See* supra note 69, preamble para 8

Convention. Nevertheless, the Convention encourages Kenya's [and all member states] cooperation with the United Nations High Commissioner for Refugees (UNHCR) on any matters involving refugees, including the execution of the right to health for the communities hosted.[77] This, along with its humanitarian mandate to secure the realization of refugee rights – though not expressly provided for within its provisions – implies member states' assurance to additionally encourage and promote refugees' access to health care services,[78] indiscriminately.[79]

2.4 United Nations General Assembly Resolutions

2.4.1 The 2016 New York Declaration on Refugees and Migrants

Through a United Nations General Assembly (UNGA) decree of 19 September 2016, all UN state parties [Kenya included] unanimously approved an instrument that sought to address the concerns facing refugees and migrants. The document that is hoped to revolutionize the international community's engagement with refugees, seeks a comprehensive approach to respond to refugees' concerns, particularly defending their human rights entitlements outside their countries of origin. While host states, UN agencies, and local civil society organizations are primarily the main supporters of refugee populations, the Declaration[80] lays the ground that supporting the refugee communities sheltered in third states is an international obligation that is [or rather, should be] borne equitable by all member states, as a means of satisfying the purpose of the 1951 Refugee Convention.[81] Recognizing the contributions made by the international humanitarian community in all professional spheres, and reaffirming the purposes, and objectives of the UN Charter, and

[77] *See* supra note 70, Art. 8
[78] *Ibid*, preamble, para 6
[79] *Ibid*, Art. 4
[80] The New York Declaration on Refugees and Migrants (adopted 3 October 2016 UNGA Res A/RES/71/1)
[81] *See* supra note 79, para 11

UDHR,[82] states by the adoption of this instrument solemnly pledge adherence to its principles to safeguard and secure practical fulfillment of inherent rights found in International Human Rights, and Humanitarian Law Instruments.

The Declaration's elements, forming an all-inclusive refugee response framework[83] are formulated in a manner that guarantees support for host countries on matters concerning refugees' general protection, educational, and healthcare needs, to foster self-resilience, and ease states' burden. Unlike the preexisting refugee instruments designed to find durable solutions with minimum stipulations on the provision of humanitarian support, the Comprehensive Refugee Response Framework (CRRF) initiated by UNHCR, aims at providing a more efficient, and viable response intended at profiting both refugees and the host population. It aims at practically mobilizing states' financial funding to cover for the humanitarian needs of refugees and migrants residing in third states,[84] through defending global solidarity, and their inclusion in the 2030 Sustainable Development Agenda.[85]

2.4.1.1 Global Compact on Refugees, 2018

Along with setting out the Comprehensive Refugee Response Framework (CRRF)[86] and urging its practical implementation, in 2016, the New York Declaration called upon the Refugee High Commissioner to propose what we now have as the Global Compact on Refugees.[87] The document, though not legally binding seeks to encourage UN member states' contribution of skills and

[82] *See* supra note 76, para 8
[83] *See* Supra note 67, Annex I
[84] *See* supra note 74, para 6 (a)
[85] *Ibid*, para 16
[86] The CRRF as adopted by UNGA sets out member states' commitments on dealing with large refugee influxes.
[87] Global Compact on Refugees (adopted on 17 December 2018 UNGA Res A/RES/73/151)

resources, by upgrading medical care facilities and strengthening health systems to enhance host states' health standards, and to facilitate the realization of refugees' health rights, along with the local communities that welcome them. This voluntary yet robust inter-governmental agreement seeks to build upon the international refugee frameworks through actively strengthening the support system for refugees, as well as host states and governments.[88]

It responds to one of the key gaps found in the 1951 Refugee Convention and its 1967 Protocol. A gap that, to an extent justifies the inability of poor host countries to fully meet refugees' protection needs, including maximizing the realization and enjoyment of their right to health: unlike the legally binding frameworks, the Global Compact on Refugees, in line with the principle of state sovereignty, specifies on how states can equitably share the refugee burden and responsibility. Successful implementation of it is that Kenya will have the financial resources adequate to comply fully with its refugee health directive. In principle, this Compact seeks to provide either a stronger global response to millions of refugees accommodated in economically stressed countries, where the entire international community acting in solidarity, supports refugees through taking them in, or investing in them while hosted in third countries. The instrument is guided by the idea of "*helping refugees thrive*", in that, the durable solution to the refugee problem being sought since the adoption of the 1951 Refugee Convention, can be achieved through a burden and responsibility sharing arrangement that promotes refugee self-reliance, while at the same time benefitting them, and the locals alike.[89]

[88] Kate Mlauzi and Michelle Small, 'Is the Global Compact on Refugees Fit for Africa's Purposes?' (2019) *South African Institute of International Affairs* <www.jstor.org/stable/resrep25889 > accessed 29 August 2021

[89]Asmita, Parshotam, 'The UN Global Compacts on Migration and Refugees: *A New Solution to Migration Management, or More of the Same?*' (2017) *South African Institute of International* Affairs, pp. 2-5 <www.jstor.org/stable/resrep25910> Accessed 23 August 2021

2.4.1.2 Global Compact for Safe, Orderly and Regular Migration, 2018

This Compact[90] is the first of its kind: an inter-governmentally negotiated agreement that comprehensively covers all corners of global migration, in line with target 10.7[91] of the 2030 Sustainable Development Goals. Non-binding in character, the agreement between United Nations member states acknowledge respect for states' sovereignty, while at the same time encouraging international cooperation. Affirming that refugees and migrants are two separate groups regulated by distinct legislative structures, this global mechanism maintains that they are equally entitled to fundamental rights and liberties, and reserve the right to its respect, enjoyment, and protection.[92] The Global Compact on Migration[93] provides an inclusive framework that addresses migration in all dimensions.[94] The instrument seeks to encourage global cooperation for all migrants – as opposed solely to refugees – in a safe and orderly manner that secures the protection of their central human rights, including the availability, and accessibility of quality medical care, while still upholding states' sovereignty. As the Global Compact on Refugees, both serving as complementary international refugee frameworks,[95] this particular instrument also seeks to improve international cooperation in addressing human mobility,[96] thus aiming at improving migration conditions through availing sufficient healthcare access for migrants.

[90]Global Compact for Safe, Orderly and Regular Migration (adopted on 19 December 2018 UNGA Res A/RES/73/195)
[91] SDG Target 10.7 calls upon governments to facilitate safe and orderly migration, including enhancing human mobility, through implementation of strategic migration policies
[92] *See* supra note 83, para 4
[93] 152 States approved the Global Compact on Orderly, Safe and Regular Migration while 12 States including Algeria, Australia, Libya and Italy abstained, and 5 states among them Poland and the United States of America voted against its adoption.
[94] Jane, McAdam 'Global Compact for Safe, Orderly and Regular Migration' (2019) *Jane, McAdam 'Global Compact for Safe, Orderly and Regular Migration'* vol. 58 (160), pp. 160-163
[95] *See* supra note 71, preamble
[96] *Ibid*

2.4.2 Declaration of Alma-Ata, 1978

This instrument is an important breakthrough towards the promotion of public health access by the international community. While reaffirming the WHO Constitution's definition of 'health', the Declaration, though merely persuasive urges states and governments, as well as funding organizations to prioritize health as a fundamental human right through inter-sectoral efforts aimed at securing its highest quality possible.[97] Criticizing the deteriorating health care situation of developing countries, states, including Kenya, adopting this framework view the prevailing health situation as necessitating immediate intervention by the global community, collectively, as a means to secure development. Notably, the Declaration focuses on states' overall population without exclusion of its refugee residents.

However, over four decades since its inception, Kenya's current refugee health system is adequate proof of its failed commitment to this 20th Century health promotion instrument it pledged implementation. As recently echoed by the New York Declaration, this intergovernmental framework advises on the need to procure an availability and adequacy of socially tolerable measures essential to enable individuals to lead a productive life.[98] Noting that public health education is an essential tool in securing health equity, states commit to advancing inter-sectoral approaches tailored towards safeguarding communities' development and self-reliance by application of extensive research and relevant health care experience.[99] The 1978 Declaration

[97] Declaration of Alma-Ata : International Conference on Primary Health Care, Alma Ata, USSR (adopted 6-12 September 1978) (Alma Ata Declaration), para I
[98] *See* supra note 71, para V
[99] *See* supra note 92, para VII

urges cooperation between states, and relevant agencies to make use of the available resources, formulate and implement policies, and action plans sustainable to its national health systems, as a basis for achieving universal health equity.[100]

2.4.3 The Ottawa Charter for Health Promotion, 1986

Thirty-five years later and the Ottawa Charter[101] [hereafter referred to as "the Charter"] still sustains its relevance as a core health promotion framework. Reflecting on public health as a human right,[102] the international agreement maintains that good health is crucial for development adding that, an individual's general wellbeing is dependent upon complex and interconnected social determinants and not merely on the availability of – or access to – medical resources. Grounded on the need to prioritize and endorse equitable health care access for both gender populations, the instrument sets out that, governments, health ministries, civil society organizations, and other relevant participants, should undertake the health promotion prospects, collectively.[103] The Charter seeks to promote inter-sectoral cooperation contending that such responsibility to foster health equity does not rest entirely upon the health sector. The agreement sets out action areas that states, including Kenya, should implement to promote health within their territories. It contends that policy-makers in all sectors must adopt healthy rules in recognition that the decisions they make in their respective sectors are incidentally consequential to health.[104]

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[100] *See* supra note 93, VIII and IX
[101] The Ottawa Charter for Health Promotion (adopted on 21 November 1986 1st WHO Conference on Health Promotion) (Ottawa Charter)
[102] Paul, Hunt and Gunilla, Backman 'Health Systems and the Right to the Highest Attainable Standard of Health' (2008) *Health and Human* Rights vol. 10(1) 81-4 <www.jstor.org/stable/20460089> accessed 29 June 2021
[103] *See* supra note 90, on Call for Action
[104] *See* supra note 96, on Health promotion action means

The pact reiterates the need for states to establish a system that fosters community development – a vigorous environment that supports and nurtures good health – as a means of strengthening health care access. Through this, Kenya as one of its participating member states concurs that encouraging individuals' social support by enabling them, through providing learning opportunities and funding, including enhancing their skills in all settings, health equity can be secured.[105] It further insists that the role of a health system is not merely to provide medical resources, but also to foster initiatives that level towards the promotion of health.[106] Fixated on the need to prevent rather than treat, the Charter urges states to adopt a culturally-sensitive health system that adopts a preventive rather than a curative approach, and one that ensures inter-sector cooperation between the government, individuals and groups, health practitioners, including medical institutions, as a means of improving health.

2.4.4 The Bangkok Charter, 2005

The Bangkok Charter [henceforth referred to as "the Charter"] presupposes that promoting the inherent entitlement to health is a key social and economic investment for any state.[107] The texts identify the social determinants of health as having a great impact on an individual's general well-being while recognizing the fact that its improvement is crucial towards the attainment of universal health equity. Consequent to the 1986 Ottawa Charter for Health Promotion,[108] this Charter recognizes and upholds the need to enable people to personally influence and better their wellbeing, emphasizing the necessity of securing equal opportunities for welfare.[109] The agreement

[105] *See* supra note 97, on Prerequisites for health
[106] *See* supra note 93
[107] The Bangkok Charter for Health Promotion in a Globalized World (adopted on 11 August 2005 6th WHO Conference on Health Promotion WHO/NMH/CPH/09.01) (Bangkok Charter), Purpose.
[108] *See* supra note 77
[109] *See* supra note 96, on Health Promotion

by the World Health Organization proposes the need for states to, as greatly as possible invest in the health determinants as a means to guarantee universal healthcare access. While noting that the provision of health determinants is crucial for a healthy population,[110] adopting states agree that, the achievement of health literacy through education and community empowerment is fundamental to the advancement and execution of health as a prerogative. Like its preceding agreements, including the 1997 Jakarta Declaration,[111] the Charter maintains that state cooperation through deference to human rights and solidarity is a prerequisite to building sustainable policies and actions for advancing health in the modern era.

2.4.5 The Executive Committee's Programme of the United Nations High Commissioner for Refugees

The Executive Committee (ExCom) Programme of the UNHCR which succeeded the 1958 Executive Committee of the United Nations Refugee Fund (UNREF) in 1959, was established [under GA Resolution 672(XXV)][112] by the Economic and Social Council (ECOSOC). Its directive involves promoting international protection of refugees' rights while seeking to find durable solutions to their dilemma. ExCom recommends that refugee host states like Kenya should approve projects aimed at protecting refugees, including those relating to their health, and proceeds to urge the international community to contribute funds that would be used to assist Refugees worldwide. Its annual conclusions, relative to the 1951 Convention's provisions, and adopted through a consensus between state representatives with a particular interest in refugee protection,

[110] *See* supra note 103
[111] The Jakarta Declaration on Leading Health Promotion into the 21st Century (adopted on 25 July 1997 4th WHO Conference on Health Promotion WHO/HPR/HP/4ICHP/BR/97.4) (Jakarta Declaration)
[112] UNGA Res 672 (XXV) (30 April 1958) UN Doc E/RES/672

though non-legally binding in nature, may form part of a country's national refugee protection framework.

For instance, in ExCom No.103 (LVI) of 2005, the High Commissioner reaffirms the enjoyment of fundamental human rights indiscriminately, while advising states to complementarily safeguard refugees' rights. It advances to urge states to, in relevant instances, accord the same level of protection to individuals overlooked by the 1951 Convention and its 1967 Protocol, without excluding those not falling within the "refugee" definition, as a means of actively responding to international refugee protection demands. Regarding the execution of the 1951 Convention and its subsequent Protocol, the Executive Committee's Conclusion No. 57 (XL) of 1989 urges member states to eliminate any legislative barriers that may hinder the full implementation of the refugee instruments. Essentially, the Conclusions further call upon refugee host states to prioritize and accord victims of sexual mistreatment adequate access to culturally friendly physical and psychological care, and assistance.[113]

2.5 National Legislations

Together with the laws formulated by their respective legislators, Governments generally incorporate both binding and non-binding international law provisions relating to refugees, into their national legislations. Likewise, in addition to the international and regional frameworks governing refugee protection, and in exercising its sovereignty, Kenya has adopted municipal legislation to govern refugee protection within its territory. These laws are grounded on the protection of refugees taking into account human rights standards and provisions, in the realization

[113] UNHCR EXCOM Conclusion No. 73 (XLIV) 'Refugee protection and sexual Violence' (1993)

of their healthcare needs. For Kenya, the existing legislation regulating recognition and protection of refugees is the Refugees Act no. 13 of 2006, with health care being predominantly recognized by the ultimate order – the Constitution of Kenya, 2010. It is noteworthy that the Refugee Act excludes the right to health in its refugee protection provisions, proving that the same is presumed through ratification of the 1951 Convention and its subsequent Protocol, particularly Article 23 of the former, including its "supreme law", and Article 12 of the International Covenant on Economic, Social and Cultural Rights.

2.5.1 The Constitution of Kenya, 2010

Article 2(5) and (6) of the 2010 constitution is to the effect that, "the general rules of international law shall form part of the law of Kenya", reiterating that "any Treaty or Convention ratified by Kenya shall form part of its law". This creates the implication that, based on Kenya's adoption of, among other International Human Rights instruments, the International Covenant on Economic, Social and Cultural Rights (ICESCR) in addition to the 1951 Refugee Convention and its 1967 Protocol, the relevance of these texts, having achieved the status of *jus cogens*[114] apply wholly to its jurisdiction. Under its Bill of Rights, while adopting the wordings of the ICESCR [Article 12] categorizing health as an economic and social right, the Constitution, 2010, maintains that, an individual reserves the right to "the highest attainable standard of health care services" along with reproductive health, adding that the same includes the right to access emergency medical assistance.[115] Its Chapter Four asserts that the justification behind the acknowledgment of

[114] Deepriya, Snehi, 'Right to Health: An Enforceable International Obligation?' (2020) *Cambridge International Law Journal, Edward Elgar Publishing* <http://cilj.co.uk/2020/07/15/right-to-health-an-enforceable-international-obligation/> (accessed 29 June 2021)
[115] Constitution of Kenya, 2010. Article 43 (1) (a) and 2

fundamental rights protection is particularly grounded on Kenya's need to preserve human dignity and promote social justice, including fostering the realization of individuals' potential.[116] This specific provision, being in line with the principles of international law and human dignity, hypothetically translates to safeguarding refugees' access to quality medical care equivalent to that of Kenyan nationals.

The Constitution proceeds to entitle individuals to the fundamental rights and freedoms contained under the Bill of Rights, to the maximum level compatible.[117] Further, seconded by Article 19 (3) which assures that the rights are inherent and therefore not privileges accorded by the state, health as an entitlement contained in the Constitution, 2010, is relevant to all persons indiscriminately – notwithstanding their nationality, financial situation, or legal status. Read together with Article 2 (5) and (6) with respect to Article 43 (1) (a) and (2), this provision proves Kenya's affirmation of its responsibility of securing and ensuring the refugee communities legally residing within its territorial boundaries have equitable access to quality and affordable health services pertinent to their medical needs. Additionally, by recognizing the need for a healthy nation, with particular consideration to its population's well-being, the mother law, adopting the universal Bill of Rights[118] undertakes to fulfill[119] the obligations under it – without exclusion of refugees' health entitlements.

Essentially, the Constitution 2010 theoretically guarantees, to the maximum degree all individuals, including refugees *legally* within the Kenyan territory access to health services. It seeks to promote

[116] *See* supra note 111, Article 19 (2)
[117] *Ibid*, Article 20 (2)
[118] *Ibid*, Chapter IV
[119] *Ibid*, Article 21

their equitable utilization of quality health care services,[120] with adequate availability of its social determinants, including emergency medical attention to all persons equally before the law, along with the protection and enjoyment of other fundamental rights. However, the legislation[121] does not, as per Article 25 include health as a fundamental right that cannot be limited by its provisions.

2.5.2 The Refugees Act, Kenya (2006)

As a Social and Economic right enshrined within its Constitution,[122] the Government of Kenya (GoK) recognizes individuals' right to procure the *highest attainable standard of health*, as well as the right to obtain quality reproductive health assistance.[123] Similarly, having been adopted commensurate with international law principles, and consistent with the 1951 Refugee Convention and its 1967 Protocol, the 2006 Refugee Act regulates all matters regarding refugees within Kenya's jurisdiction.

The Act has adopted both the 1951 Convention and the 1969 OAU Convention's definition of a refugee (Kenya being a signatory of both Conventions). The Statute[124] provides for the reception, registration, and adjudication of refugees[125] as an initiative the country undertakes in ensuring the utmost protection of their fundamental rights. It is noteworthy to mention that, the law does not make provision for refugees' entitlement to medical care, nor does it declare its health care

[120] *See* supra note 84, Art 43 (1)
[121] *See* supra note 87
[122] *See* supra note 84, Art 43(1)(a)
[123] *Ibid*
[124] Kenya: The Refugees Act No. 13 of 2006
[125] *Ibid*, Refugees (Reception, Registration and Adjudications) Regulations, 2009 PART I – PRELIMINARY [L.N. No 24/2009]

obligation towards the population. However, by implication, it can be construed to be mindful of refugees' medical claims.

2.6 Non-Refugee Legal Frameworks

Similarly, there are legal instruments that are not directly ascribed to refugees' protection but, based on their human rights principles and humanitarian nature, advocate for and make provisions safeguarding the health rights of victims of armed conflicts, including refugees, globally.

2.6.1 International Human Rights and Humanitarian Law Instruments

Understanding that Kenya's obligations under international law are superior to the rights and duties of its municipal law,[126] this study recognizes international human rights and humanitarian law legislations acceded to by Kenya and binding upon its obligation on refugees' health entitlements. Aside from Conventions and Statutes that expressly provide for the protection of Refugees, there are other legal mechanisms [ratified by Kenya and therefore binding] that aim at guaranteeing health care protection for victims of armed conflict by third states. These humanitarian approaches aim at ensuring armed conflict survivors, such as refugees, are accorded international support, and are treated based on principles of humanity. Laws on refugees can be said to encompass both humanitarian law and human rights principles.

Article 5 of *The Convention on Elimination of all Forms of Discrimination against Women* (CEDAW)*[127]* prohibits states' discrimination against persons of the female gender. While

[126] Thomas, Beurgenthal & Sean D., Murphy, 'Public International Law in a Nutshell' (2014) *West Academic Publishing* (5th Ed.), United States of America.
[127] Convention on the Elimination of All Forms of Discrimination Against Women (adopted 18 December 1979, 3 September 1981) 1249 UNTS 13 (CEDAW)

emphasizing their entitlement to the same rights and treatment as men, CEDAW, as portrayed in the 1951 Refugee Convention, also seeks to ensure equal access to social services, including equitable and standardized medical care assistance for both genders, indiscriminately. In reality, not only does CEDAW provide for women's rights in the area of health,[128] the Convention stipulates various measures targeted at facilitating the realization of access to quality health through making provision for health-related education, family planning, including pregnant and breastfeeding women,[129] by ICESCR [Article 12(1)]. In addition, the universal safety and fair treatment of individuals with special needs, including disabled refugees' access to health assistance and patient-friendly facilities, is assured through Kenya's adoption of the *Convention on the Rights of Persons with Disabilities.*[130] The Convention provides a non-exhaustive record of measures to be effected to ensure utmost compliance with health rights, most of which Kenya is yet to secure for its refugee population.[131]

Another human rights treaty credible to the protection of refugees' health care entitlements under the international legal frameworks is the *1989 Convention on the Rights of the Child (CRC).*[132] This agreement serves to protect the rights and fundamental freedoms of all children globally, without distinction as to gender, race, religion, or nationality. While securing every child's access to quality health,[133] as well as urging states to eradicate child mortality,[134] the Convention guarantees and emphasizes international cooperation to ensure respect for, promotion, and

[128] *See* supra note 123, Art. 12
[129] *Ibid*, Art. 10 (h), Art. 11 para. 1 (f) and 2 (d), Art. 14 para 2(b)
[130] Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) UNTS 2515, 3 (CRPD)
[131] *Ibid*, Art. 25
[132] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) E/CN.4/RES/1990/74 (CRC)
[133] *See* supra note 127, Article 24
[134] *Ibid*, Article 24 (2) (a)

protection of every child's right [including refugee children] to proper nutrition, hygienic conditions, and health care services.[135] Further, The *African Charter on Human and Peoples' Rights* (Banjul Charter),[136] a regional Convention governing the African States, and parties to the Organization of African Unity (OAU), entitles every person access to the maximum standards of physical and mental health achievable, advising member states to facilitate measures aimed at fulfilling its populations' health care demands.[137]

Additionally, international human rights Conventions also incorporate stipulations regarding the right to health with respect to rather deprived or minority population groups, which may also be construed to include the refugee communities in Kenya. Article 5 of the *International Convention on the Elimination of All Forms of Racial Discrimination* (ICERD)*[138]* enshrines a non-discriminative entitlement to proper housing, public health, including social services and security.[139] In such situations, even though these Conventions are not generally identified as incorporating international refugee law, it can be said that humanitarian laws, international refugee and human rights laws are at some level co-related, and may equally be invoked to justify, promote, and protect the realization of refugee rights within member states' territories.

[135] *See* supra note 128, Article 24 (2) (c)
[136] African Union. African Charter on Human and Peoples' Rights (adopted on 27 June 1981, entered into force 21 October 1996) CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 ("Banjul Charter")
[137] *See* supra note, Article 16 (1) and (2)
[138] Convention on the Elimination of All Forms of Racial Discrimination (adopted 21 December 1965, entered into force 4 January 1969) 660 UNTS 195 (CERD)
[139] *Ibid*. Article 5 (e), para iii and iv

2.7 The Institutional Frameworks

2.7.1 The Office of the United Nations High Commissioner for Refugees (UNHCR)

Through its annual budget of approximately $1bn,[140] UNHCR has been able to employ over 17,000 staff[141] who aid the implementation of its humanitarian functions, as well as catering to refugee emergencies, promoting their access to food, shelter, clean water and healthcare services, including advancing the need for legal documentation of refugees in resettlement regions, globally. Similarly, UNHCR advises member states and Governments on the formulation of their respective refugee legislations and policies, thereby ensuring its conformity to the international refugee system. The Statute, which is merely recommendatory hence non-binding upon states, provides for the functions of the High Commissioner in its responsibility to universally safeguard refugees' safety. Its mandate includes facilitating states' endorsement of the 1951 Refugee Convention and 1967 Protocol, an action that aims at encouraging the admission of asylum-seekers to member states' territories, as well as recommending measures that would aid in finding permanent solutions to the universal refugee plight.

The Agency's station in Kenya, operating in line with UNHCR's international mandate understands that, despite refugees' need for productive legal assistance, there is an urgency to secure access to necessities, including medical care. Refugees find it difficult to access or afford the often-overstretched healthcare facilities, access basic education and other services relied on by the indigenous population. There is therefore a vital need for both adult and minor refugees to procure adequate and quality medical diagnoses, and treatment. The demand for equitable

[140] UNHCR, 'Update on Budgets and Funding (2020-2021)' (2020) *Executive Committee of the High Commissioner's Programme*, EC/72/SC/CRP.7, pp. 12-15.
[141] UNHCR 'Meet Our People' <https://www.unhcr.org/meet-unhcr-staff.html> (accessed 15 January, 2021)

healthcare is prioritized by the Refugee Agency in Kenya, by making health care access a key factor of its protection mandate.[142] UNHCR-Kenya essentially supports the advancement of systems aimed at expediting universal access to comprehensive health care. It targets that every refugee and asylum-seeker residing in Kenya gains access to standardized essential public health services within their resettlement regions.

Having the primary obligation to oversee assistance of refugees,[143] UNHCR-Kenya takes up the responsibility of ensuring that persons falling within its mandate can access essential, and specialized healthcare services within their areas of resettlement either directly, and or through partnering with international non-governmental organizations (NGOs), Civil Societies and other humanitarian agencies, including learning institutions. The Agency collaborates with its 'sister agencies like the United Nations Children Fund (UNICEF)[144] and World Food Programme (WFP),[145] including the UN programme on HIV/AIDS (UNAIDS), to ensure food security, healthcare assistance, and, that refugee children have access to nutrition services. For instance, in 2013, the WFP distributed food to over 2 million refugees in 23 African countries, with UNAIDS supporting victims of gender-based violence, and securing their access to appropriate treatment.[146]

[142]UNHCR, 'Public Health 2014 Annual Global Overview' (2015) pp. 1-3 (Geneva) <https://www.refworld.org/docid/5534a8194.html> accessed 31 May 2020

[143] Maynard, P. D., 'The Legal Competence of the United Nations High Commissioner for Refugees' (1982) *The International and Comparative Law Quarterly* vol. 31(3) pp. 415-418 <www.jstor.org/stable/758999> accessed 31 May 2020

[144] A United Nations agency that advocates for children's rights worldwide and strives to protect their well-being.

[145] An arm of the United Nations that ensures global food assistance in an effort to promote economic and social development, worldwide.

[146] UNHCR, 'Assistance to Refugees, Returnees and Displaced Persons in Africa' (2014) *Report of the Secretary-General*, UNGA A/69/339.

Additionally, through appealing for public health ministries and partnered agencies' donations, UNHCR promotes integration and sustainable medical services for persons under its mandate. The High Commissioner's office condemns discrimination by host states' governments in providing healthcare opportunities to migrants[147] and works on ensuring fair, and equitable distribution of medical resources. The Refugee Agency advocates for, and facilitates refugees' entitlement to health care services of standards similar [and, or at a cut-rate cost] to that of locals. Alongside the United Nations Population Fund (UNPFA),[148] as the agency that works to promote and protect, through gender equality, equal opportunities, and access to healthcare services for all, UNHCR meets refugees' medical needs by protecting them from sexually transmitted diseases, together with preventing unwanted pregnancies while in resettlement regions. Equity of refugees is attributed to UNHCR's effort in ensuring that vulnerable members of the refugee community get assistance for their special needs, by supporting the rationalization of health service providers.[149]

2.7.2 The International Organization for Migration (IOM)

Quoting the Chief of Mission in IOM-Korea,

"Migrants contribute to societies just as those societies enable them to survive and thrive."

As an International Organization currently holding 173 member states, and the Republic of Kenya being its first African state party, [150] IOM as a principal inter-governmental Organization unique

[147] Handlos Line Neerup, *et al*, 'Wellbeing or welfare benefits—what are the drivers for migration?' (2016) *Scandinavian Journal of Public Health* vol. 44(2) pp. 117-119 <https://journals.sagepub.com/doi/abs/10.1177/1403494815617051> accessed 1 June, 2020

[148] The UNFPA is "the lead UN agency for delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled – United Nations sexual and reproductive health agency" <https://www.unfpa.org/about-us>

[149] UNHCR, 'Ensuring Access to Health Care; *Operational Guidance on Refugee Protection and Solutions in Urban Areas'* (2011), pp. 25-28 <https://www.refworld.org/docid/4e27d8622.html> accessed 1 June 2020

[150] IMO, 'Members and Observers' <https://www.iom.int/sites/default/files/about-iom/members_observers_en.pdf>

from UNHCR,[151] is obligated, within its constitutional provisions to arrange for the orderly movement of vulnerable migrants with strict adherence to international law and human rights to welcoming states' resettlement zones.[152] Although the IOM Constitution does not specifically make provision for refugees' entitlement to health care access, the Organization engages in support of migrants' health and wellbeing, through providing special health assistance, along with conducting medical examinations at the request of either concerning third state. Through its regional offices in Kenya, health assessment services are conducted for asylum-seekers upon their application for *refugeehood* in member states within the EU, and or prior to resettlement in the receiving state.

It is important to note that, IOM, along with facilitating the movement of migrants to host states, facilitates the reception, and integration into resettlement states' national systems to safeguard refugees' rights, including health. Through its Migration Health Service (MHS) establishment, the Organization offers both physical and psychological medical services to all categories of migrants in over 100 countries. It engages in infection control and prevention schemes with the local health systems and service providers in refugee host countries to enhance integration,[153] including providing health assessment services on transit as a means to timely respond to migrant health concerns. This is to say that, while understanding that protecting the right to migration is equally compatible with promoting access to health services, the Organization serves to protect, and

[151] Unlike IOM, the UNHCR is mandated to provide global refugee protection, find lasting solutions to their plight, along with facilitating voluntary repatriation, foster local integration and resettlement in host states. During large displacements, UNHCR provides emergency relief assistance, including health care, clean water, proper sanitation and essential supplies.

[152] Constitution of the International Organization for Migration (IOM) (1953) 207 UNTS 189, 1560 UNTS 440, OXIO 564.

[153] IOM, 'Health Assessment Programmes: Migration Health Assessments and Travel Assistance' (2019) <https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/mhd_infosheet_hap_06.05.2019_en.pdf> accessed 18 May 2021

promote a non-discriminatory environment with equitable access to social services, along with healthcare for migrants, where they are treated with absolute regard to fundamental human rights, and dignity.

2.7.3 The World Health Organization (WHO)

As suggested by Maria Van Kerkhove, the World Health Organization's COVID-19 technical chief, healthcare needs to be accessible, not based on one's status, financial capacity, or nationality,[154] but rather as a fundamental human entitlement. Article 1 of the WHO Constitution[155] acknowledges its central objective to be the realization of the highest level of health to all people. The Organization, even as currently being witnessed as a result of the pandemic, has been at the forefront in securing medical assistance to millions of people in all countries affected by the epidemic without any form of discrimination, while still urging states to do the same. Its Constitution particularly advises states to rid of any discriminatory legal provisions and practices maintaining that, health being an inherent right, should be accessible to all. Working closely with sister organizations such as UNHCR, the World Health Organization[156] has managed to secure enhancement of social services, including medical care, suitable nutrition, and proper hygienic conditions for refugees and asylum-seekers, collectively.

For decades, the World Health Organization, in advocating for global health coverage, has worked closely with UNHCR to guarantee healthcare access to millions of refugees in host states and other

[154] *See* UNMigration Instagram post posted on 18 May, 2021, at <https://www.instagram.com/p/CPAVGwSqfl_/?utm_medium=copy_link>
[155] *See* supra note 9
[156] A United Nations Specialized Agency, established in 1948 deals exclusively with universal health-related matters. Its mandate includes the attainment of the highest level of healthcare services for all individuals, worldwide.

vulnerable communities around the world, while supporting their inclusion into national health systems. Just recently, for instance, WHO joined forces with UNHCR to strengthen, and promote public health care access to millions of persecution survivors across the globe.[157] The partnership between the two humanitarian Organizations has led to even rapid emergency action for public health solutions aimed at remedying refugees' healthcare needs, globally. This UN Specialized Agency, by prioritizing health has promoted international public health equity, and has continuously responded to health emergencies by spearheading the delivery of essential services and the detection, prevention, and eradication of medical crises. Through its association with other Organizations under the United Nations system, particularly the Refugee and Migration agencies, the World Health Organization continues to rank high the well-being of refugees by ensuring adherence to, and respect for the universal prerogative to health.

2.8 Civil Society Organizations

Civil Society Organizations have been at the forefront in protecting and promoting refugees' access to healthcare services. For instance, *CARE International*[158] in Kenya has since its operationalization actively responded to refugee emergencies through strengthening their well-being, and providing access to health determinants in form of educational training, clean water, appropriate sanitation and hygiene (WASH), along with services surrounding the treatment, and prevention of HIV/AIDS. Driven by the desire to guarantee quality health services access particularly for victims of HIV/AIDS, *CARE International* strives to secure access to HIV testing

[157] WHO, 'WHO and UNHCR Join Forces to Improve Health Services for Refugees, Displaced and Stateless People' (2020), paras. 1-6 <https://www.who.int/news/item/21-05-2020-who-and-unhcr-join-forces-to-improve-health-services-for-refugees-displaced-and-stateless-people> accessed 18 May 2021

[158] The lead agency under UNHCR and WFP that facilitates the provision of services such as water and hygiene, including food and education within refugee camps situated along the Somali border and hosting over 300,000 of Kenya's cumulative refugee population

and counseling while monitoring the implementation of its services within Kenya's refugee resettlement areas.

Further, *Amnesty International*[159] understands that thousands of women lose their lives annually as a result of preventable maternal health complications. In its institutional capacity, therefore, the Non-Governmental Organization (NGO) works with funding partners, including the Government and other civil society organizations to deter and protect violations of maternal health rights of vulnerable women and adolescent children living in Kenya, without exclusion of refugees. In its advocacy role, whilst creating awareness on the deplorable conditions of weak health systems, the Organization urges Governments, health sectors, and the general international community to provide access to medical attention: reminding host states of their responsibility to protect and safeguard the almost catastrophic infringement of refugee healthcare rights. *Amnesty International's* flagging of injustices around the world, particularly on States' transgressions surrounding the universal prerogative to health, has driven the international community and national health systems – succumbing to pressure and public demand – to work together and take effective action aimed at remedying the injustices, despite still being influenced by xenophobia.

The *United Nations Children's Fund* (UNICEF), a program of the United Nations has since its inception owned its responsibility of providing humanitarian and developmental aid to all children, indiscriminately.[160] Understanding that the impact of persecution is particularly greater on the wellbeing of refugee women and children, *UNICEF* emphasizes signatory states' obligation under

[159] An International Non-Governmental Organization that seeks to encourage the protection of migrant and refugee rights, including sexual and reproductive healthcare.
[160]Mingst, Karen, "UNICEF" *Encyclopedia Britannica*, <https://www.britannica.com/topic/UNICEF> accessed 24 May 2021

the Convention on the Rights of the Child. It contends that states should guarantee refugee women and children equitable, and affordable access to all medical services available, and suitable to their gender, age, abilities, and health status, adding that the same should be clearly and explicitly recognized in legislation.[161] The Organization's agenda – aiding national efforts for over 190 countries and territories – is grounded on saving children's lives, safeguarding their rights and interests, while supporting them reach their potential, from childhood throughout their journey to adulthood.[162]

Established in 1919, *Save the Children International* has its main purpose built on improving the lives of children through encouraging their admission to relief assistance such as medical care. Over the decades, *Save the Children* has understood that, as minorities, children globally have been majorly excluded from achieving the full realization of their rights and has strived to secure a better world for them through advocating for an improved quality of life. The NGO's response to emergencies and advocacy initiatives in the provision of quality medical care has indiscriminately helped millions overcome the impact of the child refugee crisis, guaranteeing a healthy future for every refugee child globally. The humanitarian Organization, having recognition as the principal actor for neonatal, newborn, maternal, and child health in Kenya,[163] continues to work with Kenya's health system to secure healthcare support for all children residing in rural and marginalized areas, without disregarding refugee children.

[161]UNICEF, 'Refugee and Migrant Crisis in Europe' (2017) *Advocacy Brief* pp. 1-3 <https://www.unicef.org/eca/sites/unicef.org.eca/files/UNICEF%20Advocacy%20Brief%20Health.pdf > accessed 24 May 2021
[162] *Ibid*
[163] Save the Children International, 'SAVE THE CHILDREN'S RESPONSE TO THE COVID-19 PANDEMIC IN KENYA'(2020) <https://kenya.savethechildren.net/what-we-do/our-response-covid-19> accessed 24th May 2021

2.9 Conclusion

I have fully discussed the international refugee protection system in this Chapter. I explained the international legal frameworks and noted that the same only apply, and are legally binding to Kenya since it has ratified/adopted the instruments. Furthermore, I have identified the 1969 OAU Convention as the sole instrument adopted for refugee protection at the African regional level and observed that the legislation does not explicitly provide for the protection of their health entitlements. At the domestic level, I noted that states may also adopt legislation to govern the management of refugees within their territories, and for this category of laws, I analyzed Kenya's very own statute: The 2006 Refugee Act. Having satisfied that the international, regional, and country's refugee legislation have a bearing on Kenya's compliance obligation, I argued that the state's "supreme law" is equally relevant, and can therefore be substantially cited to challenge its conformity. Establishing that health is a legal entitlement under the Universal Bill of Rights, this Chapter has noted that, although Kenya's constitutional provisions [Article 43 (1) (a) and (2)] can be argued to solely pertain to its Kenyan nationals, and therefore inapplicable to the refugee context, Article 2 (5) and (6) can be invoked to defend the validity of this fundamental human right to the Kenyan refugee system, thereby mitigating obedience.

Correspondingly, I considered the correlation between international human rights and humanitarian laws to the international refugee protection scope. I however discovered that the regional and national refugee instruments do not contain *express* provisions relating to the health care entitlement. I proceeded to explain the role of the UNHCR in the exercise of its universal protection directive, in addition to the humanitarian acts of providing relief support to persons falling within its protection directive. I confirmed the significance of the UN Refugee Agency in

the protection of refugees, with particular emphasis on its health-related mandate. Having successfully looked into the legal and institutional frameworks safeguarding refugees' rights, and critically assessed the WHO's role in guaranteeing health care access, including the local and international institutions focused on securing refugees' utilization of health care resources, it is important to further understand the health concerns and barriers commonly encountered by the minority community, and which warrant urgent resolution. The next chapter investigates the refugee impediments to health care access.

CHAPTER THREE

IMPEDIMENTS TO HEALTH CARE ACCESS

3.1 Introduction

The preceding section successfully discussed the legal frameworks and the office of the United Nations High Commissioner for Refugees (UNHCR) in relation to its unique mandate of promoting health care access for the global refugee population. Refugees and other categories of displaced persons are known to suffer from various chronic illnesses. The effect of refugee migration as a result of persecution plight, including adjusting to the new environment in the country of resettlement is quite weighty, and greatly influences the deterioration of their general wellbeing. Diverse Human Rights instruments, both at the international and national level acknowledge the inalienability of the prerogative to health. The Kenya Constitution, 2010, in classifying 'health' as an economic and social right, states that every individual has the right to its highest attainable standard, which includes the right to medical care services, including reproductive health care"[164]

Essentially, therefore, all persons are inherently entitled to access reasonable standards of health care services, indiscriminately. However, the situation is clearly questionable, with a larger fraction of refugees still lacking the required medical care and assistance. Drawing from asylum-seekers' displacement history and pre-migration conditions to gaining legal documentation in the Kenyan territory, this chapter discusses refugees' common health concerns from the point of

[164] Constitution of Kenya (2010), Art. 43 (1) (a) & (e)

persecution to safety so-*called*. I begin my discussion by analyzing the different categories of health complications they usually encounter, including instances requiring emergency response treatment, and or referrals; I further proceed to highlight the gaps and challenges necessitating the Government health system's intervention. In part three, I deliberate on the various impediments regularly restricting refugees' access to readily obtainable medical resources, with particular emphasis on Kenya's refugee situation.

3.2 Health Care Access Problems

In as much as refugee health complications are quite complex, this section particularly focuses on Sexual and Reproductive Health (SRH), Maternal and Child Health (MCH), including Mental and Psychological Health issues (MHPSS). These three illustrative case studies are adopted to specifically highlight the disproportionate prioritization within Kenya's refugee populace. I have particularly opted for a descriptive review of SRH and MCH since, according to a UNHCR statistics report, almost 80% of Kenya's registered refugees and asylum seeker population comprise of women and children,[165] necessitating the need to enhance efforts leveled at securing health equity for the targeted population. Likewise, based on the prevailing deplorable conditions of the camps, including the traumatizing nature of persecution and migration detrimental to their mental and psychological wellbeing, I delve into a descriptive account of MHPSS.

[165] UNHRC Kenya, 'Kenya Registered refugees and asylum-seekers' <https://www.unhcr.org/ke/wp-content/uploads/sites/2/2020/07/Kenya-Infographics-30-June-2020.pdf> Accessed 10 November, 2020.

3.2.1 Sexual and Reproductive Health – Consequences, Gaps, and Challenges

Continued political and civil unrest, especially in financially deprived countries greatly underscores the urgent need for specialized reproductive and sexual health services for immigrants.[166] Refugee women and childbearing girls are known to suffer wide-ranging sexual and reproductive health-related concerns, particularly during their integration into the country of resettlement. Health systems have strived to develop means and policies geared towards providing quality sexual and reproductive health (SRH) assistance as a vital form of humanitarian support. Securing admission to excellent sexual and reproductive health aid is undeniably paramount to the well-being of any individual, particularly the forcibly displaced. In Kenya and around the world, pregnancy complications are identified to be among the primary causes of death and disease among refugee women. In this regard, therefore, various challenges need to be addressed.

Refugee women and girls have major unsatisfied SRH needs compared to the host state's nationals,[167] and their stay in overcrowded refugee camps intensifies the danger of sexual violence, including rape. Refugees crowded in the violence-prone resettlement regions require urgent medical attention for various reproductive health conditions paramount to their welfare, along with access to postnatal care, contraceptives and family planning aid, medical assistance in managing abortion-related situations, prevention, and treatment of fistula and cervical cancer, which the current refugee health system inadequately provides. Therefore, sexual and reproductive health rights of persons enduring catastrophic circumstances, such as persecution and other forms of

[166] Judy, Austin, *et al*, 'Reproductive Health: A Right for Refugees and Internally Displaced Persons' (2008) vol. 16(31) pp. 11-15 <https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2808%2931351-2> accessed 6 March 2021

[167] Clark CJ, Spencer RA, Khalaf IA, *et al*, 'The Influence of Family Violence and Child Marriage on unmet need for Family Planning in Jordan'(2016) *Journal of Family Planning and Reproductive Health Care* vol. 43(2) pp. 107 <https://doi.org/10.1136/jfprhc-2014-101122> accessed on 6 March 2021

violence, pressingly require immediate attention and priority. Migrant women, particularly refugees have restricted access to sexual and reproductive assistance and continue to encounter significant threats to their consequent rights.[168]

For Kenya, the high cost of medical assistance, including contraceptives and the stigma surrounding its use by childbearing girls, is among the major factors affecting refugees in their health care services access. Poverty, as defined in a country like Kenya or Uganda is entirely a different case from the poverty experienced in third world countries. What constitutes a minimum supply of clean water and two meals may be viewed as extreme poverty in countries like Canada. Poverty, in addition to the inability to procure SRH services, has an adverse effect on the general well-being of persecution survivors and is likely to come with its own unique complications, bearing in mind that a larger percentage of refugees reside in camps, and therefore solely reliant on humanitarian assistance. Notably, before persecution flight, several refugee families in Kenya lived below the poverty line on account of resettlement issues and exposure to dreadful environments, leaving them at a high risk of long-continued SRH difficulties.

Furthermore, the inability to particularly understand refugees' problems, while still maintaining cultural values results in an obstacle in accessing and delivering effective health care, and mutual certainty between the healthcare benefactor and provider, especially in SRH concerns. This affiliation is a vitally important concept in securing refugees' fulfillment of their SRH needs. It is important to acknowledge that due to the advancements made through empowering reproductive

[168] Sustainable Development Goal 3, Target 3.7: states commit to ensure universal access to sexual and reproductive health care services by 2030, including family planning services, formal education, and integration of reproductive health into their respective national systems; Sustainable Development Goal 5, Target 5.6: aims at ensuring global access to sexual and reproductive care.

health into humanitarian responses since the 1994 International Conference on Population and Development (ICPD),[169] the consciousness of the impact associated with overlooking reproductive health services like parental care and neonatal mortality, HIV/AIDS transmission, and unsafe abortion, has greatly increased.[170] However, despite SRH progressively gaining global recognition over the decades, substantial gaps remain in Kenya's refugee health system, especially with regard to the quality of services administered, financial backing, with SRH policies and institutional capacities not being afforded the priority deserved.

3.2.2 Maternal and Child Health – Consequences, Gaps, and Challenges

Article 24 (2) (d) of the Convention on the Rights of the Child (CRC) obligates Kenya to ensure that mothers within its jurisdiction have access to maternal health care aid, including advancing preemptive health assistance, parents' support, as well as family planning education and services.[171] As was held in *J.M. v. Attorney General and 6 others*,[172] everyone deserves access to free and quality maternal healthcare in Kenya's public hospitals. However, as compared to host communities, a great fraction of refugee women and adolescents resettled in Kenya face unfavorable pregnancy and birth outcomes, with greater incidences of induced abortions, casarean sections, antenatal and postnatal delivery complications. Nevertheless, the complex services comprising of sexual and reproductive health care (SRH), along with access to vital reproductive, maternal, and child care are still of meaningful concern.[173]

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[169] Report of the International Conference on Population and Development, Cairo (5-13 September 1994) A/CONF.171/13/Rev.1 (Cairo Conference).
[170] Chynoweth, Sarah K., 'Advancing reproductive health on the humanitarian agenda: *the 2012-2014 global review'* (2015) *Conflict and Health* vol. 9 (11) <https://doi.org/10.1186/1752-1505-9-S1-I1> accessed on 6 March 2021
[171] *See* supra note 127, art. 24 (2) (f)
[172] J M v Attorney General & 6 others [2018] eKLR
[173] Malabika Sarker, Saima Mehjabeen, Avijit Saha, *et al*, 'Effective Maternal, Newborn and Child Health Programming among Rohingya Refugees in Cox's Bazar, Bangladesh: *Implementation challenges and potential*

Hundreds of thousands of maternal and neonatal deaths, along with injuries and infections resulting in disabilities occur annually, especially in third world host countries, with refugee women and children being particularly vulnerable. Risks of child mortality and maternal complications are relatively high in times of crisis and are greatly attributed to the insufficient, or lack thereof, surrounding emergency medical services and obstetricians, malnutrition, population movements, the transmission of infections, including HIV/AIDS among refugees. A high proportion of deaths during childbirth are credited to patients' delay in obtaining medical assistance, and to failure of medical personnel to recognize the seriousness of their conditions[174] – a concern that is quite prevalent in the refugee health system. As a matter of fact, UNHCR's standard maternal health strategy as recommended by the World Health Organization is that a minimum of 90% of eligible female camp residents should receive not less than four antenatal care appointments,[175] a focus that Kenya ignores.

However, despite the limited antenatal care being provided within refugee camps, maternal deaths still occur, partly due to health workers' failure to administer adequate and timely medical aid. Patient neglect in Kenya's refugee health centers, including the lack of close observation as well as delays in administering medical care by health care workers, perhaps due to negligence or night travels to healthcare facilities, are factors to consider as main triggers of maternal mortality, with many cases occurring at health institutions. Nonetheless, the providers' attitude is not entirely to

solutions (2020) <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0230732> accessed 7 March 2021

[174]Michelle, Hynes, *et al* 'A Study of Refugee Maternal Mortality in 10 Countries; *2008–2010*' (2012) doi: 10.1363/3820512, vol. 38(4), pp. 205-207 <https://www.unhcr.org/en-my/5e2048054.pdf> accessed 7 March, 2021

[175] WHO, 'Recommended Interventions for Improving Maternal and Newborn Health' (2009) Doc No. WHO/MPS/07.05, Geneva <http://apps.who.int/iris/bitstream/10665/69509/1/WHO/_MPS_07.05_eng.pdf> accessed 7 March, 2021

blame for the growing maternal deaths occurring in refugee-related settings. Delays in seeking, and or accepting care, particularly based on the mothers' cultural and religious perceptions of obtaining gynecological and post-natal care (PNC), are also quite prevailing, yet avoidable causative factors. Similarly, nutrition deficiency, the inconvenient living conditions of refugees, and insecurity, coupled with the fear of delivering in an alien environment, equally incite maternal deaths and subsequent newborn morbidity.

According to the UNHCR,[176] among the key concerns in accessing antenatal and SRH aid are particularly attributed to the fact that the camps are located in areas prone to insecurity and absence of public transport vehicles to facilitate refugees' arrival at health facilities, especially at night. Additionally, cultural and religious factors are also primary consequences with most Somali women opting to deliver in their homes, and are unwilling to approve emergency cesarean sections even when diagnostically necessary, or reject medical care assistance administered by male healthcare staff.[177] To secure free access to maternal healthcare assistance for the refugee communities in Kenya, there is an urgent necessity for the health systems' intervention in securing population outreach, satisfactory service delivery, and patient supervision. This is mainly necessary as a means of significantly improving maternal, newborn, and general health outcomes for refugee communities in Kenya.

[176] UNHCR, 'Improving Maternal Care in Dadaab Refugee Camps, Kenya' (2010) pp. 1-2 <https://www.unhcr.org/uk/4c247d969.pdf > (accessed 7 March, 2021)
[177] *See* supra note 170.

3.2.3 Mental and Psychological Health – Consequences, Gaps, and Challenges

Millions of individuals globally lack access to satisfactory mental and psychological support, and refugees, together with other persons of concern are not excluded. Refugees are known to contribute greatly to knowledge and insight, globally. In fact, refugees in Britain include icons such as the inventor of the contraceptive pill and the first governor of the Bank of England.[178] Refugees across the globe have made tremendous achievements in the fields of science, sports, law, music, engineering, art, to name but a few, and complimentarily require mental health and psychosocial support (MHPSS) to nurture their intellect. Kenya's resettled refugees are more liable to suffer from stress-related mental health complications, with unaccompanied minors, disabled, and pregnant women having the highest rates of distress tendencies.

The traumatic character of events leading to persecution survival: before the flight and the period of departure, severe resettlement conditions, along with the stigma and struggles of adapting to entirely new surroundings, aggravate refugees' mental and psychological health. The most commonly diagnosed mental and psychological health disorders associated with the refugee populations, incidences of which vary extensively for every individual comprise Post-Traumatic Stress Disorder (PTSD), clinical depression, stress, and anxiety, including panic attacks. While a number of refugees may be able to cope with the crisis and easily adjust to the new environment, others may find coping relatively hard, and suffer complex mental health issues that could be lifelong if not urgently and adequately diagnosed.[179] The prevalence of mental health disorders

[178] Rachel, Tribe 'Mental Health of Refugees and Asylum-seekers: 8 *Advances in Psychiatric Treatment*' (2018) *Cambridge University Press* vol. 8(4), pp. 240-244.
[179] Saada, Kinago, 'An Insight on the Psychological Wellbeing of Persecution Survivors: *A Refugee Mental Health Crisis*' (2020) *The Platform*, vol. 57 pp. 82 <https://theplatform.co.ke/issue-57-september-2020/> 7 March 2021

among the refugee population is relatively high as compared to that of Kenya's host populations. For instance, a WHO mental health manual highlights that there are substantial and consistent differences in comparative prevalence, particularly in PTSD with 9–36% of refugees suffering in contrast to 1–2% of host states' nationals.[180]

All persons in Kenya with mental health concerns obtain all the support necessary, especially with the currently ongoing Covid-19 pandemic, and it is even more vital for the refugee communities. To secure this for Kenya's refugee populace, the existing mental health and psychological support (MHPSS) government activities should be cautiously reviewed to clearly define its vitality to reduce infection and maintain the functionality of service beneficiaries. While refugees living with mental health disorders are not afforded the required medical services, these unattended cases pose as the leading cause of self-harm and suicides among the communities. It is worth noting that some of the main challenges affecting access to mental health aid by refugees can be drawn from their perception of what mental health constitutes. Most cultures, especially in Africa have a peculiar understanding of what mental health is all about.[181] The issue of mental health is deeply misconceived, and denounced by a majority of the world's population, including refugee communities resettled in Kenya. Globally, victims of clinical depression and schizophrenia are projected to have a 40% to 60% higher risk of dying early as compared to the overall population.[182] Research shows that most refugees requiring medical attention, including mental health, have

[180] WHO 'Mental Health Promotion and Mental Health Care in Refugees and Migrants: *Technical guidance*' (2018) *Copenhagen: WHO Regional Office for Europe, Technical Guidance on Refugee and Migrant Health* pp. 1-4 <https://www.euro.who.int/__data/assets/pdf_file/0004/386563/mental-health-eng.pdf%3Fua%3D1> accessed on 8 March 2021

[181] *See* supra note 141

[182] Shekhar Saxena and Elisha London, 'Opinion: *Why integrating mental health into UHC is key to ensuring human rights*'(2021) paras. 2-4 <https://www.devex.com/news/sponsored/opinion-why-integrating-mental-health-into-uhc-is-key-to-ensuring-human-rights-98741> accessed on 8 March 2021

difficulties in communicating their issues. This, together with ignorance of their legal entitlement, consequentially bars their access to mental health care and aid.

3.3 Barriers to Healthcare Access

Sadly, the possession of identification documents is an integral part of accessing any form of asylum protection by migrants, including healthcare services. A relatively high percentage of unaccompanied child migrants, along with adults, are undocumented since their entry into the Kenyan territory is irregular, another factor inhibiting their access to medical services and assistance. The entitlement to healthcare does not necessarily guarantee free access, and despite the rights being legally established for specific migrant groups, thus guaranteeing access, further restrictions pertaining to the composition of health services, ignorance of rightful claims by health service providers and recipients, including lack of expertise by health personnel, communication, and societal barriers, may exist. Some of the main challenges commonly curtailing refugees' efforts to procure equitable and standardized healthcare assistance in Kenya include:

3.3.1 Social Barriers

3.3.1.1 Illiteracy and Language/Communication Difficulties

Among the refugee communities globally, communication difficulties are commonly mentioned as one of the key hindrances to accessing health care for both physical and mental health complications.[183] Language and communication is a major obstacle when healthcare access is

[183] Molly, Green 'Language Barriers and Health of Syrian Refugees in Germany' (2017) *American journal of* public *health* vol. 107(4), pp. 486 <https://doi.org/10.2105/AJPH.2016.303676> accessed on 27 May 2021

concerned, particularly attributed to the lack thereof, or inadequacy of competent translation and interpretation services. The ability for migrants to clearly communicate is not only vital for scheduling medical appointments and accessing Kenya's health system, but it is undeniably critical for medical compliance, understanding, and administering effective diagnoses. Migrants' inability to communicate effectively with healthcare providers often leads to uncertainty and admission of improper treatment to medical care beneficiaries. While a family member may come in handy to serve this purpose, issues of confidentiality, coupled with the fear of social stigma often mulled over as shame, by the community emerge – especially where the translator is of the opposite sex. These struggles extensively exist among Kenya's refugee population.

Language is a social determinant that continues to impede refugees' access to health resources.[184] Incompetency in English and Swahili, along with health illiteracy, further facilitate unfortunate health outcomes, and exhibit health-related complications for refugees.[185] Refugees' access to healthcare services is further complicated by patients' inability to explain and comprehend their medical needs and diagnoses, respectively. For a considerable number of refugees in Kenya, their health and general well-being are diminished based on their incapacity to articulate medical information. Most refugee communities, particularly those of Somali origin are unable to read, nor understand health treatments, let alone describe their medical dilemmas, and have a hard time accessing medical assistance, negatively impacting their health, particularly during emergencies.

[184] Haran, Ratna 'The Importance of Effective Communication in Healthcare Practice' (2019) *Harvard Public Health Review* vol. 23, pp. 1–3 <www.jstor.org/stable/48546767> Accessed 5 Sept. 2021

[185] Feinberg Iris, O'Connor Mary Hellen, *et al*, 'The Relationship Between Refugee Health Status and Language, Literacy, and Time Spent in the United States' (2020) *Health literacy research and practice*' vol. 4(4), pp. 231 <https://doi.org/10.3928/24748307-20201109-01> accessed 28 May 2021

3.3.1.2 Adverse Living Conditions

Article 21 of the 1951 Refugee Convention requires Kenya to ensure the refugees lawfully in the country, with regard to housing, are accorded treatment equal to that afforded to aliens.[186] Despite this, however, the living conditions inside one of Africa's largest refugee camps are quite appalling. Substandard houses, poor infrastructure, and sanitation are what define the resettlement condition of the Kakuma refugee camp. Tens of thousands of refugees escape the camps' deplorable surroundings only for a percentage of them to settle in slums, where the living conditions are not at all pleasing. The small and poorly ventilated houses that were initially constructed as temporary way stations have become a permanent home to thousands of refugees, despite its minimum standards of living. The conditions of Kenya's resettlement areas are quite poor with crucial services such as conducive learning facilities, clean water, and proper sanitation, lacking. As the migrant dilemma continues to grow globally, the conditions in camps continue to creak with health hazards threatening refugees' wellbeing, and various medical needs remaining unmet.

Respiratory infections and skin diseases caused by unhygienic lifestyles are rampant within Kenya's refugee community, with minimal efforts from the UN agency (UNHCR) and the government's Ministry of Health (MoH). The mental health of the camps' population worsens by the day: a health factor that ought to be prioritized as being a significant indicator of an individual's general well-being.[187] The international community may partly be blamed for the pre-existing inhumane standards of refugee camps, particularly due to its failure to adequately fund refugee

[186] *See* supra note 60

[187] Daria, Mendola and Annalisa, Busetta 'Health and Living Conditions of Refugees and Asylum-seekers: A Survey of Informal Settlements in Italy'(2018) *Refugee* Survey *Quarterly*, vol. 37 (4) pp. 477–479

operations for the most financially vulnerable host states, like Kenya. However, the same degree of blame may be modeled against the Kenyan government and its health sector for doing the minimum concerning its human rights protection responsibility under international law. This raises another concern for the global medical-care efforts and their response to public health emergencies. Social support, particularly housing, work, and learning environment, including living standards, and healthcare aid for refugees and asylum seekers, is limited as a consequence of underfunding, and inadequate resources to support health care operations, successfully – taking a toll on their overall health.

3.3.1.3 Cultural/Religious Differences

Refugees in Kenya comprise individuals from different parts of Africa with unique and complex cultural backgrounds, a factor that poses a challenge in administering health care aid.[188] Female refugees may reject medical examinations conducted by male health officers, especially obstetricians. The cultural differences between refugees and healthcare service providers can greatly influence the treatment outcome.[189] In as much as the proper treatments may be available, thereby facilitating refugees' access to health services, their cultural perceptions of the health systems or illness may limit their satisfaction. Health caregivers ought to keep track of the perceptions, dreads, and religious/cultural differences or prospects, including being sensitive to particular needs of migrant patients, while still balancing their role as physicians and members of society. There is a dire need for health officers to be aware and understand individuals' cultural

[188] Nikolai, Kiselev 'Structural and socio-cultural barriers to accessing mental healthcare among Syrian refugees and asylum seekers in Switzerland' (2020) *European Journal of Psychotraumatology* vol. 11 (1), pp. 5
[189] Victor, Mutiso et al, 'Intrigues of Accessing Mental Health Services Among Urban Refugees Living in Kenya: The Case of Somali Refugees Living in Eastleigh, Nairobi' (2018) *Journal of Immigrant & Refugee Studies,* vol. 17 (2) pp. 204-6

backgrounds, along with their previous experiences and health history to respond to their medical needs, satisfactorily. Fundamentally, cultural sensitivity is as crucial a consideration as is communication.

3.3.1.4 Discrimination

Both mental and physical health challenges are an issue of concern among lesbians, gays, bisexuals, and transgender (LGBT) refugees and asylum seekers, globally. In as much as the legal frameworks emphasize the necessity to secure access to equitable health-care services for all refugees, indiscriminately, bigotry among members of the LGBT community persists – especially in camps. This discrimination of the sexual minorities causes social stigmatization and trauma that greatly affects their psychological wellbeing. Health care service providers within refugee settlement areas are mostly known to discriminate against persons within these communities, thus denying them access to the rightfully entitled medical care and assistance. Sadly, a decent percentage of preventable deaths for this minority group is mainly attributed to failure to access health care aid. Discrimination is indeed a great challenge, particularly in securing access to health care assistance for Kenya's refugee population.

Similarly, identifying and registering persons living with disabilities is crucial in determining the kind of health care assistance to be administered. This factor remains a challenge to health systems, particularly in gathering disability-related data, the differing views regarding the concept of disability, including obtaining candid information on refugees' medical history. The fear of facing stigmatization and possible repatriation makes families not disclose cases of disability among their family members. This in turn affects their access to health care, especially in instances that require

emergency and specialized medical attention, despite UNHCR's constant efforts to prevent the same. However, while discrimination is not entirely displayed by health service providers within camps, the Dadaab refugee complex, being one of the largest refugee camps, globally, currently holds over 400,000 refugees and asylum seekers[190] has three healthcare centers with only 500 beds. This means that for approximately every 133,000 patients, only one hospital is available thus complicating dispensation and accessibility of services by overcrowding.[191] This shows that while the country is working towards securing universal health coverage, refugees and asylum seekers are disregarded from this significant Agenda.

3.3.2 Financial Barriers

Whereas refugees' access to health services may not exclusively be influenced by language and communication difficulties, for labor migrants, undocumented and unaccompanied persons, the financial burden of outstanding medical costs restricts their entitlement to health services. Such migrants shun access to health facilities for fear of medical bills and even deportation[192] thereby restricting the utilization of medical care and services.

3.3.2.1 Inadequate Financial Resources

Notably, the main challenge facing the Government of Kenya (GoK) and the Refugee Agency's efforts on providing humanitarian and relief assistance, is the inadequacy of finances. With

[190]Medecins Sans Frontieres, 'Dadaab refugees: An uncertain tomorrow' (2014) pp. 2 <https://reliefweb.int/sites/reliefweb.int/files/resources/bp-dadaab-march-2014-low.pdf> (accessed 15, July 2021)
[191] UNHCR, 'Briefing Note on the Health Sector: Dadaab Refugee Camps' (2011) pp. 1-2 <file:///C:/Users/user/AppData/Local/Temp/515.pdf> accessed 15 July 2021
[192] WHO, 'Report on Regional Situation Analysis, Practices, Experiences, Lessons Learned and Ways Forward' (2018) paras. 4-5<https://www.who.int/migrants/publications/EURO-report.pdf> accessed on 8 March 2021

Kenya's low economy and reliance on international donors, the host state lacks the required funds and support to finance the refugee health care system, and maintain healthy environments, especially within camps. A high percentage of refugees in Kenya's camps are financially unable to cater for their medical expenses such as surgeries; including emergencies requiring specialized care in as far as, the medical resources are made available. Further, UNHCR's annual budget is inadequate to cater for worldwide refugee-related operations, along with salaries for its frontline staff, financially funding refugee host-states, including responding to various other emergencies, globally. With the current pandemic claiming thousands of lives each passing day, over 30 million refugees globally seek refuge in countries having weak health care systems and are therefore most likely to bear the extreme effects of the pandemic. Kenya for instance was completely reliant on loans and donations from the EU to support its citizens from the effects of the pandemic, let alone have the funds to cater equitably for the refugee populaces it hosts. Essentially, therefore, financial vulnerability negatively affects the distribution of health resources, thus worsening refugees' health status in economically disadvantaged jurisdictions like Kenya.[193]

UNHCR's inadequacy of financial resources to administer healthcare services to over 82 million[194] displaced persons, globally, is undoubtedly the Agency's main challenge. Just recently, for instance, the office of the High Commissioner, through appealing for donations, sought to raise around US$900 million, funds it requires to respond to the Covid-19 crisis' impact on refugee health.[195] Additionally, donations are not only required due to the recent pandemic but also to

[193] Gary J. Young, 'Do Financial Barriers to Healthcare Services Affect Health Status?' (2010) *Medical Care* vol. 48 no. 2 pp. 86 JSTOR <www.jstor.org/stable/27798412> Accessed 5 Sept. 2021
[194] UNHCR 'Figures at a Glance'(2021) <https://www.unhcr.org/figures-at-a-glance.html>
[195] UNHCR 'Covid-19 Supplementary Appeal 2021'(2020) pp. 2-4 <https://reporting.unhcr.org/sites/default/files/COVID-19%20Supplementary%20Appeal%202021%20-%2018%20December%202020.pdf>

finance various other refugee healthcare projects. For instance, UNHCR is urging prospective donors to make cash contributions towards the refugee operation in Dadaab that the Agency requires to respond to emergencies, while ensuring maximum healthcare service delivery within the resettlement region. Lack of donors, together with the global community's unwillingness to make financial contributions hinders the agency's operations to cater to refugees' health care demands.

3.3.3 Administrative Barriers

3.3.3.1 Insecurity

Access to humanitarian services, including accessing healthcare facilities is quite problematic due to the continuing violence in some refugee settings. It is impracticable to quantify the actual level of violence dominating the Kenyan refugee camps. Furthermore, violence, coupled with poor living conditions in refugee resettlement areas hinders their ability to respond to UNHCR and humanitarian-led treatments. Both physical and psychological healthcare aid administered by the various health systems, including the Government, and local stakeholders through its medical personnel in appalling conditions of conflict, as well as poor hygienic, and sanitation practices, proves futile in improving the general wellbeing of refugees. Sadly, most of the violence experienced as a daily reality in refugee settings is attributed to family and community members' mistreatment.[196] Women and girls, making close to 50% of Kakuma's population, face a high risk of violence because of conflict and displacement, forced and premature marriages, including sexual violence and abuse.

[196] Jeff, Crisp 'A State of Insecurity: The Political Economy of Violence in Kenya's Refugee Camps' (2000) vol. 99(397), pp. 604 <http://www.jstor.org/stable/723318> accessed 13 July, 2021

For instance, adding to the grave impact of the currently ongoing pandemic, conflict-prone regions such as Tahoua and Diffa in Niger are unable to gain access to UNHCR's relief assistance, including healthcare services. The Moria refugee camp[197] within the Greek island of Lesbos, known for its extreme violence and unpleasant living conditions, houses four times the capacity of refugees it can adequately sustain. Additionally, for the Rohingya refugee dilemma, despite the Bangladeshi government's generous response to the refugee influx into its territory, a huge challenge shoulders the government with regard to preparedness and financial capacity to provide health-care access to over a million displaced Burmese nationals. These situations show that violence is a problem that faces most [if not all] refugee host countries. The decline in Kenya's security as a result of major terrorist attacks has gravely affected the healthcare entitlements of refugees in camps, including threatening their closure despite their existence for over three decades.[198] With gender-based violence remaining unaddressed, refugee women and girls, particularly those in camps remain vulnerable to physical and sexual danger.

3.3.3.2 Corruption

The unending corruption practices within refugee host countries, predominantly at the regional and national level is yet another UNHCR confrontational issue limiting refugee healthcare access in Kenya. Disappointingly, most middle-income countries do not utilize the financial funding

[197] The camp, monitored by Greek government initially began hosting refugees from Syria, Turkey and Afghanistan in 2015. It was merely created to temporarily host refugees for a couple of days before later being moved to their permanent areas. 5 years down the life and the camp is still a home to over 8000 refugees (allegedly due to Greece's enforcement of the EU policy of "containment" to ensure that refugees remain at the Island rather than being moved to the larger Greek territory including the return of thousands of refugee back to Turkey)

[198] Dadaab refugee complex was established in early 1990 to host over half a million victims of violence fleeing Somalia.

granted by international well-wishers to cater for refugee assistance, including healthcare equipment and other facilities. The government's embezzlement of cash and in-kind donations to refugee host states' by the UN Agency, including its partners and other benefactors, restrain any efforts to ensure adequate, consistent, and efficient medical care provision. This in turn hinders refugee utilization of medical resources, with the provision under Article 43 remaining far reached. In Soobramoney v Minister of Health,[199] the court found that, despite the existence of the fundamental right to health, its realization is dependent upon the availability of resources, provided the authorities act in good faith. For instance, in Pakistan, health care is considered the country's most corrupt sectors having the lowest regard for patients' health.[200] First-rate physical and psychological health-care services are particularly reserved for the wealthy nationals; this is despite the High Commissioner's efforts to ensure that vulnerable communities such as refugees impartially benefit from accessing quality health care as locals.

Further, despite its universal recognition as the main protector for migrants' rights, it is saddening to note that UNHCR-Kenya has numerously been accused of exploiting refugees and asylum-seekers[201] for almost every service rendered, from resettlement to accessing medical services.[202] Despite Kenya's healthcare system being highly decentralized, and mainly reliant on donations from public donors, the degree of corruption entitles only the "highest bidders" to access quality medical assistance. Public officials, including the police and medical practitioners, have constantly

[199] *See* Soobramoney v Minister of Health ZACC 17, 1998 (1) SA 765 (CC), 1997 (12) BCLR 1696 (CC)
[200] IRIN, 'Challenges to improving health care in Pakistan'<https://www.refworld.org/docid/519b3df94.html> accessed 13 June 2020
[201] Charlotte, Hauswedell 'UNHCR probing corruption in resettlement cases in Uganda, Kenya' (2020) *INFO Migrants* pp. 3 <https://www.infomigrants.net/en/post/22018/unhcr-probing-corruption-in-resettlement-cases-in-uganda-kenya> accessed14 June 2020
[202] TNH 'Kenya: UNHCR head accepts Nairobi corruption report' (2002) *The New Humanitarian* para. 1-3<https://reliefweb.int/report/kenya/kenya-unhcr-head-accepts-nairobi-corruption-report> accessed 14 June 2020

demanded bribes, abusing their positions of power, in exchange for services otherwise rendered free. For instance, heartened by the control over migrants that the 2016 border closure threat had paved the way for, Kenyan authorities detained newly arriving asylum seekers, sought bribes – through use of coercion and violence, including sexual assault – and exiled the nonpaying back to Somalia,[203] constituting a denial of essential health services,[204] thus adding to their distress. Essentially, for decades, corruption has existed at all stages of public office, and Kenya's healthcare sector is not exempted, even for those helpless, and on the brink of death.

3.3.3.3 Unaccountability

Accountability will only exist when power-holders have the obligation to account, and when account holders are entitled to demand an account for the actions, or inactions of the power holders.[205] Kenya is currently a host to over half a million refugees and other displaced persons, with a larger fraction of its population residing within the Garissa, Turkana, and Nairobi regions. Although refugees are generally the mandate of the national government,[206] following the adoption of the Kenya Constitution 2010, which introduced the devolved governance system, some pertinent matters affecting refugees, including the provision of water and health-care services, fall under the authority of the respective county governments.

[203] Human Rights Watch, 'From Horror to Hopelessness: *Kenya's Forgotten Somali Refugee Crisis'* (2009) pp. 2-6 <https://www.hrw.org/reports/kenya0309_brochure_low_1.pdf> accessed 2 June 2021

[204] In International Pen and Others (on behalf of Ken Saro Wiwa) v Nigeria, the African Commission found that, a denial of medical assistance constitutes a violation of human rights

[205] Kristine Onarheim and Danielle Hanna Rached, 'Searching for accountability: *Can the WHO global action plan for refugees and migrants deliver*?' (2019) *BMJ Global Health* pp. 1-5 <http://dx.doi.org/10.1136/bmjgh-2019-002095> accessed 2 June 2021

[206] Constitution of Kenya, 1963 (Independence Constitution)

Undeniably, the 2010 Constitution of Kenya has brought about significant developments in the governance of the country, with an inscription of the canon of separation of powers, and the notion of devolution, which despite its substantial advancements, has greatly affected resource accountability, particularly on its impact on the handling of humanitarian matters. Notably, however, funds from the international community to enable refugee host states to accept and admit more asylum-seekers into their territories are granted to the national government, hence raising the question of accountability, predominantly in instances of underdeveloped healthcare systems within refugees resettlement regions.

3.4 Pandemics as Hindrances to Access - The Covid-19 crisis

A mental health situation is on the rise in Kenya's refugee camps with residents living in fear and anxiety because of the COVID-19 pandemic.[207] However, as the coronavirus pandemic continues to bite and threaten the entire global population, there is an extreme need to stockpile appropriate healthcare essentials, including medicine and equipment in refugee health centers. As the epidemic endures, inadequate food and supplies, including the lack of employment have seen several refugees battling mental health meltdowns, with suicide attempts being on the rise.[208] The High Commissioner's office in Kenya works together with its team, the staff at both regional and national levels to monitor the situation while ensuring preparedness and readiness.[209] Nevertheless,

[207] Doctors Without Borders, 'Kenya: *In the Shadow of COVID-19, a Growing Mental Health Crisis in Dadaab Refugee Camp'* (2020) para. 1-3 <https://www.doctorswithoutborders.org/what-we-do/news-stories/story/kenya-shadow-covid-19-growing-mental-health-crisis-dadaab-refugee> accessed 3 June 2021
[208] *See* supra note 155
[209] Jonathan, Clayton 'Q&A: Access to Health Services is Key to Halting Covid-19 and Saving Refugee Lives' (2020) <https://www.unhcr.org/news/latest/2020/3/5e7dab2c4/qa-access-health-services-key-halting-covid-19-saving-refugee-lives.html> accessed 12 June, 2020

most of the general refugee population is accommodated in developing countries: states with weak and underdeveloped health systems.

Additionally, the delivery of protective gear, as well as masks to refugees and health care workers in respective settlement regions is quite challenging due to the restriction on international, as well as inter-county movements. The suspension of counseling services as a result of UNHCR-Kenya's execution of the presidential directive has seen thousands of refugees unable to cope and navigate the difficult situations they are in.[210] Likewise, Kenya's interruption of the movement of camp residents to Nairobi has barred their access to specialized care.[211] The entire global refugee community, particularly those residing in camps has been greatly impacted by the pandemic. For instance, the resettlement of thousands of refugees vacated from Libya has automatically been suspended due to the continuing travel restrictions worldwide,[212] thereby restricting access to UNHCR's healthcare assistance.

In addition to this, the closure of national border territories as a means to limit the spread of the deadly virus has caused more harm than anticipated. Thousands of Afghans daily return home from Iran, one of the many states most unpleasantly hit by the novel coronavirus, with thousands more returning from Pakistan, the most hard-hit state within South Asia. This unprecedented movement, along with overwhelming the health sectors, particularly the hospitals and medical personnel, greatly disturbs UNHCR's efforts to oversee and actively protect the refugee and

[210] UNHCR-Kenya, 'Coronavirus (COVID-19) Update: *Information for Refugees and Asylum-Seekers regarding Coronavirus*' (2020) <https://www.unhcr.org/ke/coronavirus-covid-19-update> accessed 12 June, 2020
[211] *Ibid*
[212] UNHCR, 'West and Central Africa: *UNHCR Steps Up Efforts as Combined Challenges of Conflict and Coronavirus Threaten Millions of People*' (2020) <https://www.unhcr.org/news/briefing/2020/4/5e995d934/west-central-africa-unhcr-steps-efforts-combined-challenges-conflict-coronavirus.html> accessed 13 June 2020

asylum-seeker population from the agonizing consequences of the pandemic, including monitoring host countries' health systems. The psychological well-being of Kenya's in-camp refugee population has greatly deteriorated since the start of the pandemic. Despair, fear, and anxiety have rented the camps, with an increase in suicide attempts witnessed from all corners: their uncertainty of the resettlement outcome being replaced with the horrors of the pandemic. Humanitarian aid from partnered agencies has significantly reduced, with the availability of food and employment being adversely affected, creating a mental health *crisis*.

The overcrowding situation of the camps does not leave room for implementing basic COVID-19 precautions like social distancing, with residents queuing for relatively every service rendered – from water and food, to medical assistance.[213] However, despite UNHCR-Kenya's initiative to provide assistance of clean water, soaps, sanitizers, and other hygienic necessities, the lack of important facilities necessary to aid the treatment of the deadly virus, including intensive care units and medical ventilators,[214] tenders a great risk to the physical and psychological well-being of refugees.[215] Essentially, due to the unfledged health sector of developing nations like Kenya, the agency's intention to support the evolving governments in mitigating the hostile effects of the pandemic remains a huge challenge. Additionally, fear and anxiety caused by the Covid-19 outbreak may result in refugees feeling unsafe, and therefore unwilling to seek medical assistance, thus posing an even greater risk to their physical as well as psychological welfare.

[213] Ismail Einashe, 'In a Kenyan refugee camp, a radio host fights Covid-19 disinformation' (2020) <https://www.codastory.com/disinformation/coronavirus-kenya-refugee-camp/>
[214] Ruairi, Casey 'In vast Kenya camp, refugee journalists on coronavirus front line'(2020) *Aljazeera* <https://www.aljazeera.com/news/2020/5/27/in-vast-kenya-camp-refugee-journalists-on-coronavirus-front-line>
[215] Joseph, Akwiri 'In Kenya, COVID-19's Rural Spread Strains Creaky Healthcare'(2020) *Reuters* <https://www.reuters.com/article/us-health-coronavirus-kenya-idUSKBN28H0J0>

3.5 Conclusion

This chapter has successfully analyzed the refugee health issues, highlighting the gaps and challenges restricting their access to healthcare resources. Since it is not possible to review all psychological, reproductive, and maternal health issues, I selected the most commonly identified medical complications among refugees. Crucially, I assessed the discussion and argued that, while access to healthcare services is a universally-accepted central right, a person's legal and administrative status plays a huge role – if not the only determining factor – in its utilization and implementation. Even for refugee host states that have ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Charter of Fundamental Rights of the European Union,[216] including the Banjul Charter, implementation practices deviate from this crucial obligation. I observed that a migrant's legal status is generally the main issue that stands between them and their utilization of healthcare assistance – in as far as quality health care services actually exist. The next chapter discusses the health systems' interventions and active responses to the healthcare access dilemma.

[216] Charter of Fundamental Rights of the European Union (2012) Document 12012P/TXT

CHAPTER FOUR

STRATEGIES TO REMEDY THE REFUGEE HEALTH CARE DILEMMA

4.1 Introduction

The previous chapter interrogated the refugee health concerns, revealing the gaps and challenges hindering their quest for health care aid. It appears that despite the various complications endured by refugees in accessing healthcare services, the health systems in place have fairly responded to their cries. Following this, decades since the genesis of forceful migrations, refugees' access to medical assistance is still greatly impeded, with an even higher percentage of both men, women, and refugee children being unable to fully secure this indispensable right. International actors are yet to fully prioritize and implement the entitlement to health, through facilitating its access and promoting the provision of social health determinants for the refugee populations they host.

Since 'access' is linked to the availability of medical services, the quality of health care assistance afforded to refugees is primarily based on their ability to access the resources. In an attempt to secure medical access for all groups of individuals, collectively, backed by Article 14[217] of the 1948 Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social, and Cultural Rights (ICESCR) acknowledges the absolute right to "the highest attainable standard of physical and mental health". Arguing that nationality and legal status should not be a basis for determining an individual's access to healthcare resources, I relay through his Chapter that Kenya's refugee health system ought to establish interventions and innovative ways of

[217] Article 14 of the UDHR guarantees individuals access standards of living suitable for their health and general well-being, along with an sufficient food, clothing, housing, access to social services, financial reassurance in instances of employment termination, disease or incapacity, or in any other circumstances beyond their control.

guaranteeing healthcare delivery. Approaches that would secure the implementation and sequential utilization of medical resources, if at all Universal Health Coverage (UHC) outlined in international agreements are to be achieved. Drawing from a rich history of the developments in the refugee healthcare access struggles, this chapter interrogates some of the necessary strategies – guided by the New York Declaration and Ottawa Charter's approach – leveled towards meeting refugees' healthcare demands.

I commence the discussion with an analysis of the vital role played by social health care determinants in securing the protection of refugees' healthcare rights, primarily targeting its availability, while suggesting necessary reforms and crucial advances. This section progresses to discuss the financial and administrative interventions as potential remedies to the lack of funding and administrative pitfalls, respectively, impeding healthcare access. Noting that impediments are not credited to individuals' incapacities wholly, I further proceed to discuss the legislative and structural interventions that, if successfully enacted and skillfully implemented, secured access to top-notch healthcare services can be achieved. This part advances to discuss an oversight monitoring system and social integration and inclusion as a means of attaining health equity in Kenya's refugee system. In consideration of the impossibility to review all prospective solutions to resolve the refugee healthcare problem, I have preferred a few for exemplification purposes.

4.2 Interventions to Refugee Health Access Barriers

4.2.1 Social Interventions

According to a famous quote by Pope Francis, "Education, work, and access to healthcare for all are key elements for development and the just distribution of goods, for the attainment of social

justice, for membership in the society, and free and responsible participation..."[218]Whereas health care alone can be openly perceived as crucial yet inadequate within refugee settings, the health determinants, particularly the political, economic, social, cultural, environmental, and behavioral factors greatly impact individuals' general wellbeing. In fact, an effective response to refugees' health needs can essentially be achieved through a multi-sectoral and culturally sensitive response that considers the interconnection between healthcare and protection – the social factors. The World Health Organization (WHO) delineates 'social determinants of health' (SDH) as the non-medical issues that suggest individuals' health outcomes.[219]

Armed conflicts, including human rights violations as a result of persecution plight, met with resettlement into a safe environment with inadequate access to clean water and unhygienic shelters can greatly undermine an individual's ability to avoid, and react effectively to health-related complications.[220] Likewise, the migration process on its own exists as a social determinant of health. With thousands of refugees fleeing jurisdictions like Somalia and South Sudan, due to their high poverty rate, conflict, and poor health care systems, including high illiteracy levels, the conditions surrounding their plight, and long asylum application processes they are met with exposing them to even more negative health outcomes.

The national authority's duty to warrant access to "the highest attainable standard of health", being a guarantee to suitable and prompt medical care access is, and should be interpreted as inclusive

[218] Pope, Francis 'Pope Francis Quotes' <https://quotefancy.com/quote/890103/Pope-Francis-Education-work-and-access-to-health-care-for-all-are-key-elements-for> accessed on 16 August 2021
[219] World Health Organization, 'Social Determinants of Health' <https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1> accessed on 18 April 2021
[220] UNHCR, *Handbook for the Protection of Internally Displaced Persons* (Action sheet 15) vol. 287 pp. 287-9 <https://www.unhcr.org/4794b5d32.pdf> accessed 19 April 2021

of its determinants. However, a majority of refugee resettlement areas including the Dadaab refugee complex, Kakuma camp, and its neighboring Kalobeyei settlement lack adequate access to food, clean water, suitable living conditions, conducive learning environments, including proper sanitation and hygiene. The preexisting living conditions refugees are surviving in can in no way complement a good health system that advances a health-led objective. Without first establishing proper and decent housings to shelter the thousands of refugees crowded in the dreadful camps, as well as promoting initiatives that will enhance efficient communication between refugees and health officers, quality health care that reflects the general well-being of Kenya's refugee communities cannot be said to be secured.

Health-related risks within refugee settings are not only compounded by an inadequacy in healthcare facilities and supplies, but rather the lack of access to appropriate housing and sanitation, sufficient food, and clean water are quite detrimental to their wellbeing. Diseases that have effectively been controlled in the past can result in fresh outbreaks due to poor standards of living, particularly in crowded camp environments.[221] The obligation, therefore, remains for the Government, through its health system, to take progressive steps towards achieving utmost fulfillment of the right to health – including ensuring that the healthcare determinants such as clean water, proper sanitation, conducive educational and occupational environments, along with nutritious food, is made available. Such initiatives will essentially confront some of the key issues impeding refugees' procurement of readily obtainable medical resources. By establishing health care centers that are gender-sensitive and inclusive, adequately equipped and favorable to patients, including suitable shelters and learning facilities, while at the same time removing the language

[221] *See* supra note 167, pp. 287

and communication barriers, refugees' health care needs can be partially realized through the available resources. Moreover, a committed medical team that is sensitive to the needs, beliefs, cultural, and religious perceptions of its healthcare beneficiaries, as well as educative of the various medical complications and the involved treatments, is essential in ensuring that the marginalized community is not excluded from the benefits of Kenya' health system.

Ascribing health as an indispensable human entitlement, the Office of the High Commissioner for Human Rights (OHCHR) asserts that the prerogative to health extends to its underlying determining factors,[222] which includes the availability of clean water and proper sanitation, nutritious food, and hygienic dwellings, a safe occupational environment, including admittance to formal health education and information.[223] Likewise, the 1986 Ottawa Charter[224] and Jakarta Declaration of 1997[225] identify that, for universal health access to be attained; certain prerequisites must first be met which, inter alia, include peaceful surroundings, social justice, and equity. One of the crucial strategies in the attainment of quality, and equitable health for refugees is through promoting access to its underlying determinants, for instance through education – an initiative that will seek to promote cultural sensitivity and eradicate discrimination of the refugee communities. Refugees' realization of their full potential is influenced by their health, which is likewise determined by access to a satisfactory living environment, where all basic needs are adequately

[222] CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4)
[223] *Ibid*
[224] The Ottawa Charter for Health Promotion (adopted on 21 November 1986 1st WHO Conference on Health Promotion) (Ottawa Charter)
[225]The Jakarta Declaration on Leading Health Promotion into the 21st Century (adopted on 25 July 1997 4th WHO Conference on Health Promotion WHO/HPR/HP/4ICHP/BR/97.4) (Jakarta Declaration)

met. Similarly, a World Health Assembly resolution also identified addressing the health determinants as a vital step towards the achievement of universal health equality.[226]

Conclusively, therefore, Kenya must address the underlying factors essential to the health and well-being of individuals, including incorporating the same into its national policies as a means of promoting, protecting, and securing health equity. By firstly ensuring adequate and equitable access to the social determinants, either through their commitment to universal health equity or by advancing and reinforcing direct and inclusive social protection policies, the Kenyan Government can brag about being a step further in achieving nationwide health justice – particularly for its refugee population. However, this cannot entirely be realized through efforts by Kenya's health sector alone, and a well-coordinated action plan between the Government, the health and education sector, UNHCR, and partner agencies, including local and foreign civil society organizations, have a huge responsibility towards accelerating refugees' pursuit of health. This initiative, if efficiently put to action should be viewed as an investment to the constantly declining refugee camp environment, and the *unreachable*, yet obtainable health care services.

4.2.2 Financial Intervention

One of the commonly identified barriers limiting refugees' access to healthcare services is the high medical fees. Quoting Nelson Mandela, "the very right to be human is denied every day to hundreds of millions of people as a result of poverty, the unavailability of necessities, such as food, jobs, water and shelter, education, health care, and a healthy environment." Whereas priority

[226]WHO 'Reducing Health Inequities through Action on the Social Determinants of Health: *Sixty-Second World Health Assembly'* (2009) WHA 62.14 <https://apps.who.int/iris/bitstream/handle/10665/2257/A62_R14-en.pdf> accessed 19 April 2021

remains in maximizing refugees' health status through supporting medical access of similar quality to that of hosts, the financial burden in procuring medical assistance is yet to be released. Kenya and the general international humanitarian health-aid system are currently unsustainable, overwhelmed, and low on finances, and cannot, therefore, meet the underlying demands of several, and extended health-related emergencies.[227] However, to ease such distress, a financial scheme that targets to offer unrestricted medical assistance to both documented and undocumented migrants is quite essential. If the goal remains to secure nationwide health coverage, it is only logical that no one residing within Kenya's territorial boundaries should be left out. Tying the necessity to procure health care services, to the fundamental principles of human rights, a denial of health care assistance based on documentation[228] or financial incapacity, thus increasing the risk of morbidity, is a serious violation of individuals' rights that the international community should not ignore.[229]

Owing to that expensive medical fees are a central barrier to accessing medical services, financial security through either cash assistance or insurance schemes is one of the most courteous modalities to back refugee healthcare access. The Government on behalf of the health ministry, together with UNHCR-Kenya and its partnered agencies should work together to provide monthly, if not weekly stipends to vulnerable refugees centered on individual assessment, and based on objective suitability criteria as a means of financial assistance, towards the procurement of medical

[227] Spiegel, P.B., 'The Humanitarian System is Not Just Broke, but Broken: Recommendations for Future Humanitarian Action' (2017) *Lancet* <https://doi.org/10.1016/111S0140-6736(17)31278-3> (Accessed on 5, May 2021)

[228] In *R (on Application of A) v West Middlesex University Hospital NHS Trust,* the High Court judge held that "all asylum seekers who have not been ordered to leave the UK must be given free NHS healthcare" contending that like ordinary citizens, asylum-seekers reserve the right to access medical services irrespective of whether or not they present documentation.

[229] Pharmaceutical Society of South Africa v. Tshabalala-Msimang 2005 (3) SA 23 8 (SCA) Para 77 at pp. 495–6.

care aid. Where the presence of quality healthcare resources can be guaranteed, financial assistance in form of cash may greatly heighten access thereof, and utilization of healthcare services. However, since cash assistance is unlikely to reach all persons of concern considering Kenya's financial vulnerability, enrolment of the entire refugee population, into the existing and well-functioning national health insurance schemes could be an option. Better yet, feasible and sustainable social welfare schemes specifically suited for the refugee population, indiscriminately, should be established to meet their health care demands as the country is geared towards achieving its global health coverage commitments, and in accordance with the fundamental right to health.

A medical insurance scheme with an increased public awareness strategy, adjusted eligibility criteria, affordable premiums, and improved delivery, and management system[230] is a significant move leveled towards the inclusion of vulnerable populations, and an even greater step towards securing equitable health access for Kenya's refugee population. Such a scheme would greatly improve health care access, and advance financial reassurance to the hundreds of thousands of refugees in desperate need of medical aid. Effective implementation of a closely monitored cost-effective, and indiscriminate health insurance plan would confidently permit voluntary access to healthcare for a majority of refugees. Malaysia for instance has since 2014 implemented a health insurance scheme (REMEDI) aimed at providing and improving refugees' access to healthcare services.[231] Likewise, through the Interim Federal Health Programme, Canada has since provided provisional medical assistance to persons of concern but, apart from its negative reforms and

[230] UNHCR, 'A Guidance Note on Health Insurance Schemes for Refugees and other Persons of Concern to UNHCR' (2012) pp. 6-9 <https://www.unhcr.org/4f7d4cb1342.pdf> (Accessed 5 May 2021)
[231] UNHCR, 'Public Health in Malaysia' (2018) < > Accessed on 5 May 2021

consequences, excludes from its healthcare coverage, undocumented persons.[232] However, the ultimate intention of the international community, rushing towards securing a sustainably developed society, and guided by the Global Compact on Refugees agenda, entails having an integrated healthcare system that would benefit both the targeted refugee population and the hosts.

Nevertheless, where the host's health systems are overstretched and integration is therefore next to impossible as in Kenya's case, the right to healthcare access is no less a priority, and alternatives may be established.[233] Vulnerable refugees who may not be able to afford national health insurance may be directly assisted by the Government, either through subsidization of the insurance premiums or partial payments, with essential and emergency medical services being administered equitably, and without costs. So far Thailand is the only refugee host country that provides access to healthcare services for migrants (documented and undocumented), contributing greatly to health security within the country.[234] Conclusively, during this time that Kenya continues to face the adverse effects of the COVID-19 pandemic, the inclusion of refugees into the national financial protection schemes would greatly enhance the implementation of health services within refugee settings, as the country rushes towards the attainment of the global health goal. Relying on its commitment to achieving countrywide health equity, Kenya heeds a dedication to ensuring all persons and groups of persons under its jurisdiction – regardless of their ethnicity, nationality, or legal status – gain access to quality and satisfactory health assistance, devoid of any financial constraints.

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[232]Antonipillai, V., Baumann, A., Hunter, A. et al. 'Impacts of the Interim Federal Health Program reforms: A stakeholder analysis of barriers to health care access and provision for refugees'(2017) *Journal of Public Health* vol108, 435–438 <https://doi.org/10.17269/CJPH.108.5553>

[233]Paul S., and Rebecca C., 'Innovative health financing for refugees' (2018) <https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-018-1068-9> accessed on 5 May, 2021

[234]WHO 'Implementing health insurance for migrants, Thailand' (2016) *BMC Med* vol. 16(90) <https://www.who.int/bulletin/volumes/95/2/16-179606/en/> accessed 15 May 2021.

4.2.3 Administrative Interventions

Another central issue corroding Kenya's refugee health system, and therefore necessitating immediate intervention, is the unending incidences of corruption coupled with the high levels of insecurity and lack of accountability surrounding the sector. While to an extent medical services may be available, their access and subsequent utilization can be impeded by the continuous uncertainty and corruption practices of authorities. A presumption to the effect that in exercising their right to health, refugees have a legitimate expectation that the services rendered are excellent: administered by highly skilled, and qualified medical personnel.[235] For refugee health equity to practically be achieved in Kenya's health system, a number of several discrepancies owing to the system's coordinators and its officers on the ground need to be resolved. Firstly, the Government of Kenya (GoK) through the Ministry of Health (MoH), working with humanitarian partners must implement strategies that would seek to eliminate negligent, dishonest, corrupt, and fraudulent conduct probing refugee health-related operations. This would include conducting internal investigations[236] of refugee programmes and enhancing refugee participation, by encouraging them to report any instances of suspected fraud or corruption, including violence and insecurity.

By intervening, through holding quarterly active, and or oversight investigations into allegations brought against the camps' administrative and health officials, followed by a disciplinary hearing that would see the culprits chastised, the Government will be a step further in combatting the

[235] Afrox Healthcare v. Strydom 2002 (6) SA 21 (SCA) paras 19–21

[236] Sally, Hayden 'U.N. refugee organization reopens corruption probe after NBC News report' (2019) <https://www.nbcnews.com/news/world/u-n-refugee-organization-reopens-corruption-probe-after-nbc-news-n1084181> accessed 15 May 2021

corruption that relates to, and encumbers refugees' access to medical assistance. Similarly, the same initiatives ought to be directed against those who instigate violence and insecurity within, and outside refugee resettlement centers. As occurrences of Sexual and Gender-Based Violence (SGBV) continue ravaging Kenya's refugee populations, urgent intervention is required to halt the deterioration of residents' physical and mental wellbeing. Consequently, a dedicated team of security personnel should be deployed outside the refugee camps to monitor the security situation, especially at night.

4.3 Interventions to Refugee Health System

4.3.1 Legislative Interventions

Now that migration is no longer voluntary and the number of migrants continues to grow, the need for the world's commitment to their health care needs is more than ever, justified. While committing to secure universal health coverage as their number one sustainable development goal,[237] the international community has vowed to assure accessibility to affordable, acceptable, and quality healthcare services for all.[238] However, since the right to health is determinant to the principle of non-discrimination, the implication is that no individual or group of individuals, whether documented or undocumented is excluded from this top-priority global agenda.[239] In Kenya, access to healthcare services remains a right with an inadequate effort of implementation being employed. The main matter requiring urgent intervention, therefore, lies with the overall

[237] World Health Organization 'Universal Health Coverage: For Sexual and Reproductive Health' (2020) *World Health Organization* <http://www.jstor.org/stable/resrep28233> accessed 25 June 2021

[238] World Health Organization 'Tracking universal health coverage: *2017 global monitoring report'* (2017) pp.3 <https://apps.who.int/iris/bitstream/handle/10665/259817/9789241513555-eng.pdf > accessed 11 April 2021

[239]In R (on Application of A) v West Middlesex University Hospital NHS Trust, the High Court found that asylum seekers who had not been ordered out of UK were entitled to free access to health care services, contending that like ordinary citizens, asylum-seekers reserve admittance to medical services.

refugee legislative system. The absence of binding legal provisions *specifically* mentioning medical care as a right afforded to refugees within national, regional, and international boundaries, makes implementation and state accountability difficult.

Article 23 of the 1951 Refugee Convention, by obligating states to render refugees residing within their territories "the same treatment with respect to public relief and assistance as is accorded to their nationals", *may* be interpreted to include healthcare. Likewise, Kenya's Refugee legislation is completely silent on this aspect. Similarly, section 16 (a) of the Refugees Act, 2006,[240] contends that "…every recognized refugee and member of his family in Kenya shall be entitled to the rights and […] contained in the International Conventions to which Kenya is a party." The "rights" here can be impliedly construed to include health rights. Crucially, however, prioritizing medical aid as a fundamental human right, through enforcing strategies and action plans designed to promote healthcare access, subject to refugee-inclusive national and international laws, is a vital tool towards achieving global public health.

Justified by international human rights and humanitarian law principles, an urgent need remains for Kenya's relevant sector to address the refugee healthcare dilemma. Without such direct and binding provisions, states may argue that the current frameworks exist merely as guidance hence entirely persuasive on their part, in an attempt to justify non-conformity. Therefore, before any holistic efforts targeted at responding to refugee healthcare needs can be successfully implemented, a law must specifically be in place to enforce such action. Strengthened laws establishing an obligation upon Kenya on the indispensable duty to safeguard refugee health care

[240] *See* supra note 119, Art. 16 (a)

rights, together with the incorporation of such laws into its specific national refugee legislation [the 2006 Refugee Act], should be enacted, and its practical enforcement secured if at all universal health coverage is to be achieved.

For instance, notwithstanding the establishment of the Interim Federal Health Program (IFHP) to cater to refugee medical expenses in Canada,[241] no municipal provision giving effect to the universal right to healthcare access, specific to refugees, exists. The responsibility to protect the right to medical assistance for refugees is grounded on states' international human rights obligations, as under the Universal Declaration of Human Rights.[242] International human rights instruments, save for the International Covenant on Economic, Social, and Cultural Rights[243] [despite being general and not specifically targeting the refugee population], are silent on refugees' health protection. Conventions concerning refugee protection, particularly the 1951 Refugee Convention and its 1967 Protocol should have provisions that *directly* define the host states' responsibility to promote refugees' access to this life necessity, to ensure no escape and total accountability by Kenya. In fact, since the Universal Health Coverage (UHC) agenda targets every individual across the globe, the provisions should exert an obligation upon states to facilitate public healthcare accessibility even to those unlawfully in their territory.

With "health" being a determinant for the enjoyment of all other rights, Kenya should particularly include within its national refugee legislation such provision(s). In fact, to guarantee this inherent

[241] Antonipillai, Valentina, *et al*. 'Impacts of the Interim Federal Health Program Reforms: A Stakeholder Analysis of Barriers to Health Care Access and Provision for Refugees' (2017) *Canadian Journal of Public Health* vol. 108 (4) pp. 435–36, <https://www.jstor.org/stable/90015954> accessed 15 June, 2021
[242] *See* Article 25 of the 1948 Universal Declaration of Human Rights mentions the right to health as including the right to an adequate standard of living.
[243] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) UNTS (ICESCR) Art. 12

entitlement at the national level, domestic refugee laws should encompass relative healthcare-right stipulations. For instance, the 2006 Refugee Act entitles "recognized" refugees to all rights contained in the international Conventions that Kenya is a party to.[244] This provision is to the effect that applicants denied refugee status or those unlawfully in Kenya cannot be protected. Firstly, therefore, since Kenya appreciates the 2030 Sustainable Development Goals, particularly target 3.8,[245] and is working towards achieving the same, such insensitive provision aimed at excluding health-entitled individuals based on refugee status cannot stand. Instead, a legal provision to the effect that every person within the Kenyan territory, without discrimination based on status or nationality, is entitled to healthcare services access, should be enacted.

4.3.2 Structural Interventions

4.3.2.1 System Monitoring

The aim of health-equality activists within the international community has always been to improve and guarantee refugees' healthcare access. Therefore, what better way than to monitor the management of the refugee health care situation? Through initiating a healthcare monitoring and reporting system, the health system will have control over the refugee population's behavioral health concerns, which would as a result facilitate rapid and timely medical responses.[246] A standardized monitoring and reporting system in the control of Kenya's Ministry of Health and partnered agencies is inarguably an effective strategy to cure the refugee healthcare dilemma. Abrupt changes to the refugee health facilities, including attacks and destruction of medical centers

[244] Kenya: The Refugees Act No. 13 of 2006, Sec. 16 (1) (a)
[245] SDG Target 3.8: it entails states' commitment to secure health equity, including financial security, admission to quality and affordable medical services and resources for the entire global population, indiscriminately.
[246] Brusin, Sergio 'The Communicable Disease Surveillance System in the Kosovar Refugee Camps in the Former Yugoslav Republic of Macedonia April-August 1999' (2000) *Journal of Epidemiology and Community Health* vol. 54 (1) *British Medical Journal*, pp. 52–57, <http://www.jstor.org/stable/25569123>

and equipment, infrastructural access difficulties as well as corruption, fraudulent conduct, and uncertainties can be resolved in time to respond to refugee medical emergencies, thereby reducing refugee morbidity. Surveillance will enable the health ministry to directly assess the health care situation accessed by Kenya's refugee populations, in doing so targeting, and evaluating the necessary resources.

The geographic situation of the refugee camps – designated far from Kenya's general population and closer to international borders – puts them at a greater risk of contagious disease outbreaks and health care access complications, with the delayed medical and financial response from the health ministry.[247] To prioritize and facilitate health care access, the medical services available to Kenya's refugee communities should meet the humanitarian threshold,[248] with a quality equivalence to that of the local population. This can be achieved at an early stage to address refugee survival needs through a public health surveillance plan that ensures monitoring and coordination. For instance, through EWARN and EWARS, infection monitoring and response systems programmed by the World Health Organization, it is possible to identify and timely respond to detection of communicable disease elements in the Arab Republic of Syria.[249]

Refugee populations hosted in Jordan have also benefited from an IT innovative programme launched by the WHO, since 2012. Successful implementation of the IERS has monitored healthcare access and service utilization, including trends of both communicable and non-

[247] *See* supra note 216
[248] UNHCR 'Office of the United Nations High Commissioner for Refugees' (2007) third edition, Geneva <http://www.unhcr.org/publ/PUBL/471db4c92.html> Accessed 1 May, 2021
[249] Sharif A., Ismail, Aula Abbara, Simon M. Collin, *et al*. 'Communicable disease surveillance and control in the context of conflict and mass displacement in Syria' (2016) *International Journal of Infectious Diseases* vol. 47, pp 15-17 <https://www.sciencedirect.com/science/article/pii/S1201971216310542> accessed 1 May 2021

communicable illnesses, to realize the health needs of refugees living in Jordan.[250] The Ministry of Health in collaboration with donor agencies, whether separately as Kenya or, being home to millions of refugees, in an East African region, must establish a monitoring and reporting system. This is an essential strategy to fast-track health care support, resource expenditure, and access complications in refugee settings, in a move to aptly and effectively respond to the populations' emergency medical needs, thereby preventing mortality.

4.3.2.2 Integration and Inclusion

Safeguarding the right to health is a complex challenge for host governments worldwide, especially when the health services are to be provided to vulnerable or geographically excluded populations such as refugees. Based on the current state of countries of origin where refugees in Kenya commonly originate from, repatriation may not be an option. In this case, integration into the local population could mean a lasting solution to their predicaments, and a chance to rebuild a promising future.[251] Comprehensive integration of Kenya's refugee health system into its national health ministry is crucial in accelerating an indiscriminate and all-inclusive response to the health care access problems facing refugees, towards the achievement of universal health equity, and in an effort to *leave no one behind*.[252]

[250] WHO 'Comprehensive Assessment of Jordan's Health Information System 2016; *World Health Organization Regional Office for the Eastern Mediterranean'* (2019) pp. 23 <https://applications.emro.who.int/docs/9789290222583-eng.pdf?ua=1> accessed on 1 May 2021

[251] UNHCR, 'Local Integration' (2017) <https://www.unhcr.org/local-integration-49c3646c101.html?query=integration> accessed 9 June 2021

[252] The phrase "Leave no one behind (LNOB)" represents a crucial pledge of the 2030 Agenda for Sustainable Development and its Sustainable Development Goals (SDGs), representing UN member states' commitment to eradicate poverty, discrimination and foster inclusion and integration, and enable individuals' reach their potential.

Nonetheless, refugee healthcare services can be facilitated through an integration of the same into Kenya's healthcare systems, an endeavor that would greatly satisfy the medical needs of refugees residing in urban areas. This integration is particularly important for Kenya based on the large number of vulnerable refugees it hosts in unacceptable living conditions, with minimum access to social assistance and quality health care. For instance, Djibouti, through integrating refugees and adopting more comprehensive national refugee laws, has guaranteed the enjoyment of fundamental rights for more than 27,000 refugees, with their access to health care and social services secured by inclusion.[253] Likewise, Turkey has integrated Syrian medical professionals, including bilingual translators into its health systems as a way of addressing the key barriers to access, tending to the healthcare needs for its over 3.7 million-refugee population in a culturally sensitive manner, while simultaneously promoting social inclusion. Training of Syrian health practitioners and bilingual translators has enabled the Syrian population to enjoy the relevant services administered by certified professionals, free of charge. However, this is not happening in Kenya with most of its refugee community segregated in remotely congested and unhygienic camps, away from the general population.

Encouraging integration and cultural diversification between refugees and host communities will resolve to enhance the health and general welfare of both parties concerned, foster interaction, and eradicate communication barriers, while at the same time securing access to specialized medical care. Engaging refugees with host communities through education or other activities like training, that create an enabling environment will generally promote literacy through enhancing their understanding of policies, rights, and entitlements to social determinants and public health, thereby

[253] UN High Commissioner for Refugees (UNHCR), 'UNHCR welcomes Djibouti's new refugee laws' <https://www.refworld.org/docid/5a2fb4534.html> Accessed 9 June 2021

reducing the stigma of the minority group. Successful integration through the enactment of both national and local policies has a positive impact on the wellbeing and may balance the consequences of refugees' past trauma.[254] Likewise, primary healthcare is essentially the initial form of assistance refugees have with the health system, the nearest, and most accessible form of aid, situated close to refugee resettlement areas, including those in urban centers. Integrating mental health into the primary healthcare systems ensures that the refugee communities have access to uninterrupted mental and psychological health services. UNHCR continues to advocate for the incorporation of mental health into the primary healthcare systems, as a means to early identify and manage priority refugee mental health conditions.[255]

As the Refugee Agency continues to promote strategies leveled at securing access to quality health care for refugees, it strives for and prioritizes their inclusion into national health systems. For decades now, most if not all healthcare services for refugees are administered by UNHCR-Kenya and NGOs, with the inadequacy of services, delayed response to medical care emergencies, and internal health conditions such as trauma. All this is attributed to the fact that African refugee host countries discourage inclusion and integration making it difficult for refugees to access quality and adequate physical and psychological care. Noting that the right to health exists for the entire global population, there is a need for national health policies and systems to incorporate refugees.

[254]Morgan, Poteet and Shiva, Nourpanah (Eds.) 'After the flight: The dynamics of refugee settlement and Integration' (2016) *Cambridge Scholars Publishing*, Newcastle, UK. pp. 183–186 <https://books.google.co.ke/books?id=Sd76DAAAQBAJ&lpg=PA183&ots=ikmMo5Uhgv&lr&pg=PP1#v=onepage&q&f=false> Accessed on 9th June 2021

[255]UNHCR 'The Refugee Agency, Mental Health and Psychological Support' <https://www.unhcr.org/mental-health-psychosocial-support.html?query=health%20integration> Accessed on 9 June 2021

Including vulnerable refugees into communities and surroundings where they have sought refuge, is a prerequisite to creating an enabling environment that furthers their potential,[256] and enhances their general well-being. Moreover, the health of refugees should not be excluded from that of the local community for any country that is engineered towards the attainment of the SDG Target 3, and health equity. By establishing a health structure that seeks to advance integration and participation of refugees, whilst promoting their inclusion into the local health systems, service delivery for host communities will also be improved – a step towards achieving the Global Compact on Refugees' agenda, and securing a sense of welfare and dignity for Kenya's refugee population.

4.4 Conclusion

I have successfully discussed the modalities that can be implemented to remedy the refugee dilemma. Employing an analytic approach, I have explained the imperativeness of "*leaving no one behind*" in the quest for ultimate refugee health equity, and realization of Kenya's Universal Health Coverage plan. I have observed that amendments, along with the introduction and implementation of laws and policies, together with refugee inclusion in national health systems and programmes may greatly ease their healthcare burdens. I positively brought out how a standardized data collection and reporting mechanism within refugee resettlement zones is vital in securing timely action to respond to refugee health-related emergencies. The next chapter is the conclusion. It addresses how Kenya, as a middle-income host state to over half a million refugees, can effectively

[256] UNHCR 'The UN Refugee Agency, Social Inclusion of Refugees – Background Guide Challenge Topic 3'(2020) pp. 1-3 <https://www.unhcr.org/5fc126354.pdf> Accessed on 9 June 2021

respond to its health care dilemmas in the context of its refugee health system, and in compliance with the existing regulatory frameworks.

CHAPTER FIVE

SUMMARY OF FINDINGS, RECOMMENDATIONS, AND CONCLUSION ON KENYA'S FACILITATION OF REFUGEE PUBLIC HEALTH EQUITY

5.1 Introduction

This study was motivated by the idea that whereas robust international, regional, and domestic frameworks exist to promote and guarantee the fulfillment of individuals' fundamental right to health, efforts to secure practical obedience and progressive realization of Kenya's legal and moral obligation, remain a fantasy. I have noted that while the *Constitution of Kenya, 2010,* elaborately confirms limiting its sovereignty, a scrutiny of the document's practical implementation capacity reveals that the system fails to capture the true essence of the refugee regulatory frameworks, particularly in promoting the realization of refugees' access to equitable, and quality healthcare services. My analysis of Kenya's refugee health system apropos to the prevailing international refugee and human rights laws has revealed that a wide gap exists between the host state's pledge as contained in the regulations and the reality on the ground.

The study has dived into an analysis of the current legal and institutional frameworks safeguarding refugees' entitlement to protection of their inalienable healthcare prerogative, citing relevant non-refugee instruments of humanitarian nature as a display of global advocacy, and prioritization of universal health equity. I have examined the nature of the refugee resettlement areas in this particular East African region, highlighting the dangers they incontestably pose to refugees' general welfare. This study has articulately discussed the refugee health concerns, highlighting the gaps and challenges impeding its victims' rightful access to suitable medical assistance. I have

slogged further to deliberate on the obstacles that hinder refugees' enjoyment of quality and satisfactory healthcare assistance, not ignoring the limited initiatives undertaken by UNHCR, along with humanitarian partners, including the Government of Kenya, in easing their utilization of the available medical resources.

Conclusively, this discussion on Kenya's prevailing refugee health care situation has aided my comprehension that, the desperate situation can be remedied to – at the very least – correspond with the health system ordinarily accessed by the host communities, if a number of strategies can be practically, and effectively implemented.

5.2 Testing the Hypotheses

This study was substantiated on two interconnected presumptions contending that:

1. The divergence that exists between the protection of refugees' right to access healthcare services in theory and practice in Kenya's resettlement regions is mainly attributed to the absence of *specific* binding refugee legal provisions both at the national and regional levels.

2. The shortcomings and operational gaps faced by refugees directly accredit their impeded access to the available health care resources.

The first hypothesis was aptly confirmed in Chapter 2 of this study. Analyzing the legal instruments concerning refugees' protection of their health entitlements, this study confirmed that the legislation, both at the international, regional, and domestic levels do not *directly* impose upon state parties, including Kenya, the obligation to secure access to "the highest attainable standard

of health" for their refugee populations. Without prejudice to the generality of Article 23 of the 1951 Refugee Convention, this supposition established through section 2 of this study confirms that health is specifically guaranteed through provisions of international human rights agreements – which most states, Kenya included, impliedly misinterpret as to exclude the concept of those ascribed the status of *refugeehood*.

Chapter 3 of this study settled my second hypothesis. Discussing "the shortcomings and operational gaps" and "impedes the enjoyment of their health care entitlement" as the primary variables in this presumption, a review of literature resources has substantiated that, indeed the unresolved barriers are what primarily hinder refugees' utilization of the available, despite limited medical resources. The hypothesis has been satisfied with the fact that the existing gaps, for instance as regards service delivery within refugee health centers, further restrict the realization of the refugee populations', and subsequently Kenya's compliance to refugees' health care prerogatives.

5.3 Summary of Findings

1. Without prejudice to the fact that human rights principles have been extensively codified in various legislations, during this study I discovered that despite the existence of refugee protection at different levels, states' explicit and compelling basis as regards to the right to health for all individuals, including refugees, is particularly grounded on international human rights law provisions, and for Kenya, Article 43(1) (a) of its Constitution, 2010.[257] The implementation position is however entirely different. Medical care access is quite

[257] *See* discussion on Chapter 2 of this study.

limited for Kenya's refugee communities compared to that of its citizens, despite it being accorded the status of "a central human right", and therefore inalienable on any grounds whatsoever.[258]

2. The UNHCR, humanitarian partners, as well as local and foreign stakeholders, have been at the forefront in meeting most refugees' health care demands, and have significantly assumed the government's legal and moral responsibility through facilitating access to medical care and assistance.[259]

3. I have observed that despite the enactment of Article 2(5) and (6) of the Constitution, 2010, Kenya fails to conform with the legislative requirements, particularly with respect to securing equitable access to quality health care services for the refugees it hosts.[260]

4. My analysis on Kenya's non-conformity to its international law obligations has established that, whereas the state has not entirely neglected refugees' healthcare needs, the government has not made sufficient efforts to cure the impediments barring access to the limited available resources, nor has it practically effected plans to improve the quality of health care.[261]

5. This study identified some of the main health issues common to Kenya's refugee population and highlighted the gaps demanding urgent and strategized closure. I observed

[258] *See* discussions on Chapter 1 & 2 of this study.
[259] *See* discussions on Chapters 1 & 2 of this study.
[260] *See* discussion on Chapter 2 of this study.
[261] *See* discussion on Chapter 3 of this study.

that to secure the progressive realization of refugees' healthcare entitlements, an improvement of the quality of services administered, attainment of financial security, fostering population outreach, and service delivery are among the key variances requiring the government's intervention.[262]

6. This research paper reflected that the international laws applicable to the entitlement to health maintain the need to facilitate access to healthcare services as an ancient one grounded on human rights principles, thus host states are bound to ensure its protection in their resettlement regions, irrespective of whether or not such persons fit the 1951 Convention's refugee definition.[263]

7. This study made apparent that refugees' inability to secure effective treatment for their health concerns is not entirely attributed to the government's noncompliance: in as far as, the requisite resources are available. An analysis of Kenya's refugee healthcare situation has exposed that the problems refugees face in health centers are partly built on caregivers' inconsiderate attitude towards the benefactors' medical care entitlements.[264]

8. My analysis of this extensive topic has revealed that the inadequacies in nutritious food, clean water, and proper sanitation, including the various social health determinants, pose a major risk to the general wellbeing of refugees. The unhygienic living conditions in

[262] *See* supra note 252.
[263] *See* discussions in Chapters 1 & 2 of this study.
[264] *See* discussion in Chapter 3 of this study.

Kenya's refugee camps are hazardous to the health of its residents, and should be remedied to avert a humanitarian health catastrophe.[265]

9. Notwithstanding Kenya's lack of initiatives to gradually foster the realization of refugees' healthcare needs, this study found that economic headwinds accustomed to both refugees and Kenya's financial incapacity are what primarily signals quality health care availability and access dilemma.[266]

10. Albeit the restrictive regulations inhibiting refugees' access to the available health care resources, this paper has recognized language and communication differences, the dreadful living conditions in the extensive camps, inadequacy of finances, discrimination, and cultural insensitivity, including corruption and insecurity as some of the main hurdles hindering Kenya's attainment of refugee health equity.[267]

11. Perceptible through this study, Kenya's dysfunctional refugee health system can be remedied to achieve nationwide health equity, through collaborative initiatives between UNHCR-Kenya, the government, and relevant stakeholders, with strict adherence to, and implementation of the 2016 New York Declaration.[268] This paper notes that a culturally sensitive and extensively monitored health system that fosters refugee integration and

[265] *See* supra note 252.
[266] *See* discussion under Chapter 3 (3.3.2).
[267] *See* discussions under Chapters 1 & 3
[268] GOSTIN, L., 'WHO Global Action Plan to Promote the Health of Refugees and Migrants'(2019) *The Milbank Quarterly*, vol. 97(3), 631-635 <http://www.jstor.org/stable/45218854> accessed 29 June, 2021

inclusion, with minor legislative reforms, and financial profoundness, is imperative for global health coverage.[269]

12. This analysis remarked that availability thereof, and smooth access to health facilities such as mental and psychological support, maternal and childcare, along with sexual and reproductive aid, is crucial in ensuring a comprehensive and equitable refugee health system.[270] The study highlights that such can be achieved through Kenya's deliberation on having a policy-driven system that favors integration, and minimizes social exclusion.[271]

5.4 Conclusion

My particular interest in this project has been driven by the need to access Kenya's failure fully to comply with its legal obligation of securing refugees' access to quality health care. My review of this vast theme is envisaged on four interrelated questions as previously set out in Chapter 1.4. I have demonstrated that, the disjunction that exists between the black letter law, and the reality on the ground is partly attributed to the government's ignorance of the extent of its protection responsibility. I have argued that the approach of a monitored and holistic application of the spirit of the law, along with collaborative efforts in implementing homogeneous health-system interventions, can encourage good public health practice.

[269] See discussion under Chapter 4 of this study.
[270] World Health Organization, 'World Health Organization' (2019) <http://www.jstor.org/stable/resrep28094> Retrieved June 29, 2021.
[271] World Health Organization, 'Report on the health of refugees and migrants in the WHO European Region: *No Public Health without Refugee and Migrant Health'* (2018) *World Health Organization* pp. 77-80 <http://www.jstor.org/stable/resrep27935.10> Retrieved June 29, 2021.

Question one was pertinently articulated by an analysis of the second Chapter. It set out to give a comprehensive investigation of the legal and institutional frameworks pertaining to the protection of refugees, and observation on whether the same cater for their healthcare entitlement. In reacting to question one, section two of this study assessed the refugee instruments that charge the protection obligation on Kenya. I have analyzed the health care protection mechanisms from the international law standpoint to regional instruments, and Kenyan regulations. Despite the welcoming policies prevalent in Kenya's 2006 Refugee legislation, this study noted that the prerogative to health takes a broad, and inferred view based on the provisions of refugee legal frameworks, and further highlighted that its justification is expressly captured by the Constitution, 2010 [Article 43 (1) (a) and 2].

The Chapter made a detailed assessment of the UN Resolutions and Declarations, which has brought forth the desperate intention of the international community to secure global health equity. An evaluation of United Nations General Assembly (UNGA) resolutions and binding legislations have revealed that indeed the international community has long been aware of the existing gap between theory and practice, and throughout the years has adopted tools and strategies to promote health care realization and strengthen States' protection mandate. Particularly, a review of the most recent 2016 New York Declaration and its counterpart, the Global Compact on Refugees [adopted by Kenya] brings hope to the realization of universal health security that would potentially transform the lives of millions of refugees, through strengthening solidarity between states.

Notwithstanding the fact that the 1969 OAU Convention takes a more humanitarian approach with regards to African member states' recognition of a refugee, unlike the 1951 Convention and the

1967 Protocol it claims to complement, it does not expressly, nor by implication obligate host states to secure benefits of the fundamental entitlement to health, for refugees. Noting that international human rights law predominantly establishes this fundamental right, this first chapter featured the non-refugee instruments that within their provisions ascribe to Kenya, an obligation to secure the health needs of persecution survivors. Further, in response to this question, I examined the UNHCR, IMO, and WHO as the primary institutions tasked with the mandate of facilitating the realization of refugees' rights, along with ensuring quality health care delivery. I noted that while the primary responsibility rests with host states, UNHCR-Kenya, in collaboration with affiliated humanitarian agencies, and NGOs have led the struggle of securing equitable healthcare access for Kenya's refugee population.

The second question in this study sought to investigate the health problems and obstacles impeding refugees' equitable utilization of health care services. Chapter three of this paper has undertaken to answer this question, extensively. The chapter, established entirely through doctrinal research began by analyzing the health concerns common among refugee communities, highlighting the common issues, gaps, and challenges that they face. To begin with, this section noted that access to specialized medical care is highly impeded in economically underprivileged countries – a factor that undermines the quality of services rendered. To argue that whereas access to health care and assistance is considerably curtailed, the Kenyan administration is not entirely to blame; this study has resorted to demonstrating that the refugee community is partly responsible for its derailed access to the available health care resources. The discussion examined the mental health concerns affecting refugees and noted that the main obstacle to its access is attributed to refugees' cultural misconceptions and criticisms. Proceeding to the second part of the chapter with the understanding

that, for a healthcare claim to be deemed as fulfilled, quality medical resources should be seen to exist, I examined the various factors impeding access and realization of refugees' healthcare demands. Further, the study noted that, while insufficient and substandard curative services may be available, its access is mainly barred by financial, administrative, and structural factors, without ignoring the socio-cultural constraints.

I have demonstrated that, for refugee health care access to be secured, collective strategies ought to be implemented to remedy the preexisting challenges. The third question of this study is on what strategies may be instigated to promote equitable health care access and has been tackled under Chapter four. Contending that detecting gaps is the precursor to filling them, while reflecting on the previous Chapter's discussions, this Section of the paper has made a distinctive evaluation of scholarly works, as well as a lesson-compelled analysis of the trends in more-developed, and impartially-driven refugee health systems. It has supported the presumption that a vigorous implementation system on equitable health-access strategies by the Kenyan government, in collaboration with both local and international stakeholders, is one way of facilitating refugees' fulfillment of their health care entitlements. I have established a remarkable series of interventions particularly suited to remedying Kenya's defective refugee health system and aimed at securing a progressive realization of its international law obligations. Reflecting on the binding legal frameworks directly pertaining to the protection of refugees, the segment concluded with a discussion of the legislative reforms warranted.

It further advanced to identify the social determinants influencing refugees' health, emphasizing the necessity for a surveillance system to oversee the dispensation of health care services, while at

the same time ensuring timely response to refugee health emergencies. Echoing the sentiments of the Ottawa Charter and General Assembly recommendations as contained in the Global Compact on Refugees, the chapter dictated the need for inclusive financial interventions by Kenya, as a means to promote and facilitate refugee health equity. This study has confirmed that Kenya is far from meeting its compliance obligations regarding an equitable provision of quality health care for the refugees it voluntarily hosts. The inadequate assistance it makes available to refugees does not meet a third of what the disadvantaged population desperately demands. Throughout the previous chapters, by illuminating the difficulties refugees continue to face in the lamentable camps they are doomed to call home, the study gives impetus to the insistent struggle for their physical, social, and psychological wellbeing, directly impactful on their health. Making various proposals and recommendations for reform, this final chapter seeks to react to the fourth and ultimate question of this study: the proposals necessary to progressively secure the realization of refugees' access to "the highest attainable standards of health", by Kenya.

5.5 Recommendations

An unhealthy refugee generation is detrimental to international peace, development, and prosperity. To uphold justice and defend individuals' self-determination and dignity, the government must be open to scrutiny and constant enrichment by the common subjects of its laws. Closing the gaps in refugee health protection is a prerequisite to establishing measures that seek to prioritize and enhance Kenya's protection capacity. To address the above-mentioned challenges, and to secure refugee health equity, I make the following recommendations:

a. As evidenced by my analysis of Chapter 4.3.1, the Government should strongly consider amending the Refugee Act to include the inalienable right for refugees, and

asylum-seekers to procure admission to health care services *similar to that of its local population*. This is especially important given that the international legal frameworks such as the OAU Convention are silent on a matter of global significance, and a prerequisite to the attainment of Universal Health Coverage (UHC), thus demanding reformative action. Given that all persons [including refugees] are equally entitled to health care assistance,[272] the same should be expressly highlighted in the country's relevant regulatory texts.

b. My evaluation of the legislative instruments in Chapter 2 reveals that, based on Kenya's fidelity to achieve health equity as contained in the sustainable development agenda, healthcare cannot be said to be universal if undocumented migrants are excluded.[273] This means that Kenya as a refugee resettlement state should practically occasion health care to be *unconditionally* accessible to all persons – irrespective of immigration status, and or documentation – as a moral and humanitarian duty. As UNHCR suggests, the most crucial initiative to improve access to healthcare services is to practically remove any legal constraints and inequitable practices that hinder its access.[274] Currently, Thailand is the only migrant resettlement country that provides health care

[272] Francoise, Girard and Wilhelmina, Waldman, 'Ensuring the Reproductive Rights of Refugees and Internally Displaced Persons: *Legal and Policy Issues*'(2000) *International Family Planning Perspectives* vol. 26(4), pp. 167-168 <www.jstor.org/stable/2648254> accessed 13 July 2021

[273]Helen, Clark, 'What will it take to achieve the Sustainable Development Goals?' (2017) *Journal of International Affairs*, pp. 53-55 <http://www.jstor.org/stable/44842600> accessed July 13, 2021

[274] UNHCR, 'Ensuring access to health care: operational guidance on refugee protection and solutions in urban areas' (2011).

access to its entire migrant population, regardless of their immigration status[275] - a position the entire refugee host states community ought to emulate.

c. As apparent in my observation of chapter 4.3, this study proposes that the relevant authorities should fast-track the currently procrastinated resolution of a backload of Refugee Status Determination (RSD) cases, and supervise the issuance of legal documentation to eligible candidates, to extensively minimize the negative impact of migration and resettlement.[276] This will mitigate against rendering some individuals undocumented, and therefore ineligible for accustomed refugee rights.

d. Based on my analysis in Chapter 2.4, the health ministry along with stakeholders should establish mechanisms aimed at promoting and facilitating equitable access to comprehensive available, affordable, and indiscriminate health care services. This should include the adoption of health promotion strategies as suggested by United Nations General Assembly, the Ottawa Charter[277] and Global Compacts, disease prevention, and securing financial health security, as well as establishing refugee health

[275] Wah Yun Low, Wen Ting Tong and Colin Binns, 'Migrant Workers in Asia Pacific and Their Rights to Health' (2015) *Asia Pacific Journal of Public Health* vol. 27(6) pp. 585-587 <http://www.jstor.org/stable/26725663> accessed July 13, 2021

[276] The Kenya Refugees Act of 2006 requires that asylum seekers to first apply to the Commissioner for Refugee Affairs (the Commissioner). If they are dissatisfied with the commissioner's outcome regarding their asylum applications, they may make an appeal with the Board (section 9) to have the decision of the Commissioner reviewed. If the party is still displeased with the Board's decision, they may then access the High Court, which is the final institution. Currently no RSD case has progressed to the High Court since UNHCR-Kenya dispensed its RSD mandate to the Refugee Affairs Secretariat – headed by the Commissioner – in July 2014 with the cases that have graced the High Court remaining unresolved.

[277]The Ottawa Charter for Health Promotion (adopted on 21 November 1986 1st WHO Conference on Health Promotion) (Ottawa Charter)

care facilities in target urban settlements such as Garissa County and Nairobi's Kibera slums, and Eastleigh region.

e. An evaluation of Chapter 4.2.1 of this study contends that, in solidarity with UNHCR and partner agencies, the government of Kenya should enhance capacities, and foster the distribution of items and services such as clean water, proper sanitation, including effecting infrastructural developments essential to enable refugees to live in dignity.[278] This can be done through an inter-sectoral approach that takes into account the general wellbeing of refugees, with particular attention to factors such as transport, appropriate and hygienic shelters to replace the temporarily-designed living quarters, safe and conducive educational facilities, secure working conditions, along with ensuring culturally-appropriate medical care services.

f. My observations of Chapters 3 and 4 recommend that specialized Institutional or reference bodies be established to oversee, manage and report on aspects of refugees' health care access across the spectrum of physical, mental, and psychological wellbeing,[279] including the provision of the broad social determinants, and health inequality framework. The ministry of health should introduce strategies and an action plan base that gives special attention to assessing the availability and adequacy of healthcare limiting factors, medications, and treatment for chronic illnesses at refugee

[278] Morton, Beiser 'The Health of Immigrants and Refugees in Canada' (2005) *Canadian Journal of Public Health* vol. 96, pp. 30-44 <http://www.jstor.org/stable/41994458> accessed July 14, 2021
[279] Sergio, Brusin, 'The Communicable Disease Surveillance System in the Kosovar Refugee Camps in the Former Yugoslav Republic of Macedonia April-August 1999' (2000) *Journal of Epidemiology and Community Health* vol. 54(1), pp. 56-57 <http://www.jstor.org/stable/25569123> accessed July 14, 2021

reception centers and medical facilities, along with evaluating the outbreak of diseases that can potentially cause morbidity and mortality among camps' residents.[280] This can be achieved through conducting, and directly supervising medical examinations and disease screenings, training to assist overcome cultural, religious, and language barriers, along with improving the surroundings and living conditions of refugee populaces.

g. An analysis of the health access barriers in Chapter 3 of this study proposes that, to alleviate the ignorant conduct problem of health workers on refugee patients, the government should conduct mandatory educational training and periodic assessments of the medical practitioners and health officers, collectively, with service continuation being based on merit. Similarly, civic education and community outreach should be extended to the entire refugee population to enable them to voice out their concerns and demand dignified services, and treatment of their health complications at relevant health facilities.

h. With reference to Chapters 2 and 4, this study advises the government to issue clear and unambiguous policy guidelines and preemptive solutions proposing that all persons be allowed access to medical screening, and utilization of services relative to their health care needs, at any given time, and in any part of the territory, without regard to their legal status. This should further be facilitated by a committed workforce that is

[280] *See* supra note 210

devoted to reaching out to public health facilities to ensure that refugees are included, and directly benefit from the national health care systems.[281]

i. Reflecting on the observations of Sections 3.2, 3.3 and 4.3.2 of this paper, I suggest that an interlinked system of database for refuge seekers' consolidated personal, and medical records be created and connected between the government, UNHCR-Kenya, and local humanitarian partners' systems to monitor, and expedite the full automation of healthcare service provision and access for refugees in need of specialized medical care. This will not only enable efficient, effective, and impartial resource and financial contribution in obtaining suitable diagnoses for emergency outbreaks, various chronic diseases, and expedite referrals, but will also make disease prevention, minimize corruption, and identification of target victims easier, quicker, and less costly.

j. Based on my comments in Chapter 3.2, I recommend that the Government of Kenya (GoK) should fund, and encourage dedicated refugee support groups as a tool in building resilience and providing moral and psychological support assistance to traumatized survivors of persecution, with particular attention toward victims of sexual and gender-based violence. This therapeutic initiative can be effected by conducting weekly sessions where groups meet to vent and share their challenges, and experiences, including their encounters, experiences, and grievances (if any) of the medical system.

[281] UNHCR, 'Emergency Handbook; *Health in Urban Areas'* (4th edition) 1-4

This has been successfully done in Australia, where peer support programmes have heightened social support and increased empowerment among refugee women.[282]

k. Centered on engaging the strategy in Chapter 4.3.2.2, this research paper recommends that the Government, together with the health ministry and UNHCR-Kenya should identify, and authorize refugee health professionals and humanitarian workers to offer medical services, and assistance in refugee health facilities as a means of promoting, and facilitating participation and inclusion. This can be done through practical training and licensing of competent doctors, nurses, including bilingual translators from among refugee communities living in Kenya. This form of integration will greatly address some of the key barriers such as language/communication and cultural differences currently prevailing, and impeding access to the available health care resources; while at the same time strengthening health system capacity.

l. Driven by the need to address the general health inequalities in Kenya's refugee health system, my reflection of Section 2.4 submits that the Government, collaborating with the Ministry of Health should greatly consider adopting, and integrating relevant United Nations General Assembly Resolutions on public health promotion into its national health legislation, as a means of achieving the Convention's objectives.[283]

[282] Liamputtong, Pranee *et al*, 'Peer support groups, mobile phones and refugee women in Melbourne'(2016) *Health Promotion International'* vol. 31 (3), pp 715–717, <https://doi.org/10.1093/heapro/dav015> accessed 16 October, 2021

[283] General Assembly Resolutions Relating to UNHCR and Promotion of Refugee Health Equality.

m. A recollection of the findings in Chapters 3.2.3 and 4.3.2.2 insist that, the incorporation of mental and psychological health services within the broader public health system should be a prioritized agenda of the Government's health ministry in collaboration with UNHCR-Kenya and relevant humanitarian partners. This can be secured through the development of policies, funding initiatives, and advocacy to ensure that MHPSS is equally ranked and efficiently utilized, thus bridging the treatment gap existing within the refugee communities.

n. A review of Chapter 2 notes that Kenya does not have in place policy provisions relating to the health care entitlements for its non-local population. There is therefore a dire need for the Government to formulate policy measures geared towards promoting a comprehensive approach that nurtures refugee [or migrants collectively] inclusion into the national health system. This idea will necessitate a coordinated review of the Immigration Act, the Refugee Act, along with relevant health legislation.

o. Based on my analysis of Chapters 3.3.2 and 4.2.2, I endorse that an empowerment program should be established to allow for private individuals' monetary, and or material support. While Kenya's refugee system is currently financially overwhelmed despite assistance from the international humanitarian community, millions of persons from the country's general populace are able, and willing to lend a helping hand and ease the government's burden, facilitating the attainment of sustainable peace and health security for the refugee population.

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