REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA AT NAIROBI

CONSTITUTIONAL AND HUMAN RIGHTS DIVISION

PETITION NO. 151 OF 2020

IN THE MATTER OF THE DEFENCE OF THE CONSTITUTION UNDER ARTICLES 3, 10, 19, 20, 22 AND 258 OF THE CONSTITUTION OF KENYA

AND

IN THE MATTER OF THE ALLEGED VIOLATION OF ARTICLES 19, 21, 28, 29, 31, 39,43, 47,51 AND 53 OF THE CONSTITUTION OF KENYA, 2010

AND

IN THE MATTER OF THE ALLEGED VIOLATION OF SECTION 8(6) OF THE PUBLIC ORDER ACT, CAP 56 OF THE LAWS OF KENYA

AND

IN THE MATTER OF THE ALLEGED CONTRAVENTION OF SECTIONS 4 AND 5 OF THE HEALTH ACT NO. 21 OF 2017

AND

IN THE MATTER OF THE ALLEGED VIOLATION OF SECTIONS 4 AND 5 OF THE ACCESS TO INFORMATION ACT, NO. 31 OF 2016

AND

IN THE MATTER OF SECTIONS 4 AND 5 OF THE FAIR ADMINISTRATIVE ACTION ACT NO. 4 OF 2015

AND

IN THE MATTER OF THE ALLEGED CONTRAVENTION OF THE PUBLIC HEALTH (COVID 19 RESTRICTION OF MOVEMENT OF PERSONS AND OTHER RELATED MEASURES) RULES, 2020 AND

PUBLUC HEALTH ACT (PREVENTION, CONTROL AND SUPPRESSION OF COVID 19) REGULATIONS, 2020

BETWEEN

C.M (Suing on her on behalf and on behalf of PM (Minor) as parent..... 1ST PETITIONER

M.O..... 2ND PETITIONER

M.O..... 3RD PETITIONER

M.W.M..... 4TH PETITIONER

K.F..... 5TH PETITIONER

F.A..... 6TH PETITIONER

K.B..... 7TH PETITIONER

KENYA LEGAL & ETHICAL ISSUES NETWORK ON HIV & AIDS (KELIN)..... 8TH PETITIONER

KATIBA INSTITUTE..... 9TH PETITIONER

VERSUS

HON. ATTORNEY GENERAL .....1ST RESPONDENT

THE CABINET SECRETARY, HEALTH .....2ND RESPONDENT

THE CABINET SECRETARY, INTERIOR AND COORDINATION OF NATIONAL GOVERNMENT.....3RD RESPONDENT

AND

INDEPENDENT MEDICO-LEGAL UNIT (IMLU) .....1ST INTERESTED PARTY

DR MARGARET MAKANYENGO OTHIENO.....1ST AMICUS CURIAE

INTERNATIONAL COMMISSION OF JURISTS (ICJ) KENYA.....2ND AMICUS CURIAE

1ST AMICUS CURIAE'S SUBMISSIONS

A. INTRODUCTION

1. The purpose of these submissions is to assist the Honourable Court in appreciating the following issues:

1.1. What is the objective of quarantine in relation to protection and advancement of individual and public health?

1.2. What are the rights of people under quarantine?

1.3. What is the mental health impact of quarantine?

1.4. What measure would mitigate any negative impacts on mental health during quarantine?

2. Dr Makanyengo's application for admission as friend of this Honourable Court detailed her extensive experience in mental health work as a clinician in the public service, an educator and policy-maker. In particular, she has demonstrated her experience in the intersections between mental health and emergency or crisis contexts, epidemic and public health interventions, and in relation to children.

3. On the basis of Dr Makanyengo's expertise, these submissions broadly make three inter-linked arguments:

3.1 First, the Amicus demonstrates that the proper objectives of quarantine relate to the protection and advancement of both individual and public health. As

mental health is a core component of health, the objectives of quarantine must take into account the fact of mental health.

3.2 Second, the Amicus demonstrates that the right to health under our Constitution includes the right to the highest attainable standard of mental health. This right is an inclusive right and one which particularly recognizes the negative impact of stigma on both individual and public health.

3.3 Third, the Amicus applies the right to the highest attainable standard of mental health to the use of quarantine, including through examining the facts placed on record by the Petitioners. In doing so, the Amicus submits that the manner in which quarantine was enforced against the petitioners unnecessarily undermined their rights to mental health. The Amicus proposes that applying the normative framework of the right to mental health to the use of quarantine in the COVID-19 pandemic will minimize the negative mental health impact of such measures and advance public health.

B. THE OBJECTIVES OF QUARANTINE IN PROTECTION AND ADVANCEMENT OF INDIVIDUAL AND PUBLIC HEALTH.

4. The dictionary definition of quarantine states that it is :

"a state, period, or place of isolation in which people or animals that have arrived from elsewhere or been exposed to infectious or contagious disease are placed".

5. Internationally, there is a distinction made between the terms "quarantine" and "isolation"

   The World Health Organization ("WHO") distinguishes the terms as follows:[1]

a. Quarantine is the **separation and restriction of movement of people who have potentially been exposed** to a contagious disease, with the objective of monitoring their symptoms and early detection of cases.

b. Isolation is the **separation of people who have been diagnosed** with a contagious disease from people who are not sick to prevent the spread of infection or contamination. This is slightly different from the meaning of "isolation" in section 2 of the Public Health Act (Chapter 242), which applies to both persons who are infected with a communicable disease and persons suspected of being infected.[2]

6. The COVID-19 Quarantine Protocols distinguish between "self-quarantine" and "mandatory quarantine". While both forms of quarantine appear to be mandatory, the terms are used seemingly to distinguish were a person who has been potentially exposed to COVID-19 remains in their home and avoids social contact, as opposed to where such a person is required to remain in a State-designated facility for the quarantine period.

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[1] World Health Organisation, Considerations for Quarantine of Individuals in the Context of Containment for Coronavirus Disease (COVID-19) 19 Marc 2020.

[2] Section 2 of the Public Health Act defines isolation as follows:

> "the segregation and the separation from and interdiction of communication with others, of persons who are or are suspected of being infected; "isolated" has a corresponding meaning".

7. The Ministry of Health's 27 March 2020 **COVID-19 Quarantine Protocols** describe the purpose of quarantine to be:

"for people or groups who don't have symptoms but were exposed to the sickness. Quarantine keeps them away from others so they don't unknowingly infect anyone."

8. The Centre for Disease Control (CDC) states the purpose of Quarantine from a public health perspective to be as follows;

"Quarantine separates and restricts the movement of people who were exposed to a contagious disease to see if they become sick. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms".

9. It is the humble submissions of the amicus that although the sole objective of quarantine is to protect the general public from an infectious disease, it may have a negative impact on the well-being of the people whose freedom has been restricted leading to harm if it is not conducted well. For the objective to be effective, it should be conducted in a manner that does not cause more harm to the victims and the rest of the public. As a result of the mental health effects of quarantine, W.H.O made the following recommendations for implementation in quarantine situations:

"If a decision to implement quarantine is taken, the authorities should ensure that:

a. ***Basic needs like adequate food, water, protection, hygiene and communication provisions can be made for the quarantine period;***

b. *The infection prevention and control (IPC) measures can be implemented;*

c. *The requirements for monitoring the health of quarantined persons can be met during quarantine.*

10. It is therefore of extreme importance that the authorities involved exercise caution on how they handle people who are admitted to quarantine. The public should understand why they are going into quarantine and they should be willing to go having adequate information on what to expect while they are there. They should not be forced. People admitted to Quarantine need to be treated well so that they are able to fully cooperate with the public health department to ensure that the objectives are met.

11. In line with the decision in **Daniel Ng'etich & 2 others v Attorney General & 3 others [2016] eKLR (Petition 329 of 2014)** (hereinafter "**Ng'etich**") and in recognition of the public health objectives of quarantine, the Amicus further affirms its interpretation that punitive or crime prevention purposes are never permissible objectives of quarantine.[3]

12. In order to understand whether a particular measure is necessary to achieve the objectives of quarantine, this Court may have regard to, amongst others, international best practice. In the **Ng'etich**, the Court considered that in appreciating whether a particular limitation of right meets a health objective, section 26 of the Siracusa Principles on the Limitation and Derogation Provisions

[3] Para 61: "*it is clear that the intention behind isolation is not punishment*".

in the International Covenant on Civil and Political Rights is of guidance,[4] where it states:

"Due regard shall be had to the international health regulations of the World Health Organization."

United Nations Economic and Social Council Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, U.N. Doc. E/CN.4/1985/4, Annex (1985) ("The Siracusa Principles").

13. The WHO has issued interim guidance to States on implementing quarantine measures as a response to COVID-19 being **World Health Organisation, Considerations for Quarantine of Individuals in the Context of Containment for Coronavirus Disease (COVID-19) 19 March 2020** (hereinafter **"WHO recommendations").**

14. The Amicus submits that this guidance is an expression of international best practice. Amongst others, the WHO recommendations include the following points:

14.1 Quarantine should be implemented "only as a part of a comprehensive package

[4] See para 53 et seq.

of public health response and containment measures"[5] and, in accordance with

Article 3 of the International Health Regulations (2005), the practice should be

fully respectful of the dignity, human rights and fundamental freedoms of

persons.

14.2 States "should properly communicate such measures to reduce panic and improve compliance."[6] Amongst others, the WHO emphasizes clarity, transparency, consistency and reliability of communications and information on quarantine measures and constructive engagement with affected communities. Quarantined people must receive an understandable explanation of their rights, available services, how long they will stay, and what will happen if they get sick.[7]

14.3 The WHO states expressly that "Psychosocial support **must** be available."[8]

14.4 Moreover, the WHO states that quarantined persons "need to be provided with health care (including appropriate medical treatment for existing conditions and daily follow ups), financial, social and psychosocial

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[5] World Health Organisation, Considerations for Quarantine of Individuals in the Context of Containment for Coronavirus Disease (COVID-19) 19 March 2020, p 1.

[6] WHO, p 1.

[7] WHO, p 2.

[8] WHO, p 2. Emphasis added.

support and basic needs including food, water and other essentials. The needs of vulnerable populations should be prioritized."[9]

14.5 The WHO warns that if quarantine measures are not implemented properly, there is a risk that the practice "may also create additional sources of contamination and dissemination of the disease."[10] The WHO guidance for what amounts to an appropriate setting for quarantine therefore includes ventilated, spacious rooms, with suitable environmental infection controls and that social distance must be maintained between all persons.[11]

14.6 The WHO recommends quarantine only for a period of 14 days from the last time a contact of a COVID-19 patient had contact with the patient.

C. THE RIGHTS OF PEOPLE UNDER QUARANTINE

15. People under quarantine have rights to health as stipulated in the WHO comprehensive care package of public health response and containment measures in accordance with Article 3 of the International Health regulations (2005). It states that the practice of quarantine should be fully respectful of the dignity, human rights and fundamental freedoms of persons.

16. WHO Constitution defines health as follows:

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[9] WHO, p 1.

[10] WHO, p 1.

[11] WHO, p 2.

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities.

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.

Mental health is fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. On this basis, the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world.

17. The Office of the High Commissioner for Human Rights (hereinafter "**OHCHR**") has endorsed this definition.[12] This same definition is adopted in the **Ministry of Health "Kenya Mental Health Policy 2015-2030: Towards Attaining the Highest Standard of Mental Health", 2015, p 1** (hereinafter "**Mental Health Policy**").

18. The case of **Federation of Women Lawyers (FIDA – Kenya) & 3 others v Attorney General & 2 Others; East Africa Center for Law & Justice & 6 Others (Interested Party) & Women's Link Worldwide & 2 Others (Amicus Curiae) [2019] eKLR (Petition 266 of 2015)** (hereinafter "**FIDA Kenya**"), also relied on the WHO definition to find that "health" is "a state of

[12] Human Rights Council (2017) Mental Health and Human Rights: Report of the United Nations High Commissioner for Human Rights A/HRC/34/32, para 4.

complete physical, mental and social well-being, and … not only the absence of disease or infirmity."[13]

19. This mirrors the definition of "health" in section 2 of the **Health Act 21 of 2017.**[14]

20. The Kenya Constitution similarly guarantees the right to the highest attainable standard of health. The Kenya National Mental Health Policy 2015-2030 reiterates the position as captured in the Kenya Constitution at Article 43 thereof. The right to health under the Constitution is understood to encompass the protection of the right to the highest attainable standard of mental health. Article 43(1)(a) of the Constitution protects the right of *every person* –

"to the highest attainable standard of health, which includes the right to health care services, including reproductive health care".

21. In addition, article 53(1)(c) of the Constitution further entrenches that "Every child has a right to basic nutrition, shelter and health care." The OHCHR defines mental health, in relation to children and adolescents to mean "*the capacity to achieve and maintain optimal psychological functioning and well-being*".[15]

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[13] At para 36. This is also the definition of health contained in the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

[14] It is noted that government policy endorses the State's recognition that mental health is a human rights. See Ministry of Health "Kenya Mental Health Policy 2015-2030: Towards Attaining the Highest Standard of Mental Health", 2015, p 6.

[15] As above.

22. While the Constitution is not explicit in the inclusion of the words "mental health", the Amicus submits that the rights in articles 43(1)(a) and 53(1)(c) include the protection of both physical and mental health for at least four reasons:

22.1 First, it is inherent in the ordinary and legal meaning of "health" as detailed above.

22.2 Second, this inclusion is established precedent. The court in **FIDA Kenya** considered that applying the ordinary meaning of the term "health" in interpreting the Constitution required consideration of mental, psychological and physical health.[16] The Court stated that "*Health, in our view, encompasses both physical and mental health.*"[17]

22.3 Third, the inclusion of mental health follows as an incident to the broad, liberal and purposive approach to be taken to interpretation of constitutional rights.[18]

22.4 Fourth, the inclusion of mental health under the rubric of the right to health is founded under international human rights law to which Kenya is bound. For example, in **Mathew Okwanda v Minister of Health and Medical Services & 3 Others [2013] eKLR (Petition 94 of 2012)** (hereinafter "**Okwanda**") Majanja J held:

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[16] Para 362.

[17] Para 372.

[18] Njoya & 6 Others v The Attorney General & 4 Others (2004), KLR 232, as endorsed by the Supreme Court in Jasbir Singh Rai & 3 others v Tarlochan Singh Rai Estate of & 4 others [2013] eKLR at para 126.

"Apart from Constitutional provisions governing economic and social rights, Article 2(6) provides that treaties and conventions ratified by Kenya shall form part of the law of Kenya. ... Article 25.1 of the Universal Declaration of Human Rights (UDHR) provides that: 'Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services.' The African Charter on Human and People's Rights (ACHPR) guarantees every individual the right to enjoy the best attainable state of ***physical and mental health.***"[19]

23. Mental health is therefore a crucial part of health in any person. There is no health without mental health. Individuals in Quarantine have the right to health under our constitution like any other citizen.

24. Accepting that the proper objectives of quarantine are to preserve and protect individual and public heath, the Amicus submits that this objective must be understood to include the preservation and protection of **mental** health in toto.

The Doctrinal Content of the Right to mental health

25. The Amicus submits that the right to health under the Constitution, and the right to mental health in particular, is not exclusively a right to access healthcare treatment and services. As demonstrated to follow, the right to health is an inclusive right that embodies both "positive" and "negative" obligations on the State and which is inter-linked to the protection of other fundamental rights.

[19] At para 14. Emphasis added.

26. Article 21(1) of the Constitution states that it is the fundamental duty of the State "to observe, respect, protect, promote and fulfil the rights and fundamental freedoms in the Bill of Rights."

27. Applied to the right to health generally, this means that, amongst others, the State has "negative" duties, such as to refrain from directly or indirectly interfering in the right to health. [20] In addition, the State has "positive" duties. It must preserve and protect the enjoyment of the right to health that people already enjoy. Moreover, it must promote and fulfil the right and, in doing so, progressively realise the right. This requires that the State must immediately take steps and must be seen to be taking steps to realise these rights.[21]

28. Importantly, as a component of these protections, Article 43(3) creates a duty on the State to positively fulfil the right to health when individuals are unable to do so themselves such as, the Amicus submits, where a person's freedom of movement is denied in quarantine:

"The State shall provide appropriate social security to persons who are unable to support themselves and their dependents."

29. The Court in **Okwanda** referred to the Committee on Economic, Social and Cultural Rights (CESCR)'s General Comment No 14 on The Right to the

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[20] Mitu-Bell Welfare Society v Attorney General & 2 Others [2013] eKLR (Petition 164 of 2011) (hereinafter "Mitu-Bell"), para 55-56.

[21] Mitu-Bell, para 53.

Highest Attainable Standard of Health[22] in recognising the inclusive and interdependent nature of the right to health:

"The scope, content and nature of State obligations under Article 12 of the ICESCR ... recognises that the right to health is closely related to the economic rights and is dependent on the realization of the other rights including the rights to food, housing, water, work, education, human dignity, life, non-discrimination, equality, prohibition of torture, privacy, access to information and other freedoms."

30. The CESCR's General Comment 14 (as referred to in **Okwanda**) further sets out that the right to health is a guarantee –

"not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health."

31. In application to the right to mental health, the OHCHR states that:

"*Mental health is not merely a health or medical concern, it is very much a matter of human rights, dignity and social justice.*"[23]

32. The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

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[22] United Nations Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, available at: https://www.refworld.org/docid/4538838d0.html.

[23] Para 34.

("**Special Rapporteur on Health**") states that, like all aspects of health, "*a range of biological, social and psychological factors affect mental health*".[24]

33. UN Special Rapporteur describes how a rights-based approach to mental health requires a move away from seeing mental health in a "*reductionist biomedical paradigm*" and away from the use of non-consensual treatment measures. [25]

34. Rights-based approaches start from an understanding of mental health as embedded in social, cultural, economic contexts and unequal power relations. In the result, rights-based approaches to mental health emphasise empowerment, consent, social inclusion, socio-economic support and community-based support and care services. As stated by the Special Rapporteur:

"The evolving normative context around mental health involves the intimate connection between the right to health, with the entitlement to underlying determinants, and the freedom to control one's own health and body. That is also linked to the right to liberty, freedom from non-consensual interference and respect for legal capacity."[26]

D. THE MENTAL HEALTH IMPACT OF QUARANTINE

[24] United Nations Human Rights Council (2017) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health A/HRC/35/21, available at: https://www.un.org/en/ga/search/view_doc.asp?symbol=A/HRC/35/21, para 30.

[25] As above, para 7.

[26] Para 31.

35. That the right to the highest attainable standard of mental health emphasises (amongst others) access to information, autonomy, empowerment, consent and inclusion, finds congruence in a principles of rights limitations that our Courts have developed to require that the State engage in "*meaningful consultation with persons directly*"[27] affected by its decisions. This was emphasised in **Attorney General v Kituo Cha Sheria & 7 others [2017] eKLR** where the Court's reasoning stresses the functional connection between consultation and communication with stakeholders and effecting rights-affirming and rational decisions.[28]

36. This approach to the right to health generally, and to the right to mental health specifically, includes a growing appreciation that subjecting people to coercive and rights-violating health interventions is harmful to people's physical and mental health and, therefore, counter-productive.

36.1 For example, in the context of psychiatry, the Special Rapporteur on Health has described how the use of coercion perpetuates power imbalances in health care relationships, causes mistrust, exacerbates stigma and discrimination and has made many turn away, fearful of seeking help within mainstream mental health services.[29]

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[27] Attorney General v Kituo Cha Sheria & 7 others [2017] eKLR, p 21.

[28] See p 21.

[29] United Nations Human Rights Council (2017) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health A/HRC/35/21, available at: https://www.un.org/en/ga/search/view_doc.asp?symbol=A/HRC/35/21, para 65.

36.2 In the context of HIV, the Special Rapporteur on Health has described how coercion is documented to undermine the effectiveness of HIV prevention programmes, particularly because of the stigmatising effect of these laws.[30] The Special Rapporteur stated further that coercive and criminalising measures undermine public health responses, amongst others, by creating distrust in the healthcare system.[31]

37. Applying these principles in the context of the Amicus' expertise, the Amicus submits that coercion in healthcare, and particularly the removal of peoples' freedoms and sense of autonomy and control over their bodies, deeply undermines peoples' dignity and their emotional and mental well-being. Such is the case when enforcing quarantine. This has direct implications for health care services. Trust between health care providers and health care users is eroded and people become disempowered in making informed decisions about their care.

38. Understanding the right to health as interdependent and inclusive requires an approach to services that considers the human being as a whole (in their full social and economic contexts) and that makes services and care accessible in the community. As a result, the use of coercive means as a health care intervention, such as mandatory quarantine, should be a measure of the very last resort.

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[30] United Nations Human Rights Council Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover (2010) A/HRC/14/20. Para 54-5.

[31] As above, para 63.

Stigma and Coercive Public Health Measures

39. As stated by the Special Rapporteur on Health, referred to above, the Amicus submits that stigma is a common effect of the use of coercive public health measures, a phenomenon which deeply undermines both individual rights and public health.

40. The African Commission on Human and Peoples' Rights describes the term "stigma" as –

"a dynamic process of devaluation that significantly discredits an individual in the eyes of others, such as when certain attributes are seized upon within particular cultures or settings and defined as discreditable or unworthy."

African Commission on Human and Peoples' Rights, "HIV, the Law and Human Rights in the African Human Rights System: Key Challenges and Opportunities for Rights-Based Responses" (2017), p xi.

41. Stigma makes deep intrusions on an individual's dignity and mental health. In considering the impact of stigma in the context of child offenders and victims of crime, the South African Constitutional Court said that:

"Stigma, while largely influenced by external factors, is an internalized struggle and the consequences are deeply personal."

Centre for Child Law and Others v Media 24 Limited and Others (CCT261/18) [2019] ZACC 46; 2020 (3) BCLR 245 (CC), para 79.

42. Stigma does not only threaten individual well-being. Where associated with disease or illness, stigma has dangerously negative impacts on public health. In

the context of HIV, international, foreign and domestic law has recognised this harmful impact. For example:

42.1 The African Commission on Human and Peoples' Rights considers HIV-related stigma and discrimination to hinder efforts to end HIV because stigma discourages openness and disclosure on one's health status and undermines the ability and willingness of people to access and adhere to treatment.[32]

42.2 The South African Constitutional Court, in a case concerning a person's right to privacy of their HIV-status held that:

"the social construction and stigma associated with the disease make fear, ignorance and discrimination the key pillars that continue to hinder progress in its prevention and treatment. These pessimistic perceptions persist to fuel prejudice towards people living with HIV/AIDS." **NM and Others v Smith and Others [2007] ZACC 6; 2007 (5) SA 250 (CC), para 48.**

43. The Amicus submits that stigma similarly threatens individual rights and public health in the COVID-19 response.

44. The Ministry of Health is aware of the threat of COVID-19-related stigma. On 1 April 2020, the Ministry of Health published "A Comprehensive Guide on Mental Health and Psychosocial Support During the COVID-19 Pandemic" (hereinafter "**MOH Mental Health Guide**"). The MOH Mental Health Guide aims to assist

[32] African Commission on Human and Peoples' Rights HIV, the Law and Human Rights in the African Human Rights System: Key Challenges and Opportunities for Rights-Based Responses (2017), para 30.

clinicians and healthcare workers to "cover the needs of the population, people on treatment for COVID-19, those in quarantine and isolation, people with mental health conditions requiring continuing care in these settings, and health workers."[33]

45. The MOH Mental Health Guide specifically considers the implications of COVID-19-related stigma on mental health. It states that stigma associated with COVID-19 can be reduced, amongst others, by "acknowledging that people affected by COVID-19 have not done anything wrong and deserve our love and kindness" and by "being ready to welcome persons who have recovered from COVID-19 back into the community without discrimination."

46. Yet the experiences described by the Petitioners indicate that the State failed in fulfilling these guidelines. For example:

46.1 CM, the first Petitioner, said she was treated "differently" as if she was an infectious person that would transmit a disease.[34]

46.2 FA, the sixth Petitioner, is aggrieved by what he describes as "ad hominem disparaging statements on people in quarantine" made by the Ministry of health as having "social effects", leaving him with a sense of having a "cloud of irresponsibility and / or stigma hanging around" him and that he feels inhibited to talk about his experience in his community.[35]

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[33] The Amicus notes that the document was published during the period in which the facts giving rise to the Petition occurred.

[34] CM Affidavit, para 23.

[35] FA Affidavit, paras 42-43.

46.3 MWM, the fourth Petitioner, says that the climate of stigma made her "fearful" and that she felt alienated.[36]

46.4 KF, the fifth Petitioner, describes being "decontaminated" by State officials with a chemical substance, despite her protestations.[37]

47. The Amicus submits that where State interventions create or perpetuate stigma, this violates the right to health and the right to dignity. In addition, it violates Article 21(3) of the Constitution, which provides that all state organs and public officers "have a duty to address the needs of vulnerable groups within society" including (amongst others) women, persons with disabilities and other "members of minority or marginalised communities".

COVID-19 and mental health impact

48. That a public health emergency will inevitably impact mental health in particular is recognised in government policy. The Mental Health Policy, for example, specifically provides for the coordination of mental health services in "national disasters, emergencies and disease outbreaks"[38]

49. For people in quarantine, stress-factors may be even more acute in a public health emergency. Such factors may include the greater duration of

[36] MWM Affidavit, paras 65-66.

[37] KM Affidavit, paras 28-30

[38] Ministry of Health "Kenya Mental Health Policy 2015-2030: Towards Attaining the Highest Standard of Mental Health", 2015, p 15.

confinement, having inadequate supplies, difficulties securing medical care, and resulting financial losses.[39] In relation to persons in quarantine and isolation the MOH Mental Health Guide states as follows:

49.1 Persons in quarantine "are likely to report distress due to fear and risk perceptions. Their distress can be amplified in the face of unclear information and communication." The MOH Mental Health Guide therefore stresses the importance of establishing "safe communication channels" for people in quarantine.

49.2 Amongst what the Ministry considers the "typical reactions of people in quarantine / isolation" are the following:

49.2.1 Anxiety, worry or fear relating to their health status and that of others.

49.2.2 Potential loss of income and job security.

49.2.3 Challenges securing necessities such as groceries and personal care items.

49.2.4 Uncertainty or frustration about the future and length of their situation.

49.2.5 Concerns about being able to care effectively for children.

49.2.6 Loneliness, anger, boredom and frustration.

49.2.7 Symptoms of depression such as feelings of hopelessness, changes in appetite or sleeping.

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[39] Pfefferbaul B 2020 "Mental Health and the COVID-19 Pandemic" The New England Journal of Medicine, p 1.

49.2.8 Symptoms of post-traumatic stress disorder such as intrusive distressing memories, flashbacks, nightmares, being easily startled and changes in throughs and moods.

49.3 The MOH Mental Health Guide also describes ways to support people in quarantine and isolation as including providing accurate information about COVID-19, infection and risk, encouraging practical ways to manage stress, and encouraging people to speak about their needs and be self-advocates.

50. On examining the Petitioners' statements, the Amicus notes that the Petitioners have described worrying experiences of negative mental health effects that align with these anticipated effects in the MOH Mental Health Guide. However, the Amicus submits that these experiences go further than what should be expected as inevitable consequences of quarantine *per se* and relate directly to key aspects of the right to health outlined above that have not adequately been fulfilled in enacting quarantine measures.

51. The following examples are drawn from the Petitioners' evidence to substantiate this submission:

51.1 For example, FA, the sixth Petitioner, stated that for a number of hours on arriving at the airport, no immigration, port health or other officials

provided any information about what would happen to the passengers[40] and that the situation made him feel "restless".[41]

51.2 MWM, the fourth Petitioner, says that "the lack of communications or information on out circumstances was particularly distressing".[42] She describes further the "tension and anxiety" of the quarantined individuals after not receiving direct information on the results of COVID-19 tests in the hotel[43] and that the absence of information "added to the stress of the situation."[44]

51.3 KM, the fifth Petitioner, states that the quarantine process was traumatizing as information was piecemeal which left her "guessing for the worst."[45]

51.4 These extensive references to the impact of inadequate communication in both the period of quarantine and its initial enforcement could have caused the Petitioners distress. As stated above, the right to access information is a core component of the right to health. As referenced in the WHO Guidelines on quarantine, proper, clear, reliable and consistent communication and transparency should be a feature of the appropriate use of quarantine.

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[40] FA Affidavit, paras 8-14.

[41] FA Affidavit, para 11.

[42] MWM Affidavit, para 43.

[43] MWM Affidavit, para 49.

[44] MWM Affidavit, para 51.

[45] KM Affidavit, para 45.

52. In relation to the State's duty to respect and protect the right to physical health and not to expose people to threats to their health, the Petitioners describe distress in being exposed to circumstances where they were unable to apply precautionary measures to avoid COVID-19 infection (such as "social distancing")[46] both in the preliminary stages leading to quarantine as well as in quarantine facilities. For example, CM, the first Petitioner, says she was scared, fearful and concerned when noticing the crowds in the airport.[47] MWM, the fourth Petitioner, says she was "anxious" when being unable to keep sufficient distance from other passengers when being held in the airport and concerned when officials were not equipped to maintain hygiene practices or wearing masks.[48]

53. In relation to the right to access adequate health care services, a source of distress for the Petitioners is indicated in the lack of medical attention, timely testing for COVID-19, and delivery of test results. For example, CM, the first Petitioner, describes the inadequacy of medical attention beyond having temperatures taken as "traumatizing".[49] KM, the fifth Petitioner, says that the delays in receiving her test results and lack of information particularly caused her anxiety.[50]

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[46] The term is used here to refer to the practice of ensuring distance between individuals who are quarantined. The WHO recommends at least 1 m distance to be maintained at all times between persons in quarantine (World Health Organisation, Considerations for Quarantine of Individuals in the Context of Containment for Coronavirus Disease (COVID-19) 19 Marc 2020).

[47] CM Affidavit, para 8 and 11.

[48] MWM Affidavit, para 17-18.

[49] CM Affidavit, para 41.

[50] KM Affidavit, para 40.

54. In relation to the social determinants of health and the State's duty to provide for the basic needs when depriving individuals of their freedom of movement, the Petitioners describe heightened anxieties around the financial pressure imposed of them by needing to raise funds to pay for the quarantine facilities, food and water. The following excerpts demonstrates the point:

> MWM, the fourth petitioner, states that her mother was placed under "extreme duress" to raise funds to pay for the hotel.[51] She says that despite extensive efforts to negotiate in the situation, the imposition of fees was "shocking and distressing".[52]
>
> FA, the sixth Petitioner, describes a state of heightened anxiety at the possibility of a prolonged period of quarantine imposing unplanned financial expenditures on his family.[53] CM, the first Petitioner, describes feeling "exploited"[54]

55. As a result of these failures to fulfil the right to heath in the course of quarantining the Petitioners, the evidence shows severe impacts on the Petitioners' mental health:

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[51] MWM Affidavit, para 30.

[52] MWM Affidavit, para 76.

[53] FA Affidavit, para 28.

[54] CM Affidavit, para 45.

55.1 For example, after a period in quarantine, a number of the Petitioners describe exhibiting physical symptoms of distress including sleep disturbances, insomnia, a lack of appetite,[55] and panic attacks.[56]

55.2 MWM, the fourth Petitioner, says she made efforts to sustain her mental well-being by keeping contact with family and friends and attending to school work but that she was "struggling emotionally, feeling isolated, unsure, anxious and afraid" in quarantine.[57] She describes having panic attacks, hyperventilating, feeling faint, shaking uncontrollably, crying, losing her ability to speak "because of the stress and uncertainty" of her situation.[58]

55.3 Similarly, KM, the fifth Petitioner, describes insomnia and panic attacks where she had a rapid heart rate, intense feelings of fear and light-headedness. She relates the cause of these experiences as being from feeling "threatened, stressed and anxious from being isolated, deprived of my liberty and having no control of the situation".[59] She describes "intense anxiety, … sadness due to isolation from human contact [and] suicidal thoughts."[60]

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[55] KM Affidavit, para 45.

[56] MWM Affidavit, para 39.

[57] MWM Affidavit, para 53.

[58] MWM Affidavit, para 55.

[59] KM Affidavit, para 36.

[60] KM Affidavit, para 45.

55.4 As a result of a climate of uncertainty and insecurity, the Petitioners describe feeling "tired"[61], "deflated", mentally "exhausted",[62] "worried"[63], confused, shocked,[64] frantic,[65] and in chaos.[66] They describe arguments between passengers and officials, being shouted at and scolded.[67]

55.5 The Petitioners describe anger at the situation in total and in particular in relation to a sense of lack of control. MWM, the fourth Petitioner, said the incident created bitterness and distrust.[68] KM, the fifth Petitioner, says she was "very angry and disappointed" and scared by her experience.[69] FA, the sixth Petitioner, describes feeling "deeply aggrieved" and "troubled".[70]

56. The Amicus submits that the MOH Mental Health Guideline appropriately identifies the mental health risks inherent to the enforcement of quarantine on individuals. The Amicus submits, however, that on the basis of the facts provided by the Petitioners, the State failed to meet its own standards and failed to address the mental health needs of the Petitioners and more particularly that:

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[61] FA Affidavit, para 20.

[62] MWM Affidavit, para 35.

[63] FA Affidavit, para 23.

[64] MWM Affidavit, para 23.

[65] MWM Affidavit, para 29.

[66] FA Affidavit, para 23.

[67] MWM Affidavit, para 31-32.

[68] MWM Affidavit, para 80.

[69] KM Affidavit, para 31.

[70] FA Affidavit, para 37.

56.1 Despite knowledge of the inherent threat of quarantine to individual's mental health, the State failed to undertake the very support measures described in the Guide.

56.2 Despite the MOH Mental Health Guide noting the importance of encouraging people to speak out about their concerns and be self-advocates, the opposite occurred. MWM, the fourth Petitioner, describes being "shouted at and told to stop complaining so much" when seeking clarity and information from officials.[71] She describes that Hotel Management (which the Amicus submits were providing State services and thus acting on the State's behalf) controlled who could access and participate in communication platforms by blocking people who asked difficult questions or became confrontational.[72]

56.3 KM, the fifth Petitioner, describes being told that there were complaints about her from the Hotel management and that she received a phone call from the Ministry of Health for "talking too much and causing panic".[73] She was told by the Ministry of Health official to stop talking and tell her family she was doing well.

56.4 The State did not articulate the Guide as well as implementing in practice, measures to minimize the mental health harms to the Petitioners and other quarantined persons. For example, the Ministry of Health's Interim Guidelines on Management of COVID-19 in Kenya make no proactive provision for psychosocial support or mental health care and

[71] MWM Affidavit, para 27.

[72] MWM Affidavit, para 611

[73] KM Affidavit, paras 33-34.

services for affected persons or children, including those in isolation. The only reference to mental health in the Quarantine Protocols is where the 1199 telephone number is noted for Mental Health and Psychosocial support services.

57. It is evident from the above descriptions that the Petitioners indeed needed psychosocial services and support. For example, the fifth Petitioner, KM, describes that after experiencing a 36-hour period of sleeplessness, at her own initiative and expense engaged the services of a psychiatrist to prescribe medication to assist her.[74]

58. The Amicus observes that the negative mental health impacts evidenced by the Petitioners were not necessary or incident to the mere fact of quarantine. The Amicus submits that this is evident in the resilience and adaptability described by the Petitioners when faced with restrictions in contexts where they were given adequate information and support. For example, MWM, the fourth Petitioner states that she was "completely adjusted to living in a COVID-19 impacted area" and appreciated the importance of the restrictive measures she was subjected to prior to returning to Kenya from Singapore.[75]

59. That the extent of the negative mental health impacts on the Petitioners exceeded any necessary incident of the mere fact of quarantine is further evident in how the Petitioners describe moments of relief from their distress when their rights were respected. This includes instances when the Petitioners were eventually consulted by a doctor, provided with information, tested for

[74] KM Affidavit, para 38.

[75] MWM Affidavit, para 9.

COVID-19, or having confirmation of a negative COVD-19 test result after prolonged delays. For example, MWM, the fourth Petitioner, describes a "combination of relief but also concern" when assuming she was COVID-19 free on the basis that that no one had been contacted with a positive-test result.[76] FA, the sixth Petitioner states it was "a relief" when a doctor explained some physical symptoms he was experiencing, even though he persisted with doubt having not been tested for COVID-19.[77]

Impact of quarantine on children

60. In addition to the child's right to health outlined above, article 53(2) of the Constitution states that the "child's best interests are of paramount importance in every matter concerning the child." The child's best interests are legally the "*supreme parameter in matters concerning the welfare of a child*".[78]

61. In **Mitu-Bell Welfare Society v Attorney General & 2 Others [2013] eKLR (Petition 164 of 2011)** (hereinafter "**Mitu-Bell**"), the Court held that the State has a particular duty to take "*action to provide for the needs of vulnerable groups, particularly children*" in the course of complying with its duties in relation to social and economic rights.[79]

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[76] MWM Affidavit, para 50.

[77] FA Affidavit, para 26.

[78] N M M v J O W [2016] eKLR (Civil Appeal 30 of 2016), para 53.

[79] At para 72.

62. Children who are quarantined in the circumstances described in the Petition undoubtedly experience all these same stresses and emotions as adults, only being more vulnerable to their effects as a result of their youth.

63. The amicus submits that any form of isolation and confinement is inherently harmful to children's mental health and wellbeing is recognized under human rights law. The law relevant to the deprivation of liberty of children in other contexts is instructive:

63.1 The United Nations Committee on the Rights of the Child ("**UNCRC**") consider, for example, that actions that hamper a child's full participation in their community, such as stigmatization and social isolation, violates children's rights.[80]

63.2 The UNCRC considers solitary confinement of children unlawful because it violates the prohibition against torture, cruel, inhuman and degrading treatment and the child's right to dignity. This view is shared by the United Nations Committee against Torture and the United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment ("Special Rapporteur on Torture").[81]

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[80] UN Committee on the Rights of the Child (CRC), General comment No. 10 (2007): Children's Rights in Juvenile Justice, 25 April 2007, CRC/C/GC/10, available at: https://www.refworld.org/docid/4670fca12.html, para 29.

[81] UN Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 5 March 2015, A/HRC/28/68, available at: https://www.refworld.org/docid/550824454.html, para 41.

63.3 The Special Rapporteur against Torture considers the use of seclusion against children in healthcare settings such as in psychiatric institutions abusive and a violation of human rights to liberty and the prohibition against torture.[82] In this regard, the Special Rapporteur explains:

> *"Children need more than physical sustenance; they also require emotional companionship and attention to flourish."*[83]

63.4 The Special Rapporteur against Torture[84] further reinforces that, owing to their vulnerability, children should only be deprived of their liberty, including in healthcare settings, where such deprivation is in the child's best interests. This may only be as a measure of absolute last resort and in exceptional cases. States should always seek less restrictive alternatives such as community-based care.

64. The Amicus submits that on the basis of the Petitioners' evidence, there is no indication that any measures were undertaken to accommodate children's best interests in quarantine, in stark violation of the rights of the child. To the contrary, the Petitioners evidence indicates that quarantined children suffered violations of their right to mental health unnecessarily.

65. For example, in describing the sense of chaos and uncertainty in the airport, MWM, the fourth Petitioner, says that the children "became increasingly

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[82] As above, para 53-55.

[83] As above, para 56.

[84] As above, para 72.

agitated".[85] CM states that her 9-year old daughter was crying and she describes feeling helpless in her inability to comfort her child, to feed her or find a safe place for her to sleep.[86] Following overnight delays, CM describes her daughter's hunger and that she "looked exhausted" and "distressed".[87]

66. There is also no indication that any special measures were undertaken to accommodate for the needs of children while in quarantine. This is despite that the Mental Health Policy recognises children as a vulnerable group.[88]

67. For example, CM, the first Petitioner, states that, being worried about the effect of isolation on her daughter, she took the initiative to ask a friend to bring toys and a colouring in book for the child. She described that during quarantine, her child was "traumatized and was not well."[89] CM further states her concern that her daughter would be affected by the stress and weakness she felt and that it was difficult and traumatizing for her child.[90]

E. MEASURE THAT WOULD MITIGATE NEGATIVE IMPACTS ON MENTAL HEALTH DURING QUARANTINE

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[85] MWM Affidavit, para 20.

[86] CM Affidavit, para 25.

[87] CM Affidavit, para 33 and 35.

[88] Ministry of Health "Kenya Mental Health Policy 2015-2030: Towards Attaining the Highest Standard of Mental Health", 2015, p 19.

[89] CM affidavit, para 47.

[90] CM Affidavit, paras 53-54.

68. At the facility level, WHO recommends that the following are ideal conditions of quarantine;

a. The facilities should ensure adequate ventilation and air conditioning in public buildings as recommended in the context of COVID-19.

b. The rooms should ideally be a single room with unsuited hand hygiene and toilet facilities. If single rooms are not available, beds should be placed at least 1 metre apart.

c. Physical distance of at least 1 metre must be maintained between all persons who are quarantined.

d. Suitable environmental infection controls must be used, including ensuring access to basic hygiene facilities (i.e. running water and toilets) and waste-management protocols.

e. Accommodation should include: –

    - Provision of adequate food, water, and hygiene facilities;
    - Secure storage places for baggage and other possessions;

f. Health care (***inclusive of mental health***) must be provided for those requiring medical assistance. Medical treatment for existing conditions as necessary.

g. Communication in a language that the quarantined individuals can understand, with an explanation of their rights, services that are available, how long they will need to stay and what will happen if they become sick; if necessary, contact information for their local embassy or consular support should be provided.

h. Those who are in quarantine, including children, must have some form of communication with family members who are outside the quarantine facility,

for example, telephone. If possible, access to the internet, news, and entertainment should be provided.

i. Psychosocial support should be available.

j. Consideration to older persons and those with co morbid conditions requiring special attention because of their increased risk for severe COVID-19, including access to medical provisions and equipment (e.g. medical masks).

69. At a national level, additional recommendations have been made along the same line. Results from a Kenyan study titled: *"Mental health response to the COVID-19 pandemic in Kenya: a review by Florence Jaguga & Edith Kwobah"*, strengthen the WHO guidelines when it states as follows in part:

"The COVID-19 response in Kenya has no formal mental health response plan. There is an unmet need for psychological first aid in the community. While guidelines for the management of mental health conditions during the COVID-19 pandemic have been prepared, implementation remains a major challenge due to a poorly resourced mental health system. There is no mental health surveillance system in place limiting ability to design evidence-based interventions".

The report concludes by stating as follows:

"We propose four key strategies for strengthening the mental health response in order to mitigate the harmful impact of COVID-19 on public mental health in Kenya:

(1) Preparation of *a formal mental health response plan specific to the COVID-19 pandemic* ***with allocation of funding for the response***

(2) Training of community health workers and community health volunteers ***on psychological first aid to enable access to support for those in need during the pandemic***

(3) Scaling up of mobile health ***to increase access to care***

(4) Conducting systematic and continuous text message surveys ***on the mental health impact of the COVID-19 pandemic in order to inform decision-making."***

70. In summary, where a coercive measure such as quarantine is applied, and such a measure is justified, a rights-based approach requires, at a minimum:

a. the provision of the necessities of life such as food, water, shelter and healthcare services to protect the individual's wellbeing;
b. the guarantee of equality and freedom from discontinuation;
c. respect for privacy, autonomy and consent;
d. the preservation of a healthy environment; and
e. the empowerment of health care users to know and assert their rights through, amongst others, providing accessible, accurate and sufficient information and through enabling effective communication and consultation.

71. The need for the Government to adopt best practices in managing COVID 19 and any other pandemics should go a long way in fighting the stigma and associated psychiatric or psychosocial effects of the illness on people. Involving the community and empowering them to be front line workers in prevention of the infection will de-stigmatize the disease and minimize the numbers that end up in hospitals. The community leaders and health care workers need to be fully trained and equipped to educate the public, enforce

the laws and implement home based quarantine with the support of the government law enforcement and public health department.

72. The outcome of the results of such an intervention should be documented for the purpose of establishing a baseline data of lessons learnt and the results to be disseminated accordingly. This will lead to a better society where the people will feel they belong and will feel motivated to participate in the prevention and protection of the citizens of this nation.

F. CONCLUSION

73. The objective of quarantine is to protect and advance individual and public health. However, the application of quarantine and isolation inevitably has negative effects on a person's right to mental health. It must therefore only ever be used as a measure of last resort, and in disciplined adherence to the respect for quarantined and isolated persons' human rights.

74. While the Amicus does not deal with whether the institution of quarantine in the current circumstances was necessary as a measure of last resort, the submissions have analysed the manner in which quarantine was applied. On the Petitioners' facts, the Amicus submits that State's use of quarantine violated the right to mental health in a way that is irrational in relation to the individual and public health objectives of quarantine. This is because many of the practices employed were at odds with monitoring the health of quarantined persons, allowing for early detection, preventing the spread of COVID-19, and generally preserving

individual and public health – that is to say, the legitimate or proper objectives of quarantine.

75. These practices incurred unnecessary, disproportionate and excessive incursions into the right to mental health of the Petitioners.

76. The Amicus submits that it is a misconception to conceive the COVID-19 pandemic as creating a necessary tension between the individual's right to health and public health. This misconception emboldens the stigmatizing and counter-productive notion that people infected with or affected by COVID-19 are the "other" from whom the community needs protection. To the contrary, individuals infected with and affected by COVID-19 are part of the community whose right to health our State has a duty to realise under the Constitution. Protecting the public's right to health need not, and ought not, come at the expense of the individual's right to physical and mental health.

77. The Amicus has sought to demonstrate that by adopting a "right to health" approach to disciplining the objectives of quarantine and to determining the permissible shape and form of these measures, quarantined persons' liberty can be minimally impaired and their right to physical and mental health protected.

78. The effect of violating quarantined individuals' right to mental health, is not only to exceeded what the public health objectives of quarantine reasonably require, but further threatens public health by instilling stigma against people affected by COVID-19, by aggravating fear for health and quarantine services, and by contributing to the burden of ill-health by compromising the mental health and wellbeing of quarantined persons and their families.

DATED at Nairobi this 11th day of December 2020.

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