

## Is Kenya Ready? Human Rights, COVID-19 and Vaccine Preparedness

Kenya's response to the global pandemic has so far been marked by two phases. The first was a rapid but coercive and badly thought-out lockdown that was [challenged](#) in court for infringing civil and political liberties.

The second has been the much slower move to procure and distribute vaccines. This current phase also has human rights implications. Both Kenya's [constitution](#) and [international law](#) [require](#) the state to take effective and prompt steps to protect and promote health. In relation to COVID-19, this [includes](#) ensuring vaccines are available, accessible without geographic or economic barriers, culturally acceptable within reason, and of sufficient quality.

This may be an uphill challenge. According to the World Health Organisation's (WHO) [Vaccine Introduction Readiness Assessment Tool](#), African countries overall record an average score of [33%](#) preparedness for COVID-19 vaccine roll-out against a recommended rate of 80%.

How is Kenya faring, in terms of procurement ("availability"), distribution ("accessibility") and uptake ("acceptability")?

### Procurement

Kenya requires [30 million doses](#) to vaccinate 60% of its population, as recommended by the global public-private health partnership [GAVI](#). Efforts at procurement, however, have been hindered, first by the Cabinet Secretary for Health's [doubts](#) about the effectiveness of vaccines, and then by the delay in establishing a national taskforce for vaccine deployment until December 2020.

Nonetheless, some progress has been made. Kenya is due to get 24 million doses of the Oxford/AstraZeneca vaccine through the joint [WHO-GAVI COVAX facility](#), and a further 12 million through bilateral engagements. It also stands to receive 10.8 million of the [270 million doses](#) the African Union (AU) acquired through its African Vaccine Acquisition Task Team ([AVATT](#)), though this will be slowed by the need for WHO approval. (A further [400 million doses](#) has been received by the AU but the structure for allocating them between countries has not yet been determined.)

[COVAX has promised](#) to deliver the first 4 million doses by the end of February, but beyond that, Kenya worrying has no clear timelines for the delivery of its vaccines. It was set to start receiving the Oxford/AstraZeneca vaccines this month, but that plan has [been thrown into disarray](#) after the EU banned the export of vaccines produced within its member states. The situation of scarcity is worsened by the fact that the UK pre-signed contracts that [prohibited exports](#) until its domestic needs are met. This vaccine nationalism has given no regard to Kenya's role in hosting trials of the vaccine. India has similarly blocked exports from its [Serum Institute until at least 100 million](#) doses are available for domestic use.

These challenges in accessing the procured Oxford/Astrazeneca vaccines cannot be made up by the Pfizer/BioNTech or the Moderna vaccines as they require storage at -70 degrees Celsius which is not feasible on a mass scale in Kenya.

### Distribution

Planning for distribution has been marked by similar [delays](#). It was only on 29 January that Kenya's Ministry of Health [outlined](#) the three phases of its vaccine roll-out. Phase one (February to June 2021) will target 1.25 Million health workers, security and immigration officials. Phase two (July 2021 to June 2022) will cover 9.7 million over-50s and over-18s with underlying health conditions. Phase three, run concurrently with phase two, will target 4.9 million vulnerable people such as those in informal settlements.

This broadly reflects WHO [guidelines](#) which prioritise groups most at risk. What it neglects are the realities of caring for vulnerable people, which is often done within families and by unpaid women.

The [Kenya-Gavi Technical Assistance Plan for 2021](#) sets out goals for several aspects of the vaccine delivery, but it remains aspirational. Experts [warn](#) in particular that failure to prepare for the vaccines' transport to more remote counties as well as poor storage and administration could undermine preparation efforts.

Inadequacy of personnel and training is also likely to pose a challenge. At the onset of the pandemic, Kenya's response was led by "[Ebola Champions](#)": 155 medical practitioners sent to West Africa during the 2016 outbreak there. While this cadre, along with those experienced in the administration of [other vaccines](#), will be invaluable, there has been no specific training in [administering](#) the COVID-19 vaccine to date. These shortcomings are compounded by an ongoing strike of [healthcare workers](#) in some counties. The unequal distribution of [healthcare facilities](#) in the country may also undermine distribution efforts in marginalised areas.

## **Uptake**

These challenges may be compounded by the inability or unwillingness of certain population groups to attend vaccination centres. Poor terrain for travel, a suspicion of state-backed interventions, and the nomadic practices of some rural communities has inhibited the uptake of [other vaccines](#) and may do again. Pastoralists' movement across international borders may lead them to miss out, while people in areas with [high poverty levels](#) may feel they cannot prioritise accessing the vaccine.

Vaccine scepticism is also evident around the world. In Kenya, faith groups like [Kavonokoya and Wakorino](#) have long rejected modern medicine either on grounds of their religious beliefs and their preference for traditional medicine. These communities have [resisted strategies](#) such as wearing masks and are likely to refuse the COVID-19 vaccination as they have done with the [polio vaccine](#).

## **Conclusion: The International Context**

Kenya is not yet ready to deliver vaccines in sufficient quantity to those most at risk or to the population as a whole. While important steps have been taken, earlier government inaction, enduring structural discrimination, and widespread distrust of the state present major challenges.

At the same time, Kenya's fate has been crucially shaped by the decisions of states and corporate actors in the Global North. The UK, EU and US have all engaged in competitive national procurement strategies with little regard for the needs of vulnerable populations in the Global South. This is not simply a question of realpolitik, tempered by occasional charity

in the interests of soft-power and diplomacy. It violates the legal obligation on states to allow each other to realise the right to health in their own territories, as the UN committee has [recently emphasised](#).

Put simply, buying up available supplies and barring their export, as well as enforcing applicable patents in a time of global emergency, amount to vaccine imperialism, inconsistent with a just international order based on human rights.

**Authors:**

Prof John Harrington- Prof, of Law and Politics, Cardiff University and

Dr. David Ngira- Postdoctoral Research Associate, Cardiff University School of Law and Politics