



KNOWLEDGE PLATFORM ON INCLUSIVE DEVELOPMENT POLICIES

Kenya Country Case Study

*Equity in COVID-19 mitigation and policy
responses*



USC Institute on Inequalities in Global Health

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Acronyms

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal Care
ARV	Antiretroviral
CEO	Chief executive officer
COVID-19	The coronavirus disease 2019
CSO	Civil Society Organizations
DHIS2	The District Health Information Software
DHIS	District Health Information System
HIV	Human immunodeficiency virus
EU	European Union
FAO	Food and Agriculture Organisation
ICJ Kenya	International Commission of Jurists Kenya
ICU	Intensive Care Unit
IPOA	Independent Police Oversight Authority (IPOA)
KELIN	Kenya Legal & Ethical Issues Network on HIV and AIDS
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supplies Agency
KICD	Kenya Institute for Curriculum Development
KNBS	Kenya National Bureau of Statistics,
KIHBS	Kenya Integrated Household Budget Survey
LGBT	Lesbian, gay, bisexual and transgender
NCAJ	National Council of the Administration of Justice
NGO	Non-Governmental Organisation
NERC	National Emergency Response Committee
NHIF	National Health Insurance Fund
PHA	Public Health Act
PI	Principal Investigator
PPE	Personal Protective Equipment
SARS-CoV-2	The severe acute respiratory syndrome coronavirus
SMS	Short messaging services
SRHR	Sexual and reproductive health and rights
SSA	Sub-Saharan Africa
USC	University of Southern California
WHO	World Health Organisation
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WFP	World Food Programme

Introduction

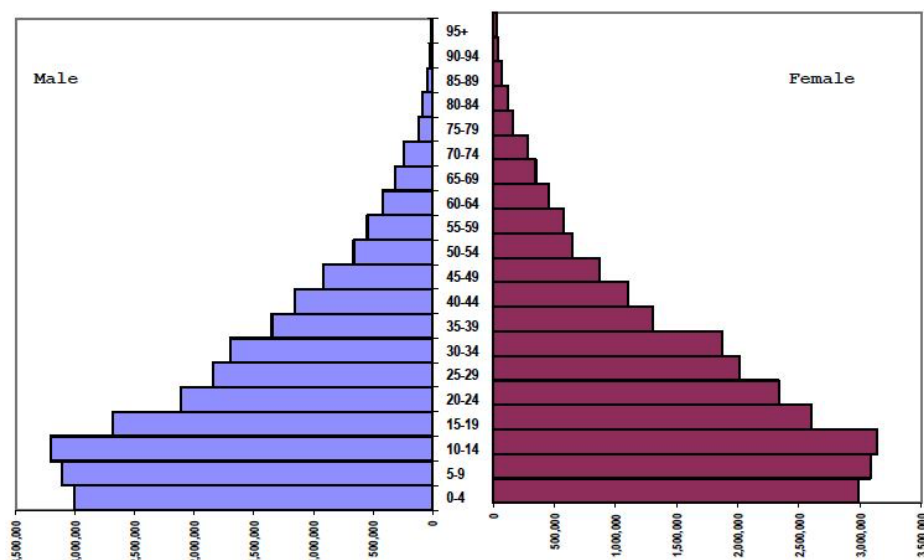
Even prior to COVID, health and ill-health were not equitably distributed in Kenya. History has shown that public health emergencies such as COVID can have a disproportionate impact on communities that are already disadvantaged. Not paying explicit attention to existing inequalities and the particular needs of vulnerable and marginalized groups subjects them to a higher risk of infection and also undermines the broader response to COVID. It is already clear that not only does COVID disproportionately affect people who are already vulnerable due to comorbidities that are often a result of pre-existing social inequalities, but mitigation and policy responses in Africa have disproportionate negative impacts on socially marginalized or disadvantaged groups. People with underlying conditions (e.g. cancer, diabetes, being immunocompromised) are disproportionately vulnerable to severe illness from the coronavirus. Adherence to government response measures might be compromised by a range of factors, with poverty prime amongst them. The pandemic has shone a light on pre-existing societal inequalities and it is now exacerbating them.

This case study explores Kenya's national legal and policy response to COVID with particular attention to human rights and equity. It encompasses issues such as civil society participation in the response as well as the unequal impact of the response on different populations.

Background

According to the 2019 Kenya Population and Housing Census there are about 47.5 million people living in Kenya, with the age distribution skewed towards younger people (Figure1):

Figure 1. Population pyramid (Source: KNBS, 2019)



19.5 million of the population are classified as poor, with 14 million, 1.3 million and 4.2 million living in rural areas, peri-urban and core-urban and informal settlements, respectively (Kenya National Bureau of Statistics [KNBS], 2019). Poverty is also feminized. The 2015/16 Kenya Integrated Household Budget Survey (KIHBS) results show that 30.2% of female headed households are poor compared to 26.0% of their male counterparts (KNBS, 2018).

Kenya's Gini coefficient of 44.540 is above the 2013 Sub-Saharan African average of 43.841, indicating higher than average wealth inequalities in Kenya. However, the latest KIHBS results show that nationally, more than half (59.4%) of total expenditure is controlled by the top quintile while the bottom quintile controls a mere 3.6% of expenditure. Pre-pandemic, the KNBS estimated that unemployment stood at 14.2% amongst youth aged 20 – 24 years. Women comprise 70% of low wage earners. Most are employed in the informal sector or run micro and small enterprises. This sector is characterized by daily wages, limited social protection measures and savings, making women particularly vulnerable.

Health system

Even prior to the pandemic, shortcomings with Kenya's health system were evident: health worker strikes are frequent, health facilities are unequally distributed and health worker to population ratios are low. There are also challenges with regard to health facilities: only 22 of the 47 counties have at least one intensive care unit; there are 537 ICU beds for the country's population of 51 million people, three-quarters of which are in Nairobi or Mombasa; and only 58% of hospital beds nationally are in hospitals with an oxygen supply.¹ In January 2021, a national-level stakeholder noted that there were insufficient health facilities to address the number of COVID cases.²

On top of this, the cost of accessing care is unattainable for many. Although the National Hospital Insurance Fund (NHIF) was introduced in 2004 to facilitate cheaper access to services, in 2019 the Ministry of Health reported that only 11% of Kenyans are covered by this scheme. Furthermore, with 70% of the Kenyan workforce working in the informal sector, most of them are ineligible for the NHIF or unable to afford its premiums. Most Kenyans pay out of pocket to access health services, which means that they delay care-seeking as long as possible, which, in the context of COVID, has particularly serious consequences.³

All of this raised concerns both about the ability to mount an effective biomedical response to the pandemic, alongside the fear that necessary public health measures such as physical distancing, hand-washing and wearing face-masks might also be difficult to implement, particularly among certain populations including the poorest of the poor.

COVID testing

Widespread COVID testing is required to understand the scale and distribution of COVID anywhere, and Dr Patrick Amoth, the acting Director-General of Health, explained that the country ought to conduct 6,000 to 10,000 tests a day for a minimum of two weeks to get clear indication of positivity rates and trend in the country. However, testing for COVID has been far from universal.

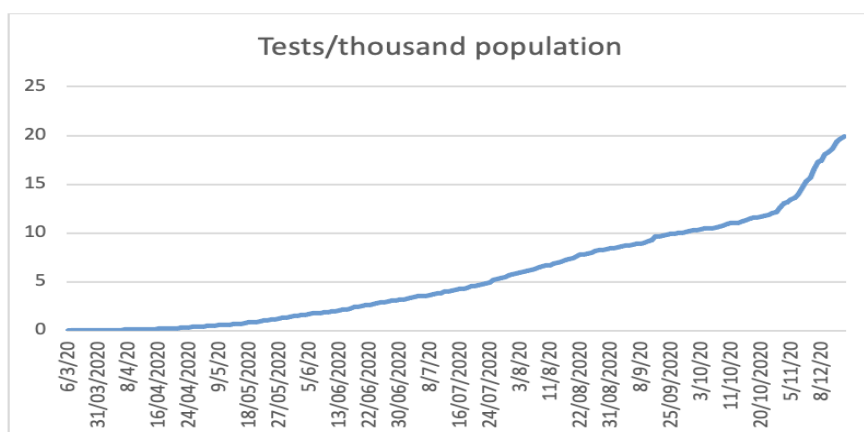
Initial testing was free and done for contacts of people who had positive COVID results. The government received donations of testing kits from well-wishers e.g. 7000 testing kits received from Roche.

Free testing was launched in Kenya in May 2020 in urban informal settlements such as Kawangware, Eastleigh, and Kibera which were considered to be hotspots; however, the turnout was lower than expected due to the associated stigma and the fear of isolation in case of positive results. The testing patterns changed as the government began lifting restrictions. As parts of the economy started opening up, employers required COVID tests from employees as a requirement to return to work, truck drivers had to take tests to cross the border, travelers also required to test for travel.

Initial testing was conducted by the Kenya Medical Research Institute (KEMRI) centres, a government institution. When the private labs and pathologists started testing a charge was placed on the tests. Many could not afford the COVID test (up to \$100) as insurance companies declined to cover it.

Over the course of 2020, the number of tests per thousand population gradually increased (Figure 2a).

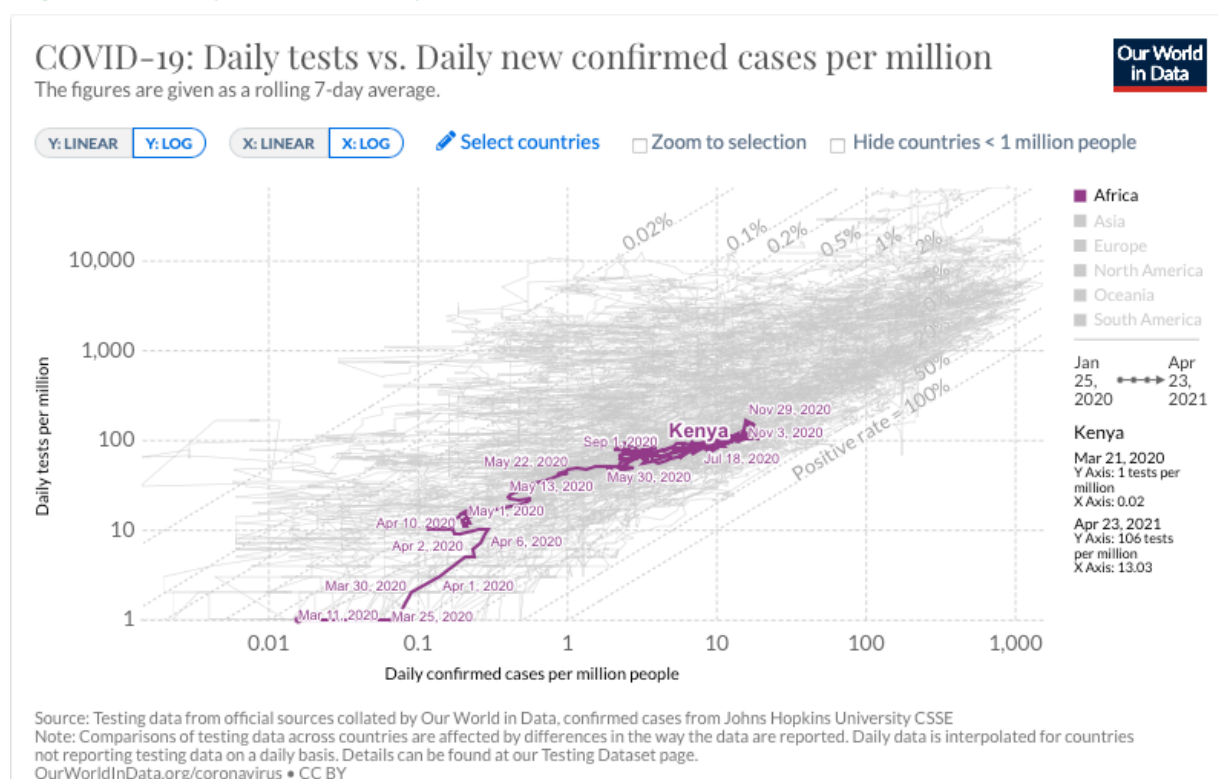
Figure 2a. COVID tests per thousand population



However, the number of tests has since been declining, with the decline being attributed to a shortage of testing kits and a decline in demand. The shortage is being experienced in KEMRI centres (Nairobi, Kilifi and Kisumu), Coast General Provincial Hospital, and the National Public Health Laboratories Services. The decline in testing capacity is raising concern that it could affect control of the pandemic. Dr Ahmed Kalebi, the chief executive officer (CEO) of Pathologist Lancet Kenya, one of the private labs conducting tests, has acknowledged that at the current testing levels, it may be difficult to determine the true burden of COVID.

This same conclusion can be reached looking at the high positivity rate, which suggests that insufficient testing is being carried out to appropriately monitor the epidemic (Figure 2b). The implication is that the number of cases might be underestimated.

Figure 2b. Daily tests vs. daily new confirmed cases per million



Conceptual framework

This work has been guided by a social ecological framework whereby individuals' experiences are shaped by a range of nested, inter-related factors around them, from seemingly 'distant' factors such as laws and policies down to more 'proximal' factors such as their immediate living situation. The interplay of these factors, particularly the range of laws, policies and regulations relevant to COVID-19 (both national and sub-national) and how they impact different populations is explored.

Methodology

This mixed methods study includes policy, quantitative and qualitative research as well as a joint analysis to bring together all of these different types of data.

Legal and policy review

For the purposes of the legal and policy analysis, we reviewed web-based search engines such as Google and Google Scholar. Searches were limited by date range of publication and were restricted to the year 2020. Searches included "Kenya + COVID + policy," "Kenya + COVID + law," "international + COVID + policy + tracker," "Kenya + COVID + legal + response." Data were assessed for relevance and systematically extracted based on their direct or indirect implications for vulnerable communities. The data were organized thematically and categorized according to date, issuing body, and type of measure issued to create a timeline of the national response.

Peer-reviewed literature searches

Searches were conducted on PubMed (24/10/20), Google Scholar (25/10/20), and Scopus (25/10/20) using the search terms "Kenya" AND "covid". PubMed searches were inclusive of the abstract and article while Google Scholar and Scopus searches were only inclusive of the title. The PubMed search yielded 142 total results, with 44 articles deemed relevant after a title and abstract review, and 24 articles included in the final review. The Google Scholar search yielded 110 total results, of which 36 were unique to Google Scholar and deemed relevant after a title and abstract review. Thirty-two articles were included in the final review. The Scopus search yielded 13 unique results, only one of which was deemed relevant by the title and abstract review and included in the final review. All other Scopus search results overlapped with either PubMed or Google Scholar searches. Thus, a total of 57 articles were included for full review.

Media analysis

Media searches were carried out between September and November focusing on articles published from March to November 2020. This entailed a two-step strategy, starting with a broad strategy where specific media houses were searched generally for published articles covering COVID news in Kenya. These generated about a hundred articles listed chronologically with about 10 articles per page. From each page only 2 to 3 were selected, based on relevance as determined by the research questions to be answered. Out of 400 articles reviewed in total for local media 59 articles were analysed for the study. The second level search was based on specific search words linked to this study's research questions keyed into Google and Bing. These searches yielded about 15 articles per media house, although some of the articles had already been captured in general searches. For international media 228 articles were reviewed out of which 23 articles were selected for the study. The data generated was tabulated indicating the date, main issue reported and reference.

The local media houses reviewed include: The Nation, The Standard media group and The Star Newspaper. Very few articles were obtained from smaller media houses. The international media articles were mostly sourced from the websites of Reuters, BBC, The Guardian, and the Washington Post. Social media searches were also included particularly from Twitter.

Grey literature search

Organizations actively engaged in the COVID response in Kenya were identified from the media analysis including UN organizations such as the WHO, UNDP, UNICEF, WFP, FAO, UN Women as well as civil society organizations including Amref Health Africa, The Red Cross, the Population Council, KELIN Kenya and Amnesty International. Their latest reports on areas of interest were reviewed and data relevant to answering the study's research questions was systematically extracted. The information obtained was drawn from their research findings, programmatic reports and experiences of the realities encountered in their programme implementation.

Key informant interviews

Key informant interviews were carried out with ten participants using a semi-structured interview guide. This included 4 representatives of government (governance, health, education and gender and culture), 3 representatives of parastatal organisations, and 3 representatives of civil society (working across, health, law, and inequalities). These interviews took place at the national level and at the county level in Homa Bay county, as an example of how the COVID response has been implemented sub-nationally. Interviews were recorded and transcribed verbatim for analysis. Ethical approvals were secured through the Amref Ethics Review Committee and the USC Institutional Review Board.

Overview of the legal and policy response

The government has put in place a range of legal and policy measures since the start of the pandemic, each covering different aspects of their response. An overview of these measures is provided below, organized by the different sectors they are designed to impact. The section ends with an analysis of how these measures may have influenced the spread of COVID over the course of 2020. The actual impact of the measures will be explored in the subsequent sections.

Health: Biomedical and Public Health Legal and Policy Response

On February 28th, as a response to the looming threat of coronavirus, President Kenyatta issued the first executive order addressing COVID-19, in which he calls attention to the necessity of bolstering health systems. He calls for the completion of a national and isolation treatment facility at Mbagathi Hospital in Nairobi and establishes a National Emergency Response Committee (NERC) on Coronavirus. The NERC entails a COVID-19 Task Force, composed of the Ministry of Health, other government agencies, United Nations agency representatives, development partners, NGOs and civil society, which plays an advisory role to the committee.⁴ Noticeably missing from the task force is representation from religious leaders, youth, women and women's organizations in civil society, marginalized communities such as refugees, and the private sector. The primary role of NERC, which is 81% male, is to advise the President and coordinate preparedness, prevention and response to the threat of COVID-19.⁵

On March 24th, the Ministry of Health issued guidelines for the promotion of preventive measures, such as physical distancing and handwashing, and ensuring the continuity of antiretroviral treatment for the 1 million people living with HIV, among other essential services. The next day, the government announced that it would put aside Ksh1 billion for the recruitment of medical personnel. The Cabinet Secretary for Health followed these guidelines with the issuance on April 3rd of the Public Health Act on COVID, which consisted of general guidelines for medical officers with regard to COVID-19 patients as well as people potentially exposed to the coronavirus. Later in April, a guideline was issued to support the continuity of reproductive, maternal, newborn and family planning services.

The next significant health system measures were launched by the Kenyan government on June 10th in response to data showing that 78% of infected persons admitted in hospitals were either asymptomatic or mildly symptomatic. These protocols included advice on home-based isolation and care, especially as asymptomatic COVID-19 positive cases were discharged from health centers. Protocol implementation was designed to start immediately. According to the protocols, if positive cases could not afford to be isolated at home due to spatial concerns, facilities within the community that met specific recommendations were available to provide care.

The Nairobi Hospital formed a strategic partnership with the United Nations on July 21st in an effort to manage diplomatic personnel and all dependents with suspected or confirmed cases of COVID-19. The agreement includes the construction of a Sh1.1 billion health facility with an Intensive Care Unit consisting of 25 beds and an additional 50 in the High Dependency Unit. The facility is intended to serve over 20,000 United Nations staff based in Kenya and East Africa, along with locals in the vicinity.

During a September 10th meeting overseen by President Kenyatta, the Cabinet approved a plan for comprehensive insurance coverage intended to cover all health workers on the frontline of the pandemic.

They also announced an Inter-Agency Programme to prevent and respond to gender-based violence, which had been increasing as a result of COVID-19.

At the county level, Homa Bay county had enacted a County Health Act less than a month before the COVID pandemic, which included guidance on how to address emergencies such as pandemics and was therefore useful in guiding the local response.⁶

Travel Restrictions, Curfew and Quarantine

A long series of travel restrictions was implemented by the national government beginning on March 15 when all inbound travel from countries with documented cases of coronavirus was suspended. Additionally, Kenyan citizens and foreigners with valid visas were the only visitors allowed to enter the country for the next 30 days. Anyone arriving 2 weeks prior had to self-quarantine, and if individuals had symptoms they were required to present themselves to the nearest health facility. This was followed up with a suspension of all international flights on March 25. On the same day, the government issued a daily curfew from 7pm to 5am, restricting individual movement and prohibiting all public gatherings during curfew.

Measures designed around the quarantine and confinement of the general population began in earnest on March 30th. On this date, the Cabinet Secretary for the Interior issued a notice for employers statewide to ensure that staff not designated as critical or essential service providers leave the workplace by 4pm. Challenges with the implementation of quarantine measures led to these being replaced with the requirement for self-isolation.

Travel restrictions were updated on April 6, as Kenyan authorities announced that all road, rail, and air traffic to and from Nairobi would be halted for 21 days. These measures also applied starting on April 8 to the counties of Kwale, Kilifi, and Mombasa. President Kenyatta issued a statement on April 7th, warning Kenyans that the government might impose a lockdown if citizens did not follow directives issued by the Ministry of Health. All entry and exit into Kakuma refugee camp was banned. On April 24th, the president also announced that citizens would not be allowed into or out of the capital and various coastal areas for three weeks. A few weeks later on May 6, the Kenyan government updated these measures to limit movement into and out of Zone A (Eastleigh Area, Nairobi County within the Nairobi Metropolitan Area) and Zone B (Old Town, Mombasa County within the Kenyan Coastal Strip). On May 16, the government closed the border with Tanzania and Somalia and pushed the curfew to June 6 as COVID-19 cases reached 800 nationwide. President Kenyatta again extended the nationwide curfew by 30 days on June 6 while relaxing curfew hours, changing them to 9pm to 4am. The curfew has been extended several times since then in response to an increase in cases.

On July 6, President Kenyatta announced that domestic commercial and passenger flights would resume on July 15, and international travel on August 1. He also outlined a phased reopening of the country in which restrictions around Nairobi, Mombasa, and Mandera counties would be lifted. These measures were expanded on in a July 31 release from the government that identified 18 countries whose citizens would be exempt from quarantine on arrival. The Kenyan Civil Aviation Authority added more countries to this list, bringing the total to 147 on September 15. On September 14th, the Department of Immigration services announced that with immediate effect, the amnesty stay for foreigners with expired visas would end and that foreigners stuck in that situation would either need to leave the country or apply for residence permits within 14 days.

Closure of Public Spaces

In early March, the government began to respond to the coronavirus threat by closing public spaces and cancelling large public events. This started on March 13 when the Ministry of Health ordered the suspension of all public gatherings and meetings for 30 days. This was immediately updated on March 15 with orders for citizens to avoid crowds, such as those at weddings, funerals, churches, and shopping malls, as well as limiting visits to hospitals. On March 22nd the government decided to suspend all religious gatherings.

The Independent Electoral and Boundaries Commission announced on April 1st the indefinite postponement of the by-election for members of both county and national assemblies; these began in December 2020.

On May 3rd, religious leaders were issued revised prayer times for places of worship and mosques were allowed to open for nightly services during the month of Ramadan. In addition to this, the National Emergency Response Committee (NERC), directed the Inspector General to designate a location where curfew offenders can go, as long as they are socially distanced.

On June 6th President Kenyatta announced that bars could not re-open for another 30 days, extending the ban. One month later on July 6th, President Kenyatta changed the rules for places of worship, announcing they would open in three weeks for crowds of up to 100 and services that last for up to one hour. No one under the age of 13 or over the age of 58 or persons with underlying conditions could attend. Rules around weddings and funerals were updated by the president on August 26 so allow for a maximum of 100 people to attend.

President Kenyatta addressed the nation on September 28th, revealing that pubs would open the next day, nearly 6 months after they were shut down. Additionally, he raised the maximum number of guests at funerals and weddings to 200 people and allowed churches to allow up to 1/3 of their capacity.

Education

On March 15, the Kenyan government, through the Ministry of Education, decided to close all schools and colleges nationwide. The Ministry of Education provided guidelines to its teachers and students for teaching and learning outside of the school grounds. By March 23, there were four main platforms delivering education programs and other resources to students. These included: different radio programs broadcast on weekdays, television broadcasts sponsored by the Kenya Institute for Curriculum Development (KICD), on demand programming delivered on YouTube, and digital learning resources available on the Kenya Education Cloud hosted by KICD. The Kenya Civil Aviation Authority also partnered with Google to distribute better internet coverage through the use of balloons equipped with 4G base stations.

In early May, the Education Ministry appointed a 9-member committee (comprising two women and seven men) to seek out the best ways to bring normalcy back to the education sector. This COVID-19 Education Response Committee would also explore the demand for education put on poor households and potential mitigation measures.⁷

President Kenyatta, in an announcement on June 6th, stated that the Ministry of Education should prepare schools to reopen in early September. This was followed by a July 7th announcement by the

Education Minister, George Magoha, who noted that the 2020 school calendar year ending in November was cancelled and that all primary and secondary schools would be closed until January of 2021. Universities would open on a case-by-case basis.

During the period of school closures, the government developed guidelines on health and safety protocols for reopening whenever was practical. The guidelines also cover mental health and psychosocial support. Heads of institutions were given a manual to train head teachers on COVID protocols and guidelines; there is also one for the board of management, education officials and the parent teacher associations. This has all been done through cascade training starting at national level and reaching all the way down to individual schools.⁸

On Sept 20, the Ministry of Education ordered teachers to report to schools on the 28th with expectations for students to return to school on November 2nd. This was updated on the 29th of September with an announcement that final year students in universities would resume classes on the 5th of October. Schools reopened partially in October with a full reopening scheduled for January 2021.

Business and Trade

The Health Cabinet Secretary announced on June 16th that restaurants and hotels, that had previously had to close at 5pm, would be allowed to remain open until 7:30pm daily. Those who broke the law would be punished with the removal of their operating licenses. On July 6th, President Kenyatta maintained that all bars would stay closed until further notice. Restaurants, which were allowed to reopen, had to comply with social distancing measures. President Kenyatta recommitted to the shutdown of bars and nightclubs on August 26, stating that the lockdown would last until the 26th of September.

On August 7th, in an effort to prevent transnational spread and minimize loss of lives, the East African Community launched the Regional Electronic Cargo and Driver Tracking System. It was designed to cover five key border points separating the East African countries.

Fiscal Measures

Kenya has implemented a range of fiscal measures to counter the negative economic impact of the pandemic on individuals and businesses. This began on March 12th when the Ministry of Tourism and Wildlife announced that it had set aside US \$5 million to support the tourism sector for a post-COVID recovery plan.

On March 15, Safaricom and the Central Bank announced that charges on mobile money transactions would be dropped to limit the use of cash. Then on March 24th, the Central Bank lowered its policy rate to 7.25% (which was then lowered to 7% on April 29th), lowered banks' cash reserve ratio to 4.25%, increased the maximum tenor of repurchase agreements from 28 to 91 days, and announced flexibility to banks on loan classification and provisioning for loans that were performing on March 2 but were restructured due to the pandemic.

Immediately after this on the 25th of March, President Kenyatta outlined tax interventions the government would make so as to protect the country against the economic effects of COVID. This included the government's decision to earmark funds for expediting payments of existing obligations so as to maintain cash flow for businesses during the crisis. The President also declared that resident corporate income tax would be reduced from 30 to 25% and that the turnover tax rate would be reduced for Micro, Small,

and Medium enterprises from 3% to 1%. The plan included 100% tax relief for anyone in the low-income earners category. In addition, the Ministry of Labour and Social Protection planned to allocate Ksh10 billion (about €76m) to elderly, orphans and other vulnerable groups through cash-transfers so as to cushion them against the effects of COVID.

On April 15th, the Central Bank suspended the listing of negative credit information for borrowers whose loans became non-performing after April 1 for six months, setting a new minimum threshold of \$10 for negative credit information submitted to credit reference bureaus.

The Head of Public Service Joseph Kinyua announced a voluntary government pay cut programme that would start in April and aim to cover lower cadre civil servants. With savings going towards funding the COVID response, voluntary pay cuts of 80% for the president and his deputy, 30% for cabinet secretaries and 20% for chief administrative were announced.

President Kenyatta announced the creation of a National Hygiene Program on April 25, which was designed to create youth employment while simultaneously addressing health promotion. Phase 1 of the program launched on the 29th of April and targeted 26,000 youth in 23 informal settlements targeted as being most affected by the pandemic. Also in April, the government earmarked Ksh40 billion (about €315m Euro) for the following additional health expenditures: surveillance, laboratory services, isolation units, equipment, supplies, and communication; social protection and cash transfers; food relief; and funds for expediting payments of existing obligations to maintain cash flow for businesses during the crisis.

On May 23rd, President Kenyatta showcased a new 8-Point Economic Stimulus Programme which totaled Ksh 53.7 Billion. The programme focused on 1) infrastructure, including the hiring of local labor to fix roads and bridges, 2) education, including the hiring of 10,000 teachers and ICT interns to support digital learning, 3) fast-track payment of outstanding VAT refunds and other pending payments to small and medium enterprises, 4) healthcare, including 5,000 healthcare workers and the expansion of bed capacity in public hospitals, 5) agriculture, including e-vouchers for 200,000 small scale farmers, 7) the environment, including the rehabilitation of wells, water pans, and underground tanks, and 8) manufacturing, such as the investment to purchase locally manufactured vehicles under the “Buy Kenya Build Kenya” policy.

Kenya's National Treasury announced on May 1st that they would create a fund of close to Ksh 100 billion to protect micro, small, and medium enterprises against the effects of COVID. Additionally on August 8th, the Education Cabinet Secretary stated that the Ministry would provide Ksh 7 billion in concessionary loans to struggling private schools. Finally, on September 10th, the government approved the establishment of a Credit Guarantee Scheme to support the businesses mentioned above.

In September, Kenya introduced the COVID-19 Country Socio-economic Re-engineering and Recovery Strategies (CCSERS). As part of these strategies, Kenya planned to protect health services and systems, scale up social protections and basic services, protect jobs and support small and medium sized enterprises (including the most vulnerable productive actors), enhance social cohesion and community resilience, and provide “green” recovery strategies that embrace technology. As a subset of these measures, initiatives were introduced to enhance access to affordable credit for microenterprises, financial literacy programs were promoted, frameworks were introduced for microleasing, and access to a credit guarantee scheme. Kenya also introduced plans to provide material and non-material resources that can help build business capacity. Among these resources were support to improve market access,

the improvement of physical infrastructure, and designated worksites for the creation and sale of goods and services.⁹

On December 22nd, Kenya's parliament voted to end all COVID tax relief schemes, noting that this would help plug gaps in government revenue even as others warned of a negative impact on individuals. The only tax relief measure that was maintained was that Kenyans earning less than KShs 24,000 (\$220) will still be granted 100% tax relief.¹⁰

Justice Measures

A range of measures were introduced by the National Council on the Administration of Justice (NCAJ) as part of the justice system's response to the COVID-19 pandemic. The first of these measures was issued on March 15. In it, the NCAJ had the court system scale down its activities, limited arrests to be dealt with at police stations, suspended hearings and mentions for all criminal and civil cases, suspended execution proceedings, and gave staff new provisional roles for the ensuing months of the pandemic. On March 19, additional measures issued by the NCAJ included a provision for judges to review prison files for inmates with less than 6 months left to serve, where they could determine if early release was acceptable. Bond and bail terms were revised, judges switched to electronic delivery for many case decisions, prison visits were halted, and police were ordered not to effect warrants of arrest nor assist in the execution of court orders for a two-week period. These measures were reissued on April the 1st with updates including: orders to release petty and traffic offenders held at police stations for more than 24 hours, enhanced transparency and accountability measures for police including showing the number of people arrested and handled in all stations and terms of their release, an update on plea-taking and urgent criminal hearings including one section that responds to a significant spike in sexual offences and the courts response, continuing the decongestion of prisons, and additional guidelines on execution, staff safety, and judgments. On April 15th, the NCAJ updated these measures again, with specific attention to scaling up hearings for criminal appeals, operations and services in all registries, and hearings of civil matters. Additionally, this statement ordered the suspension of execution of civil orders and decrees and eviction orders made before the 16th of March and would be enforced until the 22nd of April. Finally, in response to requests to scale up court operations due to backlog, the NCAJ announced on April 21 that it would be leveraging video-conferencing, e-filing, and email technology to "dispense justice" while continuing to avoid open court sessions.

Although sorely needed at this time, most oversight bodies, including the Kenya National Human Rights Commission, the National Gender and Equality Commission, the Office of the Controller of Budget, and the County Assemblies Forum, have been unable to operate from their offices and have not been given resources to engage virtually, impeding important governance and accountability mechanisms. For example, the various assemblies were not able to meet to discuss annual budget proposals at national and county levels as per constitutional provisions.¹¹

Determining the legal and policy response to COVID

This section provides an overview of the genesis of the national COVID response, with attention to inclusivity, innovation and accountability.

Where do the policy responses originate from?

Kenya relied on lessons learned from other countries impacted by the pandemic, including China, Italy, Spain, the United States, and parts of the Middle East to inform its COVID response. Drawing upon containment measures from other countries as well as data and advice from the Kenyan Ministry of Health, schools were closed with a view to continuing this until the data suggests it is safe to re-open.¹²

With regard to the national legal environment, the Public Health Act and Public Order Act have been the primary vehicles for executive orders during the pandemic.¹³ For example, the government drew upon the Public Health Act (PHA; Cap 242: The Public Health (Prevention, Control and Suppression of Covid-19) Rules, 2020), the Health Act No. 21 of 2017, and the Public Order Act Cap 50 within the Kenyan Constitution in order to carry out a 21-day period of movement restrictions in Nairobi, Mombasa, Kilifi, and Kwale counties starting April 6th.¹⁴

Policy responses have been adapted over the course of the months of the pandemic, partly in response to pressure from civil society. For example, citing the negative impact of the lockdown on “citizens and their livelihoods,” the government adapted its containment procedures to be less stringent. Sign language interpretation of COVID media briefs was introduced following lobbying efforts. Concerns remained however that the lack of representation of people with disabilities in the National Emergency Response Committee led to lack of consideration of relevant issues.¹⁵ This may also be true for other constituencies, including women and young people.

Throughout the pandemic response, seven major committees were introduced, all of which were found to be dominated by men. Overall 20% of committee members were female and 80% male. Among these were the National Coordination Committee on the Response to the Coronavirus Pandemic (NCCRCP), the National Emergency Response Committee on Coronavirus (NERC), the National Economic and Business Response Working Group, and the Inter-Faith Council Religious Committee.

Homa Bay County formed a range of committees to respond to the pandemic including a COVID Committee, chaired by the county governor, a COVID-19 Emergency Fund Committee and a forum for regular meetings of all development partners in health. These helped coordinate the response at county level.¹⁶

Overall, the experiences of vulnerable populations and socio-cultural factors impacting the formation of COVID policies are largely absent from the literature. Key informants noted that these perspectives were largely neglected in policy development, with vulnerability defined in terms of medical co-morbidities rather than socio-cultural factors and vulnerable populations under-represented on national committees.¹⁷

Non-state actors' inclusion in the national COVID response

Little information was found in published literature about how the media, international organisations and the private sector pressed for their inclusion in the national COVID response. All of these types of stakeholders have been active in the COVID response but seemingly working independently rather than seeking involvement in the national response. The main role of these non-state actors seems to be to provide financial support for vulnerable communities and to direct funds for COVID-related relief and innovation. Global and international organizations, as well as the private sector, have collaborated to provide support to Kenya in the form of money, food assistance, and other essential resources.^{18 19 20 21}

^{22 23 24 25} The national private sector institutions involved in these efforts appear to represent large-scale, well-established companies. Representatives of the informal economy, on which the majority of Kenyans rely, were not included in advisory committees nor in the management and distribution of COVID-related relief funds.²⁶

Civil society have been more proactive in pushing for inclusion in the governmental response as well as demanding government accountability for the response. National-level civil society actors tried to help shape the legal and policy environment from the very beginning of the response, informing the government about things it would be important to take into account. However, one key informant described this as “an exercise in futility” as the government did not heed this advice. In some instances, they only provided 1-2 days for civil society input, which made wide consultation impossible; in most cases, none of the recommendations were taken on board.²⁷ The minimal room for public input into the regulations, which limited public and parliamentary scrutiny of the response, is currently being challenged in court.²⁸

There is disappointment among civil society actors with the measures that the government introduced, with one key informant highlighting the stigmatizing language used in some regulations and the negative impacts that many of the regulations have had. Furthermore, the top-down approach led to inappropriate measures with negative unintended consequences that might have been better foreseen had civil society, including representatives of vulnerable and marginalized populations, been active participants in designing the response.²⁹

In some counties, there has been better involvement of civil society in informing the local response. In Homa Bay, for example, there is a technical working group, which includes members of civil society. A local government official noted the importance of working with civil society given their connections with and knowledge of communities.³⁰

KELIN and 50 other stakeholders, including civil society, community organizations, non-governmental organisations (NGOs), and other representatives of health and human rights organisations, signed an advisory to the government on a rights-based approach to COVID in response to the government's COVID directive.³¹ Seeking to influence the government response, Amnesty International Kenya and 15 other community organisations and NGOs have called for a moratorium on water and electricity charges as well as the removal of a ban on rainwater harvesting in Nairobi's slums.³²

Even as not substantiated in other interviews, one key informant explained that civil society involvement in response to the second pandemic spike was much better than at the very beginning of the pandemic, suggesting that inclusivity may have improved over time.³³

The different levels of involvement civil society had in the pandemic response speaks to the heterogeneity of their role. Public health NGOs and other CSOs were seen to have larger roles compared to

organizations involved in areas like rights or poverty alleviation.³⁴ Several key informants noted that in terms of input for COVID-19 policies, human rights organizations were not seen to be directly involved, nor was there much of an idea of other organizations that were.³⁵ This highlights the inadequacy of considering civil society as a single stakeholder: participation of different constituents within civil society is critical.

Inclusivity of mitigation measures and policy responses

There is little information in the published literature about the inclusion of different population groups in policy development, implementation and monitoring efforts. However, one study noted that members within the Ministry of Health have advocated for the inclusion of sex workers in the national response and have set up communication platforms for government partners to exchange inclusive strategies.³⁶ In addition, in an initiative in Siaya, efforts were made to include adolescent girls in COVID prevention efforts.³⁷

Most key informants felt that there had been insufficient inclusion of vulnerable communities in policy development, or even consideration of their needs in the policy response. Even where they were considered -- such as the cash transfer programmes that targeted the elderly, people with disabilities and orphans and vulnerable children -- these groups were not involved in the development or implementation of the programmes, there was a lack of clarity about how people were selected to be participants and awareness of these programmes remains low even among the populations they target.³⁸ The unforeseen negative impacts of the curfew on women who needed to access health facilities for deliveries at night were attributed to the very limited participation of women in designing policy responses.³⁹

One key informant noted an important class differential in impact of the COVID response: the 'political class', which includes those involved in policy-making, were least affected while the 'low income earners', the people who rely entirely on the informal economy and survive on daily income, were most affected.⁴⁰ This suggests that the elite designed a policy response with minimal participation of less advantaged groups and little consideration of how these policies might work for and affect them.

Within the education sector, in the guidelines and training for safe return to school, consideration of children with disabilities was included e.g. how to help children with autism wear masks appropriately; ensuring that children in wheelchairs can reach handwashing facilities; adapting materials for students or teachers with visual or hearing impairments. Some efforts were also made to distribute learning materials to students in hard-to-reach areas during the time that schools were closed. Although efforts were made to teach online and to broadcast educational programmes on the radio, the coverage remained low and it was the most vulnerable students who could not access these programmes.⁴¹

There have been some sensitisation efforts with duty bearers to highlight the needs of people with visual or hearing impairments, particularly in the context of required face masks.⁴²

There are concerns about the plans for using the private sector to roll out vaccines, which will likely disadvantage those of lower socioeconomic status who might struggle to access these services.⁴³

Innovations in response to COVID and its mitigation responses

There has been a lot of innovation in Kenya in response to COVID, some directly fostered by the governmental policy response. Innovations fall primarily into two categories: those relating to the promotion of health and those designed to promote continued access to education.

Health-specific interventions

Within the realm of health service delivery, health workers adopted the use of cell phone technologies, including WhatsApp, to communicate among themselves and to provide teleconsultations with patients.⁴⁴ Phones were also used as platforms for peer outreach workers to communicate with the community and provide COVID-related updates.⁴⁵ Facilities are utilizing community health workers to distribute contraceptives and antiretroviral therapy so as to limit people accessing health services while maintaining continuity of access to medications.^{46 47}

The wheel for life initiative was introduced as a collaboration between various NGOs, the Ministry of Health and the University of Nairobi to overcome the challenge of transport to hospital for maternal health emergencies during the curfew hours. Interventions included a hotline number for assistance, provision of taxis, and pre-arranged letters for pregnant women to access passage during the curfew hours in case of an emergency.⁴⁸

The Kenyan government launched the 'Great Covid-19 Innovation Challenge' in order to harness the technology sector.⁴⁹ This call by the government resulted in the following:

- The development, by university students, of ventilators using locally available materials that would run on solar, electrical or battery power. Once approved by the government, the students will be able to create up to 50 ventilators.^{50 51 52}
- The development by the Kenya Medical Research Institute of automated modern testing kits with a testing rate of 35000 samples per day and the 'Point of Contact Rapid Test'.^{53 54}

The government commissioned specific manufacturers to produce locally designed PPE that meets infection control standards.⁵⁵ COVID medical devices, COVID rapid testing kits, face masks, hand sanitizer, and hand wash are also being locally manufactured.^{56 57} Kitui County Textile Centre was turned into a 24-hour production facility that produces 30,000 masks daily and Eldoret-based Rivatex has also contributed to mass production of masks.⁵⁸

A Kenyatta University student produced an innovative prototype that could produce medical swabs needed in COVID testing, while a team of students from Jomo Kenyatta University of Agriculture and Technology created a Contact Tracing and Case Management App and a web-based digital platform that predicts COVID infection trends.^{59 60 61} A toll-free hotline and mobile application have been established to allow for anonymous reporting of GBV and child abuse.⁶²

Kenyan innovators also created hands-free hand washing stations. UN Habitat recognized a Kenyan who created a hands-free hand washing pedal machine, and he was rewarded with Ksh 3 million for further production.^{63 64}

Education-specific innovations:

There have been concerted efforts by diverse stakeholders to make education accessible during the time of school closures. Private schools and universities have adopted online learning and have created opportunities for content developers to be included in education, and for the establishment of these online

educational institutions in remote locations.⁶⁵ Kenyans in the diaspora have created websites with free learning materials and international companies have provided free learning management systems.⁶⁶ Mobile phones have been utilized to enhance online learning for secondary school students while schools are closed. However, barriers to all of these innovations include lack of digital and technical skills among parents as well as internet connectivity issues, which disproportionately affect those of lower socioeconomic status.⁶⁷

Accountability mechanisms for laws, policies and regulations

There have been challenges to ensuring accountability for the national COVID response. Ostensibly, the Kenyan Judicial system is an accountability mechanism to ensure that all laws enforced during the pandemic do not infringe upon the civil, political, economic or social rights of citizens. In some cases, this has worked well. For example, when Kenya Airways tried to amend workers' contracts due to economic hardships during the pandemic without consulting unions, the Court ruled against this. They specifically protected the rights of the workers and prevented the company from making decisions that could have consequences for employees, regardless of the pandemic.⁶⁸ However, in other cases, perceived impunity persists. For example, one key informant shared reports that parliamentarians were involved in the 'disappearance' of PPE and yet no action has been taken to investigate this. Responsibility for the health worker strike is battled between the national and county governments with nobody assuming ultimate responsibility for its cause or resolution.⁶⁹

Civil society organizations have taken the lead in pressuring the government to put in place COVID measures and address accounts of police brutality.⁷⁰ In Homa Bay County and Siaya County, lobby groups and civil society, respectively, contacted the police and released statements urging police to not act with force.⁷¹

In a separate case, Amnesty International Kenya, Haki Africa, Kituo Cha Sheria, and International Justice Mission Kenya have brought a lawsuit against the police, alleging that they used nighttime curfew to violate people's rights and carry out killings, all of which was widely reported in the media. The organisations are calling for compensation from the government, legal reform, and an end to police brutality.^{72 73}

Twenty-five different lobby groups joined the movement to push for accountability for the public officials who allegedly were involved in illegal expenditure of COVID funds. These lobby groups comprised civil society and non-governmental organisations, the private sector, professional bodies and trade unions (see Section 9 below for additional information).⁷⁴

Other civil society-led court cases in process in relation to the COVID response include one challenging the manner in which mandatory quarantine has been implemented, and one challenging forceful detention for failure to meet costs of isolation and treatment of COVID in public health facilities.⁷⁵ However, even when such cases are successful, there are reports that the judgments are ignored and violations persist.⁷⁶

Accountability efforts have been diminished as civil society organizations and trade unions have been excluded from national coordination and planning within the COVID response.⁷⁷ This has been noted by several non-state actors involved in lobby groups, who have noted the gaps in transparency and accountability within government agencies during COVID.⁷⁸

Lobby groups composed of several non-state actors state that the lack of transparency and presence of loopholes have contributed to the failure of the government to provide PPE to frontline healthcare workers.⁷⁹ Kenya Medical Supplies Agency (KEMSA) admitted that there was no accountability or regulation mechanism in place for the distribution of PPE to companies; representatives of companies could ask for tenders to produce PPE without proof of deliverability, approval from a board of directors, or projections related to demand (see Section 9 below for additional information).⁸⁰ In many cases, the tender price was negotiated retrospectively and the price did not match what was initially proposed.⁸¹ The government has also been accused of misusing funds intended for medical supplies.⁸²

There have been calls to ensure that existing oversight institutions including the Ethics and Anti-Corruption Commission, Office of the Director of Public Prosecution, Directorate of Criminal Investigations and Judiciary, support efforts to urge for accountability in the management of COVID related funds by investigating and prosecuting wrongdoing.⁸³

Immediate impacts of the response on COVID-19-related outcomes

This section explores the immediate impacts of the response on COVID-related outcomes on different populations. After a brief overview of some of the perceptions of governance of the response, it outlines the impacts of different public health measures on a range of vulnerable groups as well as health workers.

What works and does not work for vulnerable groups?

One of the challenges that has existed from the outset, from a civil society perspective is the definition of ‘vulnerable’ in the context of COVID. The government has focused on older people and people with underlying medical conditions i.e. they have defined vulnerability biomedically. This overlooks the social and economic vulnerability that is so prevalent in Kenya. The government has reportedly given very little attention to addressing poverty in the context of the pandemic, including trying to understand the potential impacts of mitigation measures on people living in poverty, which has undermined the success of these efforts. The lack of attention to people living in urban informal settlements and people living on the street is a particularly striking shortcoming of the national response.⁸⁴ A member of the national Covid 19 Response Taskforce explained that the government wanted to reach the most vulnerable but due to the inadequacy in the identification and classification of the very poor and the near poor population this might not have happened as intended.⁸⁵ Relatively early in the pandemic response, members of the national task force visited different counties to document the situation and capacity to respond across the country.⁸⁶ More recently, the Presidential Policy & Strategy Unit, Executive Office of the President, working with partners, has carried out a study to document the impact COVID19 has had on adolescent girls in particular around school dropout, teenage pregnancy, and early marriage; and how these short-term effects translate into longer term economic disadvantages, poorer health outcomes, and increased violence for women. The report launch is planned for the end of April 2021.

The primary ‘vulnerable groups’ covered in the literature include people living in urban informal settlements, informal sector workers, people living in informal settlements, boda boda (motorcycle taxi) riders, individuals in poverty, youth, and women. The literature documents lessons learned about what does and does not work for vulnerable groups across different areas of the response, as explored below.

It appears that compliance with government response measures has varied widely. Some people have chosen not to comply, particularly if the regulation does not make biomedical sense (e.g. wearing a mask while driving alone in a car); some people simply do not want to comply; and some people cannot comply due to more urgent competing needs (e.g. they cannot afford a face mask). Of those who do comply, many believe in the public health measures while some are simply trying to avoid arrest.⁸⁷

General Governance

According to a survey of adults in Nairobi and Mombasa in late March, perceptions of the government response were positive. 61% of individuals were satisfied with the response and 57% trusted the information provided by the government. While younger adults were more satisfied with the response, they were also less likely to trust government information.⁸⁸ By later in the pandemic, corruption, unreliability, and inability to believe in the effectiveness of the government were all cited as reasons why individuals had no trust in the government to combat the COVID crisis.^{89 90} In a survey distributed to

residents in Mombasa in late May 2020, 44% of respondents stated that they did not trust the government to take care of vulnerable people. 40% of individuals cited this was due to corruption whereas 20% said the government was unprepared for emergencies and 40% called the government unreliable.⁹¹

Different types of shortcomings in the COVID response have been documented. It has been reported that positions on the existing disaster response and risk mitigation committees are politically motivated and lack technical support, leading to ill-informed and inadequate responses.⁹² One study found that the centralized coordination of the national COVID response could have contributed to challenges related to obtaining and distributing supplies.⁹³ The reduction in county revenue will most likely cut essential county services and impact the ability of the county to fulfill obligations.⁹⁴

There have been important differences in application of the law among different groups. E.g. in terms of limits to the number of people who can attend a gathering (maximum 15). There has been a double standard in application of COVID response measures on the ground, with law enforcement taking advantage of these measures to abuse their position of power and harass poor people.⁹⁵ Next year's national election is already preoccupying some of the leading politicians in the country. Some of them have held rallies bringing together large crowds, beyond the numbers allowed by regulation, which has led to spikes in infection and also made people question the regulations in place.⁹⁶ At the same time, poor people at funerals and weddings were charged when political rallies were allowed to proceed. This has contributed towards ill-will towards the elite who flaunt rules by which others have to abide.

Within the health system, the government and health authorities need timely data, particularly for urban informal settlement inhabitants and other vulnerable populations, in order to design policies and interventions that are applicable and understood.⁹⁷ However, health system weaknesses are well-known, and these may have contributed to poor COVID related outcomes, particularly among those of lower socioeconomic status.⁹⁸ There is a need for more technical expertise across different health fields at the national level.⁹⁹

The importance of government working in collaboration with a wide range of stakeholders and quickly addressing the identified gaps in the response is a good lesson from the County government of Homa Bay, which is known for good, transparent governance. The response was well coordinated due to the involvement of all the development partners. Stakeholders formed the adapt a school initiative through which better endowed members of the community supported schools to operationalise the Covid 19 prevention guidelines. Additionally, complaints from the clients in facilities led to the introduction of pass letters during curfews for those who escorted patients and for the health care workers.

Access to information

Studies have found that communication and awareness of COVID-19 self-protective measures are not sufficient in communities where these measures are impractical to follow (e.g. informal settlements).¹⁰⁰ Some residents state that messages were difficult to follow due to inability to social distance in certain crowded communities but no alternative strategies were provided for them.¹⁰¹ For others, lack of access to information was an issue with some reporting that they lack access to phones and radios, which led many to be unaware of the curfew and exposed them to police violence.¹⁰²

People with disabilities were initially excluded from national COVID response communications making it hard for them to find out what government guidance was. After lobbying efforts, a sign-language interpreter was brought on for COVID media briefs.¹⁰³

The need for better communication and educational outreach related to COVID in slum communities has been noted.¹⁰⁴ It has been suggested that messaging campaigns focus on reaching the most vulnerable households and addressing issues related to income loss and food insecurity. Behavior change promotion must be tailored to living conditions of specific communities.¹⁰⁵ One promising practice is the use of pharmacies and patent medicine vendors who can be designated as facilitators in communicating COVID information to slum communities, either verbally or through posters.¹⁰⁶

Women are less likely to access the internet or social media and therefore they could be missing out on reliable COVID information.¹⁰⁷

While most youth have not been actively involved in creating awareness around COVID, in Siaya, engaging with youth and community health workers has allowed easier access to households and has led to a flatter epidemic curve.¹⁰⁸

Misinformation and lack of information are issues that require additional governmental attention. Some individuals are reported to lack information on how to protect themselves.¹⁰⁹ Others have reported that the mixed messaging of the government has led to confusion and conflicting information, and that the government has done little to correct this.¹¹⁰ Information overload was also noted as an issue that needs to be addressed within Nairobi informal settlements.¹¹¹ Examples of misinformation include people believing that masks guarantee protection from infection, leading to unsafe behaviors while wearing masks, people believing that if they do not travel, they will be at low risk for contracting COVID, and people believing that God will protect them and therefore they are at low risk for contracting COVID.¹¹²

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Social distancing, curfew, quarantine and self-isolation measures

The importance of the community culture can constitute a barrier to some of the policy measures for controlling COVID spread (social distancing, isolation), perhaps rendering these methods counterproductive.¹¹⁴ The crowded nature of informal settlements makes social distancing measures difficult to follow, limiting their effectiveness.¹¹⁵ Isolating extended families rather than individuals could be an effective method of harnessing community values.¹¹⁶

Women, who mostly work in the informal sector, are unprotected by social assistance programs and have a high risk of contracting COVID, also placing them in danger of financial troubles and poverty.¹¹⁷ Social distancing regulations were also difficult for some employers to adhere to. For example, in the transport sector, vehicles were mandated to run at half capacity but with everyone trying to get home at the same time to respect the curfew this meant that many people were left without transport.¹¹⁸

There have been reports that individuals who were caught not socially distancing or breaking curfew were forced into unregulated government isolation centers, where they became exposed to COVID and were released to spread disease in their communities.^{119 120} Conditions in government isolation centers were reported to be very bad, with poor hygiene, unregulated mingling, and the inability for patients to choose which facility to isolate in.¹²¹ As a result, many people resisted forced quarantine or bribed officials in order to escape isolation.¹²²

Until challenged in the courts, individuals who were placed into hotels or state centres during isolation were forced to pay the entire cost.^{123 124 125} The fear within the population of having to pay to be in COVID

quarantine facilities led to a reluctance to seek COVID testing, follow orders to quarantine in state facilities, visit hospitals, or participate in contact tracing initiatives.^{126 127 128 129 130} These policies, and the ways in which they were implemented, may have exacerbated communities' lack of trust in the government.

The imposition of curfews had a negative impact because of how they were implemented. This duty was left to the police who were given no training and had no public health knowledge so the ways they enforced curfew -- often rounding up people who were on the streets as curfew approached, beating them, corralling them into confined spaces and in some cases sending them to quarantine facilities -- served only to antagonise the populace and create the conditions for further pandemic spread. This loss of trust in the government was exacerbated by the Ministry of Health's implicit condoning of these actions.¹³¹ The KNHRC recorded many cases of people who had been brutally harassed, and in a court case, the court agreed that the police had used excessive force and this was unconstitutional.¹³²

Handwashing practices

While the idea of handwashing and sanitizing has been embraced by the majority, only 59% of the population has access to clean water services, with access particularly limited in informal settlements.^{133 134 135 136} In the largest informal settlement in Kenya, one third of the population does not have access to in-house piped water.¹³⁷ In rural areas, women must walk multiple kilometers for clean water, while more crowded regions lack a constant supply of clean water entirely.¹³⁸ In the face of this limited access for certain populations, suggesting that they use the little water they have to wash their hands may not be effective.^{139 140} Alcohol-based hand sanitizers are too expensive for many living in informal settlements: cost has been explicitly cited as reasons for not participating in preventive behaviors.^{141 142 143}

The government allocated schools KShs500 per student to help improve infrastructure during the period that schools were closed. Much of this was invested in improving school infrastructure, particularly hygiene facilities such as handwashing stations. This can help promote better hand hygiene than was previously possible and could have a lasting positive impact beyond the pandemic.¹⁴⁴

At the local level, partnerships between agencies and local governments acted as important levers for the adoption of sanitation practices. In partnership with the Nairobi City Water and Sewage Company, the Athi Water Works development Agency installed 500 free handwashing points around Nairobi county.¹⁴⁵ Unilever partnered with the county government of Nakuru to install handwashing facilities and to distribute soap in informal settlements around Kenya.¹⁴⁶

Wearing masks

Masks (costing approximately USD \$1) are too expensive for many families.¹⁴⁷ Poverty levels, particularly among people living in informal settlements, is a major driver in the manufacturing of low-quality face masks, which can pose more health challenges than not wearing one at all. These masks are substandard, used, and unhygienic. While online purchasing of masks is recommended, the public does not trust this method of purchase.¹⁴⁸

Discomfort while wearing masks was cited as a deterrent, but some individuals wear masks to avoid being fined rather than for self-protection, leading to an environment where poverty is criminalized due to high mask costs.^{149 150} For boda boda riders specifically, fear appeals were effective in increasing compliance with preventive measures including wearing masks.¹⁵¹

Mapping the evolution of the pandemic in the context of this policy response

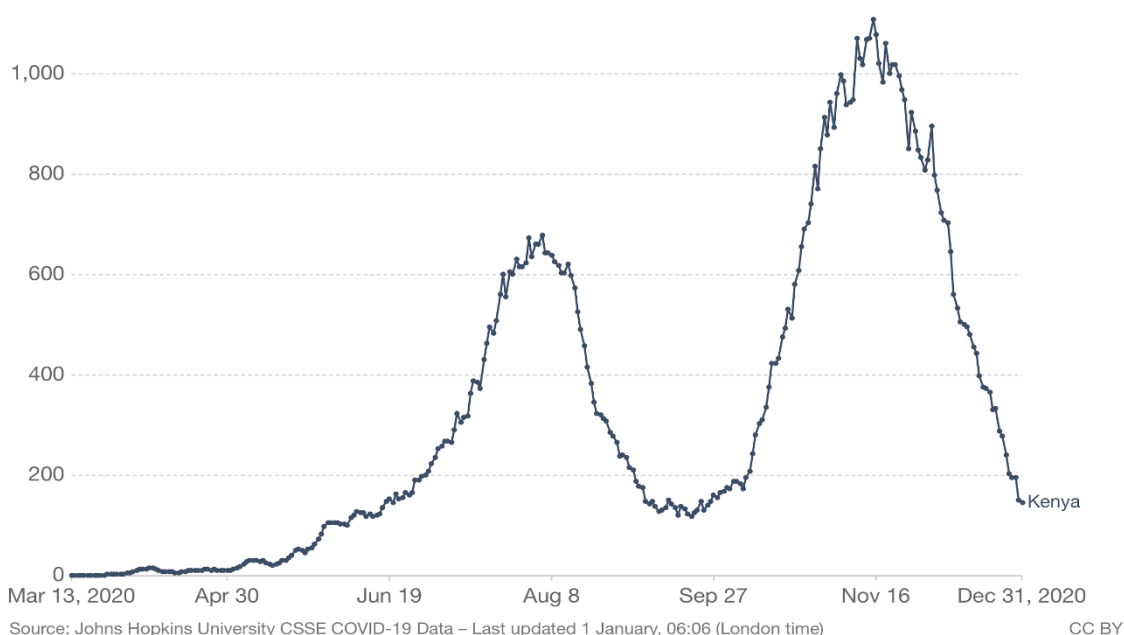
Looking at the graph of daily new confirmed COVID-19 cases (Figure 3), it is very apparent that Kenya experienced two spikes in cases in 2020, the first reaching its height around August 8th and the second on November 16th. A variety of factors have contributed to these surges, some of which we attempt to explain as a correlate to the legal and policy measures introduced by the Kenyan government. In some cases, increases in testing have been attributed to a rise in cases, yet that may not fully explain any upticks.

Figure 3. Daily new confirmed COVID cases

Daily new confirmed COVID-19 cases

Shown is the rolling 7-day average. The number of confirmed cases is lower than the number of actual cases; the main reason for that is limited testing.

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The first spike, which began in May and accelerated through June has been attributed by media outlets to crowded streets as a result of the easing of government restrictions. The government initially identified Mombasa's Old Town and Eastleigh in Nairobi as hotspots for infection and by May 20th declared a cessation of movement in and out of these areas in addition to the counties of Kilifi, Kwale, and Mandera. On June 6th, despite a consistent rise in new cases, President Kenyatta relaxed curfew hours and lifted the above-mentioned cessation of movement. On June 16th, Kenya's Health secretary announced that restaurants and hotels could now close 2.5 hours later, at 7:30pm. Shortly thereafter, the number of new cases spikes dramatically. Another theory that has been advanced to explain this spike was that it coincided with the beginning of the cold season.

Truck drivers were found to be responsible for a lot of COVID spread. It was in early August that the East African Community states launched the regional cargo and driver tracking system in an attempt at prevention. It is around this time that cases begin trending downwards and the first major spike subsides.

In late September, the second spike in new COVID cases began. In the waning days of September protocols were relaxed by the President.¹⁵² Bars and clubs were allowed to operate as of Sept 29, public schools were partially reopened, and the nighttime curfew was extended to 11pm. Additionally, guests allowed at weddings and funerals were increased from 100 to 200 and churches were allowed to host up

to a third of their capacity. The loosening of all of these restrictions may have contributed to the second spike. Some reports have attributed the second rise in cases to people outside the capital seeking care at the country's best facilities in Nairobi and Mombasa.

Uptake of COVID-related services

At the very beginning of the pandemic, the plan was that everyone infected with the coronavirus would be treated in health facilities but it soon became apparent that home care was a much better option. With this in mind, community health workers were brought into the response, creating a more devolved program with much wider reach.¹⁵³ Of course, this also shifts the onus of care-giving to communities (primarily women), with impacts on their vulnerability to infection and their ability to earn a living.

Individuals in under-resourced communities do not have the financial means to afford testing and treatment for COVID.¹⁵⁴ The majority of Kenyans survive on less than US \$2 a day, but COVID testing costs US \$100 and treatment is far more expensive.¹⁵⁵

Conclusion

A thread running through these lessons learned is that poverty constitutes a critical barrier to accessing information, adopting preventive measures and also for accessing testing and treatment services.

One civil society respondent claimed that overall, the government is touting a successful pandemic response but some civil society actors are more skeptical suggesting that, due to a lack of testing, there is no clear understanding of the extent of the pandemic nationally. Furthermore, they suggest that it is important to also consider the negative impact on non-COVID related outcomes, including deaths from police violence, excess mortality from other health issues and impact on people's livelihoods.¹⁵⁶

Sustainability of positive measures and potential for change of negative measures

There was very little in the literature to help understand the sustainability of successful measures or the potential for overcoming harmful measures. One study noted that stringent measures that cause economic and food insecurity cannot be sustainable in the long-term without social protection mechanisms.¹⁵⁷ Local economists and analysts have called for a \$1 billion fund for businesses and a universal basic income of \$20 per month. However, it is reportedly unlikely that this will occur due to the "triple threat" facing Kenyan leadership: the pandemic, the struggling economy, and a political succession battle.¹⁵⁸ The Ministry of Health has explicitly stated that the cost burden of using the National Hospital Insurance Fund to cover COVID bills is not financially viable and that this avenue will not be pursued.¹⁵⁹

A key informant reported that there has been renewed attention to import substitution as a result of the disruption caused by early restrictions on flights entering and leaving the country, which might improve the national balance of payments in the long-term. Furthermore, investment in local infrastructure will have a lasting positive impact, including investments in schools, ICU capacity and oxygen availability in hospitals and, in Homa Bay, the Belgian government has invested in expanding water production to increase residents' access to clean water.¹⁶⁰

It is of concern that the Kenyan government recently received a warning from the IMF about their excessive levels of borrowing. Most of the COVID response is donor funded, raising questions about its sustainability.¹⁶¹

Health worker and care-giver protection and support

There has been insufficient support and protection from health risks for health workers and care givers throughout Kenya. From very early on in the pandemic, health workers complained about a lack of personal protective equipment (PPE), including N95 masks and surgical gloves.^{162 163 164 165} Clinics have reported shortages of hand sanitizer even though they have been recommended to use sanitizer between client visits when water is not accessible.¹⁶⁶ Furthermore, smaller clinics are unable to follow 1.5 metre separation guidelines due to their small rooms.¹⁶⁷

Community health workers are not supplied with protection and must buy and bring their own sanitizing products and/or water containers before visiting households.^{168 169} In addition, their transportation costs to carry out their work is not covered.¹⁷⁰

Healthcare providers and community health workers have reported lack of training on COVID.¹⁷¹ In the case of healthcare providers, there have been reports that they have fled from patients with COVID-like symptoms.^{172 173}

Poor quality PPE has been linked to COVID infections in healthcare workers.¹⁷⁴ There have also been reports that many health workers have died from COVID having been refused medical care because they could not afford to pay for it. Doctors demanded comprehensive medical insurance, on-time salaries, compensation, and leave for doctors with pre-existing conditions or those who are pregnant.¹⁷⁵ However, no agreement was reached between the government and the Kenya Medical Practitioners, Pharmacists and Dentists Union, which has 7,000 members, resulting in a health worker strike that started on December 21st.¹⁷⁶ Following intervention by the President, an agreement was reached on December 25th for doctors to return to work. However, nurses and clinical officers, the majority of the health workforce, remained on strike. Some workers had refused to work earlier in the pandemic due to low pay and insufficient PPE but the scale of this strike is much larger.^{177 178}

The majority of nurses are women in Kenya and therefore women disproportionately carry a heavier burden in COVID care.

Other immediate impacts of the response

Given the breadth of the pandemic response, it has impacted not only COVID-related outcomes but other spheres of life too including health, nutrition, education and livelihoods. The impact of the COVID response on these other areas is explored below with particular attention to who benefits most and who is left behind.

Impact on different groups within society

While the Kenyan government was swift in its legal and policy response to COVID, there appears to have been little consideration for the differential impacts that their actions might have on vulnerable communities. Following the same structure as the previous chapter, the impacts of the legal and policy response described above on different groups within Kenya is explored below, drawing on published evidence and interview data.

Impact of the Fiscal Response

Impact on individual livelihoods

Overall, COVID has been characterised by mass unemployment, loss of income, and an increase in dependents. Labour participation fell due to the pandemic from 75% in 2019 to 56.8% in April 2020.¹⁷⁹ At least one million people lost their jobs or were placed on unpaid leave as of June in both formal and informal sectors.¹⁸⁰ This is in part because curfews and restrictions have made jobs redundant.¹⁸¹ According to a survey published in August, 69% of Kenyans report reduced earnings and 43% report a complete loss of income.¹⁸² Many upper/middle-class Kenyans have let go of their domestic workers due to fears of contracting COVID, exacerbating unemployment among the lower-class.¹⁸³

Economic insecurity caused by reduced earnings and job cuts has made it difficult for vulnerable individuals to pay rent, with 30.5% of Kenyans reporting that they were unable to pay rent in April and only 41.7% tenants reporting that they paid their rent on time.¹⁸⁴ However, only 8.7% of landlords waived rent in April and some have resorted to ending contracts, locking tenants out, and cutting basic services.¹⁸⁵

According to one survey, 92% of Nairobi County's low-income residents had suffered reduced income by May.¹⁸⁶ A study by the Population Council revealed that 80% of individuals living in Nairobi's largest urban informal settlements experienced a decline in income, increase in expenditures, and increase in food prices. Most respondents had not received government support.^{187 188} In general, there is a lack of social support systems that could provide adequate resources for sustenance.¹⁸⁹

Individuals who work from home often experience internet problems, including low connectivity and affordability of internet services. This restricts ability to work from home forcing some back to workplaces where they cannot socially distance.¹⁹⁰

According to one key informant, it appeared that the guidelines influencing the fiscal response were "copy-pasted" from well-established economies that have substantial stimulus packages that Kenya does not. In doing this the response did not accurately take into account the challenge of supporting vulnerable groups.¹⁹¹ Another key informant pointed to the gaps in mitigation measures when it came to vulnerable

groups, noting that the extent of their consideration was not very reflective in the issuance of guidelines. Had the government focused their attention on specific populations, the language would have been less generalized across policies.¹⁹²

Research suggests that attempts to create policies and plans mitigating the impact of the lockdown did not take into consideration the specific needs of women, and as a result, the lockdown measures also disproportionately impact the livelihood of women.^{193 194} More women work jobs that have been vulnerable to disruption, including the service and manufacturing industries. Women also tend to operate businesses that are associated with traditional gender roles and therefore require face to face interactions. Single mothers who contract COVID or cannot work due to pandemic measures risk bringing the household into economic insecurity more so than in two-parent households. In addition, fewer women work in formal employment and thus have not benefitted from tax reliefs to the same extent as men have.¹⁹⁵

Women comprise more than 60% of informal businesses. The partial lockdown has disproportionately impacted informal sector workers, who survive on daily wages and work in casual labour or petty trade and often lack access to the financial resources, social protection or employment benefits necessary to survive financial shocks.^{196 197 198} In addition to the impact of travel restrictions, the imposition of a curfew has limited their income and put them in danger of poverty.¹⁹⁹ Due to the lack of a regional response to COVID, trade declined by more than 50% in the early months of the pandemic and impacted cross-border traders, most of whom are women.^{200 201} Finally, significantly more women than men have reported increases in household expenses.^{202 203}

Many of the fiscal policies designed to provide financial relief focus on those with steady income, leaving out all of those in the informal sector (which comprises 85% of the urban population). Examples of these exclusionary policies include tax relief for low-income individuals, relief funds, suspension of listing with the Credit Reference Bureau, and a COVID-19 support stipend meant to target poor communities.^{204 205} Social protection relief measures came into effect after people had lost their income source and logistical challenges impeded implementation in many cases, leading to minimal relief.²⁰⁶ One study proposed that direct cash transfers and utility fee waivers could have been more useful for informal sector workers.²⁰⁷ Tax relief programmes do not, of course, reach those who do not pay taxes such as those in the informal sector who live most 'hand to mouth'. Eligibility for cash transfers was determined by pre-existing government registers, which are widely recognised to be very incomplete. Key informants noted that there is a 'poverty of data' to help identify those who are most vulnerable and that the few data that do exist are under-utilised for appropriate targeting.²⁰⁸ A key informant explained that the cash transfer programme, which pre-dates the pandemic "has been based on a single registry, but this single registry has a blind spot on poverty", which seems like a major shortcoming for such a programme.²⁰⁹ Referring to the cash transfers, another key informant described them as "basically seeping out of the pipes that are supposed to deliver them to the recipients" suggesting that, whether through corruption or inefficiencies, they did not reach their intended beneficiaries.²¹⁰

A key informant noted that had the government considered the number of people in Kenya who are small scale traders or women youths living in informal settlements, or even in rural communities, and had brought populations such as these to the decision making table, the economy may not have been as affected as it was.²¹¹ The absence of trade unions, including those street hawkers, 'matatu' drivers and other informal business sectors, from policy development processes created blind spots that have exacerbated the economic impact of the response.²¹²

For young children, alongside the vulnerability of caregivers to morbidity and mortality, the restricted access to social protection services or psychosocial support may prevent caregivers from providing effective nurturing care to their children.²¹³ When caregivers experience financial hardship or become ill during the pandemic, children are forced to beg for food, engage in hazardous work, and they also become vulnerable to violence and exploitation.²¹⁴ When caregivers succumb to COVID or to indirect health impacts of COVID, children are orphaned.²¹⁵ To supplement family income, children have participated in a variety of labour activities including khat plucking, fetching firewood, tea picking, coffee harvesting, working as part-time house help, running farming errands, household chores for employers, selling water at kiosks, and babysitting, all of which prevents them from engaging in learning.²¹⁶ The tax relief benefit has been repealed even as curfew remains, still limiting the hours that people can work, which makes it hard for them to earn enough money to start paying taxes again in addition to supporting their families.²¹⁷

Young people are also disproportionately affected as they are also mostly employed in the informal sector.²¹⁸ Youth have reported income loss, increased expenses, increased food cost, and loss of jobs.²¹⁹ As a result, they have been forced to engage in income-generating activity to support their families.²²⁰ The latest economic stimulus plan includes a special focus on youth in order to reach large segments of informal workers and invest in long-term economic success; it will be important to track its implementation.²²¹

Sex workers, whose income was essentially wiped out by curfew measures, are noted to lack alternative sources of income and yet some have been openly criticized for breaking physical distancing rules in crowded informal settlements.²²² Sex workers have been producing and selling personal protective equipment (masks, sanitizer) to generate alternative forms of income.²²³

Released prisoners face a range of challenges including vulnerability to criminality, difficulties reintegrating into the community due to insufficient reentry preparation and a lack of counseling, lack of access to income-generating activities, and, for those living with HIV, particularly the elderly, a potential lack of support.²²⁴ Offenders on probation will have challenges meeting with probation officers due to COVID measures.²²⁵

The pandemic measures have exacerbated challenges faced by refugees trying to be economically productive and resulted in greater economic instability among this population.²²⁶

The most common coping strategy has been to change dietary patterns and rely on savings. Other strategies include reduced gifts/remittances given out, lent less money, postponed loan repayments, deposited less new savings, increased support from family and friends as well as selling assets.^{227 228} As economic strain has increased, there has been a reported increase in dependence on relatives and friends for food, remittance, masks, sanitizers, and medicine.²²⁹ Coping through savings is more associated with the ability to withstand income shocks and remain food secure in comparison to coping through social protection schemes.²³⁰

Two groups of people reported financial gains from the pandemic: boda boda riders who indicated that sneaking individuals past road barriers was financially rewarding due to their increased rates, and those who were eligible for full or partial tax relief.²³¹

Impact on businesses

GDP growth of about 6% was forecast prior to the pandemic but this was not realised, subsequently affecting the financial sector. The effects of this contraction are widespread and had significant implications on government ability to raise taxes and carry out necessary functions. One key informant pointed out that the debt level rose as Kenya had to take on additional debt from the World Bank, among others, for the emergency response.²³²

Small businesses have been negatively impacted, with permanent closures and/or the enormous loss of savings.²³³ Overall, businesses have experienced a decrease in production, shortage of goods, and a disruption within the supply chain.²³⁴ The worst hit sectors are tourism, transport, horticulture, communications, and education.²³⁵ Changes in burial traditions due to COVID has had a spiraling impact on multiple different groups of people, including: catering service groups, photographers, small traders selling things outside funerals, music providers, motorcycle operators transporting mourners to funerals, loitering groups who preyed on food at funerals, and illicit brew sellers.²³⁶ Closure of bars, restaurants and schools have pushed employers to terminate contracts, sometimes in a manner contrary to their employment contracts.²³⁷

Curfews and other restrictions have reduced the number of hours of work available per week in almost all sectors of the economy, especially in education and the hotel sector, causing reduced revenue and job loss.^{238 239} While Kenya reduced VAT from 16% to 14%, this has not helped the business community because their volume of sales has decreased so dramatically.²⁴⁰ One study suggested that in order to aid businesses, it would be helpful for the government to remove payroll costs.²⁴¹

Some businesses benefited from the pandemic response; 12 companies were awarded Ksh 3 billion contracts with KEMSA to provide items not covered by the government budget. There are accusations of corruption in this deal (more details are provided below in Section 9 below).²⁴²

Impact on agricultural industries

Pandemic measures specifically impacted the fishing industry, causing a decline in fishing trips. Market closures made it hard for fisherfolk to sell their fish and farmers to sell their cattle.^{243 244}

Farmers have been more likely to suffer income shocks in comparison to salary and wage earners because they report difficulties in accessing their farms, accessing farming inputs, and transporting their produce to markets due to the lockdown.²⁴⁵ Wage earners, on the other hand, can work from home and earn an income.²⁴⁶ Kenyan farms have also reduced exports to 50%, placing them in danger of downsizing and closure, which would increase poverty, insecurity and hunger.²⁴⁷ A lack of manufacturing from neighboring countries caused a halt in production of dairy meal and unaffordable hay, leading to reductions in milk yield for farmers and an increase in milk prices.²⁴⁸

Rather than relying on savings as a coping strategy as salary-earning workers do, farmers and wage earners are more likely to cope by changing dietary patterns.²⁴⁹

Though there was intention to reach the most vulnerable including the poor through the different measures, it appears that this was unsuccessful due to two main factors: first, the government appears not to have anticipated the impact the mitigation policies would have particularly on the vulnerable and therefore failed to consider this when structuring the pandemic mitigation as well as the social protection measures.²⁵⁰ Secondly, the system that was in place to implement the social protection measures such as the cash transfers and the tax relief were blind to poverty and the informal sector,²⁵¹ hence it further

disadvantaged the poorest and the near poor who were sliding back into poverty. The need to update the register through various means was clearly articulated by most of the key informants who were not from the government sector.

Impact on non-governmental organizations

NGOs, which operate on grant funding and international donations, have been financially impacted by global economic instability.²⁵²

Impacts of the Biomedical and Public Health Response

Physical distancing

The policy of physical distancing is particularly difficult for certain groups of people including people who live in high density informal settlements in which the spread of disease is much more likely, people who work in jobs requiring them to be on site, people with disabilities who may be reliant on caregivers, and the elderly who may also need carers and who may suffer disproportionately from mental health challenges created by separation from their families.^{253 254 255 256}

Measures were put in place to promote physical distancing on public transportation so as to try to reduce transmission, including halving the number of passengers, requiring masks, and providing sanitizer and hand washing facilities at boarding points. These measures have increased the cost of operations and therefore increased the fare for passengers by 51.7% nationally. This reduced accessibility for individuals in poverty and the vulnerable, causing them to walk or use bikes instead.²⁵⁷

Within refugee camp settings, social distancing and the necessary access to clean water during COVID is not feasible. Overcrowding in food distribution centers makes social distancing particularly difficult.²⁵⁸

Handwashing

Early in the pandemic, water rationing was reported in the Nairobi informal settlement of Kariobangi, making it difficult to abide by hand-washing and sanitizing directives (KIM6, April). Proceeds from government anti-corruption programs have been ear-marked for providing clean water to vulnerable communities. However, the government faces challenges in implementing measures for populations that lack piped water systems, have poor hygienic conditions, and do not have easy access to formal service providers.²⁵⁹ Certain initiatives intended to provide handwashing stations have been narrow in terms of the scope of their accessibility. Persons with disabilities are not always able to safely utilize these stations.

Due to the ban on prison visits due to COVID, the government provided prisons funds to purchase soap and hand sanitizer in an attempt to limit spread of COVID within the facilities.²⁶⁰ The sufficiency of this intervention is unclear.

Face masks

There are concerns about the disposal of face masks both in relation to the environmental impact of improper disposal as well as the risk of disease transmission.²⁶¹

Home care

The government's policy promoting home care for asymptomatic COVID patients disproportionately increases the burden of unpaid care on women. While both men and women reported an increase in

housework during the pandemic, women were more impacted.²⁶² The expectation of housework and caring for children also impedes working at home for women.

Sexual and physical violence

There have been reported rises in sexual offences, domestic violence, intimate partner violence, gender-based violence, and violations of the rights of children during the pandemic.^{263 264265} Financial pressure due to COVID stimulated violence against individuals, some of whom were then thrown out of their homes during the pandemic without financial support. A survey revealed that 10% of Kenyans reported being worried about GBV and 21% reported being worried about domestic violence during the pandemic.²⁶⁶

School closures, barriers to school re-enrollment, unstable housing, absent parents and the lack of available safe spaces have had a plethora of negative consequences for children, particularly girls. This includes increased risk for neglect, domestic abuse, sexual exploitation, rape, and early pregnancy; vulnerability to engaging in transactional sex to obtain food, provide for their families or buy sanitary pads that were provided by schools before their closure; vulnerability to sex predators and online harm; and female genital cutting, child marriage and teenage pregnancy.^{267 268 269 270 271 272 273 274 275}

Elderly women have been subjected to unreported rape and violence. Abusers have also reportedly taken away the monthly stipend provided to elderly women through coercion and violence.²⁷⁶ Despite the increase in sexual and physical violence against elderly women, they are less likely to report due to shame, fear, and stigma.²⁷⁷

Sex workers are vulnerable to physical and sexual violence (as well as not being paid) because they are entering the homes of clients due to reduced work opportunities. Because they work around their clients' schedules, sex workers often miss curfew and so become susceptible to police violence and harassment. Some reports reveal that sex workers are forced to engage in unprotected sex with law enforcement agents in order to bribe their way out of curfew-related charges. While there are some peer sex workers who are trained as paralegals to protect sex worker rights, they have limited ability to combat curfew-related abuses. Migrant sex workers have been deserted by their employers, exposing them to violence.²⁷⁸

The judiciary has tried to provide an expedited process to ensure that cases relating to interpersonal violence could be addressed despite the COVID restrictions on judicial processes but the impact of this is not yet clear.²⁷⁹

Police violence

Security personnel enforcing curfew and other lockdown measures have been violent and harsh.²⁸⁰ At least 15 deaths have been linked to police brutality triggered by the enforcement of COVID curfews.²⁸¹ In particular, urban poor living in informal settlements have been susceptible to violent altercations, forced displacement, riots, and police brutality.^{282 283}

Women who travel after curfew without a letter from the chief are often harassed verbally and physically by local authorities even if in labour and trying to reach a health facility.²⁸⁴ While doctors and nurses have "essential workers" badges to exempt them from these measures, community health workers do not. Therefore, they fear violence from the police for 'breaking' curfew.²⁸⁵

Mental health implications

COVID-related isolation and economic anxiety has amplified the mental health crisis in Kenya: isolation, cessation of movement, and loss of jobs due to the pandemic has caused fear, anger, loneliness, stress and anxiety in the majority of Kenyans, particularly those of low-income.^{286 287} 75% of Kenyans have reported worry, stress, and anxiety, and suicides have been reported.^{288 289} The inability to attend social gatherings is a contributor to these feelings of fear, uncertainty, and stress.²⁹⁰ The mental and psychological stress can partially be attributed to lack of health insurance and fear of loss of livelihood, both of which disproportionately affect those of lower socioeconomic status.^{291 292}

Peer-reviewed literature identified sex workers, released prisoners, and salaried workers as groups who are particularly vulnerable to psychological distress due to the aforementioned factors.^{293 294 295} In addition, national media and peer-reviewed literature have highlighted the mental toll that school closures and job loss have had on youth and students.^{296 297 298 299 300}

The United Disabled Persons of Kenya (UDPK) and the Caucus on Disability Rights Advocacy (CDRA) have called on the government to protect the rights of people with disabilities in responding to the pandemic. They have specifically highlighted the need for government to identify and attend to people with disabilities living in crowded informal settings. A key informant noted that in some institutions, individuals being treated for mental illness in isolation may have been moved to other areas to allow for COVID-19 patients without any plan to treat both.³⁰¹

Health service delivery

Following the guidelines to ensure the continuity of reproductive, maternal, newborn and family planning services, some services were restructured to minimize clinic overcrowding. This included reducing the number of ANC visits, delaying some immunizations, promoting long-term contraceptive methods and, for women on short-term methods, providing multi-month supplies. Some facilities stopped providing youth-friendly services, particularly in the evenings.³⁰² These changes all led to some confusion among clients, some of whom missed rescheduled appointments.

Food security

Accessibility to food has been reduced due to food shortages, income loss, increases in food prices, bans on outdoor markets and diversion of funding for nutrition services to the COVID response.^{303 304 305 306 307} ³⁰⁸ The pandemic is reported to be worsening an already bad food crisis, with many individuals limiting food consumption and a majority of Kenyans worrying about food insecurity.^{309 310 311 312 313 314} Three quarters of individuals reported eating less or skipping meals and that their biggest unmet need was food.^{315 316 317} 86% of Kenyans overall are worried about having food.³¹⁸ Families are incurring debts from vendors, neighbors, and landlords and sacrificing their own nutrition to provide adequate food for children.³¹⁹

Income-poor individuals and individuals employed in casual work are more likely to be food insecure.³²⁰ ^{321 322} There are concerns that any efforts to isolate or keep physical distance among informal sector workers and informal settlement residents might make them vulnerable to food insecurity.^{323 324} Individuals below the poverty line have resorted to only purchasing essential food.³²⁵ 54.8% of informal settlement households in Nairobi are food insecure according to a survey of 10 informal settlements.³²⁶ People of low socioeconomic status, particularly poor urban families, relying on daily wages from informal employment are disproportionately impacted by containment measures due to their lack of food reserves.^{327 328 329} People who are food insecure have been forced to choose between adhering to COVID

measures and obtaining food, which is still a challenge due to costs, and also exposes them to potential repercussions by police.^{330 331}

Access to food for children and those in pastoral communities has been diminished by school closures and market closures, respectively.^{332 333 334 335 336} That some children attend school primarily to access food (rather than education) was highlighted by key informants.³³⁷

A key informant noted that there had been food relief programmes for people living in informal settlements but that these were “mired in corruption”, meaning that many people in need were not reached.³³⁸

In partnership with the Ministry of Agriculture, county governors have committed to prioritizing communities vulnerable to food insecurity in creating plans that ensure affordability.³³⁹ At the sub-national level, the Governor of Kirinyaga county declared that at least 6,500 households would be targeted in a new relief food programme from May.³⁴⁰ It will be important to monitor these interventions moving forward.

In support of the Kenyan Ministry of Health, the UN World Food Bank is providing vital nutrition support, to 16,000 children under 5 years, 700 pregnant and breastfeeding mothers, and 6,800 elderly people in informal urban settlements. Specifically, it is distributing therapeutic ready-to-use nutrient rich foods and fortified flour.³⁴¹ In addition, the World Food Programme (WFP) is providing three months’ assistance for 300k urban inhabitants in Nairobi and 100k in Mombasa.³⁴²

Education

Schools were closed for essentially the whole academic year. Although there were some efforts to provide online education, lack of access to phones or computers, intermittent electricity, limited phone or internet capacity and lack of technical skills are barriers to accessing and downloading learning materials for online education, particularly among those of lower socioeconomic status.³⁴³ Many parents facilitated the learning of their children through applications such as WhatsApp or Zoom, and several parents have also purchased internet bundles for the purpose of online learning.³⁴⁴ Most students use phones to play games and chat with friends, highlighting the importance of phones in also facilitating online social interaction.³⁴⁵ All of this disproportionately impacts children in poorer families who cannot afford private tutoring as well as children with special needs.^{346 347}

The immediate impact on children’s education as well as their socialization is clear. Restrictions and lockdowns impede children from exploring their environment and communicating with other children, therefore impacting development and future learning outcomes.³⁴⁸ The focus and funds of the policy response has been on physical health rather than all aspects of child development, including early education.

For children who require special education or children with developmental challenges who require special teachers, the pandemic proved especially difficult. These students could only access services at a school and for most special training aids were not available at home.³⁴⁹

As schools re-opened, shortcomings in school infrastructure remained despite government investment. In response, in Homa Bay, the ‘adapt a school’ intervention was implemented whereby people of relatively high socioeconomic status could invest in ensuring that schools could adhere to COVID guidelines.³⁵⁰

The longer-term impacts are not yet clear. Many pupils will have to retake this year of classes and it is feared that many may not even return to school if they are now working (and supplying income for the family) or if, as is the case for many girls, they have become married and may already be starting a family.

Sustainability of the response

Very little literature addressed the sustainability of positive measures or potential for changing harmful measures. One study noted that it is not clear how long the COVID-19 Support Stipend initiative will be sustained.³⁵¹

A civil society representative suggested that the response is entirely unsustainable without greater participation of society in its design, implementation, monitoring and evaluation: that people are already tiring of the measures that are in place and lack of trust in government is negatively impacting their willingness to comply. An inclusive planning team that includes stakeholders beyond the biomedical sphere, and is open to criticism and sufficiently agile to adapt the response as new data emerges might help promote a more sustainable response. All of this requires political will in order for such changes to be implemented and civil society is not optimistic that this exists.³⁵²

Policy responses promoting structural changes

Relatively little has been written about the extent to which policy responses and mitigation measures might promote structural changes within Kenya. The focus has been much more on immediate needs. However, two examples were found where longer term change was a consideration in intervention design.

There is a 2020 Community Health Services Bill in Parliament that seeks to entrench community health workers into the health system. This pre-dated the COVID pandemic but the importance of community health workers has been highlighted during the pandemic. They could play an important role spearheading hygiene campaigns, facilitating contact tracing, contributing to home-based care, and easing overall government planning.³⁵³ This may help expedite the passage of the bill through Parliament.

The World Economic Forum worked alongside the Ministry of Health to incorporate young people, technology and community volunteers in the COVID response in Siaya County. This partnership helped ensure rapid implementation of an appropriate solution and build results into policy decisions and because it led to the inclusion of activities in the Ministry's workplan, which was designed to promote the sustainability of the intervention.³⁵⁴

Media messages to promote pandemic guidelines

There is little information in the peer-reviewed and grey literature about messaging to promote adherence to policies and guidelines to curb the pandemic. Early in the pandemic, it was noted that local radio programs that target a Luo audience had not expressed opposition to halting traditional funeral practices to curb the spread of COVID.³⁵⁵ Furthermore, social media was flooded with reports of “ambivalent response mechanisms and arbitrary directives” that were not expressed through any clear channels of communication, which created confusion among the population as to what the guidelines actually were. A key informant explained that the media had played an important role informing the public about COVID and the response to it, including broadcasting in vernacular languages. In Homa Bay, a media representative was included on the COVID committee to accurately report via radio the guidance that

was being issued.³⁵⁶ Dettol Kenya, a disinfectant brand, launched television campaigns to help educate Kenyans on the best ways in which their products can be used to protect against COVID-19.³⁵⁷

Key figures in the public health response have been seen to leverage their position to influence communities via their own social media channels in addition to traditional media. According to one key informant, this use of media was used with explicit intent of shaping the response and public opinion.³⁵⁸ Figures such as these have been useful resources in the demystification of issues and speculations associated around the disease – from vaccination to self-care measures – and have been seen to assist the government with issues around publicity. The same key informant noted that support given to the government by foundations, NGOs and private actors amplifies government messaging and has an overall positive response on the population.³⁵⁹

Impact on access to other services

Access to other services has been greatly disrupted by the COVID response, as outlined below.

Impacts on healthcare access:

The COVID response has reduced affordability of healthcare services (due to lost income) as well as the quantity and speed of services available due to pandemic restrictions.^{360 361 362} Fear of COVID and an increase in transport costs has interrupted access to health facilities.^{363 364 365 366 367} In addition, the supply of medication has decreased and there are reported shortages of contraceptives, antiretroviral drugs for HIV, antibiotics, and more due to supply chain disruptions.³⁶⁸ The removal of health insurance coverage due to the loss of employment along with the halting of contributions to the National Health Insurance Fund (NHIF) have contributed to a decline in patient flow to hospitals.^{369 370} National media articles specifically mention that vaccination coverage rates have also significantly dropped.^{371 372 373} Several articles have highlighted reduced accessibility and quality of care in sexual and reproductive health services, leading to outcomes such as reduced antenatal clients, an increase in stillbirths, worsening maternal and child health, a reduction in long-term family planning methods and exacerbation of disparities among vulnerable households.^{374 375 376 377} Fear has also become a large contributor in preventing pregnant women from accessing reproductive health services.^{378 379 380 381} The worst affected period appears to have been the first few months, with attendance at health services beginning to pick up again around May, June or July.³⁸² Despite publication of guidelines for ensuring the continuity of maternal and child health services through the pandemic, shortcomings remain: for example, while the Ministry of Health *recommended* that all women were given a three-month extension period for prescriptions, there is no official policy in place.³⁸³ Research published in August 2020 found that at that time health workers and managers reported being unaware of any guidelines for treatment of non-COVID illness.³⁸⁴

It is of concern that Caesarean-section rates have increased during the pandemic to beyond WHO recommendation of 10-15%.³⁸⁵ Maternal health resources including health workers were being reallocated for COVID patients, slowing down maternal health services.³⁸⁶ In neonatal care, health providers were under increased burden because regulations mandate that COVID positive mothers should be separated from their babies and that both should be cared for separately.³⁸⁷ In addition to the health system strain, mandating separation of COVID positive mothers from their infants is more harmful than helpful and can cause physiological stress for both mothers and children.³⁸⁸

Some important work has taken place at the sub-national level to promote continuity of maternal and child health services. For example, in Siaya, the World Economic Forum worked alongside the Ministry

of Health to ensure essential health services, particularly maternal and child health, were sustained throughout the pandemic. The issue of rising teen pregnancies was also acknowledged and addressed.³⁸⁹ Some innovative local initiatives were created to provide free transport for pregnant women courtesy of taxi drivers to ensure that women could continue to access health services. Despite this effort, taxi drivers are more likely to work in affluent neighborhoods and as a result this policy disproportionately aids the privileged.³⁹⁰

Some elective visits and surgical procedures were entirely suspended in public hospitals (K6, August).

There are insufficient services to address gender-based violence, the government lacks a systemic mechanism to record crimes and track them, and trends related to sexual and other violence are difficult to assess during the pandemic.³⁹¹

Peer-reviewed articles have mentioned that access to HIV services has been greatly impacted, including a reduction in HIV test quantity and speed, shortages in antiretrovirals, inaccessibility to HIV counseling and long delays in getting viral load test results.^{392 393} All of this can negatively impact the health of people living with HIV and magnify the risk of new HIV infections. The networks of people living with HIV came together to help ensure continued access to antiretroviral medications, including clients being given medication for more months than usual so that they wouldn't have to return to the health facility. However, even as it has not yet been documented, there are concerns that poverty, depression and food insecurity may be affecting adherence to medications and health outcomes.³⁹⁴ Articles have additionally mentioned reduced access to pharmacies, cancer facilities, speech pathology therapy, and disability services.^{395 396 397 398} This has disproportionately impacted women, people with disabilities, and the elderly.^{399 400 401}

People with chronic diseases, including cancer, diabetes and hypertension, have been found to be disproportionately impacted by health system supply chain disruptions and COVID responses that create barriers to healthcare access because they are in need of long-term healthcare.^{402 403} As a result of lack of direction from the Ministry of Health as to how to manage cancer patients during the COVID crisis, some health facilities have created their own specific guidelines for treatment during the pandemic; for example, private hospitals have initiated tele-consultations but these are not accessible to low-income patients.⁴⁰⁴

Due to the curfew, some clinics have reduced their opening hours to allow healthcare workers sufficient travel time to get home before curfew.⁴⁰⁵ In addition, medical students and volunteers can no longer support healthcare staff.⁴⁰⁶ The result of both of these changes is a heavier workload for clinic doctors and nurses.

Policies designed to curb alcohol use, which rose during the pandemic, are inconsistent. While the Ministry of Health banned the opening of bars, alcohol was considered an essential product and was still available online and in supermarkets.⁴⁰⁷ Furthermore, while the government created guidelines for continuity of care for those with substance abuse disorders, the understaffed mental health workforce has been unable to fully see this through.⁴⁰⁸ These health worker shortages may also be impacting the degree to which the guide for health workers on mental health and providing psychosocial support, created by the Ministry of Health, has been disseminated or whether all affected populations can access this information.⁴⁰⁹

COVID-related stigma has emerged as an important barrier to the national response. Many caregivers reported that they would not go for community testing for fear of testing positive and experiencing

community stigma. Residents of urban informal settlements were fearful of going to a hospital for cough / fever symptoms in case they could be suspected of having COVID, with potentially negative impacts on their own health as well as the potential for disease transmission.^{410 411} This is particularly true for pneumonia and tuberculosis patients.⁴¹²

COVID-related stigma is and will continue to cause psychological distress in those who have recovered as well as health workers.^{413 414} Released prisoners, healthcare workers, and those who travel from Nairobi to villages have all been stigmatized due to perceptions that they may be carrying and spreading COVID.⁴¹⁵ Even relatives and friends of infected individuals are stigmatized and victimized.⁴¹⁶ A Daily Nation report revealed that some families have convinced doctors not to mark deaths as COVID-related in order to have a regular burial without stigma.⁴¹⁷

Additional stigmas layer on top of COVID-related stigma for certain populations. For example, sex workers are afraid of accessing sexual health services due to the intersecting stigmas of sex work, HIV and COVID as well as the fear of contracting COVID and having to pay for state-mandated quarantine facilities.⁴¹⁸ In addition, due to the stigmatization of cancer, combined with the elevated risk of COVID for oncology patients, oncology nurses may fear treating their patients.⁴¹⁹

Impact on access to food and nutrition services:

Access to nutrition services has diminished due to restrictive COVID measures and reallocation of funding away from nutrition services to the COVID response.^{420 421} The reduced accessibility of nutrition services is worsening child development outcomes and further exacerbating disparities among vulnerable households.^{422 423}

Education

Closure of schools due to COVID has disrupted access to education and learning facilities, removing an avenue for emotional support and sense of stability.⁴²⁴ A total of 91,591 learning institutions closed as a result of pandemic restrictions.⁴²⁵ Approximately 146 private schools have shut down permanently as a result of the required school closures.⁴²⁶ When (and if) schools reopen in January, approximately 15 million primary and secondary school students will have to repeat content again, delaying their learning.⁴²⁷

The Kenya Institute of Curriculum Development has broadcast lessons for students during online learning, but this has not alleviated the gap.⁴²⁸ The private sector has aided education amidst COVID, with tele-companies like Safaricom offering internet data bundles at a reduced price for students attending school online.⁴²⁹ However, for poor and rural communities, there are still substantial gaps in access to remote-learning technologies. Only half of Kenyans can access the internet through mobile phones, and only one-fifth of Kenyans have access to a computer.

The government investment in school infrastructure development and training of educators prior to schools reopening is very positive viewed within the education sector.⁴³⁰ It will be important to track interventions in schools over time to assess their impact.

Government dilemmas: resource allocation and prioritization

Relatively little has been published about the difficult choices and trade-offs that the government has had to make since the start of the pandemic. However, it has been suggested that harsh preventive measures could have more dramatic and dangerous consequences than the coronavirus itself.⁴³¹ Modelling

suggests that the excess deaths to other health conditions currently outweigh the COVID-related burden of disease.

The presidential addresses indicate that the decisions taken by the government are based on medical and empirical evidence and that he continues to follow the advice by the multi stakeholder advisory committees.⁴³² According to the presidential address on 25th March 2020, the response was comprehensive and multi-faceted; with the Ministry of Health leading the charge by announcing policy measures and behavioural protocols, geared towards limiting the spread of this disease. The president further indicated that the government had made and would continue to make targeted state interventions to cushion every Kenyan from shocks arising from COVID-19.⁴³³ Despite this, decision-making processes remain opaque and evidence shows that the most vulnerable groups have not been appropriately cushioned in the response.

Even key informants were unable to shed very much light on the government's processes of decision-making in the face of competing priorities. All of the multi-stakeholder committees that were formed to guide the COVID response play an advisory role to government, with ultimate decision-making power lying with the President. Even as some of these committees included representatives of some parts of civil society and the private sector, the relative sway of these voices was something that interview participants did not feel they could comment on.

Impact of mobility restrictions on access to services

A key informant reported that movement restrictions impeded access to health services, which even led to some deaths.⁴³⁴ The restrictions have created barriers to accessing healthcare, particularly for women in labour, women with disabilities and women wanting to access sexual and reproductive health services.^{435 436 437 438 439} Women need a letter from the chief to move around after curfew, which is reportedly difficult to obtain. While community members have asked for an exemption to the rule for pregnant women, this has not been implemented.⁴⁴⁰ The total lockdown contained no provisions for emergencies or for people who need to travel to care facilities for treatment.^{441 442} Restrictions on movement and increased transport prices also prevented healthcare staff from getting to work.⁴⁴³ Some health care workers were harassed by the police or even arrested as they were going to or coming from health facilities before the passes were introduced.⁴⁴⁴ There are some examples of good practice at the county level. For example, the Homabay County Department of Health introduced an authorization letter which was issued by the health facilities to serve as a curfew pass for the people who escorted the women to the health facilities, including the transport person(s) for use as they returned.⁴⁴⁵

Reductions in local healthcare access have forced individuals to travel further for care, but this too is difficult due to movement restrictions and because people want to avoid public transport.^{446 447} The ban on travel to the capital Nairobi did not take into account the fact that the city has the vast majority of cancer and other tertiary healthcare services, meaning that people needed to travel to Nairobi to access important health services.⁴⁴⁸

Urban poor residing in informal settlements are also heavily impacted by restrictions on movement, which has caused food insecurity.⁴⁴⁹ Movement restrictions for food sellers and potential buyers has impacted access to food.⁴⁵⁰

Social protection or cash transfer programmes

The Ministry of Labour and Social Protection is responsible for social protection and cash transfer programmes. They used pre-existing cash transfer programmes to reach “the most vulnerable” (elderly, orphans, people with disabilities) with cash transfers.⁴⁵¹ The reach and impact of these programmes has not yet been documented but the absence of poverty status as an inclusion criterion is striking.

The government social protection programmes are complemented by programmes implemented by non-State actors. These are described below in turn.

Design and management of social protection programs

The government has implemented four main cash transfer programmes (see Table 1).

Table 1.

Programme	Target group	Target numbers	Budget allocation	Amount disbursed	Mode of payment
COVID-19 emergency response fund	Nairobi’s most vulnerable communities & hotspot towns	Not known. KShs2000 weekly payment	KShs500m on cash transfers (out of the total 2.8 billion in the overall fund).	Ongoing	M-Pesa
Additional cash transfers	Expansion of the existing cash transfer programmes, across the country for the elderly, orphans, vulnerable children and people with disabilities	669,000 households across the country to be paid KShs 1,000 weekly	KShs. 10 billion (\$100m)	Between May and August: 341,958 households. Due to dwindling funds, it was expected to end by October 2020	M-Pesa
Kazi Mtaani	Public works programme across the country aimed at engaging youth in restoring public hygiene standards and urban civil works and providing them with cash relief	200,000 youth in 23 informal settlements among them; Mathare, Mukuru and Kibera	KShs.10 billion	Ongoing with a pilot of 26,000 youth in Nairobi informal settlements	M-Pesa
Inua Jamii	Across the country	1.1m beneficiaries paid, KShs 4,000 every two months	KShs. 13 billion	KShs.13 billion	Inua Jamii payment system-bank accounts

Sources:^{452 453 454}

That all of the government programmes pre-dated the pandemic suggests that stakeholders key to the COVID response were not included in the design of these programmes, nor were they tailored to the realities of the COVID pandemic.

Under the COVID-19 Emergency Response Fund, Kenya's private sector has stepped in to try to help fill the gap between the government's limited response, and those in need, establishing a Board, led by the CEOs of the biggest companies, which is working with a consortium of NGOs to disburse money via M-Pesa.⁴⁵⁵ Under the Inua Jamii programme, KShs13 billion was disbursed by the government to cover January to June Government to Persons (G2P) payments and has cushioned recipients from COVID shocks.⁴⁵⁶ The Ministry of Labour and Social Protection was instrumental in the successful transforming this programme's payment delivery mechanism from a manual system to a fully digital solution that offers choice, convenience and greater dignity to the recipients.⁴⁵⁷ No literature was found documenting (potential) beneficiaries' experiences of the programme. Key informants suggested that government-run cash transfer programmes did not reach all intended beneficiaries and that, for those in the programme, long delays were experienced. They intimated that there were some problems with corruption but they could not be specific regarding the extent to which the different cash transfer programmes was affected.

The governmental cash transfer programmes have been complemented by a range of additional programmes implemented by multilateral agencies and NGOs. For example, the European Union (EU) partnered with several other organisations and foundations aiming to provide cash transfers to 20k households in Nairobi informal settlements for 3 months starting in June. The EU also has provided Ksh 606 million to be distributed to 80k households in informal settlements through M-Pesa.⁴⁵⁸ Aiming to reach 120,000 people, Oxfam Kenya, with other NGO partners, is distributing cash transfers through M-Pesa to Nairobi urban settlers and women and girls at risk of gender-based violence in Mombasa and Nairobi.

Despite all of these programmes being documented, many studies reported participants stating that they had not received any support of this nature. There have also been complaints that the transfer amounts are insufficient, delays in payments have been a challenge, some people have been overlooked, and others told they were ineligible. People have noted that registration processes have not been transparent and people do not have information about how to access these cash transfers. Caregivers are not included even if they are unable to work due to their care duties: the transfer is designed to be sufficient only for the vulnerable individual targeted.⁴⁵⁹ Evaluation of these cash transfer programmes is urgently needed.

A final note on the cash transfer dilemma hinges on unease about privacy concerns. A key informant explained that individuals are concerned as to what the government might do with any personal data about them and therefore remain unwilling to share the type of information that might better underpin cash transfer and other social safety net programmes.⁴⁶⁰

Impact on specific populations

The pilot cash transfer program (mentioned above) has been described as the most relevant measure supporting vulnerable populations.⁴⁶¹ Yet even as conditional and unconditional cash transfer programs have provided an economic safety net and positively impacted health, there is consensus that the current aid provided is not sufficient for addressing concerns.^{462 463 464} Economically vulnerable people and those who had lost jobs have been helped through these emergency funds.⁴⁶⁵ However, employees are expected to have disposable income and cushioned in the event of future salary reductions.⁴⁶⁶ Furthermore, relief measures are not applicable to households employed by the informal sector or

individuals who operate their own small businesses and are self-employed.⁴⁶⁷ This group of workers has been mostly left out from government social assistance programs. As mentioned above, recipients of cash transfers are determined from a single social security registry which does not account for large vulnerable populations, especially those in informal settlements. Due to systemic limitations in the classification of vulnerable groups, these populations may have been overlooked and therefore were ineligible for transfers.⁴⁶⁸ The above-mentioned donor-funded cash transfer programmes have gone some way towards reaching some vulnerable groups but this work remains piecemeal.

Social welfare programs face the challenge of selecting beneficiaries, made more difficult by the lack of a centralized database to refer to. Complaints by the public suggest government bias in selecting beneficiaries and there are claims that the government has disadvantaged informal workers in cash assistance responses. Many have also accused chiefs, who are in charge of providing community member information to the government, of favoritism.⁴⁶⁹

Although the Kazi Mtaani programme aims to provide a daily wage of \$4.50 to 270,000 young people, there have been several protests due to claims of non-payment, payment delays and favouritism over who is chosen to receive the wage.⁴⁷⁰ Despite some efforts to ensure inclusivity, the Kazi Mitaani programme involves manual work so people with disabilities may be disadvantaged.⁴⁷¹

Addressing police brutality and other human rights violations in the COVID response

While several articles mention the issue of police brutality, no articles mention how policy makers are addressing this issue or how law enforcement has been trained to handle people in the context of pandemic response.

One article details what police do if they find individuals breaking COVID measures: individuals are bundled together into cars, potentially exposing them to infection, and are then forced into isolation centers regardless of COVID status.⁴⁷² Another article mentioned that police brutality was triggered by the enforcement of movement restrictions, leading to the securitization of the health sector, illegal detainments, and extortion. The media covered police tear-gassing protesters in a demonstration against COVID corruption.⁴⁷³ This was all exacerbated by the denial of justice due to unavailable judicial officers. The government had not responded to the allegations as of September 6th.⁴⁷⁴

A key informant noted that there is a clear legal framework to protect against police brutality but it is not applied even as oversight mechanisms such as the Independent Police Oversight Authority are in place.⁴⁷⁵ Another respondent reported that there have been some efforts by the Independent Police Oversight Authority to follow up on reported cases of police brutality and the Ministry of the Interior appears invested in trying to prevent this happening again.⁴⁷⁶ The same respondent went on to say that in the meantime police violence continues, with very little ever reported to authorities.⁴⁷⁷ But another key informant had a slightly different perspective, suggesting that there has already been a lot of capacity building, learning from the mistakes that occurred, resulting in a more “service driven force.”⁴⁷⁸ Yet another respondent suggests that to avoid human rights issues like police brutality, community education and community ownership of measures were important in the first place.⁴⁷⁹

Several CSOs (e.g. Independent Medical Legal Unit, Amnesty International, ICJ Kenya, KELIN) are all pushing for police accountability but the culture of impunity persists.⁴⁸⁰ Amnesty International Kenya, Haki

Africa, Kituo Cha Sheria, International Justice Mission Kenya have brought a lawsuit against the police, alleging that they use nighttime curfew to violate victim rights and carry out killings. They are calling for compensation from the government, legal reform, and an end to police brutality.^{481 482} KELIN has partnered with other civil society organisations to provide legal advice to vulnerable populations during the pandemic.⁴⁸³ The impact of police brutality (among other factors such as job losses and hunger) have eroded people's trust in the government.⁴⁸⁴

Longer-term changes – structural, institutional and personal – foreshadowed by the COVID-19 response

This section provides an overview of the longer-term changes that might be expected on the basis of the national pandemic response, including how different groups will be disproportionately affected by compounded disadvantage arising from the response.

Impact on structures and systems of power and governance

There is little information in the literature to date about the potential longer-term impacts of COVID on governmental structures and systems of power and governance.

A few opportunities for change have been highlighted across different sectors. Several peer-reviewed articles focused on the need to expand healthcare, including cancer and mental health services, as well as transition to new forms of healthcare, such as the community midwifery model and decentralized cancer care.^{485 486} A need has been noted to expand social security coverage to population groups that do not typically qualify but have now been pushed into poverty due to the pandemic.⁴⁸⁷ COVID has exposed the lack of protection for the majority of women and youth in the informal sector. One publication suggests that representative unions be formed for these women in order to allow for access to benefits and transition them to the formal economy.⁴⁸⁸

The corruption allegation levelled at KEMSA have proven a real roadblock in the pandemic response as counties are legally obliged to do all of their procurement through this mechanism. When supplies have come through, they have been insufficient and staggered over time.⁴⁸⁹ While the expediency for the national government of KEMSA as sole supplier is acknowledged, current challenges might open up a conversation about a more diversified field of suppliers to ensure continuity of services.

The pandemic has also brought attention to the insufficient access to clean water and water-related services, with publications noting the need to increase access and to ensure that women are involved in these efforts as they are usually responsible for obtaining clean water for their families.^{490 491}

One study foreshadows a significant boost for the renewable energy sector post COVID due to the emergence of independent funding opportunities, including the REACT Kenya Relief Fund.⁴⁹² Greater potential adoption of technology in long-term work conditions and learning institutions has also be suggested.⁴⁹³ The rapid development of innovative ventilators and test kits during the pandemic has demonstrated that, with political will, adequate financing, and establishment of innovation hubs, Kenya might industrialize earlier than anticipated.⁴⁹⁴

The reduction in GDP and resulting reduction of government expenditure had significant impacts on how the government may structure its spending in the future. Not all of this is negative. For example, funds that would have gone into per diems, meetings and travel have been saved because people can engage virtually. A key informant points to this as a silver lining through which the pandemic has opened new avenues for governance to restructure through which broad participation may be fostered while keeping costs low.⁴⁹⁵

Disruptions of systems through which members of government have usually met has particularly come through the rapid adoption of virtual platforms. Whereas before the pandemic people were skeptical of their potential, the government now has virtual platform capacity with the ability to engage more people. Meetings, such as between the President and governors are now much less complicated, which has drastically changed the governance landscape in terms of ease in interactions.⁴⁹⁶

In terms of governance structures, a key informant suggested that the relationship between national government and county governments has become closer. In some areas, structures have been duplicated from national to county level, which a key informant notes is providing benefits in containing the virus.⁴⁹⁷ COVID-19 has presented itself as a “common enemy” through which intergovernmental relations can improve and better systems can be established. The respondent notes that there has also been more focus on public health to the point that Kenya is considering the creation of a national public health institute or a Kenya Center for Disease Control.

Key informants widely valued the complementary contributions of the government, civil society and the private sector, underscoring the need for better mutual support moving forward, which will require additional efforts to foster improved trust among these different stakeholders.

Impact on corruption in the distribution of welfare benefits to the most marginalized

Several articles detail allegations of corruption, not in relation to the distribution of welfare benefits to the most marginalized but in relation to COVID-related interventions. Corruption has been found to have contributed to people’s lack of trust in the government to respond to COVID.

There are reports that corruption in government agencies during the pandemic has contributed to all of the following: overpricing of commodities, purchase and distribution of poor quality PPE, embezzlement of COVID commodities, and the misappropriation of public funds intended for COVID.⁴⁹⁸ There have been several reports of corruption in relation to delivering PPE to Kenya. There are allegations that COVID-related donations, including donations from Chinese billionaire Jack Ma, have been diverted, misused, or resold: while 100,000 masks were donated by Ma, only 20,000 reached KEMSA.⁴⁹⁹

KEMSA is accused of offering multi-billion Kenya Shilling tenders to produce necessary items to well-connected individuals and friends.^{500 501} Several laws were disregarded in the offering of these tenders and 15 top government officials and business people are to be prosecuted due to alleged misuse of \$7.5 million in funds intended for COVID medical supplies.^{502 503} The Ethics and Anti-Corruption Commission is investigating and has determined that there was an “irregular expenditure” of Ksh 7.8 billion through KEMSA.⁵⁰⁴

How might these disadvantages become compounded over time?

Both the impacts of the pandemic itself as well as the impacts of certain government measures could compound disadvantages for vulnerable populations. A decline in household income alongside increased debt accumulation could result in future economic insecurity, potentially limiting future entrepreneurship activities, and food insecurity.^{505 506}

For young children, stress as a result of school closures, job losses, economic uncertainty, food insecurity, and lack of accessibility to services can have long term effects on a child's brain. This could manifest in cognitive, behavioral, and emotional difficulties later in life.⁵⁰⁷ Undernourishment exacerbated by pandemic-related food insecurity could lead to long-term negative developmental and cognitive effects in children.⁵⁰⁸ In addition, the repeat of the school year will cause the poor to lag behind their counterparts more when school is reopened, causing ripple effects in performance in the future.⁵⁰⁹

With regard to health, teenage pregnancy, which has increased during the pandemic, results in a cycle of ill-health and reduced possibilities. It has been associated with a loss of education, early marriages, economic disempowerment, and the intergenerational transmission of poverty to girls' children who risk poor child development outcomes.⁵¹⁰ Similarly, sexual abuse could limit future educational opportunities and ability to achieve financial independence. The decrease in HIV testing due to various barriers will likely cause poorer clinical outcomes, increased transmission, and diminished initiation and retention of ART.⁵¹¹

Kenya's high levels of international borrowing raise concerns regarding loan repayments. Even prior to the pandemic, the government was struggling to repay some international loans so the additional borrowing for the COVID response increases the burden of repayments at a time when GDP has reduced and the need for investment in local infrastructure and support systems remains high.

How is the media generating public interest discussions to benefit the policy makers and the population?

The government has used the media, including television, radio, print, online news, and short messaging services (SMS), to disseminate COVID-related press briefings, information and updates.^{512 513 514} The Ministry of Health gave daily press briefings through some of the pandemic at which journalists asked important questions about the national COVID response. These included questions about health workers' access to PPE, when people would have access to COVID testing, and the costs and management of the quarantine centres. Although responses were often not provided, just by asking the questions, journalists brought attention to these issues and the overarching issue of accountability for the response. The lack of information provided by the government on these issues limited the extent to which discussion could be generated.⁵¹⁵ Nonetheless, the media has been a useful source of information on the coronavirus and the spread of the pandemic nationally.⁵¹⁶

One survey showed that 26.9% of respondents nationally considered electronic media an important information source.⁵¹⁷ One study reported that government messages about COVID on radio, television, or SMS are the most popular sources of information and were perceived to be the most trustworthy. Social media and internet sources are popular among men and younger adults, but were not considered to be as trustworthy.⁵¹⁸ A study highlighted that television, radio, and social media could be better used to disseminate educational content and facilitate early childhood learning during at-home periods.⁵¹⁹ However, individuals with little or no education were less likely to receive media messages via radio, television, or SMS.⁵²⁰ Another study, however, found that the majority of individuals reported using social media to access any COVID information, raising fears about potential misinformation.⁵²¹

Social media, particularly Twitter, has been a venue where suspicions of graft have been widely voiced, leading to trending hashtags including “#Money Heist” and “#COVIDmillionaires”. The former emerged following publication of a government report on COVID-related spending that included KShs 42 million

used to lease ambulances, KShs 4 million on tea and snacks, KShs 70 million on communication and KShs 2 million on mobile phone airtime. This raised questions as to why the existing fleet of ambulances was not used (or a new fleet purchased), why these communication costs were incurred as media houses had already contributed to airtime for coronavirus-related news updates, and why money was spent on airtime when Safaricom had offered free airtime to all officials involved in the response.⁵²²

Health workers have posted pictures to social media as proof that they are being provided inadequate PPE while the general public has used social media to critique government pandemic decisions, including bar closures.⁵²³ Some Kenyans have alleged on social media that police used these closures to force citizens to pay bribes.⁵²⁴

In addition, the media has shed light on social issues such as the spike in teenage pregnancies that has occurred since the school closures in March as well as accountability and transparency in relation to the management of COVID related funds.^{525 526} There was early criticism of some media for using stigmatising language in relation to COVID and even for revealing the identities of people affected by the disease.⁵²⁷

How might the attention brought to issues such as police brutality in the context of the COVID-19 response be capitalized on to promote positive structural change moving forward?

No publications discussed how attention brought to certain issues could be capitalized on to promote structural change. Key informants highlighted the need for additional training for the police on human rights in policing, which would be useful beyond the context of COVID.⁵²⁸

Conclusions

Lessons learned for maximising benefit and minimizing harm of the current COVID-19 response

The pandemic exposed societal inequalities as well as lack of emergency preparedness, which must now be addressed. Fighting poverty and addressing inequalities should be prioritized.⁵²⁹ The importance of a targeted approach that takes into account people's differing vulnerabilities and resilience has been emphasised.⁵³⁰ This might best be achieved by ensuring that all appropriate stakeholders are represented in the design and governance of the COVID response. While this might not have been possible in the initial stages of the response, at this stage, membership of advisory committees and other governance structures might usefully be revisited. It will be important to improve coordination between national and county governments as well as between government at all levels and civil society.⁵³¹ Transparency in decision-making will also be important to allow people to understand how trade-offs among competing needs are being made and to provide avenues for accountability as necessary.

There is a wealth of talent in Kenya that was not drawn upon in the COVID response. While fully recognising the government's need to move quickly in the face of a crisis, adopting a participatory approach that included broader inclusion of stakeholders from different parts of the private sector as well as civil society might have helped identify potential shortcomings and allowed for more appropriate options to be put forward. Young people constitute a large proportion of the total population; they are embedded in communities and often committed to effecting positive change. This is a demographic whose involvement in the response might be particularly beneficial.⁵³² In addition, agencies such as the Kenya chamber of mines, the federation of Kenya employers, the Central Organization of Trade Unions (COTU), representatives of the transport sector and other specialized private sector agencies need to layer on representation from civil society and organisations that represent marginalized communities, including women, people living in informal settlements, people with disabilities and people of low socioeconomic status.⁵³³

Although key informants' views on government receptivity to criticism varied, civil society representatives working on health noted that the government has been fairly open to criticism and magnanimous even in accepting that criticism. Instead of ignoring feedback, the government listened and has shown that degree of openness to the media too.⁵³⁴ Furthermore, as the pandemic progressed, the government appeared to react more responsibly and responsively to people's needs.⁵³⁵

Stay-at-home restrictions, including curfews, are regressive measures that disproportionately affect those of low socioeconomic status who are forced to choose between following government directives and making a daily wage so as to be able to put food on the table. If any such severe measures seem warranted from an epidemiological perspective, it will be critical to ensure that direct cash transfers are available to *all* those who need them, including those working in the informal sector, prior to imposition of the restrictions. Building on this, inclusion mechanisms within social protection programmes are vital, such as mechanisms that align skill development to youth income generation.⁵³⁶ The logistical challenges of this are self-evident and the government will have to plan ahead for this contingency, ensuring appropriate involvement of all stakeholders to develop structures and mechanisms tailored to the local realities of different communities.

Measures with short term effects such as lock downs and curfews may need to be reconfigured to adjust to long term thinking, which will also require more involvement of key stakeholders. Another respondent noted that long term planning may require having a stimulus saving for the current or future pandemics.⁵³⁷

There is a very high risk of food insecurity, hunger and malnutrition resulting in part from restrictions on movement. This should be better understood and every effort made to increase access to nutrition services. In addition, support to farmers may be required to help them re-establish their crops where these might have suffered from not being tended. The integrity of the food supply chain (both domestic and international), particularly with regard to nutrient-dense food, is a critical part of national infrastructure; it fell short during the pandemic and efforts must be made to bolster its resilience. The regional COVID testing and prevention programme is an example of good practice that allowed trade to continue while minimising the risk of disease spread.

That people, including health workers, have died because they were unable to pay for COVID-related treatments is a gross failure of the government. It is critical that a mechanism be created to ensure access to COVID-related services for everyone irrespective of their ability to pay. It is true that the government budget is limited but the allegations of corruption on a very large scale suggest that if their own resources, as well as those provided by the international community, were appropriately directed, this might be possible. Key informants lamented the national government's over-reliance on international financing and support, noting that more efficient use of local resources would constitute a more sustainable response to the pandemic even as some recourse to international financial support would still be needed.⁵³⁸

From a health perspective, some key government interventions would help mitigate the health-related impacts of the pandemic: ensuring sufficient PPE for health workers and clients is available; improving staffing in health facilities; strengthening the supply chain to ensure uninterrupted provision of commodities, drugs and supplies; promoting community outreach and providing emergency ambulance services; and expanding health education and promotion activities.

Large increases in domestic violence and child abuse have been reported during the pandemic and there has been an insufficient response to date. There is a need to expand access to helplines and appropriate health and legal support services. Community health workers -- known and trusted members of the community -- might be a useful entry point for the provision of information and linkage to services. Community health workers might also be an additional source of support for people with disabilities who have faced many challenges throughout the pandemic. This cadre of workers is currently being under-utilised.

While some efforts have been made to ensure the continuity of access to health services, there have been many gaps in services, disproportionately affecting people of low socioeconomic status, people with chronic health conditions and pregnant women. For health services to be effectively provided, health workers have to be paid, they have to be provided appropriate PPE, and the supply chain of drugs and equipment has to be maintained. These should all be areas of priority at both national and county levels. The innovation funds proved the entrepreneurial spirit within Kenya and these efforts could be built upon to further leverage existing industry and infrastructure to expand production of and access to key supplies.

Closing all schools for almost a whole year has had a detrimental effect on children both academically and developmentally. With schools reopening, attention to safety must now be paramount. While regular testing might be unfeasible, attention to public health measures can be maintained; teachers should be supported in this endeavour including with training on how to create a COVID-safe school environment.

Should it become necessary to close schools again (and the pandemic would have to be very bad for this to be a recommended option), alternatives to online education have to be found as so many children, particularly those from disadvantaged households, are unable to attend online classes. It will be important to track school enrolments and compare them to pre-pandemic levels. Programmes may be needed to promote re-enrolment in schools, particularly among children who have started working since the schools closed.

One group of stakeholders that has received insufficient attention to date is the judiciary. With COVID-related cases already coming to the courts, most judges do not have the necessary public health knowledge to rule appropriately. It may discredit the judicial system and impede accountability if this is not addressed through immediate capacity building.⁵³⁹

Particularly in light of the complexity of the government response to COVID, it is critical that information be widely disseminated on recommended preventive measures as well as programmes available to support different populations. Without better knowledge of their rights and legal entitlements, some communities are unable to access needed services.⁵⁴⁰

The COVID response has been driven by a political elite with limited participation of or regard for some of the most marginalised groups in the country. The massive increase in poverty is of grave concern both in the immediate as well as the long-term. It is urgent that financial support can be targeted to reach those most in need to ensure that basic necessities can be covered. Longer-term plans should also include training and employment generation, particularly for young people to provide opportunities for them to support themselves and their families, and to become productive contributors to the economy. Reducing youth unemployment, which was already very high before the pandemic, is critical to the future of Kenya's economy.

Evidence for different stakeholders to hold the duty bearers accountable

With regard to accountability, the challenge is not a lack of evidence of wrongdoing, it is the immense difficulty of accessing justice through existing mechanisms that are often designed to protect the duty bearers accused of wrongdoing. There have been some excellent initiatives to build the capacity of civil society to demand accountability and justice, and to build the capacity of the judiciary itself to better respond to any such demands, but more is needed. This work remains challenging in the face of limited government responsiveness to legally mandated changes to their response, with civil society frustrated by their inability to right wrongs. Civil society key informants working on issues of inequalities and accountability were pessimistic about opportunities to improve government accountability in the short to medium term.

Lessons learned for informing future responses to infectious disease outbreaks

The people having trust in their government is critical during a crisis such as COVID when the government has to ask people to make sacrifices and follow public health directives. Mired in a long history of corruption allegations, the government was not well positioned in this regard going into the COVID pandemic. It should not wait for the next disaster to try to build this trust. A conscious effort to rebuild trust in government structures, institutions and leaders is urgently needed. As noted by one interview participant, community trust in government is critical and two immediate opportunities for helping to re-

build this trust include ensuring an efficient and equitable vaccine rollout programme and building a strong health system to support achievement of Universal Health Coverage.⁵⁴¹

Recognising the need for rapid action during disease outbreaks, it would be useful to create emergency structures that can be mobilised as the need arises. This would include multi-stakeholder planning groups that would allow for government responses to be informed by a broad range civil society and private sector actors as well as representatives of different sectors including public health, economy, education, labour and justice to help ensure a coherent, comprehensive response. Understanding and better documenting the synergies that exist between different stakeholders' work in the response will help allay concerns of competition and identify how best each organisation or constituency can play to its strengths in a collaborative and coordinated response.

All restrictions can have economic consequences. That is not to say that epidemic response is a trade-off between health and the economy, rather that if restrictions are warranted from a public health perspective, the economic impacts on different groups of people have to be foreseen and mitigated. Given that there will be more infectious disease outbreaks, it will be useful for the government to plan how they might financially support a large proportion of the population in order that they might be able to follow the necessary directives. For any response to succeed, it has to be pro-poor. This is another area where attention to committee membership is critical: those with a seat at the table can lobby for their constituents' interest; those excluded from the committees have no voice in these policy discussions.

Infectious disease control is a job for medical and public health officials, not the police or the military. The latter were not trained in how to enforce COVID-related public health measures and their practices put people at risk of contracting COVID and severely eroded trust in the government. There should be no fines or other punishment incurred for breaking public health regulations: it is most often those of low socioeconomic status who break the rules so that they can earn money or access food - they have no alternative. What is needed is practical information and recommendations for people in different living situations to prevent disease. This guidance might look different for those living in urban informal settlements than pastoralist communities but participatory development of guidelines and messages can help overcome this.

The National Hospital Insurance Fund is an inadequate mechanism for ensuring that all Kenyans have access to health services. Furthermore, linked to formal employment, where there is sudden mass job loss (as can occur in an infectious disease outbreak), people also lose their health insurance. An alternative system that can reach all those working in the informal sector is needed. On top of this, the government may still have to subsidise services to address the outbreak in order to bring it under control.

One of the challenges faced by the government during this pandemic response was the lack of data on populations, including those who might be considered most vulnerable. Ideally, the government would create a regularly updated database that might help target social protection interventions in future pandemics. There are, however, important challenges to be considered including: a high level of population mobility; the different ways in which 'vulnerability' is understood (which might vary by disease); and concerns over privacy and security of data that have led to citizen distrust of the government. A key informant spoke to the benefits of a reliable database that is well categorized. They pointed to community networks and community based organizations, local administrations and individual volunteers who have served their communities as potential entry points for the identification of vulnerable groups which resonates with a clear need for informed professionals who can complement and feed into a database system.⁵⁴² A different respondent spoke to the sustainability of a well-maintained registry, without which,

in addition to potential future pandemics, initiatives like cash transfers and UHC will continue to bypass the poor.⁵⁴³

Greater ongoing investment in the health system is needed, including regularly paying health workers, developing its infrastructure (including disease surveillance capacity), ensuring a reliable supply chain and providing mechanisms for accountability at every level. Community health workers should be recognised for the roles that they play and remunerated appropriately. They are a critical resource in pandemic times.

Future research directions

There is currently a paucity of evidence with regard to implementation and impact of programmes put in place as part of the COVID response. It will be important to ensure that process and impact evaluations of the different cash transfer, food security and other large-scale programmes relating to the COVID response are carried out so as to inform programme adjustments if needed as well as future programmes in these areas. Food security is an area of particular ongoing concern; additional research on which populations are most affected, how they are affected and the (potential) impact of this would help inform a targeted response.

In light of the limited disaggregation of data on COVID infections and other impacts, it would be useful to carry out research purposively sampling groups that might be disproportionately affected such as prisons and refugee camps. Efforts should also be made to promote the availability of more disaggregated data through routine monitoring systems. Antibody testing within the general population and/or specific groups could usefully give an idea of community spread.

Key informants have noted the need for a more reliable, inclusive database that adequately accounts for vulnerable communities. One key informant suggests that socioeconomic mapping can be carried out for people who are poor or near poor using data from the community level in conjunction with efforts from community health workers and local administrations.⁵⁴⁴ Research to ensure the most effective and efficient ways for creating and maintaining data appropriate for informing targeted government responses should be carried out alongside any implementation efforts.

Given the devolved nature of Kenya's government, it would be useful to do a comparative analysis of different counties' responses: some counties such as Homa Bay are recognised as having performed well, and might serve as useful models for other counties moving forward. There are, of course, large differences between some of the counties but some lessons would be transferable such as governance structures and stakeholder coordination.

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Annexes

Notes

- a) The data request is based on the need for a comparative pre-corona context analysis and the three core objectives of the project, namely the influence of COVID-19 policies and measures on:
 - 1) Work and income
 - 2) Access to basic services, notably education
 - 3) Political empowerment
- b) Depending on the availability of data, we are interested in disaggregation by the following major axes of inequality that INCLUDE is particularly interested in (gender, rural/urban, expenditure quintiles (esp. the 20% poorest), age (youth and elderly), disability (where available) and regional inequalities-where relevant).