

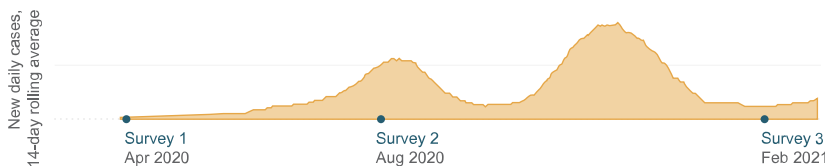
Finding the Balance: Public Health and Social Measures in Kenya

What is the purpose of this report?

This report describes findings from a telephone survey with 1,461 people conducted in February 2021. The survey examined how people respond to public health and social measures (PHSMs) to prevent COVID-19. The sample is representative of households with access to a landline or cell phone, but does not include people without access to phones. As phone penetration varies by country, findings should be interpreted with caution.

Survey data are analyzed alongside epidemiological, mobility, and media data. Triangulating these data sources offers valuable context to better understand the acceptability, impact and effectiveness of PHSMs.

This is the third survey and analysis conducted since the pandemic began (see the [first](#) and [second](#) reports).



National COVID-19 Data Snapshot on 26 February 2021

Total reported cases	105,467
Cumulative incidence rate per 100,000 people	202
Test positivity rate	5.2%
Proportion of people who test positive for COVID-19 among all people who took a test, averaged over 7 days	
Total confirmed COVID-19 deaths	1,853
Case fatality ratio	1.8%
Proportion of total reported deaths among all people reported as testing positive for COVID-19	

What are the highlights from this report?

Disease Dynamics and PHSM Implementation

After experiencing two waves of COVID-19 cases in quick succession in July/August and November/December of 2020, Kenya was headed for a third wave in early March 2021, likely driven by the highly transmissible variants of concern (B.1.1.7 and B.1.351) detected since January. Kenya has one of the highest cumulative incidence rates among African Union (AU) Member States in the Eastern Region. Beyond a nighttime curfew and limitations on large gatherings, few PHSMs were in place during the survey. Mobility had returned to near pre-pandemic levels and 72% of survey respondents said they had resumed normal activities.

PHSM Support and Self-Reported Adherence

Since August 2020, there has been a sharp drop in support for and self-reported adherence to PHSMs limiting social gatherings and movement. The decline in support and adherence was especially steep for measures that required avoiding places of worship and staying home. However, both support for and adherence to individual measures such as mask-wearing and hand-washing remained high.

Risk Perceptions and Information

Despite the grave epidemiological situation and news outlets urging risk awareness and adherence to PHSMs, perceptions of personal risk and risk to the country from COVID-19 were low in Kenya compared to the regional average. Vaccine hesitancy was high among survey respondents, in line with misinformation narratives about vaccines shared on social media.

Secondary Burdens

Nearly half of survey respondents that needed health care reported missing visits or having difficulty accessing medicines. The share of households missing visits had increased slightly since August, and may be linked to a health care worker strike in December 2020. Economic burdens were severe, with 88% of survey respondents saying their income had fallen and more than two-thirds of households missing meals; these challenges disproportionately affected lower-income households.

Disease Dynamics and PHSM Implementation

What is the relationship between PHSMs and cases reported?

The political and social context influences how well PHSMs are implemented and adhered to, which affects COVID-19 disease transmission and mitigation.

Situational Awareness

Despite stringent PHSMs which initially kept COVID-19 cases low in Kenya, the country experienced two waves in quick succession. The first wave peaked in late July and early August 2020 with around 650 cases reported per day, followed by a second wave that peaked in mid-November with more than 1,000 cases reported per day. New reported cases are again on the rise as of early March 2021, suggesting Kenya is entering a third wave. Kenya has the highest cumulative incidence per capita among Member States in the Eastern Region apart from Comoros, Djibouti and Seychelles (all of which have populations of one million or less).

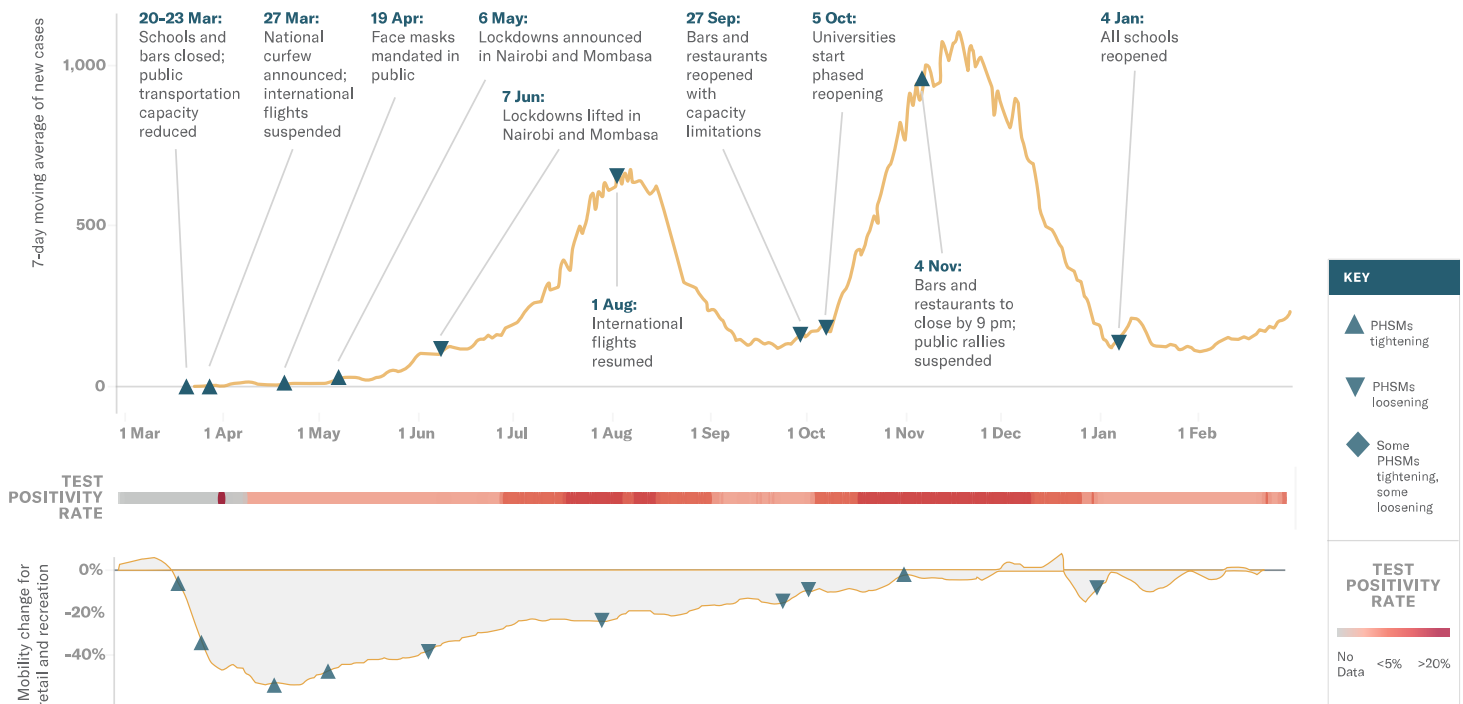
Early in the pandemic, the Kenyan government closed schools, places of worship, bars and restaurants; imposed a curfew nationwide and locked down heavily affected areas. Many of these measures were gradually relaxed beginning in June of 2020, and mobility gradually returned to baseline levels by early November, although some measures remained in place. Schools were closed for most classes for 10 months, only reopening fully in January. The nighttime curfew, as well as a ban on political gatherings first introduced in November, were [extended on 12 March](#) amidst rising cases, and the government has also [strengthened surveillance at the Tanzanian border](#) over reports of likely COVID-19 cases and deaths in Tanzania.

Testing capacity has fluctuated. The number of tests conducted daily peaked in late November during the second wave, when test positivity was also high, reaching 16% in mid-November. The decline in the number of tests conducted in December likely reflected lower demand, but there were also [reports of supply shortages](#). At the time of this writing, positivity rates were again on the rise. Testing capacity—particularly in major cities, including Nairobi and Mombasa—was a major topic of coverage in traditional news and social media in February 2021.

Both the B.1.1.7 and the B.1.351 variants of concern have been identified in Kenya since January 2021, although only imported cases have been detected to date. The Kenya Medical Research Institute is also [investigating a locally-discovered variant](#) to determine if it poses greater risk of transmission or severe illness.

[Kenya received its first shipment](#) of just over one million doses of the AstraZeneca vaccine through the COVAX initiative in early March. [Priority](#) will go to health care workers and other essential workers, including security forces and teachers. The government aims to reach 30% of the population by mid-2023.

Kenya experienced two waves of COVID-19 cases after gradual loosening of PHSMs beginning in June.



PHSM Support and Self-Reported Adherence

Do people support and follow measures?

PHSM effectiveness relies on widespread acceptance and behavior change.

What the data say

Support for and self-reported adherence to individual measures to curb transmission of COVID-19 remained high, but dropped markedly between August and February for measures restricting social gatherings and movement. The August survey was conducted during the country’s first major wave of cases.

- Support for avoiding places of worship was much lower than in other Member States in the Eastern Region surveyed (Sudan, Uganda and Ethiopia) where majorities of survey respondents agreed this was a necessary measure; this suggests that maintaining safe ways to continue religious gatherings should be a priority.
- Lower-income survey respondents were more likely to support and adhere to measures restricting movement, which is notable given that these measures may impose a heavier economic burden on households with limited means.

In the media

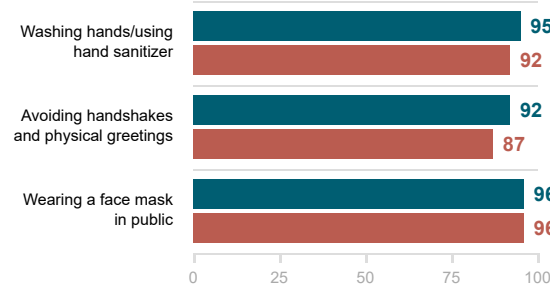
“If we put in place #WASH facilities at our business premises, bars, and eateries, we are keeping our customers safe. Hoteliers and managers should consider this as a priority. #RaisingTheBar.”

—Twitter user, March 2021

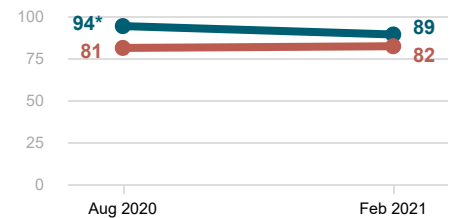
Individual measures

While support for individual measures was slightly lower in February than in August, self-reported adherence to these measures remained high. Women were more likely to support and adhere to individual measures.

Percent that **support** and **adhere** to each individual measure in Feb 2021



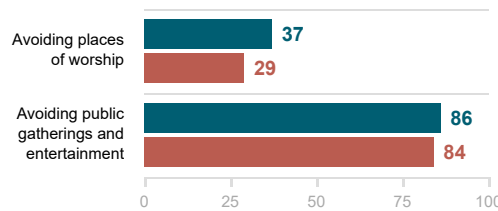
Trend in percent that **support** and **adhere** to all individual measures (composite score)



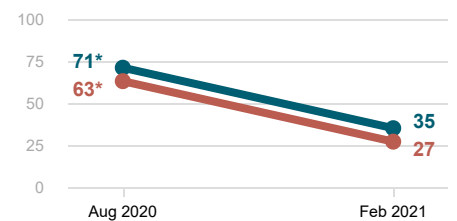
Measures restricting social gatherings

Falling support for and self-reported adherence to avoiding places of worship drove the large decline in support for and adherence to social gathering measures between August and February. Places of worship were allowed to reopen in July.

Percent that **support** and **adhere** to each social measure in Feb 2021



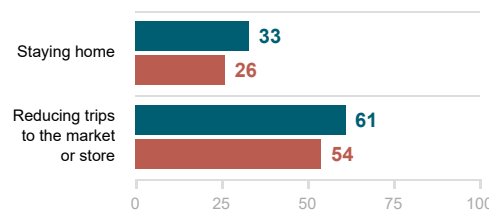
Trend in percent that **support** and **adhere** to all social measures (composite score)



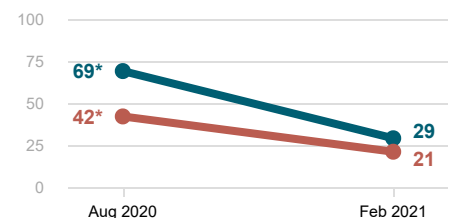
Measures restricting movement

Support for and adherence to measures restricting movement have declined. Women were more likely to support stay-at-home measures (37% compared to 29% of men) and to report having stayed home (29% compared to 22%).

Percent that **support** and **adhere** to each movement measure in Feb 2021



Trend in percent that **support** and **adhere** to all movement measures (composite score)



PHSM Support and Self-Reported Adherence

Whom do people trust?

Public trust in government and institutions is a key driver of support for and adherence to PHSMs.

What the data say

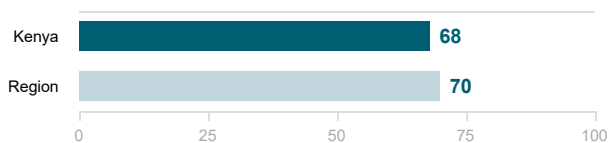
A majority of survey respondents (68%) expressed satisfaction with the government's COVID-19 response, although a sizable minority (31%) were dissatisfied. Women, rural, less-educated and lower-income respondents were more likely to be satisfied.

- Levels of satisfaction were slightly lower in February compared to August (73%), driven by a higher share of respondents who said they were very dissatisfied in February (19%) compared to August (15%).
- Trust in handling the pandemic was highest for public health/health care institutions and international organizations. A majority of respondents (82%) also said they trusted the media, although this share was lower among young people aged 18-25 (75%). A majority also trusted religious institutions (82%), and the President (77%).
- There was lower support for the police (40%) and security forces (43%) for their handling of the pandemic, in line with concerns shared on social media about excessive enforcement of PHSMs.

What do people think about their country's institutions?

More than two-thirds of survey respondents said they were satisfied with the government response; this share was fairly evenly split between those who were very satisfied (33%) and only somewhat satisfied (36%). This was on par with the average across all Member States in the Eastern Region surveyed.

68% are satisfied with the government's pandemic response



Top five most trusted institutions and individuals

Percent of people reporting trust in each source

Hospitals/health centers	90%
World Health Organization (WHO)	85%
Ministry of Health	85%
Medical professional associations	84%
Community health workers	83%

What are people saying in the news and on social media?

Coverage of the government's COVID-19 response in both traditional news and social media has been predominantly negative. In late August 2020, anti-government messaging surged in response to corruption scandals about government agencies allegedly selling donated medical supplies and officials looting COVID-19 funds. Social media criticism in September and October drew attention to political rallies held by ruling politicians, with accusations of hypocrisy in light of COVID-19 restrictions limiting public gatherings.

Narratives around PHSMs have been mixed. Social media users criticized school reopening plans, expressing concerns about student and teacher safety. In contrast, social media users were largely positive about the loosening of other PHSMs, such as reopening bars and lifting a ban on alcohol sales. Social media users also discussed the economic burdens caused by public transport and international travel restrictions.

There has been sustained concern about police harassment, intimidation and extortion in enforcing PHSMs. In early November, Alfred Mutua, the Governor of Machakos County, called on President Kenyatta to deploy security forces to enforce PHSMs. Social media users expressed concern and accused Governor Mutua of hypocrisy for not wearing a mask when appearing in public himself.

In the media

"SHAME! NO MASKS! NO SOCIAL DISTANCE! Kenyan politicians + their confirmed belief that their FOLLOWERS' LIVES DON'T MATTER are the weakest link in the fight against COVID-19."

—Twitter user, October 2020

Risk Perceptions and Information

How do people understand risk?

Perceptions of risk are influenced by the epidemiology of an outbreak as well as the type and quality of information disseminated by trusted sources.

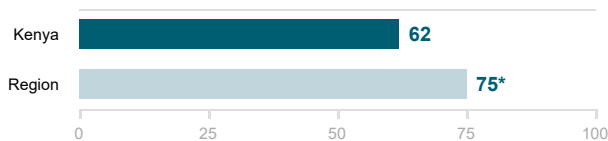
What the data say

While a majority of survey respondents agreed that COVID-19 would affect many Kenyans, overall risk perception was lower than the average across Member States in the Eastern Region surveyed. This is notable given that Kenya's cumulative incidence rate is higher than the other Member States surveyed.

- Perceptions of both personal risk and risk to the country were lower in February than in August, consistent with February's lower incidence of reported cases.
- Perceived risk of catching COVID-19 was slightly higher (27%) among respondents from less-educated households and lower among respondents aged 18-25 (16%).
- Perceptions of disease severity were relatively high in Kenya compared to the regional average, with 55% of survey respondents saying COVID-19 would seriously affect their health if infected. This was an increase from August (47%). Women and people with longstanding health conditions had higher perceptions of severity.
- Survey respondents were relatively well-informed about COVID-19, although a substantial minority did hold beliefs about the need to avoid health care workers and recovered people, which could contribute to stigma.
- In contrast to low risk perceptions among survey respondents, both traditional news and social media coverage of COVID-19 emphasized high risk of transmission and disease severity, especially during the second wave in November.

How do people understand the risk of COVID-19?

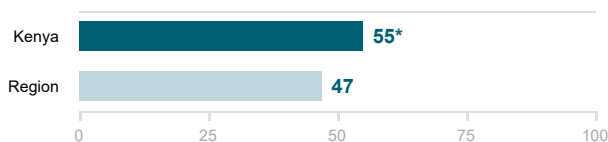
62% believe that COVID-19 will affect many people in their country



22% believe that their personal risk of being infected with COVID-19 is high



55% believe that their health would be seriously affected by COVID-19



Do people stigmatize others?

40% think they should avoid health care workers because they could get COVID-19 from them

37% think they should avoid people who have had COVID-19 in the past because they remain infectious

Do people believe accurate information?

87% understand that infected people may never show symptoms but could still infect others

83% understand that infected people may not show symptoms for five to 14 days

28% believe that COVID-19 can be cured with herbal remedies

Risk Perceptions and Information

How are perceptions of risk informing actions?

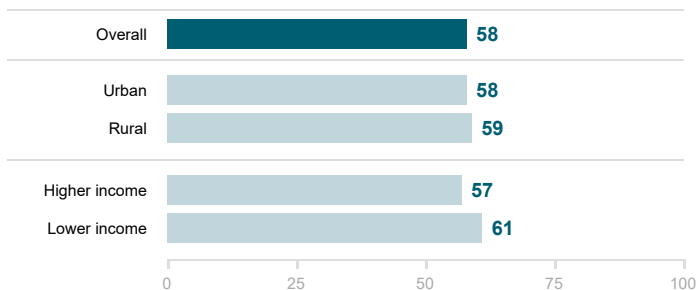
How people understand risk influences key behaviors and decisions that could mitigate disease transmission, including adherence to PHSMs and vaccine uptake.

How do people feel about resuming day-to-day activities?

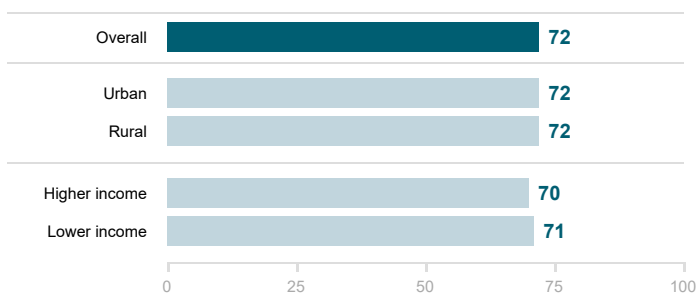
A majority of survey respondents said they had already resumed their normal activities, even though most felt anxious about doing so.

- A higher share (70%) of those with high risk perceptions reported anxiety about resuming activities, compared to 53% of people with low risk perceptions. However, 70% of those with high risk perceptions said they had resumed activities, similar to the share among people with low risk perceptions (73%), suggesting that avoiding normal activities may not be possible for many people.
- Just over half of survey respondents said they were comfortable using public transport.

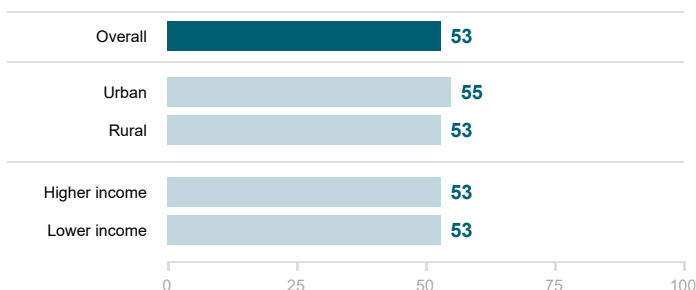
58% feel anxious about resuming normal activities



72% have already resumed normal activities because they believe COVID-19 risk is low



53% feel comfortable taking public transportation

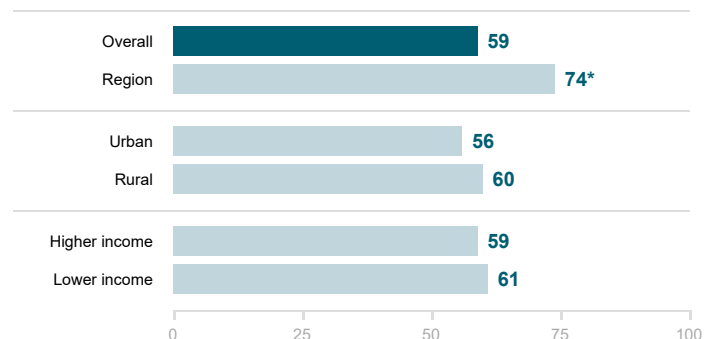


What do people think about vaccines?

The survey showed significant vaccine hesitancy in Kenya, a major concern as the government begins to roll out its vaccination campaign. Vaccine intentions were similar across socio-demographic groups, but people with high-risk perceptions or longstanding illnesses were more likely to say they would get vaccinated (71% and 66%, respectively).

- Skepticism around vaccines has been a major narrative in Kenyan social media since mid-2020. Social media discussion of the government's vaccination plan was largely negative, with concerns about the government's ability to manage vaccine distribution transparently and efficiently.
- The most common reason for not planning to get vaccinated was lack of information, suggesting it may be possible to increase uptake with effective communications.

59% plan to get a vaccine when available



Top reasons people would not get the vaccine

Among people who said they would not get the vaccine, their reasons were:

I do not yet know enough about the vaccine to make a decision	41%
I do not believe that the virus exists	22%
Approval/development for the vaccine may be rushed and not thoroughly tested	15%

In the media

"Just to let you know...our political leadership are hoarding the vaccines for themselves, it's for their loved ones, families and mistresses. Another scandal loading..."

—Twitter user, March 2021

Secondary Burdens

Are people skipping or delaying health care?

Mobility restrictions, overburdened health care facilities, and fear of catching COVID-19 can prevent people from seeking essential health care; understanding the barriers to access can help improve linkages to care.

What the data say

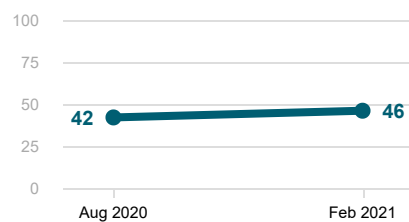
Among households needing health care or medication, 43% reported missing visits in the previous six months and 46% reported recent difficulty accessing medications.

- Together, visits for respiratory problems, fever/chills and malaria represented 50% of missed visits. These symptoms overlap with COVID-19 and may be an indication that cases are going undetected as people choose not to seek care for their symptoms.
- Among households that missed visits, health facility disruptions, costs of care and risk of catching COVID-19 were frequently cited. Health facility disruptions may have been tied to the [December strike by health care workers](#) demanding better protection and remuneration during the pandemic. Concerns about conditions for health care workers have been a major topic of coverage in traditional news and social media.

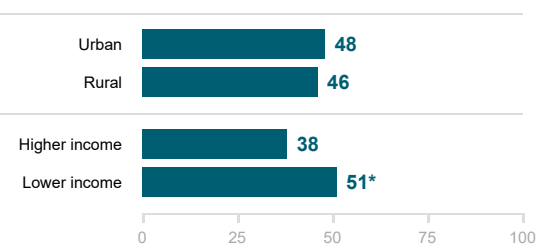
Difficulty getting medicines

Access to medicines was more challenging for households in which the respondent had a longstanding illness, lower-income households and/or households that had lost income during the pandemic.

Trend in percent of households having difficulty getting medicines in the past three months



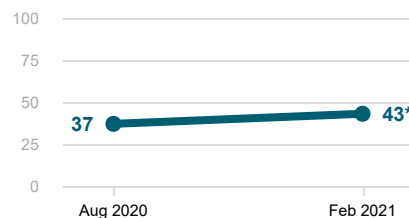
Percent having difficulty getting medicines by category



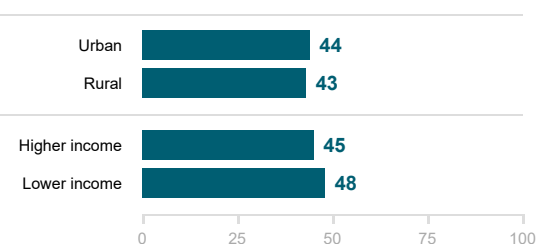
Skipping or delaying health visits

The share of households needing care that missed visits in the previous six months had increased since August. Access challenges were similar across socio-demographic groups.

Trend in percent of households skipping or delaying health care visits in the past six months



Percent skipping or delaying health care visits by category



The reasons why visits were skipped or delayed

People could choose multiple responses

Health facility disruption	41%
Cost/affordability	29%
Worried about catching COVID-19	21%
Mobility restrictions/transport challenges	10%
Caretaker responsibilities	1%

The types of visits which were skipped or delayed

People could choose multiple responses

Diagnostic services/symptoms	34%
Communicable diseases	25%
Non-communicable diseases	21%
General/routine check-up	18%
Reproductive, maternal and child health	14%

Secondary Burdens

Are people experiencing income loss or food insecurity?

Measures restricting economic activities can severely disrupt livelihoods and access to markets; understanding the type and extent of these burdens can help inform policy changes and identify people who need support.

What the data say

The vast majority of Kenyan households said they were experiencing economic hardship during the pandemic, with nearly nine in 10 reporting that their household income had fallen and more than two-thirds saying that their household had restricted food consumption. More than one in five households (22%) said they had lost all their income since the start of the pandemic.

- Lower-income and less-educated households were more likely to report both income loss and barriers to food access, although all socio-demographic groups were heavily affected.
- Income losses during the pandemic appear to be a driver of food insecurity, with a much higher share of those households that had lost some or all of their income reporting that they were reducing food consumption (69% and 77% respectively, compared to 38% of households whose income had remained stable). The crisis has exacerbated other ongoing threats to food security, [including lower than average rainfall and a desert locust invasion in 2020](#).
- Early in the pandemic, the Kenyan government announced social assistance measures to cushion against economic losses for vulnerable segments of the population, including providing [additional cash transfers](#) to existing beneficiaries of the National Safety Net Programme (Inua Jamii) and adding three million new beneficiaries. The government also provided [tax relief](#) and launched a [cash-for-work program](#). International organizations (e.g., the [World Food Programme](#)) and [non-governmental organizations](#) have also rolled out cash transfer programs.
- However, in the survey, only 4% of respondents said they had received any additional assistance from the government over the previous month, evenly split between those who had received cash and food. Lower-income households were no more likely to have received assistance.

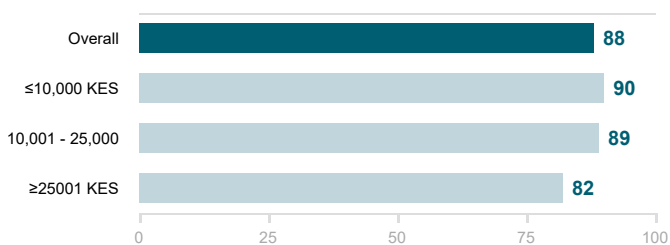
Reported barriers to food access

Percent of people reporting each barrier

Less income	79%
Higher food prices	77%
Food markets closed	33%
Mobility restrictions	28%
Food market supply shortages	46%

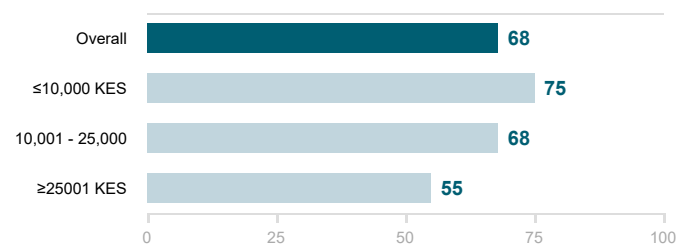
Household income

Percent of households experiencing **income loss** by category



*Household income is significantly associated with income loss.

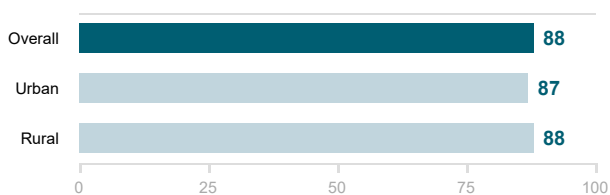
Percent of households **missing meals** by category



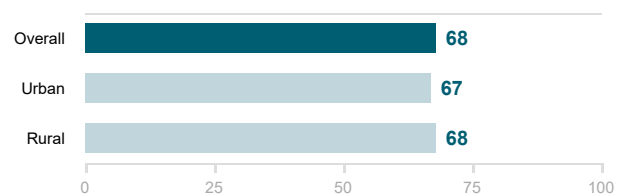
*Household income is significantly associated with missing meals.

Location

Percent of households experiencing **income loss** by category



Percent of households **missing meals** by category



Appendix

Endnotes

Report notes

Regional comparisons were conducted as per the following categories: Eastern Africa (Ethiopia, Kenya, Uganda, Sudan); Western Africa (Ghana, Nigeria, Liberia, Guinea Conakry, Senegal, Côte d'Ivoire); Northern Africa (Tunisia, Morocco, Egypt); Central Africa (Cameroon, Democratic Republic of Congo); and Southern Africa (Mozambique, South Africa, Zambia, Zimbabwe).

Two-tailed t-tests to compare two categories, and chi-square tests to compare more than two categories were conducted to assess statistical differences. An asterisk (*) indicates statistical significance where $p < 0.05$.

The figure on page 2 of the report shows the 7-day rolling average of new cases alongside test positivity and mobility data from March 2020 to February 2021. Where test positivity data and/or mobility data are missing, the data are unavailable.

Full survey results are available here and on the PERC online [dashboard](#). For full details on data sources, methods and limitations, see preventepidemics.org/perc.

- Ipsos conducted a telephone survey of a nationally representative sample of households with access to a landline or cell phone. Results should be interpreted with caution as populations without access to a phone are not represented in the findings. The percentages reported in Ipsos charts may be different from percentages reported in other PERC products and communication of these data. Differences may be reconciled by investigating the denominator and/or weights used.
- Novetta Mission Analytics conducted research to collect insights from *traditional and social media* sources using online, open-source African media, and geolocated African Twitter and Facebook sources. These qualitative data reflect public narratives in online media sources and among social media users. Quotes have been edited where necessary for clarity, with modified text in brackets. Content from social media sources in the public domain should be interpreted with caution given that views reflected might be extreme in nature and are not representative of the population of a given country or demographic.
- Africa Centres for Disease Control and Prevention (Africa CDC) provides *epidemiological* data daily for African Union (AU) Member States. Africa CDC receives case, death and testing data from each AU Member State. Because not all AU Member States report daily, numbers could be delayed, especially for testing data which is more commonly reported late, or in periodic batches (e.g. weekly).
- Other Data is drawn from publicly available sources.

Findings reflect the latest available information from listed sources at the time of analysis, and may not reflect more recent developments or data from other sources. Data vary in completeness, representativeness, and timeliness.

Country notes

The survey sampled from Kenya consisted of 1,461 adults (542 urban, 919 rural), collected between 12 to 22 February 2021.

Income classifications were based on existing data on local income distributions, which were used to create three income bands, defined as:

- Lower-income: Monthly household income 10,000 KES or less
- Middle income: Monthly household income 10,001 KES - 25,000 KES
- Higher-income: Monthly household income 25,001 KES and above