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Vaccination Laws, Policy, and Herd Immunity across Borders: A Comparative Legal Perspective from Poland and Kenya

1. Introduction

Vaccination remains one of the most effective public health interventions of the modern era.[1] A key concept underpinning immunization policy is herd immunity, the point at which a communicable disease can no longer erupt in a major outbreak in a community because a critical mass of its members is immune. Epidemiologists recognize herd immunity as the threshold beyond which a disease cannot spread significantly due to sufficient vaccination coverage within a population.[2]

Given the importance of herd immunity to public health strategy, it is essential to explore how different legal systems regulate vaccination and balance individual rights with collective protection. This article offers a comparative legal analysis of two contrasting jurisdictions – Poland and Kenya – examining their approaches to vaccination and herd immunity. Despite differences in geography, legal culture, and socio-political context, both face common legal and policy challenges, such as vaccine hesitancy, misinformation, and tensions between public health and individual rights. These shared concerns highlight the global dimension of the vaccination debate and the need for legally sound, ethically balanced public health strategies across diverse legal systems.

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[1] See: T. Haelle, "The Staggering Success of Vaccines," *Nature* 2024, no. 634(8035), pp. S34–S39; A.J. Shattock, H.C. Johnson, S.Y. Sim *et al.*, "Contribution of Vaccination to Improved Survival and Health: Modelling 50 Years of the Expanded Programme on Immunization," *The Lancet* 2024, vol. 403, no. 10441, pp. 2307–2316.

[2] A. Ciolli, "Religious and Philosophical Exemptions to Mandatory School Vaccinations: Who Should Bear the Costs to Society?," *Missouri Law Review* 2009, no. 74, no. 2, p. 288.

Following standard comparative legal methodology, this article first presents each legal system separately before moving to comparative analysis.[3] This structure ensures contextual accuracy and respects each system's internal coherence. It begins with Kenya's policy-based, largely non-coercive model,[4] then turns to Poland's statutory and enforcement-driven approach.[5] Only thereafter are convergences, divergences, and broader legal implications identified.[6]

The legal scope of promoting or mandating vaccination remains a question of lasting importance, one made more urgent by global health crises such as the COVID-19 pandemic. In an interconnected world where epidemics cross borders, public health measures must be both effective and conscious of rights. This article offers a comparative legal reflection on how different jurisdictions pursue public health through immunization.

2. Voluntary compliance and public health: Lessons from Kenya

In Kenya, immunization is a key component of primary health care. National policies emphasize universal access to vaccines, but the system largely operates on voluntary compliance, public health initiatives, and international support. Unlike some countries with strict vaccination laws, Kenya promotes immunization through accessibility and public education.

2.1. Legal and policy framework for vaccination in Kenya

Kenya's legal and policy framework emphasizes the right to health and the provision of immunization as a public good, without imposing mandatory vaccination for the general population. The 2010 Constitution guarantees every Kenyan the right to the highest attainable standard of health, obligating the state to implement measures to achieve this right.[7]

Immunization is considered a fundamental component of primary healthcare and is integrated into the Kenya Essential Package for Health under Universal Health Coverage.[8] The government prioritizes immunization through policy measures rather than legal mandates. The Ministry of Health has issued National Policy Guidelines on Immunization[9] These guidelines, most recently updated for 2013–2023, outlining the routine childhood immunization schedule.[10]

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[3] M. Siems, *Comparative Law*, 3rd ed., Cambridge 2022, pp. 20–22.
[4] Cf. section 2 of this article.
[5] Cf. section 3 of this article.
[6] Cf. section 4 of this article.
[7] *The Constitution of Kenya* (2010), Article 43(1)(a).
[8] Ministry of Health (Kenya), *Kenya Essential Package for Health (KEPH) under Universal Health Coverage*, Nairobi 2023.
[9] Ministry of Health (Kenya), *National Policy Guidelines on Immunization*, 2013–2023.
[10] Ministry of Health (Kenya), *Routine Immunization Schedule*, Nairobi 2023, https://www.health.go.ke/immunization [accessed: 16.03.2025].

Although public messaging may suggest that immunization is compulsory, Kenya has no general legal mandate. Instead, the focus is on ensuring free and widespread access through the National Vaccines and Immunization Programme.[11] Parents are not legally required to vaccinate their children, and no penalties apply. The government promotes uptake through community engagement, public education, and outreach, rather than through coercive measures.[12]

The Public Health Act provides for compulsory vaccination against certain diseases, such as smallpox, and authorizes emergency campaigns during outbreaks.[13] These provisions, however, are rarely enforced; routine vaccines are delivered voluntarily through Kenya's Expanded Programme on Immunization (KEPI).[14] A major controversy arose in 2014–2015, when the Kenya Conference of Catholic Bishops claimed that a WHO/UNICEF tetanus vaccine contained a fertility-suppressing hormone; an allegation that was later refuted by the government and UN agencies.[15] Despite existing legal provisions, Kenya continues to rely primarily on voluntary immunization, with enforcement limited to emergencies.

Although routine immunization is voluntary, certain vaccinations are mandatory in specific contexts; for example, proof of yellow fever vaccination is required for travelers from endemic regions.[16] The Public Health Act empowers the Director of Medical Services to implement disease control measures, including mass vaccination campaigns during outbreaks of polio or measles.[17] While it also permits other interventions like quarantine, the Act does not establish a general mandate for routine immunization.

The 2017 Health Act affirms Kenya's commitment to Universal Health Coverage, recognizing immunization as an essential service. It obliges national and county governments to ensure vaccine availability and delivery but does not impose a general legal duty on citizens to vaccinate.[18]

Kenya follows a voluntary compliance model, grounded in the belief that access and public trust are more effective than legal penalties.[19] This has supported relatively high childhood vaccination rates, though challenges such as hesitancy, misinformation, and logistical barriers persist. While the law imposes no direct obligation to vaccinate, institutional and policy frameworks support broad immunization.

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[11] Ministry of Health (Kenya), *National Vaccines and Immunization Programme (NVIP)*, https://www.health.go.ke [accessed: 15.03.2025].

[12] Kenya National Bureau of Statistics, *Demographic and Health Survey*, Nairobi 2022.

[13] *Public Health Act* (Cap. 242, Laws of Kenya), pp. 104, 105, 106.

[14] Ministry of Health (Kenya), *Kenya Expanded Programme on Immunization*, Nairobi 2023, https://www.health.go.ke [accessed: 16.03.2025].

[15] National Catholic Reporter, *Kenyan Bishops' Vaccine Claims Rejected by UN, Government*, 2015, https://www.ncronline.org [accessed: 16.03.2025].

[16] *International Health Regulations* (2005), Article 36.

[17] *Public Health Act* (Cap. 242, Laws of Kenya), p. 17.

[18] *Health Act*, No. 21 of 2017 (Kenya), p. 6(2).

[19] UNICEF, *Vaccine Hesitancy in Kenya: Addressing Challenges in Immunization*, Nairobi 2023, https://www.unicef.org/kenya [accessed: 13.03.2025].

Kenya's legislative framework for health was also significantly expanded by a package of four statutes enacted in 2023: the Primary Health Care Act (No. 13 of 2023), the Digital Health Act, the Social Health Insurance Act, and the Facility Improvement Financing Act.[20] The Digital Health Act established a Digital Health Agency tasked with creating a Comprehensive Integrated Health Information System.[21] For immunization, this is particularly significant as it provides the legal basis for the KeNVIP digital portal, the Kenya National Vaccination and Immunization Program platform, which seeks to improve immunization coverage through data-driven decision-making and manage immunization data across all levels of the devolved healthcare system.[22] While implementation was briefly delayed by a conservatory court order in late November 2023, the reforms represent Kenya's most substantial legislative investment in health infrastructure in over a decade.

Courts have also begun addressing vaccination-related disputes, particularly during the COVID-19 pandemic. This evolving case law highlights the legal and ethical tensions surrounding immunization policy in Kenya, balancing the state's public health duties with constitutional protections of individual rights.

In August 2021, the government mandated COVID-19 vaccination for public servants, with non-compliance treated as a disciplinary offence. The Employment and Labour Relations Court upheld the directive in September 2022, citing public health concerns and referring to *Jacobson v Massachusetts* (1905) and *Vavřička v Czech Republic* (2021).[23] A separate November 2021 directive requiring proof of vaccination to access public services was suspended by the High Court a month later, which ruled that such mandates must be legally justified and proportionate.[24] This evolving jurisprudence reaffirms the state's public health powers while subjecting vaccine mandates to constitutional scrutiny under the 2010 Constitution.

2.2. Vaccine coverage challenges and herd immunity

Kenya maintains high childhood immunization rates, with most vaccines exceeding 85% coverage, despite COVID-19 disruptions, staff shortages, and supply issues.[25] However, follow-up challenges, especially for second doses like the 2024–2025 measles (MCV2) outbreak,[26] and religious or cultural hesitancy, such as the 2014

[20] *Primary Health Care Act*, No. 13 of 2023 (Kenya); *Digital Health Act*, 2023 (Kenya); *Social Health Insurance Act*, 2023 (Kenya); *Facility Improvement Financing Act*, 2023 (Kenya), all assented to on 19 October 2023, *Kenya Gazette Supplement* No. 190.

[21] *Digital Health Act*, 2023 (Kenya), p. 4 (establishing the Digital Health Agency and Comprehensive Integrated Digital Health Information System).

[22] CODATA, *Launch of Kenya National Vaccination and Immunization Program (KeNVIP) Portal*, 2024, https://codata.org/kenya-national-vaccination-and-immunization-program-kenvip-portal [accessed: 7.05.2026].

[23] *Koigi & another v Kinyua & 5 others (Petition E155 of 2021)*.

[24] High Court of Kenya, *Interim Ruling on COVID-19 Vaccine Directive*, 14 December 2021.

[25] UNICEF, *Immunization Data*, 2023, https://data.unicef.org [accessed: 15.03.2025].

[26] WHO Regional Office for Africa/The Star (Kenya), *Measles Deaths Fall Sharply, but Kenya Still Faces Outbreak Threat*, 29 November 2025, https://www.the-star.co.ke/health/2025-11-29-measles-deaths-

tetanus vaccine controversy, have led to localised refusals.[27] Launched in March 2021, the COVID-19 vaccination campaign began with health workers and high-risk groups, later expanding as supply improved.[28] Uptake was higher in urban areas, while rural and pastoralist regions lagged because of misinformation, and lower perceived risk.[29] Booster coverage remained low, though awareness campaigns gradually reduced refusals. Bridging equity gaps and restoring trust remain key to sustaining future immunization progress.[30]

Kenya faces notable geographic and socio-economic disparities in vaccine coverage, with lower rates in remote, nomadic, and informal communities, leading to localized outbreaks.[31] A persistent issue is the 2% of zero-dose children in marginalized areas.[32] Stockouts and supply chain gaps have disrupted immunization, including a 3.8-month polio vaccine shortage, while COVID-19 further delayed deliveries until late 2021.[33] Coverage is also affected by health worker shortages and poor infrastructure, particularly in rural areas with limited cold-chain capacity.

2.3. Strategies to improve vaccine uptake

To close these gaps, Kenya employs mass immunization campaigns, such as polio and measles catch-up programs, which have prevented major disease resurgences. Mobile vaccination clinics in nomadic and remote areas address access barriers, bringing vaccines directly to communities.[34]

Community engagement is also crucial as collaborations with local leaders and religious groups help dispel vaccine misinformation. This approach was effective in restoring trust after the 2014 tetanus vaccine scare.[35] School-based vaccination programmes have also expanded, particularly for HPV vaccines, improving adolescent immunization rates.[36]

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27 See footnote no. 17.

28 Al Jazeera, *Kenya's COVID-19 Vaccine Progress*, 2022, https://www.aljazeera.com [accessed: 17.03.2025].

29 WHO, *COVID-19 Vaccine Dashboard for Africa*, 2023, https://www.who.int [accessed: 16.03.2025].

30 Reuters, *Kenya's Vaccine Uptake Trends*, 2023, https://www.reuters.com [accessed: 17.03.2025].

31 WHO Africa, *Immunization Coverage and Gaps*, 2023, https://www.afro.who.int [accessed: 16.03.2025].

32 UNICEF, *Zero-Dose Children in Africa*, 2023, https://data.unicef.org [accessed: 13.03.2025].

33 HRW, *COVID-19 Vaccine Inequity in Africa*, 2022, https://www.hrw.org [accessed: 13.03.2025].

34 KELIN, *Kenya's Immunization Strategies*, 2023, https://www.kelinkenya.org [accessed: 13.03.2025] and Reuters, *Mobile Clinics Boost COVID-19 Vaccine Uptake*, 2022, https://www.reuters.com [accessed: 13.03.2025].

35 National Catholic Reporter, *Vaccine Trust Restoration in Kenya*, 2016, https://www.ncronline.org [accessed: 19.03.2025].

36 WHO Africa, *HPV Vaccine Rollout in Kenya*, 2023, https://www.afro.who.int [accessed: 11.03.2025].

Policy reforms and financing efforts are ongoing. The Kenyan government is transitioning from Gavi support to domestic vaccine financing, ensuring immunizations remain free.[37] Proposed legal updates to the Public Health Act may also clarify the framework for vaccine mandates, balancing public health needs with individual rights.[38]

3. Poland: Between legal obligation and waning compliance

3.1. Legal and policy framework for vaccination in Poland

Poland has a long-standing legislative tradition of mandatory vaccinations for certain groups.[39] The principal act governing this issue is the Act of 5 December 2008 on the prevention and control of infections and infectious diseases in humans (hereinafter: the 2008 Act).[40] Its legal basis lies at the constitutional level; Article 68(4) of the Constitution obliges public authorities to combat epidemic diseases.[41] The 2008 Act gives concrete effect to this obligation by requiring vaccination against infectious diseases specified in executive regulations.[42]

Exemptions from the vaccination obligation are allowed only in narrowly defined cases, mainly where permanent or temporary medical contraindications exist.[43] The 2008 Act does not provide for a general conscience or religious exemption. A limited exception also applies to individuals staying in Poland for less than three months,

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37 *Ibid.*

38 Reuters, *Kenya's Public Health Law Reforms*, 2023, https://www.reuters.com [accessed: 12.03.2025].

39 Mandatory vaccination provisions have existed in Poland since the period of the Second Republic, including the Acts of 7 February and 19 July 1919 (*Journal of Laws* No. 14, item 184; No. 63, item 372), the Act of 25 July 1919 on combating infectious diseases (*Journal of Laws* No. 67, item 402), the Act of 6 June 1963 (*Journal of Laws* No. 33, item 185), the Act of 6 September 2001 (*Journal of Laws* No. 126, item 1384), and the currently binding Act of 5 December 2008 on the prevention and control of infections and infectious diseases (consolidated text: *Journal of Laws* of 2024, item 924, 1897). For an overview of the evolution of these rules from the interwar period to the present day, see: P.M. Pilarczyk, "*Ubi periculum, ibi lex*. Prawo a nowe zagrożenia (uwagi na marginesie pandemii w Polsce)" [in:] *Prawne i medyczne wyzwania stanu pandemii*, eds. J. Długosz-Jóźwiak, E. Paszyńska, Warszawa 2021.

40 Act of 5 December 2008 on the prevention and control of infections and infectious diseases (consolidated text: *Journal of Laws* of 2024, item 924, 1897).

41 Constitution of the Republic of Poland of 2 April 1997 (*Journal of Laws* No. 78, item 483, as amended).

42 Article 5(2) of the 2008 Act provides that in the case of a person lacking full legal capacity, the obligation to comply with the duties referred to in Article 5(1) rests with the person exercising legal custody or, where applicable, a de facto guardian.

43 Pursuant to Article 17(10) of the 2008 Act, the Minister of Health is authorised to regulate the procedures for mandatory vaccinations, including cases of medical exemption. This competence is exercised through the Regulation of 27 September 2023 on mandatory preventive vaccinations (*Journal of Laws*, item 2077).

except in cases of post-exposure prophylactic vaccination against diphtheria, tetanus, and rabies.[44]

The Minister of Health defines the scope of mandatory vaccinations by regulation.[45] For many years, the national immunization schedule was published annually as a communiqué by the Chief Sanitary Inspector (GIS), detailing the types and timing of vaccinations, especially for children. However, in its judgment of 9 March 2023 (SK 81/19), the Constitutional Tribunal held that such a communiqué, being an administrative notice rather than a normative act, was unconstitutional.[46] The Tribunal emphasized that elements such as age thresholds must be set by ministerial regulation based on statutory authorization. In response, the Minister of Health issued a new regulation on 27 September 2023 (in force from 1 October 2023), now listing all mandatory vaccinations along with age groups and covered diseases.[47] As of 2025, Poland's schedule includes fourteen diseases, such as tuberculosis, hepatitis B, diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, Hib, and pneumococcal infections, spanning from birth to age nineteen.[48]

3.2. Enforcement mechanisms and administrative practice

Polish law mandates vaccinations for children under the national immunization schedule. The 2008 Act and related secondary legislation provide only indirect enforcement mechanisms – through administrative measures. The framework explicitly excludes the use of physical coercion to compel vaccination.

Under Article 17(1) of the 2008 Act, non-compliance with vaccination obligations is subject to administrative enforcement. If a person fails to appear despite being summoned, the State Sanitary Inspectorate may request the voivode (head of a major administrative district) to initiate enforcement proceedings. The voivode may then impose a fine under the Act of 17 June 1966 on Administrative Enforcement Proceedings.[49] This fine, intended to compel compliance rather than punishment, may be imposed repeatedly.[50]

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[44] Under Article 17(1a) of the 2008 Act, mandatory vaccinations apply to individuals residing in Poland for more than three months. However, post-exposure prophylactic vaccinations against diphtheria, rabies, and tetanus may be required regardless of the length of stay (see § 8(1) of the Regulation of 27 September 2023 on mandatory preventive vaccinations, *Journal of Laws*, item 2077).

[45] See: § 2 of the Regulation of 27 September 2023 on mandatory preventive vaccinations (*Journal of Laws*, item 2077).

[46] Judgment of the Constitutional Tribunal of 9 March 2023, SK 81/19.

[47] Regulation of 27 September 2023 on mandatory preventive vaccinations (*Journal of Laws*, item 2077).

[48] See: § 2 of the Regulation of 27 September 2023 on mandatory preventive vaccinations (*Journal of Laws*, item 2077).

[49] Act of 17 June 1966 on administrative enforcement proceedings (consolidated text: *Journal of Laws* of 2025, item 132).

[50] The Act of 17 June 1966 on administrative enforcement proceedings limits a single compliance fine to 10,000 PLN, with a total cap of 50,000 PLN per case (Articles 119 §§ 1–2, 121 §§ 1–3). The person fined may appeal and file a complaint with the competent Voivodeship Administrative Court.

The 2008 Act explicitly excludes the use of physical force to vaccinate a healthy individual. Under Article 36(1), coercive vaccination without consent is allowed only for persons suffering from particularly dangerous, highly contagious diseases who pose a threat to others. This applies to compulsory hospitalization or isolation (for example, for multidrug-resistant tuberculosis), not to preventive vaccination. In cases of refusal, physicians may not vaccinate by force but must document the refusal and notify the sanitary inspectorate, which may then initiate administrative measures.

As in many legal systems, Polish law places strong emphasis on patient consent. Under Article 32(1) of the Act on the Professions of Doctor and Dentist, medical procedures may be performed only with the patient's consent, unless a statutory exception applies. The Voivodeship Administrative Court in Białystok (judgment of 16 April 2013) confirmed that mandatory vaccination is such an exception; refusal is excluded by law.[51] The obligation is legal in nature, not merely advisory, and a patient's refusal has no legal effect.[52]

In short, refusal to comply with a mandatory vaccination requirement constitutes a legal breach and may entail legal and financial consequences. However, Polish law does not allow physical coercion to administer a vaccine, except in cases involving the treatment of individuals with particularly dangerous infectious diseases.[53]

3.3. Vaccination coverage, public trust, and herd immunity

Herd immunity, or population immunity, occurs when a sufficiently high share of the population is immune, through vaccination or prior infection, so that a disease cannot spread effectively.[54] This protects not only the immune but also those who cannot be vaccinated, such as infants or people with medical contraindications. For highly contagious diseases like measles, the threshold is estimated at around 95%.[55]

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[51] Judgment of the Voivodeship Administrative Court in Białystok of 16 April 2013, II SA/Bk 18/13.

[52] *Ibid.*

[53] In 2017, the Polish Supreme Medical Council called for requiring proof of vaccination when enrolling children in nurseries, kindergartens, and schools (Resolution No. 7/17/VII of 22 September 2017). Similar exclusionary measures exist in several European countries. In Italy, the Lorenzin law bars unvaccinated children under six from attending early childhood institutions. In Germany, the 2020 Measles Protection Act requires measles vaccination for all children in schools or daycare, with fines of up to €2,500 for non-compliance. Since 2018, France mandates proof of immunization against eleven diseases, including measles, for admission to childcare and schools. In contrast, Poland has adopted no such measures – access to education remains unaffected by vaccination status, and administrative fines remain the only enforcement tool.

[54] A. Ciolli, "Religious and Philosophical Exemptions…," p. 288.

[55] WHO, "Measles vaccines: WHO position paper – April 2017," *Weekly Epidemiological Record* 2017, vol. 92, no. 17, p. 221.

In Poland, measles vaccination rates, along with similar declines for other diseases, have dropped below the herd immunity threshold[56] contributing to recent measles outbreaks.[57]

The decline in vaccination coverage is strongly linked to the rise in parental refusals of mandatory childhood vaccinations. Between 2006 and 2010, refusals averaged around 4,000 per year, but by 2016 had exceeded 23,000. The trend accelerated during the COVID-19 pandemic, with refusals reaching 72,700 in 2022 and 87,300 in 2023.[58]

As a result, coverage for several childhood diseases has approached or fallen below the herd immunity threshold, posing a serious risk of disease resurgence and complications for vulnerable groups, including children with medical exemptions and the immuno-compromised.

Recently, rising non-compliance with vaccination obligations has prompted institutional action. In March–April 2025, the Chief Sanitary Inspectorate (GIS) conducted a nationwide audit of vaccination records for over 7.5 million individuals aged 0–19 across 10,000 medical facilities. The aim was to assess actual coverage and prepare for the rollout of electronic vaccination records to improve monitoring and public health responsiveness.[59]

4. Comparative reflections and broader legal implications

Our analysis shows that Poland and Kenya adopt fundamentally different legal approaches to vaccination. These differences go beyond geography or legal tradition, reflecting distinct regulatory choices about the state's role in promoting immunization. Poland relies on a statutory framework of compulsory childhood vaccinations, backed by constitutional norms and administrative enforcement. Kenya, by contrast, follows a policy-based model focused on voluntary compliance, public engagement, and health education. Legal mandates exist in Kenya but are limited to exceptional cases, such as health emergencies or cross-border requirements.

Despite structural differences, both countries face similar challenges in sustaining high vaccination rates, particularly because of declining public trust and vaccine hesitancy, fueled by misinformation and politicization. In Poland, parental refusals

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[56] UNICEF, *Szczepienia nadal poniżej poziomu notowanego przed pandemią*, 26 April 2023, https://centrum-prasowe.unicef.pl/335243-szczepienia-nadal-ponizej-poziomu-notowanego-przed-pandemia [accessed: 7.04.2025].

[57] *Ibid.*

[58] Statista, *Poland: refusal to vaccinate 2003–2023*, https://www.statista.com/statistics/1080847/poland-refusal-to-vaccinate/ [accessed: 8.04.2025]; see also: K. Wójcik, "Rodzice nieszczepiący dzieci wygrywają w sądach," *Gazeta Prawna*, 5 February 2025, https://www.gazetaprawna.pl/praca/artykuly/9665597,rodzice-nieszczepiac-dzieci-wygrywaja-w-sadach.html [accessed: 7.04.2025].

[59] See: "Rozpoczęła się kontrola kart szczepień. Rzecznik GIS o szczegółach," *PAP*, 26 March 2025, https://www.pap.pl/aktualnosci/rozpoczela-sie-kontrola-kart-szczepien-rzecznik-gis-o-szczegolach [accessed: 7.04.2025].

of mandatory childhood vaccines have increased in recent years. In Kenya, although vaccination is voluntary, similar reluctance has emerged especially after public controversies like the 2014–2015 tetanus vaccine case.

The emergence of such trends in both contexts reflects broader concerns within legal and public health scholarship. Across jurisdictions, the question of whether declining immunization rates justify stronger legal enforcement has become increasingly prominent. Scholars have debated whether vaccination should be framed as a civic responsibility, comparable to other duties owed to the community, and whether this might legitimize limiting non-medical exemptions in law.[60] These discussions point to a deeper normative tension between the protection of individual autonomy and the safeguarding of collective health. As the examples of Poland and Kenya illustrate, such tensions are not confined to specific legal cultures, geographic contexts or levels of economic development, but rather form part of a global debate on the legitimate scope of state intervention in the pursuit of herd immunity.

Ultimately, the comparison between Poland and Kenya suggests that legal obligation alone may not be sufficient to ensure high vaccination coverage. Where trust in institutions is low or public narratives are shaped by misinformation, enforcement measures may exacerbate resistance rather than overcome it. Conversely, voluntary systems that fail to address access barriers or cultural concerns may fall short of protecting vulnerable populations. The challenge for legal systems, therefore, lies in balancing normative commitments to public health with a realistic understanding of social behaviour, institutional legitimacy, and scientific complexity.

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[60] See for example: A. Janet, "Striving for Herd Immunity," *N.Y.U. Law Review Online* 2015, vol. 90, pp. 1–16; I. Trispiotis, "Mandatory Vaccinations, Religious Freedom, and Discrimination," *Oxford Journal of Law and Religion* 2022, vol. 11, no. 1, pp. 145–164; I.A. Emhoff, E. Fugate, N. Eyal, "Is There a Moral Right to Nonmedical Vaccine Exemption?," *American Journal of Law & Medicine* 2016, vol. 42, no. 2–3, pp. 598–620; P. Slotte, L.C. Karlsson, A. Soveri, "Attitudes Towards Mandatory Vaccination and Sanctions for Vaccination Refusal," *Vaccine* 2022, vol. 40, no. 51, pp. 7378–7388.

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Summary

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Vaccination Laws, Policy, and Herd Immunity across Borders: A Comparative Legal Perspective from Poland and Kenya

This article presents a comparative legal analysis of vaccination laws and policies in Poland and Kenya, focusing on how these two jurisdictions seek to promote herd immunity. Poland, a civil law country with a strong regulatory tradition, mandates childhood vaccinations through statutory instruments and administrative enforcement. In contrast, Kenya primarily relies on voluntary compliance and policy frameworks to achieve immunization goals. The authors examine legal foundations, enforcement mechanisms, and public health outcomes in each country, highlighting common challenges such as vaccine hesitancy and public distrust. The authors argue that while legal obligation can support immunization policy, long-term effectiveness also depends on public trust, access to healthcare, and cultural sensitivity. The comparison demonstrates how different legal models, coercive and voluntary, respond to the universal challenge of achieving and maintaining herd immunity in the face of misinformation and structural barriers.

Keywords: mandatory vaccination, public health law, constitutional right to health, herd immunity, vaccine refusal, comparative law.

Streszczenie

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Prawo szczepień, polityka zdrowotna i odporność zbiorowa w ujęciu transgranicznym – porównawcza analiza prawna na przykładzie Polski i Kenii

W artykule przedstawiono porównawczą analizę prawną przepisów i polityk dotyczących szczepień w Polsce i Kenii, koncentrując się na tym, w jaki sposób oba państwa dążą do osiągnięcia odporności zbiorowej. Polska, jako państwo prawa kontynentalnego o silnej tradycji regulacyjnej, wprowadza obowiązek szczepień dzieci za pomocą aktów ustawowych i mechanizmów administracyjnych. Z kolei w Kenii system szczepień opiera się głównie na dobrowolności oraz działaniach prowadzonych w ramach polityki publicznej. Autorzy analizują podstawy prawne,

mechanizmy egzekwowania obowiązków oraz skutki zdrowotne w obu krajach, wskazując na wspólne wyzwania, takie jak wahania wobec szczepień czy brak zaufania społecznego. W opracowaniu postawiono tezę, że choć ramy prawne mogą wspierać realizację polityki zdrowotnej, to ich długofalowa skuteczność zależy również od zaufania społecznego, dostępności usług medycznych i wrażliwości kulturowej. Porównanie pokazuje, w jaki sposób różne modele prawne – przymusowe i dobrowolne – odpowiadają na uniwersalne wyzwanie, jakim jest zapewnienie i utrzymanie odporności zbiorowej w warunkach dezinformacji i barier systemowych.

Słowa kluczowe: obowiązkowe szczepienia, prawo zdrowia publicznego, konstytucyjne prawo do ochrony zdrowia, odporność zbiorowa, odmowa szczepienia, prawo porównawcze.