Heightened marginalization of communities on the margins: A blanket approach to the Pandemic and the impact on women and girls in Kenya

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March 2021

RWI supported the above research through its capacity building programs worldwide. These publications reflect the authors' views and are not necessarily endorsed by RWI. This research is part of RWI's publication platform that aims to improve visibility scholars in the Global South and networking opportunities among researchers. https://rwi.lu.se/rwi-supported-publications/

Heightened marginalization of communities on the margins: A blanket approach to the Pandemic and the impact on women and girls in Kenya

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Abstract

The COVID-19 pandemic has caught the world by storm stretching many health systems and exposing the gaps in the resilience of these health systems. Kenya recorded its first confirmed case on 12 March 2020 and has since recorded 126,710 confirmed cases and a total of 2,092 fatalities as at 25 March 2021.[2] Kenya's pandemic response has been delayed and fragmented and the communication and information around it has been piece-meal and opaque.[3] However, in the past year the State has made some strides in its response to the pandemic and has progressively implemented a series of preventive measures such as a dusk to dawn curfew, cessation of movement restrictions, prohibition of social gatherings and religious engagements as well as other safety measures.[4]

Pandemics and their responses do not affect different communities in the same way and marginalised communities can be negatively impacted both by a pandemic and the measures put in place to respond to it. Despite efforts by the government to respond to the pandemic, there has inevitably been a shift in focus and a reallocation of resources away from other healthcare services such as those to secure sexual and reproductive health towards the control of the spread of the virus. This has led to a range of adverse outcomes with respect to the provision and protection of sexual and reproductive health and rights (SRHR) such as: reduced access to family planning services; increased gender-based violence; economic stress leading to transactional sex and exploitation; and higher rate of maternal mortality to name a few.[5]

This research paper shall conduct an analysis on the impact of the Pandemic response on the sexual and reproductive health and rights of women and girls in Kenya by considering the legal and policy framework guiding the pandemic response vis a vis the documented experience of communities of women and girls seeking to access sexual and reproductive health services. This shall be framed within the lens of the obligation of the State to protect marginalised communities and unpack whether the actions taken have met the threshold and if they have, has the resultant impact been for the benefit of women and girls. The hypothesis to be explored is that pandemics and their responses do not impact different communities in the same way and

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[2] Ministry of Health, *'Kenya Discharges 175 recoveries of COVID-19 Nairobi'*, </www.health.go.ke/kenya-discharges-175-recoveries-of-covid-19-nairobi-wednesday-june-10-2020/> visited on 12 October 2020.

[3] KELIN, *'Advisory Note on Ensuring a Rights-Based Response to Curb the Spread of COVID-19'*, <www.kelinkenya.org/wp-content/uploads/2020/03/letter2-min-1.pdf,>, visited on 16 January 2021.

[4] A. Maleche, N. Were and T. Imalingat, '*Excessive Law Enforcement in Kenya*', <verfassungsblog.de/excessive-law-enforcement-in-kenya/>, visited on 18 November 2020.

[5] S. Oketch, '*Effects of COVID-19 on Sexual Reproductive Health and Rights (SRHR) among young people in Africa'*, <dukecenterforglobalreproductivehealth.org/2020/04/26/effects-of-covid-19-on-sexual-reproductive-health-and-rights-srhr-among-young-people-in-africa/¯>, visited on 20 September 2020.

thus gendering a response is critical in ensuring that specific populations can be protected; particularly those already operating within the margins of society.

1. Introduction

The COVID-19 pandemic has caught the world by storm stretching many health systems and exposing the gaps in the resilience of these health systems. Kenya recorded its first confirmed case on 12 March 2020 and has since recorded 126,710 confirmed cases and a total of 2,092 fatalities as at 25 March 2021.[6] This research paper shall conduct an analysis on the impact of the Pandemic response on the sexual and reproductive health and rights (SRHR) of women and girls in Kenya by considering the legal and policy framework guiding the pandemic response vis a vis the documented experience of communities of women and girls seeking to access sexual and reproductive health services. We shall look at both primary and secondary data and shall analyse the findings in light of Kenya's obligation to protect and secure SRHR.

2. Theoretical framework

The right to health is enshrined in the Constitution of Kenya, 2010 which under Article 43(1) (a), states: "*every person has the right to the highest attainable standard of health which includes the right to health care services, including reproductive health care*." Article 43(2) provides further that a person shall not be denied emergency medical treatment. In seeking to understand how this constitutional guarantee translates into an obligation on Kenya we look at constitutional provisions that support this as well as international law which are significant in fleshing out state obligation.

With respect to the implementation of Article 43, the Constitution provides in Article 21(2) that the state shall take legislative, policy and other measures, including the setting of standards, to achieve the progressive realisation of the rights guaranteed therein. Sub-section three goes further and obliges the State and public officers to take into account the needs of vulnerable groups in our society including women, older members of society, persons with disabilities, children, youth, members of minority or marginalized communities, and members of particular ethnic, religious or cultural communities. Also relevant is Article 26(4) on the right to life which prohibits abortion except for where a trained health professional has confirmed the need for emergency treatment, or the life/health of the pregnant woman is in danger or if permitted by any other written law. Further, the Constitution through Article 53(1) (c) guarantees the child's right to healthcare.[7]

These provisions are understood within the context of Article (6) of the Constitution which ensures that every treaty and convention ratified by Kenya forms a part of Kenyan law. In respect to this Kenya is bound by several international and regional treaty documents that enumerate the state's duty significantly the International Covenant on Economic, Social and Cultural Rights (ICESCR).[8] The Committee on Economic, Social and Cultural Rights (CESCR), the body that monitors implementation of ICESCR, issued General Comment No. 14 which addresses substantive issues arising in the implementation of Article 12 on the right to health. This General Comment expands the definition of the right to health to include a set of freedoms and entitlements that accommodate the individual's biological and social

[6] Ministry of Health, *supra* note 1.
[7] The Constitution of Kenya, 2010.
[8] Kenya acceded to the International Covenant of Economic, Social and Cultural Rights in 1972.

conditions, as well as available state resources, which may preclude a right to be healthy. General Comment No 14 provides states with a framework for which to both conceptualise and measure progress with realising the right to health in all its forms and at all levels contains four interrelated elements:

a. *Availability*: Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. This varies in accordance with a state's capacity but will include programmes aimed at addressing the underlying determinants of health.
b. *Accessibility:* facilities, goods and services have to be accessible. Accessibility is unpacked into four areas: non-discrimination which speaks to the ability to access services without fear of discrimination; physical accessibility which requires that goods and services be within safe physical reach; economic accessibility which speaks to services and goods that are affordable by all; and information accessibility which guarantees the right to seek, receive and impart information and ideas concerning health.
c. *Acceptability*: health facilities, goods and services must be respectful of medical ethics and culturally appropriate.
d. *Quality*: Health facilities, goods and services must be scientifically and medically appropriate and of good quality.[9]

We rely on the lens of availability, accessibility, acceptability and quality (AAAQ) in our analysis on the State's obligation to guarantee the right to health. The utility of this analysis is bolstered by *Maimuna Awour and another* v *The Attorney General and Others*[10] where the court held:

> "In this regard, the CESCR states that ICESCR requires state parties to ensure that health services are available, accessible, acceptable, and of good quality. It interprets availability to encompass "not only ... timely and appropriate health care but also the … underlying determinants of health such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related ... information.
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> Accessibility requires non-discriminatory access to health facilities, goods and services, "especially [for] the most vulnerable or marginalized sections of the population." In addition, accessibility also requires that health services be available and free from discrimination; they must be physically accessible; and they must also be economically accessible, that is they must be affordable."[11]

While General Comments may be considered persuasive this has been adopted into the Kenyan normative framework through jurisprudence. This is strengthened by General Comment No.

[9] CESCR, *'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12)'*, <www.refworld.org/pdfid/4538838d0.pdf>, visited on 20 November 2020.
[10] Petition No. 562 of 2012.
[11] *Ibid.*, paras. 137-138.

22 on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) which co-opts the AAAQ framework.[12]

3. Methodology

The study relies on both quantitative and qualitative analyses of primary and secondary data on women's perspectives and experiences on the impact of the COVID pandemic on availability, accessibility, acceptability and quality of SRHR services.

3.1. Data collection

3.1.1. Primary data

a. Assessment on trends in health related human rights violation in the COVID response

The Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN) and other civil society organisations have been working in partnership to advocate for a rights-based response to the pandemic through a platform called COVID-Rights Based Approach Advisory Group (COVID-RBA).[13] Through this platform, we conducted an online assessment aimed at identifying health related human rights violations experienced by vulnerable and marginalised communities in the pandemic response across six counties: Nairobi, Mombasa, Kisumu, Migori, Kakamega and Kwale.

The sampling frame consisted of community-based organisations working in the representative counties. The data was collected from 9th to 30th September 2020 and administered through KOBO collect platform. The data collection forms in KOBO collect contained data validation checks and skip logics that decreased human error in data entry. We also checked for duplicate entries in the KOBO toolkit system as well as outliers throughout the data collection exercise.

While the survey targeted at least 384 community members, we were only able to reach 150 community members hence the findings cannot be completely generalized to represent all vulnerable and marginalised communities. Additionally, the survey was targeted at assessing experiences with availability and quality of all health services. Therefore, perspectives on availability and quality of SRHR services were generalized. The limitations of our primary data necessitated analysis of secondary data with specific focus on SRHR.

b. Understanding the extent of the COVID pandemic effects on reproductive, maternal, newborn and child health services in Kenya[14]

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[12] CESCR, '*General Comment No. 22 on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights*', <www.escr-net.org/resources/general-comment-no-22-2016-right-sexual-and-reproductive-health>, visited on 30 November 2020.

[13] After the first COVID case was confirmed in Kenya, KELIN mobilised over 50 civil society organisations, healthcare worker associations and unions, and economics and governance experts to collaboratively develop and issue an advisory note to the government on ensuring that the COVID response adopts a rights-based approach. This multi-sectoral response was the launching pad for the civil society led platform, COVID-Rights Based Approach Initiative (COVID-RBA) to monitor the COVID response. *See* KELIN, *supra* note 3.

[14] E. Ateva, White Ribbon Alliance, '*COVID-19 Curfew Restrictions Impact Reproductive, Maternal and Newborn Health and Rights Worldwide*' <www.whiteribbonalliance.org/2020/06/08/covid-19-curfew-restrictions-impact-women-and-newborns-worldwide/ >, visited on 15 December 2020.

Through the COVID-RBA platform, KELIN supported the design of a study led by White Ribbon Alliance Kenya (WRA Kenya) aimed at understanding the extent to which the COVID pandemic has affected reproductive, maternal, newborn and child health services in five counties: Bungoma, Kajiado, Nairobi, Kisumu and Narok counties.

10 community mobilisers collected perspectives from their communities. They applied mixed methods to engage community members, including phone conversations, WhatsApp messaging, an online survey and face-to-face conversations where possible. Approximately, 325 responses were submitted by adolescent girls, single mothers, women, men, people with disability, community health workers and local administration officials.

3.1.2. Secondary data

We also relied on qualitative analysis of secondary data on the effect of the pandemic on various aspects of SRHR. Data was obtained from research studies conducted by civil society organisations and academia. These studies were used to corroborate our primary data and the research studies consulted include:

a. Effect on Access to Maternal Health Services in Kenya[15]

This study aimed to assess the extent of the impact of imposed lockdowns and curfew on access to maternal health services for women living in informal settlements in the Embakasi area in Nairobi City, Kenya and collected perspectives from 71 women between May and June 2020.

b. Knowledge, Attitudes, Practices and Effects of COVID-19 Among the Youth[16]

This study was conducted by Amref Health Africa and Youth in Action to determine the effect of the pandemic on the youth including their SRHR. The study reached 2,153 youth across 47 counties in Kenya.

c. Access to Healthcare in a time of COVID-19: Sex Workers in Crisis in Nairobi[17]

Conducted by the Bar Hostess Empowerment and Support Program (BHESP), the research project sought perspectives from 115 female sex workers living in Nairobi East's informal settlements on the effect of the pandemic on access to health services.

d. The Gendered Face of COVID-19: Implications of COVID-19 related corruption on women[18]

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[15] J. Oluoch-Aridi, T. Chelagat, M. Nyikuri, J. Onyango, D. Guzman, C. Makanga, L. Miller-Graff and R. Dowd, Frontiers in Global Women's Health, *'COVID-19 Effect on Access to Maternal Health Services in Kenya'* <www.frontiersin.org/articles/10.3389/fgwh.2020.599267/full#h3>, visited on 25 January 2021.

[16] Amref Health Africa, Population Council and Youth in Action, *'Kenya: Knowledge, Attitudes, Practices and Effects of COVID-19 among the Youth'* <amref.org/kenya/download/knowledge-attitudes-practices-and-effects-of-covid-19-among-the-youth/>, visited on 25 January 2021 .

[17] S. Gichuna, R. Hassan, T. Sanders, R. Campbell, M. Mutonyi and P. Mwangi, 'Access to Healthcare in a time of COVID-19: Sex Workers in Crisis in Nairobi, Kenya' 15:10 *Global Public Health* <www.tandfonline.com/doi/full/10.1080/17441692.2020.1810298>, visited on 12 January 2021.

[18] Mzalendo Trust, *'The Gendered Face of COVID-19: Implications of COVID-19 Related Corruption on Women'* <info.mzalendo.com/media_root/file_archive/The_Gendered_Face_of_Covid-19__-_Implications_of_Covid-19_Corruption_on_Women.pdf.>, visited on 12 March 2021.

Mzalendo Trust collected data from 104 women across 16 counties on their perception of the effect of COVID related corruption on women's health.

4. Findings

4.1. Assessment on Health Related Human Rights Violations during the COVID-19 Pandemic Period

We collected from 150 respondents and findings show Mombasa had the highest number of respondents at 39% and Kwale the least at 1%.

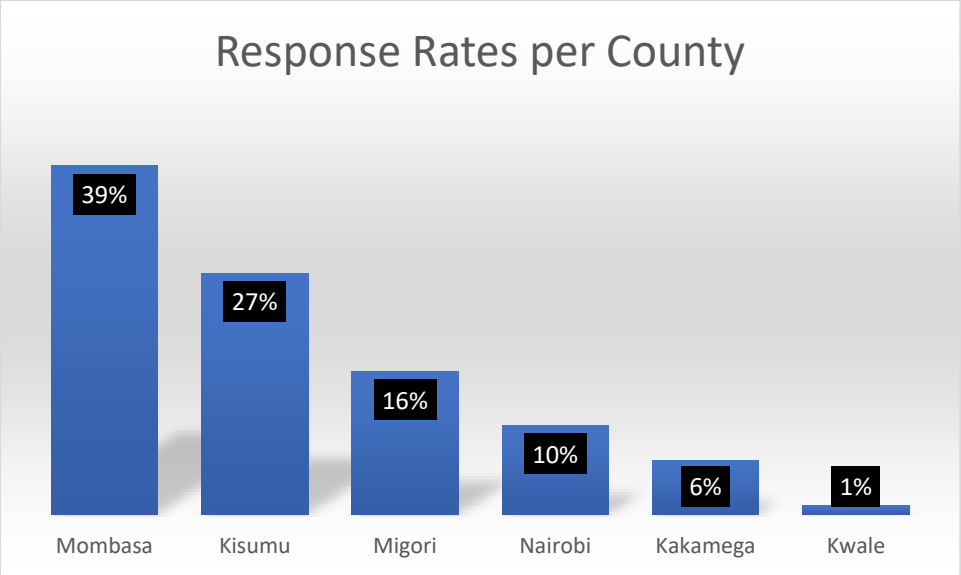

Figure 1: Response Rates

Majority of the respondents were female (57%) followed by male respondents (41%) and transgender people (2%).

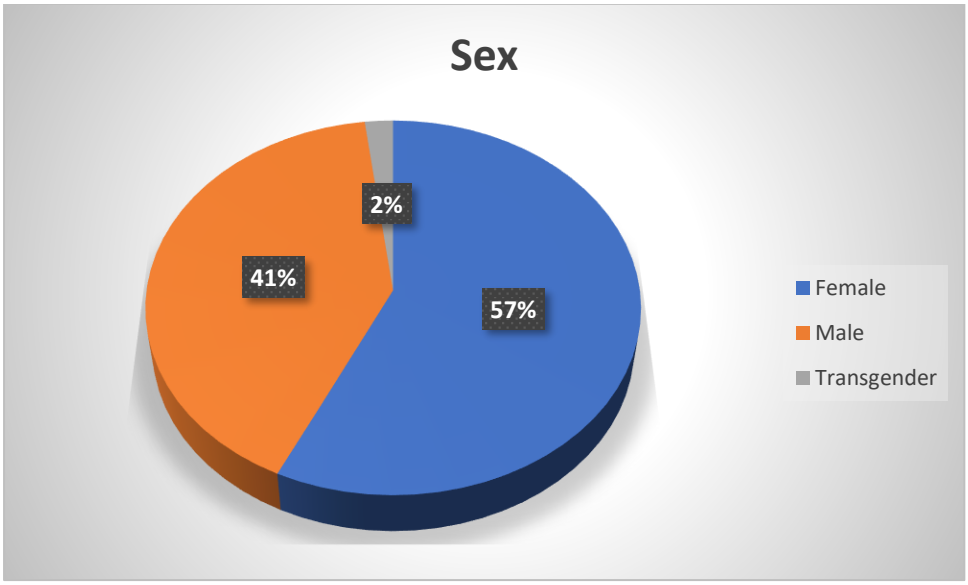

Figure 2: Sex of the respondent

The majority of the respondents (27%) are between 25 – 30 years while the minority (3%) are between 51 – 55 years.

Table 1:Age of the respondents

Age	**Frequency**	**Percentage**
18-24 Years	24	16%
25-30 Years	40	27%
31-35 Years	37	25%
36-40 Years	15	10%
41-45 Years	11	7%
Above 55 years	10	7%
46-50 Years	8	5%
51-55 Years	4	3%

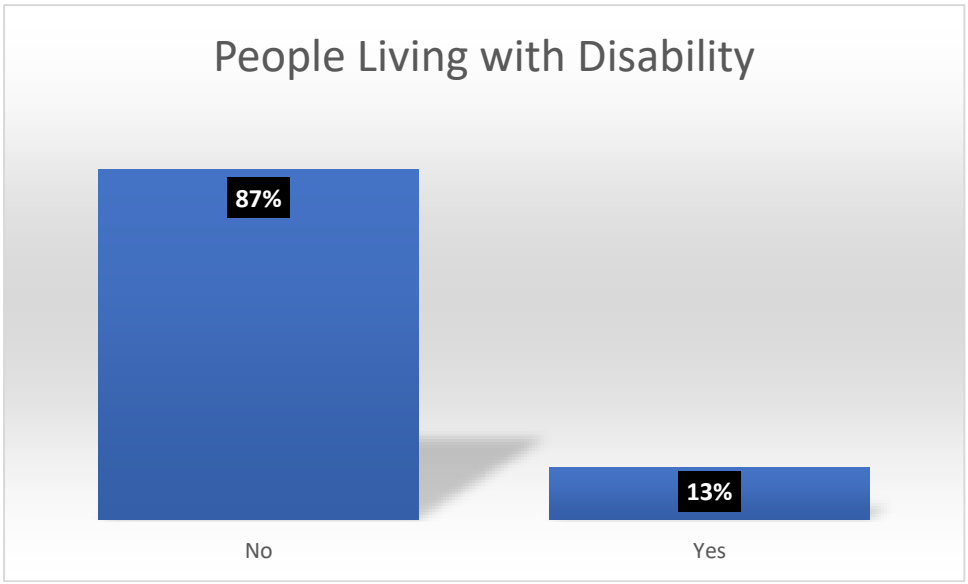

Figure 3: People with disability

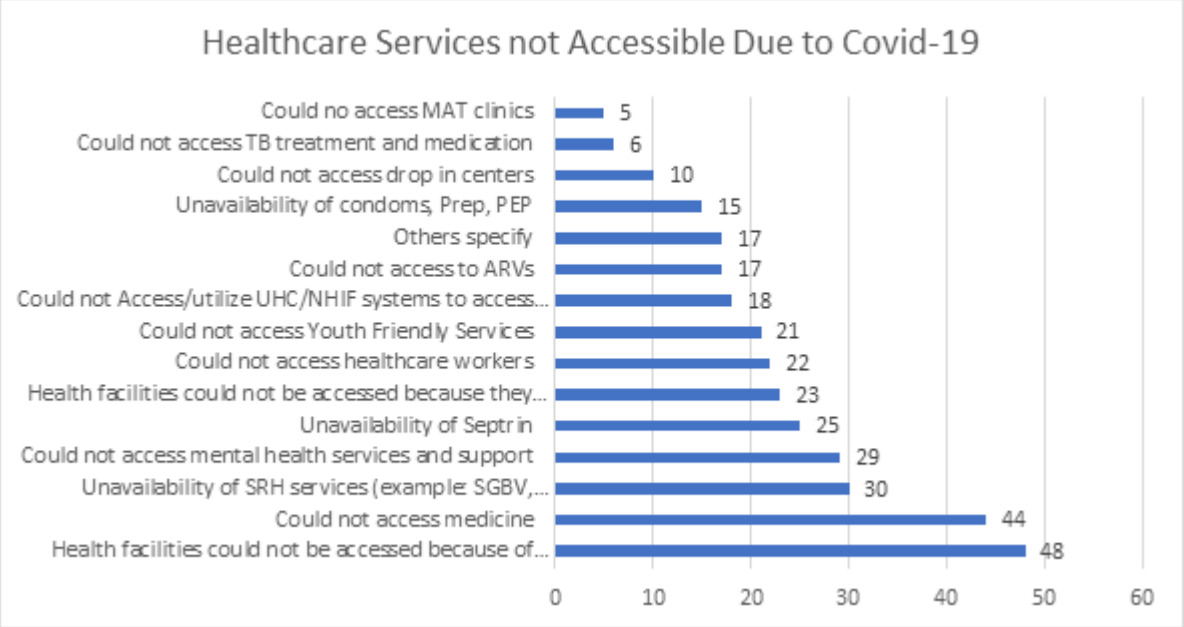

Figure 4: Healthcare services that were unavailable and inaccessible due to the pandemic

Based off our primary and secondary data on the lived experiences and perceived impact of the COVID pandemic on the provision and protection of SRHR, we identified three main themes:

1. Maternal health services. This theme describes the findings on the perspectives of women and girls on availability, accessibility, acceptability and quality of maternal health services, including pre-natal, neo-natal and post-natal services, since the start of the COVID pandemic.
2. Family planning services and commodities. This theme outlines the findings on availability, accessibility, acceptability and quality of family planning services and commodities during the pandemic.
3. Incidences of SGBV. In this theme, we discuss the findings on the impact that pandemic response has had on incidences of domestic violence and sexual exploitation.

4.2. Maternal health services

The studies reflected a trend of decreased availability, accessibility and quality of maternal health services. Eight per cent of the respondents in the Mzalendo study noted that they had difficulties in accessing maternal healthcare.[19] The WRA Kenya study reported that maternal health services were inaccessible due to curfew and movement restrictions. Women noted that they were unable to find transport to facilities when going into labour, and faced physical and verbal harassment from law enforcement when walking to health facilities.[20] Respondents in the study on access to maternal health services in Embakasi noted that there were changes in availability of routine prenatal services. Women were turned away when they took their babies for growth monitoring and were informed by health workers that it was unnecessary during COVID times. They also reported increased waiting times due to social distancing measures,

[19] *Ibid., pp* 12-13.
[20] Ateva, *supra* note 14.

slower services and overcrowding in public maternity hospital wards.[21] Lower quality of care was also reported by female sex workers in the BHESP study for post-natal care.[22]

4.3. Family Planning Services and Commodities

The WRA Kenya study reported that availability of family planning commodities was severely affected, especially in Kisumu county.[23] Both healthcare workers and sex workers in the BHESP study reported that family planning commodities were unavailable especially pregnancy test kits, birth control implants and family planning injectables, and this disrupted availability of family planning follow-up services within public health facilities.[24] Women also noted that they were unable to access family planning services due to economic constraints. Sex workers who received free family planning services and commodities from drop-in centres[25] reported that they could not access services due to the cost of transport as well as preventive directives such as partial lockdowns and movement restrictions.[26] Five per cent of the female respondents in the study on the effect of COVID on the youth noted that they could not access emergency contraception.[27]

4.4. Incidences of SGBV

63 per cent of the respondents in the study on gendered implications of COVID-related corruption felt that greater economic hardship had led to increased incidences of domestic violence and increased sexual exploitation of underage girls in exchange for basic needs. Police posts in certain areas in Nairobi reported increased helpline and emergency calls related to domestic violence since the outbreak of the pandemic in March 2020.[28] Healthcare workers in the BHESP study observed that young sex workers were being coerced into discontinuing family planning methods.[29] These findings are consistent with reports from the United Nations Office of the Coordination of Humanitarian Affairs that there have been increased incidences of sexual abuse and domestic violence,[30] as well as anecdotal evidence from community organisers in informal settlements in Nairobi.[31]

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[21] Oluoch-Aridi, *supra* note 15.
[22] Gichuna, *supra* note 17.
[23] Ateva, *supra* note 14.
[24] Gichuna, *supra* note 17.
[25] Drop-in centres are civil society hosted safe spaces to provide services, including HIV testing, STI screening and treatment, prevention commodity distribution among others, especially aimed at key and affected populations such as sex workers and men who have sex with men. *See* Differentiated Service Delivery, '*Optional drop-in centres',* <differentiatedservicedelivery.org/Models/OptionalDropInCentres> visited on 23 February 2021.
[26] Gichuna, *supra* note 17.
[27] Amref Health Africa, *supra* note 16, pp. 4-5.
[28] Mzalendo Trust, *supra* note 18, p. 11.
[29] Gichuna, *supra* note 17.
[30] United Nations Office of the Coordination of Humanitarian Affairs, '*Kenya Situation Report*' <reports.unocha.org/en/country/kenya/#cf-2rC8ktJetxZ4Z8kaabrv0s> visited on 15 March 2021.
[31] United Nations Office of the High Commissioner for Human Rights, '*On the Frontlines: Defending Rights in the Time of COVID-19*' <www.ohchr.org/_layouts/15/WopiFrame.aspx?sourcedoc=/Documents/Issues/Women/WRGS/DefendingRightsinthetimeofCovid-19.pdf&action=default&DefaultItemOpen=1>, visited on 13 February 2021, pp. 22 and 27.

5. Analysis and Discussion

On 1st April 2020, in light of its obligation under Article 21(2) to undertake legislative and policy measures towards the progressive realisation of the right to health, the Ministry of Health published the Kenya COVID-19 RMNH (Reproductive, Maternal, Newborn Health) Guidelines (the Guidelines).[32] These were to serve as a practical guide for the continuity of reproductive, maternal, newborn and family planning care and services against the backdrop of the COVID-19 Pandemic. These guidelines were a timely effort to address the need to guarantee access to sexual and reproductive health services and safeguard gains made towards guaranteeing access to sexual and reproductive health and rights.

The guidelines proved problematic in three areas: firstly, the failure to provide for comprehensive abortion care and post abortion care (the guidelines are silent on this). Research on abortion in Kenya, to which this Ministry contributed and was a study partner, found that there were around 464,000 abortions induced in 2012; translating to an abortion rate of 48 per 1,000 in women aged 15 to 49.[33] Further, it was estimated that around 120,000 women are hospitalised in Kenya each year due to abortion related complications. Further research carried out by the Ministry of Health and the Africa Population and Health Research Council has shown that the cost of unsafe abortions borne by the Public Sector each year is estimated at KES 533 Million with 58 per cent of the cost being towards the cost of the personnel and 42 per cent of this cost being allocated to medication and other related costs.[34] Given that abortion and abortion care are a significant burden on our public health system and an inability to access both safe and legal abortion and post abortion care puts the lives of many women and girls in danger this omission was concerning. In an attempt to address this gap civil society actors brought this to the attention of the Ministry of Health through a letter on 28 April 2020 which went unanswered.[35]

Second, the guidelines failed to provide directives on how to access emergency health treatment in light of the nationwide curfew, between the seven o clock in the evening and five o'clock in the morning, in force at the time.[36] The Order specified exempt services and personnel including health workers, but made no provision for people seeking emergency health services. The guidelines provided telemedicine as an alternative during lockdowns, curfews or emergency restrictions and guided that communities devise ways of ensuring that women in labour or experiencing pregnancy emergencies could reach the nearest hospital without restrictions or threats to their safety.[37] However, telemedicine cannot adequately

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[32] Ministry of Health, *'Kenya COVID-19 RMNH Guidelines: A Kenya Practical Guide for Continuity of Reproductive, Maternal, Newborn and Family Planning Care and Services in the Background of COVID-19 Pandemic'*,<kenya.unfpa.org/sites/default/files/pub-pdf/KENYA%20-%20COVID19%20RMNH%20GUIDELINES.pdf >, visited on 13 February 2021.

[33] Ministry of Health and the African Population and Health Research Council, *'Incidence and complications of unsafe abortion in Kenya'*, <www.guttmacher.org/sites/default/files/report_pdf/abortion-in-kenya.pdf>, visited on 15 February 2021.

[34] Ministry of Health and the African Population and Health Research Council, *'The costs of treating unsafe abortion complications in public health facilities in Kenya'*, <aphrc.org/wp-content/uploads/2019/07/The-Costs-of-Treating-Unsafe-Abortion-Complications-in-Public-Health-Facilities-in-Kenya_Final.pdf.>, visited on 15 February 2021.

[35] Unpublished Letter dated 28th April 2020, authored by Women's Link Worldwide and co-signed by KELIN, Amnesty International, Boda Boda Association of Kenya amongst others.

[36] The Public Order (State Curfew) Order, 2020

[37] Ministry of Health, *Kenya COVID-19 RMNH Guidelines*, *supra* note 32, para. 4.

address the needs of survivors of SGBV or pregnant women who go into labour at curfew hours. Moreover, the government placed the onus on communities to ensure the safety of pregnant women seeking emergency treatment during curfew hours[38] when law enforcement and local authorities have been the main perpetrators of harassment.[39] In fact, one of the lives lost to police brutality was a young man who was ferrying an expectant woman to a health centre for delivery.[40]

Having noted the gaps in the policy framework we will now analyse whether or not Kenya met its obligations to secure and guarantee sexual and reproductive health services in line with the AAAQ framework informed by our study findings:

5.1. Availability

Generally, public health outbreaks have a detrimental effect on the availability of SRHR services and commodities due to strained public health systems, diversion of resources from SRHR services and disruption of supply chains of SRHR commodities.[41] This is particularly dire as the public health sector is a major provider of SRHR in Kenya providing contraception to six out of 10 current users;[42] and 46 per cent of live births happening in public sector hospitals.[43] At the onset of the pandemic in Kenya, civil society urged the government to protect essential health services for women and girls including SRHR in recognition of the fact that SRHR is part and parcel of the right to health.[44]

Even before the pandemic hit, Kenya was failing to ensure that SRHR services were available, with some counties even lacking budget lines for family planning.[45] The combined findings in section 3 above point to Kenya having followed this trend with SRHR services including family planning services and certain post-natal services that were deemed non-essential. Availability of contraceptives and other family planning commodities was severely affected as well. IPSOS surveys conducted in June reflected that there were supply side constraints that affected availability of SRHR services including facility closures, unavailable treatments or being turned away from facilities.[46]

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[38] *Ibid.*
[39] Ateva, *supra* note 14.
[40] Defenders Coalition, *'Situation of Human Rights Defenders in the Wake of COVID-19'* <crd.org/wp-content/uploads/2020/04/COVID-19-impact-in-Kenya.pdf> para. 3, visited on 1 March 2021.
[41] Guttmacher Institute, *'Estimates of the Potential Impact of the COVID-19 Pandemic on Sexual and Reproductive Health in Low and Middle-Income Countries*', <www.guttmacher.org/sites/default/files/article_files/4607320.pdf>, visited on 6 March 2021.
[42] Kenya National Bureau of Statistics, '*2014 Kenya Demographic Health Survey*' <www.nutritionhealth.or.ke/wpcontent/uploads/Downloads/Kenya%20Demographic%20and%20Health%20Survey%20KDHS%20Report%202014.pdf>, p. 97, visited on 6 March 2021.
[43] *Ibid.*, p. 8.
[44] KELIN, *supra* note 3.
[45] C. Baswony, '*Counties in Kenya Make Progress Towards Achieving Family Planning Funding Commodities'*, <www.dsw.org/en/2019/03/dsw-partner-counties-in-kenya-make-progress-towards-achieving-family-planning-funding-commitments/>, visited on 12 March 2021.
[46] Program for Appropriate Technology in Health (PATH), ' *Essential Health Services during and after COVID-19: A Sprint Analysis of Disruptions and Responses across Six Countries*' <path.azureedge.net/media/documents/EHS_sprint_intro_and_full_report_revised-compressed.pdf> visited on 13 March 2021.

Human resources for health have also been stretched and/or diverted to the COVID response with routine SRHR services suffering as a result.[47] This situation has been further exacerbated by the numerous health worker strikes in the past year with the joint unions of nurses, clinical officers and medical practitioners issuing multiple strike notices on 4 May 2020, 20 August 2020, and as individual unions in November 2020 demanding provision of health and risk insurance, quality PPEs and, isolation and treatment centers for health workers.[48] Public sector nurses, the largest cadre of health workers, were on strike for 79 days.[49]

Comprehensive SGBV care was also rendered unavailable as safe houses and shelters were overstretched and overwhelmed.[50]

5.2. Accessibility

The combined results found that the pandemic has negatively affected the physical, economic, and information accessibility of SRHR services and commodities. The government put in place a number of directives that affected physical accessibility of services including movement restrictions in counties with high rates of infection[51] and nationwide curfews. Female sex workers reported being unable to access free SRHR services and commodities at drop in centers due to movement restrictions into Nairobi. Movement restrictions during curfew limited women and girls' access to SRHR services in case of emergencies as they feared threats and harassment from overzealous law enforcement. Even if a woman was willing to risk it, transport providers were unable or unwilling to take pregnant women in labour to health facilities for fear of harassment.[52]

SRHR services and commodities were also economically inaccessible. Research shows that the primary effect of lockdowns and stay-at-home is economic[53] and the impact is highly gendered with young women and girls being most affected.[54] Women in the various study analysed noted that they experienced reduction in means of livelihood due to the pandemic. Women noted difficulties finding sources of income, job loss, reduction in salaries and wages, and difficulty accessing stimulus packages put in place for vulnerable groups.[55] Sex workers and BHESP also

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[47] PATH, 'RMNCAH-N Services during COVID-19: A Spotlight on Kenya's Policy Responses to Maintain and Adapt Essential Health Services', <path.azureedge.net/media/documents/Kenya_RMNCH_Deep_Dive_brief.pdf>, p. 3, visited on 15 March 2021.

[48] 'Health workers in Kenya set to embark on strike on 7 December' *People's Dispatch*, 25 December 2020, <peoplesdispatch.org/2020/11/25/health-workers-in-kenya-set-to-embark-on-strike-on-december-7/>, visited on 12 March 2021.

[49] I. Omondi, 'Nurses ordered to report back to work immediately as strike called off', *Citizen Digital*, 24 February 2021,<citizentv.co.ke/news/nurses-ordered-to-report-back-to-work-immediately-as-strike-called-off-7111540/>, visited on 12 March 2021.

[50] Equality Now, *'COVID-19 Conversations: The Need for Safe Shelters in Kenya'*, <www.equalitynow.org/kenya_shelters>, visited on 22 March 2021.

[51] The Public Health (COVID-19 Restriction of Movement of Persons and Related Measures) Order, 2020

[52] N. Warega and L. Muthiani, 'Roadblocks to Health Care for Women During COVID-19 in East Africa', *Global Voices*, 15 June 2020, <globalvoices.org/2020/06/15/part-ii-roadblocks-to-health-care-for-women-during-covid-19-in-east-africa/>, visited on 18 March 2021.

[53] Oluoch-Aridi, *supra* note 15.

[54] Performance Monitoring for Action, '*Study reveals stark gendered social and economic impacts of COVID-19 for youth in Kenya'*, <www.pmadata.org/news/study-reveals-stark-gendered-social-and-economic-impacts-covid-19-youth-kenya-0>, visited on 21 March 2021.

[55] Mzalendo Trust, *supra* note 18, p. 10.

noted a reduction in income because of the curfew restrictions[56] and there is anecdotal evidence that suggests that they were excluded from receiving stimulus packages from the government.[57] Economic constraints also contributed to an increase in transactional sex and sexual exploitation of young women in exchange for basic needs.

Vulnerable and marginalised populations were also unable to access SRHR services and commodities due to stigma and discrimination. Sex workers are a criminalised population in Kenya which places them in a uniquely vulnerable position. Sex workers who were unable to access drop-in centers noted that they could not visit public health facilities to seek family planning services for fear of discrimination, being turned away and/or receiving lower quality of care.[58] Moreover, social and cultural narratives affect adolescent access to SRHR and adolescent girls and young women reported being turned away from public health facilities when seeking contraception for being too young.[59] After reports of a worrying rise in teenage pregnancies, the President ordered a nationwide crackdown on clinics offering emergency contraceptives to underage girls, stating that they offered minors 'sexual insurance' for promiscuity,[60] despite the statistics that show that sexual violence affects around a third of pregnant girls.[61] In the KELIN-led study, youth reported that youth-friendly facilities were inaccessible hindering their access to SRHR.

5.3. Acceptability

The Guidelines provided telemedicine as an alternative for physical access to health services. It is unclear whether the government consulted with women to determine whether telemedicine was an acceptable and effective alternative.[62] Moreover, the guidelines make no mention of how the privacy of users' and their personal health information would be protected.

5.4. Quality

The combined findings of the studies also pointed to reduced quality of care for SRHR services. Women noted that the quality of certain maternal health services especially post-natal services were reduced due to the public health system being overstretched. Women also reported lower quality for inpatient maternity services as the maternity wards were overcrowded and understaffed.[63]

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[56] Gichuna, *supra* note 17.
[57] Personal Interview with Sex Worker in Mombasa, 18 February 2021.
[58] Gichuna, *supra* note 17.
[59] *Ibid.*
[60] J. Omondi, 'President Kenyatta orders crackdown against clinics offering contraceptives to underage girls', *CGTN Africa*, 28 July 2020, <africa.cgtn.com/2020/07/28/president-kenyatta-orders-crackdown-against-clinics-offering-contraceptives-to-underage-girls/>, visited on 28 February 2021.
[61] Plan International, '*COVID-19: Lockdown Linked to High Number of Unintended Teen Pregnancies in Kenya'* <plan-international.org/news/2020-06-25-covid-19-lockdown-linked-high-number-unintended-teen-pregnancies-kenya>, visited on 3 March 2021.
[62] PATH, *supra* note 47, p. 6.
[63] Oluoch-Aridi, *supra* note 15.

6. Recommendations

From our analysis we are able to pick out significant gaps in guaranteeing availability and accessibility of sexual and reproductive health services; and while acceptability and quality of services also came into question the evidence around a shortfall on these two areas was limited. Understanding the obligation on the State we would recommend as follows:

1) Firstly, Kenya should seek to protect essential health services for women and girls, recognising that sexual and reproductive health services are essential. The country should make provision for the comprehensive health care of women in all stages of pregnancy; and prioritise services for prevention and response to gender-based violence. The cumulative study findings show both supply and demand side barriers of access to services; and with the supply side the State should work towards defining an essential package of sexual and reproductive health services that is guaranteed in both national and county policy frameworks and budgets and that are protected from deviation in instances of emergency.
2) Secondly, the need to provide timely, accurate and transparent communication on both our risk as a country and on the availability and continuity of services. While the Guidelines were indicative that telemedicine would be an alternative to physical services the study findings around persons being turned away for maternal and early child health services are indicative that there was not a shared understanding of this. It is important to not only put frameworks in place but additionally, there must be significant efforts to disseminate the information and ensure that citizens and residents are aware and have access to information to inform their decision making around access to health services. We have seen similar gaps from the experience in the Democratic Republic of Congo in the management of the Ebola epidemic which resulted in persons refusing to seek treatment and clinics being affected with death threats as well as community members believing that the epidemic was a government scheme.[64] The Guidelines were necessary but we recommend that such guidelines are not only drafted and published expeditiously but also with the buy-in from County governments who would then carry the burden of disseminating them at local level.
3) Thirdly, is the need to gender pandemic responses, because health crises affect women and men differently either due to biological or societal factors. Kenya put in place regulations to restrict movement, encouraged working from home, as well as requiring social distancing and the impact of this was increased transportation costs and reduced access to economic activities resulting in women and girls not being able to afford reproductive health services. Therefore, it is significant not only seek to secure the availability of services and to check the costs of services at the point of service delivery but the State must also analyse the increased costs pandemic restrictions may have on women and girls and develop mechanisms to address that so as to secure access to sexual and reproductive health services.
4) Additionally, Kenya must stop straddling the fence around access to abortion and work towards the implementation of Article 26(4) of the Constitution that guarantees access

[64] On sharing accurate and timely information, *see* H. Legido-Quigely, N. Asgari, Y.Y Teo, G. Leung, H. Oshitani and K. Fukuda, 'Are high performing health systems resilient against the COVID-19 Pandemic', 395: 10227 *The Lancet* (2020), <www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30551-1/fulltext>, visited on 12 March 2021. *See also* Nature, *'Building trust is essential to combatting Ebola outbreak',* <www.nature.com/articles/d41586-019-00892-6>, visited on 23 March 2021.

to safe abortion.[65] The omission of comprehensive abortion care and post abortion care from the Guidelines is part of continuing conduct by the Ministry of Health to undermine the Constitution and the rights of women and girls. There is a constitutional obligation to guarantee access to these services and this has to be apparent in policy documents.

5) Finally, Kenya must take lessons from this Pandemic and previous pandemics to strengthen its policy around discriminative practices that result in barriers of access to services for vulnerable populations. This was particularly problematic for adolescent girls and sex workers and the response from the State in increase of unintended teenage pregnancies was both denialist and short sighted. The concerns around teen pregnancies were exacerbated by the Pandemic but they are not a new problem and the refusal to learn from crises in the past such as HIV where a rights based approach is encouraged is significant in that we will continue to lament about the same things.

7. Conclusion

Pandemics and their responses impact communities differently, and a pandemic and its response can have the impact of heightening the marginalisation of communities that are already vulnerable. Women and girls in Kenya are a vulnerable population that is protected by the Constitution, and Kenya has an obligation to not only protect every person's right to health but to do so in a manner that takes cognisance of the different needs women and girls have. Kenya has made significant strides in managing the COVID-19 Pandemic but has fallen short of doing so in a differentiated manner that protects the rights of women and girls.

[65] For an analysis of the Kenyan government's reluctance to make access to safe abortion a reality in Kenya, *see* N.A. Were, L. W. Kroeger and T.G. Saoyo, 'Unmasking patriarchy: The family and traditional values discourse and the quest for reproductive health and rights of women' in C. Kioko, R. Kagumire and M. Matandela (eds.), 2020, *Challenging patriarchy: The role of patriarchy in the roll-back of democracy* (Heinrich-Böll-Stiftung, Nairobi, 2020), pp. 21 to 33, <www.ke.boell.org/sites/default/files/2020-05/Final%20copy-%20Challenging%20Patriarchy%20.pdf..> , visited on 22 March 2021.