10 May 2021

I have the honour to address you in my capacity as Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, pursuant to Human Rights Council resolution 42/16.

I would like to invite you to respond to the questionnaire below. Submissions received will inform my next thematic report on the right of everyone to sexual and reproductive health – challenges and opportunities during COVID-19, which will be presented to the UN General Assembly in October 2021.

The questionnaire on the report is available at OHCHR website in English (original language) as well as in French, and Spanish: (<https://www.ohchr.org/EN/Issues/health/pages/srrighthealthindex.aspx>).

All submissions received will be published in the aforementioned website, unless it is indicated that the submission should be kept confidential.

There is a word limit of 3000 words per questionnaire. Please submit the completed questionnaire to srhealth@ohchr.org. The deadline for submissions is: **10 June 2021.**

Tlaleng Mofokeng

Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

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**Contact Details**

Please provide your contact details in case we need to contact you in connection with this survey. Note that this is optional.

|  |  |
| --- | --- |
| Type of Stakeholder (please select one) | [ ]  Member State [ ]  Observer State[x]  Other (please specify) partnership of non government organisations and university |
| Name of StateName of Survey Respondent | KenyaDr Fiona Bloomer, Ulster University |
| Email | Fk.bloomer@ulster.ac.uk |
| Can we attribute responses to this questionnaire to your State publicly\*? \*On OHCHR website, under the section of SR health |  **Yes**  NoComments (if any): |

**QUESTIONNAIRE**

# Background

The right to sexual and reproductive health is an integral part of the right to health enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights and a key priority theme for the work of the Special Rapporteur on the right to physical and mental health during her tenure.

The Special Rapporteur, Tlaleng Mofokeng will focus her next thematic report to the General Assembly on “The right to sexual and reproductive health – challenges and opportunities during COVID – 19”.

# Objectives of the report

With her report, the Special Rapporteur intends to shed light on the current status/level of realization of the right to sexual and reproductive health and the availability, accessibility, acceptability and quality of related services, during the COVID-19 pandemic. Building on the work and previous reports of the mandate, she aims to further develop understanding of the structural and systemic issues preventing all persons from freely and fully enjoying the right to sexual and reproductive health.

She will focus on elements historically neglected, including the impact of colonialism and racism in the enjoyment of these right, with an intersectional approach and will also analyze the impact of COVID -19 and related policies, legal developments and practices on access to sexual and reproductive health services. She will also aim to present challenges and opportunities in the operationalization of the right to sexual and reproductive health in the current context of pandemic.

*For the purpose of this questionnaire:*

*The* ***Right to sexual and reproductive health*** *entails the right to make free and responsible decisions and choices, free of violence coercion and discrimination regarding matters concerning one’s body and sexual and reproductive health. It also entails entitlement to unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health under article 12 of CESCR.*

***Sexual reproductive health care*** *refers to services, goods and facilities including:*

* *Pregnancy and post-natal related services*
* *Family planning and contraception, including access to safe abortion*
* *Prevention, diagnosis and treatment of reproductive cancers, sexually transmitted infections, and, HIV/AIDS*
* *Hormonal treatments*
* *Gender affirming treatments*
* *Access to information on all aspects of sexual and reproductive health issues.*

This response has been prepared by the project team from ‘Radical Abortion Care in a Pandemic’, which focuses on Zambia and Kenya. Project partners are:

|  |  |  |
| --- | --- | --- |
| Name | Organisation  | Country |
| Brian Chiluba  | Decisive Minds / University of Zambia/  | Zambia |
| Roy Lukama  | Decisive Minds / Zambia Royal Medical University | Zambia |
| Keratin Mwai Mwai |  Independent consultant | Kenya |
| Phyllis Ndolo   | Women Spaces Africa  | Kenya |
| Lilian Kivuti | Women Spaces Africa  | Kenya |
| Emma Campbell | Alliance for Choice | Northern Ireland |
| Fiona Bloomer | Ulster University | Northern Ireland |

Our analysis of Zambia is ongoing and due for completion by the end of June 20 21. This report focuses on the Kenyan context. In our response we draw on findings from a review of policy legislative and research publications[[1]](#footnote-2). A full copy of the review is attached alongside a global review of the policy context.

# Key questions

1. Since the beginning of COVID-19 pandemic, States have adopted new policies, laws and other measures in response to the crisis. Please refer to the relevant measures in your country (or countries in focus) and their impact on the right to sexual and reproductive health. Please share information on opportunities and challenges.

**Pre-pandemic**

1. In Kenya the legal context regarding abortion is complex. A Kenyan girl or woman can receive ‘post-abortion’ care legally in all public health facilities, but she cannot get safe legal access to any abortion services whether in a public or private health facility. It has been a contentious issue that arouses public debate about morality in a mostly traditional and religious conservative African society.
2. For many years legislators and policy makers lacked the political goodwill to create a legal framework to domesticate updated WHO international guidelines and other related regional protocols regarding safe abortion as part of fundamental reproductive health rights. For instance, the East African Community Sexual and Reproductive Health Rights Bill of 2017, is a regional legal instrument that Kenya is obliged to adopt to improve the legal and policy situation of abortion in tandem to the Maputo Plan. However, Kenya still lacks an operational guideline in accordance with part III section 15 of the bill, which states that partner countries have a mandate to protect and facilitate a woman’s reproductive rights by permitting abortion based on the recommendation of a trained medic (Federation of Women Lawyers, 2019)[[2]](#footnote-3).
3. Despite all the existing legal laws including the Constitution, amendments and policy briefs, it took a ruling in 2019 High Court of Kenya Constitutional and Human Rights Division to enforce Kenya's obligation to provide legal abortion services (the JMM case).
4. The JMM case provided a comprehensive ruling that the blanket prohibition of abortion under the Penal Code cannot stand because it is inconsistent with the provisions of the Constitution as well as the Sexual Offences Act. Kenya’s refusal to be bound by Article 14 (2) (c) of the Maputo Protocol to the African Charter on Human and People’s Rights has no effect to the extent that those provisions of the Protocol mirror those in Article 26 (4) of the Constitution of Kenya, which is binding. Trained health professionals permitted by the Constitution to make an opinion that an abortion is necessary include nurses, clinical officers and midwives in addition to doctors and specialist obstetrician gynaecologists. The court agreed with and adopted the World Health Organisation’s definition of health to mean “a state of complete physical, mental and social well-being, and not only the absence of disease or infirmity” (Center for Reproductive Rights, 2019).
5. **Despite what appears to be a straightforward legal position that the High Court ruling on the JMM case provides, studies show that one fifth of women in Kenya do not know abortion is legal. This lack of information highlights the first barrier to access to safe abortion services in the country.**
6. It is reported that 41 percent of unintended pregnancies in Kenya will end in an abortion, resulting in approximately 500,000 abortions each year. As a result, maternal mortality is high with about 6,000 deaths per year, 17 percent of which are due to complications stemming from unsafe abortion practices. These statistics are primarily ascribed to a lack of information on access to safe abortion and post-abortion care as women are not aware of what options may be available to them or the health complications they may be facing should they opt for back-alley abortions. (Privacy International’s Global Research, 2020)[[3]](#footnote-4).
7. The secrecy associated with abortions in the country perpetuate the idea that abortion care is an illegal and illicit “back door” activity which often leads to unsafe abortions. This is a direct consequence of health providers not receiving training on how to administer safe abortion care and not knowing whether or not they can legally do so, thereby creating a barrier of access to abortion care services. Though the withdrawal of the guidelines and the memo were successfully challenged in court, the Ministry of Health is yet to fully comply with the ruling. It has also been reported that despite the ruling many Kenyans, including health, practitioners continue to be ignorant about the contents of the Guidelines. (Privacy International’s Global Research, 2020)
8. Socio-economic factors also play a role in the exercise of sexual and reproductive rights. Safe abortion care in clinics is said to cost about 20,000 Kenyan shillings, whereas unsafe abortions are roughly a tenth of that price. It is clear that women from poorer communities will therefore suffer as they cannot afford to pay for a safe abortion and will have no choice but to resort to back-door abortions. The African Population and Health Research Center calculated that in 2012 the Kenyan government spent an estimated US $5.1 million treating women who had developed complications from unsafe abortion in public health facilities, a number that increased to about $6.3 million in 2016. It would probably cost less for the Kenyan government to provide affordable abortion services than it does to treat the complications borne by unsafe abortions in the country. (Privacy International’s Global Research, 2020)
9. Reorganisation of the public health system at county and national levels in response to COVID-19 requires adequate resourcing to meet sexual and reproductive healthcare needs of women and girls. Unfortunately, in 2018, the United States cut aid to foreign family planning programs which left many women in Kenya without affordable access to contraceptives leading to many resorting to back-door and unsafe abortions. This foreign policy change acted as a blanket ban for the use of foreign aid funds for abortion care under any circumstances and affected notable providers of sexual and reproductive health services in Kenya. (Privacy International’s Global Research, 2020)[[4]](#footnote-5).
10. In addition, the Trump administration restored the Mexico City Policy or ‘Global Gag rule’ which required all non-governmental organisations’ operating abroad to cease the provision of pregnancy by choice initiatives or risk being denied federal funding. The policy which was intended to reduce the number of abortions instead had the opposite effect. Lack of funding due to the above policies has closed clinics and curtailed family planning and maternal child healthcare services thereby frustrating the affordable access to safe abortion care services. (Privacy International’s Global Research, 2020)
11. Another barrier to safe abortion care is the stigma which is partly fuelled by gender stereotypes. Societal attitudes towards women who access abortion care remain largely negative and studies show that psychosocial and cultural barriers are to blame for women not seeking abortion care from healthcare facilities. The fear of stigmatisation founded on negative religious and cultural beliefs held constitutes a major barrier to the access of safe and legal abortion care. (Privacy International’s Global Research, 2020)

**Pandemic**

1. The Ministry of Health in Kenya has issued directives, protocols and guidelines, such as screening all patients at entry points before they enter facilities, to curb virus spread while accessing SRH services. The Ministry has also conducted sensitisation and training for service providers on how to handle suspected COVID-19 cases who may present to their facilities. In addition, it has provided reproductive health facilities in the respective counties with hotlines for reporting suspected cases and a directory of quarantine facilities in each county.
2. The Ministry of Health has provided a guideline to offer practical consideration of both preventive and clinical aspects of safe continuity of quality Reproductive, Maternal, Newborn and Family planning services during the COVID-19 Pandemic in Kenya. This guide borrows from various international recommendations; including the World Health Organisation, preceding country COVID-19 response guidelines by MOH, as well as from experience of other countries such as China, Europe and America that have struggled with the evolving impact of the outbreak a little earlier and in a more severe form than is presently being witnessed here in Kenya. As experience and knowledge on COVID-19 is rapidly evolving, it is expected that these interim guidelines will be updated periodically as significant new information becomes available (MOH, April, 2020)[[5]](#footnote-6).
3. Family planning remains an essential service and continuity of care remains a key focus. To guard the safety of clients and providers while relieving pressure on health facilities during the COVID-19 pandemic, rational use of contraceptive methods to deliberately prevent infection or transmission of COVID-19 has been encouraged. Elective surgical contraception is suspended and where applicable, removal of long-acting methods deferred. Due to the high risk of perpetuating community transmission of COVID-19 infection, community-based distribution of contraceptives is restricted to condoms and oral pills. For the same reason, community family planning outreach services are suspended. Care for gender-based violence survivors remain a priority and an essential service.
4. A situational analysis conducted in a rural pastoralist community had some noteworthy findings, since the beginning of COVID-19, routine maternal services in Kajiado County have come under threat because of competing tasks in the health facilities where more energy has been focused on COVID-19. Some of the effects on delivery SRH include: reduced access to family planning services; increased sexual and gender based violence; increased child marriages; increased teenage pregnancies; female genital mutilation and other harmful cultural practices; higher risk of increase of maternal and perinatal mortality due to reduced access to SRH services caused by restriction of movement due to current lockdown or curfews imposed by the government and fear of contracting the virus; and increased maternal mortality due to home deliveries caused by curfews. There has been a reduction in the use of family planning services among adolescents. The 15–19 age bracket appears to be having difficulty in accessing family planning compared to the 20–24 age group. This correlates with increased teenage and adolescent pregnancy, which went up from 29% in 2018 to 34% in 2019, although early indications are that the 2020 figure will be lower, perhaps because of higher access to services during the pandemic. (Likalamu, 2020)
5. As previous noted the costs of safe abortion services are too high for many girls and women seeking those services. After the withdrawal of the 2012 standards and guidelines for reducing morbidity and mortality related to unsafe abortion in Kenya, only private health facilities offer safe abortion services, albeit in secret for fear of victimisation and harassment. This has made access to safe abortion too expensive and out of reach for most girls and women in need of the services.. This exposes Kenyans to unsafe services black-market which are mostly conducted through self-prescription or in the hands of unqualified and ill-equipped individuals. (Federation of Women Lawyers, 2019)[[6]](#footnote-7)
6. Comprehensive national data on the impact of COVID-19 on teen pregnancy rates are not yet available. At least anecdotally, though, some healthcare providers suspect a coronavirus effect. Increased barriers to accessing safe services: due to quarantines, self-isolation rules, school closures which impact caring responsibilities, travel bans, borders closing, and reduction in-availability of public services, it has become more difficult for both providers and clients to travel to deliver or receive safe abortion and contraceptive care, impacting people’s SRH in particular. With school closures, Comprehensive Sexuality Education programs that assist adolescents in understanding and accessing SRH care and rights have also been curtailed. Furthermore, economic insecurity for many, in particular those already living in vulnerable situations, is increasing as a result of the pandemic, leading to greater difficulty in paying for care.
7. National lockdowns have also led to disruptions to reproductive supply chains, leading to an increasing shortage of abortion medications and contraceptives and further limiting individuals’ ability to access abortion and contraceptive care that suits their needs and preferences. A shortage of health care providers and increased waiting times for procedures considered to be non-emergency care, are also making it harder for individuals to access care, particularly in public facilities. In tandem, emergency reproductive and maternal health services are affected by over-stretched facilities and staff. There is a remaining risk of diversion of funds from critical SRH programs due to competing government and donor priorities.
8. The Kenyan healthcare system has now shifted focus to COVID-19 response, a move that is likely to jeopardise access to SRH services which are not deemed a priority in the face of the COVID-19 crisis. Requirements of social distancing, consistent wearing of masks and regular sanitising has limited the number of face-to-face consultations and physical public sensitisation activities. However, it has led to increase in use of tele-counselling and use of social media including Twitter, Facebook and WhatsApp to share information, conduct online comprehensive sexuality education (CSE) by trained CSE facilitators to young people, and referrals to designated accessible health facilities for SRH services through SMS text interventions.
9. During the period of the first 6 months of the locked down through implementing a virtual training, the MAMA network supported the launch of 6 hotlines including here in Kenya. These hotlines in their first days of implementation recorded a minimum of 5 calls a week with the highest number being 22 calls. Despite access to limited resources hotlines through peer-to-peer learning mentorship from more established hotlines have adopted new and improved marketing strategies while constantly updating their posters, IEC material and interactive posts and campaigns on social media (Ebankali, December, 2020).
10. This pandemic has also created new opportunities for online counselling, referral and information platforms such as Safe2Choose to leverage the power of the digital revolution and the increased in the local smartphone market penetration and access to cable and wireless internet. As and when needed Safe2choose refers women to trusted, trained and pro-choice healthcare providers close to their location for safe and empathetic abortion care. In 2020 Safe2Choose also opened a TikTok account and a YouTube channel and has collaborated with influencers to target younger audiences with relatable content. In the same year (2020) it counselled 441 and referred 382 Kenyans (Diaz, December,2020).
11. Technology has significantly evolved and changed trends in the health sector. Patients are now able to secure appointments and receive medical appointments online. The Kenyan Health Act 2017 defines tele-medicine as the provision of healthcare services and sharing of medical knowledge over distance using telecommunications, including consultative, diagnostic and treatment services. In the wake of COVID, the sexual and reproductive health arena has equally seen creative evolutions in access to safe abortion with organisations advancing the use of misoprostol through online platforms. This route has been lauded as encouraging access to otherwise highly restrictive services. This form has farther been appreciated as discreet and thus protecting the true identity of the woman/girl and maintaining her privacy. Legal and ethical issues surrounding access to misoprostol via online websites are yet to be critically nuanced in Kenya. Online dispensation of abortion-related drugs is premised on the presumption that the pregnancy’s gestational period has been ascertained. In the wake of teenage pregnancies, irregular period cycles and sexual violence where young girls and survivors respectively are often unsure of the exact date of last period, online platforms run the risk of prescribing an overdose of misoprostol to an unsuspecting client who maybe more eager to have the pregnancy terminated than ascertain the gestational period. Additionally, not all existing online platforms are linked to physical facilities where patients can be referred to should complications arise. As a result of such gaps patients with adverse reactions to misoprostol risk over bleeding in the silence of their homes for fear of prosecution, stigmatisation or victimisation if they present themselves at facilities that are not sensitive to abortion issues legally the use of the online platforms not only presents a probable cause for worry due to the above complications but also the risks of lawsuits for medical malpractice (Saayo, Leteipan, & Sibande, December, 2020)[[7]](#footnote-8).
12. It’s important to note due to the social inequality digital divide between urban and rural youth, avenues for offering SRH services and commodities to AGYW have been increased, for instance, through the use of Community Health Volunteers in remote regions and/or informal settlements where internet isn’t available. Through homebased approach using community key resource persons marginalised youth such as adolescent and young women with disability have had increased and sustained access to basic SRH products such as condoms and oral pills and safe abortion information and knowledge (Mirzoyants, Thuku, Kapi, Namalenya, & Antillon, December, 2020).
13. ~~Please also specify legal or other measures introduced during the pandemic aiming at recognizing, or restricting, banning or criminalizing: a) access to legal abortion; b) consensual sex between adults; c) same sex sexual relations, d) consensual sex between adolescents of similar ages, e) sex work, f) same sex marriage, g) information on the right to sexual and reproductive health; h) HIV transmission and i) autonomy and free decision making on one’s body and sexual and reproductive health.~~
14. Regarding sexual and reproductive health care, what services, goods and information is being provided in your country (or countries in focus), during the pandemic?
	1. Any changes compared to pre-COVID 19? Has any service, good or information been deprioritized or defunded? Who is this affecting in particular?
	2. Please explain if there has been any impacts on the availability, accessibility, acceptability or quality of sexual reproductive services during COVID – 19.
	3. Please also share information on other practical obstacles or challenges to access sexual reproductive services during the pandemic, and who were most affected.
	4. Please also share good practices and opportunities in the provision of sexual and reproductive health care during the pandemic.

We have identified pre-COVID-19 context and challenges faced during the pandemic regarding SRH. On abortion, these include:

**Pre-COVID-19**

* + Lack of public knowledge on the legal status on abortion
	+ Lack of health professional knowledge on the legal status on abortion
	+ Prohibitive costs in accessing safe abortion
	+ Abortion stigma
	+ Restricted or removal of funding from international donors

**During COVID-19**

* + Curtailment of SRH services
	+ Curtailment of Comprehensive Sexuality Education programs
	+ Disruptions to reproductive supply chains, leading to an increasing shortage of abortion medications and contraceptives limiting individuals’ ability to access abortion and contraceptive care that suits their needs and preferences.
	+ A shortage of health care providers
	+ Increased waiting times for procedures

**Positive developments during COVID-19**

* + Increase in use of technology to raise awareness of tele-medicine, however this is limited to those with access to IT

In the next phase of the project the research team seek to explore the direct experience of stakeholder groups such as activists, abortion providers and pharmacists on the impact of COVID-19 on access to abortion.

1. ~~In connection to questions 1 to 3, please also share other relevant information on legal, policy or other changes affecting the right to sexual and reproductive health and related health care in your country or countries in focus, unrelated to COVID-19.~~
2. ~~Please indicate if your country, institution or organization has decreased financial support or aid to other State, donor or institution or programme in the area of sexual and reproductive health, including through international cooperation, compared to pre-Covid time.~~
3. ~~Please indicate if your country, institution or organization has been affected by a decreased in financial support or aid, including through international cooperation, compared to pre-COVID time, and how this has affected sexual and reproductive health care.~~
1. The review can be accessed at <https://pure.ulster.ac.uk/en/publications/legislative-and-policy-analysis-practice-guidelines-and-related-p> Ndolo, P., Kivuti, L., Mwai, K., Chiluba, B., Lukama, R., Campbell, E., & Bloomer, F. K. (2021). *Legislative and Policy Analysis, Practice Guidelines and Related Publications within the Kenyan Context; Radical Abortion Care in a Pandemic, Briefing Report 2, May 2021*. Ulster University. [↑](#footnote-ref-2)
2. A review of 70 abortion related studies from 28 countries between 1994 and 2014 indicated that at least 9% of abortion-related hospital admissions had a near-miss event (complications which would have most likely resulted in death had the woman not made it to hospital) and approximately 1.5% ended up in death. [↑](#footnote-ref-3)
3. Although legalising abortion alone may not reduce the incidence of abortion, it reduces women’s resort to unsafe terminations and delays in seeking care and increases service provider willingness to provide care. [↑](#footnote-ref-4)
4. Access to family planning and reproductive health (FP/RH) services is critical to the health of women and children worldwide. Improving access to FP/RH services globally can help prevent maternal deaths and reduce unintended pregnancies. Each year, approximately 303,000 women die from complications during pregnancy and childbirth, almost all in developing countries. It is also estimated that approximately one-third of maternal deaths could be prevented annually if women who did not wish to become pregnant had access to and used effective contraception. [↑](#footnote-ref-5)
5. The COVID-19 pandemic has caused a very high demand for sexual health services and the government of Kenya struggles to keep up with that as well as the COVID-19 cases surge. [↑](#footnote-ref-6)
6. We calculated that in 2012 the Kenyan government would have spent an estimated US $5.1 million treating women who had developed complications from unsafe abortions. We estimated that by 2016 this figure would have gone up to US $5.2 million. This is roughly what the Kenyan government spends funding free primary health care for six months of the year.

 [↑](#footnote-ref-7)
7. But for those women who cannot get the vet drugs, prefer to use ulcers tablets. The most common being Cytotec and Misoprostol that can be easily bought over the counter for Sh90 per tablet at various city pharmacies. Only three tablets are needed to procure an abortion.

Mioprostol is not used orally but inserted into the private parts to avoid deadly side effects.

“The drug has very unpleasant side effects, including nausea and vomiting. So, to reduce side effects, they insert it to be absorbed into the bloodstream,” [↑](#footnote-ref-8)