Perspectives of an SRHR advocate on the impact of the Global Gag Rule in Kenya

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It is estimated that 465,000 abortions occur in Kenya annually, a majority of which are unsafe.¹ Unsafe abortions account for over 13% of all cases of maternal mortality,² and 60% of all gynaecological emergency hospital admissions.³ Alarmingly, a study conducted by the Ministry of Health (MOH)¹ revealed that about half of all post-abortion care (PAC) clients reporting to health facilities were less than 25 years of age, with 17% between 10 and 19 years old. The economic cost of unsafe abortion is also very high – according to a study conducted in 2018, the treatment of unsafe abortion complications costs the public health system Ksh 432.7 million (about US$5.1 million) annually, in health personnel salaries and medical supplies.⁴ The grave impact and toll are indicative of the barriers women and girls face in accessing safe abortion and PAC. Although the MOH has stated that PAC is legal and not punishable by Kenyan laws,⁵ women often delay seeking health services when suffering complications due to fear of social stigma and the legal risks associated with abortion, including harassment by the police, possible prosecution⁶,⁷ and fear of experiencing disrespect or abuse from providers who suspect that an abortion is induced.

To address the high mortality and injuries due to unsafe abortion, provisions affirming women’s and girls’ right to life and health, including their right to access reproductive health services were included in the 2010 revised Constitution. In particular, Article 26 of the Constitution provides the right to access abortion when “in the opinion of a trained health professional, there is need for emergency treatment or the life or health of the pregnant woman is in danger”.* The Constitution thus affirms that reproductive health care is essential to the right to health and forms an integral part of health care services. Article 43(2) reinforces that “a person shall not be denied emergency medical treatment.”†

Despite the clear constitutional provisions on reproductive health and rights, the government’s actions have been inconsistent and, in some cases, contrary to the rule of law or scientific evidence. For instance, in 2012, as part of the implementation of the constitutional provision on abortion, the MOH developed “Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion” [hereinafter Standards and Guidelines].⁸ The guidelines were to assist clinicians and patients to make informed decisions about abortion care and clearly explained to medical providers the minimum requirements that each health facility needed to meet in order to provide abortion services and when they could legally terminate a pregnancy. However, in 2014, the MOH arbitrarily withdrew the Standards and Guidelines with no explanation and banned the training of medical providers on safe abortion services. The MOH further threatened to take legal action against health professionals if they attended any abortion training, despite having earlier identified this as a critical need to reduce maternal mortality and morbidity. By these actions, the MOH was sending mixed messages to health professionals around the legality of abortion in Kenya, especially given that the Standards and Guidelines on

*Constitution of Kenya (2010), art. 26(4).
†Constitution of Kenya (2010), art. 43(2).
abortion were developed barely a year before. Suddenly, the MOH was finding it hard to acknowledge even the constitutional provision on abortion and was determined to be as vague as possible and to frustrate the provision of services stipulated within the law. On close examination, it was clear that the MOH was playing in tune with powerful voices behind the scenes even to the extent of disowning its own policy positions. One such powerful voice was that of USAID.

On 2 December 2013, USAID Kenya sent a mail to its grantees advising them not to attend an MOH meeting which aimed to discuss the strategy to reduce maternal mortality in Kenya. USAID’s main concern was that the meeting would take a reproductive health rights approach and that US government funds could not be used to advocate or promote certain reproductive health services. This mail was sent out without any due regard to the constitutional requirement on the part of the MOH to involve key stakeholders in developing policies and the need for these key stakeholders to represent their constituencies in important policy consultations. The next day, the MOH withdrew the Standard and Guidelines for reducing unsafe abortion and the training curriculum that was to accompany the guidelines. On 24 February 2014, the MOH sent a memo to all health workers prohibiting all trainings on abortions and on the same day, issued a letter to the Kenya Obstetrical and Gynaecological Society reprimanding them for developing a training curriculum on safe abortion services and for allegedly spending 60% of their time on abortion during their annual scientific conference.

Concerned about the actions of the MOH, in 2015, the Center for Reproductive Rights filed a High Court case challenging the MOH’s withdrawal of the guidelines and training curriculum on behalf of FIDA (the Spanish acronym for International Federation of Women Lawyers) Kenya, two community advocates and a minor known as JMM. JMM had an unsafe abortion during the time of uncertainty caused by the MOH and could not access quality PAC. She developed serious kidney problems due to the delayed care and succumbed to her injuries in 2018. The case argued that the lack of clear guidelines for when health care professionals can provide legal abortion services and the complete ban on abortion trainings contributed to JMM’s — and others like her — inability to access safe and legal abortion and PAC. Additionally, the petition demonstrated that these actions violated the rights of women and girls to equality and non-discrimination, health, information, and benefit from scientific progress as enshrined in the Kenyan Constitution and binding international human rights treaties.

In 2019, the five-judge bench at the High Court issued a landmark decision finding that the actions of the MOH, that is the withdrawing of the guidelines and curriculum, were unlawful and unconstitutional and therefore null and void from the start. Critically, the Court recognised the following:

1. The MOH’s withdrawal of the Standards and Guidelines was illegal, arbitrary, and unconstitutional;
2. The constitutional provision that allows for abortion when a medical professional deems the pregnant woman’s health to be at risk includes threats to mental and social health, not just physical wellbeing;
3. Abortion is permitted in instances of rape and defilement;
4. Not just medical doctors, but nurses, mid-wives, and clinical officers are constitutionally permitted to opine whether an abortion is necessary and provide the service accordingly.

Since the court’s decision, the MOH has been dragging its feet despite repeated calls from health professionals to issue a clarifying memo on its position on the reinstated Standards and Guidelines. The MOH’s actions constitute a stark reminder of the level of impunity in Kenya around reproductive rights violations and the continued efforts of the influencers “behind the scenes”, particularly those that have publicly declared their opposition to abortion even within the law – such as the US, which heavily funds the MOH.

The US government’s assault on human rights, particularly in sexual reproductive health and rights (SRHR), is not new with the Trump administration, but his administration has demystified the US human rights and democracy myth to levels never seen before. Previously, the US was globally

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1Petition 266 of 2015: FIDA Kenya and 3 others V. AG and others (High Court of Kenya at Nairobi), available at: http://kenyalaw.org/caselaw/cases/view/175490/
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regarded as a leader in human rights, since they pursued the rule of law, democracy and human rights in their foreign policy. This gave the impression to the outside world that they held the same values domestically. For the most part, they spoke publicly against and condemned governments known for human rights abuses. However, the 2016 American presidential election campaign was an eye-opener. At the end of the campaign, it was clear that America struggles with many of the same human rights issues, including women’s rights, that many parts of the world also struggle with. How was it that Americans were not living up to the values they espouse and insist on for the rest of the world? It also became clear that they no longer consistently advocated for the protection of human rights in their engagement with other countries. The reintroduction of a more expanded Global Gag Rule was thus in tune with the pattern that we were witnessing from the US.

The reinstatement of the expanded Global Gag Rule (GGR) in January 2017 is the clearest indication of the Trump administration turning its back on the human rights of women and girls. This policy prohibits non-governmental organisations incorporated outside the US and receiving US global health assistance funds, from using this money, or any of their own funds from any other sources, to perform or actively promote abortion as a method of family planning. This has affected the operations of many reproductive health care providers in Kenya. For instance, Kenya’s foremost sexual and reproductive health provider, Family Health Options Kenya, has reported a 60% reduction of its funding due to the expanded GGR. As a result, one of its mobile outreach initiatives, which provided 76,000 women each year with free sexual and reproductive health care, has been discontinued. Specialist clinics serving sex workers and religious minorities have been closed, and the capacity of its other medical services have been reduced, including vaccinations, cervical cancer screening, maternity care, paediatrics, as well as HIV/AIDS prevention and treatment. The GGR is expected to have devastating effects on HIV/AIDS prevention and care since two-thirds of the funding that is made vulnerable by Trump’s expansion of the policy was earmarked for HIV/AIDS programmes.

We continue to witness other forms of increased attacks on SRHR under the Trump administration with effects seen across the globe. Anti-abortion groups are increasingly targeting and intimidating policy makers. The Kenyan High Court in its decision recognised that, whereas the MOH acknowledges the challenges posed by unsafe abortion that result from lack of clear policy framework and have in the past issued guidelines on the same, the MOH was somewhat intimidated by the faith-based sector. One of the more recent anti-abortion attacks was witnessed during the 25th year anniversary summit of the International Conference on Population and Development (ICPD) which was co-convened by the government of Kenya in Nairobi. On the first day of the summit, the US ambassador to Kenya, Kyle McCarter, published an op-ed in two newspapers in which the ambassador inaccurately claimed that pro-choice groups were attempting to rewrite ICPD’s Programme of Action. The ambassador also completely failed to appreciate that the Kenyan Constitution provides for explicit grounds on when abortion may be legally accessed. The anti-abortion groups loudly protesting the ICPD +25 conference received another boost in their campaign when the US special representative for global women’s health, Valerie Huber, declared that the US did not fully endorse the outcome of the summit, their main concern being around discussions on abortion.

However, the world has not just watched idly by as the US leads an onslaught on SRHR. Many countries and donors have stepped up to bridge the funding gap created by the expanded GGR and counter the anti-abortion narrative. For instance, SheDecides, a global movement which began in 2017 as an immediate response to US President Donald Trump’s reinstatement and dramatic expansion of the GGR, has by far been the most outstanding protestor of the Gag rule.

Currently, other pressing concerns such as Covid-19 are impacting the reproductive health sector which was already weakened by widespread health facility closures because of the restrictions imposed by the expanded GGR. Covid-19 has further strained the health systems and exacerbated system deficiencies and subpopulation vulnerabilities, thus “exposing the damaging impact of inequities, in every society.” The Covid-19 curfew and travel restrictions are making it difficult

**Petition 266 of 2015: FIDA Kenya and 3 others V. AG and others (High Court of Kenya at Nairobi), available at: http://kenyalaw.org/caselaw/cases/view/175490/ .
for women and girls to access health facilities for contraceptives, abortion, PAC, and other reproductive health care. There are reports of reproductive health services being deprioritised in public facilities and resources being redirected to the Covid-19 response. The MOH has reported that they are witnessing low hospital visits for health services during Covid-19 and warns that this kind of health-seeking behaviour can lead to more serious health consequences.17

Ultimately, the government of Kenya, based on its constitution and the commitments it has entered at the international and regional level, has the obligation to ensure that safe abortion and PAC are accessible, available, and of good quality. External governments such as the US should not interfere in the measures the Kenyan government takes to fulfil this obligation, including any legal and policy measures it puts in place. The Kenyan government has the primary responsibility to allocate resources for the realisation of the right to the highest attainable standard of health, including reproductive health. The government must not shy away from implementing the constitution, no matter where the pressure might come from.

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