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Abstract

Reproductive health is crucial in female empowerment, as it enhances one’s physical and mental well-being. In Sub-Saharan Africa, national health infrastructure and institutional financing lag behind individuals’ need for access to reproductive healthcare services. The COVID-19 pandemic halted essential reproductive care delivery by limiting in-person visits and reducing workforce and funding. To meet population needs in post-pandemic life, the government needs to adjust a national rights-based framework for reproductive health to lessons from this global health crisis. This thesis aims to construct a post-pandemic reproductive healthcare service recovery framework grounded on theoretical knowledge of reproductive rights as ‘social rights’. This framework highlights the need for practical actions mentioned in the Kenyan government’s Reproductive Health Policy Strategy (2022-2032) and incorporates key informants’ lessons on reproductive justice during the COVID-19 pandemic.

Interviews with 25 Kenyan reproductive health key informant organisations were conducted to collect data. Responses were initially coded using factors of the health policy framework, and any noteworthy codes were later defined during the analysis. Then, these codes were later redistributed by each factor of Political, Economic, Sociological, Technological, Legal and Environmental (PESTEL) analysis utilised in the national Reproductive Health Policy Strategy (2022-2032). Key findings are the critical impact of the government’s decisions to halt transmission being a major disruptor of RH service delivery and two distinct perspectives of returning to “normalcy” among service providers. Acknowledging the government’s role in achieving reproductive justice, this framework will be crucial in ascertaining necessary critical changes to move a step further for reproductive health equity in post-pandemic lives.
Acknowledgement

I am forever indebted to my parents for supporting me through uncountable Facetimes at 5:30 am with a 14-hour time difference. Without your unconditional love, I would not have had the confidence to study abroad 8000 miles from home, explore various global health inequalities and find my true passion in reproductive justice and law.

This thesis would not be possible without the guidance of Dr. Megan Huchko, who helped me create an indispensable bond with Kenya through the SRT 2022 Kenya team. I want to express my gratitude to my thesis committee members: Dr. Proeschold-Bell, who was my first research mentor at Duke during my first-year summer as an intern for the project Selah, and Dr. Quick, who equipped me with an analytical lens and offered me his deep insights on global health policy. I am eternally grateful to Dr. Sumi Ariely for teaching me a rights-based approach to viewing global health inequities and social rights.

I also want to thank the Nakayama Public Service Scholars program, which empowered me to explore a future career in reproductive health diplomacy and provided me with a great mentor and peers. Lastly, my puppies from Duke Canine Cognition Centre, Laney, Maestro, Neely, and Rissie, I cannot imagine my undergraduate experience without listening to your barks.
1. Introduction

In April 2020, a pregnant Kenyan woman living in Nairobi County waited a week after giving birth to her newborn to receive surgery for an obstetric fistula, an abnormal opening between the genital tract and her urinary tract or rectum. A government-supported clinic was overwhelmed with treating COVID-positive patients with critical condition, and to effectively manage public health, the national government announced essential healthcare services, which excluded reproductive health-related (RH) services from the list. This woman had to wait helplessly without any protection of her fundamental human right: the right to health. How has the COVID-19 pandemic disrupted RH care service delivery and reproductive justice in Kenya? The introduction reviews the importance of applying human rights approach in reproductive justice discourse, the impact of COVID-19 pandemic on Kenyan reproductive health service delivery, and current reproductive health frameworks and policy agendas issued by the Kenyan government.

1.1. Human Rights Approach to Reproductive Justice

Human rights are inalienable and inherent to everyone, regardless of their identity. Human rights are also an umbrella term encompassing various situation-specific rights: civil, political, economic and labour, social, and cultural. According to the International Covenant of Economic, Social, and Cultural Rights (ICESCR), social rights are “rights to an adequate standard of living, affordable housing, food, education, an equitable health system, and social security based on respect, not sanctions” (Hunt, 2017). Fabre (1998) contends that social rights should be constitutionalised since they are morally valuable and rest on a certain view of people as autonomous agents. The author added that constitutionalising political and civil rights are
intrinsic to democracy because “it appeals to the value of political participation, basic liberties, and ultimately, people’s autonomy” (Fabre, 1998). If social rights are left out of the constitution or legally binding treaties, it creates two issues in protecting one’s autonomy. First, the government has reasons not to fulfil the duties imposed by social rights, and second, when there is a conflict of interests protected by social rights and that of civil rights, the former will be overlooked as the protection of interests in civil rights is legally mandated.

Social rights actualise one’s autonomy, physical and mental well-being, and equality through “the government’s purposive, continuous work” (Hunt, 2017). Hunt (2017) argues that realising social rights requires “a deliberate, concrete, targeted, evidence-based, wide-ranging social justice strategy for all”, which underscores the government’s role in establishing subsequent institutions and overseeing the implementation of equitable policies (Hunt, 2017). While social rights are crucial in acknowledging one’s well-being and contributing to eliminating economic and social causes of authoritarianism, the United Nations Human Rights Committee (UNHRC) condemns and responds to primarily civil and political rights violations, which leaves social rights invisible in global politics and national governments’ priority agenda.

In the book *On Suffering*, the American medical anthropologist and physician Paul Farmer described how the Haitian political leaders disenfranchised AIDS patients by creating large-scale systemic oppression and exoticising their physical and mental suffering (Farmer, 1996). James Dwyer, the American bioethicist, proposed establishing just social policies and basic institutions to oversee the violence since a basic structure of a society influences the health prospects of its population profoundly and combating domestic-level social injustices will clarify the role of global justice (Dwyer, 2005).
According to Fabre, the right to the highest attainable standard of health is a social right since without resources given by the government or institutions, “[citizens] would be unable to develop the physical and mental capacities necessary to become autonomous” (Fabre, 1998). Reproductive right, which includes one’s ability to access contraception, abortion, fertility treatment, reproductive health, and access to information about reproductive body, is a crucial social right since it ensures one’s autonomy to decide whether to (or not) reproduce (Schurr & Militz, 2020). For instance, the Italian constitution affirms the right to health as a fundamental right of individuals and an affair of collective interest. This legal framework that underpins human rights has shaped national health services and community health schemes by setting goals of improving access to contraceptives or increasing cancer screening programmes for rare cancer (Bustreo et al., 2013). The WHO study showed positive changes in health indices especially among Italian women and children (e.g., a decrease in under-five mortality rate, pregnancy complication prevalence, and unsafe abortion rate) after acknowledging health as human rights (Bustreo et al., 2013).

The American philosopher John Rawls defined inequality as “differences in benefits and burdens attached to participating parties either indirectly or directly” (Rawls, 1985). The community’s lack of attention to reproductive rights is closely related to prevalent gender and socioeconomic inequalities. For instance, with race, African American women are more than five times more likely to be diagnosed with sexually transmitted diseases (STDs) than their white counterparts, and their access to reproductive healthcare services is often limited due to providers’ implicit biases (Prather et al., 2016). Globally, a quarter of women live under the law that penalises safe abortion and diversity in sexual orientation or gender identity, which limits one’s decision-making process for bodily autonomy (Center for Reproductive Rights, 2022).
Articles 11 and 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDEW) identify the state parties to be responsible for ensuring the right to protection of women’s health and protect them from any forms of discrimination due to marriage and maternity (United Nations Human Rights Office of the High Commissioner, 1979). Despite this convention, women’s rights are not equal to their male counterparts in more than half of countries around the world. Dissecting the intersectionality of various identities behind current reproductive rights issues can be used to propose political solutions to end oppression against women and create an equitable society.

In order to follow the global covenants such as CEDEW and ICESCR, the Kenyan national government has established various public health frameworks focusing on resolving health inequities. In the latest National Reproductive Health Strategy guideline, the Kenyan government defines reproductive rights as the basic right of individuals “to make decisions concerning reproduction (number, spacing and timing of their children) free of discrimination, coercion and violence” (Republic of Kenya Ministry of Health, 2022). A similar acknowledgement of reproductive rights is in the Constitution, as it guarantees a right to “the highest attainable standard of health (including reproductive health) regardless of gender, age, and ethnicity” (Republic of Kenya Ministry of Health, 2022). While it is a big social and political leap to nationally recognise reproductive rights as equivalent to human rights on paper, it is important to examine whether these rights are properly protected from the community level as well. The next section will evaluate how the national and local (both county and sub-county level) government responded to reproductive rights during the COVID-19 pandemic.
1.2. Impact of COVID

In March 2020, the National Emergency Response Committee was established under the President’s Executive Order in Kenya. The committee oversaw health, security, education, transport, finance, and trade sectors to coordinate prompt response to COVID-19. Subsequently, the government introduced several measures to prevent domestic viral transmissions, such as night curfews, mandatory 14-day quarantine upon positive test results, and mandatory mask-wearing in public spaces. Despite its effort, there was still a high unmet need for sexual and reproductive healthcare and its resources were diverted to an urgent demand of COVID-19 patients. A maternity wing of numerous government-funded clinics was converted into isolation centres across the country and was advised to offer emergency maternal services (Wangamati & Sundby, 2020).

Shadow pandemic refers to indirect public health crises followed by a visible pandemic. For instance, gender-based violence (GBV) is a shadow pandemic of COVID-19 in Kenya, as a third of all reported crimes since March 2020 were related to sexual violence (Mutavati & Zaman, 2020). Financial hardships, with stress from physical confinement due to curfew, may cause all forms of violence and makes women and children more vulnerable. To curtail GBV prevalence, the United Nations and Kenyan government launched a $267 million appeal to provide lifesaving medical treatment, psycho-social support and legal representation.

The COVID-19 pandemic widely influenced reproductive healthcare service delivery from prenatal care to children and adolescent health. For instance, in-depth interviews with facility staff working in predominantly refugee populations in urban Eastleigh indicated that the lack of migrant-inclusive healthcare policies and financial barriers delayed pregnant women’s
first antenatal care (ANC) visits and increased the frequency of home deliveries with traditional birth attendants (Lusambili et al., 2020).

Researchers also pointed out that the implicit bias of hospital staff against refugee mothers prevented them from accessing care services. The national health insurance fund (NHIF) initiated a “Linda Mama Mtoto” program to ensure all pregnant women and infants access affordable maternity care at government-run healthcare facilities. While refugees are qualified to receive complimentary antenatal care services, the NHIF covers delivery only for Kenyan nationals, leaving refugee mothers vulnerable to health complications. A cross-sectional study between pre- and mid-pandemic depicted the trend of delay in first ANC visits during the pandemic across public and private clinics (Landrian et al., 2022). The research on prenatal care service disruption reported fewer maternal health clinic visits during pregnancy, thus, a higher rate of stillbirths and neonatal and maternal death (Pallangyo et al., 2020). While the Ministry of Health (MoH) implemented strict measures to keep midwives safe from the virus, key reproductive healthcare providers showed concern about insufficient training on practical pandemic response and prompt updates from the government (Pallangyo et al., 2020).

The pandemic also influenced the retention rate of care among populations at risk, such as adolescents living with HIV (ALHIV). The Academic Model Providing Access to Healthcare (AMPATH) in Eldoret was long known to provide peer support groups and social activities to reduce stigma and create a more adolescent-friendly care environment. Due to COVID-related government regulations, an abrupt decentralisation of care services (e.g., multi-month refills, transfer out to local hospitals) took place, which left vulnerable adolescents abandoned from care (Enane et al., 2022).
The African Population and Health Research Center (APHRC) reported that 32.1% of Kenyan women did not receive modern contraceptives due to stockout and cost increases (APHRC, 2021). For instance, Karp et al. (2021)’s findings showed that women with economic concerns were more likely to discontinue contraception, and those experiencing food insecurity were less likely to switch to more effective family planning methods (Karp et al., 2021). Although the Kenyan government continuously tries to distribute contraceptives and increase access to reproductive healthcare, the uptake varies significantly by class and marital status. Women with higher educational attainment and a high social class had a higher uptake in contraceptive use (Peterson, 2021). This class division was exacerbated from March 2020 as one’s class and geographic location determined their ability to access reproductive health services. A study on poor urban households living in informal settlements in Nairobi showed that, despite its proximity to the nation’s capital, more women than men received adverse economic, social and health effects of COVID-19 mitigation policies (Pinchoff et al., 2021). In setting priority in different categories of health issues, the APHRC pointed out that the pandemic raised the question of “whether the rights of women, especially around contraceptive choices, were subjugated in the process of dealing with the virus” (APHRC, 2021). Numerous examples mentioned above convey that, on the national level, the Kenyan health infrastructure was “unequipped” to handle the pressures of the COVID-19 pandemic with everyday healthcare demands. The Global Policy Review underscored the importance of CHVs in slums to provide essential family planning services and condemned the government for overlooking their roles and being unable to provide PPE or proper training (Peterson, 2021).

Despite various difficulties, some grassroots organisations put effort into increasing access to reproductive healthcare services. For instance, ‘Wheels for Life’, an initiative between
the MoH, Amref Health Africa, and private transportation service Bolt, created a system to coordinate drivers with mothers who need emergency clinic visits, which benefits both drivers who face financial hurdles due to curfew and mothers who do not have access to clinics in Nairobi (Peterson, 2021). In Kakamega county, local administrators registered pregnant women to facilitate easier transport when in labour during the night curfew (Wangamati & Sundby, 2020).

Civil society organisations (CSO) in Kenya utilised various channels (e.g. phones, social media, and audio-visual materials) to disseminate reproductive health (RH) information during the pandemic. Community health volunteers (CHVs) also shared information on gender-based violence, menstrual hygiene, and safe delivery and motherhood services to their communities (APHRC, 2021). To reduce the risk of transmission, the government encouraged using alternative consultation methods such as telemedicine. By directly connecting providers with the pharmacy near patients’ locations through phone calls, people in remote areas could continue their HIV antiretroviral medication (APHRC, 2021).

The national government also proposed the community midwifery model (CMM), which incorporates CHVs and informal community networks and creates midwifery centres proximate to pregnant mothers (Kimani et al., 2020). Midwives’ ability to triage, offer advice, and refer women to maternal services reduces the burden on physicians and strengthens facility-community linkages. Researchers also exhibited improved attendance rates for ANC, skilled birth, and a longer exclusive breastfeeding period after implementing the CMM (Kimani et al., 2020).

The COVID-19 pandemic unveiled an inequity and disruption in access to reproductive healthcare services in Kenya, and various research conveys its long-term effect on child and
adolescent health. Reflecting on lessons learned from the pandemic, building a resilient healthcare system to protect every citizen against national-level public health emergencies is crucial.

1.3. **Current Reproductive Health Frameworks in Kenya**

This section reviews current or past reproductive health frameworks that shaped the current landscape of reproductive healthcare service delivery.


The Kenyan national government has strived to bolster its reproductive health infrastructure since the late 1980s to respond to increased global awareness of HIV/AIDS. The MoH established the National AIDS and STIs Control Programme (NASCOP) in 1987, but the increase in awareness and advocacy took place in the 1990s when the government declared HIV/AIDS a national disaster (NASCOP, 2023). NASCOP still plays a crucial role in the Kenyan reproductive health sector as it coordinates basic youth education on HIV transmission, youth-to-youth initiatives, and mass mobilisation for HIV testing. This programme influenced the establishment of the Kenya AIDS Strategic Framework (KASF, 2014-2019) and developing guidelines for HIV-related campaigns.

1.3.2. **Senate Bill on Reproductive Health (2014)**

From 2014, the progressive politicians in the Senate proposed the Reproductive Health Bill to the parliament to expand services covered under universal health coverage (e.g., abortion)
and increase accessibility of reproductive health beyond clinic settings (e.g., extending sex education curriculum to primary school students). In 2019, a few politicians at the Senate modified a bill to expand “access to family planning, safe motherhood, termination of pregnancy, reproductive health of adolescents and assisted reproduction”, which further reinforces every citizen’s right to access reproductive health services (Ajayi & Mwoka, 2020). However, this 2019 bill did not pass due to various contentions from religious and political opponents, mainly on ambiguous legal standards of abortion and surrogacy against Christianity. Without this bill being passed, it is difficult to expect the full protection of reproductive rights under the Constitution.

1.3.3. Adolescent Sexual Reproductive Health Framework (2015)

In this framework, the MoH acknowledged adolescents (ages of 10 and 19 years) representing a substantial proportion of their demographics (24 per-cent) and aimed to defend their reproductive rights. It is important to note that the ministry recognised the harmful cultural practices (e.g., female genital mutilation and child marriage) that deteriorate not only one’s physical health but also their mental well-being and urged to establish policies to end these practices. Furthermore, this framework emphasises the role of non-state actors like schools and families in empowering youth by informing correct information on sexual health, assisting with bodily decisions, and supporting their fundamental freedoms.
1.3.4. **Kenya Community Health Policy (2020-2030)**

The 2018 evaluation of community health services showed severe lack of community health assistants (CHAs) and registered community health volunteers (CHVs)\(^1\) to meet the nation-wide demand (Republic of Kenya Ministry of Health, 2018). To tackle this human resource shortage, the Kenya Community Health Policy focuses (2020-2030) proposes various solutions to strengthen community health workforces grounded on equity, community participation and utilisation of appropriate technology. For instance, Policy Object Two highlights the recruitment and retention of community health human resources, resource allocation to increase opportunities for capacity building and professional development. Under this policy, CHVs are mainly regarded as a bridge between the government and community members by offering counselling for reproductive health issues (HIV/AIDS prevention, cancer screening, and family planning). To promote their retention rate, this policy framework also recommends regular sub-county-level CHV training based on a pre-structured curriculum with basic and technical modules.

1.3.5. **Reproductive Health Policy Strategy of Kenya (2022-2032)**

To develop the latest Reproductive Health Policy Strategy (2022-2032), the Ministry of Health conducted the SWOT (strength, weakness, opportunity, and threat) and PESTEL (political, economic, social, technological, environmental, legal factors) analyses to examine the status quo of the national reproductive healthcare services’ internal and external environment. This strategy particularly seeks to advance key indicators like an increase in antenatal care visits

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\(^1\) Community health assistant (CHA) or officer (CHO) is directly employed by the county government to promote health within local communities. On the other hand, community health volunteers (CHVs) are members of the local community who are usually selected by each MoH-run facility to meet the demand of specific health programmes.
and underscores the need to improve stigma around infertility and provide adequate family planning services. Regarding strengthening health infrastructure, the MoH proposed increasing physical access to facilities, stabilising equipment supplies for service delivery, and redesigning a client-centred clinic flow (Ministry of Health, 2022). Notably, the MoH recognised the lack of coordination for current reproductive health research, which led to an inefficient allocation of limited resources and funding. The ministry aims to mandate objective contextual effectiveness evaluation to ensure the quality and adaptability of intervention programs.

Various strategies issued by the national government share the common theme of restructuring service delivery in response to issues in access. Acknowledging reproductive rights as the fundamental human rights in law is the initial step, but subsequent actions should be followed. Due to the COVID-19 pandemic, global health faced huge global disruption in service delivery, and it is important to create a new strategy and framework to build a resilient infrastructure for future health crises. This thesis aims to identify the status quo of the notion of ‘reproductive rights as human rights’ in Kenya through interviewing key informants of Kenyan reproductive healthcare and reviewing literature published between early 2020 and 2022 and create a recovery agenda based on lessons learned during the COVID-19 pandemic.
2. Method

2.1. Setting

The literature review provided a philosophical foundation underscoring the importance of protecting reproductive rights as social rights. To better understand the local experience of reproductive healthcare service disruption due to the COVID-19 pandemic, I conducted in-depth interviews with key informants at reproductive health stakeholder organisations in Kenya. Key informants were not limited to those physically residing in Kenya to receive perspectives from diverse organisations.

2.2. Sample

I conducted 32 in-depth interviews from August to October 2022 using an online conference tool (Zoom) due to geographical constraints between the interviewer and key informants. The breakdown of key informants is listed below:

- Large Health Care Providers/Service Delivery Organisations: 5
- Reproductive Health Advocacy Groups in Kenya: 5
- International Organisations with presence in Kenya: 5
- NGOs in Western Kenya (based in Kisumu): 5
- Reproductive Health Legal Groups (International, national-level): 5

These groups were categorised by the impact size of their service (local, national, and global), political proximity with the government (legal groups, NGOs), and representation of human infrastructure necessary for reproductive healthcare service delivery (advocacy groups).
2.3. Data Collection

I used Duke Center for Global Reproductive Health’s key stakeholder database for an initial contact network for key informants under each category, and an additional snowball sampling method was employed. Before recruiting for the interview, I confirmed that potential interviewees were still in key positions during the pandemic. Key informants in the database were included in the potential interviewee pool if they worked at key stakeholder organisations in any time frame between one year before the first case of COVID (March 10, 2019) and up to date. After each in-depth interview, I additionally asked the key informant about their colleagues at different organisations who will be valuable informants for this study. Each interview lasted 45 minutes and was conducted in English. All data were collected through note-taking by the interviewer without audio recordings, and notes were reviewed after the respective interview session.

The KIIIs were semi-structured with questions from the interview guide and probes based on the interviewee’s response. The interview guide was created before the interview using findings from the initial literature review. First, I asked basic information about the key informant’s organisations, such as size, geographic reach, and services offered, and no direct identifiers (e.g., name and location of headquarters) were asked or omitted during the analysis. To holistically investigate the impact of COVID-19 on reproductive healthcare delivery, questions were created based on four contextual factors (situational, structural, cultural, and international) from the Health Policy Framework theory (Kent, Nicholas & McGill, 2012). The interview guide is attached as Appendix 1.
2.4. Data Analysis

Before starting the analysis, I categorised interview notes by the organisation. Among 32 interviews conducted, three interviewees worked in the same organisation (IO_4) with different RH projects, so the notes were combined during the data analysis to understand the organisation as a whole. In two legal groups (LG_NGO_1 and LG_IO_3), I was referred to the director after the initial interview with key informants in the database. After sorting out interviews by organisations, I redacted their names and assigned individual IDs. The meaning of each initial is described below:

<table>
<thead>
<tr>
<th>Initial</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PR_</td>
<td>Provider including physicians, nurse, community health officer and assistant</td>
</tr>
<tr>
<td>AG_</td>
<td>Advocacy group</td>
</tr>
<tr>
<td>LG_</td>
<td>Legal group</td>
</tr>
<tr>
<td>IO_</td>
<td>International organisations with presence in Kenya</td>
</tr>
<tr>
<td>_KS</td>
<td>Kisumu-based groups (Since this does not categorise the role/sector of organisation but geographical location of organisations, I put the dash before the initials)</td>
</tr>
<tr>
<td>NGO_</td>
<td>Non-governmental organisations that received the national or county government licence for activities/campaigns</td>
</tr>
</tbody>
</table>

Table 1. List of initials used for sorting key informants’ organisations in the Result section

After sorting out notes by organisations, thematic analysis using an inductive approach was applied to construct the post-pandemic framework. Responses were initially coded by four contextual factors (situational, structural, cultural, and international) from the Health Policy Framework theory (Kent, Nicholas & McGill, 2012). Specific words that were mentioned in multiple interviews, such as stigma, school shutdown, or ‘new normal (and going back to normal)’ were later generated as separate codes during the analysis. Then, axial coding was
conducted to find converging codes across different key stakeholder organisations (Williams & Moser, 2019). These converging themes were redistributed by factors of PESTEL analysis that was used in the national Reproductive Health Policy Strategy (2022-2032).

Political, Economic, Social, Technological, Environmental, and Legal (PESTEL) analysis is commonly used to evaluate external factors that influence an organisation's decisions. Beyond marketing, this framework was also utilised by public health researchers, as researchers in Australia employed it to examine external environmental factors on mental health management (Tijani et al., 2022). In this study, I used this framework to propose tangible actions by each stakeholder of Kenyan reproductive healthcare to achieve goals listed in the national Reproductive Health Policy Strategy (2022-2032).

2.5. Ethics Statement

The study protocol was approved by Duke University Campus Institutional Review Board (Protocol: 2020-0566). Written consent forms were delivered to all participants with recruitment emails, and verbal consent was administered before each in-depth interview began.
3. Results

Findings from key informant interviews (KII) are divided into seven categories in this section: 1) demographics of organisations, 2) impact of politics on RH service delivery, 3) barriers to access RH services, 4) human resources management, 5) technology and innovation, 6) “new normal” discourse, and 7) reproductive rights as human rights. These sections serve as a foundation of the post-pandemic RH service delivery framework that will be introduced in the discussion.

3.1. Demographics of Key Informant Organisations

Among 25 organisations, 12 offer services on a local or county level (mainly Nairobi and nearby counties, Kakamega, and Kisumu counties), and seven of them are national service providers. The remaining six are international organisations with ongoing RH projects in Kenya. Most organisations did not have strict descriptors, but almost all of them had specific target populations, such as people living in informal settlements, women with disabilities, adolescent mothers (ages 13 to 24), and orphans or vulnerable children (OVC). The proportion of employees who are Kenyan-born or national decreased as the organisation’s scale increased. For instance, all international organisations noted at least 20 percent of Kenyan nationals but no more than 30 percent, whereas local advocacy groups consisted of all volunteers and activists born in the same county. Quantifiable measures developed and reported by the organisations to track RH service delivery are largely divided into five categories in Table 2 below.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Description</th>
</tr>
</thead>
</table>
| Family Planning  | ● Monthly count of modern contraceptives administered  
|                  | ● Weekly or monthly family planning consultations  |
Community Empowerment Activities

- Frequency and number of participants in community dialogue or volunteer-led education
- Number of school girls who received female empowerment programs
- Number of youths visiting the youth resource centre

Gender-Based Violence (GBV) Prevention

- Monthly count of calls received through the GBV toll-free hotline
- Monthly count of pro bono representation for GBV victims

HIV/AIDS Prevention

- Monthly count of prevention of mother-to-child transmission (PMTCT) program recipients
- Monthly count of PrEP recipients
- Monthly count of antiretroviral treatments (ART) recipients

Pregnancy-Related Services

- Monthly count of safe abortion
- Proportion of deliveries with skilled birth attendants

Table 2. Quantifiable measures to track RH service delivery by measures

3.2. Impact of COVID Policies on RH Service Delivery

This section summarises findings reported in KII on how COVID-related policies influenced organisational governance and RH service delivery. President Kenyatta enacted an executive order to reduce a COVID-19 transmission on March 15th, 2020, which includes daytime movement restrictions, a curfew between 9pm to 4am, and a school shutdown for an indeterminate period. However, one key informant described that the government’s decision to restrict the movement “swindled” a lot, which made their organisation (IO_5) follow both their internal fieldwork rules and government regulations. For instance, the organisation (IO_5) planned to begin data collection from July 2020, but they had to reschedule the data collection timeline due to the president’s order to extend the national dusk-to-dawn curfew in June.

A key informant (IO_1) mentioned an unequal effect of COVID across counties due to disparate movement restrictions and police abuse. For instance, people living in informal
settlements around big counties like Nairobi, which had more rigid restrictions, were more vulnerable to RH issues like unintended pregnancies and acquisition of sexually-transmitted diseases (STDs). Also, police violence was mentioned in multiple interviews, as people living in informal settlements and sex workers were deemed as not abiding by social distancing rules and were subject to physical and verbal abuse by the police (LG_NGO_1, NGO_3).

School shutdown influenced many female empowerment programs since they were mainly operated by school-by-school reach (LG_IO_3). These programs not only educated school girls about their decision-making power but also offered free HIV testing in remote areas (on pause until early 2021), access to sanitation supplies, and protection from domestic violence and unintended pregnancy.

Beyond movement restrictions, the national government excluded RH services from the essential healthcare service category in March 2020, and this decision imposed additional logistical barriers for the organisation across different levels. For instance, community-based organisations (CBOs) had to receive permission to host RH empowerment events from the county governments, which “prevented them from continuing without government red tapes and frequent rescheduling” (IO_4). Local private practitioners had to create an emergency triage plan for pregnant individuals who were admitted before the government decision to larger MoH-funded clinics with subpar conditions (PR_2). An abrupt government decision immediately disrupted RH service delivery and also left school girls with potential long-term harm such as unintended pregnancies. A concern about immediate disruption to accessing RH services will be discussed in the next section.
3.2.1. Effect of COVID Vaccine Distribution on RH Service Delivery

After the distribution of COVID vaccination, providers could go back to full capacity, and patients were advised to receive it and visit clinics two weeks after the last dose, which some thought may have inadvertently blocked them from accessing RH services on time (PR_NGO_4_KS). Some providers reported misinformation spread among the public on COVID vaccines in early pregnancy causing miscarriage (PR_1).

3.3. Barriers to Access RH Services

Social support for reproductive rights had been challenging even before the pandemic, as some communities like religious bodies did not accept girls and women using family planning products, claiming it as a sign of unfaithfulness (AG_2_KS). During the pandemic, RH stigma has been exacerbated due to various government decisions to prevent COVID transmission. Movement restrictions increased the prevalence of domestic violence, and some providers noted family members physically abusing women who wanted to visit RH care services (PR_3). People who did not have access to masks and other PPEs were often harassed by clinic staff partially for safety reasons (IO_2). The stigma around bodily autonomy and wrong gender norms, discontinuation of education on reproductive rights due to school closure, and providers’ prejudice on low-income patients who want to receive RH services left them with unmet needs.

On a structural level, the COVID-19 pandemic created an immediate disruption to obtaining RH services in two ways. On the supply side, 72 percent of organisations reported a reduction or cancellation of scheduled services due to regulations. In private clinics, working hours were reduced by two hours (PR_1), or there was a downsizing of clinic staff (AG_2_KS). Three of five provider organisations limited the number of patients visiting the clinic per day,
and a partnership with Cure Cervical Cancer to provide HPV testing and treatment in remote communities was on halt for a year (LG_2_NGO_KS). Both private practitioners and government-funded clinics faced stockouts of contraceptives due to global supply chain delays. Legal groups also reported a delay in pro bono clinics and self-representation training due to risks of COVID transmission (LG_NGO_5). A lack of confidential, quality, non-judgemental RH services left people with unmet needs.

On the demand side, the pandemic caused a loss of medical insurance, which led to an increased cost of accessing these services. Approximately 30 percent of the population who frequently visited private obstetricians and gynaecologists lost health insurance provided by their workplace due to layoffs at the beginning of the pandemic (PR_1). A subsequent increase in cost prevented them from accessing reproductive health services as regularly as they were pre-COVID, and movement restriction correlated with increases in unemployment, which made a lot of women unable to afford the cost of contraceptives and discontinue family planning (AG_4_KS). As a result, the private practitioner in Nairobi and nearby counties reported a 50 percent reduction in general RH services uptake, a 30 percent decrease in family planning consultations, and a 20 percent decrease in at-clinic delivery (PR_1). In addition, without government policy responses, private practitioners individually had to negotiate with insurance companies to set up “affordable” prices during the pandemic (PR_1 and PR_2).

There were also changes in domestic and international donor funding schemes that affected the RH service delivery. On a domestic level, the Ministry of Health, one of the biggest RH service financial contributors, diverted tax revenues to respond to the pandemic, such as purchasing equipment for ICU patients and self-diagnosis kits. 20 percent of key informant organisations observed changes in financing, and a local advocacy group specifically
experienced removal of funding from safe delivery with a skilled birth attendant project to a new COVID vaccination (AG_4_KS).

3.4. Human Resources Management

In 80 percent of organisations, there were various changes in distributing human resources, such as layoffs, hiring long-term unpaid volunteers, and supporting local advocacy networks that could reach a broader community instead of funding county governments. Among provider groups, key informants mentioned redundancies during the early pandemic. However, the clinic also experienced an overwhelmed inpatient unit due to a decrease in the workforce, and eventually, they decreased the number of hospital beds to balance providers’ workload (PR_NGO_4_KS).

A Kisumu-based NGO noted that movement restrictions and fear of contracting COVID lowered volunteers’ adherence and participation rate to empowerment programs (NGO_1_KS). While many organisations redirected their volunteers to meet public demands for COVID, community health assistants, who are volunteers directly hired by the county government, made regular phone calls or home visits to assist medical needs of populations with a higher risk, such as people living with HIV (PLHIV) (PR_3).

3.5. Technology and Innovation

The national government’s restrictions on movement have been an opportunity to explore various communication methods beyond utilising community health assistants. For instance, a legal group hosted a social media panel to increase sexual and reproductive health rights (SRHR) among professionals and attract activists or legal advocates in Kenya in November 2021
(NGO_LG_5), and an NGO initiated hashtag campaigns to increase the visibility of RH services crises in Kenya. Although some advocacy groups for empowering youth reproductive health held virtual discussion groups, the participation was lower than in-person events due to a lack of access to the Internet among target populations. Technologies that do not involve the Internet attracted bigger populations, as a toll-free hotline for safe abortion or GBV reporting experienced an user increase of 24 percent (IO_1, NGO_3). Furthermore, 28 percent of organisations utilised local radio stations to disseminate reproductive, maternal, newborn, and child health (RMNCH) information to neighbourhoods without cell signals.

All providers reported a shift in the mode of interaction with their patients. Text message prescriptions and distant consultations became prevalent, and clinics utilised local motorbike networks to deliver medications to women who received safe abortion before the pandemic or those who wanted to receive prescription refills (PR_1, PR_2). As a result, the transition of remote work and ensuring access to laptops or computers with stable Internet connection became a crux of delivering RH service. In addition to virtual consultations, there were direct RH service delivery innovations, as seen in the literature review. Some provider networks collaborated with local transportation enterprises to offer emergency services to pregnant mothers while the movement restriction took place (AG_3).

Changes in research methods are another notable digital innovation. A county/sub-county level case study became a more predominant research method as international organisations increased their interaction with non-state actors, such as local advocacy groups, to offer direct RH services without overwhelmed government clinics (LG_IO_3). Researchers utilised online survey tools, SMS, telephone surveys, and interactive voice responses to collect data on RH advocacy programs (AG_3, IO_5). Although technological developments facilitated an easier
transition to remote work structure for providers, unequal distribution of technology among patients still remains an issue.

3.6. “New Normal” Discourse

There were different perspectives on post-pandemic lives across key informants during interviews. Opinions on the ‘new normal’ were divided into two parts: the same life as if COVID did not exist or living with long-term changes based on lessons learned from the pandemic. Some key informants viewed this as an opportunity to lead a positive transformation of their organisations.

First, a key informant from an international organisation mentioned that going back to “normal” (quote by key informant) means not adjusting lives to COVID but actually reconstructing the economy and healthcare system as if COVID did not happen (IO_3). They contended that the aggravation of material insecurities in quotidian life (food insecurity and lack of access to sanitation devices) should be resolved as well as re-establishing social understanding of reproductive rights (LG_IO_3). Local advocacy groups also believed that addressing public health goals established before the pandemic should be a priority instead of adding a new agenda to the table when the current healthcare system confronts a huge burden (AG_1).

On the other hand, some key informants stated that adjusting to the new normal starts with updating RH information to be COVID-relevant. There were some international organisations that established new projects to focus on quantifying a pandemic’s long-term impact on SRH in Sub-Saharan African countries, and those projects related to the impact of COVID on SRH received priority funding from donors. For instance, a new three-year maternal and newborn health (MNH) capacity building project has been implemented in Kenya since
March 2022, and one of the key outcomes to measure was a spread about misinformation of COVID-19 infection among pregnant and lactating women (IO_2). Also, legal and advocacy groups are utilising a participatory advocacy model for youth (PAMY) to generate sustainable, long-term participation by youth to change the social perception towards reproductive rights (AG_4_KS).

3.7. Reproductive Rights as Human Rights

The COVID-19 pandemic revealed a scarcity of resources, fragility of the healthcare system, and lack of citizens’ trust in the judicial system to protect reproductive rights in Kenya. For instance, anti-rights groups took advantage of national-level healthcare disruptions to increase their voice against LGBTQ+ rights (LG_NGO_1). A key informant from a legal group mentioned a case of a woman with an obstetric fistula who had to wait for a week to receive emergency surgery due to the government’s narrow designation of essential services in an early pandemic and an organisation’s subsequent effort to report this incident as human rights violation (LG_4). One of the providers revisited their organisation’s mission, which underscored support for human rights and social empowerment on socio-economic issues through integrated health services (PR_NGO_5).²

Legal groups in Kenya have played crucial roles in ensuring reproductive rights even before the pandemic. Some key informant organisations were constitutional reference groups in drafting the recent Constitution in 2010 and held the national government accountable for reproductive rights violations by publishing annual reproductive justice reports (NGO_LG_5).

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² A complete mission statement was “to provide health services while upholding human rights and empowering society on socio-economic issues through capacity building, integrated health services, support for income generating activities and creation of beneficial linkages and partnerships”.

These groups pointed out a lack of public trust and credibility of the judicial system as major barriers to increasing public visibility of reproductive rights. An advocacy group mentioned that the current reproductive health policy framework lacked acknowledgement of reproductive rights for marginalised populations such as people with disabilities (AG_5). Some NGOs hosted meetings with the association of doctors and public health experts to discuss SRHR violations during COVID, but they noticed a clear disjunction between organisations’ efforts and the government’s indifference to reproductive rights protections (LG_NGO_1).
4. Discussion

This thesis aims to construct a post-pandemic reproductive healthcare service delivery agenda in Kenya using theoretical approach of reproductive rights as social rights. The concept of ‘health as human rights’ has been vital to protect one’s autonomy, physical and mental well-being, and social rights specifically intended to ensure an equitable health system based on respect. Reproductive rights, in particular, should be recognised as social rights due to their close relationship with socioeconomic and gender disparities that require constant public institutional support for eradication.

In 2020, COVID-19 brought a nationwide healthcare service disruption in Kenya, and reproductive, maternal, newborn, and child health was no exception. It not only discontinued service offerings but also put reproductive rights protections in danger as the national government divested their public health focus to halt the transmission of the virus. Samuels and Daigle (2021) added that this pandemic revealed the “shallowness of political commitments on sexual, reproductive health rights when we see [RH] services being quickly withdrawn all with pandemic as justification” (Samuels and Daigle, 2021). In order to identify the impact of the recent pandemic on RH service delivery, interviews with 32 key informants from 25 distinct organisations were conducted. At first, organisations were divided into advocacy groups, providers, NGOs, international organisations, and legal groups based on previous classifications on the Center for Global Reproductive Health’s Kenya RH key informant database. The thematic analysis using an inductive approach was applied to find themes congruent with the main findings of PESTEL analysis in the national Reproductive Health Policy Strategy (2022-2032).

Findings showed that public health decisions to curb COVID transmission were major barriers to accessing and delivering RH care services. Global travel restrictions led to stockouts
of medical equipment and PPEs for providers, and executive orders on domestic movement restrictions and curfews directly obstructed patients’ access to RH care in a timely manner. This order indirectly led to a spike in unemployment and subsequent deprivation of healthcare insurance among 30 percent of the population. Despite the Ministry of Health’s effort to implement ‘Afya Care’, a pilot program to provide minimum primary healthcare packages to all citizens, Kenyan citizens still face high out-of-pocket costs at public and private clinics (Owino et al., 2020). An interview with a private practitioner showed a lack of government intervention in negotiating affordable service costs with insurance companies, which burdened their practice.

Furthermore, there was an implicit long-term impact on school girls due to school closure. Many advocacy groups offered school-based female empowerment programs along with free HIV testing and sanitation supplies, and the government’s decision to close schools prevented these girls from accessing basic RH needs. Also, power abuse by police on marginalised populations such as sex workers and people living in informal settlements was prevalent, and police neglect of GBV reporting heightened RH stigma. As mentioned in Introduction, one’s access to RH services became closely related to one’s socioeconomic status and marital status.

Researchers at the University of British Columbia utilised disruptions as an opportunity to achieve health equity in primary care clinics through innovation and strengthening interdependence among provider organisations (Browne et al., 2018). Similar phenomena were observed in Kenya, such as a transition to a remote work structure, messenger services to facilitate patient-provider interactions beyond physical distance and collaboration between local taxi businesses and providers to transport pregnant mothers during the curfew. However, unequal technology distribution across regions still contributed to RH inequity among marginalised
people in remote areas. There was an increasing tendency to implement community-oriented research methods as international organisations began interacting with local communities directly through advocacy groups instead of government clinics to avoid bureaucratic red tape for fieldwork. By redirecting communication routes, international organisations were able to diversify their research projects and reduce

There were a few notable limitations in this study. The KIIs were conducted from August to October 2022 based on a pre-established database, so perspectives from unlisted organisations could be left out. Since key informants were usually project directors or community leaders, it is possible to overlook employee’s opinions on organisational management. Also, geographical constraints influenced the data collection process. For instance, I had initially scheduled virtual interviews with key informants from seven organisations, but due to schedule conflicts and an unstable Internet connection, interviews were delayed or cancelled. During interviews, some local advocacy groups asked to redact their words for safe abortion services or ensure the organisation’s anonymity to prevent potential repercussions.

Key informant groups pointed out the ambiguity of legal ethnic minority protections and lack of public trust in the judicial system as a factor inhibiting social awareness of reproductive rights. To adequately safeguard reproductive rights, it is important to hold the government accountable for acting beyond establishing new policy frameworks. The following section proposes tangible actions for each stakeholder of Kenyan reproductive healthcare.

4.1. **Post-Pandemic Reproductive Healthcare Service Recovery Agenda**

Key informant groups pointed out the ambiguity of legal minority protections and lack of public trust in the judicial system as a factor inhibiting social awareness of reproductive rights.
To adequately safeguard reproductive rights, it is important to hold the government accountable for acting beyond establishing theoretical policy frameworks. The Kenya Community Health Policy (2020-2030) mentions rerouting resources for capacity building and professional development. An investment for capacity building should centre around procuring multiple supply chains in case of emergency, nurturing future providers, and creating solidarity across different stakeholders (providers, government, businesses, and patients) to enhance everyone’s well-being.

Institutional intervention in reproductive healthcare does not end at capacity building, but it extends to the government’s constant interest in funding research and science-based decision-making. For instance, the government should consider the ramifications of their crisis responses and establish emergency plans to prevent a shadow pandemic like an increase in GBV and domestic violence prevalence. Based on KIIs and literature review, I propose supplemental framework of tangible actions for each stakeholder of Kenyan reproductive healthcare in Table 3 below as a response to challenges confronted during C.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Actions</th>
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</thead>
</table>
| National Government  | ● Funding for research  
|                      | ● Evidence-based decision making  
|                      | ● Establish a GBV\(^3\) victim protection system  
|                      | ● Ensure sexual and gender minority and disability rights in national laws and policies  
|                      | ● Inequitable distribution of technology  
|                      | ● Stabilise PPE\(^4\) supplies  
|                      | ● Promotion of universal health coverage  |
| County Government    | ● Create systems of an emergency evacuation plan for |

\(^3\) Gender-based violence  
\(^4\) Personal protection equipments
| Advocacy Groups | • Use volunteers with various identities to increase social awareness of RH (e.g. inviting male facilitators to menstrual hygiene awareness activity)  
| Legal Groups | • Self-representation training for women in marginalised communities  
| Providers | • Regular bias training  
| Local Business Owners | • Collaborations with providers in creating emergency transport networks  
| International Organisations | • Maintaining funding schemes under crises  
| Non-Governmental Organisations | • Collaborations with local advocacy groups or grassroots networks to deliver services |

Table 3. Recommended tangible actions for each RH stakeholders in Kenya as a part of RH recovery agenda

### 4.2. Moving Forward: Abortion is a Fundamental Right

Many key informant interviewees pointed out the government’s decision to legalise abortion, which was previously restricted for life-or-death emergency situations or rape. In

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5 Community health officer/community health assistant  
6 Reproductive health  
7 Short message services
March 2022, the Kenyan High Court affirmed the right to abortion as a fundamental right under the Constitution. The ruling on *PAK and Salim Mohammed v. Attorney General et al.* stated that “arbitrary arrests and prosecution of patients and healthcare providers seeking or offering such services is illegal” (Sobol, 2022). This landmark case was the first time the High Court favoured for reproductive rights after enacting the new Constitution in 2010 and facing constant frustration with the Senate Bill on Reproductive Health from 2014. By setting up a legal precedent of women’s rights on accessing safe abortion services without repercussions, the Kenyan government demonstrated its path to build a stronger and inclusive judicial system.

However, COVID also showed the disenfranchisement of reproductive rights of marginalised populations (sex workers, people living in informal settlements, youths) by providers and police officers. Thus, in order to live with sustainable changes based on lessons learned from the pandemic as discussed in the ‘New Normal’ discourse, the next step for reproductive justice should be establishing policies ensuring their safety and access to RH services.
5. Conclusion

This qualitative study identified a need for more practical actions in various health policy frameworks of Kenya and sought to construct a post-pandemic reproductive healthcare service recovery framework grounded on theoretical knowledge of reproductive rights as social rights. KIIIs with providers the need for an increase in the national government’s investment in universal health coverage in RH, and advocacy groups’ successful technology adaptation in delivering RH knowledge to their target populations offers a potential to utilise technology to remove access barriers in low-and middle-income countries. This study noticed a shift in public perceptions of COVID as an opportunity to build a resilient health system to better deliver RH services and a stronger judicial system to better protect women’s rights.

As this research underscores capacity building and bolstering the relationship between four stakeholders (providers, patients, business owners, and government), it is recommended to adapt tangible and immediate recommendations in Table 3 to Kenya Community Health Policy (2020-2030), Reproductive Health Policy Strategy of Kenya (2022-2032), and real-life practices. Further research is necessary to evaluate the impact of suggested actions on the quality of life and well-being of Kenyan populations and how the ‘new normal’ discourse could influence the creation of public health policy in the post-pandemic world.
Appendix 1. Post-Pandemic Framework Key Information Interview Guide

Identifier: 
Date: 
Interview Time: 
Verbal Consent: Yes No 
Written Consent: Yes No

Basic information of the organisation
- Demographic information
  - Size of organisation
    - Employees, volunteers, patients served
  - Geographic reach
    - Rural/urban
    - Level of community served (county, sub-county, community unit)
    - # of communities served
  - Years in existence
  - Percentage of employees working in Kenya, percentage of employees born and raised in Kenya
  - Description of their mission statement/services offered

Contextual factors that affect reproductive healthcare delivery:
- Situational factors
  - Impact of COVID
    - How has COVID affected the reproductive healthcare service delivery (logistics) of your organisation, such as supplies of reproductive healthcare resources (contraceptives, medications, personal protection equipment (PPE))?
      - What services have been affected?
      - How did the cost of care change?
    - How did you see the funding scheme change for reproductive healthcare before and during the COVID-19 pandemic?
      - Are funds being diverted from sexual and reproductive healthcare to COVID-19 pandemic response relief?
        - If YES: What services have been affected?
        - If YES: Has your organisation responded by cutting back employees?
          - If YES: What positions/employees have been affected?
    - How did COVID vaccine distribution change your organisation’s reproductive healthcare delivery? (February 2021-current)
- How did it change patient-provider interactions?
  - What methods did you or your organisation employ to reach out to community members on reproductive health during the pandemic and national lockdown (i.e. community health volunteers, telemedicine, van services)?
    - If CHV: How did you train community health volunteers? Are they fully aware of COVID precaution measures and provided personal protection equipment from your organisation?
    - If telemedicine: What technology did you use, and were there other organisations involved in developing this technology?
    - If mobile van services: How often did the service provide to clients (per week, per month)? What services were delivered?

- Structural factors
  - Government decision
    - Has your organisation experienced disruption in providing care services due to the Kenyan government’s curfew, mandatory isolation procedure, and mask mandates to prevent COVID transmission from March 2020 to October 2021?
      - If YES: How did it affect service delivery and interactions with patients?
  - What changes have you observed in the Kenyan healthcare system due to COVID-19?

- Cultural factors
  - What quantifiable measures do you track for reproductive healthcare delivery (i.e., number of services offered, clients visited)?
    - How has COVID-19 changed these measures?
    - What are trends in modern contraceptives/family planning services among your target population/clients?
  - To your knowledge, has there been a change in stigma around accessing reproductive healthcare services among clients?
    - If YES: What have you observed?
  - What societal factors encouraged women to visit reproductive health providers during the pandemic?
    - What interpersonal factors encouraged women to visit reproductive health providers during the pandemic?
  - What societal factors prevented women from visiting reproductive health providers during the pandemic?
What interpersonal factors prevented women from visiting reproductive health providers during the pandemic?

- International factors
  - Does your organisation receive funding from international donors?
    - If YES: Has your organisation experienced change in power structure due to the COVID-19 pandemic?
      - If YES: How did it affect the organisation’s interplay with key stakeholders in Kenya?
      - If YES: How did it affect funding for your organisation’s reproductive care service scheme?
**Appendix 2. Kenya COVID-19 Government Action Timeline**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>March 13, 2020</td>
<td>First COVID case confirmed in Kenya</td>
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<tr>
<td>March 15, 2020</td>
<td>President Kenyatta enacted an executive order to curb COVID-19, such as international travel ban, quarantine policies, school closure, group gathering ban, curfew, recommendation to work remotely, etc.</td>
</tr>
<tr>
<td>April 6, 2020</td>
<td>President Kenyatta announced ‘Cessation of movement in and out of The Nairobi Metropolitan Area’ for 21 days, effective April 8th</td>
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<tr>
<td>June 6, 2020</td>
<td>President Kenyatta announced the extension of national dusk-to-dawn curfew (9pm to 4am) for 30 days and school reopening from September 1, 2020</td>
</tr>
<tr>
<td>July 6, 2020</td>
<td>President Kenyatta announced another extension of group gathering ban and curfew for 30 days</td>
</tr>
<tr>
<td>July 7, 2020</td>
<td>Cessation of movement in and out of The Nairobi Metropolitan Area was lifted School closing across all levels</td>
</tr>
<tr>
<td>August 1, 2020</td>
<td>Resumption of international flights</td>
</tr>
<tr>
<td>January 7, 2021</td>
<td>Dr. Patrick Amoth (Director general of public health) announced import of 24 million Oxford-AstraZeneca vaccine in February</td>
</tr>
<tr>
<td>January 20, 2021</td>
<td>Two Beta variant cases confirmed</td>
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<tr>
<td>March 5, 2021</td>
<td>Voluntary COVID vaccination started</td>
</tr>
<tr>
<td>March 26, 2021</td>
<td>President Kenyatta announced cessation of any transportation in and out of disease-infected areas such as Nairobi counties and revision of curfew (10pm to 4am) except counties with high COVID cases (e.g., Nairobi, Nakuru)</td>
</tr>
<tr>
<td>December 15, 2021</td>
<td>First Omicron variant case confirmed</td>
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<tr>
<td>March 18, 2022</td>
<td>All international travellers who received COVID vaccination are exempted for entry testing</td>
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</tbody>
</table>
References


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https://reproductiverights.org/malindi-kenya-court-affirms-abortion-right-pak/


