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CONVERSATIONS

"If you don't help me, I'm going to take my life": the devastating impact of the US's global gag rule and the COVID-19 pandemic on women's sexual and reproductive health in Kenya

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Introduction

The 17-year-old girl walked into the facility seeking access to the abortion pill to terminate her pregnancy and uttered these words to the director: "If you don't help me, I'm going to take my life." The quotation was lodged in the director's brain, and not just because this incident had occurred the day before our interview. The director had recently received word that another one of her clients nearly bled to death trying to obtain an unsafe abortion elsewhere. The possibility of dying in pursuit of an abortion was all too real. The director's community-based organization has a reputation for educating girls on sexuality, empowering them to understand their rights, and providing youth-friendly services. Unfortunately, due to funding cuts, the organization is also struggling to meet the expanding needs of its clients. The 17-year-old girl was referred to one of the few remaining organizations in Kenya that performs abortions, and when the director checked in on her a few hours prior to our interview, she was relieved to discover that the girl had taken the abortion pill and was fine. Her life had been saved because she was able to access sexual and reproductive healthcare during the COVID-19 pandemic, but unfortunately this access is dwindling for many women in Kenya.

Sadly, the desperation in this story is not unique. During the past few months, we have been conducting interviews with directors of community-based and non-governmental organizations (NGOs) focused on providing

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sexual and reproductive health services and advocacy in Kenya. Their responses include common themes that reveal how United States (US) policy – specifically, the policy commonly known as the global gag rule (GGR) – has exacerbated the conditions of the COVID-19 pandemic for women and girls in Kenya and hampered the NGOs' ability to respond to the corresponding escalation in demand. After conversing with more than 30 stakeholders in Kenya, we have learned that in order to fully understand the impact of the COVID-19 pandemic on women and girls, we must first understand the dire sexual and reproductive health landscape that has emerged under the GGR.

What is the GGR?

The GGR (officially the "Protecting Life in Global Health Assistance Policy") was most recently implemented in January 2017, but it dates back to August 1984 when it was introduced as the "Mexico City Policy" under the Reagan administration. It requires "foreign nongovernmental organizations to agree as a condition of their receipt of Federal funds for family planning activities that such organizations would neither perform nor actively promote abortion as a method of family planning in other nations" (Bush 2001, 17303). The GGR has been implemented by every Republican president and retracted by every Democratic president since 1984.

Donald Trump became the first president to apply these restrictions to nearly all federal global health assistance, including the President's Emergency Plan for AIDS Relief (PEPFAR), a program established in 2003 by George W. Bush to combat HIV and AIDS (*The Lancet* 2019). In March 2019, US Secretary of State Mike Pompeo announced the expansion of the policy to include both prime and sub-awardees. Under the Pompeo Expansion, any NGO receiving US global health assistance is prohibited from providing financial support to another NGO that fails to meet the strict guidelines regarding abortion (Gootnick et al. 2020). The wider implementation of the policy affects more NGOs and therefore places further strain on the NGO funding landscape.

On the surface, the GGR may seem to be narrow in scope, as it explicitly affects funding related to organizations that offer abortions and abortion counseling. However, in many areas, NGOs provide a more comprehensive suite of services. For example, patients can not only receive safe abortion care, but may also obtain contraceptives, HIV-related care, immunizations, and maternal healthcare (Starrs 2017). This model is especially common in resource-poor settings where healthcare is limited. Denying funding to these NGOs affects all of the clinic's operations. NGOs are therefore left with a dire choice: accept US funding and forgo providing these comprehensive sexual and reproductive health services, or forgo US funding altogether.

Since Kenya's health system relies heavily on funding from external donors and NGOs interface with the public to provide a referral base to clinics for sexual and reproductive health,[1] the loss of US funds has left these NGOs with far fewer resources to treat the growing demand for sexual and reproductive health services that have arisen during the COVID-19 pandemic. Time and again, our conversations with stakeholders revealed that the US-imposed restrictions have hampered the ability of the Kenyan healthcare system to keep up and that women are paying the price.

The COVID-19 pandemic's impact on sexual and reproductive health and rights in Kenya

Thousands of miles from Nairobi, living through some of the most historic times to face the modern international community, we spoke via video-conferencing technology to motivated stakeholders, galvanized to meet the needs of women and girls across Kenya, despite facing substantial obstacles. In interviews with over 30 leaders of NGOs, civil society organizations, research organizations, and healthcare service providers, we learned first-hand of the interaction between the GGR and the COVID-19 pandemic and its impact on the access to and fulfillment of sexual and reproductive health services and rights for women and marginalized populations. The systemic problems are highlighted by tragic stories like that of the aforementioned 17-year-old girl, and by common themes raised by nearly every stakeholder.

The professionals with whom we spoke said that the COVID-19 pandemic has created an increase in demand for sexual and reproductive health services stemming from a rise in teen pregnancy as well as sexual and gender-based violence. With schools closed and curfews and travel restrictions in place, many women and girls are trapped at home with their abusers. This dangerous situation poses grave challenges, and organizations have tried to increase outreach by offering meetings online but one interviewee lamented that "we could not reach all young people, because some don't have phones and internet and are unable to reach the online platforms." Another advocate emphasized that "we need more education and tools for girls to react to adverse experiences like rape and abuse." All interviewees recognized a need for increased focus on these issues; one director said that "we need to put measures in place to account for the safety of women no matter what the circumstance." However, funding cuts initially imposed by the GGR limit their ability to provide a robust response and women's and girls' lives hang in the balance.

Unfortunately, this increased demand has been met with a decrease in the supply of sexual and reproductive health providers and resources during the COVID-19 pandemic. At a time when the need for more financial resources

has never been greater, organizations are functioning with leaner budgets. Stakeholders expressed frustration and concern to us that the already scarce sexual and reproductive health funding has been diverted to the COVID-19 response and some clinics that provide sexual and reproductive health services have been forced to close. One interviewee warned that "if we neglect this [need for sexual and reproductive health funding] … we will be faced with worse issues moving forward." Indeed, the consequences of fewer clinics, such as negative birth outcomes and maternal mortality stemming from inadequate ante-natal and post-natal care, cannot be erased. Pregnant teens and women must now travel greater distances in a pandemic to seek the care that they need, requiring more of their own time and resources, and increasing their risk of exposure. In some instances, they may not be able to access a clinic at all. Outcomes stemming from this scenario worry sexual and reproductive health leaders. One participant cautioned that "some pregnant women have to deliver at home," which could lead to a "high mortality rate for delivery." Even when clinics remain open, COVID-19 restrictions have limited the family planning options available to women. One director lamented that

> because of the physical contact required to administer long-term contraceptives,[2] we are being diverted away from these more effective methods to avoid COVID transmission. There is actually a policy in place by the Ministry of Health encouraging healthcare workers to provide short-term methods[3] to women.

If we allow circumstances to dictate sub-standard care, women will die and unwanted pregnancies will increase. This has long been a concern of critics of the GGR; the COVID-19 crisis only intensifies this possibility.

Stakeholders highlighted for us the enormous issues associated with women's ability to access the sexual and reproductive health services that do remain available to them. Government restrictions and official messaging tied to the COVID-19 pandemic carry a number of direct and indirect consequences for the practical accessibility and immediacy of sexual and reproductive health services. Warnings from authoritative sources, such as "Stay at home – we are only accepting emergencies," in combination with government-imposed nationwide curfews and travel restrictions, have prompted women to believe that sexual and reproductive health services are not an emergency. As one director said, "[T]he initial communication is to blame, not the people. Some people misunderstand and think that family planning is not an emergency. But if you need protection, you cannot wait to get it." Indeed, family planning has life-altering consequences for women and their families. The government's failure to properly prioritize family planning during the COVID-19 pandemic will affect their futures long after it is over.

Lastly, we heard professionals frequently report concerns regarding the unintended spillover of GGR effects, exacerbated by pandemic-related restrictions, to HIV services, particularly those targeting women and adolescents. Multiple people reported that inadequate funding due to the GGR and a reallocation of resources to the COVID-19 response has forced both youth centers and clinics to close, leaving many women and young people unable to access antiretrovirals and counseling services. As one advocate said, "[W]hen something happens, young people don't have anywhere to go." The devastation brought on by the COVID-19 pandemic has made the need for those facilities even greater. There is a heightened demand for HIV services as a result of the increased occurrence of gender-based violence and unsafe or transactional sexual activity in the wake of lockdowns and school closures. The gains made in combating HIV over the last several years could be compromised if sexual and reproductive healthcare is not fully restored.

Frustration and hope: looking to the future

Despite the concern that permeated their words, the passionate dedication that the sexual and reproductive health and rights leaders and organizers bring to their work carries with it enormous hope for global health community in uncertain times. Our conversations led to a greater mutual understanding about the challenges and the possibilities that advocates envision for sexual and reproductive health and rights during the COVID-19 pandemic and beyond.

The most pervasive sentiment expressed by the interviewees was one of frustration with gendered health inequities and policy choices that have failed to protect women and girls, such as the lack of funding for sexual and reproductive health services. One woman recounted that, when the COVID-19 pandemic worsened, the government declared that each county should have 300 intensive care unit (ICU) beds. By contrast, sexual and reproductive health and rights advocates have long been requesting facilities to maintain as few as ten delivery beds (which are cheaper than ICU beds), with low rates of success. One interviewee pointed out indignantly that "we were never willing to sacrifice [funds] for women giving birth, but we are giving attention to the situation that is affecting men and women."

Despite this, most stakeholders mentioned their hopes for improvement. Many people with whom we spoke viewed collaboration with other NGOs as the key to accomplishing their goals and several described how consortia of organizations were working together to address health challenges in their communities. They also mentioned feeling hopeful about the trajectory of healthcare systems after the COVID-19 pandemic. Several noted that this pandemic has highlighted inadequacies in the current systems, and they hope to see structural change following the urgency of COVID-19 efforts. For example,

Kenya recently piloted a universal healthcare program in a few of its counties and NGO leaders expressed hope that, after seeing the devastation of the pandemic, the government would approve an expansion.

Moving forward, the professionals with whom we spoke are pushing for debates about how their system could have been better prepared for the COVID-19 pandemic. These committed stakeholders are leveraging this moment as a real catalyst for change. Many acknowledged that the system did not serve people well even before the pandemic, and that increasing access is pivotal to improving future health outcomes. For example, one stakeholder discussed the low healthcare coverage rate, estimating that only 10 percent of the Kenyan population is privately insured – a dismal figure in a country without universal coverage. In particular, most noted that the healthcare system needs to prioritize marginalized groups, including women and girls, more actively. Others named investment in the human side of healthcare as a pillar of meaningful structural change. Increased attention to human resources will require serious internal, financial commitments. However, the pandemic has highlighted that without trained professionals and adequate funding, the system cannot meet the needs of all people.

With the US's GGR exacerbating the challenges that NGOs face during the COVID-19 pandemic, there is a recognition that fundamental structural weaknesses have become too severe to go unaddressed. Stakeholders with whom we spoke across the country see the simultaneous destruction of and heightened need for sexual and reproductive health services and rights during the COVID-19 pandemic as the final straw. These leaders are fiercely committed to demanding more for Kenya's women and are hopeful that, through collaboration and continued advocacy for sexual and reproductive health, a better future is achievable.

Prioritizing sexual and reproductive health: the need for global support

We have gained valuable insights into the implications of the GGR for sexual and reproductive health and rights advocacy and service provision within Kenya in the time of COVID-19. Yet, as women working in the field of global health and as Americans, our conversations with advocates weigh heavy in our minds. The interviews have left us with an overwhelming despondency at the role that our country plays in weakening sexual and reproductive health and rights NGOs, leaving them unequipped to fully respond to women's needs at this crucial time. The GGR's impact on perpetuating the COVID-19 crisis for women and girls outside our borders reminds us of a message that the interviewees with whom we spoke made abundantly clear: in global health interventionism and international aid mechanisms, there are no gender-neutral policies.

A rise in pandemic-related gender-based violence is paralleled by an accumulation of structural violence against women in the Global South. The GGR, fueled by the US anti-choice movement, represents a widespread, systemic attack not just on bodily autonomy, but on the health and rights of women in low- and middle-income countries. Its weakening of the women's health system and the sexual and reproductive health and rights advocacy space within Kenya is distinctly gendered and is viewed by some advocates within the country as a "deliberate attempt to colonize civil society organizations." These effects cannot be detached from a global pandemic that has already disproportionately impacted women and girls. It is not implausible to say the women of Kenya would not face such significant barriers to accessing high-quality sexual and reproductive healthcare had the pandemic occurred four years prior within health systems unburdened by the constraints of the GGR.

The US, with its large foreign aid budget, has the power to be a strong advocate for the expansion of women's reproductive rights across the world; yet for many people with whom we spoke, the GGR is an example of how Americans are just "selfish" by imposing our agenda on others. Steps to rectify this have fallen short. In 2017 and again in 2019, the Global Health, Empowerment, and Rights (HER) Act was introduced into both the US House of Representatives and the US Senate. The Global HER Act would reverse the GGR and prohibit any future enactment of the policy. Alas, the bill was not brought to the floor for a vote and never left the committee – not even in the Democrat-led House in the 116th Congress. As researchers, but foremost as women, we cannot sit back, observe, analyze, and allow this to continue. Merely relying on the GGR being lifted with the inauguration of the Biden–Harris administration is not enough; a conscious decision must be made within US foreign assistance policy to prioritize the health and well-being of women and girls globally.

Notes

1. This information was obtained from interviews conducted by the authors in April 2020 with government health officials, healthcare providers, and stakeholders who work in sexual and reproductive health in Kenya. Information from these interviews is in Gravitt et al. (2021).
2. These include IUDs (intrauterine devices) and implants, which are inserted by a healthcare provider at a clinic visit and provide 99 percent effective pregnancy prevention for three to seven years, depending on the method used.
3. These include oral contraceptives, condoms, diaphragms, and sponges, which are only 76–91 percent effective in preventing pregnancy, but are self-administered on a regular basis, thus obviating the need for an in-person clinic visit (although do, in some cases, require a prescription).

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