REPRODUCTIVE HEALTH matters

FEATURE

The Kenyan national response to internationally agreed sexual and reproductive health and rights goals: a case study of three policies

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Abstract: *While priorities for, and decision-making processes on, sexual and reproductive health and rights have been determined and led mainly at the international level, conflicting power dynamics and responses at the national level in some countries have continued to pose challenges for operationalising international agreements. This paper demonstrates how these conflicts have played out in Kenya through an analysis of three policy-making processes, which led to the Adolescent Reproductive Health and Development Policy (2003), the Sexual Offences Act (2006), and the National Reproductive Health Policy (2007). The paper is based on data from a broader study on the drivers and inhibitors of sexual and reproductive health policy reform in Kenya, using a qualitative, case study design. Information was gathered through 54 semi-structured, in-depth interviews with governmental and civil society policy actors and an extensive review of policy documents and media reports. The paper shows that the transformative human rights framing of access to sexual and reproductive health, supported by both a strong global women's rights movement and progressive governmental and inter-governmental actors to defeat opposition to sexual and reproductive health and rights at the international level, has not been as influential or successful at the national level in Kenya, and has made comprehensive national reforms difficult to achieve.*

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Sexual and reproductive health (SRH) issues are often neglected, particularly by many developing country governments, because of religious and cultural opposition. This has necessitated international as well as regional efforts to commit governments to addressing these issues. The most significant of these was the 1994 International Conference on Population and Development (ICPD), which reframed them as a human rights issue,[1] in order to increase international and national attention to persistent high rates of maternal mortality and morbidity, teenage pregnancy, gender-based and sexual violence, and low rates of contraceptive use, among other issues. At the time, both international and national efforts had been focused on population control and safe motherhood, without much attention to individual needs or health outcomes. The reframing therefore sought to shift the focus to individual needs, rights and health, particularly of women, girls and adolescents, and to addressing the structural issues that underpinned poor reproductive and sexual health outcomes.

Although ICPD put human rights at the centre of responses to SRH issues, it was not the first UN gathering to link human rights to SRH. Indeed, the 1993 UN Conference on Human Rights in Vienna was the first to formally recognise women's rights as human rights.[2] But even before this, a 1979 UN General Assembly had adopted the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which sought to end discrimination and violence against women.[3] These commitments were buttressed by the 1995 4th World Conference on Women in Beijing, which emphasised the concept of reproductive health and rights, and expanded on the sexual health and rights of women.[4]

These successes at the international level were realised in spite of strong opposition from the Vatican, other Christian and Muslim religious groups

and conservative governments, mainly from Africa, Asia, Latin America and the Caribbean. The successes have been attributed to the growing influence of the global women's movement in UN processes and its ability to penetrate and influence the UN's decision-making mechanisms.[5] The opposition argued mainly that these issues were a threat to national cultural and religious values, power and interests,[6] which resulted in compromise on contested issues such as the right to safe, legal abortion.

In 2000, the Millennium Development Goals (MDGs) included a focus on ending gender inequality and improving maternal health. A revision in 2005 saw the MDGs include a target on reproductive health (RH). Even then, it has been argued that the MDGs adopted a piecemeal technocratic approach to development, effectively marginalizing ICPD's holistic, human rights approach to development.[7] In 2011, however, the human rights approach to SRH was expanded when the UN General Assembly resolved to recognise discrimination on the basis of sexual orientation and gender identity as a violation of human rights.[8] Except for South Africa, all sub-Saharan African countries present at the Assembly voted against this resolution. This resolution was especially motivated by increasing hostility towards gay rights in various African countries.[9–13]

At the regional level, the African Union (AU) adopted the Protocol to the African Charter on Human and People's Rights on the Rights of the Women in Africa (the Maputo Protocol) in 2003.[14] The Protocol seeks to protect and promote women's rights by putting an end to discrimination, violence and negative gender stereotyping. The Protocol explicitly addresses violence against women and the right of girls and women to access SRH services, including safe abortion. To date, 36 out of the 54 African states have ratified the Protocol. The AU further adopted the Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007–2010 in 2006. On youth SRH, the AU Heads of State in 2006 endorsed the African Youth Charter, which is the first ever legal framework for youth development on the continent. The Charter highlights, among others, adolescent health including SRH and HIV, youth and culture, and the elimination of harmful cultural practices and discrimination against girls.

Although Kenya is party to these international and regional commitments, the country has, like many other sub-Saharan African countries, operationalised some aspects of these commitments and ignored others. This makes it important to understand the differing power dynamics and dominant political views at the national level that produce this variance, given the expectation that countries like Kenya will realise more comprehensive SRH reforms. This paper seeks to contribute to this understanding by deconstructing three SRH policy development processes in Kenya – Adolescent Reproductive Health and Development Policy (2003), the Sexual Offences Act (2006), and the National Reproductive Health Policy (2007) – in order to lay bare the political interests and power dynamics that have determined the resultant policies.

Methodology

The data on which this paper is based are part of a bigger study conducted for my PhD research, which investigated the drivers and inhibitors of change in SRH policies and laws in Kenya. This research was approved by the University of Sussex following a successful ethical review and clearance process. The study used a qualitative case-study design and focused on the critical role of context in understanding national policy decisions and the legislative process[15] with regard to the contested issues of adolescent reproductive health and sexual offences, and in case of the national RH policy, to get a holistic understanding of the responses.

Data collection involved semi-structured, in-depth interviews in Nairobi between March and September 2011 with 54 SRH state and non-state policy actors in Kenya who were involved in the policy-making processes. Individuals interviewed ranged from Members of Parliament (MPs), government officials from the Division of Reproductive Health, National Council for Population and Development and the Kenya National Commission on Human Rights, researchers,* funding agencies,† programme implementers,** human rights and women's rights advocates,†† officials of

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†USAID-Kenya, DFID-East Africa and GTZ/GIZ.

**Including Pathfinder International, JHPIEGO and FHI 360.

††Including FIDA-Kenya, Urgent Action Fund, WILDAF-Kenya, Coalition on Violence Against Women, Health Rights Forum, Reproductive Health and Rights Alliance, Planned Parenthood Federation of America (Nairobi office), and International Planned Parenthood Federation-Africa Regional Office.