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# New directions in African education: challenges and possibilities

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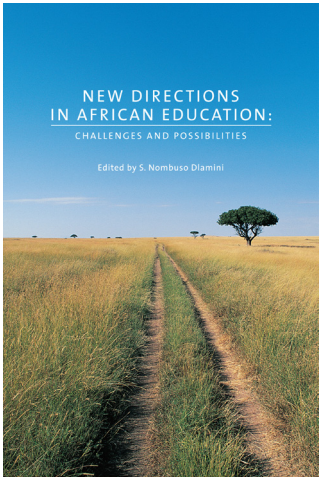


**NEW DIRECTIONS IN AFRICAN EDUCATION: CHALLENGES AND POSSIBILITIES**

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# 3

# REPRODUCTIVE HEALTH IN KENYA: A MATTER OF SOCIAL JUSTICE[1]

Jacinta K. Muteshi

## ABSTRACT

*In this chapter the argument is made that access to health services and to education is a human right yet to be realized by many Kenyans; these are issues that have a profound impact on the sexual and reproductive health of many women in Kenya. The author argues that the language used to write policy about these human rights should be illustrative of government commitment to access and should include stipulated measures of accountability. The author demonstrates the explicit connection between education and reproductive health that must be understood and incorporated into public policy so that women in both urban and rural African areas benefit from the knowledge. Furthermore, and most importantly, the chapter highlights how women from nations of the north and the south equally share profound challenges with regard to their reproductive and sexual rights and freedoms. The author ends by offering a discussion of these challenges and potential new directions for activism and policy initiation and implementation.*

> A 15-year-old girl was jailed for three years after she admitted throwing her newborn baby into a pit latrine in Nyahururu town. In mitigation the girl said she could not afford to look after two children. (*Daily Nation*, 2003, p. 6)

## INTRODUCTION

In many African cultures childbearing is cause for jubilation, and the arrival of a new life is often a source of empowerment and status for women. Yet the cultural constructions of motherhood reinscribe inequality for women, for they also experience enormous burdens in their roles as mother; they are beleaguered by heavy workloads, deprived of access to adequate resources and exposed to laws and cultural values that increase their vulnerability.

In Kenya motherhood remains a high-risk activity. Current studies estimate a maternal mortality rate, which is the number of women who die in pregnancy and childbirth, to be 414 for every hundred thousand live births (Government of Kenya, 2003a). While the number of perinatal deaths in Kenyan is four per cent of births (Cook et al., 2003), no accurate figures are available for those infants who do survive birth but are killed or simply go missing within a few days of being born as a consequence of being unwanted. On the whole, births to unmarried or young adolescents are unintentional; however, one out of every two hundred adolescent girls is likely to die from complications of motherhood and unwanted pregnancies (Rogo, 1995). Compounding these issues is the fact that, even after a safe delivery, poor women are unable to provide their children the resources they need in order to live and have healthy lives.

Table 3.1 provides information about the reproductive health realities of women and girls in Kenya. Table 3.2 provides information about medically assisted births.

*Table 3.1: Reproductive health information on Kenyan women and girls.*

| | |
|---|---|
| Estimated maternal mortality rates in Kenya, ages 15–49 | 414 for every 100,000 live births[a] |
| Number of unsafe abortions annually | 300,000 (accounts for 30–40% of maternal mortality)[b] |
| Number of deaths from abortions annually | 2,000[b] |
| Number of pre-natal deaths | 40 out of 1,000 births[c] |
| Number of adolescent girls likely to die from complications of motherhood and unwanted pregnancies | 4 out of 10[c] |
| Number of adolescents (single or married) who have already begun childbearing (15–24 years of age) | 106 out of 1,000 (10.6%)[c] |

*Sources:*
a = Kenya Demographic Health Survey (Government of Kenya, 2003a)
b = Advocacy Safe Motherhood (Reproductive Health Advocacy Project, 2004)
c = Kenya Demographic Health Survey (Government of Kenya, 1998).

*Table 3.2: Percentage of assisted births in Kenya. (Total = 3,464 births).*

| | |
|---|---|
| Doctor | 12.3 |
| Nurses/trained midwife | 32.0 |
| Traditional birth attendant | 21.2 |
| Relative/other | 23.9 |
| No one | 10.2 |
| Don't know/missing | 0.4 |
| Total | 100.0 |

*Source:* Magadi (2002).

Health, in general, is defined and constructed within socio-cultural, political, and economic environments, which in turn affect health outcomes. Consequently, disadvantaged social, political, and economic environments affect the lives of Kenyan women and increase the harmful effects on women's reproductive health, which include unplanned births, early pregnancies, and experiences of life-threatening complications when giving birth or when terminating unwanted pregnancies. This chapter lays out the issues behind these serious threats to women's reproductive health and analyzes the place of reproductive health in its social, economic, and political contexts. The chapter also focuses on the language of human rights as necessary for interrogating what is said about the bodily experience of reproduction and the opportunities offered by the discourses of rights aimed at asserting and improving the reproductive and sexual health of Kenyan women.

## SEXUAL AND REPRODUCTIVE HEALTH IN THE EDUCATION SYSTEM[2]

Formal education as presented in schools is often seen to have significant influence on how people make informed decisions about their lives, which includes making decisions about sexual behaviour. Historically, however, sexual and reproductive health has not been part of the Kenyan education curriculum. According to Brockman (1997), even though family life education sometimes addresses menstruation, anatomy, and so on, until 1997, sex education was not officially covered in the curriculum. Additionally, even if sex education was covered in the school curriculum, not everyone had access to this information through school because the education of girls was not seen as a priority in some rural communities.

With the rise of HIV/AIDS, however, there have been some attempts to deliver sexual and reproductive health education in schools. Boler et al. (2003) argue that these attempts have been faced with challenges emanating from the crisis in the education system (overcrowded classes, overstretched curriculum, and a shortage of training opportunities and learning materials) and, more importantly, from a long line of social disapprovals and taboos

surrounding sex education. For instance, in the case of males, sex education, traditionally, is associated with initiation rights and the transition from boyhood to manhood. This happens partly because often parents are uncomfortable talking to their children about sexual issues; in fact, in some communities, it is considered shameful for parents to discuss sexually related issues with children. The role of talking to children about sexuality, varies by communities, but traditionally falls to the grandparents, or aunts, or those charged with the ceremonies of initiation into adulthood. For example, among the Kisii people, the grandmother is the children's source for learning about their sexuality. Brockman (1997) argues that taboos, traditional ways of teaching about sexual practices, and the fear of negative reactions from traditional families explain why teachers resist teaching sexual, reproductive, and health education.

Boler et al.'s (2003) study of educational response to the HIV/AIDS epidemic also documents teachers' reluctance to discuss sex and HIV/AIDS with students. The study found that teachers select the messages they want to give students, choosing to overemphasize scientific-based information and not make any direct reference to sex or sexual relationships. Like Brockman, the authors indicate that there are social and cultural constraints when it comes to teaching sex education and about HIV/AIDS. There exists a societal assumption that young people do not and will not have pre-marital sex. In sex education, traditionally, girls were taught to be docile and subservient, which was enforced through female genital cutting and the woman's role in marriage. Girls were also taught that to be married was of greater value than to be educated; as a result, many girls were married off early before completing compulsory schooling (Brockman, 1997). Therefore, even though there have been attempts to include sexual, reproductive, and health education in schools, these programs have been severely curtailed by the wider crisis in education and by social and cultural beliefs. These constraints are evident in health institutions such as clinics and in the behaviour of health personnel towards young people attempting to learn more about their sexuality and to access sex-related health resources such as condoms.

## SOCIAL CONSTRUCTION OF GENDER AND REPRODUCTIVE HEALTH OUTCOMES

Gender, defined as the different opportunities and attributes associated with being female or male, has a powerful influence on sexual and reproductive behaviour and outcomes. The views and practices of femininity and masculinity that reinforce female dependence, men's privileged status, and the inequity between women and men have meant that health is also experienced and defined within social relations of gender, which place women in subordinate positions. Throughout Kenya, women who face poor reproductive health do so because of poverty and other forms of marginality that can be located within gender inequalities. Conditions of inequity have limited females from accessing resources such as education, resulting in lower literacy rates which, in turn, lead to less frequent use of reproductive health services and less knowledge about the importance of reproductive health care.

Gender aspects also go a long way in helping explain the reluctance of women to seek reproductive health care. The heavy work burden that falls upon women provides them with little time or space to care for themselves, thus discouraging them from seeking health care because of the time it would take away from household, agricultural, and market work, as well as community obligations. Furthermore, for most rural women, the nearest health clinic tends to be a daunting six kilometres away. If and when women or men do get to the clinic, they face other disabling factors such as an inordinate amount of waiting time. In their study, "Integrating men into the reproductive health equation: Acceptability and feasibility in Kenya," Muia et al. (2000) concluded that structural constraints, including waiting time in clinics, decreases male participation. For employed men, time spent waiting at the clinic translates into wages lost. Furthermore, at the clinic, women often find themselves faced with discouraging staff attitudes and behaviours, which also discourage male participation.[3] One attitudinal example is that staff will provide very narrowly defined maternal and family planning programs and mainly offer these services to women who are married or to pregnant adult women; young unmarried girls are not seen as deserving such services.

The value placed on women also determines their health care practices. When less value is placed on females because of gender, they will not seek out health care if doing so requires payment. Among the poor, for example, if seeking health care requires spending family income, women's health will come second to other family needs requiring money. Concurrently, the low social status of women often means they lack autonomy over their own bodies. They are often denied the power to make decisions or negotiate with men on matters such as if and when they will have sex or even if contraception will be used. Thus, such issues of power prevent women not only from exercising their procreative power but also their sexuality. These unequal relations of power in sexual relationships expose women to sexual violence, sexually transmitted infections, and unwanted pregnancies.

Women's reproductive health is also challenged or unattainable if men are not involved in promoting women's health, or if men's own reproductive health needs remain unlinked to women's. Men are also a group affected by gender factors. Concepts of masculinity, which include risk-taking, unreasonable expectations that men should endure pain or ill-health, and the idea that reproductive health concerns are a woman's affair, hold men back from seeking reproductive health care; thus increasing the gravity of their illness, possibly even leading to death. Thus, while the burden of reproduction still falls upon women who lack decision-making power, concrete actions are yet to be taken that will encourage and enable men to shoulder responsibility for their sexual and reproductive behaviour, given the consequences this responsibility has on social and family roles. The outcome of gender disparities ultimately leads to an increase in ill-health for women, and often for men.

## CULTURAL NORMS AND THE IMPACT ON REPRODUCTIVE HEALTH

The recognition of indigenous customs as the personal laws of the Kenyan ethnic communities has an impact on women's general and reproductive health. For example, among the Luo communities, wife

inheritance is a traditional practice in which a widow is "inherited" by one of her dead husband's brothers. Traditionally, this was a way of ensuring resource support for the widow and her children, as well as to keep the children and the family unit together. Sexual activity was, among other things, expected in this arrangement as the "inherited" widow became the wife of her former brother-in-law. Complexities emerge in cases where the inheritor/new husband already had a wife as polygamous families may be characterized by inner-family tension and strife over issues such as access to resources, time spent with husband, number and sex of children in a wife's house, and a wife's individual capacities and opportunities.[4] Nowadays, wife inheritance presents an added threat of the widow contracting HIV/AIDS from the new husband, in the absence or lack of negotiating power and social support for women to insist on safe sex or reject sexual advances and the demands of inheritance practices may force her to engage in sexual activity. Inheritance laws among some Kenyan communities often leave widows impoverished, creating new vulnerabilities for women, at times forcing women and their young daughters into risky sex work or relationships placing them at risk of violence and sexually transmitted infections.

In addition to wife inheritance and its associated women-endangering practices, there are other forms of "adapted" polygamous unions that exist in present-day Kenya and other neighbouring countries. Researching these unions in Nigeria, Karanja (1986) referred to these women as "inside wives" and "outside wives." In these cases, polygamous marital arrangements are modified such that men may have "inside wives" that they have legally married and are publicly recognized and with clear marital rights and at the same time initiate relationships with other women, known as "outside wives," that will not be legally binding and thus unrecognized. Such marital transformations that often create legally unrecognized families not only pose risks to both inside and outside wives' access to marital wealth and resources, but also have an impact on women's reproductive and sexual health. Furthermore, such marital transformations challenge satisfying relationships and affect balanced family lives and the ability to safeguard one's reproductive-sexual health. For the majority of African women, HIV/AIDS infection is often in the context of marriage. For example, where rules of polygamy are changing, and/or where there is the frequent change of partners, sexual encounters

increase. Such practices increase the risk of sexually transmitted infections such as AIDS and concerns leading to infertility and newborn diseases associated with these infections. Even though harmful customary practices such as female genital mutilation and early and forced marriages have been declared illegal under both the new Kenyan statutes and the recently adopted Children's Act (2001), they continue to be part of present-day Kenyan society. Thus, although statutes may legally enable Kenyan women to seek legal action, most women find that, culturally, they have no power to act against strong masculine values. The main reason is because the Kenyan state continues to give constitutional recognition to patriarchal customary laws, thus contradicting its own statutory prohibitions in favour of cultural traditions that harm the health of women. In this way, some cultural practices remain a key reproductive health concern for Kenyan women insofar as they determine or have influence over reproductive health decision-making and shape the context of reproductive behaviour in ways that are harmful to women.

## ADOLESCENT ACCESS TO SEXUAL REPRODUCTIVE HEALTH SERVICES

Socio-cultural practices, including intolerance towards adolescent sexuality, continue to foster discrimination against female adolescents. Health service providers often fail or refuse to recognize that Kenyan adolescents are sexually active and in need of information and services. Other barriers that stand in the way of access to services can be the shyness and fear of embarrassment on the part of adolescents in undergoing medical examinations and the stigma associated with being sexually active as an adolescent (Daily Nation, 2006). Whereas studies show that it is common for young people in Kenya to start having sex in their early teens (World Health Organization, 2003), what is not so well known is that, unlike in Western nations, where sexually active adolescents are unmarried, in developing countries most are married and therefore face different challenges than their single counterparts (Population Council, 2001). For example, results from a study of youth sexuality and reproductive health, conducted

by the Population Council (2001), reveals that 10.6 per cent of single adolescents in Kenya, mostly between ages fifteen and nineteen, are already having children. Their physical immaturity means they are ill-prepared for childbearing. There is also a belief among some Kenyan communities that sex with a young virgin will cure a man of AIDS. This belief suggests that young women and girls are much more at risk of being infected than their male counterparts. Furthermore, many young girls are also growing up at a time of increasing poverty in sub-Saharan Africa, which has compounded the risks they face. For example, girls growing up in poverty seek work earlier, which, given their age, places them in situations of risk of sexual abuse or exploitation. Child marriages and the fact that they are more likely to drop out of school given household-caring responsibilities or pregnancy means they have less access to information, and because they are young girls, they have less negotiating power to protect themselves against HIV/AIDS. Girls are also more vulnerable to HIV infections because, if not fully mature, their reproductive tracts are more susceptible to tearing, increasing their risk of sexually transmitted infections. In Kenya there is an increasing practice of older men, who would have had more partners and therefore be most likely to have been exposed to HIV, to have adolescents as sexual partners in a context where poverty can be the driving force towards the exchange of sex for school fees, support for families, or need for money.

Adolescent girls from poor families face a high risk of early marriage, sexual violence, HIV/AIDS, unplanned pregnancies, and unsafe abortions because of their socio-economic vulnerability. Yet these young, single women are not likely to receive reproductive health counselling support, family planning information, or access to all available family planning methods. Reproductive health staff members often impose age restrictions on information and resource access, depending on the types of women they feel should have such access (Population Council, 2001). Furthermore, as the epigraph to this chapter illustrates, custodial sentences handed out to young girls who kill their infants demonstrate a failure on the part of the Kenyan state and society to respond effectively to its vulnerable adolescents, especially those who are legal minors. Incongruously, the men responsible for the pregnancies remain untouched by law. Youth, therefore, remain ignored and vulnerable while politicians and secular and religious leaders continue to argue and disagree over

the relevance or value of providing crucial services and life-saving information to adolescents.

## POVERTY AND REPRODUCTIVE HEALTH NEEDS

Absolute poverty increased from 48 per cent to 53 per cent in rural areas of Kenya between 1992 and 1997, and poverty in urban areas increased by a much higher margin, from 29 per cent in 1992 to about 50 per cent in 1997 (Africa Population and Health Research Center, 2002). Rapid population growth has stretched infrastructures, which, combined with the Kenya government's inability to address infrastructural limits, means that the majority of households are becoming poorer. A large number of Kenyan women who live in households below the poverty line lack access to resources and opportunities, making it impossible for them to have healthy reproductive lives. For Kenyan women living in remote communities, pastoralist nomadic women, and internally displaced women, the demand and access to affordable, accessible, and quality reproductive health care remains difficult or unfulfilled even when health facilities exist. Maureen Mackintosh writes, "where systems have failed, that failure is experienced as a core element of exclusion … contributing profoundly to people's experience of what it is to be poor" (cited in Freedman, 2003). In 1996, it was estimated that skilled health professionals attended to 45 per cent of births in Kenya (Cook et al., 2003). However, the likelihood of a Kenyan mother delivering her child in a hospital depends not only on her poverty status but also on where she lives. The importance of location is evidenced by the fact that only 30 per cent of children born to the rural poor are delivered in hospitals compared with 87 per cent of children born to the urban non-poor who are delivered in hospitals (Human Resources and Social Services Department and Central Bureau of Statistics, 2001). Freedman (2003) noted that 80 per cent of maternal deaths are caused by five direct obstetric complications: haemorrhage, infection, hypertensive disorders, obstructed labour, and unsafe abortions. Freedman outlines that, with the exception of deaths due to abortion, all the other four complications cannot be predicted or prevented. Emergency

Obstetric Care (EmOC) can, however, ensure that all births have a skilled attendant at hand to save lives and that all women with complications can get to it. Reproductive health risks are of course not the same for all Kenyan women; rather, risks are defined by where women live, their age, ethnicity, economic status, and educational levels. According to Graham et al. (2004), "women who died of maternal causes were more likely to have had no education and generally had worse dwelling characteristics than the women dying of non-maternal causes and those who were still alive" (p. 23).

## POLITICS AND REPRODUCTIVE RIGHTS

In general, Kenyan women continue to confront strong political challenges in articulating reproductive health rights. In fact, Kenyan women now find themselves publicly censured and constrained when they seek transformations in gender norms and attitudes, or raise demands of their right to make informed decisions concerning their bodies, marriage, child-bearing, power to negotiate reproductive decisions, and the legal rights that safeguard reproductive and sexual health rights. Current constitutional review discussions and the opening up of political space to raise human rights issues has not enabled women leaders seeking to, for example, openly discuss issues of abortion. Rather, the provisional draft will constitutionally prohibit abortion and provide a new legal recognition of a foetus. In effect, the short-term political interests of policy-makers – who are predominantly men – and the need of men to retain control over women's sexuality and procreative roles often take priority over women's own reproductive health needs. As a consequence, there continues to be a lack of dialogue between leaders, policy-makers, service providers, and women clients on reproductive health issues. There is a need for these players to develop a deep understanding of how gender, culture, and health factors intersect and result in what are preventable maternal complications, deaths, and illnesses.

The cost of maternal illness, which often results in death, is that it threatens the health and survival of children, fathers, extended families, and the larger community. A mother's death means the loss of

both her monetary and non-monetary contributions to all the aforementioned parties. A mother's death also increases the likelihood of economic, social, and psychological harm to her children, and it increases the burden on her survivors to take care for her children and home (UNFPA, 2000). If her survivors are unable or unwilling to assume these added responsibilities, the cost of support or assistance must surely fall upon the state. Raising the status of women by protecting and promoting their rights and empowering them so that they can make decisions, have choices, and exert control over their own lives is key to addressing the reproductive health concerns of women and the overall health and well-being of communities.

International human rights law and principles stipulate the responsibility of states to continuously take steps that improve people's enjoyment of these rights. Furthermore, these principles affirm that no state is too poor to meet basic needs, and that the services that governments provide must be guaranteed to all of its citizens equally; otherwise, the state is in violation of its duties. International human rights laws thus open the doors for a variety of actors – be they individuals, institutions, or groups – to process and articulate actions that are desirable to promote and protect the reproductive health and sexual rights of women.

Reproductive health rights imply the following:

- The freedom for girls, women, and men to decide if, when, and how to engage in sexual relations and/or to have children.
- The provision of information and services that enable girls, women, and men to meet their reproductive health needs.
- The provision of prenatal, post-partum, and post-abortion care, so that women can safely experience pregnancy and childbirth. (This is a matter of right to life and survival for all women, which depends on the fulfilment of two things: access to facilities that can provide emergency obstetric care, as noted in Freedman [2003]; and, access to affordable, effective, and safe methods of family planning.)
- Access to knowledge and care to enable awareness and prevention of sexually transmitted infections, including HIV/AIDS, as well as anti-retroviral treatment for pregnant women.

- Individual control over one's own sexuality.
- The right to liberty and security for women, which can only be ensured through strong support for the abandonment of cultural practices that harm women's health.
- The right to make decisions that are free from discrimination, violence, and coercion.
- The right to obtain the highest standard of sexual and reproductive health.

## TOWARDS NEW INITIATIVES AND THE ROLE OF GOVERNMENT IN GUARANTEEING RIGHTS

One of the roles of government is to guarantee the human rights that entitle citizens to social arrangements that facilitate secure access to resources such as health care. Towards this end, Kenya has developed policies to help ensure the well-being and health status of all Kenyans. Spurred by the Program of Action that came out of the 1994 International Conference on Population and Development (ICPD), Kenya developed the National Implementation Plan for Family Planning Program, 1995–2000. Other specific Kenyan reproductive health care policies followed, such as the Reproductive Health and Family Planning Policy Guidelines (Ministry of Health, Government of Kenya, 1997) and the National Reproductive Health Strategy, 1997–2003 (Ministry of Health, Government of Kenya, 1999). There was also the National Development Plan (Ministry of Planning and National Development, Government of Kenya, 1997) and Poverty Reduction Strategy Paper, 2002–2003 (Ministry of Finance and Planning, Government of Kenya, 2002). These latter two prioritized the provision of health services that, importantly, emphasized the needs of Kenyan women and children. Such policies have brought attention to the discrimination faced by women by recognizing gender disadvantage as the source of Kenyan women's poor reproductive health. Of great significance is the government's mandate to ensure that women's rights are respected by all, as outlined in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979), to which Kenya is a signatory. Accordingly, "it is discriminatory for a State party to refuse to legally provide for the performance of certain

reproductive health services for women." The CEDAW convention further states that "barriers to women's access to appropriate health care include laws that dehumanise medical procedures only needed by women and that punish women who undergo those procedures" (Kenya Medical Association and the Kenya Obstetrics and Gynaecology Society, 2004, p. 27).

There are also the United Nations Millennium Development Goals (MDGs) that, since 2002, have placed far-reaching responsibilities on governments around the world to ensure human development; four of the eight goals are health related.[5] Reproductive health is, therefore, an integral part of a country's development and under MDGs the Kenyan government has committed to reduce the maternal mortality rate by 75 per cent by 2015 (World Health Organization, 2003). This means that the Kenyan government must "offer total political commitment and provide capacity building for delivery of quality health care; provision of a minimum of 15 per cent of annual budget to health with at least 20 per cent of that to reproductive health; free delivery of services to women and a health system that is built around emergency obstetric care" (World Health Organization, 2002, p. 128).

All the aforementioned policies have tremendous implications because of what they can make possible; they also form a basis for putting pressure on the government in order to ensure that women's reproductive and sexual health becomes a reality. These policies are framed in ways that mandate initiatives to address women's reproductive health concerns and to provide for a multitude of services, thereby recognizing the interconnections between diverse reproductive health needs. Already, these policies have been instrumental in stimulating action that addresses women's health issues in concrete ways. For instance, policy initiatives addressing health needs helped launch the Safe Motherhood drive, a nationwide endeavour whose goal is to reduce the number of deaths and illness associated with childbirth. Additionally, the recommendations to strengthen district-level hospitals so that they guarantee reproductive health services for all women extend to all regions. These policies have further brought recognition to the important and positive role of men in ensuring reproductive health for themselves as well as for women. Thus, when governments ratify international human rights agreements, an enabling environment is created for women to attain good health.

However, because governments are predominantly male, structural, and attitudinal barriers to gender equality persist, compromising women's health status and well being.

International standards and policies notwithstanding, the Kenyan state has remained constrained in its ability to deliver on its reproductive health sector policies, thereby often failing to provide remedies against the human rights violations that persist. Policy instruments such as the Safe Motherhood initiative have made sporadic gains; however, their impact on reproductive health of Kenyan women will need time to be felt as, currently, high rates of maternal mortality and morbidity exist. Similarly, the needs of Kenyan adolescents remain unmet, while the dilemma of abortion rights continues to bedevil the Kenyan nation. The criminalizing of abortion has resulted in women and girls being subjected to unsafe abortions, contributing to an estimated three hundred thousand deaths per year or 30–40 per cent of maternal mortality rates (World Health Organization, 2002). Non-fatal resultant complications, in turn, place a very heavy burden on Kenya's health care system, whose obstetric budget is needlessly spent on attempts to remedy these avoidable consequences. In addition, the HIV pandemic continues to challenge the provision of health care, especially for Kenya's poor.

In general, the constraints that the Kenyan health sector face in deploying resources can be partially attributed to insufficient national funds, which is further compounded by government allocations when deciding priorities for the national budget. Even though Kenya subscribes to international recommendations and international human rights laws, the absence of national legislation undermines efforts that would enable affordable health insurance provisions for all Kenyans. At a different level, long-term government-supported ethnic marginalization, as manifested in the state's failure to serve all Kenyan communities equally—resulting in the concentration of resources in ethnically connected communities—has had devastating effects on the non-connected. Other related reasons for this failure within the health sector can be blamed on the moral bankruptcy of national officials, which has led to the mismanagement and theft of national resources, with little capital left to invest in women's reproductive health. Furthermore, there is a lack of awareness or disinterest and even fear on the part of some national leaders in taking measures to ensure women enjoy their reproductive health rights, given the

divisiveness of reproductive health issues, the barriers of tradition with regards to sexuality, and the increasing size of the demand for reproductive health services.

Gender has not been a "core competence" of policy-making bodies (Kabeer, 2003); yet there is need to mainstream gender perspectives into the health care system because to have sustainable development with social justice requires the recognition of the social and economic costs that gender discrimination has on women and children. There is also the need to recognize the advantages of promoting gender equality such as the immediate gains it will bring to the national output. Additionally, it is important to note the cumulative nature of human rights and the ways that they could interactively be applied to advance interests in reproductive and sexual health (Cook et al., 2003). Consequently, out of this fundamental strategy flow three key interventions. First is reforming Kenyan laws to ensure compliance with human rights statutes. In this regard, this intervention is exemplified by the Reproductive Health Advocacy Project (RHAP), which is designed to review Kenya reproductive health policies and laws and seek changes, also to create awareness about unsafe abortions in Kenya. This project was initiated by collaboration between the Kenyan chapter of the Federation of Women Lawyers (FIDA) and the Kenyan Medical association. Additionally, Kenya is drafting a new constitution with a Bill of Rights that guarantees freedom from discrimination, recognizes and protects human rights and promotes social justice. Article 61 of the draft constitution brings a new recognition to the protection of rights to health and reproductive health care. However, challenges have emerged with new proposals from the religious right that is seeking a way to define, within the draft constitution, a statement that stipulates that life begins at conception. However a "no" vote on the Constitutional Referendum in November 2005 has meant that, for now, Kenya will have to wait for the process to restart. What is clear is that there remains a demand by Kenyans for a new constitution.

Second is creating accessible and equitable reproductive health care for all Kenyans. Seeds of change are present with regard to Post-Abortion Care (PAC), which is being successfully decentralized and democratized. Practitioners, especially nurses and clinical officers who were previously barred from rendering this care, are managing more PAC patients at lower levels of the health system (Onyango et

al., 2003). The health sector is beginning to reach out to adolescents with programmes that will get youth to seek out reproductive health services through the establishment of "youth friendly health facilities". An Adolescent Reproductive Health and Development Policy is to be launched shortly. This policy will address the challenges of law, culture, poverty, and access to information and services that currently hinder reproductive health services for youth, by creating an enabling environment to improve the well-being and health status of youth.

Third is educating the public about the health aspect of women's rights, in particular, and human rights, in general, by establishing collaborative networks encompassing women, civil society organizations, health professionals, and policy-makers to disseminate needed information and monitor and enforce reproductive rights. Non-governmental organizations have initiatives to lobby, advocate, and raise awareness for a new constitutional order that will positively embrace women's reproductive health rights. Kenyan laws are also under review, and projects addressing gender responsive legal sector reform are underway. Women's non-governmental organizations are developing strategies for actions to influence legislation in favour of women's rights. More broadly, with regard to the Millennium Development Goals (MDGs), there are civil society organizations that have recently developed a campaign to input into government costing of the MDGs, as well as strategizing on actions that will roll out into villages across Kenya, targeting the poor, women, and the marginalized, with the intent to communicate the imperatives of the MDGs. At the same time this campaign is seeking to build the capacity of individuals and communities at the grassroots to hold the government accountable on the MDGs.

Fourth is understanding and responding to what women's named priorities are by taking into account the gendered dimensions of the socio-economic context, of service delivery and of decision-making within the health sector. Women's organisations already exist on the ground with clear understanding of the health issues of Kenyan women and are an important voice on these issues. Such organisations, together with gender experts must be present, represented and allocated with resources in the current reforms in the health sector to continue to provide services, carry out advocacy, as well as facilitate

decision-making that will be responsive to mainstreaming gender into the health sector.

Kenya's *Economic Recovery Strategy for Wealth and Employment Creation: 2003–2007* recognizes the need to undertake corrective measures that provide for health insurance for the most vulnerable groups, rehabilitation of existing health facilities and wider coverage of quality health services, and improved affordability to improve the well being of the poor (Government of Kenya, 2003b). However, the discourses of gender equality have not sufficiently informed this key development strategy paper. It is clear, however, that the government must continue to undertake the implementation of measures that will strengthen good governance, enable economic justice, and expand democratic practices, thus setting the stage for the realization of social justice and gender equality.

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**Notes**

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2 I treat sexual health and reproductive health as one thing – reproductive health and rights because the questions and concerns under discussion in this chapter encompass actions and decisions regarding reproduction and sexual behaviour that cannot be separated if reproductive health conditions are to be understood. Such conflation does not pre-empt the new ground-breaking work in Africa on sexuality, sexual relationships, and sexual rights as a separate field of research.

3 I recognize that men's partnership is essential to advancing the reproductive and sexual health rights of women and gender equality; however, space does not allow for a realistic exploration of these joint responsibilities between women and men for assuring the health of women and families.

4 Because of inheritance laws, in many traditional Kenyan communities, male children are valued over female children.

5 United Nations Millennium Development Goals: (1) eradicate extreme poverty and hunger; (2) achieve universal primary education; (3) promote gender equality and empower women; (4) reduce child mortality; (5) improve maternal health; (6) combat HIV/AIDS, malaria and other diseases; (7) ensure environmental sustainability; and (8) develop global partnerships for development.