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"The Distant 'Big' Hospital": Linking Development, Poverty and Reproductive Health—A Gender Mainstreaming Approach

Edith Miguda*

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I. Introduction

What are the critical links between development, poverty, and reproductive rights? What are the specific challenges poverty poses for women’s reproductive health? How does the link with development provide opportunity to enhance women’s reproductive rights? This Article addresses these three questions with regard to specific challenges that poor women face in realizing these reproductive rights. Drawing from examples in Kenya, I discuss the way in which poverty continues to offset potential gains that may be made through the recognition of women's reproductive rights as part of women’s

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human rights, particularly as stated in the Protocol to the African Charter on the
Rights of Women.

This Article will draw from specific development thinking and explore the
strengths and limitations of certain development frameworks in enabling poor
women to realize their full reproductive rights. This Article concludes by
identifying some of the necessary links that need to be made in order for
development to offset the challenges that poverty poses to the realization of
women's reproductive rights. In particular, I make the case for gender
mainstreaming and point out some of the ways in which mainstreaming
reproductive rights to empower women can counterbalance the negative impact
of poverty on women's ability to actualize their reproductive rights.

II. Reproductive Health and Poverty

Any reflection on the links between development, poverty, and
reproductive rights forces one to think of a myriad of stories of women who
have lost their lives due to the distance from a hospital; an expectant mother
who has lost her child due to her inability to access the necessary healthcare
during pregnancy. Poor people are often unable to gain access to reproductive
services and necessary maternal healthcare. They are often furthest away from
hospitals that provide the necessary care at childbirth or requisite care due to
complications during pregnancy. Poor women are also the most likely to use
the cheapest and most dangerous methods of abortion in unwanted pregnancies.
In most rural areas, the closest dispensaries often do not have adequate
facilities such that many poor women are forced to seek maternal health care
from hospitals that may provide the needed care: "the big hospital."

The phenomenon of the big hospital, meaning the hospital with the
supposed facilities to help complicated birth processes to which pregnant
women are frequently referred, often without any means of transport to take
them there, continues to deny poor women the necessary reproductive
healthcare services. The big hospital is often too far away from the women
who need them. Secondly, when they need them, there is a lack of adequate
transportation to help take the patient to these hospitals. Two of my personal
experiences sprang back to my mind when I was asked to write this paper: case
one and case two described below, which offer a glimpse into the lives of two
women whose agony at childbirth and pregnancy I witnessed, one as a little girl
and the other as an adult. For ease of reference, we shall use fictitious names in
both of the cases. For case one we shall call the woman in question Atieno, and
for case two, we shall refer to the young girl as Adhiambo. The stories of these
two women stand nearly three decades apart, but their experiences are more or less similar. In terms of development contexts, even the two women’s experiences appear similar, yet the two stood at very different contexts in the evolution of development practice and development discourse. I analyze these personal experiences to show the development frameworks that underpin the story in each era and to demonstrate the ways in which poverty undermines reproductive healthcare and reproductive rights.

CASE 1: Atieno 1975

When I was about age ten, I was driving with my father on one of the rural roads in the Nyanza province in Kenya. On our way home, we saw a group of people frantically trying to stop the car and pointing to someone lying down. My father stopped the car and two young men came running to the car: "Please help us," they said urgently, "this mama has problems, she is miscarrying a baby and we need to take her to the big hospital. There has been no bus here since we came and we do not know when the next one will come. There is one bus that passes here around six p.m., but that would be late—this mama is suffering, please help her." My father agreed and the woman was helped into the car. She sat next to me, together with a second woman who was to accompany her to the hospital. Although I was only a child at the time, I could see her writhing in pain and struggling, and the other woman encouraging and comforting her. I do not remember all the words she uttered but I do remember her repeating, as the pregnant women shrieked in agony, "just try and calm down, at least now we have help—soon we will be at the big hospital and there you will find help."

Looking back, this was a clear story of possibly poor women in a rural area with little access to adequate care during pregnancy and no transport to take her to get the necessary care and attendance during childbirth. The case of Atieno shows her lack of access to adequate healthcare, safe pregnancy, and certainly safe motherhood. This was a time in the 1970s when it was realized that development efforts had left women out.¹ The United Nation’s (UN) First Development Decade was established in the 1960s to stimulate economic

¹. See MARGARET SNYDER, TRANSFORMING DEVELOPMENT: WOMEN, POVERTY AND POLITICS 14–15 (1995) (stating that the Second Development Decade in the 1970s proposed to integrate women, who were not accounted for in previous development agendas, into the Second Development Decade effort).
growth and end poverty, but development was soon portrayed as a site of the exclusion of women. Atieno was excluded from development as a woman, which means that her needs and concerns as a woman were not part of the development efforts and certainly not the target of the Poverty Alleviation endeavor. Secondly, she was simultaneously left out because development was conceived of in economic terms with little or no acknowledgement of the significance of the human development aspect. This was a period before the United Nations Development Program (UNDP) defined poverty in terms of human development and introduced the Human Development Index measure with its three aspects of human deprivation: longevity, literacy, and living standard (the latter aspect of the index including access to health services). In the words of Maxine Molyneux, we can argue that both her strategic needs (needs arising from an analysis of women’s subordination to men) and practical needs (those formulated from concrete conditions experienced in her engendered position with sexual division of labour) were left unconsidered. In this regard, it is a small wonder that Atieno could be stuck on the side of the road during pregnancy with little or no help as development efforts could not trickle down to her to help alleviate her poverty and enable her to attain a minimal standard of living in a meaningful way.

2. See id. at 13 (discussing the early theories of development, including the United Nation’s First Development Decade, and their focus on “stimula[ing] economic growth and end[ing] poverty in the former colonies”).

3. See Ester Boserup, Women’s Role in Economic Development 179–80 (1970) (“[I]n the early phases of development, jobs in modern occupations are given almost exclusively to men, the small modern sector in developing countries usually employing only 5 to 15 percent of women.”).

4. See Kaushik Basu, On the Goals of Development, in Frontiers of Development Economics, 61, 63–64 (Gerald M. Meir & Joseph E. Stiglitz eds., 2001) (discussing the shift from progress and development being "measured in terms of gross national product (GNP)" to "focus[ing] attention on improvements in income distribution, environment, health, and education").

5. See Ravi Kanbur & Lyn Squire, The Evolution of Thinking about Poverty: Exploring the Interactions, in Frontiers of Development Economics, supra note 4, at 183, 197 (“The United Nations Development Program (UNDP) has played a leading role in defining poverty in terms of human development and has introduced several measures, including the Human Development Index and Human Poverty Index (HPI) . . . . It concentrates on three aspects of human deprivation: longevity, literacy, and living standard.”).

The 1990 World Development Report by the World Bank defines poverty as the "inability to attain a minimal standard of living." The Kenya national gender and development policy underscores the multi-dimensional nature of poverty, "including shortage of income and deprivation in access to basic social services (education, health, and water), food, security, shelter, credit, and employment." Amartya Sen defines poverty in terms of "capabilities." According to Sen, capability means, "the substantive freedoms he or she enjoys to lead the kind of life he or she have reason to value," such as social functioning, better basic education, healthcare, and longevity. Kunbar and Squire point out that, in talking about their situation, the poor detailed the ways in which "fluctuations, seasons, and crises affected their well-being." From these descriptions, they gained insight about the importance of poverty not just as a state of "having little, but also of being vulnerable to losing the little one has." Furthermore, the poor also pointed to the lack of political power and voice as a significant factor of living in poverty. From the perspectives provided by these definitions, multiple factors are embedded in poverty that affect reproductive health including socio-economic status, social values, accessibility, and quality of health care.

In addition to the distance to the hospital, many times when women reach the so-called, "big hospital," there are no adequate medical resources, medicine, medical equipment, or bed facilities. In many instances, the "big hospital" remains big in name only as compared to the small dispensary in the rural areas and the possible availability of a doctor, but the conditions are often very dire for women who need these reproductive health services in order to realize their reproductive health rights. Kimani describes the lack of sufficient resources,

10. Id.
11. See id. at 66 (discussing the "substantive freedom of individuals to achieve those things to which they have reason to attach great importance, including escaping avoidable mortality, being well nourished and healthy, being able to read, write and count and so on").
12. Kanbur & Squire, supra note 5, at 205.
13. Id.
14. See id. ("Some see this lack of voice and political rights, often described as a sense of powerlessness, as the most fundamental characteristic of poverty.").
equipment, and staff at the Pumwani Maternity Hospital in Nairobi, Kenya—one of the "largest maternal health centre[s] in East and Central Africa," located close to two of Nairobi's biggest slums, catering to "poor and young girls between the ages of fourteen and eighteen." She cites a former head of the nursing staff who illustrates the difficulties encountered by larger hospitals: "We told patients to come with gloves, to buy their own syringes, needles, cotton wool and maternity pads." To the extent that reproductive health is a right of women as earlier stated, and as United Nations Office of the High Commissioner for Human Rights (OHCHR) states "the denial of human rights is inherent in poverty," the prevalence of poverty subsequently means that women are denied their reproductive rights.

"[Ninety-nine percent] of... maternal deaths occur[] in developing countries," most of them preventable. Infections, blood loss, and unsafe abortions account for the majority of deaths. To reduce maternal mortality, more investment in health systems is needed to improve the quality and coverage of delivery services and to provide prenatal and postnatal care for the poor. The necessary services include family planning, basic maternal care, skilled birth attendants, neonatal care, and preventing and treating unsafe abortions and the complications of pregnancy and delivery. According to the World Health Organization (WHO), "[t]he five core aspects of reproductive and sexual health are: improving antenatal, prenatal, postpartum, and newborn

16. Id.
17. See id. ("The government-run hospital struggles to provide even the most basic services, since it lacks sufficient resources, equipment and staff.").
20. See id. at 10 ("In 2000, an estimated 529,000 women died during pregnancy and childbirth from largely preventable causes.").
21. See id. at 11 ("Most maternal deaths arise from complications during childbirth (e.g. severely obstructed labor, especially in early first pregnancies; hemorrhage and hypertensive complications), in the immediate postpartum period (sepsis and hemorrhage), or after unsafe abortion.").
22. See id. at 9, 11 (discussing the need to reduce maternal mortality through an innovative country-specific strategy that provides adequate healthcare services, including services during pregnancy, childbirth, and the postpartum period, to the poor).
23. See id. at 22 (elaborating on the necessary services to reduce maternal morbidity).
care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer, and other gynecological morbidities; and promoting sexual health.  

III. Reproductive Health and Development

Closely linked to the development agenda is that which stands in the way of addressing reproductive health and related issues such as "[u]nsafe water, [i]nadequate immunization, [w]ar and civil conflict, [h]igh levels of poverty and malnutrition, [p]oor access to basic education, especially for girls, [t]he spread of HIV/AIDS" and so on. Furthermore, what measures it will take to adequately address these problems, such as ensuring that hospitals are well equipped and sufficiently funded to meet objectives of safe motherhood and ensuring that adequate services are available, are also inherently linked to development policies. As the poor are the most vulnerable to the lack of adequate services, development is ultimately linked to women's reproductive life, especially given the consensus that development is synonymous with poverty reduction. "It is development that gives priority to the poor, enlarging their choices and opportunities and providing their participation in decisions that affect their lives."

Development is a process which enables human beings to realize their potential, build self-confidence and lead lives of dignity and fulfillment... It is a process of self-reliant growth, achieved through the participation of people acting in their own interest... and under their own control. Its first objective must be to end poverty, provide productive employment, and satisfy basic needs of all the people."

24. Id. at 21.
27. SNYDER, supra note 1, at 4.
According to the Kenya National Gender and Development policy, "the basic objective of any type of development is to enlarge people's choices by facilitating equal access to opportunities, for all men and women in society, and ensuring that such opportunities and empowerment of people are sustained so that they are able to participate in and benefit from the development process." 29

The history of development around which women were incorporated into the development process, and the larger frameworks around which development efforts were implemented, put women in precarious positions relative to development efforts. 30 As stated earlier, by the 1970s, it was realized that development efforts had left women out. 31 It was not until the International Development Strategy for the Second Development Decade identified the ultimate purpose of development as "to bring about sustained improvement in the wellbeing of the individual and to bestow benefits on all" and the proposed addition to the resolution which called for the "full integration of women in the development effort" when women were brought to the fore of development agenda. 32 This resulted in a whole new field, Women in Development (WID), in the 1970s and the 1980s. 33 WID as a development approach represented women primarily as mothers and wives, and with regard to women's reproductive health, initiated Family Planning programmes.

A policy shift in the 1980s adopted a Gender and Development (GAD) Approach. 35 Since then, the history of women and development processes have


30. See Snyder, supra note 1, at 4 (stating that the economic growth approach to development fails to include gender disparities).

31. See Boserup, supra note 3 ("[I]n the early phases of development, jobs in modern occupations are given almost exclusively to men, the small modern sector in developing countries usually employing only 5 to 15 per cent of women.").


33. See Arturo Escobar, Encountering Development: The Making and Unmaking of the Third World 13 (1994) (explaining that once people realized women had been bypassed by earlier development interventions there was a "growth during the late 1970s and 1980s of a whole new field, women in development (WID)").

34. See Jane Parpart, Deconstructing the Development 'Expert': Gender Development and the 'Vulnerable Groups', in Feminism/Postmodernism/Development 221, 227 (Marianne H. Marchand & Jane L. Parpart eds., 1995) (discussing how women were left out "of polices and plans of development experts" because women were regarded "primarily as mothers and wives rather than as economic actors").

35. See Eva M. Rathgeber, Gender and Development in Action, in Feminism/Postmodernism/Development supra note 34, at 204 (stating "[I]n the 1970s and 1980s, the
revolved around two policy positions: Women in Development (WID), "which aims to include women in development programme[s] in order to make them efficient" and the Gender and Development (GAD) framework, which "address[es] inequalities in women’s and men’s social roles in relation to development." Regardless of policy differences, the importance of women in the development effort is clear, especially to women whose reproductive health needs are meant to get beyond family planning programmes, use of contraceptives, and spacing of children to a more comprehensive reproductive health.

The critical importance of reproductive health to development has been acknowledged at a number of high levels in national, regional, and international forums. At the 2005 World Summit, world leaders added universal access to reproductive health as a target in the Millennium Development Goals framework, underscoring the critical link between reproductive health and development. More recently, the World Bank identified some core principles, which reinforce the link between development and poverty and, by extension, to women’s reproductive health.

From the earlier discussion on WID and GAD, it is clear that women are critical to development and women’s health is critical to their performance in development efforts. Employing a rights-based approach to development, the UN Office of the High Commissioner developed guidelines for the integration of human rights into poverty reduction strategies. In its explanation, the draft guidelines are "intended to assist countries, international agencies and
development practitioners to translate human rights norms, standards and
principles into pro-poor policies and strategies. Guideline Seven in the draft
guidelines deals with the right to health and further reinforces the link between
poverty, development, and health. The guideline states:

Ill health causes and contributes to poverty by destroying livelihoods,
reducing worker productivity, lowering educational achievement and
limiting opportunities. Because poverty may lead to diminished access to
medical care, increased exposure to environmental risks, and malnutrition,
il health is also often a consequence of poverty. Accordingly, ill health is
both a cause and a consequence of poverty: sick people are more likely to
become poor and the poor are more vulnerable to disease and disability
... Good health is not just an outcome of development: it is a way of
achieving development.

IV. Reproductive Health and Reproductive Rights—Inching Towards the
Mainstream

Kenya has made some progress in the area of health in general and in
reproductive health in particular. There are clear indications that reproductive
health and reproductive rights issues have been inching to the surface in a
variety of discussions in the recent past in Kenya. I teach in the United States
but have been in Kenya for about three weeks as I complete this paper, having
presented an earlier version at the Washington and Lee University symposium,
Reproductive and Sexual Health and the African Women's Protocol. Within
this period, I have attended three different workshops on reproductive rights
organized within the NGO sector but with significant government participation.
References to earlier workshops as discussants address reproductive health and
rights issues point to a high priority currently given to reproductive health in
Kenya. A concept note by the Kenya National Commission on Human Rights
(KNCHHR) confirms that sexual and reproductive health are integral elements of
the right of everyone to the enjoyment of the highest attainable standard of

41. Id.
42. Id. at 22.
43. Id.
(2008), www.strathmore.edu/pdf/reproductive-health-bill.pdf (describing a bill that would
recognize the basic right of all couples to make their own reproductive choices including
"spacing and timing of children, the right to information on reproductive health, the right to
attain the highest standards of reproductive health" etc.).
45. Id.
physical and mental health with one of its aims as strengthening civil society organization to advocate for reproductive health rights.46

Within the government, the Ministry of Health included a significant section on adolescent reproductive health in their National Guidelines for Provision of Youth-Friendly Services in Kenya.47 The National Reproductive Health Strategy, 1997–2010 initially guided the implementation of reproductive health programs.48 The Ministry has also recently developed a National Reproductive Health Policy Document.49 The Reproductive Health and Rights Act, 2008 is an Act of Parliament to:

[P]rovide for the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, the right to information on reproductive health, the right to attain the highest standards of reproductive health and the right to make decisions regarding reproduction free from discrimination, coercion and violence, and for connected purposes.50

Reproductive health has come to the forefront, partly due to national debates on reproductive health and the concomitant debates on abortion globally, but also in Kenya particularly in the constitutional debates, and the place of life of the unborn child viz the rights of the mother to choose.51 Between 2001 and 2002, for example, four public debates were held in different parts of the country to "get a perspective of the public’s level of awareness about reproductive rights issues, as well as the general opinion on the kind of policy and legislative regime that Kenyans desire.”52 The surfacing of reproductive rights as pertinent is also partly due to the international drive on

46. THE KENYA NATIONAL COMMISSION ON HUMAN RIGHTS, CONCEPT NOTE: PROGRAMMING ON SEXUAL AND REPRODUCTIVE RIGHTS (undated).

47. See DIVISION OF REPRODUCTIVE HEALTH, MINISTRY OF HEALTH, NATIONAL GUIDELINES FOR PROVISION OF YOUTH-FRIENDLY SERVICES IN KENYA (2005) (explaining that adolescents face many reproductive challenges from pregnancy to HIV/AIDS).

48. See Peter W. Thumbi, Kenya Country Report on Reproductive Health and Reproductive Rights: Emphasis on HIV/AIDS, in 2007 NAT’L COUNCIL FOR POPULATION AND DEV. 9 (explaining that the National Reproductive Health Strategy was developed in 1996 and was the first activity to "operationalise the reproductive health agenda as recommended by ICPD" i.e. the International Conference on Population and Development).


50. DRAFT REPRODUCTIVE HEALTH AND RIGHTS BILL, supra note 44, at 2.

51. CENTRE FOR REPRODUCTIVE RIGHTS, BRINGING RIGHTS TO BEAR, AN ANALYSIS OF THE WORK OF UNITED NATIONS TREATY MONITORING BODIES ON REPRODUCTIVE AND SEXUAL RIGHTS (2002).

52. FEDERATION OF WOMEN LAWYERS (FIDA) KENYA, REPRODUCTIVE RIGHTS IN KENYA: FROM REALITY TO ACTION 29 (Medical Association, IPAS, FIDA 2002).
reproductive health. As the Kenyan government and nongovernmental organizations address reproductive health issues, the global and local links facilitating the attention of reproductive health issues are apparent.

References are frequently made to reproductive, and sexual, rights already included in several internationally recognized treaties and programs of action and in international agreements, which specifically address reproductive health rights. Among the most frequently cited are: The 1979 Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), the 1990 Convention on the Rights of the Child (CRC), the 1993 Vienna Declaration and the Program of Action of the World Conference on Human Rights, the 1993 Declaration on Violence against Women, the 1994 Program of Action of the International Conference on Population and Development (ICPD) including the ICPD+5 of 1995, the Beijing Platform for Action, the Millennium Development Goals, and the African Charter on Human and People's Rights (Banjul Charter). Such close links demonstrate the position taken by the Centre for Reproductive Rights that reproductive health and rights are firmly rooted principles guaranteed by international laws, and that since the 1990s social concerns as to women's reproductive health rights have come to be recognized and addressed as human rights.53

The Kenyan draft Reproductive Health and Rights Bill, as well as the National Reproductive Health Policy Guidelines of the Ministry of Health draw from the larger framework of health as defined by the World Health Organization (WHO). Subsequently, reproductive health is defined as a state of complete physical, mental, and social well being, not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its function and processes.54 This encompasses "the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems."55 Complementing this definition is the idea of reproductive rights, which draws from a rights-based approach.56 In this regard, reproductive rights include the right of all individuals to "attain the highest standard of sexual and reproductive health and

53. CENTRE FOR REPRODUCTIVE RIGHTS, supra note 51.
54. See DRAFT REPRODUCTIVE HEALTH AND RIGHTS BILL, supra note 44, at 5 (defining reproductive rights as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes").
55. Id. at 6.
56. Id. at 2 (stating the purpose of the proposed Act is for Parliament "to provide for the recognition of the basic right of all couples to decide freely and responsibly the number, spacing and timing of their children").
to make informed decisions regarding reproductive lives free from discrimination, coercion or violence" in the reproductive processes, functions, and system at all stages of life. Implicit in this is the right of men and women to be informed of and to have access to "safe, effective, affordable and acceptable methods of fertility regulation of their choice," and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

In spite of the national and international efforts and progress made, studies continue to show that "[r]eproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide." It has been shown that "[i]mpoverished women, especially those living in developing countries, suffer disproportionately from unintended pregnancies, maternal death and disability, sexually transmitted infections including HIV, gender-based violence and other problems related to their reproductive system and sexual behavior." In Kenya, for example, both infant and under-five mortality rates have increased from 74 and 112 per thousand respectively in 1998 to 77 and 115 per thousand respectively in 2003, maternal mortality ratio remains high at over 400 per 100,000 live births since 1998 nationally, and only 42 percent of births in Kenya were attended to by a skilled attendant. These problems are particularly compounded by high poverty levels in Kenya and are exemplified in this second case, also coming from my personal experience, only this time in 2007.
During the general elections in 2007 in Kenya, I was travelling with my sister in Karachuonyo. We were driving towards Kisumu, the main city in the area, when we came across two women, one lying on the grass and another one who was frantically flagging us trying to stop the car. My sister who was driving stopped and the woman came to the window. She spoke in Luo saying, "We need help, this lady is my sister-in-law and she is in labor, we brought her here to the dispensary [pointing to the dispensary just across the road] early in the morning and the clinician did not see her until around 11:00 am. When he saw her, he said we need to go to the big hospital in Kendu [Kendu Bay]. We have been trying to stop cars but they are not stopping and we have not seen a matatu [name of local public transport vehicles] here since." My sister agreed to take the two women to the hospital. We helped the woman into the car and once again, many years later, I was sitting with a woman writhing in pain. She seemed a young girl, perhaps no more that 16 or 17 years of age. They told us that this is her first child but she was having problems as she was only about 6 months pregnant. She was bleeding and most likely facing a possible miscarriage.

Adhiambo’s situation occurs at a time when international and national policies have conferred reproductive rights upon her. Kenya is a signatory to many human rights conventions that uphold a woman’s right to health, health care, and non-discrimination on grounds of sex and gender. These conventions include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), and the African Charter on Human and People's Rights (ACHPR). These treaties guarantee the right to health both physical and mental, and in the case of CEDAW, require state parties to eliminate discrimination against women in the area of healthcare including reproductive health care such as family planning services.


In spite of these rights, Adhiambo, like Atieno in case one, lacks access to adequate healthcare, safe pregnancy, and certainly safe motherhood. Unlike Atieno, Adhiambo is not excluded from development as a woman but rather incorporated as a significant person in the development efforts. WID and GAD activities have been trying to ensure that her needs and concerns as a woman are an integral part of the development effort and that she is part of the agenda in the Poverty Alleviation endeavour. Her human rights have been the subject of various national and international discussions such as, "women’s rights are human rights." Yet Adhiambo lacks the capacity or ability to actualize the rights. Like Atieno in case one, poverty continues to undermine her ability to realize these rights and thus, like Atieno, she remains disempowered.

Adhiambo’s story fits neatly within Amartya Sen’s definition of poverty in terms of "capabilities." Her experience is also within the context of the United Nations Committee on Economic, Social and Cultural Rights comprehensive and rights sensitive definition of poverty as "a human condition characterized by the sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights." A poor person remains disempowered in spite of whatever rights she may be assumed to have. Adhiambo’s story portrays the link between these two frameworks in development.

A. Rights and Empowerment

In the course of WID, there was an evolution of development policy and planning from a welfare approach to one that prioritized equity, then efficiency, and finally women’s empowerment as its goal. However, there has been a
rather bumpy history between the concept of rights and that of empowerment in determining the central tenet around which to address the women’s question. Indeed, the use of rights language has been a powerful instrument in advocating for women’s human rights. However, critiques of a rights-based approach have argued that the discourse of rights has had little resonance for the majority of African women, while the national and international procedures and rules for enforcement of rights have rarely been the arenas of African women’s struggle. In the past, a variety of voices have suggested the language of empowerment as a way of conceiving development and its results, particularly on women. According to Margaret Snyder, empowerment is defined by community workers as "the state of a person (women and men), being enabled to take their destiny into their own hands."\(^7\)

The African Charter on Women’s Rights utilizes a rights-based approach.\(^7\) According to the International Conference on Population and Development (ICPD), "reproductive rights embrace certain human rights that are already recognized in national laws, international laws and international rights documents and other consensus documents."\(^7\) The right rests on the recognition of the basic right of all couples and individuals freely and responsibly to decide the number, spacing, and timing of their children, to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.\(^7\) Article 14 of the African Charter on Women’s Rights addresses health and reproductive rights, making the case that State Parties shall ensure that the right to health of women, including sexual and reproductive health, is respected and promoted. The rights include:

1. the right to control their fertility;

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71. Snyder, supra note 1, at 6.


74. Id. at Chapter VII.
b) the right to decide whether to have children, the number of children and the spacing of children;
c) the right to choose any method of contraception;
d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS;
e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with international recognized standards and best practices;
f) the right to have family planning education.\(^7^5\)

Given the close link between women's reproductive health and the development agenda, as earlier discussed, it seems useful and perhaps strategic to employ the language of empowerment to complement the rights-based language. In the introductory remarks to the *Draft Guidelines: A Human Rights Approach to Poverty Reduction Strategies*, the UN High Commissioner wrote:

> Lawyers should not be the only voice in human rights and, equally, economists should not be the only voice in development. The challenge now is to demonstrate how the assets represented by human rights principles, a form of international public goods, can be of value in pursuing the overarching development objective, the eradication of poverty. \(^7^6\)

One of these ways perhaps is to acknowledge and employ the language of empowerment as a complementary asset in defining what these rights entail for women.

Empowerment came into the women and development vocabulary in the mid 1980s, championed by the women's group Development Alternatives with Women for a New Era (DAWN) with personal autonomy and self-reliance at its core.\(^7^7\) The three elements of empowerment are: access to productive assets like land, credit, technologies, etc. that can produce income (economic); human development augmented by access to health services, education, shelter, pure water, fuel etc.; and participation in decision making.\(^7^8\) Empowerment is related to individual strength.\(^7^9\) While initial sentiments appeared to suggest

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\(^7^6\) Draft Guidelines, *supra* note 18, at preface ¶ 4.
\(^7^7\) Snyder, *supra* note 1, at 6.
\(^7^8\) *Id.*
\(^7^9\) *Id.*
the perception that the language of empowerment undermined rights based language, it would appear that the language of empowerment and that of rights are more complementary than contradictory. However, they are not similar. Unlike Atieno who had to depend on the unreliable trickle down benefits of development, Adhiambo had acknowledged rights and a rights-based approach allowing for advocacy and demands for these rights to be actualized through government and state parties' provision of the requisite services for safe motherhood. The empowerment approach incorporates Adhiambo with her rights, as an active agent in this process, empowered through such rights not only to access requisite services but indeed to play her role in the development effort.

B. Mainstreaming Reproductive Health

The United Nations Economic and Social Council (ECOSOC) define the concept of gender mainstreaming as follows:

"Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in any area and at all levels. It is a strategy for making the concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal of mainstreaming is to achieve gender equality."  

According to the United Nations Office of the Special Adviser on Gender Issues and Advancement of Women, "[gender] mainstreaming involves ensuring that gender perspectives and attention to the goal of gender equality are central to all activities—policy development, research, advocacy/dialogue, legislation, resource allocation, and planning, implementation and monitoring of programs and projects." The Council of Europe, Human Rights and Legal Affairs, has pointed out that "[a] good time to start mainstreaming is when a new law is


being prepared or a policy is being planned or revised . . . . "82 In Kenya at the moment, the constitutional debates provide just such an opportunity. J.M. Majiwa suggests that the Constitutional review process provides an opportunity to revisit some of the matters especially those deemed to be contentious.83 She argues that it is crucial to be strategic in pursuing reform in reproductive health rights in the constitution, and in particular ensuring that no aspect of reproductive health is rendered unconstitutional.84 This includes correct assessment of how far reproductive health and rights can be pushed in the current climate, in preparing strategic arguments, information, and materials, and in securing technical assistance and strategic alliance with local and international NGOs, politicians, and the government.85 The pursuit of reform in the issue of abortion will require negotiation and compromise; the question is how much? In particular, she calls for enlarging the constitutional circumstances that support all aspects of reproductive health as much as possible.86

The current efforts to address reproductive health at the international and national levels provided a significant opportunity to mainstream reproductive health, particularly given the close interface among development, poverty, and reproductive health/reproductive rights. One example is the way that reproductive health has been mainstreamed in the Millennium Development Goals (MDGs). In Reproductive Health Issues in Rural Western Kenya, Anna M. van Eijk, et al., suggest that "the [MDGs] represent a commitment of countries to address global poverty and ill health, and are intended as a global framework to assess progress in countries and regions. Reproductive health was initially omitted from the Millennium Development Goals; however, it is now recognized as a key issue for all goals."87

83. Majiwa, supra note 63.
84. Id.
85. Id.
86. Id.
C. The Big 'A'

As reproductive health and rights issues come to the fore, the debates on abortion have also taken centre-stage as church-based organizations and pro-life groups are pitched against pro-choice groups. At one of the meetings on reproductive rights that I attended, one of the participants quipped, "On our way here, if you meet someone and they ask, 'What are you doing here?' and you answer, 'I am attending a workshop on reproductive health,' their immediate response will be, ‘Oh! Abortion!'"

Clearly, the issue of abortion has become pertinent to reproductive health although it is by no means the only one as other reproductive health and reproductive rights issues such as FGM, HIV/AIDS, various aspects of safe motherhood, and access to adequate medical care among others discussed above suggest. A large portion of the concerns addressed regarding reproductive health is the subject of abortion, particularly because of the controversy of a woman’s right to choose versus the right to life. At the time of writing this Article, this is a major issue in the on-going constitutional debates in Kenya. The question therefore becomes, what position should the abortion controversy hold in the move forward with reproductive health and rights.

Currently in Kenya, the issue of abortion has entered the constitutional debates and is currently being addressed at this level. High levels of poverty make the issue of abortion pertinent in Kenya because of the disturbingly high rates of unsafe abortions. Data shows that:

- An estimated one-third of maternal deaths in Kenya are due to unsafe abortion.
- At the Kenyatta national Hospital in Nairobi, 50% of gynecological admissions are due to induced and incomplete abortion, which translates to 10,000 cases a year.
- Approximately 252,800 abortions occur among girls ages 15-19 in Kenya each year.
- About 10 girls die daily of unsafe abortions.
- Abortion remains one of the biggest killers in Kenya.

88. See WORLD HEALTH ORGANIZATION, supra note 19, at 10 (explaining some of the core components of sexual and reproductive health include family planning, but also include prevention and treatment of HIV, newborn care, gynecological morbidities and promotion of healthy sexuality).

According to Joyce Majiwa, the ongoing constitutional review process presents an opportunity to make provisions of the law that guarantee promotion and protection of reproductive rights.90 She explains the way in which the three different Kenyan draft constitutions, the Constitution of Kenya Review Commission draft (the CKRC draft), The ‘Bomas’ Draft constitution91 and the Proposed New Constitution of Kenya Bill, have attempted to provide for Reproductive Health and Rights in the bill of Rights (which spells out the fundamental rights and freedoms, their applications, category and imitations to those rights) relative to the abortion issue.92

Majiwa explains that both the ‘Bomas’ Draft constitution and the Proposed New Constitution of Kenya Bill address the issue of abortion.93 She cites Section 35 of the ‘Bomas’ draft, which states that:

1. Every person has the right to life.
2. The life of a person begins at conception.
3. Abortion is not permitted unless, in the opinion of a registered medical practitioner, the life of the mother is in danger.94

In this regard, as she elucidates, the Proposed New Constitution of Kenya draft Bill retains both articles on health and family from the ‘Bomas’ draft.95 However, Majiwa argues that the ideal scenario is the one contained in the CKRC draft constitution where the relevant provision simply guaranteed the right to life without any qualification as to when life begins and without mentioning abortion, while guarantying the right to health including reproductive health in a separate section in the Bill of Rights.96 Certainly the question of abortion will remain a contentious issue within the larger question of reproductive rights. However, the healthy debates ensure that reproductive health and reproductive rights remain within the mainstream of the constitutional debates.

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90. Majiwa, supra note 63.
91. The ‘Bomas’ draft constitution is named after the Bomas of Kenya, the venue where the constitutional debates took place.
92. Majiwa, supra note 63; see also DRAFT REPRODUCTIVE HEALTH AND RIGHTS BILL, supra note 44, at 6 (defining as a part of reproductive rights "safe and accessible abortion related care").
93. Id.
94. Id.
95. Id.
96. Majiwa, supra note 63.
IV. Conclusion

There are critical links between development, poverty, and reproductive rights. Poverty in particular continues to pose challenges for women’s reproductive health and undermines the actualizations of reproductive rights now enshrined in international laws and pursued by national policies. However, the link with development provides an opportunity to enhance women’s reproductive rights especially by complementing the language of rights with that of empowerment and by a gender mainstreaming approach to reproductive health as a strategy to implement women’s reproductive rights as stated in the protocol to the African Charter on the Rights of Women.