Towards Realising Sexual and Reproductive Health Rights in Eastern and Southern Africa: Promoting rights and responsibilities beyond the individual

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Sexual and reproductive rights have been on the international health policy agenda since the International Conference on Population and Development (ICPD) in 1994 [1, 2]. International human rights law provides well established conceptual frameworks for sexual and reproductive health (SRH) rights[3.4], but how far are they relevant to the policy debate on SRH in Eastern and Southern Africa? The gulf between legal human rights and the reality in the region is huge, particularly for poor women, men, girls and boys[5]. The obstacles to making SRH rights a reality in the region are multiple and mutually reinforcing, encompassing socio-cultural norms, gender inequalities, resource and capacity constraints, and unfavourable legal environments. These are the challenges being explored by a new Research Programme Consortium (RPC) on Realising Sexual and Reproductive Health Rights.1 While these constraints might appear intractable, emerging messages from a regional workshop suggest strategies for making the concept of rights more relevant to SRH in this region.

On 9 November 2005, the African Population and Health Research Centre (APHRC) held a consultative meeting in Nairobi, Kenya under the auspices of the RPC. The meeting brought together 35 policymakers, service providers, activists and academics from eight countries to exchange ideas and guide the RPC’s research in the region.

Drawing on previous work, Celestine Nyamu-Musembi, a human rights lawyer and academic, presented a framework for analysing rights (See Figure 1) [6]. Rights are defined as ‘legitimate claims’ which involve three intersecting dimensions: social, legal and personal. Social rights consist of claims that are legitimised variously by religion, ideology, traditions, culture and general social assent. Legal rights are defined in international and national law, but interact with customary and religious law and practice. The personal dimension concerns how individuals perceive their rights, based on their experience, knowledge and multiple influences from the social dimension.

1 The Realising Rights Consortium is funded by the Department for International Development and brings together APHRC, BRAC Bangladesh, EngenderHealth, the INDEPTH Network, the Institute of Development Studies (IDS) at the University of Sussex and the London School of Hygiene and Tropical Medicine in a five year programme which will address shortfalls and constraints in SRH measurement, access to services and technologies, and rights and entitlements, focusing on the unmet needs of poor and vulnerable populations.
Subsequent discussion among participants explored the intersections and disconnects between the three dimensions. Examples taken from wide ranging professional experience demonstrated how the intersection between social and personal aspects of SRH rights is particularly crucial in Africa, where personal SRH rights are often mediated by claimed cultural norms and beliefs and by gendered household and community relations. One government official noted how interventions aiming to empower women to negotiate over sex in western Kenya resulted in gender-based violence because they failed to address social norms and expectations about the roles of men and women in sexual relationships. This discussion resonated with research findings from the region, which highlight how SRH rights are constrained by sexual identities such as ideas about maleness and femaleness, which themselves are shaped by poverty[7, 8, 9]. Participants concluded that younger and older men should be involved in all research, advocacy and action on SRH rights.

Many of the examples discussed concerned situations where rights violations are socially legitimised, where issues are stigmatised, and where marginalized groups lack voice or have internalized their ‘rightlessness’. Participants noted that SRH language often shapes the overlap or disparity between the three dimensions of rights. For example, in some languages, there is no term for fistula, or there are only derogatory words for the condition. This makes open discussion difficult and perpetuates stigma and discrimination, thus restricting access to services. Strategies therefore include working on mutual forms of communication between service providers and users, and paying attention to local language and meaning. It was argued that the scope for contesting social norms must not be underestimated. Participants cited positive
examples where community-based theatre in Malawi enabled discussion on taboo subjects such as the difficulties faced by women living with HIV. Participants also pointed to opportunities to work creatively to strengthen the social structures that legitimise claims and mediate disputes, and increase their accessibility to marginalised groups. This could include working with religious and community leaders, and mothers in law, who often have the authority to define or challenge norms and beliefs.

The consultation drew out the following implications for contextualising approaches to SRH rights:

- Ground approaches in local gendered realities, culture and language,
- Look beyond the individual to strengthen the collectively defined rights and responsibilities that exist in communities, for example by working with influential social actors,
- Focus on strengthening the overlap between the personal and social dimensions of rights, including by involving men in all SRH rights initiatives,
- The lively discussions during the workshop revealed the potential gains from developing strategic alliances between different professions and sectors.

The Realising Rights RPC will develop research on these issues over the next five years. The RPC partners welcome comments, suggestions, and interest in collaboration from other researchers and practitioners. For further information, please contact the Director, Hilary Standing h.standing@ids.ac.uk or visit the website http://www.realising-rights.org

References


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