Examples of health policy making processes in Kenya

The two examples of health policy making processes and one example of a legislative process in Kenya are provided to demonstrate complexity in policy making processes and the role of research in the process.

.....

Summary of the Change of Malaria Treatment Policy in Kenya in 1998

Chloroquine had been used for Malaria treatment for nearly 50 years until in 1982 when evidence on Chloroquine resistance emerged among some semi-immune Kenyans. Subsequent studies continued to show increasing levels of resistance to Chloroquine throughout the 1980s. Even then, it was not until 1998, when the Kenyan government issued a policy to change the first-line of treatment of Malaria from Chloroquine to SP.

The initial delays throughout the 1980s were as a result of confusion among Malaria researchers on what constitutes drug failure. Increasing studies on Chloroquine failure in 1991 pushed the government to make constitute a technical committee to review the guidelines of management of uncomplicated Malaria. The committee was dominated by researchers and within it, there was no consensus on that the available evidence was adequate to change policy.

Between 1991 and 1995, there were new studies and although the committee held several meetings, no policy action was taken. In July 1995, the committee agreed that new guidelines could not be established before resolving the failure issue. Within the MoH, there were also concerns that alternative treatments had higher incidences of side effects, but were also expensive. Also, Malawi had just changed its treatment policy from Chloroquine to SP and WHO had been very critical of this as there were fears that the interests of pharmaceutical companies had played some role in this process.

In August 1995, District Medical Offiers from 13 epidemic-prone zones reported their dissatisfaction with Chloroquine in a meeting organized by UNICEF. But MoH argued that such evidence was anecdotal and not enough to change guidelines. In Nov 1995, a summary of the available studies Chloroquine failure was re-presented to the technical committee. The presentation triggered a shift in the committee's view of the failure. As a result the committee recommended to the MoH that SP replace Chloroquine as first line treatment.

Even then the researchers within the committee continued disagreeing on the evidence of failure and whether it warranted a change in treatment. As disagreements persisted, the WHO AFRO office was at time developing new sensitivity guidelines. The MoH was then persuaded by the WHO to conduct sensitivity studies in January 1996. The findings of these studies showed the low efficacy levels of Chloroquine. With this evidence, donors pressured the MoH to change the first line of treatment.

So in March 1996, the MoH agreed to change the first-line of treatment from Chloroquine to SP. Subsequent failure studies were disseminated at a meeting organized by the WHO and the MoH's Malaria Control Program in March 1997; the meeting endorsed the transition from Chloroquine to SP. In October 1997, draft guidelines were issued by the MoH; these guidelines were officially launched in August 1998, representing a period of more than 6 years after a call by the MoH to revise national guidelines on Malaria treatment.

Throughout this process, a number of key stakeholders were left out including Provincial Medical Officers of Health (PMOs) as well as the private and informal distributors of medical drugs. This presented a major challenge in the implementation of the policy.

Source: Shretta, R., J. Omumbo, B. Rapuoda, R. Snow (2000) Using evidence to change antimalarial drug policy in Kenya. Tropical Medicine and International Health, 5(11): 755-764.

.....

The making of the Adolescent Reproductive Health Policy of 2003

Research, advocacy and tension in making the case for Adolescent RH Policy

The agitation for an adolescent RH policy in Kenya can be traced back to the research and advocacy efforts of the Centre for the Study of Adolescence (CSA) dating back to the late 1980s and early 1990s. CSA, an NGO focused on research and programming for adolescent SRH, was generating research that showed high levels of teenage pregnancy and abortion. For example, their research revealed that in 1994 there were 142,000 unwanted pregnancies among girls aged 15-19 and 252,000 abortions in the same age group (CSA 1995). With this evidence, CSA researchers forged a close network with UNFPA-Kenya and the National Council for Population and Development (NCPD) to push for the development of an adolescent RH policy and the introduction of sexuality education in schools. CSA researchers also formed a broader advocacy network of organizations targeting adolescents, the Kenya Association for the Promotion of Adolescent Health (KAPAH), in 1994 in order to mobilise more actors around the need to prioritise adolescent SRH.

The focus in the advocacy efforts for an adolescent policy and sexuality education avoided any mention of contentious issues such as abortion or adolescents' access to contraception. At the time, the church was strongly opposed to any focus on adolescent SRH issues. Also, the then President Moi and the Planning Minister, George Saitoti, were strongly opposed to adolescent SRH.

Calls by CSA and KAPAH to provide adolescents with SRH information were opposed by religious groups, organising under the Inter-Religious Council of Kenya and politicians. Religious leaders condemned the calls for sexuality education as 'immoral' and likely to 'teach children about sex'. During the same period, CSA in collaboration with the Ministry of Education were piloting a sexuality education programme in a few schools. The decision by the Ministry of Education to scale up this programme countrywide in 1996 occasioned the peak of the controversy. Religious groups, led by the then Catholic Cardinal (the late Maurice Otunga) on August 31, 1996, burned text books that were being used in the pilot programme in Nairobi streets and other towns. Alongside the books, the group also burned condoms.

Underpinning their arguments by moral and cultural arguments, religious groups accused the Ministry and its partners of teaching 'children about sex'. Taking the position of religious leaders, President Moi strongly opposed the sexuality education programme, arguing that it was not only 'immoral', but was also bound to teach children 'bad manners' (Trust 2011). This opposition to any reforms on adolescent SRH issues persisted with the result that throughout the 1990s, despite sustained evidence-informed advocacy, no policy reforms were realised.

However, in the late 1990s, three things happened. Between 1998 and 2001, one of CSA's co-founders (Dr. Khama Rogo) became the chairperson of NCPD's governing board. Around the same time, another co-founder of CSA (Dr. Wangoi Njau) joined UNFPA as the deputy Kenya country representative. This greatly strengthened the CSA-UNFPA-NCPD network, putting CSA's adolescent SRH champions in influential positions. Then, in 1999, President Moi declared HIV/AIDS a national emergency and committed to make all efforts to fight the disease (Ogot 2004).

Further, Moi, who was well known for his strong opposition to condoms, declared his support for condoms in the fight against HIV/AIDS (see Ogot 2004).

This political shift unsettled the hegemonic moral and cultural opposition to SRH reforms, creating political space for change. Three factors were at play here: first, HIV/AIDS prevalence (estimated at 13% in 1999) was rising rapidly (NASCOP and MoH 2006) and Kenya's economy was crumbling partly as a result of the impact of the disease[1,2]. Second, given the devastating effects of HIV/AIDS, donors were putting Moi under pressure to prioritise the disease in order to receive donor funding (Ogot 2004). Third, Moi was serving his final term as president and so politically, he did not have much to lose by abandoning the moral and cultural discourses. These changes saw NCPD's governing board decide to develop an adolescent RH policy in 1999, and UNFPA country office commit to fund the policy development process.

Developing an 'Adolescent' RH Policy that meets the interests of 'Religious and Political Leaders'

NCPD formed a committee to develop the adolescent RH policy comprising CSA, KAPAH, UNFPA, Family Planning Association of Kenya, Christian Health Association of Kenya, Population Studies and Research Institute, Pathfinder International, Population Council, Family Health International, and the Catholic church (Kenya Episcopal Conference-Catholic Secretariat). Specifically, CSA and KAPAH secretariat developed the draft policy that was reviewed and approved by the committee. A former researcher at CSA who led the drafting of the policy noted that the committee, particularly the Catholic church, watered down the policy draft to ensure that it meets its interests:

> '...we wanted the policy to very clearly spell out what needs to be done in terms of service delivery and clearly show how government will deal with these issues…the fact that young people had a right to services, contraceptives, and you see that is not mentioned in the policy…Although in the beginning we talk of ICPD principles, when you get in you see the broad statements that hide a lot of things...' [Former official, CSA, August 3, 2011, Nairobi].

The policy produced made no mention of adolescent contraception education or provision, or safe abortion where legal (except post-abortion care). Instead, the policy prioritised HIV/AIDS education for adolescents and the provision of 'appropriate' RH information. The policy did not mention 'comprehensive' 'sexuality', 'lifeskills' or 'family life' education, or 'contraceptives'. Even after the policy was drafted, it was never approved by the *Opus Dei* Planning Minister, demonstrating the pervasive and institutionalised influence of the Catholic church in blocking SRH reforms. It was only after a new government assumed power in 2002, with supportive Ministers for Planning and Health that the policy was approved and issued in 2003.

Source: ***Oronje, RN*** *(2013) Understanding the drivers of change in sexual and reproductive health policy and legislation in Kenya. PhD Thesis submitted to the University of Sussex, Brighton, UK [http://sro.sussex.ac.uk/46469/].*

……

[1] Interview, official, NACC, October 5, 2011, Nairobi, who noted that towards the end of the 1990s, Kenya's public service sector, especially the education sector, was feeling the impact of HIV/AIDS.

[2] Kenya's economic growth was on the decline from mid 1990s, peaking in 2000 with a negative growth of -0.2%. This was a huge decline from the over 4% growth rate of the mid 1990s (AfDB/OECD 2003).

The Debate preceding the passage of the 2006 Sexual Offences Act

Increased media reports of sexual violence in Kenya from the early 1990s prompted human rights and women's rights groups to initiate advocacy efforts for law reforms since the existing law was ineffective in responding to these issues. One incident that stood out was a 1991 rape ordeal in a secondary school, perpetrated by boys, that left 19 girls dead. There were also reports of an increase in rape of very young children (as young as five months) and grandmothers (as old as 86 years). Existing law was ineffective, according to respondents (Woman MP and human rights activist, Interview, August 4, 2011; Women's rights activist, WILDAF-Kenya, Interview, July 28, 2011), as it treated sexual offences as offences against morality and not as criminal offences. This was compounded by the fact that the law did not stipulate any minimum sentence for offenders, who often walked away free or with very light sentences. Also, the magistrates at the time were instructed by a 1970s Chief Justice to always treat women's evidence in sexual violence cases with doubt as: "girls and women do sometimes tell an entirely false story" (Hansard April 26-27, 2006:829). Finally, there were gaps in the existing law, which did not address gang rape or the rape of boys, as the law had assumed that boys and men could not be raped.

The 1990s advocacy efforts were spearheaded by the Federation of Women Lawyers (FIDA)-Kenya and the Kenya Anti-Rape Organisation. They involved production of reports on sexual violence and close lobbying of the Attorney General's office. However, given the unsupportive political environment of the 1990s, as described above, advocacy efforts did not achieve much except an amendment to the Penal Code pertaining to minors that removed inconsistencies in penalties and protected the minors' identity.

The 2002 change of government opened a policy window for reforms in this area too, as it saw the coming into parliament of some progressive MPs, among them a women's rights lawyer and activist, Njoki Ndung'u, who was later to move the Sexual Offences bill. This political change motivated a children's and women's rights network – the Juvenile Justice Network (JJN) – to revive the 1990s agitations for comprehensive reforms in 2003 (Woman MP and human rights activist, Interview, August 4, 2011).

Between 2003 and 2004, the JJN drafted a sexual offences bill and unsuccessfully sought to convince the Attorney General to present the draft bill in Parliament for debate as a government bill. Reprieve came in 2004 when MP Njoki Ndung'u proposed to present a similar bill. The Attorney General then formed a committee comprising Ndung'u, the JJN, Kenya Law Review Com- mission and officers from the Attorney General's office, which developed the draft bill that was debated. That bill sought to criminalise a wide range of sexual offences including defilement, rape, rape in marriage, female genital mutilation (FGM), unwelcome sexual advances, and emerging offences such as gang rape, trafficking for sexual exploitation and child pornography, among others. The bill further provided for the offences of rape to include both males and females as survivors and perpetrators, expanded the definition of rape to include penetration by other objects in addition to the penis, defined the offence of sodomy as the penetration of boys below age 14, and sought to introduce chemical castration of offenders.

At the time, there were only 18 women MPs versus 204 male MPs in Parliament. While a majority of male MPs supported the criminalisation of rape and defilement, they strongly opposed the criminalisation of rape in marriage, unwelcome sexual advances, FGM, and chemical castration of offenders, issues seen as challenging men's authority and control over women's sexuality. Criminalising FGM was opposed as outlawing "our culture". These MPs expressed fear that the law would be used to punish men; they cited the then ongoing cases of sexual violation against South Africa's president Jacob Zuma and Uganda's vice president Kiiza Besigye, as examples. It was also

argued that the proposed law was against African culture and would abolish important aspects of social life, such as courtship. Criminalisation of rape in marriage was opposed as a "Western idea", with the claim that African women give consent to all sexual activities within marriage once they agree to marriage. One MP argued:

> *"An activity between a man and his wife in his bedroom cannot within reason be constituted to be rape. Many people believe and think this is not an African issue. Marriage creates sexual license to each party... that is the license they get by saying 'I do'".*

This opposition led to intensified lobbying and campaign within and outside parliament in order to generate support. Within parliament, Njoki Ndung'u worked with fellow women MPs to lobby male MPs opposed to the bill. Outside parliament, JJN members fronted public campaigns, mainly through the media, public demonstrations, and lobbying of MPs. In order to generate support, these advocacy efforts deliberately focused on the rights of children to sexual integrity rather than those of "generic" women. The media contributed to this framing of the issues by giving prominence to the rape of children and grandmothers, and the health dangers that minors faced following rape.

> *"...there is a lot of support for protection of children in terms of sexual integrity, but had the bill been pegged just to women's sexual and reproductive health and rights, it would have faced even more resistance than it actually faced."* (Women's rights activist, Urgent Action Africa Fund, Inter- view, August 5, 2011).

> *"You'll remember that during the debate of the bill in Parliament, the media all of a sudden were covering a lot of rape incidents, particularly rapes of babies and grandmothers. And these were given prominence as headlines or lead stories. This was not a coincidence. We engaged with editors of major media houses and media owners to encourage them to cover these incidents and give them prominence."* (Women's rights activist, WILDAF-Kenya, Interview, July 28, 2011)

In the end, rape in marriage, unwelcome sexual advances, and FGM were not criminalised in the bill that was passed into law in 2006. As regards implementation of the law, Kilonzo et al (2009) found that implementation of the law was slow, with persistent separation of processes in the medical and legal sectors. They further noted the low awareness of the law among "implementers in government agencies and departments, the police, the prosecution, the judiciary and the general public"(Kilonzo et al 2009:15). An important recent development was the passage of a law in 2011 that criminalised FGM. While this was opposed in 2006 for cultural reasons, it was passed unanimously in 2011. This has been attributed to sustained advocacy by women MPs and rights groups, as well as a change of MPs. The 2007 general election saw the departure of some of the male MPs who opposed the criminalisation of FGM in 2006 and the entry of new male MPs who supported it (Woman MP, Interview, August 9, 2011). Indeed, the bill was introduced for debate in Parliament by a male MP.

Source: **Oronje, RN** (2013) *The Kenyan national response to internationally agreed sexual and reproductive health and rights goals: A case study of three policies.* http://www.ncbi.nlm.nih.gov/pubmed/24315071

.