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# UNDERSTANDING THE DRIVERS OF CHANGE IN SEXUAL AND REPRODUCTIVE HEALTH POLICY AND LEGISLATION IN KENYA

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HEALTH POLICY AND LEGISLATION IN KENYA

## **Summary**

The thesis explored the drivers and inhibitors of change in sexual and reproductive health (SRH) policy and legislation in Kenya. The overall purpose was to contribute to the limited knowledge on national-level debates that shape how developing countries adapt the SRH agenda, which originated from international processes. The thesis explains how and why some SRH reforms have been realised in Kenya amid contention, while others have been blocked. Guided by a synthesis conceptual framework that emphasised the central role of discursive power in decision-making, the thesis adopted a qualitative case-study design enriched with various anthropological concepts. Three case-studies (two bureaucratic, i.e. adolescent RH policy and national RH policy, and one legislative, i.e. sexual offences law) were deconstructed. Data collection involved semi-structured in-depth interviews with policy actors, observations and note-taking in meetings, and document review.

Findings revealed that four influential narratives of SRH – the moral narrative, cultural narrative, medical narrative (with two variations i.e. ‘moralised’ versus ‘comprehensive’ medical narratives), and human rights narrative – underpinned by conflicting actor interests, mediated the interplay of actor networks, knowledge, context and institutions to determine reforms. The findings revealed that the strong entrenchment of the moral and cultural narratives in the Kenyan context (mainly public structures and institutions) was a major barrier to reforms on contested SRH issues. Even then, the hegemonic narratives were in some cases unsettled to make reforms possible. The most important factors in unsettling the hegemonic narratives to facilitate reforms included: a change in the political context that brought in new political actors supportive of reforms, the presence of knowledgeable and charismatic issue champions within political and bureaucratic institutions, the availability of compelling knowledge (scientific or lay) on an issue, sustained evidence-informed advocacy by civil society/non-governmental organisations, donor pressure, and reduced political costs (for politicians and bureaucrats) for supporting reforms.

The main contribution of the thesis is three-fold. First, the thesis captures the disconnect between international SRH agreements and national-level realities, showing the need for international actors to consider national-level realities that shape decision-making. Second, its findings provide lessons for informing future SRH reform efforts in Kenya and in other sub-Saharan African countries. Third, its analysis of discursive power contributes to a major theoretical gap in health systems research in developing countries identified as lack of critical analysis of power in decision-making.

## **Dedication**

To my son, Mike O. Ochieng', for bravely bearing the brunt of my absentia during my PhD studies in very early years of his life. To my husband Mr Michael O. Adwera for supporting me throughout the PhD study period. And, to my parents, Mrs Alice N. Oronje and Mr Hannington Oronje, for their unwavering confidence in me, encouragement, and support.

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## **List of Abbreviations and Acronyms**

AG – Attorney General  
 BBC – British Broadcasting Corporation  
 CBS – Central Bureau of Statistics  
 CEDAW – Convention for Elimination of all forms of Discrimination Against Women  
 CHAK - Christian Health Association of Kenya  
 COVAW - Coalition of Violence Against Women  
 CRR – Centre for Reproductive Rights  
 CSA – Centre for the Study of Adolescence  
 DAWN - Development Alternatives with Women for a New Era  
 DFID – UK Department for International Development  
 DMS – Director of Medical Services  
 DRH – Division of Reproductive Health  
 EVIPNet/SURE - Evidence-Informed Policy Network in Africa/Supporting Use of Research Evidence  
 FGM – Female Genital Mutilation  
 FIDA-Kenya – International Federation of Women Lawyers (Kenya Chapter)  
 FHI - Family Health International  
 FHOK - Family Health Options Kenya  
 FCI-Kenya - Family Care International-Kenya,  
 FPPS - Family Programmes Promotions Services  
 FP – Family Planning  
 GALCK - Gay and Lesbian Coalition of Kenya  
 GIZ – Deutsche Gesellschaft für Internationale Zusammenarbeit  
 GTZ – German Technical Cooperation  
 HEART – Health and Education Advice and Research Team  
 HERAF – Health Rights Forum  
 H-ICC - Health-Interagency Coordinating Committee  
 ICPD – International Conference on Population and Development  
 IWHC - International Women's Health Coalition  
 IRCK - Inter-Religious Council of Kenya  
 IPPF-AR - International Planned Parenthood Federation-Africa Region  
 KANCO - Kenya AIDS NGO Consortium  
 KAPAH - Kenya Association for the Promotion of Adolescent Health  
 KDHS – Kenya Demographic and Health Survey  
 KEC-CS – Kenya Episcopal Conference-Catholic Secretariat  
 KEWOPA – Kenya Women Parliamentarians Association  
 KLRC - Kenya Law Review Commission  
 KMA – Kenya Medical Association  
 KNACC – Kenya National AIDS Control Council  
 KNBS – Kenya National Bureau of Statistics  
 KNCHR – Kenya National Commission on Human Rights  
 KOGS – Kenya Obstetrics and Gynaecologists Society  
 LGBTIs – Lesbian, Gay, Bisexual, Trans-sexual, Intersex

L&MICs – Low and Middle Income Countries  
 MDGs – Millennium Development Goals  
 MoH – Ministry of Health  
 MoMS - Ministry of Medical Services  
 MoPHS - Ministry of Public Health and Sanitation  
 MSMs – Men who have sex with men  
 MYWO – Maendeleo ya Wanawake Organisation  
 MYW – Maendeleo ya Wanaume  
 MP – Member of Parliament  
 NACC – National AIDS Control Council  
 NASCOP - National AIDS Control Council and the National AIDS and STD Control Programme  
 NCCCK – National Council of Churches of Kenya  
 NCPD – National Council for Population and Development  
 NCWK – National Council of Women of Kenya  
 PAC – Post-abortion care  
 PEPFAR – US President’s Emergency Plan for AIDS Relief  
 PPFA-AR - Planned Parenthood Federation of America-Africa Region  
 RCT – Random Control Trial  
 RH – Reproductive Health  
 RH-ICC – Reproductive Health-Interagency Coordinating Committee  
 RHRA – Reproductive Health and Rights Alliance  
 SRH – Sexual and Reproduce Health  
 SRHR – Sexual and Reproductive Health and Rights  
 SUPKEM – Supreme Council of Kenya Muslims  
 SWAp - Sector Wide Approach  
 TAC – Treatment Action Campaign  
 TBAs – Traditional Birth Attendants  
 TWG – Technical Working Group  
 UHAI-EASHRI – UHAI-East African Sexual Health and Rights Initiative  
 UK POST – UK Parliamentary Office on Science and Technology  
 UN – United Nations  
 UNFPA – United Nations Population Fund  
 UNICEF – United Nations Children’s Fund  
 USAID – United Stated Aid for International Development  
 WHO – World Health Organisation  
 WILDAF-Kenya – Women in Law and Development-Kenya

## Chapter 1

### Introduction

‘A lot of local stakeholders, especially religious leaders, often reduce reproductive health rights to abortion and do not therefore support the language of reproductive health rights. At the international level, we easily talk about reproductive health rights and even adopt them in international policy documents, but when it comes to the country level, reality hits home, and so we have to be very alert to the context, the culture, and the religion. We also talk about these informed by our understanding of where these [reproductive health rights] started from, they did not start in Africa and are therefore viewed as foreign.’

This statement by one of the Kenyan reproductive health (RH) experts<sup>1</sup> who provided technical assistance and guidance for the development of Kenya’s National RH Policy of 2007, captures succinctly the contentiousness and uneasy reality of sexual and reproductive health (SRH) in the Kenyan polity. The concept of RH emerged in international development policy at the 1994 International Conference on Population and Development (ICPD) through a heavily contested process (Roseman and Reichenbach 2009). ICPD defined RH as:

‘[A] state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so’ (UNFPA 1995).

Prior to ICPD, both international and national efforts focused on population control and safe motherhood. However, given the marginalisation of individual needs, particularly women’s needs, in these efforts and persistent high rates of maternal mortality and morbidity, teenage pregnancy, and gender-based and sexual violence, ICPD sought to shift focus to the structural underpinnings that produced these poor outcomes. The ICPD, which was a culmination of increased influence of the global women’s movement in UN processes produced by two decades of sustained advocacy for women’s health and rights, introduced the concept of human rights in issues of sexuality and reproduction in order to raise the profile of SRH, particularly as it relates to marginalised and vulnerable groups. ICPD argued for the human right of women, girls and adolescents to access comprehensive SRH information and services. It further argued for gender equality between men and women, and for women’s autonomy in sexuality and reproduction matters.

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<sup>1</sup> Interview, former official of an international health policy organisation, March 25, 2011, Nairobi.

By linking gender, rights, health, and development, ICPD conceptualised promoting RH as encompassing advancing gender equality, eliminating violence against women, ensuring women's control of their own fertility, and ensuring universal access for all to SRH information and services (Roseman and Reichenbach 2009; UNFPA 1995). However, the concept of RH as human rights was strongly contested and opposed at ICPD mainly by Christian (Catholic/Vatican) and Muslim religious groups and conservative governments (mainly from Africa, Caribbean, Asia and Latin America). Specific issues opposed included: the right of individuals and couples to decide on family size, the right of adolescents to confidential information and contraceptive services, efforts to prevent unsafe abortion or address the public health problems associated with unsafe abortion, access to condoms as a way to prevent the transmission of HIV/AIDS, and sexuality education that was not exclusively focused on abstinence (Kissling 2009). Underlying this opposition was religious ideology and cultural interests that undermine women's and adolescents' autonomy on issues of sexuality and reproduction. Miller and Roseman (2011: 115-116) argued that the opposition was underpinned by 'the fact that sexuality, gender and reproduction joined to rights do...challenge and shift and potentially reconstitute the nature of the state and state power.'

Given the opposition, the ICPD's framing of RH as human rights had to compromise on some of the contested issues. The issue of abortion, in particular, was not addressed as the ICPD only required governments to tackle complications from unsafe abortion. The UN's Fourth World Conference on Women in Beijing in 1995 buttressed the concept of RH rights, and sought to expand on the sexual rights of women. Even then, sexual rights in general remained contentious and despite heightened advocacy for their recognition at the Beijing conference, the conference failed to commit to sexual rights, particularly as they relate to homosexuality (Girard 2007).

UN member states were required to operationalize and implement the ICPD and Beijing agreements guided by their own socio-cultural contexts given the contestations that surrounded the deliberations. This has resulted in varied adoptions of the SRH rights concept at national level informed by local power dynamics in SRH decision-making processes, and therefore made it necessary to understand the national level processes that have influenced countries' operationalization of the international SRH agreements. As a signatory to the ICPD and Beijing agreements, Kenya has made various efforts through policy and legal reforms to move the SRH rights agenda forward. It is these efforts that form the basis of this thesis. The thesis seeks to understand the drivers as well as inhibitors

of change in SRH policy and legal reforms in Kenya. The overarching aim is to explain how and why some SRH policy changes have been realised in Kenya amid contention and opposition, while others have been blocked. The purpose is to contribute to the limited knowledge on national level debates and processes through which low and middle income countries (L&MICs) in the global south, particularly in sub-Saharan Africa (SSA), have adapted and operationalized the SRH rights concept, which originated from international processes, into national policies and laws.

Guided by a synthesis conceptual framework of policy change that emphasised the central role of power in decision-making, the thesis adopts a qualitative case study design enriched with some anthropological concepts, particularly the use of language and discourse as a tool for control and paying special attention to power embedded within social contexts. Three case studies, comprising two bureaucratic (the 2003 Adolescent RH Policy and the 2007 National RH Policy) and one legislative (the 2006 Sexual Offences Act) decision-making processes, are analysed. Various methods were used in gathering data including semi-structured in-depth interviews with key policy actors in Kenya's SRH sector, observations and note-taking in SRH meetings in Kenya, and an extensive review of documents. This thesis is important in three different ways. In one way, this thesis is a collection of accounts of how a sensitive issue that touches on strongly held socio-cultural values, of which reform efforts emerge from the international scene, is debated at national level where different power dynamics are at play and which greatly shape its transformation. In this way, the thesis offers a comprehensive and critical account of SRH decision-making in the bureaucracy and legislature in Kenya, from which lessons can be drawn for future reform efforts.

At the same time, this thesis speaks to broader international debates on health and SRH in L&MICs in two ways. First, the thesis captures the disconnect between international SRH agreements and national level realities, showing the critical need for international SRH policy actors to take into account national level realities that shape how international SRH concepts are adapted locally. For instance, the deep insights from national level SRH decision-making processes in Kenya contained in this thesis<sup>2</sup> reveal real obstacles to reforms, which international efforts should contribute to overcoming if developing countries are to benefit from international agreements on SRH. Second, the thesis speaks to theoretical weaknesses in health policy analysis in L&MICs as identified by various studies

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<sup>2</sup> Such as the weak women's rights movement in Kenya.

(see Gilson and Raphaely 2008; Gilson et al 2011; Sheikh et al 2011). These studies have pointed out the need for health policy analysis in poor countries to focus on deepening theory in this field by conducting a critical analysis of power (Gilson and Raphaely 2008; Sheikh et al 2011), as well as the need to look beyond health and medical concepts to also employ useful social science concepts in explaining health policy change since health systems are complex social phenomena (Gilson et al 2011; Sheikh et al 2011). In this way, the thesis's focus on power, and specifically examining how 'discursive power', a social science concept, mediates other forms of power (i.e. power embodied in actor interests and networks, power embodied in knowledge, and power embedded in contexts and institutions) to influence SRH policies and laws in Kenya, contributes to filling these theoretical gaps in health policy analysis in L&MICs. It is necessary to note that the thesis's focus on understanding power meant that its analyses paid special attention to SRH issues that are contested in order to examine the contestations and how they shaped the content of the resultant policies.

### **1.1 Sexual and Reproductive Health: Contested Origins, Contested Reality**

As noted, the coining of the terms SRH and its framing as human rights was first formalised internationally at the ICPD. In reframing reproduction as a human rights issue, ICPD stated that:

'reproductive rights ... rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents' (UNFPA 1995).

Prior to ICPD, the 1993 UN Conference on Human Rights in Vienna had formally recognised women's rights as human rights following pressure from global activism for women's rights. The Vienna conference formally recognised the human rights of women as 'an inalienable integral and indivisible part of human rights' (UN 1993: 4). The 1995 women's conference in Beijing reinforced the Vienna and ICPD conference agreements on women's sexual rights, the Beijing Platform of Action stated that:

'The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence' (UN 1995).

These achievements were attributed to the sustained advocacy efforts of the global women's rights movement initiated in the mid-1970s (Roseman and Reichenbach 2009).

These efforts enabled the global women's rights movement to gain access in UN processes and influence UN agreements. Larson and Reich (2009) have argued that besides the global women's rights movement, the success of the 1990s conferences in drawing focus to SRH and framing these as human rights was as a result of the supportive US Democrat administration of Bill Clinton, given the US' powerful position in world politics. Clinton's administration had, in 1993, rescinded the 1984 'global gag rule' (Mexico City policy) passed by the conservative Reagan administration which banned the provision of US foreign aid to organisations that provide information and/or services on abortion (ibid). The 1990s SRH rights achievements forced the opposition to SRH rights – led by the Holy See, conservative countries, and North American right-wing groups – to focus on strengthening its efforts and networks to ensure the SRH rights concept was not implemented (Girard 2001). Indeed, Girard (2009) has argued that oppositional efforts focused on 'killing' the whole concept of SRH rights. As a result, ICPD+5 meeting in 1999 and the Beijing+5 in 2000 witnessed a strong presence of North American right-wing groups and consequently failed to make progress on extending SRH rights, focusing instead on renewed debates on issues previously agreed upon such as 'reproductive rights' (ibid).

Moreover, the 2000 Millennium Development Goals (MDG) framework's omission of RH as one of the eight goals was said to have been a result of these oppositional efforts (see Campbell-White et al 2006; Girard 2001). A change in US government in 2001 that saw the return of a conservative administration (that of George W Bush), provided the strongest ally for the religious groups opposed to the SRH agenda (Girard 2001). Consequently, throughout Bush's administration (2001-2008), the US government used its political and financial influence to fight the SRH agenda on the international scene. It reinstated the 'global gag rule' and initiated HIV/AIDS funding through the US President's Emergency Plan for AIDS Relief (PEPFAR) initiative that focused on funding abstinence-only HIV prevention efforts. At ICPD+10 regional meetings in 2004, the US government delegation made concerted efforts to annul the ICPD agreement (Girard 2009). This forced international efforts to focus on saving the SRH rights agenda at the expense of moving forward, and it has been argued that the survival of the agenda at international level throughout the 2000s was the result of funding from supportive western European governments (Girard 2009). It is therefore unsurprising that reviews of the SRH rights agenda at ten years found that it had achieved little operationally since its inception in 1994 (Roseman and Reichenbach 2009; Glasier et al 2006).



Notably, throughout this period, while there seemed to be some level of agreement internationally on reproductive rights, the issue of sexual rights remained contentious. In fact, sexual rights were not defined by ICPD or Beijing conferences, and WHO later noted that sexual rights are closely related to reproductive rights since human reproduction involves sexual activity (WHO 2006). The contention on sexual rights continued throughout the 2000s at the annual meetings of the UN Human Rights Council (Girard 2007), and it was not until July 2011, that a UN resolution was passed to recognise discrimination on the basis of sexual orientation and gender identity as a violation of human rights (UN 2011). Except for South Africa, all SSA countries at the UN General Assembly that passed this resolution voted against it. This decision was especially motivated by increasing hostility towards gay rights in various SSA countries<sup>3</sup>.

In Kenya, like the international scene, SRH remains an area that is riddled with a lot of contestations. Specific contested issues include abortion, adolescent SRH, gender equality, and homosexuality. Deliberation of these issues in policy debates always attracts opposition mainly on religious and cultural grounds because religion and culture remain important aspects of life in the Kenyan context. Religious institutions (Christian and Islam) remain powerful in the Kenyan polity and therefore influential in policy decisions. Also, the general culture of patriarchy<sup>4</sup> in Kenya has meant that SRH reforms that challenge men's control over women's sexuality and reproduction remain contested. A weak women's rights and generally human rights movement in Kenya particularly at the grassroots level has compounded the situation, with the result that the framing of SRH as human rights is largely misunderstood by political leaders and the populace at large. All these factors interact to produce overwhelming opposition to the contested SRH issues in Kenya, with the result that policies and laws have largely been used to control people's sexuality rather than to facilitate universal access to SRH information and services for all.

In a word, although the framing of SRH as human rights has helped focus developing countries on reforming policies and laws to promote better SRH, the universalist and legal nature of human rights has been criticised as being unable to meaningfully impact local

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<sup>3</sup> In 2010, the Malawi government jailed a gay couple and only released them following international pressure. In 2011, Uganda's gay rights activist was murdered following calls by politicians to exterminate gays in the country. Still, Uganda and Nigeria in 2011 were in the process of passing stringent anti-gay laws.

<sup>4</sup> I use the concept of patriarchy as defined by McCloskey (1999) to mean 'A system of social structures and practices in which men dominate, oppress and exploit women...the manifestation and institutionalisation of male dominance over women and children in the family and the extension of male dominance over women in society in general. It means that men hold power in all important institutions in society' (cited in Kamau 2009: 108).

commitments and translate into better SRH in many developing countries whose contexts are markedly different from the Western contexts that have shaped the global human rights concept (see Undie and Izugbara 2011; Izugbara and Undie 2009; Correa and Petchesky 1994). Thus, while this study's motivating assumption has been the normative view that the framing of SRH as human rights has been important in bringing about reforms, its findings contribute to deepening our understanding of the critique of the human rights concept and the ways in which actors in Kenya have navigated or taken advantage of its limitations to facilitate or block reforms.

## **1.2 Background on Kenya**

### **1.2.1 The SRH Challenge in Kenya**

Kenya is a low income country in East Africa, with an estimated population of 38.6 million, of which more than 75% live in rural areas (KNBS 2010). A large proportion of Kenya's population is poor, with an estimated 46% of the population said to live on less than US\$1 a day, and the gross national income (GNI) per capita standing at \$820 (World Bank 2011). Like many poor countries, Kenya faces major socio-economic and health challenges. And although the country made progress on key RH indicators such as reducing fertility, decreasing maternal mortality and increasing contraceptive use during the 1970s and 1980s, these indicators stagnated or reversed in the late 1990s and early 2000s (CBS, MoH and ORC Macro 2004), and are either still stagnant or have shown minimal positive change in the recent past (KNBS and ICF Macro 2010).

The maternal mortality rate is estimated at 488 per 100,000 live births (KNBS and ICF Macro 2010). Abortion, a major contentious issue, accounts for about 20-35% of all maternal deaths in Kenya (CRR 2010; Guttmacher Institute 2008; Ipas 2004; Rogo 1990). The Kenya Demographic and Health Survey (KDHS) 2008-09 estimated HIV prevalence at 6% (KNBS and ICF Macro 2010). Approximately, 1.5 million Kenyans are living with HIV/AIDS and 80,000 die annually from the disease (UNAIDS 2009); HIV/AIDS has had a devastating impact on Kenya's weak healthcare system. Contraceptive use among married women is estimated at 46%, fertility remains high at the average of 4.6 children per woman, and 24% of married women wishing to delay or stop childbearing are not using contraception (KNBS and ICF Macro 2010). Other major SRH issues include early marriages, teenage pregnancy, sexual and gender-based violence, and STIs (see Table 1 for SRH indicators in Kenya).

**Table 1: Development and SRH Indicators in Kenya**

Indicators	
Population (million) 2009	38.6
Population growth rate	2.6%
Life expectancy at birth	54
Poverty rate (% living on 1US\$ or less) (2008)	46.6
GNI per capita US\$	820
Contraceptive prevalence rate among married women (2008/9)	46%
Percentage of married women wishing to delay or stop child bearing but are not using contraception (unmet need) (2008/9)	24%
Unsafe abortions (2004)	300,000 abortions annually; 20,000 women hospitalised annually with unsafe abortion complications
Teenage sexual activity	14% of girls have sex by age 15
Teenage pregnancy	25% pregnant between 15-19 years
Under 5 mortality rate	74 per 1000
Maternal morbidity (women experiencing illnesses & injuries caused by pregnancy and/or child birth)	294,000-441,000 each year
Maternal deaths	488 per 100,000 live births
Delivery with care/delivery in a health facility	44%/43%
HIV prevalence	6% average; 4% for men, 8% for women
Sexual violence (rape)	16,500 girls and women raped each year

Source: Various – World Bank, 2010; KNBS and ICF Macro 2010; CREAW and GTZ undated; and Ipas 2004.

## **1.2.2 Policy and legal framework guiding Kenya's health sector**

### ***Health policy framework***

Overall Kenya's health sector has been guided by the Kenya Health Policy Framework 1994-2010, and now the Kenya Health Policy 2012-2030. Health policies are developed based on existing laws, and therefore seek to operationalize laws. The main focus of the Kenya Health Policy 2012-2030 is ensuring 'equity, people centeredness and participatory approach, efficiency, multi-sectoral approach and social accountability' (Republic of Kenya 2011: 2). Implementation strategies for the policy have been devised in a series of five-year National Health Sector Strategic Plans since 1999. The plans have emphasised the need for better coordination of health activities across the country and consequently adopted a Sector Wide Approach (SWAp) since 2006. Ideally, the SWAp should bring together all stakeholders – the government, donors and non-governmental organisations both for-profit and non-profit – on a common platform that supports health priorities in a coordinated manner. Both the two national health policy frameworks have identified RH as one of the key health challenges in Kenya. In addition to these policy documents, health

sector development is also informed by Kenya's long-term government policy, the Vision 2030 (Government of the Republic of Kenya 2003; 2007a).

### ***Typical health policymaking process in Kenya***

Generally, health in Kenya is seen as a technical issue and therefore health decision-making is regarded as the preserve of health/medical professionals at the health ministry. For policy development, these experts often consult with other experts in donor and UN agencies, and in international-type research and programme organisations (see Mackenzie et al 2009), who in most cases are fellow health/medical professionals. Within the health ministry, there exists the Health - Inter-agency Coordinating Committee (H-ICC), an organ comprising senior ministry officials and representatives of relevant UN agencies (WHO, UNICEF), donors, and international-type programme and research organisations, which has the overall mandate for identifying policy issues and deciding on policy responses. There are also issue-based Technical Working Groups (TWGs) that bring together technical experts in the ministry and non-governmental organisations (mainly international-type programme and research organisations). The TWGs, which hold regular meetings, are mainly information exchange fora between government and non-government agencies on specific health issues. MacKenzie et al (2009) have argued that within Kenya's health ministry, the need for policy reforms often emanates from new global or local evidence. They also argued that sometimes policy issues arise from TWG meetings (ibid). What is evident is that in Kenya, beneficiaries of health policies, including SRH, are not involved or consulted in the health policy development process. Although decentralisation has seen the formation of district health management boards and community representation in such boards, such community representatives hardly take part in national level health policymaking. In addition, organisations not involved in medical interventions to health issues are typically not involved in health decision-making in Kenya. Health policies are discussed and approved by the cabinet and the health minister; they are neither discussed nor approved by parliament.

### ***SRH national institutional structure***

The health ministry in Kenya is currently divided into two ministries, namely, the Ministry of Medical Services (MoMS) and the Ministry of Public Health and Sanitation (MoPHS) since 2008<sup>5</sup>. The Division of Reproductive Health (DRH), which is primarily charged with

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<sup>5</sup> This changed in April 2013 when a new government came into power and combined the two ministries into one ministry of health.

developing SRH-related policies and over-seeing their implementation, is under the Family Health Department in MoPHS. There is also the semi-autonomous National Council for Population and Development (NCPD) under the Ministry of State for Planning, National Development and Vision 2030, which is charged with developing and overseeing the implementation of the country's population policy. The DRH develops RH-related policies in consultation with the NCPD and a wide range of state and non-state actors including donors, non-governmental research and programme organisations, religious groups, and healthcare professionals. The Kenyan parliament, for its part, debates and enacts (or rejects) SRH-related bills (i.e. proposed laws). The bills can either originate from government ministries, the Attorney General's office or from members of parliament (MPs).

### ***Kenya's legal framework as it relates to SRH***

Kenya is governed by a dual legal system, i.e. statutory law applies alongside customary law (Republic of Kenya 2003; 2007b). Thus, the difference between these two types of laws has important consequences for SRH, particularly in cases where the Kenyan Constitution allows for application of customary law in personal matters. For example, although the Kenyan Constitution prohibits any kind of discrimination, most Kenyan women's lives are governed by a separate set of local laws based on religion or custom, which the Constitution also allows<sup>6</sup>. Table 2 summarises the important implications of this dual legal system in terms of the statutory versus customary law approaches to issues of gender equality, harmful practices against women, child marriage, and polygamy. Furthermore, Kenyan laws that govern sexuality and reproduction are prohibitive and therefore impede individuals' access to health services. Although the 2010 Constitution recognises the right to health care including RH care, it prohibits abortion (except when in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger), as well as same sex unions (Republic of Kenya 2010). Prior to the 2010 Constitution, laws governing sexuality and reproduction were contained in the country's Penal Code which criminalised abortion (except in instances where a woman's life was in danger) and homosexuality.

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<sup>6</sup> In practice, a respondent noted that courts in Kenya tend to rule in favour of customs and/or religious beliefs on personal and sexual matters as opposed to the requirements of the statutory law (Interview, Official, women's rights organisation, August 5, 2011, Nairobi).

Table 2: Statutory versus customary legal systems as relates to SRH rights in Kenya

Reproductive health issue	Statutory law provisions	Customary law provisions
<b>Equality</b>	<ul style="list-style-type: none"> <li>Section 27(3) of the Constitution which provides for equality indicates that women and men have the right to equal treatment.</li> <li>Section 27(4) of the Constitution, which provides for protection from discrimination, includes the sex attribute as one of the descriptions covered by the term "discriminatory."</li> <li>Section 43(1a) of the Constitution which protects economic and social rights provides for the right to health care, including reproductive health care.</li> </ul>	<ul style="list-style-type: none"> <li>Women regarded as minors under the care and control of a male. As a result:               <ul style="list-style-type: none"> <li>women cannot own or inherit property</li> <li>women do not participate in public life</li> <li>women have limited decision-making powers; thus decisions touching on sexuality and reproduction are a preserve for men.</li> </ul> </li> </ul>
<b>Elimination of harmful practices</b> Violence against women	<ul style="list-style-type: none"> <li>Domestic violence addressed under general assault and civil offenses of assault and battery.</li> <li>No domestic violence courts exist.</li> <li>Rape is a criminal offense punishable by a maximum of life imprisonment and minimum sentence of ten years. However, marital rape is not recognised as an offense.</li> <li>Female circumcision is prohibited under the Children's Act of 2001, and under the FGM Act of 2011.</li> <li>Sexual Offences Act prohibits various categories of sexual offenses against women and children.</li> </ul>	<ul style="list-style-type: none"> <li>Wife beating accepted as a form of cultural "disciplining" of wife.</li> <li>Rape is an offense, not against the victim but against her family. The same is true for impregnating a single woman.</li> <li>Cultural attachment to female circumcision as a rite of passage among some ethnic groups.</li> </ul>
Child marriages	<ul style="list-style-type: none"> <li>Early marriages of children prohibited under the Children's Act.</li> <li>Minimum age of marriage under the Marriage Act is set at 16 years with consent.</li> <li>Various definitions of "child" under civil and criminal laws.</li> </ul>	<ul style="list-style-type: none"> <li>No minimum age; girls can be betrothed at birth.</li> </ul>
Polygamy	<ul style="list-style-type: none"> <li>Polygamy is illegal and penal code provides for offence of bigamy.</li> </ul>	<ul style="list-style-type: none"> <li>Polygamy is allowed.</li> <li>Wife inheritance practised among some communities.</li> </ul>

Source: Mbote et al (2009 in Briscoombe et al 2010), with author updates.

### ***SRH-related decision-making in Kenya***

Historically and mirroring the international scene prior to ICPD, issues of RH in Kenya were addressed narrowly through a population and public health approach that focused on family planning (FP) and safe motherhood. The first population policy in Kenya was enacted in 1967 with its main focus on population growth control (Chimbwete et al 2005). The development of this policy was attributed to influence from the then US-based Population Council, whose representatives held high level meetings with senior Kenyan government officials that culminated in the formulation of the policy (ibid). Even then, the policy did not receive priority, and it was not until the late 1970s that its implementation began with the introduction of a national FP programme (ibid). Following the ICPD, Kenya developed a National Reproductive Health Strategy in 1997, which became the first government document to recognise RH as rights, but this was never implemented<sup>7</sup>.

In 2003, the government issued the first ever Adolescent RH and Development Policy. The adolescent RH policy was an initiative of the NCPD in collaboration with the DRH, the Centre for the Study of Adolescence (CSA) and the Kenya Association for the Promotion of Adolescent Health (KAPAH). In 2005, the NCPD led advocacy efforts to reposition FP, which saw the government establish a budget line for FP for the very first time<sup>8</sup> (Thaxton 2007). In 2006, Kenya enacted the Sexual Offences Act to address sexual violence, which, based on media and police reports, had been rising since the 1990s (Onyango-Ouma et al 2009). This was a legislative process spearheaded by human rights civil society<sup>9</sup> organisations and channelled through the Attorney General's (AG) office and parliament. In 2007, the government issued the National RH Policy, whose development was spearheaded by the DRH. Efforts in 2008 by FIDA-Kenya to introduce an RH and Rights Bill for debate in parliament were blocked by religious leaders, even before the bill reached parliament, on grounds that the bill proposed to legalise abortion. In August 2010, Kenyans passed a new constitution that, among others, reduced abortion restrictions minimally by allowing other trained medical professionals (midwives and clinical officers) in addition to medical doctors to make decisions on abortion as well as provide safe abortion care. The constitution also recognised access to RH care as a human right. Finally, in July 2011, the Kenyan parliament passed a law that criminalised female genital mutilation (FGM).

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<sup>7</sup> Interview, former official, DRH, May 16, 2011, Nairobi.

<sup>8</sup> I was involved in this process.

<sup>9</sup> In this thesis, civil society refers to voluntary, not-for-profit, non-governmental organisations that implement development programmes on a charitable basis.

In summary, the post-ICPD SRH policy reforms in Kenya have been guided by the ICPD Programme of Action among other international agreements and conventions (including UN Convention of Human Rights, Beijing Platform of Action, and Convention for the Elimination of all forms of Discrimination Against Women (CEDAW)) and Kenya's overall health policy framework and governing laws. The processes of developing the policies and legislations have involved debates and contestations among actors especially regarding modern contraception, abortion, adolescents' SRH, sexual violence against women, FGM, and recognition of homosexuality. It is some of these policy processes that this thesis investigates in order to provide an in-depth account of how and why certain policy reforms have been realised in Kenya while others have been blocked.

### **1.3 Research Problem**

At the international level, the processes that have produced, and continue to shape, the SRH concept are well documented. However, at different national levels, particularly in L&MIC settings in SSA, little empirical knowledge is available on what really influences and shapes policy development processes and resultant policies. Yet, such knowledge needs to inform national and international debates and conventions on SRH. Kenya is such a setting. For Kenya, some studies have argued that although international human rights law, to which Kenya is a signatory, provides well established conceptual frameworks for SRH rights, these are yet to resonate with policy debates in the country (Merali 2000 in Crichton et al 2006). Crichton et al (2006) have argued that the obstacles to making SRH rights a reality in Kenya are multiple and mutually reinforcing, and they encompass socio-cultural norms, gender inequality, resource and capacity constraints, and an unfavourable legal environment. They have further argued that in Kenya and in other parts of SSA, rights violations are socially legitimised, and marginalised groups lack voice or have internalized their 'rightlessness' (ibid).

Other studies have noted that efforts to reform policies and laws relating to SRH in Kenya are often turned into a battle of sexes between men and women, driven by the need to control women's sexual behaviour, and framed along the lines of 'foreign/unAfrican' versus 'African', or 'modern' versus 'traditional' (Onyango-Ouma et al 2009; Thomas 2000). Thomas (2000) found that the parliamentary debates that saw the repealing of the Affiliation Act in 1967<sup>10</sup>, and other later debates opposing the gender equality, marriage,

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<sup>10</sup> In 1959, Kenya's colonial parliament passed the Affiliation Act to enable single women in Kenya to sue fathers of their children for paternity support, but this was repealed in 1967.



divorce and inheritance bills, used the duality of the 'modern' versus 'traditional' as a powerful tool for safeguarding Kenyan men's privileged legal position and sabotaging efforts to empower women through the law. Onyango-Ouma et al (2009) argued that the parliamentary debates on the 2006 Sexual Offences Act were divided between 'traditionalist' politicians who did not believe in women's rights, versus 'liberalist' politicians who supported women's rights. Thomas (2000) argued that the terms – 'modern' versus 'traditional' – have been grounded in particular visions of gender and reproductive relations. Supporting these views, Izugbara et al (2009a) found that Kenyan men's condemnatory attitudes towards abortion centred not on morality, but on men's concern over women's use of their reproductive capacity and sexuality in ways that threatened men's control over women's sexuality.

While these studies have been most informative regarding SRH-related policy debates in Kenya, given their issue-specific focus, they have not provided an in-depth and broad understanding of the power dynamics that have shaped the different actor interests and networks, the influence of different types of knowledge, and the influence of context and institutions, in different SRH policy and legislative processes. This thesis has sought to contribute to filling this gap. The thesis provides an in-depth and analytical account of factors, conditions and processes that have produced certain SRH policy and legislative reforms in Kenya and blocked others. Four specific objectives have guided this thesis: the need to identify and examine the different narrative framings of SRH that have influenced SRH policy and legal reforms in Kenya; the need to identify the different actors, interests and networks behind the different narratives and their influence on policy and legal reform efforts; the need to understand how knowledge<sup>11</sup> has influenced SRH policy and legal reforms in Kenya; and the need to examine the influence of the context and institutions, within which actors operate, on SRH policy and legal reforms realised.

The thesis's main research question is: What are the drivers and inhibitors of policy change in SRH in Kenya? Four specific research questions feed into this main question:

*Research question 1: Which narrative framings of SRH have influenced SRH policy debates and policies in Kenya?*

This question explored the existence of differing narrative framings of SRH in Kenya promoted by different policy actors, and how these narratives play out in actor networks, in

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<sup>11</sup> The terms 'knowledge' and 'evidence' are used interchangeably in this thesis and they refer to the same thing. In this thesis, knowledge/evidence refers to both research/scientific and non-research/non-scientific knowledge/evidence.

research use, and in different contexts and institutions in the policy and legislative processes studied. For each narrative identified, the thesis explored how and why it framed SRH the way it did, which issues and interests were prioritised and which ones were marginalised. It further explored the interactions between different narrative framings of SRH, and how they overlap or contradict each other in their efforts to influence SRH policy and legislative reforms. Moreover, the question explored which narratives were dominant in each of the different policy and legislative processes studied and why. Finally, the question examined how narrative shifts occurred to make reforms possible. The main aim of this question was to understand discursive power and how it shapes SRH policy and legislative processes in Kenya.

*Research question 2: Which actors, interests, and networks have influenced SRH policy change?*

This question concerned itself with identifying key SRH policy actors behind the narrative framings in 1 above, and exploring the interests that underpin their efforts in facilitating or blocking SRH policy/legislative reforms. The question further sought to understand the influential actor connections that made policy change possible or impossible. It further analysed the nature of the different actor networks found to have been influential in policy or legislative processes, as well as the dominant narratives in the different networks. The overriding aim of the question was to understand the power dynamics embodied in actor interests, agency and connections that have shaped and influenced SRH policy and legislative reforms in Kenya.

*Research question 3: What has been the role of knowledge in SRH policy change?*

This question concerned itself with exploring whether and how knowledge informed the different policy and legislative processes. The question sought to understand what knowledge was available on an issue, to what extent did it influence policy decisions, and who determined all these (i.e. what knowledge was available and to what extent it influenced policy). The primary aim of the question was to provide a deeper understanding of knowledge as power and how this power was used to shape and inform different SRH policy and legislative processes in Kenya.

*Research question 4: How have the context and institutions within which policy actors operate influenced SRH policy change?*

This question explored how contextual and institutional factors have enabled or hindered reforms relating to SRH in Kenya. Specifically, the question examined how the socio-cultural and political contexts in Kenya have facilitated or hindered SRH policy/legal

reforms. It also investigated how the regional and international contexts influenced SRH policy and legal changes in Kenya. Regarding institutions, the question examined how formal structures (government agencies, parliament, religious institutions, civil society), rules and laws, as well as informal norms, conventions and unwritten codes of conduct in Kenya have influenced SRH policy reforms. The focus of this question was to understand not just how power embedded in context and institutions shapes and determines SRH policy and legal reforms in Kenya, but also how power shifts within contexts and institutions to create room for change.

#### **1.4 Chapter Outline**

This thesis is organised in nine chapters. Chapter 2 provides the conceptual and methodological approach of the thesis. Different concepts of the policymaking process are explored and linked to provide a synthesis framework that guides this study. In addition, the study's methodology is discussed. Chapter 3 offers the first part of the empirical findings of the thesis that identifies and discusses the different competing narrative framings of SRH in Kenya, and how these influence policy and legal reform processes. Its purpose is to set the stage for Chapters 4-6, which discuss specific SRH decision-making processes. Chapter 4 discusses the first policy process case study, the development of the Adolescent RH and Development Policy issued in 2003. Chapter 5 discusses the second case study that focused on the legislative process that produced the 2006 Sexual Offences Act, while Chapter 6 discusses the third and final case study, the development of the National RH Policy issued in 2007. Chapter 7 offers a reflective synthesis of the decision-making processes discussed in Chapters 4-6, focusing on the forces behind narrative shifts that produced reforms or those that sustained hegemonic oppositional narratives to block reforms. Chapter 8 extends the discussions in Chapter 7 to analyse the power embedded within the competing narratives of SRH in view of the study's findings. Finally, Chapter 9 summarises the main findings, discusses the thesis's contribution to theory, and suggests a way forward based on the thesis's findings.

## **Chapter 2**

### **Concepts and Methods**

#### **2.1. Introduction**

This chapter provides an account of the concepts and methods that have informed the design and implementation of this thesis. It is divided into two main sections: conceptual framework and methodology. In the first section, different concepts of the policymaking process are examined and linked to provide a synthesis framework that guides this study. The overall concept is that of discursive power proffered by various scholars (Fischer 2003; Foucault 1980), which argues that power is embodied in the discourses and narrative framings of issues, and determines how policy issues are tackled. The second section sets out the methodological approach that has been employed in conducting the study. The thesis employed a qualitative case study design that was enriched with some anthropological concepts, particularly the use of language and discourse as a tool for social and political control and paying special attention to power embedded within the social context, in order to enable a richer and deeper analysis and understanding of the SRH policy and legislative processes in Kenya.

#### **2.2 Conceptual Framework: What Accounts for SRH Policy Change in Kenya?**

To investigate the drivers of change in SRH decision-making in Kenya, this study has drawn on the existing multiplicity of frameworks and models put forth by different scholars to explain how public policy change happens. Since the 1950s, various frameworks have been proposed for understanding the public policy process and explaining change. The linear process (i.e. stages heuristics), first formulated by Harold Lasswell in 1956, conceives of policy as a linear process that flows from agenda setting, to policy formulation, to implementation, and then evaluation. However, this framework has been criticised for oversimplifying and rationalising a complex and power-laden process (Sabatier 2007). In the wake of this criticism over the past three decades, a number of alternative theoretical frameworks have been either developed or extensively modified in different fields (including political science, public policy and anthropology (Sabatier 2007)) to explain the policy process and how change happens. These include:

- Frameworks that emphasise the complexity of the policy process, including Lindblom's incrementalism 1959; 1979; Kingdon's multiple streams (2003); Grindle and Thomas's (1991) political economy of the policy process; Baumgartner and Jones's

(1993) punctuated equilibrium theory; Walt and Gilson's 1994 policy triangle; ODI's 2002 Research and Policy in Development (RAPID) framework (Court and Young 2003); IDS-KNOTS team's 2006 model of actors and networks, narratives, and politics and interests; and Sumner and Jones (2008) model of interlocking power relations among actors, institutions and discourse.

- Frameworks that emphasise actor networks, including Heclo's 1978 policy networks; Sabatier and Jenkins-Smith's 1998 advocacy coalition; Marsh and Rhodes's 1992 policy communities; Haas's 1992 epistemic communities; and
- Frameworks that emphasise discourse as power, deriving from the works of Michel Foucault (1926-1984); Gasper and Apthorpe 1996; Fischer's (2003) discursive approach; and Roe's 1994 narrative policy analysis.

Studies focusing on L&MICs have emphasised the important role of different factors in bringing about policy change, including: policy actors and networks (IDS-KNOTS Team 2006; Scoones 2005; Keeley and Scoones 2003; Grindle and Thomas 1991); actor interests and politics (Sumner and Jones 2008; IDS-KNOTS 2006); context and institutions in which actors operate (Sumner and Jones 2008; Walt and Gilson 1994; Grindle and Thomas 1991); policy narratives and discourse (Scoones and Forster 2008; Walt et al 2008; Sumner and Jones 2008; Leach et al 2007; IDS-KNOTS 2006; Scoones 2005; Keeley and Scoones 2003); and power (Erasmus and Gilson 2008; Gaventa 2006). Gilson and Raphaely's (2008) review of studies in health policy analysis in L&MICs found that the Policy Triangle model developed by Gill Walt and Lucy Gilson in 1994 had dominated studies that seek to explain change in health policy. The Policy Triangle model proposes that understanding health policy change needs to focus on analysing actors involved, context, process and policy content. Even then, Gilson and Raphaely (2008) found that most health policy analysis studies conducted in L&MICS since 1994 to 2007 had not focused on investigating power and had consequently failed to contribute to the existing policy-change theory in this field.

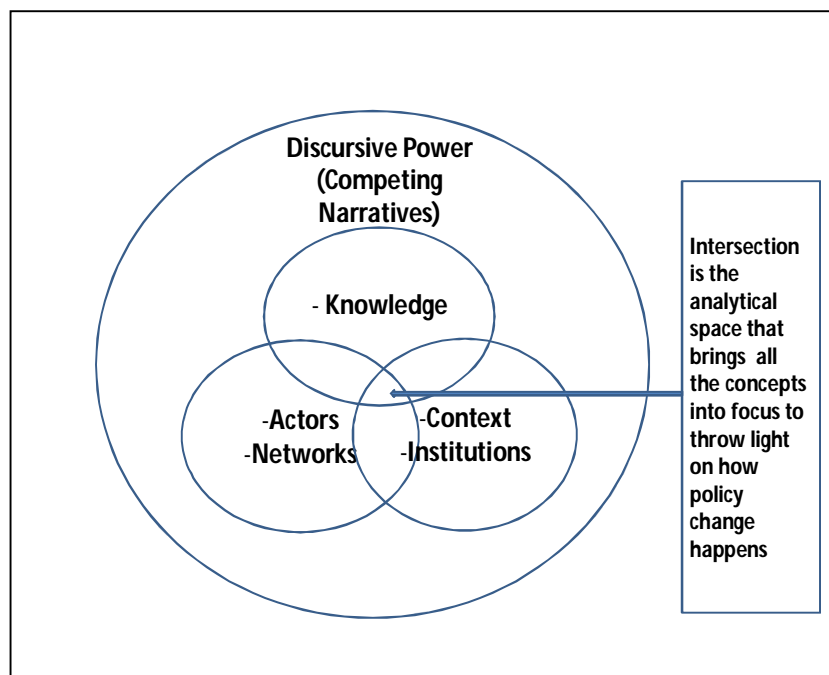
Drawing on the extensive literature review and the identified gap in theory in health policy analysis in L&MICs, I developed a synthesis conceptual framework that would enable a critical exploration of the drivers and inhibitors of change in SRH policy and legislative processes in Kenya. In particular, my synthesis framework is an adaptation of two policy change models, namely the IDS-KNOTS 2006 model and Sumner and Jones (2008) framework. The IDS-KNOTS model conceives of policy change as happening as a result of the interaction of three important factors, namely, knowledge and discourse, actors and networks, and politics and interests. The Sumner and Jones (2008) model is closely related

to the IDS-KNOTs model and it conceives of policy change as determined by multiple and interlocking domains of power, namely (Sumner and Jones 2008: 363):

- Actors - The policy actors and networks and their political interests and incentive/disincentive structures (i.e., power as material political economy).
- Institutions - The context and institutions and how the socio-economic, political and cultural environment shapes policy processes and the formal/informal 'rules of the game' (i.e., power as institutions or habitus).
- Discourses - The policy narrative/discourses and their underlying evidence or knowledge (i.e., power as discourse).

Adapting these two models, this thesis's synthesis framework adopts a discursive approach to power (Fischer 2003; Foucault 1980) as its overall component that mediates three other forms of power – power as embodied in actor interests and networks, in knowledge, and in context and institutions – to determine policy change in SRH in Kenya. This framework is presented in Figure 1 and its components discussed below.

**Figure 1: Conceptual Framework for Analysing SRH Policy Change**



Source: Author 2013, an adaptation of the Sumner and Jones 2008 and IDS-KNOTS 2006 models.

### 2.2.1 Discursive power

It has been long acknowledged that public policymaking is about power (Hill 2005; Fischer 2003). While Marxist scholars view power in the policy process as held by elites (Marx 1963 in Hill 2005), pluralist scholars argue that power is diffused throughout society and that no one group holds power over others (Dahl 1958 in Hill 2005; Smyth 1977 in Walt 1996). Hall et al (1975 in Walt 1996) argue that the Marxist view (also referred to as the elitist view) applies only in issues of 'high politics' (e.g. economic issues), but most domestic routine policies (in developed countries), such as health and education, are developed along pluralist lines with the participation of many different groups. Others have argued, however, that the elitist view may apply in most policy sectors in poor countries where power is often held by certain influential actors such as bureaucrats, businessmen, military, and donors (Hyden and Mmuya 2008; Walt 1996). Even then, it is acknowledged that interest groups in these countries (e.g. professional bodies and religious groups), though not sufficiently organised, have some level of access to and influence over government (Walt 1996).

Taking forward the pluralist view of power, Foucault (1980; 1991) challenges the idea that power is held by individual actors, but rather argues that 'power is everywhere', and that it is 'diffuse, pervasive, and embodied in social relations'. Foucault (1980) suggests that power is at the centre of all social relations and is dispersed through a network of discourses of possibility that govern people's thinking and actions. He defines discourse as:

ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledges and relations between them. Discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects they seek to govern (Weedon 1987: 108).

Fischer (2003) has taken Foucault's concepts of power as discourse forward, arguing for the importance of analyses of public policy processes to focus on understanding discursive power. According to Fischer (2003: 41), 'a discursive approach takes a more fundamental view of language and discourse'. A discursive approach therefore sees language and discourse as having a more underlying role in structuring social and political action. Thus, in this perspective, Fischer (2003: 41) argues that 'the very terrain of social and political action is constructed and understood in terms of the languages used to portray and talk about political phenomenon'. Thus, language is important in this approach, but not just in a linguistic sense. Rather, discourse here is grounded in the awareness that language

strongly shapes people's view of the socio-political world rather than simply mirroring it (Fischer 2003). As such, through 'the signs and symbols of a language, people construct their social world and the political actions they undertake to influence it' (Fischer 2003: 42). He argues that 'the policy process is still about gaining and exercising power. But the process is mediated through competing discourses (including hegemonic and challenging discourses) that reflect – often subtly – the distribution of power' Fischer (2003: 46). As such, political action is shaped and controlled by the discourses that supply it with meaning, and consequently, problems don't just come onto the political agenda because they are there, they come as a reinforcement of ideologies (Fischer 2003).

Discourses or narratives are represented by ideations about origins of, and solutions to, public problems (John 2003). Roe (1994:34) defines policy narratives as 'stories (scenarios and arguments) which underwrite and stabilise the assumptions of policymaking in situations that persist with many unknowns, a high degree of interdependence, and little, if any, agreement.' Discourses or narratives frame a problem and attempt to explain the best method of solving it (Keeley and Scoones 2003). According to Grillo (1997), discourses legitimate particular ways of practising or thinking and speaking about an issue, while undermining alternative ways. Wolmer and Scoones (2005) argue that some narratives tend to gain more authority, persisting at the expense of others, and hence have more bearing on policy decisions, but they are often contested by alternative policy narratives that frame problems and solutions in different ways. They contend that narratives employ a variety of value-laden/subjective concepts to argue for prioritisation of certain issues over others (ibid). It is important to note that in this thesis, the terms 'narrative' and 'discourse' are used interchangeably. I am aware that in general use in policy analysis literature, a narrative has a narrow focus whereas a discourse has a broad focus, and often a discourse comprises of more than one narrative. My conflation of these two terms therefore is deliberate and not a misunderstanding of their meanings in policy analysis literature. Also important is the need to note that the term narrative as used in this thesis refers to 'policy narratives' as defined above by Roe Emery (1994) and as used by various scholars including Keeley and Scoones 2003, Wolmer and Scoones 2005, Leach et al 2010, among others. This is different from the way the term is used in medical anthropology, where it refers to patient narrations about their personal and social experiences of illness and suffering (Levy 2005).

It has been argued that 'the form of explanation depends on the nature of the particular social reality to be explained' (Fischer 2003: 21). Thus, discursive power was adopted as the overall concept of study because sexuality and reproduction are socially complex issues and



the concept's concern with the politics of meaning and social construction, and the use of language as a political resource or control (Seidel 1993), provide important lenses for uncovering the workings of power in SRH decision-making processes. The approach, thus, conceives of power as embedded in competing narrative framings of SRH that mediate the interactions of three other forms of power in SRH decision-making processes, i.e. power embodied in actor interests and networks, power embodied in knowledge, and power embedded in context and institutions. Discursive power, in this thesis, encompasses the ways in which competing discourses or narratives legitimate particular ways of responding to a policy issue, while undermining alternative ways.

More generally, the discursive approach was adopted because it challenges the dominant technocratic, empiricist approach to policy analysis, which is often insensitive to politics (Fischer 2003). This is especially the case in the area of health policy and systems research, where Gilson et al (2011), have argued that much of the policy analysis research takes an empiricist or neopositivist approach that is dominant in the field of health. The discursive approach is critical in policy analysis because of its focus on values and social meaning, which Fischer (2003:vii) argues that, 'are among the essential driving forces of politics and policymaking', and so without studying them, it becomes difficult to understand politics and policymaking processes detached from the values and social meanings that underlie them as their normative realities.

This thesis' strong focus on analysing power in the SRH policy processes in Kenya is important because various studies have shown that power is rarely explicitly analysed in health policy studies in L&MICs (Erasmus and Gilson 2008). In fact, it has been acknowledged in recent years that the health policy analysis field in L&MICs is still in its infancy and most studies conducted have not focused on investigating the role of power in the policy process (Erasmus and Gilson 2008; Gilson and Raphaely 2008; Sheikh et al 2011). It has also been argued that health policy analysis research in L&MICs has been mostly framed around positivistic knowledge on health systems, without drawing on useful explanatory concepts from the social science field, yet health systems are complex social and political phenomena (Gilson et al 2011; Sheikh et al 2011). This thesis attempted to contribute to filling these theoretical gaps by focusing on analysing how discursive power mediates the interplay of other forms of power, i.e. actor interests and networks, knowledge, and context and institutions, in the policy process to determine policy change in SRH in Kenya.

### 2.2.2 Actor interests and networks as power

Actors involved in public policy processes seek to influence decisions to address their interests and concerns using resources at their disposal (Lewis 2006). McGee (2004:9) has argued that 'actors hold opinions and interests; they are embedded in institutional and political cultures; they exercise agency. Each [actor] is a power holder'. Actors work through networks and connections with other actors to influence policy decisions. Indeed, since the 1960s, policymaking has been acknowledged to occur within subsystems, what in the US was referred to as the 'iron triangles', since policymaking often involved three major actors, i.e. administrative agency, a congressional subcommittee, and a pressure group (Kavanagh et al 2006).

Later developments have suggested the existence of different typologies of actor networks in policymaking. Marsh and Rhodes (1992) have argued that there are different types of networks in policymaking, which can vary from policy communities located at one end of a continuum that involve tightly bound relationships, and issue networks at the opposing end that involve much looser group interaction. Haas (1992:3), on the other hand, has conceived of policy networks, which he refers to as 'epistemic communities' that are driven by knowledge and expertise in a given area. He defines an epistemic community as 'a network of professionals with recognised expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area.' According to Haas (1992:2), epistemic communities articulate the cause-and-effect relationships of complex problems, help states identify their interests, frame the issues of collective debate, propose specific policies, and identify salient points for negotiation. In such networks, control over knowledge and its diffusion is considered to be an important dimension of power within the networks. Sabatier and Jenkins-Smith (1998), on their part, have proposed the existence of networks they refer to as advocacy coalitions in any policy subsystem. They have argued that policy change is produced by the competition between different advocacy coalitions within a policy subsystem; each advocacy coalition consists of actors from a variety of institutions who share a set of deep core beliefs on a policy issue.

Whatever their names, the main point from the different theories of policy networks is the importance of understanding which actors set the terms of debate, how power is distributed among actors, and how networks operate in pushing for or blocking reforms. An important point that I kept in mind when analysing the influence of networks is the fact that it is particular individuals in institutions who form networks and who move between

organisations, create links and modify existing networks (Walt et al 2004). An exploration of how different actors and networks employed and promoted different narrative framings of SRH underpinned by their interests in order to facilitate or block reforms was overriding in these analyses.

### **2.2.3 Knowledge as power**

Knowledge is a broad term and arguably complex. Hess and Ostrom (2007:8) define knowledge as 'assimilated information and understanding of how to use it.' In this thesis, knowledge refers to policy relevant knowledge, that is, knowledge concerning a given policy issue. It has been long acknowledged that knowledge alone does not lead to reforms; the politics have to be right (Buse et al 2006; Fischer 2003). Even then, knowledge still plays an important role in decision-making, especially drawing attention to issues that need redress. Although knowledge in policy processes is often construed to mean scientific knowledge (i.e. research evidence), this thesis looks beyond systematically generated research evidence to also understand the role of non-scientific knowledge in SRH decision-making in Kenya. Indeed, Jones et al (2009) have identified different types of knowledge that could influence decision-making to include research-based knowledge, project/programme knowledge, and participatory knowledge (that includes grassroots voices). Focusing on scientific knowledge, Sumner et al (2011) noted that research influences policy either in instrumental ways by influencing changes in policy, practice or behaviour or in conceptual ways by influencing people's knowledge, understanding and attitudes towards a social issue. Instrumentally, Jones and Sumner (2011) have argued that research influences policy in three different ways, namely, agenda setting, policy content, and policy implementation.

In the health systems sector, different types of knowledge/evidence are often organised into a hierarchy, with quantitative evidence in general and randomised control trials (RCTs) in particular representing the most trustworthy and robust forms of knowledge (i.e. the gold standard), whereas anecdotes represent the least robust type of knowledge (EBNP undated; Sackett et al 1996). This is because the process of generating biomedical knowledge is seen as purely scientific and therefore objective and independent of society, culture, bias and/or subjective interests. On the other hand, qualitative evidence is regarded as biased and therefore not credible for informing health policies. The perception that biomedical evidence is objective and neutral has been criticised extensively (see Lock and Nguyen 2010; Pigg and Adams 2005) as discussed in detail in Chapter 3, with arguments

that biomedical evidence and technologies are largely influenced by values and context. Even then, given the perceived objectivity and neutrality of biomedical evidence, most actors in the health systems sector regard it as the only credible evidence that should inform health policies (see Lewin 2012). Thus, health policymaking is largely framed as a technical process that seeks to respond to problems revealed by biomedical evidence. Such framing of health policymaking as a technical exercise has been argued as necessary to remove politics and cast the process as rational and neutral (Shore and Wright 2011).

However, the bias towards biomedical knowledge in shaping health policies has received extensive criticism, with commentators highlighting the resistance to other types of knowledge, specifically qualitative evidence, in medical sciences and arguing for the importance of complementing quantitative with qualitative evidence in informing health policies (Tucker and Roth 2006; Popay and Williams 1998). Narrowing down, SRH issues are often value-driven and therefore highly contested and politicised (Sumner et al 2011; Buse et al 2006), a situation that often renders the positivistic biomedical knowledge ineffective in influencing policy. Jones et al (2009:17) have noted that 'research on reproductive health issues is often dismissed as the area is highly contested and value-driven, and moral arguments typically carry greater weight'. All these made it necessary to examine the role of knowledge in the SRH decision-making processes studied in this thesis.

In analysing how knowledge influenced the decision-making processes studied, I adopted a critical view to ascertain how the nature and kind of knowledge used in the policy processes shaped the policies produced. I also looked at the issues that such knowledge addressed and the ones it ignored, as well as the availability of scientific knowledge on different SRH issues. Furthermore, I considered the role of non-scientific knowledge in influencing the policy processes. Finally, I considered the competition between scientific knowledge and other factors in shaping the different policy processes studied in this thesis. All these were analysed through the lens of the competing narratives to understand how the narratives mediated the extent to which knowledge could influence SRH policies and laws in Kenya.

#### **2.2.4 Context and institutions as power**

Context and institutions influence policy change (Court and Cotterrell 2006; Fischer 2003; Walt and Gilson 1994). Shore and Wright (2011) have argued that policies both reflect and produce context. Context shapes the likelihood of policy change taking place, the positions and perspectives of actors, and the effectiveness or appropriateness of different actions

(ODI 2006). Bourdieu (1986) and North (1990) conceptualise power as embedded in culture and institutions, respectively. Bourdieu (1986) suggests that power is embedded and legitimised through culture, which he defines as dispositions, objects, institutions, language, values, judgements, and activities of everyday life. He argues that power operates through 'habitus' or socialised norms that guide people's thinking and behaviour. Navarro (2006) has argued that Bourdieu's conceptualisation of power offers ways of unearthing hidden power mechanisms of social domination. North (1990), on the other hand, sees power as facilitated or constrained by formal (structures, rules, laws and constitutions) and informal institutions (norms and self-imposed codes of conduct). Institutions, he argues, are the humanly devised constraints that structure human interaction (North 1990).

Taking forward the role of institutions in shaping policy change, Fischer (2003:28) argues that:

It is not that institutions cause political action; rather it is their discursive practices that shape the behaviours of actors who do. Supplying them with regularised behavioural rules, standards of assessment, and emotive commitments, institutions influence political actors by structuring or shaping the political and social interpretations of problems they have to deal with and by limiting the choice of policy solutions that might be implemented. The interests of actors are still there, but they are influenced by institutional structures, norms and rules through which they are pursued.

According to Fischer (2003: 27), proponents of neo-institutionalism (which he defines as a theoretical orientation focused on the evolutionary relationship of ideas and norms of institutions) have argued that institutions not only facilitate the ability of some groups to achieve their goals, they also block or hinder the attempts of others. The proponents therefore see political and policymaking practices as 'grounded in institutions dominated by ideas, rules, procedural routines, roles, organizational structures and strategies which constitute an "institutional construction of meaning" that shapes actors' preferences, expectations, experiences, and interpretations of actions' (Fischer 2003:29).

The context and institutional aspects of the framework informed the analysis of the socio-cultural, political and international influence as well as the influence of institutions (i.e. rules, laws, parliament, and government agencies) in the different policy processes. I conceptualised context and institutions as dynamic and therefore focused on investigating both their enabling as well as constraining factors. Kingdon's (2003) ideas of how changes in the 'political stream' or the emergence of new problems open up policy windows were explored. Overriding these analyses was the examination of how different narrative framings of SRH operate in, and are supported or undermined by, the different contexts

and institutions within which SRH policy reforms take place. The purpose was to explore obvious and hidden power embedded in contexts and in formal and informal institutions, and which shape SRH policy reforms in Kenya.

## **2.3 Methodology**

### **2.3.1 A policy analysis design enriched with anthropological concepts**

The overall design of this study has drawn from policy analysis concepts, which have been enriched with various anthropological concepts. From a policy analysis point of view, the thesis adopted a qualitative case study design commonly used in policy analysis studies to explore the influential actors and factors that bring about change in a given policy issue. This policy analysis design was enriched with anthropological concepts of policymaking that conceptualise the policymaking process as deeply political and driven by powerful discourses and ideology. This meant that the thesis prioritised methods that help unravel the subliminal forms of power embedded in discourse, institutions and context. Below, I expound on each of these two designs.

#### ***Policy analysis: The qualitative case study design***

Policy analysis is a methodologically diverse field that uses both quantitative and qualitative methods. Harold Lasswell, considered the founder of 'policy sciences', in the 1950s envisioned policy analysis as a multidisciplinary field capable of guiding the political decision processes (Torgerson 2007). He envisioned a field of study that would cut across various specialisations, including political science, sociology, anthropology, psychology, statistics and mathematics, and even the physical and natural sciences in some cases (ibid). The field was to employ both quantitative and qualitative methods (ibid). Quantitative methods in policy analysis often seek to demonstrate whether a relationship exists between policy design and policy outcomes, test whether the relationship can be generalized to similar settings, evaluate magnitudes of the effects of policy on social, economic and political factors, and find better policy alternatives (see Yang, 2007). Qualitative methods, on the other hand, seek to provide an understanding of the policy-making processes, meaning and interpretation of policy decisions (see Yanow 2007).

Given the focus of this thesis - understanding the drivers and inhibitors of change in SRH policy-making - the qualitative design was adopted. To enable an understanding of different SRH decision-making processes in order to generate a synthesis of lessons, the case study approach was adopted. Gilson and Raphaely (2008) have shown that studies that seek to

understand and explain health policymaking have traditionally drawn heavily on the case study design to illustrate the policy processes, the interaction between various actors and power relations, and the context of policymaking and implementation. In a systematic review, they found that most of the health policy analysis studies in L&MICs adopted the qualitative case study design (ibid). Yin (2003:13) defines case study as ‘an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident’. Qualitative case study research method is adopted when the context is important to the phenomenon to be studied and when an investigator wishes to answer ‘how’ and ‘why’ questions (Yin 2003). Schramm (1971 cited in Yin 2003:12) noted that ‘[t]he essence of a case study ... is that it tries to illuminate a decision or a set of decisions: why they were taken, how they were implemented, and with what result’. Given the focus of this thesis on the ‘how’ and ‘why’ questions, and the importance of the context to answering these questions, the qualitative case study design was deemed as the most appropriate approach that would enable the understanding of the drivers and inhibitors of change in SRH policy-making in Kenya. The thesis examined three carefully selected case studies of decision-making processes in SRH in Kenya (discussed further below) in order to understand how and why certain policy changes were realised while others were blocked.

### ***Anthropological concepts***

The need to draw on anthropological concepts was informed by the fact that the thesis focused on exploring issues that Shore and Wright (1997:4) have described as being ‘at the heart of anthropology: norms and institutions; ideology and consciousness; knowledge and power; rhetoric and discourse; meaning and interpretation; the global and the local...’ Drawing on this argument, the thesis focused on understanding how discursive power has shaped debates on SRH issues in Kenya and how such debates have determined which policy decisions are possible and which ones are not. It also focused on understanding how SRH policy has been used as political technology, to use Foucault’s terminology, for governmentality and subjectivity. Foucault has demonstrated how the body has been caught up in a political field of power relations, and identified the ‘polymorphous sites of power’ and the interplay between modes of domination and different forms of classification (Rabinow 1991). In line with this thinking, this thesis has explored how power is exercised through discourse in SRH decision-making in Kenya.

Furthermore, the thesis has sought to challenge the assumption by many health policy analysis studies that policy is neutral and free of ideology by problematizing policy as truly political and ideological. The thesis is therefore informed by Reinhold's (1994:477-9 in Shore and Wright 1997: 14) call for "studying through": [by] tracing ways in which power creates webs and relations between actors, institutions and discourses... Anthropological approaches to policy analysis often treat policy communities as not just rhetorical, but contested political spaces, focusing on answering such questions as: 'Whose voices prevail?' and 'How are their discourses made authoritative?' (Wright 1995:95 in Shore and Wright 1997). Furthermore, the thesis moves beyond the policy analysis way of treating policy documents as neutral texts that state how government addresses issues, but rather as 'rhetorical devices and discursive formations that function to empower some and silence others' (Shore and Wright 1997:15). Another important aspect of anthropology that has informed this thesis is that it pays special attention to social context, i.e. questions of power and inequality, emphasises what people say and do, and looks closely to the use of language (Bernard 1994). Anthropological insights also informed the methods employed in data collection as explained on pages 34 and 38. Overall, this thesis remains a policy analysis piece of work focused on explaining policy change, but draws on anthropological concepts to deepen its analysis of power and provide a deep and nuanced understanding of policy change in SRH in Kenya.

### **2.3.2 Rationale for Kenya**

Kenya was chosen as the study site because it presented a fertile ground for investigating health policymaking processes, given that only a handful of such studies have been conducted in the country. Yet, such studies are necessary to generate findings that inform and improve health policymaking processes to facilitate more effective policies.

Furthermore, within the SSA region, Kenya is one of the many countries with the most restrictive laws as well as conservative context as relates to SRH rights (especially gender equality, abortion care, homosexuality), both of which impact SRH decision-making.

Therefore, to some extent, Kenya typifies the SRH policymaking and implementation challenge in much of SSA. Thus, the findings of this thesis may inform future SRH policy reforms in the region. Finally, Kenya was chosen because of my extensive understanding of the country's overall health policy and political environment. I have lived in Kenya all my life and worked in the field of health and population research and policymaking for seven years. As already noted, policymaking is best understood within the context it takes place, and so my deep understanding of the Kenyan context enabled me to contextualise the



study design and data gathering and analysis that ultimately produced more accurate and credible findings.

### **2.3.3 The case studies**

Three carefully selected case studies were the main focus of this thesis, namely, two bureaucratic policies (the adolescent RH policy and the national RH policy) developed by technocrats within government ministries with the contribution of non-state actors, and a parliamentary/legislative process (sexual offences law) that mainly involved members of parliament and women's rights civil society groups. Overall, three main factors informed the selection of these cases. First, I sought to represent cases of decision-making within both the bureaucracy (adolescent RH and national RH policies) and the legislature (sexual offences law). Second, I sought to capture contestation and so two of the cases focused on highly contested SRH issues (i.e. adolescent SRH and sexual violence). Third, I sought to present cases from different time periods in order to demonstrate how SRH rights debates have progressed in Kenya over time; the adolescent RH policy represented the early 1990s to 2002, whereas the sexual offences and the national RH policy processes represented the period from 2003 to 2007.

In addition to the main case studies, in August 2010, three months before my fieldwork (December 2010-October 2011), Kenyans passed a new constitution that minimally relaxed restrictions on abortion and recognised RH as a human right. And, several months into my fieldwork period (July 2011), the Kenyan parliament passed a law to criminalise FGM. These new policy shifts were interesting because they touched on sensitive SRH issues in Kenya – abortion, RH as rights, and FGM – that were greatly contested in the three main case studies. And, because several of my interviewees participated in the processes and were willing to share their experiences, and the wide documentation of the processes (through the media and publications), I decided to also draw on these two policy shifts as 'mini-case studies'. Importantly, the two mini-case studies complement the three main case studies by providing the state of SRH debates and contestations between 2007 and 2011. The 2010 constitutional mini-case study is discussed as an 'add-on' to the national RH policy, whereas the 2011 FGM law mini-case study is discussed as an 'add-on' to the sexual offences legislative process. All the case studies facilitated the analysis of how different narrative framings of SRH shaped and mediated actor interactions and influence, use and influence of knowledge, and the influence of context and institutions in decision-making processes. These case studies are discussed below.

### ***The Development of the Adolescent RH and Development Policy 2003***

In 2003, Kenya issued the first ever Adolescent RH and Development Policy. The policy sought to integrate adolescents' RH and development concerns into Kenya's national development process. The development of the policy was a result of many years of lobbying for the government's attention to adolescents' SRH challenges. This case was chosen because the provision of SRH information and services to adolescents remains one of the most contentious SRH rights issues in Kenya to date. At the ICPD, this was one of the issues that a number of African governments, including Kenya, expressed reservations towards (Glasier et al 2006; UNFPA 1995). Analysing this case, therefore, provided an opportunity to understand how different policy actors and factors interacted to overcome opposition, and more importantly, to shape the resultant policy.

### ***The Development and Enactment of Kenya's Sexual Offences Act 2006***

In 2006, Kenya enacted the Sexual Offences Act to provide a legal framework for addressing sexual violence. The enactment of the Act was a response to the country's weak legal framework for addressing sexual violence. The process of enacting the law witnessed polarised debates in parliament, with most male parliamentarians generally opposed to the bill. This case was chosen because of a number of reasons. First, investigating the case provided an opportunity to understand the attitudes and influence of parliamentarians on a controversial SRH rights issue as they directly participated in the process through debates in parliament. Second, this was the first gender-related legislation to ever pass in Kenya's male dominated parliament since independence; several bills on gender-related issues such as the gender equality bill, inheritance bill, and marriage bill, had all been rejected (Onyango-Ouma 2009). Thus, studying the case facilitated an understanding of the tactics and constellations of actors that made change possible. While FGM was contested and omitted from the sexual offences law in 2006, it was criminalised by the Kenyan parliament in July 2011 without any opposition. This made it necessary to also examine the FGM law process as part of the sexual offences law case study to understand what made later reforms on the FGM issue possible.

### ***The Development of Kenya's National Reproductive Health Policy 2007***

The National RH Policy 2007 provides the overall framework adopted by the Kenyan government in responding to SRH issues in the country. The policy was the first ever RH policy following on the 1997 RH strategy developed to operationalize the ICPD Programme of Action. The processes that produced the national RH policy provided a rich

reservoir of experiences and lessons from the different state and non-state actors involved. Therefore, studying this case provided an opportunity to understand how an issue that was conceived at the global stage (i.e. RH) was contextualised in Kenya. To complement and enrich the understanding of the debates in the national RH policymaking process and the resultant policy, the mini-case study on Kenya's new constitution promulgated in August 2010 was also examined. The new constitution recognised RH as a human right, and also minimally expanded access to abortion as noted in Chapter 1. Past Kenyan laws only allowed medical doctors to decide on, and carry out, legal abortion. The new constitution's provisions on abortion made abortion the main campaign issue against the proposed constitution, pitting religious leaders and a section of politicians against human rights and women's rights civil society organisations and a section of leading politicians. In the end, Kenyan voters voted in favour of the proposed constitution, making it necessary to understand the dynamics that produced this policy shift given the contextual sensitivity of the issue of abortion and RH rights in the country.

### **2.3.4 Positionality**

As opposed to quantitative research which takes a positivist approach, qualitative research may be subjective since the researcher becomes a core part of the research process and interpretation of the findings. This makes it important for me to reflect on my positionality in relation to the research process. Prior to my PhD journey (between 2002-2009), I worked in national and international research organisations in Kenya with the responsibility for leading research communications efforts to influence health and population policies in Kenya and SSA. Thus, prior to the PhD process, I had been, to some extent, part of the decision-making processes that I now studied. This meant that throughout the study, I had to be conscious of how my previous experiences and knowledge came to bear on the thesis's findings.

While my previous work in Kenya provided me with ready contacts for interviewing, it also meant that respondents who knew my previous work could have had a particular view of my research that could have influenced the responses they provided. To mitigate this, I probed responses for details whenever I deemed necessary in order to ascertain their truthfulness. Second, my previous work meant that I had a good understanding of the debates in the SRH subsector in Kenya and the positions of different actors on SRH issues. Furthermore, as a Kenyan who has lived and worked in Kenya all my life, I had an in-depth understanding of the informal context and institutions as they relate to SRH. Taken

together, these two aspects provided me with an understanding that enabled me not only to ask meaningful questions, but also to interrogate responses in order to get deeper insights, as well as put responses into context.

Importantly, given my background working with health and population research evidence in Kenya that constantly showed poor SRH outcomes largely occasioned by ineffective policies and programmes or a lack of these, I am interested in seeing more evidence-informed and effective SRH laws, policies and programmes. Therefore, I implemented this study not as a completely 'disinterested observer', but as someone interested in seeing progress through better SRH laws, policies and programmes, and ultimately, outcomes. In addition, given my previous work in the SRH policy sector in Kenya, I am coming from a position that is sympathetic to the framing of SRH as universal human rights as I believe this framing has the potential to challenge socio-cultural and political opposition to SRH policy reforms in Kenya. Therefore, discussions in this thesis that criticise the human rights framing of SRH are not focused on discarding the concept, but on raising important questions on how best Kenya can make meaningful use of the human rights framing in bringing about policy reforms.

Finally, given the nature of my study topic – sexuality and reproduction, issues that are largely driven by values and beliefs – it is imperative that I declare my religious beliefs. As a child, I was brought up as a Christian of the Anglican denomination. As an adult, I've remained a Christian in the Anglican denomination although my Christian beliefs have continued to be shaped and enriched by critical thinking and questioning of the doctrines that underpin Christianity. This disposition has certainly had a bearing on this study.

### **2.3.5 Ethics**

The thesis was approved by the University of Sussex following a successful ethical review and clearance process (see Appendix I for ethics certificate). The thesis proposal was also reviewed by the Kenya Medical Research Institute (KEMRI)'s research ethical review board, whose only concern was the adequacy of the nine-month period allocated for data collection, which they felt would be inadequate (see Appendix II). Data collection was guided by the major ethical principles in social science research, including beneficence or the avoidance of harm, veracity or the avoidance of deception, privacy or anonymity, confidentiality, and consent (Kvale and Brinkmann 2009). Prior to recruitment of interviewees, I sent out letters and a study information sheet to possible interviewees, which described the study, its objectives and benefits, and stated that participation in the

study was voluntary (see appendices III and IV). These were followed by a phone call to establish each interviewee's willingness to participate in the study. For interviewees who accepted to take part in the study, I again gave an oral introduction to the study before the interviewing and discussed confidentiality issues, following which I requested them to sign a consent form (see Appendix V). All documents used during data collection – letters, consent form, interview schedules – were all reviewed and approved by the University of Sussex. The information collected during the study has not been used for any other purposes except for this study. The information has been stored under pass-word protection on my lap-top computer. In presenting the findings, I have striven to protect respondents' confidentiality and anonymity by not stating their names, positions or descriptions of their positions, and on sensitive issues or in cases of small organisations where it would be obvious to people in the industry who the respondent is, not stating the names of their organisations. Instead, I've identified quotes using the word 'official' and giving either the name of the organisation or a description of the organisation. I have not anonymised the names of the organisations that played lead roles in the different policy processes because these are well acknowledged in the policy documents, which are public documents, making anonymity here pointless. These organisations include CSA, NCPD, USAID, Policy Project, and the DRH.

### **2.3.6 Data Collection Methods**

The choice of data collection methods was informed by the research question and the overall study design. Yin (2009) has noted that the case study approach typically combines data collection methods such as interviews, questionnaires, archives and observations. Consequently, this thesis combined semi-structured in-depth interviews; participation, observation and note-taking in meetings; media content review; and document review, for data collection. The use of observations was also informed by the fact that participant observation is an important data collection method in anthropology that enables a more holistic understanding of phenomena (DeWALT and DeWALT 2002). Thus, since my overall design also drew on anthropological concepts as discussed above, participant observation in meetings was deemed as important in enabling a more holistic understanding of power dynamics.

#### ***Semi-structured in-depth interviews***

Qualitative interviews afford research respondents the opportunity to reflect on their roles and experiences in policymaking processes, their relationships with other actors, and their

views on the ways in which decisions are made (Erasmus and Gilson 2008). I conducted semi-structured in-depth interviews with state and non-state SRH policy actors; the majority of these had participated in either one or two of the three case-study policy processes, whereas a few had not necessarily taken part in the processes, but were identified by other actors as important in influencing SRH policies in Kenya. The selection of interviewees was purposive, which is an appropriate method when studying such socially complex phenomena. I employed different methods to identify interviewees for the different case studies. The initial list of interviewees for the adolescent and the national RH policies was drawn from the individuals acknowledged in these policies as having contributed to the policy development processes. As I started interviewing, I adopted the snow-balling technique where I asked interviewees to suggest individuals who contributed to the policy development process and whom I should also interview. This exercise increased the number of interviewees for each case. For the Sexual Offences Act, I generated the initial list from the parliament *Hansard's* coverage of the Sexual Offences Act debates (the *Hansard* publishes parliament debates verbatim) and Onyango-Ouma et al's (2009) publication which has documented the legislative process. Similarly, as I interviewed, the list snow-balled as respondents pointed out more individuals for interviewing.

Individuals interviewed ranged from legislative and government officials in relevant agencies, researchers, programme implementers, human rights and women's rights experts, officials of professional associations, and representatives of key religious institutions. Table 3 summarises the types of institutions from which interviewees were drawn and the number of interviewees from the institutions, while the next subsection provides a summary sample description. In total, 54 interviews were conducted. This number of interviews was deemed as adequate in providing a base for concrete findings and conclusions as it is nearly equivalent to the median of 58 interviews conducted in several health policy process studies in both developed and developing countries as revealed by Innvaer et al's (2002) systematic review of interview studies on health policymakers' use of research in decision-making. I conducted all the interviews myself in a face-to-face setting of the interviewees' choice; often this was the interviewee's workplace.

**Table 3: Interviewee Summary**

<b>Institution Type</b>	<b>Total Number of Institutions</b>	<b>Total Number of Respondents</b>
Government Agencies	5	12
UN Agencies	2	2
Donor Institutions	3	4
Research Institutions	3	8
Programme Implementing Institutions	8	10
Human Rights and Women's Rights Advocacy Institutions	11	12
Professional Networks	3	4
Religious Institutions	2	2
<b>Total</b>		<b>54</b>

The interviewees were largely elite members of society as they included MPs, chief executives of government agencies, heads of ministry divisions as well as senior technocrats within these agencies/divisions. Outside government, interviewees included directors of organisations and/or senior officials within organisations, and chair/secretary generals of associations. I drew upon the extensive literature on methodological challenges unique to elite interviewing in informing the study design and data collection (see Hertz and Imber 1995; Walford 1994; Moyser and Wagstaffe 1987; Zuckerman 1972; Dexter 1970). Often conceptualised as 'researching up', elite interviewing usually involves social dynamics in which the interviewer is less powerful compared to the interviewee (Desmond 2004; Dexter 1970). Elite interviewing is thus associated with various difficulties, including accessing interviewees, researcher's lack of control of the interview agenda, and interviewees' tight schedules (Hertz and Imber 1995; Walford 1994; Dexter 1970). Lessons learnt from the elite interviewing literature were most useful as they enabled me to overcome these challenges.

The interviews were guided by an interview schedule (see Appendix VI) with general open-ended questions on policy actors' interests and perceptions of SRH issues, interactions with other actors, influence, and their views on influential factors that drive or hinder SRH policy/legislative reforms. Although the decision on open-ended questions was informed by the nature of my research, it was also determined by the general agreement that elite interviewees 'prefer not to be asked closed-ended questions' (Aberbach and Rockman 2002: 674) as they prefer to explain what they mean in their own terms as opposed to try to fit in the researcher's terms (Schoenberger 1991). The semi-structured nature of the interviews helped me to cover the salient issues for all respondents as well as permit flexibility for interviewees to respond in a unique way. This way, I was able to direct the

interview, but at the same time adopt the inquiry by probing interesting responses for clarifications and elaborations (Bauer and Gaskell 2000).

While accessing some interviewees was difficult, particularly MPs and senior DRH officials, I persisted on seeking interviews and in some instances, I had to request for interviews in person. Specifically, for senior DRH officials, I had to attend meetings in which they were leading and talk to them about my study and need for interview during tea breaks. Patience and politeness were critical; in one instance, I waited for an MP for three hours and when she walked in, she announced she had just 5 minutes for the interview. In some instances, interviews were cancelled last minute, and I had to reschedule. All these meant that I had to be flexible. I also found that transparency throughout the interview process was important to avoid any confusion – for instance, from the beginning of the interview, I set out clearly what my study was about, what the interview would entail including that I would like to take notes and record the interview if the interviewee would allow me, and how long the interview would last (about 30 minutes). Four interviewees were opposed to audio-recording while none were opposed to note-taking. On the issue of interviewers losing control of interview agenda during elite interviewing, this was mostly experienced with government officials, who often focused on giving the government's position on an issue as opposed to their own views or how the issue was tackled during the policy development process. For instance, some easily dismissed questions on abortion and homosexuality, stating that these issues were prohibited by Kenyan law or were not practised in Kenya. In such cases, I realised that probing would have likely annoyed the bureaucrats, and so I complemented their responses with responses from non-government interviewees, most of who were at ease to talk about sensitive SRH issues and how they were discussed during the policy process. All the recorded interviews were transcribed by one research assistant and myself. For the non-recorded interviews, I typed the notes up immediately after the interview to ensure that I correctly captured interviewee responses.

#### *Sample description*

In Kenya, the SRH policy environment comprises a wide range of actors including government institutions, UN agencies, donor institutions, research and academic institutions, programme implementing agencies, human rights and women's rights institutions, professional bodies, and religious institutions. As such, interviewees were drawn from these institutions based mainly on their participation in one or more of the case studies. As already noted, interviewees were also drawn from some key SRH



institutions, which had not necessarily taken part in any of the case studies, but which were currently perceived (by interviewees and myself) as playing a pivotal role in SRH policy and legal issues in Kenya. For instance, the DFID office in Kenya did not take part in any of the policy case studies, but because interviewees felt that DFID was a key SRH donor in Kenya, I decided to interview the DFID SRH representative. These kinds of interviewees provided their experiences and perceptions on decision-making on their specific SRH issues of interest.

The SRH policy environment in Kenya appears to be divided between actors involved in legal SRH issues on the one hand, and those involved in technical/policy-level SRH issues, on the other. The legal SRH issues arm brings together the government's legal agencies, MPs, and human rights and women's rights activists (mainly legal professionals). The technical/policy-level arm, on the other hand, brings together government technocrats in the two health ministries (mainly gynaecologists and midwives by profession) and the population agency (mainly demographers), donor representatives (often biomedical experts), researchers (mainly biomedical experts and demographers), and programme implementers (mainly gynaecologists and midwives). Straddling in between are professional bodies (medical doctors, gynaecologists and obstetricians, and nurses and midwives) and religious bodies. It appears actors interact closely within each arm, but hardly interact with actors from the other arm. Professional bodies and religious bodies straddle in between because they seem to interact with both sides – the legal arm and the technical/policy-level arm. Appendix VII provides brief contextual descriptions of the institutional groups from which interviewees were drawn. Although I have designated each respondent to a specific category for the purpose of clear presentation, in reality there is some level of overlap between the different groups in each arm. For instance, one researcher had moved into government as a policymaker two years earlier and some government policymakers had shifted into programme implementing agencies. Similarly, one human rights and women's rights activist had become an MP.

### ***Participation in SRH meetings (observation and note-taking)***

DeWALT and DeWALT (2002: 92) believe that participant observation enables the researcher to 'develop a holistic understanding of the phenomena under study'. They argue that participant observation increases the validity of a study since observations enable the researcher to have a better understanding of the context and phenomenon under study. The use of participant observation in data collection for this thesis was not one of the data

collection methods identified prior to fieldwork mainly because the study focused on retrospective policy analysis. However, while in Nairobi on fieldwork (December 2010-October 2011), I had an opportunity to attend three SRH policy-related meetings that presented opportunities for participant observation and note-taking on actor interactions and their narrative framings of SRH issues. These meetings included the African Women Leaders Network annual meeting in Kenya on August 30, 2011 (organised by IPPF-Africa Region); Maternal Health TWG meeting on September 13, 2011 (organised by DRH); and 2<sup>nd</sup> State of Maternal Mortality in Kenya Conference on September 15-16, 2011 (organised collaboratively by the Kenya Medical Association (KMA) and the Reproductive Health and Rights Alliance (RHRA)). This ethnographic data collection method enriched field data as it provided data on policy actor interactions, and the different narratives of SRH promoted by different actors.

### ***Media content review***

To capture debates and the various narrative framings of SRH issues by different policy actors, I conducted an extensive media content review and monitoring throughout the first two and half years of the PhD programme (2010 and June 2012). Also, media content of previous years was searched and reviewed, mainly media coverage of the 2006 debates on the sexual offences law, as well as past media coverage of contentious SRH issues i.e. abortion, adolescent SRH, and homosexuality (dating back to 1999). Searches of past media coverage were restricted to media content available on the Internet. Media channels targeted were mainstream national newspapers, TV and radio<sup>12</sup>, which ensured that I captured content from channels that national level policy actors access and use for information and public communication. International media, particularly the British Broadcasting Corporation (BBC) and the Voice of America (VOA), that capture SRH debates in SSA were also monitored and content reviewed (see Appendix VIII for a list of media stories reviewed).

### ***Document review***

Alongside the preceding data collection methods, I conducted a comprehensive review of policy documents, organisational publications and reports, and academic literature. I gathered SRH policy documents from government agencies (DRH and NCPD), old issues of the *Hansard* from the Kenyan parliament library, and institutional publications and reports from various non-government organisations in Nairobi. Legal documents (Sexual

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<sup>12</sup> Daily Nation, The Standard, The Star, Kenya Broadcasting Corporation, Capital FM, etc.

Offences Act of 2006 and new constitution of 2010) were downloaded from the websites of the Kenya Law Reforms Commission and the National Council for Law Reporting (both are government agencies). In addition, I searched websites of key organisations (government agencies, parliament, UN agencies, African Union, and major SRH non-governmental organisations operating in Kenya, among others) for more institutional publications, reports and conventions or declarations (e.g. ICPD Programme of Action, Beijing Platform of Action, and CEDAW). I searched the Internet for academic literature (mainly journal articles) on SRH issues in Kenya and elsewhere.

My document review was informed by both policy analysis practices and anthropological practices. Policy analysts, it is argued, rely heavily on written documents which they often treat as straightforward sources that reveal the workings of government (e.g. Sabatier and Jenkins-Smith 1993) (Shore and Wright 1997). As already noted, anthropologists, on the other hand, treat documents as cultural texts or classificatory devices, as 'narratives that serve to justify or condemn the present, or as rhetoric devices and discursive formations that function to empower some and silence others' (Shore and Wright 1997:15).

Appreciating the anthropological approach to document review, Erasmus and Gilson (2008:366) have argued that 'Documents can provide an entry point into the language or discourses that are used in relation to a particular policy'. My document review struts these two extremes, since I used documents both to provide data on government policy commitments as well as to interrogate what the commitments really meant – whose interests do they prioritise and whose interests do they marginalise, and why?

### ***Challenges relating to data collection***

I experienced four main challenges during fieldwork, including tracing interviewees, accessing interviewees/interview declines, recall, and difficulties with discussing sensitive SRH issues. First, some of the case studies had taken place more than five years earlier and so tracing all actors involved was not easy since some had retired while others had moved to other jobs without leaving contact details. To tackle this issue, I conducted extensive Internet searches as well as requested interviewees for contacts of people who played major roles in the policy process. This enabled me to trace most of the key actors in the policy processes, but a few of these were never traced. Second, accessing some interviewees (especially MPs) was most difficult, while others declined interviews. For instance, six out of ten MPs did not respond to interview requests and although I contacted their parliament offices several times and where possible left messages on their mobile phones, these efforts

did not yield positive responses. The Kenya Episcopal Conference - Catholic Secretariat (KEC-CS), the religious institution most opposed to SRH issues in Kenya, did not agree to an interview despite many follow-ups. Maendeleo ya Wanawake Organisation (MYWO), a national women's organisation, declined to an interview, indicating that it did not have much programming on SRH. Two government officials in the two ministries of health declined to be interviewed, indicating that their colleagues whom I had already interviewed had provided all the relevant information. To address this problem, I tried to get as much information as possible from actors who agreed to interviews, which I complemented with documented evidence from publications, institutional websites and Internet searches.

Third, recall was an issue raised by some actors who could not remember some of the information I was looking for. I addressed this issue by corroborating information from different actors who took part in the same policy processes, as well as triangulating with written documents and media reports where these were available. Fourth, getting some respondents to talk about how sensitive SRH issues, especially abortion and homosexuality, were handled during the policy process was not easy. Often, respondents especially those in government appeared uneasy and would not say much apart from giving such statements as 'those things were never discussed' or 'how could we even discuss things that are not permitted by Kenyan law'. To address this problem, I conducted extensive probing on these issues with non-government actors (many of whom were more at ease with these issues), who participated in the same policy processes as the government officials.

### **2.3.7 Analysis**

Bernard (1994:452) defines analysis of qualitative data as 'the search for patterns in data and for ideas that help explain why those patterns are there in the first place.' Although qualitative data can be analysed in a variety of ways, some more structured than others, policy analysis studies have mostly analysed data in structured ways. However, such structured analyses can easily miss out the complexity of the policy process and how it reflects on resultant policies. To address this shortcoming, I decided to blend more structured policy studies analytical methods with those from anthropology, which tend to be less structured and more iterative and inductive. Consequently, my method of analysis was both deductive and inductive and aimed to describe, analyse and explain. Thus, although interview data helped me describe policy processes, I also employed a constructivist approach that treated interview data not simply as 'representations of the world', but as 'part of the world they describe' (Hammersley and Atkinson 1983:107 in

Silverman 2001:95). As such, in addition to the direct access to actors' experiences that the interviews provided, they also gave access to the repertoire of narratives that people use in producing accounts (Gilbert and Mulkay 1983 in Silverman 2001).

In order to facilitate proper management of data, I used the NVivo software<sup>13</sup> for storing and structuring textual data from interviews. I used NVivo for initial coding of data into broad themes. I then extracted the data to study it further and generate sub-themes. Then, I supplemented my initial NVivo coding with manual coding of transcript printouts for broad themes and sub-themes. My initial analysis stage started while in the field and it helped me identify emerging broad themes. These themes then fed into revised versions of the interview schedules. This initial analysis was then followed by a second level of analysis shortly after the fieldwork period from October 2011. This second level of analysis enabled me to revise some of the earlier broad themes as well as introduce new ones emerging from the data. It was also at this stage that I compared interview statements with data from document review to ensure a more accurate picture of the policymaking processes. I used both documented data and interview data to create a coherent story of the decision-making processes. Throughout the analysis, I looked out for unusual or unexpected findings that would point to a different way of thinking about SRH decision-making in Kenya.

The findings of this thesis have benefited from critique and insights from research colleagues in Kenya and the UK. Immediately after my fieldwork in October 2011, I presented preliminary findings from the interviews to research colleagues at the African Institute for Development Policy in Nairobi. And, midway the thesis writing process in June 2012, I presented the thesis findings to Research Fellows and PhD students at the Institute of Development Studies at the University of Sussex. These two presentations provided important critique and insights that greatly enriched the analysis and the findings presented in this thesis.

### **2.3.8 Limitations**

This thesis has generated new knowledge on SRH policymaking in Kenya and tested a synthesis framework, both of which could be relevant to studying and/or understanding SRH policymaking in other resource-poor settings with relatively conservative cultures and patriarchal systems. However, its findings have some limitations. The focus of the thesis on Kenya and on SRH policy limits the extent to which these generalisations can be made.

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<sup>13</sup> A software package for storing and analysing qualitative data.

Also, its focus on national level SRH policymaking meant that I did not gather data from mid-level policy managers/implementers, and the grassroots. This could have provided data on how SRH policy implementers and beneficiaries (i.e. grassroots) feed into the policymaking processes or fail to do so. However, I focused on national level leaders due to time and financial constraints, but also because implementers and grassroots were not identified as having played any role in the three main policy processes studied. To address this, I relied on published information on Kenyan communities' experiences with various SRH issues in the form of journal articles, books and media reports.

This thesis is not an anthropological piece of work; thus it does not provide an anthropology of SRH policymaking in Kenya. Rather, it is a policy analysis account that has employed some anthropological concepts in explaining SRH policy change. Furthermore, the thesis did not focus on analysing global-local policy processes; rather, its focus was national level SRH policymaking processes in Kenya. Finally, this thesis only focused on policymaking processes; it did not look at the implementation processes of the policies analysed. The thesis therefore does not provide answers on whether the policies studied were implemented or not, or what their impact has been. Nevertheless, it is necessary to note that many interviewees felt that the policies studied in this thesis were not being effectively implemented.

## Chapter 3

### Competing Narratives of SRH in Decision-making in Kenya

#### 3.1 Introduction

As noted in Chapter 2, policymaking is about power. From a discursive perspective, Foucault (1980; 1982) has pointed out the subliminal character of power, arguing that power is at the centre of all social relations and is dispersed through a network of *discourses* of possibility that govern people's thinking and actions. In policymaking, John (2003) has argued that ideas for addressing policy issues present ideations about origins of, and solutions to, public problems, and can be in the form of narratives or discourses. Foucault's (1991) concept of 'governmentality' emphasises the values and expressions of power concealed in the neutral language of policy. According to him, policies are powerful discourses masked in neutral language that governments employ to govern citizens, to control their way of life. The storylines and framing of issues in policy discourses are constructed by those involved in the policy process and are thus an important component of any policymaking environment. Seidel and Vidal (1997:59) observe that in any policy setting, each different discourse 'is a particular 'way of thinking and arguing'' about an issue and the causes and solutions to the issue which exclude 'other ways of thinking.' Thus, different narratives prioritise certain elements of an issue while marginalising others based on values, interests and perspectives of the different actors behind them (Leach et al 2010).

This chapter identifies the major narrative framings of SRH in Kenya. In other words, the chapter is concerned with the way SRH is 'talked about' by different actors involved in SRH-related decision-making processes in Kenya. This understanding is important because sexuality and reproduction are socially complex issues in which the workings of power and control are often masked under the politics of meaning, social construction and the use of language (Seidel 1993). The chapter identifies and deconstructs four main distinctive, but overlapping narrative framings of SRH that compete for hegemony in SRH-related decision-making in Kenya, namely, SRH as a moral issue, SRH as a cultural issue, SRH as a medical issue (with two variations i.e. 'comprehensive' medical and 'moralised' medical narratives), and SRH as human rights. I argue that the different narratives voice certain SRH issues while silencing others, and are driven by actor interests, beliefs and values. The narratives supported by contextually powerful actors (i.e. moral, cultural and moralised medical narratives) are hegemonic in SRH decision-making, whereas those that voice the interests of non-powerful actors remain at the margins of decision-making. This chapter

sets the stage for the analyses and discussions in the next three Chapters (4-6), which focus on specific SRH decision-making processes in Kenya. It provides the lens for analysing the power struggles in these processes.

Borrowing from Seidel's (1993) categorisation of HIV/AIDS discourses in SSA, the SRH narratives identified by this thesis can be categorised as: narratives of control and exclusion versus narratives of access and rights. The moral and cultural narratives largely focus on controlling individuals' sexuality and reproduction or excluding certain sexuality and reproduction issues. The moralised medical narrative, while driven by the need to provide access to medical services, excludes sensitive SRH issues. The comprehensive medical and human rights narratives largely focus on ensuring comprehensive access to services and the rights of individuals. Evidently, some of the narratives are not local to Kenya, rather they are part of the global discourses of SRH, but are given a particular Kenyan inflection.

It is necessary to note here that although only one of the SRH narratives is identified as the 'moral' narrative, all the four narratives have moral underpinnings. For the cultural narrative, its moral foundation concerns the need for people to respect and abide by certain unquestionable cultural beliefs and practices. For the medical narrative, its moral foundation is not only in the fact that biomedical sciences are founded on moral principles (Pigg and Adams 2005), but also the need to base decisions on tested and trialled biomedical evidence. The human rights narrative's moral underpinning has to do with the equality of all human beings and the belief in the universality of human rights, that all people are born free and equal, and therefore there is a responsibility to protect and enable all to realise their human rights without discrimination.

By deconstructing and contextualising the contending narratives, this chapter lays bare the different actor interests, values and beliefs that underpin the narratives and the workings of power through the different narratives and/or their intersectionalities that determine what is possible and what is not in SRH-related reform processes in Kenya. The representation of the narratives in this chapter as distinct from each other should not obfuscate the fact that in reality policy processes are messy and actors often combine frames from different narratives in policy debates in efforts to block or facilitate reforms (i.e. the narrative intersectionalities) as opposed to sticking to one particular narrative. By combining different narratives, actors seek to harness the power inherent in each narrative to shape SRH policy and legislative debates. Indeed, it is the narrative intersectionalities that often produce overwhelming opposition or considerable support for certain SRH issues. Three



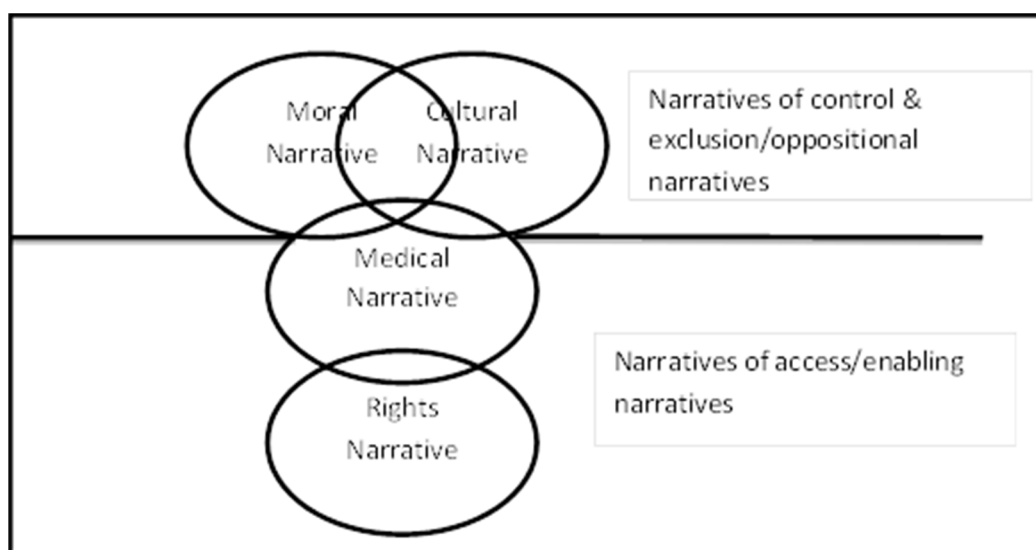
major narrative intersectionalities are identified as discussed and demonstrated by Figure 2 below. These intersectionalities are mainly informed by my field data as well as theoretical concepts.

*Moral/Cultural* - The moral narrative of SRH is strongly interrelated with the cultural narrative. Both narratives focus on control and exclusion, and are underpinned by patriarchy and conservativeness. Thus, actors behind the two narratives, mainly religious leaders and politicians, often draw on both narratives to oppose reforms on certain SRH issues as both 'immoral' and 'unAfrican'.

*Medical/Moral/Cultural* – It has been argued that the biomedical sciences that underpin the medical narrative have been founded on moral principles (Pigg and Adams 2005), and often reinforce moral arguments (Seidel and Vidal 1997). Similarly, the marginalisation of girls' and women's voices in the medical narrative, even whilst these groups bear the brunt of poor SRH outcomes, reinforces patriarchal practices ingrained in both the cultural and moral narratives.

*Medical/Rights* – Although with different foundations, the medical and the human rights narratives intersect mainly on the universal recognition of the human right to health. Thus, combining biomedical evidence on the burden of ill-health and death, and the universal human rights concept, actors behind both narratives often argue for SRH reforms to ensure the realisation of the universal human right to health and the human right to life.

**Figure 2: Conceptualisation of the Narrative Intersectionalities**



Source: Author 2013.

### **3.2 SRH as a 'Moral Responsibility' for All**

#### **3.2.1 Origins, framing, actors and interests**

Worldwide, the moral discourse of SRH is advanced by religious groups and conservative sections of society. The moral arguments pertaining to SRH are mainly drawn from a religious ideology embodied in Christianity and Islam, which prescribes how human beings should conduct their sexuality and reproduction. Historians have also argued that the concept of morality as it relates to sexuality emerged mainly from the 19<sup>th</sup> century Victorian era in Europe during which sex having previously been silenced was thrust into multiple discursivities aimed at controlling people's sexual practices (Foucault 1979 in Rabinow 1984). Through the various discourses, this period saw the definition of a norm of sexual development and all possible deviations from the norm were branded as abnormal and immoral, and legal sanctions were established against them (ibid).

In Kenya, notions of morality particularly as they relate to sexuality and reproduction (i.e. the moral narrative) date back to the introduction of Christianity and Islam in the East African region a couple of centuries ago. Christian missionaries' work in much of Africa (including Kenya), which dates back to the 15<sup>th</sup> century (BBC World Service), focused on discarding a lot of African beliefs and practices relating to sexuality as 'sinful' and 'immoral', and replacing these with 'chastised' Christian beliefs and practices (Jeater 1993: 45). The work of missionaries was reinforced by colonialism (from late 1800), which focused on uprooting African beliefs and practices as 'primitive' and 'immoral', and replacing these with 'civilised' European/English beliefs and practices (Jeater 1993: 45) as discussed in the next subsection under the cultural narrative. Upon independence in 1963, Kenya inherited Victorian era English laws, much of which focused on societal control, particularly as it relates to sexuality and morality (Foucault 1979); most of these laws are still in operation in Kenya today.

The moral narrative emphasises the sanctity of life and perceives human sexuality as a gift from God for procreation. It is therefore focused on controlling people's sexuality and reproduction to ensure that these are practised in line with religious prescriptions. Feldman and Clark (1996:12), while analysing religion and reproduction, argued that 'religious fundamentalism is a type of modern political movement which uses religion as a base from which to try and gain power and extend social control'. In the narrative, sexual relations are

only permissible between married adult man and woman<sup>14</sup>; thus, sexual relations among young people, unmarried people, and people of the same sex are sinful and immoral, and therefore not permissible. Regarding reproduction, given the narrative's framing of procreation as God's gift for continuation of society, it is opposed to modern contraception. Still on reproduction, the narrative holds that 'life begins at conception', and is therefore strongly opposed to emergency contraception and abortion, which it frames as 'murder'. Even then, Stephen et al (2010) found that while all Christian and Islamic religions generally oppose abortion, some allow it in certain circumstances while only Catholics prohibit abortion on all grounds. Protestants (Lutherans, Anglicans, and Jewish) allow abortion to save a woman's life, whereas Islam allows abortion both to save a woman's life and in case of rape or incest (Stephen et al 2010; Ellingsen 1990).

In this narrative, the voices of women are silenced and their SRH needs, rights and interests are marginalised. Considerations of gender equality and women's empowerment are also marginalised. In addition, SRH needs, rights and interests of adolescents are marginalised since the narrative prescribes chastity until marriage. In addition, the narrative marginalises the interests, needs and rights of people involved in same-sex practices and sex work. The narrative imbues with normative prescriptions and marginalises scientific evidence that shows things to be happening otherwise, as aptly captured by a Kenyan Muslim cleric, who noted that 'unwanted pregnancy is caused by moral decay and so it is totally not permitted'<sup>15</sup>. It has been argued that the narrative tends to bestow society's moral duty on girls and women, whose sexuality and reproduction it is keen to control (Kamau 2009; Izugbara 2004; Seidel 1993). By focusing on religious and conservative values, the narrative serves the interests of religious groups, political leaders, men and conservative sections of the Kenyan society. For religious groups and conservative Kenyans, the narrative is a powerful resource for controlling the sexuality and reproduction of Kenyans. For politicians, supporting the narrative assures them of political endorsement from religious leaders, whom, given their perceived influential positions within the Kenyan context, are seen as critical for political survival.

The main actors behind this narrative in Kenya are religious groups (mainly the KEC-CS, National Council of Churches of Kenya (NCCCK), Supreme Council of Kenya Muslims

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<sup>14</sup> Although in Islam sex is allowed among people below 18 years as long as they are married; also polygamous marriages are allowed.

<sup>15</sup> Dr. Sheikh Abdhallah Kheir, Kenyatta University, addressing Maternal Mortality Conference, September 15-16, 2011, Nairobi.

(SUPKEM), and the Inter-Religious Council of Kenya (IRCK)<sup>16</sup>) and politicians. However, the narrative is pervasive in Kenya since religion has come to occupy an important part in the socio-economic and political life of most Kenyans, with nearly 90% of Kenyans 'proclaiming' Christianity or Islam<sup>17</sup>. Indeed, FHI (1997) has noted that 'Kenyan people are very religious, and moral arguments from their church leaders and religious organisations are extremely influential. There are few other institutions in Kenyan society with such ability ...' Given such pervasiveness of the narrative in Kenya, it is further propagated by individuals in positions of authority in government institutions (including bureaucrats in the ministry of health and healthcare providers), professional networks, non-government organisations, mass media, communities, schools and families. For instance, the women's movement in Kenya has been argued as weak on SRH issues affecting women because it is divided on the abortion issue on moral grounds (Kulczycki 1999)<sup>18</sup>. Consequently, the movement has failed to front a strong grassroots campaign for the abortion issue (ibid), despite the many Kenyan women who die from unsafe abortion. The narrative is also pervasive in the medical fraternity, with a section of doctors fronting the moral narrative, whereas another section of doctors front alternative narratives. The Catholic Medical Doctors Association in Kenya is a strong professional voice opposed to modern contraception and abortion<sup>19</sup>. The Kenya Women Doctors Association has also been largely led by women doctors opposed to abortion and some of whom publicly condemn abortion as 'murder' and 'unAfrican'<sup>20</sup>. On the other hand, a section of medical doctors has come out in support of contraceptives and the need to legalise abortion to reduce deaths from unsafe procedures<sup>21</sup>.

Globally, the Holy See (Catholic Church/Vatican) is the main voice behind this narrative together with North American right-wing NGOs (such as the American Centre for Law and Justice, Human Life International), Islamic leaders, US government (during

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<sup>16</sup> IRCK (<http://www.interreligiouscouncil.or.ke/>) members include: KEC-CS, NCKK, SUPKEM, Evangelical Alliance of Kenya, Organisation of African Instituted Churches-Kenya, Seventh Day Adventist for Christians, National Muslim Leaders Forum, and Shia Ithnashari Muslim Association.

<sup>17</sup> Catholics (33%), Anglicans (45%), Muslims (10%), other faiths including traditional religions (12%).

<sup>18</sup> Also, interview, official, an international FP and SRH rights organisation, September 22, 2011, Nairobi.

<sup>19</sup> NTV interview (March 13, 2010) with Dr. Stephen Karanja (veteran gynaecologist and chairperson of Catholic Doctors Association in Kenya) condemned modern contraceptives as 'abortifacients', and abortion as 'murder'.

<sup>20</sup> Dr. Jean Kagia (veteran gynaecologist and longstanding chairperson of Kenya Women Doctors Association) has given several media interviews locally and internationally where she has strongly condemned abortion as 'murder' and 'unAfrican' (see BBC News 2002; VOA 2009).

<sup>21</sup> Dr. Joseph Karanja (veteran gynaecologist, former chairperson of KMA and current chairperson of KOGS), Prof. Japheth Mati (veteran gynaecologist), Dr. Boas Otieno-Nyunya (current chairperson of KMA) are examples of Kenyan doctors who have publicly advocated for the need to make abortion legal to reduce deaths from unsafe abortion.

Conservative Administrations), and governments of most African, Caribbean and Muslim countries (see Table 4 on page 70 for details on actors and interests behind the four narratives).

To draw support from Kenyans, the moral narrative is propagated as 'Kenyan', as a norm for all Kenyans, and as part of Kenyan culture. Propagators of the narrative position it as a homogeneous Kenyan value and therefore anyone with different views is marginalised as promoting a 'foreign' agenda. An example is captured in the quote below from a statement by the Kenya Episcopal Conference condemning a conference in Nairobi on abortion-related maternal deaths in 2011<sup>22</sup> published in mainstream Kenyan dailies as an advert:

'...when did unborn children become 'unwanted' when according to *our traditional values* all children were considered valued members of the community? What is the source of these *alien and non-African* values we now propagate?' (KEC-CS September 14, 2011, emphasis mine).

Narratives employ 'naming' and 'classifying' in order to influence the way people think about an issue (Shore and Wright 1997). The moral narrative names its framing of SRH as 'pro-life', 'pro-family', and driven by the 'sanctity of life', among others. It, however, names alternative framings as 'anti-life', 'anti-family' or focused on 'destroying the family', 'ungodly' and not respecting the 'sanctity of life'. Catholic bishops in Kenya have, for instance, openly referred to the work of FIDA-Kenya, a women's rights organisation, as 'ungodly'<sup>23</sup>. Besides naming, another technique that the narrative has often employed in Kenya (as elsewhere, see Miller and Roseman 2011: 111) to influence people's views has been the misrepresentation of facts. For instance, the narrative's opposition to condom use in Kenya has always argued that condoms do not stop the spread of HIV; rather they fuel the spread of the virus. Given that scientific evidence shows condoms to have up to 87-96% ability to protect one from contracting HIV (Davis and Weller 1999), this argument by the narrative has significantly misrepresented scientific facts. Moreover, religious leaders and Catholic doctors in Kenya have publicly argued that modern contraceptives are abortifacients<sup>24</sup>.

### 3.2.2 Some manifestations of the moral narrative in Kenya

The emergence of HIV/AIDS in the early 1980s in Kenya focused attention on sexuality issues (Kamau 2009) and considerably challenged the moral narrative. As a predominantly

<sup>22</sup> Conference was organised by KMA and RHRA to discuss abortion-related deaths in Kenya in view of the new Constitution that has reduced abortion restrictions and recognised RH as a human right, September 15-16, 2011, Nairobi.

<sup>23</sup> 'FIDA Kenya's philosophy is ungodly...' Father Ferdinand Lugonzo on June 6, 2011 [<http://fidakenya.org/2011/06/open-letter-to-the-episcopal-conference/>] accessed on March 17, 2012.

<sup>24</sup> Dr. Stephen Karanja (Chair of the Catholic Doctors Association in Kenya) on NTV March 2011.

sexually transmitted disease, HIV/AIDS was moralised and stigmatised by religious leaders and politicians alike (Kamau 2009; Ogot 2004). It was portrayed as a disease of people who are sexually immoral; indeed religious groups argued that the only way to address HIV/AIDS was to address 'sexual immorality' (Ogot 2004). Thus, they openly condemned the disease and any efforts to respond to it that did not focus on addressing sexual immorality. As such, religious groups and politicians opposed any efforts to open up space for public discussions on sexuality or to promote and provide condoms for stemming the spread of the virus. Thus, throughout the 1990s there was a protracted and controversy-ridden debate in Kenya on whether the government should introduce sexuality education in schools or not, especially in light of HIV/AIDS and therefore the need to equip young people with the information they need to protect themselves from infection. There was also debate on whether the government should adopt and promote condoms as a major national intervention in the fight against HIV/AIDS. Religious groups opposed the provision of SRH information to young people and the promotion of condoms, arguing that such interventions would fuel sexual immorality and intensify the spread of HIV/AIDS (Ogot 2004).

The groups were supported by the then President Moi, who argued that sexuality education in schools would teach children 'bad manners', evidently drawing from the moral narrative. Moi went on to block a proposed bill on Family Life Education from being debated in parliament in 1997. To date, Kenyan schools do not offer sexuality education; rather, the school curriculum focuses on providing HIV/AIDS information, reflecting the hegemony of the moral narrative. While some religious groups have relaxed their stand on condoms<sup>25</sup>, the Catholic church has remained adamant; in 2011, the Catholic Cardinal (Njue) in Kenya condemned an announcement by government that it would build a condom factory in the country, arguing that this would make Kenya 'a perverse society' (The Star 2011a).

Regarding abortion, the moral narrative works through religious groups, politicians and the mass media to block any meaningful debate on how best to respond to the huge challenge of unsafe abortion in the country. In 2005, Kenya's first attempt at passing a new constitution at a referendum failed, as many people voted against the proposed draft. One of the major campaign issues against the draft was an argument underpinned by the moral narrative that the proposed constitution would legalise abortion, yet the draft constitution

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<sup>25</sup> For instance, an official of a national Muslims religious network in an interview (Nairobi, August 1, 2011) noted that the network allows condom use in some cases such as where one spouse is HIV positive and the other one is not.

only provided for abortion to save a woman's life. This was the same argument adopted by religious leaders and politicians opposed to the 2010 Constitutional draft, as we will see in Chapter 6. What is more, in 2008, efforts by civil society, led by FIDA-Kenya, to introduce a Reproductive Health and Rights bill in parliament were blocked by religious groups because a section of the bill proposed to make abortion legal on certain grounds.

Regarding homosexuality, incidents where people suspected to be gay are attacked and/or condemned are not uncommon in Kenya. For instance, in February 2010, Muslim and Christian religious leaders and youth in Mombasa attacked a couple suspected to be planning a gay wedding (Daily Nation 2010a). The couple was rescued by police, who in turn arrested the couple because homosexuality is prohibited in Kenya. In February 2012, participants at a meeting on LGBTIs in Mombasa were attacked by members of the public and only rescued by police (Daily Nation 2012a). What is more, a call on Kenyans by the Minister for Gender in October 2010 to accept homosexuals attracted heavy criticism from religious leaders and fellow politicians, some of whom called for the Minister's sacking. The most striking incident, however, was efforts by religious leaders in 2011 to block the appointment of two highly qualified and experienced lawyers, Dr. Willy Mutunga and Ms. Nancy Baraza, as Kenya's Chief Justice and deputy Chief Justice, respectively, on suspicions that they could be gay. For Mutunga, the suspicions were based on the fact that he wears a stud, whereas for Baraza, these were based on the fact that her PhD thesis focused on lesbianism in Kenya (Daily Nation 2011a). Religious leaders argued that the two candidates lacked the 'moral standing' for holding political positions in Kenya. The opposition was, however, defeated and the two became Kenya's CJ and deputy CJ<sup>26</sup>, respectively.

Similarly, efforts to lobby government to decriminalise sex work are always condemned by religious leaders. An announcement by the Nairobi mayor in February 2012 that the city's council would consider legalising sex work in order to stop police harassment of sex workers as well as generate tax income was strongly condemned by religious leaders, and the mayor was forced to retract his statement (The Standard 2011). Following this, sex workers in March 2012 demonstrated in Nairobi streets demanding the decriminalisation of the practice to stop police harassment (Capital FM 2012). Moreover, the demonstration was condemned by religious leaders, politicians and sections of the Kenyan public (on social media).

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<sup>26</sup> Baraza was forced to resign in late 2012 following an incident in which she was accused of violating the rights of a security officer.

### **3.2.3 From where does the narrative draw its power?**

Given decades of Christianity and colonisation, the moral narrative has been entrenched in local culture and is therefore internalised by many Kenyans. This gives the narrative a strong support base from the grassroots to the top government and political leadership. Thus, although Kenya is not a 'religious' state, the narrative has found support in government structures and institutions. Consequently, the moral narrative draws power and legitimacy from politicians and top government officials. Given such political support, the narrative is not only dominant, but authoritative in SRH decision-making processes in Kenya. In addition, the narrative draws power from Kenya's legislative framework, which prohibits some of the contested SRH issues. Moreover, since religious groups provide more than a third of healthcare services in Kenya, they have a strong voice in health policymaking as well as a direct channel to influence SRH service provision. Given this reality, voices challenging the narrative in Kenya are not only easily marginalised, but are also perceived as promoting 'foreign' agenda. Because of this relatively hegemonic status, the narrative has tended to over-power scientific knowledge in influencing decision-making on sensitive SRH issues in Kenya as we will see in the next three chapters.

## **3.3 The Cultural Construction of SRH**

### **3.3.1 Origins, framing, actors and interests**

The cultural construction of SRH is situated in the way communities conceptualise, understand and practise sexuality and reproduction. The Kenyan society, like many others in SSA, is patriarchal, with men dominating decision-making in nearly all spheres of life, including sexuality and reproduction. Conservativeness is also strongly entrenched in the Kenyan society. Intertwined with conservativeness is a sense of silence (or lack of openness) surrounding issues of sexuality and reproduction; a feeling that these issues are private and taboo, and should therefore not be subjects of public discussion or intervention (Makinwa-Adebusoye and Tiemoko 2007). Thus, patriarchy, conservativeness and silence surrounding SRH largely constitute the African cultural framing of SRH. Even then, it has been argued that much of African culture has been strongly influenced by Christianity and Victorian era British/European beliefs and practices imposed on African communities through decades of missionary work and colonisation (Kamau 2009; Schmid 2005; Jeater 1993). Ranger (1983:212) has argued that:

Since so few connections could be made between British and African political, social and legal systems, British administrators set about inventing African traditions for Africans. Their own respect for tradition took them to look with favour upon what



they took to be traditional in Africa. They set about to codify and promulgate these traditions, thereby transforming flexible custom into hard prescription... The invented traditions imported from Europe not only provided whites with models of command but also offered many Africans models of 'modern' behaviour.

Furthermore, Ranger (1983: 250) has argued that 'What were called customary law... were in fact all invented by colonial codification.' By codifying the invented 'African traditions', the colonisers made constructs of customary law rigid and unable to reflect change in future (Ranger 1983). The invented customs gave the colonisers a model of command by concealing the power and wealth imbalance, thereby enabling them to govern Africans (Ranger 1983). Similarly, African men readily appealed to the invented customs to marginalise women since these favoured men's dominance (Ranger 1983). Indeed, some scholars have noted that African women had been catalysts of change before colonialism, but their efforts were greatly undermined by colonial laws and structures (House-Midamba 1996; Tibbetts 1994). In Kenya, Tibbetts (1994: 27) has argued that women played an important role in mobilising for women's interests in pre-colonial periods, and also formed part of the movement that ended colonialism. However, after independence, women's political activism was severely oppressed and has since remained marginal (Tibbetts 1994).

As adopted in Kenya and in much of SSA, the cultural narrative seeks to control and exclude, and is propagated mainly by male politicians and religious leaders in decision-making in Kenya. Controlling the sexuality and reproduction of women is a particularly important aspect of the narrative and a fundamental mechanism by which power is exerted in Kenyan society. The narrative privileges men's interests and needs over women's, constructing women as unequal to men and therefore needing to be guided and controlled (Izugbara 2004). Constructing male sexuality as dominant and desirable, the narrative seeks to preserve men's privileged control over, and access to, women's sexuality in the name of African culture (Ankrah 1991). While the narrative dignifies the 'penis' (male sexuality) (Izugbara 2004), it constructs female sexuality as, according to Seidel (1993: 180), 'shameful and both polluted and polluting' and 'unspeakable, other than in the crudest of terms'. Female sexuality is further constructed as 'wild' and a 'danger' to society that must be controlled (Izugbara 2004). Upon marriage, the narrative confers women's sexual and reproductive rights to their husbands (Seidel 1993). In all its framings, which are commonly drawn upon in decision-making debates in Kenya, the narrative silences women's interests, needs and rights in relation to sexuality and reproduction.

Furthermore, the cultural narrative constructs adolescents as being too young to know or to be involved in sexual activities. Thus, it argues for shielding adolescents from SRH information and services lest they are enticed into sexual activity before marriage. However, such conservativeness is in fact 'unAfrican' and reflects the influence of Christianity, since traditional African societies had systems in place to educate and prepare adolescents for adulthood and marriage (Njau 1992). Although the cultural argument advocates for adolescent sexuality to be left to families, who should teach and guide adolescents on these issues based on their values, family structures that facilitated sexuality education in traditional African societies have disintegrated and are no longer functional (Munthali and Zulu 2007). In addition, the narrative constructs homosexuality as 'deviant' and 'unAfrican'. It is not that homosexuality never existed in traditional African communities, some scholars have noted that it was rare (rather than non-existent) (Ocholla-Ayayo, 1976), while others have noted its existence only that it was not explicitly discussed or identified as such (Arnfred 2006; Izugbara 2004). Izugbara (2004) has noted that in pre-colonial Nigerian communities, homosexual practices were often treated with more tolerance than during and after the colonial period. The narrative's focus on promoting patriarchy, conservativeness and silence around sexuality and reproduction supports the moral narrative's tenets and therefore serves the interests of religious groups in addition to serving those of male politicians and conservative sections of the Kenyan society.

Although in Kenya's policy debates the cultural narrative is mainly adopted to oppose SRH reforms, it is important to note that culture is not entirely negative. Indeed, it has been demonstrated that culture in Kenya and much of SSA has both negative and positive aspects (see Izugbara and Undie 2008; Nyamu-Musembi). Nyamu-Musembi (2002) demonstrated, for instance, that cultural land rights in Kenya offer both barriers and opportunities for women empowerment. Izugbara and Undie (2008) found that in some communities in Nigeria and in other parts of SSA, women's natal communities are bestowed with the responsibility of protecting them (women) regardless of their age and marital status. But such protective aspects of culture are often silent in SRH reform debates in Kenya. Thus, as we will see in the next subsection, the focus on using culture to oppose SRH reforms in Kenya should be seen as a framing strategy rather than that culture is all negative and therefore an obstacle to reforms. What is evident is that in Kenya, reform actors have failed to draw on positive aspects of culture that are protective of SRH to promote reforms by questioning some of the oppositional arguments made in the name of

culture. For instance, the cultural narrative's argument that families and communities should be left to practise sexuality informed by their own values and norms, constructs communities as homogeneous and closed to outside influence. In reality, however, with modernisation and globalisation, it is unrealistic to think that communities are not constantly changing given external interaction, which implies that culture is also constantly changing. Yet, this narrative constructs culture as static and something that should always be protected from outside influence. In sum, patriarchy and conservativeness, which are strengthened and underpinned by dominant foreign religions of Christianity and Islam, interact to generate contention and opposition to legal and policy proposals for addressing many SRH challenges in Kenya in the name of African culture.

### **3.3.2 Culture is used instrumentally**

Those opposed to the cultural narrative of SRH argue that culture is often used instrumentally to block women's emancipation. Respondents from the women's rights movement in Kenya argued that men always draw on the cultural argument whenever they fear that their privileges and power are threatened. This questions whether indeed men are usually concerned about cultural values or about their own interests? Chanock (2000) has argued that culture is often drawn upon not to protect the rights and needs of the oppressed, but to protect the interests of those in power. This selective cultural argument for opposing women's rights has been aptly captured by one commentator in a Kenyan magazine (see quote below), who questions the moral authority of Kenyan men in blocking reforms to facilitate women's rights as 'unAfrican', but wearing 'Western' suits and shoes even as they denounce such proposals as 'foreign':

'[T]here is nothing 'African' about injustice or violence, whether it takes the form of mistreated wives or mothers...or circumcision. Often the very men who ...excuse injustice to women are wearing three-piece pinstriped suits and shiny shoes' (in Penna and Campbell 1998: 14).

Echoing this view, Butegwa (2002: 123) has called on African women and men to 'join others who actively wonder and ask why it is only when women want to bring about change for their own benefit do culture and custom become sacred and unchangeable'. Questioning the genuineness of cultural opposition to human rights issues, Cowan et al (2001:6) asked: 'is it always *really* 'culture' that is at issue?' Evidence from past SRH-related legislative reform efforts in Kenya suggests that cultural opposition to SRH rights often has more to do with preserving men's privileges than a genuine concern for cultural values. For instance, in 1966, the Kenyan parliament rejected a bill that would have criminalised wife

battering, arguing that the practice of wife chastisement was an inherent traditional right of an African man and a private matter that did not require state intervention (Kameri-Mbote 2000-1). And, in 1967, the Kenyan parliament repealed the Affiliation Act of 1959 that had been enacted by the colonial government to enable single women in Kenya to sue the fathers of their children for paternity support. Thomas (2000:170) has argued that by repealing this Act, Kenyan politicians 'contributed to the construction of a political order that refused to hold men financially responsible for children that they fathered outside wedlock.' More recently, an affirmative action bill for gender equality was first rejected by the Kenyan parliament in 1997, and 1999 efforts to bring it back were also defeated. In addition, a domestic violence bill was rejected by parliament in 1999 (Kameri-Mbote 2000-1). Evidently, the cultural narrative has mainly been drawn upon to preserve men's privileges by blocking reforms that seek to address gender inequalities in Kenya. On the other hand, the aspects of culture that are protective of SRH or women's health have been silenced.

### **3.3.3 From where does the narrative draw its power?**

The cultural narrative is sustained by a number of factors including Kenyan society's support for the narrative, women's low socio-economic status, men's domination in government and political decision-making structures, and existing laws. Kenyan communities, including women, to a great extent support and promote the cultural construction of sexuality and reproduction. Indeed, as Bourdieu (1986) has argued, culture is deposited in people, as such many Kenyans, including women, have internalised the cultural construction of SRH as a norm. Supporting this argument, Crichton et al's (2008) study on gender-based violence in Kenya found that many Kenyan women had internalised their rightlessness in regard to gender-based violence and did not often challenge such violation of their rights. Kenyan communities' support for this narrative is further manifested in continued cultural practices such as FGM, which, despite having been outlawed, are still practised.

The cultural narrative of SRH is further sustained by the low socio-economic status of most Kenyan women. Education and economic freedom, which many Kenyan women lack, tend to empower people to counter domination and oppression. The high levels of poverty and illiteracy, particularly among girls and women in Kenya, deny them the agency to fight against patriarchy. This situation is compounded by the absence of a strong

grassroots movement for women's health and rights in the country<sup>27</sup> (Nzomo 1989). Furthermore, men dominate public and political positions, with women occupying a very small and sometimes negligible proportion. For instance, the Kenyan parliament has remained male-dominated since independence, with women MPs often accounting for a negligible proportion (see WILDAF Kenya 2010: 6). The 9<sup>th</sup> parliament that debated and passed the 2006 Sexual Offences Act (see Chapter 5) comprised 204 male and 18 female MPs. The limited representation of women in public and political positions is a product of a patriarchal system<sup>28</sup> that in turn produces policies and laws that favour men underpinned by masked arguments of 'preserving our culture'. Finally, while the cultural narrative has precipitated the enactment of laws and policies that outlaw certain SRH practices (abortion, homosexuality and sex work) by government as its political technologies for governing people's behaviour (Foucault 1991), the narrative is in turn sustained by these constraining laws. Also, Kenya's dual legal system that recognises both statutory and customary laws, as noted in Chapter 1, has entrenched power in the cultural narrative.

### **3.4 The Medical Dimension of SRH**

#### **3.4.1 Origins, framing, actors and interests**

The medical narrative, underpinned by the biomedical sciences of epidemiology and public health, frames SRH as a predominantly medical issue and therefore requiring medical solutions. As noted in Chapter 2, in the health sector, biomedical knowledge that guides the medical field is deemed as the gold standard for informing health policies. As Lock and Nguyen (2010: 54) have noted, biomedicine assumes a 'universal, decontextualized body as the primary site for the production of medical knowledge and management of disease'. The medical narrative is, therefore, highly depersonalised and concerned with symptoms (Seidel 1993). However, as Lock and Nguyen (2010) have argued, human bodies are neither universal nor free of the context that surrounds them. Rather, human bodies are, 'the products of evolutionary, historical and contemporary social change resulting from ceaseless interactions among human beings, their environments, and the social and political milieu in which they live' (Lock and Nguyen 2010: 1). Further, they have argued that, 'biomedical technologies are not autonomous entities: their development and

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<sup>27</sup> Interviews: former chairperson of a national women's organisation, September 20, 2011, Nairobi; official, an FP and SRH rights international organisation, September 22, 2011, Nairobi.

<sup>28</sup> Because of low levels of education among women, majority of Kenyan women are unable to compete equally with men for key public positions, and as such, these positions are dominated by men. In political positions, only few women stand for election and society is more likely to vote for a male candidate than a female one as it generally still questions women's ability to lead.

implementation are enmeshed with medical, social, and political interests that have practical and moral consequences' (ibid). Indeed, social science studies that have focused on situating biomedicine in the cultural, social and political context, have made clear how political and economic interests, prevailing moral concerns, and gender bias are often implicated in biomedicine (see Lock and Nguyen 2010). Thus, Lock and Nguyen (2010: 54) have argued that 'biomedical knowledge and practice are culturally embedded'. Supporting this argument, Pigg and Adams (2005: 23) have noted that biomedical knowledge is 'a contingent cultural production infused with ideological biases'. Explaining their point, Pigg and Adams (2005: 23) argued that:

'...the processes of scientific knowledge production are social from start to finish, as are their technological applications. To see science as a social practice is not to render its products less "scientific" (Keller 1995); rather, it is to fully appreciate the grounded, real-world complexities and contingencies located within the actual practices of science. The posing of research questions, the designing of experimental procedures, and the interpretation of evidence all involve myriad decisions and choices that are made in a messy middle ground where scientists' interactions with the natural world are shaped by cultural schema and sociological constraints.'

Focusing on SRH, Seidel and Vidal (1997) have argued that, being embedded in human sexuality, SRH issues are as much social phenomena as they are medical. Thus, the dominant biomedical focus has marginalised important contextual factors that produce and sustain such conditions. For instance, in the case of HIV/AIDS, Seidel (1993) has argued that the dominant medical narrative has resulted in the targeting of interventions at so-called 'high-risk' groups such as 'prostitutes', with no reference to the social and sexual contexts within which the 'prostitutes' acquire or transmit the virus. Moreover, because of the medical narrative, women attending antenatal clinics have been targeted with male condoms and HIV messages to pass to their husbands without an appreciation of the social contexts within which these women live and how these impact the effectiveness of such interventions (ibid). Seidel (1993: 176) concluded that in the case of HIV/AIDS, the hegemonic medical narrative, which silences women's voices, had hampered the introduction of appropriate and more sensitive interventions.

Even then, it appears the medical narrative's power lies in its ability to conceal power, interests, and biases by presenting biomedical science as the most objective gold standard scientific knowledge that should inform health policies. Sumner et al (2011:7) have argued that the medical sciences of epidemiology and public health from which the narrative is embedded are both positivistic in outlook and therefore driven by the need to frame policy as 'evidence-based'; evidence in the biomedical sciences mainly refers to trialled and tested

quantitative evidence, preferably from RCTs. Basing SRH policies on biomedical science gives the impression that the policies are objective and neutral, without any political or interest group interference. Thus, although policies have largely been acknowledged as inherently political (Shore and Wright 1997), the medical narrative constructs SRH policies as objective, neutral, and evidence-based. Indeed, Shore and Wright (1997: 8) have argued that:

‘Policies are most obviously political phenomena, yet it is a feature of policies that their political nature is disguised by the objective, neutral, legal-rational idioms in which they are portrayed. In this guise, policies appear to be mere instruments for promoting efficiency and effectiveness. This masking of the political under the cloak of neutrality is a key feature of modern power.’

In this sense, the medical narrative can be seen as what Foucault has termed ‘political technologies’, i.e. the means by which power conceals its own operation. Dreyfus and Rabinow (1982:196) have summed this up as: ‘political technologies advance by taking what is essentially a political problem, removing it from the realm of political discourse, and recasting it in the neutral language of science’.

Seidel and Vidal (1997:61) have argued that the medical narrative is often authoritative and dominant because of the ‘structural dominance and prestige of the medical profession, the power invested in bio-medical culture...and in health bureaucracies.’ In Kenya, like elsewhere, the medical narrative is mediated by the ministry of health and to a large extent by the WHO (which often dominates national health efforts in poor countries such as Kenya). The narrative is dominant in the health bureaucracy because its supporters (medical experts) dominate government’s health ministry and the DRH, as well as the country-level WHO, UNFPA, and USAID-funded international-type NGOs<sup>29</sup>, which dominate bureaucratic SRH decision-making in Kenya. This dominance ensures that power in decision-making in the health bureaucracy remains in the hands of biomedical experts.

Notably, the medical narrative in Kenya has two main variations, what I refer to as the ‘moralised’ medical narrative and the ‘comprehensive’ medical narrative. At the global level, the WHO’s medical narrative frames all SRH issues, including sensitive issues of abortion (WHO 2003)<sup>30</sup> and SRH needs of sexual minorities<sup>31</sup>, as health concerns deserving attention; this is what I call the ‘comprehensive’ medical narrative. However, the medical

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<sup>29</sup> FHI, JHPIEGO, Pathfinder International, etc.

<sup>30</sup> WHO, however, qualifies this requirement in cases where abortion is legal under the laws of a country.

<sup>31</sup> On May 17, 1990, WHO removed homosexuality from its list of diseases. On April 8, 2011, WHO Director-General decreed that two decades later, stigma and discrimination against homosexuality still existed and often restricted access to services by homosexuals (UN 2011).

narrative adopted by the health bureaucracy in Kenya excludes sensitive issues (i.e. abortion, homosexuality and sex work) because proponents of the narrative argue that these are not medical issues. This is what I call the 'moralised' medical narrative, and it reflects the co-construction of the narrative with religious interests and politics to produce a version that marginalises issues not supported by powerful actors and institutions locally. The moralised medical narrative in this thesis is akin to Seidel's (1993: 178) 'medico-moral' discourse in the case of HIV/AIDS, which, it is argued, is often 'judgemental' and for a long time presented HIV/AIDS as 'God's punishment', promoted 'chastity interventions' to HIV/AIDS, and condemned condoms. The medico-moral narrative of HIV/AIDS, according to Seidel (1993), is authoritative in predominantly Christian communities (such as Kenya) and is mediated by Christian groups such as the Catholic missionary health workers in various SSA countries.

On the other hand, the KMA, Kenya Obstetricians and Gynaecologists Society (KOGS), and National Nurses Association of Kenya (NNAK) adopt the 'comprehensive' medical narrative that frames the sensitive issue of abortion as a public health issue given the high burden of death and ill-health that arise from unsafe abortion as noted here:

'...abortion is a public health problem [in Kenya] which was recognised by KMA in 1986 who recommended reform of law. According to the National RH Strategy 1997-2010, abortion is responsible for over 50% gynaecological admissions, and about 35% MM [maternal mortality] (KMA 2004:17).

It is important to note, however, that the medical narrative adopted in these associations varies with the values of the individuals leading the associations at any given time. So whenever the associations elect leaders who support the comprehensive medical narrative, these are often on the forefront in lobbying for the need to make abortion legal in Kenya as a life-saving intervention.

By focusing on the ideals of biomedicine at the expense of other phenomena, the medical narrative mainly serves the interests of medical experts by maintaining the power that biomedical experts wield in health-related policymaking. Although biomedical driven interventions remain critical in healthcare and have greatly addressed ill-health for centuries, they have been criticised for promoting stigma, especially in the case of HIV/AIDS as already noted above. Seidel and Vidal (1997:65) have argued that the 'epidemiological categorization is not only blaming, but overlaps with and reinforces moral discourses'. Furthermore, Pigg and Adams (2005: 27) have argued that '...the processes that make believable scientific claims about sex inevitably make evident the moral fields



that have invested these claims with credibility.’ As such, ‘moralities do not stand outside processes of scientific object making and sociality; rather they are constituted by them’ (ibid: 27). By justifying moral arguments, the medical narrative, particularly the moralised medical narrative, serves the government’s political interests by ensuring that it does not contradict the position of religious groups on sensitive SRH issues and therefore maintains a ‘cordial’ relationship with these groups, which in turn assures it of political survival.

On the other hand, the medical narrative marginalises women’s voices and interests, as well as, gender power imbalances and the social contexts that produce and sustain most SRH challenges. By marginalising women, the narrative does not only play into the hands of the moral argument as noted above, but also overlaps with patriarchy, which is a key aspect of the cultural narrative. The moralised medical narrative also marginalises adolescent sexuality, abortion and LGBTI issues, which are also marginalised by the moral and the cultural narratives. Such overlaps with the moral and cultural narratives of control reinforce the arguments within these narratives, with negative implications for SRH policies and outcomes. Furthermore, the narrative marginalises other types of knowledge (i.e. non-biomedical science) and policy actors who lack technical expertise in biomedicine (such as human rights actors, women’s rights activists) in health-related SRH decision-making processes. Ultimately, by treating SRH policymaking as a technical issue for biomedical professionals, the narrative marginalises power and politics, which are critical drivers of policy/legislative reforms.

### **3.4.2 Manifestations of the medical narrative**

A number of incidents observed by the researcher during fieldwork depict the workings of the moralised medical narrative in Kenya. Kenya’s current head of DRH (2009-to date), Dr. Isaak Bashir, snubbed a major national conference on abortion-related maternal deaths in Nairobi on September 16-17, 2011, mainly because, according to a respondent, the conference ‘turned into an “abortion” conference instead of a “maternal health” conference’<sup>32</sup>. Although he had been scheduled to speak at the conference, Bashir attended the first session of the conference and left even before the session ended and before giving his address. As the top government official in charge of formulating and overseeing implementation of Kenya’s SRH policies, he was an important speaker at this conference. Similarly, the Minister for Public Health and Sanitation (hon. Beth Mugo), under whose Ministry the DRH falls (and publicly known for her opposition to abortion), snubbed the

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<sup>32</sup> Interview, official, conference organisers, September 19, 2011.

conference which she had been invited to grace; it was indicated that her office did not give any reasons why the Minister couldn't attend the meeting or send a representative.

Respondents indicated that DRH officials only support a focus on 'maternal health' and not 'abortion'<sup>33</sup>, except for post-abortion care. This is despite the fact that unsafe abortion is estimated to account for 20-30% of all maternal deaths in Kenya (CRR 2010; Guttmacher Institute 2008; Ipas 2004; Rogo 1990). Indeed, successive heads of the DRH have generally not been supportive of abortion<sup>34</sup>. For instance, a respondent intimated that a past head of DRH once said to him: 'I hate abortion' when his organisation sought permission from the Division to train health workers on post-abortion care<sup>35</sup>. It is likely that the government's recruitment process for the head of DRH screens to ensure that the person employed is not supportive of abortion. Even then, not all government officials in the health bureaucracy are opposed to the issue of abortion or homosexuality. The current Minister for Medical Services (Prof. Anyang' Nyong'o) supports abortion and often makes public appeals for policy reforms to facilitate the provision of safe abortion<sup>36</sup>. Also, the government's Director of Medical Services (DMS) (Dr. Francis Kimani) supports abortion; while representing the Medical Services Minister at the 2011 conference on abortion-related maternal deaths, the DMS decried the burden of ill-health and death occasioned by unsafe abortion and, interestingly, called on the 'government to shift focus and start implementing the current constitution', which provides for a human right to RH services. This shows that although there are individuals in government who support the comprehensive medical narrative, particularly the abortion issue, due to either the 'non-powerful' positions they hold or the overwhelming opposition to the narrative within government and society or both, they are unable to steer reforms.

The medical narrative is also evident in Kenya's HIV/AIDS policies, which, driven by biomedical evidence, have recognised the need to target men who have sex with men (MSMs) and sex workers with interventions in order to stem the spread of HIV. MSMs and sex workers are among the groups identified by biomedical evidence as 'high-risk' groups for HIV transmission. The policies, however, make no mention of the need to reform laws

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<sup>33</sup> Interviews: official, DRH, July 14, 2011, Nairobi; official, an international research organisation, March 11, 2011, Nairobi.

<sup>34</sup> Dr. Josephine Kibaru 2002-2008 and Dr. Issak Bashir 2009-to date (2012) – these have been generally opposed to any focus or discussions on abortion.

<sup>35</sup> Interview, official, an international reproductive rights programme and advocacy organisation, August 8, 2011, Nairobi.

<sup>36</sup> 'Nyong'o calls for safe abortion policies', Kenya Broadcasting Corporation, July 27, 2011 [<http://abortionnews.info/article/Nyong--39-o-calls-for-safe-abortion-policies>].

to decriminalise the practices or to challenge the social norms that stigmatise the practices, which in effect contribute to the groups' vulnerability. A women's rights activist argued that the focus on 'medical', while ignoring the underlying root causes of SRH issues is defeatist and explains why the Kenyan government had made little progress on reducing the spread of HIV, particularly among married couples as captured in the quote below. Current statistics show high rates of HIV infection among married people (14.3% compared to the national average of 6.3%) (NACC and NASCOP 2010).

'If you think even of how they have approached HIV, we are very comfortable talking about transmission of HIV and women's reproductive health...and there is a lot support for that, you know, the medical approach. But when you begin talking about rights...that becomes difficult. And the truth is if you think about HIV, the problem in Kenya is not awareness, no, ...telling people use condoms and what have you. So, why is it that marriage is the highest risk zone for HIV infection? For me, that begins to go into the territory of rights and power, it is no longer about the medical things which you can point out and provide services.' [Official, women's rights organisation, August 5, 2011].

### **3.5 SRH as Human Rights**

#### **3.5.1 Origins, framing, actors and interests**

The human rights narrative of SRH, as noted in Chapter 1, was articulated for the first time at the UN's ICPD in Cairo in 1994 (UNFPA 1995). Given the fundamental principle of human rights of non-discrimination in the enjoyment of rights and liberties, this narrative espouses equality, autonomy and empowerment. The SRH rights narrative derives from international human rights covenants, mainly the UN Universal Declaration of Human Rights of 1948. The main significance of the declaration, as argued by Seidel (1993:181), is the fact that 'it represents the basic international pronouncement of these rights, carries considerable moral weight, and is widely considered to form part of customary international law'. The language of 'reproductive rights', as noted by Petchesky (2003:3), originated from Northern-based women's health movements in Europe and the United States during the 1970s and 1980s, galvanised by the conservative attacks on women's access to abortion and the need for women to have control over their bodies in matters of reproduction and sexuality.

The overarching reason for the framing of SRH as human rights was to unsettle the strong societal power embedded in patriarchal and religious systems that focus on controlling women's sexuality and reproduction (Roseman and Reichenbach 2009). It was argued that the then focus of development efforts on population control and safe motherhood

marginalised women's interests and needs (ibid). Examples that stood out were the coercive FP programmes in India and China. Given the ethical and legal norms inherent in the human rights concept and their implication of a duty on the part of those in power to enable the realisation of rights, the rights concept was conceived of as powerful in challenging gender inequalities between men and women, and the legal, socio-economic and cultural systems that discriminated against women. Indeed, it has been argued that the rights framing sought to put 'power' into SRH or to 'politicise' SRH in order to compel poor governments to address underlying structural, legal, economic and socio-cultural systems that continued to marginalise women's sexuality and reproduction, occasioning persistently poor SRH outcomes among women and girls (Ortega 2011).

The SRH rights narrative seeks to, *inter alia*: advance gender equality, eliminate violence against women, ensure women's ability to control their own fertility, and ensure universal access to RH information and services (UNFPA 1995). 'Sexual rights', the latest addition to the narrative, seeks to protect the right of all persons to express their sexual orientation without fear of persecution, denial of liberty, or social interference. At the heart of the SRH rights narrative is equality and freedom for individuals, men and women alike, to conduct their sexual and reproductive lives as they wish, and to be facilitated by the government to do so. The narrative therefore imbues with an emancipatory aura to address, among other issues, sexual and reproductive injustices arising from inequality between men and women, government laws and policies that criminalise sexual and reproductive practices (e.g. abortion, homosexuality), governments' focus on population control without a concern for individual needs, religious and moral control of sexuality and reproduction, and socio-cultural and health systems that deny adolescents and LGBTIs access to SRH information and services. As noted in Chapter 1, the framing of SRH as rights was and continues to be strongly contested especially as it relates to adolescents' access to comprehensive SRH information and services, abortion, sexual rights, and homosexuality. Moreover, as mentioned in Chapter 1, the human rights framework has been criticised for being unable to impact local commitments and translate into improved development outcomes in developing countries given its universal and legal nature that marginalises local contexts, which shape how countries adopt and operationalize the framework (Wilson and Mitchell 2003; Englund 2006; Correa et al 2008). This issue is discussed in detail in Chapter 8.

### ***'Kenyanising' SRH rights***

At the ICPD, Kenya supported the language of SRH rights, but contested the proposal to provide comprehensive SRH information and services to adolescents noting that:

'We...do not subscribe to the idea that the youth should be exposed to a contraceptive mentality, Kenya believes in the dignity of human life. Although we teach a number of topics related to the biological processes in schools, these must always be complemented with the utmost respect for the family's ability to inculcate its own religious and cultural values...' George Saitoti, then Minister for Planning and the leader of Kenya's delegation at the 1994 ICPD (UN-POPIN).

Even then, Kenya committed to implement the ICPD Programme of Action informed by its context, effectively paving way for the conceptualisation of SRH as 'rights' in government policies. However, like the ICPD and Beijing processes, the processes of adopting SRH as rights in Kenya have been characterised by contestations and controversy. At the time, Kenyan laws prohibited abortion (except if a woman's life is in danger), homosexuality and sex work. Apart from being illegal, abortion and homosexuality are also stigmatised and scorned upon by large sections of Kenyan society. The strongest opposition to contentious SRH rights issues in Kenya has, unsurprisingly, come from religious groups (mainly KEC-CS, SUPKEM and NCKK) and politicians.

Opposition to the SRH rights narrative in Kenya is often on two grounds, i.e. morality and culture, as already seen in the subsections on the moral and cultural narratives. The rights narrative's marginalisation of 'morals' and its storylines of 'freedom' and 'entitlements' in regard to sexuality and reproduction contradict religious storylines of 'morality', 'procreation', 'responsibility', and 'sanctity of life'. Moreover, its storylines of 'equality' of men and women and 'freedom' for individuals to be facilitated to live their sexual lives as they wish, are threatening to Kenya's patriarchal and conservative context. Given its origins in international processes, opposition to the SRH rights narrative on cultural grounds often employs the storylines of 'unAfrican' or 'foreign' to marginalise the narrative as not promoting African cultural values, beliefs and practices, and to appeal to people's emotions. Yet, as Undie and Izugbara (2011) and Mamdani (2000) have argued, concepts of human rights and entitlements are part and parcel of African cultures, only they are constructed and practised differently from the 'Western' concepts of rights, which dominate the international human rights discourse.

The moral and cultural opposition to the SRH rights narrative finds legitimacy in Kenya's legal framework, which, as mentioned, outlaws abortion and homosexuality, and recognises

customary law. In addition, the opposition has found its support in political leaders and conservative sections of the Kenyan public. President Moi (1978-2002) openly criticised any reform efforts for women's rights and SRH issues. For instance, he publicly ridiculed the 1995 Beijing women's conference that focused on drawing poor governments' attention to the need to protect women's rights, including SRH rights. Also in 2001, while addressing an East African regional meeting of women MPs, Moi is reported to have warned women parliamentarians that 'You [women] can achieve more, can get more but because of your little minds, you cannot get what you are expected to get!' (BBC News 2001). Religious groups have often used politicians to resist the SRH rights narrative by threatening to mobilise the Kenyan public against re-electing them if they do not support the moral view of SRH<sup>37</sup>. This influence on politicians suggests that political opposition to the SRH rights narrative is, as argued by Cowan et al (2001:7), driven more by 'political opportunism' than by a concern for religious or cultural values. The enjoining of religious groups and politicians is reinforced by the large conservative sections of the Kenyan society to form strong opposition to the SRH rights narrative in the country. Indeed, the sensitivity of the language of human rights as they relate to SRH is so strong in Kenya that religious groups often equate the terms 'SRH rights'/'RH rights' to 'abortion', 'adolescent sexuality' and 'homosexuality', and are therefore generally opposed to any policy propositions that mention 'SRH rights' or 'RH rights'<sup>38</sup>.

### ***Interests***

The SRH rights narrative prioritises and situates the needs, interests, and autonomy of women at the heart of SRH. It further prioritises the rights and needs of other marginalised groups such as adolescents and LGBTIs. The narrative constructs women and men as equal human beings able to make independent decisions regarding their sexuality and reproduction, thereby prioritising gender equality. It constructs LGBTIs as human beings deserving of human rights regardless of their sexual orientation. The narrative also recognises adolescents as having a right to comprehensive SRH information and services to enable them to live healthy sexual and reproductive lives. On the other hand, the SRH rights narrative marginalises moral and cultural arguments that focus on controlling how people practise their sexuality and reproduction, and propagate discrimination and exclusion. It effectively marginalises religious groups, politicians (opposed to SRH as

<sup>37</sup> 'The head of Kenya's Catholic Church (1997-2007), Archbishop Ndingi Mwana'a Nzeki, vowed to mobilise faithful to "vote out politicians who support abortion"' (BBC News 2004).

<sup>38</sup> Interviews: former official of a non-governmental international health policy agency, March 25, 2011, Nairobi; official, UN agency, June 7, 2011, Nairobi.

rights), and conservative sections of society. Furthermore, given its foundation in the universalism of human rights, the narrative pays little attention to the different social and cultural contexts in which the 'victims' of sexual and reproductive injustices are situated. It names alternative framings of SRH that focus on controlling people's sexuality and reproduction as 'violations of human rights'.

### **Actors**

At the international level, the international women's health and rights movement<sup>39</sup> and international LGBTI movement are strongly behind this narrative. Moreover, UN agencies and some powerful Western governments support this narrative, including the US government (during Democrat Administrations), the UK government and other Western European governments. Some donors have tied development aid to countries' human rights record (Seidel 1993); more recently, actions and decisions by African governments that have violated the rights of LGBTIs (as noted in Chapter 1) have seen the UK and US governments threaten to discontinue development aid to these countries (Daily Mail Online 2011). Furthermore, by funding research and advocacy on sensitive SRH rights issues such as homosexuality and abortion, some donors have continued to subtly push for the recognition and response to these issues. For instance, the Ford Foundation and GTZ have continued to fund research and advocacy on LGBTI issues in Kenya.

At the national level, the women's movement and human rights organisations have led advocacy efforts for SRH rights. Specifically, FIDA-Kenya (founded in 1985) and the RHRA<sup>40</sup> have notably been on the frontline pushing for SRH rights, particularly as they relate to abortion and FGM. Other organisations not part of the RHRA, which have also continued to promote SRH as rights in Kenya include the CRADDLE, Family Health Options Kenya (FHOK), Urgent Action Fund (Africa), Ipas Africa Alliance, PPFA-Africa

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<sup>39</sup> The transnational networks and NGOs that have pushed for SRH rights include Development Alternatives with Women for a New Era (DAWN), Isis International, the Latin American and Caribbean Women's Health Network, the Caribbean Association for Feminist Research, the East and South-east Asia-Pacific Regional Women and Health Network, the Feminist International Network for Reproductive Rights and Against Genetic Engineering, Women in Law and Development-Africa, Women Living Under Muslim Laws Network (Petchesky 2003), and PPFA, IPPF, Ipas, among others.

<sup>40</sup> RHRA was formed in 2004 following a high-profile case where a Kenyan gynaecologist (Dr. John Nyamu) and two nurses were arrested and accused of murder by the Kenyan government on claims that they were offering abortion. The network brought together medical and legal professionals as well as women's rights activists to support the accused, which saw their acquittal after 1 year in prison (for details: <http://www.bmj.com/content/330/7481/10.6.full>). The network emerged from this process to advocate for the decriminalisation of abortion in Kenya in order to pave way for the provision of safe abortion services. RHRA members include: FIDA-Kenya, KMA, KOGS, NNAK, Family Health Options Kenya (FHOK), and Reproductive Health Services. The RHRA has its secretariat at the PPFA offices in Nairobi and receives its funding support mainly from the PPFA.

Region, IPPF-Africa Region, the Kenya Human Rights Commission (founded in 1992), and the Kenya National Commission on Human Rights (founded in 2003). The Gender 10 (G10), a group of ten civil society organisations working on gender-related issues<sup>41</sup>, has also continued to advocate for SRH rights. However, these organisations/networks have mainly focused on access to modern contraception, abortion, gender-based violence, FGM and women's rights in general. Thus, for a long time, there has not been much focus on the SRH rights of adolescents and LGBTIs. It is only recently that the LGBTIs issue has started gaining currency in Kenya, especially with the recent establishment of lobby organisations/networks such as the Gay and Lesbian Coalition of Kenya (GALCK) (established in 2007) and UHAI-East African Sexual Health and Rights Initiative (EASHRI) (established in 2010). Also, human rights organisations (i.e. Kenya National Commission on Human Rights (KNCHR)), Kenya Human Rights Commission, and Health Rights Forum) have only recently started focusing on SRH rights and the need for these to inform laws, policies and programmes on SRH in Kenya<sup>42</sup>. The KNCHR has also recently published a report that revealed the violation of the rights of homosexuals and sex workers in which they called on the government to legalise homosexuality and sex work to protect the rights of individuals involved in these practices (KNCHR 2012).

### **3.5.2 What has local hostility meant for the rights narrative in Kenya?**

The hostility to the SRH rights narrative, coupled with the unsupportive legislative framework in Kenya, has meant that the conceptualisation of SRH as rights has remained a source of controversy in the country. Indeed, the conceptualisation of SRH as 'rights' in Kenya often closes possible policy spaces for reforms as seen in the case of FIDA-Kenya's 2008 RH and Rights Bill. When the RH Rights Bill failed to even get to parliament, RH experts, pondering on the way forward for the bill, asked:

'Could it [the bill] not then be branded as the Maternal Healthcare Bill to better capture the imagination and support of parliamentarians, a significant cross section of which is sceptical about the Reproductive Health Bill that is perceived as a law that legalizes abortion?' (KNCHR 2009: 7).

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<sup>41</sup> G10 members include WILDAF, MYWO, National Council of Women of Kenya, Coalition on Violence Against Women (COVAW), Women Political Leadership, Centre for Rights Education and Awareness (CREAW), Tomorrow's Child Initiative, African Women and Child and Development through Media, Young Women Leadership Institute, and FIDA-Kenya.

<sup>42</sup> In June 2011, the KNCHR implemented a country-wide public hearing on the status of SRH rights in Kenya. On December 7, 2011, KNCHR gave a press conference calling on government to legalise abortion to facilitate the provision of safe abortion services to avert the many deaths of women from unsafe abortion (Daily Nation 2011b). HERAF through its website and newsletter has been giving LGBTIs issues 'publicity' and calling on the government to decriminalise homosexuality (*Health Rights Today*, Special Edition September 2009 available at: <http://www.heraf.or.ke/>).



Driven by its own opposition to the SRH rights narrative and the opposition the narrative has attracted from other influential actors (i.e. religious leaders and politicians), the Kenyan government has not strongly and explicitly supported or promoted the SRH rights narrative despite the fact that its various policy documents acknowledge SRH as a human right. In fact, the government has remained ambivalent, if not completely unsupportive of the narrative. A senior officer at the DRH noted that the DRH is not supportive of the language of 'reproductive health rights', rather it is supportive of 'maternal health' since the 'reproductive health rights' language always attracts strong opposition from religious leaders<sup>43</sup>.

Furthermore, there have been no efforts by the government to sensitise Kenyans on SRH rights or to facilitate rights-based planning and programming for SRH. Neither has the government sought to promote the participation of key publics (e.g. women, adolescents) in SRH decision-making, yet participation is a key component of the human rights approach. In addition, the government's lack of support for the narrative has been manifest in its recent ratification of the African Union's Maputo Protocol (Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa) in October 2010 with reservations on section 14, which calls on states to protect the reproductive rights of women by authorising medical abortion in case of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother (African Union 2003).

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<sup>43</sup> Interview, official, DRH, July 14, 2011, Nairobi.

Table 4: Actor Interests behind Narratives

Narrative	Actors	What/who is prioritised?	What/who is marginalised?
<b>Moral Narrative</b>	<u>In Kenya:</u> -Kenya Episcopal Conference-Catholic Secretariat (KEC) -Supreme Council of Kenya Muslims (SUPKEM) -National Council of Churches of Kenya (NCCCK) -Inter-Religious Council of Kenya (IRCK) -Politicians -NGOs: Human Life International-Kenya; East African Centre for Law and Justice -Networks: Kenya Catholic Doctors Association, Kenya Catholic Professionals, etc. <u>Globally:</u> -Holy See (Vatican/Catholic Church) -North American NGOs and networks: American Centre for Law and Justice, Human Life International, etc. -US government (during Conservative Administrations)	-Christian/Islamic religious ideology -Interests of religious leaders	-Girls, women, adolescents, sexual minorities -Needs and interests of girls, women, adolescents, and sexual minorities -Societal power dynamics, particularly gender power imbalance and how it impacts decision-making and individual health outcomes
<b>Cultural Narrative</b>	-Politicians -Religious leaders -Cultural/community leaders	-Boys and men -Cultural beliefs and practices that prioritise the interests of boys and men	-Girls, women, adolescents, sexual minorities -Needs and interests of girls, women, adolescents, and sexual minorities -Societal power dynamics, particularly gender power imbalance and how it impacts decision-making and individual health outcomes
<b>Medical Narrative</b>	<u>In Kenya:</u> -Health bureaucracy -Medical experts <u>Globally:</u> -World Health Organisation (WHO)	-Interests of biomedical experts -Biomedical science -Medical conditions	-Individuals, in this case, girls, women, adolescents and sexual minorities -Voices, needs and interests of girls, women, adolescents and sexual minorities -Societal power dynamics, particularly gender power imbalance and how it impacts decision-making and individual health outcomes -Context - socio-cultural, legal, economic, and political – within which individuals live
<b>Rights Narrative</b>	<u>In Kenya:</u> -Women's health and rights movement in Kenya: Fida-Kenya, WILDAF, G10, etc. -Networks: RHRA, KMA, KOGS, NNAK -NGOs: Ipas Africa Alliance, IPPF-Africa Region, PPFA-Africa Region <u>Globally:</u> -Global women's health and rights movement -UN agencies: UNFPA -US government (during Democrat Administrations)	-Girls, women, adolescents, and sexual minorities -Needs and interests of girls, women, adolescents and sexual minorities -Equality, autonomy, freedom, non-discrimination, empowerment -Societal power dynamics, particularly gender power imbalance and how it impacts decision-making and individual health outcomes	-Christian/Islamic religious ideology -Culture, particularly cultural beliefs and practices that undermine marginalised or vulnerable populations

### 3.6 Conclusion

This chapter has explored the subliminal nature of power in SRH policymaking embodied in the different framings of SRH in Kenya that shape SRH-related decision-making in the country. As noted at the beginning, the different narratives are not independent of each other, rather they overlap and reinforce each other to produce often overwhelming opposition or considerable support for SRH issues in Kenya. On the whole, the medical narrative, particularly its moralised version, is dominant in the health bureaucracy, whereas the moral/cultural narratives dominate legislative processes on sensitive SRH issues and the rights narrative dominates only on non-sensitive SRH issues. Notably, the medical narrative has been instrumental in opening up policy spaces for (partial) reforms on issues that would have hitherto remained opposed. The rights narrative is often in great conflict with the moral and cultural narratives of SRH in Kenya. All the sensitive issues that the rights narrative frames as human rights and therefore deserving attention by the Kenyan government are strongly opposed by the two narratives as 'immoral' and 'unAfrican'. Indeed, most conflicts in SRH decision-making in Kenya are often between the moral and cultural narratives on the one hand, and the rights narrative on the other, as we will see in Chapters 4-6. Even then, the rights narrative has gained some level of hegemony partly because of its international origins and support, and the fact that it has lent voice to civil society and marginalised groups and legitimated their advocacy. However, the Kenyan government's ambivalence towards the narrative, particularly as it relates to sensitive SRH issues, remains a considerable hindrance to its meaningful influence in reforms. Although the medical narrative has been argued here as mainly driven by the positivistic biomedical evidence, it is important to note that all the four narratives draw on scientific knowledge to support their arguments. Commonly drawn upon is biomedical and demographic evidence on various SRH issues such as teenage pregnancy, maternal ill-health and deaths, unsafe abortion, HIV/AIDS prevalence and contraceptive use. In addition, the rights narrative also draws on analyses of human rights violations relating to SRH to support its arguments.

This account of pre-existing SRH narratives and how they compete with or reinforce each other provides the setting for the next three Chapters (4-6), which focus on explaining how change has happened or failed to happen in specific SRH decision-making processes in Kenya. These Chapters demonstrate how the different competing framings of SRH come to bear on SRH-related policy/legislative debates in Kenya. Also, these Chapters enable an understanding of how hegemonic narratives of SRH in Kenya shift to facilitate reforms or fail to shift to hinder reforms.

## Chapter 4

### The Making of the Adolescent Reproductive Health and Development Policy of 2003

#### 4.1. Introduction

This chapter deconstructs the policymaking process that produced Kenya's 2003 adolescent RH policy in order to explain the drivers and inhibitors of reforms that shaped the resultant policy. I argue that an unsupportive political context underpinned by strong religious, cultural and political interests blocked adolescent SRH policy reforms for a decade despite sustained evidence-informed advocacy by researchers and other actors. It took the severity of HIV/AIDS, donor pressure and reduced political costs for the then president (Moi) to unsettle these interests, when Moi declared HIV/AIDS a national emergency in 1999, effectively opening space for reforms. However, the entrenchment of the religious/moral and cultural narratives within political and bureaucratic institutions in Kenya still blocked reforms until a new government came into power in 2002, bringing in a new political order. The chapter is divided into four sections. The first section traces the inception of the policy reform efforts up to the period when the government made the decision to develop an adolescent RH policy. The second section discusses the actual policy drafting process, highlighting the different actors involved, the contentions and the compromises, up to the point when the policy was adopted and issued by government. The third section focuses on deepening the understanding of the nature and dimensions of power in the policymaking process and how this shaped the process and the resultant policy. The fourth and final section draws all arguments of the different sections together into a conclusion.

#### 4.2 Research, Advocacy and Tension in making the case for an Adolescent RH Policy in Kenya

The agitation for an adolescent RH policy in Kenya can be traced back to the late 1980s' and early 1990s' research and advocacy efforts of the Centre for the Study of Adolescence (CSA)<sup>44</sup>. In the policy 'agitation' and policy development processes, a tightly-knit epistemic community (Haas 1992) of SRH medical professionals and demographers from CSA, UNFPA and NCPD, surrounded by a broader loosely connected issue network (Marsh and Rhodes 1992) of varied adolescent SRH stakeholders (the Kenya Association for the

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<sup>44</sup> CSA was established in 1988 with the mandate for research, advocacy and programming for adolescent health issues.

Promotion of Adolescent Health (KAPAH)), were instrumental. Driven by the research they were generating that revealed high levels of teenage pregnancy and unsafe abortion – for example that in 1994 there were 142,000 unwanted pregnancies among girls age 15-19 and 252,000 abortions in the same age group (CSA 1995) - CSA researchers (who were mainly medical professionals) in the early 1990s established connections with the UNFPA country office. This was a strategic move given UNFPA's mandate on population and RH and its influential connection with the Kenyan government through NCPD (in the Ministry of Planning) and DRH (in the Ministry of Health). Thus, a strong connection with UNFPA gave CSA researchers almost automatic access to NCPD and DRH. The UNFPA country office is largely staffed by medical professionals, thus CSA researchers and UNFPA representatives had a shared expert knowledge (Haas 1992) on SRH. In addition, the UN's 1994 ICPD, which identified adolescent SRH as one of the major SRH challenges, put the issue on UNFPA's agenda. The NCPD, which is largely staffed by demographers, has the main mandate of promoting policies that address Kenya's rapid population growth. Thus, adolescent fertility/teenage pregnancy is one of its main concerns. As such, the thinking of actors from the three institutions (CSA, UNFPA, and NCPD) converged on addressing teenage pregnancy and the consequent unsafe abortion, forming an informal but closely-knit epistemic community.

Given the professional background of the actors in this network, the dominant narrative within the network was the positivistic medical narrative which argued that adolescents' lack of access to comprehensive SRH information and services was the main cause of the high levels of teenage pregnancy, which consequently resulted in high incidents of unsafe abortion. A respondent recalled that:

'I had been a gynaecologist in charge of the famous ward 6 at KNH [Kenyatta National Hospital] where a lot of abortion cases were being handled at that time. The data that we were producing there... It was clear that we could not just be downstream managing these cases of abortion and pregnancy without doing anything upstream at the higher level, which was now prevention through education.'  
[Biomedical researcher and adolescent RH reforms champion, Nairobi, June 10, 2011].

Even then, the medical narrative adopted in the network was biased towards morality partly because of the important role of NCPD within the network, which as a government agency could not embrace issues (of adolescent contraception or abortion) strongly opposed by top government and political leadership. In particular, the then president Moi and the planning minister, George Saitoti, were strongly opposed to adolescent SRH. Indeed, the

planning minister (an *Opus Dei*<sup>45</sup> Catholic under whose docket the NCPD falls) who led the Kenyan government delegation to the ICPD declared at the conference (as noted in Chapter 3) that Kenya would not embrace adolescent sexuality education and contraception because of the country's 'moral and cultural values'. This argument ignored the fact that the once effective traditional systems and structures at community level that facilitated sexuality education were no longer functional (Njau 1992). Thus, while CSA research showed high rates of teenage pregnancy and unsafe abortion among teenagers, the advocacy efforts by the epistemic community did not emphasise the need to provide adolescents with contraception or safe abortion services (i.e. moralised medical narrative) as seen in the last quote, instead focusing on the relatively less emotive issue of providing adolescents with SRH information.

Even then, calls to provide adolescents with comprehensive SRH information were opposed by religious groups, organising under the Inter-Religious Council of Kenya and politicians. Religious leaders through public pronouncements and demonstrations 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 (i.e. Family Life Education) 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 in Kenya (the late Maurice Otunga) on August 31, 1996, burned text books that were being used in the pilot programme in the streets of Nairobi city and other towns. Alongside the books, the group also burned condoms. Describing the controversy, a respondent said:

'We had been piloting life skills education programme in schools. It was in a report of UNFPA. So, we had piloted for several years and now it was time to scale it up and that is when the controversy broke... So what happened was the Catholics and the Muslims, they went burning the [lifeskills] curriculum on the streets throughout the country...because it was against Kenyan culture.' [Former official, CSA, August 3, 2011, Nairobi].

Underpinning their arguments by the moral and cultural narratives, the religious groups accused the Ministry and its partners of teaching 'children about sex'. Terming the books 'pornographic', they condemned their use in Kenya; they also condemned the use of condoms and the Cardinal urged 'Kenyans... *to choose life and not death* through careless

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<sup>45</sup> Opus Dei (Latin for "the Work of God") is one of the most conservative orders in the Catholic church, and it is strongly opposed to the promotion and provision of a wide range of sexual and reproductive health services (Catholics for Choice undated [<http://www.catholicsforchoice.org/oppositionwatch/documents/OpusDeiinLatinAmerica.pdf>]).

indulgence in sex' (Ogot 2004:52, emphasis mine). Taking the position of the 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). Furthermore, in 1997, Moi blocked parliament debate on a bill on Family Life Education that would have paved the way for the introduction of sexuality education in Kenyan schools. Thus, the moralised medical narrative within the CSA-UNFPA-NCPD epistemic community clashed with the moral and cultural narratives within the religious network and the political establishment.

The opposition to adolescent SRH had motivated CSA to form the broader issue network - KAPAH - in 1994 to provide a constituency of wide-ranging actors behind the campaign for responding to adolescent SRH challenges. KAPAH members included CSA and government agencies, as well as non-government and faith-based organisations<sup>46</sup>. Since KAPAH was spearheaded by CSA, the narrative within the network was also medical. While KAPAH was a formal network, it worked alongside the informal but closely-knit CSA-NCPD-UNFPA network. KAPAH implemented various evidence-based adolescent SRH advocacy activities during the same period, including developing and sharing fact sheets, conducting stakeholder forums, and working with the media to publish stories on adolescent SRH challenges (Shannon 1998). However, the 1996 demonstration by religious leaders and president Moi's subsequent public opposition saw government agencies, faith-based organisations, and international-type organisations pull out of KAPAH, leaving CSA (which also hosted the KAPAH secretariat) alone in the struggle for adolescent SRH, as aptly captured by a respondent:

'...the opposition was so well organised they really scared us...I remember KAPAH had membership from all over including PATH, Pathfinder International, and Population Council, you know, everybody was in it, they were about 35 organisations as members...And of course after the controversy NCPD as a government body couldn't get involved so were left out, and some of the big players were feeling they didn't want to get involved because nobody wants controversy, so in the end people ran away. So it was CSA and a few other people who were left.' [Former official, CSA, August 3, 2011, Nairobi].

It is worth noting that although the SRH rights narrative had already emerged from ICPD (i.e. adolescents' right to SRH information and services), this narrative was not emphasised by these two networks mainly because of the medical/demographic focus of dominant

<sup>46</sup> KAPAH members included NCPD, DRH, Family Planning Association of Kenya (FPAK), Kenya's cultural associations, Young Women's Christian Association of Kenya, Kenya Girl Guides, Program for Appropriate Technology in Health, Pathfinder International, Population Council, the Single Mothers Association, and youth representatives, among others (Shannon 1998).

actors in the network, but also because of the hostile context within which adolescent SRH issues were being discussed. Also important is the fact that actors who support a rights-based approach to SRH were not part of the two networks. Even though local actors did not adopt the ICPD's rights narrative in the adolescent SRH advocacy efforts, they felt that the ICPD legitimated their advocacy<sup>47</sup>. So, for a long time, the moral and cultural narratives promoted by religious leaders and top politicians dominated adolescent SRH debates, with the result that throughout the 1990s, despite sustained evidence-informed advocacy on adolescent SRH challenges, no policy reforms were realised.

However, in the late 1990s, a number of 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 epistemic community, putting CSA's adolescent SRH champions in important positions of power within NCPD and UNFPA. Then, in 1999, president Moi declared HIV/AIDS a national emergency and said that Kenya would make all efforts to fight the disease:

'AIDS is not just a serious threat to our social and economic development, it is a real threat to our very existence, and every effort must be made to bring the problem under control' said Moi in November 1999 (Ogot 2004: 62).

Further, the president, who was well known for his strong opposition to condoms, declared his support for condoms in the fight against HIV/AIDS in Kenya. On December 2, 1999, while officiating an event organised by Catholic bishops, Moi said:

'Unlike his Grace (Kirima [the Catholic bishop]), I am the President of both Christians and drunkards. If everybody was a saved Christian, I would be among those advocating for the ban of condoms' (Ogot 2004: 64).

From then on, Moi continued to publicly declare his support for condoms in the fight against HIV/AIDS. This political shift unsettled the hegemonic moral and cultural narratives surrounding SRH, dipping power in favour of the medical narrative to create political space for change. Three factors were at play here: first, HIV/AIDS prevalence (estimated at 13% in 1999)<sup>48</sup> was rising rapidly and Kenya's economy was crumbling partly as a result of the impact of the disease<sup>49,50</sup>. Thus,

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<sup>47</sup> Interview, a biomedical researcher and adolescent RH reforms champion, June 10, 2011, Nairobi.

<sup>48</sup> NASCOP and Ministry of Health (2006) 'Sentinel surveillance of HIV and STDs in Kenya'.

<sup>49</sup> Interview, official, NACC, October 5, 2011, Nairobi, who noted that towards the end of the 1990s, Kenya's public service sector was feeling the impact of HIV/AIDS; he noted, for example, that a lot of



something needed to be done urgently to tackle HIV/AIDS. Second, given the devastating effects of HIV/AIDS, donors were putting Moi under pressure to prioritise the disease in order to receive donor funding to respond to it<sup>51</sup>. As a country whose economy was on its knees at the time, donor aid was critical. 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 narratives; so the political costs to Moi were minimal. This political shift saw NCPD's governing board (under the chairmanship of Dr. Rogo, CSA co-founder) decide to develop an adolescent RH policy in 1999, and UNFPA country office commit to fund the policy development process.

### **4.3 Drafting an 'Adolescent' RH Policy that meets the Interests of 'Religious and Political Leaders'**

Following the decision to develop an adolescent RH policy, NCPD formed a committee of stakeholders to draft the policy. The stakeholders were drawn from government ministries/agencies including ministries of health, youth, education, and environment, as well as non-government organisations, including CSA, KAPAH, UNFPA, FPAK, Christian Health Association of Kenya (CHAK), Population Studies and Research Institute (PSRI at the University of Nairobi), Pathfinder International, Population Council, Family Health International (FHI), and the Catholic Church (KEC-CS). It was argued by government that these organisations were invited to participate in the policy development process because they were perceived (by government) as the most active in adolescent RH issues in the country at the time. CSA and KAPAH, having been at the forefront of the policy advocacy efforts, were tasked by NCPD to develop the policy draft to be discussed by the committee. The draft policy developed by CSA and KAPAH was then discussed, revised and approved by the committee. Committee discussions were said to have watered-down the policy according to a respondent:

'In order to get a buy-in, we had a steering committee formed that had the Catholic secretariat on board, and a lot of other people and everything was on the table, we would read each section of the policy and it would be edited on the screen. So if you

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school teachers were dying or missing school due to AIDS-related illnesses, and so president Moi could no longer ignore the disease.

<sup>50</sup> Kenya's economic growth was on the decline from mid 1990s, peaking in 2000 with a negative growth of -0.2%. Years preceding 1998 and 1999 had both recorded below 2% growth rates. This was a huge decline from the over 4% growth rate of the mid 1990s (AfDB/OECD 2003).

<sup>51</sup> A British government official pledged to give Kenya a grant of Ksh 3 billion to fight HIV/AIDS at the same event where Moi declared HIV/AIDS a national emergency (Ogot 2004); this could not have been a coincidence.

had issues, you said what you didn't like and why and what should replace it. So in the process, it got watered down a lot.' [Former official, CSA, August 3, 2011, Nairobi].

The leadership role of the CSA and KAPAH in the policy development process shows the blurring of boundaries between government and non-government institutions in public policy development in Kenya. It also reflects the relational aspects of power i.e. that through their connections with NCPD and their technical expertise of adolescent SRH in Kenya, CSA and KAPAH gained power to determine the content of the adolescent RH policy draft that would be discussed with other stakeholders. However, as captured in the quote above, CSA argued that the committee deliberations watered-down the commitments in the draft policy and produced a policy with 'broad statements' that failed to commit the government to the provision of comprehensive SRH information and services to young people. Although I did not get access to the original policy document developed by CSA and KAPAH, it was argued that the original policy draft had used 'strong language' to commit the government on the provision of comprehensive SRH information and services to young people:

'...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 certain services, contraceptives, and you see that is not very clear 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].

Indeed, the draft 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 does not mention 'comprehensive' 'sexuality', 'lifeskills' or 'family life' education, or 'contraceptives'. The involvement of the religious groups, especially the Catholic Church, in the policy development process, partly explains this. This supports the argument that public policymaking is a process of negotiation and compromise, and power relations among actors often determine what gets into a policy and what is left out (Anderson 2010). It is however worth noting that although a comparison of excerpts from the Kenya adolescent RH policy and the ICPD Programme of Action's commitments on adolescent RH did reveal some differences in the wording and issues covered, the substantive content of the two commitments is not very different (see Table 5 on page 82). Indeed, the Kenyan document does use the terms 'adolescent SRH and rights' even though

the language of rights was not promoted by actors agitating for reforms, reflecting the influence of the language used in international agreements in national level policies.

However, there were still remnants of political opposition to adolescent SRH in Moi's government, and so even after the policy was drafted, it was never approved by the *Opus Dei* planning minister. The minister's personal values shaped by Catholic doctrines sustained the hegemonic moral opposition to adolescent SRH issues despite presidential support for all efforts in stemming the spread of HIV/AIDS. A respondent noted that:

'... it took several years, because after it had been done, the then government didn't want to do anything about it, the minister under whose docket NCPD fell was an *Opus Dei*, Professor Saitoti. ... it wouldn't move beyond the cabinet because I don't think he would even present it and it was his responsibility. So then it existed in draft form until when NARC came into power in 2002 is when the policy was launched by Professor Nyong'o.' [Former official, CSA, August 3, 2011, Nairobi].

This revealed the pervasive and institutionalised influence of the Catholic Church in blocking SRH reforms. It was also argued by respondents that this problem was compounded by the fact that NCPD's leadership was weak at the time, with its director being a political appointee who lacked interest in, and knowledge of, population and RH issues<sup>52</sup>. Thus, NCPD as the lead government agency on the policy lacked a powerful champion to push for the Minister's approval of the policy. So the policy, whose development had started in 1999, remained in draft form until a new government came into power in December 2002 and approved it in 2003. The new government had risen to power with commitment to end Moi's autocratic politics, expand the political democratic space, and promote human rights, occasioning a major and positive change in Kenya's political context, as noted by a respondent:

'When NARC [National Rainbow Coalition] came in, there was now a more progressive platform and they wanted to push through, so we took advantage of that. At around the same time also the NCPD status changed and there was a lot of involvement by that new government in reviewing policies, in trying to implement things. There was more urgency when they came in ...' [Former official, CSA, August 3, 2011, Nairobi].

Furthermore, the change saw new Ministers installed, i.e. Peter Anyang' Nyong'o for Ministry of Planning and Charity Ngilu for Ministry of Health, both of whom were

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<sup>52</sup> Respondents noted that throughout the 1990s and early 2000s, NCPD's director (SBA Bullut) was a political appointee who constantly admitted publicly that he did not have any knowledge of population and RH issues. The same respondents noted that the coming in of Dr. Richard Muga (a medical professional with interest in SRH issues) in 2003 gave NCPD a major turn-around in terms of design and implementation of new population-related policies and programmes.

supportive of SRH issues at personal level<sup>53</sup>. Moreover, NCPD got a new director, Richard Muga, a paediatrician who was noted to have been supportive of SRH and the need for policy reforms. The change therefore dipped power in favour of the medical and rights narratives. Taking advantage of this change, actors quickly revived the policy development efforts that saw the adolescent RH policy approved by cabinet in 2003. However, while this change presented policy windows, actors behind reforms failed to seize this opportunity to revise the draft policy so that it responded to the main motivation behind its formulation (i.e. addressing teenage pregnancy) by incorporating contraception education and provision, and safe abortion care in circumstances permitted by Kenyan law. This reflects the strong moralised medical narrative adopted by key actors in the policy process, which evidently was also underpinned by reform actors' own values besides religious and political opposition.

It is worth noting that the DRH did not play an important leadership role in the adolescent RH policy development process despite being the relevant agency that should have led the process. Respondents argued that, as a division in MoH, the DRH experiences a lot of political interference, and since the issue of adolescent SRH had been highly politicised, the DRH shied away from taking a leadership role on this. NCPD, on the other hand, was said not to be as susceptible to strong political interference because of its institutional status as a semi-autonomous government agency, and as such, it was able to play a lead role in this highly politicised issue.

On the whole, these complex and highly contested processes help explain why Kenya's adolescent RH policy does not: expressly commit to contraceptive education or provision for adolescents; commit to the provision of 'comprehensive' sexuality education/information to adolescents; mention the need for safe abortion care in cases where this is legal (only providing for post-abortion care); and, address SRH issues of adolescent sexual minorities (LGBTIs). Respondents argued that abortion and homosexuality were not discussed during the policy development process as these are prohibited by Kenyan law. It is notable that although Kenyan laws at the time allowed abortion if the pregnancy endangered the woman's life, abortion was completely omitted in the policy, reflecting the absolute position of the Catholic Church, which prohibits

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<sup>53</sup> As noted, Nyong'o publicly advocates for the need to make abortion legal in Kenya in order to save lives. Also, in the initial period of becoming Health Minister, Ngilu publicly called for the need to legalise abortion in March 2003, but quickly retracted her statement after religious leaders issued statements calling for her resignation (World Press Review 2003).

abortion completely regardless of the woman's condition. This not only depicts the influence of the Catholic Church's way of thinking in SRH-related decision-making in Kenya, but also the fact that actors involved in the process had either internalised this position or were supportive of it and did not therefore challenge it. Most importantly, it depicts the absence of rights-focused actors in technocratic health policymaking processes; had these actors been part of this process, it is likely that this issue would have been raised. Regarding homosexuality, some government respondents indicated that homosexuality issues could not be discussed during the policy development process as these 'are not practised in Kenya'<sup>54</sup>. This not only points to the cultural conservativeness of these policy actors and the impact that this bears on policies adopted, but also to the lack of research and/or advocacy on these issues at the time when the policy was developed. Indeed, there seem not to have been any major research and/or advocacy on LGBTI rights in Kenya during the 1990s and early 2000s. It is only in recent years that some research<sup>55</sup> and networks<sup>56</sup> have emerged focusing on these issues. Thus, the SRH rights narrative as it relates to the rights of LGBTIs did not really have a clear support base in Kenya at the time when the adolescent RH policy was developed, and so the issue was completely marginalised.

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<sup>54</sup> Interview, official, NCPD, March 14, 2011, Nairobi.

<sup>55</sup> Population Council conducted a study on HIV/AIDS risks and prevention needs of men who have sex with men (MSMs) in Kenya in 2005 (see Onyango-Ouma et al 2005).

<sup>56</sup> The Gay and Lesbian Coalition of Kenya (<http://galck.org/>) and UHAI-East African Sexual Health and Rights Initiative (EASHRI).

**Table 5: Comparing ICPD's and the Kenyan government's commitments to adolescent SRH**

<b>ICPD 1994 Programme of Action – Excerpt on Adolescent SRH</b>	<b>Excerpts from Kenya's Adolescent Reproductive Health and Development Policy 2003 (pages16-17)</b>
<p>7.46 Countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies.</p> <p>7.47 Governments, in collaboration with non-governmental organisations, are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs. Such programmes should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family-planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention. Programmes for the prevention and treatment of sexual abuse and incest and other reproductive health services should be provided. Such programmes should provide information to adolescents and make a conscious effort to strengthen positive social and cultural values. Sexually active adolescents require special family-planning information, counselling and services, and those who become pregnant require special support from their families and community during pregnancy and early child care. Adolescents must be fully involved in the planning, implementation and evaluation of such information and services with proper regard for parental guidance and responsibilities.</p>	<p>4.1 Adolescent Sexual and Reproductive Health and Rights</p> <ul style="list-style-type: none"> <li>i) Provide appropriate sexual and reproductive health information and services at all levels.</li> <li>ii) Review existing or enact relevant legislation on reproductive health with a view to protecting adolescents and youth.</li> <li>iii) Incorporate adolescent sexual and reproductive health education into the curricula of all education and training institutions.</li> <li>iv) Sensitise the various groups within communities on the protection of children's rights and the provisions and enforcement of the Children's Act.</li> <li>v) Provide education to parents and the community on the sexual and reproductive rights and health of adolescents and youth.</li> <li>vi) Address gender concerns in all sexual and reproductive health programmes.</li> <li>vii) Support programmes that encourage adolescents and the youth to delay their sexual debut and practice abstinence.</li> <li>viii) Collect and analyse data for policy, programming and service delivery.</li> <li>ix) Strengthen capacities of institutions, service providers and communities to provide appropriate information and services such as post-abortion care, family planning (FP), and maternal, antenatal and delivery services for adolescents and youth.</li> <li>x) Promote appropriate HIV/AIDS education programmes for adolescents and youth in and out of school.</li> <li>xi) Advocate for behaviour change communication programmes by target groups (10–14 years, in and out of school, married, disabled, displaced including street children).</li> <li>xii) Strengthen the capacity of teachers, parents and leaders within communities to provide appropriate information on HIV/AIDS.</li> <li>xiii) Promote adolescent involvement and participation in planning, decision making, implementation and management of adolescent sexual and reproductive rights and health programmes.</li> <li>xiv) Establish and promote adolescent-friendly voluntary counselling and testing (VCT) sites, and link them to other agencies.</li> </ul>

## **4.4 Nature and Dimensions of Power in the Adolescent RH Policy Development Process**

### **4.4.1 Biomedical researchers challenged deep-seated hegemonic narratives on adolescent sexuality**

The adolescent RH policy development process manifests the conflicting interests of different policy actors in adolescent SRH. Biomedical experts, driven by the high rates of teenage pregnancy and the consequent unsafe abortions they had to cope with in health facilities, focused on generating evidence on these issues and using such evidence to push for policy reforms that would facilitate the provision of comprehensive SRH information to young people. On the other hand, religious groups and politicians, keen to maintain 'high morals' and conservative 'cultural values' among adolescents with regard to sexuality, organised and sustained an oppositional campaign. While biomedical experts argued that providing adolescents with comprehensive SRH information would enable them to make informed decisions on sexuality and reproduction and therefore help reduce the high rates of teenage pregnancy and unsafe abortion, religious leaders and politicians argued that such information would instead motivate adolescents to engage in sexual activity and result in a sexually immoral society. Thus, while biomedical researchers were driven by the need to respond to medical conditions (i.e. teenage pregnancy and the resultant unsafe abortion), religious leaders and politicians were driven by the need to control adolescents' sexuality in order to ensure an idyllic 'moral' society.

Driven by their different interests, the two opposing groups mediated different narratives, i.e. the biomedical experts mediated the medical narrative whereas the religious groups and politicians combined the moral and cultural narratives to support their arguments. To achieve their varied interests in the policy process, the different actors involved themselves in influencing activities as detailed in Table 6. The biomedical researchers at CSA established and maintained strong links with influential organisations, such as the UNFPA country office, as well as with relevant government agencies, the NCPD and DRH. In efforts to strengthen his influence, Dr. Rogo, the biomedical researcher and co-founder of CSA, manoeuvred his way into a powerful decision-making position at the NCPD, to become an individual issue champion, what Kingdon (2003) and Shiffman (2007) call a 'policy/political entrepreneur', and therefore able to steer reforms. On the other hand, religious groups connected with top politicians (the president and planning minister) both ideologically and politically to ensure powerful opposition to reforms.

The dominant moralised medical narrative within the policy subsystem marginalised the voices of other actors, including adolescents and human rights organisations/groups, in the policymaking process. Although respondents indicated that some young people (individual university students) were involved in the policy process, it was evident that there was no clear group representing the views of young people that made meaningful contribution to the decision-making process. However, this exclusion is typical of health policymaking in Kenya, which, as noted in Chapter 1, remains a technical and elite-dominated process. With the voices of adolescents and human rights groups silenced, the policymaking process focused on the interests of biomedical experts, religious leaders and politicians. It is, however, important to note that at the time there was no notable local organisation/movement in Kenya that mobilised young people in advocating for their needs, interests and human rights as they relate to SRH. Instead, much of the work on adolescent SRH in the country was mainly research and programming undertaken by organisations such as CSA, Population Council, FHI, PATH, and Pathfinder International. In addition, there was no notable organisation focused specifically on advocating for adolescent SRH rights at the time. Although FIDA-Kenya and the Kenya Human Rights Commission had recently been established (in 1985 and 1992, respectively), it was argued that the two organisations did not have much focus on adolescent SRH rights at the time.

**Table 6: Influencing roles/activities of different actors in the adolescent RH Policy Process**

<b>Actors</b>	<b>Influencing roles/activities</b>
Researchers (CSA)	<ul style="list-style-type: none"> <li>- Generated evidence on adolescent SRH challenges</li> <li>- Led evidence-based advocacy efforts for these issues to be addressed</li> <li>- Formed KAPAH to provide a joint advocacy platform with other actors</li> <li>- Established important influential connections with NCPD and UNFPA</li> <li>- Drafted the policy that was discussed, amended and approved</li> </ul>
Civil society (Programme implementers, KAPAH)	<ul style="list-style-type: none"> <li>- Fronted joint advocacy efforts for adolescent SRH issues</li> <li>- Participated in the policy development process</li> </ul>
Government institutions and officials (NCPD, DRH)	<ul style="list-style-type: none"> <li>- NCPD made the decision to develop an adolescent RH policy and spearheaded the policy development efforts</li> <li>- DRH was the relevant government agency to spearhead the policy process but failed to do so given the obtaining political controversy surrounding the issue</li> </ul>
Politicians (President Moi, Planning Minister Saitoti; new political entrants – Planning Minister Nyong'o and Health Minister Ngilu)	<ul style="list-style-type: none"> <li>- President Moi and Planning Minister Saitoti blocked policy and legislative reforms to address adolescent SRH issues</li> <li>- Moi declared HIV/AIDS a government emergency, effectively opening up policy space for an adolescent policy and condom promotion</li> <li>- Nyong'o and Ngilu approved and issued the adolescent RH policy</li> </ul>
Donors and UN Agencies (British government, UNFPA)	<ul style="list-style-type: none"> <li>- Put pressure on government to declare HIV/AIDS a national emergency</li> <li>- Funded the adolescent RH policy development process</li> </ul>
Religious groups (Inter-Religious Network of Kenya, Kenya Episcopal Conference, Christian Health Association of Kenya)	<ul style="list-style-type: none"> <li>- Opposed efforts to address adolescent SRH issues, particularly provision of comprehensive SRH information and services</li> <li>- Used politicians to block policy and legal reforms on adolescent SRH</li> <li>- Influenced policy content to ensure the policy did not expressly provide for the promotion and provision of comprehensive adolescent SRH information and services, and did not address abortion and homosexuality issues</li> </ul>

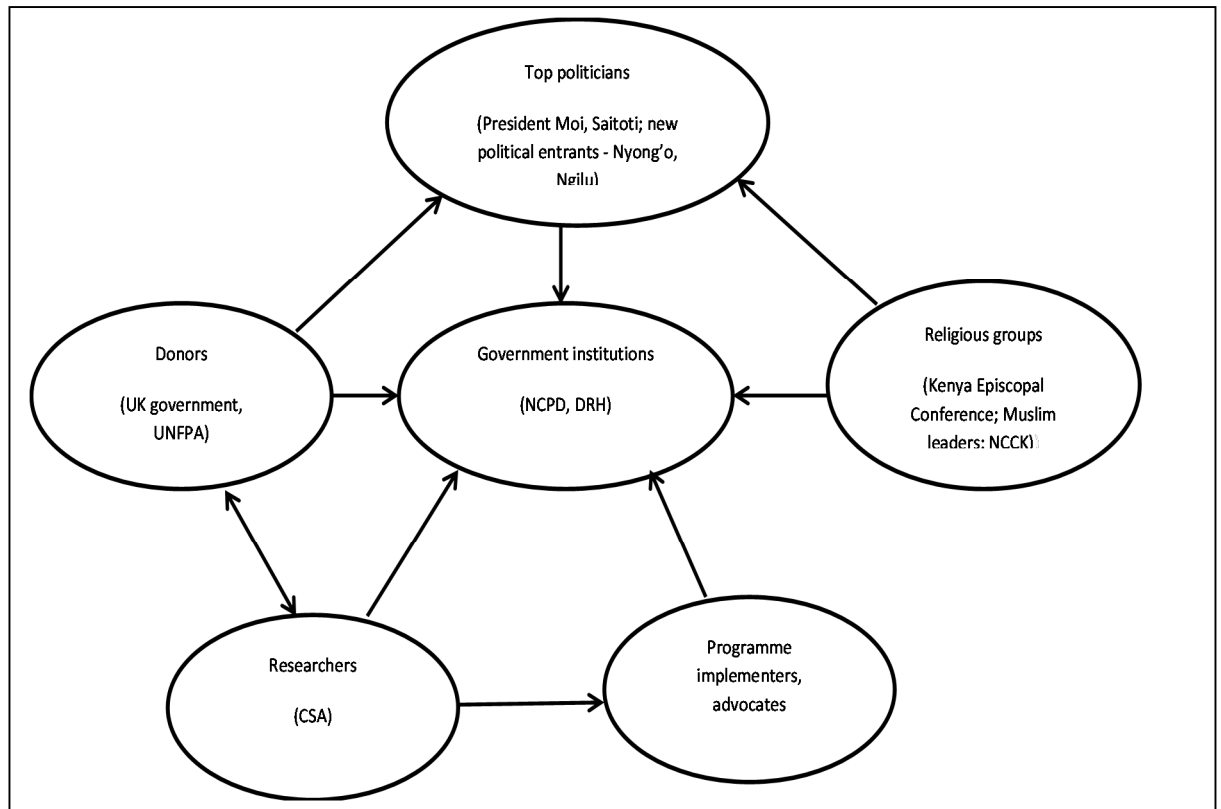


As revealed by the policy process, both formal and informal connections among actors were critical in facilitating or blocking reforms. While the CSA-UNFPA-NCPD informal connection was critical in driving change, the political and ideological connection between religious leaders and politicians was critical in blocking change. Indeed, it was only when the powerful connection between religious leaders and political leaders was severed (with Moi's declaration of HIV/AIDS as a national emergency and support for condoms, and the coming into power of a new government supportive of the medical and rights narratives) that policy reforms were possible. KAPAH, the only formal network in the adolescent RH policy process, was more of Heclo's (1978) issue network than Sabatier and Jenkins-Smith's (1998) advocacy coalition. This is mainly because, while KAPAH brought together organisations that believed in providing adolescents with comprehensive SRH information and services to enable them to live healthy lives, this was not a deep core belief because KAPAH quickly disintegrated when the controversy surrounding adolescent SRH issues intensified in 1996. This supports Thatcher's (1998) argument that the advocacy coalition framework is not useful in studying policy change in developing countries where long-term issue coalitions are often non-existent. The connections of local actors with international actors through funding (for instance, donors funded CSA research and advocacy) and support for adolescent SRH (such as through ICPD) was critical in bringing about policy reforms in SRH issues in Kenya. Except for UNFPA (country office) and GTZ, no donor organisations had direct input in the adolescent policy process. It is indeed interesting that USAID was not involved in this policy process. However, donor pressure on the Kenyan government to prioritise HIV/AIDS was necessary to shift the country's political position on the disease, which in turn paved way for an adolescent RH policy by marginalising religious opposition.

The influential political and ideological connections between religious leaders and top politicians in Kenya meant that the policy had to address the interests of religious groups and politicians for it to receive political backing. For this reason, the policy did not address the need for adolescent contraception education and provision, and safe abortion in cases where abortion is legal. Notably though, issues of abortion and homosexuality did not have much support even among the policy actors who developed the adolescent RH policy. This reflects the strong influence of the moral and cultural narratives on Kenya's bureaucrats, and how this influences public policies and programmes. This analysis illustrates not only complex, but overlapping actor connections that influenced the development and content

of the adolescent RH policy. Figure 3 attempts to depict a simplified simulation of these complex influential actor connections.

**Figure 3: Actor connections in the adolescent RH policy process** (arrow indicates direction of influence)



Source: Author 2013.

#### 4.4.2 Scientific knowledge was critical in drawing attention to adolescents' sexuality challenges

Scientific knowledge was critical in putting the issue of adolescent SRH on the public platform for discussion in Kenya, given the contextual sensitivity and opposition to the issue. Research evidence on the prevalence of teenage pregnancy and unsafe abortion among adolescents in Kenya became the main argument against the strong moral and cultural opposition, especially since a focus on rights could have potentially increased opposition. The knowledge drawn upon in this policy process was largely the positivistic biomedical knowledge perceived as objective and neutral and therefore free of interests. Alternative scientific knowledge (e.g. anthropological knowledge) or other types of knowledge, such as the perspectives of adolescents on their experiences with sexuality and reproduction, were marginalised. The focus on positivistic knowledge shaped the kind of reforms that actors focused on realising, i.e. the need for adolescent RH policy to facilitate the provision of SRH information to adolescents.

An important point raised by the policy process is the evident struggle between scientific knowledge and ideological conceptualisations of adolescent sexuality (underpinned by religious and cultural narratives) in influencing policy. Despite there being evidence of high rates of teenage pregnancy and unsafe abortion among teenagers in Kenya, proposals for the provision of comprehensive SRH information and services to adolescents were rejected on the grounds that these would promote 'sexual immorality' among young people. This is despite the fact that research evidence from elsewhere has shown that providing young people with comprehensive SRH information does not encourage them to have sex, rather it increases their likelihood of using protection at their first sex (cf Dawson 1986). This struggle pointed to the already acknowledged fact that scientific knowledge does not lead to reforms unless the politics are right (Buse et al 2006; Fischer 2003). In fact, scientific knowledge did not speak for itself, researchers had to go the extra mile to lead strong and targeted evidence-informed advocacy and networking efforts in order to tackle opposition and draw the attention of government to the issue. In addition, research actors had to manoeuvre their way into important political positions in order to directly influence the decision to develop an adolescent RH policy.

#### **4.4.3 Contextual and institutional dynamics shaped adolescent RH reform possibilities**

The adolescent RH policy process revealed the strong influence of the different aspects of context and institutions in SRH-related decision-making in Kenya. These ranged from the clash between the international context and the local socio-cultural and political contexts, to the formal and informal codes and rules that govern different government agencies and which have implications for reforms. To start with, the international stage on which the 1994 ICPD happened and the fact that Kenya was party to the ICPD, lent legitimacy to local advocacy efforts to address the SRH needs of adolescents. The development of the adolescent RH policy is acknowledged as Kenya's efforts to operationalise the ICPD Programme of Action. As already noted, the content of the policy was greatly shaped by the ICPD Programme of Action. The policy also acknowledges the influence of other international level agreements or conventions, including: the Universal Declaration of Human Rights, CEDAW, the Beijing conference, the International Convention on the Rights of the Child, and the UN World Programme for Youth for the Year 2000 and Beyond. What is clear from the policy process is that international agreements interact with the local context in Kenya resulting in variations in what is agreed upon internationally and

what is eventually adopted into policy locally, given the different power dynamics at the two levels.

Regarding socio-cultural context, the adolescent RH policy process is perhaps the case study where this influence played out most strongly. The strong religious and cultural norms and values on adolescent sexuality, abortion and homosexuality greatly influenced the policy deliberations and the resultant decisions. The controversy that dominated adolescent sexuality debates throughout the 1990s was underpinned by dominant moral and cultural narratives produced and maintained by the prevailing socio-cultural context. The emergence of HIV/AIDS onto the social scene in Kenya in the 1980s shifted the socio-cultural dynamics and created partial policy space for deliberation and redress of adolescent SRH challenges. However, culture is inherent in people and since the policy development committee was comprised of Kenyans, the local cultural and religious beliefs, norms and values shaped the policy deliberations and the content. The critical political context discussed next was the product of the existing socio-cultural context.

The political landscape was most influential in determining whether or not there would be a policy responding to adolescents' SRH issues in Kenya. Throughout the 1990s, president Moi, a strong opponent of SRH rights, sided with religious leaders in condemning calls for the provision of sexuality education to adolescents and consequently blocked efforts to have an adolescent RH policy. His change of tune in 1999 was a major shift that symbolised political leadership and commitment on tackling HIV/AIDS, paving way for both government and non-government actors to push forward with different interventions aimed at stemming the spread of HIV. Furthermore, the political shift marginalised the moral and cultural opposition and legitimated the work of donors, researchers, advocates and programme implementers involved in adolescent SRH in Kenya. Indeed, with HIV/AIDS as a government priority, advocates could now talk about condoms (hitherto vehemently opposed by religious leaders and Moi) as a key strategy for reducing HIV transmission among young people and adults. But more importantly, the change of government in 2002, which saw the entry of a new government perceived to be committed to reforms and safeguarding human rights, opened political space for the issuance of the adolescent RH policy.

Regarding the influence of Kenya's legal framework, existing laws at the time (contained in the country's Penal Code) outlawed abortion (except if a woman's life is in danger) and homosexuality. This legitimated opposition efforts and made it easy for these issues to be

blocked even for discussion during the policy development process. The strong influence of the Catholic Church also meant that the existing law on abortion was conveniently misinterpreted to mean that abortion was completely prohibited and so the policy did not tackle abortion at all, even in cases where this would be legal.

Lastly, the adolescent RH policy process revealed differences between the two government agencies - NCPD and DRH - in tackling sensitive SRH issues. NCPD's semi-autonomous status gives its executives considerable power and political space to take on sensitive SRH issues without much political interference, whereas DRH's junior status in the health ministry means its executives lack necessary power and are constantly exposed to direct political influence within the ministry. For instance, the NCPD head reports directly to the Permanent Secretary (PS) in the Planning Ministry who is the 'technocratic' head of the ministry reporting directly to the Minister, whereas the DRH head has to report to the head of the Family Health department, then to the Director of Public Health, before reaching the PS and the Minister. This implies that the junior institutional status of the DRH, the relevant agency for developing SRH-related policies, has negative implications for SRH reforms in Kenya.

#### **4.5 Conclusion**

This chapter deconstructed the policymaking process that produced the 2003 adolescent RH policy in Kenya in order to explain the drivers and inhibitors of reforms that shaped the policy. The adolescent RH policy process was complex, involving strong and sustained contestations among actors, given the conflicting actor interests that underpinned the competing framings of adolescent sexuality and reproduction. Throughout the 1990s, the medical narrative promoted by researchers from CSA and legitimated by the combined rights and medical narratives from ICPD challenged the deeply rooted moral and cultural narratives (promoted mainly by religious and political leaders in Kenya) on adolescent SRH issues with no success. Employing mainly the positivistic biomedical knowledge on adolescent SRH, actors behind the narrative did not seek any alliances with actors focused on human rights so as to combine the power of the medical and rights narratives in pushing for adolescent SRH policy reforms. However, this has to be understood within the context that it was happening; Kenya's president at the time was autocratic and generally unsupportive of reforms and human rights, particularly as they relate to SRH rights. Moreover, the moral and cultural narratives of SRH were embedded in the government's structures, as seen in the case of the *Opus Dei* Planning Minister (who blocked progress on

adolescent RH policy) and conservative government officials at NCPD (who argued, for instance, that homosexuality was not discussed during the adolescent policymaking process because it 'is not practised in Kenya'). This produced a political environment that was, for a long time, indifferent if not completely unsupportive of SRH rights including adolescent SRH issues. Thus, actors' failure to embrace the rights narrative that emerged from ICPD or to network with rights actors was mainly because the rights narrative, especially as it relates to adolescent SRH issues was strongly opposed locally. In addition, actors supporting and advocating for the rights narrative as it relates to adolescents SRH were lacking at the time.

The emergence of HIV/AIDS in the 1980s and its increasing severity throughout the 1990s unsettled the once hegemonic narratives of morality and culture as relates to SRH. This largely occasioned Moi's change of tune in 1999, when he declared HIV/AIDS a national emergency and announced his support for condoms, producing a turning point for adolescent SRH in Kenya by dipping power in favour of the medical narrative. Besides the devastating health and economic impacts of HIV/AIDS, this narrative shift also came as a result of sustained evidence-informed advocacy for reforms, donor pressure and reduced political costs to the president, since he was not planning to stand for re-election. During the adolescent policy development process, religious leaders' narratives of morality and cultural conservativeness, which focused on controlling adolescents' SRH competed with the medical narrative to greatly shape the content of the adolescent RH policy as already noted.

Another and perhaps most important turning point for adolescent SRH in Kenya was the coming in of a new government in late 2002 that rode into power on the promise of reforms and safeguarding human rights. The new political dispensation unsettled the once strong moral and cultural arguments opposing adolescent SRH, giving actors within and outside government the opportunity to facilitate policy reforms. Although this provided an opportunity for a more rights focused adolescent RH policy, actors failed to take this opportunity to revise the draft policy so that it would address some of the issues opposed by religious leaders (such as adolescent contraception and safe abortion), in order to facilitate adolescents' realisation of SRH rights, reflecting the strong moralised medical narrative among actors involved in the process. In the next chapter, I examine how civil society took advantage of this political window (i.e. 2002 new government and parliament) to push for legal reforms on the sensitive issue of sexual violence in Kenya.

## **Chapter 5**

### **The 2006 Sexual Offences Act Legislative Process**

#### **5.1. Introduction**

This chapter traces the legislative process that produced Kenya's 2006 sexual offences law to lay bare the drivers and inhibitors of reforms that shaped the resultant law. I argue that civil society was critical in using the global narrative of human rights to put the issue of sexual violence on Kenya's male dominated and deeply patriarchal political platform. The struggle between the global narrative of rights and the dominant narrative of culture, which masks men's interests, in Kenya's parliament that ensued reflected the patriarchal marginalisation of women's needs and rights in the country. While the narrative of rights enabled the realisation of partial legal reforms on tackling sexual violence, it unintentionally marginalised important actors and scientific knowledge that could have potentially enriched the debates and the resultant law.

The chapter is divided into six sections. The first section traces the inception of the law reform efforts up to the time when the draft law was ready for debate in parliament. The second section presents the debates in parliament on the proposed law up to the point when this was passed into law. The third section summarises the advocacy efforts implemented throughout the legislative process period to generate support for the law from MPs and the public. The fourth section looks at the intriguing unanimous passage of a law criminalising FGM in 2011 by the Kenyan parliament, given that FGM was contentious in the 2006 sexual offences legislative debates and its criminalisation was opposed. The purpose is to understand what changed between 2006 and 2011 to make reforms on FGM possible. The fifth section focuses on deepening the understanding on the nature and dimensions of power in the legislative process and how this influenced the process and the resultant law. The sixth and final section draws all arguments of the different sections together into a conclusion.

#### **5.2 Increase in Rape Incidence propelled Civil Society into action to address Gaps in the Law**

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 mixed<sup>57</sup> secondary school perpetrated by boys that left 19 girls dead<sup>58</sup>. Another dimension of the sexual violence was the increase in rape of very young children (as young as 5 months) and grandmothers (as old as 86 years) (Ndung'u 2008). These incidents propelled the civil society, mainly FIDA-Kenya and the Kenya Anti-Rape Organisation, into action to push for law reforms. According to respondents, the existing law was ineffective as it treated sexual offences as offences against morality and not criminal offences; thus, offenders easily walked away scot-free or with very light sentences. This was compounded by the fact that the law did not stipulate any minimum sentence for offenders. Also, the courts at the time treated sexual violence cases in favour of the defendants (men) following a 1970s Chief Justice's instruction to magistrates to always treat women's evidence in sexual violence cases with doubt as '*girls and women do sometimes tell an entirely false story*' (Hansard May 2, 2006: 829). And finally, there were gaps in the existing law as it did not address emerging forms of sexual violence such as gang rape, or the rape of boys, which the law had assumed that boys and men could not be raped.

The early 1990s efforts at law reforms did not achieve much given the non-supportive political context as noted in Chapter 4, particularly president Moi's outright opposition to women's rights. The only achievement of these efforts was the government's enactment of the Criminal Law Amendment Act of 2001 through the office of the Attorney General (AG) (Onyango-Ouma et al 2009). Onyango-Ouma et al (2009: 8) noted that:

'The amendment was made to the Penal Code pertaining to minors and, in effect, removed inconsistencies in penalties and protected the identity of minors. It did not, however, address evidentiary burdens leaving out the whole issue of comprehensive legislation to deal with sexual violence.'

So, the 2002 change in the political context in Kenya, which, as noted in Chapter 4, saw Moi's departure and the coming in of a new government that promised to support reforms and promote human rights, opened a policy window for reforms. Furthermore, this change ushered in a 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 in parliament.

Civil society organisations seized the opportunity presented by the political change, which had dipped political power in favour of the human rights narrative, to renew efforts in

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<sup>57</sup> School for both boys and girls.

<sup>58</sup> On July 13, 1991, 70 girls were raped and 19 of these died at St. Kizito secondary school for declining to participate in a strike organised by boys at the school. An angering report from the school's head-teacher included comments that the boys meant no harm, but 'only wanted to rape.'  
(<http://heinonline.org/HOL/LandingPage?collection=journals&handle=hein.journals/nylsintcom13&div=21&id=&page=>).



getting a comprehensive law on sexual violence. These efforts, led by The CRADDLE<sup>59</sup>, built on FIDA-Kenya's 1990s work through the formation of an advocacy coalition (Sabatier and Jenkins-Smith 1993) - the Juvenile Justice Network (JJN) that brings together 20 children's and women's rights advocacy and programme organisations<sup>60</sup> - that spearheaded the push for a comprehensive sexual offences law from 2003 (Onyango-Ouma et al 2009). The narrative in this network was predominantly rights given the network's legal focus and its membership. Thus, the drive for the sexual offences law was informed by the need to address the rights abuses that children and women experienced from sexual violence by enacting a law that would facilitate the punishment of offenders as well as discourage future offences. Although some scientific knowledge on sexual violence in Kenya was available<sup>61</sup>, this did not underpin the rights narrative adopted; rather, information on sexual violation reports from the mass media, police records<sup>62</sup>, and hospital admission records (from the Nairobi Women's Hospital) underpinned the rights narrative in the agitation for reforms.

However, the rights narrative in this network was not underpinned by the feminist argument of girls' and women's bodily autonomy and self-determination in the context of their right to equality and full social development (see Ortega 2011; Petchesky 2003). Rather, it was underpinned by the need to protect children's sexual integrity and to protect children and grandmothers from the danger and health hazards resulting from rape. Respondents argued that a focus on the rape of children and grandmothers, and the health hazards resulting from rape, was critical in generating support for the law. They argued that a focus solely on women's rights and bodily autonomy would have generated more opposition given the unsupportive patriarchal context in which rape is never taken seriously and leaders often joke about it in public<sup>63</sup>. Thus, women's rights were pegged on children's rights in order to reduce opposition as argued by a respondent:

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<sup>59</sup> CRADDLE's broad mandate is to protect and promote the rights of the child, especially that of the girl-child.

<sup>60</sup> Members of the JJN: FIDA-Kenya, Coalition of Violence Against Women (COVAW), The Child Rights Advisory Documentation and Legal Centre (CRADDLE), Urgent Action Fund (Africa), IPAS Africa Alliance, WILDAF), and Centre for Rights Education and Awareness (CREAW), among others. The Network's secretariat was at CRADDLE.

<sup>61</sup> The 2003 KDHS reported that 29% of women in Kenya had experienced sexual violence – this was the first national level survey capturing data on sexual violence in Kenya.

<sup>62</sup> Police reports showed that rape incidence increased in Kenya from 515 in 1990 and 1,675 in 2000 (Statistics given by the Kenya Police Headquarters in Nairobi and quoted in Amnesty International 2002).

<sup>63</sup> See Footnote on page 94 on the comment by a head-teacher that the boys meant no harm, but 'only wanted to rape'. In 2005, Kenya's Justice Minister Kiraitu Murungi said donor criticism of Kenya's fight against corruption was 'like raping a woman who is already willing.' In June 2006, Father Dominic Wamugunda, dean of students and chaplain at University of Nairobi joked about a man who breaks into a

‘...a lot of times there is a lot of support for protection of children in terms of sexual integrity, but had the bill been pegged to just women’s sexual and reproductive health and rights, it would have faced so much resistance than it actually faced. It had more support than the legal gendered bills face because it was tagged to children’s rights protection.’ [Official, women’s rights organisation, August 5, 2011, Nairobi].

Indeed, as we will see in section 5.4 on the campaign strategies for the proposed law, actors focused advocacy messages on the defilement of children and grandmothers, rather than on the rape of ‘generic women’. Spearheaded by CRADDLE, the JJN drafted a sexual offences bill and sought to convince the AG to present this in parliament as a government bill. However, these efforts failed since the AG, being a government employee, felt that the bill’s SRH rights narrative was not supported by government and political leaders, and so he declined to present it in parliament<sup>64</sup>. Reprieve came when the woman MP Njoki Ndung’u (a women’s rights lawyer and activist), proposed to present a similar bill in parliament. The AG then formed a committee comprising the JJN, the MP, FIDA-Kenya, Kenya Law Review Commission (KLRC), KNCHR, and legal officers from his (AG’s) office (Onyango-Ouma et al 2009). Using the earlier draft by the JJN, this taskforce drafted the sexual offences bill that was presented in parliament for debate by the woman MP. The proposed bill sought to, among others, criminalise all forms of sexual violence ranging from rape (including rape in marriage), defilement, unwelcome sexual advances, sexual harassment, and FGM (see Table 7 on page 100 for a detailed list). Within parliament, the MP mobilised all women MPs through the Kenya Women Parliamentarians Association (KEWOPA)<sup>65</sup> to support the bill and to lobby male MPs for support.

### **5.3 Debating Sexual Offences Law put Gender Power Imbalance at Centre Stage**

#### **5.3.1 First reading and debate of the bill**

The first reading of the bill in parliament by hon. Ndung’u was strategically seconded by a male MP, who was also the spokesperson of the Official Opposition in order to leverage support from opposition since the mover (Ndung’u) was from the government side. However, the rights focus of the bill clashed with the dominant cultural narrative in Kenya’s male dominated parliament and society at large. In fact, the first reading of the bill generated a negative and trivialised debate on a number of issues that the bill was seeking

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convent and vows to rape every nun, sparing only Mother Superior, at a sexual health conference. Later he said: ‘That joke came into my mind and I love a good joke...Some women take feminism too far’ (Associated Press, June 22, 2006).

<sup>64</sup> Interview, woman MP and human rights activist, August 4, 2011, Nairobi.

<sup>65</sup> KEWOPA is a formal women MPs parliamentary association established in 2001 and whose operations are supported by parliament (<http://www.kewopa.org/>).

to address. From the interviews, the main reasons behind the opposition to the bill by male MPs included: fear that the bill was targeting to punish men and would be used by women to 'frame' and 'fix' men; that the bill was proposing to outlaw social and cultural norms, values and practices; that the bill was introducing 'unAfrican' or 'Western' ideas; male MPs' fear that voting for the bill would deny them the male vote for re-election; and that the bill contradicted Kenya's constitution on some issues.

Male MPs who perceived the bill as targeting to punish men argued that it was a tool that women would use to blackmail or bring false accusations against men. They cited the then on-going sexual violence cases against South Africa's president, Jacob Zuma and Uganda's Opposition leader, Kiiza Besigye, as examples of how women in other African countries were using similar laws to 'frame and fix men'. Male MPs further claimed that the bill sought to legislate against social and cultural norms and values. For instance, an MP opposing the bill argued that the following clause in the draft bill would 'abolish courtship', a social norm in Kenya:

'Any person who attempts to unlawfully and intentionally commit an act which causes penetration with his or her genital organ is guilty of the offence of attempted rape...' (*Hansard*, April 26, 2006: 749).

The MP argued that if 'you leave this clause there, all you are doing is abolishing courtship. This is because when you court a girl, at the back of your mind you want to penetrate her one day. You are, therefore, "attempting"' (*Hansard*, April 26, 2006: 749). Another MP argued that the clause was outlawing 'the basic tenets of social life of courtship' (*Hansard*, April 27, 2006: 803). This clause was further argued to be 'prohibiting' men from marrying because for them to marry, they 'had to make advances'. Trivialised opposition to this clause was 'crowned' by a male MP who referred to women as 'creatures' who were 'shy' and so they said 'NO' to sexual advances when they actually meant 'YES'. This remark, applauded by male MPs, outraged women MPs who walked out of parliament in protest (except the mover of the bill and the Justice Minister).

Furthermore, the bill's proposition to criminalise marital rape was strongly opposed as 'unAfrican', with male MPs arguing that African women give life-long consent to sex with their husbands once they get married. In reference to this clause and depicting the contempt with which Kenyan men treat women's rights issues, one male MP argued that the bill contained 'a lot of rubbish' (*Hansard*, April 26, 2006: 758). By proposing to outlaw rape in marriage and unwelcome sexual advances, the bill was condemned as proposing 'Western ideas', and was likely to promote homosexuality as these provisions 'would force

men to turn to fellow men'. The homosexuality argument was further used against the bill's definition of genital organs to include the 'anus', yet this was included mainly to address sexual abuse of boys and men. Still on cultural grounds, the bill's suggestion to outlaw FGM was opposed as this was 'a cultural practice that should not be legislated against'. Yet, it is widely acknowledged that FGM is conducted to 'contain' girls' and women's sexual desire (Osakue and Martin-Hilber 1998; Ragab 2008). Underpinning all the opposition was fear by male MPs that they would become victims, would lose the male vote in the country, and that men would lose power over women on sexuality matters. One male MP summed it thus: 'This Bill is being opposed because some people see it as a gender campaign to deal with men' (*Hansard*, April 27, 2006: 787).

Although these trivialised debates were interjected by MPs supporting the bill, they persisted throughout the initial debates of the bill in parliament. These trivialised debates were allowed by the speaker (a man), who overruled any interjections arguing that each MP had a right to speak his mind in parliament. Indeed, the speaker condemned the protest by women MPs of walking out of parliament and reminded them that parliament was a place where they ought to conduct themselves with 'honour and dignity'. This begs the question: what was so *honourable* and *dignified* about referring to women as 'creatures' and trivialising a bill meant to address sexual violence? This points to the speaker's bias towards men's interests and lack of sympathy for women's rights. These debates depict the Kenyan parliament as a political space dominated with powerful masculine discourses that greatly silence and undermine women's issues.

From the debates, many male MPs supported legislating against certain forms of sexual violence such as defilement, rape (but not in marriage), gang rape, and insertion of objects in genital organs, among others. However, they opposed other forms of sexual abuse such as sexual harassment, unwelcome sexual advances, and rape in marriage, which were seen to be threatening men's power over women's bodies. Some MPs further opposed the bill for addressing the very issues that made it necessary i.e. need for corroboration of evidence, the provision for looking at complainants' sexual history, and no minimum sentence. For instance, MPs opposed the removal of the need for corroboration of evidence given by complainants, yet this was one of the weaknesses of the old law because rape or defilement occurs in hidden places, so corroboration of evidence is always a problem. The MPs argued that if evidence of rape or defilement was not corroborated, then a lot of 'innocent' men would be jailed. They were further opposed to the removal of the provision for looking at a complainant's sexual history, arguing that this should be

looked at to discern if the complainant is of 'good moral standing', indirectly justifying the rape of women deemed by men as 'immoral'. Some opposed putting a minimum sentence so that these could be left to the discretion of judges based on the situation of the offender. For instance, some argued that if a drunk teenager raped a girl, he should not be jailed but given lenient correctional sentence as jailing him for ten years (the proposed minimum sentence) would mess his entire life. But, what about the life of the girl he raped?

Some opposition to the bill mainly from male MPs who were lawyers by profession was based on the grounds that the bill contradicted Kenya's constitution. For instance, the lawyer MPs argued that for the bill to propose that the burden of proof be borne by the defendant and not the complainant<sup>66</sup> was against the constitution which provided that in any criminal case, the burden of proof was to be borne by the complainant and not the defendant. Further contradiction to the constitution was cited in relation to the fact that the proposed bill stated that sexual organs included the 'anus', which they argued acknowledged homosexuality, a practice outlawed by the constitution.

Evidently, gender battles dominated the initial debates of the proposed law, but were often masked in arguments of cultural and social norms and values, 'unAfrican/Western' or unconstitutional. These battles were focused on protecting men's interests by all means at the expense of women's bodily and sexual autonomy, and rights. The perceived 'aggressiveness' of civil society organisation (dominated by women) in campaigning for the passage of this bill could have contributed to the initial and somewhat overwhelming hostility that the bill received in parliament. Male MPs ridiculed women activists as 'loitering in the streets', referring to civil society demonstrations in support of the bill. Furthermore, the tactics employed by civil society of sending male MPs threatening text and email messages that they should vote for the bill or otherwise their names would be published were not only condemned by male MPs, but female MPs also felt that these tactics were counterproductive (Ndung'u 2008). Following the initial negative debates running over two days in parliament, hon. Ndung'u withdrew the bill to allow tempers to cool (Onyango-Ouma et al 2009) and address the contentious issues as well as re-strategize. Indeed, the initial debate on the bill forced women MPs and civil society to intensify their lobbying activities as well as consider enormous revisions of the bill.

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<sup>66</sup> That it's up to the defendant to prove his/her innocence and not up to the complainant to prove the defendant guilty.

### 5.3.2 Second reading and debate of the bill

When the bill was presented for second reading after several revisions and intense lobbying, it received considerably less opposition and the debate was more constructive. Although the opposition was reduced, Onyango-Ouma et al (2009) argued that the remaining opposition was focused on killing the bill at this second debating stage. According to the rules of parliament, the second round of debates determine whether a bill proceeds to the next level or not since at the end of the debates, MPs vote for or against the bill. To get the bill beyond this stage, the mover had to be tactical, and so she decided to be monitoring the presence of the opposition in parliament every time the bill was scheduled for debate. Onyango-Ouma et al (2009:18) noted that:

‘...one afternoon, the mover realised that the opposition was not in the house and pleaded with members present to allow debate to end and a vote be called. The speaker and members present (mainly women [and a few male supporters of the bill]) obliged, and they voted and passed the bill.’

After passing this stage, the bill could not be thrown out by parliament, it could only be amended.

### 5.3.3 Final reading and debate of the bill

When the bill was presented for final reading and debate, it had undergone several revisions. Furthermore, during the same period, intense lobbying of MPs opposed to the bill was taking place, and so, many male MPs opposed to the bill softened their stand. Even then, there was still some opposition and so more revisions were made on the floor of parliament. At this stage, women MPs did not have numbers to overcome the opposition. The removal of the clause criminalising rape in marriage was done at this stage, and a woman MP opposed it arguing that this should be left in to protect women who know that their husbands are HIV-positive, but insist on having sexual intercourse without protection:

‘Whereas I understand that in marriage many people say they cannot be raped, ...we are now in the age of the HIV/AIDS scourge and we must protect both spouses. If one spouse suspects that the other spouse is infected with the HIV/AIDS virus, that spouse has a right to say "no" unless the partner uses a condom. We know that, in most cases, women are not able to negotiate with their husbands to use a condom because they are over-powered. In that instance, we are putting the lives of women in danger of transmission of the HIV/AIDS. I feel that women should be protected by leaving the clause as it is. Where there is love and there is no suspicion of any infection, no wife will say "no", so that she is raped.’ (*Hansard*, May 31, 2006: 1104).

However, this argument was rejected and the clause was removed. Although HIV/AIDS was instrumental in opening up political space for the adolescent RH policy as seen in Chapter 4, this attempt to use HIV/AIDS to address the sensitive issue of rape in marriage failed. The rationale for removing the marital rape clause was argued by male MPs as the need to 'protect and safeguard the marriage institution' (*Hansard*, May 31, 2006:1104). By framing this as 'safeguarding the marriage institution', male MPs masked the fact that criminalising rape in marriage was in fact threatening men's power over women's sexuality. Other propositions that were opposed and removed from the bill during the three debating sessions included: criminalising FGM; criminalising unwelcome sexual advances; burden of proof to be borne by the defendant; having age of consent at marriage for girls raised from 16 to 18; definition of a child to include all people less than 18 years; intentional exposure of genital organs; and chemical castration for offenders. A clause that allows for any person who makes false allegations of sexual abuse to be convicted and to receive the exact sentence that the accused will have received if found guilty was introduced in the bill by male MPs at this stage. Although strongly opposed by women MPs, this clause sailed through. Some respondents condemned the clause as undermining the spirit of the bill as it discourages survivors of sexual violence from coming out to report sexual offences in fear that if they do not win the case, then the accused could come up and accuse them of false allegations and they may end up in prison instead.

In the end, the mover of the bill had to accept trade-offs in order for the bill to pass into law. Thus, while the amendments watered-down the bill, it was eventually passed into law in a form that was acceptable to majority male MPs in July 2006 (see Table 7 for details on what was passed and what was rejected). Notably, not all contested issues were removed from the bill. For instance, sexual harassment and the ten-year minimum sentence provisions, although contested, remained in the bill and are now law.

**Table 7: Main Content of the Sexual Offences Act**

Offences covered in the Sexual Offences Act	Provisions deleted from the bill
<ul style="list-style-type: none"> <li>• Rape</li> <li>• Attempted rape</li> <li>• Sexual assault</li> <li>• Compelled or induced indecent acts</li> <li>• Acts which cause penetration or indecent acts committed within the view of a child or person with mental disabilities</li> <li>• Defilement</li> <li>• Attempted defilement</li> <li>• Gang rape</li> <li>• Indecent act with child or adult</li> <li>• Promotion of sexual offences with a child</li> <li>• Child trafficking</li> <li>• Child sex tourism</li> <li>• Child prostitution</li> <li>• Child pornography</li> <li>• Exploitation of prostitution</li> <li>• Trafficking for sexual exploitation</li> <li>• Prostitution of persons with mental disabilities</li> <li>• Incest</li> <li>• Sexual harassment</li> <li>• Sexual offences relating to position of authority and persons in position of trust</li> <li>• Deliberate transmission of HIV or any other life threatening sexually transmitted disease</li> <li>• Administering substance with intent</li> <li>• Cultural and religious sexual offences</li> <li>• Offence to make false allegation</li> <li>• Conclusive presumptions about consent</li> </ul> <p>Source: The Sexual Offences Act, 2006</p>	<ul style="list-style-type: none"> <li>• Trespass with intent to commit a sexual offence</li> <li>• Intentional exposure of genital organs</li> <li>• Assessors to sit in cases of sexual offences</li> <li>• Application of caution and requirement for corroboration</li> <li>• Presumption that a boy under 12 years is incapable of sexual intercourse</li> <li>• Age of consent for marriage to be moved from 16 to 18</li> <li>• Children competent to testify in criminal proceedings</li> <li>• Marital rape</li> <li>• Female genital mutilation</li> <li>• Forced wife inheritance</li> <li>• Unwelcome sexual advances</li> </ul> <p>Source: Draft Sexual Offences Bill 2005 in Onyango-Ouma et al 2009.</p>

#### 5.4 Generating Support for proposed Sexual Offences Law

Given Kenya's patriarchal context, opposition to the bill in parliament and among the Kenyan public was anticipated. Prior to this bill, there had been several bills on issues touching on gender power imbalances and women's rights in the post-independence parliaments, and all had been rejected (i.e. the family protection bill, gender equality bill, and matrimonial property bill). At the time, there were only 18 female MPs against 204 male MPs in parliament, and as such it was imperative that support from male MPs is sought for the bill to pass. Women MPs hatched various campaign strategies to elicit the support of male MPs. At the same time, JJN members and other civil society



organisations<sup>67</sup> implemented separate national campaign programmes to generate support for the bill from the public and male MPs. The advocacy efforts are summarised below.

#### **5.4.1 Forming and working through networks**

From the onset of agitations for a more effective law to tackle sexual violence in Kenya in the 1990s, organisations did not work individually, but through coalitions. Although FIDA-Kenya was on the forefront in the early efforts, it worked hand-in-hand with the Kenya Anti-Rape Organisation and other groups to collectively agitate for law reforms on tackling sexual assault. Later efforts from 2003 saw the formation of the JJN, to lead collective advocacy efforts. AG's efforts brought together the woman MP who was to lead the bill in parliament, JJN, and government's legal and human rights agencies into one joint group that developed the draft law. In parliament, women MPs organising under KEWOPA, put their different political party interests aside to jointly support and campaign for the bill. Outside parliament, JJN linked with religious networks, particularly the Kenya Women Guild and Mothers Union, and grassroots women groups, to extend the coalitions in order to generate more support and agitation for the bill at grassroots levels. On the other hand, apart from individual male MPs opposing the bill in parliament, respondents indicated that there was no organised group within or outside parliament that was opposed to the passing of the bill. On the whole therefore, collective efforts through formal and informal networks, played an important enabling role in the legislative process.

#### **5.4.2 Lobbying and advocacy**

A major advocacy strategy was the framing of the bill as meant *to protect children, daughters, mothers and grandmothers* as opposed to that meant to protect 'generic women' in order to appeal to the emotions of male MPs and the Kenyan public. Given the marginalisation of women's needs in the Kenyan society, respondents believed that this framing was critical in softening hard-line opposition to the bill by male MPs. In addition, reform actors worked with the mass media to prioritise sexual abuse issues in news and commentary. Specifically, they negotiated with the media to prioritise the coverage of the sexual abuse of children and grandmothers in line with the strategy above. Specific lobbying activities included targeted lobbying of individual MPs, meetings with MPs and other stakeholders, media publicity through TV and radio programmes, newspaper columns and adverts, billboards, and street demonstrations (see Appendix IX for detailed lobbying and advocacy activities).

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<sup>67</sup> Specific organisations that implemented campaigns included CRADDLE, FIDA-Kenya, COVAW, CREAW, Urgent Action Fund-Africa, WILDAF-Kenya, and Ipas Africa Alliance.

### 5.5 Why was Criminalising FGM rejected in 2006 but supported in 2011?

As argued in the preceding sections, a proposal to criminalise FGM in the Sexual Offences Bill was opposed in 2006 on the grounds that it would 'criminalise our culture'. Before this, earlier efforts to ban FGM through a motion in parliament in 1996 had also been defeated. But in July 2011, the Kenyan parliament unanimously enacted a new law to criminalise FGM in the country. What changed? For some background, FGM is a deeply rooted cultural rite of passage for girls in some Kenyan communities. Recent data show that 27% of Kenyan women are circumcised (KNBS and ICF Macro 2010). The practice has, however, been internationally recognised as a violation of the human rights of girls and women because of its harmful effects (WHO 2010). WHO notes that FGM can 'cause severe bleeding and problems urinating, and later, potential childbirth complications and newborn deaths' (ibid). FGM was outlawed in Kenya among children through the Children's Act of 2001. At the time, FGM was not hotly contested because it was presented as a children's issue<sup>68</sup>. However, since the Children's Act of 2001 did not cover the whole population, a provision criminalising FGM was included in the Sexual Offences Bill so as to protect women older than 18 years from forced circumcision. Even then, it was one of the issues that was contested on cultural grounds and removed from the 2006 Sexual Offences Act.

In 2011, respondents argued that three things made the difference. First was the relentless advocacy by women MPs (from communities that practice FGM) and FIDA-Kenya to have this issue addressed by law. A woman MP who, for years, had been on the frontline advocating against FGM noted that the one thing that made it possible to pass the FGM Act in 2011 was the fact that they (women MPs and civil society) had convinced male MPs through sustained advocacy that FGM was wrong. Specifically, she highlighted the use of videos (on the health hazards resulting from FGM) in their campaign efforts, which she argued shifted the position of many male MPs from communities that practise FGM to support the need to outlaw the practice. In fact, their advocacy efforts got male MPs from communities practising FGM to start advocating against the practice publicly (*The Star* 2011b). It was argued that one of the main reasons why the bill received unanimous support in parliament was the fact that it was moved by a male MP, which gave it the perception that it was not a 'men versus women' issue. A woman MP observed that:

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<sup>68</sup> Interview, women's rights lawyer, a national legal and women's rights organisation, September 30, 2011, Nairobi.

‘What we did was to lobby male MPs about FGM. We actually showed them videos on FGM and after that, a lot of male MPs vowed to support the FGM bill. Indeed, if you noticed, the bill was motioned in parliament by a male MP, hon. Kapondi of Mt. Elgon. I have personally advocated for years against FGM, but that day in parliament when the bill was being moved, I was seated very far and quiet because we had already convinced male MPs about the need to stop FGM through the law and now they were the ones moving the bill in parliament.’ [Woman MP, Nairobi, August 9, 2011].

Second, some of the male MPs who strongly opposed criminalising FGM in 2006 were no longer in parliament in 2011<sup>69</sup>; instead some new MPs in parliament were sympathetic to the FGM issue. Indeed, the male MP who moved the FGM bill in parliament is among the new MPs who came into parliament through the 2007 general election. Thirdly, there was the new Constitution passed in 2010, which recognised RH as a human right, and it was argued that the FGM Act did not attract much opposition ‘in the spirit of the new constitutional recognition of reproductive health as human rights’<sup>70</sup>. This case demonstrates how three factors interacted to crumble the once dominant cultural narrative as it relates to FGM in the Kenyan parliament to make reforms possible, including: sustained and targeted evidence-informed advocacy, new sympathetic male MPs in parliament, and a supportive legal framework.

## **5.6 Nature and Dimensions of Power in the Sexual Offences Legislative Process**

### **5.6.1 Civil society and women MPs fought for ‘rights’ while male MPs fought for ‘culture’**

This case study illuminates the different interests and influential roles and connections of multiple policy actors in a legislative process, effectively highlighting the multi-sited nature of power in SRH-related legislative processes in Kenya (see Figure 4 on page 105 for actor connections and Table 8 on page 105 for actor roles). Driven by the need to protect the rights of women and children from sexual violation, a range of policy actors, including civil society, politicians, government agencies and mass media, played key roles either as individuals, organisations or networks to make change possible. Civil society organisations, specifically FIDA-Kenya and CRADDLE, took leadership on the need for law reforms on sexual violence to form networks through which they pushed for reforms. Focusing on coalescing organisations working on human rights and legal issues, the networks were dominated by legal experts who adopted the human rights narrative to the issue of sexual violence. As already noted, the rights narrative adopted, however, focused on protecting

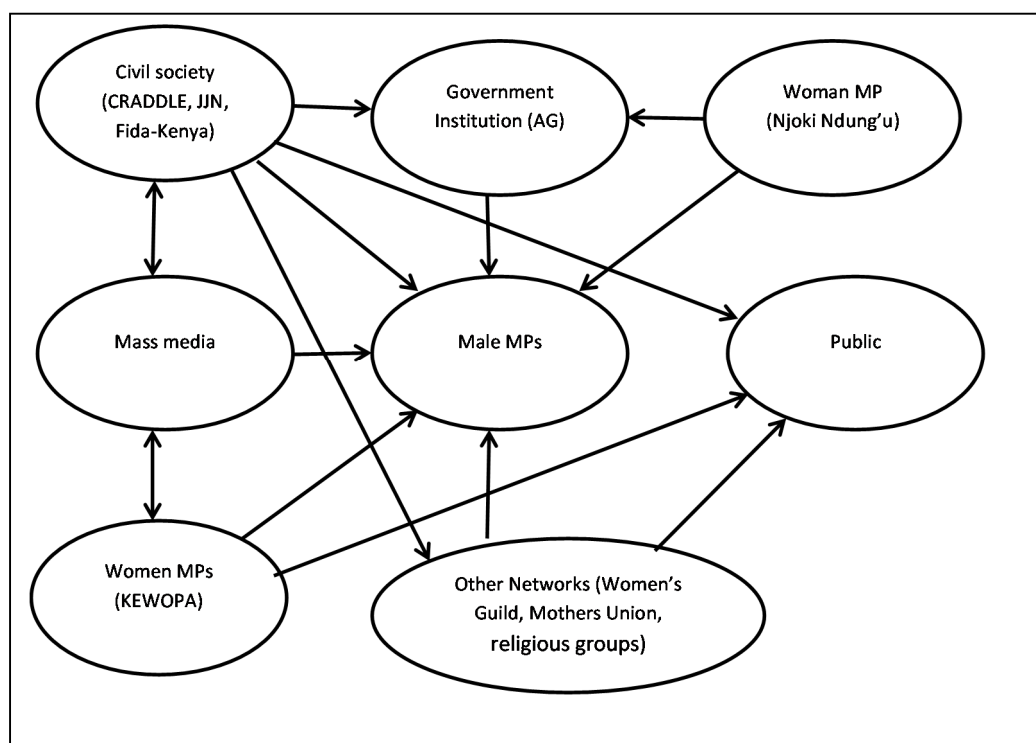
<sup>69</sup> E.g. Jimmy Angwenyi and Moody Awuori.

<sup>70</sup> Interview, woman MP, August 9, 2011, Nairobi.

children's rights to sexual integrity and not on women's rights to bodily autonomy and self-determination in fear of increasing opposition, given the context of strong patriarchal beliefs and practices that marginalise women. It further emphasised the dangers and health hazards resulting from rape and the need to protect children, grandmothers and women from these. Respondents argued that their focus on the rights of children to sexual integrity and the dangers of rape as opposed to focusing on women's rights to bodily autonomy could have been the only reason that saw the bill through parliament. They further argued that had they focused solely on women's rights and the rape of 'generic women', the bill could have possibly been 'laughed out of parliament' like other past women-oriented bills given the entrenched patriarchy in Kenya's parliament and society.

This raises the question: in such a strong patriarchal context, how do we generate open and critical deliberations on sexual violations that challenge deeply entrenched gender power norms and values that belie these violations without closing doors on these debates? The FGM case discussed in section 5.5 could provide some lessons. For instance, sustained evidence-informed advocacy with a focus on the danger and health hazards and other effects of rape in marriage could be the way forward in generating support for criminalising the issue in Kenya. However, faced with a relatively similar situation, an FGM Task Force in Egypt took a totally different route. The Task Force's efforts to have FGM, a culturally and socially entrenched practice, banned in Egypt did not focus on the health hazards of FGM; rather it took a holistic approach to women's rights to bodily autonomy and self-determination (see Petchesky 2003). The effectiveness of the Task Force in having FGM banned in Egypt was attributed to, among others, its feminist approach that focused not on isolating FGM (as a health issue), but rather, on integrating it into the larger political struggle for women's rights as well as its 'strong grassroots base and inclusive, open organising methods' (Petchesky 2003: 204). Yet, this feminist argument is what actors in Kenya avoided, arguing that it had only closed doors in the past. Could it be that actors in Kenya need to foster a strong grassroots appreciation and support of the feminist argument before employing it in advocacy efforts for reforms? It is acknowledged that the feminist approach to the struggle for women's rights in Kenya is not well understood and appreciated by both men and women alike, and has not been fully embraced by the elitist women's movement in the country (Kamau 2009; Machera 2004).

**Figure 4: Actor Connections in the Sexual Offences Legislative Process** (arrow indicates direction of influence)



Source: Author 2013.

**Table 8: Influencing roles/activities of different actors in the Sexual Offences legislative process**

Actors	Influencing roles/activities
Civil society (FIDA-Kenya, The CRADDLE, JJN)	<ul style="list-style-type: none"> <li>- Established influential links (with the AG, mass media, religious groups) and coalitions (e.g. JJN) that provided platforms for joint advocacy for law reforms on sexual violence</li> <li>- Led advocacy efforts for law reforms on sexual violence</li> <li>- Drafted initial versions of the law</li> </ul>
Politicians (Ndung'u, women MPs, male MPs)	<ul style="list-style-type: none"> <li>- Woman MP, Ndung'u, led law presentation in parliament</li> <li>- Women MPs lobbied male MPs for support of the bill</li> <li>- Male MPs largely debated against the bill and consequently succeeded in having numerous changes made before they passed it into law</li> </ul>
Government institutions and officials (Attorney General, KNCHR, KLRC)	<ul style="list-style-type: none"> <li>- AG declined to present bill in parliament as a government proposal</li> <li>- AG formed a taskforce that developed proposed law that was debated in parliament</li> </ul>
Mass media	<ul style="list-style-type: none"> <li>- Media news reports on sexual violence helped put the issue on national agenda</li> <li>- Media framed the issue as abuse against children and grandmothers and consequently shaped parliament and public debate on the issue</li> </ul>

As seen in the adolescent RH policy process where SRH rights groups or organisations were excluded from the 'technical' networks dominated by the medical narrative, similarly in the sexual offences legislative process, groups not focused on legal aspects of sexual

violation (e.g. healthcare professionals who treat sexual violence survivors, SRH rights researchers) were not centrally involved in the networks, which were dominated by the rights narrative. Nonetheless, civil society demonstrated their power in making the case for the law, drafting the law, and campaigning for public support and passage in parliament. The role played by civil society in this case study is similar to the role played by the non-governmental research organisation (i.e. CSA) in the adolescent RH policy process, pointing to the critical role of non-governmental organisations in bringing about policy reforms on SRH issues deemed as sensitive in Kenya.

Politicians played both facilitative and inhibitive roles in the legislative process. Like Dr. Rogo in the adolescent RH policy process, hon. Ndung'u's role in the policy process revealed the importance of issue champions within government or legislative structures in bringing about reforms on sensitive issues. Given her background in women's rights and her passion for reforms on sexual violence, she fearlessly took the issue into parliament and followed through to the point when the law was enacted. She also played a key role in raising funds for financing parliament-related lobbying activities. Capturing the important role Ndung'u played in the legislative process, a respondent observed that:

'The political leverage was critical...without Njoki and her fire, this bill would not have gone far. Yes, the civil society did a lot of work, and there was a bit of fights between civil society and Njoki...but at the level where it was, they needed someone from within parliament to push it from within. It needed political impetus for it to move from stage one of the reading to stage two, three, etc.' [Official, women's rights organisation, Nairobi, August 5, 2011].

The role played by Ndung'u in the process also demonstrates the porousness of the boundaries between state and non-state actors in policy processes. Previously before joining parliament, Ndung'u had been actively involved in the women's rights movement and so after joining parliament, she pushed on with the women's rights agenda to make reforms possible. Other women MPs, keen to protect the rights of girls and women, organised through KEWOPA to play important facilitative roles, particularly within parliament, that greatly contributed to the passage of the bill.

For their part, majority male MPs driven by patriarchal interests, played largely inhibitive roles that saw important provisions in the proposed law dropped and eventually passed a law that failed to criminalise all forms of sexual violence. By removing clauses that sought to criminalise marital rape, unwelcome sexual advances and FGM, which they argued were part of African culture, male MPs used the law to re-legitimise men's power to control girls' and women's sexuality. Their trivialisation of the debate did not only depict their self-

seeking interests, but also the general marginalisation and belittling of women's issues in Kenya's patriarchal society in the name of culture. Earlier studies have concluded that male politicians in Kenya use 'unAfrican' versus 'African' arguments or 'traditional' versus 'Western' arguments to have their way in decision-making, while hiding their own underlying interests to resist policies/laws that promote women's rights or seek to address gender inequalities in Kenya (see Thomas 2000; Onyango-Ouma et al 2009).

Regarding government officials and institutions, it is notable that the AG declined to present the bill in parliament as a government bill despite increased reports and severity of sexual violence. Again, this highlights the reluctance by government officials and agencies to lead reforms on 'politically' sensitive SRH issues as seen in the case of DRH in the adolescent RH policy process. Even so, the AG's support after a woman MP offered to present the bill in parliament point to the fact that bureaucrats are not always fixed on blocking reforms; rather, they can be dynamic in their stance if presented with alternative strategies that pose reduced costs to their careers. The support from the AG's office lent legitimacy to the bill and could have reduced opposition from the government's side. Indeed, a woman MP noted that their main focus for lobbying was the 'backbenchers' (i.e. opposition) in parliament, as these were perceived as the opposition since the government side was perceived as unlikely to pose strong opposition.

In this case study, the mass media were powerful in their agenda-setting role (McCombs and Shaw 1972). By mere reporting of increased incidents of sexual violence, the media created a sense of urgency about the issue of sexual violence. And, with a push from civil society, the media prioritised the rape of children and grandmothers to subtly generate sympathy from those opposed to criminalising sexual violence. The media further contributed to shaping how MPs debated the issue since its focus on the issue gave MPs the impression that the public was 'watching' the debate and this could influence how the public voted in the next election. While the media were employed in the adolescent RH policy process to draw attention to adolescent SRH challenges, it was their use in this case study that captured the considerable power wielded by the media in setting policy agenda and shaping debate on sensitive SRH issues, if engaged strategically.

Finally, the absence of some actors in this legislative process cannot go unnoticed. Representatives of agencies that would implement different aspects of the sexual offences law were missing, including the Ministry of Health (in facilitating provision of healthcare to

survivors), the Police Force (in enforcing the law), and healthcare professionals (in provision of healthcare to survivors). Also, the beneficiaries of the law (mainly girls and women) were missing in the process; the women rights groups that spearheaded the process were mainly elite-led civil society organisations that do not necessarily represent the voices of grassroots girls and women. Also missing were SRH rights researchers, pointing to the weak links between the SRH rights advocates and researchers; the impact of this weak link is made evident in the next subsection on knowledge. Inputs from these groups could have undoubtedly enriched the debates and the content of the law.

### **5.6.2 Anecdotal not scientific knowledge made case for reforms**

In this case study, scientific knowledge did not play a major role in making the case for reforms. Despite the existence of some research evidence on the issue as already noted, actors did not draw on this evidence, focusing instead on anecdotal media reports, police reports and hospital admission records of rape survivors. And, although the insufficient scientific knowledge on sexual violence in Kenya has been acknowledged as a key hindrance to legal and policy reforms on the issue (see Maternowska et al 2009), it did not deter progress on this issue, mainly because the actors behind the push for reforms were activists, who are often driven by sensationalised anecdotal information rather than robust scientific knowledge. Moreover, the ideological focus of the rights narrative dominant in the networks that were spearheading reforms meant that the narrative easily drew on anecdotal evidence without much need or focus on scientific knowledge. Thus, individual cases of sexual violations reported in the media, to the police or admitted at Nairobi Women's Hospital sufficed in informing advocacy efforts that made the case for reforms. The non-use of the limited scientific knowledge available on sexual violence points to the weak links between SRH rights advocates and researchers.

The focus on anecdotal evidence meant that other forms of sexual violations that were not being reported in the media, to the police or admitted in hospital did not receive much attention in the advocacy efforts. For instance, the issue of marital rape or intimate partner sexual violence, did not feature at all in the advocacy messages. While respondents argued that not focusing on marital rape in the campaigns was strategic in generating male support, it could be the reason why the issue was strongly opposed and easily dismissed by parliament. However, this also points to the avoidance of sensitive issues by actors pushing for SRH reforms in Kenya in order to reduce opposition, as seen in the adolescent RH policy process, where issues of adolescent contraception and safe abortion were completely



avoided in the advocacy efforts for an adolescent RH policy so as to reduce opposition. While such 'silences' are employed as strategies for bringing about reforms on sensitive SRH issues, they determine what reforms are adopted as is evident in the adolescent RH policy and the sexual offences law.

Moreover, like in the adolescent RH policy process, there was a struggle between knowledge/information and ideological opposition. For instance, while male MPs did not deny that rape happens in marriage, they argued that culturally 'African women consent to all sex within marriage when they say 'I do''<sup>71</sup> and that not criminalising marital rape was necessary 'to safeguard the marriage institution'. Yet, this is a case where scientific knowledge on the extent of rape in marriage (or intimate partner sexual violence) and its effects could have potentially produced a more meaningful discussion of the issue. Crichton et al (2008: 3), in their study on intimate partner violence in Kenya, found that 'physical and sexual abuse within relationships often leads to repeated exposure to sexual and reproductive health risks, and abused women lack knowledge about these impacts, experience feelings of hopelessness about their health, and are unable to access the health services they need.' Could use of such scientific evidence have yielded a more sober debate on rape in marriage than the dismissive patriarchal arguments witnessed?

### **5.6.3 Contextual and institutional dynamics determined reform possibilities**

As in the adolescent RH policy process, context and institutions were critical in determining which reforms were possible and which ones were not in the sexual offences legislative process. Most critical aspects were the socio-cultural and political contexts, and parliament as an institution. Other contextual and institutional aspects that influenced the legislative process included international conventions and agreements, regional contexts in neighbouring African countries, and the existing legal framework.

*Socio-cultural context:* Socio-cultural norms, beliefs and practices underpinned by patriarchy in Kenya were the main reasons behind all the opposition to various proposals in the sexual offences law. The trivialised initial debates of the bill were indeed the stark reflection of how patriarchy marginalises women and their rights. Opposition to proposals for outlawing marital rape, unwelcome sexual advances, and FGM were all grounded in the social norms and cultural beliefs that sanction these practices in Kenyan communities. Indeed, the patriarchal social system in Kenya meant that the bill was debated as a 'women versus men'

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<sup>71</sup> This argument is linked to the common practice of bride-price payment in many SSA communities, which is often interpreted to mean that once a man has paid bride-price, then his wife is his property to 'use' as he wishes (Kaye et al 2005).

issue and therefore provisions that were seen as threatening men's power over women were opposed. Thus, the existing socio-cultural context shaped how the political context and institutions reacted to, and influenced, the proposed law as discussed next.

*Political context and institutions:* The 2002 change of government and the political landscape motivated civil society to renew the campaign for a comprehensive law on sexual offences in 2003 that saw the enactment of the law in 2006. Furthermore, president Moi's exit is said to have paved way for a freer atmosphere in parliament, with MPs voting for bills (including the sexual offences bill) not based on the president's position, but on their own personal beliefs and values as captured in the quote below. In fact, it was argued that in the Moi era, it would not have been possible for women MPs to put their different political party interests aside to jointly support the sexual offences bill:

'The 9<sup>th</sup> parliament was operating under a different aura, a Kibaki aura, where when you come to parliament you can't tell who is in opposition and who is in government. In the Moi era you were not even supposed to be seen talking to someone from a perceived opposition. So I think we were freer, there was more space, more democracy. In the new political context, we were feeling more democratic, so there was more space democratically.' [Former Woman MP, Nairobi, October 5, 2011].

The change in the political landscape also saw new MPs get into parliament, including some human rights and women's rights activists, providing a parliament that was relatively supportive of human rights in comparison to previous parliaments. The new MPs hailing from the human rights movement in Kenya were instrumental in bringing the bill to parliament and in its debating and passage.

On the other hand, parliament as an important political institution in Kenya presented a major barrier to the passage of the law given the nature of the proposed law (where men are generally seen as the perpetrators of sexual violence) and the patriarchal discursive space that is the Kenyan parliament. The nature of the bill pitted women MPs against male MPs, with the result that some important aspects of the bill were rejected by the majority male MPs leading to the passing of a watered-down law. The outcome of the sexual offences law and the previous rejection of gender-related bills suggest that the entrenched and institutionalised patriarchy in the Kenyan parliament has meant that parliament has remained a barrier instead of a facilitator of reforms on SRH and women's empowerment issues. This situation has been compounded by the very low representation of women in the Kenyan parliament, which reflects prevailing socio-cultural norms and numerous barriers to women's entry into politics, as well as women's own perception of politics as a

risky and dirty game (Hunt 2007). And, even though parliament draws its power from the people (as voters), there have not been visible and sustained advocacy efforts to shape how the public votes in Kenya to ensure a parliament that is more supportive of SRH issues.

*International context:* Although not acknowledged by respondents or the Act, a number of international conventions and agreements underpinned the agitation for law reforms to address sexual violence in Kenya, including: the Universal Declaration of Human Rights, CEDAW, the International Convention on the Rights of the Child, the ICPD Programme of Action, and the Beijing Platform of Action. These conventions and the meetings they emerged from underwrote the global commitment to protect women's and children's rights, including protection from sexual violence. For instance, the Beijing Platform of Action adopted by government delegates, including Kenya, stated that:

Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences (UN 1995).

So the opposition by male MPs to certain forms of sexual violations on cultural grounds captured the struggle between the global narrative of rights that the Kenyan government has signed to versus the local political narrative of culture that privileges men's interests, while marginalising women's needs. This struggle, and the fact that male MPs ultimately had their way in the resulting law, points to the limitations of the rights narrative in challenging arguments based on deeply rooted cultural and social norms and beliefs that privilege those in power.

At the regional level, the contexts in other African countries influenced the legislative debates both negatively and positively. As noted, on-going cases of sexual violence against Uganda's Opposition leader and South Africa's president increased opposition to the law, with male MPs fearing victimisation. On the other hand, women MPs reported that the fact that other African countries such as Rwanda, Tanzania and South Africa had reformed their laws to address sexual violence gave them the impetus to ensure that Kenya, like these countries, reforms its laws so as not to be left behind in tackling sexual violence. Finally, Kenya's existing *legal framework* was drawn upon to block reforms on some issues just like in the adolescent RH policy process (in the case of abortion). Specifically, the proposals for the burden of proof to be borne by the defendant and the one to recognise the 'anus' as a genital organ were opposed as contravening Kenyan laws, and consequently omitted from the law.

## 5.7 Conclusion

This chapter has traced the legislative process that produced the 2006 sexual offences law in Kenya. The case study demonstrates the critical role of civil society in bringing SRH rights to marginalised populations in the context of a polity steeped in a strong patriarchal culture. Despite the increase in sexual violence reports and severity in Kenya from the 1990s, the government was unwilling to spearhead law reforms, given the perceived unsupportive context. Indeed, for over a decade, no meaningful reforms could be realised until the 2002 change in the political landscape that dipped power in favour of the human rights narrative, heralding a relatively more supportive political context. Civil society's efforts (i.e. sustained advocacy and drafting of possible law) and the coming into parliament of a women's rights advocate (as a champion of women's rights from the civil society) put this issue on the political agenda. However, the human rights focus of the civil society clashed with the strong cultural narrative embedded in Kenya's male dominated parliament that privileges men's power and interests, and sanctions their control over girls' and women's sexuality. Majority male MPs supported the criminalisation of rape and defilement, but strongly opposed the criminalisation of rape in marriage, unwelcome sexual advances and FGM, reflecting their unwillingness to lose their cultural power and privileges over women. They argued that criminalising these practices was tantamount to legislating against African social and cultural norms and values. The debates in this case study depict a classic struggle between the global human rights narrative and the local politically dominant narrative of African culture. Given the local power dynamics, the rights narrative prevailed only on non-sensitive sexual violations that did not threaten men's power, whereas the cultural narrative prevailed on the patriarchy-sanctioned violations (i.e. rape in marriage, unwelcome sexual advances, and FGM) to re-legitimise men's power over women. This points to the limitations of the rights narrative in challenging arguments based on deeply rooted cultural and social norms and beliefs that privilege those in power, suggesting the need for actors to think beyond the rights narrative.

And perhaps, in thinking beyond the rights narrative, civil society's reform campaigns for this law had avoided focusing on the culturally sensitive issues that embody men's power over women's sexuality (e.g. rape in marriage, unwelcome sexual advances, and FGM). Instead, the campaigns focused on the rape of children and grandmothers in order to avoid a backlash and elicit sympathy and support for reforms. Thus, the rights narrative adopted in civil society's campaigns focused on protecting children's rights to sexual integrity as well as protecting children and women from the dangers and health hazards resulting from

sexual violence, rather than on women's right to bodily autonomy and self-determination. This strategy, however, meant that the sensitive issues of rape in marriage, FGM and unwelcome sexual advances, were not discussed in the public campaigns, and were consequently easily dismissed in parliament. The passing of the FGM Act in 2011 offers some lessons on the critical importance of sustained evidence-informed advocacy that could be employed in advocating for the criminalisation of the remaining culturally sensitive sexual violations. Another lesson from the passage of the FGM Act is the need for strategic efforts that could ensure that more SRH-sympathetic actors get into parliament. Lessons could also be drawn from other African countries that have made reforms on relatively sensitive issues amid strong cultural opposition, such as the civil society advocacy efforts that resulted in the banning of FGM in Egypt (see Petchesky 2003). Instead of isolating FGM as a health issue, these efforts used the feminist approach to situate FGM in the larger political struggle for women's rights in Egypt.

The case study also demonstrated the power of anecdotal knowledge and mass media in putting issues on the political platform, but only if actors follow through with sustained advocacy. The dominant rights narrative in the networks pushing for reforms easily drew on anecdotal evidence from the media, hospital and police reports to make the case for reforms without any recourse to scientific knowledge, yet this could have arguably enriched the legislative debates and potentially helped to draw focus on a wide range of sexual violations. The dominant rights narrative also marginalised other relevant actors not directly focused on the legal aspects of rights (including healthcare providers, law enforcers, SRH rights researchers, and beneficiaries of the law (girls and women)), but whose involvement could have potentially enriched the legislative process and resulting law. On the whole, the changes in the content of the law that occurred over time reflect the negotiations and compromises that form the policy process. In the next chapter, I deconstruct the making of the National RH Policy of 2007 to provide an understanding of how different SRH issues deemed as sensitive were debated and addressed by the policy.

## Chapter 6

### The Making of the National Reproductive Health Policy of 2007

#### 6.1. Introduction

This chapter traces the policymaking process that produced Kenya's 2007 National RH Policy to discern the drivers and inhibitors of change that shaped the resultant policy. The main argument of the chapter is that SRH narratives supported by the political establishment, key religious and funding institutions (moral narrative), and bureaucratic medical professionals (moralised medical narrative) dominated the policy deliberations, determining which actors and which knowledge could influence the policy process and content. The chapter is divided into five sections. The first section traces the inception of the policy reform efforts up to the time when a decision was made to develop a national RH policy. The second section discusses actual policy drafting process, highlighting the different actors involved, the contentions and the compromises, up to the point when the policy was adopted and issued by government. The third section summarises the abortion debate during Kenya's 2010 constitutional process to help contextualise the sensitivity of the abortion issue and therefore enhance understanding of the way the issue was tackled in the national RH policy process. The fourth section focuses on deepening understanding of the nature and dimensions of power in the policymaking process and how this shaped the process and the resultant policy. The fifth and final section draws all arguments of the different sections together into a conclusion.

#### 6.2 Evidential Low Profile of Reproductive Health Stimulated the Need for a Policy

Following the 1994 ICPD, the Kenyan government developed an RH Strategy of 1997-2010 to 'Kenyanise' and operationalize the ICPD Programme of Action. This strategy development process was spearheaded by UNFPA (country office), which provided funding and technical support. The strategy was the first government's recognition of, and commitment to, RH in the country, and so it served as a 'policy' at the time, but was never implemented<sup>72</sup>. The need for an RH policy emerged in 2002 from the organising efforts of newly deployed RH medical professionals at the DRH. The medical professionals established an epistemic community (Haas 1992) - the Reproductive Health-Interagency Coordinating Committee (RH-ICC) - comprising stakeholders from donor and UN

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<sup>72</sup> Interviews: Former official, DRH, May 16, 2011, Nairobi; Technical expert, National RH Policy, July 18, 2011, Nairobi.

agencies, and international-type research and programme organisations (who were largely fellow medical professionals)<sup>73</sup>. This network played a significant role in agenda setting and policy development for the national RH policy.

Although the formation of the RH-ICC was argued as necessary to 'bring order in the national RH sector'<sup>74</sup>, the underlying motive was for the DRH to draw on the agencies' financial and technical resources to run the government's RH programme since the national budget provided considerably limited support for RH. The need for a national RH policy emerged from the deliberations of the RH-ICC. Respondents noted that the low profile of RH on the government's agenda, given that the 1997 RH strategy was never implemented, was a major issue of discussion in the initial meetings of the RH-ICC. This issue was buttressed by the release of the 2003 KDHS, which showed poor RH-related indicators (i.e. high maternal mortality, low contraceptive use, and stalled fertility decline). It was also argued that there was other new research that revealed 'emerging' RH issues that had not been addressed in the 1997 RH strategy, such as reproductive tract cancers, Prevention of Mother to Child Transmission of HIV (PMTCT), and RH and HIV/AIDS linkages and integration. It was felt that these 'emerging' RH issues needed a policy response.

Like the CSA-UNFPA-NCPD network in the adolescent RH policy process, the RH-ICC adopted the medical narrative that argued that the high burden of poor SRH outcomes necessitated a national RH policy that would draw government's attention to SRH challenges. However, partly because of its 'government home' (as a network led by DRH), the RH-ICC's medical narrative was moralised and did not put any emphasis on issues opposed by religious leaders, top government and political leaders or by Kenyan laws (i.e. adolescents' access to contraception, safe abortion, and homosexuality). Furthermore, as individuals, senior officers at DRH spearheading this network held their own personal values on sensitive SRH issues, some of which were unsupportive of these issues. For instance, a respondent intimated that the DRH head at the time 'hated abortion'<sup>75</sup>. Moreover, the organisations that dominated the network were being funded by USAID, which under the US government's 'global gag rule', does not support abortion-related

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<sup>73</sup> RH-ICC members at the time included: UNFPA-Kenya, WHO-Kenya, USAID-Kenya, GTZ-Kenya, DFID-Eastern Africa, Policy Project, Population Council, FHI, Pathfinder International, IntraHealth International, and AMKENI.

<sup>74</sup> Interview, former official, DRH, May 16, 2011, Nairobi.

<sup>75</sup> Interview, official, an international reproductive rights programme and advocacy organisation, August 8, 2011 – the respondent said that he once contacted the DRH seeking permission to train health workers on post-abortion care, and one of the things the DRH head told him was: 'I hate abortion'.

work, and only supported abstinence-only adolescent SRH programmes at the time through PEPFAR. Thus, USAID could not support a narrative recognising abortion and adolescent contraception. So all these contextual, structural, funding as well as personal factors produced the moralised medical narrative adopted by the network. It is therefore unsurprising that although the SRH rights narrative was an alternative, it was not given much attention in the RH-ICC's policy deliberations. Avoidance of the SRH rights narrative was also a strategy to depoliticise the process (Shore and Wright 1998) as respondents argued that the SRH rights narrative attracts opposition from religious and political leaders. Indeed, as noted earlier, a senior officer at the DRH, who is part of the network, admitted that the DRH avoids the terms 'reproductive health rights', preferring instead 'maternal health'. The network's focus on avoiding the rights narrative explains why SRH organisations that take a rights focus were excluded from this network. The decision to develop a national RH policy was made by the RH-ICC in 2004.

### **6.3 Developing a 'Politics-Free' Reproductive Health Policy**

Given its weak technical capacity and limited financial resources, the DRH decided to delegate the policy development task to Policy Project<sup>76</sup> (a USAID project) and to request for funding for the process from USAID; both institutions were members of the RH-ICC. Policy Project had provided technical assistance to the development of the 1994 health policy framework, and its acceptance of the DRH's request saw it take over and drive the RH policy development process. The decision to request for assistance from Policy Project and USAID reflected the RH-ICC's dominant moralised medical narrative, which made it appropriate to engage these two institutions in the policy development process given USAID's position on abortion and adolescent contraception. Notably though, compared to other institutions, USAID had invested the most resources both technical and financial in Kenya's RH sector in the past<sup>77</sup>, and so its resource endowment contributed to making its SRH narrative more influential. The Policy Project, in consultation with DRH, engaged

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<sup>76</sup> Implemented by the Futures Group, the Policy Project was a USAID-funded initiative that led efforts to improve the policy environment for FP/RH, HIV, and maternal health in developing countries between 1995-2006 (Futures Group undated [[http://futuresgroup.com/projects/policy\\_project\\_i\\_ii](http://futuresgroup.com/projects/policy_project_i_ii)]).

<sup>77</sup> Interview, official, UN agency, July 7, 2011, Nairobi, who argued that besides USAID, there weren't other 'big funders' of SRH in Kenya, whom DRH could have turned to for support for the policy development process if it was unsupportive of USAID funding policies.



two consultants (a gynaecologist and a demographer)<sup>78</sup> in drafting the policy, and collaborated closely with the USAID and DRH.

The DRH, on its part, formed a policy development committee drawing members from the RH-ICC that worked together with Policy Project in reviewing policy drafts developed by consultants. Specifically, committee members included experts from GTZ, Population Council, AMKENI, IntraHealth International, FHI, UNFPA, and WHO. DRH determines membership to the RH-ICC and this membership has mainly drawn from donors and 'international-type' programme and research NGOs funded by these donors<sup>79</sup>. By restricting the development of the policy to members of the RH-ICC, the DRH locked out other RH stakeholders not members of the RH-ICC to ensure that the decision-making process remained a technical exercise dominated by biomedical professionals supportive of the politically-accepted narratives of SRH in Kenya. Conspicuously missing on RH-ICC membership list are, among others, local as well as international organisations that often take a comprehensive medical approach or a rights approach to SRH, particularly those that prioritise abortion, such as KMA, KOGS, FIDA-Kenya, Ipas Africa Alliance, PPFA-Africa Region, and IPPF-Africa Region<sup>80</sup>. It should be noted that among the existing rights actors at the time, none was focused on the SRH rights of sexual minorities or adolescents; in fact, the main issue that the existing rights actors focused on was abortion. Evidently, the dominant moralised medical narrative within the RH-ICC dictated which actors took part in the policy process and which ones did not.

Although it was argued that the content of the policy was mainly informed by the ICPD Programme of Action and scientific knowledge, Policy Project's powerful role of coordinating the process gave it enormous influence on the policy. Policy drafts from consultants were discussed with Policy Project officials before being discussed by the RH-ICC committee as revealed by a respondent:

'I was the link between my organisation [Policy Project], the funders [USAID], the government [DRH], the taskforce, and the consultants... The policy document drafts developed by the consultants were discussed with me in-house at Policy

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<sup>78</sup> The two professionals were identified based on their prior experience in policy development - the gynaecologist had taken part in the development of the 1997 RH strategy, whereas the demographer had participated in the development of Kenya's population policy of 2000.

<sup>79</sup> DRH's decision on who joins the RH-ICC is informed by how the DRH perceives the role and extent of an organisation's work in Kenya [Interview, DRH Head, September 29, 2011, Nairobi].

<sup>80</sup> Although not acknowledged, RH-ICC members appear to be organisations endowed with financial and technical resources, which makes them attractive to DRH given its serious resource constraints. As such, many local organisations are not part of the RH-ICC as they lack the 'resource attractiveness'. Such local organisations are therefore locked out of policymaking processes and consequently have limited influence on RH policies emanating from DRH.

Project before being presented to the taskforce for comments.' [Former official, Policy Project, March 25, 2011, Nairobi].

This gave Policy Project, a USAID project, full discretion to decide on what gets discussed by the committee and ultimately what gets into the policy.

Draft policy was then shared with a wide range of stakeholders including government agencies, NGOs and FBOs implementing SRH programmes. Respondents noted that religious leaders and representatives of major women's rights organisations (i.e. FIDA-Kenya, MYWO) did not take part in these consultative meetings. For religious groups, it was noted that they were represented by faith-based service providers (such as the Christian Health Association of Kenya (CHAK)), but not the major religious networks (i.e. KEC-CS, NCKK, and SUPKEM). It was however not clear whether these groups were not invited to take part in the meetings, or they were invited but did not attend the meetings<sup>81</sup>.

Contentious issues during the policy development and consultative process included adolescent SRH, abortion and post-abortion care, the language of rights (i.e. 'sexual rights' and 'reproductive rights'), and the prohibition of traditional birth attendants (TBAs) from attending to births. Issues to do with adolescent SRH were contested by religious groups on moral grounds in fear that the policy would allow for the provision of comprehensive SRH information and services to adolescents, which they argued would encourage adolescents to become sexually active. As argued by a respondent:

'Adolescent sexual and reproductive health is always controversial, with religious groups feeling that we wanted to loosen the morals of adolescents. Religious groups never wanted to hear the word 'sexual' because to them this means you want to teach or encourage adolescents to have sex. They also opposed post-abortion services, saying they shouldn't be provided since abortion shouldn't be happening.' [Technical expert, National RH policy, March 22, 2011, Nairobi].

Respondents argued that abortion and homosexuality were not discussed during the policy development process as these are prohibited by Kenyan law. As one respondent put it: 'Abortion could not even be talked about since Kenyan law outlaws it, so how could we even discuss it?'<sup>82</sup> It was also argued that abortion was omitted from the policy to avoid moral and cultural opposition from religious and political leaders. Moreover, some medical experts involved in the policy development process argued that the policy could not address abortion since 'abortion is not a medical issue'. However, noteworthy is the fact that even ICPD did not address abortion; rather it required governments to 'deal with the

<sup>81</sup> KEC-CS and MYWO did not agree to an interview, whereas the FIDA-Kenya, NCKK and SUPKEM respondents did not have much information on this policy process.

<sup>82</sup> Interview, technical expert, National RH policy, March 22, 2011, Nairobi.

health impact of unsafe abortion as a major public health concern' (UNFPA 1995: ICPD Programme of Action paragraph 8.25), and not to reform laws to facilitate the provision of safe abortion care given the contentiousness of the issue at the conference.

Inclusion of post-abortion care was also opposed by religious groups as it was argued that this would facilitate the provision of abortion. Although contested, post-abortion care was eventually included as medical actors argued that it was 'a medical emergency' and healthcare providers could not chase away patients brought to facilities with complications from unsafe abortion. The framing of abortion complications as a 'medical emergency' made the case for its inclusion in the policy as noted here by a respondent:

'[W]e provided for the provision of post-abortion care services in the policy and although this was opposed, we had to explain that there were data from our health facilities showing that people were showing up with complications from unsafe abortion and these cannot just be left to die – that the health system needs to provide post-abortion services as a medical emergency to save lives.' [Technical expert, National RH policy, March 22, 2011, Nairobi].

As seen above, the inclusion of post-abortion care was indeed in line with the ICPD commitment. Respondents also argued that the fact that post-abortion was a WHO directive also helped to marginalise the opposition to its inclusion in the policy. Indeed, a WHO respondent noted that one of her roles in the policy development process was to ensure that the policy adheres to WHO global health standards. By adopting the moralised medical narrative, the committee developing the policy avoided tackling abortion, adolescent contraception and homosexuality, and consequently avoided strong opposition from religious and political leaders.

Prohibition of TBAs<sup>83</sup> from delivering women was opposed by some actors, particularly nurses and midwives, who felt that TBAs were playing a crucial role in delivering women who were unable to deliver in hospitals for one reason or another. This argument was, however, countered with the fact that the need to outlaw TBAs from delivering women was a WHO directive based on global evidence that many women were dying at the hands of TBAs who were not skilled in saving lives in case of complications. There was also the issue of PMTCT of HIV/AIDS, which TBAs neither had the skills nor the equipment to provide. However, this decision highlights the absence of women's voices in the SRH

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<sup>83</sup> It's worth noting that from the 1970s, WHO and World Bank had recognised TBAs as critical in saving women's lives since a lot of women in poor countries delivered at home. Consequently, these institutions invested in training programmes for TBAs. But from the 1990s, focus started shifting to investing in skilled birth attendants since evidence was showing that TBAs were in fact not saving women's lives in cases of complications (WHO 2005).

policy debates especially since some studies have shown that considerable proportions of poor and/or rural women prefer TBAs and/or home delivery than hospital delivery (cf Titaley et al 2010; Izugbara et al 2009b; Bullough et al 2005) for a number of reasons. The policy should have considered and committed to addressing these reasons in order to discourage TBA and home delivery.

The language of 'sexual rights' and 'reproductive rights' was contested and avoided in the policy as it was argued that religious groups and the public viewed this as 'foreign' and translated it to mean sanctioning abortion, homosexuality, and adolescents' involvement in sexual activities. Agreeing with the statement at the beginning of this thesis that captures the uneasiness that surrounded the language of SRH rights in the policy processes, another respondent argued that:

'The language of sexual rights was avoided in the document as much as possible because we know our communities do not support this, and it would have easily led to opposition. The Kenyan community in general does not condone sexuality [homosexuality] issues. These behaviours are also prohibited by the law. We couldn't include in the document issues that we know the Kenyan community in general doesn't support. ...so we had to be very careful with our language and avoid issues that communities and the Kenyan law do not support...' [Technical expert, National RH policy, March 22, 2011, Nairobi].

Following the stakeholder consultations, the policy document was finalised and shared with a ministerial technical committee for approval. The committee suggested changes on the rights language to indicate that it only applied to issues not prohibited by Kenyan law. Thus, the policy states that: 'Reproductive and sexual health rights, within the context of the law, are components of human rights...' (Government of Kenya 2007: 3). After this revision, the policy was submitted to the Health Minister for approval. At the Health Minister's desk, the policy encountered delays for nearly a year before it was signed. Respondents indicated that the delay at the Minister's desk was occasioned by religious groups who, after failing to influence the policy development process on the post-abortion-care issue, were lobbying the Minister to reject the policy, as noted here:

'You know some lobby groups when they failed to influence the policy through the RH-ICC, they decided to lobby higher levels of authority to reject the policy and this resulted in the delays in the Minister signing the policy. In fact, hon. Charity Ngilu only signed the policy just before she left office. This delay was mainly occasioned by lobby groups trying to get her not to sign the policy.' [Technical expert, National RH policy, March 22, 2011, Nairobi].

Despite the lobbying, the Health Minister eventually signed the RH policy without any revisions and issued it in 2007. Notably, the Minister was personally supportive of abortion

and had, in 2003, called on the government to make abortion legal, but was forced to retract her statement following condemnation from religious leaders who called for her resignation (World Press Review 2003).

The dominance of the moralised medical narrative in the RH-ICC network explains why the national RH policy did not address unsafe abortion (even though maternal health is the policy's top priority and unsafe abortion accounts for 20-30% of all maternal deaths in Kenya (Ipas 2004; Rogo 1990)), adolescent contraception education and provision, and SRH needs of sexual minorities (homosexuals and sex workers) (see Table 9 on page 122 for a summary of the content of the national RH policy). Indeed, the findings of a highly publicised national study on the magnitude of unsafe abortion in Kenya published in 2004, the same year that the policy development process was initiated, did not influence the policy in any way; the study revealed that unsafe abortion accounted for over 30% of all maternal deaths in Kenya, at least 2,600 women died from unsafe abortion in Kenya every year, and another 21,000 were hospitalised annually with complications from unsafe abortion (Ipas 2004). Interestingly, the Ministry of Health was a collaborator in this study. Not long after the release of the abortion study, several foetuses were discovered on a riverbank in Nairobi leading to a high-profile case in which a gynaecologist (Dr. John Nyamu) and his two nurses were arrested and accused of murder by the Kenyan government on claims that they were offering abortion since documentation with details of the doctor's clinic was found alongside the foetuses. Respondents argued that this incident was orchestrated by the Kenyan Catholic church to counter the impact of the abortion study. The nationwide condemnation the incident attracted from top political leadership contributed to the exclusion of abortion in the 2007 National RH Policy, whose development started the same year, 2004. Evidently, it is unlikely that other research on unsafe abortion could have influenced the national RH policy, given that these issues had been marginalised by the dominant narrative within the epistemic community underpinned by political, religious, financial, and individual interests.

Furthermore, like in the adolescent RH policy process, the dominant moralised medical narrative in the epistemic community meant that Kenya's legal provision on abortion (allowed to save a woman's life) was ignored and so the network produced a policy that omitted abortion (except post-abortion care) as though abortion was completely prohibited in Kenya. It is worth noting, however, that not all RH-ICC members support the moralised medical narrative that dominates this network. A donor representative and two researchers, who are part of this network, argued that although they would have liked the policy to

address the high rates of unsafe abortion in Kenya, they did not challenge its omission because 'the government does not support abortion'<sup>84</sup>. This points to the powerful position of government (i.e. DRH) in this network and the unwillingness of some local-based donor representatives and researchers to antagonise government on sensitive issues. Given the contentiousness of the issue of abortion and the language of SRH rights in this policy process, the next section summarises the abortion controversy in Kenya's 2010 new constitution-making process to help contextualise the sensitivity of the issue in a predominantly political process. The aim is to demonstrate the important political dimension of the abortion issue, which may not come through explicitly in the predominantly bureaucratic National RH Policy process.

**Table 9: Summary of key components in the National RH Policy 2007**

<b>Key Contents of Kenya's National Reproductive Health Policy 2007</b>
<p>Reproductive health policy goal (Ministry of Health 2007: 9)</p> <p>To enhance the reproductive health status of all Kenyans by:</p> <ul style="list-style-type: none"> <li>• Increasing equitable access to reproductive health services;</li> <li>• Improving quality, efficiency and effectiveness of service delivery at all levels; and</li> <li>• Improving responsiveness to client needs.</li> </ul> <p>Objectives of the reproductive health policy are to:</p> <ul style="list-style-type: none"> <li>• Reduce maternal, perinatal and neonatal morbidity and mortality;</li> <li>• Reduce unmet family planning needs;</li> <li>• Improve sexual and reproductive health of adolescents and youth;</li> <li>• Promote gender equity and equality in matters of reproductive health, including access to appropriate services;</li> <li>• Contribute to reduction of the HIV/AIDS burden and improvement of the RH status of infected and affected persons;</li> <li>• Reduce the burden of reproductive tract infections (RTIs) and improve access to, and quality of, RTI services;</li> <li>• Reduce the magnitude of infertility and increase access to efficient and effective investigative services for enhanced management of infertile individuals and couples;</li> <li>• Reduce morbidity and mortality associated with the common cancers of the reproductive organs in men and women;</li> <li>• Address RH-related needs of the elderly; and</li> <li>• Address the special RH-related needs of people with disabilities.</li> </ul>
<p>RH Components (defined and priority actions outlined) (Ministry of Health 2007: 10)</p> <ul style="list-style-type: none"> <li>• Safe motherhood, maternal and neonatal health</li> <li>• Family Planning</li> <li>• Adolescent/Youth Sexual and Reproductive Health</li> <li>• Gender Issues, Sexual and Reproductive Rights</li> <li>• HIV and AIDS</li> <li>• Reproductive Tract Infections</li> <li>• Infertility</li> <li>• Cancers of reproductive organs</li> <li>• Reproductive health of elderly persons</li> </ul>
<p><i>Source: Government of Kenya, 2007.</i></p>

<sup>84</sup> Interviews: Official, international research organisation, March 10, 2011, Nairobi; Official, international research organisation, April 5, 2011, Nairobi; Donor representative, September 12, 2011, Nairobi.

#### 6.4 Kenya's 2010 Constitution-making Process: Abortion became the Campaign Issue

The quest for a new constitution in Kenya started way back in 1990, and was motivated by the need to reduce presidential powers, which had been abused by incumbent presidents, and to address inequalities in land ownership. However, as the process evolved in 2010, abortion became the big issue. The Inter-Religious Network, driven by its moral narrative, engaged the committee developing the constitution to ensure that the constitution stated: *'life begins at conception'* and *'abortion is not permitted'*. However, the RHRA, an advocacy coalition, strongly opposed this proposal with a combined medical and human rights narrative to ensure that the draft constitution permitted abortion on certain grounds and recognised RH as human rights. To make a strong case to the committee overseeing the drafting of the constitution, RHRA respondents indicated that they avoided the language of human rights and instead focused on using public health research evidence on the extent of unsafe abortion and the resultant deaths, as well as technical evidence on the low doctor-to-patient ratio to make the case for other medical professionals to be allowed to make decisions on abortion. They argued that had they focused their arguments on women's rights, they would have attracted strong opposition and would not have made any progress. This is similar to the argument in Chapter 5 on framing sexual violence as meant to protect children and as a health issue rather than as a solely women's rights issue. Moreover, the committee drafting the constitution was especially sympathetic to the medical-rights narrative given its composition, which included two leading women's rights lawyers<sup>85</sup>.

The draft constitution therefore stated that, *'abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law'*<sup>86</sup> and recognised RH as human rights. This angered the Inter-Religious Network, which consequently put up a spirited national campaign, with funding from some US fundamentalist organisations (e.g. the American Centre for Law and Justice), against the proposed constitution arguing that it would

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<sup>85</sup> The deputy chair of the committee, Atsango Chesoni, and Njoki Ndung'u, a member of the committee, are renowned women's rights lawyers and activists.

<sup>86</sup> This statement reduced the abortion restrictions in Kenya in a number of ways. One, it allowed for other 'trained health professionals' to make decisions on abortion; before, such a decision could only be made by three different medical doctors. By allowing other health professionals, it meant that more women (especially poor women) who often have no access to doctors could access abortion. Two, it provided for abortion to be legal if permitted by any other law, thus leaving the door open for future possibilities of enacting an abortion law.

'legalise abortion'<sup>87</sup>. The move to oppose the proposed constitution demonstrated the extent to which religious leaders can go to oppose any minimal reduction of abortion restrictions, especially since religious leaders in Kenya had, from the 1980s, been most outspoken on the need for constitutional reforms in the country and were instrumental in Kenya's return to multi-party politics in 1992 (cf Sabar 2002). However, for abortion, they were willing to oppose the same constitutional reforms they had been agitating for, for decades.

Even so, as religious groups embarked on the opposition campaign, the Muslim leadership pulled out since the proposed constitution provided for the recognition of *Kadhi's* courts<sup>88</sup>. Indeed, this was another reason why Christian groups opposed the proposed constitution, arguing that religious courts should not be embedded in Kenyan law. This divided the religious network, with Christians opposing the constitution, while Muslims supported it. A small section of politicians, many of whom feared that the proposed constitutional provisions on land would enable the recovery of land they had acquired unlawfully<sup>89</sup>, joined the religious leaders to oppose the proposed constitution on grounds that it proposed to 'legalise abortion'.

However, the urgency for Kenya to have a new constitution given the 2007 post-election violence occasioned largely by constitutional weaknesses and the increased international pressure for reforms, meant that the proposed constitution received support from the president and the prime minister. The two leaders marshalled other politicians to support the proposed law. Furthermore, the government and RHRA members, and other civil society groups implemented an extensive nationwide civic education that focused on, among others, clarifying to the public the proposed constitutional provisions on abortion and countering false statements by religious leaders that the proposed constitution allowed 'abortion on demand'. The political support, coupled with the extensive civic education, lent support to the combined medical and rights narratives and marginalised the moral narrative, convincing many Kenyans to vote in favour of the proposed constitution in the August 2010 referendum.

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<sup>87</sup> Opposition campaigns focused on misinforming Kenyans with arguments that the proposed constitution permitted abortion on demand and homosexuality, even though the constitution in fact outlawed homosexuality and only allowed abortion to save the woman's life.

<sup>88</sup> A Kadhi's court is a Muslim court that determines questions of Muslim law relating to personal status, marriage, divorce or inheritance in proceedings in which all the parties profess the Muslim religion ((Kenya) National Council for Law Reporting, 2008).

<sup>89</sup> Hon. William Ruto, the MP who led the 'NO' campaign against the new constitution has been in court from 2011 over land that he grabbed from people displaced by the violence that followed the 2007 disputed elections (The Standard March 27, 2012).



Although abortion was the main issue under debate, it would be misleading to argue that the passing of the constitution meant that many Kenyans were now supportive of the abortion issue. In fact, it is possible that majority voted for the new constitution because the president and the prime minister supported it or because it addressed the issue of a powerful presidency and the long-standing land ownership challenges. However, it could be a pointer to the fact that many Kenyans are beginning to question absolutist statements on abortion by religious groups. Notably though, while the new constitution recognises RH as human rights, it outlaws homosexuality and sex work. The RH rights realised in the 2010 constitution (i.e. entrenchment of RH as human rights in Kenyan law and reduction of restrictions on access to safe abortion) could potentially change future bureaucratic RH policymaking in Kenya. For instance, SRH rights actors, whose issues have now been partly legitimated by the constitution, could start playing an important role in bureaucratic SRH-related policymaking, and future RH policies could address RH rights more substantively. But this remains to be seen.

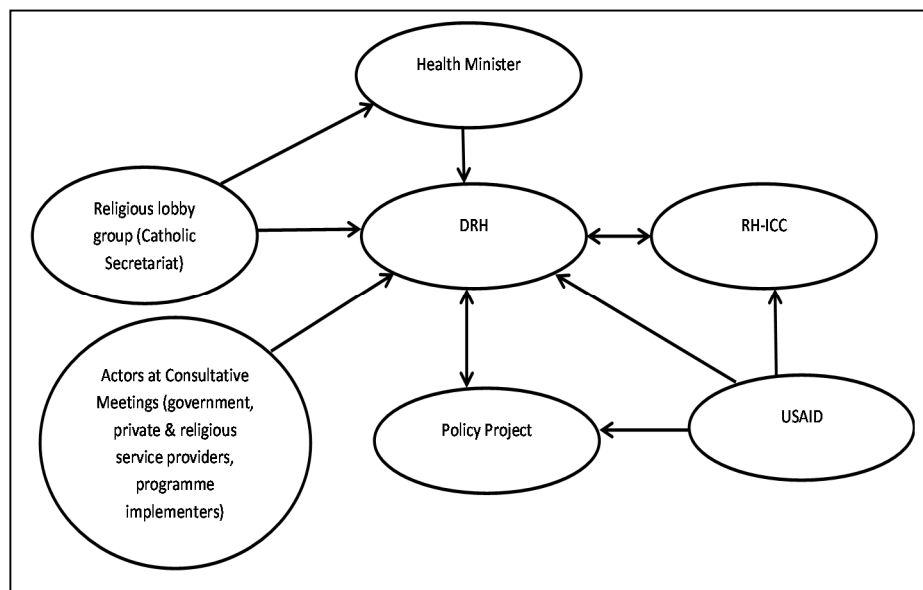
## **6.5 Nature and Dimensions of Power in the National RH Policy Process**

### **6.5.1 Medical actors dominated process while rights actors were marginalised**

Medical professionals in the health ministry, UN agencies (WHO and UNFPA), and USAID-funded research and programme organisations dominated the national RH policy development process. This partly explains why the moralised medical narrative dominated the process, marginalising actors who focus on sensitive SRH issues by taking a comprehensive medical approach and/or a human rights approach. The moralised medical narrative dominated the network for a range of reasons, including political reasons (longstanding political opposition to sensitive SRH issues), financial reasons (USAID's global gag rule policy and abstinence-only funding policy for adolescent SRH), and personal reasons (influential individuals in the network held personal values non-supportive of sensitive SRH issues). Furthermore, the medical narrative that dominated the RH-ICC network meant that actors lacking technical knowledge on SRH were excluded, such as women's rights organisations (e.g. FIDA-Kenya, MYWO). However, this (exclusion of non-medical actors) is typical of health policymaking in Kenya as noted in Chapter 1 and also evidenced in Chapter 4. What is important in the case of SRH is the fact that the exclusion of rights organisations was necessary for medical professionals to appear as only offering neutral 'evidence-based' solutions to medical problems, and consequently avoid opposition from political and religious leaders. Furthermore, given that the underlying

formation of the RH-ICC was so as to draw on the resources of donors and international-type organisations, this locked out relevant organisations perceived as lacking the resources (mainly financial) that the DRH was targeting to benefit from such as CSA, for instance. DRH's weak capacity meant that non-government actors took lead in the policy development process and consequently shaped the policy content (see Figure 5 and Table 10 for influential actor connections and roles).

**Figure 5: Actor Connections in the National RH Policy Process** (arrow indicates direction of influence)



Source: Author 2013.

Although religious leaders did not take part in the policy drafting process, their longstanding opposition to sensitive SRH issues still influenced the content of the policy, given their influential political position in Kenya. In addition, their non-participation in the 'formal' policy process did not necessarily block them from influencing the policy since they still held behind-the-scenes lobbying of the health minister to influence the content of the policy. The behind-the-scenes efforts by religious groups to influence the RH policy makes apparent the absence of similar efforts from other excluded groups, particularly the comprehensive medical and rights groups such as KMA, KOGS, RHRA, FIDA-Kenya, Ipas Africa Alliance, among others. Respondents from these organisations argued that given the government's open opposition to sensitive SRH issues (adolescent contraception, abortion, and homosexuality), they do not see the value of engaging government agencies on these issues since such efforts would not achieve much. However, such an argument stands in contrast to evidence from ICPD and Beijing conferences, for instance, which shows that the effectiveness of women's rights groups in influencing the conference

agreements was attributable to their working both from within and outside the UN and government decision-making machineries that produced the agreements (see Carbert 2004). Evidently, such indifference from local medical and SRH rights actors denies them opportunities for influencing bureaucratic SRH-related policies. For instance, had these (comprehensive medical and rights) groups participated in the policy process, they could have potentially contested the misinterpretation of Kenyan laws' prohibitions on abortion to ensure that the policy commits to the provision of safe abortion where this is legal as opposed to the policy's complete omission of abortion as though this is completely illegal in Kenya.

**Table 10: Influencing roles/activities of actors in the National RH Policy Process**

<b>Actors</b>	<b>Influencing roles/activities</b>
Government institution (DRH)	<ul style="list-style-type: none"> <li>- Established the epistemic community (RH-ICC) that became instrumental in the policy development process</li> <li>- Sought technical and financial resources for the policy development process</li> <li>- Together with Policy Project, selected consultants to develop policy</li> <li>- Oversight for the policy development process – drafting and consultations</li> <li>- Coordinated links with top bureaucrats (ministerial committee) and political leaders (health minister) for policy's approval</li> </ul>
Donors and UN agencies (USAID, GTZ, UNFPA, WHO)	<ul style="list-style-type: none"> <li>- USAID funded policy process, and its technical experts reviewed policy drafts</li> <li>- GTZ, WHO and UNFPA representatives took part in policy development process</li> </ul>
Policy Experts (Policy Project)	<ul style="list-style-type: none"> <li>- Spearheaded the policy drafting process and coordinated consultations between USAID, DRH and RH-ICC</li> <li>- Together with DRH, selected consultants to draft policy</li> </ul>
Researchers (Lead consultants, Population Council)	<ul style="list-style-type: none"> <li>- Synthesised research evidence that informed policy development</li> </ul>
Programme implementers (FHI, Pathfinder International, AMKENI, and IntraHealth)	<ul style="list-style-type: none"> <li>- Took part in policy development process and contributed to policy debates and resultant content</li> </ul>
Religious groups (Christian Health Association of Kenya, Catholic Secretariat)	<ul style="list-style-type: none"> <li>- Took part in policy development process and influenced how policy tackled sensitive SRH issues</li> <li>- Held behind-the-scenes lobbying of health minister to oppose the inclusion of post-abortion care in the draft policy</li> </ul>

In the 2010 constitution-making process, a completely different set of medical and rights actors who were marginalised in the bureaucratic RH policy process combined efforts to push for the relaxation of restrictions on abortion and recognition of RH as human rights in Kenya. Their efforts were buttressed by the presence of women's rights champions on the committee that drafted the constitution. More importantly, Kenya's political urgency for a new constitution forced top political leaders to marginalise religious leaders and support the proposed constitution, facilitating the expansion of abortion rights in Kenya. Furthermore, the political costs of abandoning religious leaders to the president and the prime minister were minimal given that the president (a Catholic) did not intent to stand

for re-election, whereas for the prime minister (a non-Catholic), who intended to vie for the presidency, the political gains of ensuring Kenya's much fought-for constitutional reforms far outweighed the gains that he could have accrued from supporting the church's position. Moreover, divisions in the religious network that saw Muslims pull out to support the proposed constitution weakened the influence of religious groups in the constitutional process, paving way for the limited SRH rights reforms realised.

### **6.5.2 Positivistic scientific knowledge selectively used to shape policy**

Like in the adolescent RH policy process, positivistic scientific knowledge was the base that supported the case for the national RH policy. The focus on addressing SRH challenges highlighted by this knowledge was aimed at presenting the policy process as a neutral, evidence-based process free of politics and interests. However, as noted above, the use of positivistic knowledge was selective as the process ignored recently published research on the extent of abortion in Kenya. This was dictated by the moralised medical narrative adopted by dominant actors in the policy subsystem, which marginalised sensitive SRH issues such as abortion in order to avoid controversy and opposition. The focus on positivistic knowledge, which was in line with the knowledge priority of dominant actors (biomedical professionals), marginalised other types of knowledge including qualitative scientific knowledge and lay knowledge (e.g. women's perspectives). The result was that the policy failed to meaningfully tackle contextual issues that largely produce the SRH conditions it focused on addressing with medical solutions such as gender inequality, vulnerability, and societal stigma associated with teenage sexual activity, and abortion, among others.

Furthermore, as seen in the adolescent RH policy and the sexual offences legislative processes, there was a struggle between knowledge and ideology. For example, despite there being knowledge on the extent of abortion and the resultant huge burden of ill-health and death, the policy failed to propose ways of dealing with abortion (except post-abortion care) for ideological and political reasons embodied in the dominant moral, cultural, and moralised medical narratives. The struggle manifests the prioritisation of the interests of religious leaders, politicians and individual bureaucrats in RH-related policies at the expense of the interests of girls and women who bear the consequences of unsafe abortion in Kenya as well as other marginalised groups (adolescents and sexual minorities). Furthermore, the struggle points to the limitation of knowledge in bringing about policy change especially on highly contested issues as also noted in Chapter 4.

### 6.5.3 Influential contextual and institutional dynamics

As seen in the sexual offences legislative process, the national RH policy process also depicted the clash between international narratives versus national narratives of SRH in Kenya. While the policy development process was a response to the ICPD narrative of rights as regards SRH, the process marginalised SRH rights actors and women's voices in order to focus on contextually non-sensitive technical solutions to SRH challenges. Thus, the dominant narrative of women's rights from the ICPD and Beijing conferences was replaced by the moralised medical narrative in the national RH policy process so as to avoid controversy and opposition by projecting the policy process as neutral and evidence-driven. While the policy content acknowledges RH rights, it qualifies these to refer only to those issues that are not prohibited under Kenyan law.

The influence of the local socio-cultural and political contexts was further evident in the important role played by the narratives of morality and culture – often internalised and supported by many Kenyans – in shaping the policy deliberations and content. The policy was developed by Kenyans whose views on sensitive SRH issues are shaped by the local socio-cultural norms and values that are largely a product of Christianity, Victorian era English law, and patriarchy as noted in Chapter 3. For instance, respondents noted that the views of key actors especially those from government on issues of abortion and homosexuality largely reflected the Kenyan society's general opposition and stigmatisation of these issues. A respondent who was involved in the policy process noted that it was common to hear 'people saying this is how we do it or we can't do that here'<sup>90</sup>.

In addition, the longstanding political and religious opposition to sensitive SRH issues (adolescent contraception, abortion, and homosexuality) meant that actors involved in the policy process were unwilling to even discuss these issues or have the policy address them as they feared this would attract controversy and opposition. The two lead consultants on the policy argued that their appreciation of the Kenyan context meant that the policy network avoided highly controversial SRH issues. Moreover, top bureaucrats at the DRH and Ministry of Health, whose role it was to ensure the policy was approved and signed by government, could not allow the inclusion of issues they perceived as not supported by top political leadership in order to safeguard their careers. Thus, the politically embedded narratives of morality and culture underpinned decisions by the policy network to omit sensitive SRH issues in the policy.

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<sup>90</sup> Official, international research organisation, April 5, 2011, Nairobi.

## 6.6 Conclusion

This chapter deconstructed the policymaking process that produced the 2007 national RH policy in Kenya in order to discern the drivers and inhibitors of change that shaped the resultant policy. As the preceding discussions have shown, the national RH policy process aptly captures how different SRH narratives influence the interplay of actors, knowledge and context that produce and shape SRH policy reforms in Kenya. Newly deployed medical professionals in the DRH selectively organised actors from donor and international-type agencies supportive of the 'politically-approved' moralised medical narrative into an epistemic community. The interactions within the epistemic community were both influential and facilitative as they did not only produce the need for a policy, but also provided the necessary technical and financial resources for the policy development process. Besides socio-cultural and political opposition to sensitive SRH issues, the role of USAID in the epistemic community as the main funder of the policy process as well as the funder of most of the organisations in the epistemic community, could have foreclosed any meaningful debates on sensitive SRH issues given the US government's policies, such as the 'global gag rule' and 'abstinence-only' funding policy for adolescent SRH programmes. Moreover, the deliberate locking out of the local and international SRH rights organisations from the epistemic community denied them any influence on the policy and weakened the rights narrative within the network. Even so, the focus of rights actors at the time was mainly abortion, and so even within rights groups, gay rights and adolescents' access to contraception had been marginalised.

The publishing of new positivistic knowledge on SRH indicators (mainly from the KDHS) stimulated the epistemic community's push for an RH policy. Given the community's dominant moralised medical narrative underpinned by its own as well as political interests, it marginalised knowledge on sensitive SRH issues in the policy development process, pointing to the limitations of scientific knowledge in bringing about policy change. The focus on biomedical knowledge as well as the side-lining of rights actors in the policy process aimed to give the policy process the image of 'a neutral, objective and 'politics-free' process' by masking the politics of religious and patriarchal control of SRH that were undoubtedly at play. Nevertheless, scientific knowledge played a critical role in ensuring that post-abortion care is provided for by the policy despite opposition. Respondents argued that facility level data showing the extent of patients seeking emergency care for complications of unsafe abortion helped make the case for inclusion of post-abortion care. Medical actors' framing of complications arising from unsafe abortion as 'medical

emergency' was instrumental in justifying the need for the policy to provide for post-abortion care.

The struggle between international level narratives of rights and comprehensive medical versus locally dominant narratives of morality and culture in the policy process pointed to the different power dynamics at the international level and at the national level in Kenya. This resulted in sensitive SRH issues (abortion, adolescent contraception, homosexuality) being marginalised and omitted in the policy, given the influential position of religious, political and bureaucratic actors at the national level versus the non-influential position of rights actors. Indeed, the influence of the moral narrative was so strong that the policy took the absolutist stance of the Catholic church on abortion, when it failed to provide for safe abortion in cases where abortion is legal under Kenyan law. Some respondents who participated in the policy development process argued that they focused on self-censoring in order to avoid controversy and opposition. Thus, compromises were made to exclude abortion (and only talk about post-abortion care), sexual minorities, and the language of rights, particularly 'sexual rights', from the policy in order to avoid backlash from religious and political leaders. The evident marginalisation of the needs and interests of groups that lack power at the 'decision-making table' (i.e. adolescents, women, and sexual minorities) remains a paradox to the policy's slogan 'Enhancing reproductive health status for all Kenyans'.

Overall, different narratives representing different actor interests competed to either create or block space for SRH policy reforms in Kenya. The narrative of SRH as rights that emerged from the ICPD, and which focused on gender equality and non-discrimination, opened the initial space for policy reforms on SRH in Kenya. However, the powerful moral and cultural narratives at the national level, and which mainly masked the interests of religious groups and men in controlling women's and adolescents' sexuality and reproduction, interacted to block reforms on sensitive SRH issues. Although the medical narrative was adopted by local actors to marginalise SRH-related politics and interests by presenting a 'neutral evidence-based' front, it had to take a moralised slant by marginalising sensitive SRH issues in order to receive political backing, confirming that health policymaking is, by all accounts, a political process. In the next chapter, a synthesis of the three policy processes discussed in Chapters 4-6 is provided with the overarching aim of interrogating the political nature and the power dynamics of SRH decision-making in Kenya.

## Chapter 7

### Unpacking Complex Dynamics of Discursive Power in SRH Decision-making in Kenya

#### 7.1 Introduction

The policy and legislative processes discussed in Chapters 4-6 demonstrate the complexity of decision-making, particularly on highly contested issues such as SRH and rights. This chapter seeks to synthesise findings from the three chapters in order to provide a more nuanced account of the different dynamics of discursive power and how they interact to facilitate or block SRH reforms in Kenya. This is important given the premise of this thesis that discursive power mediates the influence of three other forms of power (i.e. actor interests and networks, knowledge, and context and institutions) in SRH decision-making in Kenya. Furthermore, the chapter aims to situate the evidence from Kenya within the international policy processes and SRH literature in order to understand how Kenya's experiences speak to regional and international experiences and what they mean for future SRH reform efforts both in Kenya and internationally.

At international level, shifts in discursive power or narrative shifts relating to SRH have mainly been a result of changes in actors and funding focus (Ortega 2011). As noted in Chapter 1, it has been argued that the narrative shift at the ICPD and Beijing conferences to raise the profile of SRH and reframe this as a human right occurred as a result of women's rights activists getting access to UN forums and getting involved in the drafting of UN agreements (Ortega 2011; Roseman and Reichenbach 2009). Ortega (2011) has argued that five years later, the narrative shift that saw the marginalisation of the ICPD and Beijing agreements at the 2000 UN Millennium Summit that produced the MDGs, occurred as a result of a change in global leadership from the UN to the World Bank and IMF, and increased influence of religious and conservative networks in North America (US and Canada) in global SRH-related deliberations following intensified organising. It was argued that the global leadership role of the World Bank and IMF, which side-lined the UN, shifted the development ideology from looking at development and governance as a whole to looking at development as piecemeal and technocratic (Ortega 2011). This coupled with the increased influence of religious and conservative networks, side-lined the women's rights movement in the global SRH deliberations at the Millennium Summit with the result that the MDGs marginalised SRH rights. For the same reasons, the ICPD and Beijing 'plus-five' meetings that took place in 1999 and 2000, respectively, registered strong



opposition to the idea of SRH rights and consequently achieved little in extending it (Ortega 2011). Prior to these two narrative shifts at international level, the emergence of HIV/AIDS in the 1980s has been argued to have forced sexuality into the open (once considered a private issue in many developing contexts), and consequently unsettled dominant oppositional narratives surrounding it (Kamau 2009; Makinwa-Adebusoye and Tiemoko 2007; Pigg and Adams 2005). This narrative shift occasioned by the emergence of HIV/AIDS is likely to have set the stage for the 1990s reframing of SRH as a human right.

This chapter provides an in-depth synthesis of important factors behind the narrative shifts or lack of shifts in discursive power that facilitated or blocked the SRH reforms discussed in the case study chapters. I argue that the shifts or lack of shifts in discursive power that facilitate or hinder SRH reforms in Kenya are the product of a complex interplay of actor interests, agency and networks, knowledge use or non-use, and the contexts and institutions within which actors operate. An in-depth understanding of these factors is not only critical to charting pathways for more comprehensive future SRH reforms in Kenya, but also for situating Kenya's experiences within the comparative African and international SRH reform experiences.

## **7.2 Actor Interests, Agency and Networks**

As discussed in Chapter 2, actor interests, agency, and networks play an important role in policy change processes. In this section, I identify and discuss the aspects of actor interests, agency and networks that were most influential in shifting or sustaining hegemonic narratives to facilitate or block change in the case study policy processes.

### **7.2.1 Religious leaders' stranglehold on politicians and bureaucrats**

The apparent strong influence of religious institutions on the presidency and top political leadership in Kenya has meant that limited reforms have been realised on SRH issues that are moralised by religious groups. Indeed, Fischer (2003) has argued that such entrenched relations of power skew policy decisions, in this case, in favour of the interests of religious groups and politicians rather than those of citizens. This situation has to be understood within the Kenyan context. As noted in Chapter 3, religion holds an important place in the socio-economic and political life of Kenyans. Therefore, on one hand, this reality has meant that politicians and bureaucrats are reluctant to push policy decisions opposed by religious leaders mainly for political/bureaucratic career survival. Indeed, religious leaders do constantly threaten politicians that they would mobilise the public to vote against

politicians who support SRH issues framed as 'sinful' and 'unAfrican', as earlier noted. On the other hand, the reality has meant that a lot of politicians and bureaucrats are Christians or Muslims and therefore keen to uphold, or at least be seen by the public as upholding, religious positions on controversial issues. President Moi (1978-2002) proclaimed Christianity and was often seen in church. His successor Kibaki (2002-2013) is a Catholic and frequently attends church services at the country's main Catholic Church (Holy Family Basilica in Nairobi). Similarly, many other political leaders, including cabinet ministers<sup>91</sup> and bureaucrats, proclaim Christianity or Islam; in fact, some church leaders have successfully vied for political positions<sup>92</sup>. Moreover, in Kenya, like in other developing countries (see Richardson and Birn 2011), the Catholic Church has worked strategically to position its adherents in important government positions in order to block reforms on SRH rights. This has meant that religion and the state in Kenya are closely entwined and, to use Lonsdale's (2004: 5) words, 'each to some extent [is] complicit in the providential authority of the other'. This explains the strong influence of the moral narrative promoted by religious institutions on SRH-related policies and laws as is evident in the case study findings.

The situation is no different in many other SSA countries. For instance, various studies in SSA countries that have examined factors that influence sexual behaviour have found that religion has often been an important influential reason for accepting or opposing certain practices. In Zanzibar, Keele et al (2005) found that Islamic belief was a major factor in low condom usage, and in Nigeria, Smith (2004) found that most adolescent and young adult rural-urban migrants who proclaimed Christianity did not accept condom use mainly because of their religious beliefs. Various studies in Ghana have indicated that religion is pervasive in the country (Baffour et al 2010; Gyimah et al 2006; Sackey 2006; Yirenkyi 2000; Addai 1999). Adamtey (2012) has argued that in Ghana, political leaders and government officials are more accepted by the public if they appeal to religious sentiments. The religious factor therefore remains an important determinant of SRH-related policies and laws in Kenya and SSA. What is important, however, is the fact that not all religions and religious leaders in Kenya are completely opposed to sensitive SRH rights issues; this could offer a pathway for challenging the strong religious opposition to SRH-related policy/legal decisions in Kenya as discussed in Chapter 8.

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<sup>91</sup> As exemplified in the case of the *Opus Dei* Planning Minister Prof. George Saitoti.

<sup>92</sup> Rev. Mutava Musyimi (former head of the NCCK) and Bishop Margaret Wanjiru (leader of Jesus Is Alive Ministries in Nairobi, Kenya) are currently MPs in the 2007-2012 parliament.

### **7.2.2 Politicians' and bureaucrats' marginalisation of sensitive SRH issues**

Driven by the religious factor discussed above and cultural interests, politicians and bureaucrats in the case studies were either out-rightly opposed to sensitive SRH issues or uninterested in spearheading reforms on these issues. In the adolescent RH policy process, Moi and Saitoti (president and planning minister, respectively) adopted the position of religious leaders, effectively blocking reforms. In the sexual offences legislative process, male MPs, driven by patriarchal interests, blocked reforms on sexual violence practices that threatened men's control over women's sexuality. At the heart of this opposition was an interaction of two factors, namely, politics and personal values (of morality and patriarchy). As discussed in the preceding subsection, most Kenyan politicians believe that for political survival they have to portray a public image that is conservative and supportive of socio-cultural discourses on SRH, particularly sensitive SRH issues. And, at personal level, politicians hold beliefs and values supportive of morality and patriarchy shaped by the socio-cultural context they live in.

Similarly for bureaucrats, their apparent reluctance to lead reforms on contested SRH issues is a product of politics and personal values. Bureaucrats are political appointees and so their career survival in government is dependent on their support for the discourses of the top political leadership. At personal level, they also hold values and beliefs that have been shaped by the obtaining socio-cultural context in Kenya; often these values mediate morality and patriarchy. The interaction of these factors explains why the DRH in the adolescent RH policy process and the AG in the sexual offences legislative process were reluctant to lead reforms on these issues. This finding challenges Grindle and Thomas's (1991:182) argument that 'public officials are almost always actively engaged in efforts to influence' change. Instead, the finding shows that on highly contested issues such as SRH, government officials in Kenya have either shied away from these issues or readily adopted non-supportive narratives promoted by the political establishment. This is the case in several other SSA countries in regard to SRH reforms. In Ghana, for instance, a Minister for Women opposed a proposal to criminalise rape in marriage mainly because the country's president was opposed to the proposal (Fallon 2008). In Uganda, the Speaker of Parliament vowed to ensure a bill against gay rights is passed into law by the country's parliament because that 'is what Ugandans want' (BBC News 2012a).

Besides neglecting sensitive SRH issues, bureaucrats also marginalised SRH rights groups in policy networks as seen in the case studies, including the government's own autonomous

agency for promoting human rights (KNCHR) established in 2003. This strategy of marginalising actors who focus on contentious SRH issues in policy processes is commonly employed in other developing country contexts. In India, for instance, it was observed that although the government had been more willing to involve civil society in RH-related activities after ICPD, it had remained wary and some bureaucrats openly opposed involving civil society in RH-related policy discussions (Health Watch 1998 in Petchesky 2003:201). However, the situation in India has improved following the implementation of the National Rural Health Missions initiative<sup>93</sup>, which has increased civil society's contribution to policy and legislative reforms (Unnithan and Heitmeyer 2012).

In countries where such neglect and marginalisation is still happening such as Kenya, politicians and bureaucrats, most of whom are usually men and/or women supportive of top political leadership's patriarchal ideals<sup>94</sup>, have continued to use national policies and laws to control the sexuality and reproduction of adolescents, women, and sexual minorities. For politicians and bureaucrats, the interplay of political costs with moral and patriarchal values that produces opposition to sensitive SRH issues is further reinforced by the fact that often the restrictive policies they pass do not necessarily affect them at personal or family level since they or their family members can easily access the opposed SRH services in private health facilities. As Richardson and Birn (2011: 189) have argued regarding abortion restrictions in Latin America:

Those who suffer the most from restrictive laws and policies tend to be the poor, who are not an important lobbying group that politicians are concerned about pleasing. The political and economic elite have other options, such as private clinics offering clandestine abortions, which diminishes their need to support progressive policy changes... Thus, a "double discourse" persists, whereby official policy is conservative and unquestioned publicly, and privileged individuals, who have choices, can ignore the problems.

However, as noted in Chapter 3 and as evidenced in Chapter 6, there are some politicians and bureaucrats who are supportive of certain sensitive aspects of SRH, but their voices are often drowned in strong opposition from fellow politicians and religious leaders. Prof. Anyang Nyong'o, Minister for Medical Services (until April

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<sup>93</sup> National Rural Health Mission is a 7-year (2005-2012) health programme in India run by the Health Ministry that aims to improve health care delivery across rural India.

<sup>94</sup> Since the women are usually government appointees, they are appointed because they share the position of top political leadership on sensitive SRH issues, and even if they hold opposing views, they are unlikely to contradict top political leadership so as not to jeopardise their careers in government. For instance, in Ghana, a female Minister for Women was strongly opposed to criminalising marital rape, which she termed a 'Western' idea that would destroy Ghanaian families (Fallon 2008). Fallon (2008) found that the Minister's position was in line with that of Ghana's president at the time. In Kenya, a female head of DRH for several years was noted by a respondent as someone who 'hated abortion' [Nairobi, August 8, 2011].

2013) and Dr. Francis Kimani, Director of Medical Services, support the need to legalise abortion in Kenya in order to save the lives of women lost through unsafe abortion practices. Although these two officials hold important positions of power and speak publicly about the need to provide safe abortion care, their arguments remain marginal to the dominant moralised medical narrative within Kenya's health bureaucracy. Notably, the DRH (responsible for SRH policies) falls under a different ministry, the Ministry of Public Health and Sanitation, whose Minister (Beth Mugo) is strongly opposed to abortion. Similarly, the *Catholic* President (Mwai Kibaki) is also opposed to abortion. Thus, although not all politicians and bureaucrats in Kenya are opposed to SRH rights, the very few who are supportive of sensitive SRH issues remain powerless in bringing about reforms, given the open opposition by the president, most politicians and bureaucrats, religious leaders, and a large section of the Kenyan public.

### **7.2.3 Donors and UN agencies: potential drivers of reforms or contextually complicit?**

In the adolescent RH policy process, donor pressure partly contributed to forcing president Moi to declare HIV/AIDS a national emergency and commit the government to responding to the disease in order to receive funding for fighting the disease. Prior to this, donor funding had enabled the generation of scientific knowledge on adolescent SRH challenges by CSA and others, which helped make the case for the adolescent RH policy reforms. In the national RH policy process, while funding from USAID made the policy development process possible, it also determined what the policy could address and what it could not; in this case, it meant that the policy could not address abortion and adolescent contraception, issues that the US government opposed. UN agencies (UNFPA and WHO) played important roles in the adolescent RH policy and national RH policy processes. For instance, WHO's directive on post-abortion care was argued as having been important in marginalising opposition from religious leaders on the inclusion of post-abortion care in both policies<sup>95</sup> (WHO 2003). CSA's connection with the UNFPA did not only give it access to NCPD and DRH, but also legitimated its adolescent RH policy reform efforts given the Kenyan government's membership and commitment to the UN. All these demonstrate the significant role of donors and UN agencies in facilitating or blocking SRH

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<sup>95</sup> Interviews: technical expert, National RH policy, March 22, 2011, Nairobi; official, WHO-Kenya, September 12, 2011, Nairobi.

policy reforms given their resource endowment and Kenya's dependence on aid, especially for the health sector in general and SRH subsector in particular.

However, the findings also revealed the powerlessness of donors and UN agencies when it comes to reforms on highly contested issues. Contrary to Amin et al's (2007) finding on malaria policy change in Kenya that international actors (mainly the WHO) dominated and determined the policy outcome, findings from the case studies show that donors and UN agencies tended to avoid pushing for reforms on highly contested issues in order to avoid controversy, respect Kenya's sovereignty, and maintain cordial diplomatic relations<sup>96</sup>. Also, UN principles provide for countries to adopt international agreements based on own contexts. Thus, no country is forced to adopt UN-related agreements that are contrary to its cultural and religious values. This finding showed that donors and UN agencies do not have a 'blanket' influence on health policymaking in resource-poor settings; rather their influence varies depending on the issue and the context.

#### **7.2.4 Issue champions in positions of power**

The case studies demonstrated the importance of issue champions occupying institutional positions of power in bringing about reforms. The adolescent RH policy and the sexual offences legislative processes highlight the role of individual actors in manoeuvring barriers to enable reforms. Dr. Rogo (a gynaecologist) in the adolescent RH policy process straddled between non-government (CSA) and government agencies (KNH and NCPD) to gain a position of authority that partly enabled the decision to develop a policy response to adolescent SRH challenges, a highly politicised issue. MP Njoki Ndung'u (a women's rights lawyer and activist), in the sexual offences process, took up leadership on a culturally contentious issue (i.e. sexual violence) to see to its debate and criminalisation in parliament. In the new constitution-making process, the presence of two charismatic women's rights lawyers on the committee that developed the constitution was instrumental in the committee's sympathy to women's rights that resulted in the SRH rights realised in the constitution. This finding supports findings by other policy scholars who have shown that powerful individuals can play a critical role in championing a policy issue (Shiffman 2007; Kingdon 2003; Doig and Hargrove 1987). Shiffman (2007) found that powerful individual champions (whom he calls 'political entrepreneurs') were among the main factors that

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<sup>96</sup> Interview, donor representative, September 12, 2011, Nairobi, who noted that his agency's work in Kenya had not focused on abortion since abortion is a highly contested issue in the country. Interviews with officials from the UNFPA and WHO also revealed that while they would have liked to see reforms on abortion in RH policies in Kenya, the issue remained sensitive in the country.

generated political priority for maternal mortality reduction in five developing countries (i.e. Guatemala, Honduras, India, Indonesia and Nigeria)<sup>97</sup>. He argued that these individuals were 'politically influential and particularly capable individuals willing to exert effort to advance a cause' (Shiffman 2007: 799). He further noted that in countries where the safe motherhood policy communities were led by political entrepreneurs, their efforts were more effective in increasing political priority for reduction of maternal deaths than in countries where there were no clear champions for the issue (Shiffman 2007).

### **7.2.5 Networks or professional silos?**

As the case studies revealed, the individual champions (discussed above) did not work alone, rather they worked through influential networks, attesting to Foucault's (1980) relational nature of power. The networks often brought together actors within and outside government (e.g. the CSA-UNFPA-NCPD in adolescent policy process and the RH-ICC in national RH policy process). This showed the blurring of boundaries between public and private institutions in SRH policymaking in Kenya, pointing to the existence of room for influence. However, the networks that emerged in the different policy processes often brought together professionals with specific knowledge of certain aspects of SRH and locked out other actors lacking such professional knowledge. As my analyses in Chapters 4-6 have shown, the networks were mainly professional silos that were easily dominated by a particular SRH narrative and marginalised actors promoting alternative narratives including even those narratives that were not necessarily oppositional. For instance, the RH-ICC was dominated by medical professionals and locked out SRH rights and women's rights groups. Similarly, JJN was dominated by legal professionals and locked out medical-oriented groups or professionals. In fact, the bureaucratic processes were dominated by medical professionals whereas the legislative processes were dominated by legal professionals. Even then, the locking out of women's rights and SRH rights groups by the bureaucratic networks needs to be understood in the context of the politicisation of sensitive SRH issues such as abortion, which the networks sought to avoid as noted in 7.2.2 above. Indeed, medical-oriented actors often distance themselves deliberately from women rights' actors in order to avoid controversy. Storeng (2010) argued that the international re-launch of the 1987 safe motherhood initiative in 1997, which was dominated by medical

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<sup>97</sup> Other factors included: international agency efforts to establish a global norm about the unacceptability of maternal death; those agencies' provision of financial and technical resources; the degree of cohesion among national safe motherhood policy communities; the deployment of credible evidence to show policymakers a problem existed; the generation of clear policy alternatives to demonstrate the problem was surmountable; and the organisation of attention-generating events to create national visibility for the issue.

professionals, sought to distance itself from the women's rights movement in efforts to avoid controversy and attract funding. On the other hand, the findings showed that SRH rights and women's rights actors in Kenya did not seek to influence the bureaucratic policy processes mainly because they believed they would not make much impact given the government's strong opposition to these issues.

Nevertheless, my analyses in the case-study chapters which point to weaknesses of professional silo-type policy communities and the missing meaningful links between SRH rights researchers and advocacy groups suggest that policy communities that comprise actors from across the board are likely to produce more effective policies or be more influential in bringing about policy reforms than those that do not. The example of the RHRA, which comprises legal professionals, medical professionals and women's rights activists, and the influence it was able to achieve by combining the medical and rights narratives in the new constitution-making process attests to this. Other studies have found that strategic but 'non-conventional' connections between different policy actors have been instrumental in bringing about SRH policy reforms on relatively sensitive SRH issues in various SSA countries (see Sumner et al 2011; Tulloch et al 2011). For instance, Tulloch et al (2011) found that a research and advocacy collaboration between SRH researchers and a high profile women's rights lawyer in Ghana was instrumental in ensuring that Ghana's 2007 domestic violence law provided for the provision of free medical services to survivors of domestic violence in the country. In South Africa, Tulloch et al (2011) showed how SRH researchers engaged with traditional leaders and healers (among other actors) through the government's AIDS council to facilitate the adoption of a male circumcision policy that was responsive to the interests of traditional healers and cultural beliefs.

On the whole, the policy processes revealed different typologies of actor networks that facilitated or hindered policy change. In the bureaucratic processes, these networks were mainly Haas' (1992) epistemic communities given the technocratic bias of policymaking in the health ministry. Thus, the CSA-UNFPA-NCPD and KAPAH in the adolescent RH policy process and the RH-ICC in the national RH policy process were driven by biomedical knowledge on SRH indicators in making the case for a policy and informing policy content. In the legislative process, the networks were akin to Sabatier and Jenkins-Smith's (1998) advocacy coalitions. In the sexual offences legislative process, the JJN was driven by its belief in human rights and therefore the need to protect children and women from sexual violation.



### 7.2.6 Civil society critical in bringing rights reforms at national level

Findings in the case study chapters demonstrated the critical role of civil society (i.e. all non-government organisations involved in the policy/legislative reforms) in bringing about reforms on SRH issues, particularly those issues deemed as sensitive. In the adolescent RH policy process, the CSA (a non-governmental research and programme organisation) spearheaded the evidence-generation and advocacy efforts that put adolescent RH on the political agenda. It further led the adolescent RH policy drafting process. Similarly, civil society organisations and networks (i.e. FIDA-Kenya, CRADDLE and JJN) were instrumental in the sexual offences law process i.e. agitation for law reforms, actual law drafting, and campaigning for the passage of the law. The RHRA's advocacy role in the new constitution-making process was critical for the reduction of abortion restrictions and recognition of RH as human rights. It is unlikely that these reforms would have been realised without the agency of civil society organisations.

The role of civil society in advocating for reforms on contested issues or implementing programmes has been variously acknowledged (Koehlmoos et al 2009; Court et al 2006). Indeed, the international-level advocacy efforts that put SRH rights on the international agenda in the 1990s were spearheaded by civil society women's rights groups (Roseman and Reichenbach 2009; Joachim 2003). As already noted, women's rights organisations and transnational coalitions worked both within and outside government and UN machineries to make the SRH rights achievements of the ICPD and Beijing conferences possible. Petchesky (2003:1-2) noted that 'Women's health NGOs and transnational coalitions have been the central authors, advocates, custodians and implementers of a politics of reproductive health and rights, and to a somewhat lesser degree, of sexual health and rights'.

In L&MICs that have made major strides in reforming SRH rights policies and laws, women's rights groups have been recognised as having played critical roles in bringing about the reforms. For instance, the vibrant women's movement in Latin American countries has been widely credited for the SRH rights reforms realised in these countries (Richardson and Birn 2011; Velasco 2008; Molyneux 2001)<sup>98</sup>. Similarly in India, Dasgupta

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<sup>98</sup> In Ecuador, the women's movement played a key role and managed to include SRH rights in the 1998 Constitution after a hard-fought campaign, a significant milestone in Latin America (Velasco 2008). According to Safa (1990: 367), the women's movement was responsible for: Brazil's 1988 constitution's guarantees of women equality including right to property ownership, equal rights in marriage, maternity leave, and the prohibition of salary differences based on sex, age, or civil status; and Argentina's legalisation of divorce which also gave women joint custody of children and equality in other family matters in the late 1980s.

(2006) has noted the important role that the women's rights movement continues to play in drawing government's attention to addressing SRH challenges. In SSA countries, Fallon (2008) has documented the important role that the women's movement continues to play in reforms on women-related issues. In Ghana, for instance, the women's rights movement has been noted to have played an important role in the country's domestic violence legislative process that culminated in the 2007 domestic violence law.

This and the evidence from this thesis suggest that civil society, especially the women's rights movement, remain critical in SRH reform processes that touch on sensitive SRH issues in Kenya. From the case studies, the women's rights movement was blocked from participating in the bureaucratic policy processes yet its involvement in these processes could help broaden the understanding of the SRH rights approach to balance the dominant medical narrative and consequently enhance the focus on SRH rights in bureaucratic policies. It is important to note, however, that the women's movement in Kenya has been argued as weak, elitist and divided on sensitive SRH issues (House-Midamba 1990; Nzomo 1989). The movement has further been argued as uncoordinated and fragmented (Oduol and Kabira 1995). Some more recent media commentators have argued that the women's movement in Kenya is dead (Warah 2011; Oriang 2010). MYWO, once a vibrant women's organisation was, in 1987, co-opted into the then ruling party KANU, a move that compromised its ability to criticise government on SRH rights issues or to push for necessary legal and policy reforms (Nzomo 1989). Following the co-optation, MYWO shifted its focus to income generating activities and promoting the role of women as 'home-makers' (ibid).

The Kenyan government's co-optation of the MYWO was not unique as this was a strategy adopted by several other SSA governments to prevent the women's movement from fighting for women's issues that were at odds with ruling parties (Fallon 2008). Following the requirement of the 1975 UN Decade for Women that poor governments establish 'national machineries' for women's development, several African governments either established or co-opted existing nationwide women's organisations<sup>99</sup> through which community-level women's organisations only gained access to government resources if they supported the large state-run women's organisations (ibid). Further, the large state-run

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<sup>99</sup> Including Umoja wa Wanawake wa Tanzania, the Women's League of Sierra Leone, the National Union of Malian Women, the 31st December Women's Movement in Ghana, and the Better Life Programme in Nigeria (Fallon 2008).

women's organisations prevented smaller organisations from using existing gendered structures against the state (ibid).

Another national women's organisation, the National Council of Women of Kenya (NCWK), established in 1964 was most vibrant during the 1970s and 1980s despite funding challenges (Nzomo 1989). The NCWK's focus on agitating for policy and legal reforms on women's rights issues led to its suppression by government and consequently did not receive state funding for its operations (Oduol and Kabira 1995; Nzomo 1989). Even then, this organisation recorded most laudable achievements including: a programme that educated grassroots women on democracy and their political rights as Kenyan citizens during the early 1990s' re-introduction of multi-party politics; its Greenbelt Movement for fighting desertification in Kenya that successfully blocked president Moi from erecting a skyscraper in Nairobi's only recreational park (Uhuru Park) and whose leader (the late prof. Wangare Maathai) was later awarded a Nobel Peace Prize in 2004 for environmental conservation; and its leader's solidarity with mothers of political prisoners in their year-long protest that saw the release of their sons in 1993 (Oduol and Kabira 1995; Tibbetts 1994). The NCWK disintegrated in the 1990s following lack of funding and poor leadership, while MYWO has remained weakened since its 1987 co-optation by the then government. Today, FIDA-Kenya, established in 1985, together with a few other elite organisations<sup>100</sup>, has remained most vocal on women's rights issues in Kenya.

Kenya's weak women's movement is an irony to the fact that the country was the host of the 1985 Third World Women's Conference<sup>101</sup> that was a culmination of the 1975 UN Decade for Women. This weak women's movement is largely a product of the socio-cultural context in which women and their interests are subordinated in public discourses. For instance, influential religious and cultural discourses in Kenya frame 'good' women as those who are good 'home-makers' and self-less mothers, and often hold women responsible for ensuring functional families. The internalisation of these discourses by many Kenyan women has largely undermined the formation of a strong women's movement for SRH rights in the country. For instance, studies conducted in different Kenyan communities have found that many women have internalised their rightlessness (Crichton et al 2008), whereas others have found that women supported practices that violate their rights such as wife-beating, which they argued was a show of love by husbands

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<sup>100</sup> WILDAF-Kenya among other G10 organisations.

<sup>101</sup> World Conference to Review and Appraise the achievements of the United Nation Decade for Women: Equality, Development and Peace, Nairobi, 15-26, July 1985.

(Friedman and Todd 1994). Friedman and Todd (1994) found that sections of Kenyan women argued for women's submissiveness and show of love to their husbands as a way of dealing with husbands who abuse and neglect them. Challenging these longstanding and normalised frames of 'good' women to reframe women as individual human beings deserving bodily autonomy, dignity, self-determination and human rights is a task that the women's movement in Kenya continues to shy away from given the anticipated cultural and religious backlash. Yet, this is critical to generate grassroots support for SRH rights and therefore strengthen the women's movement for SRH rights in Kenya. In Chile, for instance, interventions that created awareness among grassroots women on their SRH-related rights (mainly the right to bodily autonomy and dignity) have demonstrated that an awareness of rights can inform and enable people to challenge [strongly-held] traditional ideas about gender and reproduction' (Willmott 2002: 134). Willmott (2002) found that some urban poor women in Chile who had initially been strongly opposed to abortion, given their Catholic beliefs, shifted their perceptions in support of women being allowed to make decisions on their bodies including the decision to have or not to have an abortion after participating in training programmes and discussion forums on citizenship rights and SRH rights.

### **7.2.7 Missing grassroots?**

As noted in Chapter 1, the Kenyan public (grassroots) is typically not directly involved in health decision-making processes (except in general elections and referendums), since these are framed as technical and therefore requiring professional expertise. This explains why the voices of the Kenyan public were silent in the three policy processes discussed in Chapters 4-6. The framing of health-related issues as technical and therefore requiring technical expertise in policy development is indeed a common practice in other developing countries. In India, for instance, Dasgupta (2006) has argued that the Indian government perceives maternal health as a technical issue and does not therefore involve women in maternal health policymaking processes. The difference between India and Kenya is that in India, the women's movement has taken action in bringing women's voices to government platforms where maternal health decisions are made (see Dasgupta 2006). Also, the Indian government's Rural Health Missions initiative has increased civil society's participation in government's SRH policy processes and implementation (Unnithan and Heitmeyer 2012). In Latin America, poor women have been historically involved in social movements that challenge the state in meeting their basic needs and against repression (Safa 1990). These

women have worked with middle-class feminist movements in agitating for access to health care and against sexual violence (ibid).

This suggests that the lack of a strong grassroots women's organising and mobilising for women's rights in Kenya has contributed to the current absence of women's voices in SRH-related decision-making processes in the country. This is especially the case since the few women who get access to political positions in Kenya are often elite women, whom, as argued by House-Midamba (1990: 48), 'do not represent the true cause of female liberation and change which would incorporate the basic human needs of lower class women.' Even with the vibrant MYWO and the NCWK in the 1970s and 1980s, Nzomo (1989) argued that grassroots women were still not represented in these national level women's organisations. Nzomo (1989) noted that these organisations marginalised 60% of Kenyan women since their membership required financial resources, which the majority of Kenyan women at the grassroots level lacked. As such, these remained elite dominated movements while the majority of Kenyan women remained 'unorganised, marginalised and powerless' (Nzomo 1989: 12), yet these are the women who were most vulnerable to exploitation and oppression. Similarly, there is no strong grassroots organising for other SRH rights issues in Kenya such as gay rights, sex workers rights or adolescent SRH rights. Although there have been a few grassroots-like networks on some of these issues emerging in Kenya in the recent past<sup>102</sup>, these were established after 2000 and did not therefore have any involvement or bearing on the SRH policies and laws discussed in this thesis. The emergence of these networks after 2000 can be attributed to increased political freedom following Moi's departure in 2002 and the growing awareness of SRH rights among Kenyans.

### **7.2.8 Mass media and sensitive SRH issues**

The media has been argued as an important ally in bringing about social change (Joachim 2003; Keck and Sikkink 1998; Tarrow 1994). Although not an actor that sits at the table where SRH policies are made in Kenya, the mass media, by nature of their role, illuminate SRH issues and shape public opinion on these issues. Indeed, the role of mass media in shaping public opinion and setting public agenda has long been acknowledged (McCombs and Shaw 1972). The media can therefore play an important role in sustaining oppositional SRH narratives or shifting these to make change possible. In the case studies, the mass media's influence on decision-making is evident in the adolescent RH policy and the sexual

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<sup>102</sup> Men for Gender Equality Now (MENGEN) established in 2001; Maendeleo ya Wanaume (MYW – men's development) established around 2007; Gay and Lesbian Coalition of Kenya (GALCK) established in 2006; and Kenya Sex Workers Alliance founded in 2010.

offences legislative processes. To put the adolescent SRH issue on the national agenda, CSA researchers wrote regular newspaper columns discussing adolescent SRH challenges. In the sexual offences law, the mass media were instrumental in putting sexual violence onto the national agenda through reporting and framing the debate by prioritising stories on sexual violence against children and elderly women. Elsewhere, actors have taken advantage of the media's agenda-setting role in generating support for SRH issues. For instance, women's organisations pushing for women's rights at the 1990s ICPD and Beijing conferences orchestrated media coverage to their advantage by, among others, staging actions that attracted media coverage (e.g. staging an 18-hour tribunal) and organising their own media consortium in which they selected their own experts to give media interviews and provided media kits. Oronje et al (2011), in their paper reviewing their experiences in engaging media to communicate SRH research in SSA, concluded that media could play a potentially valuable role in raising the profile of SRH rights, a neglected and often contentious issue in the region.

However, the mass media can also have strong negative influence on public and policy debates on contentious SRH issues, reflecting existing hegemonic oppositional discourses. For instance, Panos (2010) found that 44% of media coverage of SRH issues in Kenya was negative. Muita and Khamasi (2007) concluded that Kenya's mainstream media's coverage of abortion lacked objectivity, often adopting the religious stand on abortion by portraying it as unacceptable<sup>103</sup>. Although this is a reflection of the contextual opposition to abortion in Kenya, it is also often an orchestration of the church. For instance, in the high profile abortion case of Dr. John Nyamu noted in Chapter 6, respondents argued that the Catholic Church orchestrated negative media coverage condemning the discovery of foetuses.<sup>104</sup> It was noted that while some national media treaded carefully on the issue, avoiding to take a stand, some out-rightly condemned abortion (BBC News 2004). This incident and the condemnatory attention it received from top government and political officials, and which was streamed to the public through national media, was argued by some respondents<sup>105</sup> as having shaped the way the national RH policy, whose development was initiated the same

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<sup>103</sup> Based on my knowledge of Kenya and familiarity with Kenyan media coverage of SRH issues given that my master's degree research project conducted 2006/2007 was on how the media covers reproductive health in Kenya. As part of the study, I conducted an extensive review of media content for RH issues of two mainstream newspapers in Kenya (*The Daily Nation* and *The Standard*) (see Oronje 2007).

<sup>104</sup> Interview, official, a network of national level reproductive health and rights organisations, September 19, 2011, Nairobi.

<sup>105</sup> Interview, official, a network of national level reproductive health and rights organisations, September 19, 2011, Nairobi.

year (2004), tackled the issue of abortion<sup>106</sup>. This incident points not just to the complexity of media influence on SRH reforms, but also to the need for innovative strategies in engaging media on sensitive SRH issues that range from identifying and linking with supportive journalists, training and sensitising journalists on neglected SRH issues and how they impact people's lives, to providing media with personal stories on real life experiences with these issues (Oronje et al 2011).

### **7.3 The Politics of Knowledge in SRH Decision-making**

The case studies showed that research knowledge, although critical for health policymaking, had to compete with other factors in influencing SRH policy reforms in Kenya, confirming arguments by other scholars that research alone does not automatically lead to reforms (see Buse et al 2006; Fischer 2003; Lin 2003; Walt 1994). Even then, the case studies demonstrated that research evidence, particularly on sensitive SRH issues, was critical as it often provided the only firm arguments against ideological opposition. This supports Shiffman's (2007) finding that scientific evidence was critical in generating political priority for the reduction of maternal mortality in various developing countries. The importance of scientific evidence is perhaps most pronounced by the role that scientific evidence on HIV/AIDS has played in regard to sexuality. Quantitative evidence that has shown the extent of HIV/AIDS prevalence has forced moral and political opposition to condom use to retreat in much of SSA. Further, evidence from 'HIV/AIDS mode of transmission' studies conducted in many SSA countries<sup>107</sup>, has forced many SSA governments to recognise stigmatised and neglected groups (i.e. MSMs, sex workers) in their HIV/AIDS policies as targets for interventions in stemming the spread of the disease. This section focuses on the politics of knowledge in SRH decision-making in Kenya, specifically discussing why some research was more influential than others, ways in which research was made to matter, and the role of lay knowledge in SRH decision-making.

#### **7.3.1 Some scientific knowledge was more influential than others**

The research that influenced the policy processes was mainly biomedical, and so it largely supported the positivistic medical narrative. Although anthropological research on how different Kenyan communities perceive and experience sexuality and reproduction, and

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<sup>106</sup> As noted in Chapter 6, this policy completely omitted abortion as though abortion was fully illegal in Kenya (taking the position of the Catholic Church) and only mentioned the need for post-abortion care.

<sup>107</sup> These studies were conceptualised and funded by UNAIDS and World Bank, and conducted in five countries: Kenya, Lesotho, Mozambique, Uganda and Swaziland in 2008 [link: <http://www.unaidsrsta.org/thematic-areas/hiv-prevention/known-your-epidemic-modes-transmission>].

how they tackle SRH challenges exists, this was neither sought nor drawn upon to inform the decision-making processes. This reflects the professional bias of the medical and population experts who dominated SRH bureaucratic policy processes as they tended to draw mainly on biomedical research evidence, which they hold as the 'gold-standard' scientific knowledge, while marginalising other types of knowledge. Indeed, as noted in Chapter 2, health systems researchers' preference for biomedical evidence as the most credible scientific knowledge that should inform health policies (Lewin 2012) has been extensively criticised (Popay and Williams 1998; Tucker and Roth 2006; Theobald and Nhlema-Simwaka 2008). As also noted, other scholars have argued that the focus of positivistic biomedical knowledge on health risk has easily lent support to the moral discourse that names and marginalises some sexual practices as sinful and therefore unacceptable (Seidel 1993). These scholars have argued for the need to also draw on qualitative evidence that brings in the context and experiences of people or communities in decision-making and designing interventions for addressing SRH challenges. For instance, Theobald and Nhlema-Simwaka (2008: 762) have argued that qualitative research can enable the understanding of the complexity of human behaviour and the multiplicity of ways in which poverty, age, gender, geography, social capital and the dynamics of patient-health worker relationships affect access to healthcare. Furthermore, Theobald (2012) has argued that bias towards biomedical research and medical responses to SRH issues in health systems has not only overshadowed broader analyses of the role of gender in health inequities, but also meant that health research has failed to identify key attributes of a gender equitable health system. Consequently, there is little evidence that can help ensure that health system reconstruction in post-conflict contexts, for instance, does not perpetuate gender inequities in health (*ibid*).

The dominant moralised medical narrative in the bureaucratic policy networks also meant that quantitative evidence on SRH issues framed as 'not medical' was ignored<sup>108</sup>. Some actors highlighted the lack of adequate and compelling research evidence on sensitive SRH issues as having weakened their reform efforts. This reflects skewed funding for SRH research, with the major SRH donor, USAID, not funding abortion research; other studies have noted US government's moralised funding of sexuality and reproductive rights research, where non-sensitive SRH issues are funded whereas sensitive issues are not (Epstein 2006; di Mauro 1995). Such skewed and 'moralised' funding brings to the fore the

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<sup>108</sup> As seen in Chapter 6, where recently published research on the extent of unsafe abortion in Kenya was completely ignored in the national RH policymaking process.



politics of knowledge production, reflecting Foucault's (1980) conceptualisation of knowledge as discourse, in this case, the funders of knowledge production promote their own discourses by funding certain kinds of research and marginalising others. This skewed research funding eventually shapes policies and programmes that aid-dependent countries adopt. On the other hand, the evident struggle between SRH research evidence and ideological framings of SRH in the policy processes raise the question: does research on sensitive SRH issues really matter in conservative settings? This question becomes even more pertinent when you consider that in these contexts, actors behind reforms tend to focus on less sensitive issues at the expense of the more sensitive ones in order to generate support as seen in all the three case studies.

### **7.3.2 Making SRH knowledge matter**

To answer the question in the preceding subsection on whether research on sensitive SRH issues matters, I go back to the case studies, which also revealed that SRH research on sensitive issues mattered in cases where there was political support for the issue in question. For instance, in the adolescent RH policy process, research evidence on adolescent SRH challenges only mattered when president Moi changed tune on HIV/AIDS. In the national RH policy process, RH research only mattered when newly deployed medical professionals in the health bureaucracy started dialoguing with donor and international-type research and programme organisations. Thus, scientific knowledge mattered when individuals in important political positions supported the issue raised by the research. This supports the argument that research only matters when 'the politics are right' (Buse et al 2006; Fischer 2003). This makes pertinent the argument by Buse et al (2006) that the nature of SRH issues requires going beyond the rational targeting of positivistic knowledge to government officials to address the political nature of decision-making so as to ensure the use of scientific knowledge. This is especially critical because the focus on 'gold standard' biomedical evidence in the health systems sector has meant that actors have marginalised politics, believing that biomedical evidence, on its own, can drive policy change (Knezovich 2012; Buse et al 2006). This was evident in the National RH Policy process in Chapter 6, where a government respondent at the DRH insisted that RH policy in Kenya is driven by scientific evidence and not politics<sup>109</sup>.

Strategies to influence political positions on SRH issues vary as seen in the case studies including donors tying aid to political commitment to addressing these issues, or

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<sup>109</sup> Interview, official, DRH, September 29, 2011, Nairobi.

champions manoeuvring their way into powerful political positions. Still, some SRH research actors, as found by Crichton and Theobald (2011:9), have applied the 'strategic framing' technique to reframe 'research evidence in ways that are more resonant to policy actors' or sought to change the way policy actors conceptualised neglected or contested issues, in efforts to influence political positions on these issues in various SSA countries. As noted in Chapter 2, strategic framing has been applied in gender related programmes literature (see Theobald et al 2005; Pollack and Haffner-Burton 2000). In applying this strategy, Theobald and Nhlema-Simwaka (2008: 767-768) have argued that 'we may believe and work within a gender equity and rights discourse..., but we may choose to situate our research findings within instrumental or technical arguments that prioritise efficiency or sustainability, as these may be more accessible to policy makers than a discussion of gender and rights.' This is important as it demonstrates how SRH research on sensitive issues can be reframed in more acceptable technical arguments to promote the realisation of SRH rights as seen in the lobbying efforts for abortion rights in the new constitution-making process in Chapter 6. This technique masks the narrative of rights in a cloak of technical arguments in order to avoid opposition. Such reframing was also evident in the sexual offences legislative process where rights actors disguised women's rights under children's rights in order to generate support for the proposed law.

Beyond framing and reframing of SRH evidence, this thesis also found that researchers established and maintained strategic alliances with influential policy actors in government through which they influenced policy decisions with their research. These were evident in the adolescent RH policy process and were critical in establishing support for the adolescent RH issues in the Kenyan bureaucracy. This finding is in line with Crichton and Theobald's (2011) finding that SRH research actors in SSA established and sustained strategic alliances and coalitions with influential political actors in their efforts to influence political positions on SRH with research evidence. The need for research actors to establish and sustain strategic alliances with influential actors should go beyond targeting bureaucrats and politicians to also establish influential links with SRH rights advocates and women's rights movements. The case studies revealed the lack of meaningful links between SRH researchers and SRH rights advocates and women's rights movement in Kenya, yet such links are necessary to strengthen the advocacy efforts of rights actors that often target the underlying politics of control, which underpin political opposition to sensitive SRH issues in Kenya. In turn, research actors would draw learning from the activists' efforts and

experiences that would be critical in informing the kind of research needed to unsettle the dominant SRH politics of control.

All these, however, point to the central role of researchers in actively seeking to shift political positions with research evidence, a role that many researchers find questionable, particularly as it relates to their appropriateness in taking political positions on SRH issues (cf Crichton and Theobald 2011). Questioning researchers' role in advocating for influence, a researcher in Crichton and Theobald (2011: 4) argued that: 'A good academic is trained to [...] state the [...] cautions, the doubts, whereas those are fatal qualities for an advocate who has to simplify, dramatize, exaggerate.' Given the importance of researchers' role in shifting political positions on SRH as seen in the case studies in this thesis and in other studies (Davis and Howden-Chapman 1996; Gilson and McIntyre 2008), I argue with Crichton and Theobald (2011: 10) that:

'...research actors can play a variety of roles in a continuum from research for knowledge and research for advocacy, and all these roles can be valuable as long as research actors base their communications strategies explicitly on analysis of the uses and limitations of their research evidence, the context they are in, their linkages with those they wish to influence and the skill sets of themselves and their partners.'

Supporting this view that health researchers need to play a more active role in influencing political positions in order to bring about change, Gilson et al (2011:4) stated that:

'Social science perspectives ... challenge the HPSR [health policy systems research] community to think more deeply about how to support policy and system change through their research, including how to address the thorny issue of the boundary between researcher and advocate. For example, what sorts of participatory and action research with citizens, health managers, and health workers can support the reflective enquiry that generates positive change in current practices? And should and can we initiate processes that stimulate public debate about research findings—such as active media engagement, debates on public platforms, or engagement with civil society organisations?'

Researchers' ability to influence political positions on sensitive SRH issues with their research is dependent on their skills in diverse communication and policy engagement techniques or their willingness to strengthen their capacity in this area as well as the availability of resources to implement innovative policy influencing programmes (Crichton and Theobald 2011).

This leads me to the final point, which is, researchers being able to take advantage of policy windows as soon as they open since these windows do not stay open for long (Kingdon 2003). The generation of research evidence is conventionally a lengthy process, and this is

especially the case in the health sector where the gold standard research in the form of RCTs and systematic reviews takes a long time to generate. However, policy windows do not stay open for long. In such cases, health researchers may need to consider alternative means of generating evidence faster while the policy window is still open since it may not remain open long enough for an RCT or systematic review to be conducted. Indeed, in response to this challenge, some institutions have been producing 'rapid response' evidence in efforts to take advantage of policy windows before they close. Examples include: WHO's EVIPNet/SURE Project's rapid response units that seek to provide demand-driven scientific evidence to policymakers in various SSA countries in the shortest time possible; the UK Parliamentary Office on Science and Technology (POST) that produces briefings based on demand by legislators; and the new DFID-funded Health and Education Advice and Resource Team (HEART) that provide rapid responses to queries from policymakers. While such 'rapid responses' often draw on a range of existing evidence (including RCTs and systematic reviews), they offer complementary and/or alternative ways of knowledge generation to the preferred conventional ways in health systems in cases where quick policy decisions need to be made.

### **7.3.3 What role for 'non-scientific' knowledge?**

The sexual offences case study showed the important role of non-scientific knowledge in reforms. In the case study, media and police reports of rape incidents and records of hospital admissions of rape survivors, were drawn upon by rights activists to lobby for law reforms. Although the focus solely on non-scientific knowledge resulted in some weaknesses as discussed in Chapter 5, the case study highlighted the significant, but often marginalised role of non-scientific knowledge in health policy reforms. Indeed, much of the research on the influence of knowledge in health policymaking has mainly focused on scientific knowledge, while ignoring the role of lay knowledge. The case study's non-use of scientific knowledge is one of the major differences between the legislative process and the two bureaucratic SRH policy processes. Indeed, the two bureaucratic SRH policy processes did not only draw on scientific knowledge, but only drew on the positivistic biomedical knowledge, perceived as the gold standard in health systems. This difference, as already noted, is attributable to the different dominant actors in the bureaucratic and legislative processes. However, what it points to is the need for medical actors, who dominate bureaucratic policy processes, to recognise the importance of not only balancing different types of scientific knowledge (both positivist and relativist) in SRH policymaking, but also considering the role that lay knowledge can play in these processes. The disregard for lay

knowledge by medical professionals in Kenya's health bureaucracy is aptly captured by the quote below in which a medical professional argued that lay people know nothing about health policies since they are not medical experts:

'Health policies are made by medical experts, because they are the ones who understand the health issues they have to deal with. Imagine if I went to the village to ask my mother about how we should make health policy, she wouldn't know anything about it.' [Former official, DRH, May 6, 2011, Nairobi].

Yet, as argued by Popay et al (1998: 620), '[l]ay knowledge... offers a vitally important but neglected perspective on the relationship between social context and the experience of health and illness at the individual and population level', which are critical in informing SRH policy action. Arguing for the importance of lay or experiential knowledge in informing policy and programmatic decisions in health, Theobald and Nhlema-Simwaka (2008: 767) noted that 'testimonies of experiences of patients in accessing diagnosis in Malawi have been used to demonstrate the range and types of barriers faced by poor men and women and provide direction on the type of interventions needed to address the situation.' They went further to demonstrate how community knowledge in Malawi was critical in the development of a new practical intervention for TB and Malaria (Theobald and Nhlema-Simwaka 2008). Another important issue that the use of non-scientific knowledge in the sexual offences legislative process points to is that the so-called 'gold standard' scientific knowledge is not always available when policy windows open, yet such windows do not stay open for long as noted above. This challenges reform actors, particularly health systems researchers and decision-makers, on the need to consider other forms of knowledge that may be readily available in influencing reforms whenever a policy window opens.

#### **7.4 Context and Institutions: The Elephant in the Room?**

As seen in the case studies, the international and national contexts and institutions influenced the reforms that actor networks and knowledge could or could not achieve. The influence of different narratives varied in different contexts depending on the dominant actors within the contexts. However, contexts and institutions were not static since they also shifted, allowing marginalised narratives to dominate, even if temporarily. This section contends that context and institutions embody important discursive power, and in Kenya, this power is often openly oppositional to SRH reforms, yet reform efforts have not strategically targeted at unsettling this power. Within contexts and institutions, discursive power is embodied in the formal and informal norms, rules, and practices that, according

to Foucault (in Hall 2001: 72), 'rule in' certain acceptable ways of talking or writing about something or conducting ourselves, and 'rule out' other alternative ways.

#### **7.4.1 Inconsistency of international agreements versus international funding**

The international context within which Kenya operates played a significant role in putting SRH issues on Kenya's national agenda through the 1994 ICPD, 1995 Beijing conference, and other international conventions on human rights, women's rights, and children's rights. Thus, the international community created the impetus for Kenya to address SRH issues through policy and legislative responses. The Kenyan government's lack of priority for SRH issues has meant that funding for SRH issues is almost entirely provided by the international community. Yet, while the international community has pushed for SRH as human rights, its funding has not matched this paradigm shift mainly because most of the international SRH funding is provided by the US government, whose funding (particularly for sensitive SRH issues) varies depending on the governing administration. Republican administrations do not support sensitive SRH issues and therefore they always block foreign funding for these issues through such policies as the 1985 'global gag rule' and the 2001 PEPFAR initiative. On the other hand, Democrat administrations support sensitive SRH issues and so they often institute policies that provide foreign funding for these issues.

Beyond funding, US Republican administrations always work closely with the Vatican and North American fundamentalist organisations to block SRH related reforms at international platforms (cf Ortega 2011; Girard 2009). This inconsistency in the international SRH discourses is evident in the national RH policy process discussed in Chapter 6. While Kenya decided to develop a national RH policy in 2004 as part of its 1994 ICPD commitment, this was happening at a time when the US was under a Republican administration (2001-2008) and as such, USAID funding for the policy development process was only available if the policy did not tackle abortion. Still, the international organisations that dominated the policy process were largely being funded by USAID and consequently could not push for abortion in the policy so as not to jeopardise their funding. This reality means that while the international community put SRH issues on Kenya's national agenda, its funding commitments partly curtailed comprehensive SRH policy reforms in the country.

#### **7.4.2 Socio-cultural power or just religious and patriarchal interests?**

The socio-cultural context – of strong religious influence, conservativeness, and patriarchy – obtaining in Kenya and within which the policy reform efforts took place shaped reform debates and resultant policies. Indeed, socio-cultural norms and values were the grounds for all the contentious issues in the different decision-making processes. The doctrines of enduring and therefore internalised foreign religions (Christianity and Islam) were framed as ‘African’ and embodying African values and culture, and culture, was in turn, constructed as static and employed in opposing several SRH proposals argued as ‘unAfrican’. Yet, some of the sensitive SRH issues opposed as ‘unAfrican’ are issues that traditional African communities experienced and had systematic ways of dealing with (see Munthali and Zulu 2007; Njau 1992; Rogo 1990). Although it is widely acknowledged that culture is dynamic and is always evolving (Cowan 2001), culture was framed as static and employed instrumentally to oppose policy proposals that challenged the interests and privileges of powerful actors. This is not unique to Kenya as has been evidenced elsewhere (cf Cowan et al 2001; Fallon 2008). For instance, in several African countries, policy or legal proposals that seek to address sensitive SRH issues are often framed as ‘unAfrican’, ‘foreign’ or ‘Western’ by opposition in order to draw public’s support, but also, as argued by Fallon (2008), to block local actors from seeking international support for their reform efforts. A proposal for Ghana’s domestic violence law (enacted in 2007) to outlaw rape in marriage was opposed as foreign and meant to destabilise Ghanaian families (ibid). Similar proposals in Botswana and Malawi have been rejected on similar grounds that marital rape does not exist in African cultures (Mooketsi 2007 and Semu 2002 in Fallon 2008). Yet, there was no evidence from the Kenyan case studies that actors behind reforms critically challenged such questionable cultural frames of SRH or the selective use of culture employed by the opposition. Moreover, even though socio-cultural norms are deeply rooted, there was no evidence of committed advocacy efforts in challenging and reframing these norms in order to gradually generate a more supportive context for SRH reforms in Kenya.

#### **7.4.3 National political context versus international political context: differential power dynamics**

As revealed in the case studies, the local political context at any given time determined which reforms were possible and which ones were not. The disconnect between the international narrative of SRH rights and the moral-cultural narratives dominant in the local political context meant that SRH remained contentious in local decision-making

processes. While at the international platforms (ICPD, Beijing), the women's rights movement was influential, at the local level, as already noted, the weak women's rights movement did not have much influence on SRH-related decision-making. In fact, this movement had no access to the bureaucratic SRH decision-making processes. This revealed the different power dynamics at the international level versus the national level decision-making platforms, which need to be taken into account in international SRH-related policy deliberations and interventions. Another important point is that while at the international level, the 1990s brought in momentous SRH reforms (given the women's movement's access to and influence in UN forums and a supportive US Democrat administration), this did not have much positive impact in Kenya since during the same period, Kenya was under Moi's presidency, which mediated a relatively unsupportive political context for SRH rights. When Moi exited in late 2002, Kenya's political environment improved considerably as far as SRH is concerned, but this was the time when US administration changed to Republican (in 2001), making the international context largely unsupportive of comprehensive SRH reforms. Thus, Kenya's unfruitful SRH reform debates of the 1990s and the partial reforms realised in the 2000s need to be understood within these international and national contextual differentials.

As seen in the case studies, the local political context within which government bureaucracies operated determined their willingness to initiate or support reforms on sensitive SRH issues. Thus, changes in the political context were crucial as often they presented Kingdon's (2003) policy windows for reforms. In the case studies, these changes included president Moi's 1999 declaration of HIV/AIDS as a national emergency, the 2002 change in government and parliament, and the constitutional moment presented by the 2007 disputed elections. What then became critical was that policy windows did not stay open for long, and so actors needed to be always ready to take advantage of policy windows as soon as these opened. However, as noted in the adolescent RH policy process, actors behind reforms failed to take full advantage of these windows pointing to their own unsupportive values.

#### **7.4.4 Bureaucratic, legal and political institutions remain important barriers to reforms**

The case studies highlighted various institutional barriers to SRH-related policy and legislative reforms in Kenya. Bureaucratically, the adolescent RH policy process revealed that the DRH's junior status as a division in the health bureaucracy hindered the agency from leading reform initiatives on politicised SRH issues. DRH officials' junior status could



have meant that their voices were not heard at important ministerial platforms where major health decisions were made. This finding resonates with Nzomo's (1989) finding that the Kenyan government's Women's Bureau, established in the 1970s to spearhead women's development issues, was a fairly powerless agency given its low status as a division in the Ministry of Culture. Elsewhere, Sandler and Rao (2012) found that UNIFEM's junior status within the UN structure undermined its ability to influence UN agenda on women's issues. The acknowledgement of this as a major weakness is partly what led to the formation of UN Women in 2010 as a more senior UN agency with relatively more power and influence than its predecessor, UNIFEM (ibid). Given Kenya's huge burden of ill-health and death associated with SRH as documented in Chapter 1, the junior status of DRH highlights the low priority afforded SRH issues by the government and presents a barrier to reforms.

Kenya's prohibitive laws governing sexuality and reproduction were frequently cited by respondents as having been the reason why the policies and laws failed to tackle certain SRH issues. These pre-independence laws reflected the Victorian era patriarchal and moral structuring and control of society in Europe, and were easily adopted by the Kenyan government upon independence without questioning because they supported the then existing patriarchal societies that had partly been produced by colonialism and Christian missionary work. In fact, laws that did not support the patriarchal system were easily repealed after independence as was the case of the 1959 Affiliation Act, which was repealed in 1967 shortly after independence since it threatened men's power over women. This shows that these prohibitive SRH-related laws are dynamic, but because they represent the interests of powerful actors (often male politicians and religious leaders), they have continued to be used to maintain control over groups whose voices are marginalised in political and bureaucratic structures and institutions.

Finally, the Kenyan parliament, as noted in Chapter 5, presented a critical obstacle to the passage of laws that sought to address gender inequalities owing to its male domination. The sexual offences law was only passed in a form that was acceptable to majority male MPs. In fact, the sexual offences law was the very first gender-oriented law to be passed in a post-independence parliament in Kenya since all past bills that had sought to respond to various gender inequality issues had been rejected. This challenge points to underlying structures that have sustained male domination in post-independence parliaments in Kenya (House-Midamba 1996). House-Midamba (1996) has argued that party politics in Kenya have, since independence, remained a preserve for men. The Kenyan parliament is elected

on a plural majority system which favours men in any patriarchal society (Fallon 2008).

Fallon (2008: 117) has argued that:

‘In a plural majority system, money and resources are needed in order to mount a campaign. This favours men, who tend to have greater access to resources given their higher social status. The general public is more likely to view men than women as good politicians, and hence more likely to vote for a man. Because of this disposition, parties are more likely to support men. Percentages of women within plural majority systems remain low worldwide, and because of the low representation of women, policies concerning women are less likely to be passed.’

These factors therefore sustain male domination in the Kenyan parliament, and effectively limit support for laws and policies affecting women. In SSA countries where parliaments have more women representation, such as Rwanda and South Africa, the systems used are either proportional representation or a combination of proportional representation and plural majority system (Fallon 2008). Kenya’s new 2010 constitution which stipulates that no more than two-thirds of one gender may hold public positions in the country, may offer a solution to this issue, but even this provision remains contentious and problematic in terms of implementation and therefore risks being amended<sup>110</sup>. In a context like Kenya where successive male-dominated parliaments remain hostile to women’s rights issues, one would expect that actors seeking reforms would implement grassroots efforts targeted at influencing voters to elect more women or men supportive of women’s rights issues, but this was not the case in Kenya since this study did not find any visible and sustained advocacy efforts aimed at shaping how the public votes to ensure a parliament that is more supportive of SRH or women’s issues. Nzomo (1989: 14) concluded that despite constituting the majority of voters in Kenya, Kenyan women had been unable to organise themselves ‘into an interest or pressure group capable of promoting progressive women candidates into the corridors of power and decision-making’.

## 7.5 Conclusions

This chapter sought to provide a synthesis, in-depth account of the important factors behind the shifts or lack of shifts in discursive power that facilitated or blocked SRH reforms discussed in the case study chapters. The chapter has demonstrated that complex interactions of actor interests, agency and networks, knowledge use or non-use, and the

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<sup>110</sup> Opposition to the constitutional provision (article 81(b) of the 2010 Constitution) is based on the fact that under Kenya’s plural majority system, not enough women will be elected to form a third of parliament and so it will be too expensive for government to pay for extra nominated women MPs to reach the two-thirds gender rule. In July 2011, Kenya’s male dominated cabinet agreed to remove this provision, but was forced to backtrack by the women’s movement (Daily Nation 2011c). Up to September 25, 2012, no decision had been reached on how to address this issue (Daily Nation 2012b; The Standard 2012).

context and institutions within which actors operate, shift or sustain hegemonic narratives to facilitate or block policy reforms. Religious leaders remain influential in SRH decision-making processes in Kenya and their influence on political and bureaucratic actors has underpinned opposition to SRH policy/legal reforms in the country. This influence is reinforced by the fact that the moral and cultural narratives promoted mainly by religious leaders are pervasive in the Kenyan context and have therefore been internalised by many political and bureaucratic actors. On their part, donors and UN agencies use their resources to influence narrative shifts for reforms, but even this is often limited to non-sensitive SRH issues, given the entrenched opposition to sensitive SRH issues in Kenya. Issue champions in positions of power and civil society remain critical in bringing about narrative shifts for reforms, particularly on sensitive and neglected SRH issues in Kenya. Mass media's channelling of SRH policy issue debates, as well as opinions to the public, shape how SRH policy and legislative issues are deliberated and decisions made in Kenya. Even then, the Kenyan public/grassroots still lacks a direct role in SRH policymaking as these processes remain elite-driven and often marginalise interests of groups that bear the brunt of sexual and reproductive ill-health. The weak women's rights and SRH rights movement in Kenya has failed to mobilise grassroots participation in SRH-related decision-making processes, and to provide a strong support base for the SRH rights narrative.

Networking among SRH policy actors in Kenya is largely confined to professional groupings which are in turn dominated by narratives that support particular professional thinking. This has meant that particular professional knowledge is prioritised in SRH policy subsystems while other types of knowledge are marginalised. Specifically, bureaucratic SRH policy processes are dominated by medical professionals and consequently biomedical knowledge remains most important in informing SRH policies. The influence of the contextually dominant moral and cultural narratives has, however, meant that biomedical knowledge on sensitive SRH issues has been marginalised in bureaucratic policymaking processes in Kenya. This demonstrates that knowledge on its own is often not able to shift oppositional narratives to make reforms possible until the politics are right. This points to the importance of efforts that strive to make knowledge matter in SRH policymaking, such as reframing evidence in ways that resonate with political leaders or cultivating issue champions in important decision-making positions, among others. The findings also pointed to the important role of lay knowledge in helping shift strong oppositional narratives as seen in the case of the sexual offences law. The entrenchment of oppositional narratives in the Kenyan context and institutions presented the biggest barrier to reforms.

Changes in the context or institutions such as the coming in of a new government and parliament greatly contributed to shifting strong oppositional narratives to make reforms possible. On the whole, this chapter demonstrates that discursive power shifts in SRH decision-making processes in Kenya that make change possible are produced by a complex interplay of multiple factors. The next chapter extends the discussions in this chapter to analyse the power embedded in the competing SRH narratives, and what this means for reform efforts.

## Chapter 8

### **Analysing the Power Embedded in Influential SRH Narratives in Decision-making in Kenya**

#### **8.1 Introduction**

This chapter seeks to extend the discussions in Chapter 7 by analysing the power embedded within the competing SRH narratives in view of the thesis findings in order to understand the implications for reform efforts. As already noted, narratives seek to frame issues in a particular way, while shielding underlying interests, in order to influence policy decisions. The framing of issues prioritises certain aspects and actors, while marginalising others. The discussions in Chapter 7 demonstrate the bi-directional influences between the competing narratives and actor interests, agency and networks, knowledge use or non-use, and context and institutions. As the following sections show, the narratives of control (i.e. moral and cultural) have remained hegemonic on contentious SRH issues in Kenya and therefore blocked comprehensive policy and legal reforms. The medical narrative's efforts in challenging the control narratives have resulted in partial policy and legal reforms on SRH issues. The moralisation of the medical narrative in Kenya's health bureaucracy, and its marginalisation of non-medical issues, actors and knowledge, has limited the extent to which it can bring about more effective and comprehensive reforms. The human rights narrative of SRH, on the other hand, has remained both facilitative and inhibitive of reforms in Kenya. Since the narrative has been seen as threatening the interests of influential actors, reform actors have often masked the narrative in medical arguments in order to avoid opposition. While this strategy has, to some extent, made reforms possible, it has diminished the transformative power of the human rights narrative in Kenya's SRH decision-making processes. In this chapter, I argue that an analysis of the power entrenched in the competing narratives is important as it provides a critical understanding of the narratives, which is necessary for informing more effective reform efforts.

#### **8.2 The Moral and Cultural Narratives**

The moral and cultural narratives focus on controlling sexuality and reproduction. As discussed in Chapter 3, what is referred to as African culture today is largely a product of Christian beliefs and Victorian era English laws (largely shaped by Christianity) ingrained in African cultures through Christian missionary work and colonisation. This converges the two narratives given that the moral narrative in Kenya is largely based on Christianity. Thus, the two narratives overlapped to reinforce opposition to SRH reforms as seen in the

preceding chapters. The pervasiveness of the narratives within Kenya's political and bureaucratic institutions as well as within the Kenyan society in general has meant that the narratives have remained hegemonic on sensitive SRH issues. Religious leaders, politicians and bureaucrats often combined these two narratives to push their interests by opposing reforms. The two narratives underpinned the marginalisation of SRH rights language, exclusion of SRH rights groups in bureaucratic policymaking processes, the marginalisation of knowledge on sensitive SRH issues in the bureaucratic policymaking processes, and influenced the moralised medical narrative's exclusion of sensitive SRH issues. In both the adolescent RH and national RH policies, religious leaders and government officials used the two narratives to block the policies from committing to providing adolescents with contraception advice and services where necessary, and providing safe abortion care in cases where this is legal in Kenya. The two narratives were also combined in the unsuccessful efforts to block the passage of the 2010 constitution, which reduced restrictions on access to abortion care in Kenya.

Shifting these narratives was most difficult, but it did happen in some circumstances to facilitate partial reforms as seen in the case study chapters. For instance, president Moi's change of tune on HIV/AIDS in 1999, shifted SRH narratives in favour of reforms and facilitated the development of an adolescent RH policy. While the coming into power of a new government and parliament in 2002 was not the result of the actions of SRH reform actors, it presented a shift in SRH narratives that enabled the approval of the adolescent RH policy and the debate and passage of the sexual offences law. In addition, the successful debate and passage of the sexual offences law was a product of SRH narrative shifts within the Kenyan parliament that saw the realisation of the first ever reforms on a gender-related issue in a post-independence parliament in Kenya. The most important factors that stood out in shifting the moral and cultural narratives included: a change in the political context that brought in new political actors supportive of contested issues, the presence of knowledgeable and charismatic issue champions within political and bureaucratic institutions, the availability of, and extensive public deliberations on, compelling knowledge (scientific or lay) on an issue, sustained advocacy by civil society/non-governmental organisations, donor pressure, and reduced political costs (for politicians and bureaucrats) for supporting reforms.

The narrative shifts only permitted partial reforms on SRH, suggesting that the moral and cultural narratives remain a major barrier to SRH reforms in Kenya. Yet, the power

entrenched in these narratives is not entirely incontestable. For the moral narrative, some scholars have pointed to weak or lacking supportive evidence in religious texts on some of the moral framings of SRH that often block reforms (Abdi and Askew 2007; Imam 2009). For instance, Abdi and Askew (2007) found no evidence in the Qur'an or Hadith supporting FGM, yet the Somali community in Kenya in which nearly 100% of girls have undergone FGM, often perceives FGM as an Islamic religious requirement (Abdi and Askew 2007). Imam (2009), commenting on *Sharia* law in Nigeria, has argued that Islam is often used by conservatives to enact laws that hinder the realisation of SRH rights and women's rights. Imam (2009) recommended the need to demystify *Sharia* and educate the public on Islam in efforts to challenge oppressive laws enacted in the name of Islam. A case in point is the fact that Islam allows abortion in cases of rape and incest, as well as to save the woman's life<sup>111</sup>, yet religious opposition to abortion in Kenya, which encompasses Muslim religious leaders, opposes abortion on all grounds. A Muslim cleric I interviewed noted that within the Muslim clergy, there are those who believe that abortion should be allowed within the first 120 days of conception before the soul enters the foetus if the pregnancy endangers the life of the woman:

'In Islam abortion is allowed, but don't just take it that it is allowed. If you go to hospital and the doctor diagnoses something on you and says if you continue carrying this baby either you or the foetus will die, then we have to say whom do we save? So in that instance, it is allowed. So personally when I talk about abortion, I say in Islam abortion is not allowed but when there is a danger we look at whom to save and most of the time we try to save the mother. And this has to be done within the first 120 days of pregnancy before the soul enters the foetus.' [Interview, official, a national Muslims religious network, August 1, 2011, Nairobi].

Still on the issue of abortion, other Christian faiths, as noted in Chapter 3, allow abortion in some circumstances. Furthermore, some religious leaders in Kenya are supportive of women's rights including the right to safe abortion. Rev. Timothy Njoya of the Presbyterian Church of East Africa, for instance, supports women's rights including the right to safe abortion<sup>112</sup>. All these offer possibilities for challenging the current hegemony of the moral narrative on the issue of abortion in Kenya's health sector, for instance.

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<sup>111</sup> See Stephen et al 2010. Also, interview, official, a national Muslims religious network; and Dr. Sheikh Abdhallah Kheir (Muslim scholar, Kenyatta University) noted that abortion is allowed in the case of rape in Islam, at the maternal health conference, September 15-16, 2011, Nairobi.

<sup>112</sup> Rev. Timothy Njoya, who is also a human rights and social justice activist, attended the abortion-related maternal mortality conference in Nairobi in September 15-16, 2011, and speaking on abortion, he declared 'give women permission to do with their bodies what I do with mine'.

For the cultural narrative, its framings of SRH issues remain questionable. Its selective use to marginalise women's rights has been questioned extensively as discussed in Chapter 3. For instance, Nyamu-Musembi (2002) has demonstrated that local norms and practices in Kenya offer both barriers and opportunities for gender equality. Yet, the cultural narrative is mainly employed to block reforms in the country, and no efforts have been made to challenge its selective use in blocking reforms or to identify and take advantage of the opportunities it presents in pushing for reforms. Moreover, the narrative's construction of culture as homogeneous and unchanging has also been questioned (Correa et al 2008; Merry 2005; Nyamu-Musembi 2002; Cowan et al 2001). Merry (2005: 8) has argued that 'culture is not a homogeneous entity whose rule evokes universal compliance'. Rather, that culture is contested even among members of the same community and is a mode of legitimating claims to power and authority (Merry 2005: 9). Recognising this should enable reform actors to not only challenge the selective cultural narrative employed to block reforms, but also to start viewing culture more positively and explore ways they too can employ it to legitimate claims that are protective of SRH.

### **8.3 The Medical Narrative**

As discussed in Chapter 3, the medical narrative is underpinned by biomedical knowledge and practice. The perceived objectivity of biomedical knowledge has meant that the medical narrative is often seen as neutral, and only focused on providing medical solutions to medical problems. This neutrality conceals interests, biases and power struggles to make the narrative considerably influential in bringing about SRH reforms. The narrative's influential status means that it remains an important pathway for reforms in SRH decision-making in Kenya. Even then, acknowledging that the narrative's basis i.e. biomedical knowledge is in fact not neutral is necessary in order to create space for consideration of other types of knowledge in complementing biomedical knowledge, as well as the inclusion of non-medical actors in SRH policymaking processes. This could expand political space for the development of more effective SRH policies in Kenya. An important aspect of the medical narrative within Kenya's health bureaucracy is the fact that it has been greatly moralised to exclude contentious SRH issues as 'not medical'. This has censored government SRH policies from tackling contested SRH issues.

#### **8.3.1 Medical narrative as a pathway for reforms?**

From the findings of this thesis, the medical narrative presents an important pathway for the realisation of comprehensive policy and legislative reforms on SRH issues in Kenya.



This is because the narrative plays an important role in the complex interplay that produces narrative shifts to make change possible. In the adolescent RH policy case study, biomedical evidence on the extent of HIV/AIDS in Kenya and the huge burden of ill-health and death occasioned by the disease was critical in compelling the Kenyan government to prioritise the fight against HIV/AIDS, which in turn opened doors for political support for an adolescent RH policy that had hitherto been opposed. Furthermore, in both the adolescent RH policy and the national RH policy processes, the framing of complications from unsafe abortion as 'medical emergency' was critical in marginalising moral opposition to the inclusion of post-abortion care in the policies. Still, the focus on the suffering and ill-health of babies and grandmothers caused by sexual abuse was critical in generating support for the sexual offences law among male MPs and the Kenyan public. Beyond my case studies, the high risk of HIV/AIDS among MSMs and sex workers, which has been revealed by biomedical knowledge (see KNACC 2009a), has forced the Kenyan government to recognise these stigmatised and neglected groups and commit to target them with interventions in its HIV/AIDS policy (see KNACC 2009b). Beyond Kenya, in SSA countries that have made some abortion-related reforms such as Ethiopia (in 2005), Ghana (in 2003) and Zambia (in 1971) (except South Africa), the health of women and the need to reduce women deaths from unsafe abortion have been critical arguments in making the case for reforms (Brookman-Amissah 2011<sup>113</sup>; Ipas 2008; Rogo 1990).

All these point to the political power embodied in the medical narrative. The narrative's power is concealed in the 'neutral' language of biomedical science that masks the interests and ideology of different actors. As shown by the findings of this thesis, the medical narrative's ability to conceal power and interests presents a potential pathway for policy/legal reforms that advance SRH rights in contexts such as Kenya where these issues remain highly politicised. The Kenyan context, for instance, remains hostile to the human rights language of women's bodily autonomy and self-determination (i.e. the feminist approach). Thus, while long-term reform efforts could target changing this context, immediate reform efforts are likely to be more successful if they adopt the comprehensive medical narrative that is underpinned by biomedical evidence as opposed to the SRH rights narrative. As seen in Chapter 6, evidence of the extent of deaths from unsafe abortion, and on the patient-doctor ratio, was instrumental in making the case for the reduction of

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<sup>113</sup> Dr. Eunice Brookman-Amissah (Ghana's former Minister of Health, 1996-1998) noted this while addressing the Maternal Mortality Conference in Nairobi September 15-16, 2011.

abortion restrictions in Kenya's 2010 constitution. The RHRA masked its SRH rights arguments in (biomedical) science to make the case for the changes realised in Kenya's abortion law in the 2010 constitution. Furthermore, SRH rights activists in the RHRA argued that like HIV/AIDS, the Kenyan government needs to declare abortion a national public health emergency given the many deaths caused by unsafe abortion so as to marginalise opposition and raise priority for the issue<sup>114</sup>. This supports arguments by Rosenfield and Chavkin (2008) that reframing SRH issues in terms of public health might lead to real progress in improving women's health. They argue that public health favours 'pragmatic evidence-based approaches over ideology' (Rosenfield and Chavkin 2008:1869), and so when SRH issues are viewed from this perspective, important issues are more likely to emerge. While I acknowledge the power of the medical narrative in bringing about more comprehensive reforms, it is necessary to explore its limitations and their implications for reform efforts as discussed in the next subsection.

### **8.3.2 Questioning the 'gold standard' of biomedical knowledge**

As already noted, biomedical knowledge that guides the medical field is often deemed as the gold standard for informing health policies because of its perceived objectivity and neutrality. Yet, social science research has demonstrated how political and economic interests, prevailing moral concerns, and gender bias are often implicated in biomedicine (see Lock and Nguyen 2010). Narrowing down to reproduction and sexuality, Pigg and Adams (2005) have argued that 'Scientific facts about reproduction and sexuality are constitutive of moral positions; they are not neutral fields' (Pigg and Adams 2005: 26). Indeed, this explains why there is only limited biomedical knowledge on sensitive SRH issues as noted by respondents; research funders have not invested as much resources in research on sensitive SRH issues because of their own moral interests. This necessitates acknowledging the inherent limitations of biomedical knowledge as opposed to engaging with it as the only objective knowledge that should inform health policies, while marginalising alternative knowledge. This was evident in the bureaucratic policy processes where policy reforms were mainly driven by, and informed with, biomedical knowledge. This limitation of the medical narrative is more pronounced in Kenya, where the medical narrative in the health bureaucracy has been moralised in order to exclude sensitive SRH issues from policies. Such moralisation of the medical narrative within the health bureaucracy has marginalised not just all types of knowledge (including biomedical

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<sup>114</sup> Interview, official, a network of national level reproductive health and rights organisations, September 19, 2011, Nairobi.

knowledge) on sensitive SRH issues, but also medical actors supportive of sensitive SRH issues as well as SRH rights actors in bureaucratic policymaking processes.

The need therefore for actors behind the medical narrative to acknowledge other types of knowledge in health policymaking remains critical. As Lock and Nguyen (2010: 5-6) have argued:

‘While quantitative survey research can result in findings that assist in the implementation of innovative changes in health policy-making, our position is that evidence in the form of accounts given by local peoples should also be drawn on in creating policies because the promise of and the actual effects of biomedical technologies are embedded in the social relations and moral landscapes in which they are applied. Ethnography and other forms of knowledge that explicitly engage the views of local actors provide insights into the ways in which the global dissemination of biomedicine and its specific local forms transform not only human bodies, but also people’s hopes and aspirations in ways that may well have broader repercussions for society at large’.

This need is even more pronounced for SRH challenges, which are often underpinned by gender inequality between men and women, yet gender inequality remains marginalised by biomedical knowledge. Given its marginalisation of gender inequality, biomedical knowledge often prescribes unrealistic interventions for dealing with SRH-related challenges (see Seidel 1993). Recognising this challenge, Theobald (2012) has argued for the importance of broader gender inequity analyses in informing health policies.

#### **8.4 The Human Rights Narrative**

As seen in the case studies, the SRH rights narrative has both opened and closed space for policy and legislative reforms. All the SRH reforms discussed in the case studies were either as a result of, or linked to, human rights-driven international agreements or conventions on various SRH issues. Indeed, the rights narrative’s focus on challenging structural issues that underlie many SRH problems, such as inequity and inequality, discrimination, and lack of participation, has significantly opened space for policy and legal reforms on health issues once neglected and marginalised. On the other hand, the rights narrative’s disregard for national (political and socio-cultural) contexts such as Kenya or put simply, its language of freedom and equality that threatens the power and interests of influential policy actors in Kenya (i.e. male politicians and religious leaders), has meant that the narrative has remained contentious and has consequently achieved little in enabling comprehensive SRH policy and legislative reforms in the country. The findings in the case studies indeed demonstrate that the declaration of rights at the international level does not translate into rights

commitments at national level in cases where these rights challenge the power and interests of the powerful.

#### **8.4.1 Intersectionality of the human rights and medical narratives: Advancing rights without talking about rights?**

This thesis has shown that efforts to advance SRH rights in Kenya have largely drawn on medical arguments as opposed to human rights arguments in making the case for reforms. The need for an adolescent RH policy was argued as necessary to reduce the high rate of teenage pregnancy, unsafe abortion, and the need to protect adolescents from HIV infection by providing HIV/AIDS education. The need for a national RH policy was necessary in order to reduce the high rate of maternal mortality and morbidity, increase use of FP, tackle HIV/AIDS and STIs, among others (GoK 2007). Similarly, the need for a sexual offences law was largely argued as necessary to protect children and grandmothers from violence and ill-health resulting from sexual abuse. SRH rights advocates used stories of babies and grandmothers hospitalised following sexual abuse to elicit sympathy and support for the law. When the rights narrative was invoked, it focused not on women's rights, but on children's rights to sexual integrity in order to navigate the contextual hostility to women's bodily autonomy and rights.

Evidently, the language of women's rights to autonomy, equality, and freedom or even their right to health was not employed in making the case for reforms. This was partly because actors behind reforms in the bureaucratic processes were mainly medical actors who typically promote medical arguments as opposed to rights arguments. However, even in the sexual offences legislative process, which was spearheaded by rights actors, actors deliberately drew on medical/health arguments in order to gain support, and argued that a focus on women's rights to autonomy and equality could have increased opposition<sup>115</sup>. Similarly, in the new constitution-making process, advocacy to reduce abortion restrictions used medical/health arguments as opposed to women's rights arguments. As already discussed in the previous chapter, this strategy of reframing rights in the 'neutral' language of biomedicine or technical concepts has been argued by some scholars as necessary in bringing about reforms on contentious issues since the rights language is seen as threatening (Dickinson and Buse 2008; Rosenfield 2008; Theobald and Nhlema-Simwaka 2008).

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<sup>115</sup> It is worth noting that while reform advocacy efforts marginalised the language of rights, the policy documents produced partly adopted this language as used in UN documents only that this was qualified as applying to practices not prohibited in Kenya.

Nonetheless, while the largely masked language of rights has enabled partial reforms on SRH issues in Kenya, it has diminished the transformative power embodied in the language of human rights and therefore failed to reconstruct women, adolescents and sexual minorities as human beings deserving autonomy, freedom and non-discrimination. Indeed, it has been argued that such conflation of the rights and medical narratives marginalises women's autonomy and self-determination as relates to sexuality and reproduction (Miller and Roseman 2011; Nowicka 2011). Furthermore, disguising SRH rights in the language of science has meant that there has not been much focus by actors to educate and sensitise the grassroots in Kenya on the importance of human rights as they relate to health and SRH. Yet, FIDA-Kenya and CRR (2007) have noted the need to educate health care providers and the Kenyan public on the human rights to health, including SRH, since violations of the right to health are rampant in Kenya's healthcare system. This is partly because both medical staff and patients do not understand and appreciate the human right to health, and the fact that the government needs to protect this right. Similarly, there have been no efforts to contextualise the SRH rights narrative by drawing on African cultural concepts of rights, claims and responsibilities. Yet, as discussed in the next subsection, a key weakness of the rights narrative is its disregard for African cultural notions of rights, entitlements and freedoms (see Undie and Izugbara 2011; Izugbara and Undie 2008; Englund 2006), which has meant that the narrative has failed to resonate with African leaders and communities alike. Thus, while religious leaders and politicians have focused on deriding the language of SRH rights as 'foreign' and reducing it to mean abortion, adolescent sexuality and homosexuality as noted earlier, there has been no sustained counter debate to challenge these arguments.

Rather, in Kenya, the language of SRH rights has been largely confined to advocacy reports of rights organisations, which, only recently, are starting to focus on specific SRH rights issues. For instance, in 2007, CRR and FIDA-Kenya published a study that revealed extensive violations of SRH rights of women who deliver at Kenya's largest maternity facility, Pumwani Hospital in Nairobi (see CRR and FIDA-Kenya 2007). FIDA-Kenya and CRR (2007:6) concluded that:

The negligence and abuse documented ... have more than just public health implications; they also constitute serious violations of human rights that are protected under national, regional, and international law. Fundamental human rights that the government of Kenya is obligated to guarantee include the rights to life and health; the rights to equality and non-discrimination; the right to be free from torture and cruel, inhuman, or degrading treatment; the right to dignity; the right to information; the

right to privacy and family; and the right to redress. The violations described in this report demonstrate that Kenya is not honouring its domestic and global commitments to respect, protect, and fulfil these rights.

Following this study, the KNCHR in 2011 conducted an inquiry into FIDA-Kenya and CRR's 'allegations' of SRH rights violations. The report of this inquiry confirmed FIDA-Kenya and CRR's findings that SRH rights violations are not just happening in Kenya's healthcare system, but also in the legal system, as well as societal practices (see KNCHR 2012). In addition, in 2010, CRR published a report on the impact of Kenya's restrictive abortion law, which similarly took a legal and rights focus (see CRR 2010). While the SRH rights language has found its way into advocacy reports like the ones above, elite rights actors noted that whenever they engage in critical policy forums with top policymakers, politicians and religious leaders, they focus on health arguments and not on women's rights arguments in order to reduce opposition. A representative of the RHRA noted that:

'When working with the powers that be, and I am talking about policymakers, politicians, religious leaders, when you are getting into these debates, human rights approach doesn't work in this context. So it has to come from a public health perspective, using public interest stories, bringing in abortion survivors to make abortion to have a face' [Official, a network of national level reproductive health and rights organisations, September 21, 2011, Nairobi].

Mann's (1999) argument that health and human rights are linked makes the avoidance of the human rights narrative in SRH advocacy efforts in Kenya an important issue. Mann (1999) has argued that 'health and human rights are inextricably linked', while Farmer (2001) has argued that 'the most important question facing modern medicine involves human rights'. Indeed, human rights arguments have been instrumental in forcing some governments to reform health-related policies. In South Africa, for instance, given the government's recognition of health as a human right in the 1996 constitution, civil society used the argument of the 'human right to health' to bring about health policy reforms as they relate to accessing HIV/AIDS anti-retroviral treatment in early 2000s. In 2000, an activists movement, the Treatment Action Campaign (TAC), sued the South African government, arguing that the government's policy restrictions on the availability of Nevirapine and its failure to have a reasonable plan to make the drug more widely available violated the right to health of HIV-positive pregnant women and their children guaranteed by the country's 1996 constitution (Annas 2003). TAC won the case and forced the South African government to reform the policy to provide Nevirapine to all HIV positive people in the country, demonstrating the power of the 'human right to health' argument.

The use of the human rights argument in the HIV/AIDS case was possible because civil society advocacy and activism created a strong link between HIV/AIDS and human rights by focusing on how poverty and vulnerability not only expose people to HIV/AIDS, but also condemn them to death since they cannot afford treatment (Gruskins et al 1996). Gruskins et al (1996: 1111-1112) noted that by focusing on vulnerability and poverty 'it became clear that a lack of respect for human rights and dignity was a major contributor to the HIV/AIDS problem.' This link between poverty and vulnerability, and HIV/AIDS was critical in linking HIV/AIDS and human rights in South Africa. In Kenya, however, although the constitution recognises the right to health, and the 2010 constitution now recognises the right to RH, reform actors have not drawn on human rights arguments in making the case for reforms as seen in the case studies. Particularly, the language of women's right to autonomy, equality and freedom has been largely avoided by rights actors in fear of attracting strong opposition given the patriarchal context, as noted above.

It is worth noting that contexts where the rights narrative has been transformative in SRH-related reforms such as in South Africa and Latin America have had historical engagement in political struggles for general citizenship and democratic rights. Such engagement has produced strong human rights movements at grassroots levels. Thus, such understanding and appreciation of the importance of human rights and their transformative power, has largely contributed to the adoption of the human rights language in advocacy for health and SRH. Thus, the wide-ranging SRH rights realised in South Africa's 1996 constitution were as a result of the country's longstanding history of rights movement (Petchesky 2003: 230). Similarly, in Latin American countries, the presence of strong women's rights movements, which emerged as part of broad movements for democratisation and citizenship rights, have been instrumental in SRH rights reforms (Petchesky 2003: 208). Even then, while South Africa adopted the global rights narrative, in Latin America, women's movements distanced themselves from the global rights based individualism by focusing on 'familist' arguments on the role of women as wives and mothers in securing rights in order to resonate with the context (Molyneux 2001). Undoubtedly, such contextualisation of the rights narrative has had some negative effects. Nevertheless, these examples demonstrate that even in conservative contexts, the human rights narrative does possess power to bring about reforms if its frames are widely understood and accepted, and/or contextualised to resonate with the interests of influential actors. In Kenya, however, the general human rights movement has remained weak and confined to elite circles as discussed in Chapter 7. Thus, the SRH rights language has remained

misunderstood by the grassroots and some policymakers, misrepresented by religious leaders and politicians, and consequently marginalised in SRH policy and legislative debates.

#### **8.4.2 Limitations of the language of human rights**

Despite its transformative ability, the language of human rights has several limitations, which often constrain the extent to which it can bring about comprehensive policy and legal reforms and improve people's quality of life. These include: conceptual disconnect between the international concept of rights and local concepts of claims and entitlements; the fact that the declaration of rights at international level does not translate to rights locally; assumption that rights holders are able to influence policy processes to ensure their rights are respected; and the narrative's susceptibility to co-optation. First, a major limitation of the international human rights rhetoric that has been widely acknowledged is its disconnect with local concepts of claims, entitlements and responsibilities (Englund 2006; Englund and Nyamnjoh 2004; Wilson and Mitchell 2003). Relating to Africa, scholars have argued that this disconnect remains one of the reasons why the language of rights has been met with resistance (Undie and Izugbara 2011; Izugbara and Undie 2008; Englund 2006; Englund and Nyamnjoh 2004). Englund (2006:48) has argued that the legal language of rights 'replaces relationships with rules; situational considerations with abstract principles', and thus fails to provide relevant and practical solutions to social challenges that many Africans face every day. Undie and Izugbara (2011) have argued that the international framing of SRH rights as individual entitlements are resisted in Africa because they disregard local understanding of SRH rights as socially located and communal entitlements and privileges. Beyond Africa, the disconnect between the international concept of SRH rights and local concepts of claims and entitlements relating to sexuality and reproduction has also been noted in India (see Unnithan-Kumar 2003) and Latin America (see Molyneux 2001).

This disconnect remains one of the main challenges of applying the international discourse of human rights at the national level mainly because, as Merry (2005: 1) has argued, 'In order for human rights ideas to be effective, ... they need to be translated into local terms and situated within local contexts of power and meaning'. Yet, such translation has negative effects as Merry (2005:5) has observed that 'human rights ideas are more readily adopted if they are packaged in familiar terms, but they are more transformative if they challenge existing assumptions about power and relationships.' This disconnect is



demonstrated by the case study on the sexual offences legislative process in which women's individual rights to bodily autonomy clashes with the cultural claims that bestow such rights to men. Merry's (2005) acknowledgement above is therefore critical as it challenges the need to contextualise SRH rights because in a predominantly patriarchal society like Kenya, the location of SRH-related rights within social relations risks marginalising the individual needs and interests as demonstrated by the sexual offences legislative process. Thus, efforts to contextualise SRH rights must be well thought out to avoid the risk of continuing to silence the voices of marginalised groups. Correa et al (2008: 162) have proposed an understanding of human rights as 'relational, evolving and specific to historical and spatial contexts', and called for the utilisation of the power and knowledge of local people presumed to be victims of human rights violations in the human rights narrative. Earlier, Penna and Campbell (1998:17) had called for 'a new human rights approach which seeks to incorporate the powerful symbols of African women's [historical] struggles.'

Second, as demonstrated by the case studies and also as argued by other scholars (see Correa et al 2008; Englund 2004; Wilson and Mitchell 2003), the human rights language has limitations in bringing about reforms at national level or ensuring people's access to services. Wilson and Mitchell (2003) have acknowledged that there are problems in translating global rights language to the local level. As the case studies showed, the declaration of human rights at the international level has not translated to human rights commitment at the national level in Kenya. Indeed, poor governments' commitment to international human rights conventions and agreements has been described by Wilson and Mitchell (2003: 2) as 'diplomatic, paper exercises with no mechanisms for enforcement'. In India, for instance, Unnithan-Kumar (2003) argued that although feminists were successful in reframing the focus on SRH from that of 'problem of childbirth' to that of reproductive choice as a human right, the Indian government still faced the challenge of reconciling pre-existing material, political, and cultural realities with the new discourse. Furthermore, this thesis' findings have demonstrated that although the international human rights notion fits Western liberal secular states, it remains problematic in a weak state like Kenya, where religious groups remain powerful in influencing political decisions, while civil society remains weak.

Third, the narrative assumes that rights holders not only have a good understanding and appreciation of the human rights concept, but also have influence in policy processes to ensure that policies recognise and commit to the realisation of their rights. At international

level (mainly the UN forums of the 1990s), the human rights narrative was influential because actors behind the narrative (i.e. global women's movement) were influential in these processes. However, at national level in Kenya, the disconnect in the international conceptualisation of SRH as rights and the local concepts of claims and entitlements has meant that the Kenyan public lacks sufficient understanding and appreciation of the conceptualisation of SRH as rights<sup>116</sup>. This has meant that majority of Kenyans are not able to assert and claim the SRH rights that are so contested by different elite policy actors. In fact, it is the same Kenyan public that perpetuates the religious and cultural stigmatisation of certain SRH rights issues (i.e. adolescents' sexuality, abortion and homosexuality). Furthermore, the continued casting of the SRH rights narrative as 'foreign' appeals to the emotions of many people keen to promote the so-called 'African values'. Still, the high levels of poverty and illiteracy/semi-literacy among Kenyan women and girls also mean that they lack the power and voice to agitate for their SRH rights. This situation has been compounded by the weak women's movement in Kenya, which has remained elitist and divided on sensitive SRH rights issues. A respondent observed that: '*...there is lots of tension even within the women's rights movement on discussing issues of abortion, sexual rights, among others.*'<sup>117</sup> In fact, the women's movement in Kenya has not only failed to advocate for women's right to health, it has also failed to promote a human rights narrative that focuses on women's right to bodily autonomy, freedom and integrity. Consequently, the SRH rights narrative lacks a strong grassroots support base in Kenya, a situation that has advantaged the opposition to this narrative. As seen in the case studies, the women's rights movement has lacked access to bureaucratic SRH policy processes, and therefore failed to influence national SRH-related policies.

Finally, the human rights narrative's susceptibility to co-optation by conservative actors has meant that in conservative contexts, the narrative has been co-opted to promote SRH discourses of control and exclusion. For instance, the NCK noted that its main role in promoting SRH in Kenya is 'advocacy for reproductive health rights of Kenyans that comprehensively addresses holistic health that respects the sanctity of life.' This shows the use of the human rights narrative in opposing abortion, yet abortion is one of the neglected SRH issues that reform actors hoped to address by framing SRH as human rights. All these limitations point to the need for rights actors in Kenya to desist from engaging with the human rights narrative uncritically. Rather, their critical interrogation of the narrative

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<sup>116</sup> Interviews: official, an international women's legal and development organisation, July 28, 2011, Nairobi; official, a health rights organisation, August 12, 2011, Nairobi.

<sup>117</sup> Interview, official, an FP and RH rights international organisation, September 29, 2011, Nairobi.

should enable them to adapt and promote it in ways that are more likely to bring about comprehensive reforms.

## 8.5 Conclusions

This chapter has interrogated the power entrenched in the competing narratives of SRH in order to provide a critical understanding of the narratives that is necessary for informing more effective reform efforts. The moral and cultural narratives, which focus on controlling sexuality and reproduction, represent the interests of religious leaders and politicians, who remain influential actors in the Kenyan polity. These narratives reinforce each other to yield more hegemonic status on sensitive SRH issues and often foreclose possible policy spaces for reforms. What is important is that there exist opportunities for contesting and reframing these hegemonic narratives, which have not been explored. The counter narratives – medical and human rights – have unsettled the control narratives only on less sensitive SRH issues. The medical narrative has been especially important and more powerful given its perceived objectivity and the important political imperative of health. Its potential to bring about reforms has been demonstrated by all the case studies discussed in Chapters 4-6. However, the narrative, particularly as it operates in the health bureaucracy in Kenya, has been influenced by the moral narrative and therefore largely marginalises sensitive SRH issues. Moreover, its marginalisation of alternative types of knowledge and actors not specialised in medical issues has meant that its policy interventions are somewhat ineffective.

The rights narrative, on the other hand, has been both facilitative and inhibitive of reforms. On the one hand, the narrative has put SRH issues on the global and national agendas. On the other hand, the narrative has attracted strong opposition to reforms as it has been viewed as threatening the interests of influential actors. Thus, although the narrative has lent legitimacy to the reform efforts of local actors, often actors have opted to disguise rights in medical/public health language so as to avoid opposition. In one way, this captures the intersectionality between the medical and the rights narrative as used in Kenya, and how this has, in many instances, made reforms possible. In another way, this has diminished the transformative ability of the human rights language, since actors have failed to clearly and explicitly bring out the critical link between health and human rights, which could make more wide-ranging reforms possible. Furthermore, actors have not focused on using the human rights narrative to reconstruct marginalised groups (i.e. women, adolescents, sexual minorities) as deserving of rights and recognition of their needs. The

lack of a strong rights movement in Kenya, especially a women's rights and health rights movement, has contributed to the marginalisation of the SRH rights narrative in decision-making. Furthermore, reform actors in Kenya have continued to engage with the narrative uncritically without appreciating its limitations, a situation that has only served to increase opposition to the narrative.

In a word, a critical understanding of the power embedded within the competing narratives is important for informing reform efforts. For the hegemonic narratives of control and exclusion, such an understanding can potentially enable reform actors to meaningfully challenge the framings within these narratives that oppose reforms. For the medical and the human rights narratives, such an understanding can enable reform actors to appreciate the limitations of these narratives even as they employ them in pushing for reforms. In the next and final chapter, I summarise the thesis findings and offer some possibilities for shifting the narratives of control and exclusion to facilitate more comprehensive reforms. The chapter also highlights the thesis's contribution to theory in health policy analysis in L&MICs.

## Chapter 9

### Conclusions and Way Forward

This thesis set out to understand the drivers and inhibitors of change in SRH policy and legislative processes in Kenya. The overarching aim was to explain how and why some SRH policy changes have been realised in Kenya in the face of contention and opposition, while others have been blocked. Drawing mainly on in-depth interviews with key actors involved in three different SRH decision-making processes, and document and media content review, the thesis has provided an analytical account of factors, conditions and processes that have produced certain SRH policy and legislative reforms in Kenya and blocked others. This account is useful because it offers a comprehensive and critical analysis of SRH policymaking and legislating in Kenya from which future reform efforts can draw lessons. It further provides deep insights from national level SRH decision-making processes that can inform international level SRH debates and reforms. The analysis also contributes to filling a gap in theory in the field of health policy analysis in L&MICs. Several studies have noted that theory in health policy analysis in L&MICs is weak since most studies in these countries have not focused on studying power in health policymaking processes (see Gilson et al 2011; Sheikh et al 2011; Dickinson and Buse 2008; Gilson and Raphaely 2008). Thus, this thesis' central focus on studying power in the SRH policy processes in Kenya contributes to filling the acknowledged gap in theory in health policy analysis in L&MICs.

This account is especially important now for various reasons. First, there is currently increasing international focus on women's issues and SRH rights<sup>118,119</sup>. Such international focus presents opportunities for national level actors to push for policy and legal reforms on neglected and/or contested SRH issues that remain important health challenges in Kenya. Related to this is the fact that in Kenya, sensitive SRH issues, once stigmatised and kept out of public realm, are starting to come up for discussion in public. Examples include

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<sup>118</sup> For example, the establishment of the Women Deliver global advocacy organisation for maternal health around 2006/7 (<http://www.womendeliver.org/>); more focus on reproductive health and rights by major donors such as USAID ([http://www.usaid.gov/our\\_work/global\\_health/mch/mh/index.html](http://www.usaid.gov/our_work/global_health/mch/mh/index.html)) and DFID (<http://www.womendeliver.org/>).

<sup>119</sup> In July 2011, a UN General Assembly recognised gay rights as human rights (UN Human Rights Council 2011). In October 2011, the UK Prime Minister David Cameron called on poor countries to respect the human rights of gay people and threatened to revoke UK aid to African countries that do not protect the human rights of gay people (Daily Mail Online 2011). On December 6, 2011, the US Secretary of State Hilary Clinton declared that gay rights are human rights and countries need to reform laws to respect gay rights (US Department of State 2011). On May 9, 2012, US President Barack Obama became the first US president to publicly support gay marriages and declare that gay people should be allowed to marry each other like everyone else (BBC News 2012b).

meetings to discuss LGBTI issues in October 2010 (meeting attended by Minister for Gender) and February 2012 (meeting aborted after members of the public attacked delegates), calls by KNCHR, a government institution, to legalise abortion and homosexuality (October 2011; May 2012), and calls by Nairobi city Mayor and sex workers to legalise sex work (February and March 2012). Second, Kenya's new 2010 constitution now recognises RH as a human right, providing an opportunity to operationalize this right in SRH laws, policies and programmes. Third, oppositional elements towards sexuality and reproduction are strengthening their roots in Kenya, partly in retaliation to the developments outlined above. For instance, some religious leaders have joined politics and become decision-makers. Also, some US religious and fundamentalist organisations are strengthening their presence in Kenya in order to curtail SRH rights reforms. All these developments present both opportunities and threats to future SRH policy and legal reforms, and the in-depth analyses presented in this thesis can inform efforts that seek to take advantage of the opportunities and/or countering the threats. This chapter is organised in three sections; the first section provides a summary of the main findings and discussion, the second section discusses the thesis's contribution to theory, and the final section discusses the way forward.

### **9.1 Summary of Main Findings and Discussion**

Overall, the findings of this thesis suggest that political and institutional interests and pressures combined with socio-cultural and personal values and norms to shape the policy and legislative decisions made to respond to SRH challenges in Kenya. Although the failure by reform efforts to critically challenge the powerful moral/cultural frames of the sensitive SRH issues in fear of opposition and instead focus on less sensitive ones was an important strategy in ensuring partial reforms, it contributed to the failure to realise comprehensive reforms. Furthermore, the moralisation of the medical narrative dominant in the Kenyan health bureaucracy ensured that sensitive SRH issues were not tackled by government policies. Moreover, the absence of grassroots movements for SRH rights reforms and social justice in the policy and legislative processes meant that SRH policy decisions were driven by elite interests. The result was partial reforms that addressed non-sensitive aspects of SRH, but occluded sensitive ones that are often at the root of many SRH challenges in Kenya.

### **9.1.1 The overarching influence of SRH narratives in decision-making in Kenya**

In Chapter 3, the thesis identified four influential narrative framings of SRH underpinned by different actor interests, values, beliefs and ideas, which compete to influence policy reforms in Kenya. These include SRH as a moral issue, SRH as a cultural issue, SRH as a medical issue, and SRH as human rights. The moral and cultural narratives, promoted mainly by religious leaders and politicians, focus on controlling the sexuality and reproduction of individuals (especially girls, women and sexual minorities). The medical narrative is underpinned by biomedical science and is promoted by medical professionals driven by their interests to maintain their conventionally powerful position in health policy decision-making, given their technical medical expertise. Within Kenya's health bureaucracy, however, the medical narrative has been moralised to exclude sensitive SRH issues given the hegemonic moral narrative. Given the medical narrative's biomedical basis, it is presented as objective and neutral from interests, politics and ideology. However, as discussed in Chapters 3 and 8, biomedical science is not neutral since its production is influenced by contextual interests (Lock and Nguyen 2010; Pigg and Adams 2005). The dominance of the narrative in Kenya's health bureaucracy has marginalised other types of knowledge and actors lacking biomedical expertise in decision-making. The rights narrative is mainly promoted by international-type actors (donors and UN agencies) and legal and women's rights organisations, and is driven by the need to eliminate discrimination and control to enable marginalised groups that have no voice in policy debates to live sexual and reproductive lives of their choice. The rights narrative frames of freedom and equality are viewed by actors behind the moral and cultural narratives as threatening. Consequently, the narrative attracts strong opposition in SRH decision-making processes in Kenya.

As is evident, the narratives are not entirely independent of each other and the boundaries between them are somewhat blurred as some narratives overlap to reinforce each other in facilitating or blocking reforms. The moral and cultural narratives are interconnected by their focus on controlling individuals' sexuality and reproduction; the two narratives interact and reinforce each other to produce often overwhelming opposition to policy/legislative proposals for addressing sensitive SRH issues in Kenya. Moreover, the moralised medical narrative is a product of the influence of the moral narrative on the medical narrative. The SRH rights narrative is at conflict with the moral and cultural narratives because it focuses on freedom and choice, while marginalising control. All the sensitive SRH issues that the narrative frames as 'human rights' and therefore deserving attention by government are strongly opposed by the two narratives as 'immoral' and

'unAfrican'. Given the strong opposition to the rights narrative in Kenya, actors often mask the narrative in medical arguments, thus combining the medical and rights narratives. What is important is that through the narratives, different policy actors altered the frames of SRH to promote particular goals and values and justify particular policy/legislative responses to SRH challenges in Kenya as seen in the case study Chapters 4-6.

The findings in the case study chapters suggest that the SRH narratives supported by contextually powerful actors and institutions – the presidency, the bureaucracy (MoH, DRH, and NCPD), parliament, and religious bodies – dominate SRH policy and legislative processes in Kenya, while marginalising alternative narratives. In the bureaucratic policy processes (i.e. adolescent RH policy and national RH policy processes), the epistemic communities within which the policies were formulated underpinned their deliberations with the 'moralised' medical narrative that occluded sensitive SRH issues of adolescent contraception, abortion, homosexuality, issues opposed by top government and political leaders, and religious groups. In the sexual offences legislative process, the rights narrative dominated only on non-sensitive issues of sexual violence such as rape and defilement, but was marginalised by the cultural narrative, which remains dominant in Kenya's male-dominated parliament, on issues of rape within marriage, unwelcome sexual advances, and FGM.

The findings demonstrate how powerful narratives underpinned by actor interests, values, beliefs and ideas work through actor networks, knowledge, and context and institutions, determining which policy changes are possible and which ones are not. The moralised medical narrative that dominated bureaucratic policy networks determined which actors had access to, and could influence these networks and eventually the SRH policies the networks produced. In this case, actors who focus on sensitive SRH issues such as abortion or women's rights were excluded from the networks that produced the bureaucratic policies. Similarly, certain kinds of research evidence that do not support the moralised medical narrative were marginalised in the evidence base that informed the SRH policies produced. Moreover, the moral narrative influenced international funding for knowledge production, ensuring that not much evidence on sensitive SRH issues was produced in order to sustain the hegemonic status of the moral narrative in SRH policy and legislative decisions. The strong entrenchment of the moral and cultural narratives in the Kenyan context (i.e. government and political structures and institutions, and society), and of the moralised medical narrative in the health bureaucracy was a major barrier to reforms on contested SRH issues. But the findings also point to the fact that hegemonic narratives can



be unsettled (even if temporarily) by complex interactions of multiple factors, including: a change in the political context that brings in new political actors supportive of reforms, the presence of knowledgeable and charismatic issue champions within political and bureaucratic institutions, the availability of compelling knowledge (scientific or lay) on an issue, sustained evidence-informed advocacy by civil society/non-governmental organisations, donor pressure, and reduced political costs (for politicians and bureaucrats) for supporting reforms.

### **9.1.2 Actor interests, agency and networks**

Actor agency underpinned by interests and operationalized through influential connections and networks was instrumental in bringing about reforms. The adolescent RH policy and the sexual offences legislative processes highlight the role of individual actors in manoeuvring barriers to enable policy change. Also important was the presence of individual actors with strong support for SRH rights in important positions of power, as seen in the committee that drafted the new constitution. These individual actors worked through influential networks, attesting to the relational nature of power (Foucault 1980) in SRH policymaking in Kenya. In the bureaucratic processes, influential networks were mainly Haas' (1992) epistemic communities whereas in the legislative processes, the networks were akin to Sabatier and Jenkins-Smith's (1998) advocacy coalitions. Networks in both bureaucratic and legislative processes were dominated by actors of specific professions (i.e. professional silos). The networks therefore adopted SRH narratives supported by the profession of the dominant actors and easily marginalised actors promoting alternative narratives. Medical professionals in government and international-type donor, research and programme organisations dominated networks in bureaucratic policy processes, effectively marginalising non-medical actors and social aspects of SRH. Partly aligning to the prevailing political and socio-cultural contexts, which are unsupportive of sensitive SRH rights issues, and partly driven by personal values, professionals dominating bureaucratic policy processes adopted the moralised medical narrative, effectively marginalising sensitive SRH issues in these processes. The legal processes, on the other hand, were dominated by networks of legal and rights professionals, with the exception of the RHRA which included medical, legal and women's rights professionals.

Important 'actor-oriented' factors that made reforms possible included the agency of civil society, the presence of issue champions in important positions of authority, influential

formal or informal networking, and tactical engagement of the mass media. On the other hand, important 'actor-oriented' factors that blocked reforms included religious leaders' stranglehold on politicians and bureaucrats and the consequent reluctance to spearhead reforms by the latter, and the marginalisation of SRH rights and women's rights actors as well as grassroots (especially adolescents, women and sexual minorities) in decision-making processes. Also, donor funding policies as well as donors' and UN agencies' avoidance of pushing for reforms on sensitive SRH issues contributed to the lack of comprehensive SRH reforms in Kenya.

### **9.1.3 Knowledge**

As expected, knowledge had to compete with other factors in influencing SRH policy reforms in Kenya. The role of knowledge in the decision-making processes studied put to the fore the politics of knowledge in SRH decision-making in Kenya, demonstrating that certain types of knowledge were more influential than others in different political spaces. The knowledge that influenced the bureaucratic policy processes was mainly biomedical. Although non-biomedical knowledge exists, this hardly informed the policy processes. This reflects the professional bias of the medical experts who dominated SRH policy processes as they tended to draw mainly on biomedical knowledge, while marginalising non-biomedical knowledge. Although marginalised, relativist scientific knowledge and lay knowledge have been argued as critical in health policymaking as they capture contextual issues, which are critical for policy action. The dominant moralised medical narrative in the bureaucratic policy networks also meant that quantitative evidence on sensitive SRH issues was ignored. Even then, scientific evidence on sensitive SRH issues was decried by some reform actors as inadequate, reflecting the selective funding of SRH knowledge production that silences debate and reforms on sensitive issues. This is compounded by reform actors' tactic of avoiding sensitive issues in their advocacy in order to reduce opposition by keeping these issues out of policy and public debates in Kenya.

Although knowledge drew attention to SRH issues, on its own, it could not bring about reforms unless the 'politics were right'. This meant that actors had to focus on understanding and shaping political positions on SRH issues. For instance, DFID attached HIV/AIDS funding for Kenya to president Moi's political commitment to fighting the disease, while issue champions manoeuvred their way into important political positions where they were able to influence policy decisions. Moreover, strategic alliances and coalitions were formed in efforts to shape political support for issues. This highlighted the

importance of researchers going beyond their primary role of research generation, to shape the politics in efforts to make their scientific knowledge influential. Another issue was the importance of non-biomedical knowledge, which does not necessarily meet the health sector's 'gold-standard' scientific evidence (e.g. RCTs, systematic reviews) in policy reforms. In the sexual offences case study, lay knowledge was influential in the reform process, casting to the fore the need for health system researchers to consider other forms of knowledge (lay/experiential knowledge, anthropological knowledge, and human rights and gender inequity analyses) in decision-making.

#### **9.1.4 Context and institutions**

The international and national contexts and institutions within which actors operate influenced what actor agency and knowledge could or could not achieve. The international context played a significant role in putting SRH issues on Kenya's national agenda through the 1994 ICPD and other international conventions on human rights, women's rights, and children's rights. However, international funding did not match international commitments and since Kenya heavily depends on donor funding for its SRH reforms, the funding conditionalities, especially those set by US government, the biggest funder of SRH in Kenya, partly shaped the SRH policies that Kenya adopted. Furthermore, the disconnect between the international narrative of rights and the contextual reality in Kenya has meant that the rights narrative has remained contentious in local decision-making processes as it is seen as threatening the interests of influential actors. Moreover, the comprehensive medical narrative emanating from international actors such as the WHO and rights actors has been adapted locally to exclude sensitive SRH issues, producing the moralised medical narrative.

At national level, the political context at any given time determined which reforms were possible and which ones were not. However, the political context was shaped by the socio-cultural context – of patriarchy, strong religious influence, and conservativeness – obtaining in Kenya. Indeed, socio-cultural norms and values were the grounds for nearly all the contentious issues in the various decision-making processes. Politicians' and bureaucrats' patriarchal values were reinforced by foreign religious doctrines to justify the marginalisation of SRH issues, often seen as women's issues. Moreover, for career survival, politicians and bureaucrats supported religious leaders' opposition to SRH issues given the latter's strong influence on politics in Kenya. Furthermore, bureaucratic, legal and political institutions remained barriers to SRH rights reforms; in fact, these were employed to formalise/institutionalise the patriarchal and religious control of sexuality and

reproduction. Changes in the political and institutional contexts were crucial, since they often presented policy windows for reforms, including president Moi's declaration of HIV/AIDS as a national emergency in 1999, the 2002 change in government and parliament, and the constitutional moment presented by the 2007 disputed elections. The 1999 presidential declaration of HIV/AIDS as a national emergency that paved the way for SRH-related reforms and the marginalisation of religious leaders by top politicians during the 2010 constitutional process indicate that under pressure and reduced political costs, Kenyan politicians can 'abandon' religious leaders for reforms. Of concern is the fact that, even though context and institutions presented a significant barrier to reforms, there were no notable efforts by reform actors aimed at generating more supportive context and institutions in Kenya.

## **9.2 Contribution to Theory in Health Policy Analysis**

It has been acknowledged in recent years that the health policy analysis field in L&MICs is still in its infancy and most studies conducted have not focused on investigating the role of power in the policy process (Gilson et al 2011; Sheikh et al 2011; Dickinson and Buse 2008; Erasmus and Gilson 2008; Gilson and Raphaely 2008). It has also been argued that health policy analysis research in these countries has been mostly framed around positivistic concepts on health systems, without drawing on useful explanatory concepts from the social science field, even though health systems are complex social and political phenomena (Gilson et al 2011; Sheikh et al 2011). Dickinson and Buse (2008: 5) have argued that HIV/AIDS policymaking studies in developing countries between 1994-2007 have largely failed to tackle interests that underpin actor actions and policy decisions. These studies have recommended the need to invest more in understanding the role of interests and power in health decision-making processes in L&MICs.

This thesis has contributed to filling these gaps by focusing on exploring power in SRH decision-making processes in Kenya. By conceptualising power in SRH decision-making in Kenya as discursive, this thesis has: firstly, demonstrated the critical role of 'discursive power', a social science concept, in health policy processes in L&MICs and therefore the importance of examining this in efforts that seek to explain policy/legislative change in SRH, and, secondly, demonstrated one way in which 'discursive power' could be explored in studying health policy processes in L&MICs. On demonstrating the critical role of discursive power in SRH decision-making, this thesis has shown that in SRH-related issues, discursive power is pervasive: it shapes and is in turn shaped by the interplay of actor

interests and networks, knowledge, and context/institutions, to open or close spaces for change. By analysing discursive power, this thesis has exposed 'the apparent', 'the hidden' and 'the subliminal' workings of power in SRH policy/legislative processes in Kenya. Such an understanding is not only critical in explaining change in SRH decision-making in Kenya, it is also critical for future reform efforts.

More importantly, analysis of discursive power in SRH decision-making in Kenya enriches theory in the field of health policy analysis in L&MICs, since most past studies in this area have failed to focus on examining the nature of power and how it shapes health policy decisions in these countries (Sheikh et al 2011; Erasmus and Gilson 2008; Gilson and Raphaely 2008). Rather, most studies in L&MICs have taken a technocratic and empiricist approach and therefore focused on describing technical health policymaking processes that largely identify policy actors involved, process, role of research, and policy content, without offering any deep and reflective explanatory accounts of why certain issues are silenced while others are prioritised, or why certain decisions are made while others are blocked (Gilson et al 2011; Gilson and Raphaely 2008). By taking the positivist approach, these studies have avoided focusing on the 'politics' and 'power' that typically drive public policy processes. Yet, without understanding 'politics' and 'power', it remains difficult to explain policy change, particularly in a highly contested area such as SRH. As already noted, health policy systems are complex social and political phenomena (Gilson et al 2011) and therefore understanding them needs to go beyond positivistic paradigms to also draw on social science concepts of power that undoubtedly drive and shape health systems. Indeed, had this thesis conducted a technical analysis of SRH decision-making in Kenya as is typical in health systems policy research, it would not have been able to provide a critical account of power that shapes these processes.

In addition to demonstrating the importance of studying discursive power, this thesis has demonstrated one possible approach to studying discursive power in SRH policy processes. This is important because the concept of discursive power has mainly been studied in the field of anthropology, but not in policy analysis. Thus, this study has demonstrated one way in which some anthropological concepts – the use of language and discourse as a tool for control and paying special attention to power embedded within social contexts – can be incorporated into policy analysis studies to explain change. Specifically, the study's focus on analysing dominant narratives within health policy subsystems and how these determine who has access and influence in which policy subsystems, and which issues get discussed and which ones are silenced, is novel in the understanding of policy subsystems in the

health policy analysis field in developing countries. Moreover, the thesis's focus on examining knowledge in the policy processes through the lens of discursive power revealed the selectivity in SRH knowledge generation, use and influence, which would otherwise not have been possible. Lastly, the analysis of contexts and institutions that also revealed the dominant narratives within important institutions and how these shift or fail to shift to facilitate or block change, highlighted an important aspect of context and institutions that is often not a focus of health policy analysis studies in L&MICS.

### **9.3 Way Forward**

The findings of this thesis have demonstrated the critical importance of understanding the major narrative framings of SRH in decision-making processes and the way they shift to facilitate, or fail to shift to block, reforms. In recognition of this, actors behind SRH policy/legislative reform efforts need a critical rethink of the way they challenge the hegemonic moral and cultural narratives of SRH as well as the way they promote the medical and rights narratives. This is because for them to bring about comprehensive reforms, they will need to elevate the comprehensive medical and rights narratives in policymaking spaces by marginalising the socially embedded moral and cultural narratives. However, I acknowledge that changing the status quo will be deeply challenging given the entrenchment of moral, cultural and 'moralised' medical narratives in the current political and institutional set-up. This is because dominant narratives gain and maintain power through mutually reinforcing forms of knowledge production and framing, political interests, societal norms and values, professions, and bureaucratic practices that create and sustain particular ways of thinking while marginalising others. Thus, efforts to dip power in favour of narratives that can facilitate change must recognise and address these complex interactions. Indeed, policy actors keen on reforms in Kenya may need to critically engage with the following question: In a context where strong and internalised socio-cultural norms and values shape public policies on sexuality and reproduction, how do you challenge these without being 'ostracised' and marginalised as promoting a 'foreign' agenda?

Given that the moral and cultural narratives are socially embedded, reform actors cannot continue ignoring and fearing to challenge these narratives. Instead, deliberate, strategic and sustained reform efforts are needed to unsettle the hegemony of the control narratives with strong counter narratives. Deliberate efforts need to publicly challenge whose interests these narratives prioritise and whose interests they marginalise, and the consequences of

such marginalisation to the health of women, adolescents and sexual minorities. For the moral narrative, critical analyses of religious texts and doctrines relating to the sensitive SRH issues may offer opportunities for challenging blanket religious-informed opposition to reforms. Moreover, reform actors' engagement with religious leaders supportive of SRH rights should focus on generating an alternative moral narrative that promotes SRH rights.

For the cultural narrative, efforts need to challenge its instrumental use that safeguards men's interests while marginalising the interests of women. Moreover, the reframing of the narrative needs to draw on cultural frames that are supportive of SRH issues as argued by Izugbara and Undie (2008). Anthropological analyses that identify supportive cultural framings of SRH could provide evidence to inform such reframing. Furthermore, it is acknowledged that African women at the grassroots have long been engaged in struggles against patriarchal oppression and devised their own practical responses to these challenges (African Feminist Forum 2010; Penna and Campbell 1998), and so analysis of such struggles could provide evidence for challenging the negative cultural framing of SRH and women's issues. Related to this is the need to challenge the 'unAfrican' labels given to certain SRH issues, such as adolescent sexuality, abortion, and homosexuality, with evidence that shows that these practices existed in traditional Kenyan communities before colonialism, and that communities had ways of tackling these. Yet as a result of Christianity and colonisation, these practices have been moralised, condemned and stigmatised. Furthermore, efforts should challenge the concept of culture as static by drawing on the dynamism of cultural norms, values and practices (Cowan et al 2001) to reframe the SRH needs of women and other marginalised groups.

Reform actors cannot continue engaging with the rights narrative uncritically; rather, they need to acknowledge its limitations (discussed in Chapter 8) and find ways of addressing these. Correa et al (2008) have noted the insufficient, but indispensable character of the human rights narrative. Specifically, its element of context-neutrality has not only attracted opposition, but also presented challenges in implementation (see Standing et al 2011a). From Kenya's experiences discussed in this thesis, and as acknowledged by Cowan et al (2001:1), 'local concerns continue to shape how rights are implemented, resisted and transformed', necessitating a rethink of the narrative's universalist focus. The argument by Correa et al (2008:162) that 'we need human rights, but we also need models that surpass formalism and utilise the power and local knowledge of the presumed victims of rights abuses' may present a possible way out of the strong cultural opposition to the narrative

and disconnect with local realities in Kenya. Actors need a rethink on whether, and how, to localise the SRH rights narrative in Kenya without undermining the needs and interests of marginalised groups and/or falling into the trap of cultural relativity, as Standing et al (2011b) have warned.

One way of doing this, as proposed by several scholars (Undie and Izugbara 2011; Izugbara and Undie 2008; Penna and Campbell 1998), is for the rights narrative to draw on positive notions of rights and entitlements in African cultures to enable it to connect with SRH realities in Africa. Indeed, Undie and Izugbara (2011:9) have wondered whether disregarding African cultural notions of rights in the SRH rights narrative, as is currently the case, is not tantamount to 'throwing the baby out with the bath water'. While contextualising the human rights narrative could provide frames that resonate with political and religious actors and consequently reduce opposition, it should be well thought out so as not to marginalise the individual needs of women, adolescents and sexual minorities and fall into the cultural relativity trap. As Correa et al (2008: 211) have argued, 'we need a human rights framework reconceived as relationally individual and social at the same time'. Further, efforts need to focus on creating adequate understanding of the rights narrative by politicians, bureaucrats and the grassroots in Kenya in order to tackle the opposition. Such educational and sensitisation efforts should focus on repositioning participation and equity, which are central tenets of the narrative, back into the heart of the narrative.

Another way of countering opposition to the rights narrative is, as discussed in Chapter 8, to disguise it in technical arguments (Dickinson and Buse 2008; Theobald and Nhlema-Simwaka 2008) or medical arguments, as is often the case in Kenya as shown by my findings. This highlights the need to extend the frames of the medical narrative to include sensitive SRH issues to make reforms possible. Altering the frames of the moralised medical narrative dominant in government to include sensitive SRH issues may require compelling biomedical and non-biomedical knowledge, coupled with the presence of individuals who are sympathetic to these issues in positions of authority within the health bureaucracy and the top political leadership.

Efforts that marginalise the moral and cultural narratives will need to have a strategic focus on building political and institutional support for the alternative narratives, i.e. the comprehensive medical and rights. Such efforts could include sustained SRH rights advocacy, and strategic efforts that seek to influence public office appointments and elections to ensure that individuals supportive of SRH rights get into positions of authority



in government and/or in the legislature. These efforts would need to go hand-in-hand with long-term efforts that engage grassroots communities in deliberative dialogues that challenge the conventional framing of SRH, which marginalises the needs and rights of women, adolescents and sexual minorities, with alternative framings. Actors need to bear in mind that such efforts will not be 'quick fixes' and will certainly attract opposition.

Regarding actors, if more comprehensive SRH reforms are to be possible, reform actors need to strengthen and extend actor networks in SRH decision-making processes in Kenya. Reform actors within the health bureaucracy need to extend the 'professional silo-type' policy networks to be more inclusive of actors currently marginalised (i.e. SRH rights and women's rights actors, anthropologists, and grassroots groups (youth groups, women groups, LGBTIs, sex workers)). Similarly, marginalised groups should claim spaces in these networks as it might be easier for them to influence RH policies from within the networks than from outside. Meaningful engagement of these groups in policymaking processes could enable open and critical discussion of contentious SRH issues that could yield ground for more comprehensive reforms. The participation of these groups in the bureaucratic policy networks should challenge as well as balance the focus on the positivistic biomedical knowledge by bringing on board alternative knowledge from human rights and anthropological analyses, in addition to lay knowledge drawn from experiences of grassroots communities. Such inclusive policy networks would likely enable more meaningful overlaps and complementarity of the medical and the rights narratives to enhance prospects for comprehensive reforms. At the time of the study (2011), the KNCHR and RHRA<sup>120</sup> had initiated engagement with the DRH on SRH rights issues. Such efforts need to be sustained and strengthened so that future SRH policies emerging from the DRH not only address SRH rights, but also outline strategies for operationalizing the SRH rights framework.

The marginalised groups also need to establish strong connections with influential non-government actors such as donors, UN agencies and international-type research and programme implementing organisations (Population Council, FHI, JHPIEGO, and Pathfinder International). Such connections would likely reinforce the influence of these groups on future SRH policies emerging from the DRH and NCPD. For these groups to meaningfully engage in SRH policy processes, however, they will need sustained financial and technical support to strengthen their resource base and their technical capacity. Thus,

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<sup>120</sup> Interviews: official, national human rights organisation, June 10, 2011, Nairobi; official, a network of national level reproductive health and rights organisations, September 19, 2011, Nairobi.

their engagement with donors and UN agencies should challenge the bias in funding of SRH issues; currently most funding goes to medical-oriented and technocratic organisations, while organisations that focus on rights and discrimination remain greatly underfunded, and consequently, have limited impact on reforms. Efforts should also focus on supporting the establishment of a grassroots women's health and rights movement in Kenya to provide the much needed local support base for SRH rights issues. Women's organising for rights issues has been shown to be critical in getting governments to prioritise women's issues (Htun and Weldon 2012; IDS 2011; Petchesky 2003).

Related to this is the need for actors to rethink their strategies of engagement especially on sensitive SRH issues. Understandably, and as discussed in Chapter 7, actors prefer to focus on less sensitive SRH issues in their advocacy and avoid the sensitive ones in order to reduce controversy and opposition. Specifically, actors avoid engaging with the politics and ideology behind the opposition to sensitive SRH issues. This strategy has, however, only facilitated partial reforms. Actors, therefore, may need to consider tactical ways of bringing out the sensitive issues in their advocacy in order to provide an open platform for critical debating of these issues, particularly the underlying politics of power and ideology that marginalise the needs of women, adolescents and sexual minorities. Such efforts may need to focus on generating open and critical grassroots deliberations on these issues to build the public's understanding and appreciation before turning to national level legal and policy deliberations, since these issues are often taboo and stigmatised by the Kenyan public.

The focus therefore may need to be the creation of contextual spaces for SRH dialogues and reforms to reduce the entrenched stigma, silence, opposition and uncritical understanding of sensitive SRH issues in Kenya. The creation of contextual spaces for dialogue and reforms should target three different levels: local/grassroots, bureaucracy, and parliament.

At the local level, these efforts could bring SRH dialogues into already existing spaces (such as village-level meetings, women groups, youth meetings, community radio) as well as establishing new spaces. Actors, however, need to be cautious about how they engage in existing spaces since these are not empty; rather, they are already filled with normative arguments on SRH issues underpinned by religion and culture, and so innovation and tactics will need to guide such engagement in order to generate meaningful debates and not backlash.

Within the bureaucracy, spaces for SRH dialogue and reforms include relevant government ministries and agencies responsible for health, RH, gender, population, education, and legal affairs. Reform actors may need to penetrate these institutions, establishing influential links and champions for SRH rights as seen in the adolescent RH policy process in Chapter 4. For instance, could SRH reform actors influence the government's appointments for key decision-making positions in these institutions? Strategic penetration of relevant bureaucratic spaces will provide reformers with a range of opportunities for influencing government policies and programmes on sensitive SRH issues. More importantly, the high burden of sexual and reproductive ill-health and associated deaths should justify the need for the establishment of a high level SRH agency by government (such as the NCPD, for instance) that is less prone to political interference and therefore better able to lead the country's response to SRH challenges.

In regard to the Kenyan parliament, efforts to influence parliamentary support for sensitive SRH issues lie not only in constantly sensitising MPs on SRH issues, but also engaging parliamentary aspirants on these issues before they get into parliament. Networks such as the Kenya Parliamentary Network on Population and Development established in 2005 by the NCPD, and the Kenya Women Parliamentarians Association (KEWOPA) established in 2003 by women MPs present opportunities for engaging MPs. Specific parliamentary networks that focus on SRH could be established. More importantly, efforts to improve the parliamentary space should also extend to educate, sensitise and mobilise the public to elect leaders who appreciate, and are supportive of, SRH and women's rights.

With regard to knowledge, a number of things need to change to facilitate more comprehensive reforms given the crucial role of knowledge in the pathways to reforms as evidenced by the thesis's findings. There is need for knowledge production on sensitive SRH issues as well as the production and use of non-biomedical knowledge. Researchers need to challenge donor funding priorities on SRH, especially highlighting the skewed funding that favours biomedical aspects of non-sensitive SRH issues, while neglecting sensitive biomedical as well as non-biomedical issues. Yet, scientific evidence on these issues is needed to put them on the policy agenda. Related to this is the need for health researchers within and outside the bureaucracy to acknowledge that knowledge does not speak for itself. Rather, its influence is shaped by politics and other factors (Buse et al 2006; Fischer 2003). Thus, generators and promoters of evidence in SRH policy processes need to deliberately seek ways of understanding and engaging with the politics in order to enable

their research to play an important role in policymaking. Buse et al (2006:2102) have argued that '[w]ithout strategic management of the political terrain, the strength of the [SRH] evidence might not necessarily result in the implementation of evidence-based policy.' In addition to understanding and tackling the politics, strategic, effective and sustained discussions of SRH research knowledge with key actors within and outside government is critical. Also, strong links between SRH researchers and advocacy groups would contribute to strengthening the research-to-policy bridge.

Most, if not all of these suggestions will only be possible if adequate funding support is provided for SRH research, advocacy and programming to a wide range of actors beyond the medical fraternity. As Theobald (2012) has argued, the fact that medical responses have dominated SRH interventions has enabled donors to argue that they are sufficiently addressing these issues, yet these have overshadowed broader analyses of non-biomedical issues such as gender inequity, which remain crucial in determining health outcomes. Thus, comprehensive funding for SRH interventions beyond biomedicine remains critical for the realisation of more comprehensive SRH policy and legislative reforms in Kenya and elsewhere.

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## Appendices

### Appendix I: Ethical Clearance Certificate



<b>Social Sciences Cluster-based Research Ethics Committee</b> <b>CERTIFICATE OF APPROVAL</b>	
<b>Reference Number:</b>	1011/11/5
<b>School:</b>	Global Studies (IDS)
<b>Title of Project</b>	Investigating Reproductive Health Policy Processes in Kenya : What Drives Policy Change
<b>Principal Investigator:</b>	Rose ORONJE
<b>Name of Supervisor: (for student projects)</b>	Dr Andy Sumner
<b>Expected Start Date:*</b>	January 2011
<p>*NB. If the <u>actual</u> project start date is delayed beyond 12 months of the <u>expected</u> start date, this Certificate of Approval will lapse and the project will need to be reviewed again to take account of changed circumstances such as legislation, sponsor requirements and University procedures</p>	
<p><b>This project has been given ethical approval by the Social Sciences Cluster-based Research Ethics Committee (C-REC).</b></p> <p><b><i>Please note the following requirements for approved submissions:</i></b></p> <p><b>Amendments to research proposal</b>          Any changes or amendments to the approved proposal, which have ethical implications, must be submitted to the committee for authorisation prior to implementation.</p> <p><b>Feedback regarding any adverse and unexpected events</b>          Any adverse (undesirable and unintended) and unexpected events that occur during the implementation of the project must be reported to the Chair of the Social Sciences C-REC. In the event of a serious adverse event, research must be stopped immediately and the Chair alerted within 24 hours of the occurrence.</p>	
<b>Authorised Signature</b>	
<b>Name of Authorised Signatory (C-REC Chair or nominated deputy)</b>	Dr Elaine Sharland
<b>Date</b>	3 February 2011



## Appendix II: KEMRI Letter



## KENYA MEDICAL RESEARCH INSTITUTE

P.O. Box 54840 - 00200 NAIROBI, Kenya  
 Tel: (254) (020) 2722541, 2713349, 0722-205901, 0733-400003; Fax: (254) (020) 2720030  
 E-mail: director@kemri.org info@kemri.org Website: www.kemri.org

KEMRI/RES/7/3/1

February 16, 2011

**TO: ROSE ORONJE (PRINCIPAL INVESTIGATOR)**  
**AFRICAN INSTITUTE FOR DEVELOPMENT POLICY**

**THRO': DR. ELIYA ZULU,**  
**THE EXECUTIVE DIRECTOR,**  
**AFIDEP**

**RE: NON-SSC PROTOCOL NO. 276 (INITIAL SUBMISSION):**  
**INVESTIGATING REPRODUCTIVE HEALTH POLICY PROCESSES IN**  
**KENYA: WHAT DRIVES POLICY CHANGE?**

This is to inform you that during the 186<sup>th</sup> meeting of the KEMRI/ERC meeting held on 15<sup>th</sup> February 2011, the above study was reviewed.

The Committee notes that the above referenced study is a retrospective qualitative study that aims to determine the drivers behind the three policy documents that inform reproductive health policy here in Kenya.

After careful consideration, the Committee finds that more information is necessary before a final decision on the study can be reached:

1. The committee is of the opinion that the amount of work that will be entailed in the study will not be completed in 9 months. Kindly provide a detailed work plan with each activity given a specific time frame.
2. Do you have the capacity to complete the study in the given time?

Kindly address the issues raised and remit a revised proposal to the ERC Secretariat for further action.

Sincerely,

*ROKithinji*

**Caroline Kithinji,**  
**FOR: SECRETARY,**  
**KEMRI/NATIONAL ETHICS REVIEW COMMITTEE**

### Appendix III: Interviewee Recruitment Letter

Date: .....

**From:**

Rose N. Oronje  
PhD Candidate, Institute of Development Studies,  
University of Sussex,  
Brighton, BN1 9RE, United Kingdom

**To:**

.....  
.....  
.....

**Dear** .....,

**Re: Request for your participation in a Research Study on Reproductive Health Policy-Making**

I am writing to request for your participation in a research study on *Investigating Reproductive Health Policy Processes in Kenya: What Drives Policy Change?* This study is part of my doctoral degree studies at the Institute of Development Studies, University of Sussex, UK.

The study seeks to investigate factors that influence change in reproductive health policy in Kenya. Specifically, the study will provide an analytical account of the processes, conditions and factors that have influenced reproductive health policy changes in Kenya following the 1994 International Conference on Population and Development (ICPD). The motivation for this study is the fact that despite contention and opposition that surrounds sexual and reproductive health and rights issues in Kenya, some successes have been realised in terms of formulation of policies and legislation. These successes include, among others, the formulation of a national reproductive health policy in 2007, adolescent reproductive health and development policy in 2003, and the enactment of the sexual offences act in 2006.

Recognising your role in reproductive health policy processes in Kenya, the aim of this letter is to request for an interview with you. The interview will gather information on your participation in the development of the Adolescent Reproductive Health and Development Policy of 2003/National Reproductive Health Policy of 2007. The interview, which is estimated to last about 45 minutes, hopes to draw on your experiences and lessons in the policy-making process. Knowledge generated by the study, through interviews and document review, will be useful in informing efforts to raise the profile of reproductive health issues on the development and political agenda in Kenya. Please find attached the Study Information Sheet which summarises the proposed study. Please do not hesitate to contact the undersigned if you need more information.

I will appreciate your feedback on this request via email – [R.Oronje@ids.ac.uk](mailto:R.Oronje@ids.ac.uk) or phone +254(0)727935844. I will call you to make a follow-up on this request.

Yours faithfully,

Rose N. Oronje

**PhD Candidate, Institute of Development Studies at the University of Sussex, UK**

## **Appendix IV: Study Information Sheet**

### **Study Summary**

**Title:** Investigating Reproductive Health Policy-Making in Kenya: What Drives Policy Change?

#### ***Aim***

The aim of this study is to investigate factors that influence change in reproductive health (RH) policy in Kenya. Specifically, the thesis will provide an analytical account of the processes, conditions and factors that have influenced RH policy changes in Kenya following the 1994 International Conference on Population and Development (ICPD). RH issues account for a considerable burden of ill-health and deaths in Kenya, but they have been historically neglected and even though the 1994 ICPD propelled these issues onto the country's development agenda, these issues have continued to be dogged with controversy given their conflict with the Kenyan culture, values, and religious beliefs and practices.

#### ***Why is this study necessary?***

The motivation for this study is the fact that despite the controversy, some successes have been realised in terms of formulation of policies and legislation. These successes include the formulation of an RH national policy in 2007, adolescent RH and development policy in 2003, and passing of the sexual offences act in 2006. Overall, however, RH issues remain non-priority and often neglected on Kenya's political agenda. Pregnancy-related causes of deaths, for instance, account for most deaths among women of reproductive age. Conditions such as fistula and issues of intimate partner violence remain stigmatised and do not receive adequate attention. Issues relating to abortion and provision of RH information and services to adolescents also remain controversial. Therefore, this study seeks to analyse the policy-making processes that have successfully resulted in policy reform to draw learning that can inform efforts to raise the profile of RH issues and future policy reform initiatives.

#### ***Research Methods***

This is a retrospective study and it employs a qualitative case study approach. It has selected three policy-making processes, namely: the formulation of the national RH policy of 2007; the formulation of the adolescent RH and development policy of 2003; and the development and enactment of the sexual offences act in 2006, as its case studies. Data collection for the first two cases is through in-depth interviews with policymakers in relevant government agencies and departments, scientists, healthcare professionals, advocacy groups, donors, and religious leaders. These will be complemented with data from a review of documents. Data collection for the third case will be based mainly on a review of various documents including the *Hansard*, media coverage of the parliament debates on the sexual offences bill, and scientific publications, and backed with in-depth interviews with a few key actors.

#### ***Study Participants***

- Government officials in the Ministry of Public Health and Sanitation (Family Health department), and Ministry of Medical Services (Technical Planning and Coordination department)



- Government officials in National Coordinating Agency for Population and Development (NCAPD)
- Scientists
- Healthcare professionals
- Development partners
- Advocacy groups and networks
- Religious leaders

**Appendix V: Interviewee Consent Form****Consent Form**

I, Dr/Mr/Mrs/Ms ....., agree to take part in the study on *Investigating Reproductive Health Policy Processes in Kenya: What Drives Policy Change?* conducted by Ms. Rose N. Oronje as part of her Doctoral Studies, sponsored by the University of Sussex, and funded by the Commonwealth Scholarships Commission. I have been briefed about the study and understand its focus and importance. I understand that such information will be treated as strictly confidential and handled in accordance with the UK Data Protection Act 1998.

Signature: ..... Date: .....

## **Appendix VI: Interview Schedules**

### **Interview schedule for government officials**

*Adolescent Reproductive Health and Development Policy/National Reproductive Health Policy*

Introductions and preliminary information – names and positions; brief study summary.

Discussion topics:

1. How was the policy development process initiated?
2. What did the government seek to achieve with this policy?
3. Tell me about the consultative process for this policy – which actors did you consult with?
4. What were the interests of the different actors?
5. What was the role of research in the policy?
6. (For the adolescent reproductive health and development policy) Efforts to develop and implement a policy on sexuality education in Kenya in the mid-1990s were strongly opposed by different players; did this policy face similar controversy and opposition?
7. (For the national reproductive health policy) Sexual and reproductive health and rights issues in Kenya often attract a lot of controversy and strong opposition, how was the controversy and opposition dealt with?
8. How did your institutional rules, procedures and structures influence the policy process?
9. How did key public institutions in Kenya - the church, parliament, media, and civil society – influence the process?
10. Did the regional context have any influence on the policy development process?
11. What role did the international community play in the policy process?
12. What were your final thoughts and reflections on the process (whether negative or positive)?

## **Interview schedule for non-state participants**

### *Adolescent Reproductive Health and Development Policy/National Reproductive Health Policy*

Introductions and preliminary information – names and positions; brief study summary.

1. How did you get involved in the policy development process?
2. What role did you play in the policy development process?
3. (For the adolescent reproductive health & development policy) Efforts to introduce a comprehensive sexuality education policy were strongly opposed by various players in mid 1990s, what is your stand on this issue?
4. (For the national reproductive health policy) Sexual and reproductive health and rights issues in Kenya often attract a lot of controversy and strong opposition, what is your stand on these issues?
5. Who else participated in the policy development process?
6. What role did information play in the policy development process?
7. How did cultural and religious beliefs influence the policy development process?
8. Did key institutions in Kenya - parliament, the church, media, and civil society – influence the process in any way?
9. What was the influence of regional bodies (e.g. East African Community, African Union) on the policy development process?
10. What was the influence of the international community (UN Agencies, donors) on the policy development process?
11. What were your final thoughts and reflections on the process (whether negative or positive)?

## **Interview schedule for religious leaders**

### *Adolescent Reproductive Health and Development Policy/National Reproductive Health Policy*

Introductions and preliminary information – names and positions; brief study summary.

1. How did you get involved in the policy development process?
2. What role did you play in the policy development process?
3. (For adolescent reproductive health policy) Efforts to introduce a comprehensive sexuality education policy were strongly opposed by various players including religious leaders in mid 1990s, what is your stand on this issue?
4. (For the national reproductive health policy) What is your stand on sexual and reproductive health and rights issues?
5. How do you think Kenya's cultural and religious beliefs influenced the policy development process?
6. Who else participated in the policy process?
7. What role did information play in the policy development process?
8. Did key institutions in Kenya – the parliament, church, media, and civil society – influence the process in any way?
9. What was the influence of regional bodies (e.g. East African Community, African Union) on the policy development process?
10. What was the influence of the international community (UN Agencies, donors) on the policy development process?

What were your final thoughts and reflections on the process (whether negative or positive)?

## **Interview schedule for Members of Parliament**

### *Sexual Offences Bill*

Introductions and preliminary information – names and positions; brief study summary.

Discussion topics:

1. How was the bill's development process initiated?
2. What did the bill seek to achieve?
3. Tell me about the consultative process for the bill prior to introducing it in parliaments – which actors did you consult with?
4. The introduction of the bill in parliament sparked debate, controversy, and opposition, why was this?
5. How did you go about tackling the conflicts?
6. What was the role of research in the bill development process and debating in parliament?
7. How did parliament's rules, procedures and structures influence the bill development and debate process?
8. How did key public institutions in Kenya - the church, media, and civil society – influence the bill's debate in parliament?
9. How did the regional context influence the bill development and debate process?
10. What role did the international community play in the bill development and debate process?
11. What were your final thoughts and reflections on the whole process (whether negative or positive)?

## **Interview schedule for civil society (non-MP interviewees)**

### *Sexual Offences Bill*

Introductions and preliminary information – names and positions; brief study summary.

1. How did you get involved in the development and debate of the sexual offences bill?
2. What role did you play in the bill development/debate process?
3. The introduction of the bill in parliament sparked debate, controversy, and opposition, why was this?
4. Did you participate in the efforts to tackle the conflicts? If yes, how?
5. What was the role of research in the bill development process and debating in parliament?
6. How did key public institutions in Kenya - the church, media, and civil society – influence the bill's debate in parliament?
7. How did the regional context influence the bill development and debate process?
8. What role did the international community play in the bill development and debate process?
9. What were your final thoughts and reflections on the whole process (whether negative or positive)?

## Appendix VII: Sample Description

*Government institutions* – Interviewees were drawn from five different government institutions including: the DRH<sup>121</sup>, NCPD<sup>122</sup>, National AIDS Control Council (NACC), Kenya National Commission on Human Rights (KNCHR), and Parliament. The DRH and NCPD were directly involved in the development of the adolescent and the national RH policies. Parliament debated and passed the sexual offences Act. NACC is the national body (under the Office of the President) coordinating Kenya's multi-sectoral response to HIV/AIDS and as such an important stakeholder in SRH issues. KNCHR is an autonomous government body (under the Ministry of Justice) in charge of human rights issues. KNCHR is increasingly becoming vocal on SRH rights violations in Kenya, especially following the passing of the 2010 constitution which now recognises RH as a human right. For the institutions directly involved in the case study policy processes, informants comprised the individuals involved in the specific policy development processes. For NACC, the informant was its overall head (executive director), whereas for KNCHR, the informant was the commissioner in-charge of SRH rights. For parliament, interviews were conducted with members of parliament (MPs) who had either supported or opposed the sexual offences law. This targeting of informants enabled me to interview relevant officers who had the information needed.

*UN agencies* – Interviewees were drawn from the national offices of UN agencies, United Nations Population Fund (UNFPA) and the World Health Organisation (WHO). Both institutions were directly involved in the adolescent and the national RH policy development processes, and so the informants were the officers who took part in these processes. These institutions were important as they work closely alongside the DRH and NCPD in policy and programme formulation, and often fund policy and programme activities in Kenya.

*Donor institutions* – Interviewees were drawn from three major SRH donors in Kenya including USAID, DFID and GIZ (formerly GTZ). The USAID is the dominant donor for SRH issues in Kenya both through the government and non-governmental organisations. As a major donor, USAID's foreign funding policies, such as the 'global gag rule/Mexico city policy' and PEPFAR, impact Kenya's SRH policies and programmes. USAID funded the development of the national RH policy, and as such its officers were constantly involved in the policy development process. DFID is also an important SRH

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<sup>121</sup> Overall government division under the Ministry of Public Health and Sanitation in charge of reproductive health.

<sup>122</sup> Overall semi-autonomous government agency under the Ministry of Planning in-charge of population issues.



donor in Kenya, both through government and non-governmental organisations, with interest mainly in maternal health. GIZ is another important donor for SRH issues in Kenya, with interest in FP and LGBTIs issues. GIZ was involved in both the development of the adolescent as well as national RH policies. While I recognise that there are other donors for SRH issues such as Ford Foundation, Rockefeller Foundation, Bill and Melinda Gates Foundation, and the European Union, among others, these had not played a role in any of the policy processes studied, and were similarly not mentioned by interviewees as being key in SRH policymaking in Kenya. Consequently, I did not interview their representatives; instead, I gathered information from their websites on the SRH programmes they support in Kenya.

*Research institutions* – Interviewees were also drawn from research and academic institutions including the Population Council, University of Nairobi, and Centre for the Study of Adolescence (CSA). All the interviewees from the three institutions had been directly involved in the policy development processes either as consultants drafting the policies or scientific experts on the issues that the policies focused on. Researchers from the Population Council were involved in both the adolescent and national RH policy development processes because the institution works closely with the DRH and NCPD. Researchers from the University of Nairobi (specifically from the Population Studies and Research Institute and the School of Medicine) were mainly drawn on as consultants to lead the drafting of the two policies. Researchers from the CSA and also School of Medicine had been on the forefront lobbying for the need for government to address adolescent RH issues and were also directly involved in the adolescent RH policy development process.

*Programme implementers* – Interviewees were also drawn from several non-governmental organisations including: former Policy Project, Family Health International (FHI), JHPIEGO, Family Health Options Kenya (FHOK), Family Care International (FCI)-Kenya, Pathfinder International, Kenya AIDS NGO Consortium (KANCO), and Family Programmes Promotions Services (FPPS). Policy Project was the USAID-funded organisation that led and coordinated the national RH policy development process together with the DRH. Although this organisation wound up, I was able to trace and interview its former experts who led and coordinated the national RH policy development process. FHI, JHPIEGO and Pathfinder International directly participated in either one or both the adolescent and national RH policy development. FHOK, FCI-Kenya, KANCO and FPPS did not take part in the two policy development processes but were currently focusing on

key SRH issues including FP and maternal health. Informants from these institutions were mainly officers who worked closely with the DRH and NCPD in linking their institutions' work to policy.

*Human rights and women's rights organisations* – Interviewees were drawn from various human rights and women's rights civil society organisations actively involved in advocacy efforts for legal and policy reforms as well as programming in response to SRH rights issues. These included FIDA-Kenya, Coalition of Violence Against Women (COVAW), Women in Law and Development (WILDAF), Urgent Action Fund-Africa, Ipas Africa Alliance, International Planned Parenthood Federation-Africa Region (IPPF-AR), Planned Parenthood Federation of America-Africa Region (PPFA-AR), RHRA, and Health Rights Forum (HERAF). FIDA-Kenya, COVAW, WILDAF, Urgent Action Fund-Africa, and Ipas Africa Alliance were directly involved in the development and campaigning for the sexual offences Act. Informants from these institutions were mainly those who participated in the legislative processes. IPPF-AR, PPFA-AR, RHRA and HERAF were not directly involved in any of the policy case studies, but were actively engaged in advocacy efforts for SRH rights issues in Kenya, and RHRA specifically played a key role in securing the RH rights realised in the 2010 constitution. Informants from these four institutions were the relevant officers in-charge of SRH rights issues and policy advocacy.

*Professional associations* – Medical professional associations play an important role in SRH issues since it's mainly their members who implement government's SRH policies in public as well as private health facilities across the country. Interviewees from these associations were drawn from the Kenya Medical Association (KMA), Kenya Obstetricians and Gynaecologists Society (KOGS), and the National Nurses Association of Kenya (NNAK). Interviewees included the chairpersons and/or general secretaries of these associations. Although the leaders of the three associations were not directly involved in any of the case studies, the three associations were actively involved in advocacy activities for SRH rights issues including abortion and maternal health. The associations interacted directly with the DRH as well as worked closely with human rights organisations and networks especially FIDA-Kenya, Ipas Africa Alliance and the RHRA. Through the RHRA, the associations were instrumental in securing the RH rights gains in the 2010 constitution.

*Religious institutions* – Religious institutions in Kenya have remained vocal on SRH issues in the country, making them important actors in influencing SRH policies and laws. Informants were drawn from the Supreme Council of Kenya Muslims (SUPKEM) and the

National Council of Churches of Kenya (NCCK). Interviewees from the two institutions were those in-charge of RH issues. Even then, none of them had participated in any of the case study policy processes. Interviewees were none-the-less conversant with their institutions' declarations and influence on SRH policy issues in the country. Efforts to interview the most vocal religious institution, the Kenya Catholic Episcopal Conference, were unsuccessful.

### Appendix VIII: List of Media Stories Reviewed

#	Title	Writer	Medium	Date	Issue
1	HEALTH-KENYA: President Moi Joins The Campaign Against HIV/AIDS <a href="http://www.aegis.org/DisplayContent/?SectionID=43411">http://www.aegis.org/DisplayContent/?SectionID=43411</a>	Judith Achieng'	Inter Press Service	December 3, 1999	HIV/AIDS
2	Outrage at Moi Remark: Are Kenyan women owed an apology? <a href="http://news.bbc.co.uk/1/hi/world/africa/1209531.stm">http://news.bbc.co.uk/1/hi/world/africa/1209531.stm</a>	Joseph Warungu	BBC	March 8, 2001	Women SRH rights
3	Charity Ngilu: Kenya's Leading Woman <a href="http://www.worldpress.org/Africa/1125.cfm">http://www.worldpress.org/Africa/1125.cfm</a>	Sarah Coleman	World Press Review	July 2003	Women's rights
4	Kenya: Ngilu: Hospitals to Get Abortion Kits 7 May 2004 <a href="http://allafrica.com/stories/200405070042.html">http://allafrica.com/stories/200405070042.html</a>	Evelyn Kwamboka	allafrica	May 7, 2004	Abortion
5	HEALTH-KENYA: Enforcement of Abortion Law Problematic <a href="http://www.ipsnews.net/2004/06/health-kenya-enforcement-of-abortion-law-problematic/">IPS Correspondents Reprint</a> <a href="http://www.ipsnews.net/2004/06/health-kenya-enforcement-of-abortion-law-problematic/">http://www.ipsnews.net/2004/06/health-kenya-enforcement-of-abortion-law-problematic/</a>	Joyce Mulama	Inter Press Service	June 5, 2004	Abortion
6	In Kenya, Stopping Rapes Is a Challenge <a href="http://www.washingtonpost.com/wp-dyn/content/article/2006/06/22/AR2006062200590.html">http://www.washingtonpost.com/wp-dyn/content/article/2006/06/22/AR2006062200590.html</a>	Elizabeth Kennedy	Associated Press	June 22, 2006	Sexual violence
7	Kibaki and Raila to meet clergy over draft <a href="http://allafrica.com/stories/201004070986.html">http://allafrica.com/stories/201004070986.html</a>	Presidential Press Service (PPS)	Daily Nation	April 7, 2010	New constitution debates
8	Kenya PM rules out amending draft <a href="http://allafrica.com/stories/201004070801.html">http://allafrica.com/stories/201004070801.html</a>	Anthony Kariuki	Daily Nation	April 7, 2010	New constitution debates
9	Church, politicians clash ahead of crucial vote <a href="http://www.standardmedia.co.ke/?id=2000007169&amp;cid=4&amp;ttl=Church.%20politicians%20clash%20ahead%20of%20crucial%20vote&amp;articleID=2000007169">http://www.standardmedia.co.ke/?id=2000007169&amp;cid=4&amp;ttl=Church.%20politicians%20clash%20ahead%20of%20crucial%20vote&amp;articleID=2000007169</a>	The Standard Team	The Standard	April 7, 2010	New constitutional debates
10	Why I pity MPs, ignore the Church <a href="http://www.standardmedia.co.ke/?incl=SendToFriend&amp;title=Why%20I%20pity%20MPs.%20ignore%20the%20Church&amp;id=2000007141&amp;cid=497&amp;articleID=2000007141">http://www.standardmedia.co.ke/?incl=SendToFriend&amp;title=Why%20I%20pity%20MPs.%20ignore%20the%20Church&amp;id=2000007141&amp;cid=497&amp;articleID=2000007141</a>	Andrew Kipkemboi	The Standard	April 7, 2010	New constitutional debates

11	Uncertainty as leaders pull different ways <a href="http://www.standardmedia.co.ke/?incl=blogComment&amp;id=2000007072&amp;cid=&amp;articleID=2000007072">http://www.standardmedia.co.ke/?incl=blogComment&amp;id=2000007072&amp;cid=&amp;articleID=2000007072</a>	Stephen Makabila	The Standard	April 6, 2010	New constitution debates
12	Is the Draft Constitution threatened? <a href="http://www.standardmedia.co.ke/?id=2000007084&amp;cid=4&amp;articleID=2000007084">http://www.standardmedia.co.ke/?id=2000007084&amp;cid=4&amp;articleID=2000007084</a>	Standard Team	The Standard	April 6, 2010	New constitutional debates
13	Debate on proposed law reunites birds of a feather <a href="http://allafrica.com/stories/201004191793.html">http://allafrica.com/stories/201004191793.html</a>	Njeri Rugene and Emeka-Mayaka Gekara	Daily Nation	April 19, 2010	New constitutional debates
14	Church adamant on No vote in new law <a href="http://www.thecitizen.co.tz/magazines/32-political-platform/1138-church-adamant-on-no-vote-in-new-law.html">http://www.thecitizen.co.tz/magazines/32-political-platform/1138-church-adamant-on-no-vote-in-new-law.html</a>	John Ngirachu, Ouma Wanzala, Dennis Odunga, Kitavi Mutua, Tom Matoke, James Ngunjiri, Benedict Tirop, Elisha Otieno and Anthony Kitimo	Daily Nation	April 5, 2010	New constitutional debates
15	Talks with clerics moved to next week <a href="http://allafrica.com/stories/201004191797.html">http://allafrica.com/stories/201004191797.html</a>	Nation Team	Daily Nation	April 19, 2010	News item on constitutional debates
16	Let's vote Yes and amend the constitution to legalise abortion <a href="http://www.standardmedia.co.ke/?id=2000008043&amp;cid=15&amp;articleID=2000008043">http://www.standardmedia.co.ke/?id=2000008043&amp;cid=15&amp;articleID=2000008043</a>	Mary Wandia	The Standard	April 19, 2010	Opinion
17	Kenyan clergy insist on No vote <a href="http://www.capitalfm.co.ke/news/Kenyanews/Kenyan-clergy-insist-on-No-vote-8101.html#ixzz0kuBJRmXc">http://www.capitalfm.co.ke/news/Kenyanews/Kenyan-clergy-insist-on-No-vote-8101.html#ixzz0kuBJRmXc</a>	Judy Kaberia	Capital FM	April 12, 2010	News item on Constitutional debate
18	Kibaki: Let's answer the call of history and enact new constitution <a href="http://mobile.nation.co.ke/-/1292/964140/-/format/xhtml/item/8/-/un2djmz/-/index.html">http://mobile.nation.co.ke/-/1292/964140/-/format/xhtml/item/8/-/un2djmz/-/index.html</a>	Murithi Mutiga	Daily Nation	July 24, 2010	News item on constitutional debates
19	Mob attacks Gay Wedding <a href="http://humanrightshouse.org/Articles/13391.html">http://humanrightshouse.org/Articles/13391.html</a>	Galgalo Bocha	Daily Nation	February 12, 2010	Homosexuality
20	Misoprostol Can't Shake Bad Reputation <a href="http://ipsnews.net/news.asp?idnews=52385">http://ipsnews.net/news.asp?idnews=52385</a>	Susan Anyangu-Amu	IPS	August 4, 2010	Maternal health
21	Kenya's new constitution sparks hopes of rebirth	Peter Greste	BBC	August 27, 2010	New constitutional debates
22	Kenya: MPs Back Bill to Prohibit Female Genital Mutilation <a href="http://allafrica.com/stories/201104140205.html">http://allafrica.com/stories/201104140205.html</a>	Francis Mureithi	The Star	April 13, 2011	FGM

23	Championing for Muslim women's rights	Kundu Waweru	-	April 23, 2011	Women's rights
24	Uganda anti-gay bill 'shelved by parliament' <a href="http://www.bbc.co.uk/news/world-africa-13392723">http://www.bbc.co.uk/news/world-africa-13392723</a>	-	BBC	May 13, 2011	Homosexuality
25	MPs take on clerics at Mutunga hearing <a href="http://kenyaupodate.blogspot.co.uk/2011/06/mps-take-on-clerics-at-mutunga-hearing.html">http://kenyaupodate.blogspot.co.uk/2011/06/mps-take-on-clerics-at-mutunga-hearing.html</a>		The Latest Kenyan News blog	June 7, 2011	Homosexuality
26	Kenya: Misoprostol Re-Ignites Abortion Debate <a href="http://allafrica.com/stories/201106140148.html">http://allafrica.com/stories/201106140148.html</a>	Verena Buschmann	Business Daily (Nairobi)	June 13, 2011	Abortion/Maternal health
27	Gay pride and prejudice in Kenya	Nina Robinson	BBC	June 16, 2010	Homosexuality
28	UN council passes gay rights resolution <a href="http://articles.cnn.com/2011-06-17/world/un.lgbt.rights_1_gay-rights-human-rights-gay-pride-event?s=PM:WORLD">http://articles.cnn.com/2011-06-17/world/un.lgbt.rights_1_gay-rights-human-rights-gay-pride-event?s=PM:WORLD</a>	Jill Dougherty		June 17, 2011	Homosexuality
29	Kibaki: Govt to prioritise health delivery <a href="http://allafrica.com/stories/201106241183.html">http://allafrica.com/stories/201106241183.html</a>	PPS	Daily Nation	June 24, 2011	Maternal health
30	Nyong'o calls for abortion policies <a href="http://abortionnews.info/article/Nyong--39-o-calls-for-safe-abortion-policies">http://abortionnews.info/article/Nyong--39-o-calls-for-safe-abortion-policies</a> <a href="http://www.nation.co.ke/News/Gender+balance+issue+raises+heat+in+House/-/1056/1214248/-/item/0/-/dr6w64z/-/index.html">Nyong'o calls for safe abortion policies</a>		Kenya Broadcasting Corporation	July 27, 2011	Abortion
31	Gender balance issue raises heat in House <a href="http://www.nation.co.ke/News/Gender+balance+issue+raises+heat+in+House/-/1056/1214248/-/item/0/-/dr6w64z/-/index.html">http://www.nation.co.ke/News/Gender+balance+issue+raises+heat+in+House/-/1056/1214248/-/item/0/-/dr6w64z/-/index.html</a>	Julius Sigei and Jacob Ng'etich	Daily Nation	August 5, 2011	Gender equality
32	No condom factory for Kenya	Njenga Gicheha	The Star	August 23, 2011	Condoms
33	Was abortion issue really a sticking point?	Tom Odhiambo		August 26, 2011	Abortion
34	KMA conference split by protesting doctors	John Muchangi	The Star	September 16, 2011	Abortion
35	Birth control takes centre stage as world population hits 7bn <a href="http://www.nation.co.ke/News/Birth+control+takes+centre+stage+as+world+population+hits+7bn+/-/1056/1265132/-/du87eyz/-/index.html">http://www.nation.co.ke/News/Birth+control+takes+centre+stage+as+world+population+hits+7bn+/-/1056/1265132/-/du87eyz/-/index.html</a>	Edith Fortunate & Aggrey Mutambo	Daily Nation	October 31 2011	Family Planning
36	Report shows 1.8m Kenyan women have unplanned pregnancies annually	Aily Jamah		October 31, 2011	Family Planning
37	Britain is threatening to revoke financial aid to poor African countries that don't support gay rights <a href="http://www.cbn.com/cbnnews/world/2011/October/British-PM-Take-Gay-Rights-to-Third-World/">http://www.cbn.com/cbnnews/world/2011/October/British-PM-Take-Gay-Rights-to-Third-World/</a>	-	Daily Mail Online	November 2011	Homosexuality
39	Africa: UK won't force gay rights on Africa, assures minister	Elias Mbaao	Daily Nation	November 10, 2011	Homosexuality

	<a href="http://allafrica.com/stories/201111110236.html">http://allafrica.com/stories/201111110236.html</a>				
40	Tanzania: Government says no to UK <a href="http://allafrica.com/stories/201111040862.html">http://allafrica.com/stories/201111040862.html</a>	Mkinga Mkinga and Zephania Ubwani	The Citizen	November 3, 2011	Homosexuality
41	Uganda man jailed for killing gay activist David Kato <a href="http://www.bbc.co.uk/news/world-africa-15685648">http://www.bbc.co.uk/news/world-africa-15685648</a>	-	BBC	November 10, 2011	Homosexuality
42	Panic as Maasai morans raid school for 'wives' <a href="http://www.nation.co.ke/News/Panic+as+morans+raid+school+for+wives/-/1056/1271692/-/item/0/-/15fd1dc/-/index.html">http://www.nation.co.ke/News/Panic+as+morans+raid+school+for+wives/-/1056/1271692/-/item/0/-/15fd1dc/-/index.html</a>	Julius Sigei	Daily Nation	November 11, 2011	Women's rights
43	Ghana refuses to grant gays' rights despite aid threat <a href="http://www.bbc.co.uk/news/world-africa-15558769">http://www.bbc.co.uk/news/world-africa-15558769</a>	-	BBC	November 2, 2011	Homosexuality
44	Nigeria's bill to outlaw gay marriage threatens HIV/Aids cash <a href="http://www.guardian.co.uk/world/2011/dec/04/nigeria-gay-marriage-ban-aids-hiv">http://www.guardian.co.uk/world/2011/dec/04/nigeria-gay-marriage-ban-aids-hiv</a>		Associated Press	December 4, 2011	Homosexuality
45	Rights group roots for abortion law <a href="http://www.nation.co.ke/News/Rights+group+roots+for+abortion+law/-/1056/1285658/-/9hbm7nz/-/index.html">http://www.nation.co.ke/News/Rights+group+roots+for+abortion+law/-/1056/1285658/-/9hbm7nz/-/index.html</a>	Emeka Gekara Mayaka	Daily Nation	December 7, 2011	Abortion
46	KNCHR push for abortion courses <a href="http://www.standardmedia.co.ke/?id=2000047983&amp;cid=4&amp;articleID=2000047983">http://www.standardmedia.co.ke/?id=2000047983&amp;cid=4&amp;articleID=2000047983</a>	Cyrus Ombati	The Standard	December 7, 2011	Abortion
47	Villagers ignore the law and go on a girl circumcision frenzy <a href="http://www.nation.co.ke/News/Villagers+go+on+a+girl+circumcision+frenzy+/-/1056/1285678/-/item/0/-/7fruae/-/index.html">http://www.nation.co.ke/News/Villagers+go+on+a+girl+circumcision+frenzy+/-/1056/1285678/-/item/0/-/7fruae/-/index.html</a>	Daniel Otieno	Daily Nation	December 7, 2012	FGM
48	Clergy livid over gay-aid link <a href="http://www.nation.co.ke/News/Clergy+livid+over+gay+aid+link+/-/1056/1286434/-/omwaiz/-/index.html">http://www.nation.co.ke/News/Clergy+livid+over+gay+aid+link+/-/1056/1286434/-/omwaiz/-/index.html</a>	Peter Leftie	Daily Nation	December 8, 2011	Homosexuality
49	Council plans to legalise prostitution <a href="http://www.standardmedia.co.ke/InsidePage.php?id=2000051421&amp;cid=4&amp;">http://www.standardmedia.co.ke/InsidePage.php?id=2000051421&amp;cid=4&amp;</a>	Cyrus Ombati	The Standard	February 4, 2012	Prostitution
50	Persecuted at home, African homosexuals seek refuge in Kenya	AFP	AFP	February 5, 2012	Homosexuality
51	Rights group slam revived Uganda anti-gay bill	AFP	Daily Nation	February 8, 2012	Homosexuality

	<a href="http://www.rnw.nl/africa/bulletin/rights-group-slams-revived-uganda-anti-gay-bill">http://www.rnw.nl/africa/bulletin/rights-group-slams-revived-uganda-anti-gay-bill</a>				
52	Girls accused of lesbianism to be counselled <a href="http://www.standardmedia.co.ke/news/InsidePage.php?id=2000051724&amp;cid=159&amp;story=Girls%20accused%20of%20lesbianism%20to%20be%20counselled">http://www.standardmedia.co.ke/news/InsidePage.php?id=2000051724&amp;cid=159&amp;story=Girls%20accused%20of%20lesbianism%20to%20be%20counselled</a>	Linah Benyawa	The Standard	February 8, 2012	Homosexuality
53	Students condemn parents for abetting FGM <a href="http://www.standardmedia.co.ke/InsidePage.php?id=2000051762&amp;cid=4&amp;ttl=Students%20condemn%20parents%20for%20abetting%20FGM">http://www.standardmedia.co.ke/InsidePage.php?id=2000051762&amp;cid=4&amp;ttl=Students%20condemn%20parents%20for%20abetting%20FGM</a>	Osinde Obare	The Standard	February 8, 2012	Female Genital Mutilation
54	Uganda anti-gay bill 'not backed by government' <a href="http://www.bbc.co.uk/news/world-africa-16963339">http://www.bbc.co.uk/news/world-africa-16963339</a>		BBC	February 9, 2012	Homosexuality
55	Kenya's legal same-sex marriages <a href="http://www.bbc.co.uk/news/world-africa-16871435">http://www.bbc.co.uk/news/world-africa-16871435</a>	Muliro Telewa	BBC	February 15, 2012	Homosexuality
56	Gays flee as irate residents storm Likoni seminar <a href="http://allafrica.com/stories/201202240097.html">http://allafrica.com/stories/201202240097.html</a>	Daniel Nyassy	Daily Nation	February 23, 2012	Homosexuality
57	How political parties sideline women leaders <a href="http://www.nation.co.ke/News/How+political+parties+sideline+women+leaders+/-/1056/1332346/-/item/2/-/iwb1ej/-/index.html">http://www.nation.co.ke/News/How+political+parties+sideline+women+leaders+/-/1056/1332346/-/item/2/-/iwb1ej/-/index.html</a>	Tim Wanyonyi	Daily Nation	February 21, 2012	Gender equality
59	Nairobi sex workers demand recognition <a href="http://www.capitalfm.co.ke/news/2012/03/nairobi-sex-workers-demand-recognition/">http://www.capitalfm.co.ke/news/2012/03/nairobi-sex-workers-demand-recognition/</a>	Lordrick Mayabi	Capital FM	March 6, 2012	Sex work
60	We are ready to pay tax, say sex workers	Aggrey Mutambo	Daily Nation	March 6, 2012	Sex work
61	Mayor: We will not legalise sex work in city <a href="http://www.standardmedia.co.ke/InsidePage.php?id=2000053702&amp;cid=4">http://www.standardmedia.co.ke/InsidePage.php?id=2000053702&amp;cid=4</a>	Mutinda Mwanzia	The Standard	March 8, 2012	Sex work
62	Kenyan health professionals push for safe abortions <a href="http://www.keycorrespondents.org/2012/03/20/kenyan-health-professionals-push-for-safe-abortion/">http://www.keycorrespondents.org/2012/03/20/kenyan-health-professionals-push-for-safe-abortion/</a>	D Njagi	Key Correspondents	March 20, 2012	Abortion
63	Legalise prostitution and homosexuality, says KNHRC <a href="http://www.nation.co.ke/News/Legalise+prostitution+and+homosexuality+says+KNHRC/-/1056/1399154/-/3f6x1a/-/index.html">http://www.nation.co.ke/News/Legalise+prostitution+and+homosexuality+says+KNHRC/-/1056/1399154/-/3f6x1a/-/index.html</a>	Nation Reporter	Daily Nation	May 3, 2012	Sex work, homosexuality



64	Kenya: Clergy and Rights Groups Oppose KNCHR Report on Homosexuality <a href="http://allafrica.com/stories/201205060053.html">http://allafrica.com/stories/201205060053.html</a>	<i>Justus Ochieng</i>	The Star	May 4, 2012	Homosexuality
65	South African leaders strike out at gay rights		AFP	May 7, 2012	Homosexuality
66	Obama says same-sex couples should be able to marry <a href="http://www.bbc.co.uk/news/world-us-canada-18014102">http://www.bbc.co.uk/news/world-us-canada-18014102</a>		BBC	May 9, 2012	Homosexuality
67	<a href="http://www.the-star.co.ke/national/national/75161-christians-oppose-knchr-report-on-sexuality">Christians oppose KNCHR report on sexuality</a> <a href="http://www.the-star.co.ke/national/national/75161-christians-oppose-knchr-report-on-sexuality">http://www.the-star.co.ke/national/national/75161-christians-oppose-knchr-report-on-sexuality</a>	Elizabeth Were	The Star	May 10, 2012	Homosexuality/Sexuality
68	Church's big no to gay marriages <a href="http://www.standardmedia.co.ke/?articleID=2000058260&amp;story_title=Church%E2%80%99s%20big%20no%20to%20gay%20marriages">http://www.standardmedia.co.ke/?articleID=2000058260&amp;story_title=Church%E2%80%99s%20big%20no%20to%20gay%20marriages</a>	Francis Ontomwa	The Standard	May 16 2012	Homosexuality
69	Clergy help sought on maternal, child deaths <a href="http://www.standardmedia.co.ke/?articleID=2000058296&amp;story_title=Donors%20cut%20funds%20to%20NGO%20council%20over%20leadership%20wrangles">http://www.standardmedia.co.ke/?articleID=2000058296&amp;story_title=Donors%20cut%20funds%20to%20NGO%20council%20over%20leadership%20wrangles</a>	Rawlings Otieno	The Standard	May 17, 2012	Maternal health
70	I'm your dad, he's your papa <a href="http://www.nation.co.ke/Features/DN2/Same+sex+marriages+/-/957860/1410372/-/113v10g/-/index.html">http://www.nation.co.ke/Features/DN2/Same+sex+marriages+/-/957860/1410372/-/113v10g/-/index.html</a>	DN2 Correspondent	Daily Nation	May 22, 2012	Homosexuality
71	Church warns against gay marriage plan <a href="http://www.nation.co.ke/News/world/Church+warns++against+gay++marriage+plan+/-/1068/1426282/-/ajitwo/-/index.html">http://www.nation.co.ke/News/world/Church+warns++against+gay++marriage+plan+/-/1068/1426282/-/ajitwo/-/index.html</a>	AFP	Daily Nation	June 12, 2012	Homosexuality
72	Uganda pro-gay groups face ban <a href="http://www.standardmedia.co.ke/?articleID=2000060253&amp;pageNo=1">http://www.standardmedia.co.ke/?articleID=2000060253&amp;pageNo=1</a>		The Standard	June 21, 2012	Homosexuality
73	Why homophobia is fear of one's own sexuality <a href="http://www.nation.co.ke/oped/Opinion/Why+homophobia+is+fear+of+ones+own+sexuality+/-/440808/1434308/-/item/1/-/wlvotp/-/index.html">http://www.nation.co.ke/oped/Opinion/Why+homophobia+is+fear+of+ones+own+sexuality+/-/440808/1434308/-/item/1/-/wlvotp/-/index.html</a>	Makau Mutua	Daily Nation	June 23, 2012	Homosexuality
74	Will South Africa make prostitution legal? <a href="http://www.bbc.co.uk/news/world-africa-">http://www.bbc.co.uk/news/world-africa-</a>		BBC	July 4, 2012	Sex work

	<a href="#">18690345</a>				
75	Ida Odinga urges check on teenage pregnancies <a href="http://www.nation.co.ke/News/Ida+Odinga+urges+check+on+teenage+pregnancies+/-/1056/1446268/-/lg7px0/-/index.html">http://www.nation.co.ke/News/Ida+Odinga+urges+check+on+teenage+pregnancies+/-/1056/1446268/-/lg7px0/-/index.html</a>	Aggrey Mutambo	Daily Nation	July 6, 2012	Teenage Pregnancy
76	Gender rule elusive as women aspirants face teething hurdles <a href="http://www.standardmedia.co.ke/?articleID=2000061375&amp;story_title=Gender-rule-elusive-as-women-aspirants-face-teething-hurdles">http://www.standardmedia.co.ke/?articleID=2000061375&amp;story_title=Gender-rule-elusive-as-women-aspirants-face-teething-hurdles</a>	Stephen Makabila	The Standard	July 7, 2012	Gender equality
77	Put cap on family size, state told <a href="http://www.standardmedia.co.ke/?articleID=2000061713&amp;story_title=Put-cap-on-family-size,-state-told">http://www.standardmedia.co.ke/?articleID=2000061713&amp;story_title=Put-cap-on-family-size,-state-told</a>		The Standard	July 11 2012	Family Planning
78	Kenya joins global birth control push <a href="http://www.nation.co.ke/News/Kenya+joins+global+birth+control+push+/-/1056/1452570/-/12nmck9/-/index.html">http://www.nation.co.ke/News/Kenya+joins+global+birth+control+push+/-/1056/1452570/-/12nmck9/-/index.html</a>	Samuel Siringi	Daily Nation	July 12, 2012	Family Planning
79	Catholics reject family planning drive <a href="http://www.standardmedia.co.ke/?articleID=2000062391&amp;story_title=-Catholics-reject-family-planning-drive">http://www.standardmedia.co.ke/?articleID=2000062391&amp;story_title=-Catholics-reject-family-planning-drive</a>	Lucianne Limo	The Standard	July 21, 2012	Family Planning
80	Bishop: Gays dangerous than terrorists <a href="http://www.standardmedia.co.ke/?articleID=2000062448&amp;story_title=Bishop:-Gays-dangerous-than-terrorists">http://www.standardmedia.co.ke/?articleID=2000062448&amp;story_title=Bishop:-Gays-dangerous-than-terrorists</a>	Patrick Beja	The Standard	July 22, 2012	Homosexuality
81	Group vows to change Kenya's 'pro-gays' law <a href="http://www.nation.co.ke/News/Group+vows+to+change+Kenyas+pro+gays+law/-/1056/1463538/-/hba3c8z/-/index.html">http://www.nation.co.ke/News/Group+vows+to+change+Kenyas+pro+gays+law/-/1056/1463538/-/hba3c8z/-/index.html</a>	Kevin Kelley	Daily Nation	July 25, 2012	Homosexuality
82	Kenyan Roman Catholic bishops oppose push for birth control <a href="http://www.pcusa.org/news/2012/8/2/kenyan-roman-catholic-bishops-oppose-push-birth-co/">http://www.pcusa.org/news/2012/8/2/kenyan-roman-catholic-bishops-oppose-push-birth-co/</a>	Fredrick Nzwili	Ecumenical News International	August 2, 2012	Family Planning
83	Muslims opposed to proposed marriage Bills <a href="http://www.standardmedia.co.ke/?articleID=2000064540&amp;story_title=Muslims-opposed-to-proposed-marriage-Bills">http://www.standardmedia.co.ke/?articleID=2000064540&amp;story_title=Muslims-opposed-to-proposed-marriage-Bills</a>	David Ochami	The Standard	August 22, 2012	Women's rights
84	Delays in enacting the two-thirds principle a threat	Winnie Lichuma	Daily Nation	August 28, 2012	Gender equality

	to Constitution <a href="http://www.nation.co.ke/oped/Opinion/Delays+a+threat+to+Constitution/-/440808/1489020/-/cpxsksz/-/index.html">http://www.nation.co.ke/oped/Opinion/Delays+a+threat+to+Constitution/-/440808/1489020/-/cpxsksz/-/index.html</a>				
85	Gender rule still defies Kenya's top law brains <a href="http://www.nation.co.ke/News/politics/Gender+rule+still+defies+Kenyas+top+law+brains/-/1064/1517596/-/esi5ucz/-/index.html">http://www.nation.co.ke/News/politics/Gender+rule+still+defies+Kenyas+top+law+brains/-/1064/1517596/-/esi5ucz/-/index.html</a>	Nation Team	Daily Nation	September 25, 2012	Gender equality
86	Ugandan sexual rights activists get Norwegian prize <a href="http://www.nation.co.ke/News/africa/Ugandan+sexual+rights+activists+get+Norwegian+prize/-/1066/1244958/-/le7lf5/-/index.html">http://www.nation.co.ke/News/africa/Ugandan+sexual+rights+activists+get+Norwegian+prize/-/1066/1244958/-/le7lf5/-/index.html</a>	AFP	Daily Nation	September 29, 2011	Homosexuality
87	Malawi suspends laws against homosexual relationships <a href="http://www.bbc.co.uk/news/world-africa-20209802">http://www.bbc.co.uk/news/world-africa-20209802</a>		BBC	November 5, 2012	Homosexuality
88	Kenyan bid to ban bride-price payments <a href="http://www.bbc.co.uk/news/world-africa-20268785">http://www.bbc.co.uk/news/world-africa-20268785</a>		BBC	November 9, 2012	Culture and SRH rights
89	Uganda to pass anti-gay law as 'Christmas gift' <a href="http://www.bbc.co.uk/news/world-africa-20318436">http://www.bbc.co.uk/news/world-africa-20318436</a>		BBC	November 13, 2012	Homosexuality
90	Dark world of Kenyan homosexuals Monday, February 25, 2013 <a href="http://www.standardmedia.co.ke/?articleID=2000078052&amp;story_title=Kenya-Dark-world-of-Kenyan-homosexuals">http://www.standardmedia.co.ke/?articleID=2000078052&amp;story_title=Kenya-Dark-world-of-Kenyan-homosexuals</a>	Njoki Chege	The Standard	February 25, 2013	Homosexuality

## **Appendix IX: Lobbying and Advocacy Activities for the Passage of the Sexual Offences Bill**

*Framing of the bill as meant to protect children, daughters, mothers and grandmothers:* Given the strong opposition anticipated, a decision was made by both women MPs and civil society to frame the sexual offences bill as a law meant to protect 'children', 'daughters', 'mothers' and 'grandmothers' as opposed to that meant to protect 'generic women' in order to appeal to the emotions of male MPs. They argued that talking about the bill as meant to protect children, daughters and mothers would generate sympathy from male MPs as opposed to talking about it as meant to protect 'generic women', which they argued would be seen as 'targeting' men for punishment and would consequently produce a backlash. Informants believed that this framing was critical in softening hard-line opposition to the bill by male MPs.

*Targeted lobbying of male MPs:* Even before the bill's presentation in parliament, women MPs initiated lobbying efforts that targeted individual male MPs to explain the importance of the bill and clarify any confusion and concerns about it. Lobbying of individual male MPs took place both within and outside parliament. Lobbying within parliament often happened during debate on the bill before voting, which was argued as useful since MPs voted immediately after the debate while the arguments for supporting the bill were still fresh in their minds. Also, women MPs 'used' the few male MPs supporting the bill to generate support from fellow men. They strategically had all the readings of the bill in parliament 'seconded' by a male MP so as to challenge those opposed to the bill. Further, targeted lobbying of political party leaders by women MPs and civil society was conducted to marshal support for the bill among party members in parliament. Also, women MPs and civil society lobbied spouses of male MPs, appealing to them to lobby their husbands to support the bill (Onyango-Ouma et al 2009). Further, civil society organisations sent emails and text messages to male MPs appealing to them to support the bill. These messages however contained threats and were condemned by male MPs as intimidating and, as earlier noted, could have possibly contributed to increased opposition to the bill. Finally, women MPs used friendships to male MPs in order to enlist their support for the bill. This involved accompanying male MPs in their constituency tours, making financial contributions to projects spearheaded by male MPs, and letting male MPs attend international meetings outside the country which women MPs had been invited to attend, among others. For some male MPs who were totally opposed to the bill, it was reported

that women MPs requested them, out of friendship, either not to comment on the bill in parliament or not to attend parliament sessions in which the bill was debated.

*Meetings and workshops:* Meetings and workshops were held with MPs and other stakeholders including religious leaders, to facilitate comprehensive discussion of the bill and concerns. Meetings with religious leaders specifically aimed to allay fears that the bill was tackling abortion, and also appeal to them to use their religious platforms to educate the public about the bill and implore male MPs to support the bill. Besides high level meetings with MPs and other influential elite actors, civil society organised community level activities in order to create awareness and generate public support for the bill.

*Mass media visibility of sexual offences:* As part of generating public support for the bill, the mass media were used to educate and sensitise the public on sexual violence and its health implications. Specifically, women MPs gave several media interviews on the bill. Civil society organisations, collectively and individually, put up advertisements as well as ran programmes in the media about the bill and the urgent need to address sexual violence. They strategically worked with editors and media owners to prioritise sexual violence issues in media headlines. In addition, civil society negotiated with editors to give highest priority in news and feature stories to sexual violence incidents among children and grandmothers in order to appeal to the emotions of male MPs and the public, as noted here:

‘...you’ll remember that during the debate of the bill in parliament, the media all over sudden were covering a lot of rape incidents including rapes of grandmothers, babies, etc. 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 and Director, WILDAF, Nairobi, July 28, 2011].

Also, civil society put up banners and bill boards to create public concern about the bill. They also prepared and printed short and accessible versions of the bill and circulated to the public.

*Street demonstrations:* Civil society organisations held peaceful street demonstrations in Nairobi in support of the bill. The demonstrations, though peaceful, were blocked by police. This tactic was however ridiculed in parliament by male MPs as women’s attempt to intimidate men, reflecting men’s assumed superior position in the Kenyan society vis a vis women’s inferior position which implies they (women) should not tell men what to do.