Understanding Power in Sexual and Reproductive Health Policy and Legislative Reform Processes in Kenya

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Background

The development of national health policies is a complex process that is often not well understood [1][2][3][4][5]. Scholars have identified various factors that shape health policies including existing power structures within the local context [6], national and regional political processes [7][8], and the global governance and the global health arena in policy-making [5][9]. Even then, recent scholarship has revealed that the health policy analysis field in low and middle income countries (L&MICs) is still in its infancy and most studies conducted have not focused on investigating the role of power in the policy process [1][6][10][11][12]. It has also been noted that health policy analysis research in these countries has been mostly framed around positivistic concepts of the health systems, without drawing on useful explanatory concepts from the social science field, even though health systems are complex social and political phenomena [10][11].

The recent focus on systems thinking within the health sector is indeed driven by the acknowledgement that health systems are complex [13][14]. And so, understanding and working with complexity requires a paradigm shift from linear, reductionist approaches to dynamic and holistic approaches that appreciate the multifaceted and interconnected relationships among health system components, as well as the views, interests and power of its different actors and stakeholders [11][15].

This study sought to contribute to this emerging recognition of complexity in health systems and policy processes. With a focus on discursive power, the study examined the drivers and inhibitors of policy reforms in sexual and reproductive health (SRH) in Kenya in order to demonstrate complexity and generate learning for future reform efforts.

Sexual and Reproductive Health: Contested Origins, Contested Reality

The concept of reproductive health (RH) emerged in international development policy at the 1994 International Conference on Population and Development (ICPD) through a heavily contested process [16]. The further coining of sexual and reproductive health (SRH) as human rights was first formalised internationally at the ICPD. This human rights framing was strongly contested and opposed at ICPD mainly by Christian (Catholic/Vatican) and Muslim religious groups and conservative governments (mainly from Africa, the 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 [17]. Underlying this opposition was religious ideology and cultural interests that undermine women's and adolescents' autonomy on issues of sexuality and reproduction.

In Kenya, like the international scene, SRH remains an area that is riddled with a lot of contestations. 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. This study unpacks three SRH policymaking processes in Kenya to lay bear the factors and actors

that drive or inhibit reforms. The study takes a central focus on power, specifically discursive power, to explore these policy processes.

Why focus on Discursive Power?

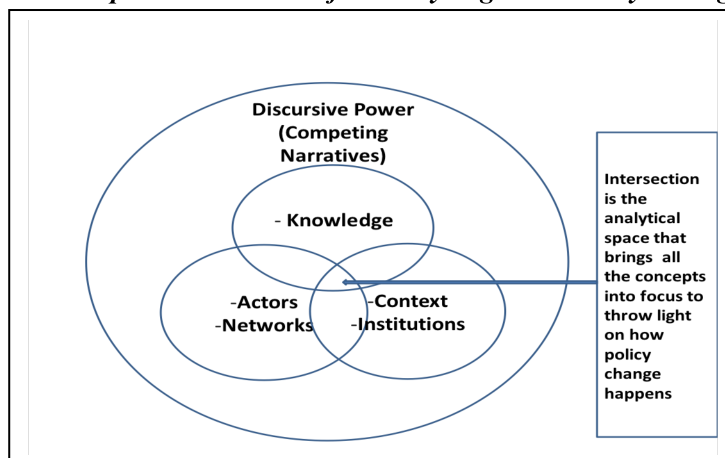
Public policymaking is about power [18][19]. Cognizant of the fact that the study's subject focus - sexuality and reproduction- are socially complex issues, the focus on power takes a discursive approach (borrowing heavily from the works of John Fischer 2003). The discursive approach to power takes a fundamental view of discourses and language that govern people's thinking and actions [20]. Foucault [20] 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 ([21], p.108].

According to Fischer [19], discursive approach sees language and discourse as having a more underlying role in structuring social and political action. Although language is important in this approach, it is 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 [19]. As such, through 'the signs and symbols of a language, people construct their social world and the political actions they undertake to influence it' ([19], p.42). Fischer goes further to argue 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 ([19], p.46). As such, political action is shaped and controlled by the discourses that supply it with meaning, and consequently, problems do not just come onto the political agenda because they are there, they come as a reinforcement of ideologies [19].

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. This study therefore conceived of power as embedded in competing discourses 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 (scientific and lay), and power embedded in context and institutions. This formed the study's conceptual framework, captured in Figure 1 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.

The conceptual framework was an adaptation of two existing models of policy change, namely the IDS-KNOTS 2006 model and Sumner and Jones [22] framework (see [22][23]).

The discursive approach to power was adopted because it challenges the dominant technocratic, empiricist/neopositivist approach to health policy analysis in LMICs [10]. The discursive approach is critical in policy analysis because of its focus on values and social meaning, which Fischer ([19], p.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.

Methods

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 some 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 determine change in a given policy issue. Yanos [24] has noted that qualitative methods in policy analysis enable the understanding of the policy-making processes, meaning and interpretation of policy decisions. The need to draw on anthropological concepts was informed by the fact that the study focused on exploring issues that Shore and Wright ([25], p.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 study 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.

The Case Studies

Three carefully selected case studies were the main focus of this study, 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.

Ethical Considerations

The study design and methodology was approved by the University of Sussex following a successful ethical review and clearance process. 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 [26]. The presentation of findings protects 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.

Data Collection

Semi-structured in-depth interviews

Fifty-four (54) semi-structured in-depth interviews were conducted 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 respondents for the different case studies. The initial list of respondents 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 respondents to suggest individuals who contributed to the policy development process and whom I should also interview. This exercise increased the number of respondents 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 [27] 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 1 summarises the types of institutions from which interviewees were drawn and the number of interviewees from the institutions.

Table : Interviewee Summary

Institution Type	**Total Number of Institutions**	**Total Number of Respondents**
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
Total		**54**

The interviews were guided by an interview schedule 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. Except four, all interviews were recorded and transcribed. For the four, which the respondents were opposed to recording, I took notes during the interview and typed out immediately after the interview.

Participant Observation

Participant observation was conducted through two main methods, i.e. participation in meetings and media content tracking and review.

Participation in SRH meetings – Participant observation was conducted through my participation in three major meetings including: 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 2nd 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)).

Media content review – I conducted an extensive media monitoring between January 2010 to June 2012 in order to capture debates and the discourses of SRH issues by different policy actors. 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[1], 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 and the Voice of America, which capture SRH debates in SSA were also monitored and content reviewed.

Document Review

Alongside the preceding data collection methods, I conducted a comprehensive review of policy documents, organisational publications and reports, and academic literature. These documents were gathered through Internet searches as well as through visits to various organisations. My document review was informed by both policy analysis practices and anthropological practices. Focusing on policy analysis, I relied on documents to understand the workings and commitments of government on SRH, whereas taking an anthropological focus, I interrogated what the commitments really meant – whose interests they prioritised and whose interests they marginalised, and why?

Analysis

I blended more structured policy studies analytical methods with those from anthropology, which tend to be less structured and more iterative and inductive. 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' ([28], p. 95). This enabled to capture the ways in which different actors frame issues. I used the NVivo software for storing and structuring textual data from interviews. 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 followed by a second level of analysis shortly after fieldwork. 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.

Limitations

By focusing on studying past policymaking processes, the findings of this study may not represent the current or future policymaking processes, especially in light of the devolution process that has taken place in Kenya since 2013 following the inauguration of the new constitution in 2010. Also, this study only focused on policymaking processes; it did not look at the implementation processes of the policies analysed. The study therefore does not provide answers on whether the policies studied were implemented or not, or what their impact has been.

Results

Four Competing Discourses of SRH shape Policymaking Processes in Kenya

This study identified four distinct, but overlapping discourses of SRH or ways in which SRH issues 'are talked about' by different policy actors in Kenya. The different discourses voice certain SRH issues while silencing others, and are driven by actor interests, beliefs and values. These discourses include: SRH as a moral issue, SRH as cultural issue, SRH as a medical issue, and SRH as a human

[1] Daily Nation, The Standard, The Star, Kenya Broadcasting Corporation, Capital FM, etc.

rights issue. Underpinned by conflicting actor interests, the discourses mediate the interplay of actor networks, knowledge, context and institutions to determine reforms. The discourses compete, but also intersect to produce overwhelming opposition or create spaces for reforms.

SRH as a Moral Responsibility for all

The moral discourse of SRH is founded largely in religion, particularly Christianity and Islam. The discourse emphasises the sanctity of life and perceives human sexuality as a gift from God for procreation. It is focused on controlling people's sexuality and reproduction to ensure that these are practised in line with religious prescriptions. In the discourse, sexual relations are only permissible between married man and woman; 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 discourse's framing of procreation as God's gift for continuation of society, it is opposed to modern contraception. Still on reproduction, the discourse holds that 'life begins at conception', and is therefore opposed to emergency contraception and abortion, which it frames as 'murder'.

The discourse silences and marginalizes the voices, needs, rights and interests of women. Considerations of gender equality and women's empowerment are also marginalised. In addition, SRH needs, rights and interests of adolescents are marginalised since the discourse prescribes chastity until marriage. Further, the discourse marginalises the interests, needs and rights of people involved in same-sex practices and sex work.

The discourse imbues with normative prescriptions and marginalises scientific evidence that shows things to be happening otherwise, as aptly captured by a Kenyan Muslim cleric, who argued that 'unwanted pregnancy is caused by moral decay and so it is totally not permitted'[2]. It has been argued that the discourse tends to bestow society's moral duty on girls and women, whose sexuality and reproduction it is keen to control [29][30][31]. By focusing on religious and conservative values, the discourse serves the interests of religious groups, political leaders, men and conservative sections of the Kenyan society. For religious groups, the discourse is a powerful resource for controlling the sexuality and reproduction of Kenyans. For politicians, supporting the discourse assures them of political endorsement from religious leaders, who remain influential in the Kenyan polity.

The main actors behind this discourse in Kenya are religious groups (mainly the Kenya Episcopal Conference-Catholic Secretariat (KEC-CS), National Council of Churches of Kenya (NCCK), Supreme Council of Kenya Muslims (SUPKEM), and the Inter-Religious Council of Kenya (IRCK)) and politicians. However, the discourse is pervasive in Kenya since religion occupies an important part in the lives of most Kenyans, with nearly 90% 'proclaiming' Christianity (78%) or Islam (10%).

The Cultural Construction of SRH

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. Intertwined with conservativeness is a sense of silence 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 [32]. Thus, patriarchy, conservativeness and silence surrounding SRH largely constitute the African cultural framing of SRH.

[2] Dr. Sheikh Abdhallah Kheir, Kenyatta University, addressing Maternal Mortality Conference, September 15-16, 2011, Nairobi.

The cultural discourse seeks to control and exclude, and is mainly propagated in decision-making processes by male politicians and religious leaders. Controlling the sexuality and reproduction of women is a particularly important aspect of the discourse and a fundamental mechanism by which power is exerted in Kenyan society. The discourse privileges men's interests and needs over women's, constructing women as unequal to men and therefore needing to be guided and controlled [30]. Constructing male sexuality as dominant and desirable, the discourse seeks to preserve men's privileged control over, and access to, women's sexuality [33]. In all its framings, the discourse silences women's interests, needs and rights in relation to sexuality and reproduction.

The cultural discourse further 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 [34]. Further, the discourse 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) [35], while others have noted its existence only that it was not explicitly discussed or identified as such [36][30]. The discourse's focus on promoting patriarchy, conservativeness and silence around sexuality and reproduction supports the moral discourse'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.

The Medical Discourse of SRH

The medical discourse, underpinned by the biomedical science, frames SRH as a predominantly medical issue that requires medical solutions. The biomedical knowledge that guides the medical field is deemed as the gold standard for informing health policies. As Lock and Nguyen ([37], p.54) have noted, biomedicine assumes a 'universal, decontextualized body as the primary site for the production of medical knowledge and management of disease'. The discourse is, therefore, highly de-personalised and margnalises context and social phenomena.

The medical discourse conceals power, interests, and biases by presenting biomedical science as the most objective gold standard scientific knowledge that should inform health policies. Thus, basing SRH policies on biomedical science gives the impression that policies are objective and neutral, without any political or interest group interference. Yet, it is widely acknowledged that policies are inherently political [25]. In this sense, the medical discourse can be seen as what Foucault has termed a 'political technology', i.e. the means by which power conceals its own operation in the neutral language of science to bring about reforms. As a political technology, the discourse is powerful in bringing about reforms.

In Kenya, the medical discourse is mediated by the Ministry of Health and is dominant in the health bureaucracy and health policymaking. Notably, the medical discourse in Kenya has two main variations. At the global level, the WHO's medical discourse frames all SRH issues, including sensitive issues of abortion [38] and SRH needs of sexual minorities, as health concerns deserving attention; this is what I call the *comprehensive medical discourse*. However, the medical discourse adopted by the health bureaucracy in Kenya excludes sensitive issues (i.e. abortion, homosexuality and sex work) because proponents of the discourse argue that these are not 'medical' issues. This is what I call the *moralised medical discourse*, and it reflects the co-construction of the discourse with religious interests and politics to produce a version that marginalises issues not supported by powerful actors and institutions locally.

The Kenya Medical Association (KMA), Kenya Obstetricians and Gynaecologists Society (KOGS), and National Nurses Association of Kenya (NNAK) adopt the 'comprehensive' medical discourse 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 (see [39], p.17). It is important to note that the medical discourse adopted in these associations varies with the values of the individuals leading the associations (the Chairperson and Secretary General) at any given time.

By focusing on the ideals of biomedicine while neglecting other phenomena and research evidence, the medical discourse mainly serves the interests of medical experts by maintaining their power in health policymaking. The moralised medical discourse justifies the moral discourse thereby serving the interests of government officials, religious and political leaders. On the other hand, the discourse marginalises women's voices and interests, as well as, gender power imbalances and the social contexts that produce and sustain most SRH challenges. Further, the moralised medical discourse marginalises adolescent sexuality, abortion and LGBTI issues. Also, the discourse 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 discourse marginalises power and politics, which are critical drivers of policy/legislative reforms.

The Human Rights Discourse of SRH

In Kenya, like on the international scene, the framing of SRH as rights continues to be strongly contested especially as it relates to adolescents' access to comprehensive SRH information and services, abortion, sexual rights, and homosexuality. At ICPD, Kenya opposed comprehensive adolescent SRH information and services, declaring 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…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 (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, the processes of adopting SRH as rights in Kenya have been characterised by contestations and controversy. Kenyan laws prohibit abortion (except if a woman's life is in danger), homosexuality and sex work. These issues are also stigmatised and scorned upon by many Kenyans. The strongest opposition to contentious SRH rights issues in Kenya has, unsurprisingly, come from religious groups (mainly KEC-CS, SUPKEM and NCCK) and politicians.

Opposition to the SRH rights narrative in Kenya is on two grounds, i.e. morality and culture. 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' 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 discourse as not promoting African cultural values, beliefs and practices.

The opposition to the SRH rights discourse finds legitimacy in Kenya's legal framework, 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. Religious groups have often used politicians

to resist the SRH rights discourse by threatening to mobilise Kenyans against re-electing them if they do not support the moral view of SRH[3]. 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 discourse in the country.

The women's movement and human rights organisations have led advocacy efforts for SRH rights. These organisations/networks have mainly focused on access to modern contraception, abortion, gender-based violence, FGM and women's rights in general. It is only recently that the LGBTIs issue has started gaining currency in Kenya, especially following the 2010 Constitution, which recognized the right to reproductive health.

Intersectionalities within the Four Discourses

As already noted, the four discourses do not operate independent of each other. In fact, actors often draw on more than one discourse to strengthen the power of their arguments.

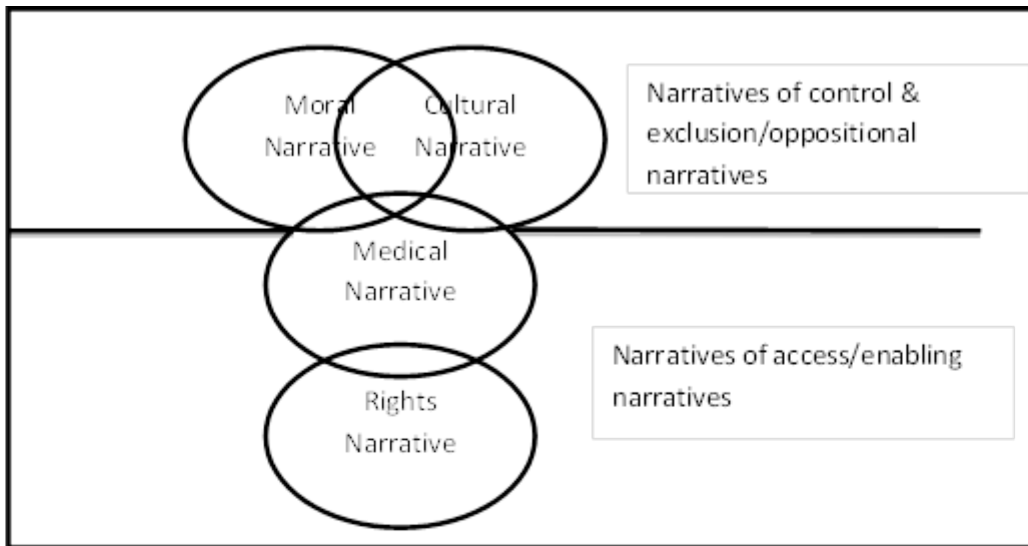
Moral/Cultural - The moral discourse is strongly interrelated with the cultural discourse. Both discourses focus on control and exclusion, and are underpinned by patriarchy and conservativeness. Thus, actors behind the two discourses often draw on both discourses to oppose reforms on certain SRH issues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

Medical/Moral/Cultural – It has been argued that the biomedical sciences that underpin the medical discourse have been founded on moral principles [40], and often reinforce moral arguments [41]. Similarly, the marginalisation of girls' and women's voices in the medical discourse, even whilst these groups bear the brunt of poor SRH outcomes, reinforces patriarchal practices ingrained in both the cultural and moral discourses.

Medical/Rights – Although with different foundations, the medical and the human rights discourses 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 discourses often argue for SRH reforms to ensure the realisation of the universal human right to health and the human right to life.

[3] '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).

Figure 2: Discourse Intersectionalities



Source: Author 2013.

The making of the Adolescent Reproductive Health Policy of 2003

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

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

Given the medical background of the lead actors within the two networks, the medical discourse was dominant within the networks. A lead actor and researcher at CSA said 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...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].

The medical discourse 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.

Calls by CSA and KAPAH to provide adolescents with SRH information were opposed by religious groups, organising under the Inter-Religious Council of Kenya and politicians. Religious leaders

condemned the calls for sexuality education as 'immoral' and likely to 'teach children about sex'. During the same period, CSA in collaboration with the Ministry of Education were piloting a sexuality education programme in a few schools. The decision by the Ministry of Education to scale up this programme countrywide in 1996 occasioned the peak of the controversy. Religious groups, led by the then Catholic Cardinal (the late Maurice Otunga) on August 31, 1996, burned text books that were being used in the pilot programme in Nairobi streets and other towns. Alongside the books, the group also burned condoms. Describing the controversy, a respondent said:

> 'We had been piloting life skills education programme in schools…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 discourses, religious groups accused the Ministry and its partners of teaching 'children about sex'. Taking the position of religious leaders, President Moi strongly opposed the sexuality education programme, arguing that it was not only 'immoral', but was also bound to teach children 'bad manners' [42]. Thus, the moralised medical discourse within the CSA-UNFPA-NCPD epistemic community clashed with the moral and cultural discourses dominant in the religious and the political establishment.

Although the SRH rights discourse had already emerged from ICPD, it was not emphasised by actors mainly because of their medical focus as well as 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. So, for a long time, the moral and cultural discourses dominated adolescent SRH debates, with the result that throughout the 1990s, despite sustained evidence-informed advocacy, no policy reforms were realised.

However, in the late 1990s, three things happened. Between 1998 and 2001, one of CSA's co-founders (Dr. Khama Rogo) became the chairperson of NCPD's governing board. Around the same time, another co-founder of CSA (Dr. Wangoi Njau) joined UNFPA as the deputy Kenya country representative. This greatly strengthened the CSA-UNFPA-NCPD epistemic community, putting CSA's adolescent SRH champions in influential positions. Then, in 1999, President Moi declared HIV/AIDS a national emergency and committed to make all efforts to fight the disease [43]. Further, Moi, who was well known for his strong opposition to condoms, declared his support for condoms in the fight against HIV/AIDS (see [43]).

This political shift unsettled the hegemonic moral and cultural discourses surrounding SRH, dipping power in favour of the medical discourse to create political space for change. Three factors were at play here: first, HIV/AIDS prevalence (estimated at 13% in 1999) was rising rapidly and Kenya's economy was crumbling partly as a result of the impact of the disease[4,5]. Second, given the devastating effects of HIV/AIDS, donors were putting Moi under pressure to prioritise the disease in order to receive donor funding [43]. Third, Moi was serving his final term as president and so politically, he did not have much to lose by abandoning the moral and cultural discourses. These changes saw NCPD's governing board decide to develop an adolescent RH policy in 1999, and UNFPA country office commit to fund the policy development process.

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

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

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

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

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

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

The 2006 Sexual Offences Act Legislative Process

Increase in rape incidence propelled civil society into action to address gaps in law

Calls by civil society (led by FIDA-Kenya) for a sexual offences law in Kenya started in the 1990s following increased media reports of sexual violence. One incident that stood out was a 1991 rape ordeal in a mixed secondary school perpetrated by boys that left 19 girls dead. Another dimension of the sexual violence was the increase in rape of very young children (youngest being 5 months) and grandmothers (oldest being 86 years) [44]. Even then, the 1990s efforts for law reforms did not achieve much given the non-supportive political context, particularly President Moi's outright opposition to women's rights as noted earlier.

So, the 2002 change in government and political leadership (noted in the previous case study) saw the coming in of some progressive members of parliament, among them, a women's rights lawyer and activist, Njoki Ndung'u. Civil society organisations seized the opportunity presented by the political change, which had substantially dipped political power in favour of the human rights discourse, to renew efforts in getting a comprehensive law on sexual violence. The main discourse within the advocacy efforts was human rights; actors argued for the need to address the rights abuses that children and women experienced from sexual violence. An important emphasis of the discourse was children's rights as actors argued that a focus solely on women's rights would have generated more opposition given the unsupportive patriarchal context in which rape of women is not taken seriously. Thus, women's rights were pegged onto children's rights to sexual integrity in order to pave way for reforms.

Civil society spearheaded by the CRADDLE, a children rights NGO, drafted a sexual offences bill, but unsuccessfully sought to convince the Attorney General (AG) to present this in parliament as a government bill. Reprieve came when the woman MP Njoki Ndung'u proposed to present a similar bill in parliament. The AG formed a committee comprising civil society, the MP, and his office [27].

Using the earlier draft by the civil society, this taskforce drafted the sexual offences bill that was presented in parliament for debate by Njoki Ndung'u. 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. Within parliament, the MP mobilised all women MPs to support the bill and to lobby male MPs for support.

Debating sexual offences law put gender power imbalance at centre stage

The first reading of the sexual offences bill in parliament demonstrated the clash between the bill's rights focus and the dominant cultural discourse in Kenya's male dominated parliament. Majority male MPs opposed the bill through trivialized debates. The main opposition was on the clauses that proposed to criminalise unwelcome sexual advances, sexual harassment, rape in marriage and FGM. The main reason for opposing these clauses was the argument that these clauses were against African cultural practices, norms and values. For instance, male MPs opposed the clause on unwelcome sexual advances and sexual harassment, saying that these were 'the basic tenets of social life of courtship' and that outlawing them would abolish courtship ([45], p.803).

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. 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'. 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 [46][47]. Evidently, gender battles dominated the initial debates of the bill, but were often masked in arguments of cultural and social norms and values, or 'unAfrican/Western'. These battles were focused on protecting men's interests by all means at the expense of women's bodily and sexual autonomy, and rights.

When the bill was presented for second reading after several revisions and intense lobbying, it received relatively less opposition. 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 ([27], p.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.

When the bill was presented for final 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 approved. At this stage, women MPs did not have numbers to overcome the opposition. The removal of the clause criminalising marital rape was done at this stage. The rationale for removing the marital rape clause was argued by male MPs as the need to 'protect and safeguard the marriage institution' ([45], p. 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 opposed and removed from the bill during the 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 the final stage. Although strongly opposed by women MPs, this clause sailed through. Supporters of the bill argued that the clause discourages survivors of sexual violence from coming out to report abuse.

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. 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. FGM was later criminalized in 2011 following the exit from parliament of MPs who were opposed to it and the coming in of some supportive male MPs in 2008.

The making of the National Reproductive Health Policy of 2007

Low Profile of RH and Poor Indicators stimulated the need for a Policy

Following the 1994 ICPD, Kenya developed an RH Strategy of 1997-2010 to operationalize the ICPD Programme of Action. However, the strategy was never implemented[6]. The need for an RH policy emerged in 2002 from the organising efforts of newly deployed RH medical professionals at the MoH's Division for Reproductive Health (DRH). The medical professionals established an epistemic community -the Reproductive Health-Interagency Coordinating Committee (RH-ICC)- comprising stakeholders from donor and UN agencies, and international research and programme organisations (who were largely fellow medical professionals)[7].

The need for an 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 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 'emerging' RH issues, such as reproductive tract cancers, had not been addressed in the 1997 RH strategy, and therefore needed a policy response.

Like the CSA-UNFPA-NCPD network in the adolescent RH policy process, the RH-ICC adopted the medical discourse 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', the RH-ICC's medical discourse 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, some of the senior officers at DRH spearheading this network held unsupportive personal values on sensitive SRH issues. For instance, a respondent intimated that the DRH head at the time 'hated abortion'[8]. Moreover, the organisations that dominated the network were funded by USAID, which

[6] Interviews: Former official, DRH, May 16, 2011, Nairobi; Technical expert, National RH Policy, July 18, 2011, Nairobi.
[7] 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.
[8] 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'.

under the US government's 'global gag rule', does not support abortion-related work, and only supported abstinence-only adolescent SRH programmes at the time through PEPFAR. Thus, the organisations could not support a discourse recognising abortion and adolescent contraception. So all these contextual, structural, funding as well as personal factors produced the moralised medical discourse adopted by the network.

It is therefore unsurprising that although the SRH rights discourse was an alternative, it was not given much attention in the RH-ICC's policy deliberations. Avoidance of the SRH rights discourse was also a strategy to depoliticise the process [25] as respondents argued that the SRH rights discourse attracts opposition from religious and political leaders. Indeed, as noted earlier, a senior officer at the DRH, who was 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 discourse 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.

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 (a USAID-funded initiative) and to request for funding for the process from USAID; both institutions were members of the RH-ICC. The DRH further formed a policy development taskforce, drawn from the RH-ICC members, which worked with Policy Project in reviewing policy drafts. Conspicuosly missing from the RH-ICC and this taskforce were organisations that take either the comprehensive medical approach or a human rights approach to SRH, particularly those that prioritise abortion, such as KMA, Kenya Obstetrics and Gynaecology Society (KOGS), FIDA-Kenya, Ipas Africa Alliance, PPFA-Africa Region, and IPPF-Africa Region. The exclusion of actors who focus on contentious SRH issues was a deliberate effort to avoid attracting opposition to the policy development process from religious and political leaders. Further, some respondents argued that the policy process focused on actors with 'technical expertise' in SRH issues and not 'activists or interest groups'.

Contentious issues during the policy development and consultative process included adolescent SRH, abortion and post-abortion care, and the language of rights (i.e. 'sexual rights' and 'reproductive rights'). 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[9]. Respondents argued that abortion and homosexuality were not discussed during the policy development process as these are prohibited by Kenyan law.[10] 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'.

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 respondents argued that it was 'a medical emergency'. Respondents also argued that the fact that post-abortion care was a WHO directive helped to marginalise the opposition to its inclusion in the policy.

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

[9] Technical expert, National RH policy, March 22, 2011, Nairobi.
[10] Interview, technical expert, National RH policy, March 22, 2011, Nairobi.

sanctioning abortion, homosexuality, and adolescents' involvement in sexual activities. The Policy Project expert leading the policy development process argued that:

> '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.' [Interview, former official of an international health policy organisation, March 25, 2011, Nairobi]

The experts developing the policy self-censored in order to avoid opposition as argued below by another respondent:

> '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….' [Technical expert, National RH policy, March 22, 2011, Nairobi].

The dominance of the moralised medical discourse in the RH-ICC 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 [48][49], adolescent contraception education and provision, and SRH needs of sexual minorities (homosexuals and sex workers). The policy was approved and issued by the Minister for Health in 2007.

Discussion

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 demonstrate the important role of influential individual actors (or issue champions) in manoeuvring barriers to enable policy change [9]. These individual actors used their influential positions as well as working through networks to bring about reforms. Networks in both bureaucratic and legislative processes were dominated by actors of specific professions (i.e. professional silos). The networks therefore adopted SRH discourses supported by the profession of the dominant actors and easily marginalised actors promoting alternative discourses. 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 discourse, effectively marginalising sensitive SRH issues in these processes. The legal processes, on the other hand, were dominated by networks of legal and rights professionals.

Important 'actor-oriented' factors that made reforms possible included actor agency/advocacy, the presence of issue champions in important positions of authority, and influential formal or informal networking. 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, particularly the US government's funding policy on abortion and adolescent SRH, contributed to the lack of comprehensive SRH reforms in Kenya.

The findings point to the need for actors leading health policymaking processes to open up these spaces for a wide range of actors, on the one hand, and for the need for marginalized actors to make deliberate efforts in accessing and influencing health policymaking spaces.

Some Scientific Knowledge was more Influential than Others

Knowledge had to compete with other factors in influencing SRH policy reforms 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, some donors attached HIV/AIDS funding for Kenya to President Moi's political commitment to fighting the disease (see [43]), while issue champions manoeuvred their way into important political positions where they were able to influence policy decisions. Moreover, researchers formed strategic alliances and networks 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.

The findings of this study further 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. Furthermore, the dominant moralised medical discourse in the bureaucratic policy networks also meant that quantitative evidence on sensitive SRH issues was ignored. For instance, a much-publicised study on the extent of abortion in Kenya was released in 2004 [50] during the same period that the policy development process was initiated. The findings of this study however did not inform the national RH policy development process or content in any way; in fact, the policy did not commit to any interventions for addressing the high rates of unsafe abortion and instead only focused on post-abortion care.

Context and Institutions largely reduced Reform Possibilities

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 discourse 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 has been adapted in local bureaucratic policymaking processes to exclude sensitive SRH issues, producing the moralised medical discourse.

At national level, the political context at any given time determined which reforms were possible and which ones were not. 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 (Christianity and Islam) 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 and 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 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 to enable future reforms on controversial SRH issues.

Competing Discourses

The findings demonstrate how powerful discourses 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 discourse 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 discourse were marginalised in the evidence base that informed the SRH policies produced. The strong entrenchment of the moral and cultural discourses in the Kenyan context (i.e. government and political structures and institutions, and society), and of the moralised medical discourse in the health bureaucracy was a major barrier to reforms on contested SRH issues. But the findings also point to the fact that hegemonic discourses 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, and donor pressure.

The findings suggest that the SRH discourses 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 discourses. 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 discourse 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 discourse dominated only on non-sensitive issues of sexual violence such as rape and defilement, but was marginalised by the cultural discourse, which remains dominant in Kenya's male-dominated parliament, on issues of rape within marriage, unwelcome sexual advances, and FGM.

The Oppositional Moral and Cultural Discourses can be challenged

The power entrenched in the moral and cultural discourses of control is not entirely incontestable. For instance, in regard to the moral discourse's strong opposition to abortion, Islam allows abortion in cases of rape and incest, as well as to save the woman's life[11]. Also except Catholicism, other Christian faiths allow abortion in some circumstances (see [51]). Yet religious opposition to abortion in Kenya, which encompasses religious leaders from Islam and other Christian faiths opposes abortion on all grounds. These are opportunities for reform actors to challenge the powerful discourse as it relates to abortion.

For the cultural discourse, its framings of SRH issues remain questionable. Its selective use to marginalise women's rights needs to be critically challenged. Nyamu-Musembi [52] 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 SRH reforms.

The Medical Discourse offers a Pathway for Reforms in the current Kenyan Context

The perceived neutrality of biomedicine, which underpins the medical discourse, conceals interests, biases and power struggles to make the discourse considerably influential in bringing about SRH reforms. From the study findings, the discourse played an important role in the complex interplay that produced discourse shifts to make change possible. In the adolescent RH policymaking, biomedical evidence on the extent of HIV/AIDS 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.

All these point to the political power embodied in the medical discourse, making it a potential pathway for reforms. The Kenyan context remains hostile to the human rights language of women's bodily autonomy and self-determination. 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 discourse that is underpinned by biomedical evidence as opposed to the SRH rights discourse.

While I acknowledge the power of the medical discourse in bringing about more comprehensive reforms, it is necessary to acknowledge that biomedical knowledge is in fact not neutral 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.

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[11] 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.

Advancing Rights without talking about Rights

As seen in the case studies, the SRH rights narrative has been both facilitative and inhibitive in opening spaces 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. Even then, this study has revealed 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 [53]. Similarly, the need for a sexual offences law was largely argued as necessary to protect children from violence and ill-health resulting from sexual abuse. 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 [12][54][55].

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 [56][57]. 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.

Despite its transformative power, the language of rights has important limitations that have constrained the extent to which it can bring comprehensive SRH reforms in the Kenyan context. Its conceptual disconnect with local concepts of claims and entitlements has been argued as an important limitation to its application in African contexts (see [58] [59]. Also, its assumption that rights holders are able to influence policy processes to ensure their rights are respected has not applied in many developing country contexts (including Kenya), where often rights holders are often unaware of their rights or have no access to political spaces or the power or resources to fight for their rights. The rights discourse's disregard for national political and socio-cultural contexts or put simply, its language of freedom and equality that threatens the power and interests of powerful policy actors in Kenya, 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.

Conclusions

This study sought to understand the drivers and inhibitors of change in SRH policy and legislative processes in Kenya. Overall, the findings suggest that political and institutional interests combined with socio-cultural and personal values and norms to shape the policy and legislative decisions made to respond to SRH challenges in Kenya. These factors are captured in the four discourses that various actors employ to prioritise their issues of interests while silencing others. The moral and cultural discourses supported by powerful institutions (government/parliament/religious), dominate policymaking, with the result that policies produced omit sensitive SRH issues. The medical

discourse does create space for change, but it remains highly moralized, effectively marginalizing sensitive SRH issues. It however remains an important discourse for bringing about more comprehensive SRH policy and legislative reforms. The internationally-supported human rights framing is largely marginalized because it threatens the power of dominant actors (i.e. male politicians, religious leaders). However, in policy processes with powerful supportive actors, the rights framing can expand space for reforms. Reform efforts will need to challenge underlying interests of control that underpin the powerful moral and cultural discourses.

Finally, this study has demonstrated that complexity of decision-making processes in the health sector and is therefore in support of the current shift to systems thinking in the health sector. Findings demonstrate the significance of social and political aspects of health systems, and therefore need for health systems research to extent beyond the biomedical focus to pay attention to all factors and actors that influence the effectiveness of health policy and programme interventions.

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