Leveraging parliamentarians: the case of Nairobi equity Gauge

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Background to the Health Systems Knowledge Network

The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise. The network engaged with other components of the Commission (see http://www.who.int/social_determinants/map/en) and also commissioned a number of systematic reviews and case studies (see www.wits.ac.za/chp/).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Southern and Eastern African network devoted to promoting health equity (www.equinetafrica.org), and the Health Policy Unit of the London School of Hygiene in the United Kingdom (www.lshtm.ac.uk/hpu). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social of determinants of health at global, regional and country level.
Acknowledgments

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1 Introduction

There have been pessimism and public criticism regarding the effectiveness of legislators, in particular members of parliament in executing their roles of oversight, representation and legislation on behalf of their constituents. For example, in a Zambian study, citizens felt that Members of Parliament do not represent them effectively and in most cases do not consult them on issues that affect their daily lives. They attributed this to the lack of capacity on the part of parliamentarians. Out of a sample of 500 adults, only 44 percent rated the committee’s capacity on legislation as strong or very strong. Despite the perceived lack of effectiveness, legislators still play an important role especially in addressing challenges of health inequities with respect to health systems in two ways: through portfolio committees on health and through leveraging of their social and political standing. Musuka and Chingombe (2006) did a review of their role through portfolio committees within the East and Southern Africa region. Portfolio committees perform varied functions but in general, they investigate or/and inquire into the activities and administration of ministries or departments assigned to each and make proposals for legislation to the house. In this paper, the author’s focus is on leveraging parliamentarians’ social and political standing as opposed to portfolio committees in promoting equity in health systems. The paper uses an example of mobilizing support for mainstreaming funding for reproductive health in the Ministry of Health budget and furthering the reproductive health agenda with a focus on young people. This paper is based on the author’s views and observations as opposed to a formal study. The process of leveraging the parliamentarians was done within the framework of the Nairobi Equity Gauge, a partnership between a research institution (African Population and Health Research Center) and two government institutions (Nairobi City Council and the National Coordinating Agency for Population and Development) in partnership with ministry of Health and development partners.

2. The Nairobi Equity Gauge

The Nairobi Equity Gauge is a partnership between the African Population and Health Research Center (APHRC), the National Coordinating Agency for Population and Development (NCAPD) and the City Council of Nairobi (CCN). The Nairobi Equity gauge is under the umbrella of Global Equity Gauge Alliance (GEGA). The mandates of the three institutions are as thus: APHRC - promote the well-being of Africans through policy-relevant research on population and health, NCAPD – undertake viable advocacy activities aimed at achieving support on certain population concerns and CCN’s public health department is responsible for all matters pertaining to the health of the residents of the city. To understand this partnership, it is useful to understand what an equity gauge is.

An Equity Gauge is an active approach to addressing inequities in health that not only monitors inequities, but also incorporate concrete actions to bring about sustained reductions in unfair disparities in health and health care. In this sense, an Equity Gauge
functions more like a thermostat than a thermometer, not just measuring or ‘gauging’ equity and inequity but also triggering actions to reduce inequities. An Equity Gauge seeks to reduce unfair disparities in health through three broad spheres of action, referred to as the ‘pillars’ of an equity gauge. The three pillars, each essential to an effective Equity Gauge, are: (a) assessment and monitoring, to analyze, understand, measure, and document inequities; (b) advocacy, to promote changes in policy, programs, and planning; and (c) community empowerment to support the role of the poor and marginalized as active participants in change rather than passive recipients of aid or help.

Due to the breadth of the approach and the need for comparative advantage, each of the institutions was charged with a specific pillar. Thus APHRC was charged with the assessment and monitoring pillar, NCAPD advocacy pillar and CCN community empowerment pillar. The advocacy pillar focused on leveraging the role of parliamentarians to respond to the growing inequities in and worsening indicators of family planning and reproductive health in Kenya. The community empowerment pillar focused on slum communities in Nairobi. Specific attention was on Korogocho and Viwandani communities. In these communities, APHRC conducts a Demographic Surveillance System (DSS). Through this system, the assessment and monitoring pillar is able to improve our understanding of factors that undermine equity and continuously monitor any changes. The different foci, that is, top-bottom and bottom-top, necessitated that the assessment and monitoring pillar generate evidence that would speak to both. To leverage the parliamentarians, national representative surveys (mainly the Demographic and Health Surveys for Kenya) was used. This was supplemented by the Demographic Surveillance System. Because this paper focuses on leveraging parliamentarians, it will dwell more on the process and evidence generated to facilitate this.

3. Context
Kenya’s total population is estimated to be over 30 million, 37 percent of who are youth 15-34 years. Among these, the 15-19 year olds are the ones with consistently the lowest contraceptive prevalence and most are preparing to vote for the first time (the voting age is 18 years). This makes the youth a “hot cake” for both the politicians and those seeking to reposition family planning in particular and reproductive health in general. The government of Kenya has also attempted to address this important age group by instituting a Ministry of Youth Affairs. The government views this age group as critical for human development “as they build on experiences of childhood and generate the foundation skills for adulthood.” However, “they have been largely excluded from designing, planning and implementing programs and policies that affect them”. And “many of the youth who are productive and energetic remain unemployed, continue to suffer from poor health, and lack sufficient support”. It is within this political context that it was thought leveraging the parliamentarians in mobilizing support for mainstreaming funding for reproductive health in the Ministry of Health budget and furthering the reproductive health agenda with a focus on young people made sense.
4. Approach
The approach of identifying areas of common interest, in this case, the youth even made more sense. Like minded parliamentarians were mobilized to a half-day meeting in April 2005. The meeting objectives were: (a) to engage parliamentarians from the Kenyan National Assembly in understanding the research evidence on current population and reproductive health indicators including funding in Kenya; (b) to elicit their support in repositioning population and reproductive health for the attainment of national and millennium development goals; and (c) to encourage parliamentarians to strengthen networking on issues of population and strengthen the link with the Southern and East African Parliamentary Alliance of Committees on Health

Before I dive into mobilization of key stakeholders, generation of compelling evidence and support from a regional network of parliamentary portfolio committees on health, let me highlight two important outcomes of the half-day meeting. At the meeting, the permanent secretary of the ministry of health announced that the ministry would include a line budget for reproductive health in the coming budget (this was done as announced in the 2005/2006 budget). Members of parliament present also resolved to form a Network on Population and Development (the Network was launched in May 2006).

5. Mobilization of stakeholders
In the build up to the ½ day meeting, there was intensive mobilization of parliamentarians for purposes of leveraging their support, development partners that support reproductive health, politicians within the line ministries of planning and health (ministers and assistant ministers), key decision makers within the line ministries (permanent secretaries and directors), key scientists (to generate evidence) and regional parliament networks (together with their civil society partners) to share experiences on such networks.

Table 1: Participants at a ½ day meeting of Parliamentarians, technical and development partners and scientists to reposition reproductive health in Kenya

<table>
<thead>
<tr>
<th>Attendees</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Politicians</td>
<td></td>
</tr>
<tr>
<td>Ass. Minister and Member of Parliament</td>
<td>1</td>
</tr>
<tr>
<td>Members of Parliament</td>
<td>6</td>
</tr>
<tr>
<td>Regional Parliament Network</td>
<td>2</td>
</tr>
<tr>
<td>City Council of Nairobi</td>
<td>3</td>
</tr>
<tr>
<td>Line ministry staff</td>
<td></td>
</tr>
<tr>
<td>Finance</td>
<td>1</td>
</tr>
<tr>
<td>Health</td>
<td>4</td>
</tr>
<tr>
<td>Planning and National Development</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Development partners</td>
<td>11</td>
</tr>
<tr>
<td>Technical partners</td>
<td>13</td>
</tr>
<tr>
<td>Scientists</td>
<td>5</td>
</tr>
<tr>
<td>Media</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>59</strong></td>
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</tbody>
</table>
The presence of each of the participant categories in table 1 had a role to play. **Politicians:** It is important to recognize that the roles of parliamentarians are legislative, representation and oversight of government activities in as far as government ensures service provision to the population. To leverage their position in society would be using their roles of representation and oversight. The underlying premise is that those in ministries of health and finance who are responsible for budgeting would listen more when the representatives of the people talk. **Scientists:** Scientists provided evidence on the need for reposition family planning in particular and reproductive health in general. **Development partners and technical partners:** were to drum up support for but also provide commitment that they would step up their efforts for family planning and reproductive health. **Media:** were supposed to mobilize public support or at least show the intention to those in decision making positions. And finally, for **line ministry staff;** those in positions of decision making authority would be compelled to make decisions by the evidence, the clout brought to bear on them by the politicians, development and technical partners.

**Personal assistants and parliamentary assistant clerks**
In table 1, there was no mention of personal assistants to Members of Parliament or assistant clerks to parliament. These two categories of people played an important role in getting the meeting to take place in at least two ways. First, they mobilized parliamentarians and demonstrated why it was important for them to be involved in such a cause. Second, they provided the organizers important tips on how to package the process of engagement with parliamentarians in a way that would be appealing and mutually fulfilling for both parties. It was important that we established personal contacts with them. One important lesson was that members of parliament receive “over 30 calls a day”¹ and this means they have to practice selective attention – the tendency for people to screen out most of the information to which they are exposed¹²,¹³. This means the organizers had to work hard to attract their attention and these two groups of people were particularly helpful.

**6. Assembling and presenting compelling evidence**
Scientific evidence was assembled to capture three key messages: (a) why should we invest in population and reproductive health, (b) what shortfalls in financing exists, and (c) the benefits of family planning and reproductive health.

**Message 1: Why Invest in Population and Reproductive Health**
Empirical evidence for investing in population as a crucial antecedent to development was presented. The first presentation covered Kenya’s Family Planning and Reproductive Health Program achievements, current status, challenges, lessons learned, opportunities

¹ The comment came up during a discussion with one of the personal assistants.
and way forward. The presenter pointed out that fertility decline in Kenya corresponded with key population program milestones (see figure 1, the dotted line represents Total Fertility Rate). He emphasized that international support from various agencies especially United States Agency for International Development (USAID), Department of International Development (DFID), United Nations Population Fund (UNFPA), and Japan International Cooperation Agency (JICA) among others was crucial in fertility change in the country.

The presenter mentioned that two important lessons were learned during this period: Committed and effective national leadership is essential. Support by high-level political and governmental leaders was important in building up Kenya’s Family Planning (FP) during the 1970s and 1980s. There is a general feeling that support for FP has declined among Kenya’s leaders in recent years, hence the need for renewed high-profile public commitment by high-level leaders to reinvigorate FP in the country.

Figure 1: Timing of Key Efforts and Fertility Decline in Kenya

The presenter attracted the attention of participants by stressing the centrality of women in the achievement of Millennium Development Goals (MDGs) (see figure 2). Women,
he suggested are faced with many heavy burdens including biological burdens caused by long working hours and trekking long distances as they fend for their families as well as physical and psychological burden resulting from balancing work and other life requirements such as taking care of the children. They are also affected by insecurity. He suggested providing choice to the woman through family planning and reproductive health will help Kenya achieve the millennium development goals.

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**Figure 2: Centrality of women in achieving MDGs**

![Diagram showing the centrality of women in achieving MDGs with roles such as Caregiver, Worker, Leader, Mother, Wife, Provider, Education, Maternal Mortality, HIV/AIDS, Environment, and Partnerships.]

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**Message 2: there is a financial shortfall for family planning and reproductive health**

The presenter decried the shortfall in funding for family planning and safe motherhood in Kenya in 2005. He told the attentive audience that while 10 million US dollars was required for family planning, only 4 million was available hence a shortfall of 6 million (see figure 3). He indicated that, safe motherhood had a much bigger deficit: the program needed 14 million but only one million was available. On the positive side, he noted that the Government of Kenya had showed commitment to population and health as exemplified by a Cabinet Memo on Health that seeks to expand investment in family planning and reproductive health, commitment to National and MDGs, and restructuring of National Coordinating Agency for Population and Development, a government agency to be more responsive to emerging needs in population.

He concluded his presentation by highlighting some of the thing Members of Parliament could do to support these efforts. Firstly in the oversight role, they can call for increased
budget for family planning and reproductive health, taking the executive to account on family planning and reproductive health, and ensure Constituency Development Fund supports family planning and reproductive health projects. Equally important is that continuous dialogue with constituents and fellow MPs as well as with Southern and East African Parliamentary Alliance of Committees on Health can help in placing family planning and reproductive health as a high priority area.

Figure 3: Financial shortfall for family planning and safe motherhood, 2005

Message 3: there benefits when we invest in Population & Reproductive Health

The second presenter provided more empirical evidence to show the benefits of increasing contraceptive use. He noted that fewer and well-spaced births reduce maternal mortality while having fewer children means more educational resources are invested per child hence better school performance. In addition, lower fertility translates into slower population growth, favorable age composition, increased economic growth, and ultimately reduction in poverty.

He however noted that key indicators were worsening for Kenya (see figure 4). He noted further that deterioration is worse among the poor more than among the rich. For instance, the poorest 20 percent have a TFR of 8 births per woman, a contraceptive prevalence rate of 15 percent and unmet need of 35 percent while the richest 20 percent have TFR of 3, CPR of 48 percent and unmet need of only 13 percent.
The presenter brought into focus the urban disadvantage. He also showed, contrary to expectations, the urban poor are more disadvantaged than rural poor (see figure 5), a
scenario that is alarming given that Africa is getting more and more urbanized. He noted that children in urban slums of Nairobi were failing poorly in immunization, infant mortality rate and under-five mortality rate (see figure 5).

He suggested that huge differences in demographic and health indicators with respect to rural-urban residence and region were noted to be worrisome. For instance, he noted that rural women are highly disadvantaged in terms of knowledge, while regional disparities in health show that a child in Central province is four time more likely to survive than a child in Nyanza province.

7. Promoting population and reproductive health through parliamentary networks

To set the discussions on the future, discussions temporarily shifted to possibilities of promoting population and reproductive health through parliamentary networks. Because of experiences with Southern and East African Parliamentary Alliance of committees on Health (SEAPACOH), the interim chairman and a representative of partner organization (Global Equity Gauge Alliance) were requested to provide their input. This input would later be instrumental in how the Network on Population and Developed launched in May 2006 would be structured.

The first presenter was from Global Equity Gauge Alliance, and he noted that as social institutions, Parliaments can be vital in the achievement of health equity through their representative, legislative, and oversight roles. They are also in a key position for development and monitoring of the implementation of equity-sensitive policies. They can build alliances with executive branch of government, across political parties, and with civil society at national and regional levels. He reassured members that evidence suggests that where parliamentarians are provided with information and technical support, they carry out responsibilities more effectively. He noted that where such strategies are used, there is “two-way” learning in that professional and civic organizations’ understanding of the processes by which parliaments work is enhanced and parliaments strategically make use of the information and technical support provided to them for evidence-based decision making.

The interim chairman of SEAPACOH reiterated that health issues play a pivotal role in today’s socio-economic and political environments. He explained how experience from SEAPACOH can be utilized to strengthen the network on population and development. First, it needs to be an association and Members of Parliament should participate without any constitutional obligations. Second, the participation of professional and civic organizations’ as partners is important for the learning process. At the launch of the network, these two issues were incorporated.

8. Discussions and recommendations

Discussions and contributions in various ways emphasized the benefits of reposition family planning and reproduction health. Several recommendations emerged from the meeting. Examples of recommendations that specifically focus on leveraging
parliamentarians in addressing inequities in family planning and reproductive health within the health system included: (a) a network of parliamentarians should be formed to mobilize support and increased budget allocation for Family Planning and Reproductive Health; (b) government and development partners were urged to either start or increase their funding for population, family planning and reproductive health; (c) in recognition of the crucial role men play in family planning and reproductive health, male involvement should be an integrated part of reinvigorated programs; and (d) parliamentarians were urged to influence allocation of constituency development funds for community based family planning and reproductive health initiatives.

9. Response from Ministry of Health

The representative of the Permanent Secretary Ministry of Health (the chief accounting officer of the Ministry) closed the half-day meeting. He expressed his sincere desire to work with NCAPD and development partners as well as with all stakeholders. He drew participants’ attention to the fact that demographic and health indicators went the same direction with funding: downwards. Some segments of the country such as urban setting have special health service delivery problems, which the Ministry was helping to solve.

He indicated that the Ministry was equally concerned that maternal and child indicators were deteriorating. He indicated that the Ministry was committed to availing more resources for reproductive health and family planning and would therefore start by creating a budget-line for these services in the 2005/2006 financial year. He conceded that under the current rate of financial allocation from the treasury, it was not possible to allocate to family planning the 2 billion shillings the program required. In this regard, he urged the Members of Parliament present in the meeting to lobby for higher budgetary allocation for the Ministry of Health to ensure reproductive health and family planning received the funding needed. He finally thanked all participants for their contribution and declared the workshop officially closed.

10. Key lessons

This piece of work shows the beginning of a wider agenda to mainstream family planning and reproductive health within the health system. Even at this point, there are a few lessons to learn. First, it is important to identify common interests that cut across different stakeholders. In this case it was the young people that were a target for the parliamentarians due to their voting power. The same young people were also an easy entry for those advocating for repositioning of family planning and reproductive health. In addition, the National Coordinating Agency for Population and Development, the Reproductive Health Division of the Ministry of Health – two arms of government were keen to reposition family planning and reproductive health as a development issue rather than a health issue. There were also champions of reproductive health among members of Parliament who were passionate about the family planning and reproductive health and the role of women. And all the stakeholders were keen. The evidence served to reinforce
their position of the need to reposition reproductive health rather than start preaching to
them.

Second lesson is to identify influencers of those you intend to target. It is important to do
a lot of homework on the network processes to and from the target audience. In our case,
the key people with whom we could explain to members of parliament were Assistant

The third key lesson is the ability to assemble quickly the necessary evidence. It was
important that the evidence required was assembled quickly to allow deliberations of the
issues at hand.

Finally, it is important not to underestimate the time and energy it takes to assemble
people of this caliber. They receive so many messages and several individuals and
organizations seek their attention. The process is quite involving and time consuming. A
note of caution for research institutions is that this is an added assignment since their
primary objective is to contribute to science. Unfortunately, they are the same institutions
that are probably the best suited to provide and communicate this evidence in the absence
of a brokerage.
11. References