Experiences of Parliamentary Committees on Health in promoting health equity in East and Southern Africa

Regional Network for Equity in Health in east and southern Africa (EQUINET)

Training and Research Support Centre (TARSC)
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Association of Parliamentary Committees on Health in east and southern Africa (SEAPACOH)

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We acknowledge the contribution of the Honourable MPs and clerks of the parliamentary committees through their responses to the questionnaires.

Executive summary

Parliaments can play a key role in promoting health and health equity through their representative, legislative and oversight roles, including budget oversight. To better understand and support the practical implementation of these roles, EQUINET (through University of Cape Town (UCT) and its secretariat at Training and Research Support Centre (TARSC) with SEAPACOH implemented a questionnaire survey in September 2008 to explore and document the work and experiences of parliamentary committees on health. This report presents the findings of the section of the questionnaire on the general progress on parliament work on health. A second report from the section of the questionnaire on parliament processes and work on health rights is analysed and reported in a separate discussion paper authored by UCT.

The survey highlighted a number of areas of current focus of parliament work in health, the potential and experience of positive outcomes, and the limits and constraints to address to support further work.

In the budget process parliaments have generally played a role in advocating and engaging on the Abuja commitment, with increasing budget shares to health in a majority of countries, although the target has only been met in two of those included in the survey. The positive trends indicate the potential of a focused, evidence-backed campaign in this area with parliaments. Supporting such a campaign with ongoing evidence would be important. EQUINET has included in its plans for 2010-2015 to provide this type of support to parliamentary processes at country and regional level. At the same time the responses indicate a need for a regional campaign on the Abuja commitment to be backed at country level with additional input on more country specific priorities, as these differ across countries (with the range including maternal and child health, AIDS treatment supplies and health worker issues). Interaction with civil society is also identified to be important to this process, and it would be useful to encourage stable civil society partnerships in each country around the Abuja commitment and the specific country level concerns, to support parliamentary roles. Finally we observe that information and engagement is needed at an early stage of the budget process, as there is greater impact at that stage. Where the budget process does not provide for this level of parliamentary committee roles and public input it weakens the possibility of influence.

In relation to legislative roles, the findings indicate that this is an area where greater support to parliaments may be needed. There are a range of areas where laws need to be updated, debated and reviewed or enacted. Legislative activity is however relatively uncommon, and areas that are of public health concern, such as incorporating TRIPS flexibilities or international commitments into national law are still not well known by parliaments or acted on. The fact that nearly half the committees reported not having seen original treaties and lacked information to support these roles is an area for attention for EQUINET and other partners. Parliament roles in implementing health rights is a focus of a second further report on this survey by UCT.

Oversight and representative roles are the most frequently reported area of committee action, and are delivered through a range of actions. The evidence highlights the important access parliaments have on health issues, which is important for raising debate on and profile of health issues. The commonly reported practice of constituency visits provides a means for communication between national policy levels and communities, if effectively used for this. The issues covered are often focused concerns on health services as well as areas of broad work and policy attention (such as the reproductive health road map or the health insurance scheme). Parliaments appear to provide an important mechanism for taking national policy issues to public and local debate and for local issues to be brought to national attention, if adequately supported to do so.

Beyond the media and constituency visits, meetings and policy workshops provide a further means for parliamentary oversight and dialogue. Public hearings are the least commonly used form, although they provide the most inclusive and accessible means of input for the public. Supporting media roles and constituency visits would seem to offer greatest potential for ensuring the vital communication roles that parliaments play in 'voice' and oversight.

A further mechanism for oversight is through questions to the executive. These are reported to have been used relatively effectively by the parliaments to raise and deal with health very specific service issues. A prior report suggests that issues raised by MPS more generally in debates have less successful outcome than these more focused questions to the executive (Musuka and Chingombe 2006). This suggests that there is need to support parliaments to raise very specific questions on priority health issues that they want executive action on, while using debates as a means of raising more general policy and public awareness on wider concerns.

The committees do not all report having clear **areas of strategic focus and action,** suggesting that there may be need for support for strategic plans. The turnover in committees and sometimes limited capacity and resource support for their roles has been previously identified as limiting their potential (Mataure 2003). This survey also suggests that committees need support for information, technical inputs, forums for dialogue and capacity building to effectively implement their roles. This should ideally come from budget resources, whilst resources are also coming from civil society and external funders. EQUINET has largely focused its support on technical and information resources, and the survey indicates that this continues to be an area where needs are expressed. The EQUINET policy and parliamentary briefs are known, used and found to be useful by 60% of the committees. There is still a gap in distribution to address therefore, given that 40% of committees have not seen them, with a particular need for translation into Portuguese.

It would be important for committees to build strategic plans where they do not already do so, and include in them links with partners for the resource, technical and information inputs they need. The parliament roles highlighted in the survey were largely seen to be limited by inadequate financial, technical and information resources and by capacity gaps, all feasible to address. Of interest, the responses did not include, and so the survey did not highlight, wider issues of political space, legal and budget processes, access to information or other potentially deeper determinants of positive outcomes for parliamentary committees working on health, as raised in other work in this area (Mataure 2003, Musuka and Chingombe 2007).

Although from a small sample of respondents, the coverage of ten countries in this survey nevertheless suggests that parliaments in east and southern Africa have the potential to have significant positive influences on health equity through laws, budgets and health system developments. The evidence suggests that they are more likely to realise this potential if they focus on pursuit of specific issues, within a wider strategic plan, and follow these issues through a range of means available to them by virtue of their roles. It appears from the evidence that parliaments can make progress on health outcomes by ensuring funding for them in the budget process, by raising awareness of the issues through parliament debates, by raising public attention to prioritised concerns through media liaison, by gathering evidence and views from communities and communicating issues to communities through constituency visits, and by raising very specific questions to the executive to address. All of these roles and actions could thus be developed to advance a specific health goal, within a strategic plan.

Common concerns across countries like the Abuja commitment appear to be useful to address at regional *and* country level, particularly in terms of support with documents, treaties, evidence and information. The evidence suggests that regional engagement needs to be complemented by attention to specific country level concerns. These vary across countries and actions on these specific country issues call for parliaments to develop stable links for information and need support with national technical and civil society partners.

1. Background

Parliaments can play a key role in promoting health and health equity through their representative, legislative and oversight roles, including budget oversight. There are a number of documented examples of how these roles have been exercised in East and Southern Africa (ESA) to prioritise health in budgets, to monitor the performance of the executive, to strengthen laws protecting health and to keep the need to redress inequity in health and to promote sexual and reproductive health high on the public agenda (EQUINET SC 2007).

Parliaments have a role in ensuring that ratified International treaties that promote health (such as TRIPS flexibilities, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)) are implemented through domestic laws and those with potential negative impacts (such as GATS) are not signed to or ratified. These roles have been used in ESA to protect or advance equity oriented public policy, promote health system reforms and prioritise allocations to specific areas of health systems. Parliamentary processes offer the opportunity for public input even in more polarised political environments.

Towards this, the Regional Network for Equity in Health in East and Southern Africa (EQUINET), a network of academic, professional, civil society, state and parliamentary institutions within East and Southern Africa that aims to promote and realise shared values of equity and social justice in health, has co-operated with parliamentarians since 2000 in different areas of work on equity in health. In 2005, this work was consolidated when a network of parliamentary committees on health in East and Southern Africa was formed in Lusaka, Zambia in January 2005. The Southern and East African Parliamentary Alliance of Committees of Health (SEAPACOH) aimed to build a more consistent collaboration of the Parliamentary Committees on Health towards achieving individual and regional goals of health equity and effective responses to HIV and AIDS. The alliance aims to strengthen the role of Parliaments in the areas of oversight of budgets, review of legislation, policy and providing leadership for achieving goals of equity in health and effective responses to HIV/ AIDS, TB, Malaria and other diseases important to the region. EQUINET has co-operated with SEAPACOH in different areas of advocacy on equity in health, such as in supporting advocacy for the Abuja commitment of 15% government funding to health. EQUINET and SEAPACOH have both also co-operated with other partners in supporting parliamentary roles in health.

To support this work, EQUINET, through the Health and Human Rights programme at the University of Cape Town (UCT) and its secretariat at Training and Research Support Centre (TARSC) have implemented a questionnaire survey in September 2008 to explore and document the work and experiences of parliamentary committees on health. The questionnaire section on the general progress on parliament work on health, developed jointly with SEAPACOH was embedded within a questionnaire developed by UCT that sought to understand the knowledge and understanding of human rights and the right to health amongst parliamentarians. The report of the questionnaire on health rights is analysed and reported on in a separate discussion paper authored by UCT.

2. Methods

A questionnaire was developed for the work based on priorities identified by EQUINET and SEAPACOH. The questionnaire was reviewed at a SEAPACOH planning meeting in November 2006 and finalised thereafter.

The questionnaire was then administered to parliamentarians attending the Regional Meeting of Parliamentary Committees on Health in East and Southern Africa, Munyonyo Uganda September 16-18 2008. The meeting gathered members of parliamentary committees

responsible for health from twelve countries in East and Southern Africa, with sixteen technical, government and civil society and regional partners to promote information exchange, facilitate policy dialogue and identify key areas of follow up action to advance health equity and sexual and reproductive health in the region. Outside of the meeting times the interviews were conducted by senior professionals from UCT, University of Western Cape and HEPS Uganda familiar with work on equity in health. Each interview took approximately 30 minutes.

Interviews were conducted with Members of Parliament (MPs) or clerks from ten committees on health in the region, viz: Malawi, Botswana, Tanzania, Kenya, Uganda, Mozambique, Namibia, Zambia, Zimbabwe and Swaziland. The committees in Uganda, Kenya, Tanzania and Botswana were represented by responses from at least two committee members. Fifteen of the respondents were MPs and four clerks of the committees. Both clerks and MPs have knowledge in the areas of the questionnaire and so were included. It was noted that with the different terms and turnover in parliaments the institutional knowledge of all MPs may not be the same so where more than one response could be obtained this was encouraged. A total of 19 respondents completed the form.

The questionnaires were analysed using excel. This report only includes the analysis of the general experiences of committees on health and health equity which was done at TARSC. The analysis of the views and experiences on rights work was analysed at UCT and is separately reported.

Respondents were assured that any individual information collected would be kept completely confidential and only aggregated data by country will be presented in any report.

Ethics approval for this study was obtained from the University of Cape Town Health Sciences Faculty Research Ethics Committee (ref # 310/2005) and consent obtained from respondents prior to interview.

The information collected is subject to various sources of bias: the recall of MPs of the work of the committee, which may be limited by their term of office; and their individual subjective views of priorities which may not necessarily be shared with all members of their committee. As the members interviewed were generally chairpersons or senior members of committees we hope that this bias is not significant, and note that where it exists it may lead to a lower level of reported activity than may be the case in practice.

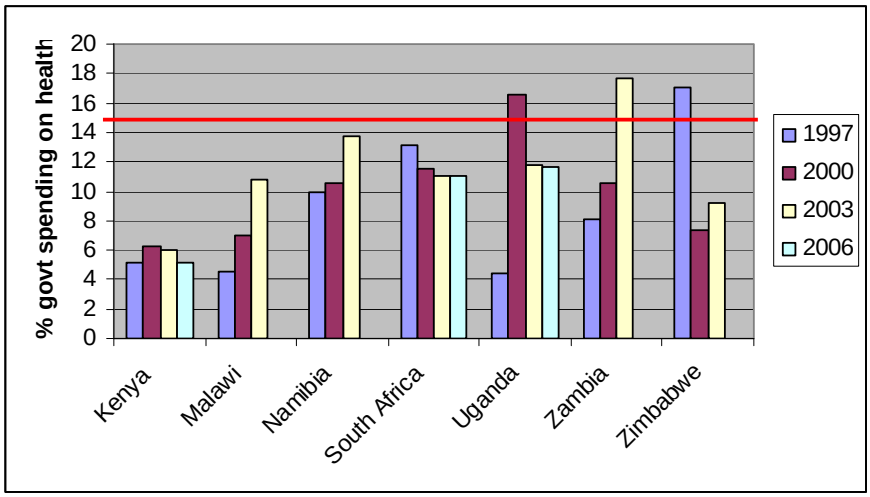
3. Results

This section presents the results of the analysis of the questionnaires. The results are organised within the three areas of parliamentary functioning (budget, legislation and oversight of the executive) followed by the more general questions.

3.1 Budget processes

The commitment made by heads of state in Abuja in 2001 set a target of 15% of government spending (excluding external sources) being spent in the health sector. A 2008 EQUINET report found that in seven countries were government data could be analysed, with the exception of Zambia, all countries are lagging behind the target, although there have been increases in the allocation to health across almost all countries. In 2006 Kenya was allocating less than 6% of their national budgets to health, while Namibia, Malawi and Uganda were moving closer to the target. (See Figure 1)

Figure 1: Percentage of total government expenditure allocated to health, 1994-2006



Parliaments have an important role in advocating for and promoting the Abuja commitment, particularly given their role in stimulating public dialogue and technical input around the budget and in scrutinising and debating the budget.

In the ten country committees, six (60%) monitor the performance of their countries on the Abuja commitment. Four (Botswana, Kenya, Mozambique and Namibia) said they do not. Two countries (Botswana, Malawi) reported that their country spent more than 15% of government spending on health, five reported spending of between 10% and 14% and one of less than 10%. Committee members from two countries (Mozambique and Namibia) were not aware of how much their spending was.

While the number of countries reaching the Abuja commitment is still low, the MPs noted an increase in government spending on health on the previous year, when only one country committee reported spending above 15% (See Table 1).

Table 1: Parliament committee monitoring of the Abuja commitment

% of Total budget Spent on Health	% respondents on 2007 levels N=6	% respondents on 2008 levels N= 8 (*)
< 5%	0	0
5-9%	17	10
10-14%	67	20
15% +	17	50
	100	**80**

(*) Non response makes up the balance

Parliament respondents reported a number of activities to support their engagement on the budget, both to draw input on proposed budgets and monitor expenditures, including

- Meetings with civil society groups (90%)
- Information exchange through briefs, papers or discussion documents (90%)
- Participation in policy or information workshops (80%)
- Public hearings (70%)
- Constituency visits (50%)

The major form of activity is civil society consultation and information exchange, while more public processes like public hearings and information workshops are also held. Less common are visits to constituencies to obtain feedback on budget priorities.

Committees themselves reported their own budget priorities as:

Botswana	an adequate health budget
Kenya	provision of health needs (personnel, commodities and facilities), and increased budget allocation
Malawi	Improved drug supplies, including for anti-retrovirals
Namibia	Anti-retroviral and testing supplies
Swaziland	HIV, AIDS and tuberculosis
Tanzania	Maternal Health
Uganda	Maternal Health, rural health, family planning, reproductive health and primary health care
Zambia	Increased funding to the health sector to improve service provision
Zimbabwe	Human resources for health

One committee did not give a response to this. Committees are thus primarily prioritising drug and personnel supplies for health services and programmes but also see the issue of an adequate budget overall as a priority to achieve this. The programme priorities are primarily focused on AIDS, maternal, and reproductive health, which are major issues for the health Millennium Development Goals. Malaria and TB were however not raised, despite their role in communicable disease burdens. Two committees referred to health services and primary health care in the wider context, and none referred to the wider population / public health issues, such as environmental health, food safety, traffic safety, workplace health and safety, despite the contribution of these issues to public health burdens in the region.

While many committees feel they have influence on the health budget (Malawi, Namibia, Tanzania, Uganda, Zimbabwe, Swaziland) four committees do not see that they are able to exert influence (Kenya, Mozambique, Zambia, Botswana). At the stage the final budget is presented parliaments have limited possibilities to reject a budget, but can in the wider budget process of consultation with the executive shape the budget presented by the executive and can advocate shifts in allocations within an overall budget framework.

3.2 Legislative roles

The separate report on parliament understanding and roles in health rights will give more focus to this area of work. As a basic platform of roles parliaments review, debate and pass laws, and review, debate and domestic through national laws the treaties and conventions that are signed by the executive.

In the survey three parliaments reported that they had debated or passed laws or policies relating to health in the previous year (2007), including Malawi (HIV AIDS National Policy),Tanzania (HIV and AIDS Bill) and Uganda (Public Health Act). One (Zambia) reported making submissions on the right to health for constitutional reform. It would not be expected that new bills would be under debate across all countries. However other EQUINET reports highlight the need to update existing laws in a number of areas to deal with new issues concerning public health and health equity (Kasimbazi et al 2008). It is thus interesting that there is relatively limited debate and review of existing legislation and that in two cases this is focused on AIDS related laws.

One areas of legal revision that has been on the agenda in many countries is that of integrating flexibilities provided for in the Agreement on Trade Related Aspects of Intellectual property Rights (TRIPS) to allow access to treatment in Africa. In particular countries have

the authority to use the flexibilities provided in the TRIPS Agreement in the interest of public health, and can incorporate these into the legal frameworks, including

- Giving transition periods for laws to be TRIPS-compliant.
- Providing for compulsory licensing, or the right to grant a license, without permission from the license holder, on various grounds including public health.
- Providing for parallel importation, or the right to import products patented in one country from another country where the price is less.
- Exceptions from patentability and limits on data protection
- The Bolar Provision, providing for generic producers to conduct tests and obtain health authority approvals before a patent expires, making cheaper generic drugs available more quickly at that time.

Incorporating these provisions into law provides an important means for countries to sustain these flexibilities beyond any concessionary periods offered by the World Trade Organisations to low income countries, currently to 2016. Given that legal review takes sometime, especially as these issues may be contested by companies or constrained by bilateral trade agreements, it would be expected that this area would be subject to legal debate across all countries in the region.

Committee members from three countries (Kenya, Zambia and Namibia) reported that they had incorporated these flexibilities in their national laws. Committee members from four countries said that they had not. A further three were, however, not aware of what had been done in this regard, signalling that this is an area where information to and involvement of parliamentary committees needs to be enhanced.

Table 2: Parliament committee reporting incorporation of TRIPS flexibilities into national laws

	Percent N=10
Use TRIPS Flexibilities	30
Don't use TRIPS Flexibilities	40
No Response/ Don't Know	30
Total	**100**

Knowledge of treaties and conventions relevant to health is a necessary starting point for raining and dealing with them. Only 32% of the nineteen respondents were aware of the treaty and its contents. This undermines parliamentary roles to debate the implications of the treaties, or to domestic such treaties in national law.

Table 3: Parliament committee reporting knowledge of international treaties and conventions

Treaty/ Convention	**% total respondents aware of the treaty N=19**
International Covenant on Civil and Political Rights	31.6
African Charter on Human and People's rights	47.4
International Covenant on Social, Economic and Cultural rights	36.8
General comment 14 to the international Covenant on Social, Economic and Cultural Rights	15.8
The agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS)	31.6
SADC protocol on Health	36.8

This was not only the case in relation to the TRIPS agreement. Equally low levels of awareness were reported in relation to other key conventions or treaties that have been ratified by their countries and that have significant relevance to policies and laws in countries. This gap and further evidence on it will be explored in the separate report on the parliament roles in health rights.

3.3 Oversight and representation roles

Parliaments provide a platform for public voice on national issues and a means of oversight of the performance of the executive in delivering on national policies, laws and budget commitments. To exercise this one fundamental step is the internal debate of health issues within the committees. Eight of the committees (80%) reported having such internal debates on health matters as part of their business, with such debates reported in Botswana, Kenya, Malawi, Namibia, Tanzania, Uganda, Zambia and Zimbabwe.

The most common activity reported by the committees in this respect was raising health issues in the media, with 90%of committees using this is a vehicle for encouraging social debate and accountability on health policies, budgets, laws and programmes. This appears to be a vital function of MPs. Committees also commonly held constituency visits, reported by 60% of the ten committees. Committees also reported holding meetings with civil society and participating in policy workshops (50%) while a third reported holding public hearings and exchanging information towards oversight and 'voice' roles. Respondents from most parliament committees (70%) though that these means of oversight and communication were important for their role, with slightly fewer only for public hearings (60%). The lower levels of implementation may thus relate to resource and other constraints.

These oversight roles were exercised over various issues shown in Table 4. Most of the issues were specific concerns about problems with areas of health sector delivery, or with policies or laws. Outcomes were reported to be positive in six of the ten countries, highlighting the influence of parliaments through these means.

Table 4: Issues raised by parliament committees and outcomes

Country	Issue Raised	Outcome
Botswana	Drug Shortage	Government took corrective steps, minister made aware
Kenya	Health Needs in country, Equity issues	Not clear
Malawi	Financing of biomedical research	Motion adopted
Namibia	Mental health	No positive outcome
Swaziland	Drug shortages	Resolved
Tanzania	HIV/AIDS bill	Bill publicised and discussed
Uganda	Maternal, Reproductive Health and reproductive health roadmap	Minister more aware, public appreciation of Maternal Health, Roadmap on Reproductive health
Zambia	Eye Health related services	Not specified
Zimbabwe	Debate on the proposed National Health Insurance Scheme	Deferred implementation of the scheme

A further means for overseeing the executive is through questions raised. Nine of the committees reported that the committees had framed and raised health questions in parliament. The issues covered are shown in Table 5. Notably the issues were even more specific concerns about problems with areas of health sector delivery or funding than those raised for debate, showing that questions are for focused executive attention and redress of specific problems . Outcomes were reported to be positive in five of the ten countries.

Table 5: Issues raised by parliament committees through questions to the executive and outcomes

Country	Issue Raised	Outcome
Botswana	Shortage of health personnel in rural areas	Addressed by minister
Kenya	Poor budget allocation	Improved budget allocation
Malawi	Service Level Agreements between government and NGOs, Mission Hospitals	Access of Mission Hospitals and NGOs to government resources
Namibia	Questions on health issues raised by opposition MPs	No answer
Swaziland	Drug shortages, welfare of nurses, corruption in drug tenders	All resolved
Tanzania	Not answered	Not answered
Uganda	Increased funding of maternal Health, reproductive health and family planning	Increased awareness in parliament, minister and funding for reproductive health and family planning obtained
Zambia	Incentives to attract back health personnel working abroad	Not specified
Zimbabwe	Not answered	Not answered

3.4 Other

Exercising these various roles and functions depends in part on the strategic understanding of MPs and committees of their role, and the information, resources and political space to exercise it. The committees identified their goals for year in various ways (see Table 6). Some reported general oversight, communication, and health goals; while others had very specific areas of focus as their primary goal. It is a strategic issue to have a wide vision of the potential areas of engagement and roles, while also proactively pursuing a more focused and specific goal. Notably there was not sufficient consensus across the committees on their key goal area for the year to identify a regional priority, indicating the high level of country specificity in goals.

Table 6: Goals for the committees for the current year as perceived by respondents

Country	Main Goals of the committee
Kenya	Oversight of Health and Social Welfare
Namibia	Public hearings
Tanzania	Constituency visits, oversee budget allocation and utilisation
Uganda	Reduction of maternal and infant mortality, advocacy, good health and universal primary education, improved resource allocation to Health sectors, Reproductive Health and food Security
Swaziland	Better Health for all by 2010
Zambia	Reduction in Maternal to child transmission of HIV, improving lives of people with disabilities
Zimbabwe	Addressing human resources in health
** The remainder of the committees had no response recorded*	

The committees largely reported need finances, technical inputs, information and forums for dialogue and capacity building to enable them to attain these set goals (See Table 7). The information needs were largely in terms of materials and data on health (60%), and the original versions of treaties and declarations that they were supposed to know and debate (40%). Many had not yet been provided with these through their regular processes.

Table 7: Resources and inputs required for committees to attain goals

Country	Resources needed to attain goals
Botswana	human & financial resources , workshops
Kenya	information exchange, increased budget allocation
Malawi	financial and technical resources
Namibia	Financial resources
Tanzania	Financial resources, research officers
Uganda	workshops on Health Treaties, financial resources, capacity building of members and operational offices,
Swaziland	member empowerment
Zambia	Expert information
Zimbabwe	Capacity building, health analysis, interpretation of rights instruments
** The remainder of the committees had no response recorded*	

EQUINET with SEAPACOH has produced a number of briefs specifically for parliaments, and has also produced a wide range of policy briefs summarising key information on specific areas of health equity, including the Abuja commitment, TRIPS flexibilities, resource allocation and other areas raised as priorities by committees. These have been sent electronically and some by hardcopy to all committees in the region. Six of the ten committees (60%; Botswana, Malawi, Tanzania , Uganda, Zambia, Zimbabwe) had respondents reporting that they had seen and used the briefs and all of these indicated that they found the briefs useful. The other four had members who had not seen the briefs. EQUINET has in 2008 begun to translate its materials into Portuguese to improve access but has not yet circulated the translations beyond electronic mailings.

4. Conclusions

The survey highlights a number of areas of current focus of parliament work in health, the potential and experience of positive outcomes, and the limits and constraints to address to support further work.

In the budget process parliaments have generally played a role in advocating and engaging on the Abuja commitment, with increasing budget shares to health in a majority of countries, although the target has only been met in two of those included in the survey. The positive trends indicate the potential of a focused, evidence-backed campaign in this area with parliaments. Supporting this work with ongoing evidence would be an important follow up. EQUINET has included in its plans for 2010-2015 to provide this type of support to parliamentary processes at country and regional level. At the same time the responses indicate a need for a focused regional campaign on the Abuja commitment to be backed at country level with additional input on country specific priorities, as these differ across countries (with the range including maternal and child health, AIDS treatment supplies and health worker issues). Interaction with civil society is also identified to be important to this process, and it would be useful to encourage stable civil society partnerships in each country around the Abuja commitment and the specific country level concerns, to support parliamentary roles. Finally we observe that information and engagement is needed at an

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A further mechanism for oversight is through questions to the executive. These are reported to have been used relatively effectively by the parliaments to raise and deal with health very specific service issues. A prior report suggests that issues raised by MPS more generally in debates have less successful outcome than these more focused questions to the executive (Musuka and Chingombe 2006). This suggests that there is need to support parliaments to raise very specific questions on priority health issues that they want executive action on, while using debates as a means of raising more general policy and public awareness on wider concerns.

The committees do not all report having clear **areas of strategic focus and action,** suggesting that there may be need for support for strategic plans. The turnover in committees and sometimes limited capacity and resource support for their roles has been previously identified as limiting their potential (Mataure 2003). This survey also suggests that committees need support for information, technical inputs, forums for dialogue and capacity building to effectively implement their roles. This should ideally come from budget resources, whilst resources are also coming from civil society and external funders. EQUINET has largely focused its support on technical and information resources, and the survey indicates that this continues to be an area where needs are expressed. The EQUINET policy and parliamentary briefs are known, used and found to be useful by 60% of the committees. There is still a gap in distribution to address therefore, given that 40% of committees have not seen them, with a particular need for translation into Portuguese.

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Although from a small sample of respondents, nevertheless the coverage of ten countries in the survey suggests that parliaments in east and southern Africa have the potential to have significant positive influences on health equity through laws, budgets and health system developments. The evidence suggests that they are more likely to realise this potential if they focus on pursuit of specific issues, within a wider strategic plan, and follow these issues through a range of means available to them by virtue of their roles.

It appears from the evidence that parliaments can make progress on health outcomes by ensuring funding for them in the budget process, by raising awareness of the issues through parliament debates, by raising public attention to prioritised concerns through media liaison, by gathering evidence and views *from* communities and communicating issues *to* communities through constituency visits, and by raising very specific questions to the executive to address. All of these roles and actions could thus be developed to advance a specific health goal, within a strategic plan.

Common concerns across countries like the Abuja commitment appear to be useful to address at regional *and* country level, particularly in terms of support with documents, treaties, evidence and information. The evidence suggests that regional engagement needs to be complemented by attention to specific country level concerns. These vary across countries and actions on these specific country issues call for parliaments to develop stable links for information and need support with national technical and civil society partners.

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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