Parliamentary committee experiences in promoting the right to health in east and southern Africa

Regional Network for Equity in Health in East and Southern Africa (EQUINET)

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Health in East and Southern Africa

EQUINET DISCUSSION PAPER 74

June 2009

With support from SIDA Sweden

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Cite as: London L. Mbombo N, Thomas J, Loewenson R, Mulumba M, Mukono A (UCT, TARSC, SEAPACOH) (2009) 'Parliamentary committee experiences on promoting the right to health in east and southern Africa,' EQUINET Discussion Paper 74 UCT, TARSC, SEAPACOH: EQUINET, Harare.

Executive summary

Parliaments can play a key role in promoting the right to health in the region, particularly in helping to oversee and realise state commitment to health rights. To better understand and support the practical implementation of this role, EQUINET, through the University of Cape Town (UCT), the secretariat at the Training and Research Support Centre (TARSC) and the Southern and East African Parliamentary Alliance of Committees on Health (SEAPACOH) implemented a questionnaire survey in September 2008 to explore and document the work and experiences of parliamentary committees on health and their understanding and engagement with human rights. This report presents the findings of the section of the questionnaire on parliament processes and work on health rights.

Parliamentary committees' legislative work has rarely been framed in terms of the right to health, even though much of its review of new and revised legislation and policy affected and spoke to the right to health directly. Knowledge of the purview and application of international human rights and related laws pertaining to the right to health was found to be limited. Parliamentarians were more likely to be familiar with Trade-related Aspects of Intellectual Property Rights (TRIPS) applications and with the provisions of the Abuja Declaration than with the substantive content of the right to health, as contained in the International Covenant on Economic, Social and Cultural Rights (ICESCR), its General Comment 14 or the African Charter on Peoples and Human Rights. All of these conventions, when ratified by states, impose substantial regulatory and programmatic obligations on governments. Therefore, important gains could be made if parliamentarians were able to analyse, interpret and integrate international human rights agreements into their parliamentary work.

Nonetheless, parliamentary debates on health were frequently able to draw on human rights claims to increase the effectiveness of arguments for the adoption of health policies and to influence resource allocation in favour of health and towards meeting the needs of vulnerable groups. Many of these successes are related to areas considered essential components of the right to health in terms of international benchmarks. Despite this, parliamentarians expressed diverse opinions as to how effective their interventions were in the budget process, highlighting the potential benefits of a rights analysis to strengthen claims for health in the budgetary process.

Public engagement with parliamentary committees took many forms, and in many cases, civil society submissions invoked rights arguments that were important in positively influencing the decision-making process. Typically, these claims related to resourcing decisions and were uncommonly directed at other rights issues, such as anti-discrimination measures. Engagement with media was also dominated by high-profile issues attracting public disquiet, although some parliamentarians reported use of media to raise awareness of rights issues and promote better uptake of available services. In general, public participation was regarding as very valuable for parliamentary processes.

Parliamentarians were, in general, acute aware of the constraints placed on the realisation of the right to health, by resource limitations. This applied not only to limitations on the provision of services, but also on the capacity of parliament to support public participation processes needed to effect health rights. However, despite this high awareness of resource limitations as a barrier to health rights, there was relatively little familiarity with the concept of progressive realisation as a mechanism to make rationing and priority-setting decision more transparent and defensible within a rights framework. Important gains could be made if work around progressive realisation was able to integrate resource allocation decisions within a rights framework.

Furthermore, although not the main finding in the analysis, parliamentarians were also generally aware that beneficiaries of human rights claims can include individuals and groups who have less need and lower vulnerability, such as higher-income individuals, companies or groups with sectoral interests. Ensuring that parliamentary processes are able to preferentially provide access to decision-making processes for the most vulnerable and poor is an essential component of a human rights approach to health. In addition, parliamentarians' experiences confirm that rights are not just about individual claims but also about socio-economic entitlements for groups and for the community at large.

Parliamentarians were generally positive about the role of rights claims in improving communication between communities and health service providers. This was notwithstanding the potential for rights claims to be perceived by providers as a threat, at least initially, because they generate criticism and demands that may not be realistic. Nonetheless, all respondents were of the view that rights are good tools to mobilise community members to take action to promote health. Information is key to enabling communities to be informed and to understand how to take up health rights issues.

Many of the annual goals set by the committees relate to core obligations of governments toward the right to health. Casting health goals in a rights paradigm would add a greater urgency and level of accountability for delivery, once agreed on. Needs for support expressed by committees were generally related to finances, technical inputs, forums for dialogue, but particularly related to capacity building to use and engage with human rights frameworks for advancing parliamentary work on health.

The survey highlights the importance of building capacity amongst parliamentarians in the region to interpret and use rights-based analyses in their parliamentary roles and to build the scope and reach of parliamentarians' work to advance the right to health in the region. Inasmuch as respondents identified the need for further inputs, work on health rights should be a priority for engagement with parliamentary committees on health in SEAPACOH by EQUINET and other organisations seeking to promote health in east and southern Africa.

1. Introduction

Parliaments can play a key role in promoting the right to health and health equity. Much of this is contingent on applying their representative, legislative and oversight roles, including budget oversight, to a human rights perspective on health (EQUINET et al, 2008a and 2008b). All countries in the region have signed and/or ratified a number of international human rights agreements that impose obligations affecting the right to health on states (Kamupira and London, 2005), obligations that may or may not be fully appreciated by parliamentarians. Further, human rights approaches are key to creating the space for, and are strengthened by, civil society mobilisation (London, 2003; London, 2007; London, 2008) so the role of parliamentary systems in promoting citizen engagement is particularly relevant to advancing health equity.

When the World Health Organization (WHO) adopted the primary health care (PHC) approach in 1978 and declared that 'the people have the right and duty to participate individually and collectively in the planning and implementation of their health care', it was not just advancing a model for health care that intended to address growing health inequalities of that period, but was also recognising that civil society oversight and participation in health care was a key mechanism for the achievement of 'Health for All' (World Health Assembly, 1978:6, paragraph IV). More than three decades later, these lessons remain as important as ever, precisely because of the impact of globalisation, trade agreements and major communicable and non-communicable diseases for the attainment of health equity. More importantly, our increased understanding of the social determinants of health has extended the purview of civil society engagement – not only in shaping health care, but also in influencing the conditions that determine health (Marmot et al, 2008). In rights terms, it is now well recognised that the right to health is more than just about rights to health care, but must extend to 'the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information' (Committee on Economic, Social and Cultural Rights, 2000: paragraph 11).

Recent work has built on the provisions of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the General Comment 14 to address the application of the right-to-health framework to health systems (Hunt and Backman, 2008) offering approaches that focus not only on individual rights or on sectoral interests, but on using rights to build sustainable health systems based on equity and social justice (Backman et al, 2008). However, the role of parliamentary processes in the adoption of human rights to build sustainable health systems has received little attention. As pointed out elsewhere (for example, Loewenson et al, 2009), there are a number of documented examples of how parliamentary roles have been exercised in east and southern Africa (ESA) to prioritise health in budgets, monitor the performance of the executive, strengthen laws protecting health, reiterate the need to redress inequity in health and promote sexual and reproductive health on the public agenda (EQUINET Steering Committee, 2007). Given the growing international movement to harness human rights to promote equitable health systems, the potential of a health rights approach in parliamentary work offers potentially strong mechanisms to further advance equity-oriented public policies and programmes for health.

Towards this end, 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 ESA 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 network 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 and AIDS, tuberculosis, 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 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.

This report, the result of work conducted by researchers from the University of Cape Town (UCT) and the University of the Western Cape (UWC) through EQUINET's health rights theme and with the collaboration of the Training and Research Support Centre (TARSC) and SEAPACOH, provides a first insight into how parliamentarians in the region understand and implement rights-based approaches to health in their work, and explores opportunities for extending this into a collaborative programme of action in future.

A questionnaire survey was implemented in September 2008 to explore and document the work and experiences of parliamentary committees on health. The questionnaire, developed jointly with SEAPACOH, included questions on general progress on parliament work on health and a section dealing specifically with the knowledge and understanding of human rights and the right to health amongst parliamentarians. This report focuses on the health rights issues and a companion report deals with the general experiences of parliamentary committees on health in health equity work (see Loewenson et al, 2009).

2. Methods

A questionnaire was developed for the work, based on priorities identified by EQUINET and SEAPACOH and on the research aim given above. The questionnaire was reviewed at a SEAPACOH planning meeting in November 2006 and finalised thereafter. It was then administered to parliamentarians attending the regional meeting of parliamentary committees on health in east and southern Africa, in Munyonyo, Uganda, from 16–18 September 2008. The meeting gathered members of parliamentary committees responsible for health from twelve countries in ESA, 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 20 members of parliament (MPs) or parliamentary staff from ten committees on health in the region, namely 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 respondents, who were either committee members (parliamentarians) or researchers/clerks. Fifteen of the respondents were MPs and five were clerks of the committees. Both clerks and MPs had knowledge in the areas of the questionnaire, so they were included. It was noted that, with the different terms and turnover in parliaments, the institutional knowledge of all MPs might not have been the same so, where more than one response could be obtained, this was encouraged. A total of twenty respondents completed the form but one respondent's answers were not usable for the present analysis.

The questionnaires were analysed using the Microsoft Excel package. This report focuses on the analysis of the views and experiences of rights to health, although general information on committees' work, as captured in a companion report, was included where appropriate (see Loewenson et al, 2009).

Respondents were assured that any individual information collected would be kept completely confidential and only aggregated data by country would be presented in any reports. Ethical approval for this study was obtained from the University of Cape Town Health Sciences Faculty Research Ethics Committee (ref # 310/2005) and consent was obtained from respondents prior to the interviews.

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 that 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. Moreover, the researchers were involved in providing an input to the programme of the SEAPACOH meeting. Because not all respondents (less than half) were interviewed before the input was given, responses may therefore overstate true knowledge and understanding. This shortcoming is discussed further below.

3. Results

This section presents the results of the analysis of the questionnaires. The results are organised as follows: first, we explore general parliamentary activities and their relationship to health rights and then we examine key issues related to the right to health, namely international human rights law, the challenge of resource limitations, the role of progressive realisation of the right to health, the issue of who claims rights in society, rights and community mobilisation, and how rights pertain to the goals and support needs of parliamentary committees.

3.1 General parliamentary activities and their relationship to health rights

As reported elsewhere (see Loewenson et al, 2009) parliamentary committees reported on two main arenas of work: legislative roles and oversight actions, both of which are integrated with civil society engagement.

Legislative roles that were reported included reviews of existing legislation (reported by four respondents) and tabling of new legislation on health (reported by three). In only two instances were rights issues explicitly cited as important. In one country (Zambia) a process of constitutional reform was reported as being underway and parliament was proactive in aiming to ensure that the right to health, as one of a range of socio-economic rights, would be justiciable. This aim was achieved by submitting a recommendation to the national Constitutional Reform Commission. In another response, it was noted that consideration of the national health bill was guided by the view that 'health is the fundamental right of every citizen'. Legislative work of parliaments was not specifically linked to health rights, although the specific laws reported as being under review applied to areas that are replete in health rights implications (such as HIV and AIDS, and maternal and child health). For example, General Comment 14 on the right to health specifically cites measures to 'improve child and maternal health, [and] sexual and reproductive health services, including access to family planning, pre- and post-natal care, [and] emergency obstetric services' as part of the right to health and therefore part of governments' obligations to fulfil rights (Committee on Economic, Social and Cultural Rights, 2000).

One respondent reported on a private member's motion to ensure adequate government support for the funding of medical research, which speaks to governments' obligations to ensure that all people realise their rights to enjoy the benefits of scientific progress and its applications (refer to Clause 15 of the ICESCR). Notably, few committees reported having incorporated Trade-related Aspects of Intellectual Property Rights (TRIPS) flexibilities in their national laws, even though such measures may make an important contribution to realising the right of access to health care for poorer countries. Committee members from only three countries reported that they had done so, while committee members from four countries said that they had not and a further three were unaware of what had been done in this regard. One respondent indicated that the matter of TRIPS flexibility was 'not in my field' and that it was regarded as a matter for the executive.

In addition to their legislative roles, they reported a wide range of areas of oversight in their parliamentary work in health. These included: drawing on public input and debate in the budgeting process (eight out of nine responding committees, or 89%); monitoring of health budgets and expenditure (eight out of nine responding committees, or 89%); and other oversight roles (eight out of nine responding committees, or 89%).

Almost all respondents (18 of 19) indicated that parliamentary committee members had been active in asking questions on health in parliament in the preceding year that had led to action on the part of the executive. These were most commonly questions related to budget allocations (three respondents, of whom two were questions focused specifically on reproductive health and on maternal and child health respectively), human resources (two respondents) and issues of corruption, drug shortages and access to health care (one respondent each). In all cases, respondent expressed the view that parliamentary intervention led to remedial action by the executive. The arguments used in parliament around these interventions drew on rights arguments in about half of these cases. For example, the right to life was invoked in arguments to increase resources for reproductive health and the prevention of maternal mortality, access to health care (and financial obstacles related to access) was used to establish service level agreements between government and services provided by non-governmental agencies and organisations in one country, and also to redress problems of unavailability of drugs and conditions for health personnel in a second country. The right of access to health care was also used to support the tabling of a motion to increase funding for maternal and child health by raising awareness amongst other parliamentarians. Many of these successes related to areas that are included in provisions outlining the essential components of the right to health and the state's core obligations in benchmarks provided by General Comment 14 of the ICESCR. Interestingly, some victories were seemingly won without reference to rights arguments. For example, increasing the health budget in one country was said to have been accomplished without a specific reference to health rights arguments.

The expressed effectiveness of committees in influencing the health budget varied widely. Slightly more than half the committees expressed the view that they were able to exert some influence over the health budget, while four committees expressed a contrary view. Influence over budgets was less feasible once the final budget was presented in parliaments but was more practical as part of a process of consultation with the executive to shape the budget and elicit shifts in allocations within an overall budget framework. A rights analysis would help to question the parameters of the overall envelope for health by giving parliamentary committees greater strength in arguing for more resources for health (to meet state obligations towards the right to health), rather than arguing about how limited resources should be distributed or re-distributed within health. Moreover, a rights analysis would also enable health parliamentary committees to include in their purview budgetary allocations to the social determinants of health, many of which lie outside the health sector.

Engaging civil society in oversight was typically accomplished through meetings with civil society groups, public hearings, constituency visits, participation in policy workshops and information exchange (involving briefs, papers or release of discussion documents), although specific actions such as participation in public media and visits to health facilities were used to supplement public engagement. All committees reported some form of engagement with civil society, the most common being public hearings (16 out of 19 respondents, or 82%) and meetings with civil society groups (14 out of 19 respondents, or 74%. Participation and involvement of civil society in policy processes was reported as being common and mostly reported as valuable (14 out of 19 respondents, or 74%).

Notably, nine respondents indicated that civil society submissions to parliament invoked rights arguments, and all nine agreed that such rights arguments were an important factor in coming to a decision on the issue at hand. For example, claims to reproductive health rights were successfully used to enhance funding allocated to reproductive health and to promote parliamentarians' capacity to undertake constituency visits to gain a better understanding of reproductive health needs. Claims regarding disability were also used to improve access to social grants. Rights arguments were used to boost transparency in the utilisation of public money by encouraging parliamentarians to trace financial expenditures in the health ministry in one case. In general, when interpreting how rights claims were used in influencing decisions, it appeared that rights were synonymous with any action related to resource allocation – either to increase resource allocation overall for health (two respondents) – or for specific target areas (two respondents) – or to improve transparency in resource allocation.

Few respondents reported engagement with civil society actors that related to so-called negative rights (where the state is expected to refrain from actions that violate rights, which are supposedly cost-free actions) or to issues of quality of care. This may reflect either the reality of what civil society brings to parliamentary engagement in the region or what parliamentarians interpret to be rights arguments.

In engaging the media and raising issues for public debate, parliamentary committees have used media to address three main categories of issues. Firstly, 'hot' issues such as drug shortages (reported by three respondents) have been a focus of media attention, which has enabled the parliamentary committees to press government into corrective action. Secondly, strategic policy areas such as reproductive health (four respondents) and mental health (one respondent) have received media attention which has raised public awareness of these issues and, for example, helped to promote better uptake of antenatal services. Lastly, public and media debates have strengthened parliamentary processes related to legislative and policy adoption.

3.2 International treaties, rights commitments and health

EQUINET research conducted by Kamupira and London in 2005 noted that, of the 14 SADC member states at the time, all had ratified the International Covenant on Civil and Political Rights, as well as the African Charter on Human and Peoples' Rights (ACPHR), and 11 had ratified the International Covenant on Social, Economic and Cultural Rights (ICESCR). Of the 15 countries in ESA, 11 had enacted laws that provide for compulsory licensing and six for parallel importation of medicines, while eight of the 15 would qualify as least-developed countries, which would have until 2016 to become TRIPS compliant, raising the possibility of important health equity-promoting interventions to enhance access to health care (Mabika and Makombe, 2006). The reach of international agreements that relate to health is therefore quite extensive in relation to countries in the region.

When asked about international treaties relevant to the right to health ratified by their countries, respondents rarely reported the main international conventions (only two respondents identified the ICESCR and/or the ACPHR). Rather, they tended to focus on non-binding agreements (such as the SADC protocol on health – one respondent – and the Abuja Declaration – three respondents) or trade agreements. Five respondents declared no knowledge of agreements impacting specifically on health and some indicated a strong need for inputs to brief parliamentarians. Only one respondent expressed the view that it is the executive's responsibility to be aware of and table such matters for parliamentarians.

When prompted further about their awareness of provisions for the right to health in these international agreements, awareness was still relatively low, with about half or fewer respondents able to confidently identify relevant conventions (see *Table 1*). At least half of participating parliamentarians had already been part of an input to the SEAPACOH meeting session on health rights prior to completing the survey, so this figure may over-inflate the true levels of awareness. Notably, General Comment 14 of the ICESCR – regarded as the definitive statement on the right to health – was least well known amongst all the treaties and conventions as pertaining to health. The lack of familiarity undermines parliamentarians' ability to critically analyse the implications of these treaties and their role in domesticating such treaties in national law. This indicates an important need for capacity building with parliamentarians given the powerful role of General Comment 14 and the provisions of the ICESCR and the ACHPR for health rights in the region. Notably, only one respondent spoke about Africa developing its own protocols before adopting international ones. He argued that, because African countries share similar problems that are different to international ones, there should be uniquely African responses. This is exactly what the African Charter on Human and People's Rights seeks to do, melding international human rights law to an African context appropriate to local cultures and perspectives.

Table 1: Parliamentarians' reported knowledge of international and regional agreements

Regional and international agreements	% total respondents aware of the agreement (n=19)	% country committees reporting awareness of the agreement (n=10)
International Covenant on Civil and Political Rights	31.6	6 (60%)
African Charter on Human and People's Rights	47.4	9 (90%)
International Covenant on Social, Economic and Cultural Rights (ICSECR)	36.8	7 (70%)
General Comment 14 to ICSECR	15.8	3 (30%)
Agreement on Trade-related Aspects of Intellectual Property Rights	31.6	6 (60%)
SADC Protocol on Health	36.8	7 (70%)

In understanding the right to health, there are different elements relevant to the parliamentary legislative and oversight roles, including consideration of the concept of resource limitations as a barrier to the realisation of rights, progressive realisation of the right to health, individual versus collective claims, and rights as effectors of community mobilisation. These are discussed below.

3.3 Resource limitations as a barrier to health rights

All respondents except one indicated they believed that cost is a barrier to implementing health rights. In general, poverty and under-development were commonly cited as problems, framed as pressures for competing needs in the face of limited resources, and manifested through a lack of availability of drugs and unaffordable user fees.

However, lack of resources was also cited as an obstacle for procedural rights, namely placing limits on government actions needed for civil society engagement in health. One respondent pointed out that the cost of effecting meaningful community consultation was a potential barrier and another raised the need for (and hence cost of) empowering poor communities with knowledge about their rights. There is increasing evidence that, without mechanisms to enable vulnerable groups to be agents in changing their own vulnerability, rights on paper are not effective (London, 2003 and 2007). Such mechanisms may also have financial implications and should be recognised as such.

3.4 Progressive realisation and health rights

Of ten responding committees, eight are from countries that have ratified the ICESCR, which includes a key provision relating to health that allows for progressive realisation of the right to health. Progressive realisation recognises that countries may have limited resources and so may not be able to provide the full extent of access to health care and to conditions needed for health immediately. It thus recognises the need to ration and prioritise funding. However, the provision also places such limitations within a time frame, emphasising that governments have obligations to gradually, over time, increase access to health care and the conditions needed for health. Put simply, governments cannot use a lack of resources as an excuse to do nothing, or worse, roll back existing health protection (so-called retrogressive measures) but must, over time, extend health rights and demonstrate how they plan to do so (London, 2003; Backman et al, 2008).

Only two respondents appeared to understand the implications of progressive realisation within a rights framework when asked. In fact, respondents were more likely to indicate they did not understand the concept and to request further input on the issue. Given the importance of this measure in the right to health, it would an important area on which to focus future work, since it can open opportunities for meaningful engagement with civil society (London, 2007).

Relatively few countries (two out of 10) reported reaching the Abuja target of 15% of government expenditure on health. Thus, the concept of progressive realisation highlights the need to monitor progress on the availability of health resources. Of ten country committees, six (60%) reported monitoring the performance of their countries on the Abuja commitment while four (Botswana, Kenya, Mozambique and Namibia) indicated there is no monitoring.

3.5 Rights claims preference organised groups and exclude marginalised groups

In the literature on health rights, there is much concern that rights claims will preference groups who are more organised and vocal at the expense of poorer, more marginal communities, thereby leading to inequities in resource allocation (London, 2003). This is a critical challenge facing parliamentarians whose role is to be responsive to their constituencies while still providing national leadership on health.

When asked who will benefit from rights claims in health, responses suggested a widespread belief that all persons stood to benefit (nine out of nineteen respondents or 52.6%) – see *Table 2*. However, when prompted about whether particular groups stood to benefit, slightly more respondents (nine out of nineteen) recognised that higher-income individuals (which included politicians, ministers and senior public officials) stood to benefit more than low-income individuals (seven out of nineteen respondents). The main reasons they believed low-income individuals would benefit were because these individuals were dependent on public sector services and government also had obligations regarding the right to health (typically expressed through free health care for all or specifically for vulnerable groups).

Table 2: Who benefits from rights claims?

Parliamentarians' responses	**No. of responses (n=19)**
All individuals	9 (47%)
Higher income individuals	9 (47%)
Low income individuals	7 (37%)
Communities	8 (42%)
Particular social groups	4 (21%)
Organisations with their own particular interests	4 (21%)
Private companies	4 (21%)

Note that answers are not mutually exclusive

As can be seen from the table, respondents identified the following groups as beneficiaries of rights claims: organisations with their own particular interests (five respondents), companies (four respondents) and particular social groups (four respondents). Although only one respondent identified high-income groups as the sole beneficiary of rights claims, it is clear, therefore that, among parliamentarians in the region, different sectoral interests may be using rights arguments to advance health claims, and that such interests may not always preference the poorest and most marginal communities. Since the true value of human rights approaches is to prioritise the needs of the most vulnerable in society (London, 2008), this finding points to an important need to build the capacity of parliamentarians to cope with and translate different civil society claims into a pro-poor agenda – if rights are genuinely going to advance health equity.

A second aspect to the reservations voiced by respondents regarding rights is the preference given to individual claims of collective good. While this is a spurious argument (London, 2003), it is interesting to note that parliamentarians' experiences rated communities and groups (nine respondents) as beneficiaries as often as individuals (also nine respondents). So, while the notion that human rights benefit individuals at the expense of a collective good has been used to discount the value of human rights for developing countries (de Cock et al, 2002), this has not been the experience in the region. This finding supports arguments detailed elsewhere (see London, 2003; London, 2007) that the realisation of socio-economic rights by necessity involves services to collectives and that individual claims are not inconsistent with social benefits, even in resource-limited settings. Interestingly, one respondent argued that 'cushioning' the disadvantaged and vulnerable 'benefits everybody' indicating a recognition of the social nature of the right to health and the positive externalities associated with protecting health rights. Such claims have been used to support the idea of a framework convention on the right to health whereby richer nations will benefit from the protection of health in poor nations on a global scale (Gostin, 2007).

3.6 Community mobilisation and communication with health service providers

Most respondents expressed positive views about the role of rights claims improving communication between communities and health service providers. For example, community action can help to highlight shortages, identify community needs and build community ownership of services and so act as an incentive to positive behaviours. However, two respondents acknowledged that rights claims may be perceived by providers as a threat, at least initially, because they generate criticism and demands that may not be realistic. Such concerns have also emerged in research addressing patients' rights in the context of the South African Patients Rights Charter (London et al, 2006). Nonetheless, all respondents were of the view that rights are good tools to mobilise community members to take action to promote health. Information is key to enabling communities to be informed and to understand how to take up health rights issues.

3.7 Goals and support needs

In the goals identified by committees for 2007, there were both general oversight, communication and health goals, as well as very specific areas of focus. These are further discussed in the complementary EQUINET discussion paper 73. Some of the health goals relate to core obligations of governments toward the right to health, such as improved food security, reduction in infant and maternal mortality and increased (universal) access to health care, but were not framed in a rights paradigm. Casting health goals in a rights paradigm would add a greater urgency and level of accountability for delivery, once agreed upon, since a rights framework demands greater accountability from government and expects core obligations to be fulfilled without reference to progressive realisation (London, 2008).

Needs for support expressed by committees were largely related to finances, technical inputs, information and forums for dialogue and capacity building to enable them to attain their goals. Opportunities for raising 'awareness in our constituencies to empower them further…,' 'sensitisation seminars' and 'capacity building on people's empowerment' all provide ways in which parliamentary committees can support building the agency of vulnerable groups to challenge the conditions that make individuals and groups vulnerable and thereby realise health rights. Committees, in identifying needs for technical support, such as research capacity, also highlighted the importance of building their own understanding and ability to engage with analysis and interpretation of rights-based approaches in their work.

For example, information on health-related and human rights-related declarations and conventions, materials on the right to health and related policy briefs were all cited as potentially valuable. EQUINET has already produced two policy briefs on human rights and health equity (see EQUINET et al, 2008a and 2008b), together with parliamentary briefs on other issues (AIDS and health systems, and fair financing) and policy briefs on a range of issues. Further theme-based policy briefs relating to health rights were suggested by the parliamentarians as being useful to them, particularly on benchmarking, more easily accessible information on declarations and treaties, materials on reproductive health rights, financing and communications packages for outreach purposes. Support for ongoing networking and exchange programmes was also expressed. Six of the ten committees (60%, namely those of Botswana, Malawi, Tanzania, Uganda, Zambia and Zimbabwe) had respondents reporting that they had seen and used the EQUINET parliament and policy briefs, and all of these indicated that they found the briefs useful.

4. Conclusions

By ratifying international conventions, states indicate their willingness to domesticate the provisions of the conventions in their national law and programmes. Given that many countries in the region have signed, if not ratified, most of the international agreements that affect the right to health, there is a large legislative role for parliamentarians to put effect to these commitments (Kamupira and London, 2005). Furthermore, many countries in the region have provisions in their constitutions that protect the right to health.

The survey highlights the importance of building capacity among parliamentarians in the region to interpret and use rights-based analyses in their parliamentary roles. Relatively few respondents were explicit about rights-based considerations in their work, despite the fact that their interventions were critical to a number of different aspects of realising the right to health. Inasmuch as respondents identified the need for further inputs and support, work on health rights should be a key priority for EQUINET support to SEAPACOH. For example, the normative content of the right to health, elaborated in the ICESCR and its General Comment 14 include specific reference to a number of priority areas identified by the committees, such as reduction of maternal and infant mortality and reproductive health services, as well as outlining minimum core obligations that state parties to the ICESCR are expected to comply with. This will, to some extent, strengthen the hand of portfolio committees seeking to increase the overall budget for health, and enable enhanced influence over the budgetary process, not only in the later stages when incremental reallocations are all that are meaningfully possible, but also in the earlier stages when budget parameters are set.

However, a rights-based approach is not simply about legal accountability but embraces a range of ways to monitor, support and hold government and other actors to their rights responsibilities. Different components of a human rights approach to health include:

- the use of human rights standards and norms to develop policy and programmes;
- the use of human rights standards and norms to analyse and critique government performance, sometimes combined with a monitoring function;
- the use of human rights standards and norms to facilitate redress for those who suffer violations of their rights; and
- the use of human rights standards and norms to support advocacy and civil society mobilisation.

Therefore, a second opportunity for greater engagement with health rights lies in the mechanisms and avenues for civil society participation and interaction with parliamentary health committees. As both part of the right to health, as well as being instrumental to the substantive content of achieving the right to health, stronger civil society engagement in health policy formulation and oversight of implementation is critical. Parliamentary committees have many opportunities to foster such cooperation in ways that will strengthen health rights in the region. Evidence from this survey suggests that such civil society participation has been effective in using rights arguments to influence policy decisions to advance health and has successfully built better long-term communication with service providers, notwithstanding caveats relating to short-term negative perceptions.

A third opportunity to strengthen parliamentary work to realise the right to health relates to emphasising the intersectoral nature of health and the social determinants of health, many of that lie outside of the immediate health sector. Although not immediately obvious from committees' current work, where most emphasis was placed on health service challenges, a number of committee members identified key elements of the right to health outside of the health sector, such as food security, social grants and education, all of which are critically important for health. Bringing the lens of state obligations to these determinants of health will be a major contribution to protecting and promoting health in the region.

State obligations regarding the right to health take different forms (*Table 3*), three of which are clearly outlined in international human rights law (London, 2003). The fourth obligation, to promote rights, emerges from the recognition that without mechanisms to make rights real for the most vulnerable of communities, rights remain too abstract to have real impact. This state obligation to promote rights has been incorporated into the South African Constitution, for example.

Table 3: State obligations regarding the right to health

Obligations	Definitions and examples
The obligation to respect rights	The state must refrain from adopting laws or policies that violate people's rights. Examples: · Health care delivery should not discriminate against women, older people, people living with HIV/AIDS or disabled people. · Workers should not be denied opportunities to belong to trade unions that would campaign for safer working conditions.
The obligation to protect rights	The state must protect peoples' rights from violation by third parties. Examples: · The state should pass regulations to prevent pollution of people's water supplies by industrial effluent. · The state should regulate the insurance industry to ensure that it does not discriminate against poor people, people with low literacy or people with HIV.
The obligation to fulfil rights	The state should take appropriate budgetary, planning and programmatic measures to enable people to realise their rights. Examples: · The state must develop national plans and allocate sufficient resources to ensure that, as far as is reasonable, people are able to access health care, and to progressively realise this over time. · The state should ensure the provision of adequate housing, whether through direct state provision or through a system of state subsidisation, by which people are able to live in healthy homes, conducive to well-being.
The obligation to promote rights	The state should take measures to ensure that people are able to access their rights in laws and the Constitution. Examples: · The state should be responsible for a programme of public education and information provision to people so that everyone is informed of how they can exercise their rights. · The state should establish institutional mechanisms and structures that enable people to lodge complaints or seek redress when their rights have been violated, such as a complaints mechanism, ombuds office or the Human Rights Commission.

Of note is that, whereas reported interactions of regional parliamentarians with civil society typically related to issues of **fulfilment** of the right to health (namely active state measures required to realise the right to health), relatively few interactions were related to so-called violations of the obligation to **respect** rights (for example discrimination or violations of the right to life) or to protect rights (from third party interference). Similarly, in their interactions with the media, parliamentarians have typically intervened on issues requiring increased government allocation of resources, rather than redressing policies that were discriminatory. This may reflect a situation in the region where such violations no longer occur, or are not brought to parliamentary fora for action because of other existing avenues for redress. Alternatively, it may be that parliamentary committees in their work have to reinterpret the specific cases within the context of a health system and so elevate individual cases to policy or legal responses where parliamentarians can have the greatest effect.

The survey suggests that with a better grasp of a number of key issues related to the right to health, parliamentarians may be able to make significant contributions to improving health equity in the region. These key issues include:

- how to deal with policy choices under conditions of severe resource constraints and, particularly, the application of the concept of progressive realisation of the right to health;
- how to balance individualist concepts of rights with rights claims that benefit groups so that it is not simply a question of those who shout the loudest getting access to decision making processes; and
- structuring engagement with civil society to preference groups who are most marginalised – a pro-poor application in human rights practice.

Support for parliamentary committees is therefore important to help build the scope and reach of parliamentarians work to advance the right to health in the region. Many of the concerns are comment across countries, such as greater familiarity and application of international rights conventions for advancing health rights. At the same time, attention to challenges that are specific to local concerns will also be important and require stable links with national technical and civil society partners to provide specific information and support.

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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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